

- Delhi:ICMR;2006 [cited 2014 Sep 2]. Available from: http://icmr.nic.in/ethical_guidelines.pdf
5. National Commission for Enterprises in the Unorganised Sector. Report on conditions of work and promotion of livelihoods in the unorganised sector. New Delhi: NCEUS; 2007 [cited 2014 Sep 2]. Available from: http://www.prsindia.org/uploads/media/Unorganised%20Sector/bill150_20071123150_Condition_of_workers_sep_2007.pdf
 6. Petryna A. When experiments travel: clinical trials and the global search for human subjects. New Jersey: Princeton University Press; 2009: 272 pp.
 7. Fisher JA. Coming soon to a Physician Near You: Medical Neoliberalism and Pharmaceutical Clinical Trials [Internet]. *Harvard Health Policy Rev.* 2007 Spring [cited 2014 Sep 2];8(1):61–70. Available from: <http://www.jillfisher.net/papers/hhpr.pdf>
 8. Department-related Parliamentary Standing Committee on Health and Family Welfare, Government of India. Fifty-ninth report on the functioning of the Central Drugs Standard Control Organisation (CDSCO). New Delhi; Rajya Sabha Secretariat, Parliament of India; 2012 May [cited 2014 Sep 2]. Available from: <http://164.100.47.5/newcommittee/reports/englishcommittees/committee%20on%20health%20and%20family%20welfare/59.pdf>

Health equity for internal migrant labourers in India: an ethical perspective

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Abstract

In the developing countries, internal migration is a survival strategy for many labourers in search of a better livelihood and opportunities. It is inevitable that many of them will leave their home towns and villages in the coming years, and that the future will see an increase in the number of migrant labourers in developing countries such as India. Migrant workers face unique health problems and it is important for the health system to prepare itself to face these. In this context, the system will need to address certain key ethical issues. There is plenty of published literature on international migration and its ethical aspects. However, there is a scarcity of information on ethical issues relating to internal migration. This article examines these issues in the context of India. It addresses the issues of equity, non-discrimination, the provision of culturally competent care to migrants, allocation of scarce resources, and achieving a balance between benefits and risks for migrants. Our analysis should be considered while planning any healthcare intervention for internal migrant workers in all developing countries.

Introduction

Situation of internal migrant labourers in India

Historically and culturally, internal migration as a coping strategy for earning a livelihood has been a pronounced trend in the entire world. There is ample evidence of both voluntary and forced migration, which may result from cultural and religious persecution, natural disasters, developmental projects such as dams, a failed monsoon and the consequent famine, and the search for better livelihood options (1). Poverty and indebtedness are the most important factors that lead to migration. Workers migrating within a country usually move from less developed regions to more developed ones. In India, there are significant inequities in the development of the various states, with states such as Kerala, Tamil Nadu, Gujarat and Maharashtra having attained a higher level of development than Uttar Pradesh, Bihar, Jharkhand and

Chhattisgarh (2). Thus people move from the underdeveloped to the developed states. The total number of migrants as per the census of 1971 was 167 million. This rose to 213 million in 1981, 232 million in 1991 and 315 million in 2001. The figure was revised to about 400 million in 2004-5 (3).

Some scholars argue that the actual number has been grossly underestimated. They claim that the census and National Sample Surveys do not capture short-term migration, rural-rural migration, and women's migration for non-marital reasons and trafficking, all of which contribute significantly to migration (4). The insufficiency of data on internal migration is typical of most developing countries and does not allow one to appreciate the true magnitude of the issue. Migrant labourers, who account for roughly one-third of India's population, form a special group as far as the delivery of healthcare is concerned. Internal migrants the world over remain on the fringes of society. They work long hours, are paid low wages and work in unsafe environments, besides the other ills of social isolation and poor access to basic services, such as education, water, sanitation and health (5). This paper focuses mainly on unskilled and semi-skilled migrant labourers who migrate from low-income states to higher-income states in India.

Social determinants of health among migrant labourers

As mentioned in the introductory paragraph, the main reasons for internal migration in India are poverty and indebtedness. Labourers migrate from the underdeveloped states to the more developed ones to find work to fight poverty and indebtedness. Poverty is a universal determinant of health among most migrant workers, strongly influencing their health status. It is associated with malnutrition, a poor overall health status, poor access to preventive and curative health services, and higher mortality and morbidity rates (5). This determinant remains unchanged despite the migrant workers' relocation to greener pastures. Sometimes, the reason for migration

is dire impoverishment due to a natural disaster, floods or famine. Once again, such migration perpetuates the cycle of poverty and ill health. Migration due to trafficking or internal displacement due to political unrest also lead to the disruption of most determinants of health (6).

Cultural beliefs and practices are an important determinant of health among these populations. One of the cultural practices which have a direct impact on health is open-air defecation. As this practice is common in the rural areas of India, most rural migrants moving to crowded urban areas find it culturally unacceptable to use toilets. This naturally creates a significant problem of sanitation in the densely populated settlements in which they live. Another important determinant of health is the language. India is home to diverse cultures and languages, and when people from one region migrate to another, language becomes an important barrier to communication. This complicates the delivery of effective healthcare services.

Unique health problems of migrant labourers

As may be inferred from the preceding paragraphs, the labourers' migrant status, their deprivation in terms of the social determinants of health and their poverty put them in a precarious position that predisposes them to unique health problems.

Spread of communicable diseases

Each state has a unique epidemiological profile of communicable diseases. For example, Orissa is hyper-endemic to malaria. When labourers from Orissa migrate to some other state, such as Kerala, where the potential vector is available but the disease is not present, they introduce the disease in the state. Several new cases of malaria have been reported in regions where the disease was absent, and this has been attributed largely to migration (7). While responding to outbreaks of diseases, the public health system often focuses on diseases which are endemic in the region. When an outbreak is caused by the importation of the disease-causing agent by migrant workers, the health system is unable to respond promptly because it is not prepared for this situation. Kerala, one of the most developed states in India with respect to health indicators, had nearly eliminated malaria. However, there has been a resurgence of malaria in the state due to a growing influx of migrant labourers from various malaria-endemic parts of the country. The Kerala health system has been suddenly faced with an increased demand for anti-malarial drugs, but the supply is not adequate to meet the need. This is a typical example of how communicable diseases can become a problem in the wake of migration.

Reproductive and child health

Many labourers who migrate with their families are in the reproductive age group. Several of them become pregnant and have their deliveries in the area to which they have migrated. These pregnant women, mothers who have just had babies and newborn babies fall outside the safety net of the reproductive and child health services of the state. It has

been reported that they are also unable to avail themselves of the maternity cash benefit scheme for institutional deliveries, the *Janani Suraksha Yojna*, due to insufficient documentary evidence of their residential status (8,9).

Violence against women

In the past, women used to migrate along with their husbands to help them with the housework while they eked out a living. In recent years, there has been an increase in the number of women who migrate independently in search of work (10). Women form more than half of the interstate migrant workforce. Ninety-two per cent of the 20 million domestic workers in the country are women and children, and 20% of these females are under 14 years of age (10). Women constitute more than one-third of the labour in the construction industry. Female migrant labourers face several important gender-based problems, including gender-based discrimination at work and violence. Several women are subjected to physical, verbal and sexual abuse at the workplace and their place of residence. Apart from this, emerging research shows that intimate partner violence is higher among migrant women than other women. Given the lack of a supportive environment and social system, this can have a significant impact on the physical and mental health of these women (11).

Child labour

Children who migrate along with their families do not get adequate opportunities for education. As a result of this, along with the poverty in which the migrants live, the children are pushed into child labour. They are often engaged in occupations which are as dangerous as those in which the adults are engaged. Thus, the children are exposed to health problems and occupational hazards similar to those faced by the adults. This hampers the overall growth and development of the child. It also contributes to increased childhood morbidity and mortality (12).

Adaptation, adjustment and psychosocial disorders

Migrant labourers do not have social capital and social support structures in the place to which they have migrated. They uproot themselves from their native place and move to a totally new environment, and initially, they face problems adjusting to the new sociocultural milieu. This gives rise to a good deal of psychological distress. The absence of strong social support perpetuates the psychosocial distress and has an adverse effect on the migrant labourers' mental health (13).

Occupational diseases

Migrant labourers are usually employed in the 3-D jobs – dangerous, dirty and degrading. These are jobs which the local population of the developed state would not take up and hence, labour is brought in from outside the state for the same wages and sometimes for less (same or less than what?). These jobs are invariably associated with more occupational hazards than other jobs. Migrant labourers working on construction sites commonly suffer from falls, injuries caused by machines, amputations and crush injuries (14). Though the employers are

required to provide personal protection equipment as per the labour laws, these laws are not heeded(15).

Key ethical principles of healthcare delivery to migrant labourers

Equity and avoiding disparities

Migrant labourers are at a significant disadvantage in the community into which they have migrated. They are in unfamiliar territory amidst strangers. They are also not familiar with the language and culture of the new place. In addition, they are discriminated against by the members of society, who feel that they “belong to another culture”. As a result of these factors, migrant labourers may be deprived of access to healthcare facilities and services. There is, therefore, an urgent need to prevent discrimination on the basis of these disparities (16).

Ensuring health as a human right

According to the UN Declaration of Human Rights, the “highest attainable form of health and well-being” has been described as a basic human right under the economic, cultural and social rights (17). The government is to ensure that all its citizens, irrespective of their state of origin or residence, enjoy the full realisation of this right. Since economic, cultural and social rights are not justiciable in the “here and now” manner, their realisation often remains a mirage. However, the realisation of favourable social determinants of health and access to healthcare services as basic human rights is an important ethical principle (13).

Efforts to mitigate negative impacts

While planning health services for migrant labourers, it is important not only to provide curative services, but also to create circumstances under which the negative health impacts of migration may be mitigated. For example, when there is an outbreak of a water-borne disease in a migrant construction colony, it is important not only to provide treatment to the patients and a proper water supply and sanitary and hygienic conditions; it is also important to make sure that the services are rendered in a culturally acceptable manner, and in a way that the migrant labourers can access and use. The availability of a healthcare provider who speaks the same language as the migrant labourers or of translators in the health system can go a long way in improving the health-seeking behaviour of the migrant labourers.

Ethical issues in delivery of healthcare to migrant labourers

Balance of risks and benefits

Migrant labourers are employed in jobs which the local people prefer to shun (18). An analysis shows that migrant workers most often take up jobs in the construction industry, with its inherent risks of accidents, injuries, crushes and falls; commercial sex work, associated with a high risk of sexually transmitted diseases; and brick kilns, in which they face the risk of burn injuries. Two population groups compete for the

healthcare services in a state – the local population and the migrant population. It is evident that the health risks are much higher among the migrant population than the other group and that the relative benefits they get from the health system are limited. On the other hand, the local population faces relatively lower risks and the benefits it enjoys are relatively higher. Sometimes, there is a distinct disregard for the moral agency of migrant workers as they are considered biological non-citizens. This form of discrimination calls the ethics of healthcare provision into question. A case study from a Chinese city that illustrates such discrimination may be found in Box 1. There is a need to assess the situation and incorporate measures to ensure a balance between risks and benefits. The following steps can be useful in establishing this balance:

- Inclusive planning of health service delivery in urban areas to ensure that the care of migrant workers is given special emphasis
- The allocation of a dedicated budget for the welfare of migrant labourers
- The inclusion of an occupational health unit at the primary care level to cater to the needs of the migrant workforce
- Dedicated outreach clinical services for migrant labourers at their worksites
- The extension of routine primary care services, such as antenatal care, immunisation, post-natal care and treatment for minor ailments, to migrant labourers through dedicated outreach programmes.

Allocation of scarce health resources

Health resources are scarce in developing countries such as India and there is intense competition for the resources available. World Bank reports state that India has less than 1 hospital bed per 1000 population and the doctor-to-population ratio is close to 1:1800 (20). Health is largely a state subject and the budget allocated to it comes mainly from the state revenue. Given the scarcity of healthcare resources in the states, there is intense competition between the local residents and interstate migrants. One may ask which of the two should receive the benefits of the scarce resources. The ethical issues involved in the allocation of resources are as follows.

Allocation of resources in the states

Most interstate migration is from low-resource states to high-resource states. The amount of funds allotted by the National Rural Health Mission and the Centre to the low-resource states is proportionately greater than that allotted to the high-resource states.

Higher demand for resources in states with lower allocation

Due to the large-scale influx of migrant labourers, and the poverty, mixed epidemiological patterns of diseases (the migrants bring different and unique illnesses into the state) and high exposure to occupational hazards that accompany this, the high-resource states have a heavy burden of morbidity. Therefore, there may be a greater need to allocate resources to these states to look after the needs of the migrant labourers.

Need-based versus entitlement-based allocation

The question arises as to whether the resources of a state should be allocated on the basis of the needs of the population or on the basis of entitlements. Being the tax-payers, the local residents are rightfully entitled to the resources. However, the needs of the migrant population are greater. This is the subject of yet another significant debate on the justice aspect of the allocation of resources.

One can apply Normal Daniels' framework of accountability for reasonableness to deliberate on this issue. The criterion of fairness can be met by taking four important steps – making reasonable decisions, ensuring that the decisions are transparent, seeing to it that they are subject to appeals and revisions, and finally, having a mechanism to enforce them (21). In the case of healthcare for migrant workers, evidence of the higher burden of health problems among this population should be collected and compiled. A baseline health survey of these labourers should be conducted to get a clear idea of their needs. This should be used as evidence to support the decision taken to allocate resources to migrant labourers. The next most important criterion is to publicise that decision. All the relevant stakeholders, including representatives of the local community and migrants, should know about and understand the decision on the allocation of resources. The decision should be open to discussion, appeals and revision. Greater allocation of resources should be allowed on a case-to-case basis, ie when the circumstances warrant it. Finally, the decision should be implemented and enforced.

Analysis of public health, human rights and ethical considerations

The provision of healthcare to migrant workers in India must take three important considerations into account. These are the public health, human rights and ethical considerations. The differences in the epidemiology of diseases in this population need to be taken seriously and warrant attention from a public health perspective. This paper has highlighted the various social determinants of health among migrant labourers and how these need to be addressed to protect the health of this population group. As for the consideration of human rights, health has been described as a basic human right. Therefore, the provision of good healthcare services should be seen as a matter of the fulfilment of a human right. There has been much discussion on the fact that migrants are often considered biological non-citizens and their human rights are neglected. We should make continued efforts to address this matter and measures must be implemented at the national and international levels to remedy the situation. Finally, from an ethical perspective, the effective allotment of scarce resources is of great importance, as is the achievement of equity in services for marginalised migrant workers. These three considerations have to be given equal importance while addressing the healthcare challenges arising from the increasing interstate migration in the country.

Initiatives for equitable delivery of healthcare to migrant workers

The Tamil Nadu story (19)

In January 2013, NGOs, labour unions and activists held a seminar to pass a resolution to urge the government of Tamil Nadu to organise dedicated child welfare services for the children of migrant labourers. The seminar was attended by a member of the National Commission for Protection of Child Rights. It pushed the government to pass a draft action plan on migrant child labour that had been framed previously. The key recommendations of the seminar were:

- To ensure the registration of all migrant labourers and issue temporary public distribution system (PDS) cards for subsidised food supplies
- To ensure the right to education for all migrant children
- To set up crèches for children below three years of age at the migrants' worksites
- To set up exclusive *anganwadi* centres (under the Integrated Child Development Scheme) for the children of migrant workers in the districts of Chennai, Kancheepuram and Tiruvallur, which see the maximum influx of migrant workers
- To form civil society monitoring groups for migrant welfare.

The outcome of the initiative is yet to be understood in detail as it has been in operation for a short period of time. But it would be very useful to understand the outcomes as it can direct future course of action in this domain.

The Kerala story

The Kerala government has taken several steps to deal with the challenges arising from the influx of migrant labourers. The most important among these are the introduction of a welfare programme for migrant workers. Under the programme, these labourers receive higher welfare benefits than before, assistance for medical care, assistance in the event of accidents leading to death and educational assistance for their children. The government has announced a few monetary packages according to the categories under the welfare programme. The Interstate Migrant Workmen (Regulation of Employment and Conditions of Service) Act of 1979 and the rules framed under it are being enforced in the state. The labour minister of the state and the Kerala Building and Other Construction Workers' Welfare Fund Board, through which the welfare scheme is being implemented, are working together. In return, the migrant labourers are expected to annually remit a minimal amount to the welfare fund by way of a contribution. The Labour Commissioner and the representatives of various trade unions have set up an advisory committee for the purpose of monitoring the programme. These steps are commendable and may serve as a model for other states to follow suit.

Construction workers' union in Rajasthan

Aajeevika Bureau is a local NGO in Rajasthan working towards the health and welfare of migrant construction laborers. The

International Organisation for Migration reports that Aajeevika has graduated from a small, local organisation, established in 2005, to one that runs in several areas that are the source and destination of migrant workers in western India. Jaipur and some places in Gujarat are among the places that have been identified as areas from which there is an especially high quantum of migration. Through a network of mini-centres, which the migrant workers can enter freely, Aajeevika Bureau offers them registration, a photo ID, training in skills, job placement, legal aid, financial services and opportunities for collectivisation. Aajeevika Bureau works both in source and destination regions, in the areas of construction, head-loading and rickshaw-pulling. By formation of effective social networks of migrant workers, Aajeevika Bureau has helped to establish spatial connection and contacts between migrants and also between migrants and their families. The organisation is growing day by day, as can be seen by the fact that two registered trade unions have emerged as a result of its activities. Aajeevika Bureau reported that in Jaipur, the

capital city of Rajasthan alone there were more than 200,000 undocumented migrant workers. The major successes achieved by 2010 were the registration of migrant construction workers and the issuance of photo IDs to them; mediation of disputes between the construction workers and their contractors, through fair documentation and dialogue; provision of assistance for placement in jobs in Jaipur; and large-scale enrolment of construction workers in state-run social security schemes for construction workers.

Conclusion

With the increasing quantum of migration within the country, the problem of providing effective healthcare services to migrant workers will assume greater proportions over the years. To avoid this scenario, we must make sure that our policies and programmes incorporate migrant health. This is important not only for the ethical reasons discussed above, but also because if health is to be realised as a human right, it has to reach all individuals in the country. The ongoing discussions about universal health access in the country should take the issue of the healthcare of migrant workers into account. For example, urban health plans should feature special interventions for migrant workers.

The issues discussed in this paper are applicable not only to India, but to all developing countries, in which internal migration is bound to be a survival option.

Competing interests

The authors have no competing interests to declare.

References

1. de Haan A. Migration and livelihoods in historical perspective: a case study of Bihar, India. *J Dev Stud.* 2002;38(5):115–42.
2. Deaton A, Dreze J. Poverty and inequality in India: a re-examination. *Econ Pol Wkly.* 2002 Vol 37 No 36 (September 7–13):3729–48.
3. Deshingkar P, Akter S. Migration and human development in India. Human Development Research Paper 2009/13; United Nations Development Funds; 2009.
4. Keshri K, Bhagat RB. Temporary and seasonal migration in India. *Genus.* 2010;66(3):25–45.
5. Kundu A, Sarangi N. Migration, employment status and poverty: an analysis across urban centres. *Econ Pol Wkly.* 2007;42(4):299–306.
6. Skeldon R. Trafficking: a perspective from Asia. *Int Migr.* 2000;38(3):7–30. doi: 10.1111/1468-2435.00113
7. Pai M, Zachariah A, Rose W, Satyajit S, Verghese S, Joseph A. Malaria and migrant labourers: socio-epidemiological inquiry. *Econ Pol Wkly.* 1997;32(16):839–42.
8. Mehrotra S. Social Insurance System for India's Unorganised Sector Workers: the case and the cost. *Indian Journal of Labour Economics.* 2008 April–June;51(2):183–96.
9. Subrahmanya RKA. Social protection of the workers in the unorganized sector. *Indian J Ind Relat.* 2013;48(3):460–70.
10. Banerjee A, Raju S. Gendered mobility: women migrants and work in urban India. *Econ Pol Wkly* 2009;54(28):115–23.
11. Raj A, Silverman JG. Violence against immigrant women the roles of culture, context, and legal immigrant status on intimate partner violence. *Violence Against Women.* 2002;8(3):367–98.
12. Mansuri G. Migration, school attainment, and child labor: evidence from rural Pakistan. *World Bank Policy Research Working Paper* 3945; 2006.
13. Rogaly B, Coppard D, Safique A, Rana K, Sengupta A, Biswas J. Seasonal migration and welfare/illfare in eastern India: a social analysis. *J Dev Stud.* 2002;38(5):89–114. doi: 10.1080/00220380412331322521
14. Schenker MB. A global perspective of migration and occupational

Case study

Discrimination against migrants during the SARS outbreak of 2003 (22)

Shenzhen is a city located on the border of China and Hong Kong. It is a cosmopolitan city with a huge population of migrants from all over China. Shenzhen has a sizeable floating population, with people commuting to and from the city for work every day. Historically, it is one of the rare cities which were built entirely by a migrant population. The year 2003 saw an outbreak of SARS in China. The public health system of Shenzhen focused systematically on quarantining the migrant groups from the city in a bid to contain the infection. There has been much discussion and debate on this public health intervention in the international bioethics circuits, and it has by and large been viewed as unethical. The intervention reflects that the authorities saw the migrants as biological non-citizens. The discrimination against the migrant population could be attributed to several important factors. Usually, migrants live in conditions of poor hygiene and sanitation and are perceived as health threats to the city. Due to the "floating" nature of their residence and the consequent difficulty in tracking them down for follow-up and preventive interventions, the public health authorities preferred to keep them out of the safety net. Public health professionals in the city had very little interpersonal interaction with the migrants. The migrants had more interactions with healthcare providers in the hospitals and clinics. Therefore, a sound moral engagement did not develop between the public health professionals and migrants. All these factors led to a disregard of the welfare and health of the migrants and a preference for catering to the needs of the local population. The case of Shenzhen is an illustration of the failure to adopt an ethical approach to public health.

- health. *Am J Ind Med*. 2010 Apr;53(4):329–37. doi: 10.1002/ajim.20834
15. Breman J. Footloose labour: working in India's informal economy. 2 ed. Cambridge: Cambridge University Press; 1996.
 16. World Health Organization. Health of Migrants: Report of the Secretariat [Internet]. Geneva: WHO; 2008 Apr 7 [cited 2014 Sep 28]. Available from: http://apps.who.int/gb/ebwha/pdf_files/A61/A61_12-en.pdf
 17. Assembly UG. The Universal declaration of human rights. Resolution adopted by the General Assembly 1948;10(12).
 18. Connell J. Kitanai, kitsui and kiken: the rise of labour migration to Japan. Economic & Regional Restructuring Research Unit, University of Sydney; 1993.
 19. Unorganized Workers Federation. Protect the rights of migrant children – Report of one-day seminar on rights of migrant children. 2013.
 20. Peters DH. Better health systems for India's poor: findings, analysis, and options. World Bank Publications; 2002.
 21. Daniels N. Accountability for reasonableness. *BMJ*. 2000 Nov 25;321(7272):1300–1.
 22. Mason KA. Mobile migrants, mobile germs: migration, contagion, and boundary – building in Shenzhen, China after SARS. *Medical anthropology: cross-cultural studies in health and illness* 2012;31(2):113–31.

A study of promotional advertisements of drugs in a medical journal: an ethics perspective

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Abstract

The study assessed 54 advertisements of 145 different drugs, published over one year (from December 2011 to November 2012) in an Indian medical journal, circulated widely mainly among general practitioners (GPs). The ethical guidelines of the World Health Organization (WHO) and Organisation of Pharmaceutical Producers of India (OPPI) for medicinal drug promotion were applied. The brand name was mentioned in all advertisements (100% compliance both with the WHO and OPPI criteria) and the names of the active ingredients were also mentioned in 128 (90.14%) advertisements. However, major adverse drug reactions were mentioned in only two advertisements (1.37%); precautions, contraindications and warnings in only two (1.37%); and major interactions in only one (0.68%). Only three advertisements (2.06%) were well substantiated with references. To ensure the ethical promotion of drugs among GPs, journals must introduce compulsory review and appraisal of promotional advertisements by a dedicated review board, including at least one member trained in pharmacology and one representative from the medical division of a pharmaceutical company.

Introduction

Physicians today are greatly concerned with the rational use of drugs. To follow safe medical practice, they have to keep themselves well informed about the hundreds of new drugs entering the market every year. For this, they often have to depend on the promotional practices followed by the pharmaceutical companies. Advertisements in different medical journals are one such source of information. Studies have revealed that what the physician prescribes is influenced by pharmaceutical advertisements (1–5). So, ideally, the information provided in such advertisements should be of high quality and help doctors to practise evidence-based medicine. However, the aim of pharmaceutical companies is not education, but commercial promotion of their product through advertisements.

Pharmaceutical companies are governed by certain ethical guidelines for drug promotional activities at the national and international levels. The “Ethical criteria for medicinal drug promotion” of the World Health Organization (WHO), 1988 (6) and the Code of Pharmaceutical Marketing Practices of the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) (7) are two guidelines at the international level. In India, drug promotion is largely governed by the Organisation of Pharmaceutical Producers of India (OPPI) (8) and national legislation (9). However, the implementation of the code of ethics developed by the OPPI is a matter of self-regulation and self-discipline. Adherence to the code is in no way mandatory for the pharmaceutical companies.

There are 1.7 million family doctors in India. This works out to roughly 0.16 general practitioners (GPs) per 1000 people. Currently, the majority of patients in the country are managed by GPs (10). GPs are busy professionals who undergo less training than other doctors/physicians. They spend less time on enhancing their knowledge through continuing medical education (CMEs) and hence, depend on promotional literature on drugs in medical journals as an important source of information. This is why it is important that the quality of advertisements of pharmaceuticals in journals should be of a high standard. Maintaining such standards will help physicians prescribe drugs in a rational manner.

Our study was aimed at evaluating the quality of the promotional advertisements published in Indian journals and exploring whether there is any scope for improvement. We considered the WHO criteria for medicinal drug promotion and the OPPI code as our standard for evaluation.

GPs depend primarily on information obtained from pharmaceutical representatives and journals to bring their knowledge up to date. Journals catering to specific specialties