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Indian Medical Parliamentarians' Forum

Newsletter

Vol. I, No.2 **November 2006**

Dear friends,
Greetings from IMPF!

We are writing on behalf of Indian Medical Parliamentarians' Forum (IMPF) to introduce our new initiative; there are about 28 medical practitioners belonging to modern system of medicine and indigenous system of medicine in our Parliament. We have joined together and formed a Forum, which aims to bring the experiences, issues and concerns of the healthcare sector and of patients directly into policy and law. We realise that as health providers directly involved in policy and decision making process we are in a unique position to bring about effective reform and initiate innovative activity in this sector.

IMPF is committed to promoting health for all, justice, equity and good governance in the country. The Forum believes that democracy is a necessary precondition for social, political and economic transformation and that parliamentarians are important catalysts in that process. The forum shall act as a bridge between people and parliament on issues related to health sector and will make itself accessible to all stakeholders including healthcare providers, patients groups, civil society and concerned citizens.

The Centre for Legislative Research and Advocacy (CLRA), an expert organisation in parliamentary related work, is the hosting/implementing organisation of IMPF. CLRA will play a facilitative role in ensuring sustained work parameters, day to day functioning and other responsibilities of the IMPF.

The Forum seeks to work closely with the Government, civil society groups and experts and thus to deepen the knowledge to influence policies, laws and practices. Hence, we look forward your cooperation and participation to carry forward our responsibilities.

R. Senthil
Convenor-Secretary

M Jagannath
Chairperson

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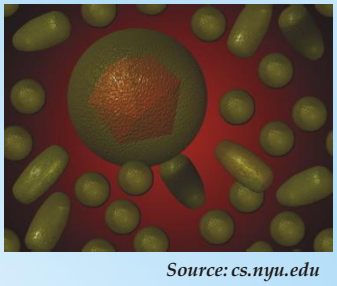
Recommemdations of the IMA's National Consultation on Hepatitis-B and Polio Eradication

In the last quarter of 2005, the Indian Medical Association (IMA) set up a sub-committee, to examine the rationale for including Hepatitis-B vaccine in the Universal Immunisation Programme (UIP) as well as the controversies regarding the Polio Eradication Initiative (PEI) in the country. After an exhaustive review of the literature on both the issues, the members of the sub-committee, put forward a set of recommendations which was deliberated upon in a national consultation held in New Delhi on the 14th May, 2006. The report of this consultation with the recommendations was released to the public on 13th September (available at the www.imanational.com).

The experts considered the inclusion of Hepatitis-B vaccine into the UIP unwarranted as the data from literature did not justify it. The schedule that had been put forward for India, (6, 10 and 14 weeks after birth), has not been shown efficacious anywhere in the world, and the one pilot study in Andhra Pradesh using this schedule has not been evaluated. Without this pre-requisite, to introduce the three dose schedule into the UIP in India would be a waste of scarce resources. The conclusion was that the proposed scaling up of the Hepatitis-B vaccination programme at an annual cost of Rs. 500 crores will benefit the vaccine manufacturers rather than the children of the country. The only group in India that might require Hepatitis-B vaccination was some of the tribal communities which showed a high chronic Hepatitis-B carrier states. However, there was a need for a well designed epidemiological study to understand the natural history of disease in this population before advocating a regular vaccination programme for them.



Source: cs.nyu.edu

Regarding the PEI, despite ten years of intensive drive and the expenditure of more than Rs. 5,000 crores, the continuing circulation of wild poliovirus in the country was noted with serious concern. No rational explanation for the increase in the Acute Flaccid Paralysis (AFP) cases, not found anywhere else in the world, has been put forward by the WHO or the GOI. Moreover, the use of mOPV1 (monovalent OPV1 vaccine) in the country was being carried out as a clinical trial without authorization or the informed consent of the parents. Concern was also expressed about the non-availability of data regarding the Vaccine Associated Paralytic Poliomyelitis (VAPP) in the public domain. The conclusion was that the year 2006 should be the year of the phased withdrawal and ultimate closure of the National Pulse Polio Program. An independent commission should be set up to review all aspects of the PEI including the high AFP rates. The improvement of sanitation and hygiene should be taken up as the highest priority, particularly in areas where high transmission is taking place. An expert committee should look into the efficacy and cost-benefit ratio of Injectable Polio Vaccine (IPV) before rushing into introducing it into the country. Finally, a comprehensive policy of rehabilitation of children with paralysis must be worked out by the authorities.

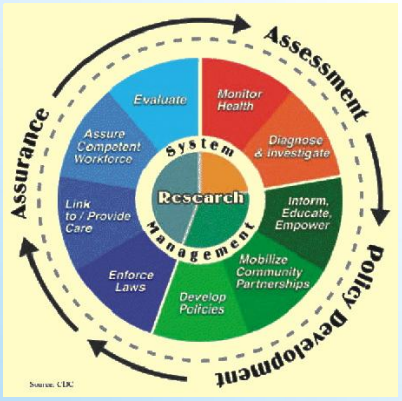
- Dr. C. Sathyamala

Public Health Foundation of India

As India experiences a rapid health transition, it is confronted both by an unfinished agenda of infectious diseases, nutritional deficiencies and unsafe pregnancies as well as the challenge of escalating epidemics of non-communicable diseases. This composite threat to the nation's health and development needs a concerted public health response that can ensure efficient delivery of cost-effective interventions for health promotion, disease prevention and affordable diagnostic and therapeutic health care. Investment in health is imperative as health is a cornerstone of human resource development and a critical component of economic growth, as well as an inalienable human right. These health challenges urgently require **capacity building** for health research, policy development and analysis, programme development and evaluation, health systems organization, models of health care financing and operationalized scientific research. Education and training in public health need to be inter-disciplinary in content so that the pathways of public health action are multi-sectoral. Public health education must include subject areas like epidemiology,

biostatistics, behavioral sciences, health economics, health services management, environmental health, health inequities and human rights, gender and health, health communication, ethics of health care and research. The interventions proposed need to be **evidence based**, **context specific** and **resource sensitive**.

The Public Health Foundation of India (PHFI) has emerged to redress the limited institutional capacity in India by strengthening training, research and policy development in the area of Public Health. It is a public-private partnership that was collaboratively evolved through consultations with multiple constituencies including State and Central governments in India, Indian and international academia, multi and bilateral agencies and civil society groups in India.



The PHFI is working towards building public health capacity in India by:

- Establishing New Institutes of Public Health (7-10);
- to train public health professionals (1 yr. DPH; 2 yr MPH) and public health functionaries in health and allied services (through short and medium term training programmes of 2-12 weeks)
- Assisting existing institutions to enhance their capacity for public health related training;
- Developing and supporting multi-disciplinary collaborative research networks to conduct public health relevant research;
- Facilitating policy development, through expert group consensus and advocacy for appropriate policy change; and
- Establishing standards for public health education and enable the creation of a credible accreditation system.

PHFI recognizes that healthcare needs to be addressed not only from the scientific perspective of what works, but also from the social perspective of who needs it the most, and has undertaken the task of imparting inter-disciplinary training to public health professionals and equipping them with the skills to undertake multi-sectoral actions to advance public health in a holistic manner.

PHFI has already initiated a dialogue with state governments seeking support in establishing Public Health Institutes. Studies have been commissioned in various states to undertake need analysis and to identify the critical requirements to strengthen the health service delivery system.

PHFI is now proactively focusing on finalizing its academic and research agenda, developing an advocacy strategy to promote the cause of public health and stimulating demand for public health professionals in the public and private sectors.

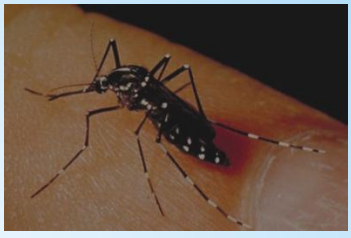
In anticipation of the need for trained faculty for the institutes of public health, a faculty development program called 'Future Faculty Program' has been initiated. This initiative involved sourcing of potential faculty from all over India with broad based field experience in health programs and projects in rural areas. In the first batch, a total of 14 candidates are pursuing public health training in USA and UK. More candidates would be sponsored, in 2007, for training in reputed institutions across the world, including some leading institutions in the developing countries.

-Dr. K. Srinath Reddy
President, PHFI [www.phfi.org] & former Head of Dept. of Cardiology, AIIMS

What is Happening to Kerala's Health Model?

After a gap of a quarter of a century, India has seen the re-emergence of Chikungunya in Kerala since early last year. The epidemic nature of the fever was first noticed in Calcutta in 1963 with 200 deaths and with 35% of those affected showed signs of hemorrhagic manifestation. In the 1970's it reared its head once again in Tamil Nadu and elsewhere. Without a vaccine or preventive drug, controlling the mosquito - the 'vector' which transmits the disease from infected persons to others, is the only way to tackle this disease. This *Aedes Aegypti* mosquito bites during the day, is attracted to humans and is also notorious for spreading Dengue and yellow fever.

***Vector Control*:** With no alternative to vector control for the prevention of Chikungunya or Dengue, most endemic countries have vector control components in their programmes. However, these are frequently insufficient or ineffective and have failed in reducing the public health burden of these diseases to an acceptable or manageable level. Environmental



Source: chikungunya.fr

management, the core component of prevention and control, includes clean-up campaigns, regular emptying and cleaning of containers, installation of water supply systems, solid waste management and urban planning. However, huge investments in infrastructure are needed in the areas of safer water supply, solid waste management and liquid waste disposal. Apart from overall health gains, such infrastructure would have a major effect on vector ecology, although the relationship is not invariably an inverse one. Cost-recovery mechanisms, such as the introduction of metered water, may encourage household collection and storage of roof catchment rainwater that can be harvested at no cost. Although unproven, the installation of community water services in rural areas may be a contributing factor in the spread of mosquito borne diseases in Southeast Asia and elsewhere.

At household and community levels, the focus of most vector control efforts, activities such as covering or cleaning water storage vessels, removing discarded food and beverage containers, and storing or disposing of used tyres so that they don't collect rainwater are encouraged. Such tasks that seem simple and well suited to the engagement by communities have seen few achievements. Yet they are widely regarded key in achieving sustainable control through behaviour change. But it is at this very important point that all our mechanisms have failed.

What happened in Kerala: Kerala which tops the country in most health indicators is no different. It has been said that Keralites are particular about personal hygiene but are poor in public or social hygiene. From the individual level to the highest policy level, several problems now plague the world renowned 'Kerala model' in public health. Why are there Dengue outbreaks every year after the monsoon? Why is our public health staff unable to identify and control preventable and communicable diseases?

There are problems in prioritisation - the introduction of inpatient or curative care in primary healthcare centres has indirectly weakened preventive components of our primary care. There has also been

Outbreak of Chikungunya: Dr. Anbumani Ramdoss, MoHFW visiting chikunhunya affected people in Alapuzha, Kerala along with Dr. K.S. Manoj, M.P., Ms. P.K. Sreemathy, Kerala's Health Minister and Ms. C.S. Sujata, M.P.

undue delay by policymakers in settling the non-cooperation strike of government doctors and the fact that the strike focussed on paralysing vaccination and preventive programmes may have contributed to an impression that paralysing preventive programmes is not as serious as paralysing curative components.

The decentralisation of healthcare was aimed at making things better. Unfortunately the experience with public health measures including sanitation, waste disposal, and environmental hygiene points only to the failure of local governments.

It is time to Awaken; time to Act. Chikungunya is only a yellow signal signalling that deadlier diseases like yellow fever are on the anvil. For each day that we delay our efforts to clean up our environment, eliminate mosquitoes (the number one killer in the history of human kind, till date) and prevent these diseases we will pay a heavy price in the years and decades to come.

- Dr. Muhammad Shaffi , MPH Scholar
Achuta Menon Centre for Health Science Studies,
Thiruvananthapuram

Data Exclusivity – Putting Profit Before People's Health

The demand of big pharmaceutical companies for exclusive rights over clinical and field trial data ('test data') has come into sharp focus due to its far reaching impact on drug prices and public health. What are the facts of the case? It is well known that before a drug enters a market it must undergo a series of trials, which cost both time and money. The test data from these trials is then submitted to regulatory agencies (i.e. the Drug Controller General of India) for marketing approvals. Current practice in India has been to grant marketing approval to similar (following the principle of establishing bio-equivalence) drugs on the basis of existing test data (submitted by originator companies). The practice has been a win-win strategy for generic producers and the consumers. If the government succumbs to the aggressive lobbying of the big boys of pharma then all this may undergo a change for the worse.

Why? Essentially, clinical trials are prohibitively expensive and time consuming and constitute high

barriers to entry offsetting the cost and time advantage to generic drugs and agrochemicals.

The outcome of grant of *data exclusivity* is similar to that of patents and in a sense, data exclusivity is patenting by other means in the absence of patent protection. It is important to understand the rationale of the demands for data exclusivity. The Indian Parliament in March 2005 acted to fulfill its obligation to protecting the right to life and health of all persons by ensuring that the Indian Patents Act (IPA) would not generally grant patents to incremental modification of known substances a practice that most big pharma - both Indian and foreign, resort to in order to extend their patent, and retain their market share. Given the fact that this practice is disallowed to an extent in the IPA, data exclusivity offers the second best option for pharmaceutical companies to continue their monopoly rights over a drug. This leaves generic companies and consumers who stand to benefit from increased competition that drive down prices high and dry under what is a thinly veiled attempt to retain patenting by other means. Effectively, the upshot is that even when the patent does not exist, a generic version of a drug/agro chemical cannot be introduced in the market.

Interestingly, earlier the demand for data exclusivity was projected as an international legal obligation under Article 39.3 of the TRIPS Agreement, which prescribes member States to protect the data submitted for marketing approval from unfair commercial use. However, the negotiating history of Article 39.3 and legal interpretation of Article 39.3 does not support that demand. Under the TRIPS Agreement India has the legal right to define the term "unfair commercial use" to permit the current practice of regulatory authority to rely on the originator data for the subsequent marketing approval.

Further, the objective of reliance on originator data has been to ensure safety and efficacy of the drug and therefore does not constitute commercial use. Hence, the only obligation under Article 39.3 is to protect the test data from unfair commercial use, which means the data submitted to the regulatory authority should not be disclosed to the third parties for unfair commercial use.

The World Health Organisation (WHO) in a briefing note published in March 2006 entitled 'Data Exclusivity and other "TRIPS-plus" measures,' has noted that "*data exclusivity diminishes the likelihood of speedy marketing of generics, and delays competition and price reductions*" and

Source: ipblog.org

categorically advised developing countries against the introduction of, what are effectively, TRIPS-plus provisions like data exclusivity. Specifically, the WHO has noted that moves to introduce such TRIPS-plus provisions are a worrying trend and "*countries should therefore be vigilant and should not 'trade away' their people's right to have access to medicines.*" Two independent international panels of experts, viz. Commission on Intellectual Property Rights (CIPR) and Commission on Intellectual property, Innovation and Public Health (CIPIH) shared the same view and explicitly advised developing countries against the adoption of data exclusivity.

In the absence of any international obligation and more importantly in light of Constitutional guarantees of life and health, nothing prevents the Government of India from putting peoples' health before profit and rejecting moves to introduce monopolies like data exclusivity over drugs that threaten access to medicines.

-Gopa Kumar K M
Centre for Trade and Development (Centad),
New Delhi

Legislating an Epidemic: The HIV/AIDS Bill 2006

Twenty years into the HIV epidemic, Indians living with or affected by HIV/AIDS continue to face discrimination they are thrown out of their jobs; their children are removed from schools; they are refused treatment in hospitals. There is no legal redress for discrimination in the private sector. HIV prevention programmes started by the government are hampered by laws that criminalise sex workers, injecting drug users and men who have sex with men. Women, who are increasingly becoming the face of this epidemic, face increased neglect, discrimination and a vicious cycle of violence that not only leaves them vulnerable to HIV but that intensifies if they are HIV-positive.

This, despite constitutional guarantees of life, health and

and equality and government policies that espouse a humane response, is the HIV epidemic in India. The law has offered little redress and India needs a clearly articulated legal response to these unjustifiable circumstances if we are to successfully tackle this epidemic.

To this end, a unique joint initiative of the government and civil society will soon see the introduction of the **HIV/AIDS Bill 2006** in Parliament. Drafted by the Lawyers Collective HIV/AIDS Unit (LCHAU), the Bill is the culmination of a rigorous three-year research, drafting and consultative process that has involved stakeholders from across the country and from every region. Regional level consultations organised in co-ordination with the National AIDS Control Organisation and State AIDS Control Societies and their representatives along with various stakeholders were held in the North, South, East, West and the Northeast of the country. Groups and communities with specific perspectives and experience of the epidemic like HIV-positive persons, sex workers, men who have sex with men, injecting drug users, healthcare providers, workers, women, children and legal experts have discussed and debated the Bill at length. Ultimately it is these discussions, debates and consultations that have shaped this Bill on HIV/AIDS that is holistic, democratic and egalitarian; that places people, communities and society at the heart of legislation.

The Bill embodies principles of human rights and seeks to establish a humane and egalitarian legal regime to support India's prevention, treatment, care and support efforts vis-à-vis the epidemic. It also seeks to fulfil India's commitments under various international covenants and treaties such as the UN Declaration of Commitment on HIV/AIDS, the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of all forms of Discrimination Against Women.

The HIV/AIDS Bill 2006 addresses issues of **discrimination** in employment, healthcare, education and other settings, **informed consent** for testing, treatment and research, **confidentiality**, **access to treatment**, **safe working environment for healthcare workers**, protection for **risk reduction** programmes like targeted interventions with vulnerable groups, **special provisions for women, children and young persons** and provides for innovative **grievance redressal mechanisms.**

Source: globalaidsalliance.org

It envisages a detailed and carefully planned strategy to address the HIV epidemic through an extensive prevention, care, treatment and support programme that entails widely disseminated and easily accessible IEC, an accountable and accessible government response, access to healthcare services and treatment and the protection and promotion of the rights of persons living with/affected by HIV/AIDS.

Ultimately the vision of the Bill is to create a strategy to tackle the HIV epidemic where every person is a stakeholder, every voice is included and no one is left behind; to help the epidemic emerge from the underground so that HIV/AIDS is no longer a synonym for fear, neglect, discrimination and violence but for empowerment, compassion, united action and triumph.

- Kajal Bhardwaj
Consultant, Lawyers Collective HIV/AIDS Unit

Millennium Development Goals and Health

The Millennium Development Goals (MDGs) were adopted by the United Nations in 2000 at the Milinnum Summit and set targets for reducing poverty, health improvements, gender equality, educational achievement, environmental sustainability and global partnership. The MDGs represent a global consensus on the broad goals of development to be achieved by 2015. The Millennium Declaration adopted 8 development goals and 18 time-bound targets. There are 48 quantitative indicators to monitor the progress towards the goals and targets. The goals, targets and indicators are meant to stimulate swift and effective action; to achieve the development and poverty eradication aims of the Millennium Declaration; and to provide concrete measurements of the progress that countries are making towards achieving these goals.

Health is a basic and inalienable human right. Equitable and efficient public health system of the country is a vital indicator of its successful economic and social development. Health is at the core of MDGs. Three of the eight development Goals, eight of the eighteen targets, and eighteen of the forty-eight indicators deal specifically with health related issues.

India is committed to achieve these Goals by 2015. The Central and States governments have set out goals more ambitious than the MDGs'. India's Tenth Five Year Plan (2002-2007) has taken note of the MDGs and outlined India's Human Development Goals and targets to be achieved during the Plan period. Most of these Goals and targets are related to and are more ambitious than the MDGs. The Government claims that India will be able to meet the challenges and achieve all the MDGs

much earlier than the targeted dates.

National Common Minimum Programme (NCMP) goals of the current UPA Government have also included and interlinked with some of the MDGs and targets.

India is currently on track in respect of eradicating extreme poverty and hunger. According to the Government report, India is moving ahead in the direction of achieving all the goals much earlier than 2015, with the current national policy interventions and initiatives in core human development areas. This may be an exaggerated confidence of the Government. Nevertheless, whatever the claims and statistics, the reality is that it needs to reinforce the efforts to achieve the goals and targets with a remarkable quantity and quality.

According to various studies and assessments, India will not achieve the health related MDGs without concerted efforts and commitment of increased resources. India's total health expenditures as percentage of GDP is 4.8. Adequate financial resource is the most important aspect in a health system, and lack thereof is the main impediment to its progress. Health care budgets remain inadequate in India, and the financial burden of the poor is unacceptably high. The health related MDGs are too distant unless adequate resources are increased, and an essential shift in its policy and strategic directions. India needs to review and reprioritize the use of existing resources, focusing more on primary health care, with access to functional and affordable public health services.

In spite of governmental claims, one needs to assess the stark realities that India is facing with respect to health sector issues. The recent outbreaks of Dengue in the national capital and Chikungunya occurrence in the State of Kerala (renowned for 'Kerala Model development') and other parts of the country are certain instances that reveal the inadequacy of existing emergency health systems in the country. India is projected to have the second largest population of people living with HIV/AIDS, next to South Africa. The epidemic has started to challenge the development achievements and to raise fundamental issues of human rights concerning people living with HIV/AIDS. The social and economic burden of HIV/AIDS will be the greatest health disaster for India. According to WHO, India has more new TB Cases annually than any other country. Malaria is one of the major public health problems in India and is prevalent in all parts of the country. To address all these issues, we need to adopt a holistic and integrated approach that views health, education, and other social sector development as inherently interrelated. We are half way to the targeted date of 2015. It is high time we further a healthy debate on health related MDGs in India in order to inform and influence public policy and thus attain theses Goals.

-Dr.Vallabhbhai Kathiria,
Member of Parliament

Millennium Development Goals

Goal 1	Eradicate extreme poverty and hunger
Goal 2	Achieve universal primary education
Goal 3	Promote gender equality and empower women
Goal 4	Reduce child mortality
Goal 5	Improve maternal health
Goal 6	Combat HIV/AIDS, malaria, and other diseases
Goal 7	Ensure environmental sustainability
Goal 8	Foster global partnership for development

Status of Health infrastructure in Scheduled areas of Andhra Pradesh

The tribal people are the most disadvantaged group in our society in terms of utilizing the health care infrastructure facilities that are available now. There are Public Health Centres in the adivasi people living in the Scheduled areas covering about 10-15 thousand population, but physically people are scattered away at a distance of kilometers. Sub Centers covers 1000-1200 population. Almost every village has got one Community Health Worker (CHW) under that sub center. The physical infrastructure like buildings, in-patient wards are available.

But the fact is that there are vacancies of doctor posts and other para medical staff. Most of the PHCs are run by doctors on contact basis or on deputation only. There are laboratories but no technicians. There are Ambulances but no drivers, no arrangement for fuel. The only medical personal available in the tribal area is CHW.

They are untrained local tribal girls with minimum or no educational qualifications for the distribution of two-three varieties of tablets. Above the PHC level there are Community Health Centres, where a team of specialists is expected to work. But they run by contract Doctors. Recently state Government tried to fill the Doctor post but Doctors are reluctant to work in the adivasi areas. The Government is not thinking of making the rural practice a compulsory obligation. Outdated X-ray

Machines where dumped into Hospitals in Scheduled areas where neither raw film was supplied nor radiologist were posted. There are operation theatres well equipped but no surgeries were taken up. Even normal deliveries refer to towns.

On one hand adivasi areas are provided with infrastructure facilities on other hand tribals are suffering from serious health problems such as Cerebral Malaria, Encephalitis, and Water born diseases. Most of the tribal women suffer with Anemia, Diarrhoea and Night blindness. The MMR is 25 per thousand, while it is 5 in plain areas. IMR is 120-150 per thousand, while 72 in plains. The IMR of under 5's is a shocking 30%. The life expectancy is not more than 45 years in some tribal sects. The incidence of TB among tribals is almost doubled when compared with plains. The deaths due to P-falciparam accounts for 75% of the states total malaria deaths.

A tribal family *Photo: T. Mohandas*

In 1997 a tribal health project was launched by Department of Tribal Welfare funded by World Bank and international fund for Agricultural development with Rs 14.06 crores in the 4 Scheduled districts, East Godavari, Srikakulam, Vishakapatnam and Vijayanagaram Districts. Under this scheme village health committees were formed and CHWs or Accredited Social Health Activists (ASHA) were identified. In most of the places no village health committee is in existence and work. The overall experience of this funded health scheme is able to improve some of the health indices. But there is no minimum use of the physical infrastructure arranged under this scheme. It is a failure story.

Health is a multi disciplinary activity where nutrition (food security), Safe drinking water, good environment, primary health care are the key factors to protect and promote tribal health in the Scheduled areas. In the absence of national health policy, the government felt no social responsibility resulting in health care becoming a low-priority item of the state. The right to health is being denied to the people living in remote hilly areas. It is imperative that the promotion of health awareness among the tribal communities be increased so as to make use of insufficient health care infrastructure and raise demands for better and required health services.

- Dr. Midiyam Babu Rao,
Member of Parliament

News from Standing Committee

Departmentally Related Parliamentary Standing Committee on Health and Family Welfare was reconstituted on 5th August, 2006 with 31 Members. Among the 31 Members, the Committee is still vacant with two Members from Rajya Sabha and one Member from the Lok Sabha.

The Indian Medical Council (Amendment) Bill, 2005 is currently with the Committee and the Hon'ble Chairman, Rajya Sabha has granted extension of time upto 5th December, 2006 for presentation of the Report to the Parliament.

Quotes:

"I was at one time a great lover of the medical profession. . . . I no longer hold that opinion. . . . Doctors have almost unhinged us. . . . I regard the present system as black magic. . . . Hospitals are institutions for propagating sin. Men take less care of their bodies and immorality increases. . . . ignoring the soul, the profession puts men at its mercy and contributes to the diminution of human dignity and self control. . . I have endeavoured to show that there is no real service of humanity in the profession, and that it is injurious to mankind. . . . I believe that a multiplicity of hospitals is not test of civilization. It is rather a symptom of decay."

--Mahatma Gandhi

"Awe-inspiring medical technology has combined with egalitarian rhetoric to create the dangerous delusion that contemporary medicine is highly effective. Although contemporary medicine is built on this erroneous assumption, it is contradicted by informed medical opinion."

*--**Ivan Illich.*** Limits to Medicine, Medical Nemesis: The Expropriation of Health

Published by Vinod Bhanu, Executive Director, CLRA for IMPF, 160, South Avenue, New Delhi-110011.