



Indian Medical Parliamentarians' Forum

Newsletter

Vol. 3, No. 1

Budget Session Issue

February-May 2008

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Vinod Bhanu

Dear friends,

Greetings from IMPF!

On behalf of IMPF, we are pleased to release the Budget Session issue of the IMPF Newsletter. We would like to thank our fellow parliamentarians and civil society groups for all the encouragement and support we have received over the past months. It also gives us great pleasure to bring news of the IMPF discussion on NRHM & the Right to Health at the IIC, New Delhi, organised in collaboration with the Wada Na Todo Abhiyan. The event provided the opportunity for the Hon'ble Union Minister, Dr. Anbumani Ramadoss and the joint secretaries of his Ministry, to participate and interact with civil society groups from across India.

The widespread disappointment with allocations on health in the 2008-9 Budget was almost unanimously reflected amongst stakeholders. The allocation of 16,534 crore in the budget is woefully inadequate if the UPA government is to achieve the goal of universal health coverage, as delineated in the National Minimum Programme (NCMP). Despite committing to increases in expenditure on health to 2-3 per cent of GDP, the current government has conceded only a sustained level of investment of 0.9 per cent.

In spite of the major launching of a mass immunisation campaign against polio in February 2003 which targeted 165 million children, the battle against polio has not yet been won. A recent report by the Global Polio Eradication Initiative has placed India at the top of the world polio map. India is one of just four countries - along with Pakistan, Nigeria and Afghanistan - where polio is still endemic. It is therefore a welcome move that the Union Health Ministry is going to review current polio programmes, and we hope that this will reveal policy gaps and pave the way for essential changes in policy and implementation.

Thought to be tabled in 2007 and already approved by the Health Ministry, a Bill on HIV/AIDS (2005) has still not been passed. The Law Ministry is currently considering the draft Bill. The Bill addresses discrimination in employment, healthcare, education and other institutions, besides the issue of informed consent for testing, treatment and research. It legalises a safe working environment for healthcare workers, proposes protection of inheritance and property rights, and recognises community-based alternatives to institutionalisation for vulnerable and affected children. Given the rate at which HIV is spreading across India and the perpetuated abuses of the rights of people living with HIV, we are most concerned about the continuing delay in introducing the Bill in the Parliament.

In this issue, we would also like to highlight the issue of healthcare financing. The taskforce report that fed into the Eleventh Five Year Plan explicitly recommends partnerships with private and non-profit organisations and NGOs. Private involvement can be effective only when it draws from sustained investment, motivated and well-paid staff, integrated audit and regulatory systems and educated citizens who know and expect well performing services as a right. The question civil society groups and policy makers need to ask themselves is whether private sector involvement will compensate for a severe lack of primary care infrastructure and investment, or whether it will merely exacerbate existing problems in securing access to treatment and medicines.

We would like to place on record our gratitude and indebtedness to all our friends and well wishers for their cooperation and solidarity. We are also thankful to all the authors for their contributions to this issue and look forward to their continuing support.

R. Senthil

Convener-Secretary

M. Jagannath

Chairperson

Issues in Mental Health Care

It is estimated that nearly 40 million Indians suffer from chronic mental disorders, and at least 20 million from mental illness (MI) classified as common mental disorders by WHO. Only 10% of these access treatment facilities; with the exception of the urban middle class, rehabilitation is a far cry from the rest.

Global Approach - "No health without mental health: "About 14% of the global burden of disease has been attributed to neuropsychiatry disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses. Such estimates have drawn attention to the importance of mental disorders for public health" observe the authors of the Lancet series on mental health advocacy (2007). Citing from the WHO's " Global Burden of Disease Report", they believe "...neuropsychiatry conditions account for up to a quarter of all disability-adjusted life-years and up to a third of those attributed to non-communicable diseases...." (2005). Hence evidence based care calls for mainstreaming mental health care as the only cost effective and efficient way of ending inequities in treatment besides optimising resource utilisation.

The Indian scenario: India is one of the few countries that have a National Health Policy (NHP, 2002) that mentions mental health, as well as a National Mental Health Program (NMHP) and a dedicated Mental Health Act 1987 (MHA). By identifying PHCs as the epicentre for psychiatric treatment, NMHP (1982) attempted to integrate mental health into general health. It also proposed to deinstitutionalise to a community rather than hospital based model. However, by 2002, only 100 of 600 districts were brought under NMHP. This failure was due to poor funding, inadequate undergrad curriculum in psychiatry, manpower shortage, poor evaluation, non-implementation of MHA and privatisation of mental health care.

The 11th Plan with a Rs1000 cr. allocation for mental health proposes to cover the remaining 500 districts by the end of the Plan period. However, MI is a progressive disorder; for every 100 districts covered each year, there will be a backlog of districts without mental health services

resulting in chronic psychosis, homelessness and tragedies like Erawadi. Psychiatrists insist that "Early treatment is early recovery", but this has escaped the attention of health experts in the Planning Commission: for this oversight, victims in rural areas are likely to pay the price.

We do appreciate the manpower constraints- around 4500 trained mental health workers for 40 million mentally disabled patients. That is precisely why global strategies call for integration into general health programs. NHRC (1999) report says that there is on an average, 1 PHC for every 30,000 population, 1 doctor for every 3000 population, one male and female worker for every 3 to 5000 population. NRHM proposes to cover 18 States under the 11th Plan.

The ASHA (Accredited Social Health Activists) volunteers are best suited to detect early and typical symptoms of mental disorders seen in the PHCs. ACMI's work on the family carers of resident patients in NIMHANS, Bangalore (2003-05) showed that the most chronic disorders and relapse cases are due to treatment delays and non compliance with treatment regimes. The advantage of dovetailing NMHP with NRHM will be that the ASHA volunteers can also promptly identify and regulate treatment drop outs.

Amendments to MHA: One of the major failures of NMHP has been the lack of accountability. Although the NSS Survey shows that 70% of mental patients in India are under family care, the Act is a medical model that does not support family care. There are no Emergency Psychiatric services in any of the Centre or State run hospitals, and admissions of involuntary patients under Sec 19-22 are still a nightmare. Legal guardianship is possible only through the Court: natural guardians or patients capable of self care and management have no access to rights of guardianship! Rule 22 calling for Minimum standards for licensing are still not implemented. There is no scope for participation of family support groups and civil society members in any of the statutory committees under Sec 37.

Solutions must lie in designing **an inclusive approach** for mental health care in India.

- Dr. Nirmala Srinivasan

Action for Mental Illness (www.acmiindia.com), Bangalore

Protecting brains of children of India

- Are you using adequately iodized salt for cooking?

How long can we continue to claim that the "Glass is half full"? Iodine deficiency Disorders (IDD) are a major public health problem in India. It was in 1956 that iodized salt was produced at a salt iodization plant for distribution in Kangra valley of Himachal Pradesh - an area with severe iodine deficiency and high prevalence of Goitre. Based on the results of the study, the Government of India

launched the National Goitre Control Programme (NGCP) in 1962. However, according to the latest National Family Health Survey, only 51% of India's population has access to adequately iodized salt - which marks a meagre increase of 2% over a six year period. This deficiency continues to put Indian children at risk of impaired intellectual development. Paradoxically, Indian scientists

Scientists have provided a sustained and significant contribution to all aspects of IDD control in many other countries worldwide.

In nearly all regions affected by iodine deficiency, the most effective way to control iodine deficiency is through salt iodization. Universal salt iodization (USI) is a term used to describe the iodization of all salt for human (food industry and household) and livestock consumption. Salt iodization is the recommended strategy for control of IDD because:

- Salt is one of the few foodstuffs universally consumed
- Salt intake is fairly regular through the year
- In most countries, salt production/importation is limited to a few sources
- Iodization technology is simple and relatively inexpensive to implement
- The addition of iodine to salt does not affect its colour or taste
- The quantity of iodine in salt can be simply monitored at the production, retail, and household levels

Iodized salt is not necessarily expensive. Even crystal salt can be easily iodized and when packed costs only Rs. 3/- per packet. Keeping in view the per capita consumption of 5 kgs per person per year, the total expenditure of an individual per year on iodized salt will be just Rs. 15/-.

Reviews of the IDD elimination programmes, clearly point to the fact that:

"The low-income segment of the Indian population, despite all development efforts don't consume sufficiently iodized salt not because they can't afford to buy the good quality product, but because either the product is not available in rural markets or the claimed iodized salt is of questionable quality."

Why then does a country like India not pay close attention To this serious public health deficit, which impacts the cognitive power of its human capital?

This is an issue on which India needs sustained political commitment. The ban on the sale of non-iodized salt in 1998 was a positive step forward, but was then lifted for a period of six years between 2000 and 2006. The mixed signals in public health problems have a detrimental effect on maintaining and achieving progress.

India needs to maintain constant public information on the problems of iodine deficiency and the dangers of absence of iodine. The behavioural communication change campaigns (BCC) so far have been periodic and on a small scale. We should give priority to advocacy and Behavioural Change Communication (BCC) in the low-income population. Additionally, there is a lack of regular national and state monitoring activity with regard to the status of IDD indicators. Monitoring time, organising resurveys and disseminating findings will keep track of progress and challenges related to specific target audiences.

Action must be taken to initiate multi-stakeholder alliances (government, multilateral agencies, private sector, NGO's, scientific institutions, communities) to address the most critical issues. Interventions are essential for opening dialogues with the private sector, including small and medium scale producers, multilateral development agencies and the government, so as to create mutually beneficial and more importantly, profitable market-based solutions. A national coalition of actors, consumers, and decision-makers will assure collaborative sharing of information and policy implementation that will address the needs of below poverty line populations.

-Prof. Chandrakant S. Pandav

Centre for Community Medicine, All India Institute of Medical Sciences (AIIMS) New Delhi,

-Arijit Chakrabarty, M.G. Karmarkar

International Council for Control of Iodine Deficiency Disorders (ICCID), New Delhi

Research and Development of Drugs for Neglected Diseases

For a compound which may have shown promising in vitro activity, the journey through the drug development pipeline is a long and arduous one: by the time it has been selected for clinical development out of hundreds of thousands of other compounds, it still has a 1-in-5 chance of reaching a patient. This process to develop new drugs is complex, requires interdisciplinary collaboration, is time-intensive, and expensive; yet, the impact of a new medicine to the market can be seen not only in the improved health outcome for individual patients and their families, but also for the socio-economic outlook of a patient's community and country.

Despite the phenomenal changes in medicine over the past half-century, drug discovery has not worked for diseases affecting poor and neglected populations in the developing world. For example, parasitic diseases such as malaria, visceral leishmaniasis (VL), Chagas disease, and human African trypanosomiasis (HAT) cause substantial

morbidity and mortality worldwide; however, because of a combination of market and public policy failures, no clinically useful and effective drugs have emerged to treat them - of the 1,556 new drugs approved between 1975 and 2004, only 21 (1.3%) were specifically developed for tropical diseases and tuberculosis, even though these diseases account for 11.4% of the global disease burden. Existing therapies are often toxic and expensive and need to be administered for long periods by injection - characteristics that are inappropriate for the environments in which they are used.

In 2003, seven organisations from around the world joined forces to establish DNDi, including national and international research and humanitarian institutions. The idea emerged from mounting frustrations with current inadequacies in treatment provision, along with the emergence of a wealth of academic research about the parasites that cause these diseases. If this knowledge could

Be coupled with techniques of modern drug discovery, the opportunity would allow DNDi to harness cutting edge science and technology to develop critically-needed treatments for neglected diseases, and then ensure that they were suitable for and accessible to the world's poorer patients.

The principle governing DNDi's work is to promote development of new products as 'public goods'. First, the needs are identified; then, mechanisms are developed to ensure that the foremost scientific innovations serve as the backbone for the research agenda. This provides an opportunity and responsibility for the scientific community interested in these diseases to take a proactive role. DNDi does not have any research facilities and will not directly conduct R&D to develop its treatments. Instead, DNDi follows the virtual research model, whereby most research is outsourced and actively managed by DNDi personnel experienced in different aspects of pharmaceutical developments. Networks and collaborations with over a hundred scientists from different private pharmaceutical, biotechnology, and public research organisations across the world have been established, including a number of agreements with Indian researchers from private and public organisations.

As an integral part of its mission, DNDi works with R&D partners built on South-South and North-South collaborations. While using and supporting existing

capacity in countries where the diseases are endemic, DNDi helps to build additional capacity in a sustainable manner through technology transfer. This includes access to chemical diversity, establishment of discovery platforms, pharmaceutical and clinical development, and working closely with control programs through, for example, the Leishmaniasis East Africa Platform (LEAP).

One of DNDi's first projects has been to develop two fixed-dose anti-malarial ACTs (FACTS). These two 'public goods' are easy to use (1-2 tablets a day over a 3-day treatment course) and offer the first-ever paediatric strengths in fixed-dose anti-malarial. One of the medicines, ASAQ (fixed-dose artesunate amodiaquine), is now available in 21 African countries through DNDi's partner, sanofi-aventis and the registration studies for India are ongoing.

Sustainability of such efforts is the biggest concern, as current attention afforded to global health may soon turn to other issues. Public leadership is needed to create policy change that will support adoption of and equitable access to new, essential health tools, and provides adequate funding to cover such R&D programs.

- **Dr. Bhawna Sharma**

*Drugs for Neglected Diseases initiative (www.dndi.org),
New Delhi.*

From the abnormal to the normal

Preventing sex selective abortions

The Census 2001 revealed an alarming decline in the sex ratio, to the disadvantage of girl children. One of the reasons for this decline is the misuse of readily available diagnostic technologies, the most popular being the relatively non-invasive procedure of ultra-sonography. This article is based on a 2007 report from the Lawyers Collective (The report is the outcome of a four year study based in National Capital Territory of Delhi), which examined the efficacy of the Pre-Conception and Pre-natal Diagnostic Techniques (Prohibition of Misuse) Act, 1994 (PC & PNDT Act).

Firstly, the incidence of sex selective abortions is not a pro-life or pro-choice issue. The right to abortion cannot be compromised: it is women who bear disproportionate biological and sociological burdens associated with delivery and child care. Sex determination on the other hand is an act of discrimination - girl children are unwanted because of social devaluation of women. To curtail the demand for sex selective abortions, we must first achieve equality in securing and upholding the rights of women.

Unlike other acts of discrimination, however, sex determination can take place only with active medical intervention- it is the doctor who has to disclose the sex of

the fetus. A law is thereby required to regulate medical professionals and guard against the misuse of medical technology. The use of diagnostic technology cannot be banned because there is a legitimate need for it. Hence what is banned is the disclosure of the sex of the fetus. The problem is that disclosure takes place behind closed doors, and there will be no complainant when a sex-selective abortion takes place. It is of course not possible for law enforcement agencies to be physically present in every doctor's chamber. For this reason, the PC & PNDT Act puts in place a system of registration and monitoring. All units engaged in either advising or conducting pre-natal diagnostic tests have to be registered under the law. Once registered, the units are mandated to self monitor by maintaining records of all pregnancy related services and advice. These records then put in place a 'paper trail' that can be monitored by the state agencies.

At the time of enactment, 'genetic' tests such as amniocentesis and chorionic villi biopsies, used to detect genetic abnormalities in fetuses, were being primarily misused for sex detection. Hence the PC & PNDT Act was designed to regulate genetic tests used for the detection of abnormalities. However, with the development of medical technology, particularly ultrasound technology, pre-natal

Diagnostics has become an integral part of antenatal care used in normal pregnancies. It is this technology that is being misused; only a limited number of mothers require tests for the detection of genetic abnormalities. Concerns related to tests used in normal pregnancies were raised at the time of drafting, the legislature, but the Act has retained the narrow schema which does not allow for the effective monitoring of ultrasound technology. Pursuant to the directions of the Supreme Court in 2001, amendments were effected in the law to specifically bring ultrasound tests within the regulatory ambit. However, this was done in a patchwork manner: the categorisation for registration bears no relation to the actual practice of antenatal care. The devastating consequence of this is that it makes the aspect of monitoring practically impossible as there is a complete break in the paper trail.

If the state is serious in efforts to curb sex selective abortions, it is essential that the PC & PNDT Act is completely overhauled to provide a mechanism that reflects the manner in which antenatal care is provided. This will require a shift from the focus of monitoring tests conducted for the detection of abnormalities to tests conducted in the interest of the wellbeing of the woman and the fetus. There is, however, a note of caution that should be kept in mind at the time of effecting any amendments to the law: that amendments should not result in the criminalisation of women or place hurdles in their access to pregnancy related medical care.

- **Asmita Basu**

Lawyers Collective (Women's Rights Initiative), New Delhi

Health in the Union Budget 2008-09

The promise to ensure universal health and education is common to the Millennium Development Goals (MDGs) and the National Common Minimum Program (NCMP). The NCMP aims to increase public expenditure on Health to 2-3% of the GDP as one of the strategies to meet this promise. However, the total investment on Health in India to date remains dismally low. Less than 1% of India's GDP is spent on public health, which is even lower than the public health expenditures of much poorer countries like Sri Lanka and Sierra Leone.

Health In India - Key Indicators

- India accounts for more than 20% of global maternal and child deaths, and, at an estimated 138,000, the highest maternal death toll in the world
- United Nations calculations show that India's spending on public health provision as a share of GDP is the 18th lowest in the world.
- Nearly 67% of the population in India do not have access to essential medicines.
- Infant Mortality Rate (IMR) in India was 57/1000 births in 2005-06. Kerala heads the progress made so far with an IMR of 15/1000 births. Uttar Pradesh has the worst IMR in the country with 73/1000 births.
- Maternal Mortality Rate (MMR) is currently 4 deaths per 1000 births. India accounts for the largest number of maternal deaths in the world.
- 79% of the children between the age of 6-35 months, and more than 50% of women, are anaemic, and 40% of the maternal deaths during pregnancy and child-birth relate to anaemia and under-nutrition.
- There are 585 rural hospitals compared to 985 urban hospitals in the country. Out of the 6, 39,729 doctors registered in India, only 67,576 are in the public sector.
- The ratio of hospital beds to population in rural areas is almost fifteen times lower than that for urban areas.

NRHM: In the Union Budget 2007-08, the overall health budget has been raised by 15% to a little over Rs16,500 crore. This may seem like an impressive amount, but it pales into insignificance given the CMP promise of raising overall public sector expenditure on health to 2 - 3% within the current UPA dispensation. Since 2005-06, collective health expenditure of States and Union Government has remained stagnant at around 0.99 percent of GDP. The proposed allocation for NRHM is Rs.12050 crore: a mere 11.4% increase over 2007-08. This is a clear departure from UPA's commitment to increase NRHM allocation by 30% every year. In addition, the FM has introduced Rashtriya Swasthya Bima Yojana, which will provide health cover of Rs.30,000, a meagre amount, for every below poverty line worker and family in the unorganised sector.

Marginalised Groups: The claims of achieving inclusive growth have once again faltered, according to the National Commission for Dalits and Human Rights. Continued denial of access to resources has resulted in an Infant Mortality Rate amongst Dalit populations of 83% and a Child Mortality Rate of 39%, as opposed to 61% and 22% respectively amongst non-Dalits. 56% of Dalit women suffer from anaemia.

Delivery of promises: The United Progressive Alliance has failed to deliver on internationally accepted levels of 2-3% GDP for public expenditure on health, and 6% GDP for public expenditure on Education by 2009, as promised in the National Common Minimum Program.

However, the integration of this target in the 11th Five Year Plan must ensure that the '9% GDP for public spending on Health & Education' goal remains a part of the national development agenda.

- **Pasang D. Lepcha**

Wada Na Todo Abhiyan (www.wadanatodo.net),
New Delhi

In Sickness and in Health: Troubled Partnerships in the Healthcare Sector

With less than 1% of the Gross Domestic Product (GDP) invested in public healthcare provision, India is currently one of the most privatised health economies in the world. This is a country which homes 20% of the world's diseases, where the regular level of malnourished children is higher than that of Sub-Saharan Africa, and with higher rates of anaemia and maternal under nourishment. The buzzwords inscribed into current government policy, including the Eleventh Five Year Plan, are Public Private Partnerships (PPPs) - contracting out, franchising, voucher schemes, subsidies. However, even proponents of PPPs in more developed states are suspicious of their application in emerging economies, where there are high proportions of people living on or below the poverty line who have never experienced healthcare as a contractual, democratic right. Solid investment, motivated and well-paid staff, established and integrated audit and regulatory systems, excellent political communication, citizens who expect well-performing public services - without these as a starting point, can marketisation realistically be expected to create equitable and sustainable delivery of essential services like healthcare?

According to the Universal Declaration of Human Rights (UDHR), every citizen has the right to social security (Article 22). Access to such provisions, however, proves to be more difficult for those in the rural or unorganised sectors - which currently account for around 90% of India's population. More often than not, it is those who live closest to subsistence level who dig into their pockets to make direct payments for essential healthcare services. Private expenditure forms more than 80% of the total outgoings on health in the country; the vast majority of this is out-of-pocket, and the second most common cause of debt in rural India is healthcare provision. This is a vicious cycle, where expenditure on healthcare creates poverty, which contributes to malnourishment, decreases economic productivity and perpetuates further ill health.

The government promised to increase public spending on health by 30% between 2006 and 2007. Reports suggest that this target has not been met, and that increases have largely been channelled into particular projects, selective

interventions and targeting disease - not into strengthening infrastructures and widening access. Currently, only 20% of overall health financing goes towards the general development of health systems. Up to one in three doctors' posts remain vacant in rural India; of those that are filled, around two thirds may be absent at any one time. There will be 1 bed per 6000 people, Public Health Centres (PHCs) will often be closed, and, according to the Indian Institute for Population Sciences, just 20% will have a phone, and only 12% will undergo "regular maintenance". In some states, the majority will not have electricity. There are obvious infrastructural problems here, which are not necessarily most effectively resolved by external contracting or compensatory "accountability measures".

According to the Working Group on Public Private Partnership for the Eleventh Five Year Plan, "partnership is not meant to be a substitution for lesser provisioning of government resources nor an abdication of Government responsibility, but a tool for augmenting the public health system". However, at a 0.9% level of investment, it is difficult to see what "public system" can be augmented. PPPs may be effective when there is an equal-footed public partner and extremely well-functioning regulatory and audit systems; at present there is not even an operational accreditation body for medical providers. Without effective oversight mechanisms, it is easy for a provider to mislead patients into buying unnecessary or more expensive services and medicines - especially when, as in many rural areas, patients do not have a choice of provider and lack the capacity to make informed decisions. Ultimately, private partnerships cannot be an alternative to adequate government investment, and it must remain the obligation of the state to ensure access to treatment for every citizen; this is not something that the market can be relied upon to provide. Until this basic infrastructure is in place, the cure could well be worse than the disease.

- Laura Keenan

Centre for Legislative Research and Advocacy (CLRA),
New Delhi

Polio Nightmares Make a Comeback: Call for Action

The polio situation in India is grim. In spite of the united efforts of UN agencies, the National Polio Surveillance Project, the Indian Academy of Paediatrics and civil society organisations such as Rotary International, India remains one of the few remaining locations of this vaccine preventable disease.

In the past 12-18 months, the polio condition has seemingly taken a turn for the worse - especially in the states of Bihar and Uttar Pradesh. Over a short span of time

the number of polio cases has accelerated, with incidences resurfacing in areas where there was zero polio status. The year 2007 witnessed 866 polio cases in the country. According to the Global Polio Eradication Initiative Data, as on March 6, 2008 India had 106 confirmed polio cases, of which 105 were P3 strains and one was P1. If no urgent action is taken, the statistics are likely to increase in the coming months.

To make matters worse, the P1 polio virus strain - globally reported to be the most dangerous and life threatening of the 3 strains due to a higher paralytic attack rate - has made a comeback in the National Capital Region. Not only is the P1 virus deadly, but it also spreads at a much faster rate than the others and can therefore result in the outbreak of the disease over larger areas. Despite being administered with several doses of the oral polio vaccine, a 14 month old baby, Gulnaaz, was diagnosed as the first case of P1 virus infection in the capital since 2006.

This issue requires serious attention. Several socio-economic determinants are serving as an obstacle to effective and universal interventions; hence, the need is for a holistic approach to governmental efforts in improving health, hygiene and sanitation facilities within states. The absence of these provides a breeding ground for the polio virus and interferes with effective administration of the oral polio vaccine. Another important focus of concern is the health and nutrition status of the children. In certain pockets of Bihar and Uttar Pradesh, malnourishment contributes to low immunity and makes children more susceptible to acquiring the disease. State Governments, NGO's and other local associations dealing with public health must therefore cater to the health needs of the children and also monitor their status on a regular basis

Care should also be taken to ensure that each and every child is vaccinated against polio. To achieve this, communities require vigilant, motivated, well-trained and agile staff, as well as mass media presence to raise awareness and trigger attitudinal and behavioural change.

Perhaps the Government also needs to consider alternative measures/options, one of which may be incorporating IPV (Inactivated Polio Vaccine) in the National Immunisation Programme. There is enough evidence to suggest that a mixed schedule of both OPV and IPV is highly effective; such a measure comes highly recommended by a series of experts including the Indian Academy of Paediatrics (IAP). In light of this, the Union Health Minister, Dr. Anbumani Ramadoss has called for a review of the National Polio Control Programme.

Given the devastation that polio can cause, the Union Finance Minister, has allocated Rs. 1042 crore in the 2008-2009 Budget for the drive to eradicate polio, with a revised focus on the high risk districts in Uttar Pradesh and Bihar. It is therefore imperative that this amount be allocated effectively and spending monitored, so as to safeguard future generations and put an end to the social catastrophe of polio once and for all.

- Reema Govil
Swabhiman, New Delhi

First Global Forum on Human Resources for Health Kampala Meet

Deficient availability of well trained, well supported and sufficiently motivated human resources (HR) is one of the major reasons why improvements in people's health have been so slow and have not kept pace with the rapid advances of medical science. In 2006, the WHO's World Health Report highlighted the correlation between numbers of trained health workers and levels of population coverage for essential health interventions such as immunisation and skilled attendance at delivery. The message was clear: no health interventions can be successful without due attention to the health workers necessary for service delivery.

In March 2-7, 2008, the Global Health Workforce Alliance - a partnership hosted by WHO - convened the first ever Global Forum on Human Resources in Kampala, Uganda, to debate and identify solutions to the health workforce crisis. This is a global crisis of acute shortages and unequal distribution of Human Resources (HR): both between rich and poor countries and within countries (rural/urban). Limited HR capacity in low income countries is not aligned with population health needs. This situation is worsened by overseas migration of the best professionals and unsatisfactory local working conditions that deplete motivation and performance levels within the local workforce.

Setting the agenda for future health workers:
Migration and rural retention of trained health

professionals were central concerns in the Kampala Forum. To cope with these, some countries have adopted systematic and innovative strategies: the Philippines' has drawn systematic national HR plans; Thailand imposes hefty fines on migrating graduates (\$10,000 so far and to be increased further) and at the same time also provides substantial rural posting allowances that raise a rural doctor's salary close to private sector levels.

Most importantly, countries appeared to be reducing their exclusive dependence on doctors and nurses for a range of health functions." Task shifting" or delegation of selected functions to suitably trained lower cadres is increasingly practiced and also recommended by WHO (see:www.who.int/healthsystems/task_shifting/en/index.html). Another strategy has been the development of mid level health practitioners who are trained for shorter periods (3 years) to provide clinical primary health care where there are no doctors. African countries including Mozambique and Malawi have also had positive experiences with upgrading mid level cadres into specialised surgical providers especially trained to provide emergency obstetric care and other essential life saving interventions in areas where no doctors are available.

An entire panel discussion revolved around the question "What types of health workers do we need for the future?" The panellists (including Dr. Shyamprasad from India) came with substantial experience of community and

Mid level health workers. Discussions covered the presence of mid level health workers providing clinical health services in 25 African countries, the comparability of the quality of surgical procedures done by clinical officers (mid level) and medical officers (university graduates) in Malawi, the Recommendations of a Medical Education Task Force in India for reforms in medical education and creation of shorter 3 year courses for rural providers, and legislative hurdles to medical education reforms.

The Call: The Kampala Declaration is a call for national governments to display capable leadership, determine the appropriate health workforce skill mix through

systematic planning, institute a massive scale up of mid level health workers, and assure a systematically improved working environment for all cadres of human resources in the health system.

India's health leaders and professionals must rise creatively and competently to this call, if we are to cure the ailing health indices of our rural and urban poor populations.

- Dr. Meenakshi Gautham & Dr. K.M. Shyamprasad
New Delhi

World Society of Cardio Thoracic Surgeons 18th World Congress

The 18th World Congress of the World Society of Cardio Thoracic Surgeons (WSCTS) will be held at Kos Island, Island of Hippocrates in Greece, on 30 April - 3 May 2008.

The World Society of Cardio Thoracic Surgeons (WSCTS) unifies cardio-thoracic surgeons from around the globe. The Society thus provides a forum where ideas and progress can be presented from all parts of the world, without geographical bias. Each year society's world congress is being held in a different location, thereby enhancing WSCTS worldwide nature and appeal.

The Society was started 18 years ago by important pioneers in the field, and meetings rotate between Europe, North America, Asia and South America. Plans are underway to hold the 2009 meeting in Buenos Aires, the 2010 meeting in India, and the 2011 meeting in Berlin.

The congress aims each year to further the advance of knowledge in cardiac and thoracic surgery, providing the opportunity to surgeons and related healthcare professionals to present the most progressive scientific information and to promote the global exchange of recent achievements in research and clinical experience.

The 18th WSCTS World Congress will focus on the advancements of the Cardio-Thoracic healthcare, featuring a combination of keynote and invited speakers, with plenary and concurrent sessions, poster presentations, symposia, lectures and round table discussions.

From India, Dr. Naresh Trehan, a renowned cardiovascular and cardiothoracic surgeon, Dr. K.M Cherian, (a leading heart surgeon who has pioneered new treatments, founded new hospitals and earned an international reputation), Dr. Murali P Vettath and Dr. H. Bedi have been invited to give keynote speeches on various plenary and scientific sessions. Dr. K.M Cherian and Dr. Naresh Trehan have been among the core members of the Honorary Committee of the 18th Congress. Dr. Murali

Vettath has been amongst the Programme Committee of the Congress. Dr. Vettath has made immeasurable contributions to the field of beating heart surgery and to cardiac surgery at large. He has been one of the pioneers of off pump surgery, having performed the first beating heart surgery in Bangladesh. He has had extensive training in coronary artery surgery from Australia, Holland and Paris. At present, Dr. Vettath is Senior Consultant & Chief, Department of Cardiothoracic Surgery Director at the Malabar Institute of Medical Sciences.

The highlight of WSCTS 2008 congress will be the representation of the Hippocratic Oath by congress participants, in the same place where Hippocrates first led his students to swear the oath, before exercising their medical profession. In addition, participants will have the opportunity to personally engrave their names in one of the stones that will constitute a monument in honour of Hippocrates, especially commissioned for this event.

- Amrutha Reddy
New Delhi



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Published by Vinod Bhanu, Executive Director, CLRA for IMPF, 160, South Avenue, New Delhi-110011. Centre for Legislative Research and Advocacy (CLRA), an organisation of expertise in parliamentary affairs and related work, is the hosting/implementing organisation of the IMPF.

Printed at A.K. Printers, New Delhi-110067, Ph: 9818114996.