For private circulation only

Indian Medical Parliamentarians' Forum

Newsletter

Vol. 2, No. 2 **Monsoon Session Issue** **August-September 2007**

Dear friends,

Greetings from IMPF!

On behalf of Indian Medical Parliamentarians' Forum (IMPF), we are releasing the fourth issue of the IMPF Newsletter. We are also pleased to announce the release of the *IMPF Policy Notes for Parliamentarians on Access to Medicines*, which can be a brief resource document informing parliamentarians and policy makers on the prevailing access issues in India.

In the month of March 2007, during Budget Session, IMPF organized an Indo-British Parliamentarians Meeting on 'Call to Stop TB'. The meeting ended with the signing the international Call to Stop TB, urging more action on the part of Parliamentarians on the issues of TB. As a follow-up, we formally announce the formation of a Parliamentarians' Group on TB (PG-TB) along the lines of the UK All Parliamentary Party Group on TB, in order to renew and continue the fight against TB. Dr. Shakeel Ahmad, Hon'ble MoS has kindly been agreed to Chair this focused group on TB.

IMPF greatly appreciates and welcome the new estimates released by the National AIDS Control Programme (NACO), demonstrating that national adult HIV prevalence in the country is approximately 0.36 percent in 2006. The estimate gives more reliable and accurate figures, when compared to the previous disputed figures. The new data is the result of an expanded surveillance system and a revised and improved methodology. Accuracy in disease prevalence is important in addressing issues of prevention and treatment. According to Union Health Minister, Dr. Ramadoss, it is clear that the lower number of cases need not mean fewer government funds to fight HIV. The recently announced NACP Phase III will have a budget of US $ 2.8 billion, compared to the Phase II in 1999, which had a budget of less than US $ 350 million.

It is *significant* to note that the Swiss pharma giant Novartis India Limited lost the case in Madras High Court, where they had challenged the provision of the Indian Patent Act. We welcome the Judgement, as the Court has recognised the anxiety of millions of patients..

This issue of the Newsletter, Monsoon Session, 2007 is being brought out by the support of the *AIDS Healthcare Foundation-India Cares*, New Delhi. We would like to place on record our acknowledgement and extend our gratitude to the AHF for their valuable support. We also thank all our well-wishers for showing their solidarity and extending their support to the IMPF concerns.

R. Senthil
Convener-Secretary

M. Jagannath
Chairperson

160, South Avenue, New Delhi-110011
Tel: 91-11- 23792862; 91- 9868180617; 91- 9818111915
E-mail: impforum@gmail.com; impforum@impf.in ❑ Website: www.impf.in

Entry of Insurance in Health Services: Some Recent Trends in India

The recent outbreak of chikungunia and dengue in several States of India has been an eye opener from a public health point of view. It has once again brought into sharp focus the importance of an effective public health strategy. Instead of such a strategy, what has been attempted is the neo-liberal agenda which include downsizing public sector employees. It also includes contracting out some key services to the private sector, introduction of user charges, etc. Several state governments in India including Kerala have given in to neoliberal solutions such as the insurance models. Generally, cost-sharing and risk-pooling initiatives had a negative impact on accessibility and utilisation of health services in poorer countries. The frequency of use of medical services decreased significantly almost everywhere after the implementation of cost-sharing measures such as user fees (Jens Holst, "User fees in healthcare: Myths, Truths and evidences," in Ulrich Laaser, and Ralf Radermacher, eds, *Financing Health Care - A Dialogue between South Eastern Europe and Germany*, Jacobs-Verlag, Dusseldorf, 2006, pp. 69-114). User charges also affect the access of women and low income groups to basic services.

OECD and WHO advocate free primary-level services, exemption systems for hospital services, charges for the use of tertiary care by those who can afford it, etc. Community Based Health Insurance (CBHI) has been proposed as a transitional mechanism to achieving universal coverage for healthcare in low-income countries on the basis of policy link between CBHI and universal coverage established by the historical experience of mutual health insurance in countries such as Germany and Japan in the 19th century (P. Mladovsky and E. Mossialos, "A conceptual framework for community-based health insurance in low-income countries: social capital and economic development," Working Paper No. 2, 2006, London School of Economics and Political Science).

The CBHI may be different from the three models that exist at present such as (1) direct reimbursement model – post-hoc payment of money as in France and Switzerland, (2) Contract models – the company contracts providers for the clients, as in Germany, and (3) Integrated Models – the insurer provides the service to the insured as in British NHS (government) and US HMO (private). The missing link in the present models of insurance being advocated is the entirely different social context. Context-dependent policy considerations such as values of scheme members, community goals and local and regional power relations are not emphasized in the analysis of CBHI by institutions such as the World Bank and the WHO.

In Kerala, the community based insurance scheme is being implemented by ICICI Lombard, a commercial insurance company. The high morbidity rate and the prevalence of diseases such as leptospirosis, dengue, gastro-intestinal diseases apart from other poverty and water related diseases and their impact on the poor are pointed out as reasons for initiating an insurance scheme for the poor in Kerala. Although basically intended for the poor in overcoming the resource crunch of families at the time illness, the market for healthcare is the basic principle on which some of the recommendations are made. For instance, the proposal on pro-poor insurance scheme is based on the financial logic that more than half of the people at the bottom of the pyramid spend more than Rs. 2400 per annum. Another argument in favour of micro health insurance (MHI) is the impact in terms of impoverishment of households due to healthcare costs. It is assumed that a community based micro insurance scheme will be able to tackle the pauperization due to catastrophic health expenditure. The outcome of this scheme is not yet known.

Insurance is a typical 'reform book' solution, which may not be able to grapple with the complexity of the existing disease burden and extreme differentials and inequalities that exist within the society. It has not worked very well in the developed countries including the United States. In this era of evidence-based approaches, insurance do not qualify as a general solution to compensate for deteriorating access to health services.

The strength of India's healthcare system is its elaborate network of health infrastructure that is being systematically undone in recent years. Any model of health financing will work only if we recognize this strength. It is still not too late to redeem the public sector health services from utter decay. The poor still depend on the health centres and hospitals in the public sector.

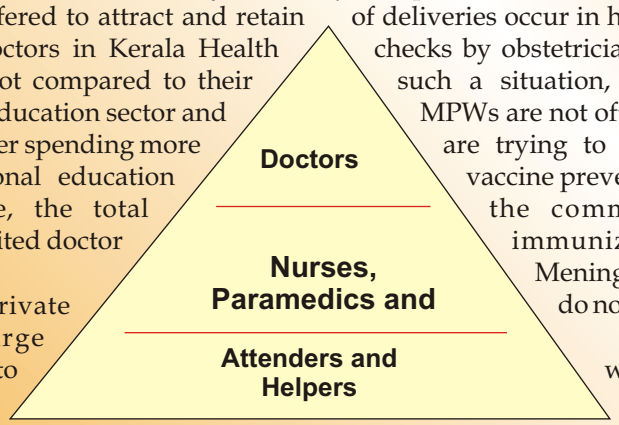
- Prof. K.R. Nayar
Centre of Social Medicine and Community Health, JNU,
New Delhi

Workforce issues in Public Health sector - Two experiences from Kerala

Kerala model of 'good health at low cost', hailed as universally replicable, was facing crisis since last decade. With a very low per capita income and lower per capita health expenditure, the state achieved health indices at Par with the West European countries. A well knit primary healthcare system depends very much on The availability of empowered workforce. Two recent experiences with workforce management give examples on how Kerala needs to learn lessons from others and what Kerala has to offer to others.

The first is in the context of shortage of doctors. Any healthcare delivery system will have highly qualified

professionals at the top, lesser skilled semi-professionals in the middle, and unskilled supporting staff at the bottom as depicted below: Though lower level of employees will be available on low salary, better incentives will have to be offered to attract and retain professionals at the top. Doctors in Kerala Health Services are a poorly paid lot compared to their counterparts in the medical education sector and other similar professions. After spending more than seven years' professional education before joining the service, the total emoluments of a newly recruited doctor still remain below Rs 20,000.



With the boom in private medical education, a large number of doctors are going to be qualified every year. To many of them the salary might not even suffice to pay back the interest of their education loans. Such qualified medical graduates will be 'exported' to other countries who would welcome them to save millions of dollars for creating doctors in their settings.

Doctors appointed on contract basis for provision of curative services are unlikely to contribute to the field activities which are crucial in primary healthcare. Over the past few years there had been steady decline in health indices in the state and the trend is likely to continue. The only way out is to revamp the primary healthcare and bring back the doctors to the system. Many other Indian states have succeeded in attracting doctors to their primary healthcare and Kerala needs to learn lessons from them.

The second experience from Kerala is replicable. Kerala is fast undergoing demographic transition, which have altered the structure of population pyramid with very few children at the bottom and large number of elderly at the top. Epidemiologic transition occurring side by side has replaced the once rampant communicable diseases with an emerging epidemic of non communicable diseases (NCDs). Realizing this, the Government has come out with certain timely interventions. The responsibilities of Multipurpose Health Workers (MHWs) and their supervisors were largely confined to Maternal and Child Health, Family Child Health, Family Welfare and some Public Health activities. Till recently, they were working according to job responsibilities decided in 1983. More than 97 percent of deliveries occur in hospitals in Kerala and antenatal checks by obstetricians start as early as 6 weeks. In such a situation, antenatal services offered by MPWs are not often acceptable. Similarly, MPWs are trying to propagate the message of six vaccine preventable diseases (VPDs) whereas the community is already availing immunizations against Hepatitis-B, Meningitis, etc about which the MPWs do not know much.

This resulted in a situation where the households did not require the services offered by the MPWs and they were not able to provide the services demanded by households. This grave situation was revealed in a study conducted and the State came out with a landmark Government Order redefining their job responsibilities. Now the gamut of services provided by the MPWs includes services related to NCDs including mental problems, trauma and early detection of malignancies. They also provide rehabilitation services related to these conditions. Thus, the responsibilities of MPWs now includes detection and monitoring of Diabetes and Hypertension in the community, detection of early forms of malignancy, support to the mentally ill, rehabilitation support to the physically and mentally challenged etc. MPWs are being trained on the redefined job responsibilities. A pilot project to train the MPWs on detection and monitoring of Diabetes and Hypertension has received overwhelming response. In several places, the workers have started organizing clinics and camps, with the help of their medical officers. Situations faced by Kerala are going to be faced by the other states in future and Kerala provides a replicable model.

- Dr. V. Mohanan Nair
Principal, Kerala State Institute of Health and Family Welfare, Thiruvananthapuram, &
Director, Collaborating Training Institute of the NIHFW

Access to Primary Healthcare and Necessary Drugs

Provisioning of primary healthcare (PHC) should be the primary responsibility of the state as economic and social inequities make access difficult for the poor. Alma Ata Declaration accepted this principle and required that it be located at the core of community welfare with full support of the secondary and tertiary level services. Today, this remains critical for several reasons. Population below poverty line is 34.7 percent (UN 2006), rural public health services are inadequate and the poor are unable to go far for treatment. As a result, the use of public hospitals for hospitalization has declined from 60 percent to 41 percent and patients not seeking treatment Treatment due to economic reasons has risen (NSS: 42nd and 52nd round). Poverty - both economic and environmental - as the cause of serious diseases is now well accepted (WHO 2006). Hence, assumption that rural disease pattern is simple and manageable, ignoring the heavy load of serious diseases is inappropriate. All these indicate a crisis of access specially, for the poor.

The root of this crisis lies in a national health policy that promotes unregulated privatization of medical care, steep rise in prices and market takeover of tertiary and

Secondary services, heavy cuts in subsidies for public sector, user fee and shift in priorities of services, creating a crisis of access to services.

According to the NSS, for ailments not needing hospitalization, 19 and 22 percent population uses public facilities against 81 and 78 percent who use private sector in urban and rural areas. In serious illnesses needing hospitalization both rural and urban population's utilization of public facilities goes up to 42 and 38 percent. Utilization of public hospitals among monthly per capita expenditure categories reveals that 60 percent of those below poverty line use public institutions and 26 percent in the lowest decile seek no treatment. This trend is heightened among scheduled castes and tribes. The importance of investing in public health infrastructure, drugs and manpower for PHC, therefore, should be emphasized.

The National Rural health Mission (NRHM), attempting to strengthen the rural infrastructure, has to address the rural urban inequity in access to secondary And tertiary services and strengthen primary health centres and their referral links. NRHM has gone back to the old model of a peripheral institution for 100,000 population (CHC), ignoring the new primary health centre's value for the less privileged. It has reduced its manpower and resource base and introduces private partners for referral. The poorest gets neglected in the initial stages and this ultimately increases the load of CHC, wasting additional resources that could be saved by first level treatment at PHC. NRHM ignores the training of paramedical workers and the need to improve the working conditions of the 2,928 PHCs with no doctors (Planning Commission, 2006). Instead of helping and supporting the 20,308 doctors posted at PHCs, it laments the non availability of doctors while 20 percent of the graduates are allowed to serve the globe through immigration.

User fee contributes less than 10 percent of the total costs incurred, but it helps the rich to usurp the free bed facilities both in public and private hospitals as shown by the NSS 52nd round and the Qureshi Committee report 2000. Removal of user fee from public institutions especially for national health programmes and all services for the poor is the key to improving access. Essential drug availability, central to PHC is another key issue. Their list has declined from 74 in 1995 to 38 drugs in 2002 (now including several irrelevant drugs). The policy of price decontrol has adversely affected PHC by increasing prices of drugs for tuberculosis, anaemia, diarrhoea, diabetes and cancer. Unless a system of bulk purchases, open tenders and procuring single ingredient drugs (as for anaemia) is used, access to treatment will remain a myth.

- Imrana Qadeer
Professor (retired), CSMCH, JNU

Status of RCH in Gujarat

NGOs in Gujarat have been active on the issue of health, especially of women's health. AWAG has been involved in responding to the health needs of rural women, on rights-based approach. Indian constitution promises right to health to every Indian. Article 12 of CEDAW asserts that "States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period…" In 1995, at Beijing women had said, "Enough of complaining. Ask for action from State." After the National Health Policy 2000, Gujarat laid down its State Population Policy in 2002. In both the policies, the emphasis was on population stabilization with the need to improve health and family welfare services.

AWAG proposed to be active on these promises made by the State. But then AWAG soon realized that in Radhanpur block where it was actively involved with rural women, the services proposed to be provided to rural women were largely on paper. AWAG made the rural women aware of their right to health so that they demanded healthcare from the health providers appointed by the State. Female Health Workers (FHWs) did not report at appointed places of work, and the medical officers at PHCs cared little for the work assigned to them. Rural women protested. It took them five years to remedy the problems. In March 2005, the block got 80 percent of the health providers at their places of work

However, AWAG found that in the nearby block the situation was as bad. Recently women's committees in a neighbouring block Sami, east of Radhanpur in Patan district, surveyed the facilities available to them as against those officially provided to them on paper in their block. There are 5 primary health centres (PHCs) and 36 sub-centres in the block. PHCs are headed by medical officers and female health workers (FHWs) look after sub-centres. The survey found that only 13 FHWs (36 percent) are working at the sub-centres allotted to them. Where 22 are expected to be on duty, 9 are not reporting for work. Fourteen positions have been vacant of which 10 have been reported vacant since 2003.

All medical officers (5) are present at their assigned places. However, none of them is competent enough to help at the time of childbirth. There is no gynaecologist at the block's community health centre (CHC), nor anyone privately practising in the block. Pregnant women turn to traditional birth attendants (TBA). They were doing so in the absence of the State providing any mechanism of service. We need efficient service providers for Reproductive and Child Health (RCH) very badly and those who are expected to provide are nowhere in sight. What is worse is that when women of Sami town went to the CHC to hold a meeting, the labour room was found housing truck tyres!

Sami block is more or less quite representative of ground realities in Gujarat. Wherever AWAG has looked closely at medical facilities for rural women, these are found to be wanting.

Such implementation of State's policy, did not seem to support the resolve to help every newborn baby survive. Questions are raised. Did the State really want to support RCH program? Goals, in terms of reducing Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR)) were set. But the State does not appear to be moving anywhere near the set targets.

Then, in 2005, the State made a volte - face and passed a Bill in its Legislative Assembly, asserting the two-child norm. This law brings under it 1.42 lakh elected representatives in local self governing bodies, panchayats, municipalities and municipal corporations. In both the national and state population policies incentives and disincentives as the means to control population were negated and RCH was considered important. This law now contradicts the above cited policies.

Is this assertion of disincentive in the form of two child norm a signal to renounce the responsibilities of RCH undertaken through the Population Policies of 2000 and 2002?

The political will of the State appears to be either confused or is taking the people of Gujarat for a ride.

- Ila Pathak
Ahmedabad Women's Action Group

India should support Thai governments action to protect public health

Since Indian law has started granting 20 year monopolies on drugs, access to affordable treatment for millions of Indians has come under threat. As an Indian living with HIV, I have personal experience with the struggle to get life saving treatment, a struggle many Indians face daily when they can't afford treatment. In today's world, we rely heavily on our government to get healthcare services. It is a Constitutional the right to life provided in Article 21. Where market monopolies reduce our negotiation power with big pharma, we need our governments step in and take actions to reach life prolonging and life saving treatment to those who need it regardless of their wealth, power or position.

One such action may be to issue a compulsory license on an essential drug. Compulsory licenses are necessary when essential medicines, which are patented, are unavailable or unaffordable. Under a product patent regime, governments are increasingly feeling the need to issue licenses, particularly where they are directly involved in providing treatment to their citizens. A compulsory license for generic importation or local production is often the only solution to solve procurement problems, increase local availability of drugs and save on costs for patients and the national health budget.

Thailand issues compulsory licenses

In keeping with its commitment to achieve universal access to essential medicines for all its citizens, and after two years of failed attempts to negotiate with pharmaceutical companies, the Thai government issued compulsory licenses on three drugs in the last few months. This allows Thailand to import affordable, safe and effective generic versions of the patented drugs from other countries or produce them on their own.

What happens when a country takes steps to ensure that its people have access to essential medicines?

First, big pharma will hold the lives of hundreds of thousands to ransom. In Thailand, Abbott Laboratories is withholding 7 of its new medicines from the Thai market. Second, developed countries will use direct and indirect threats to force that country not to protect the lives of their citizens. The US has just put Thailand on its 'priority

Drug on which Compulsory License issued	Price of patented version	Impact on price and availability after issue of Compulsory License
Efavirenz (HIV drug 5 lakh Thais live with HIV)	Rs 1749 (per month)	Rs 811 (per month) - The lower generic price is allowing Thailand to treat 20,000 more patients at the same cost.
Lopinavir+Ritonavir (Second line HIV drug patented by Abbott Laboratories)	Rs 7490 (per month)	Initially at least 20 percent price reduction expected allowing 8000 more to be treated more competition expected to lead to lower prices.
Clopidogrel (Heart disease drug 3 lakh Thais live with heart disease)	Rs 92 (per day) Only 10 percent of Thai heart patients can afford.	Rs 9 (per day) The price goes down by 10 times allowing Thai government to provide it in their Universal health scheme.

Source: White Paper issued by Thai Government "Facts and Evidences on the 10 Burning Issues Related to the Government Use of Patents on Three Patented Essential Drugs in Thailand," February 2007; available at http://www..moph.go.th

watch list' which could impact Thailand's trade margins. All this is in retaliation to the exercise of a sovereign right by the Thai government to determine how to achieve its public health goals and ensure treatment for all – a right recognized and guaranteed under international intellectual property rules.

Why should we support Thailand?

Big pharmaceutical companies backed by their governments are pressurizing countries all across the developing world against asserting their right to provide healthcare to their citizens. Abbott's actions in Thailand are no different from those of Swiss Company Novartis, which has dragged the Indian government and cancer patients to court over key public health safeguards in India's patent law. India, like other developing countries, is today facing a crisis in accessing affordable medicines. In the case of India's HIV treatment programme, the government continues to refuse to commit to providing second line treatment citing cost issues. Compulsory licenses will possibly be the only viable option for the Indian government, and now India and Indians must stand up and speak up in support of Thailand.

- Loon Gangte
President, Delhi Network of Positive People

Arya Vaidya Sala of Kottakkal: Futuristic Concerns

Ayurveda is an ancient and indigenous system of healthcare being practised in the Indian subcontinent. The objectives of Ayurveda are mainly two, the first being the maintenance of positive health, and the other treatment of diseases.

The Arya Vaidya Sala (AVS) was founded in 1902 at Kottakkal in the Malabar region of Kerala, by the visionary late Vaidyaratnam P.S. Varier. At the time of Varier's demise in 1944, Arya Vaidya Sala was converted into a Charitable Trust as per the provisions of his Will. Under the leadership of his nephew, Padmashri P.K. Varier, AVS has now grown to become a multi-crore organisation with considerable presence in medicine manufacture, clinical service, Ayurvedic research, education and publication and also in medicinal plant cultivation. There is no family or individual beneficiary for its operations and the complete earnings are pooled back to charitable activities, research, education and development. It has two medicine manufacturing facilities at Kottakkal and Palakkad where a large variety of classical formulations are prepared by adapting classical modalities to appropriate modern technological means. A third one is coming up in Karnataka. These medicines are made available through 1200 exclusive dealers in the country. AVS runs 20 direct Branch Offices where Kottakkal trained physicians are positioned. Such branch clinics operate in cities like Delhi, Mumbai, Kolkata, Chennai, Secunderabad, Bangalore, Coimbatore and Madurai, apart from major towns of Kerala.

AVS is famous for its classical Panchakarma and special therapies available in its 5 hospitals located at Kottakkal (2), Delhi, Kolkata and Kochi. The hospital at Kottakkal was the first one set up 53 years ago. The Centre for Medicinal Plants Research, inaugurated in 2003 by the then President of India, Dr. A.P.J. Abdul Kalam, is an advanced centre for research. AVS is also engaged in modern research in collaboration with Governmental Agencies like CSIR, DBT, DST and ICMR, and owns jointly some patents along with CSIR. The 90 years old VPSV Ayurveda College is financially supported by AVS.

It was only in 1994 that a Department for Indigenous Systems of Medicine was set up under the Ministry of Health and Family Welfare. The present drug licensing system and GMP regulations have imaginative provisions and they have helped the general Ayurvedic drug industry to cross the initial barrier of modernisation. However, the new centralised product registration mechanism mooted should take care to maintainthe unique and diverse capabilities of Ayurveda. There are several regional text books and traditional procedures and formulations which do not happen to be included in the Schedule-I of the Drugs and Cosmetics Act. And thus, any medicament adapted from these will be treated as Proprietary and Patented (P&P) drug and will have to be approved by the Centralised licensing authority in the new system. Since they are regional in character, the authorities may not Have epistemological clarity about these formulae. *Chikilsamanjari* of the Kerala tradition is a well known example. The evolving regulations may necessitate generation of clinical data etc for such formulations to become eligible for license.

There are several important plant species which are diversely recognised and adapted in the northern and southern traditions of Ayurveda. The Government may consider the possibility of initiating academic / policy level interactions between subject experts from both Ayurveda and modern botany to bring in further universalisation in the raw material usage.

The area of education is yet another issue. It is a good development that students after their matriculation have to pass a Common Entrance Test for trying to get admission to Ayurveda undergraduate course. But, asdropouts to modern medicine turn to Ayurveda, and as they are not equipped to appreciate and understand the typical philosophical base and epistemological paradigms of Ayurveda, the need for a separate entrance test for Ayurveda may have to be considered.

In all these efforts, the far-sighted methods of China may seem to be a role model for us. The Traditional Chinese Medicine (TCM) is in the fore front of

complimentary medicine in the West primarily because of the concerted efforts taken by that country half a century ago. May be, our Government can also take a leading role in bringing Ayurveda to the Global front. One possible first step could be to act as a facilitator of meaningful interactions between scholars, professionals, practitioners, industry, regulatory personnel and national laboratories.

- Dr. Shrinivasa Pandey
Physician, AVS, New Delhi
& Dr. T.S. Murali
Chief (R&D) AVS

AIDS Healthcare Foundation providing AIDS Treatment and Advocacy in India

AHF-India Cares was established in 2004 in India under the aegis of AIDS Healthcare Foundation (AHF) and registered as a Trust in 2006 in New Delhi. The Trust carries forward the vision and mission of AHF. People living with HIV/AIDS (PLHA) require treatment, care and support. AHF-India Cares enables PLHA to gain access to healthcare services free of cost.

AHF-India Cares follows World Health Organization and NACO criteria to initiate ART and adheres to NACO's operational guidelines and recommendations for ART centres. AHF anticipates expansion of India Cares with scale up at one site each in Karnataka and Delhi, as well as multiple sites in collaboration with NACO in Assam.

Centre of Excellence (COE): AHF-India Cares is in the process of transforming its ART centre in Delhi into a Centre of Excellence providing holistic care and treatment services for PLHA, including psycho-social services and paediatric AIDS treatment. The COE has registered more than 300 clients in the last one year. AHF-India Cares is currently providing free first-line treatment to all our patients and second-line drugs to only a few patients on account of costs. It also provides free HIV testing and CD4 count and other required test for initiation or monitoring of cases under ART.

Public-Private Partnership: AHF-India Cares began in 2004 in partnership with the Swami Vivekananda Youth Movement (SVYM) to provide ART services in Mysore, Karnataka. AHF provides financial support and technical assistance to ensure the highest quality of care to patients.

Second-Line ARV Treatment: As second line treatment is yet unavailable at government ART centres, AHF-India Cares initiated an 'AIDS Activist Program' supporting activists needing free second line treatment to advocate for the voices of the voiceless.

MoU with Government of India: In December 2006, AHF India Cares has signed a MoU with NACO, Ministry of Health and Family Welfare, Government of India to set up collaborative multiple ART project sites in Assam as a model for high quality provision of ART and associated healthcare and medical management of PLHAs.

Asia Pacific Bureau Meet: The AHF APBM 2007 is the first regional meeting held in New Delhi, India at Tivoli Garden Resort from 22 to 23 March 2007. The theme is most appropriately and strategically coined as ***Expand, Enhance and Achieve***.

Other Activities and Achievements: Organized a photo exhibition, 'Photos of Hope', a celebration of life, in collaboration with American Embassy and the American Center (photographs were by Chinkholal Thangsing of patients whose life changes due to the use of ART).

Ms. Sujatha Rao IAS, Director General NACO, Dr. Chinkholal Thangsing, Asia Pacific Bureau Chief, AHF and other officials of NACO and AHF board member witness the occasion of NACO and AHF-India Cares signing MoU.

Organized an 'Advocacy March' in consultation with larger groups including INP+, PWN+, DNP+ and other like-minded civil society groups, at India Gate, New Delhi demanding the Government to provide newer first-line and second-line treatment. A Memorandum was submitted to the Honourable President of India, Dr. A.P.J. Abdul Kalam, on 24 March 2007 for his intervention.

Launched a new campaign, targeting generic drug over-pricing beginning with a focus on Cipla followed by other drug companies including Ranbaxy, Emcure, Aurobindo Pharma and Genix, which has raised a spirited debate. The major concern and priority of AIDS activists has been second-line ART therapy. AHF had initiated a dialogue with various activists since November 2006, when it questioned Cipla's drug pricing in India. The only way ahead to make all ARVs universally available is to further bring down the prices of generic drugs charged by Indian manufacturers. AHF has loudly criticized both publicly and privately every branded AIDS drug manufacturer including Gilead, BMS, GSK, Merck and BI.

AHF's Global Presence: In the Asia/Pacific region, AHF currently provides free anti-retroviral treatment to people in need through its clinics in India (Mysore, New Delhi, Guwahati) as well as in free treatment clinics in China (three sites), Cambodia (6), Vietnam (1) and Thailand. AHF is the US' largest and oldest and non

-profit HIV/AIDS healthcare, research, prevention and education provider with twenty years history of advocacy on behalf of PLHAs, which currently provides medical care to more than 50,000 individuals in 15 countries worldwide in the US, Africa, Latin America/Caribbean and Asia. AHF will continue to expand as long as needed.

- Dr Chinkholal Thangsing
Asia Pacific Bureau Chief, AHF
Website: www.aidshealth.org

IMPF participated in IAS 2007

The 4th International AIDS Society (IAS) Conference 2007 on HIV Pathogenesis, Treatment and Prevention, was held in Sydney Australia from 22 to 25 July 2007. Global Fund held a Satellite Session on antiretroviral treatment (ART) scale up, based on new results figures. I was invited to speak on the Indian experience on ART scale up. The other invitees were Dr Agnes Binagwaho, Executive Secretary of the National AIDS Control Commission, Rwanda and Fujie Zhang Managing Director, National Center for AIDS/STD Prevention & Control, China. The Chinese response was a mix of political and bureaucratic commitment. The Rwandan was more of administrative response to start with and later became a political movement, whereas the Indian one was political and bureaucratic from the beginning. No other country has the Prime Minister as the Chairperson of the National AIDS Council. This is the genuine evidence for India's political commitment.

The Indian story of combating HIV and AIDS is a true success story. The NACO has revised the figures of the epidemic in its NACP III, released in July 2007. The figures are encouraging. The new figure of 2.5 million positive people does not mean that there is a reversal of epidemic. It means that we now have a better evaluation methodology. But it is also true that the epidemic has stabilized, and in states like Tamil Nadu there is a true reversing trend.

India was quick to act immediately after the first case of AIDS was reported from the Christian Medical College, Vellore in Tamil Nadu in 1986. Soon after the reporting of this case a National AIDS Committee was constituted under the Ministry of Health and Family Welfare. In 1989 a Medium Term Plan was envisaged with the support of WHO and a modest budget of US $ 10 million. Initially it was for programmes in only the four states of India – Tamil Nadu, Andhra Pradesh, Karnataka and Maharashtra. The interventions planned were targeting education, awareness campaign, and surveillance.

The National AIDS Control Programme I was launched in 1992, and then the National AIDS Control Organization (NACO) was established. The interventional strategies were Prevention, Awareness and Capacity Building. The Objectives were to attain below 5 percent seropositive cases in high prevalence states and less than 3 percent in states with moderate prevalence.

The NACP II was launched in 1999. During this period the National Council on AIDS was constituted with Prime Minister of India as Chairman, showing a strong political commitment. The aims and objectives of the NACP II were to reduce blood borne infection to less than 1 percent, to increase the awareness levels to more than 90 percent among youth and others in reproductive age groups, to increase the condom use to more than 90 percent, and to reduce seropositive cases to below 5 percent in high prevalent states, to below 3 percent in states where prevalence was moderate and to less than 1 to 2 percent in states where epidemic was at still nascent stage.

NACP III was launched in July 2007. The essential strategy continues to be Prevention and targets Interventions for High Risk Groups, which had been the reasons for the success so far. The NACP III will continue its focus on Care, Support and Treatment, Capacity Building, and Strengthening the infrastructure, systems and human resources. However, a new Strategic Information Management System has been introduced to have an expanded Surveillance with revised and enhanced Methodology.

1 December 2003:	Announcement of free national ART programme
January 2004:	National expert consultation to plan ART Programme
1 April 2004:	First patient started on ART
May 2005:	10,000 patients placed on ART
August 2006:	50,000 patients placed on ART
December 2006:	100 ART centres functional
March 2007:	127 centres functional
April 2007:	75,000 patients placed on ART

- Provide free access to ART for 100,000 PLHA by 2007.
- Provide free access to ART for 188,000 PLHA in 6 HP states and Delhi by 2010.
- Provide free access to ART 300,000 PLHA all over the country by 2012.

- Dr. R. Senthil
Member of Parliament, Lok Sabha

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

Supported by: AHF-India Cares

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