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From Editor's Desk

Health For All by 2000 AD was the Government's very optimistic declaration! But we are no where near this avowed goal even after nearly 15 years past. Instead, the health situation of the country has worsened. The successive Central Governments have done precious little to improve the situation. Diametrically opposed to the Bhore committee (1943-1946) recommendations to take all out measures to serve health for all "from womb to tomb", by strengthening the public health system, health care delivery is being handed over a platter to the private players. The " National Health Policy 2015 Draft" of the NDA lead Central Government is nothing but a blue print of privatization. While the Government institutions are allowed a slow death due to paucity of funds, the corporate sector is given all kinds of sops to take over, at the cost of the public exchequer! The public health expenditure of the country stands at present at just 1.2% of GDP. In the budget, allocation for health and family welfare has come down from Rs. 35,163 crores last year to Rs. 29,653 crores this year. But, in the last one decade, the government has liberally granted relief of an estimated amount of Rs 40 lakh crore rupees to the industrial houses and monopolists in the form of various waivers, exemptions and concessions!

When private insurance sector has failed miserably in an advanced country like America, with the people demanding for socialized medicine, India has welcomed it, making the impoverished people pay for their health!

Almost all the bulk drugs and a large number of essential life-saving drugs are out of price control measures at present. In spite of the minimum control that existed earlier, the drug prices were beyond the means of the people and as a result, thousands of patients were being pushed to death for want of medicine and medical treatment every year. But the NDA government has by one stroke cancelled even that little price-control in life saving and essential drugs in order to pave the way for the maximization of profit for the giant pharmaceutical multinationals and the monopoly.

The end result of all these measures is that, the out of pocket expenditure on health in India is close to 78 per cent, in stark contrast with the Maldives (14%), Bhutan (29), and Sri Lanka (53%) as per a 2011 analysis by the medical journal The Lancet.

With fewer doctors, hospitals and other health infrastructure than any of the BRICS (Brazil, Russia, India, China, South Africa) and the lowest public-health

spending, India, already the poorest among these countries, forces its people to spend a greater percentage of their incomes on private healthcare than any other BRICS nation. Unsurprisingly, healthcare, or the lack of it, has been cited as one of the major reasons that Indians fall back into poverty. It is also reflected in the country's consistently high disease burden.

Instead of evolving a scientific medical education integrating different systems of medicine, there is a hotch potch mixing in the name of encouraging indigenous medicine, endangering the lives of people. This also has created unnecessary rivalry among the practitioners of different systems. The commercialization of Medical and Paramedical education has denied the deserving, meritorious students an access to it, making it the privilege of the moneyed and allowed again the private sector to loot people.

These are the serious issues raised time and again by the well meaning professionals and the people. Medical service Centre has always stood by the cause of the people and taken up movements demanding to make health for all a reality. This Issue of Health Spectra has dealt with some of these issues. Suggestions are most welcome.

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On Draft National Health Policy - 2015

Medical Service Centre is a national level Socio-medical Voluntary Organisation working in the field of health since 1977, comprising of doctors to grassroot level health workers of medical practice of all systems in India. The organization is focused to render free services during disasters, taking part in raising health consciousness of the people, setting up regular free medical & health check up camps for the needy, inculcating medical ethics as well as fighting for right to health of the people and opposing any anti people health policies & measures.

Although the Ministry has displayed the draft in its website, but nowhere it mentioned who authored or composed it. We being deeply concerned about the right to heath of the people and right of health workers, welcome this gesture of seeking suggestion from various cross sections, but at the same time we propose, before finalizing the draft the Ministry should hold State/Zonal level discussions/debates on the subject and formulate an Expert committee/Health commission to give the Draft a final shape taking representatives of sound standing on the matter -covering all streams of Medical practices and all categories of health personnel.

Executive Summary

In the draft policy though the Govt. has acknowledged that public health expenditure of the country is the key to improve its health parameters as well as comprehensive health care services but at the end it has concluded to grant maximum 2.5% of GDP for health sector as public health expenditure which is at 1.2% at present. This is just 50% in respect to the commitment of India at 'Health for all by 2000 AD Declaration' and also of WHO and UNO guidelines which was at least 5% of GDP for the developing countries. Let alone release of 5 % GDP, Govt. has even denied to set any target for achieving this goal of 2.5% GDP in the present Draft. As per the present infrastructure and manpower availability, India has reached nearly 50% of its requirement and falls far behind even of Indian Public Health Standard (IPHS) in catering to health care delivery services through Govt. facilities. Instead of increasing the necessary infrastructure, it has envisaged to depend on private or non-Govt. hospitals and Institutions/agencies for fulfilment of the needs of its people. In the name of Universal Health Coverage (UHC) the Govt. has contemplated to mobilize reimbursement/fund through Insurance policies, as if 'insurance coverage of health' is equal to 'right of health' of the people! This is not at all. Health Entitlement Card for getting cashless or free health services from primary

and higher care centers has been advised. But why will an Indian citizen require such a card is not understood. 'Health tax 'or 'health cess' for augmentation of resources needs no introduction. If the Govt. really means health as wealth of its citizens fostering economic growth, then health expenditure in the budget should get adequate importance and quantum in spite of off & on curtailment of the paltry sum whenever allotted. With regards to medical manpower production, Doctor: Population ratio has already reached the level of 1:700 inclusive of AYUSH graduates, but 'health personnel: population' ratio is much below the requirement. Due to lack of proper planning, absorption and distribution policy, qualified doctors are always shown as a deficient entity in the vast portion of our country. Increase of number of private/Govt. medical & paramedical institutions to increase doctors and allied manpower would never help to improve deficiency situation unless realistic approach is adopted and pursued.

We need and recommend proper evaluation, research, utilization and scientific integration of AYUSH. But unscientific, irrational overemphasis on traditional and indigenous practices will not help achievement of scientific health; rather it encourages superstitions & outdated thoughts & obscurantist ideas and beliefs. Giving extraordinary weightage on private health facilities for ensuring secondary & tertiary health care of the people, the draft has planned to directly assist private health industry for its sustenance & growth. Side by side, the public facilities, including tertiary care giving medical college hospitals are left to surreptitious peril due to utter negligence and mismanagement and under funding. Not only that, proposal for handing over even primary health care facilities in totality or partially to private agencies and outsourcing are clear indications of encouraging development of private set-ups and gradual destruction of public set-ups. In the First and Second National Health Policies of 1983 and 2002 also, we had observed, encouragement and invitation to private sector in health field. Now with this draft national health policy-2015, the full circle of privatization-commercialization and commodification of health will be complete. The draft policy now virtually expresses, it is governmental responsibility of running and sustaining this fast grown up private health industry at the cost of public exchequer. What then do UHC and right to health of the people mean? Is it through insurances and private health facilities? Is the proposed rise of GDP in health from public exchequer to satisfy ever growing and highly rewarding private health industry?

In this context, we should remember the historic recommendation of the Bhore committee for all out measure to serve health for all “from womb to tomb”-which was framed on the eve on our independence reflecting dreams of our great martyrs and other freedom fighters.

Some salient points of criticism and alternative avenues:

1) Draft NHP-2015 proposed that health care services to all citizens will be made available through public sector and contracted private facilities (including NGOs and non-profit organisations). Four different options were suggested alongwith.

   Our suggestion: We strongly oppose this very health care delivery approach and related options. We seriously feel and believe comprehensive care is possible through public facilities, through their proper maintenance and upliftment as well as increase of newer and higher public facilities according to public health needs. No public exchequer ought to go to fulfil the coffer of the private health industries for their survival and growth. We cannot but feel that the draft has been framed in such a design as if the Govt. is advancing to hand over entire health sector to the national- multinational corporate houses and the role of the Govt. will be merely supervisory. The seed of privatization-commercialization-commodification of health was promptly introduced in the 1st NHP (1983) and the floodgate of it was opened in the 2nd NHP (2002) under the clout of globalisation and the cycle is now at the verge of completion with passing of this Draft Policy Document of 2015.

2) Budgetary allocation for health: Like this Draft, NHP 2002 also committed to increase % of GDP for health as well as increase of Union and state Health budgets. With regards to health finance, we strongly oppose its views and contentions. If the Govt. genuinely means health is wealth, it's a priority and good health equals to allround growth, then the Govt. must allot adequate and necessary fund for health. Whereas Central Govt. had exempted around 40 lakh crores rupees of different taxes to big industrialists in the last decade, where nearly 2 lakh crores nonperforming assets (NPA) of nationalized banks had been written off, a few lakh crores have been given as subsidy to big industrialists, is it a problem for the nation to raise the GDP for public health expenditure to 5% only? Scams and corruption of hundreds and thousands of crores and crores of rupees; about 70 lakh crores black money ; cost of luxury, security, perks, payments and tours and travels of ministers and VVIPs along with huge military budget when taken into account, is there any hindrance at all to allot adequate funds for health sector and other welfare sectors like education, water-sanitation, nutrition etc. ?

Some examples are given below of health expenditures of different countries, which the Draft makers are well aware of:

While the Draft boasts that India is the 3rd largest economy in the World and it has got the potential to grow larger, its GDP allotment for health does not correspond to its tall claims of economic growth. The attention and allotment in health of even many lower economies in the world would ridicule India's share and commitment to health.

Chart 1

Name of Country	Total Expenditure on Health as % of gross domestic product(GDP)	Share of Govt. Expenditure on Health as % of Total Expenditure on Health	Private(out of pocket) Expenditure on Health as % of Total Expenditure on Health
India	3.9	30.5	69.5
Bangladesh	3.8	38.2	61.8
Nepal	6.1	45.3	54.7
China	5.1	55.9	44.1
Republic of Korea	7.4	55.3	44.7
United Kingdom	9.4	82.8	17.2
USA	17.7	47.8	52.2
Cuba	10.0	94.7	5.3

Source: World Health Organisation Report 2014

3) **Reference of Para 2.1:** Achievement of millennium development goals. The draft showed a rosy picture of declination of MMR, IMR, and U5MR etc. On the other hand in Para 2.7, regarding burden of diseases, the draft makers are suffering from complacency regarding declination of different diseases indices. Data mentioned by the draft regarding these diseases do not depict the reality of our country. Not only it failed to quote the source but also the draft makers concealed the fact that many neighboring and economically backward countries have fared well over us in these regards. Draft analysed National Control Programme covered only 6% of diseases and Non-Communicable disease burden got scant attention. We assert that giving proper attention to the latter does not attract less importance to existing control programme. Prevailing situation demands adequate attention to both. We express our deep concern about repeated attacks of epidemics, not only of Malaria but also of JE, Swine Flu, Bird Flu, Dengue, Chikungunia etc. There is no specific proposal for controlling these kinds of epidemics and also no mechanism to strengthen the all important surveillance system in the draft.

Chart-2

Name of Country	Maternal Mortality Ratio(MMR)(100000)	Infant Mortality Rate(IMR)	Under 5 Mortality Rate	Malarial Death/ 100000	TB Death / 100000
India	190	44	56	2.3	22
Bangladesh	170	33	41	.9	45
China	32	12	14	0	3.2
Cuba	80	4	6	0	0.3
Republic of Korea	27	3	4	0	5.4
Srilanka	29	8	10	0	1.1
United Kingdom	8	4	5	0	0.5
USA	28	6	7	0	0.1

Source: World Health Organisation Report 2014

4) **Regarding AYUSH:** Para 4.3.10.2: The draft proposes preventive & promotive aspects of health to be conducted by AYUSH leadership. You are well aware that different national disease control programmes as well as immunizations are built on the fundamentals of preventive health care on the anvil of modern scientific medicine. As preventive & promotive aspects of health care are dependent on modern scientific concept, as evidence based curative aspects of today, it cannot be replaced by AYUSH. To manage scientifically it should have an MBBS doctor having scientific concept of diseases and an AYUSH doctor will be an important member of the integrated team.

Para 4.3.10.3: We like to draw attention that the draft has not favored allocation of sufficient funds for research and development of proper infrastructure of AYUSH system, neither for maintenance of the existing structures. Here we cannot but refer to the practice adopted by modern China, Vietnam, Korea, Cuba etc. Here lies no question of biasness, no question of dogmatic approach. On the question of medical care, scientific thoughts and principles will be the beacon on the anvil of which these age-old practices should be evaluated to identify the natural laws in operation in this field for ultimate adoption and application in modern science.

5) **Regarding primary Health Care:** The draft has mentioned that Sub Health Centre (SHC) will be incorporated under Primary Health Care institution. But the question is, where a vast number of SHC, PHC, and CHC etc., are remaining underutilized and unutilized due to absence of health care providers, how will it be possible to run SHCs as primary health care centers? The Draft policy does not propose massive engagement of MBBS doctors as cornerstone measures to cater to primary care services at the grass root level. The landmark Bhore Committee (1943-1946) proposed to provide highly skilled doctors to be posted at the grass root level, where as, this draft proposed

after long 68 years of that recommendation, only AYUSH doctors, Nurse practitioners, B.Sc. in Community Health Care doctors, ANM, ASHA etc. at the very ground level. It cannot be the solution for providing primary health care services. AYUSH graduates should work under supervision of and in collaboration with skilled MBBS doctors at this level.

6) **Secondary Tier:** The draft proposed CHC will be converted into secondary tier hospital. But what will be its infrastructure? A secondary tier hospital where Medicine, Pediatrics, Gynae & Obs, Surgery,Ophthalmology, ENT, Dental, Orthopedics, Dermatology, etc., departments are mandatory, is it possible to cover only with a provision of 30 beds? Existing health norms suggest that there should be 30 beds in each CHC per 1 lakh population. In reality, the maximum Blocks of the country where a CHC exists, on an average covers more than 2.5 lakhs of population. Therefore, to cope with, at least 100 beds should be provided in the CHC with all requisite disciplines and facilities. Otherwise there is no meaning in changing the nomenclature or signboard with the plea of up gradation. Similar miserable conditions are reflected for SHC and PHC also.

There is a huge shortfall of SHC, PHC, and CHC according to IPHS. The draft does not mention a single word to fulfil this gap of health institutions. We strongly recommend fulfilment of the required infrastructure as per existing IPHS within a stipulated period of time with Govt. funding.

Chart-3

Name of Infrastructure	Existing Position	Target level of NRHM	Short Fall	Percentage (%)
Sub Health Centre	147069	240000	92931	63
Primary Health Centre	23673	40000	16327	68.96
Community Health Centre	4535	12000	7465	164.60
Only 754 out of 4535 CHC are functioning as per IPHS norms				

7) In relation to district hospital up gradation to tertiary care centre, the lacunae and pitfalls should be taken care of. Let alone Super specialty, many district hospitals do not have essential specialties either. Before giving them medical college status, they should be furnished adequately with minimum MCI norms.

8) Urban Health Structure: It should not be a mere duplication of Rural Health Structure. They should consider the complex geography, environment, and economic structure, demographic and epidemiological condition of urban areas for evolving an optimal system of urban primary health care services with well built referral network.

Chart-4
Hospital Bed Capacity, in India and some other countries.

Name of Country	Beds/ 1000 Population
Sri Lanka	3.1
China	3.0
Thailand	2.2
USA	3.1
Brazil	2.4
UK	3.9
Nicaragua	0.9
Togo	0.9
India	0.9

Source: World Health Statistics (2011) (Chart-3 & Chart-4)

9) Regarding RNTCP: The draft does not seem to have any clue as to how to cope with the disastrous failure of RNTCP. The failure was foreseen by many experts in the field exposing several irrationalities, but those were not paid heed to. There should be recommendation for research at the level of microbiology, pharmacology and allied specialties along with research in socio-cultural-economic field. Proper and careful assimilation of the fruits of those endeavors into scientific practical implementation process may guide us to adopt proper method of prevention and treatment.

10) **Health Manpower Norms:** The draft makers do not seem to realize that health manpower development is a highly complex research exercise to understand the requirements of various categories of health personnel for running public health services starting from ASHA to doctor to the highest level of health personnel at the State and Central level. We are astonished that several times, various Govts. have introduced many health cadres like CHG, TD, VHSC, Link person, barefoot doctor etc. It is there for all to see what the fate of these health cadres is! All these were and are piecemeal, popular befooling irrational approaches. We are deeply concerned about the govt. attitude regarding ASHA. Govt. seems to believe that they should perform every health activity, i.e. immunization, normal delivery, family planning, treatment of common ailments; they are to vigil and control any type of epidemics, outbreaks etc. But the Draft does not arrange for neither their adequate training nor has recommended to recognize them as permanent health workers with proper wage and amenities, which we strongly demand.

11) **The draft does not utter a word regarding proper utilization of unqualified village practitioners:**

A huge number of non registered village practitioners(also they comprise bulk of unqualified urban practitioners), a product of the objective situation of our country, still stands as a solace to our health deprived millions at the time of their need. They face humiliation at every step by the administration. They should be utilized in the healthcare delivery system as designated and permanent health workers after empanelment and proper training.

(The Draft admitted, as per NSSO, 40% of private OPD services are provided by this category of health workers.) They can efficiently complement the works assigned to ASHAs and can eradicate the need of creating innovative health cadres very often planned by the Ministry and its loyal experts to ensure rural health care services.

12) **Medical Education:** The draft virtually declared Medical Education as a mere commodity. At present more than 50% of Medical Colleges are run by private and corporate sectors, where money is the prime criterion for admission, during passing of the examination, and to obtain degrees. We like to emphasize that, already medical ethics as a part of social ethics has been eroded deeply with the fall of standards of medical education. Further commodification of Medical education will practically destroy the noble ethos of medical ethics. They are to get back their investment for education from the market as early as possible, paying little regards to social values, obligations, medical ethics and professional responsibilities. Doctors, medical students and all categories of health workers as well as citizens will have to bear the brunt of this irreparable loss in the society.

13) **On drugs and medical equipments easy access to high quality :** Essential and life saving drugs are equally essential for making of a pro-people Health policy. Though envisaged in this draft, as also said in the earlier NHPs, that the generic quality medicines will be supplied free of cost through Govt. facilities, but reality is the opposite. Let alone the quality, even adequate quantity of generic medicines including just National List of Essential Medicines(NLEM) are not produced by the respective manufacturers as Govt. has no law in hand to control and compel them to do so. Public Sectors Undertakings (PSU) in pharmaceutical industry are made sick and becoming nonexistent by the lethal effect of globalization-liberalisation-privatisation policies. Almost all the bulk drugs and a large no. of essential life saving drugs are out of price control at present. Health can never be achieved with such a dismal drug production-supply-price control and quality control scenario of the country. Draft Health Policy must give due attention to this very essential sector taking its entire onus under the Health Ministry. Not only the drugs, Government should deal with public sector manufacturing units of medical equipments, diagnostic instruments, appliances, implants so that they could be given at an affordable and cheaper cost.

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The Humanist Scientist - Louis Pasteur (1822-1895)

Dr. Sudha K.
Vice President, All India MSC

"You young men - doctors and scientists of the future - do not let yourselves be tainted by apparent skepticism; nor discouraged by the sadness of certain hours that creep over nations. Do not become angry at your opponents, for no scientific theory has ever been accepted without opposition. Live in the serene peace of libraries and laboratories. Say to yourselves, first, "What have I done for my institution?" And as you gradually advance, "What am I accomplishing?" Until the time comes when you may have the immense happiness of thinking that you have contributed in some way to the welfare and progress of mankind."

Thus spoke the grand old man, the pioneer in the field of 'Microbiology',-The one and only Louis Pasteur, addressing the young scientists at the academy of medicine. It was a gathering assembled there to felicitate him.

This honour did not dawn on him all of a sudden. It was decades of hard work, perseverance, doggedness and most of all his faith in scientific methodology which brought him the accolades finally.

A new age begins...

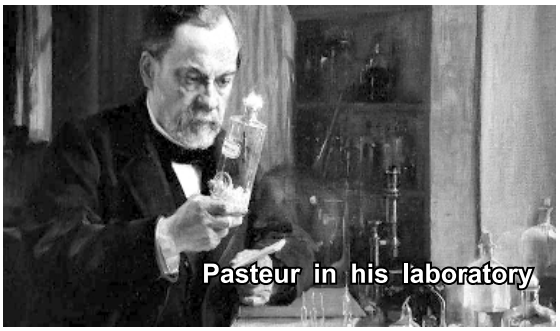
19th century Europe was the period of turmoil, an era of Democratic revolutions. With the slogans of 'Liberty, Equality and Fraternity', France had fought against the Feudalism and the autocratic rule. The thoughts of Renaissance and Humanism had ushered in a new society. But this nascent democracy was not free from old obscurantist ideas. Anyone who went against the 'established truths' was not tolerated and was hounded! But a selected few stood by what they believed to be the truth amidst all oppositions and became a beacon of light to the younger generations to come. Amongst them Louis Pasteur tops the list in the field of science.

Louis Pasteur came from a humble background. He was the son of a tanner, in Dole in Eastern France. He was born on December 27, 1822. This boy with an extraordinary talent in painting was encouraged by his teacher to take up studies in science. He went on to study at the Ecole Normale Superieure in Paris. In 1847 Pasteur was awarded his doctorate and then took up a post as assistant to one of his teachers. He spent several years teaching and carrying out research at Dijon and Strasbourg and in 1854 moved to the University of Lille where he became professor of chemistry.

Here he continued the work on fermentation he had already started at Strasbourg. By 1857 Pasteur had become world famous and took up a post at the Ecole Normale Superieure. In 1863 he became dean of the new science faculty at Lille University. While there, he started evening classes for workers.

Debunking of theory of spontaneous generation

The crowning achievements of Pasteur's career were development of the 'germ theory of disease' and the use of 'vaccines' to prevent these diseases. During those times, a majority of the scientists believed in the theory of 'spontaneous generation'. The idea that beetles, eels, maggots and now microbes could arise spontaneously from putrefying matter was speculated on from Greek and Roman times. And in the 1860s spontaneous generation was still a subject of debate in the exalted French Academy of Sciences. Pasteur too entered the fray. Based on his work on fermentation it seemed obvious to him that the sources of yeasts and other microorganisms that were found during fermentation and putrefaction entered from the outside. Pasteur conducted a series of ingenious experiments that destroyed every argument supporting "spontaneous generation". In the words of Pasteur "Never will the doctrine of spontaneous generation recover from the mortal blow of this simple experiment. No, there is now no circumstance known in which it can be affirmed that microscopic beings came into the world without germs, without parents similar to themselves."


Pasteur in his laboratory

Another significant discovery facilitated by the germ theory was the nature of contagious diseases. Pasteur intuited that if germs were the cause of fermentation, they could just as well be the cause of contagious diseases. This proved to be true for many diseases such as potato blight, silkworm diseases, and anthrax. After studying the characteristics of germs that caused diseases, he and others found that laboratory manipulations of the infectious agents can be used to immunize people and animals.

Wins a challenge…

At this time, anthrax, a fatal disease of sheep and cattle, was decimating the sheep industry and the economy of France. Already Jenner had invented vaccine for small pox. Working on the same lines, Pasteur invented Anthrax vaccine. But there was all-round skepticism. That Pasteur was not a medical man, but a chemistry scientist was a major reason for this disbelief. He was challenged by the well-known veterinarian Rossignol to prove it. Hence a public test was arranged at Pouilly le Fort, a farm in the town of Melun, south of Paris.

Twenty-five sheep were to be controls, the other twenty-five were to be vaccinated by Pasteur and then all animals would receive a lethal dose of Anthrax. All of the control sheep must die and the vaccinated sheep must live. The challenge was severe and there was no room for error. Pasteur's colleagues were concerned. The vaccines were still in the developmental stage. "What succeeded with 14 sheep in our laboratory will succeed with 50 at Melun", said Pasteur. The publicity was intense. A reporter from the London Times sent back daily dispatches. Newspapers in France followed the events with daily bulletins. There were crowds of onlookers, farmers, engineers, veterinarians, physicians, scientists and a carnival atmosphere. Would Pasteur's claims of vaccination hold up? Happily, the trial was a complete success -- indeed, a triumph! Two days after final inoculation (May 5, 1882), every one of 25 control sheep was dead and every one of the 25 vaccinated sheep was alive and healthy. The fame of Pasteur and these experiments spread throughout France, Europe and beyond. “It was,” says, Pasteur's long time collaborator, Emile Duclaux, "the anthrax vaccine that spread through the public mind faith in the science of microbes". Within 10 years a total of 3.5 Million sheep and a half Million cattle had been vaccinated with a mortality of less than 1%. The immediate savings to the French economy were enormous, at least 7 Million francs, estimated to be enough to cover the reparations that France was required to pay to Prussia for the loss of the Franco-Prussian War in 1880.

Supported by the successes with anthrax and fowl cholera diseases, Pasteur identified and isolated over the next 2-3 years, the microbes for many other diseases including swine erysipelas, childbirth fever and pneumonia.

Pasteur vaccinating sheep

Supported by the successes with anthrax and fowl cholera diseases, Pasteur identified and isolated over the next 2-3 years, the microbes for many other diseases including swine erysipelas, childbirth fever and pneumonia.

An Apostle of scientific temperament!

Pasteur was a strong believer of scientific methodology. To quote him, ***“Imagination should give wings to our thoughts, but we always need decisive experimental proof, and when the moment comes to draw conclusions and to interpret the gathered observations, imagination must be checked and documented by the factual results of the experiment.” He also said:”Do not let yourself be tainted with a barren skepticism.”*** It was his firm belief that ***“In the fields of observation chance favours only the prepared mind.”***

The famous philosopher Ernest Renan said of Pasteur's method of research: ***"This marvelous experimental method eliminates certain facts, brings forth others,interrogates nature, compels it to reply and stops only when the mind is fully satisfied. The charm of our studies, the enchantment of science, is that, everywhere and always, we can give the justification of our principles and the proof of our discoveries."***

Pasteur's achievements seem wildly diverse at first glance, but a more in-depth look at the evolution of his career indicates that there is a logical order to his discoveries. He is revered for possessing the most important qualities of a scientist: the ability to survey all the known data and link the data for all possible hypotheses, the patience and drive to conduct experiments under strictly controlled conditions, and the brilliance to uncover the road to the solution from the results. He said: "Science advances through tentative answers to a series of more and more subtle questions which reach deeper and deeper into the essence of natural phenomena."

Various Discoveries - Boon to mankind

With certainty, one hallmark of Pasteur's research was not only the importance of his individual discoveries, but the overwhelming breadth of his accomplishment. Emile Duclaux wrote, **"A mind ..... of a scientific man is a bird on the wing; we see it only when it alights or when it takes flight. .... We may by watching closely, keep it in view, and point out just where it touches the earth. But why does it alight here and not there? Why has it taken this direction and not that in its flight toward new discoveries?"**

Pasteur, himself, provided us with an answer. He believed that his research was "enchained" to an inescapable, forward moving logic. Pasteur's scientific discoveries reveal the truth of this statement: how one discovery, one concept, led almost "inescapably" to another.

> ***In the sciences, certain persons have convictions, others have only opinions. Conviction supposes proof.***
>
> ***--- Louis Pasteur***

His contributions to the field of Crystallography are remarkable. This led to his hypothesis that molecular asymmetry is one of the mechanisms of life, i.e. living organisms only produce molecules that are of one specific orientation, and these molecules are always optically active.

This also led to the conclusion that fermentation was a biological process carried out by microorganisms. This germ theory was followed by many experiments that showed unequivocally the existence of microorganisms and their effect on fermentation. Thus the specialty of 'Microbiology' was born. Germ theory also formed the foundation of numerous applications, such as the large scale brewing of beer, wine-making, pasteurization, and antiseptic operations.

Dawn of era of Antisepsis

By 1875 many physicians recognized that some diseases were accompanied by specific microorganisms, but the body of medical opinion was unwilling to concede that important diseases -- cholera, diphtheria, scarlet fever, childbirth fever, syphilis, smallpox - could ever be caused by these agents. That between April 1 and May 10, 1856, in the Paris Maternity Hospital there were 64 fatalities due to childbirth fever out of 347 confinements is an example of the magnitude of the problem! The hospital was closed and the patients were transferred to a different hospital. Sadly, the contagion followed these women and nearly all of them died!

As Pasteur wandered through hospital wards, he became increasingly aware that infection was spread by physicians and hospital attendants from sick to healthy patients. There was no practice of washing hands even during surgery! Pasteur impressed upon his physician colleagues that avoidance of microbes meant avoidance of infection.

. In a famous speech before the august Academy of Medicine in Paris he stated, "This water, this sponge, this lint with which you wash or cover a wound, may deposit germs which have the power of multiplying rapidly within the tissue....If I had the honor of being a surgeon....not only would I use none but perfectly clean instruments, but I would clean my hands with the greatest care...I would use only lint, bandages and sponges previously exposed to a temperature of 1300 to 1500 degrees."

The greatest derangement of the mind is to believe in something because one wishes it to be so.

--- Louis Pasteur

Joseph Lister in England was so impressed by Pasteur's work that he began to systematically sterilize his instruments, bandages and sprayed phenol solutions in his operation theatres, thus reducing infections following surgery to incredibly low numbers. Thus the age of safer, antiseptic surgery dawned!

But as is the norm, the medical field was at first very reluctant to accept these concepts, especially from Pasteur, an alien to their field. But slowly, but surely, through the perseverance of Pasteur, Lister and other physicians antiseptic medicine and surgery became the rule.

War against Rabies,

The final and certainly the most famous success of Pasteur's research was the development of a vaccine against Rabies. The treatments applied to victims were as horrible as the disease itself; this included cauterizing the bite wounds with a red-hot poker, use of witch craft etc. The disease which affects the brain of the victims has no cure even to this day. Nonetheless, Pasteur and his colleague Roux took it as a mission to conquer the deadly disease.

There does not exist a category of science to which one can give the name applied science. There are science and the applications of science, bound together as the fruit of the tree which bears it.

--- Louis Pasteur

In a tragic footnote to history, Joseph Meister, the first person publicly to receive the Rabies vaccine, returned to the Pasteur Institute as an employee where he served for many years as a gatekeeper. In 1940, during the World War II, 45 years after his treatment for Rabies that made medical history, he was ordered by the German occupiers of Paris to open Pasteur's crypt. Rather than comply, Joseph Meister committed suicide!

Pasteur treating Joseph Meister

Though most of the microorganisms causing diseases were visible through the microscope during those days, Rabies causing organism eluded the scientists. The modern electron microscope has unraveled the Rabies virus now, but it was not possible then. Still then, Pasteur and Roux succeeded in reproducing the disease using the extracts of rabid spinal cord. They were also victorious in developing an anti Rabies vaccine for protecting animals against the fatal disease.

Following confirmation of his reports in 1885 that he had made dogs refractory to rabies by vaccination, Pasteur received wide acclaim and much favourable publicity. But why not use the vaccine on humans? Frankly, Pasteur was terribly afraid of things going wrong and he was particularly uneasy about being unable to isolate the rabies substance. And so he continued to insist that many years of additional research was necessary before the treatment could be tried on humans. A full trial of the anti-rabies vaccine was yet to be made. But on July 6, 1885, 9 year old Joseph Meister and his mother appeared at Pasteur's laboratory.

Two days earlier the young boy had been bitten repeatedly by a rabid dog. He was so badly mauled that he could hardly walk. His mother appealed to Pasteur to treat her son as this youth faced certain death. Pasteur, with much trepidation, treated the youth. Despite Pasteur's fears, Meister made a perfect recovery and remained in fine health for the remainder of his life.

A towering personality in science

Pasteur did not belong to one country. He belonged to the whole humanity. Rightly he said: ***"Science knows no country, because knowledge belongs to humanity, and is the torch which illuminates the world. Science is the highest personification of the nation because that nation will remain the first which carries the furthest the works of thought and intelligence."***

He also implored: ***"I beseech you to take interest in these sacred domains so expressively called laboratories. Ask that there be more and that they be adorned for these are the temples of the future, wealth and well-being. It is here that humanity will grow, strengthen and improve.***

When I approach a child, he inspires in me two sentiments; tenderness for what he is, and respect for what he may become.
--- Louis Pasteur

Here, humanity will learn to read progress and individual harmony in the works of nature, while humanity's own works are all too often those of barbarism, fanaticism and destruction."

Pasteur was a great humanist. He never filed any patents for his inventions; his only purpose in life was to be of use to mankind.

It is 120 years since Pasteur departed from us. He stands as a role model for his perseverance, scientific temper, Humanitarianism and the like. The humanistic spirit of Pasteur which said ***"One does not ask of one who suffers: What is your country and what is your religion? One merely says: You suffer, that is enough for me..." inspires us.***

Today we are at cross roads. Even at the 21st century, we are not yet free from communicable diseases like Malaria, Typhoid, Cholera, Dengue, Chikun Gunya, TB, Rabies and many more! In addition, life style diseases are mounting in number. But relief from sickness has become a mirage for the majority. On one side we have Government hospitals meant for the poor which are in dire status without the required infra structure, men and material and on the other, are the corporate hospitals with the state of the art technology meant only for the few very rich, not within the reach of the common man. In a market driven economy, health also has become a commodity. At such a juncture, it is the call of the hour to free medical field from the clutches of profit mongers and make it available to all. This is the only way to pay tribute to the great personality, that is Louis Pasteur.

Let me tell you the secret that has led me to my goal.
My strength lies solely in my tenacity.
--- Louis Pasteur

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Health Insurance in India — An Overview.

- **Dr. Vasudhendra N.**
CC Member, MSC

Insurance for health has been in existence in India for many years. CGHS (Central Govt Halth scheme) and ESI (Employee's state Insurance) were started in 1950s. But it is only in last 10 years or so, health insurance and particularly Private Health insurance (HI) is being given unprecedented encouragement. This has happened rapidly after IRDA (Insurance Regulatory and Development Authority) bill was passed in 1999 which allowed for entry of Private players. According to insurance market experts, health insurance continues to be one of the most rapidly growing sectors in Indian insurance industry with gross written premiums for health insurance increased by 16 per cent from Rs 13,212 crore in 2011-12 to Rs 15,341 crore in 2012-13. The health insurance premium has registered a compounded annual growth rate (CAGR) of 32 per cent for the past eight financial years[1], However, at present, approximately 20% of Indian population is covered by some health insurance and in that private insurance part is 5%. So, there is a big 'market' for health insurance and predictably, this sector is devising ways to expand the health insurance market with the active patronage of the Govt.

Meanwhile, NDA which came to power riding high on various poll promises, is bringing one after the other 'reforms' in various sectors. In December, a few months after coming to power, central cabinet cleared for increasing FDI in insurance sector citing paucity of funds. From 26%, FDI is now increased to 49%. Same reason was cited in 1999 when 26% FDI was allowed. An ordinance has also been passed for approval. In this background, with Govt making itself clear that Health Insurance will be a priority, we have to discuss the implications of such policies on health field and also on the health of the common people. This increasing stress on insurance is in continuation of privatization policies pursued since more than 2 decades. In addition to this, Govt is mooting for UHC (Universal Health Coverage) through insurance schemes, pre-paid cards etc. Thus, Government is speaking in different voices at different times. Once, it speaks of increased spending on public health (NRHM), at other times stresses on Insurance schemes as a model of health system and simultaneously gives fillip to private health insurance. Its preference is anybody's guess - Privatization of Healthcare.

This article intends to discuss the role being played by Health insurance, its associated problems and implications of prescribing this as health system model in India. It is also better, if we examine the effects of such policies in other countries especially USA and draw lessons for our own. In the last 5 to 6 years, several Government sponsored

HI schemes have been rolled out by central as well as state Govts. Examples are RSBY, Arogyashree, Yeshaswini, Kalaignar etc. They are being propagated as successful methods of providing healthcare. We have to discuss the results of such schemes also and analyze whether they are being brought as an alternative to holistic development of Public health system.

Needless to emphasize, we have to look at this entire scenario from people's point of view keeping people's interest in mind.

Health Insurance- An introduction:

Health insurance is a contract where an individual or a group purchase in advance, health coverage by paying a fee called 'premium'. This is with the agreement that, health expenses are borne by the company just like any other insurance. In private health insurances, the buyers pay the premium amount to the company which pools similar risks. Premium amount however is decided by the risk assessment of the insured rather than on the person's income. For the company to sustain and reap profits, it has to insure more and more number of 'healthy' individuals.

Otherwise, outgoing fund will be more than incoming fund! Like any other insurance, health insurance is assumed to help the insured at the time of illness. There are varieties of health insurance policies in the market, with some paying hospital and other treatment related costs while other policies may be only for a specific illness. It can be cashless service or re-imbursement service.

Health insurance as we know today was introduced in 1912 when Insurance act was passed. The existing version is based on 1938 Insurance Act. In 1972, Insurance industry was nationalized and private insurance companies were brought under General Insurance Company. In 1986, first private insurance was introduced and was called mediclaim. After economic liberalization, IRDA bill was passed and Private players were allowed to enter Insurance sector.

Indian experience :

In India, major expenditure due to ill health is borne by individuals and is called Out of Pocket expenditure(OOP), This constitutes approximately whopping 70%. Government's share is just 20% and firms & external sources form another 10%. In terms of GDP, Govt's share is around 1% and is one of the lowest in the world! This reflects the attitude of our Govt towards health of its people. With such huge OOP, and Public health in shambles, private players see this as an opportunity to expand their market share. It seems that, for middle class and above, stress in on individual HI and for the poor, 'packaged' 'social health insurance schemes which are so designed to benefit private sector.

We have already noted the growth story of private insurance sector which is considered as 'promising'. We will come back to long-term impact of Private commercial health insurance model by way of examining in other countries. Let's turn to Govt sponsored HI schemes. Two reports have come out which have studied the effects of these schemes.

One is by the World Bank and the other by the Planning commission [2,3] Without going into the details of the reports, we can utilize the data for our own analysis and make a brief summary of it. These schemes are the outcomes of the recommendations of National Commission on Macroeconomics and Health(NCMH). Rajiv Arogyashree (AP), RSBY(Central), Yeshaswini (Ka), Kalaignar(TN) are some of the Govt sponsored HI schemes which were started after 2003. These basically cover surgical and inpatient expenditures by way of cashless facilities through tie up with Private and public hospitals. Implementing agencies are usually private, called TPA. In some of these schemes insurers have to pay premiums eg: Yeshaswini. In others, there is no premium like in Rajiv Arogyashree (AP). There are wide variations in package amounts, maximum limits, co-payments, facilities etc.

Some of the salient aspects of HI are mentioned below :

1. Financial implications: Out of total health expenditures by the Govts, 24%, 41% and 7% are spent on insurance by central, AP and Ka govts respectively in 2010. Data shows that more than 90% of networked hospitals are private, particularly in AP, Ka and TN. In RSBY, percentage of private hospitals approximates 68%. As such, the number of public hospitals are less compared to the private hospitals because of the policies of successive governments, major chunk of funds are hence spent on 'purchasing' 'treatment packages' from private sector.

If the same amount of money is spent on strengthening public sector, it would have benefitted in the long run.

2. Does it protect people from financial catastrophe? Many proponents of these schemes suggest that, they protect families from financial catastrophe whenever there is major llness. However, data shows that main cause of bankruptcy and falling into poverty is outpatient expenditure. Recent analysis of NSSO/60 round shows that around 63 million people fell into 'BPL' category due to health expenditures and nearly 80% of this is not because of inpatient/surgical expenditures, but because of outpatient care and medicines! Such is the situation in our country. Claiming to help the impoverished, our Govt is diverting the resources and money elsewhere! Apart from healthcare, there is no account of expenditures incurred in travel, stay, food etc. They also add to these. In fact, studies show that there is 20% increase in health expenditures in insured group than the uninsured ones! Our rulers probably want the same.

3. PPP at work! If we study the administration and structure of implementing agencies, we see that most of these works are outsourced to private insurance companies and other TPAs. This again raises the administrative costs!

4. Increase in 'insurance mindedness among the people:

World Bank report observes that Government sponsored HI schemes play the role of increasing the awareness of HI. This is a 'positive' development for the insurance sector and helps in its expansion. This is nothing but trying to wean people from public health system concept, from Right to health concept and replacing it with Insurance concept of getting healthcare. This is yet another purpose of Govt's intention in promoting HI.

5. In all these schemes, focus is on specialist, surgical and tertiary care rather than comprehensive care.

6. There is clear shift away from time tested concepts of Right to healthcare, doctor-patient relationships, comprehensive care, etc. Concepts like patients as consumers & health professionals as providers, incentives, performance based payments, competition between Public-Private enterprise are being encouraged. These are detrimental to health of the people.

On the whole, even though studies show that these schemes are not efficient and do not help in achieving the objective of Universal accessibility and affordability, Govt is still pushing for HI and spending huge amount of money on them.

Health insurance: Experiences in other countries.

World-wide, in low and middle income countries HI are becoming new prescriptions for healthcare reforms in the name of Universal health coverage. Side by side, there is encouragement for Commercial health insurance for individuals and families. In India, market for such HI is quite large. If we care to study the status of HI based healthcare systems in other countries, we can foresee the problems of such market-based systems. Let us see the example of USA where health is managed predominantly by Private Health Insurance companies and the network of private hospitals.

USA is probably the only developed country which does not guarantee access to healthcare for its population (http://en.wikipedia.org/wiki/Institute_of_Medicine) Healthcare in USA is a complex system with Insurance industry and market forces playing a major role. About 16% of the population do not have any insurance coverage. It means that atleast 84% of the population have some insurance coverage. With such high insurance coverage, what are the health outcomes and other parameters to assess the efficacy of this system? US spends almost 17% of GDP on health and $8608 per person annually which is one of the highest in the world according to WHO study[4] However, regarding health outcomes in terms of health indicators like life expectency, IMR, affordability and quality, US healthcare fares poorly compared to other industrialized nations. In fact according to a study by Bloomberg, USA is at 46th position among 48 nations included in the study. This study also notes that best care is in the nations where public health is robust and takes care most of the healthcare needs

of the people. So inspite of spending so much, the returns are poor and reflects on the system, its efficiency and usefulness. Not just the statistics relating to health outcomes, but also the rate of bankruptcy due to medical bills also is discouraging. Ever rising premiums, co-pays and other expenditures, dishonourment, insurance denials, underinsurance all have led to such an alarming situation that in 2007, 62% of filers for bankruptcies claimed high medical expenses[5] In 2013, almost 25% of senior citizens declared bankruptcy due to medical expenses. A new government report shows that almost 20% of US consumers – nearly 43 million people – have unpaid medical debts that have gone into collection. All these when US spends highest on healthcare. Another recent study by Commonwealth fund suggests that US healthcare is a broken system which is inefficient, unaffordable with poor health outcomes.

Dissatisfaction over such a cumber some, inefficient and costly private insurance based healthcare is rising among the public and a section of medical professionals, forcing the Govt to find ways to improve the healthcare. Some 32 percent of consumers spent a lot of time on insurance paperwork or in disputes with their insurer over denials of payment for services they thought were covered.

The parting suggestion of an article in the guardian newspaper says "We in the US can tell you, we've seen the future and it doesn't work – not for the families of Sarah Burke and Amelia Rivera, and not for tens of millions of others" That sums up the situation if we follow US healthcare model.

Common problems of Health Insurance

After studying US healthcare model and our own experience here, we can fairly get an idea of problems associated with insurance based healthcare systems. It is now appropriate to go into the details of some common problems faced by the patients (customers!) and the healthcare delivery system as a whole.

Moral hazard refers to the way in which insurance changes people's perspectives. A person knowing that he / she is insured, may indulge in more risky behaviour or may use more health services. This is called consumer moral hazard or demand side moral hazard. On the other hand, knowing that a third party is paying the medical bills, providers may alter their treatment patterns for insured patients. This is called supplier moral hazard . This is especially so if the provider is paid on a fee-for-service basis. Moral hazard is a problem both for financial viability and for public health logic, as it results in cost escalation, excessive medical treatments and even iatrogenesis.

Rising Cost of healthcare : Experiences in several countries show that profit oriented private health insurance companies raise the premiums at will and sometimes several times the inflation rate.

Even in Govt sponsored HI, premium amounts have to increase in order to sustain the scheme. Initially, it may be low, but gradually premium amount is bound to increase.

There are other problems like treatment denials and dis-honoring of agreements, Defensive medicine on the part of medical professionals, Frauds - false or inflated bills, Unnecessary investigations & treatment , Administrative costs associated with marketing, processing claims and countering frauds, Lack of transparency of information on prices and quality, Lack of accessibility and affordability, etc.,

Conclusion:

After making a brief study of the working of Insurance in health, we can come to the conclusion that insurance based healthcare delivery is fraught with several problems and cannot fulfill the objective of comprehensive, universally affordable and accessible healthcare. Its stress is mainly on surgical, specialist and tertiary care where private sector is benefitted the most. At the policy level this is a well calculated move on the part of the Govt to dismantle the public health system , deny people of their health right and privatize health system. Even though Govt's own assessments of these schemes glaringly show the problems, it is still pushing for the same.

It is well known that when there is a well-functioning public service delivery, there is no role for Health Insurance! Instead of strengthening Public health system, our Govt is pushing for HI.

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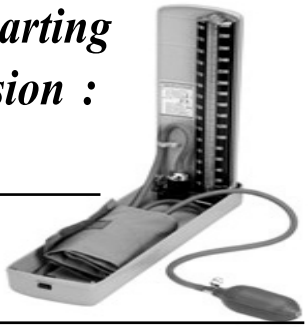
Setting a cut-off blood pressure level for starting pharmacological treatment of hypertension : A scandalous story



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Abstract:

British Medical Journal by publishing an editorial in September 2012 "Cochrane review finds no proved benefit in drug treatment for patients with mild hypertension" has done great service to mankind. Furthermore, it has opened Pandora's Box and Julian Tudor Hart's rapid response unravelled the greatest scandals of recent times in the history of medicine. He recalls how he was bullied to agree with the new guideline, directed by pharmaceutical lobby!!!.

It is widely known that modern day medical practice, especially drug therapies are heavily influenced by various kinds of lobbies by the pharmaceutical giants. America's health-care market, the world's biggest, is particularly busy. In 2012 pharmaceutical companies spent more than $24 billion marketing drugs to doctors, according to Cegedim Strategic Data, a research firm; 35% of doctors accept food, entertainment or travel from the pharmaceutical industry, said a survey by Deloitte last year, while 16% accept consulting or speaking fees. In most states, doctors take regular courses to maintain their licences. In 2011 drug and device companies sponsored nearly a third of the medical training tracked by the Accreditation Council for Continuing Medical Education [1]. But, the recent revelation that pharmaceutical lobby has dictated World Health Organization (WHO) on bringing down the cut-off level of blood pressure values for the initiation of drug treatment brings chills down the spine.

Treating patients with stage 1 (mild) hypertension has no benefit, a Cochrane review of studies conducted in the United Kingdom, Australia, and the United States has found [2]. Data from four randomised controlled trials, involving 8912 patients with stage 1 hypertension (systolic blood pressure 140-159 mm Hg or diastolic 90-99 mm Hg, or both) and treated for four to five years, found that drug treatment did not reduce total mortality (risk ratio 0.85 (95% confidence interval 0.63 to 1.15)), coronary heart disease (1.12 (0.8 to 1. 57), or stroke (0.51 (0.24 to 1.08)). Patients with pre-existing cardiovascular disease were excluded from the study.

David Cundiff, one of the reviewers, said that he believes that the analysis should lead to dramatic changes in the

way doctors treat mild hypertension, allowing patients to throw away their blood pressure pills and focus instead on far more effective as well as evidence based approaches, such as exercising, smoking cessation, and eating a DASH (diet against systolic hypertension) or Mediterranean diet. Cundiff told the BMJ that “in light of the negative results of the trials in the literature” further clinical trials of drug treatment for mild hypertension should be conducted only if patients first undergo lifestyle changes and those efforts fail [3].

British Medical Journal by publishing this editorial *“Cochrane review finds no proved benefit in drug treatment for patients with the mild hypertension”* has done great service to mankind [3]. Furthermore, it has opened Pandora's Box and Julian Tudor Hart's rapid response unravelled the greatest scandals of recent times in the history of medicine. He recalls how he was bullied to agree with the new guideline to start treatment for hypertension almost three decades back (1974), directed by pharmaceutical lobby!!! [4].

Hart, in his response to editorial comment in 2012 September issue of BMJ, wrote “In 1983 the World Health Organisation held the third of a series of international symposia on mild hypertension in Switzerland. Prior to the meeting, a letter was circulated from its chairman, Prof. Austin Doyle, main author of the Australian National Blood Pressure Study (ANBPS), which together with the United States' Hypertension Detection and Follow-up Program (HDFP), provided such evidence as there then was, from which to define an evidence-based intervention point. This letter invited those invited to attend the symposium to endorse its conclusion, namely that medication should start at 90 mm Hg (diastolic). In my reply I refused to do this, as we had been told that the symposium's purpose was to discuss the then available evidence, and thereafter try to agree a conclusion".

“Thoma Strasser, the WHO organiser of the symposium, appealed to me to do what all other participants had done, and sign the statement, reminding me that three transnational pharmaceutical companies were sponsoring all three symposia and had a right to expect results. I still refused. A committee meeting was called to discuss the statement, chaired by Doyle, to which I was invited, surrounded by most of the international great names in hypertensology. He asked me why I wouldn't sign. I replied that I had not yet seen convincing evidence that medication was justified from a diastolic level of 90 mm Hg, without other major indications for intervention; and that the workload consequent on taking blood pressure control seriously for the whole population, not just for customers in medical trade, would present huge logistic problems which should be considered. We knew that within the next few months we would have better evidence from the UK Medical Research Council trial of mild hypertension. Probably we should await that before reaching a conclusion. To which Doyle replied: Do we always have to wait for the British?" Bill Miall, who led that trial,

was sitting next to me. Like everyone else at that meeting, he had nothing to add, and advised me to sign the document like everyone else. Which I then did. I thought I had reached the limit of what a mere GP could do without becoming hopelessly isolated. In a letter to the Lancet, a few weeks later Bill withdrew his signature, on the grounds that it might compromise the then still unpublished conclusions of the MRC trial. Even when those came, I was never convinced that the very small reductions in cardiovascular and cerebrovascular event rates justified the conclusion, except in diabetics".

Of course, much water has flown in the Ganges from the time World Health Organization (WHO) in early 1980s set a present guideline for defining hypertension and initiation of treatment (Systolic =>140 and/or Diastolic =>90). Of late people started realizing we were worshipping a false god!! First to come out was the undue importance for diastolic hypertension, in particular isolated diastolic hypertension. The importance of pulse pressure is also being stressed [5, 6, 7, 8, 9, 10]. These things are understandable that sum total of human knowledge advances with time, but the revelation of BMJ has shown to the world the scandalous conspiracy behind the setting up of cut off blood pressure values for the initiation of treatment.

Recently, December 2013, report from the panel members appointed to the eight Joint National Committee (JNC 8) on evidence based guideline for the management of high blood pressure in adults has come out. Unfortunately, by citing the reason that there is no enough evidence not to start treatment for mild hypertension (at the same breath agreeing that there is no sufficient evidence on the benefit of starting the treatment also!!!!) the JNC 8 held on to the previous guideline [11].

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Amendment bill of MTP act 2014

– **Dr. Hari Prasad,** CC Member, MSC

The Indian abortion law falls under the Medical Termination of Pregnancy (MTP) Act, which was enacted by the Indian Parliament in the year 1971 with the intention of reducing the incidence of illegal abortions and consequent maternal mortality and morbidity. The MTP Act came into effect from 1 April 1972 and was amended in the years 1975 and 2002.

As per the act, pregnancies not exceeding 12 weeks may be terminated based on a single opinion formed in good faith by a registered medical practitioner. In case of pregnancies exceeding 12 weeks but less than 20 weeks, termination needs the opinion of two doctors.

MTP Act is an enabling act which

- Aims to improve the maternal health scenario by preventing a large number of unsafe abortions and consequent high incidence of maternal mortality and morbidity
- Legalizes abortion services
- Promotes access to safe abortion services to women
- De-criminalizes the abortion seeker
- Offers protection to medical practitioners who otherwise would be penalized under the Indian Penal Code (sections 315-316)

For termination up to 12 weeks:

- A practitioner who has assisted a registered medical practitioner in performing 25 cases of MTP of which at least 5 were performed independently in a hospital established or maintained or a training institute approved for this purpose by the Government

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Shwaas :

A Fresh Breath of Life

– Dr. Suresh Hegde,
Member, State Committee, MSC Karnataka

Recently I happened to see the video of a national award-winning Marathi movie 'Shwaas', directed by debutant Sandeep Savant. Even though it was released in 2004, it is a movie of relevance even today. So a review is worth it. It was a low budget film of just Rs 30 lakhs and was India's official entry to Oscar Awards in 2004 in foreign language film category. That it did not win the Oscars is a different matter, as it is a known fact that Oscar awards are a matter of wide propaganda and lobbying, requiring huge funds and clout. But it won the National Award for the best film in 2004.

THE STORY LINE:

Keshavram Shantaram Vichare lives in a small town called Pasule, in Maharashtra along with his son, who works in state road transport company, daughter-in-law and a seven year old grandson Parashuram alias Parshya. Parshya like any other child of his age, is mischievous, chirpy and utterly likeable. Keshuram's son meets with an accident, loses control over his legs and loses his job as well.

Around this time the family notices that Parshya has vision problems and Vichare takes him to Pune for a checkup with reference from a local practitioner. Dr. Sane, an oncologist sees him at the hospital and tests come as a rude shock to Vichare. Results show that the child has Retinoblastoma, a rare eye cancer in both the eyes. The child has to undergo surgery immediately to save his life and will lose his vision forever. Dr Sane is ready to do surgery free of cost, but Vichare is unable to come to terms with the situation and dithers to take decision.

Entirely unfamiliar with things like hospital and surgery, Vichare doubts the accuracy of the result and refuses surgery at first. But a helpful medico-social worker Ms. Asavari tries to convince him of the necessity of surgery to save the child's life. But Vichare is still not able to make up his mind and is unsure of the ways to convince Parshya's mother in the village and the child himself. Dr Sane himself takes responsibility of convincing the child with the help of Asavari. Finally he succeeds and surgery is planned. But, on the day of the surgery, it gets postponed due to an emergency which Dr.Sane has to attend to. Later in the day, the hospital staff find that Parshya and his grandfather are missing. A very upset Dr Sane, Asavari and Parshya's uncle who accompanied him from village, try to search for them with the help of police, but in vain. Meanwhile, newspapers get involved in it, since there were such cases earlier too. As journalists question Dr.Sane, he is embarrassed to face them and is furious about Vichare. Later in the evening Parshya and Vichare return to the hospital and Dr.Sane confronts them. The grandfather simply tells the doctor

that he wanted to show Parshya, around the city for one last time, before he gets totally blind. Dr.Sane relents and the surgery is done. The film ends with Parshya returning to his village wearing dark glasses to the hearty welcome of his mother and friends.

A touching movie indeed

Shwaas touches your heart in many ways. The story itself is novel in concept and its handling. An active, naughty, buoyant, innocent village boy gets a rare dreaded disease which can devastate any family. How an uneducated and poor grandfather, the mother and the child come to terms with the painful situation is narrated by the director in a simple and straight forward, yet a touching way.

In flashbacks, the beautiful landscape of Parshya's village and his adventures with friends are shown, in stark contrast to the reality of his turning blind in the near future and losing all these.

Grandfather and Parshya entering an unfamiliar atmosphere of a big hospital, not able to understand otherwise normal procedures and the grandfather's anxiety about the fall out of the surgery , i.e. a lifelong blindness for his beloved grandchild form the initial part of the movie. When Vichare is asked to sign the usual papers before investigations in the hospital, that, the doctor would not be responsible if anything goes wrong, he finds these terms unacceptable till Asavari convinces him. Vichare's enquiry as to what is the meaning of oncologist that is written on the name plate of the doctor outside or whether someone could donate eyes to Parshya, literally unnerve the good surgeon. This brings to the fore the necessity of our hospitals becoming more patient-friendly, educating the public, especially the poor and uneducated. Nonetheless, Dr.Sane, the surgeon, Ms Asavari and the medical staff at the hospital are very concerned and co-operative.

Dr.Sane's life of hectic schedules and his obligation towards his patients is shown in a very positive way in the film.

The way he considers his duty above his family commitments and taking Parshya home to come closer to the child and trying to prepare him for surgery are really heartening for us medical professionals in these days of commercialization of health sector.

Even Asavari goes out of the way to help. When Vichare feels helpless to reveal the truth to the child, Asavari implores upon Dr. Sane to do it. She tries different ways to console the desolate Parshya who comes to know of the reality. Her anxiety when the child goes missing, the fear that he might have met with an accident, all reveal the humane side of her.

The character of Vichare, an old villager who deeply loves the child, who has to handle a very difficult situation, is portrayed beautifully by Arun Nalawade. His ignorance regarding medical problems, his anxieties, finally the way he takes Parshya around showing the city, buying toys for him and taking him to a school for the blind to prepare him for a similar life bring tears to the viewer's eyes! The way he confronts an angry surgeon who rebukes him for the disappearance gets our appreciation.

He says,"Let the child go to the operation theatre with good, everlasting memories and not the drab vision of a

hospital ward". The Doctor realizes the truth in his statement and advances the surgery posted for the next day to the same night and gets a special ward decorated with balloons for him.

Ashwin Chitale, who has played the role of Parshya could not have done better! To a carefree child in his village, to be brought to a city hospital, to undergo a battery of investigations and finally being told in a round about way that he is going to be blind is very unnerving to say the least. But after the initial resistance, the child accepts it with aplomb! The way he understands clearly what the doctor is getting at, his tantrums at the postponement of surgery, his joy at the last escapade with his grandfather are so very naturally portrayed by this child artiste. The national film award he won for the best child artist is very deserving.

The director's use of symbolism like sparks of fire from a welding place falling on the way while the family walks indicative of the catastrophe befalling on it, makes the movie technically also very adequate.

Sandeep Kulkarni playing Dr.Sane, and Amrutha Subhash as Asavari have done justice to their roles.

Overall it is a movie not to be missed, especially by health professionals and students.

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Amendment bill of MTP act 2014

Continued from Page No. 28

For termination up to 20 weeks

- A practitioner who holds a post-graduate degree or diploma in Obstetrics and Gynecology
- A practitioner who has completed six months house job in Obstetrics and Gynecology
- A practitioner who has at least one-year experience in practice of Obstetrics and Gynecology at a hospital which has all facilities
- A practitioner registered in state medical register immediately before commencement of the Act, experience in practice of Obstetrics and Gynecology for a period not less than three years.

But the amendment bill of MTP act 2014 has made two major changes

- **The term registered medical practitioner has been replaced by Registered health care providers—i.e. Non Allopathic or modern medicine practitioners like Ayurvedic, Siddha, Unani & Homoeopathic medical practitioners and Nurse and ANMs(Auxillary Midwife Nurse) are also included after a certain period of training which is not specified.**

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MSC in the ***Jammu & Kashmir Floods 2014***

An account by **Dr. Ansuman Mitra**
Joint Secretary & In-charge, Disaster Response Cell, MSC Central Committee

Overview

The disturbed weather conditions, heavy rains and snowfall in early 2014, followed by cloudburst and torrential downpour, melting of glaciers coupled with unplanned construction activities over decades blocking flood channels and buffer zones in the Kashmir (KMR) Valley and a listless government having no sense of flood management, led to a devastating flood since the first week of September 2014, the equal of which has not been seen over a century! Apprehensions expressed by the scientific community over a period that such 'development' minus human and natural interest would create disaster in Kashmir valley had been totally neglected.

Overview

- poor flood management, blockage of flood channels, complete disregard of human interest and nature in 'development' (hotels & posh colonies in flood channels, train line, Mir Behri)
- spontaneous rescue by the people - flourish of Kashmiriyat
- care and sensitivity asked for in operations in such sensitive zone
- Is unpreparedness pardonable

Representation of the scenario to the outside world

- No news channel reported men in uniform being saved from swirling waters by locals

The days of the deluge

- Unpreparedness
- Anantnag reported Jhelum water 14' above normal 10 hrs before the water reached SGR

'Toll of democracy': another larger disaster in making

- Once disaster struck, cheap politics took centre-stage
- Lakhs of houses collapsed or are at imminent risk of collapse (of which many do not have any alternative means) – very harsh winter on the verge of setting in – no steps by any government yet on restoration – the democratic exercise with its 'model code' being clamped on, aren't we staring at another (larger) disaster in the making, another grim experience of the 'toll of democracy' in Kashmir?

The Activity

- Survey Team
- Pilot Medical Team setting up the Budgam Base; working through Srinagar (SGR)
- Venturing beyond SGR
- Efforts to make the voice of the civil society heard – without success
- The issue of an added stress upon the ongoing psychological trauma – the concept of Psychological First Aid training and workshop sessions catch the imagination of volunteers of limited education and up to the seats of highest education including health professionals
- Representations to Dr. Salim-ur Rahman, Director of

Lakhs of local inhabitants and tourists lay marooned, or were rescued spontaneously by the people to relief camps they themselves erected. In the week that followed, people in the true spirit of 'Kashmiriyat' flooded out to help all irrespective of caste, creed, religion and language.

Diminishing hope of supplies was starkly evident. Entire stretches lay water logged, with the stench of decomposing carcasses and corpses, and later dust of the drying silt made the entire region unbearable. People lay exposed to water-borne and respiratory tract diseases and starvation. Lakhs upon lakhs dumbly awaited epidemics.

Our heart went out to our hapless fellowmen, the people of Jammu & Kashmir, particularly the Kashmir Valley which was worst hit by the deluge and the subsequent misery.

Representation of the scenario to the outside world

Habitations with unaccounted hundreds upon thousands in the tourist spots and residences had been swept away or collapsed in the rushing flood and ensuing standing water over a month. Official 'rescue' was undertaken more than a week later,

to execute the 'safe extraction' of paramilitary/military and police, administrative, political and financial high-ups, and thousands of stranded tourists from all over the country and abroad. The stranded local people were simply ignored. The huge media blitz created upon such belated 'rescue' efforts to 'highlight' the 'valour and concern' of the Indian military was not only in poor taste, it deeply hurt the Kashmiri sentiment. Instead of drawing them closer, this negative approach rubbed salt into wounds that had been inflicted upon them for long. And this drew angry reactions from a people in dire straits. There were instances where men in uniform were saved from swirling waters by local youth (who are generally labelled as terrorists), and no news channel reported this. Many feel that this much-hyped 'rescue' operation was intended, to rehabilitate in the eyes of people of the mainland, the role and justification of huge deployment of the military and paramilitary forces in Kashmir, who normally are known to indulge in gross violation of peace and democracy of the local population, at the behest of the ruling class of India. During our medical camps and our interaction with local people, many told us that military/paramilitary personnel most often had a list in their hands of VIPs whom they were ordered to rescue.

Was the flood of the century unanticipated? There has been a complete disregard of nature in the question of 'development'. Though some experts had warned of the consequences of blocking flood channels and flood buffer zones, such projects were passed with impunity. Plush hotels & posh colonies have come up within flood buffer zones, probably having paid adequate amounts into the pockets that matter, to make such projects legal enough. Even the elevated railway line has proved to be a great divider, with too inadequate space for water to flow underneath. The only place where the administration seems to be stiffly implementing the laws is upon the poor Dal dwellers of Mir Behri, who have since ages been protecting the Dal and have been as an integral part of the Dal as its waters, cultivating vegetables to feed the city, maintaining the Dal floriculture, cleaning the Lake of hyacinths and other weeds, and of course maintaining the hall mark of Dal, boating – the dainty shikaras and house boats, and are the best carpet weavers. This component of the Dal is being portrayed as 'encroachers', and due to the installation of the Lakes and Water Ways Development Authority in early 80s with notified area laws clamped down, cannot even repair their mud structures that have succumbed to the floods and are forced to stay out in the open, or at best be content with staying under plastic covers in shanty tents or in boats! People all over are naturally telling they were living in a house here. That house got destroyed. How can you say: You cannot repair a house here – on whatever ground? Once this population, that is the only real buffer between the Dal and 'development' withers away, the real estate MNC sharks will have free hand in erecting sky-scraping hotels, having paid handsomely to earn rights to plunder the environment. In the corporate-driven world, it is only natural that insignificant people will have to make way for the 'MNC bosses.

The days of the deluge

Eye-witnesses at Srinagar engaged in rescuing relatives, friends and anyone who came in the way from Day 1 to Day 6 narrate that, there was no police force visible throughout the period. The preparedness is amply reflected in the fact that the IG,

Kashmir had to subsist on water and sugar for 4 days in his post – even he could not be rescued to a functioning position! But where were the police and administration at the headquarters of surrounding districts like Baramulla, Bandipora, Budgam, Ganderbal? People have been asking; They were not submerged. In Kashmir, road transport has developed only during the first half of the last century. Water transport has been used for centuries; there is the Wullar Lake, then the Manasbal Lake, with more than 3000 boats. When they have machinery to mobilise gunmen at any point of time, they could obviously requisition and mobilise required number of boats if they wanted to, the fishermen and boatmen with their boats, if they intended to evacuate the whole city. People could have walked to safety on bridges of boats! It is being said that, a written communication from the Police Chief and administration of Ananthnag reached the administration of Srinagar that the whole of Ananthnag is flooded; that the Jhelum was flowing 14 feet above normal level and when it would reach Srinagar, neither the bed of Jhelum in Srinagar, nor the Dal would be able to contain that volume of water. That gave 10 hours of vital time for crisis management. The Srinagar administration got 10 hours to save the city; but it did nothing. Men on the street are lamenting that, they could have at least saved the records. The capital could have managed to save vital and costly equipments. They could even have saved all the people. There was no public announcement. Only announcements that could be heard were from the masjids. People pointed out that during the rescue operations neither were the mainstream political parties nor were the separatist forces visible.

The 'Toll of democracy': another larger disaster in the making

Once disaster struck, cheap political bickering and propaganda competition took the centre-stage. Even the role of the PM left a big question mark. The way he came to celebrate Diwali in Srinagar knowing that it is not the main festival in this part of the country and that too after one and a half months! The man on the street said: “If you wanted to show care, you could have come on Id.” Democratic and secular minded people of the country outside Kashmir came forward with all kinds of help, like money, medicines and materials. But there were at the same time harrowing incidents, like the merciless thrashing of the VC of Vikram University, Prof. J L Kaul at the hands of RSS, VHP, Bajrang Dal activists and BJP supporters for the 'audacity' he showed in encouraging 'anti Indian activity' of relief collection for J&K flood victims. Lakhs of houses have collapsed or are at imminent risk of collapse. It is true that a section of the Kashmiris do have relatives and friends who can put them up through the winter. But a significant section of the marginalised does not have any alternative means. With a very harsh winter on the verge of setting in, the risk for those out in plastic tents or shanties, or in boats in the Dal, and a large section of rural victims up on bundhs and elsewhere, it would be a matter of life and death. The state and central governments who were conspicuous by their stark absence during the flood and its aftermath, were yet to have any visible steps on restoration and rehabilitation other than making certain empty declarations. The government was speaking of prefabricated houses which are said to cost around Rs. 7 lakhs each. Give them the money, they'll make a new and proper house, many were telling. Even in regular colonies like Bal Garden where 42 houses were razed to the ground, cumbersome procedures like taking permission from the municipality aggravated the situation.

With the state-level democratic exercise of election for the State Assembly having been declared as a 'much burning necessity', its 'model code of conduct' was clamped on. Everyone worthy of mention was busy jumping into the fray for his or her bite of the cake. Hence such mundane issues as houses for the lakhs were put in the back burner. The suffering people were left to manage their affairs themselves, where as the political parties got busy in mudslinging and electioneering. Considering the magnitude of the disaster in terms of loss of life and livelihood, could not the election be postponed by a month or two – people asked.

Were we not staring at another (larger) disaster in the making, another grim experience of the 'toll of democracy' in Kashmir?

The Activity

All India Medical Service Centre [MSC] is a national-level socio-medical voluntary organisation, working over more than past three decades and a half, *notably following the Bhopal Gas Disaster 1984-85, Riots, Super cyclone Orissa 1999, Destructive Earthquake Gujarat 2001, Devastating Tsunami-ravaged Tamilnadu-Andaman & Nicobar-Kerala in the 2004-05, Tillers of the soil battling to save their homes and turf from the clutches of SEZ in Nandigram & in Singur 2006-2008, the Devastating Cyclone AILA in 2009 and Floods in Assam-Bihar-Bengal-Odisha-Gujarat-Maharashtra-Andhra in 1978, 2000 & again in 2004, 06, 07, 08, 11, 12,* and over a year with the devastated Uttarakhand, committed to stand by the hapless in times of disaster, distress and deprivation. MSC responded to the devastation at J&K by sending its first medical response teams to work with the local inhabitants centring round the affected capital city and district of Srinagar [SGR] and its surrounding affected districts.

Survey Team

The 3-member Survey Team comprising of Ms. Rimmi Vaghela of Gujarat and volunteers familiar with the life in Srinagar surveyed the heart of the capital city on and from 22 September 2014, walking through Lal Chowk, Jehangir Chowk from Karannagar and up to Rajbagh Bridge. Large parts of the commercial centre of the city, the head-quarters of the state were still under water, to almost the height of a man, a fortnight after the flood had set in. Communication was a big problem, particularly for us from outside not so familiar with the life out there. As neither mobile nor internet was working in the city, and telephone lines washed out, it was very much difficult to contact anybody.

With no supply of power, the city would plunge into darkness as soon as the sun set. People were trying to pick up the broken ends just by themselves. The condition of the peripheries is well imaginable – those parts have been far beyond the limelight as ever. The drainage systems as well as the roads were choked in heavy silts deposited by the flood waters. Hence resentment was grossly evident. We had to make clear our standing as a voluntary organisation supported by contributions of the students, youth, teachers, medical professionals, and toiling masses of the country coming to the rescue of the people of Kashmir, that we were not a funded NGO, that we have no truck with any government body. 25th September saw further reinforcement of the Survey Team led

by Dr. Ansuman Mitra, Joint Secretary & In-charge, Disaster Response Cell and Dr. Inderjit Singh, Member, MSC Central Committee. Contacts that had been made by our friends from Gujarat, Chandigarh, Punjab, Delhi and Bengal over the last 10 days were worked upon. Budgam district headquarters, just about 10 km from the SGR Airport and at a slight elevation, was uninundated, hence had civic amenities functioning which was not the case with the city. We were offered accommodation there by the activists of the democratic J&K RTI Movement which we gladly accepted. From Budgam we ventured out first with our new contacts to the worst affected regions of SGR where they could give us access, to gain first hand experience of the present nature and magnitude of the medical crisis, and identify zones where we have expertise to intervene.

On 26th September 2014, the team moved across the city to conduct a series of meetings with various contacts to ascertain the line of action. Survey was conducted at the flood relief camp at the Government Girls' School, Saida Kadal, PO/PS: Rainawari, Srinagar district (SGR) where more than 200 families of the Dal area were put up as their houses had partially collapsed. People here were agitated as dog biscuits and expired packed food had been air-dropped in this campus during the worst initial days. One elderly man had sustained injury to his chest wall hit by the droppings. About 100 families had been moving back to clear up their houses. We had a short meeting with the president, elders, women and other inhabitants of the camp. As they said that, they had neither any government aid nor any medical assistance worth mention, we planned our first camp there on 27th September. We also surveyed the Foreshore Road, Dal, SGR where it was reported by our sources that people of very limited means were put up in the open without any assistance of any mention. We discussed with some youth there; found them to be habitants of Habakshanpur, Akhoon Mohalla in Dal under the PS. Nagin, who had lost their meagre shanties by the Dal. These young people took the responsibility of helping us conduct our second camp the next day on 28th September.

Camps Conducted

We thus conducted daily camps from the morning. General, paediatric, gynaecology, orthopaedic and dental camps were held. Camps were held at:

1 ***Srinagar district*** *Mir Behri Dal, PS. Rainawari and Nagin (among Dal dwellers of Akhoon Mohalla, Kani Kachi, Ranger Stop, Ashai Bagh, Zaildar Mohalla, Roni Mohalla Khurd & Kalan, Moti Mohalla, Sultan Mohalla with the active cooperation of the local residents' welfare society), in Padshahi Bagh, Mehjoornagar, Bemina (Hamdaniya & Boatman Colonies), Raj Bagh, Jawaharnagar(Yakhrajpora), Balhama (Pantha Chowk) localities*

2 ***Budgam district*** *(Summer Bugh, Arwah, Otligam)*

3 ***Baramulla district*** *(villages of Mechimar Mir Gund & Gund Ibrahim around Patan)*

4 ***Bandipora district*** *(villages of Nowgam, Sonawari, Sumbal, Zalapora)*

5 ***Pulwama district*** *(Gulzarpora)*

6 ***Anantnag district*** *(Hassanpora Tawaila, Hassanpora Bagh in Bij Baira)*

7 ***Kulgam district*** *(Aari Gutnoo, Kilan Gund)*

About 5000 patients from about 135 villages of 7 districts were treated in 51 camps conducted by 39 medical specialists and general volunteers from 8 states, involving more than 75 local volunteers.

The camps were followed by discussions with local volunteers wherever we found them serious or could generate interest, upon the impact of the disaster, prevailing health crises and necessary measures which they themselves may adopt to reduce the problem load, promote rational practices, and tide over the crisis. We also explored other regions in problem and scope of our further activity in the afternoon. In the evening our team used to sit to sum up the day's experience and plan and prepare for the next day's work.

Public programme on Health Awareness

A public programme titled Sensiti-sation on Community Health Post-flood was conducted at the Imamia Public School, Kani Kachi Mohalla, Mir Behri, SGR on 19th October 2014 to improve health awareness and promote health problems intervention of the local students and youth, who had volunteered in the camps we had organised in these Dal backwaters, which are backward economically and educationally. Prof. Abid Gulzar of the Centre of Central Asian Studies, Kashmir University and a prominent citizen of the locality has taken great pains to initiate the localites into educational and rational practices against obscurantism and age-old oppression. When he introduced in local vernacular, the health and economic advantages brought in and strength generated by health awareness and practices which Mr. Pran Wantoo in Kashmiri and Dr. Ansuman Mitra in Hindi had elaborated, the more than 200-strong audience from the community could well relate.

Efforts to make the voice of the civil society heard – without success

As relief activity was proceeding, we were racked by thoughts of how to generate a strength and sustain a preparedness in Kashmir, at least in the field of health where we had intervened. When our new friends were asking 'how long will you stay?', we answered that we have come bearing the ethics and approach of the pioneers. Once we hand that over to you, the fruits shall pass on to the people. It is immaterial whether I, she or you are practising it! The spontaneity with which the different sections of the professionals had jumped headlong into rescue and relief had warmed us. We tried to initiate a dialogue into the teachings of this unprecedented flood and the response that it had created. With no governance in view, if the professional viewpoints could be integrated, concretised and circulated, that we expected would build up a pressure upon the government and force it to act. But around the turn of the month, everybody was hard pressed to fend for himself and his family, put up some act to face the oncoming harsh winter. And none had any bit of faith upon the governments who had proved umpteen times that they were well capable of doing absolutely nothing for the people; hence everyone we approached was averse to address anything to the government. New to the psyche, it took us a bit of time before this thinking sunk in.

While the rescue and relief activities were coming to an end, the MSC was of the opinion that the whole focus of the state administration and the medical fraternity should be on:

1. The rehabilitation of the displaced people, and of those people whose houses have been rendered highly risky and non-usable

2. Tackling the possible stress and trauma due to the neglect of these urgent issues.

Training on Disaster Mental Health: Psychological First Aid Camps

We broached the issue of disaster mental health support among our new friends. It caught the imagination of both the volunteers of limited education and those in the seats of highest education including the health professionals. They readily accepted this support for their heavily traumatised people. Psychological First Aid Camps were initiated among children, volunteers who had worked in the disaster, teachers and guardians, and people at large, in the affected sections where we had been working to communicate with them about how to deal with their own trauma, and help in building up a support system within the community to enable it to function without external help and return to the daily life.

Accordingly a series of Psychological First Aid Sensitisation and Training workshops were organised by MSC across the flood-hit regions of Kashmir Valley. A 2-day workshop was conducted on 23-24 October 2014 at Sultan Mohalla with 13 students and youth studying in the 9th Standard to post-graduation, all of whom had volunteered in our camps in Mir Behri Dal. One-day workshop on 26th October 2014, was organised by Mother Care Clinic, Bagaat Barzulla, SGR which was conducted ith the active participation of Dr, Muzaffar Khan, Clinical Psychologist, Dr. Zahida Shah, Director of the Clinic, Dr. Yasir Wani, Paediatrician and others. It was attended by 40 doctors, nurses, psychologists, health workers and people working in the J&K Flood 2014.

Workshop on *"Management of Socio-Psychological Issues in Post Flood Scenario of Kashmir"* was organised by the Centre of Central Asian Studies (CCAS), University of Kashmir, Hazratbal on 29 October 2014 at its Conference Hall, in collaboration with the J&K RTI Movement, and conducted by Medical Service Centre Disaster Response Team. A minute's silence was observed in memory of those who untimely lost their lives in the disaster, and those who gave their lives to save their fellowmen in the flood.

The workshop was attended by about 150 delegates, faculty, research scholars & PG students, doctors, nurses, psychologists, health workers and people working voluntarily in the J&K Flood 2014. Plans were set to continue orientation of the people to such issues to reduce the stress. Prof. G N Khaki, Director of the CCAS took special care in the details of the workshop so that the benefits could be put to use by most of the faculties and scholars who had stood against the devastation. In his Chairman's address, he welcomed volunteers of Medical Service Centre from across the country who came all the way to the rescue of the people of Kashmir and took up the initiative to organise psychological first aid sensitisation and training workshops to help people cope with the ongoing stress. Dr. Ansuman Mitra, elaborated upon the voluntary efforts of MSC to work for the hapless in disaster, deprivation and distress; how they involved the local students and youth to deliver medical relief. Dr. P K Roy, Clinical Psychologist & Disaster Mental Health specialist trained the students and citizens on post-disaster socio-psychological issues. He elaborated on the importance of moving out or ahead of the "Disease mode" which looks for diseases after the problem has aggravated to an advanced level, to work on the "Problem mode" which cares to look for the problem and prevents it from getting larger. He appealed to the audience to volunteer and reach out to the community to ensure sustainability. Psychiatrists and psychologists reported 'distribution' of Alprazolam and other medicines – by paramedics, not prescriptions being served/ dispensed by doctors, and high risk of abuse of benzodiazepines – this in the background of a society that already has a huge load of alprazolam abuse as people were in conflict over the last 2 decades. The people have been facing a huge stress. There is not a single household where the lady members do not have disturbed sleep and do not take Alprazolam.

A total of about **300** volunteers were given orientation through 5 training camps in disaster mental health & psychosocial intervention. Plans were initiated for Dr. Muzaffar Khan, Clinical Psychologist of the city to continue the necessary follow up of training of volunteers.

Reaching out

We went out in batches to meet doctors, psychiatrists, psychologists, medical and dental students and junior doctors, nurses and other health professionals of Sher-i-Kashmir Institute of Medical Sciences (SKIMS) and Government Medical College, Srinagar and Medical College, Jammu and doctors in private practice. We met teachers and students, software professionals and journalists, and people from different walks of life who had faced the devastating floods to seek their experience, guidance and cooperation in continuing the medical and psychological relief.

Findings on health, water, sanitation, hygiene and habitation status

1 Water logging has lead to the contamination of water sources. Mud houses in the banks of the Dal were either down or partially tilted, hence uninhabitable. People in that area were being forced to stay in the open either in the marshes, or in boats.

Some huddled into small tents put up in some clearing. Civic systems were unthinkable. Frequent rains made the life more risky. The harsh imminent winter was ominous, as we had been alarmed to think of, and tried to rouse the administration in our deputations and statements issued to the media.

2 Gastro-intestinal infections were a major risk under such circumstances. We found an average of 15% patients suffering from such infections; but in camps at Rainawari among Dal dwellers, we found such infections as low as 6%. The local people, particularly those who cannot afford, need to be provided with treated/ chlorinated potable drinking water. Hygiene and sanitation of localities, including regular spraying of bleaching powder need to be maintained.

3 Health hazards due to non-functioning of sanitary & sewage systems.

4 Structures at some places were too weak and risky for dwelling, particularly in the face of imminent harsh winter. Exposure to cold is causing respiratory problems, allergies and infections, in an average of 25% of the patients we saw. But among Dal dwellers who are most exposed, we found it above 35%.

5 Disruption and non-restoration of electric, water and communication lines.

6 Rescue, medical and other relief is coming to an end. But acute stress reaction due to loss of life, livelihood, destruction of the known world, imminent risk of further exposure in the coming winter needed proper assessment and redressal. With lack of proper and adequate rehabilitation of the victims, psychological issues related to the trauma were bound to be in the forefront. MSC realised the need to take care of psychological trauma, and started to hold various sensitisation and training programmes on how to address this issue. We appealed to all medical professionals and the Government to visualise this trauma and to deal with this crisis.

7 In the background of the massive disruption of lives and livelihood of the people of the affected areas, they need to be provided with an immediate short term interim monetary relief, family-wise, to enable them to meet daily needs with dignity.

Representations to Dr. Salim-ur Rahman, Director of Health Services, Kashmir, and Mr. Gazanfar Ali, Director, Social Welfare, Kashmir

Considering it as part of our service to the society we tried as in our previous efforts in other parts of the country to reach out to the health administration within a fortnight of our activity to put our findings, observations and suggestions regarding the state of people's health in the Kashmir Valley following the devastation, and ways to best ease the sufferings of the ailing humanity. The reservation and scepticism of the people at large about the government probably got us delayed in developing a communication. Finally we summed up our first experience of working in the state of Jammu & Kashmir with representations to Dr. Salim-ur Rahman, Director of Health Services, Kashmir, and Mr. Gazanfar Ali, Director, Social Welfare, Kashmir on 30 October 2014

led by Dr. Ansuman Mitra, Joint Secretary and In-charge, Disaster Response Cell, and Mr. Pran Wantoo, Activist of MSC. We stressed the urgency of rehabilitation on the face of the imminent harsh winter, and proposed continuation of the disaster mental health programme to cope up with the high level of stress to which the people of Kashmir have been exposed to since decades.

But more organizations should come forward. MSC will be happy to guide and coordinate anybody in this process.

Some points to remember:

1. Travelling cost is huge. So organizations should arrange for funds to meet this necessity before reaching there.

2. The way MSC works, the model has been proved to be effective. We rely more on local people rather than administration. It helps us to get a place to stay and to get local involvement. It requires patience and down to earth approach.

3. Any help has to be culturally sensitive irrespective of our own belief. MSC has upheld the spirit of Kashmiriyat which has imbibed one and all to stand as one man to brave such odds even after decades of discrimination and strife; we have pledged to all our new Kashmiri friends that we are ready to join in the efforts to uphold this great spirit of renaissance which can restore peace upon the people of Kashmir.

Using the computer and internet

As in our response following the Uttarakhand Disasater last year, this time too our activity was visible on the net through uploading on the Facebook (www.facebook.com/kashmirreliefactivity). Our common circle believes us personally, organisationally, sees our publications after a few months, and often chides us for the delay, expecting us to be better propagated. A large number of people across the net outside this circle, childhood and school friends, relatives, and people at large thus came to know almost in real time, i.e. even before the general media (which never really covered us). Only delay was in uploading, caused by network problem post-disaster. This visibility thus yielded much more participation, confidence and contributions than our social (and MSC) circles. We thus improved upon usage of alternative media.

We have at least a bit improved documentation of our activities. We had been trying to systematise the process of disaster response that we have applied up to Uttarakhand.

Our appeal

Medical Service Centre Central Committee appealed particularly to all pro-people doctors & health professionals especially from North Indian states to volunteer to come to the devastated region to share the plight of the hapless, and to all well-meaning people to stand by them and support and strengthen this ongoing medical mission by all means.

We heartily hail the valiant efforts of the medical community, other professionals and people at large of J&K to rescue and stand by their distressed brethren in the days of deluge. We hope that the civil society will take the teaching from this disaster to the people at large so that the people emerge stronger, with higher bondage to face such challenges in future.

Continued on Page No. 47

Universal Health Coverage :

- Is it a guarantee of People's Health?

Dr.Sajal Biswas
CC member, MSC

"Health for All by 2000 AD" is now in the pages of history. National Rural Health Mission (NRHM), supposedly a protector of people's health from 2005 to 2012, is also a past fact, and is now known as National Health Mission (NHM). There may have been some improvements in public health planning , but fact is, programmes - Missions - visions etc, have failed to protect the people's health. People's health has been converted from right to a commodity. It saddens to note that families of 40% of hospitalized patients have to borrow money to meet the cost of treatment. In this situation, the government is set to launch another health policy named Universal Health Coverage (UHC).

The Prime Minister of India had declared that, health would be accorded the highest priority in the 12th Five years plan, which began in 2012. But before that, in 2010, a High Level Expert Group (HLEG) on Universal Health Coverage (UHC) was constituted by the planning commission of India with the mandate of developing a framework for providing easily accessible and affordable health care to all Indians. While financial protection was the principal objective of this initiative, it was recognized that the delivery of UHC also requires the availability of adequate healthcare infrastructure, skilled health workforce and access to affordable drugs and technologies to ensure the entitled level and quality of care given to every citizen. Further, the design and delivery of health programs and services called for efficient management systems as well as active engagement of empowered communities. The original terms of reference directed the HLEG to address all of those needs of UHC. Since the social determinants of health have a profound influence not only on the health of populations but also on the ability of individuals to access healthcare, the HLEG decided to include a clear reference to them, though such determinants are conventionally regarded as falling in the domain of non-health sectors.

Universal Health Coverage by 2022: The Vision

Entitlement	National Health Package	Choice of facilities
Universal health	Guaranteed access to an	People are free to chose between
Entitlement to	essential health package	Public sector facilities
Every citizen	(including cashless inpatient	Contracted private health providers
	And outpatient care provider	
	Free of cost)	
	Primary care	
	Secondary care	
	Tertiary care	

Mode of implementation of National Health Package : Health care services to all citizens covered under UHC will be made available through the public sector and contracted private facilities (including NGOS and non-profit organisations). There may be several different options:

i) **The first option:** Private providers opting for inclusion in the UHC system would have to ensure that at least 75 % of OPD care and 50% of in-patient services care are offered to citizens under the NHP. For these services, they would be appropriately regulated and monitored to ensure that services guaranteed under the NHP are delivered cashless with equity and quality. For the remainder of the OPD (25%) and in-patient (50%) coverage, service providers would be permitted to offer additional non-NHP services over and beyond the NHP package, for which they could accept additional payments from individuals or through privately purchased insurance policies.

ii) **The second alternative:** It entails that institutions participating in UHC would commit to provide only the cashless services related to the NHP and not provide any other services which would require private insurance coverage or out of pocket payment. In this regard, purchases of all health care services under the UHC system should be undertaken either directly by the Central and State Governments through their Department of Health or by Quasi-government autonomous agencies established for the purpose.

iii) All Government funded insurance scheme should, over time, be integrated with the UHC system. All health insurance cards should, in due course, be replaced by National Health Entitlement Cards. UHC will cover all aspects like primary, secondary and tertiary health care, and also, it will emphasize on preventive aspects of health too.

iv) UHC advocates a shift from a primary focus on garnering additional financial resources from the private sector or subsidizing it, to an approach in which there is a well -defined service delivery partnership between government as a purchaser and the private sector as a provider. Government would ensure only regulatory and supervisory work only.

Health care delivery architecture:

It is said that UHC is committed to build adequate health infrastructure. Is it a new phenomenon? Similar commitments were given earlier in 'Health for all by 2000 AD' and by NRHM. Like UHC, all had committed to develop a huge number of new health institutions from sub health centres to Medical colleges. By 2022, according to UHC, there would be one SHC against 3000-50000 population, one primary health centre among 20,000-30,000 population and at least one CHC to be set up for 80,000-120,000 population. The new approach taken here is that, there would be a provision for one Sub-District level hospital among 10,00000 population and in each district

there would be one Medical College consisting of 750 beds which would cater to about 25,00000 population. Meanwhile, in the vision of UHC there would be the following institutions:

Tertiary- level: Consists of Medical colleges and District Hospitals

Secondary –level: Sub-district level hospitals and CHCs

Primary-level: PHCs and SHCs

It is claimed that the projected human resources which are to be increased several folds would meet the demands of newer health care services. For this, UHC recommends introduction of Rural Health Care Practitioners; i.e. it encourages introduction of proposed BRHC (Bachelor of Rural Health Care) course, which would only produce truncated doctors to care for the rural population. Regarding proposed promotional norms, there are provisions for promotion of ASHA to ANM to GNM to Block Public Health Nurse to District public health nurse and also up to the topmost post like Director of nursing also! Can one forget what the selection criteria of ASHA are! How can UHC recommend this type of promotional norms? Will it maintain quality of health care services? Another proposal of UHC is that, Nursing personnel and non medical public health personnel could act as in-charge of a CHC, a secondary tier hospital, only by promotional basis. Further, they might reach up to district level managerial post. Is it rational? What will be the quality of service providers? Definitely this is something to ponder over.

In this context, we need to recollect the recommendations of the Bhore Committee which was set up in 1946. The committee recommended that, a highly qualified doctor should be posted at the primary care level, who would be able to act as a basic doctor. But in UHC, there would be an open provision for posting of cadres like, BRHC, nursing staff, non medical health managers etc. to such posts, who has to act as a basic doctor.

Regarding the infrastructure at a glance as per Bhore committee Recommendation:

Primary unit: 75 bedded hospital for 10000-20000 population.

Secondary unit: 60 primary units under a secondary unit. 650 bedded hospital with provision of 140 doctors, 180 nurses, 178 other staff etc.

District Hospital: 2500 bedded with 269 doctors, 625 nurses, 50 Hospital social workers, and 723 other staff.

So, UHC recommendation is definitely far behind Bhore committee recommendation. Previously NRHM had also given the same commitment. After spending crores of rupees to execute the programme, let us see where we stand at present in context to infrastructure and manpower:

Chart- I

Name of infrastructure	Existing position	Target level of NRHM	Short fall	percentage
Sub Health Centre	**147069**	**240000**	**92931**	**63%**
Primary Health Centre	23673	40000	163227	**68.96%**
Community health Centre	4535	12000	7465	164.60%

Only 754 out of existing 4535 CHC are functioning as per IPHS norms.

Chart- II

Hospital Bed Capacity, in India and some other countries at present:

Name of Country	Beds/1000 population
Sri Lanka	3.1
China	3.0
Thailand	2.2
USA	3.1
Brazil	2.4
UK	3.9
Nicaragua	0.9
Togo	0.9
India	0.9

Sources: World health Statistics (2011)

Chart-III

Distribution of functional beds in India:

India has around 1.37 million hospital beds:

Private beds		**Government beds**	
833000		540000	
Functional	non functional	Functional	Nonfunctional
70%	30%	50%	50%
Top 20 cities	other cities	Top 20 cities	other cities
70%	30%	60%	40%

Sources: Mehata and colleagues (Techno pack)

Chart-IV

Particulars	India at present(2011)	Projected by UHC(2025)
Health worker density per 1000 population (Doctors-Allopathy, Nurses and Midwives)	1.29	3.33
Population served per doctor(Allopathy)	1953	1201
Ratio of Nurses and midwives to a doctor	1.53	3.01
Ratio of nurses to a doctor	1.05	2.19

Sources: HLEG Secretariat

Hence, it is obvious how the rosy picture illustrated by 'Health for all by 2000 AD' by NRHM, NUHM, PPPP etc. has now faded; The true status of Health care in India after crores of rupees of public expenditure is un raveled before the people . HealthCare is increasingly privatized and it is now a commodity. Perhaps we have to wait to see the real outcome of UHC by 2022!

Health Financing and Financial protection of UHC: As per UHC, the Government (Central and States combined) should increase public expenditures on health from the current level of 1.2% of GDP to at least 2.5% by the end of the 12th plan and to at least 3 % of GDP by 2022.

Where do we stand at present on health expenditure?

Some key indicators: India compared with other countries:

Indicator	India	China	Brazil	Srilanka	Thailand
IMR/1000 live-birth	**50**	17	17	13	12
Under-5 mortality/1000 live-births	**66**	19	21	16	13
Fully immunized (%)	66	95	99	99	98
Birth by skilled attendants %	47	96	98	97	99
Health expenditure as percentage of GDP(Govt.and Private)	4.2	4.3	8.4	4.1	4.1
Government share of total health expenditure (%)	**32.4**	47.3	44	43.7	74.3
Per capita spending in US dollars	**122**	265	875	187	328

Sources: World health Statistics (2011)

Thus, according to UHC, India is committed to increase the health expenditure at least by five folds from the current status. But what would be the mode of extra budget generation? Is it from the existing budget curtailed from military-police or taxes for the big industrialists? Answer is obviously no.

At present, the amount allocated to the military is increasing in every budget. Also the amount of various tax concessions given to the big industrialists is crores of Rupees, not to mention about the huge black money being generated.

But our Government is not willing to collect money from this domain. It is planning to impose extra tax on every citizen in the name of health tax or Health cess. After pooling of these revenues , the Government will be purchasing health care services on behalf of the entire population. So, the Government would become the health purchaser and the private sectors, including the private insurances will be the health providers. They would be paid directly by the Government or its nominated body.

What are the current trends of public regarding treatment? Will it be towards the Government sector or will it be to the private sector, when both would be 'free', i.e. cashless? The answer is anybody's guess. People tend to go to the private sectors more, hoping to get a better quality treatment there, as they are disillusioned with the government set up. Thus the private sector business will flourish many folds; while the Government would be the purchaser, payment would be more guaranteed. But the poverty level would be increased by many folds in our country.

Where are we at present:

28% of rural residents and 20% of the urban have no funds for health care.

Over 40% of hospitalized persons have to borrow money or sell assets to pay for their health care.

Over 35 % of hospitalized personnel fall below poverty line because of hospital expenses.

Over 2.2% of the population may be impoverished because of hospitalization.

But it is not estimated how many people would fall under below poverty line after payment of extra health taxes year after year to meet the expenditures of UHC.

Finally, it can be said that, UHC is nothing but a form of health insurance, where people would have to pay for the health expenditure even before they receive it. Universal Health Coverage cannot be Universal Health Insurance. Dr. Norman Bethune has already implied that Health Insurance is not Nationalization of Health. On the other hand,if we recollect the recommendation of Bhore committee, this was the guiding principle -"No individual should be denied to secure adequate medical care because of inability to pay." Medical services should be free to all without discrimination. Here there was no recommendation of health card or heath taxes provision.

After independence, Indian constitution declared India as a welfare state, where health is Government's responsibility. And people already pay taxes directly or indirectly for health and welfare purposes. Why should additional taxes be fixed by UHC? Is it not against our welfare concept? Why do people require National Health Entitlement Card (NHEC) though all are citizens of Indian welfare state? Every citizen needs to think deeply over the UHC proposals before its implementation, as health is not a commodity, but a fundamental right.

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Continued from Page No. 41

People of Kashmir for the hapless of Assam flood

By end of October, the government and health set ups had started functioning, and winter was setting in very fast. We were winding up the first phase of our medical camps and our psychological first aid training programme was in full swing. A group of Kashmiri students studying in Delhi who had supported us throughout our activity had collected a fresh stock of medicines, and were asking us how and where to send to Kashmir. We had no infrastructure in Kashmir to handle such stock over months, and we told them so. Assam was then in floods; MSC had already dispatched medical relief team there. So we suggested to these Kashmiri students, just as students and youth across the country had stood shoulder to shoulder for the hapless people of Kashmir, now Kashmiri students in their turn can stand with the hapless people of Assam. They happily agreed. While the powers-that-be are going all out to divide our people on this or that obscurant jingoistic pretext, we could do at least some service to provide a small platform to stand together in unity in times of distress! This we consider a measure of the achievement of our mission, the soaring of the spirit of renaissance and humanism we carry forward: the students of Uttarakhand who had worked with us the previous year in their devastation came together in Garhwal Srinagar to collect medicines and funds for the hapless of Kashmir Srinagar!

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Amendment bill of MTP act 2014 *Continued from Page No. 31*

The Abortion Assessment Project, a multicentre survey, estimates that very few abortions in India are performed by trained physicians in approved clinics. Of the 6.4 million abortions performed annually, 3.6 million or 56% are unsafe . Deaths from unsafe abortion are estimated to constitute 10%–13% of the total maternal deaths in India. These deaths can be attributed to numerous causes, ranging from lack of awareness of the legality of abortion to the lack of affordable services, lack of investment in the public health sector and a providers' base that is not large enough to meet the need for safe abortion.

- **The period of gestation allowing for termination has been extended up to 24 weeks.**

  The concerns

  - When MTP conducted by qualified, trained personnel could cause complications resulting in morbidity and mortality, how can it be expected to be any better in the hands of lesser qualified persons with some training? Rather, will it not worsen the situation?
  - The Government is reportedly taking these adhoc measures to solve the problem of non availability of qualified, trained personnel in the periphery. Instead, is it not better for the Government to go in depth into the matter of allopathic doctors not going to rural areas and solve it? Should our less privileged women be subjected to the risk of complications?
  - When termination of second trimester pregnancy is to be handled with extreme care by gynaecologists, can others manage it without jeopardizing the life of the woman, that too beyond 20 weeks?
  - Instead of permitting termination of a pregnancy beyond 20 weeks up to 24 weeks only in specified cases with a strict regulatory mechanism in place, will not a blanket permission be harmful to the life of the woman?
  - Will this extension without any regulation not lead to sex selective abortions contravening the dictates of PDPNDT act?

Instead of bickering over whether it should be only allopathic doctors or doctors from other systems of medicine or Nurses/ANMs who should conduct MTPs, the need of the hour is-A scientifically qualified, well trained professional who is capable of managing complications should they occur, in a well equipped set up with a support staff. Only then our hapless women can be expected to be safe. Additionally, any extension of period of gestation should only be on medical grounds as deemed fit by the specialists in the field. Along side, our women need to be educated regarding the problems of abortions, especially repeated ones and advised in this regard. They should also be educated to approach only recognized centres not falling prey to quacks endangering their lives.

It is expected of any pro people Government to take adequate measures in this regard.

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PHOTO REPORTS OF MSC ACTIVITIES

Dr. Binayak Sen, Dr. Asok Samanta and others lead a rally demanding justice for Korpan Shah, a mentally challenged youth who was lynched in the hostel of NRS Medical College, allegedly on suspicion of stealing.
4 Dec. 2014, Kolkata

Convention against DPCO Curtailment, Bengal Tuberculosis Association Auditorium, Kolkata, organised by MSC WB 30 Oct 2014

Dr. Sajal Biswas, Member, CC, MSC speaking on the occasion. Dr. Biswanath Paria, Senior Vice President and Dr.Bignan Bera, General Secretary, CC, MSC on the dais.

"Let us redefine medical ethics, not as a code of professional etiquette between doctors but as a code of fundamental morality and justice between medicine and the people"

- Dr. Norman Bethune

PHOTO REPORTS OF MSC ACTIVITIES

Inauguration of Dr. Bhaskar Bhadra Free Homoeopathy Treatment Centre, 9 Nov 2014 at Raghunathpur Purulia with active participation of MSC Purulia District Committee in memory of the departed popular mass leader Dr. Bhaskar Bhadra, Vice President, MSC West Bengal State Committee

Dr. Ansuman Mitra, In-charge of MSC's Disaster Response in Uttarakhand, and Mr. Mukesh Semwal conducted an interactive session, "The understanding & motivation of working with the distressed: the Uttarakhand Disaster Experience" jointly with the Department of SPM, VCSG Government Medical College, Uttarakhand guided by Principal Prof. I.S.Yog and Dr. Amit Kumar Singh, HOD, SPM on 26 February 2015. More than 150 students participated; most gave their valuable feedback.

Mass meeting organised by MSC WB against DPCO & 108 medicines' curtailment, at approach to Sealdah Station, Kolkata, 9 Jan 2015

Press conference against NHP 2015 Draft by MSC Central Committee, MSC Central Office, 10 March 2015

Scientific Seminar on Swine Flu Organised by MSC Calcutta District Committee LT 2 RGKar Medical College, Kolkat on 27 Feb 2015 Prof. Manish Chakraborty, Virologist, Former HOD, Virology & Director, Calcutta School of Tropical Medicine addressing the gathering

PHOTO REPORTS OF MSC ACTIVITIES

MSC Cultural Day, Sept 21, 2014, Nayana Auditorium, Bangalore. Inaugurated by Dr. Dharmanand, Senior Consultant Rheumatology. On this occasion, a Panel discussion on "Changing Trends in Clinical Practice – Repercussions' was organized. Dr.Tarun Mondal Ex MP, Vice-President of All India MSC, Dr.Srinivas Kakkilaya, Renowned Physician, Managalore, Dr.Sudha K, President, MSC, Karnataka, Dr. Gangadhar, Vice President, and Dr Vasudhendra N, Secretary, MSC, Karnataka conducted the discussion

MSC Cultural Day, Sept 2014: Colourful Cultural programmes by Medical professionals enthralled the audience. Drama "Rajabhavana Raste Manhole" by MSC, Bangalore troupe, Ragaranjini by Dr HG Jayalakshmi and group, Yakshagana (Folk dance form of Karnataka) were some of the programs.Pic: Yakshagaana by Dr.Shreepad Hegde and students.

Dr. Hegde is the Profesor, Govt. Homeopathic Medical College Bangalore.

Free Healthcamp at Siddarth Nagar, Bangalore, 20th July, 2014. Inauguration by Dr.Sudha K, Vice President, All India MSC. Dr.Gangadhar K S, Vice President, MSC, Karnataka on the dais.

Dr.Rajshekhar, State committee member, MSC, Karnataka examining the patients.

PHOTO REPORTS OF MSC ACTIVITIES

A State level Study Camp was conducted by MSC, Karnataka State Committee at Maralukunte Village near Bangalore on 14th and 15th February. Medical and Nursing students participated in the camp where many burning issues confronting health and medical, Paramedical education were discussed.

Free Health camp at Anjinappa Nagar, Bellary, Karnataka, 30th November, 2014. Dr. Bhanu Prasad, renowned Pediatrician, Bellary speaking on the occasion. Dr.Divya, Assistant Prof, Dept of Microbiology, VIMS and organizer MSC, Bellary and Dr. Pushpalata, Associate Prof, Dept of Microbiology, VIMS, Bellary and also member, MSC, Bellary on the dais.

PHOTO REPORTS OF MSC ACTIVITIES

Health checkup camp organized by MSC, Davangere at Kogganur Village on 12.02.2015 in association with
Kumuda College of Nursing, Davangere.
Dr.Vasudhendra N, Ophthalmologist and Secretary, MSC, State committee, examining the patient.

School Eye check up camp at Channagiri
Davangere Dist. Karnaraka
by MSC, Davangere on 08.01.2015

Streetplay Program by MSC, Davangere, November 30, 2014: Medical and nursing students of MSC davangere, organised a Streetplay program in Turchghatta and Tolhunase villages near Davangere. The play "Bhanamati", exposing practices of Black magic was successfully performed.

Awareness program by MSC Davangere on the occasion of World Health Day, April 7th, 2015 at AVK College for Women. Dr Ranjita, PG, Dept of PSM, JJMMC, Davangere gave a talk on "Safe Food, From Farm to Plate"
Prof. Hanumantappa, Principal, AVK College,
Dr Shivkumar, Organiser, MSC on the dais.

PHOTO REPORT OF MSC ACTIVITIES

3rd All Odisha Conference and Seminar on 15th Feb. 2015, Bhubaneshwara, Odisha.

3rd All Odisha Conference at "Lohia Academy, Bhubaneswar". 260 doctors from all streams, medical students from 9 medical colleges, nurses, pharmacists, pathologists and Health workers attended the conference as delegates. Prof. (Dr.) Sanatan Rath, President, MSC, All India Committee inaugurated the conference. Dr. Tarun Mandal, Vice-President, MSC, CC, as the main speaker of the inaugural session explained the present scenario of health in our country and our role. Prof. (Dr.) Krupasindhu Panda, eminent onco-surgeon, and the guest of honour of the conference encouraged the delegates to work from the core of the heart for the development of the medical science. Dr. Surajit Sahu, President, MSC, Odisha State Committee presided over the conference session. Odisha state secretary Dr. Ratnakar Panda placed the organisational report and then the joint secretary Dr. Manoranjan Mahakur placed the resolution. Students from different medical institutions and delegates from different units actively participated in the discussion from various angles on the resolution. Dr. Biswanath Paria, Vice-President, MSC, CC gave the concluding speech of the conference session. A 55 members new state committee headed by Dr. Surajit Sahu as President and Dr. Ratnakar Panda as secretary was proposed by the senior most advisor of the state committee Dr. Bhagirathi Mohanty which was unanimously accepted. Vote of thanks was given by Dr. Badrinath Tripathy

In the second session a Seminar on "Oral Carcinoma" was conducted. This session was chaired jointly by Dr. Bhagirathi Mohanty and Dr. Mohini Mohan Behera. Prof (Dr.) Surendranath Senapati, H.O.D., Dept of Radiation Oncology, A.H. Regional Cancer Centre, Cuttack, Dr. Niranjan Mishra, Asst. Proffessor, Dept. of Oral & Maxillofacial surgery, SCB Dental College and Hospital, Cuttack, Dr. Chaturbhuja Bhuyan, Ex-Professsor, Jamnagar Ayurved University, Gujurat and Dr. Chintamani Nayak, Lecturer National Institute of Homoeopathy (NIH) shared their valuable knowledge as the resource personels of the academic seminar session. The programme ended with vote of thanks by Dr. Manas Ranjan Mishra.

World Homeopathy Day at Rourkela, Odisha on 10-04-2015

MSC Rourkela City Committee observed the Birth Anniversary of Dr. C.F.S. Hahnemann as the world Homoeopathic day at Redcross Bhawan, Govt. Hospital Campus, Rourkela. Dr. Bhagirathi Mohanty, Senior Most advisor of MSC, odisha State Committee and President, Rourkela city committee presided over the meeting. Dr. Naresh Panda, Secretary gave the introductory speech. Prof. (Dr.) Ramesh Chandra Sahu, Ex-principal, Odisha Homoeopathic Medical College & Research, Sambalpur was the Main Speaker. Dr. Biswajit Mohapatra, MS, Veshaj Patel Hospital Rourkela was the Chief Guest.

PHOTO REPORT OF MSC ACTIVITIES

1st MSC Rourkela City Conference at IMA Hall, Rourkela, Dec 28, 2014. Dr. Bijnan Bera, General Secretary, MSC, All India Committee addressed the conference as the main speaker. Dr. Bhagirathi Mohanty presided over the conference. Dr. Ratnakar Panda gave the introduction along with the aims and objectives of MSC. Dr. Naresh Panda placed the organisational report.A 22 members new committee was declared where Dr. Bhagirathi Mohanty and Dr. Naresh Panda remained as President and secretary respectively.

Kerala : Experience sharing programme of Kashmir Relief activity:

Experience sharing programme of Kashmir Relief activity: Programme conducted on behalf of Medical service centre on October 30 at Kottayam, Kerala, for honouring and sharing experiences of volunteers , who went for Kashmir Relief camp. Welcome by Muhammed shafeek. Inauguration by Dr. C.P.Vijayan (Prof of Gyneacology& obstetrics, MCH , Kottayam) Prof.N.Thankachan, Jaison Joseph felicitated the occasion . Dr.Hariprasad & Rameez shahusad shared their camp experiences. Dr Venugopal gave the keynote address.

Appeal and Report of medical relief activity of Medical Service Centre, India (MSC) in earthquake-devastated Nepal.

The devastating earthquake that hit on 25 April 2015, again on 12 May 2015, and the subsequent aftershocks have razed the Nepal Valley and parts of northern and eastern India. Millions lie homeless, having lost their kith and kin under the rubble. Being a socio-medical organisation, Medical Service Centre is committed to stand by the people in times of disaster, distress and deprivation and has launched its disaster response to the calamity. A 7 member Pilot Medical Team headed by Dr. Susovan Ghosh reached Kathmandu on 9 May and established base at 'SenaChhauni' at Swoyambhu area, KTM. On 10 May medical camps were started in devastated areas around Katmandu. Subsequently 4 more teams, headed by Dr. AnsumanMitra, In-charge, Disaster Response Cell, MSC, Dr. Swapan Biswas, Dr. Hariprasad (Consultant orthopaedic surgeon from Kerala) & Dr. Sams Mushafir started working.

MSC did medical relief work in the devastated rural district of Dolakha in Jungu, Kshatrapa, Namdu, Jhanku Marbuetc over 200km away from Karnandu, as allotted by the Ministry of Health & Population, Govt. of Nepal. More than 25 MEDICAL CAMPS have been conducted, over 4000 patients examined, medicines dispensed worth over INR 8 lakhs, collected by medical, nursing, paramedical & general students, health professionals & common people of India for their earthquake-stricken neighbours. A Psychological First Aid Orientation Camp was conducted by Dr. Mitra on 15 May with 40 students and youths at SantiNikunj School, Maruhiti, near Hanuman Doka, KTM. ORTHOPAEDIC CAMPS were also conducted in Dolakha, Lalitpur and Kathmandu district.

Another team of 7 members headed by Dr. HarekrishnaMaity and Dr. Bharat Chandra Das worked in Raxaul, Bihar, India, near Nepal Border, treated 539 patients with similar problems from 4 to 8 May.

Medical Service Centre Central Committee appeals to all well-meaning people and organisations to share the plight of the hapless and to stand by them, to come forward, as in the past, extend help to the best of ones' ability in terms of money, medicine, baby food & packed/preserved foodstuff, water, tents and tarpaulin and corrugated roofing sheet, means of transport and communication and logistic support.

Details: Website:

www.medicalservicecentre.org; FB: www.facebook.com/MSCNepalBiharRelief.