News from here and there

Jan Swasthya Abhiyan demands more on health from political parties in election campaign

Jan Swasthya Abhiyan (JSA), the Indian regional circle of the global People's Health Movement, has developed a people's health manifesto 2009 for Indian political parties. The purpose of the manifesto is to make health a national political issue in the framework of quality healthcare for all and access to basic determinants of health as a basic right. The JSA hopes political parties will include these recommendations in their election manifestos.

Highlighting that 'health for all' still remains a mirage for the vast majority in India, the manifesto details shortcomings in children and women's health. It addresses the burden of communicable diseases, and the issues of poor infrastructure, coverage and outreach of the public health system. Commenting on the increasing privatization in the healthcare sector, the manifesto states 'public provision of healthcare is not doomed to fail as some suggest, but making it work requires determined political leadership, adequate investment, evidence-based policies and popular support'. The manifesto raises concerns about the largely unregulated private sector and pharmaceutical industry, and trends such as medical tourism. The manifesto argues that public financing of healthcare in India is grossly inadequate (being among the lowest in the world). Social determinants of health need to be addressed in a comprehensive manner through intersectoral coordinated action; environmental/occupational health, health effects of conflicts/displacement and caste-based discrimination are also major challenges.

With these arguments, the JSA has called upon all political parties to consider adopting the People's Health Manifesto in their political agenda. The manifesto includes the demand for enactment of a National Health Act, which would help take effective measures to achieve the right to health in India. The National Rural Health Mission not only needs more funds, but also a mechanism to ensure accountability and effective spending of funds. Lists of essential drugs and consumables need to be generated in all states, and regulatory structures strengthened in the field of drug development, marketing and sale. The action steps in the manifesto include concerted efforts in the area of gender and health (such as recognition of violence against women as a public health issue) and child heath (such as an urgent need for national policy on child health and nutrition).

ANANT BHAN, *Pune, Maharashtra*

Influenza A (swine flu) outbreak

As of 27 April 2009, the United States Government reported 40 laboratory confirmed human cases of influenza A (H1N1), with no deaths. Mexico reported 26 confirmed human cases of infection with the same virus, with 7 deaths. Canada reported 6 cases, with no deaths, while Spain reported 1 case, with no deaths. The Emergency Committee of the WHO, established in compliance with the International Health Regulations (2005), held its second meeting on 27 April 2009 to discuss the unfolding outbreak of H1N1 influenza.

On the advice of the Committee, the WHO raised the level of the influenza pandemic alert from phase 3 to phase 4. While the change to a higher phase of pandemic alert indicates that the likelihood of a pandemic has increased, it does not indicate that a pandemic is inevitable. This decision was based primarily on epidemiological data confirming human-to-human transmission and the ability of the virus to cause community-level outbreaks. It was felt that, given the widespread presence of the virus, containment of the outbreak was not feasible; it recommended a focus on mitigation measures instead. The WHO clarified that there is no risk of infection from consumption of well-cooked pork and pork products. Individuals are advised to wash hands thoroughly with soap and water on a regular basis and seek medical attention if they develop any symptoms of influenza-like illness. At this point, the WHO does not recommend restriction of international travel. However, it is considered prudent for people who are ill to delay international travel and for people developing symptoms following international travel to seek medical attention, in line with guidance from national authorities. Meanwhile, the WHO intends to facilitate the process needed to develop a vaccine against influenza A/H1N1 virus.

PRABHA DESIKAN, *Bhopal, Madhya Pradesh*

Fall in number of takers for a career in medicine in India

Fewer students in India now want to be doctors. Though the demand for admission to medical schools is still higher than supply, there is a progressive decline in the number of students appearing for all-India medical entrance examinations. This is ironical considering that India is short of around 600 000 doctors, according to an estimate by the country's apex planning agency, the Planning Commission. In 2006, a total of 233 591 students appeared for the entrance examination. This number decreased to 210 318 in 2007 and to 161 230 in 2008. In 2009, only 145 200 students had registered for the examination. India's 289 medical schools can admit up to 31 298 students every year. Of this, 10 000 are admitted through the All-India Premedical Entrance Examination (AIPMT). The remaining students are admitted through state-level admission tests.

According to the Medical Council of India (MCI), the country has 1 doctor for every 1722 people. Data from the WHO shows that the doctor-to-patient ratio in India is 6:10 000 (or 1:1667), compared with 14:10 000 (or 1:714) in China, 26:10 000 (1:384) in the USA and 23:10 000 (1:434) in the UK. That number is unlikely to get any better because the number of students opting for biology in school—a pre-requisite for medical school admission—is falling by around 15% a year, according to the head of a large Bangalore school. More and more students are opting for non-medical subjects.

Several reasons could be behind the fall in interest in medicine: lower salaries for doctors, coupled with a much longer tenure for the course (5.5 years compared with 4 years for engineering), limited number of postgraduate seats and stiff competition to secure a seat (of choice), and a mandatory 1-year rural posting for postgraduate medical students (implemented in some states).

Meanwhile, leading coaching institutes across the country are feeling the pinch too. There is a fall in the number of aspirants seeking coaching. However, the slowdown in economy and some lay-offs from jobs in the information technology industry, etc. may see a reversal in this trend as illness is ubiquitous and there is no dearth of patients for a doctor.

ANIMESH JAIN, *Mangalore, Karnataka*

Clinical trial registration to be compulsory in India

The Drugs Controller General of India (DCGI) has announced that starting June 2009, all clinical trials must be registered on the Indian Council of Medical Research's Clinical Trials Registry-India (CTRI).

The CTRI, at *www.ctri.in*, was set up in July 2007 and is one of the registries in the WHO's International Clinical Trials Registry Platform. It is a public database which can be searched free of charge. The purpose of trial registration is to increase transparency in clinical trials, improve their quality and ensure that the information generated by the trials benefits medical and public health practice.

Trials registered in the CTRI must provide information on 20 items required by the WHO registry, which include a description of the trial, health condition and intervention studied, details of the study protocol, sponsors, sources of support and complete contact details of all Indian sites in the study. In addition, the CTRI requires details of the ethics committees which reviewed the proposal, and approval letters from the ethics committees and the DCGI.

The need for compulsory registration of clinical trials has been discussed for some years. In 2005, the International Committee for Medical Journal Editors (ICMJE) announced that ICMJE journals would not consider a submission on a clinical trial unless the trial had been registered in a public database before the first participant was recruited. The ICMJE's definition of a clinical trial is 'any research study that prospectively assigns human subjects to intervention and comparison groups to study the cause-and-effect relationship between a medical intervention and a health outcome'. In 2008, Indian editors made a similar announcement.

The Declaration of Helsinki of the World Medical Association, revised in October 2008, made registration of clinical trials mandatory. Schedule Y of the Indian Drugs and Cosmetics Rules requires clinical trials to follow the Helsinki guidelines.

Mandatory registration of clinical trials is one of the steps announced by the DCGI to regulate clinical trials in India. Other plans include registration of contract research organizations.

Health activists have welcomed the DCGI's announcement. 'This requirement is important because voluntary trial registration doesn't work,' said Amit Sengupta of the All India People's Science Network and the People's Health Movement (India). Indeed, almost 2 years after the establishment of the CTRI, the majority of clinical trials were not registered. This is expected to change with the government's notification. However, Sengupta points out: 'Registration is only the first step to actual regulation of trials in terms of ensuring the ethical conduct of trials—such as how consent is taken, how volunteers are recruited, ethical questions in the study design, and so on.'

SANDHYA SRINIVASAN, *Mumbai, Maharashtra*

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