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Knowledge for all?

This article critically examines the question of Open Access (OA) to research output in the context of public investment in research and development (R&D) in India, providing an outline of the present scenario and suggestions for improvement. Compared to other developing countries, India's allocation of funds to R&D is high, and more than 50% of this money is allocated to central government institutions involved in basic and applied research. It is essential to disseminate the results of this research to the rest of society through cost- and time-effective means by making them publicly available online after publication. During the period 1998-2007, 2, 35,679 articles were published from India, out of which only 0.32% are cited at least 100 times. This is so because publishers are concerned about losing revenues from subscriptions and researchers are worried about intellectual property issues like copyright violation. In reality, OA increases the readership and visibility of a journal through increased citations and this gradually builds up the impact of researchers' work, thereby bringing professional recognition and fame to the institution. It also helps researchers to advance in their careers and obtain more funding for their research projects. If OA is practised across research disciplines, Indian research can be better showcased at the international level as well.

In the western world, over the last five years there has been a significant amount of OA advocacy and awareness generation by way of workshops, seminars and conferences. Similar efforts need to be made in India. The government should take the initiative to pass legislation in India to enable open access to Indian research through search engines. Eventually, Indian institutes will attain greater visibility in the world.

Gutam S, Aneja G, Mishra A K, Pandey P S, Chandrasekharan H. Open access: making science research accessible. *Econ Polit Wkly*. 2010 Nov 20; 45(30): 19-22

Health security for the urban poor

The world is becoming more urbanised overall. Asia and Africa are projected to double their urban populations between 2000 and 2030. In India, the rate is even faster: by 2030, 40.76% of India's population will be living in urban areas compared to about 28.4% at present. To address the health issues of the urban population, India is due to launch a National Urban Health Mission, possibly after 2012. Both Urban and Rural Health Missions are supposed to be combined as a joint National Health Mission.

A large proportion of the urban population lives in slums where people struggle daily with poor housing and a lack of basic services. Moreover, urban slum populations are not considered to be a part of urban society. They cannot afford healthcare the way that wealthy city dwellers can. At the same time, they do not get the benefits of health programmes

run by nongovernmental organisations or governments in the way that those in rural areas do. Moreover, extreme overcrowding in urban slums often leads to infectious disease epidemics. According to the Urban Health Resource Centre in India, slum children are even more likely than rural children to be malnourished. In urban areas, greater priority is given to affordability of healthcare access than physical accessibility. There needs to be a major shift in policy makers' attitudes to urbanisation. Ideally, one must use a combination of sample survey information (that considers a wealth measure) and creative mapping techniques to describe various aspects of urban poverty. Otherwise extreme poverty, scarce resources, and social exclusion will provoke violence and other actions threatening the social fabric; this situation exists in slums in many countries. Experts say that the mere provision for home-based or facility-based care is unlikely to solve the problem. An important intermediate step would be to bring poor people under a social security net. Local community health workers can be trained to provide basic health care and education.

Shetty P. Health care for urban poor falls through the gap. *The Lancet*. 2011 Feb 19; 377: 627-28

Health of the NRHM

In April 2005, the government of India launched the National Rural Health Mission (NRHM) to strengthen the public health system in an integrated manner by 2012. With just one year left to reach that deadline, the author attempts a review of the progress of the NRHM with respect to its core strategies, based on evaluation studies undertaken by different independent authorities.

In India, health has traditionally been given a low priority. The survey undertaken by the Population Research Centres observed that the numbers of Indian Public Health Standard facilities are a matter of concern for many states. There are shortages of equipment, medicine and manpower and optimal use is not made of even available resources. The training of Accredited Social Health Workers (ASHAs) is not satisfactory, and the supply of kits for ASHAs is not maintained. Mainstreaming indigenous health systems is a good step provided that AYUSH (ayurveda, yoga, unani, siddha and homoeopathy) practitioners are a supplement to allopathic staff, and not their substitutes. When medicines are out of stock or in irregular supply, this leads to high out-of-pocket expenditure and pushes households below the poverty line. Though the government has started providing health facilities under an annual fund to meet these local needs, very few facilities have received money from this fund. Moreover, it has been found that most local officers are unaware of the guidelines for utilising the fund. Under the NRHM, it is expected that decentralisation will shift the ownership of the public health system to panchayati raj institutions. However, it has been found in many places that higher authorities bypass

their members. Moreover, for community monitoring, the Rogi Kalyan Samitis, or patient welfare committees, have fallen short of expectations. Finally, the health management information system is not used adequately for planning and corrective action.

The author suggests simplifying guidelines to the states regarding the expenditure of different funds and also recommends the involvement of population research centres for capacity building with respect to health management information systems. Finally, it is suggested that the tasks identified in this review cannot be completed by the 2012 deadline.

Husain Z. Health of the National Rural Health Mission. *Econ Polit Wkly*. 2011 Jan 22; 46(4): 53-60.

Gender and universal health coverage

India is on its way to implementing universal health coverage and there is much discussion on the need to ensure that everyone gets access to basic healthcare. The author argues that any move towards universal health care coverage can be successful only when there is an increased effort to improve the health of women. India, even with the advancements of recent years, is ranked 132nd out of 134 countries in respect to gender equity in health and survival. Indian women are far behind their male counterparts in matters of education, engagement in economically productive activities and political participation. Indian women are still plagued by poor maternal health and high levels of maternal mortality. It has been established that gender inequalities manifested in the form of early marriage and inadequate access to family planning options and contraceptives are directly linked to poor maternal health. The author points out that poor, illiterate rural women are more susceptible to poor maternal health and also brings to our notice the fact that such gender-based inequities are being transferred to the next generation. Another area of concern that the author identifies is gender-based violence which is also linked to poor health outcomes. The author asserts that in the absence of a conscious effort to reduce existing gender disparities in India, any effort to universalise healthcare access will fail to benefit millions of women and girl children in this country.

Raj A. Gender equity and universal health coverage in India. *Lancet*. 2011 Feb 19;377:618-9.

Global HPV vaccination

Nearly 275,000 women in developing countries succumb to cervical cancer annually; in such countries this is also the most common type of cancer. With rates rising and with a lack of vaccines in developing countries, by 2010, according to WHO estimates, 90% of cervical cancer deaths will take place in the developing world. Multinational drug giants GlaxoSmithKline (GSK) and Merck have come up with vaccines to help prevent infection of the human papilloma virus that is linked to this cancer, but the high cost of these vaccines has

prevented low and middle income countries from taking it up as a public health priority. The Global Alliance for Vaccines and Immunisation and other global players have come together to make HPV vaccines available in countries that need it most, but cost might not be the only deterrent. In Andhra Pradesh and Gujarat, a large-scale vaccination drive in 2010 was stopped by activists and scientists who felt that the side-effects of the vaccines had not been made public. Also, countries like Brazil and India are often distrustful of multinational drug firms and hope to develop their own generic HPV vaccine. Some western scientists believe that the challenge to them is to transfer their knowledge to parts of the world that are just approaching the problem; but the intervention might involve not just making the vaccine cheap, but also developing parallel processes of generating awareness, putting in place effective screening measures, developing a generic drug and taking into consideration the specific needs and demands of the target population - often poor women. India has faltered in the past while adopting demography-driven public health measures; the exercise with the HPV vaccine - either a low cost GSK/Merck vaccine or our own generic one - should be better strategised.

Arie S. Global HPV vaccination. *BMJ*. 2011 Feb 16; 342: d1042

Time for nation-wide ban on endosulfan?

Debates over endosulfan usage and its side effects have raged in Kerala for about a dozen years now. At the recent Persistent Organic Pollutants Review Committee of the Stockholm Convention, India opposed the recommendation for a global ban on endosulfan. The background to this stand is that Indian manufacturers have built up a large domestic and export market. According to the author, press reports say seventy per cent of the global market is controlled by India which produces 12 million litres of endosulfan, earning Rs 4,500 crore annually.

The author of this article questions the central government's disregard of convincing evidence from various studies on the side-effects of the chemical. Endosulfan was aerielly sprayed in cashew plantations in Kasargod district of Kerala for nearly two decades. Changes in environment and health were noticed by villagers and doctors practising in the area. Media reports highlighted the health hazards of endosulfan usage. The Centre for Science and Environment conducted a laboratory analysis and found dangerous levels of endosulfan in water, soil, human and bovine milk, and vegetable samples. A study by the National Institution of Occupational Health noticed an alarmingly high incidence of "neurobehavioural disorders, congenital malformations in women and abnormalities related to the male reproductive system in the study village", which the researchers linked to continuous exposure to endosulfan. More recently, the Indian Council of Medical Research conducted studies that found that the necessary precautionary measures had not been implemented before using the pesticide.

Finally in 2004, the Kerala government banned the use of endosulfan. But the chemical still finds its way into plantations across the state, imported through the neighbouring states,

a fact that strengthens the case for a nation-wide ban. The pesticide is also used widely in various regions across India. In Karnataka, three villages in Belthangady taluk of Dakshina Kannada have been found to be the worst affected. Here endosulfan was used till 2001 in the Karnataka Cashew Development Corporation-owned plantations. Recently, the National Human Rights Commission has demanded a comprehensive survey of populations across the country affected by the use of endosulfan, particularly those subjected to aerial spraying, to determine relief and rehabilitation measures that may be needed. In conclusion, the author argues that the central government must take a strong stand and follow 70 other nations which have banned the use of endosulfan.

Solomon L. Endosulfan: centre in denial. *Econ Polit Wkly.* 2011 Feb 19; 46(8): 21-4.

Disability and the parent

The author of this article explores the question of whether parents with seriously disabled children may be justified in retarding the children's growth. This question arose when the parents of a disabled child decided to administer an oestrogen patch to their daughter to stop her from growing to her natural height. They argued that they would be better able to take care of their child if her growth was retarded, and the child could also participate in other leisure activities. Disability Rights Washington, an advocacy group, considered the issue in order to arrive at guidelines on this subject for health professionals. Growth retardation is an aberration, considering that clinical paediatrics strives to achieve growth in children. It was argued that while improvement in the medical and social services was the main concern, society's attitude towards the disabled also needed to change.

The authors try to reach a common ground between two extreme positions, acknowledging the perspectives of both parent and child, and suggest that the two can be interlinked - bettering the child's interests can in turn better the parents' interests. They argue that growth retardation can be allowed under strict supervision. Parents routinely take decisions for their children so the point of view of the parents cannot be ignored.

The only children who can be considered for growth retardation are the severely mentally and physically disabled, who need complete support from their parents or caretakers. There is a need to inspect each case separately and study the child over a period of time. The views of the families taking

care of such children should be given utmost importance in deciding growth retardation

Diekema DS, Dudzinski DM, Goaring S, Korfiatis C, Miller PS, Wilfond BS, and the Seattle Growth Attenuation and Ethics Working Group. Navigating growth attenuation in children with profound disabilities: children's interests, family decision-making, and community concerns. *Hastings Cent Rep.* 2010 Nov-Dec; 40(6): 27-40.

Wanted: academic honesty

The decision by the University Grants Commission of India to relax the National Entrance Test requirements for teaching posts for those who have completed a PhD or MPhil, and for better scholarship opportunities, has created a greater demand for research degrees in academic institutes. The doctoral degree also plays a role in the assessment of a university teacher's academic performance and promotion prospects. The author points out that even successful guidance of a PhD thesis is seen as an opportunity for career advancement by those in a position to guide doctoral students. This hype about the PhD, the author argues, has resulted in a deterioration of academic standards where research is now being conducted to acquire a higher qualification to aid in career advancement. The lack of institutional infrastructure and well qualified and knowledgeable academicians is also responsible for the low standards of research. Grants from national and international agencies are often not invested in developing libraries and other research infrastructure. There is also a concentration of research in a few centres which are often located in metropolitan cities, depriving students and faculty in regional centres of access to good research resources. The author also points out that when the research guide develops an interest beyond academics in the doctoral thesis, it promotes dishonesty and practices like plagiarism in research work. Mention is made of "doctoral shops" which flout all norms and regulations. The author argues that research ethics is something that cannot be compromised in the confrontation between quantity and quality of research.

Deshpande R. How does the system encourage academic dishonesty? *Econ Polit Wkly.* 2011 Feb 19; 46(8): 14-6.

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