**FROM THE PRESS Jan-March 2014**

# Nobel winner declares boycott of top science journals

Randy Schekman says his lab will no longer send papers to Nature, Cell and Science as they distort scientific process

* [The Guardian](http://www.guardian.co.uk/theguardian), Monday 9 December 2013 19.42 GMT

Leading academic journals are distorting the scientific process and represent a "tyranny" that must be broken, according to a Nobel prize winner who has declared a boycott on the publications.

Randy Schekman, a US biologist who won the [Nobel prize in physiology or medicine](http://www.theguardian.com/science/2013/oct/07/nobel-prize-in-physiology-or-medicine-2013-live-blog) this year and receives his prize in Stockholm on Tuesday, said his lab would no longer send research papers to the top-tier journals, Nature, Cell and Science.

Schekman said pressure to publish in "luxury" journals encouraged researchers to cut corners and pursue trendy fields of science instead of doing more important work. The problem was exacerbated, he said, by editors who were not active scientists but professionals who favoured studies that were likely to make a splash.

The prestige of appearing in the major journals has led the Chinese Academy of Sciences to pay successful authors the equivalent of $30,000 (£18,000). Some researchers made half of their income through such "bribes", Schekman said in an interview.

[Writing in the Guardian](http://www.theguardian.com/commentisfree/2013/dec/09/how-journals-nature-science-cell-damage-science), Schekman raises serious concerns over the journals' practices and calls on others in the scientific community to take action.

"I have published in the big brands, including papers that won me a Nobel prize. But no longer," he writes. "Just as Wall Street needs to break the hold of bonus culture, so science must break the tyranny of the luxury journals."

Schekman is the editor of [eLife](http://www.elifesciences.org/), an online journal set up by the Wellcome Trust. Articles submitted to the journal – a competitor to Nature, Cell and Science – are discussed by reviewers who are working scientists and accepted if all agree. The papers are free for anyone to read.

Schekman criticises Nature, Cell and Science for artificially restricting the number of papers they accept, a policy he says stokes demand "like fashion designers who create limited-edition handbags." He also attacks a widespread metric called an "impact factor", used by many top-tier journals in their marketing.

A journal's impact factor is a measure of how often its papers are cited, and is used as a proxy for quality. But Schekman said it was "toxic influence" on science that "introduced a distortion". He writes: "A paper can become highly cited because it is good science - or because it is eye-catching, provocative, or wrong."

[Daniel Sirkis](http://mcb.berkeley.edu/labs/schekman/pages/lab%20members.html), a postdoc in Schekman's lab, said many scientists wasted a lot of time trying to get their work into Cell, Science and Nature. "It's true I could have a harder time getting my foot in the door of certain elite institutions without papers in these journals during my postdoc, but I don't think I'd want to do science at a place that had this as one of their most important criteria for hiring anyway," he told the Guardian.

[Sebastian Springer](http://www.jacobs-university.de/ses/sspringer), a biochemist at Jacobs University in Bremen, who worked with Schekman at the University of California, Berkeley, said he agreed there were major problems in scientific publishing, but no better model yet existed. "The system is not meritocratic. You don't necessarily see the best papers published in those journals. The editors are not professional scientists, they are journalists which isn't necessarily the greatest problem, but they emphasise novelty over solid work," he said.

Springer said it was not enough for individual scientists to take a stand. Scientists are hired and awarded grants and fellowships on the basis of which journals they publish in. "The hiring committees all around the world need to acknowledge this issue," he said.

[Philip Campbell](http://www.nature.com/nature/about/editors/), editor-in-chief at Nature, said the journal had worked with the scientific community for more than 140 years and the support it had from authors and reviewers was validation that it served their needs.

"We select research for publication in Nature on the basis of scientific significance. That in turn may lead to citation impact and media coverage, but Nature editors aren't driven by those considerations, and couldn't predict them even if they wished to do so," he said.

"The research community tends towards an over-reliance in assessing research by the journal in which it appears, or the impact factor of that journal. In a survey Nature Publishing Group conducted this year of over 20,000 scientists, the three most important factors in choosing a journal to submit to were: the reputation of the journal; the relevance of the journal content to their discipline; and the journal's impact factor. My colleagues and I have expressed concerns about over-reliance on impact factors many times over the years, both in the pages of Nature and elsewhere."

[Monica Bradford](http://www.sciencemag.org/site/help/about/management.xhtml#section_monica-m-bradford-executive-editor), executive editor at Science, said: "We have a large circulation and printing additional papers has a real economic cost … Our editorial staff is dedicated to ensuring a thorough and professional peer review upon which they determine which papers to select for inclusion in our journal. There is nothing artificial about the acceptance rate. It reflects the scope and mission of our journal."

Emilie Marcus, editor of Cell, said: "Since its launch nearly 40 years ago, Cell has focused on providing strong editorial vision, best-in-class author service with informed and responsive professional editors, rapid and rigorous peer-review from leading academic researchers, and sophisticated production quality. Cell's raison d'etre is to serve science and scientists and if we fail to offer value for both our authors and readers, the journal will not flourish; for us doing so is a founding principle, not a luxury."

• This article was amended on 10 December 2013 to include a response from Cell editor Emilie Marcus, which arrived after the initial publication deadline.

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# If HPV vaccines were consumer goods would they still be on the market?

DECEMBER 2, 2013 BY [ADMIN](http://sanevax.org/author/admin/) [LEAVE A COMMENT](http://sanevax.org/hpv-vaccines-consumer-goods-still-market/#respond)

By Stephen Tunley, Director, SaneVax Inc.

<http://sanevax.org/hpv-vaccines-consumer-goods-still-market/>

The latest statistics from the USA’s Vaccine Adverse Events Reporting System (VAERS) statistics concerning the serious side effects and deaths associated with HPV vaccines such as Gardasil make for chilling reading.

In summary a single investigation of the VAERS database, widely accepted as being 10-100 times under reported about, shows the following:

1. 148 deaths recorded after HPV vaccinations,
2. Over 3,000 hospitalizations and
3. More than 6,000 who did not recover from the new medical conditions experienced after HPV vaccines.

The picture is not pretty and were you to add a zero or two to these numbers to account for under-reporting, the picture is frightening indeed. It’s important to note that the statistics are for events occurring primarily in the USA; not taking into account other countries, which have faced very similar health issues.

In the case of Gardasil for some reason the same safety issues that govern say; automobiles, baby equipment, tires, peanut butter and more do not apply. Vaccines appear to be subject to very different standards, standards where it is quite acceptable to have deaths, life threatening and life changing illness associated with your product. Standards where reports made to anyone from the manufacturer, to the regulator(s), to the so-called experts result in scant investigations by those who have worryingly close ties to the industry which they are supposed to be investigating.

To put this in perspective, imagine if Gardasil were a car associated with the same level of deaths (to date over 148) and tens of thousands of serious adverse events; would the car still be on the road? I do not think so.

Consider Toyota in January 21, 2010 recalled 4.1 million vehicles sold in the U.S. and Europe to fix faulty accelerator (gas) pedals which had a tendency to get stuck, causing unintended acceleration. In November the previous year 5.3 million cars were recalled as they believed that ill-fitting floor mats-had a tendency to trap pedals. In total, Toyota has recalled more than 9 million cars worldwide for pedal-related flaws. That’s nearly the same as the total number of all vehicles sold in the U.S. in 2009. The House Oversight and Government Reform Committee announced plans to investigate whether the Japanese-based automaker had needlessly put the public at risk.

What committee is reviewing the considerable health issues that surround HPV vaccines? To date, the answer is none.

If Gardasil were a baby sling, it would have been pulled from the market after just 3 deaths as was the case with the Infantino baby sling – one million were recalled in March, 2010.

More than 400,000 drop-side cribs made by Simplicity in the USA were recalled in July 2009 after an 8-month-old child in Houston suffocated.

Yet many tens of thousands of serious adverse reactions and over 148 deaths temporally associated with Gardasil do not appear to issue a single raised eyebrow amongst those charged with overseeing safety, by this I mean in the USA the FDA, in Europe the EMA, and the TGA in Australia!

In 1982 Tylenol recalled 31 million bottles of the product after 7 Deaths. I resisted putting ‘just’ before 7 but it sure puts the issues to do with Gardasil into perspective!

So why is Gardasil treated differently? The fact is it should not be. It’s a product just like Tylenol or Toyota. Consumers pay for it (directly or via tax imposts) and it should be governed by the same rules as any other product i.e. it should be a product fit for use and if it’s not then it should be recalled immediately.

I cannot imagine any person of sound mind going ahead and purchasing a baby sling from Infantino if they knew it had caused, or could cause, a single death, yet they will merrily march their daughters, and now sons, to the local medical center and have them vaccinated with a vaccine that has demonstrated considerable and very serious health issues associated with it?

But it gets worse. Gardasil has not only far too many deaths and serious health issues associated with it, there is no proof that it works!

## Lack of proven efficacy:

* HPV vaccines have not been proven to prevent even one case of cervical cancer
* HPV infections are only one of several risk factors contributing to the development of cervical cancer
* When detected, HPV infections are easily managed and rarely proceed to cervical cancer
* At least 50% of sexually active men and women are exposed to HPV at some point in their lives.
* 90% of these infections clear on their own within two years without incident
* Those exposed to vaccine relevant HPV types may experience an increased risk of precancerous lesions **if vaccinated**
* HPV vaccines would have to be effective for at least 15 years to prove effective at preventing cervical cancer.
* Yet, HPV vaccine efficacy begins to wane at 5 years!
* Symptoms experienced after HPV vaccinations are lasting longer than 5 years in some girls.
* Pap screening has already been proven to be a safe and effective means of controlling cervical cancer. It’s also very inexpensive and causes no significant health issues. No one has died from a PAP smear.
* 11% of the population has been exposed to HPV regardless of sexual status according to Dr Diane Harper a researcher who was involved in the safety and efficacy trials for the Human Papillomavirus (HPV) vaccine – Gardasil, in a paper published in the  Journal of Vaccines & Vaccination that “**We do not know how long the vaccine will last, the HPV types covered by the vaccine are limited, and the very safe alternative of PAP screening with early detection and treatment is a proven successful program**. Gardasil is not likely to extend a woman’s life in countries with cytology (PAP) screening…”

## Potential Safety Issues:

* In the September 2008 FDA closing statement on Gardasil it was noted that 73.3% of girls in the clinical trials developed “new medical conditions” post vaccination. 17 girls died on the clinical trials. (No inert placebo was used during the vast majority of clinical trials, which means the vaccines were proven no more dangerous than the active ingredients in the control solution.)
* Recombinant HPV DNA L1 gene DNA fragments possibly attached to the aluminum adjuvant, were discovered in 100% of samples tested Gardasil in 2011. To date there has been no serious investigation as to potential health impacts. The FDA simply declared the ‘expected’ presence of residual DNA is not a safety factor. No documentation was provided in support of this. The fact HPV vaccines were approved by Governments worldwide based on manufacturers’ assertions that the vaccines contained ‘no viral DNA’ was ignored completely [5] , [6]   The possibility of recombinant HPV DNA fragments being attached to aluminum adjuvant particles was also ignored.
* One of the antigens used in Gardasil was discovered in the central nervous system samples from two girls who died after being vaccinated with Gardasil. No cause of death was identified upon autopsy in either case. [7]
* HPV-16 L1 gene DNA fragments of vaccine origin apparently attached to aluminum adjuvant particles were discovered in postmortem blood and spleen samples of a girl who died 6 months Gardasil Effective injections. [8] , [9]
* It was discovered that the naked HPV 16 L1 gene fragments bound to aluminum particles by ligand exchange in Gardasil-have acquired a non-B conformation. This conformational change may have stabilized the HPV 16 gene fragments in Gardasil preventing their normal enzymatic degradation in vaccine recipients.[10] , [11]Non-B DNA conformations and their relationship to diseases has been studied since the 1960′s. Based on current scientific knowledge, the human genetic consequences of these non-B DNA structures are approximately 20 neurological diseases, Approximately 50 genomic disorders and several psychiatric diseases.[12] , [13]The impact of injected foreign non-B DNA on human health is totally unknown.

Note – the above was taken from this article - <http://sanevax.org/hpv-vaccines-betrayal-of-the-public-trust/>

In recent years there has-been a tremendous and as yet uninvestigated rise in Chlamydia, which is a sexually transmitted infection (STI) that can affect women and men, following the introduction of HPV vaccines. If left untreated, chlamydia can causes pelvic inflammatory disease (PID) in women, all of which can lead to chronic pain and infertility. Chlamydia may have no symptoms, but can easily be treated with antibiotics. (See the charts below for information from the United States following the introduction of HPV vaccines in late 2006, early 2007.)

Now for the good news, the manufacturer of Gardasil, Merck have sold hundreds of millions of vials of Gardasil resulting in billions of dollars of revenue from the product worldwide and now are working on a vaccine for…. Yep – you guessed it – Chlamydia!

So the company that is plausibly linked to a product that has (for some reason as yet unknown) has led to a rise in pretty serious STD, will at some stage launch a vaccine to fight it. Now that’s an integrated marketing strategy if ever I saw one.

But wait there’s more … sadly a lot more.

In the USA the regulator that oversees products like Gardasil – the FDA -is largely funded by virtue of the fees it charges Pharma and others to approve the product it regulates. This is the same position in Australia, where the TGA is along similar lines Funded.

In the USA the senior agency to the FDA is the NIH All which is in fact a share holder in the patent behind Gardasil and benefits from its success via the receipt of increasing patent income.

One more thing and it’s a big one. If your baby or automobile product is defective and proved it led to a single death, the manufacturer can be taken to court, sued and if the case proven, liable for considerable damages.

This is not the case with vaccines where the ability to sue the manufacturer was removed by the creation of the Vaccine Injury Compensation Program in 1988.  (link here - <http://www.hrsa.gov/vaccinecompensation/index.html>) This leaves those damaged by vaccines to apply for compensation under VICP, which is funded by a tax on each vaccine administered.

Now, the powers that be add insult to injury.  If the injury experienced after a vaccine is not listed on the very limited table of injuries and occur within the time frame listed, it is up to the consumer to find experts who can prove their injury was caused or exacerbated by the vaccine. When it comes to HPV vaccines, the consumer is on their own because there are NO injuries listed on the VICP injury table – these vaccines are too new to have established a track record for damages.

Contrast this to a normal court case where it would be up to the manufacturer to prove their product did NOT cause the damage.

Sadly, the same is true in many other countries where the ability to sue a vaccine manufacturer is limited, or has been removed by statute.

 HOWEVER, there is one country where government health officials appear to actually be concerned about what happens to their citizens after vaccinations. Interestingly, Japan has recently stopped recommending the continued use of HPV vaccines until a safety investigation has been completed.

So there you have it. One set of rules for vaccine manufacturers and a completely different set of rules for everyone else.

It’s time for this farce to stop. There is absolutely no basis that supports Gardasil is a product fit for use. It does not do what it purports to do, damages far too many that receive it, leads to some pretty horrible health effects and consequences . Yet the manufacturer stands above being sued by virtue of legislation.

This product must be recalled and recalled now. A truly independent review of what happened and why needs to be conducted with the ability to amend / repeal legislation, overhaul the regulators, and ensure the disclosure of conflicts that exist between the manufacturer so called independent experts and the regulators.

In the meantime, as a parent wake up, do the research before you vaccinate – or your child could be one more ignored VAERS statistic – is that the future you want for them?

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## A year as a doctor’s apprentice

Monday, December 2, 2013

by [**Dr Varun Patel**](mailto:varunipatel@yahoo.com)

I have completed my internship, which was just for one year but felt as if it is an end of an era. This year was the best so far in terms of learning medicine but it was also worst ethically and has left a deep impact somewhere deep down in my conscience. I have been shown a glimpse of reality which I used to feel was only a part of books and newspapers. From abandoning an unknown [patient](http://en.wikipedia.org/wiki/Patient) to slapping a [pregnant woman](http://www.webmd.com/baby/default.htm) in labour, I have seen the worst possible scenarios which I would like to share here. This is what you go through when you work as a doctor’s apprentice.

[](http://www.indiamedicaltimes.com/wp-content/uploads/2013/12/Dr-Varun-Patel.jpg)

Dr Varun Patel

You wake up at dawn, iron your clothes and apron, open up your newly bought stethoscope and are ready, totally pumped up to serve patients on the very first day. But the whole excitement crashes as soon as you enter the hospital chaos and the hospital staffs leave no room at all to humiliate you in worst possible way. ‘Aye[Intern](http://en.wikipedia.org/wiki/Internship)!’, ‘Aye Intern!’ and you turn back, that’s an instinct, because it takes a while for a mind to adjust to the reality, and you see a Mausi (ward maid) shouting at you to get off the recently mopped floor. On the first day itself they make you regret your decision to join this profession. You are startled at the trailer itself and you don’t feel like watching the movie anymore.

A month passes by and you get acquainted to the routine insults and are compelled to treat the patients in an unhygienic way, yes, you heard it right, unhygienic is the right way. You spend few hours in the casualty and you will see the resident doctors fighting over a patient. Nobody wants the patient admitted in his own ward. They call it ‘Batting’, you would see them proudly blabbering around – ‘Hey! Aaj [Maine](http://maps.google.com/maps?ll=45.5,-69.0&spn=3.0,3.0&q=45.5,-69.0%20(Maine)&t=h) 6 Bat Kiye’, meaning he got rid of six patients that day. Where do these patients go! You wonder. They get admitted to the wrong department where they don’t get a proper treatment or else they are encouraged to go home, in spite of their vulnerable health.

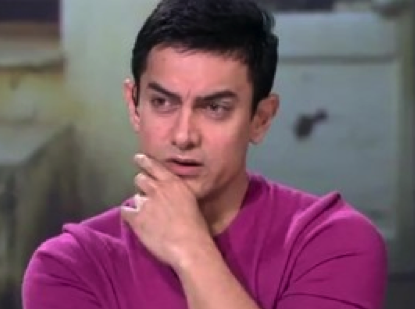
You are just getting yourself accustomed to batting, when your eyes suddenly catch the sight of a patient sitting outside the casualty (shown in the picture below), inside the hospital campus. You inspect him to find out a ‘diabetic foot’ totally necrotized till an extent which requires an amputation. You want to help him; so you talk to the person in charge and try to take the patient inside, when you hear a roar… the CMO (casualty [medical officer](http://en.wikipedia.org/wiki/Physician)) is shouting at top of his voice; he is shouting so loudly that you tend to focus on the loudness rather than listening to what he is trying to say. Then over a period of time you start understanding his rhythmic squawks; you are shocked to learn that you are not supposed to help patients like this. Bringing patients in will increase the workload!

Instead the CMO asks you to shoo the patient away. Now, it is unethical for you and you refuse. But his smell becomes so unbearable that the guard shoos him away with a stick. That’s the moment when you feel helpless for the first time in your career. It makes you think, “Are you really treating a patient in need?” A government hospital is not expected to show such a behaviour towards the poor; wasn’t it bloody built for the poor?

[](http://www.indiamedicaltimes.com/wp-content/uploads/2013/12/A-patient-waiting-outside-the-casualty-department-of-Sassoon-General-Hospital-Pune.-Photo-Dr-Varun-Patel.png)

A patient waiting outside the [casualty department](http://en.wikipedia.org/wiki/Emergency_department) of [Sassoon General Hospital](http://maps.google.com/maps?ll=18.5334,73.8772&spn=0.01,0.01&q=18.5334,73.8772%20(Sassoon%20Hospital)&t=h),[Pune](http://maps.google.com/maps?ll=18.5202777778,73.8566666667&spn=0.1,0.1&q=18.5202777778,73.8566666667%20(Pune)&t=h" \o "Pune" \t "_blank). Photo: Dr Varun Patel

You feel like you have seen everything when you land up in the worst possible departments one by one. You are trying to insert an intravenous catheter into a patient’s vein, when your ears fall on something which pops up a memory of [Aamir Khan (from Satyamev Jayate)](http://www.indiamedicaltimes.com/2012/05/28/what-do-you-think-of-the-%E2%80%98every-life-is-precious%E2%80%99-episode-of-the-tv-programme-satyamev-jayate/) in your mind.

[](http://www.indiamedicaltimes.com/wp-content/uploads/2013/12/Aamir-Khan.png)

Aamir Khan in Satyamev Jayate

“I have sent the patient with Code Blue.” And the resident puts down the receiver. You then find out that he was talking to the chemist regarding his own ‘cut’ (the per cent income he gets for a referral of a patient to that chemist’s shop). If you have read carefully, the first question that baffles you is: What is Code Blue? Codes are implemented for secret communication:  
• Code Blue: Make a Bill of Rs 4,000  
• Code Black: Make a Bill of Rs 7,500  
• Code Red: Make a Bill of Rs 10,000

The chemist gets this code from the resident and accordingly he formulates a bill, 35 per cent of which goes to the resident doctor. Aamir Khan was opposed by so many doctors for his proclaiming episode on doctors. You now realize the essence of it and understand the reason for the opposition.

[](http://www.indiamedicaltimes.com/wp-content/uploads/2013/12/A-pregnant-woman-in-a-government-hospital..png)

A pregnant woman in a government hospital.

“Giving birth should be your greatest achievement not your greatest fear,” said Jane Weideman since a woman needs a lot of support during pregnancy. But in an Indian government hospital giving birth to a child is not a unit less than suffering the third degree torture in jails.

Pregnant women are beaten like anything and, worst of all, the doctors feel it as justified. Before delivery it’s obligatory for an obstetrician to do a Per Vaginal (PV) examination, which according to norms is to be done with rubber gloves on and with the use of a lubricant. You will not even once see a government hospital using a lubricant over rubber gloves during a PVE. It’s discernible that the woman will be in pain without a lubricant and would shout out of pain but the thing you find implausible is when the doctor hits her and asks her to keep her mouth shut.

Unreasonable usage of Buscopan and Drotaverine to speed up the labour and unwanted episiotomies with accompanying fundal pressure manoeuvres (which are contraindicated) leave you baffled. You decide at that very moment that none of your loved ones will ever deliver in a government hospital hereafter. It’s better to be childless than making a woman go through such crucifixion.

You meet malpractices at each and every step. You discover that the true sense of ‘noble’ (profession) is lost somewhere. For one whole year you have to suffer both physically and mentally. You try to fight your inner conscience. You try to make changes, bring reforms. But after myriads of attempts when nothing works, you realize that ‘ignorance is bliss’ and learn to live with it and instead write an article about it.

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**Read more here-**[**http://www.indiamedicaltimes.com/2013/12/02/guest-article-a-year-as-a-doctors-apprentice-by-dr-varun-patel/**](http://www.indiamedicaltimes.com/2013/12/02/guest-article-a-year-as-a-doctors-apprentice-by-dr-varun-patel/)

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Tuesday, Sep 24, 2013, 9:12 IST | Agency: DNA

[Dinesh C Sharma](http://www.dnaindia.com/authors/dinesh-c-sharma)

The emergence of non-state actors on the health scene has serious repercussions for people.

the report has pointed out lapses on the part of state agencies like the Indian Council of Medical Research (ICMR) and the Drug Controller General of India (DCGI), it has not fully explored the wider context in which the illegal vaccine trials took place in the first place. The malaise is not limited to this particular vaccine nor to American voluntary agency, Programme for Appropriate Technology in Health (PATH), which has been indicted in the report.

Health policy of any sovereign nation is supposed to be decided independently by its government in consultation with experts within and, if necessary, outside the government. Any external or foreign agency including the World Health Organization (WHO)  can only play an advisory role.

However, the emergence of global donor agencies with pockets deeper than WHO but with a narrower approach and scientific acumen, has changed the dynamics of national health policy-making.

Unlike the WHO, these new donor-players are tinkering with health policies of recipient countries and imposing priorities decided by themselves behind closed doors. The biggest of them all is the Bill and Melinda Gates Foundation, which had funded PATH to undertake HPV trials in India with the declared objective of getting the vaccine included in the Universal Immunization Programme (UIP).

This case best illustrates the new paradigm, in which health policy-making has passed into the hands of non-state actors.

PATH initiated the HPV study — taking ICMR onboard — to generate data necessary for the vaccine’s introduction in UIP even before it had received regulatory nod for marketing in India. By initiating this project — PATH and its funder Gates Foundation — took vital decisions relating to India’s health policy. First, the two decided that India needs to tackle the problem of cervical cancer or the cancer of the cervix (HPV is among its various causes) through the approach of vaccination.

Second, they decided that the problem of cervical cancer was so severe in India that the vaccine needs to be included in the government-funded UIP. Both the decisions clearly fall in the realm of policy making — which is the sole preserve of the Government of India.

In order to justify and push their decision — which would have resulted in a windfall for vaccine manufacturers Merck and GSK as per the parliamentary panel’s findings — data relating to occurrence of HPV was falsified. Actually, even now ICMR does not have national data on HPV prevalence. On the other hand, ICMR’s own data on cervical cancer — of which HPV is one of the causes — shows that cervical cancer is on a decline in India.

Time trends in cancer incidence rates: 1982-2010, recently published by ICMR, collates data from 13 population-based cancer registries across the country. It shows “a decline in the incidence of cancer cervix across all registries including the rural registry at Barshi in Maharashtra”.

In Mumbai, for instance, the proportion of cervical cancer as percentage of all cancers among women has dropped from 18.5 to 9.4 between 1982-83 and 2009-2010. The overall decline, according to the report, has been registered without any preventive steps like organized screening or early detection for cervical cancer. A vaccine was not even in the picture.

If this is the trend emerging from cancer registries, do we still need to inject our young girls with costly HPV vaccines?  Just because a group of experts in Seattle — not accountable to anyone — have decided that it be so? Forget UIP, does India need HPV vaccines at all or mere health education in genital hygiene and regular screening would do? The Ministry of Health, ICMR and DCGI owe an answer to all of us.

Gates is backing two more controversial vaccines — a five-in-one Pentavalent vaccine which combines Hepatitis B and haemophilus influenzae type b vaccine (Hib) with the existing DPT; and a rotavirus vaccine to prevent severe form of diarrhoea caused by rotavirus.

The Global Alliance for Vaccines and Immunizations (GAVI), another outfit supported by Gates, funded the health ministry to do studies for introduction of Pentavalent vaccine in UIP. Again, exaggerated data was presented to justify its inclusion in government programme. Besides high pricing, the vaccine has become controversial because of reported deaths of children following vaccination.

Like HPV, the idea of including Pentavalent vaccine in the government programme was not initiated by the Ministry of Health but by non-state actors.

The number of children dying after vaccination is more than the number of deaths the vaccine is supposed to prevent, according to data presented in a writ petition currently before the Supreme Court. Similarly, the opinion on rotavirus vaccine being a panacea for diarrhoeal deaths in India is divided.

Shouldn’t the Government of India pump in more money in improving sanitation and nutritional deficiencies — underlying causes of diarrhoea — to tackle the problem on a permanent basis or keep spending billions of rupees on vaccines year after year, critics have questioned.

In a globalised world of the 21st century, one can’t argue that countries remain in their cocoons cut-off from international collaboration or even funding but there is everything wrong with allowing collaboration and funding to drive our national health priorities. If the level to which health policies in a sovereign and democratic country with a sound administrative framework like India can be compromised with donor dollars, one can imagine the plight of the least-developed nations in Africa. It’s time to wake up and take charge.

**3) A lifeline that rural India cannot do without The Hindu, Sep 25, 20**

**5) *No Clinical trial on 'Global clinical trials' including New Chemical Entities* without proper mechanism” - Supreme Court, (Sep 30. 2013)**

## 6) Vaccine Manufacturer’s Documents Show HPV Vaccines May Induce Seizures **October 12, 2013**

**In 2010, the Japanese government and doctors enthusiastically implemented a country wide campaign to immunise young girls aged 11 to 14 years against cervical cancer. Although the scheme was voluntary, around $ 187.5 million was allocated for the immunisation effort, with three doses of the vaccine costing $ 600. This was to be administered free to the girls over the two years of the campaign.** Totally, 3.28 million girls and adult women were administered the HPV vaccine.

However, after regular monitoring by the Vaccine Adverse Reactions Review Committee (JVARRC), 1968 cases of adverse events were detected. Of these, 358 cases were categorised as serious by the committee and by the concerned ministry.  These adverse effects of cervical cancer vaccine were revealed early in 2013. Parents of the affected girls called on the health minister, in April and described disturbances such as seizures, tics, clonic movements and difficulties in walking. The government ended the immunisation drive and instituted two probes

Covering 17 hospitals; one which will study the effects on cerebral and neural areas, while the second will research the use of cognitive behavioral therapy to relieve pain reported in some cases, and study the causes.

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Japan Medical Association and Japan Pediatrics Association supported HPV vaccination program. From the end of 2012 to Feb. 15 2013, JMA conducted a signature-collecting campaign for a petition to urge the addition of seven vaccinations (HB, PCV7, PCV23, Hib, HPV, chicken pox, mumps) to the list of mandatory ones.  After discussions in the Japanese parliaments, it was decided to add three vaccinations (HPV, Hib and PCV7) to the mandatory ones on Mar 28 2013. There was no political party which stated an opinion opposing the addition of HPV vaccines.

June 14 2013, JVRRC decided to suspend the recommendation for HPV vaccination. The same day, JMLHW sent a notification to local governments that HPV vaccination should not be recommended actively until the time when MHLW and JVRRC made a report as to the safety concerns of HPV vaccines and that vaccination should be done for those who want vaccination. In the meantime, HPV vaccination should be available for those who wished it.

The Congress of Professionals for Suppressing Uterine Cervical Cancer and Japan Pediatrics Association made a statement that JMHLW should

“withdraw the suspension of recommendation” for HPV vaccination and should “restore the recommendation” for the vaccination.

Sotaro Sato MD, internist & cardiologist

**----------------------------------------------**

[**(SANEVAX)**](http://sanevax.org/vaccine-manufacturers-documents-show-hpv-vaccines-may-induce-seizures/)**-**Much the same as in US, UK, Australia and other countries, Japanese obstetricians and gynecologists advocated HPV vaccines as a highly effective method of preventing uterine cervical cancer.  In 2008, they formed an organization named “the Congress of Professionals for Suppressing Uterine Cervical Cancer” to further promote this recommendation.                                                                                                                                          By Sotaro Sato MD, internist & cardiologist

HPV vaccination programs began in 2010 under a recommendation made by the Japanese Ministry of Health, Labor and Welfare (JMHLW) to administer HPV vaccines to girls from 11 to 14 years old. The Japanese government allocated 15 billion yen (187.5 million dollars) for urgent HPV Vaccination programs. As HPV vaccination was voluntary and not yet mandatory, local governments eagerly recommended the vaccination. Officials visited junior high schools to advocate the effectiveness of the vaccine and persuade students to be vaccinated. They also stressed that the expensive vaccination (48,000 yen, $600, for three shots) would be free within the 2 year limit. Municipal offices sent letters to families which had girls of the targeted age group to urge vaccination.

[](http://www.omsj.org/wp-content/uploads/untitled-8.png)Japan Medical Association and Japan Pediatrics Association supported HPV vaccination program. From the end of 2012 to Feb. 15 2013, JMA conducted a signature-collecting campaign for a petition to urge the addition of seven vaccinations (HB, PCV7, PCV23, Hib, HPV, chicken pox, mumps) to the list of mandatory ones.  After discussions in the Japanese parliaments, it was decided to add three vaccinations (HPV, Hib and PCV7) to the mandatory ones on Mar 28 2013. There was no political party which stated an opinion opposing the addition of HPV vaccines.

March 11 2011, huge earthquakes and tsunami attacked the north-eastern area of Honshu island of Japan, and atomic power plant in Fukushima lost external power supply and lost the means to cool reactor cores.  Aftershocks hit repeatedly. The biggest one was during the night of April 7. Nuclear power plants in Fukushima blew up by hydrogen explosion on Mar 12 and 14.

In the midst of this turmoil, a non-commercial video made by Advertising Council Japan was broadcasted on TV repeatedly and repeatedly. In that video, an actress known to have recovered from uterine cervical cancer and her daughter stressed the importance of cervical cancer checkups. Two or three months later, this video program was replaced with HPV vaccine promotion video programs of Cervarix (GSK K.K.) and Gardasil (MSD K.K.).

Up to today, 3.28 million girls, including adult women, were vaccinated with HPV vaccine. Total dose is estimated as 8.64 million. The figure below shows the transition of vaccination count reported to JMLHW from local governments. The population of Japanese girls age 11 is, for example, 580,000. March is the last month of the academic year.

Joint meetings of the Vaccine Adverse Reactions Review Committee (JVARRC) are held three times a year. 1968 cases of adverse events have been reported to JMLHW and JVARRC. 358 cases which were evaluated as serious by the committee and JMLHW are included.  The presence of girls suffering from adverse effects of cervical cancer vaccine was revealed gradually from the beginning of 2013. The Nationwide Liaison Association of Cervical Cancer Vaccine Victims and Parents was organized by efforts of Toshie Ikeda, Mika Matsufuji and members of municipal assembly on Mar 25, 2013.

Parents of vaccine victims called our health minister on April 8. During the press conference after that, videos in which girls are suffering from walking disturbances, tic of the body, absence seizure and choreic movement was presented.

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# 1 woman dies for every 1,000 sterilisation surgeries in Tamil Nadu

[Ekatha Ann John](http://timesofindia.indiatimes.com/toireporter/author-Ekatha-Ann-John.cms), TNN Oct 20, 2013, 06.05AM IST

In the five months from April to August 2013, 129 women out of 1.39 lakh who underwent surgery for sterilisation in Tamil Nadu died. This makes for a ratio of about one per 1000. Tamil Nadu has had a good record hitherto for maternal health, so this is especially disturbing. Official statistics show that 27 women died after sterilisation in 2011, and 34 in 2012. Why the sudden rise in fatalities? Experts cite several reasons:

-the pressure of fulfilling annual targets coupled with inadequate infrastructure;

-the carrying out of tubectomies immediately after caesarian surgeries;

-lack of infrastructure resulting in tubectomies rather than the safer laparoscopic procedures;

-not following the necessary steps for pre- and post-operative care;

-the lack of experienced surgeons at district level;

-complications related to anaesthesia;

On the question of death due to ‘complications’, experts have said that these are not specified or recorded, revealing negligence on the part of the authorities. The same is reflected in the large number of failed sterilisations, going up to 15,460 from 408 in 2012! They stressed the urgent need for a proper and sustained investigation into the circumstances.

# Ekatha Ann John, 1 woman dies for every 1,000 sterilisation surgeries in Tamil Nadu

Times News Network, October 20, 2013 Available from: http://articles.timesofindia.indiatimes.com/2013-10-20/india/43220267\_1\_sterilisation-operations-maternal-deaths-state-health-department

CHENNAI: For a state that prides itself in maternal health, this should be a shocker: One mother dies for every 1,000 sterilisation operations in Tamil Nadu. In five months, between April and August this year, of the 1.39 lakh [women](http://timesofindia.indiatimes.com/topic/Women) who went under the knife for sterilisation, 129 died following the procedure.

While officials in the health department say they have to conduct further investigation to ascertain the cause of death, experts in the field say it is the mad rush to achieve annual targets, and poor infrastructure that claim lives. In the past three years, 190 women died post operation. This year, there has been a three-fold increase.

According to statistics from the directorate of family welfare, 27 women died in 2011 and 34 in 2012 - the highest in the country. Senior officials suspect sterilisation immediately after a C-section could be the reason behind the spurt. "At least 70% of the cases occurred following tubectomy done immediately after caesarian operations. We are investigating the reason behind the increase. As of now, we've asked district level officials to avoid undertaking the procedure immediately after a C-section," said the official.

Though sterlisation is less complicated for men, only 1% or just 750 of them came forward for sterilisation in 2013. While for men, it is a simple 20-minute procedure, doctors have to keep in mind several factors for women. The government records show no man had died after sterilisation. "Sterilisation is often combined with caesarian, abortion or normal delivery, so complications could arise because of other factors," said Dr S Rathnakumar, maternal health advisor to the state health society, Tamil Nadu.

Sources in the state health department, however, attributed the deaths to poor adherence to pre and post-operative care and complications due to anesthesia. Although the state has introduced a safer and a more advanced method of sterilisation - through laparoscopic incisions, 85% of the surgeries are usual tubectomy procedures, due to lack of infrastructure. In this procedure, the fallopian tubes - through which the egg travels to the uterus - are surgically blocked or cut. The pin-hole procedures are reserved only for women after an abortion or during an interval period after delivery.

The unusual increase in deaths underlines two issues - callousness in recording data and poor facilities, say public health experts. "If the number is to be believed, then the government must have been under-reporting the actual number of deaths all along. It just shows the laxity of the government in collecting facts," said Venkatesh Athreya, an economist who has worked extensively with the state government on maternity welfare.

"If these women had died of other complications like they say, then what are these complications. Why aren't they reflected in the statistics? It just shows that certain procedural protocols are not followed while investigating maternal deaths at the district level. I am deeply shocked," said Athreya.

The number of failed sterilisation operations in women also increased by 400 times in one year. According to the statistics submitted by the state government to the Union ministry, the number of failures following female sterilisation stood at 15,460 this year, 456 in 2012 and 408 in 2011. Officials had no explanation for this unusual rise.

Simultaneously the number of cases of complications following female sterilisation also saw a four-fold rise, from 16 in 2011 to 63 this year. Officials said "most" of these complications were not life threatening. Gynecologists say if post operative care is not given properly, even seemingly simple complications could result in death.

The Ambiguous Allure of the E-Cig

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| **Beware those wonder cells** |
| Stem cell clinics have been mushrooming in India. Most promise patients the moon, but not a few take away your money without a cure, says **T.V. Jayan** |
| |  | | --- | | [[http://www.telegraphindia.com/1110306/images/06zzinsight.jpg](javascript:MM_openBrWindow('../../images/06zzinsightbig.jpg','ThumbNail','resizable=yes,scrollbars=yes,width=500,height=400,left=50,top=100'))](javascript:MM_openBrWindow('../../images/06zzinsightbig.jpg','ThumbNail','resizable=yes,scrollbars=yes,width=500,height=400,left=50,top=100')) |   Pretty faces tend to endorse bling. So when Lisa Ray was named a brand ambassador, many thought the model and actress was going to promote yet another luxury watch, or perhaps a global brand of diamonds. It turned out to be another story.  Last October, the controversial stem cell therapy got a new face when Ray volunteered to be its brand ambassador. She had good reason to do so — stem cells had saved her from death.  The actress, born to a Bengali father and Polish mother and raised in Canada, had been suffering from multiple myeloma, a rare cancer afflicting white blood cells. Her doctors injected her with stem cells extracted from her bone marrow and cured her.  Still, her offer to endorse stem cell therapy has raised many eyebrows in scientific circles. After all, it’s a gray area in India, with unproven stem cell therapies gaining ground. Most promise the moon. But quite a few take away your money without a cure. And some treatments, doctors warn, can also lead to cancer.  Stem cells are said to be the future of medicine because they are the potential solution to untreatable diseases. The use of stem cells from bone marrow and cord blood is more common, but scientists are also experimenting with stem cells derived from human embryos. These special cells are much more potent as they have the capacity to turn into any of the 200 cell types found in the body.  Stem cells have the ability to replace damaged and diseased cells when they are supplied to the site of injury or damage. But scientists are yet to figure out exactly how the cells would behave once they have been put back into the human body.   |  | | --- | |  | | Lisa Ray |   Yet in India, stem cell clinics have been mushrooming in the last five years or so. The clinics, some even attached to established private hospitals, peddle stem cell therapy as a magic pill for any incurable disease from autism and cerebral palsy to muscular dystrophy and stroke. Diabetes, cardiac problems and end-stage renal disease are the other conditions the clinics say they can cure. These centres use either the bone marrow or stored umbilical cords for extracting stem cells.  There are no checks and balances on the use of stem cells in India. The Centre is considering a law, which is still being drafted even as the clinics flourish. Some ineffectual guidelines were issued by the Indian Council of Medical Research (ICMR) and the department of Biotechnology in 2007. But since the guidelines are not legally binding on them, few adhere to the code of conduct.  A large number of such clinics that have come up in Indian cities since 2006 use stem cells derived from bone marrow and umbilical cord for a variety of incurable diseases, even though the therapy is not clinically approved.  For instance, a chief doctor at a stem cell clinic told **The Telegraph** that his clinic had so far treated 120 patients, mostly suffering from neurological problems. Nearly 70 per cent of its patients claimed to have shown variable degrees of improvement. The clinic’s website is replete with testimonials written by patients who have benefited by the stem cell treatment.  And that, says the Australian Stem Cell Centre (ASCC), a research watchdog, is the sign to look out for. Most of these clinics, it says, work through direct marketing via the Internet, chat rooms and blogs. They claim success based on patients’ anecdotes. “The claims are unsubstantiated and cannot be verified,” ASCC says.  “Individual reports of success may be real, or may be owing to the placebo effect, or a desire to report a positive outcome because of the amount of time and money invested in obtaining the treatment,” adds ASCC.  “You name a grave disease, they have treatment for it,” says Vasanta Muthuswamy, former deputy director general of ICMR, who spearheaded the effort to draft the stem cell guidelines. Many centres target people who are desperate for a cure to a disease they suffer from. “For them any hope is better than no hope. They are willing to spend any amount of money because they are desperate,” she says.  Many believe the government should regulate such treatments. “The government is entirely responsible for the mess we are in,” says S.G.A. Rao, chairman and managing director of the International Stemcell Services Limited (ISSL), Bangalore.  Rao, a senior stem cell biologist, stresses that such therapy, if properly done, can benefit patients. ISSL also treats terminal diseases including Duchene Muscular Dystrophy, osteoarthritis and spinal cord injuries, besides offering services like banking cord blood for future use.  Independent scientists, however, say that while they do not deny the benefits, they are worried whether the systems have been tested and put to scientific scrutiny. Chandra M. Gulhati, editor, *Monthly Index of Medical Specialities*, a journal of drugs and therapeutics, says that before any treatment is tested on people, experiments in laboratories should indicate that the scientific reasoning is sound. Its safety has to be then evaluated by testing it on healthy volunteers, not on patients, he says.  Clinical trials are essential because they tell you not just that a treatment works but also that it’s safe. At least 16 stem cell-related clinical trials are underway in India, conducted by public research institutions and private healthcare and research firms.  Alok Srivastava, head of the Centre for Stem Cell Research at the Christian Medical College, Vellore, and a member of the committee that drafted the guidelines, says India has so far approved stem cell transplantation only for some blood diseases and conditions of the skin and eye. Any treatment for other diseases should only be done as a clinical trial, which should be conducted in an institution recognised for such research.  “It is a matter of concern that so many clinics are offering stem cell treatments without any scientifically established evidence of their safety or efficacy,” Srivastava says. Patients are also charged huge amounts of money.  On the other hand, clinical trials conducted by authentic research institutes are done free of charge. Patients thronging the dubious stem cell clinics can take part in these clinical trials, the experts point out. The government’s Clinical Trials Registry India invites volunteers.  Stem cell clinics charge between Rs 2 lakh and Rs 5 lakh for a complete treatment course. “I do not understand why these clinics charge so much for the procedure of extracting, purifying and injecting bone marrow stem cells into the body,” says Kalkunte R. Suresh, director of the Jain Institute of Vascular Sciences, Bangalore. “The preparation of stem cells for injection doesn’t cost more than Rs 5,000,” says Suresh, who along with his colleagues published one of India’s first studies on adult stem cells used for the regeneration of blood vessels.  The government has to step in to avoid exploitation of “inadequately informed, helpless patients” while supporting novel therapies, Srivastava says.  The health ministry took a step in this direction recently by constituting a National Apex Committee on Stem Cell Research and Therapy. Though this happened four years after it was recommended by the expert committee that drafted the guidelines, doctors are happy that a step has at least been taken.  But the government has hardly been proactive in this field, the experts point out. Even the decision to frame guidelines seemed like an afterthought. And this was when it knew that illegal clinical trials were being conducted at a Mumbai hospital by a UK-based biotech company jointly with an ICMR lab, and a Delhi clinic was offering therapy using embryonic stem cells six or seven years ago.  The trial using an unproven technology was called off in 2004. But Nu Tech Mediworld, the clinic started in 2002 by Geeta Shroff, a fertility expert-turned stem cell therapist, continues to do roaring business. “We have so far treated 880 patients suffering from many incurable diseases,” Shroff says. Nearly 20 per cent of these patients are from overseas, she adds.  Shroff, however, claims her technology has gone way beyond what’s available in the West. She says the cell lines she uses for treatment are derived from a single embryo which she used in the early years.  Shroff, who has not published her work in peer-reviewed journals, says she has patented the technique, and the details are in the public domain. She is also willing to allow any authority to inspect her facilities. Srivastava, however, wonders how her work was allowed to proceed in the first place without the necessary approval. “If that had been done, these questions would never have arisen,” he says. But Shroff says that government agencies were not even aware of the technique involved.  What’s worrying about stem cell therapy, say experts, is the safety angle. Hyperactive embryonic stem cells are capable of forming any type of cells, including cancer cells. Stem cells can only work in treatment once it is certain what kind of cells they are going to turn into when they are put in the human body.  So enter at your own risk, the uncharted world of wonder cells.  Academics linked to drug industry 'exaggerated' swine flu risk (<http://www.medicalnewstoday.com/articles/268654.php>)  Honor Whiteman  Tuesday 12 November 2013 - 12am PST    **New research published in the BMJ has suggested that academics with links to the pharmaceutical industry were more likely to give increased risk assessments of the swine flu pandemic of 2009/10 when talking to the media, compared with academics who were not linked to the pharmaceutical industry.**  [**Swine flu**](http://www.medicalnewstoday.com/articles/147720.php) is a highly contagious respiratory disease found in pigs. The [**H1N1 influenza**](http://www.medicalnewstoday.com/articles/147720.php) subtype is the type that has been known to infect humans, with outbreaks occurring worldwide throughout 2009 and 2010.  Earlier this year, Medical News Today reported on research led by the World Health Organization (WHO), stating that the swine flu pandemic is thought to have [**infected 1 in every 5 people worldwide**](http://www.medicalnewstoday.com/articles/255456.php).  In terms of cost, the researchers say that during the pandemic in the UK, there was an estimated £1 billion ($1.6 billion) spent on pharmaceuticals, such as antiviral drugs and the [**H1N1**](http://www.medicalnewstoday.com/articles/147720.php)vaccine. They add that the pharmaceutical industry made between £4.5 and £6.5 billion ($7.2 and $10.4 billion) profit on the H1N1 vaccine alone.  The researchers say that from these hefty numbers, there were concerns raised regarding "competing interests" that experts on "influential scientific advisory committees" may have had with drug companies. Analysis of newspapers and tabloids To determine whether competing interests were at play, the researchers analyzed UK newspaper print coverage of the swine flu pandemic between April and July 2009. They note that this was the time period when major decisions were being made regarding the best way to respond to the outbreak.  The analysis included a variety of 425 articles from newspapers and tabloids in order to gain a strong range of reporting styles and perspectives. Broadcast media was excluded, as the researchers believed print publications would provide more in-depth viewpoints.  All articles were analyzed for the sources quoted, how these sources assessed the risk of swine flu to the population, and the promotion or rejection of swine flu drugs and vaccines.  The team then looked to uncover the competing interests of each named academic who was quoted. This was done through the use of conflict of interest statements, funding sources that were detailed on social profile pages, web searches and the analysis of funding declarations on all publications 4 years previously.  The researchers deemed the following as competing interests:   * Paid advisory or consultancy roles * Directorship or stock in companies specializing in antiviral products * Research grants or commercial work funded by pharmaceutical companies.  'Risk assessments higher' in academics with competing interests From the analysis, it was found that health ministers were the most common source, quoted on 34% of the articles regarding swine flu. This was closely followed by academics, at 30%.  Of the 61 academics who were quoted, 18 (30%) were found to have competing interests.  The academics made 74 risk assessments in the articles. Of these, almost 60% were higher than risk assessments made by official agencies, such as the Department of Health, within the same article.  The analysis revealed that 35 of these academic risk assessments were made by individuals with competing interests.  **The researchers explain that this means the academic risk assessments from those with competing interests were nearly six times as likely to be higher, compared with risk assessments from academics who had no links.**  Antiviral drugs and the H1N1 vaccine was commented on specifically in 36 articles by 20 academics. The researchers found that around 50% of these academics had competing interests.  **It was found that academics who promoted the use of antiviral drugs in the articles were eight times more likely to have competing interests, compared with those who did not comment on the use of antiviral drugs.**  Furthermore, the researchers found that only three of the 425 articles clearly mentioned that the sources have competing interests. Public confidence in academics 'could be degraded' The research team notes that interviews with these academics may "have contained more nuance views" than what appeared in print and the journalists may have deliberately sought more newsworthy views.  However, they say that academics are a highly trusted source for journalists and are in a "unique and powerful" position during public health threats, meaning many people will follow their recommendations.  The researchers add that undisclosed competing interests could damage public confidence:  **"Our results provide some evidence that the provision of higher risk assessments and the promotion of [antiviral drugs] are associated with [competing interests] among academics."**  "These add to the growing body of literature highlighting the potential influence of the pharmaceutical industry on policy decisions through multiple avenues, including advisory committees, drafting of guidelines, and media commentary.  Undisclosed [competing interests] degrades public confidence in medical research, to the detriment of the whole scientific community. Academics should declare, and journalists report, relevant [competing interests] for media interviews." |

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| [Ethics Abandoned](http://bioethicsbulletin.org/archive/ethics-abandoned/) *November 4, 2013* |

By[*Leah Ramsay*](http://www.bioethicsinstitute.org/people/leah-ramsay-3)

Should health professionals working in national security and intelligence be held to different ethical standards?  No, according to an independent task force of military, ethics, medical, public health and legal experts.

The Task Force on Preserving Medical Professionalism in National Security Detention Centers has charged the U.S. military and intelligence agencies with directing physicians and psychologists to violate standard medical ethics principles in a [report](http://imapny.org/medicine_as_a_profession/interrogationtorture-and-dual-loyalty) titled Ethics Abandoned: Medical Professionalism and Detainee Abuse in the War on Terror.

Specifically, the report charges that since September 11, 2001, the Department of Defense (DoD) and CIA improperly demanded that their health professionals design, participate in and enable “torture and cruel, inhumane and degrading treatment” of detainees.

[Len Rubenstein](http://www.bioethicsinstitute.org/people/leonard-rubenstein-4), JD, a faculty member of the Johns Hopkins Berman Institute of Bioethics, was a co-chair of the 19-member task force and a principal author of its report.  He says, “There is a disturbing legacy in the distortion of medical ethics standards and appropriate professional roles in military detention of terrorist suspects. The DoD has rewritten standards in a way that undermine core duties of beneficence, non-maleficence, use of independent professional judgment.”

The task force’s report details how DoD and CIA policies institutionalized breaches of medical ethics by military and intelligence agency physicians and psychologists, including:

* Involvement in abusive interrogation; consulting on conditions of confinement to increase the disorientation and anxiety of detainees
* Using medical information for interrogation purposes
* Force-feeding of hunger strikers

In addition to this active breach of ethical standards, the report also says that DoD policies and practices impeded the ability to provide detainees with medical care, and vary greatly from the standards that apply to civilian health professionals.

Specifically, Rubenstein highlights the continued protocols that require health professionals to participate in the force-feeding of detainees. “Force-feeding by physicians in violation of ethical standards is illustrative of a much broader legacy in which medical professionalism has been undermined,” he says, according to a press release issued by the [Institute on Medicine as a Profession](http://www.imapny.org/), which supported the task force, along with the [Open Society Foundations](http://www.opensocietyfoundations.org/).

Earlier this year, Rubenstein spoke out against force-feeding policies at Guantanamo Bay Prison after [reviewing the Standard Operating Procedure for hunger strikers](http://www.aljazeera.com/humanrights/2013/05/201358152317954140.html), saying, “It is a very frightening idea that the medical staff is an adjunct of the security force.  The clinical judgment of a doctor or a nurse is basically trumped by this policy and protocol. Doctors are not acting with the kind of professional medical independence [they should].”

Among its recommendations, the task force calls on the DoD to establish new guidelines for responding to detainee hunger strikes, in line with the [World Medical Association’s Declaration of Malta](http://www.wma.net/en/30publications/10policies/h31/), “including the use of their independent medical judgment in assessing detainee competence to make decisions.”

Other recommendations include:

* Require states to make it explicit that health professionals who support interrogation and participate in torture or cruel, inhumane or degrading treatment be disciplined.
* Urge professional medical associations to strengthen their ethical standards around interrogation and detention of detainees and take proactive steps to foster compliance.
* Require military medical training programs, including pre-deployment training, to include human rights and professional ethical principles regarding treatment of detainees.

<http://bioethicsbulletin.org/archive/ethics-abandoned/>

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| P A Francis Wednesday, September 11, 2013, 08:00 Hrs  [IST] |
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**http://www.pharmabiz.com/ArticleDetails.aspx?aid=77943&sid=3**

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| **DRUGS FOR NEGLECTED DISEASES** |
| P A Francis Thursday, October 03, 2013, 08:00 Hrs  [IST] |
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| Finding drugs for growing number of neglected diseases has been a serious task for healthcare experts and other stakeholders in developing countries for some time now. Although pharmaceutical industry developed over the past fifty years with invention of several life saving drugs, there are only very few drugs available for treating some of the deadly diseases afflicting poor people of Africa and Asia. Global pharma industry has been ignoring these neglected diseases mainly on account of their stand that there is no sufficient market to bring out such drugs. Such a position of the global pharma industry has been worrying the governments of several nations including India as the number of people suffering on account of these diseases has been steadily rising over the years. The World Health Organisation has been tracking availability of drugs for neglected diseases and its recent report claims some progress has been attained against 17 such tropical diseases. The report charts whatever progress made in controlling, eliminating and eradicating these diseases. Two diseases targeted for global eradication are dracunculiasis (guinea worm disease) in 2015 and yaws in 2020. The report outlines six targets set for the elimination of five diseases by 2015 and a further 10 targets for nine diseases for 2020, either globally or in selected geographical areas. The report further says a reduction in cases of dracunculiasis with only 521 cases between January and September 2012 compared with 1006 confirmed cases for the same period in 2011 and of human African trypanosomiasis (sleeping sickness) to less than 7000 in 2011 from a high of 30000 annual cases at the turn of the century.  In India, the Central government has been concerned over the rising number of diseases for which no effective drugs are available. A conference organised on the theme “Partnering for Success – Reducing India's Burden of Neglected Diseases” by Global Health Progress, Organisation of Pharmaceutical Producers of India and International Federation of Pharmaceutical Manufacturers & Associations early last month in New Delhi attempted to address this issue to some extend. Apart from the government officials, representatives from health organizations, industry and international experts joined the deliberations to work out future strategies for the control and elimination of neglected diseases. Indian pharmaceutical companies have neither been taking interest to develop drugs for  rare tropical diseases nor helping government with supplies of drugs for the same. Take the case of kala-azar. There is only one company that supplies the drug to the government for the national programme and that too the company takes six months to supply the drug. In many other cases also the situation is the same. Whatever new drug research programme undertaken by India's large companies has been for finding new molecules for lifestyle diseases. In situation like this, government owned research labs and institutions need to take the lead for finding new drugs for neglected diseases in India. That calls for higher allocation of Central funds for developing and producing these drugs. |

**He was sacked as President of the Medical Council of India and subsequently jailed on serious charges of corruption, but an interview in The Times of India claims Dr Ketan Desai has”bounced back”. On the charges of corruption, Dr Desai says “**A large number of private medical colleges, run by influential people, had

failed to obtain favourable orders from the MCI. They gunned for me. Regulations were introduced to check cheating by medical colleges.

Eight private medical colleges were debarred in 2010 but after the supersession of the MCI, the new board of governors reversed the decisions. Then tough laws were notified to prevent pharma companies from luring doctors. Show-cause notices were issued to two big pharma companies which had taken more than 200 doctors each abroad for a conference. Sadlynothing happened after I was dethroned.”

Strangely, the primary charge against him was one of

# Ketan Desai is back in Medical Council of India

[Arun Ram](http://timesofindia.indiatimes.com/toireporter/author-Arun-Ram.cms), TNN Oct 29, 2013, 05.44AM IST

http://articles.timesofindia.indiatimes.com/images/pixel.gif

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* [Supreme Court](http://timesofindia.indiatimes.com/topic/Supreme-Court)|
* [Medical Council of India](http://timesofindia.indiatimes.com/topic/Medical-Council-of-India)|
* [Ketan Desai](http://timesofindia.indiatimes.com/topic/Ketan-Desai)

CHENNAI: The Medical Council of India is a picture of irony: It now has a member whose medical practitioner's licence it suspended two years ago.

Dr Ketan Desai, suspended by the MCI in October 2010 following his arrest by the CBI on charges of corruption, will now be part of the statutory body that presides over medical education and professional ethics of physicians in the country. In an unusual Sunday meeting that lasted barely 10 minutes, the Gujarat University senate unanimously nominated Dr Desai to the MCI, which apparently has no powers to reject the nomination.

http://articles.timesofindia.indiatimes.com/images/pixel.gif

States send representatives to the council to represent medical colleges and the state medical council. Dr Desai represents medical colleges in Gujarat. Dr Desai said there was no legal impediment to his election. "I am registered with the Gujarat State Medical Council, and not with the MCI. So the MCI cannot suspend my licence. And it has no powers to stop my nomination," he told TOI. What about moral grounds? "What moral grounds?" he retorted. "When I have done nothing wrong, why should I take a moral high ground?"

The CBI arrested Dr Desai, then MCI president, on April 22, 2010 on charges of taking bribe to give recognition to the Patiala-based Gyan Sagar Medical College. On October 9, the MCI suspended his licence to practice, following a complaint from US-based Dr Kunal Saha, who recently won a 15-year legal battle and Rs 5.96 crore as compensation for the death of his wife Dr Anuradha Saha due to medical negligence at AMRI Hospital, Kolkata.

Arguing that the MCI has no powers to suspend his licence, Dr Desai, with the support of his home state's medical council, went on to become the head of the department of urology at BJ Medical College, Ahmedabad, and now, the MCI member. "It is ridiculous," said Dr Saha, "to imagine how a doctor who was barred from practicing medicine and participating as a doctor anywhere including the medical council could be elected or nominated to the MCI. After spending time in jail, Dr Desai has been out on bail, and he is still facing serious criminal charges for bribery and corruption."

Dr Desai said the Supreme Court has stayed proceedings against him in the bribery case, and that a CBI court has accepted the investigating agency's proposal to close the case against him. "There is a bigger political game against me," he said. Asked why he didn't challenge the MCI's suspension, he said the Indian Medical Council Act, 1956 has given powers of registration and suspension of licences only to the state medical councils. "The MCI merely enrols doctors based on the list given by the state medical councils," he said.

None of the MCI office bearers were available for comment. While calls to MCI chairman Dr R K Srivastava's office went unanswered, its secretary Dr Sanjay Srivastava's office said he would not be available for two days because of a meeting of the board of governors. MCI additional secretary P Prasannarajan said he was attending to a personal emergency, and would not be able to comment on Dr Desai's nomination.

<http://articles.timesofindia.indiatimes.com/2013-10-29/india/43494567_1_mci-indian-medical-council-act-gyan-sagar-medical-college>

### [Opinion](http://www.thehindu.com/opinion/) » [Lead](http://www.thehindu.com/opinion/lead/)

September 24, 2013

Updated: September 24, 2013 01:31 IST

# Justice cannot follow a tough act

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B. B. Pande

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# China to End Loophole in Child Rape Law, Experts Say

By [DIDI KIRSTEN TATLOW](http://sinosphere.blogs.nytimes.com/author/didi-kirsten-tatlow/)

For 16 years, children’s rights advocates have called on the Chinese government to do away with a law that allows men who have sex with girls under 14 years of age, the legal age of consent, to receive a more lenient punishment than those convicted of raping older girls or women if they can “prove” that the child was paid or otherwise compensated for sex.

The crime of “[spending the night in a brothel with a young girl](http://sinosphere.blogs.nytimes.com/2013/10/28/new-guidelines-on-punishing-child-rape-win-praise-and-criticism/)” provides an incentive for sexual predators to choose younger girls in order to evade the heaviest sentences, critics say. Men accused of raping a child could bribe or force the girl or her family to testify that she had been paid. The law also stigmatizes the girls by labeling them as prostitutes, activists say.

The Chinese Supreme Court has indicated to a leading proponent of changing the law, National People’s Congress deputy Sun Xiaomei, that it accepts the argument that the law, which has been on the books since 1997, is unfair and wrong. While no date has been set for the legal change, child rights activists and feminists are jubilant.

“It’s a really, really positive change,” said Zhang Rongli, a law professor at the China Women’s University. “And it’s an example of the government listening to public opinion. This law was very unpopular throughout society. Surveys showed that 98 or 99 percent of people opposed it. The government listened.”

“While we have to wait for the change to become law, and the Supreme Court can’t legislate, only the National People’s Congress can, we’ve been told that it is already effectively over,” Ms. Zhang said.

Word of the decision spread last Saturday at a conference on child rights attended by activists, academics and reporters, she said. For years, Ms. Sun, a university colleague of Ms. Zhang, had pushed in the National People’s Congress for the law to be changed, as had many others. Last July Ms. Sun received the first indication from officials that they would do so, said Ms. Zhang.

On Monday, Beijing Youth Daily, a Communist Party newspaper, cited unnamed officials in the Supreme Court as saying it “completely agreed” that the law should be expunged. The main reason they gave was that “while the crime of ‘spending the night with a young girl in a brothel’ did punish the man, it also gave the girl a shameful label,” the newspaper said.

The discrepancy in penalties depending on payment was also a problem, said Ms. Zhang. As was the fact that the law set no “lower limit” for age, applying to children from birth to 14. “It was awful,” she said.

The penalty for rape in China can include life in jail and execution, whereas the penalty for “spending a night with a young girl in a brothel” is capped at 15 years. “Of course, it’s not at all the same thing if you can’t get life or execution,” said Ms. Zhang.

<http://sinosphere.blogs.nytimes.com/2013/12/09/china-to-end-loophole-in-child-rape-law-experts-say/>



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## Equating juveniles with adult criminals is neither scientifically correct nor normatively defensible

The August 31 verdict of the Juvenile Justice Board (JJB) in the Delhi gang rape case, handing down a bare three-year custodial sentence to the juvenile member, has generated a fresh round of debate on the legality and desirability of juvenile justice itself: why should juveniles above 16 indulging in violent crimes not be treated as adult criminals? Why should juveniles who are privy to a heinous crime not be given the same punishment as others? Why should our juvenile justice law not follow the 1990s American society’s ‘get tough with violent juveniles’ approach? The debate has spilled over to visual and print media [(Aparna Viswanathan’s article in The Hindu, September 9, 2013,](http://www.thehindu.com/opinion/lead/balancing-the-juvenile-act/article5107620.ece) and scores of letters to the editor) as well as the pending Special Leave Petition in the Supreme Court (*Dr. Subramanian Swamy Vs. Raju*, Member, JJB).

**The American model**

Our juvenile justice makes no distinction between the age group or the violent or non-violent criminality of the juveniles just like American society till the end of the 1980s, when the U.S. Supreme Court, in *Stanford v. Kentucky* (192 U.S.361 at 395-96 (1989)), strongly endorsed the observation of the Task Force on Sentencing Policy Towards Young Offenders thus: “Youth crime … is not exclusively the offender’s fault; offences by the young represent a failure of family, school and social system, which share responsibility for the development of America’s youth.”

However, in the U.S., things changed dramatically as the 1990s witnessed a shift towards retributive juvenile justice policy. Such a shift was the outcome of a massive rise in the incidence of juvenile offences (the rate of juvenile offending in the U.S. was almost half the total crime rate) as well as extraordinary violence and brutality of juvenile crimes. A substantially large percentage of juvenile crimes related to offences involving confrontation with victims (homicides, forcible rapes, aggravated assaults and robbery) and narcotic crimes. As a strong response, Congress felt compelled to resort to a “get tough” approach, leading to the amendment of the Federal and State juvenile justice laws by introducing transfer proceedings before the court in all cases where a juvenile above 15 years was involved in a violent crime or narcotics crime. The continued spiral of violent juvenile criminality evidenced in several school shooting cases involving juveniles less than 15 years led Congress to further tighten the re-criminalisation noose by leaving transfer or waiver to prosecutorial discretion without due process safeguards for many new kinds of delinquencies, and reducing the juvenile age limit to 14 or 12 years. In many States, the age limit was waived altogether. However, in recent times, under the influence of brain science research, the re-criminalisation trend appears to be abating, as evidenced by the U.S. Supreme Court ruling in *Roper v Simmons* (2005), which abolished the juvenile death penalty and later in a 2010 ruling in *Graham v Florida*, which prohibited sentencing juveniles of crimes other than homicide to life without parole.

Therefore, the U.S. re-criminalisation model has hardly any relevance for India where, for a period between 2001 and 2011, the juvenile delinquency rate has ranged between 1.6 to 2.1 per cent of the total crimes (as against half of the total crime rate in the U.S.) and of these only 5 to 8 per cent are violent crimes like murder and rape (as against a substantial percentage of violent crimes in the U.S.).

**Brain science insights**

There was very little scientific basis for the American re-criminalisation aberration, but it did inspire brain science experts to undertake a scientific exploration of the adolescent brain system and establish that any deviant behaviour is a function of two distinct sets of brain systems, namely, the socio-emotional system and the cognitive control system that involve different regions of the brain which mature along different timetables. Thus competence-related abilities mature by 16, but the capacity relevant to decisions about criminal culpability continues to mature till young adulthood. These findings of the MacArthur Foundation, Washington, are supported by later brain science researchers such as Laurence Steinberg who argues in his paper “Should the Science of Adolescent Brain Development Inform Public Policy?” (*Issues in Science and Technology*, Spring 2012) thus: “Adolescents should be viewed as inherently less responsible than adults, and should be punished less harshly than adults, even when crimes they are convicted of are identical.”

Therefore, just because the public is angry with juvenile criminals, including the Delhi gang rape juvenile, should we disregard scientific evidence and reverse the long-accepted juvenile justice policy?

**In line with U.N. norms**

The roots of Indian juvenile justice can be traced to the 1920s when the Indian Jail Committee, 1919-20, for the first time, recommended a distinct and comprehensive handling of child offenders, leading to the enactment of the Children Act in several progressive provinces like Madras, West Bengal and Bombay, in 1920, 1922 and 1924 respectively. Dealing with child offenders through a different and exclusive system of justicing received a fresh and renewed impetus with the passage of the U.N. Rules for the Administration of Juvenile Justice, 1985, and the U.N. Convention on the Rights of the Child, 1989 — both the instruments are duly ratified by the Government of India. As a sequel to the U.N. Rules of 1985, the first Central law on the subject, the Juvenile Justice Act, 1986, was enacted with a view to imparting uniformity and bringing juvenile justice in line with the current international trends. The ratification of CRC 1989 in 1992 and the submission of Action Taken Report led to the enactment of the Juvenile Justice (Care and Protection of Children) Act 2000.

This new juvenile justice law differed from the earlier laws in three important respects: first, the Juvenile Court had been replaced by a three-member Juvenile Justice Board (a magistrate and two social work members); second, the age of juvenility was raised for the male child from 16 to 18 years, and, third, custodial sentence under Section 15 (1) (g) was to be limited to a maximum of three years. Of the three, the latter two have become very controversial. The age issue was resolved very much under U.N. pressure, because the U.N. Committee on the Rights of the Child in its 23rd Session vide Resolution 26 and 27 (dated 23/02/2000) expressly observed: “Of particular concern to the U.N. Committee is the very low age of criminal responsibility … And possibility of trying boys between 16-18 as adults.” Raising the age to 18 was later supported by brain science scholars like Laurence Steinberg who takes it as “presumptive age of majority,” which is the mean between 15 and 22 years. However, the provisions relating to sentencing, particularly the limitation of three years on custodial sentence, are the weakest link in the juvenile justice law that calls for unmediated reform.

**Need for reforms**

The juvenile justice system is in operation throughout the country but very little effort has gone into creating the required infrastructure and developing skilled manpower. The J J Act 2000 has expanded the ambit of the law and created an obligation to cater to the adjudicatory and custodial needs of the 16-18 age group, without caring for their special needs. Particularly problematic is the limitation of a maximum period of three years for a custodial sentence. Such a short period is neither justifiable on grounds of deterrence nor adequate for any kind of reform programme. For example, under the U.K. system even for the most brutal crimes a juvenile is tried by a Youth Court, but sentenced at Her Majesty’s pleasure. In *Re Rebert Thompson and Jon Venables*, in 2000, the House of Lords was required to decide a matter of tariff and Chief Justice Lord Woolf agreed on an eight-year sentence because the main object of juvenile sentencing was to reform and ultimately rehabilitate the juvenile. In the words of Lord Woolf: “In the case of both these young men, the information before me makes it clear that they have done all that is open to them to redeem themselves. While their crime remains horrendous, they are entitled to credit for this.” Therefore, the most urgent reform in the juvenile justice law is to enhance the ranking of custodial sentence and increase its maximum limit, during which meaningful reform programme can be implemented to ensure that the juveniles in conflict with law are really redeemed and society feels it is adequately protected.

http://www.thehindu.com/opinion/lead/justice-cannot-follow-a-tough-act/article5161208.ece?ref=relatedNews

***(The author is a former Professor of Law and a Member of the Juvenile Justice Drafting Committee and Chairman of the J J Rules 2007 Drafting Committee)***

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September 6, 2013

Updated: September 6, 2013 00:07 IST

# Justice and the juvenile

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Calls to dilute the Juvenile Justice Act in light of what is perceived as lenient punishment to the juvenile offender in the Delhi gang rape case are understandable but misplaced. The crime shook the country’s conscience, brought forth an unprecedented outpouring of anger and triggered collective introspection on the safety of women and girls. But even though there is a view that the young perpetrator has been able to get away lightly, this is not reason enough to question or do away with the principles underlying juvenile justice. Separate legislation has existed in many countries around the world since the early 20th century for the care and protection of children, including child offenders. The present system in India was introduced by a 1986 Act and improved upon in 2000. The JJ Act, 2000, a progressive legislation, replaced the regular judicial process with a reformatory regime, favouring supervised probation or stay in an observation home over imprisonment. The law tries to reform a young offender’s conduct rather than confine him for decades in a prison with adult criminals, which only works to fan recidivist tendencies.

While refusing to allow the Delhi gang rape juvenile offender to be tried as an adult, the Supreme Court pointed out in its order that underage crime still forms only a tiny percentage of the large body of crime in the country. However, merely going through a differential process for juvenile offenders is not enough. It is obvious that the social contract underlying a lenient regime requires equal attention to be paid to the design and implementation of a proper rehabilitation process. Society will only countenance shielding young offenders guilty of great brutality from the rigours of adult justice if it is confident that they will indeed benefit from the rehabilitative approach to juvenile justice. In India, we need to guard against the complacent belief that a stint in a remand home is enough for their rehabilitation. The atmosphere in many such facilities is not conducive for reformation, and in fact may toughen or entrench criminal propensities. The system should not end up creating a new underclass that combines a sense of triumph over avoiding a prison term after committing heinous crimes, with the psychological effects of staying under bleak, hope-denying conditions. Making juvenile correctional facilities more humane is one part of the answer. But to address the need for proportionality — not so much in punishment as in the necessity of socio-psychological repair — when a young offender commits truly heinous crimes, a longer period of sustained counselling and rehabilitation ought to be an essential part of the juvenile justice process even after the maximum period of remand is over.

<http://www.thehindu.com/opinion/editorial/justice-and-the-juvenile/article5097614.ece?ref=relatedNews>

# Should the Juvenile Justice Act be amended?

Mohamed Imranullah S. Sep 5, 2013

Members of the All India Mahila Sanskritik Sangathan (AIMSS) staged a demonstration in the city on Tuesday to highlight their demands, which included meting out “exemplary punishment” to juveniles (those below 18 years of age) involved in heinous crimes, such as rape and murder , by amending the Juvenile Justice (Care and Protection of Children) Act, 2000.

The protest comes in the wake of an order passed by the Juvenile Justice Board in New Delhi on August 31 directing a 17-year-old convict in the gang rape of a 23-year-old physiotherapy student to undergo three years, the maximum tenure prescribed under the JJ Act, in a correctional home. The protestors called for more stringent punishment to the offender.

Other demands included stopping sex education in schools, banning obscenity on television, cinema and Internet, and prohibiting the sale of liquor.

The protest was supported by the All India Democratic Students Organisation and All India Democratic Youth Organisation.

T. Hilda Mary, State Committee member of AIMSS, told *The Hindu* that it was unfair to order a juvenile to be lodged in a correctional home for petty crimes such as theft as well as heinous crimes such as rape and murder. “Ordering a rape convict to spend just three years in a correctional home is not going to deter others from committing crimes against women,” she observed.

But S. Syed Ahmed, former chairman of Child Welfare Committee, a statutory body, said the aim of the Juvenile Justice Board is not to punish but reform offenders. “I can understand the agony and anguish of women victims of rape. At the same time, I expect them to understand the circumstances that lead to juveniles committing heinous crimes,” he said.

According to him, juvenile offenders undergo severe mental trauma owing to their upbringing in crime-prone localities. Constant exposure to criminal activities turns them into criminals. Providing psychological counselling , and not punishing them, will help in their transformation.

“T here is nothing wrong with the Juvenile Justice Act. If at all something has to be changed, it is the functioning of the correctional homes run by the government. At present, these homes are places where even petty offenders are groomed to become hardcore criminals. The government must and change this situation,” he suggested.

He also pointed out that there was no concrete data to prove that stiff punishment resulted in the lowering of the crime rate anywhere in the world . “Crimes occur even in nations such as Saudi Arabia which follow the policy of an eye- for-an-eye and tooth-for-a-tooth. Therefore, what is required is a change in our outlook and not stringent punishment,”he added.

R. Alagumani, a lawyer practising at the Madras High Court Bench here, wondered why there was such a hue and cry over amending the Juvenile Justice Act when it had been used time and again in the last 12 years to get many murder convicts released from jail even after their conviction had been confirmed at the level of the Supreme Court.

In July, 2010, a 26-year-old youth, convicted and sentenced to life imprisonment by a Tirunelveli sessions court as well as the High Court in a triple murder case, was ordered to be released by the High Court Bench after it was proved through a habeas corpus petition that he was only 17 years, 7 months and 8 days old on March 3, 2001, the day when he murdered three people.

The High Court had held that the youngster’s failure to prove his age at the time of trial and get himself exempted from facing trial could not be reasons to deny him the benefit of the JJ Act. In the same year, three other individuals from Tuticorin were also ordered to be released on the same ground, despite their conviction in a murder case.

“The list is endless. The JJ Act should not be understood as a piece of legislation that protects men alone. It applies equally to women also. Before the year 2000, boys aged below 16 years were provided protection under the Act. The age for boys was raised to 18 after deep deliberation. Therefore, in my view, there is no need to tinker with the enactment,” he said.

http://www.thehindu.com/news/cities/Madurai/should-the-juvenile-justice-act-be-amended/article5095898.ece

Following the death on December 29, 2012, of the young physiotherapy student, christened ‘Nirbhaya’ by the media, after being raped and brutalised by six men in a Delhi bus, four of the accused were sentenced to death, and a fifth died in jail. But the sixth, declared a minor, and sentenced to three years in a juvenile home, has aroused the maximum anger and protest. In November 2013, Nirbhaya’s parents filed a petition demanding that he be tried in a criminal court and given more stringent punishment depending not on his age, but on the grievous nature of the crime. A nationwide debate has been taking place on the issue, with child rights activists and legal experts slugging it out with many citizens and organisations like All India Mahila Sanskritik Sangathan (AIMSS) demanding revision in the juvenile justice law. Legal experts have also expressed their suggestions and comments in the media, some of which are summarised below:

-- S Syed Ahmed, a former chairman of the Child Welfare Committee, said he sympathised with those who demanded justice against rapists, but he hope they would understand the circumstances that lead to juveniles committing heinous crimes. Further, Mr Ahmed said “There is nothing wrong with the Juvenile Justice Act. If at all something has to be changed, it is the functioning of the correctional homes run by the government. At present, these homes are places where even petty offenders are groomed to become hardcore criminals. The government must change this situation”.

-- R Alagumani, an advocate practising at the Madras High Court Bench, expressed the view that “The JJ (Juvenile Justice) Act should not be understood as a piece of legislation that protects men alone. It applies equally to women also. Before the year 2000, boys aged below 16 years were provided protection under the Act. The age for boys was raised to 18 after deep deliberation. Therefore, in my view, there is no need to tinker with the enactment,”.

-- T Hilda Mary, State Committee member of AIMSS, commented “Ordering a rape convict to spend just three years in a correctional home is not going to deter others from committing crimes against women,”. The organisation also demanded discontinuation of sex education in schools, censorship of obscenity in the media, and prohibition of the sale of alcohol.

--BB Pande, a Member of the Juvenile Justice Drafting Committee and Chairman of the J J Rules 2007 Drafting Committee, has in a signed lead article in The Hindu, pointed out that reforms regarding the minor involved in crime have been hard won and are based on brain science research in the West which found that “any deviant behaviour is a function of two distinct sets of brain systems, namely, the socio-emotional system and the cognitive control system that involve different regions of the brain which mature along different timetables. Thus competence-related abilities mature by 16, but the capacity relevant to decisions about criminal culpability continues to mature till young adulthood.” He says the “re-criminalisation” policy in the US under which minors had been treated by the courts as adults when committing violent or serious crimes, was influenced by a spurt in the volume of violent crimes committed by juveniles, which were almost 50 % of the total number of crimes. With the new findings of science, this policy is also undergoing a change. According to Pande, the figure for juvenile crime in India is not more than

Mohamed Imranullah S, Should the Juvenile Justice Act be amended? The Hindu.com, September 5, 2013. Available from: http://www.thehindu.com/news/cities/Madurai/should-the-juvenile-justice-act-be-amended/article5095898.ece