

News from here and there

Malaria at the crossroads: WHO report, 2017

The World Health Organization (WHO) released the latest World Malaria Report on 29 November 2017. This report is published annually and provides wide-ranging and comprehensive updates on the data and trends of global and local malaria. The 2017 report shows the trajectories of investments in various malaria programmes and research plus improvement in all intervention areas, including prevention, diagnosis, treatment and surveillance. The report also has chapters devoted to elimination of the disease and the key threats faced in the combat against malaria. Most of the data, based on statistics provided by national malaria control programmes and other partners in endemic countries, are from 2016. The key points in the report are:

- After many years of improvement in the global response to malaria, including declines in cases and deaths, there has now been a disconcerting shift in the course of this disease. The overall drop in the worldwide malaria affliction has levelled off, and, in fact, in some of the regions and countries, there have even been setbacks in the gains accomplished so far.
- A total of 216 million cases of malaria were reported by 91 countries, which is an increase of 5 million cases from 2015. However, the number of malaria deaths reported remains approximately the same as in 2015, at 445 000.
- The WHO African Region accounts for around 90% of all worldwide cases. The WHO South-East Asia Region is next at 7%.
- Eighty per cent of the global malaria burden is carried by 15 countries: 14 sub-Saharan African countries and India.
- Forty-four countries reported fewer than 10 000 cases of malaria, up from the 37 countries in 2010. Kyrgyzstan and Sri Lanka were certified as malaria-free.
- The E-2020 countries are the 21 countries that were identified by WHO as having the potential to eliminate malaria by the year 2020. Some of these countries are on track to achieve their elimination goals, but 11 have reported increases in indigenous malaria cases since 2015; five countries stated an increase of >100 cases since 2015.
- The challenges obstructing countries' abilities to stay on the track of eliminating malaria include inadequate funding, risks posed by various conflicts in malaria endemic areas, inconsistent climate patterns, and the emergence of parasite resistance to antimalarial therapies and mosquito resistance to insecticides.
- A minimum investment of US\$ 6.5 billion is required annually by 2020 to reach the 2030 global malaria targets. However, less than half of this amount was invested in 2016. In the 41 high-burden countries, funding for each person at risk of malaria is <US\$ 2.
- The most widespread malarial parasite in sub-Saharan Africa was *Plasmodium falciparum*. It accounted for 99% of the estimated cases. In other parts, *P. vivax* was predominant in the WHO Region of the Americas (64%), and was above 30% in the WHO South-East Asia and 40% in the Eastern Mediterranean regions.

- Among the South-East Asian countries, India accounted for 80% of the reported cases and 60% of malaria deaths. India is likely to achieve a 20%–40% reduction in case incidence by 2020. But, the goal for this region is to become malaria-free by 2030.
- The highest endemic state in India was Odisha, which reported a rise in the number of cases in 2016, i.e. double the number from 2013.

The cover of the report aptly has a crossroads sign, depicting the current status of the global response to malaria. At the current levels of funding and coverage with current tools, the world has reached its limits of what can be accomplished in the fight against this scourge. Unless efforts are increased, there will be no further progress.

P.M. NISCHAL, *Bengaluru, Karnataka*

WHO raises concern about quality of medical products in developing countries

WHO, in its November 2017 news release, highlighted concerns about the inferior quality of medical products in low- and middle-income countries (LMICs). An estimated one in ten medicines was anticipated to be substandard or falsified, thereby raising doubts about the effectiveness of such medications and their potential to cause more harm than good. The data, released by WHO in conjunction with the first report from the Global Surveillance and Monitoring System, are based on a study by the Member State Mechanism that collected data over 4 years, two peer-review models by the University of Edinburgh and the London School of Hygiene and Tropical Medicine and on more than 100 published research papers on medicine quality surveys done in 88 LMICs. An estimated 48 000 samples of drugs were studied. Antibiotics, cancer medicines, contraceptives, vaccines and *in vitro* diagnostic tests were among the more common medical products involved and the malpractice was seen to extend to patented drugs, renowned pharmaceutical brands and generic medicines alike. This amounts to a suspected failure rate of 10.5% in all medical products used in LMICs. Lack of technical expertise to assess quality standards during the manufacture and supply stages, poor governance and inadequate laws to curb malpractice by pharmaceutical companies, distributors and healthcare workers are some of the reasons cited as causes of substandard medicine production and falsified drug distribution. The advent of globalization has further compounded worries of offshore accounts being used as sources of finance to boost production of substandard drugs in countries remote from the place of their final distribution. Thus medical products are manufactured by suboptimal methods in one country, and then supplied to another country (sometimes on a different continent) for sale. The financial trail is often difficult to follow.

S. Srinivasan, co-founder and managing trustee, Low cost standard therapeutics (LOCOST), Baroda said, 'If you go by the

National Drug Survey, the figures in India are much lower. I feel the somewhat dated report ... does not apply to India by and large. Indian law has only NSQ (Not of Standard Quality) drugs by which is meant drugs not complying with the IP (Indian Pharmacopoeia) and or other standard pharmacopoeias. Indian law also has misbranded, adulterated and spurious drugs. We have other problems—that of irrational FDCs (fixed-drug combinations) accounting for at least 25% of the market—which need to be banned. The recent attempt to ban 344 FDCs is about 3% of the domestic market of ₹1 lakh crore. I feel the National Drug Survey is unsung—possibly because it shows the MNCs (multinational companies) having quality issues.'

MAHARRA HUSSAIN, *Dubai, United Arab Emirates*

Indian Medical Association opposes the proposed National Medical Commission Bill to replace Medical Council of India

The Medical Council of India (MCI) is a statutory body for establishing uniform and high standards of medical education in India. MCI was established in 1934 under the Indian Medical Council Act, 1933. In recent years, MCI has been at the centre of controversy because of charges of corruption, inefficiency, lack of transparency and accountability.

WHO considers a healthy doctor-patient ratio as 1:1000. Presently, the ratio in India is <1 doctor per 1000 patients and is very variable all over the country.

NITI Aayog has suggested establishment of the National Medical Commission (NMC) with 25 members, which aims to overhaul medical education in India by replacing the present 83-year-old MCI. The NMC Bill was tabled in Parliament on 29 December 2017. However, the Indian Medical Association (IMA), the largest body of doctors in India is opposing the same and demanded rollback of the NMC—2 January 2018 was

declared as 'Black Day' and saw nationwide mass opposition to the bill.

The main reasons for the strong opposition to the NMC Bill are:

1. Doctors are opposed to the Bridge Course proposed under Section 49 for all practitioners of Indian systems of medicine as it will promote quackery. This unscientific bridging will pose threats to patient care;
2. IMA claims that the bill will cripple the medical profession by making it completely answerable to the bureaucracy and non-medical administrators as it was reported that 'regulators in the new body will be selected and will not be elected'. This will take away the voting right of every doctor in India to elect their medical council. At present any registered medical practitioner in the country can contest the election. In the present form, the NMC will be non-representative and undemocratic;
3. The bill abolishes the MCI and 'possibly' Section 15 of the IMC Act, which says that the basic qualification to practise modern medicine is MBBS. The NMC Bill remains a questionable remedy, and it has drawn criticism from several quarters, including the country's medical fraternity;
4. Private medical colleges are allowed to charge fees at will, nullifying the overall purpose of the National Eligibility and Entrance Test;
5. Fees can be hiked in private medical colleges by NMC without any regulation.

IMA states that the bill is 'anti-people and anti-poor' and requires revision. IMA has been opposing the NMC Bill for the past 18 months. The NMC Bill, which has now removed the separate exit examination at the end of the MBBS course (NEXT), is still unacceptable. The bill has now been referred to a standing committee for review.

JYOTI PRIYADARSHINI SHRIVASTAVA, *Gwalior, Madhya Pradesh*

The National Medical Journal of India is looking for correspondents for the 'News from here and there' section. We are particularly interested in getting newswriters from the north and northeast regions of India as well as from other countries. By news, we refer to anything that might have happened in your region which will impact on the practice of medicine or will be of interest to physicians in India. The emphasis of the news items in this column, which are usually from 200 to 450 words, is on factual reporting. Comments and personal opinions should be kept to a minimum if at all. Interested correspondents should contact SANJAY A. PAI at sanjayapai@gmail.com or nmji@nmji.in