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Editorial

The Millennium Development Goals (MDGs) which include eight goals were framed to address the world's major development challenges with health and its related areas as the prime focus. In India, considerable progress has been made in the field of basic universal education, gender equality in education, and global economic growth. However there is slow progress in the improvement of health indicators related to mortality, morbidity, and various environmental factors contributing to poor health conditions.

The MDGs adopted by the United Nations in the year 2000 project the efforts of the international community to “spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty.” The MDGs are eight goals to be achieved by 2015 that respond to the world's main development challenges. Health constitutes the prime focus of the MDGs. While three out of eight goals are directly related to health, the other goals are related to factors which have a significant influence on health.

India’s progress towards achieving the MDGs, as reported in the latest official MDG Report, India is likely to fall short of a majority of the targets and indicators with respect to Goal 1: poverty and hunger; Goal 3: gender equality; Goal 4: infant mortality, Goal 5: maternal mortality and Goal 7: environmental sustainability, all of which, with the possible exception of environmental sustainability, is appalling. Even the partial successes achieved on targets and indicators with respect to goal 2: education; Goal 6: health, have a few caveats. For example, the school enrollment rates are ahead of the targets, but the dropout rates are also high, making the enrollment rates meaningless. The incidence of HIV/AIDS has come down, but what is alarming is that HIV/AIDS incidence is increasing in states where it was hitherto low. There are also wide variations in the penetration of information and communication devices as agreed under Goal 8: development partnership. And, as the report indicates, the performance of the majority of states on many of the goals and targets is even more appalling. The quality of achievements that have been made is also far from satisfactory.

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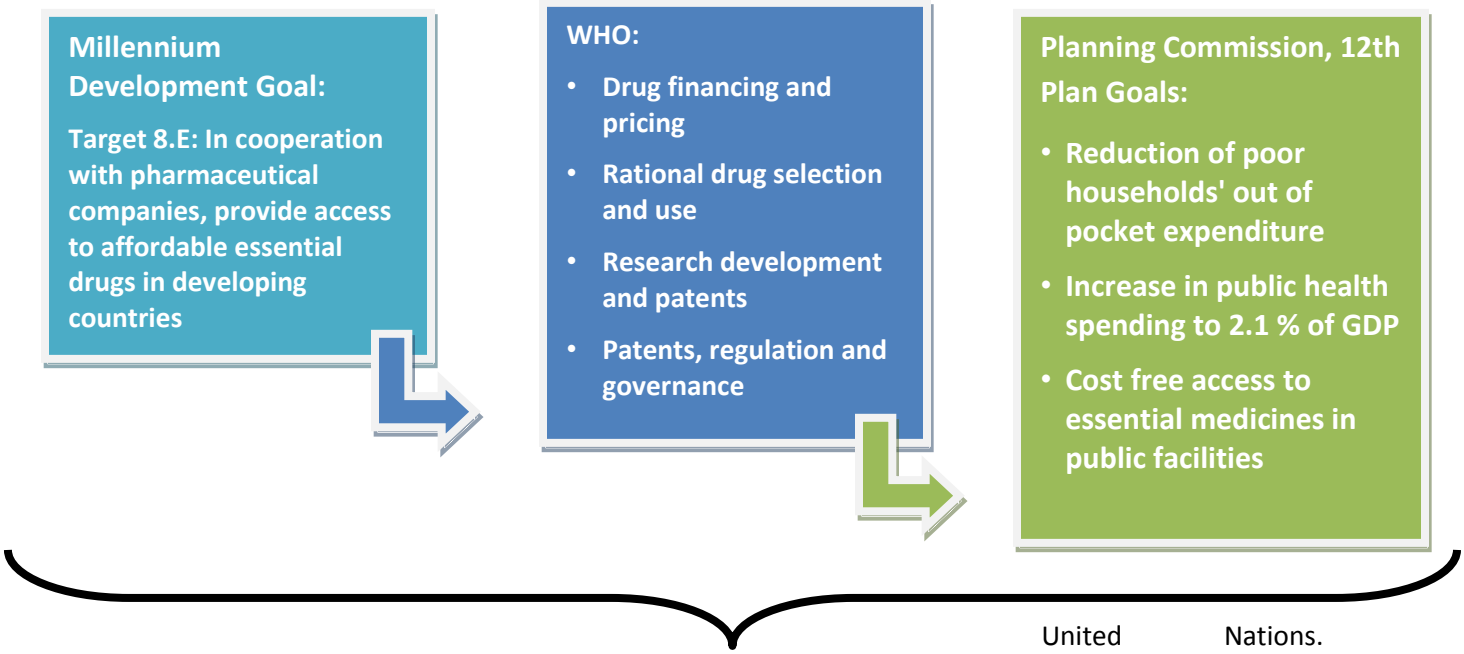
Millenium development goal – our response

Pallavi Paul

specific broad objectives that include various sub-objecti

time bound, being monitored regularly by the United Nations.



CDMU Goals:

- **Procuring essential medicines and reaching them to the poor on non-profit basis**
- **Enhancing rational use of medicine and promoting standardized treatment**

In September 2000, building upon a decade of major United Nations conferences and summits, world leaders came together at United Nations Headquarters in New York to adopt the United Nations Millennium Declaration, committing their nations to a new global partnership to reduce extreme poverty and setting out a series of time-bound targets - with a deadline of 2015 - that have become known as the Millennium Development Goals (MDG).[1] The MDG has eight

However, it is interesting to note that of the eight MDGs listed below that guide the efforts of virtually all organizations working in development and have been commonly accepted as a framework for measuring development progress, four are associated with the health sector:

- Eradicate extreme poverty and hunger
- Achieve universal primary education
- Promote gender equality and empower women
- Reduce child mortality
- Improve maternal health

[1] http://www.un.org/millenniumgoals/bkgd.shtml as viewed end December 2013.

- Combat HIV/AIDS, malaria, and other diseases
- Ensure environmental sustainability
- Develop a Global Partnership for Development

Each of the goals or objectives as defined above has one or more targets to be achieved by the end of 2015. There are in all 18 such targets. In the run up, to meet the targets, the progress of the countries is to be measured quantitatively with the help of a number of quantitative indicators. There are 48 such indicators listed by the UN and standard International definitions for these indicators have also been enunciated. There is no compulsion for any country to work towards meeting the MDG targets. However, the MDGs have become a framework for judging the progress of different nations. Failure to achieve MDG targets will reflect poorly on a nation's capability and will also bring in international pressure. India has a very crucial position in the global scenario of MDG framework. For instance, the first target of the first MDG i.e. halving the global poverty by 2015, cannot be achieved unless the world's most populous countries, India and China, halve the number of people living below the poverty line by that year.

Furthermore, specifically sub-target E of target number 8, also referred to as Target 8.E (see figure above) highlights the need for a public-private partnership to promote essential drugs at affordable prices in developing countries. This in turn would automatically take care of the other health related targets in the MDG list and also the poverty alleviation issue, given that many families are pushed below the poverty line merely due to the expenses incurred on buying medicines.

On 23 September 2013, the Secretary-General hosted a high-level forum to catalyze and accelerate further action to achieve the MDGs and enrich the deliberations of the General Assembly and beyond. The forum focused on concrete examples of scaling up success and identifying further opportunities. Again on 25 September 2013, the President of the UN General Assembly hosted a special event to follow up on efforts made towards achieving the MDGs where, world leaders renewed their commitment to meet the MDG's targets and agreed to hold a high-level Summit in September 2015 to adopt a new set of Goals building on the achievements of the MDGs.

This initiative by United Nations has been adopted not only by various member states for monitoring the development in their respective nations, but the World Health organisation (WHO) also embraced the MDG to design its own projects and initiatives. Evidences are available that WHO in its own capacity promoted the MDG in various ways, namely,

- WHO has "prequalified" more than 250 medicines for HIV/AIDS, tuberculosis (TB), malaria, and reproductive health, and promotes the greater availability of generic essential medicines in the public sector.
- Promote ways to replace user fees with pooled, pre-payment financing systems such as taxation and/ or insurance so as to prevent people from falling into poverty.
- Develop strategies to address critical shortages of health workers.

- Ensure that sick children get quality health care within 24 hours of becoming ill, and provide safe, effective medicines for children.
- Increase focus on prenatal - antenatal care, infant mortality, HIV/AIDS protection and prevention of transmission, effective protection against malaria and tuberculosis, etc.

Thus WHO actively reached out through its programs to the various countries it works with to effectively reach the targets defined in MDG. It worked with country specific organizations to help them design ways address the health related targets in the MDG.

Coming closer to home, India in the meanwhile figured itself among the 10 fastest growing economies in the world with an average growth rate of the GDP of 5.8% during the first decade of reforms (1992-2001). This favorable situation led India to take certain important policy initiatives. The Government of India thereafter launched various new countrywide programs for extending the benefits of the policy initiatives and demonstrated its commitment by significant enhancement of allocations for these programs in the budgets. Most of the programs launched, quite interestingly were aligned to the MDG. National Rural Health Mission was one of the many programs under the initiative that specifically catered to the health sector. Furthermore, the 10th Five Year Plan (2002-2007) while outlining India's human development goals and targets were not only related to but were more ambitious than the MDGs. Some of the health sector related targets for the 10th were as follows:-

- Reduction of infant mortality rate to 45 per thousand live births by 2007 and to 28 by 2012.
- Reduction of maternal mortality rate to 2 per thousand live births by 2007 and to 1 by 2012.
- Specific HIV/AIDS targets within the 10th Plan Period.
- Specific malaria targets within the 10th Plan Period.

The 12th Plan (2012-2017) worked on the deficits of the health sector. It continued to focus on the targets of the MDG and shortfalls of the same. At the same time it promoted the concept of a sound health system with active participation of communities in preventive and promotive health care. The National Health Outcome Goals for the 12th Plan prioritized the making of the system responsive to the needs of citizens, and the attainment of financial protection for the health care of households. More specifically, the national health outcome goals, which are meant to reflect the broader commitments during the 12th Plan were specified as the following:[2]

Reduction of Infant Mortality Rate (IMR) to 25: At the past rate of decline of 2 points per year, India is projected to have an IMR of 38 by 2015 and 34 by 2017. An achievement of the MDG of reducing IMR to 27 by 2015 would require further acceleration of this historical rate of decline. If this accelerated rate is sustained, the country can achieve an IMR of 25 by 2017.

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[2] http://planningcommission.gov.in/sectors/index.php?sectors=hea viewed in December 2013.

Reduction of Maternal Mortality Ratio (MMR) to 100: At the recent rate of decline of 5.5% per annum India is projected to have an MMR of 143 by 2015 and 127 by 2017. An achievement of the Millennium Development Goal (MDG) of reducing MMR to 109 by 2015 would require an acceleration of this historical rate of decline. At this accelerated rate of decline, the country can achieve an MMR of 100 2017

Reduction of Total Fertility Rate (TFR) to 2.1: India is on track for the achievement of a TFR target of 2.1 by 2017, which is necessary to achieve net replacement level of unity, and realize the long cherished goal of the National Health Policy, 1983 and National Population Policy of 2000.

Prevention and reduction of underweight children under 3 years to 23%: Underweight children are at an increased risk of mortality and morbidity. At the current rate of decline, the prevalence of underweight children is expected to be 29% by 2015, and 27% by 2017. An achievement of the MDG of reducing undernourished children under 3 years to 26% by 2015 would require an acceleration of this historical rate of decline. If this accelerated rate is sustained, the country can achieve an under 3 child under nutrition level of 23% by 2017. This particular health outcome has a very direct bearing on the broader commitment to security of life, as do MMR, IMR, anemia and child sex ratio.

Prevention and reduction of anemia among women aged 15-49 years to 28%: Anemia, an underlying determinant of maternal mortality and low birth weight, is preventable and treatable by a very simple intervention. The prevalence of anemia has shown a rising trend (58.8% in 2007, DLHS), which needs to be reversed and steeply reduced to 28%, which is half the current levels, by the end of the 12th Plan.

Raising child sex ratio in the 0-6 year age group from 914 to 935: Like anemia, child sex ratio is another important indicator which has been showing a deteriorating trend, and needs to be targeted for priority attention.

Prevention and reduction of burden of Communicable and Non-Communicable diseases (including mental illnesses) and injuries: State wise and national targets for each of these conditions will be set by the Ministry of Health and Family Welfare (MoHFW) as robust systems are put in place to measure their burden. Broadly, the goals of communicable diseases shall be as indicated as in the Table

National Health Goals for Communicable Disease

Disease	12th Plan Goal
Tuberculosis	Reduce annual incidence and mortality by half
Leprosy	Reduce prevalence to < 1/10,000 pop. and incidence to zero in all districts,
Malaria	Annual Malaria Incidence of < 1/1000
Filariasis	<1% microfilaria prevalence in all districts
Dengue	Sustaining case fatality rate of <1%
Chikungunya	Containment of outbreaks
Japanese Encephalitis	Reduction in JE mortality by 30%
Kala-azar	<1% microfilaria prevalence in

HIV/AIDS	all districts Reduce new infections to zero and provide comprehensive care and support to all persons living with HIV/AIDS and treatment services for all those who require it.

Reduction of poor households' out of pocket expenditure: Out of pocket expenditure on health care is a burden on poor families, leads to impoverishment and a regressive system of financing. Increase in public health spending to 2.1% of GDP by the end of the 12th Plan, cost free access to essential medicines in public facilities, regulatory measures proposed in the 12th Plan are likely to lead to increase in share of public spending. The 12th Plan measures will also aim to reduce out of pocket spending as a proportion of private spending on health.

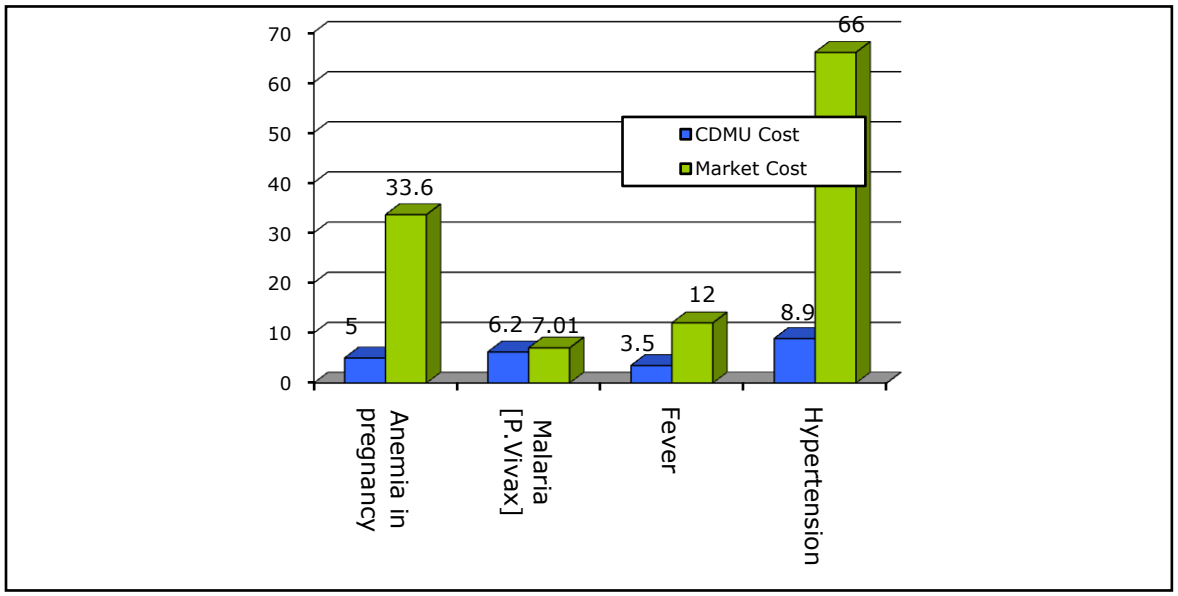
Thus an overall analysis provides enough evidence of the importance being associated to the MDG, hence for any organization working in one of the segments being targeted under MDG, it makes adequate sense to align themselves to the goals and objectives of MDG. Since MDG targets segments that are mainly catered to by the NGO sector, one observes that NGOs not only have redefined their objectives but are also adopting the indicators suggested under MDG to assess their achievements. However, in case of CDMU, quite interestingly their objective or mission right from the start addressed one of the key MDG goals, namely promoting rational use of medicine and ensuring access to essential medicine at affordable price. Thus specifically, target 8.E of MDG is perfectly aligned to the mission and vision of CDMU.

CDMU in their endeavor to serve and reach essential medicine have been working with various organizations with health centres in remote areas. The model that CDMU works ensures major savings to most of these centres and the community at large. The savings are two folds, as CDMU provides quality medicine at low cost. Since the medicine is quality tested, the recipients are assured effective treatment, hence the spend on patient treatment is not multiplied simply because spurious medicine is not provided thereby reducing the need for the patient to revisit and restart treatment for the same ailment. This obviously translates to savings for not only the patient, who is already burdened to meet regular household expenses being below poverty line. Also, at the health centre level, there is a saving due to availability of low cost medicine. Since most of these health centres are donor dependent centres providing health care service at subsidized rate, any savings translates to ability to serve more people.

A simple analysis of a few common ailments prevalent in centres served by CDMU provide startling revelation as to the quantum of savings per treatment CDMU can provide. The table below provides the cost figures for simple ailment like fever and some of the target disease under MDG, like, anemia, malaria, hypertension, etc.

Disease	Medicines	Treatment Dosage	Cost at CDMU	Cost at Retail	% Difference
Anemia in pregnancy	Ferrous Sulphate + Folic Acid	2 tabs for 100 days	108	672	522
Malaria [P.Vivax]	Chloroquinine [Above 15 years]	3 days	6.2	7.01	13
Fever	Paracetamol 500 mg	1500 mg/ day for 3 days	3.5	12	243
Hypertension	Amlodipine 5 mg	30 days	8.9	66	642

As seen above, the cost difference of a treatment simply based on procuring medicine from CDMU can range from 13 percent to as high as 642 percent. For a household below poverty line, this could translate to a huge savings and move towards poverty alleviation. If we consider malaria, where the savings is least, for a household a 13 rupees savings for every 100 rupees spent on treatment could mean a meal for themselves. At the health centre level the savings from every 6 patients treated for malaria would provide fund for treating the seventh patient. Below is a diagrammatic representation of the cost difference.



In conclusion, it can be reiterated that MDG has been a perfect vision document for the world in overall development. It provides a common platform for all and aims to bring a global parity at grass root level. Since health is a basic requirement for any form of progress in the world, it is essential to ensure its access to all. CDMU in its own way has been ensuring the same and is playing a vital role in achieving some of the key targets of MDG.

CDMU News

Quality of drugs is a matter of global concern. This issue is even more important in a developing country like India where the problem of substandard and spurious drugs is rampant. CDMU and its member partners are justifiably anxious about the quality of the products being procured, stored and distributed by CDMU. As per this SOP, in addition to rigorous pre-qualification of suppliers, we now stress on quality control tests of selected batches at the government approved laboratory in Kolkata. The list of the medicines tested in 2012-13 are as follows:

Sl no	Name of the medicines	Batch no	Manufacturer	Status
	Pantoprazole 40 mg Tab	12A366	Astam Health Care Pvt Ltd	Passed
	Amoxicillin 250 mg Cap	OC3B02V	Ankur Drugs & Pharma Ltd	Passed
	Paracetamol 500 mg Tab	TAH13145	Pro Laboratories P Ltd	Passed
	Paracetamol 500 mg Tab	TAF121321	Pro Laboratories P Ltd	Passed
	Diclofenac Sodium 50 mg Tab	TAF13286	Pro Laboratories P Ltd	Passed
	Losartan Potassium 50 mg Tab	CK2G07G	Helios Pharmaceuticals P Ltd	Passed
	Ciprofloxacin 500 mg Tab	503	Syncom Health Care Ltd	Passed
	Levocetrizine 5 mg Tab	ARKN2124	Kanha Biogenetic Laboratories Ltd	Passed
	Alprazolam 0.25 mg Tab	C13L347	Stadmed Pvt Ltd	Passed
	Ibuprofen 400 mg Tab	DG2402	Cipla Ltd	Passed
	Paracetamol 650 mg Tab	AFD2006	Caretech Formulations P Ltd	Passed
	Amoxicillin & Potassium Clavulanate 625 mg Tab	12A357	Astom Health Care Pvt Ltd	Passed
	Norfloxacin 400 mg Tab	INF1218	Ridley Life Sciences Pvt Ltd	Passed
	Gabapentin 100 mg tab	375S12C01	Shine Pharmaceuticals Ltd	Passed
	Mebendazole 100 mg Tab	1201	Anil Health Care	Passed
	Amoxicillin 500 mg Tab	3072016	Innova CapTab	Passed
	Omeprazole 20 mg Cap	CAF 12372	Pro Laboratories P Ltd	Passed
	ORS	Z-12275	Zurich Health Care	Passed
	Paracetamol Syr	SK2832	Skymap Pharmaceuticals	Passed
	Ambroxol Guaphenesin Syr	SR2030	Saar Biotech	Passed
	Azithromycin 100 mg Syr	SK2896	Skymap Pharmaceuticals	Passed
	Cefixime Susp	AP2086	Alffy Parenterals	Passed

What is CDMU?

- **CDMU is a non-profit organization**
- **CDMU's aim is ensuring rational use of medicine**
- **CDMU ensure quality generic medicine at affordable price**

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