AccessNews

CAMPAIGN FOR ACCESS TO ESSENTIAL MEDICINES

MEDECINS SANS FRONTIERES

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The MSF Access Campaign is rooted in the frustration experienced by our medical teams who find that too often, they are unable to meet the needs of those in their care because, among other factors, of the lack of affordable and adapted treatments, vaccines and diagnostics.

This edition is aimed at giving some idea of the range of activities in which we are involved and offering you some ideas on how you too can participate in the Campaign for Access to Essential Medicines.

Never a Greater Need

Nathan Ford, Head of Medical Unit, MSF South Africa

When I first joined MSF ten years ago, I attended the International AIDS Conference in Geneva. Together with an MSF field doctor from Thailand, I spent most of my time at the conference trying to put pressure on the pharmaceutical company, Pfizer. We wanted the company to reduce the price of fluconazole, an antifungal drug needed to treat cryptococcal meningitis, an opportunistic infection responsible for a third of AIDS-related deaths in Thailand.

At the time, antiretroviral treatment cost over US$ 10 000 per patient per year. All we were hoping to achieve at that point was for just a few dollars off the price of fluconazole, which at the time cost US$ 14 per day, almost four times the average daily wage of an office worker in Thailand.

Pfizer responded with belligerence; journalists ignored our press statement; the MSF doctor went back to Thailand without making a dent in the cost of treatment. And patients continued to die of cryptococcal meningitis.

But in less than a year, everything changed.

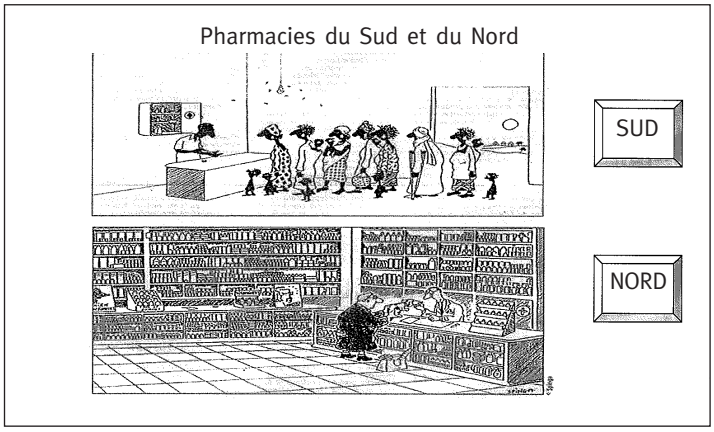
The crisis in access to medicines made international headlines during a World Trade Organization summit in Seattle, where the high price of AIDS drugs became a banner of the world's inequities: on one side of the globe, Western multinationals made billions of dollars; on the other, millions of people suffered and died of treatable infectious diseases.

Civil society groups across the world that had for years been working in impotent isolation joined together in an international campaign that linked civil society groups in Thailand, India, South Africa and Brazil with AIDS activists from 'ACT UP' and Health GAP, consumer groups such as Consumer Project on Technology (now called Knowledge Ecology International), and international agencies like Oxfam and MSF. Their activism was reinforced by the work of patent lawyers, doctors, health economists and pharmacists who together provided rigorous evidence to inform policy.

Several significant price reductions followed as generic manufacturers in Thailand and India vied to bring down the cost of drugs against the originator prices. Within months, MSF in South Africa and Thailand began to provide antiretroviral treatment to a handful of patients as the cost of generic ARVs dropped to as little as a dollar a day.

That HIV has been transformed from an untreatable disease to one where universal access to treatment is an attainable goal was largely stimulated by the work of activists. However, there is no time for complacency: past success in reducing drug prices has largely depended on two factors, neither of which are today a given.

First, public pressure has been essential to force company concessions over drug prices and court cases. However, this relies on the glare of media attention, which is both fickle and exhaustible. Second, market competition between different manufacturers has been the main engine driving down drug prices. However, the patent system has tightened its grip over generic manufacturers in the last decade. As I write this from South Africa today, an increasing number of people with HIV/AIDS require access to newer medicines like tenofovir and lopinavir/ritonavir, needed to overcome serious side-effects of older drugs such as d4T and drug resistance. But because of the high cost of these newer drugs, patients are condemned to taking medicines that for reasons of safety and efficacy have long been abandoned in wealthier countries.



Activists cannot be expected to continue to fight on a 'drug per drug, country per country' basis every time an important new medicine comes to market. Systematic changes are therefore

Continued on page 8

Contents

Rumblings of a Revolution – Finally?

In November 2007, the first ever street demonstration by activists demanding better treatment for tuberculosis (TB) took place in Cape Town, South Africa. The rally gave observers some hope that finally a genuine popular movement was forming that would fight for the rights of people with TB. Although the World Health Organisation (WHO) and other international bodies have been sounding the alert for some time now on the resurgence of TB around the world, until recently there's been no corresponding mobilisation in the communities most affected. Gregg Gonsalves, a seasoned AIDS activist, argues that to bring about lasting change you need to work both inside the system and out...

Photo © Lori Waselchuk

In 2001, a concerted campaign by activists around the world was instrumental in forcing 39 of the world's largest pharmaceutical companies to drop a court case against the South African government which was trying to pass a law to increase the availability of affordable medicines.

Close to thirty years of AIDS activism have shown that an "inside-outside" strategy is best for effecting change. From the beginning of the epidemic, it was the presence of community experts, whether professionals or self-taught laypersons, who helped lay the foundation for many of the advances we take for granted today, from safer sex and needle exchange, to prophylaxis for pneumocystis carinii pneumonia, from speedy approval through drug regulatory agencies, to basic protections of the civil rights of people living with AIDS.

So many of these great achievements, which came out of communities affected by HIV/AIDS, were also made possible by the willingness of many people to 'act up', to mobilise in the streets in protest. In this way, government and public health leaders had to pay attention – we knew our facts, and we had the evidence to back our arguments, but we also had thousands of people marching with placards, shouting chants, sending letters, making phone calls. This model of AIDS activism, whether employed by gay men in ACT UP in New York City in the 1980s or African women in the Treatment Action Campaign in South Africa more recently, is one that is here to stay.

Over the past few years, AIDS activists have broadened their focus as the movement matures and many realise that HIV isn't the only health issue for communities confronted by the AIDS epidemic.

One of the newest frontiers of AIDS activism has been the fight against TB, which is the leading killer of people living with AIDS, particularly in developing countries. AIDS activists are now bringing a new vitality to advocacy and service provision around TB. Where I have worked in Southern Africa, I see the rumblings of a revolution in how developing countries are going to have to deal with TB. That revolution is starting in one of the most unlikely places: Botswana.

Two years ago, we began working with our partners in Botswana, offering them some training on the science and clinical care of HIV and TB. Knowledge is power and in the case of Botswana it was the spark for a movement to challenge the country's poor TB programme. Using the facts and their knowledge of the science of TB and HIV, activists with the Botswana Treatment Literacy Coalition have gone on national television to talk about TB infection control, have taken their government to court over the deportation of refugees with multidrug-resistant TB, have issued a scathing critique of the entire TB programme at a major national research conference.

This is the new face of TB activism, of people in the developing world, armed with knowledge, taking their case for better TB diagnosis, prevention and treatment to their leaders, both as community experts and in protest when necessary.

It's the old "inside-outside" strategy once again, and it works. What's important to do is to foster this new generation of activists in developing countries to do the work on the ground like my brilliant colleagues in Botswana. Change occurs when people who are most closely affected by a situation take charge of their own destinies and this only happens at a local level, where the stakes are the highest.

While "experts" in meetings in Paris, in Washington DC, or Geneva often make decisions that will affect people's lives, sustainable and real change starts from the bottom up.

Cough Up for TB!

MSF is campaigning to increase both the total amount of global funding devoted to research and development (R&D) into tuberculosis and other neglected diseases and at the same time we are calling for alternative ways to stimulate R&D.

Recently, MSF published two reports revealing the low levels of TB research funding provided by the European Commission (EC) and, separately, Germany.

The EC Report finds that the Commission spent barely 18 million Euros on TB R&D in 2007, when MSF estimates that its fair contribution should stand at around 100 million Euros in order to close the TB R&D funding gap. MSF is also calling on the EC to look at alternative funding mechanisms for R&D: it should, for instance, invest in a prize fund for a rapid, affordable, point-of-care TB test – a reward model which can eliminate the need for high prices to recover research and development costs.

The MSF reports, part of a series looking at European countries' funding for neglected diseases R&D, are available at: **www.msfaccess.org**

Meet the Campaigner: *Boosting TB research funding*

Oliver Moldenhauer: MSF Access Campaign Coordinator in Germany.

"We wanted to grab people's attention about the shockingly low level of funding that Germany gives to TB research. So we staged a 'Die-In' right outside Germany's parliament, the Reichstag, in Berlin. We emailed people on our medical student networks and also created a Facebook event to drum up volunteers for the event. On the day, 'TB patients' queued up to see a 'doctor' with a very old-fashioned microscope, to be 'tested' and 'treated' for TB. Every ten minutes we got someone to fall down 'dead' to represent the huge number of people who die from this curable disease. It was a tough time to try to create waves right in the middle of the financial crisis but I think we got the message out. The politicians have promised to increase spending by 6 million Euros next year. Now we just have to make sure they deliver on their promises – we'll be snapping at their heels!"

Photo © Barbara Sigge

Students Ring the Changes

Universities and other academic institutions have historically played a central role in the basic scientific discoveries that have led to the development of new drugs, diagnostics and vaccines. Often pharmaceutical companies make use of this research in order to develop new drugs. But who actually has the right to benefit from these innovations? Is it only the pharmaceutical companies or can universities play a central role in trying to assure better access to medicines for those most in need – patients in poor countries?

Universities Alliance for Essential Medicines (UAEM) was set up by students in 2002 and now has over 50 chapters in the US, Canada and Europe. Rachel Kiddell-Monroe, Chair of the Board of UAEM explains how it all began and what it has achieved so far.

How did UAEM start?

It all started at Yale University in 2000 with the drug stavudine – an antiretroviral used in the treatment of HIV – which MSF wanted to use for its projects in South Africa. The drug had been developed by a scientist at Yale and the university had licenced it out to the drug company Bristol-Myers Squibb. MSF had approached both Yale and the company but had been unable to convince them to make the drug available. MSF then took the unprecedented step of contacting some students at Yale and asking them to take on the issue. The students launched a fearsome campaign at the university and managed to persuade Yale and Bristol-Myers Squibb to export the drug at much lower prices – almost 95% lower. That success inspired students elsewhere in the US and UAEM was set up two years later. Now over 50 universities are involved.

UAEM student members campaigning at Yale University in 2007.

What are UAEM's main achievements?

Getting across the message that it's not just about money – it's what you do with the results of your research. We have put together a document containing UAEM's principles – the Philadelphia Consensus Statement. This states universities should ensure that medicines that come out from their campuses can be made available for developing countries, and that they should prioritise research into neglected diseases. Thousands of people have signed this statement supporting its aims. It is also a useful starting point for students to begin negotiating about these issues with their university policy makers.

How enthusiastic have university authorities been to adopt UAEM principles?

Three universities in the US and Canada have taken the significant step of integrating UAEM's core principles into their university constitution and numerous other universities are now considering how to better integrate these principles into their work. Practically speaking, those universities that have 'signed up' still grant exclusive licences to pharmaceutical companies on their discoveries, but written into these licences is the requirement that any drug and medical technology relevant to developing countries is made accessible to them. For example, currently the University of British Columbia is making sure that a drug they have developed for leishmaniasis is available to developing countries.

***Get in touch with UAEM** – Contact student volunteer coordinators Gloria Tavera on grtavera@ufl.edu and Taylor Gilliland on ctgilliland@gmail.com*

The Battle for Lopinavir/Ritonavir

What is heat-stable lopinavir/ritonavir?

Lopinavir/ritonavir (LPV/r) belongs to the class of antiretroviral drugs called protease inhibitors. In 2006 the drug was included by World Health Organization (WHO) in its guidelines for second-line AIDS treatment. The US company, Abbott Laboratories, brought out a new formulation of this drug in 2005 – heat-stable lopinavir/ritonavir – marketed under the tradename of Kaletra/Aluvia and sold in the United States for US$ 10 000 per patient per year. This formulation is a great improvement on the older version because, among other benefits, it doesn't require refrigeration – a critical factor for many patients in developing countries who can't afford a fridge. Without refrigeration, the older version of the drug deteriorates in high temperatures into a gluey mess.

Photo © AIDS

Waiting for the Iceman Somying lives in the slums of Bangkok with her ten year old son Amcorn, and daughter Kaew, aged 13. Both mother and son are infected with HIV. Each day Somying is forced to buy ice to prevent her antiretroviral medicines from spoiling in the stifling heat because she can't afford a fridge. The ice costs her a quarter of her monthly budget.

Beginning 2006: Price of Abbott's new formulation of LPV/r in middle-income countries at US$ 2 967 per patient per year.

March 2006: Abbott announces a price of US$ 500 per patient per year for patients in least-developed countries and Africa. No prices announced for some low- and all middle-income countries. Nor is the drug registered anywhere else in the developing world apart from South Africa, meaning that the offer is in reality unavailable.

March 2006: Ordering Change MSF launches international campaign and puts in an order to Abbott for the new formulation of LPV/r for 400 of its own patients in nine countries – including Thailand. This order is used as a springboard to launch an international campaign with press launches in New York, Berlin and Lagos. Abbott at first does not confirm the order and then stalls, putting administrative and logistical obstacles in the path of the procurement process. MSF keeps the pressure up and the drugs are finally delivered in July 2006 but only to MSF projects in Africa. Abbott refuses to deliver drugs for use in Thailand or Guatemala as these are 'middle-income' countries.

April 2006: Dear Mr White... MSF publishes an open letter to the CEO of Abbott Laboratories signed by physicians, HIV/AIDS researchers and clinicians, investor groups, treatment advocates, and policy-makers from around 25 countries. The letter calls on Abbott to stop dragging its heels and push ahead with registering the new version of the drug in developing countries. The signatories also call for the drug to be made affordable in middle-income countries.

7 August 2006: Abbott announces a price of US$ 2 200 per patient per year for low- and middle-income countries including Thailand. This price is still nearly sixteen times the cost of first-line antiretroviral therapy which at this date cost US$ 140.

January 2007: Thailand issues compulsory licence. After futile negotiations with Abbott, the Thai government begins the process of issuing a compulsory licence on lopinavir/ritonavir and another drug used to treat heart disease. This mechanism, built into international trade law, allows governments to set aside a patent, in exchange for the payment of a royalty to the originator company, and authorises the generic production of a drug by others. Although entirely legal, most developing countries have shied away from this procedure because of the repercussions from powerful trade interests. Thailand was no exception to these pressures but held firm.

9 March 2007: Abbott hits back and provokes universal outrage. In a retaliatory move, Abbott says it won't register any further new drugs in Thailand including the new heat-stable version of LPV/r until the compulsory licences are dropped. MSF and other health activists denounce the company for holding HIV patients hostage. MSF calls for WHO and UNAIDS to support Thailand and other developing countries vocally in their use of compulsory licencing to increase access to medicines.

Photo © Paiilttra Katanyuta (Amena)

> ***"Our patients in Thailand, who still use the old version of the medicine, have been waiting for this new version for a very long time. Refusing to sell the drug here is a major betrayal of patients."***
> Dr. David Wilson, MSF Thailand

26 April 2007: Global Action Day against Abbott marked by international demonstrations.

> ***"Thailand's move to issue compulsory licences is an important way to help bring prices down and increase availability of medicines. In light of this, Abbott's move is appalling."*** Ellen 't Hoen, Policy Director, MSF Access Campaign

April 2007: Abbott announces price drop to US$ 1 000 per patient per year in low- and middle-income countries. But Thailand is specifically excluded. Later Abbott offers the drug at the same price to Thailand on condition the compulsory licence is dropped. Thailand refuses.

US$ 2 967

US$ 2 200

US$ 1 000

In 2006 MSF launched a campaign alongside other activists to get hold of a new drug for HIV patients. This is the story.

Thailand's urgent need for lopinavir/ritonavir

The cost of the new formulation in Thailand at the start of 2006 was US$ 2 967 per patient per year. The Thai government is committed to universal access to AIDS treatment but at these prices, such a goal looked unattainable and with a national average annual wage of US$ 1 600, private access would be restricted to the wealthy. Abbott offered a lower price of US$ 500 per patient per year but only for patients in the poorest countries - mainly in Africa. Middle-income countries such as Thailand, Brazil, Guatemala and others, did not receive the discount though many patients were in need.

> ***"It boils down to the fact that we still have two classes of patients; one in the rich world to whom a whole range of treatments is available, another in the poor world where even first-line treatment is hard to get. We will sit down and discuss this with Abbott, or if necessary we'll fight them on it, and in the end we will get these drugs to our patients, because for them it's a matter of life or death"***
>
> Tobias Luppe, Campaigner, MSF Access Campaign

May 2007: Generic production steps in to bring prices down. Generic companies in India, where Abbott's product is not patented, agree with the Clinton Foundation to produce generic versions of the new formulation at a cost of US$ 695 per patient per year. That figure drops as companies vie to better both the originator offer and that of other generic competitors.

By 2008, MSF is using a generic version of this drug at a cost of US$ 574.

Some countries are able to purchase the product through the Clinton Foundation at US$ 550.

US$ 574

US$ 550

13 August 2008: Taking the battle on... Colombian activists at the Mexico AIDS conference hold demonstrations demanding that their government follow the example of Thailand and issue a compulsory licence for LPV/r. The public sector cost of this drug in Colombia is US$ 1 683 per patient per year and jumps to US$ 4 449 for the private sector.

Photo © Janice Lee

The Outcome: Success... for now

There is no happily ever after in this story: Abbott's price at US$ 1 000 per patient per year is still too high for most patients in all middle-income countries and those low-income countries excluded by Abbott from the company's lowest price offer of US$ 500.

Even at the lowest price available – in the poorest countries – the US$ 500 price tag still puts the drug out of reach for many. Thailand now sources a generic version of the drug from India for its HIV treatment programmes as does MSF. However, if Abbott is granted a patent on this drug in India, the opportunities for affordable generic production from India will be shut down.

> ***"If the big pharmaceutical companies get their way, they will block every avenue that allows generic companies to produce quality generic drugs for the developing world, and then where is MSF going to source its drugs from? So it's critical for MSF but also for governments in countries where we work to also be able to take their responsibilities and treat their own people."***
>
> Paul Cawthorne, MSF Access Campaign, Thailand

Meet the Lawyer:
Safeguarding India's role as pharmacy to the developing world

Leena Menghaney, MSF Access Campaign, India.

The patent status of drugs in India, where a vast number of generic medicines are produced, can be critical in determining whether they are available elsewhere in the world or not. A lawyer by training, Leena worked on the campaign to ensure that India's new patent law included public health safeguards to limit the impact of patents on access to affordable medicines. She then fought alongside local activists to defend these safeguards, when the drug company Novartis sought to have them overturned. She continues to fight for access to a number of Indian generic medicines.

Photo © Delhi Network of Positive People

"I think the biggest challenge in our work is to demystify how patent monopolies work. I think often people don't understand why a drug is expensive. They just assume that the drug costs a lot to manufacture. Whereas in fact it is the monopoly protection afforded to companies by patents that allows them to get away with charging very high prices. Getting this across to people and policiticans to mobilise them takes a huge effort. We were successful finally because we worked in partnership and coalition with the very strong and influential activist groups here. I think MSF can bring a lot of international attention to some of these issues at a global level, which make governments rethink what they're really doing. You need a democratic process and pressure from civil society to make governments accountable but if the world doesn't pay attention, governments can get away with murder."

Scientists Unite Online to Find Solutions

Working for the 'cause' can take many forms. Dr. Zakir Thomas and his colleagues at the Open Source Drug Discovery Foundation (OSDD) in Delhi believe there's a moral responsibility to provide affordable healthcare to the developing world. They're putting their beliefs into practice with the creation of an online global platform where scientific expertise can be exchanged with the aim of discovering novel therapies for neglected diseases.

What was the idea behind the OSDD project?
The pharmaceutical industry has ignored many neglected diseases because they don't expect to be able to recoup the research and development costs through selling their product in developing countries. So it has been the responsibility of the scientific community working in publicly-funded institutions to find cures for these diseases. In India alone, someone dies every 90 seconds of tuberculosis and that's why it's important for an Indian institution to look at these issues of public health seriously. We want to open up the 'closed doors' of research that takes place inside pharmaceutical companies. Because of traditional confidentiality and intellectual property requirements, the research findings – successes and failures – are not available to be shared among scientists which can mean we end up constantly reinventing the wheel.

So how does the project work?
Essentially we are working in the field of bioinformatics – that is the application of information technology to the field of molecular biology. Basically we use mathematics and computer science to understand biological processes – in the first instance relating to the TB bug, mycobacterium tuberculosis. We have a portal www.osdd.net where researchers can upload their information and work and share information on molecular research with other people in the field. The website also contains the largest collection of information relating to mycobacterium tuberculosis and computational resources for drug discovery. Thus scientists and researchers all over the world can, if you like, carry out experiments to test their findings online. Here in India we have an entire team working to facilitate this process.

It takes about ten years to develop a new drug, how do you hope this initiative will speed up the process?
In the conventional way of doing things it may take ten years but if one problem is looked at by many people, in many different ways, it is more likely that we'll succeed in getting a breakthrough. As the mantra in the software world goes 'with many eyeballs, all bugs are shallow'. There's clearly an appetite out there for this kind of collaboration. Since the site was launched in September 2008, we have about 350 scientists and researchers who have joined – that includes about 80 to 90 international participants from the US, Canada, England and Australia, so there is a clear interest from across the world.

Photo © Donald Weber

How do you ensure that no-one exploits this resource by taking the freely-offered research from the website?
To enter the area of the site where the data is stored, you have to sign an agreement which mandates that whoever joins the site and wants the information and data is bound to contribute any improvement back. You can use the information to commercialise it also – we welcome anyone who is interested taking the information and bringing it out to the people – but if you are making any addition or improvement to the information that is available, you are duty-bound to contribute back.

Do you consider yourself and your colleagues to be 'activists'?
We would like to see ourselves as scientists working to a common cause – we are working to try to solve a problem that has evaded a solution.

Meet the Volunteer: *Raising TB awareness in the community*

Vathiswa Kamkam: Volunteer working with Treatment Action Campaign in Khayelitsha township outside Cape Town in South Africa.

Photo © Pupa Fumba

Vathiswa (on the right) at work with the TB community outreach campaign.

Vathiswa is working alongside MSF and other community groups to raise awareness about TB and get patients to adhere to their treatment.

"We go to each house, sit down with the people and using pamphlets, we educate them on TB; what TB is, what the signs and symptoms are, what people can do when they think they might be ill. We try to work out whether anyone in the house or anyone they know has TB or the symptoms of TB, and then we refer these people to the clinic. Because it's an airborne disease, we need to help people prevent the spread of tuberculosis in the home, but also outside the home, in public spaces. So we've begun working with taxi drivers. Shared taxis are one of the most popular forms of public transport in the area and taxi drivers or passengers don't know who has TB or not inside the taxi. So we're encouraging the taxi drivers to open their windows. MSF has created a sticker that says 'Stop TB – Open the window' and we are trying to encourage taxi drivers to use the stickers and put them in the windows so that people can have something to remind them to open the windows."

One Pill When the Sun Rises and One When It Sets

As the sun rises in Homa Bay, in western Kenya's Nyanza Province, Pamela gets her two-year-old son Pascal dressed and ready for the day. At seven o'clock she sits with her husband Charles and father, mother and son all take their morning dose of antiretroviral drugs. All three are HIV positive and must take a tablet every morning and every evening for the rest of their lives. As soon as he sees the brightly coloured tablet in his father's hand, Pascal reaches for it and puts it in his mouth. With a little water he swallows the pill easily. The whole process takes a couple of minutes. Yet it has not always been this way.

It was only last year that a fixed-dose combination (FDC) antiretroviral – one pill that combines the three different drugs needed to treat HIV/AIDS – for children became available. Pascal has only been taking them for a few months. Prior to that, he had to take up to four or five different syrups containing the drugs he needs every morning and evening. Making sure that happened was no easy task, as Pamela explains: "It was a real struggle getting Pascal to take the syrups every day. He didn't like the taste and sometimes we had to hold him down and force him to take them."

It was also difficult for Pamela, who lives 40 minutes walk from the hospital where MSF runs its HIV clinic, to carry and store all the different bottles of syrups that Pascal needed. The bottles are quite heavy, but rather than take public transport, Pamela still preferred to carry them and walk home after her monthly appointments. In this part of Kenya, the stigma surrounding HIV is still very strong and many patients do not want to do anything that will identify that either themselves or their child is infected with the disease. Others cannot afford the 50 cents needed for the journey. For Pamela, with only one child, the walk carrying the bottles was manageable but for those patients with more than one child, living far from the hospital, it was tough.

Ensuring the right dosages were given was hard as the different syrups come with different size syringes or measuring cups. Half a syringe from one syrup might be equal to 50ml whereas with a different syrup it could be 25ml. "We had many different bottles," explains Pamela, "and for each one we had to give Pascal a different amount. Sometimes I got confused and I'm not sure that I always gave him the right amounts."

Giving children the wrong treatment dosage can have serious repercussions. But as there are still only a very limited number of paediatric fixed-dose combinations available in tablet form, syrups are used by most treatment programmes as they offer more scope to combine different single drug formulations. Yet as Pamela's experience shows, the difficulty in taking these syrups can mean that children do not receive the right dosages and do not take their medication properly.

MSF's experience treating patients with HIV shows that the simpler the treatment, the better the outcomes.

As MSF's medical coordinator, Dr. Helena Huerga, says: "With the paediatric fixed-dose combination, our patients know they have to take one pill when the sun rises and one when it sets. In Homa Bay, where we're treating more than 1 000 children infected with HIV, we've seen the difference this drug has made. If we really want to reduce the number of child deaths caused by HIV/AIDS, existing fixed-dose combination drugs need to be much more widely used and many more easy-to-use drug formulations need to be developed for children."

Photo© Susan Sandars

Of the 22 antiretroviral drugs currently available, eight are not approved for paediatric use and nine are not available in paediatric formulations. There is a clear and urgent need for more research and development of child-friendly antiretroviral drugs. Such research should focus not only on creating the best quality drugs possible, but also on producing drugs that are easy for children to take. MSF's Access Campaign proposed and is backing the creation of a so-called 'patent pool' hosted by UNITAID that it is hoped will accelerate the development of paediatric FDCs for the newer antiretrovirals.

Never a Greater Need

Continued from front cover

needed. There are exciting new initiatives supported by public health activists that could now usher in new ways of funding and conducting research and development for new drugs, diagnostics and vaccines, on a needs-driven and not market-driven agenda.

Critically, these new models aim to decouple the price of the final product from the costs of research and development, making new drugs affordable for those most in need. In May 2008, the World Health Assembly adopted a global strategy to look into various ways this realignment of priorities could be achieved, including ideas such as patent pools and prize funds. These initiatives must be given serious consideration and support.

But as long as life-saving medicines remain out of reach, activists – from the grass roots level up – will have to take to the streets, across the globe and by the thousands. They will need to do so because governments continue to fail to take responsibility for the health of the world's poorest. This being the sad reality, the need for activism is as great as ever.

Meet the Doctor: *Taking action against Chagas disease*

Dr. Tom Ellman: MSF Head of Mission in Bolivia.
"Having worked most of the last eight years on malaria, TB, and HIV care I am now managing MSF's Chagas disease programme in Bolivia. The insights from working on HIV and TB in the past are invaluable – the need for community activism, the concept of treatment preparedness, and development of needs-based research.

Photo © Juan Carlos Tomasi

In Bolivia we are treating both children and adults with the disease in areas where as many as 80% of adults are infected, and working hard to demonstrate how and why prevention and treatment should be rolled out to other areas in need. Through adapting our strategies to the context we work in and to the ubiquitous problems of poverty – lack of health workers, lack of health facilities, lack of free treatment, lack of education – we hope to make a difference on Chagas and hopefully impact on other health problems in Bolivia as well.

As with other diseases of poverty, those affected have little money to buy drugs and therefore there is very little interest from pharmaceutical companies in researching better drugs. It also means that the people with most interest in pushing their governments to do more - those with the disease or at risk of catching it – have the least power to do so.

We need better pin-prick rapid tests for the disease so that we don't have to send blood samples away to a lab for diagnosis. We are supporting the idea of setting up a prize fund to stimulate R&D into better diagnostics. Together with partners, we plan a trial of a new drug to treat our patients - the current treatment relies on two toxic drugs. We're also working to get paediatric formulations developed because at the moment none exist and we have to break adult tablets into approximate sizes to treat children."

Meet the Paediatrician: *Fighting childhood malnutrition*

Dr. Susan Shepherd, Medical Advisor to MSF's Starved for Attention campaign on malnutrition.
"I started working with MSF in field projects in 2003. I stayed in Niger for almost two years – one of the malnutrition hotspots of the world. When I was there, I saw how most of the food aid that is given out doesn't work for young growing children – it's not an appropriate food for malnourished children.

Armed with my field experience, I try to explain to UN agencies and governments and other NGOs why it is so vital that we change the way we think about childhood malnutrition. And we're seeing some promising changes at the international level – the World Food Programme is now developing and distributing other types of food specifically adapted to the nutritional needs of young children.

As part of our malnutrition campaign, 'Starved For Attention', we're working with civil society in India and elsewhere to push governments to respond and adapt their food aid policies, with food producers to come up with specially adapted products to treat childhood malnutrition, and with the big UN agencies and the World Bank to identify funding streams to be able to pay for all of this.

As a general paediatrician by training and as the medical advisor to the campaign, it's my job to take what MSF knows, based on solid evidence, and translate that into what people can understand and then push for necessary policy change. We have the possibility of doing a much better job for these kids."