CAMPAIGN FOR ACCESS TO ESSENTIAL MEDICINES

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How much more for an effective malaria treatment?

Traditional anti-malarials such as chloroquine and sulphadoxine-pyrimethamine (SP, also known by its brand name Fansidar®) had for a while helped slow the spread of malaria. But in the past few years, increasing resistance has rendered these drugs next to useless in many regions.

Imagine if the medicine you were prescribed for a serious and sometimes life-threatening disease was about as effective as a placebo. Imagine newer, more effective medicines existed, but you could not have access to them even though they are routinely prescribed to Western travellers.

This is the reality for many of the 1.8 million people who die from malaria in Africa every year. The reasons for this failure are complex and solutions will require multiple actions from national governments, donor governments and the WHO.

The problem is known

Increased resistance to chloroquine and SP has led experts to recommend changing national treatment protocols to fight *Plasmodium falciparum*, the species responsible for most malaria-related deaths.

Clinical trials have demonstrated the efficacy of using combination treatments, which help protect against development of drug resistance and improve compliance by shortening treatment time. It is widely agreed that the best option for first-line treatment of malaria is a combination using derivatives of artemisinin, a highly potent Chinese plant. To date, no resistance to artemisinin-containing combinations has been reported.

Choosing the lesser evil?

However, despite the evidence in favour of artemisinin derivatives, many governments are changing their malaria treatment protocol from chloroquine to other monotherapies, or to combinations without artemisinin derivatives. For example, the East African Network for Monitoring Antimalarial Treatment (EANMAT) countries have recently switched from chloroquine to SP monotherapy for first-line treatment of malaria.

Considering the high levels of resistance to SP in East Africa (up to 60% or more in Burundi and Uganda), this short-sighted policy is likely to backfire. It will lead to continued increases in morbidity and mortality as well as a rapid rise in resistance to SP.

Ministries of health are aware of the drawbacks of SP monotherapy and are planning to introduce combinations. But they are not planning to use the more effective artemisinin-based drugs – they are simply too expensive for these governments to afford, unless they apply for external funding.

Longer term savings can be achieved by using artemisinin combinations

Every year, malaria infects 500 million people worldwide and kills two million people. 1.8 million of these victims are Africans, mostly children living in rural areas.

Rwanda has 1.2 million cases of malaria every year and is about to change its national treatment protocol. It has been estimated that it would cost the country an extra US$945,000 to introduce artemisinin-containing combinations rather than a less effective combination. For Burundi, with 2 million cases of malaria a year, the switch would cost an extra US$1.6 million.

MSF believes that the only way to prevent the widespread use of sub-optimal, ineffective treatment and further malaria epidemics is to find resources to fund the use of more effective drugs. The increase in cost today will be repaid in years to come by saved lives, increased productivity, decreased burden on health services and the avoided expense of ineffective treatment.

Malaria is one of three priority diseases that the international community has committed to fight. UN secretary general Kofi Annan has estimated US$8 billion a year will be needed for the Global Fund, but so far only US$1.9 billion has been pledged and even this amount is to be spread over a three year period. Providing the cash to change national malaria treatment protocols in East Africa in a sustainable manner is a worthwhile investment and a pragmatic step forward in combating one of the leading killers in Africa today. Whether this is accomplished through bilateral aid or through the Global Fund is not important. What does matter is taking action to avoid the needless deaths that will be caused by using treatment that no longer works.

By Laura Hakoköngäs and Ingrid Cox

The EANMAT countries – Kenya, Rwanda, Tanzania and Uganda - and Burundi are meeting in Nairobi on 11-13 February 2002. Changing national malaria treatment protocols is on the agenda.

"As doctors, we want to use effective treatments. We cannot continue prescribing a first-line malaria treatment – such as Fansidar – which we know is not going to cure the patient. It is inconceivable to us that our teams should not be able to use artemisinin-based combination therapies, which we know will work."
Christophe Fournier, Programme Director for Burundi, MSF Paris

Children queue for consultation at the mobile malaria clinic in Kayanza, Burundi

SUMMARY

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MSF in Burundi – thrown out for flouting ineffective treatment protocol

In October 2000, Burundi was devastated by a malaria epidemic worse than it had ever seen: almost 3 million people were infected within a six month period and thousands died. MSF, which has a long history of working in Burundi, immediately set up an emergency response to deal with the outbreak. But the toughest battle was not conducted against malaria itself: MSF staff spent months arguing the nature of the treatment protocol with national authorities.

When the epidemic started in October 2000, Burundi's national protocol recommended chloroquine for first-line malaria treatment, and Fansidar® (generic name sulphadoxine-pyrimethamine) for second-line treatment. From the start, the MSF team on the ground suspected that chloroquine would be ineffective, given the high levels of resistance already recorded in the region. The team suggested using a combination based on artesunate, a faster-acting more potent drug, but were refused by national authorities. All the same, they began treating children with an artesunate combination at the nutritional centre in Ngozi, with the tacit understanding of regional authorities.

In an effort to better understand the dynamics of malaria in Burundi, the government carried out resistance testing in early 2001 and organised a consensus meeting with WHO and other partners to discuss the results. The studies conducted by MSF were excluded because the government claimed that they had not followed the official protocol. But they may have been excluded because the results were particularly telling: in the province of Kayanza, for instance, resistance to chloroquine was 100%, resistance to Fansidar® 74%, and resistance to a combination of both drugs, 57%. Although all studies showed resistance levels higher than 25% – the level at which WHO recommends a switch in first-line treatment – the Ministry of Health decided to adopt a "transition" protocol with Fansidar® as first-line treatment, quinine as second-line, and Coartem® (a fixed dose combination of artemether and lumefantrine) in case of epidemic only.

MSF, once again, protested against this decision and increased the pressure on the Ministry by announcing it was introducing artemisinin drugs into all its programmes in Burundi. Colette Gadenne, head of the MSF mission, publicly challenged the Minister of Health on his refusal to authorise the organisation's use of artemisinin

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Doha: a breakthrough for public health?

"We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitments to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all."

The adoption of the declaration on TRIPS and Public Health at the 4th WTO Ministerial Conference in Doha represents a real breakthrough in international discussions on TRIPS and access to medicines. The declaration clearly acknowledges the right of countries to take measures to protect public health, and offers a road map to the TRIPS Agreement's key measures and flexibilities that can be used to overcome intellectual property barriers to access to medicines.

Compulsory licensing allows public authorities to grant licenses to a third party to produce a patented drug without the consent of the patent holder. The Declaration has now made it unambiguously clear that the use of compulsory licenses is in no way confined to cases of emergency and that the grounds for issuing a compulsory license are unlimited.

Regarding the authorisation of parallel importation – which allows a country which provides pharmaceutical patents can produce generics for export to a country that has issued a compulsory license but does not itself have manufacturing capacity. The TRIPS Agreement currently limits the use of compulsory licences "predominantly for the supply of the domestic market". Further clarification is therefore necessary to ensure that countries with no manufacturing capacity can make use of compulsory licensing provisions in the same way as countries with manufacturing capacity, and that manufacturing countries are able to produce and export the drugs needed even if they are under patent. The Doha declaration acknowledges the problem and "instruct[s] the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002."

Other issues to tackle include allowing production for export from countries that provide pharmaceutical patents to countries that do not (and therefore do not grant compulsory licenses). Least developed WTO Members can now delay the granting of pharmaceutical product patents until 2016 – but their access to sources of affordable medicines may dry up when producer countries such as India reach their 2005 deadline for TRIPS implementation.

The Declaration gives a strong political message but it will become a useless piece of paper if countries do not enact and implement pro public health intellectual property rights legislation and start using the TRIPS provisions to encourage the availability of more affordable medicines. The World Intellectual Property Organisation (WIPO) could help by adapting its technical advice to countries to give legislative hand and feet to the Doha Declaration on TRIPS and Public Health at the national level. The World Health Organisation also has an important role to play in helping countries to exercise their rights. MSF has recommended that WHO take the initiative to develop sample laws based on the Doha Declaration.

During the Doha process, developing countries and NGOs highlighted the commercial and public sector neglect of R&D directed at addressing the health needs of developing countries. Is the present system for funding R&D the most efficient, and is it sufficient to fuel innovation? In the area of neglected diseases, the answer is clearly no. A major challenge in the years to come will be to find ways to encourage health R&D that will benefit people in developing as well as developed countries.

By Ellen 't Hoen

What now?

A key issue that remained unresolved in Doha is how to ensure that a country which provides pharmaceutical pat-

It is not possible to fully predict how the Doha Declaration on TRIPS and Public Health will be used in practice, but commentators have indicated the following:

- ***The Declaration will play a role in dispute settlement procedures on TRIPS and public health related issues before the WTO. The panels and the appellate body will need to take the interpretation given in the Declaration into account.***
- ***At a national level, the Declaration will guide governments in implementing legislation that allows them to address health needs.***
- ***The Declaration can be used as a checklist in bilateral agreements which include provisions on intellectual property rights.***
- ***The Declaration should give WTO Members the confidence to make full use of safeguards, including compulsory licensing, to increase the availability of affordable medicines and increase generic competition.***

Long distance diagnosis

On the difficulties of diagnosing MDR-TB in former Soviet countries

Every year, around 8 million people are infected with tuberculosis (TB) worldwide and 3 million die of the disease. Resistance to available anti-TB drugs is increasing and is already alarmingly high in many areas of the world. TB is considered to be multidrug-resistant when it is resistant to at least the two most effective drugs, isoniazid and rifampicin.

Resistance is diagnosed using drug sensitivity testing (DST), a long and complicated process. A sputum sample is taken from the patient with TB and cultured, then tested with different drugs in various concentrations. Results are obtained two to three months later.

TB treatment using "Directly Observed Treatment Short Course" (DOTS) is effective and relatively cheap, but it is still long and labour-intensive: a combination of drugs is taken over 6-8 months, and health workers administer them individually to each patient. This is a heavy burden for already overstretched health services, and the cost of implementation is often beyond the means of poor countries.

Maryline Bonnet is a regional TB advisor for Former Soviet Countries for MSF. She has been working for 2 years on TB projects in Kazakhstan, Southern Caucasus, Siberia and the Aral Sea Area.

How many of your patients have multidrug-resistant TB (MDR-TB)?

In our DOTS projects in the Former Soviet Countries, we realised a while back that between 10 and 20% of our patients didn't respond to treatment, so we conducted drug sensitivity surveys. Our results showed varying rates of resistance: in North Karabagh, none of the new cases and 10% of the previously treated cases had MDR-TB. In the Kemerovo region prisons, the rates were much worse: 21% among new cases and 38% among previously treated cases.

How do you treat patients with MDR-TB?

Treating MDR-TB takes 2 years using expensive second line drugs. It's essential to have adequate treatment with first-line drugs already in place, otherwise resistance to second-line drugs can emerge. Duration of treatment and side-effects increase the risk of treatment interruption, so we have to use inclusion criteria to select patients – for instance the patient's history of adherence to treatment and presence of co-disease.

In the programmes where we don't have second-line drugs, we monitor the MDR-TB patients and show their families how to protect themselves. It's very hard for all concerned, because many patients don't get better and die of their TB.

What kind of laboratory facilities do you have for diagnosis and drug susceptibility testing?

In Abkhazia, we send samples to a supranational reference lab in Rome. In Nagorno Karabagh, they are sent to a lab in Antwerp and in the Aral Sea Area, to a German lab.

It sounds like you always send samples to laboratories abroad – are there no lab facilities in the countries you work in?

Our TB project in the Koromovo prison in Siberia is the only one that has a bacteriological lab which can conduct drug sensitivity testing on site. Ideally, we really should have access to a lab nearby. But in Abkhazia and Karabagh, our programmes are small and run in unstable areas where it's impossible to set up a lab. So we continue to send samples to a supranational lab.

How many supranational labs are there in the world? What difficulties do you encounter using them?

I know of 23 laboratories in the supranational reference network, mostly in rich countries. There is still no supranational laboratory in Russia, despite its very high TB burden.

It took MSF Holland a whole year to find a lab that would accept samples for a resistance surveillance study. They asked the New Delhi lab first, because it was closest, but they refused. Then Bangkok refused, and the English lab asked for an expensive fee for each sample. Finally the German lab accepted to take them.

What big challenges will your projects face in the years to come?

Our biggest problem is improving adherence to treatment – the shortest treatment courses are still six months, which is enormously long. We have to find ways of making observed treatment easier – we're trying to offer patients more support and involve the community.

Another challenge is to get easier and cheaper access to the supranational labs. A lab in Moscow should be receiving the supranational title soon and another one in Almaty should become a referential lab for Central Asia – so things are moving in the right direction.

But this won't be sufficient – we need new drugs for TB. Reducing the duration of treatment to a few weeks would really help us make progress against this disease. At the very least we should develop drugs that are easier to use, such as blister packs for example. There is also an urgent need to develop drug sensitivity tests that are cheaper and faster. The rapid method that exists today is too expensive and difficult to implement in field conditions.

Interview by Ingrid Cox

Life with Chagas

American trypanosomiasis, also known as Chagas Disease, is endemic in all 17 Central and South American countries but is poorly known outside Latin America. The disease was named after the Brazilian doctor Carlos Chagas who first described its symptoms almost a hundred years ago. From Mexico to Chile, an estimated 18 million people are currently infected and a quarter of the Latin American population is threatened by the disease.

What is Chagas Disease?

Transmission

Chagas is a parasitic disease caused by a protozoan parasite (Trypanosoma cruzi) found in Latin America. The parasite is transmitted to mammals, including humans, through the bite of an insect. Houses made of straw and mud in the poor regions of Latin America provide an ideal breeding ground for the vectors, the insects that carry the disease. The bugs and their eggs are seldom visible and therefore hard to detect or eradicate. The disease can also be transmitted by blood transfusions, and women may pass it on to their babies during pregnancy. Infected people can spread the disease further by acting as human reservoirs as they migrate into previously unaffected regions.

Symptoms and progression

The bite of the insect carrying the disease is barely detectable. During the early stage of the disease, the parasites multiply in a person's blood – in most cases, this causes no noticeable symptoms, so people can carry the disease for years without being aware of it or being diagnosed. As the disease progresses to the chronic phase, irreversible symptoms such as heart failure or dysfunction of the oesophagus and the colon may appear.


© Serge Sibert

The insects that carry the disease are eradicated with the help of insecticides, fumigation and housing renovation campaigns. Although these measures have decreased the incidence of Chagas by 72% in some South American countries in recent years, more investments are needed to vitalise research and development into finding new cures for the millions of people already infected.


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The disease-spreading bugs, called "chinche" in Honduras, live in the walls of mud-and-straw houses. In their previous house, Julia and her two children were constantly pestered by the bugs during the night, to the point where they could no longer sleep – the insects would drop on them from the ceiling and through the cracks in the walls. The children will be tested for Chagas and treated, but no effective treatment exists for infected adults.

The access problem

Because the early stage of Chagas disease is in most cases asymptomatic, it is usually not detected. By the time an adult patient has developed chronic Chagas, treatment with current drugs is only effective in about 50% of cases. Children – who in most cases haven't yet reached the advanced, chronic stage of the disease – benefit the most from the existing medicines, nifurtimox and benznidazole. Meanwhile, millions of adults are left untreated, while the disease slowly but inexorably deteriorates their quality of life.

Chagas is an example of a neglected disease, a term referring to an affliction which affects large numbers of people who have little or no purchasing power.

The drug industry, driven by considerations of profitability, is not interested in developing medicines to treat these diseases. In a 2001 survey of the top pharmaceutical companies, only one out of eleven was developing a drug against Chagas Disease. Not one has brought a Chagas drug to market in the past five years. Unfortunately, governments are also not directing research and development based on real public health needs.

"Es triste vivir con Chagas," (life with Chagas is sad) sighs Juana Francisca, who has endured life with the disease for twenty years. Every day she has palpitations, headaches, dizzy spells, pains in her arms, poor circulation and breathlessness. At night she sleeps sitting up – she says her heart works better in that position – but she only catches a few hours. Her husband, a farm labourer, uses half his wages to pay for the drugs she needs to fight the disease. A little further up the street, Juana's nephew, Agustin, also lives with the parasite in his blood and a sluggish heart. His sons have had to replace him in the fields.

With the backing of the World Health Organization, all Latin American states have decided to try and block the transmission of Chagas disease by focusing mainly on eradicating the insect vector of the parasite. As a result of fumigation and housing-renovation campaigns, the incidence of the disease has fallen by 72% in several South American countries. Vector control programmes are essential to keep epidemics at bay, but they are not an adequate response to the medical and socio-economic crisis which Chagas causes in many Latin American countries. The millions of people infected ten or twenty years ago, the adults who go untested for want of a suitable drug, and all those who have reached or will reach the chronic phase of the disease are left to suffer and die in neglect.

MSF, which treats Chagas in the mountainous regions of Francisco Morazan and Yoro in Honduras, advocates for research and development into early diagnostic methods and new, less toxic and more potent drugs to treat adults and children alike.

By Laurence Binet and Laura Hakokõngäs


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A simple blood test is sufficient to detect the parasite which causes Chagas disease. MSF has set up a test centre at a village school in the isolated mountain region of Francisco Morazan, Honduras.

TRAPPED in the Access crisis: Mobile MSF exhibition

What if your doctor told you that you were suffering from a life-threatening disease but couldn't be treated because the necessary drug costs ten times your monthly salary? What if you were told to go home to die, that no-one is doing research into the disease which is killing you and thousands of people like you, because you aren't a "market worth investing in"?

These are the kinds of questions MSF invites the public to explore from a personal point of view in "TRAPPED: Neglected Diseases, Forgotten Lives", a mobile exhibition, which will be touring Europe and North America during 2002. Visitors start at the "wheel of misfortune" where they are assigned, by chance or circumstance, the role of a person carrying one of five diseases. Following a colour-coded path through the exhibition, and with the help of photos, texts and face-to-face contact with MSF volunteers, the visitors discover more about the disease they "carry", the lack of research into diseases affecting the poor, the unaffordability of HIV/AIDS treatment and other life-saving medicines, and what can be done to solve the crisis.

See www.accessmed-msf.org or the websites of MSF's sections for more details about the exhibits, their tour schedule and satellite events near you.

Photo exhibition:
Too poor to be treated

MSF has produced a new photo exhibition to raise awareness about neglected diseases, the people suffering from them, and the lack of access to medicines to treat them. The 75 colour photos take us through the everyday lives of people who are exposed to or suffering from five different deadly diseases on three continents. We learn about the lack of effective or affordable treatments and diagnostic methods, and the campaign MSF is conducting to overcome these barriers. The exhibit will be produced in different languages and displayed in several European countries during 2002 and beyond.

The Honduran photos and the one on p.2 are part of the exhibition, which was created by Serge Sibert (photos) and Laurence Binet (text).

Portrait

Living with HIV: an MSF counsellor speaks out

Patricia Asero (left) became a counsellor to help others who have been diagnosed HIV positive, "so that they would not go through the same trauma I suffered in my first year".

"You can't be HIV positive, you look so normal", a close friend told Patricia when she was diagnosed with the virus in 1990. She was 22. Patricia, a counsellor working with Médecins Sans Frontières, explains that in the early 90's in Kenya, HIV/AIDS conjured images of skeletal people and certain death.

Patricia Asero was told that she was HIV positive soon after delivering her second child, Consolata. The hospital had carried out a blood test without asking her for consent and without informing her. Two weeks after the birth of her child, she received a letter asking her to go to the hospital; there, she was informed of her status, and sent home without further explanation or counselling as to how to deal with her new reality. "I can't remember how I managed to cross the road and get myself home that day. I was in total shock. All I could see were images of death and doom," she described. "The year that followed was hell on earth. I stopped eating and neglected my newborn child. I was waiting to die."

A year later, she received another letter from the same hospital. A Belgian doctor referred her to a counsellor. "The counsellor was a nurse who had seen HIV patients mishandled," Patricia recalls. "Counselling changed my life: I realized that all was not lost and that there was life beyond HIV. I learned to accept my situation and was inspired enough to make the decision to help others, so that they would not go through the same trauma I had suffered in that first year."

Patricia trained as a counsellor and began educating people about HIV/AIDS, helping them to improve their own health and learn how to avoid spreading the infection to others. She now works with MSF in the Langata Health Centre in Nairobi, where she counsels several patients every day. She believes that counselling is an essential part of dealing with HIV. "It can save people so much unnecessary anguish if they are advised and informed, and if they have someone to talk to who will not judge or reject them," she says. "I have clients who aren't able to share their status with their spouses, family or friends."

Patricia has always been open about her status, but she says: "I am luckier than many of my clients, I have supportive parents, and until under a year ago, I had a loving husband who shared my life and work." Patricia's husband Simon died of AIDS last November. "He was also an activist. We did everything together, we shared everything," says Patricia. "We set up a small group, and as two people living with HIV, we knew what existed and what the gaps were. We had great plans, we had a vision. He wasn't sick, in fact I was the one who had been poorly all year while he ran around organizing. But then one morning he woke up and felt unwell, and a day later he died in hospital."

In Kenya, the price of a year's course of ARVs has come down over the last year from 720,000 ksh (US$9,600) to approximately 120,000 ksh (US$1,540). At this price and without subsidy, treatment is still out of reach for most people in Kenya.

"I believe that African people should have access to affordable ARVs and other medicines needed to extend their lives. If you provide medication to parents, they will live to look after their children, who will then not end up on the streets, destitute and uneducated. We are talking about looking after our economic future – at the moment, everyone is dying," Patricia explains. "I want to see effective treatment for Kenyans and Africans. We are worth it, we deserve to live as well."

By Malini Morzaria

Meningitis outbreaks:

Challenging the international response

As one of the major users and distributors of vaccines against meningococcal meningitis, MSF is concerned that the existing bivalent (A+C) vaccine stocks will not be adequate to respond to both the 2002 epidemics anticipated in the African "meningitis belt" and the usual volume of cases that are expected in other regions of Africa.

When the number of meningitis cases exceeds five per 100 000 population in one week, MSF teams are on the alert for upcoming epidemics, which are defined as more than a hundred cases per 100 000 population over a year. In recent years, a pandemic has been ravaging Nigeria, Burkina Faso, Sudan and Niger. New waves of epidemics are expected to emerge in 2002, starting from Ethiopia and Benin, where the number of detected cases is already growing.

Currently, mass vaccination of the population is the only way to halt a meningitis epidemic. An international emergency vaccine stock was created by the International Coordinating Group on Vaccine Provision for Epidemic Meningitis Control (ICG) in 1997, after the particularly intense epidemics of 1995 and 1996. This stock now contains 3.3 million doses. Given that in 2000, MSF alone injected 5 million doses of the vaccine, and in 2001, MSF's teams used 3.9 million doses, it is extremely unlikely that the existing ICG stock will be enough to cover all countries and patients in imminent need. Pasteur Aventis has produced 50 million doses of which 20 million were set aside for use by the ICG members. But at present, the ICG does not have the funds to buy the necessary stock to respond to this year's epidemics and is therefore not able to coordinate an adequate emergency response.

The dilemma is not new, nor is it unexpected. Worldwide, there are currently only two manufacturers of meningitis vaccines, Pasteur Aventis and GlaxoSmithKline. But it is not only the limited production capacity of the vaccine that has led to the current crisis. The price of the products is another barrier: Aventis has increased the price of its vaccine from 0.14 euros per dose to 0.25 euros. Access to the existing stock at producer level is a question of money: poor countries simply cannot afford to buy the necessary amounts of vaccine, and the ICG has not been able to secure the funding either.

While wealthy countries such as France and the UK are gearing up to fight individual cases of meningitis by vaccinating large numbers of people in high risk groups, the governments of poor countries most affected by the pandemic in Africa have no means of protecting their population because of the price of such prevention measures and the lack of a coordinated international response. A further threat is a new, potentially epidemic strain of meningococcus (W135) for which no contingency stock of vaccine is currently available in developing countries. The ICG is stepping up efforts to find new short and medium term approaches to dealing with the outbreaks.

In the long term, a new conjugate vaccine, which is designed to bring about stronger and longer lasting immune protection and therefore requires less frequent boosters, is needed to prevent meningitis epidemics in Africa.

By Laura Hakokõngäs

In the past two years, MSF has responded to epidemics of meningitis in Angola, Burkina Faso, Cameroon, Central African Republic, Niger, Chad and Ethiopia. But the existing ICG stocks of vaccine aren't sufficient to cover mass vaccination campaigns in all the countries in need during the next large epidemic. MSF is working to find a long-term solution.

MSF in Burundi – thrown out for flouting ineffective treatment protocol

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derivatives even though they are available in most private pharmacies in Burundi and prescribed to patients who can afford the commercial price. The government swiftly revoked Ms Gadenne's credentials and halted the team's activities in the province of Kayanza for a period of two months. MSF was also threatened with legal action if government edicts, including treatment protocols, were not followed in the future.

Beyond the complexities of relations with national authorities, this story is a good illustration of the difficulties and controversy surrounding the issue of malaria treatment protocol change. MSF believes that switching to a protocol containing artemisinin derivatives is critically important in order to effectively treat patients with malaria. Many countries are ready to make the change in protocol, but cannot implement it because of the increased expense of purchasing newer, more potent medicines. Chloroquine costs as little as US$ 0.10 per dose, while a combination containing an artemisinin derivative, such as Coartem®, costs a minimum of US$2.20 per adult treatment. It is therefore essential that international donors support governments that are ready to make the switch, especially countries such as Burundi that face periodic epidemics.

By Caroline Livio and Philippe Ribeiro