Cost is killing patients: subsidising effective antimalarials

National and global efforts to treat malaria have focused largely on provision of effective antimalarial treatment, mainly through public health services. The private sector (although a key source of antimalarials in most countries) has been mostly ignored in the effort to find solutions to the issues of accessibility, availability, and affordability of effective drugs.¹ The cost of artemisinin-based combination treatments (ACTs), the only truly effective antimalarials,⁷ is far beyond the reach of the average family in Africa, let alone poorer populations. The Affordable Medicines Facility for malaria (AMFm), an initiative of the Global Fund to Fight AIDS, Tuberculosis and Malaria, offers a radical solution,¹ the possibility for countries to procure heavily subsidised ACTs that will reduce the price for patients so it is similar to that of chloroquine. On July 1, 2009, 11 countries submitted (and financial) crises on people’s lives, and thus be more convincing to policy makers than simulation-based generalisations. Having such a global surveillance system would also hopefully encourage a preventive—as opposed to reactionary—approach to food insecurity.

*Craig Hadley, Kenneth Maes

Department of Anthropology, Emory University, Atlanta, GA 30322, USA
chadley@emory.edu

We declare that we have no conflicts of interest.

a first round of proposals to the AMFm. In November, 2009, they will know whether their proposal has been successful.

Is the solution suggested by the AMFm workable and relevant? As with all innovative ideas, the AMFm has to contend with scepticism. Is the Global Fund falling prey to mission creep (namely, expansion of a project beyond its original goals)? Is this a good use of resources? Will the AMFm work? Where is the evidence? Evidence is available from two pilot studies in Tanzania and Uganda in 2007–08 and 2008–09, respectively. Both studies have informed the design of the AMFm. Let us take the example of Uganda.

Malaria is one of the major causes of death in Uganda, and one of the main reasons for this mortality is the exorbitant price of non-effective antimalarials and of ACTs in the private sector, which is the first port of call for more than 60% of Ugandans. The AMFm solution will greatly reduce the price of ACTs both to governments and in the private sector. The pilot study in Uganda, led by the Ministry of Health and Medicines for Malaria Venture, showed that availability of subsidised ACTs led to rapid growth of stocks of these drugs. Drug shops seemed to charge reasonable markups. Supportive interventions such as communication and training were essential to ensure accessibility and uptake of ACTs. Affordability of drugs rose in the private sector with a concomitant increase in uptake by children younger than 5 years (figure). Even more heartening, augmented ACT uptake eroded the market share of ineffective antimalarials such as chloroquine.

In Uganda, although the much-reduced price increased affordability in licensed drug shops in the four study districts, unlicensed shops were more accessible and widely used. All countries that participate in the AMFm have to show a willingness to also implement systems to remove barriers to ACT availability. Ugandan researchers are looking into ways to upgrade unlicensed shops and are considering granting over-the-counter status to ACTs, even though this step is not mandatory.

Advances in malaria prevention have affected the burden of the disease for the better, but we cannot lay down arms and claim a victory against malaria. Although worth celebrating, these successes cannot hide the fact that close to a million people (mostly young children) continue to die every year and more than 250 million individuals are infected annually, of whom only 3% have access to ACTs. We have to find a way to get effective drugs to these vulnerable children whose futures hang in the balance.

The AMFm is attempting to find that elusive solution. By hosting and managing this initiative, the Global Fund is not subjecting itself to mission creep: AMFm funds for subsidising ACTs are not part of the larger Global Fund bursary but have been specially allocated from the UK Government and UNITAID. The AMFm is based on a robust idea and will be rigorously evaluated at every step. How else should responsible innovation take place?

**Ambrose Talisuna, Penny Grewal, John Bosco Rwakimari, Susan Mukasa, George Jagoe, †Jaya Banerji**

Medicines for Malaria Venture, 1215 Geneva 15, Switzerland (AT, PG, GJ, JB); Ministry of Health, Kampala, Uganda (JBR); and Program for Accessible Health, Communication, and Education, Kampala, Uganda (SM)

banerjjj@mmv.org

We thank Caroline Nkatha-Matiko (Steadman Group, Nairobi, Kenya) for providing data for the figure. AT is a member of the Global Fund Technical Review Panel. PG was a member of the former AMFm Task Force of the Roll Back Malaria Partnership. JBR, SM, GJ, and JB declare that they have no conflicts of interest.

Retraction—Combination treatment of angiotensin-II receptor blocker and angiotensin-converting-enzyme inhibitor in non-diabetic renal disease (COOPERATE): a randomised controlled trial

After a letter of concern, which arose when Regina Kunz and colleagues attempted to include the data from COOPERATE into a meta-analysis, we have now received the conclusions of an institutional investigation into the COOPERATE trial. The investigation committee led by Yutuka Sanada, the President of Showa University Fujigaoka Hospital, met seven times, questioned the lead author, Naoyuki Nakao, directly, and examined the original medical records of his patients at Gen Gen-Do Kimitsu Hospital, where the trial was conducted. They concluded that contrary to statements in the paper, the trial had not been approved by the ethics committee of Gen Gen-Do Kimitsu Hospital. Also, contrary to the statement on patients’ consent, Dr Nakao reposted that he had received verbal consent from patients shortly after the start of the study and written consent only during the study. The involvement of a statistician could not be verified. The committee concluded that the trial was not a double-blind study, because Dr Nakao knew the treatment allocation. In the attempt to assess the validity of the data, a sample of medical records was compared with the data provided by Dr Nakao. The committee concluded that it was unable to prove the authenticity of the data.

The conclusions of this thorough investigation mean that the paper must be retracted from the published record.

The Editors of The Lancet

The Lancet, London NW1 7BY, UK