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Thank you Mr /Madam chair for the opportunity to distribute this statement in the name of Médecins Sans Frontières (MSF), as it was impossible for us to attend the open session and read it ourselves.

We would like to reiterate the comments done in July 2007.

As we already stated in the Expert Committee Meeting for the 15th edition of the Essential Medicines List (EML) and in the First Meeting of the Subcommittee of the Expert Committee on the Selection and Use of Essential Medicines, we fully support the initiative to create an Essential Medicines List for Children. We encourage WHO to publish the list after the decisions taken last July, as it will be instrumental to improving pediatric care in developing countries. We must however recognize that there is another task for WHO in the field of pediatric medicines, and that is to ensure that the research and development of these products and formulations indeed takes place.

WHO recommends the use of ACT (artemisinin-based Combination therapies) for the treatment of non-severe *P. falciparum* malaria. At the same time, WHO recommends the use of fixed-dose combinations as it simplifies treatment regimens, improves patient adherence and facilitates the implementation of interventional programs. In the 15th edition of WHO Model List of Essential Medicines, a text was included encouraging the development of fixed-dose combinations. For that reason, we support the inclusion of artesunate+amodiaquine fixed-dose combination (FDC) in the Essential Medicines List.

We further ask the Expert Committee on the Selection and Use of Essential Medicines NOT to remove the oily suspension of chloramphenicol for injection (as sodium succinate) 0.5 grams in 2 ml ampoules, as suggested by the Secretariat, as it is essential for the management of meningococcal meningitis epidemics. A single dose or treatment is sufficient to cure the vast majority of patients. Based on incomplete data, (since age breakdown is not routinely registered during outbreaks), we can estimate that two third of the meningitis cases occurs in children below 15 years of age. We have extensive experience of using oily chloramphenicol in the meningitis belt during meningococcal meningitis epidemics. As an illustration, over the last three years, MSF has used 228,500 units and additionally UNICEF has sent around 30,000 vials each year to countries in the meningitis belt. So far in 2007, more than 50,000 cases of meningitis have been recorded by WHO, most of which have occurred during outbreaks in the meningitis belt. The case fatality rate has been 9.1%, thanks to standard single dose treatment with oily chloramphenicol, as also mentioned by the letters sent by several African Ministries of Health. The pre-positioning of treatment at peripheral level and its access free of charge are key factors in response to outbreaks.

It is therefore essential that we continue to have access to oily chloramphenicol, together with ceftriaxone, as we cannot have only one option for once-daily treatment in case of meningococcal meningitis epidemics. This year, for the first time, a ceftriaxone single dose protocol¹ was used, and several difficulties were encountered: pre-positioning was not successful, as the ceftriaxone was rapidly used up for other diseases; was sold on the market because of its high financial potential (one vial is equivalent to five days' of a nurse's salary). Furthermore, partial doses were also given to patients (three vials were injected and one was

¹ http://www.who.int/csr/resources/publications/meningitis/WHO_CDS_EPR_2007_3/en/index.html

kept by a nurse to be sold on the market). Additionally, there were several difficulties linked with the introduction of a new treatment protocol in the middle of an outbreak.

Oily chloramphenicol has been and will continue to be an important tool to decrease case fatality during meningitis outbreaks, when the vast majority of the cases are due to meningococcus. Our main hopes lie with the development of new conjugate vaccines against meningococcus A, which is primarily responsible for the large outbreaks of meningitis in Africa. The first demonstration project with a new vaccine will take place in Burkina Faso in the fall of 2008. If it is as successful as the current studies have shown, vaccination of a large proportion of the population in the most affected countries will significantly reduce the size of meningitis outbreaks and therefore the need for oily chloramphenicol. The impact of the new vaccines is expected to be significant as of 2012, but until new conjugate vaccines are widely used, we will continue to need oily chloramphenicol to reduce mortality caused by meningococcal meningitis.

We have also noticed that many vaccines were added to the EML last March with very few specifications (e.g. which meningitis vaccine has been added: polysaccharide AC, ACW, ACWY, or conjugate C?). We understand that the relevant information can be found elsewhere, but there is some discrepancy between the precisions given for medicines (including different dosages, and presentation) and only the name of the vaccines.

Concerning tuberculosis, pediatric FDC dosages should be included on the list in order to encourage manufacturers to produce them, and national programmes to use them.

Concerning HIV/AIDS, most of the ARVs proposed for inclusion in the EML for children do not correspond to the WHO recommended formulations. In addition, not all of the existing pediatric fixed-dose combinations (Ranbaxy, Emcure and Cipla) have applied for inclusion in the EML. However, until appropriate recommended formulations are available, existing fixed-dose combinations should be listed. We also encourage WHO to push manufacturers to develop appropriate formulations and to apply for prequalification.

We have previously shared our concerns regarding the quality of several essential medicine sources and would like to reiterate this. Attention should be paid to the quality of the sources available on the worldwide market for various products. We would like to recommend that these products and dosage forms are assessed by the WHO prequalification team and therefore are listed in the Expression of Interest to allow manufacturers to submit their dossiers for evaluation

We would also like to share our concerns regarding the preferred dosage forms. It appears that the constraints linked with the work in developing countries have been incorrectly or underestimated.

Several useful formulations appear to be ignored in the proposed document: powder for oral suspension to be diluted extemporaneously are usually preferred to liquid forms (syrups); dispersible formulations have been used with success (even for FDC). FDCs clearly simplify the management of stocks, decrease the risk of resistance (e.g. antibiotics or antimalarials) and improve compliance. Cutting tablets into four pieces by hand is not an appropriate solution, particularly when exact doses must be given. We have used tablet cutters when there were no other options, and have advised that the same patient receive the two parts of the same tablet, in order to try to compensate for the variation in the amount of medicines received.

Further, different colours and markings may seem like a good idea, but could end up causing significant difficulties in practice for manufacturing. This should not be underestimated, particularly when the aim is to have several generic sources available for each medicine.

Slow-release tablets are recommended for morphine and we are surprised by the very restrictive statement in the document.

Oral dosing syringes are not very well known in many countries and the risk of them being used for injection should not be underestimated (some oral rotavirus vaccine presented in an oral syringe was recently injected in France!).

Many constraints are linked to the active ingredients rather than to the formulations (stability, solubility, permeability), therefore requirement for temperature, protection from light, shelf life, dilution with different type of vehicles / infusions, etc has to be related to this as well.

Finally, we ask the committee to consider our concerns about the age categories defined for drug dosages as explained in the position paper submitted and posted on the website. All our concerns are public and available.

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