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"IN FAILING HEALTH? THE INSIDE STORY OF THE WHO"

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EXTRACT FROM ARCHIVE

MAN: On the first day, many arrived in their traditional costumes. A delegation from Saudi Arabia, from Burma, from India ….

MAN SPEAKING IN FOREIGN LANGUAGE …

MAN: interpreters earphones and …

URRY: The World Health Organisation was set up with an ambitious objective - the attainment by all peoples of the highest possible level of health.

EXTRACT FROM ARCHIVE

MAN: Many were old friends, at this seventh meeting of the World Health Organisation, and had helped to found it in 1948 as a specialised agency of the United Nations.

URRY: But, nearly sixty years since it was formed, how close is it to that ambition? In these two programmes, we assess the health of the UN's leading medical agency itself. Does it live up to the high expectations, which developing countries have of it? Born after the end of the Second World War, is it fit for purpose now in 2005? This week we look at how well it's acquitted itself in trying to help combat one of the world's major tropical health issues – malaria.

ACTUALITY OF VILLAGE NOISES

URRY: In Kenya's central province, the rains are over and this year they've been good, and it means that the rich, red, fertile soil of this area can grow crops that are plentiful. But all this comes at a price. The rains, which make the crops grow, also make it ideal breeding ground for mosquitos, and people in Kiburu village, where we are now, can't escape from the insects, they can't escape the infestation that's happening at this time of year. This is the peak season now for malaria, and people in this village are suffering badly. In many parts of Kenya, malaria is endemic. There's no escape. In Kiburu, they are luckier than many - there's a little clinic. No fancy equipment, no running water even, but some basic medicines.

ACTUALITY IN CLINIC

WOMAN: How long have you been unwell?

MAN: For about three days.

WOMAN: Three days. How are you feeling?

MAN: Cold. I'm not able to work and manage.

URRY: The clinic is supported by an NGO, the Sustainable Health Care Foundation. Julius Ombogo, who runs the Foundation's Kenyan operation, recognises the challenge that a disease like malaria presents.

OMBOGO: The malaria parasite is a very unique parasite. It's a parasite that is difficult to deal with, because it's so adaptable. Now the parasite is transmitted into human beings by the female Anopheles mosquito through their feeding on the blood of an infected person. When the mosquito feeds on the next person, it transmits this parasite into the next person, and the parasites then blow up in the blood and what happens then is that the fever goes up. Now we have extremely vulnerable people, specifically pregnant women and children, and of course below the five year olds. Malaria is a killer to the extent that if you look at the number of deaths in Kenya, the total number of deaths arising because of malaria is more than the total number of deaths recorded from HIV, AIDS and TB put together.

URRY: A million Africans, mostly children, whose immune systems are not fully developed, die every year from this preventable and curable disease. And if it doesn't kill you, it can still have a profound impact. It's a poor country, people have little, so if mums and dads are ill and can't work, everyone goes hungry. In Kiburu, Lillian Gitau from the Sustainable Health Care Foundation, wanted to show us the difference that that can make to a family.

ACTUALITY WITH COW

GITAU: As you can see, they have only one cow to feed the entire family, so they can't even sell the milk to get more money.

URRY: We're standing in a garden, it's probably fifty metres long, if that, so they can only eat what they can grow here on this little bit of land.

GITAU: Yes.

URRY: Is it a little girl or boy?

GITAU: It's a boy.

URRY: It's a boy.

WOMAN: It's a boy, yes.

URRY: Has he had malaria as well?

WOMAN: Yes, he doesn't want anything and then crying, vomiting or even diarrhoea. When children they get sick and the mother fails to realise, it's very serious because the child can die within a very short time.

URRY: Is he better now?

WOMAN: Yes, he is better.

URRY: The economic burden for Africa caused by this one disease alone has been estimated at $12 billion. In 1998, in response to this mounting crisis, the World Health Organisation, working in partnership with other agencies, launched an initiative called Roll Back Malaria, its ambitious aim to halve the number of cases around the globe by the year 2010. In May, at the World Health Assembly, its supreme decision-making body, which is made up of representatives of WHO's 192 member states, the Director General, Lee Jong-wook, made it clear that the illness was still a priority.

EXTRACT FROM JONG-WOOK'S SPEECH

JONG-WOOK: This health assembly, it gives us a unique opportunity to ensure that our action is well informed and our knowledge is well used and ….

URRY: He spoke about the intense effort required to get resources funded, and into areas they were most needed.

JONG-WOOK: Health work teachers … that action without the knowledge is wasted effort, just as the knowledge without action is a wasted resource.

URRY: But, away from Geneva, the WHO is accused of being ill-informed. Bob Snow, Professor of Tropical Medicine at Oxford University has spent

URRY cont: sixteen years in Kenya, working on the frontline in the fight against malaria. He's published new research showing the numbers of infections globally of the most deadly form of the disease were almost double that which had been previously estimated by the World Health Organisation. The WHO has insisted it's not been underestimating the problem, but Bob Snow argues the data used by its Geneva headquarters was incomplete.

SNOW: The size of the problem is massive. I mean, half a billion clinical attacks a year is a huge public health problem worldwide. We've also tried to estimate how many people die of malaria. We've only done that for Africa so far, but there are a million people a year that die of malaria. And this was considerably higher than the WHO had estimated, and the primary reason for that is that the WHO rely very heavily on national statistics. And the unique feature about malaria is that everyone, almost everyone gets a fever and they may or may not go to a clinic to get treated. They may treat themselves at home. So if you rely only on national statistics, you will get only those that go to government clinics.

URRY: Were your findings disputed to start with or did people simply accept what you had to say?

SNOW: Well, the WHO weren't happy with being challenged with the numbers that they had reported previously against the numbers that we'd reported. I mean, it's not a competition to try and work out who, you know, who can come up with the highest number. Rather what we wanted to provide was a sort of transparent and reproducible way of estimating disease burden worldwide, and if you don't have the right numbers on the size of the problem and where the people are located in relation to the malaria problem, it's very hard to estimate how much money you need. And again, this is where getting the numbers right is so important and you need some technical leadership there to try and identify numbers to define resources.

ACTUALITY WITH BROCHURE

URRY: Just before we came to Kenya, a 300 page glossy brochure called the World Malaria Report was published by the WHO and a UN partner agency, UNICEF, so we brought a copy with us to see what it said about the country we are visiting. And if I turn to the pages which give data for Kenya, there's a figure here about the numbers of deaths that's almost impossible to believe. This appears to be the sort of statistical error that Professor Snow is worried about. We're in Nairobi, on our way to see the WHO's country representative, Dr Peter Eriki. He's a senior advisor to the Ministry of Health here, part of the WHO's commitment to helping developing countries with best policy and practice. So I want to ask him about this astounding mortality data, because something doesn't add up.
How many people die from malaria each year in Kenya?

ERIKI: It says thirty thousand die of malaria, mainly children under five years.

URRY: Thirty thousand?

ERIKI: Yes, exactly.

URRY: Because in the World Malaria Report of 2005, in the Kenyan section here, it says 135. Does that surprise you that that's been published in the World Malaria Report?

ERIKI: Erm … 135 cases, only 135 …

URRY: Because it suggests you don't even have a problem if that figure's accurate and you don't think it is.

ERIKI: No, I don't think that's correct, accurate information. I don't know … I think they need to collect the most latest information.

URRY: There followed a short intermission, in which Dr Eriki's colleagues went in search of more accurate government figures. However, some of the data that we were then shown also turned out to be useless.
So you're being handed some statistics here. What do they tell you? I'm just looking at the columns for 2002 here and there's, no, there's no figures in it at all. So in the Kenya malaria profile, there are no statistics at all from the year 2001 onwards that are available. Does WHO have its own figures for the number of deaths from malaria each year in Kenya?

ERIKI: We do not have figures around, they're up at the ministry, so we rely on the government of Kenya, and the problem to provide this information. Based on what we have, for example, we know it causes mortality for 25%, depending on the people who go home. We know that 35,000 deaths annually under fives.

URRY: 35,000 children under five die every year?

ERIKI: Yes. And puts a huge burden on health systems.

URRY: Why haven't those figures made their way into the World Malaria Report then?

ERIKI: The WHO is part of the team to see whether they can get accurate figures. Plus using the existing information gathered.

URRY: But how do you help the government plan its strategies if you don't know the extent of the problem?

ERIKI: From the clinics, we have information based in every district, you get some of this information available.

URRY: But why hasn't this information found its way to the Kenyan government?

ERIKI: Because this is Kenyan government information, and we are working with them to re-update this information to get the latest, we are working to support the development of credible information systems.

URRY: Later the WHO told us that the figure of 135 deaths was a misprint. Later still, they decided it referred to mortality recorded in just one hospital, and that an unreferenced footnote in the World Malaria Report mentioned that. But the headline figures are still capable of being highly misleading, and for Professor Nick White, a leading malaria scientist, it's an illustration of a much more worrying trend.

WHITE: I think the World Health Organisation, because it's a United Nations body and represents the countries, it feels an obligation to use the country's own information primarily to respect that source of information. But it's become abundantly clear in recent years perhaps that much of the epidemiological data – that's the information from countries on how much disease they have – is not correct. Putting it bluntly, the most efficient way to get rid of an epidemic of something unpleasant is not to report it.

URRY: Is that what's been going on? Countries have not been reporting malaria epidemics?

WHITE: Well, I think they've not been, they've had no method of knowing how much malaria they had, and they've just taken a convenient estimate. And if it's politically not acceptable to have a lot of malaria, then it's been underestimated. It's not just malaria where this happens, it's a common problem, and you know, you can sympathise with the poor, the unfortunate Ministry of Health official who's responsible for providing data and has no methods of obtaining it.

URRY: But doesn't the World Health Organisation, which after all is the world's doctor, don't they have a better system than that?

WHITE: They don't have that much money to survey the whole world, but I think it would have been much better for the world if it had been conceded, as

WHITE cont: was abundantly clear, that these methods weren't working and providing really quite unreal estimates of a disease.

URRY: While there's criticism of the data on which estimates are based, there's also concern about the slow progress in getting help with prevention measures - trying to stop mosquitoes from biting those most at risk.

ACTUALITY WITH LORRY

URRY: That means bed nets. These are treated with insecticide which act as a repellent. Insecticide Treated Nets are a key WHO recommendation for prevention of malaria, but the organisation hasn't got the staff or the money to do this work itself. It relies on donor countries for funding, NGOs or other groups, to get the nets to the people. This has been achieved by using what's called a social model of delivery. If people are willing to pay for a bed net, it's more likely they'll value it and use it properly. But Professor Bob Snow of the Kenya Medical Research Institute, argues that bed net coverage is poor and has been moving far too slowly.

SNOW: The WHO is the broker, the technical broker, and their role is to ensure that the right policies are put in place and that the bilateral agencies resource the right strategies.

URRY: Have they decided what the right strategy is?

SNOW: No, because what they tend to do is take a very middle ground on almost everything. They say, 'In this part of Eritrea it was very successful to use social marketing,' or 'In one part of Tanzania private sector delivery of bed nets has grown.' So basically what they try and do is satisfy everybody's particular preference to the way bed nets are given. The trouble is we're facing a crisis. Malaria mortality is rising, it's not going down, it's going up. You can't afford to wait for five or ten years. I mean, you just have to go now with what you think will work best in maximising coverage fastest.

URRY: The World Health Organisation concedes that slow delivery is in part due to miscalculations about market forces and the benefits of selling bed nets as opposed to giving them away. Dr Allan Schapira, the coordinator for the organisation's Roll Back Malaria Department, says the thinking now is that they should be free.

SCHAPIRA: There was in many quarters an exaggerated belief in the possibility of market mechanisms.

URRY: The idea being that if you sell something to somebody, it makes them value it more?

SCHAPIRA: Yes. To some extent this has worked, but fortunately there has been a shift here in thinking towards much more emphasis on public sector free or highly subsidised delivery of insecticide treated nets. What we're doing concretely is that we are now running a project for distribution of nets free or highly subsidised, together with antenatal care services or immunisation services.

URRY: But why's it taken so long?

SCHAPIRA: Things can take long. I mean, you need to understand ...

URRY: It's seven years since Roll Back Malaria was started.

SCHAPIRA: There were no resources available, seriously, during the first years. It's only since 2004 that resources have really started to run. I mean, we wouldn't mind being able to do them more quickly if we had more staff.

URRY: I sense your frustration on this. It must have been a frustrating period for you.

SCHAPIRA: It is still a frustrating period, because I know that if we had more staff – I mean, you look at a country like Kenya, we have two excellent, but very

SCHAPIRA cont: junior persons. We should have three senior persons as WHO staff for malaria control in a country which has a huge malaria problem.

URRY: While bed nets are an important strategy to try to prevent infection, the WHO has been accused of poor leadership in the area which is a matter of life and death once mosquitoes have struck - drug treatment.

ACTUALITY AT CLINIC

WOMAN: Today you take three tablets, then tomorrow three tablets, then day after day you take two tablets.

MAN: Okay.

URRY: In Kiburu the malaria upsurge is reaching its peak and people are coming into the clinic for help.

WOMAN: This is anti malaria tablets.

MAN: Okay.

WOMAN: You take after three days …

URRY: Health workers here admit that the drugs they are giving people don't work very well. That's because the parasite carried by the mosquito has become resistant to the older drugs like chloroquine and sulphurdoxine–prymethamine or SPs as they're known.
What have you got here? What's in that tube?

NURSE: Here we have the generic sulphur drugs and we also have the original SP drugs.

URRY: And that's a sulphur based treatment as well?

NURSE: Yes, that's sulphur based as well.

URRY: They're having to buy the drugs that don't really work very well.

NURSE: Yes. They have to, and that's why we still have them in stock, because it's better to give them what might not work, but something that might work.

URRY: And hope for the best.

NURSE: Hope for the best, yes.

URRY: But in 2005, should Africa still have to hope for the best? Roll Back Malaria, launched seven years ago, was supposed to be tackling this. Some say the world's doctor was too slow to deal with drug resistance, a problem which has costs millions of lives. The aid organisation, Medicine Sans Frontiers, was amongst those which, during the 1990s, began to recognise that drug treatment was failing. Dr Christa Hook says where MSF medics were on the ground in Africa, the patients they gave chloroquine or SP to would get no better.

HOOK: One of the first things that happens is that the child's fever comes down, and that's because chloroquine, even if it does not have any effect at all on the parasites, it still has an effect rather like giving aspirin or paracetamol, it actually brings the fever down.

URRY: It can fool you.

HOOK: It absolutely can fool you. So the consequences may be that it comes back, basically. The illness returns because the parasites have never gone away.

URRY: Medics from your organisation were becoming concerned about drug resistance.

HOOK: Absolutely. They see it very clearly when you're, you know, seeing a lot of severe malaria and they're not getting better, or you're seeing like an outbreak of malaria, an epidemic, and the death rates are enormously high, even when the people are being given the treatment. So we could see that the drugs were not working and that we must change treatment and that the only way to do that in a scientific way was in fact to have the studies which will show which drugs will work in which places. So that was why we started studying it. Basically we found that the figures for resistance were much higher than were in any of the published documents.

URRY: Even before the research conducted by MSF, there'd been other published studies which raised the alarm. Professor Nicholas White, a leading malaria scientist, says he knew of data in the 1980s showing resistance to chloroquine. Nick White is Professor of Tropical Medicine at Mahidol university in Bangkok. Thailand is the epicentre of malaria drug resistance. Professor White told us that by the early 1990s there was very strong evidence for concern. He believes the WHO were slow to recognise the problem, and that when they finally did draw up a scientific method to investigate resistance, they got it wrong.

WHITE: In 1996 it was recommended that in areas where you get a lot of malaria, the follow-up after you gave the chloroquine to see if the patient was cured or not would be only two weeks. Most of the people who failed the treatment, the malaria came back after two weeks, so people signed off and said, 'Yes, it's working at two weeks.' Now that test is completely useless at detecting resistance. There's quite good evidence that mortality, deaths from malaria, certainly in eastern in southern Africa, doubled in the 1990s and that can only be attributed to drug resistance.

URRY: In a statement, the World Health Organisation told us:

READER IN STUDIO: The objective was to discover rapidly in which countries clinical failure had reached an unacceptable threshold. It was possible to detect treatment failures with these drugs very quickly. The WHO has never recommended a fourteen day follow-up in drug resistance testing outside Africa, and no longer does so for Africa. This was a temporary expedient.

URRY: All this would have been bad enough, but while the disagreements about which drugs were resistant and to what degree dragged on through the 1990s, there was one which did work. It's based on Artemesinin, an extract from a plant, the sweet wormwood. When it's used in combination with other drugs, it's been found to be more than 90% effective. Taken in this way, it's known as ACT, Artemesinin Combination Therapy. But there's a problem - it costs more than ten times that of the older drugs, which were failing. Professor Nick White was among those on expert WHO committees making the case for ACTs. There were difficulties because the WHO relies on donor countries to fund major campaigns like malaria control. But even so, Professor White says some in the WHO should have done more.

WHITE: I think the technical people at WHO really did appreciate that something important was being discovered here. But there are other people who felt that these were just a bridge too far, that we should just carry on trying to contain it and that cholorquine may not work very well, but people said it was okay and therefore we should keep going on with it, as it was affordable. But I have to say that, when we tried to push to get acceptance of Artemesinin Combinations, it was strongly resisted.

URRY: How strongly? I mean, what was the atmosphere like in these meetings?

WHITE: Sometimes very tense. We were accused of being troublemakers basically.

URRY: Troublemakers?

WHITE: Yes.

URRY: Why was that view?

WHITE: I think the view was that by saying that there was a big problem that was not being addressed, in other words by criticising, we were reducing donor confidence. So it was a sort of catch 22 situation. Don't make a fuss about the size of the

WHITE cont: problem, because that will indicate to the donors that things are not going well and they might be frightened off providing money.

URRY: In Geneva, the coordinator of the WHO's Roll Back Malaria department sees things differently. Dr Allan Schapira denies the charge of failing to deal effectively with issues about drug resistance and ACTs.
Can you help us understand why it took so long for WHO to accept the need for new drugs to combat malaria?

SCHAPIRA: It didn't take long for WHO to accept the need for new drugs. This is something that WHO has worked on very systematically since the 1990s. We worked very closely with Thailand and Vietnam, in order to work with them on assessing different new drug regimens and combinations, how effective and safe they would be in relation to the problem of drug resistance which was emerging rapidly there.

URRY: One of the leading field scientists, Professor Nicholas White, says that he is frustrated with the amount of time that WHO took over this issue, and he doesn't feel that you grasped the nettle anywhere near quick enough.

SCHAPIRA: That's total rubbish. Nick White is a very good man and, you know, he's the kind of scientist whom it has been very good for WHO to work with, because he has brought the evidence fresh to WHO and he has advised us, and as a result of that already in 1998 we had an expert committee report which pointed in the direction of Artemesinin-based Combination Therapies. We have been very rapid in acting on the data for combination therapy, Artemesinin-based Combination Therapy in terms of issuing policies and guidelines. Certainly there has been a lag between the WHO policies coming out and the implementation.

URRY: A lag?

SCHAPIRA: Yes, a lag time.

URRY: Why is that?

SCHAPIRA: During the early part of the decade, there was no, almost no international allocation of funds for malaria control.

URRY: There was, however, plenty of money around for the drugs which didn't work. In 2002 a new player emerged in the efforts to scale up resources needed to tackle the world's most devastating diseases. The Global Fund was created to attract, manage and disburse billions of dollars for AIDS, TB and malaria. It's designed to be a kind of international bank, to which countries can apply for money to help combat these diseases. The previous year, the World Health Organisation had decided to endorse the new, more expensive

URRY cont: ACTs as the drug of choice for countries which had problems with resistance to the older treatments, so the timing could hardly have been better. But, last year, it emerged that some WHO representatives had been approving applications to the Global Fund for money to buy the old, clinically obsolete drugs. The applications came from the developing countries themselves, but those who advise them on behalf of the WHO had also given their approval and signed off the paperwork. Without those signatures the funds would not have been authorised. Because of this, a group of tropical medicine and health policy experts, led by Professor Amir Attaran of the Royal Institute for International Affairs in London, went so far as to accuse the World Health Organisation of medical malpractice.

ATTARAN: What we learned was that WHO had publicly said on many occasions and published glossy pamphlets stating that chloroquine, the old medicine, should no longer be used where there was drug resistance, including in Africa, and WHO published a large number of reports about how there was extensive drug resistance to chloroquine in Africa. So that was their public point of view. There was the same concern about another drug known as Sulphadoxin Pyrimethamine, and although it was the public position in the glossy pamphlets that chloroquine and SP should no longer be used in Africa because of drug resistance, when African countries applied to the Global Fund - which is a closely allied organisation, but not the WHO itself – and those countries asked for chloroquine or for SP, which they were being made to ask for, because if they asked for anything else, the US Government and the British Government time and again were on their

backs, to not ask ATTARAN cont: for the different medicine it would cost more money. Well, as soon as they asked for it and WHO had to sign their applications and grant its okay, WHO did. So WHO in country, on numerous occasions, violated its own policy guidance.

ACTUALITY IN NAIROBI

URRY: It's one thing to have a policy, but those who represent the WHO in countries like Kenya are in a difficult position. They, by necessity, have a close working relationship with the Department of Health, and countries sometimes don't want to accept that they've got a big problem with malaria, or to commit themselves to more expensive drugs because they fear that further down the line the plug will be pulled on the aid money. Here in Nairobi, the WHO's Dr Peter Eriki was one of those who approved an application for funds for drugs.
This was approved by yourself, wasn't it? This was approved by you, because your name is on that document. Isn't it?

ERIKI: Erm … Just hold on. Let me …

URRY: Well I've seen your name on that document. And also on that document is a statement that WHO has taken a full part in the process of application to the Global Fund and that it's happy with what's being applied for.

ERIKI: I'm not being happy …

URRY: Well that's what it says.

ERIKI: It was not even being happy. Because if you looked at the application, it wasn't only that WHO in that application. There are quite a number of people who are meeting in the Global Fund. Now if a country has decided or sees that this is the position, until we confirm that there is a need for change, there was not yet clear evidence that this resistance was widespread in the country.

URRY: Yes, well there was evidence, wasn't there? There was evidence that sulphur-based drugs in some parts of Kenya …

ERIKI: Some parts.

URRY: Yes. In some parts of Kenya were meeting resistance levels of about 50% and more. So the question is, why have you signed off on an application for millions of dollars worth of aid to buy drugs that are known not to work?

ERIKI: Authorities were clearly convinced that this was still the way to go forward. The studies at that time are not enough evidence and the country was convinced that the sulphur-based drugs were still effective.

URRY: But they rely on your technical expertise for that, your medical expertise to tell them, don't they? What were you telling them?

ERIKI: We were telling them that, you see, as you are moving on, be mindful, keep monitoring. So at that time when this was signed this was still thought to be a functional drug at country level.

URRY: The World Health Organisation says it can't tell countries what to do, it can only advise on policy and best practice. But Professor Amir Attaran says that's not good enough.

ATTARAN: WHO is the world's doctor, it's the world's medical expert. The position that it's up to Kenya, who in this case is the patient, is morally equivalent of saying that if I'm a doctor and a patient walks into my office with cancer and asks for a chocolate bar to treat his cancer, I'm justified to write the prescription for a chocolate bar. I'm not. I have to exercise independent professional judgement, or there is no use in having me there. And so it is with WHO. WHO cannot simply abandon its judgement and let countries decide to deal with disease however they might. If it does that, we don't need a WHO. We could abolish it. WHO was placed in a position of having to either ask outsiders for that financial help and browbeat them and shame them if necessary into

ATTARAN cont: providing that outside help, or simply go on providing the voiceless, sick, powerless children in Africa a medicine that it knew didn't work, and in many cases would kill them. WHO chose the second option, and it's medical malpractice in my view and the view of many others.

URRY: It's an allegation which struck at the heart of the world's doctor. In Geneva the WHO's Dr Allan Schapira strongly denies any accusation of malpractice.

SCHAPIRA: These applications were made by countries, usually by national programs, and the national programs that we're talking about had in some cases not made the policy shift, despite the fact that WHO had been advocating with them for making the policy shift. Furthermore …

URRY: Yes, but WHO officials signed off on those applications. I've seen the signatures.

SCHAPIRA: Furthermore, if I can continue, with the available funds from the Global Fund, overall for control of malaria, the kind of funding that was going to control malaria, it was highly uncertain whether the Global Fund would actually be able to raise the amounts necessary for this very resource-demanding shift. WHO …

URRY: With respect, that's the Global Fund's problem and issue in partnership with you, isn't it? Your job, at WHO, is to make sure countries get the best possible drugs, not sign off on ineffective ones.

SCHAPIRA: Yes. The fact is that WHO staff based in countries cannot dictate policy to the countries in this situation, in these scenarios.

URRY: Well, we're not talking about …

SCHAPIRA: … if I can just continue.

URRY: Well, but just let me make this point. When you say they can't do that, they can refuse to sign that, can't they?

SCHAPIRA: Yes.

URRY: They can refuse to sign that application if they know it's not best practice medicine.

SCHAPIRA: They …

URRY: So my question is, why didn't they do that?

SCHAPIRA: They can refuse to sign. In this kind of issue and in many similar issues, WHO staff very often finds itself in a difficult dilemma. It may refuse to sign off, thereby potentially being seen as the cause of an application not having been approved. I think altogether the discussion around this issue has not been particularly pleasant for WHO, but it has been healthy for us in that it has strengthened the awareness of WHO as an organisation, and it needs to be strong in terms of pushing its own policies.

ACTUALITY WITH MOTHERS AND CHILDREN

URRY: The Global Fund is now making money available for the new ACT therapies. The WHO has joined forces with a drug company to produce a lower cost version. Kenya may get the money for them sometime next year. But just at the moment when it seems to all be coming together for Africa, there's yet another problem - a critical shortage of the new wonder drug. Not enough plants have been grown to provide the raw ingredient, not enough planning has been done to meet demand. It's the next big challenge for Roll Back Malaria and it needs to be met as quickly as possibly, because, even since this radio programme came on air, more than seventy children have died from this preventable, curable disease. Another will die every thirty seconds.