

Most human cases were in direct contact with sick or dead birds, although no one involved in culling birds appears to have caught avian flu, WHO said. Avian flu is believed to have first jumped species from bird to man in 1997, when an outbreak of the disease caused by the A (H5N1) virus among birds triggered 18 human cases in Hong Kong Special Administrative Region of which 6 died.

WHO is conducting investigations into reports of H5N1 infection of domestic cats from a single household in Thailand. Fourteen out of the 15 cats have died, two of which have been reported infected with H5N1 by the Faculty of Veterinary Sciences at Thailand's Kasetsart University. According to WHO, confirmation of the virus in cats is not likely to enhance the present risks to human health.

First symptoms are fever, sore throat and cough, but the disease can lead also to hepatitis and even damage to the heart or kidneys.

For the latest information on avian flu, visit: <http://www.who.int/csr/don/en/> ■

Fiona Fleck, *Geneva*

WHO refutes malaria malpractice allegations

WHO's Roll Back Malaria department has refuted allegations by an international group of 13 malaria researchers accusing WHO and the Global Fund to Fight, AIDS, Tuberculosis and Malaria (GFATM) of failing to promote available and effective malaria treatment in favour of ineffective but less-expensive drugs.

In a commentary published in the UK-based medical journal, the *Lancet* (2004;363:237–40), the critics led by Amir Attaran from London's Royal Institute of International Affairs, accuse the two agencies of blocking the introduction of highly effective artemisinin-based combination therapy (ACT) whilst continuing to approve grants for the conventional chloroquine and sulfadoxine-pyrimethamine in countries where these treatments are failing.

"For WHO and GFATM to provide chloroquine and sulfadoxine-pyrimethamine treatments ... at least wastes precious international aid money and at most, kills patients who have malaria ... at least tens of thousands of children die every year as a direct result," say

the authors who compare the agencies with a "doctor who knowingly furnished treatments that failed perhaps 80% of the time, while withholding the alternatives as "too expensive".

In a letter published in the *Lancet* (2004;363:397), Fatoumata Nafou-Traoré, Director of WHO's Roll Back Malaria Department, counters the accusations pointing out that "WHO has been making many of the same arguments for the past 3 years and fully supports the use of ACT."

Chloroquine and sulfadoxine-pyrimethamine have become increasingly ineffective due to the development of resistance in the deadly species of malaria, *Plasmodium falciparum*. Surveillance and clinical trial data in East Africa, for example, show that up to 64% of patients given chloroquine and 45% given sulfadoxine-pyrimethamine will fail treatment, and those figures are climbing, say the critics, Attaran et al.

They point out that artemisins, on the other hand, which form the basis of ACT treatments, have been used in Chinese traditional medicine for 2000 years, with no observed resistance. "In studies done on nearly every continent, ACT successfully treats 90% or more of patients," say Attaran et al.

The problem is cost: ACT is around ten times more expensive forcing most African countries to stick with conventional but increasingly useless malaria treatments. At the centre of the criticisms voiced in the *Lancet* is the continued approval by GFATM and WHO of funding for chloroquine and sulfadoxine-pyrimethamine for those countries which should be switching to ACT. "When those same countries seek financial aid from [GFATM] to purchase ACT, they are forcefully pressured out of it by governments such as the USA, whose aid officials say that ACT is too expensive ... and WHO signs its approval," say Attaran et al.

According to WHO, one reason for poor countries' continuing applications to GFATM for the cheaper but less-effective anti-malaria drugs has been their uncertainty about GFATM — which has only been in existence for two years — as a source of long-term support. In other words, countries did not wish to switch to a more expensive drug only to see this income cut off a few years later. "Governments need to trust that sustainable funding from the Global Fund [GFATM] and other sources

will be available before they can make the commitment — of up to US\$ 2 per head per year — of switching to ACTs," said Nafou-Traoré.

Both agencies have also emphasized their roles as advisers or funders, insisting that antimalarial drug policy decisions must be led by national governments. However, as Nafou-Traoré points out, since 2001 "WHO has been actively promoting the use of ACT in countries before resistance to currently used monotherapies reaches an unacceptable level." Since 2001, South Africa (KwaZulu Natal), Zambia, Zanzibar and Burundi have switched to ACTs as first-line treatment. By 2004 WHO expects at least 16 African countries to have adopted ACTs as first-line treatment. According to WHO, this timeframe is exceptionally short for such a far-reaching policy change. In addition, the threshold for the unacceptable level of therapeutic failures has been lowered from 25% to 15% and "countries will be strongly encouraged to modify their treatment policies accordingly," says Nafou-Traoré.

Rather than refusing requests for suboptimal drugs which are based on current national policy, says Nafou-Traoré, GFATM has generally stipulated a policy review within a short period of time as a condition of funding. "As a result, WHO is able to work more effectively with decision-makers in countries to accelerate rational and feasible policy change."

Malaria causes more than one million deaths worldwide every year, 90% of which occur in Africa, costing the continent more than US\$ 12 billion every year. ■

West Africa prepares for the final battle against polio

Ten West African countries will begin a massive, synchronized polio immunization campaign on 23 February 2004 aimed at vaccinating 63 million children in the region in just a few days. The campaign comes just one month after Health Ministers gathered for an emergency meeting at WHO in Geneva calling for commitment to end polio transmission in 2004.

Political, religious and traditional leaders from Benin, Burkina Faso, Cameroon (due to begin vaccination on 20 February), Central African Republic, Chad (due to join the campaign in