**Argentina**

Providing essential medicines and supplies

Argentina’s economic collapse in late 2001 had severe consequences for the country’s civilians.

Extreme financial hardship made it difficult for many people to pay for medical care. The public health system went from providing care to 30 percent of the population to assisting up to 70 percent (many of whom previously had been covered by private insurance). While demand at all health structures increased enormously, supplies dwindled and health staff could not meet the ever-growing needs.

MSF started a project in 2002 to provide basic medical supplies and medicines to hospitals in the country’s northern region – historically one of its most disadvantaged areas. MSF assisted hospitals in the Salta and Jujuy provinces and in 2003 also aided facilities in the Formosa and Chaco provinces. MSF donated medicines and medical supplies to the hospitals and helped manage pharmacies until December 2003. The project concluded at the end of 2003.

In May 2003, heavy rainfall caused floods affecting more than 110,000 people living in Santa Fe province. For two months after the disaster, an MSF team provided emergency help to improve shelter and increase water and sanitation facilities. The team also monitored the area for disease outbreaks.

MSF worked in Argentina from 2001 until 2003.

**Bolivia**

Chagas disease (American trypanosomiasis) kills more than 50,000 people every year in Latin America. Bolivia is the hardest hit country. The disease affects more than half of the country’s inhabitants, mostly those who live in poverty or in rural areas. Approximately 3.5 million people are at risk of contracting it and 300,000 children younger than 12 are infected. Chagas accounts for 13 percent of all deaths in the nation. Yet the problem extends far beyond Bolivia’s borders. More than 18 million people have the parasite causing the disease in their blood stream, and 100 million people in 21 Latin American countries are at risk of infection.

MSF has been treating people with Chagas disease in Bolivia’s O’Connor province, Tarija department since October 2002. Its teams have found, despite considerable challenges and difficulties that programs to diagnose and treat people with the disease are not only needed, but possible. The Tarija region was chosen because of its particularly high prevalence (28 percent among children under 14), the lack of health care available and the presence of a government program that methodically tracks and kills the insects responsible for the disease’s transmission. Controlling the number of insects, and in the long term, their eradication is essential for treatment to be effective as there is no vaccine against Chagas. Even those who are recovering from it can be easily re-infected if no control and surveillance activities are taking place.

MSF’s project includes information, education and communication for the general population and for key groups including health personnel and teachers. It also involves active screening of newborns and blood donors in the hospital and for children between 9 months and 14 in the community. Children who test positive for the disease are treated with the drug, benznidazol. The drug, nifurtimox, is used as a second-line treatment for those who cannot tolerate benznidazol. Both drugs were discovered during veterinary research conducted in the 1970s. Because of the possible side effects, children getting treatment are followed weekly at health centers or schools and whenever needed. At the end of 2003, 89 percent of the targeted children had been screened and a prevalence rate of 20 percent was found.

A killer that preys on the poor: Chagas disease

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Sixty-one percent of the newborns delivered in the province’s hospitals were screened and no positive cases were identified. Prevalence among blood donors was found to be 25 percent. MSF has treated hundreds of people with the disease since the project started.

MSF’s experience in Bolivia underlines the relevance of diagnosis and treatment in the framework of a global approach to Chagas disease. Prevention activities, including information and education, need to be included within Chagas programs and all activities should be performed within primary health care systems under the supervision of a hospital physician. Further, congenital protocols need to be adapted to rural contexts where hospital delivery is rare. MSF is now asking the
Bolivian national Chagas program to prepare and implement a protocol for diagnosis and treatment and to create a system for case notification and drug surveillance.

Focusing on a neglected disease
Chagas is a neglected disease – there is virtually no research being done to develop a new and effective drug to treat those infected with it. The reason? There is no profit to be made from drugs that treat the poor. MSF doctors have witnessed the lack of life-saving medicines and diagnostic tools available for Chagas. This “empty pipeline” is a direct consequence of the lack of research aimed at finding less toxic and more effective drugs that would enable Chagas patients of all ages to receive better treatment. Today MSF is doing everything it can to ensure Chagas is recognized as an international public health risk, but there is a long way to go before new drug treatments become available. MSF is also working with the newly established Drugs for Neglected Diseases Initiative to find potential new drugs to treat this disease and thereby circumvent the lack of interest shown by the pharmaceutical industry.

MSF teams in Bolivia are actively raising concerns related to access to essential medicines and treatments at the national level, particularly those involved in the current negotiation of a free trade agreement between Bolivia and the United States. In May 2004, MSF urged the Bolivian government to exclude intellectual property provisions from the US-Andean free trade negotiations. MSF remains concerned that their inclusion will have a devastating effect on access to medicines for millions of people living in the country and the Andean region.

Under current trade conditions, if a new drug for Chagas were developed, the Bolivian government would be able to issue a compulsory license to overcome the patent barrier and produce the drug locally. (A patent allows only the company holding it to produce the medicine and profit from it. A compulsory license enables others to produce the medicine, usually at a much lower cost, while paying a compensatory fee to the patent holder.) This ability would be lost if Bolivia signed the free trade agreement with the US, because the US wants to limit dramatically the circumstances under which compulsory licenses can be issued. It would also affect the availability of generic drugs by reducing competition in the market. This could lead to a monopolistic situation with devastating effects for access to treatment, making the drug unaffordable for the majority of the Bolivian population, the poorest on the continent after Haiti.

Providing emergency assistance
MSF also provides emergency assistance in Bolivia. In January 2004, torrential rains flooded the town of Trinidad, the capital of Beni province. Floods affected nearly 40,000 people – more than half of the town’s population – and approximately 12,000 people had to be evacuated. MSF aided those taken to temporary shelters, donated medicine and organized water and sanitation facilities. The MSF team also worked closely with local health authorities to strengthen the existing epidemiological surveillance network.

MSF has worked in Bolivia since 1987.