We declare that we have no conflicts of interest.

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The availability of drugs for rich and poor people in developing countries

Raffaella M Ravinetto and colleagues[1] stressed the need to overcome the situation of disparate qualities of drugs in rich and poor developing countries. Interagency collaboration, the enforcement of international regulation, and the use of appropriate procurement policies and practices were therefore proposed to supply countries with the best quality drugs.

For sub-Saharan Africa, other measures are urgently needed at the national level. Indeed, after the Bamako initiative, essential drugs were introduced into health systems, and national public supply systems for drugs and other medical supplies were created in each country, but to date the availability of drugs is still poor.[2] Also, the introduction of user fees with this initiative excluded poor people from access to health care, especially in countries where more than 60% of health-care expenditure is through out-of-pocket payments and more than 50% of the population are living below the poverty line.[3]

Figure: **A drug retailer in the street with inadequately stored drugs, Maroua, Cameroon**

The consequence of this exclusion is the development of an informal drugs market: drug retailers—passively endorsed by public health authorities—selling, drugs from tablet to injectable, inside shops or along the streets under the sun, sometimes at more than 40°C in the shade (figure). For people excluded from access to healthcare, the retailers in the street making consultations and selling drugs directly to patients are the only recourse, and their fake drugs are the only medication that can be taken before the development of complications.

Formal drugstores selling branded medicines—usually imported—are only found in urban areas. In general, they follow the rules and regulations set out by the health ministry and have better storage conditions. Nevertheless, poor people and people living in rural areas are unable to access branded drugs. Health-care facilities that are supposed to stock essential drugs are often unable to store them correctly, exposing the drugs to damaging shifts in temperature and humidity.[4]

There are many countries, irrespective of the international rules, that participate in these informal drugs market. These countries should buy drugs only from countries and companies that follow the international rules and regulations on drug production for both domestic use and export purposes, and not from the cheapest unregulated manufacturers. Drugs should also be sold at highly subsidised prices to health facilities, making them affordable to local populations, and stored and transported appropriately to avoid damage.

To get these results, support from international health agencies is urgently needed to reinforce national drug supply systems or programmes. With affordable drugs in all health facilities, both rich and poor people in developing countries will have access to the same standard of drugs, and the fight against retailers in the street and other informal companies will have more chance of success.

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Beyond cholera—the Zimbabwe health crisis

All I wanted to do was to wash my hands. Hunched over the sink in quiet solace after a hard day in the cholera ward, I was at peace. And then it happened, "Eric, there's a baby I want you to see."

The Zimbabwe cholera outbreak of 2008–09 surpassed the WHO worst-case scenario. In the end, WHO reported 100 000 cases and 4200 fatalities. These values were likely underestimates, because during the crisis reporting clinics were largely on strike, communication was severed by stolen telephone lines, and deaths in the bush devalue as fast as the currency.

Community-based verbal autopsies might be the only way to know the true numbers someday.

In addition to the size, the length of the outbreak was unprecedented. Ironically, one hypothesis is that years of public health success meant *Vibrio cholerae,* the cause of cholera, was not sufficiently present to provide natural vaccination. A susceptible population paired with the ubiquitous failure of the Mugabe government to provide clean water made Zimbabwe a modern-day cholera frenzy.

Our team's assistance was requested by a rural hospital because we had coauthored an ebook, *COTS Program*, on the management of cholera outbreaks. We had lived in the ugliness of cholera in Bangladesh. When we arrived in Zimbabwe, we felt confident. But this outbreak proved different.

The mother sat in the corner with the baby swaddled in her arms. Her posture was frank, her impatience mute. Her 2-week-old was a sick baby. Chestwall not rising. After a pause, a gasped breath. Faint irregular pulse. Floppy limbs. Feverish.

The differential diagnosis was broad. This child definitely did not have cholera. Cholera is the painless death. You sit on the toilet and observe in wonderment as the fluids of your body exit with haste, without effort, distress, or fever.

Cholera treatment is simple: oral rehydration solution (litre upon litre). Antibiotics only shorten the course of the disease. Untreated, cholera rapidly kills 20% of its victims; if treated, fewer than 1% die.

Topping the differential was group B streptococcus. However, diagnosis was secondary, and resuscitation was now primary. I inserted a needle into her arm—with a passive flash of blood, I pushed deeper to get the real thing. No blood. Weak pulse.

I ran down to the house to get the medical director. I told her we had a young tyke with a limited desire to breathe. She sighed and flipped a page of her novel. Gazing over her spectacles she smiled and calmly said, "fluids… cefotaxime if it's in stock, ampicillin otherwise". She had raised her book before I had turned. It would take me days to appreciate that I had just had my first lesson in triage.

The Zimbabwean dollar is dead—it doesn't matter how often you subtract zeroes off the currency. If you want a radiograph, the cost is six chickens. If you want cefotaxime, pray that a donor donates it.

For more on **COTS Program** see http://www.cotsprogram.org