

MSF Access Campaign

1999–2019

**20 Years
of Advocacy
in Action**



Page 12

**6 THINGS
BIG PHARMA
DOESN'T
WANT YOU
TO KNOW!**

Page 14

**TIMELINE:
KEY MOMENTS
OF THE ACCESS
CAMPAIGN**

Page 8

**A WORLDWIDE
REVOLT FOR
ACCESS TO HIV
MEDICINES**

Page 28

**FUTURE
HEADLINES**



TABLE OF CONTENTS

Letter from the Director

Page 3

'We Had to Do Something': Beginnings of the Access Campaign

Page 4

A Worldwide Revolt for Access to HIV Medicines

Page 8

6 Things Big Pharma Doesn't Want You to Know!

Page 12

Timeline: Key Moments of the Access Campaign

Page 14

Then & Now: Changes and Challenges

Page 16

Bhakti's Story: Strength to Survive Drug-Resistant TB

Page 19

Profile of a Campaign: A Fair Shot

Page 24

Transforming Tomorrow into Today: Imperatives for Change

Page 26



Also in this issue:

Q&As!

Learn about the multidisciplinary work of the Access Campaign:

Lawyer [Page 6](#)

Doctor [Page 9](#)

Communications Advisor [Page 17](#)

Pharmacist [Page 20](#)

Policy Advocate [Page 22](#)

Diagnostics Expert [Page 25](#)

Artwork!

View illustrations by artists and people living with HIV/AIDS [Page 10](#) and TB [Page 20](#)

Future Headlines!

Read the news headlines we hope to see in the future [Page 28](#)

The Access Campaign is part of Médecins Sans Frontières (MSF), an international, independent medical humanitarian organisation. The Campaign's work is rooted in MSF's medical operations and supports people in our projects and beyond. The Campaign advocates for effective drugs, tests and vaccines that are available, affordable, suited to the people we care for, and adapted to the places where they live.



GOT PILLS? Millions Don't.

Join the campaign.

20 Years On, the Access-to-Medicines Battle Is Going Global

ELS TORREELE

EXECUTIVE DIRECTOR, MSF ACCESS CAMPAIGN



What were you doing in 1999?

In 1999, MSF launched the Access Campaign out of medical necessity and frustration. MSF staff in the field were facing multiple challenges – unable to provide adequate treatment to people dying from HIV/AIDS, tuberculosis,

malaria, and neglected tropical diseases because new or existing drugs were priced out of reach; were ineffective, toxic, or ill-adapted for use in the places we work; or simply did not exist at all.

These deficiencies were not due to scientific or technical limitations. They were the result of conscious political choices about how medical innovation and access to health tools are organised and financed globally. Rooted in an economic and political system put forth by wealthy governments, the multinational pharmaceutical industry has wielded unchecked pricing power through patents and other monopolies, imposed globally through trade laws that prioritise profits over people's health. **"Medicines Shouldn't Be a Luxury"** has been, and remains, the Campaign's most poignant rallying cry.

The Campaign's initial priority was on overcoming barriers to accessing lifesaving HIV antiretroviral drugs, then sold at more than US\$10,000 per person per year. Together with patient activists, MSF spoke out about the fundamental injustice of letting people with HIV/AIDS die because they cannot afford the deliberately high prices companies charged for medicines. An emerging access-to-medicines movement put pressure on pharmaceutical corporations, governments and other 'powers that be' to crack this deadly gridlock and obtain lower drug prices to increase access to HIV treatment.

It worked. By overcoming the companies' monopolies and fostering generic production and competition, the price of antiretroviral drugs dropped 99% over the next decade, paving the way towards scaling up treatment for people living with HIV/AIDS to over 22 million at the end of 2018. Other successes followed, from increasing access to rapid diagnostic tests and artemisinin-based combination treatments for malaria, to decreasing the prices of the pneumococcal conjugate vaccine and hepatitis C drugs, and fostering research and development (R&D) for the most neglected diseases – including the creation of the Drugs for

Neglected Diseases *initiative* (DNDi), who are now celebrating the launch of fexinidazole, a new all-oral cure for African sleeping sickness.

Each advancement reflects the unique multidisciplinary nature of the Campaign. Our staff combine technical and political analysis based on MSF medical data and operational experience together with strategic advocacy in partnership with allies worldwide – all to get adequate health tools to people who need them most, as well as catalyse broader systemic change so we do not need to keep fighting the same access battles over and over again.

But where do we stand today, 20 years on?

Unfortunately, despite winning some battles, the access-to-medicines challenges are larger than ever, with many new drugs, diagnostics and vaccines marketed at increasingly high prices, monopolies more entrenched, and pharmaceutical corporate powers more globalised. At the same time, we are missing the tools we need to control rising antimicrobial resistance and outbreaks of epidemic diseases such as Ebola.

But herein lies an opportunity. The crisis of access to medicines and innovation is no longer one of only 'poor people' in developing countries, but a truly global one. Our slogan "Medicines Shouldn't Be a Luxury" is valid for people all over the world, and finding solutions is a topic of public and political debate in wealthy and developing countries alike.

In this ever-changing world, we are advocating for needs-driven medical R&D and access as a collective responsibility, with the results of this concerted effort considered as a public health commons, with collective right of use. Given that medical R&D is largely financed by public funds, it is unacceptable that unchecked monopolies are privatising and financialising this common scientific progress, while health systems collapse under the financial burden and people die for lack of medicines. Access to health, including medicines, is a matter of justice, not charity.

Marking the 20th anniversary of the Access Campaign provides an opportunity to look back on what we've learned, reflect on this new reality, and carve out new ways for MSF to engage in transforming the medical innovation and access ecosystem to better address the health needs of people in our care.

What will you be doing in 2019 and beyond to help us achieve this shared goal?

**"ACCESS
TO
HEALTH,
INCLUDING
MEDICINES,
IS A
MATTER
OF
JUSTICE,
NOT
CHARITY"**

'We Had to Do Something'

Beginnings of the Access Campaign



Interview with Bernard Pécoul

© PIERRE-IVES BERNARD/MSF

Dr Bernard Pécoul was a leading founder and the first director of the then-called Campaign for Access to Essential Medicines, launched by MSF in 1999. Prior to the Campaign, he was the Executive Director of MSF France. Currently, he is Executive Director of the Drugs for Neglected Diseases initiative (DNDi). Here he speaks about the beginnings of the Campaign.



▲ A NURSE INJECTS MELARSOPROL, A DRUG DERIVED FROM ARSENIC, TO TREAT A PATIENT WITH SLEEPING SICKNESS, IN OMUGO, UGANDA, 1998. AT THE TIME, THIS TOXIC DRUG WAS THE ONLY REMEDY AVAILABLE. © SERGE SIBERT/COSMOS

What led MSF to start the Access Campaign?

Unaddressed medical needs from the field led to the start, and the need to understand how to overcome the problems that stood in the way of better treatment for patients.

One example – in the 1980s-90s, MSF was confronted with sleeping sickness in Uganda. We knew existing treatments were terribly toxic, based on arsenic, even killing 5% of people treated. But we had no choice as the disease is otherwise 100% fatal! A much better option existed, but the drug was no longer being produced so our field programmes couldn't access it.

For other diseases like kala azar, meningitis, shigella – we were confronted with a lack of products, or a lack of access to products, or both. After the 25th anniversary of MSF in 1996, we created a working group to understand the causes for this.

We knew we had to do something.

But what? And how?

The first step was to understand exactly where the problems were, and gather the expertise so that the access and R&D [research and development] barriers could be confronted and overcome – that was the role for the Campaign.

What kind of shift did the creation of the Campaign mean for MSF?

As a medical organisation, MSF was not assessing the political and legal environment that governed access to medicine. We were logistically oriented and had made great progress in bringing medicines and vaccines to the field – we knew how to purchase and deliver. But we needed to address the situations when we had nothing to purchase, and nothing to deliver!

Take HIV – it was obvious that intellectual property [IP] was a major challenge, pricing treatments out of reach. Addressing IP barriers was a priority. But for sleeping sickness or leishmaniasis, the issue was a lack of R&D. You cannot address both IP and R&D with the same tools and response. The Campaign was the structure that developed a deep understanding of the problems, and then proposed solutions.

In this we are all indebted to Jacques Pinel. He was my mentor, he is why I was asking a lot of questions on this.

What were the first achievements of the Access Campaign?

Getting rid of toxic sleeping sickness treatment was a first success. On a trip to the US, I suddenly saw on TV an advertisement for a hair reduction cream containing eflornithine, the drug we had tried and failed to access for many years. So this lifesaving drug wasn't available for people at risk of dying, but could be bought as a cosmetic product! We took the story to *The New York Times*, and to [US TV news programme] *60 Minutes*. This was the beginning of a long process which led to massive improvement in sleeping sickness treatment.

The Campaign also led on malaria. In the 1990s, field programmes were starting to observe that chloroquine was not doing the job. But there was reluctance to change the status quo. MSF and Epicentre [research arm of MSF] conducted a

series of studies to document resistance, and on that basis the Campaign came up with a strong message: "ACT NOW" to change treatment, make artemisinin-based combination therapy [ACT] available, and do it everywhere. This campaign put pressure on the World Health Organization and led to the adoption of ACTs.

For HIV, the Campaign also had a role in challenging the status quo. Externally, the drive to reduce the price from \$12,000 for a year's treatment, down to \$1 a day was driven

by the Campaign. And internally, this contributed massively to unblock the hesitancy in MSF to treat HIV, as it was now seen as something feasible.

And as convener of an expert group of idealists that thought we can do things better, the Campaign also led to the creation of DNDi. After investigating the problems on the R&D side, we realised that to develop solutions we needed to create a separate initiative, one that could demonstrate a different model, a different way of doing R&D, and that could deliver. DNDi's achievements are also the Campaign's!



▲ A TABLET OF FEXINIDAZOLE, A NEW ORAL DRUG APPROVED IN 2018 FOR THE TREATMENT OF SLEEPING SICKNESS. © XAVIER VAHEDI/DNDI

"WE NEEDED TO ADDRESS THE SITUATIONS WHEN WE HAD NOTHING TO PURCHASE, AND NOTHING TO DELIVER!"



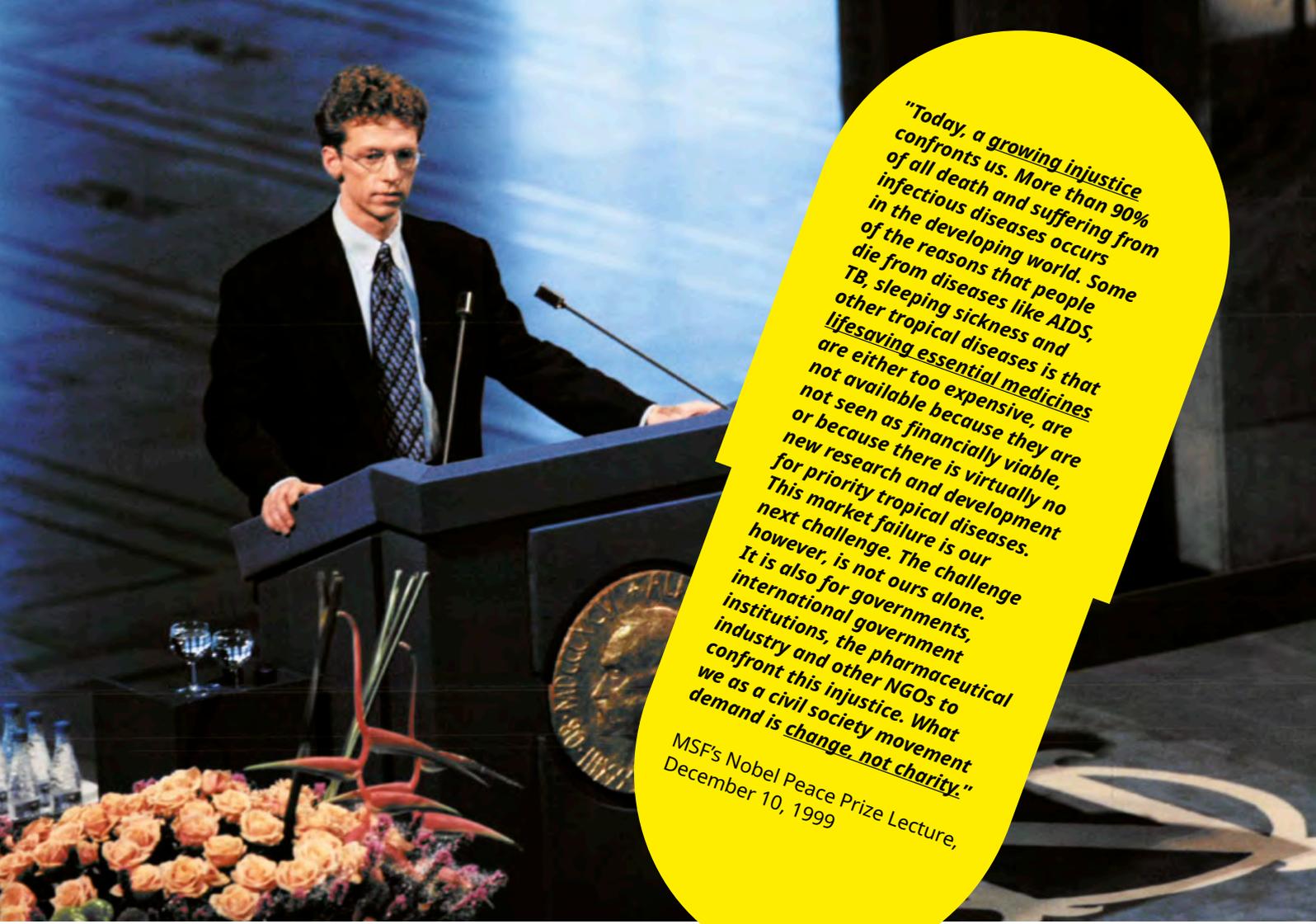
▲ ACCESS CAMPAIGN'S 2003 ACT NOW REPORT, URGING RAPID IMPLEMENTATION OF BETTER MALARIA TREATMENTS.

In Memoriam



© LUDOVIC WEYLAND

Jacques Pinel, who passed away in 2015, was a pillar for MSF since 1979. Trained as a pharmacist, he was instrumental in the set-up of MSF's logistics, pharmacy, and medicines policies, including guidelines and emergency kits. In the 1990s, he played a leading role in the movement that would become the MSF Access Campaign.



© PATRICK ROBERT. NORWAY, 1999.

"Today, a growing injustice confronts us. More than 90% of all death and suffering from infectious diseases occurs in the developing world. Some of the reasons that people die from diseases like AIDS, TB, sleeping sickness and other tropical diseases are lifesaving essential medicines are either too expensive, are not available because they are not seen as financially viable, or because there is virtually no new research and development for priority tropical diseases. This market failure is our next challenge. The challenge however, is not ours alone. It is also for governments, international government institutions, the pharmaceutical industry and other NGOs to confront this injustice. What we as a civil society movement demand is change, not charity."
MSF's Nobel Peace Prize Lecture,
December 10, 1999

3 QUESTIONS WITH:



© MEDICINES LAW & POLICY

Ellen 't Hoen

Lawyer

Former Director of Policy Advocacy, MSF Access Campaign

.....
Why is it important for the Access Campaign to pay close attention to patents and intellectual property law?

Patents and other market exclusivities create monopolies that allow drug companies to charge high prices well above the cost of production and what they need to recoup their investment in the development of a medicine. The work of the Access Campaign has helped to create some flexibility in patent law. Patents do not have to form a barrier. If patent owners, or governments, are willing to grant licences, the patent loses its monopoly effect and lower-priced generics can be made available.

.....
You played an important role in the negotiations for lower-priced HIV drugs in the early 2000s. How was your legal expertise applied?

I had some understanding of how the pharmaceutical industry functions and of the power they have over law and

policymaking. Asking the companies nicely to lower the prices was not the way to go. We set out to change the rules of the game and took the issue of high drug pricing to the negotiating table of the World Trade Organization and other international institutions. We worked [in coalitions] with groups such as TAC [Treatment Action Campaign] in South Africa and the Lawyers Collective in India, who fought hard court battles for access to medicines.

.....
Who are the 'powers that be' standing in the way of access, and how do we overcome them?

Governments that lack the courage to take action. To overcome that, you need political action. The fact that the high pricing of medicines is now a global crisis that also affects wealthy nations will help drive change.

MILLIONS OF BABIES

WON'T LIVE TO SEE THIS DAY.



Without treatment, half of all children with HIV/AIDS in developing countries will die before their second birthday. **We desperately need diagnostic tests that work for babies, and pills that kids can swallow.** HIV/AIDS is treatable, but millions of children are still waiting.



2005

A Worldwide Revolt for Access:

Getting Lifesaving Medicines to People With HIV/AIDS

In South Africa in the early 2000s, an unprecedented mix of events and developments was happening: the first decade of post-apartheid rule; alarming numbers of people dying from HIV/AIDS, despite lifesaving antiretroviral (ARV) treatment being available in wealthy countries; government denialism about the crisis and even that HIV causes AIDS; MSF's beginning to treat people in the face of unaffordable ARV drugs; the start of MSF's Access Campaign; the International AIDS Conference in Durban in 2000; and a lawsuit brought by the pharmaceutical industry against Nelson Mandela's governmental attempt to override patents and obtain affordable generic ARVs.

Together, these elements triggered international outrage and action among health activists everywhere. This is the remarkable story of how widespread revolt of public opinion led to lifesaving access to medicines for people living with HIV/AIDS – **told through the words of those who were there.**



Pan-African HIV/AIDS Treatment Access Movement Declaration of Action, representing activists and organisations from 21 African countries, August 2002.

EARLY DAYS



Where are the drugs? The drugs are where the disease is not. And where is the disease? The disease is where the drugs are not.

Dr **Peter Mugenyi**, HIV/AIDS researcher and physician, and director of Uganda's Joint Clinical Research Centre, July 2000, International AIDS Conference, Durban.



[There] was an internal resistance. People were not ready to launch an HIV programme to treat patients in MSF. Treatment was too expensive at the time. We're talking US\$12,000 per treatment per year [for lifelong treatment]. Patient groups...were very vocal during this bit of time. Activists influenced us a lot. We started to build some alliances with them.

Dr **Bernard Pécoul**, director of MSF Access Campaign, 1999-2002.



© FRANCESCO ZICOLANNOOR

© JONATHAN TORGOVNIK



© ERIC MILLER

MSF INTERVENTION



We opened the first clinic in February 2000. People literally came in masses. [A] few months after we opened, we had registered several hundred people as HIV-positive. People were coming from all over the place.

Dr **Eric Goemaere**, coordinator of MSF's HIV and TB programme in Khayelitsha, a township of Cape Town, where the team was struggling to cope with the high number of people coming to the clinic for treatment given the high prices pharmaceutical corporations were charging for the drugs.

SPEAKING OUT, TAKING ACTION



The only reason we are dying is because we are poor.

Zackie Achmat, founder of Treatment Action Campaign (TAC).



Due to government denialism and pharmaceutical greed, the poor were sent home to die while those who could afford to buy antiretrovirals in the private sector were able to live. The size of your pocket determined whether you lived or died.

Vuyeska Dubula, former nurse in MSF's Khayelitsha programme and former Secretary-General of TAC.



HIV causes AIDS.

Durban Declaration, International AIDS Conference, 2000, signed by 5,000 scientists and physicians in response to government denialism.

DROP THE CASE!



We don't have the intention of breaking the law. What we will be doing is breaking Pfizer's patent. We will be showing that Pfizer and other companies are abusing their patents. We have no criminal intention. Our only intention is to defend people's lives.

Zackie Achmat, on bringing generic fluconazole, a drug for treating an AIDS complication, from Thailand where it cost 5 cents per capsule, to South Africa, where it cost US\$30.

TREATMENT TO THE PEOPLE



It was a losing proposition at the time. But we thought, 'Why should one make money on things that we know people can't afford? Let's go ahead, and do this on a humanitarian basis.

Yusuf Hamied, chairman of Indian generic drug manufacturer Cipla, on their 2001 announcement offering the main ARV drug cocktail for US\$350 per treatment per year – about \$1 a day.



© ERIC MILLER

THE HIV-POSITIVE PEOPLE WE SEE HERE TODAY ARE ALIVE, THEY ARE HEALTHY, AND THEY ARE HAPPY. WHAT WE SEE IS PROOF THAT THERE IS LIFE AFTER HIV/AIDS.

Nelson Mandela, former President of South Africa, December 2003, at the launch of a new MSF clinic in Lusikisiki, a few months after the South African government announced universal rollout of ARVs.

ADAPTED FROM: "NO VALLEY WITHOUT SHADOWS", 2014 BOOK; "FIRE IN THE BLOOD", 2014 FILM; INDIVIDUAL INTERVIEWS AND STATEMENTS.

3 QUESTIONS WITH:



Eric Goemaere

Doctor
MSF South Africa

Dr Eric Goemaere opened MSF's first HIV treatment programme in South Africa in 2000, in Khayelitsha. At the time, the medical situation was dire, with many sick people coming to the clinic seeking treatment. Access to antiretroviral (ARV) and other essential drugs was very difficult due to high prices and patent barriers. Dr Goemaere, patient advocates, and health rights groups stood up to the pharmaceutical industry, and government denialism and inaction, to get these medicines to people who needed them to survive.

What was the crisis you were facing as an MSF doctor treating HIV/AIDS in South Africa in the 2000s?

The majority of people [coming to our clinic] could not walk anymore. They were brought literally in wheelbarrows, or carried on the backs of their relatives. People were dying in the waiting room. While we were consulting behind the door, regularly we could hear people screaming, and this was a sign there was another death. And honestly, there was no single day without a death in the waiting room.

What were the access barriers to ARV drugs at the time?

People could not afford it. It was as simple as that. [And] there was a blockage at the government level. All sorts of things came out – that they were toxic, that the drugs were killing people, problems with the tests. There was a lot of denial on ARVs.

How were you able to get drugs to patients then?

We shipped them clandestinely, because we could not officially pass them through. The idea was the defiance campaign [of illegally importing affordable HIV drugs] will only work if we put a few people on treatment, and everybody will see it works. It's exactly what we did.

© SUSAN AMANDAYAC



The court was filled with people and...they started to sing. Every hair on my body was standing on end. It was in the air that they were going to drop the case, that we had won. And when it did, the whole thing just broke out in one big dancing party.

Ellen 't Hoen, former policy advocacy director of the Access Campaign, when in April 2001 the Pharmaceutical Manufacturers' Association, representing 39 corporations, withdrew their lawsuit against the South African government for circumventing patents to make low-cost medicines more available.



When lifesaving medicines are unaffordable because of high prices resulting from exclusive marketing rights (patents), intellectual property protection threatens people's health.

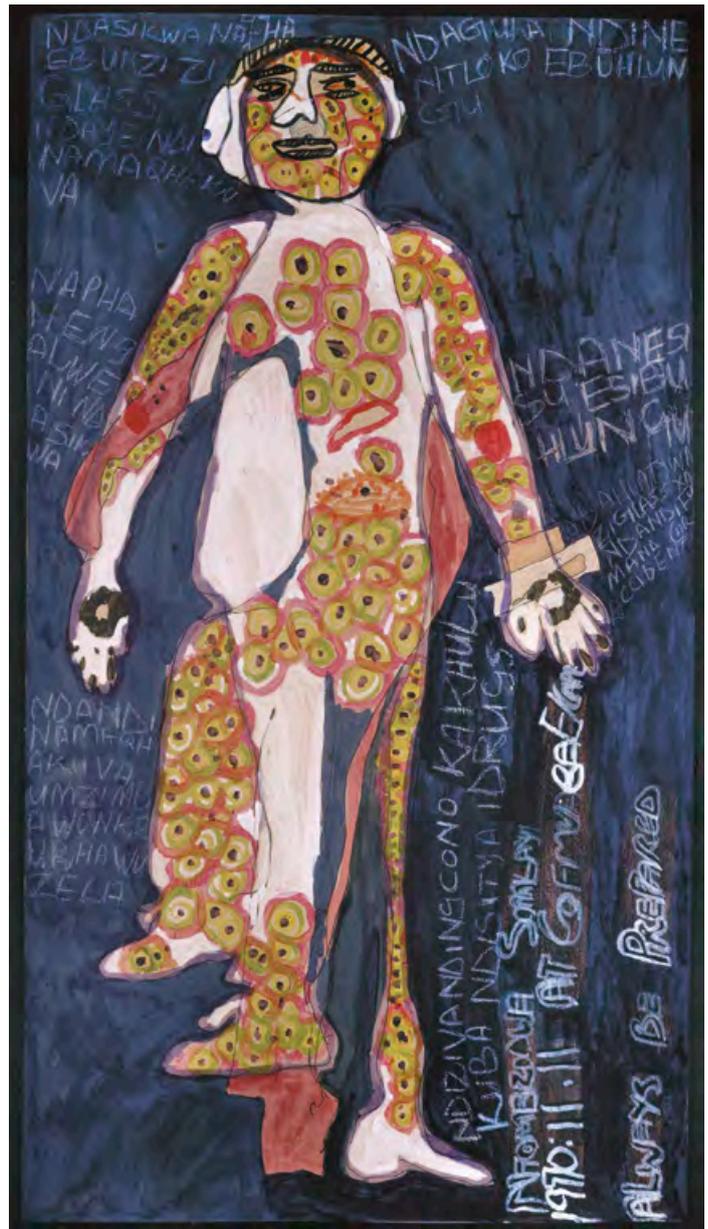
Carmen Perez-Casas, Pierre Chirac, Daniel Berman and Nathan Ford, MSF Access Campaign, Lancet correspondence, December 2000.

BODY MAPS: ART AND MEMORY

People living with HIV/AIDS

In 2003, a group of women living with HIV/AIDS receiving antiretroviral treatment from MSF in Cape Town, South Africa, participated in a body mapping workshop led by South African artist Jane Solomon. A unique form of art and memory therapy, body mapping is a deeply personal form of storytelling. To create the Body Maps, participants filled a life-sized outline of their bodies with handprints, footprints, symbols of hope and emotive text. The Body Maps empowered the participants to sustain courage and hope, and provided a means for each individual to share their personal experiences.

These Body Maps were published in a collaborative book titled *Long Life —Positive HIV Stories*. Here are three Body Maps by Ntombizodwa, Nomawethu and Ncedeka, with interview excerpts from the book.



Ntombizodwa

“I have written ‘always be prepared’ on my body map. ... It means you must be prepared for everything either bad or good. If you get bad, you must be prepared for it how to solve this problem, even HIV. The time I was diagnosed, I was worried I was going to die of HIV. ...

“Look here where I have painted the virus. On 19 January 2001 I became very sick. Stomach pains and headache. It was summer time, the season of peach and apricot, and I thought that’s why I had a sore stomach.

“I went to the doctor who was telling me I am having ulcers, and he gave me the medicine but I didn’t get better. ...I decided to go to the Mapongwane Hospital. I asked for a blood test and they diagnosed me HIV positive. Many of our stories are the same.”

Nomawethu

"I wrote Mount Fletcher on my painting because I want to tell the people I come from there. I'm proud of my province. ...

"That scar on the foot, I think I was 8 years. I was playing with the tennis ball in front of the shack and there is a zinc there in the door. ... As soon as I start to play the zinc in our door cut me on my foot. ...

"When I was small I played in the back yard and not the street. I was a brilliant child and I had a good time. My parents protected me. I thank my parents. I'm a good parent now to my two children, one 7 years and one 12 months. I have not told my 7-year-old about my HIV status. I will tell her one day. It is just too difficult."



Ncedeka

"When I see this picture I feel much happier just because when I look at it, I see what I can't see when I look at myself in the mirror. My picture is like an X-ray.

"At the top of my painting it says, 'I'm still hurt about my child's death who passed away in 1999 when she was one year four months old.' Did I already tell you that because I never knew my status, I passed mother to child transmission to her from breast milk or just by birth? ...

"She died on April 1999. It was only at Coronation Hospital in Johannesburg where they tested her and she was found positive. And me too.

"I felt so badly I even cried. ... I felt worse because I had breastfed her because I was ignorant about my status. And no one had helped me to find out, even though I had asked for help."

6 THINGS BIG PHARMA DOESN'T WANT YOU TO KNOW!

For decades, the global pharmaceutical industry has spread a deceptive narrative justifying the ever-increasing, sky-high prices of drugs, vaccines and diagnostics as something necessary and inevitable. The Access Campaign has repeatedly challenged this deadly narrative, calling for affordable access to lifesaving medicines, prioritisation of people's health over profits, and transparency around the research and development (R&D) process. Yet pharmaceutical corporations continue to perpetuate a series of

myths about the development costs and pricing of medicines and other health products, in order to protect their profit-maximising practices – at the expense of people's lives. One pharmaceutical financial investors' report even went as far as to ask, "Is curing patients a sustainable business model?"

Here are some of the industry's dirty, not-so-little secrets they'd prefer you not know!

PATIENTS

1

DEVELOPING DRUGS IS NOT AS EXPENSIVE AS THEY SAY

Big Pharma exaggerates the costs of R&D of new medicines to justify their high pricing, and often categorise 'opportunity costs' and non-research activities, such as the cost of buying another company, as R&D costs. While Big Pharma often says it costs US\$2-3 billion to develop a new drug, other credible estimates are at least 10 times lower – in the \$100-200 million range.

2

YOU'RE PAYING TWICE FOR YOUR MEDICINES

Corporations free-ride off public, taxpayer-funded research at government and university laboratories, from which most new drugs and health technologies originate. They get tax credits and other financial incentives to 'de-risk' their research investments, and privatise and patent the resulting products. Then they charge high prices to taxpayers and governments.

3

THE PHARMA INDUSTRY IS POOR AT INNOVATION

About two-thirds of the new drugs that arrive on the market are **no better than what we already have**. Pharma corporations put more effort into developing so-called 'me-too drugs' than finding true therapeutic breakthroughs.

4

PATENTS ARE EXTENDED – OVER AND OVER – TO PROLONG MONOPOLIES

A notorious pharma tactic is **patent 'evergreening'**, where corporations file for additional patents on small changes to existing drugs, thereby lengthening their monopoly and blocking affordable generic products.

5

PHARMA BULLIES DEVELOPING COUNTRIES FOR GOING AGAINST THEIR CORPORATE INTERESTS

Time and again, Big Pharma uses **pressure tactics or oppressive legal actions** against low- and middle-income countries like India, South Africa, Thailand, Brazil, Colombia and Malaysia for prioritising people's health over pharma's interests. Together with some wealthy countries, pharma tries hard to influence international trade rules to benefit themselves, even if it hurts public health.

6

PHARMA POCKETS MORE THAN THEY RE-INVEST

Big Pharma says they need huge profits so they can pay for R&D and innovation. But in reality, they **spend more on share buybacks to boost their own stock prices, and on sales and marketing,** than on R&D.

PEOPLE BEFORE PATENTS:

**PROTECT ACCESS TO
AFFORDABLE MEDICINES!!**

NOVARTIS,

DR**P**

DR**P**

DR**P**

THE CASE IN INDIA!

**Don't shut down the pharmacy
of the developing world.**

MSF ACCESS CAMPAIGN: 20 YEARS OF ADVOCACY IN ACTION

1998



© ROGER JOB

Frustration mounts over people dying from treatable infectious diseases, and MSF publicly demands access to key lifesaving drugs

1999



MSF's Access Campaign is created to break down policy, legal and political barriers that block access to medicines in MSF projects and beyond

MEDICINES
SHOULDN'T
BE A
LUXURY

2001



Landmark \$1-a-day price, publicly offered to MSF, boosts political will to treat HIV/AIDS in developing countries

2001



© WTO

After years of campaigning, MSF applauds WTO Doha Declaration on primacy of public health and access to medicines over commercial interests

2001



© TOM STODDART

MSF works with WHO to get lifesaving drugs back into production for sleeping sickness, which is fatal without treatment

2001



© ALEXANDER GIVADRELOV

Fatal Imbalance report: MSF and partners publish seminal evidence to spotlight crisis in neglected disease research

A
FAIR
SHOT

2005



© MSF

MSF stands with India to defend developing countries' rights to protect access to affordable medicines in trade pacts, patent laws

2006



© TON KOENIG

For the first time, MSF supports a legal challenge to a patent, for HIV drug tenofovir, to increase access to lower-priced generics

2006



© SHEILA SHETLE

MSF campaigns to protect India's production of affordable drugs from Novartis' first attack on its patent law, which eventually fails

2014



© LOUISE ANNAUD

The West Africa Ebola outbreak spurs R&D into vaccines and treatments; MSF later supports clinical trials and pushes for affordable, accessible tools

DROP
THE
CASE!

2015

MSF's A Fair Shot campaign kicks off. We later win a lower pneumonia vaccine price for humanitarian use, but many countries still can't afford it



© IRAMIN GAOI

Today, the challenges we face are bigger than ever before. The crisis of access to medicines and innovation is no longer one affecting only developing countries, but is truly a global one.

The MSF Access Campaign continues to advocate for medical R&D that prioritises the medical needs of the people we care for and delivers treatments that people can afford, for the global public good.

As we prepare for our work ahead, it's important to reflect on what we have achieved and how we got here.

2000



MSF breaks rules to import drugs to treat people dying of HIV/AIDS in Thailand, and backs civil disobedience to demand treatment access in South Africa

2000



MSF helps bring down exorbitant prices for five key drugs used to treat drug-resistant tuberculosis

HANDS OFF OUR MEDICINES

2001



Big Pharma vs Mandela: MSF's "Drop the Case" petition adds to public pressure on pharma, and South Africa wins the ability to import cheaper HIV drugs

2003



MSF's 'ACT Now' campaign for more effective malaria treatment spurs change in sub-Saharan Africa

TB OUT OF STEP

2003



MSF and partners create the Drugs for Neglected Diseases *initiative*, a non-profit that has since delivered eight new treatments

2007



To prevent and treat malnutrition, MSF calls for global scale-up of ready-to-use therapeutic food that contains essential nutrients

2010



MSF proposes and campaigns for the creation of the Medicines Patent Pool to facilitate licensing of affordable generic HIV drugs

2010



Europe! Hands Off Our Medicine! MSF campaigns to remove provisions from the EU-India trade pact that would block access to medicines

2013



An MSF doctor and XDR-TB survivor write the Test Me, Treat Me Manifesto, then deliver their petition at the 2014 World Health Assembly

2017



Patent challenges and pressure on companies by MSF and civil society lead to lower hepatitis C drug prices; MSF starts scaling up treatment

GOT PILLS? MILLIONS DON'T.

2018



DNDi's collaborative, public interest R&D approach delivers a new oral drug for sleeping sickness, filling a longstanding medical need

THEN & NOW IN ACCESS TO MEDICINES

CHANGES & CHALLENGES

ANTIRETROVIRALS FOR HIV



Twenty years ago, the price charged for the triple cocktail of drugs to treat HIV was over US\$10,000 for one person for one year, because of patent monopolies. Now, the same treatment is available for less than \$100 per person per year, thanks to robust competition among generic drug manufacturers. This has **allowed treatment scale-up** from <1% of people with HIV in low- and middle-income

countries having access to treatment in 2000, to 59% global treatment coverage in 2017 (over 20 million people on treatment). However, we currently face access and innovation issues with child-friendly medicines, second- and third-line drugs for people whose initial treatment fails, and drugs for AIDS-related opportunistic infections. There are still too many people dying from this treatable disease!

TUBERCULOSIS DRUGS AND DIAGNOSTICS



Despite recent advances in new drugs and diagnostics for TB, **progress has been slow** in scaling up treatment for people with the world's leading infectious disease killer. In the past several years, two new drugs (bedaquiline and delamanid) and a powerful diagnostic testing device (GeneXpert) have become available, ending a decades-long gap in innovation. However, access and uptake of these new tools is lagging, as is continued R&D for

faster, safer, simpler treatments for all forms of TB – including drug-resistant TB, which has become a major public health threat. Multiple political commitments have been made over the years, including the declaration of the first-ever UN High-Level Meeting on TB in 2018. But these need to be put into action. Governments have a collective responsibility to rapidly get many more people tested and treated, and to mobilise R&D and access to new tools.

HEPATITIS C MEDICATIONS



More than 70 million people worldwide have chronic hepatitis C virus (HCV) infection – but in 2016, only about 2 million people had received treatment. After many years of ineffective treatments, **a breakthrough cure emerged – but at an outrageous price.** In 2013, Gilead Sciences began charging US\$1,000 per tablet for its new HCV drug sofosbuvir, while in 2015, Bristol-Myers Squibb started charging \$750 per pill for its new drug daclatasvir. This resulted in a price of \$147,000 per person for a single three-month treatment of both drugs! Following a similar strategy used for HIV drugs a

decade before, MSF and civil society partners worked hard to overcome monopolies and seek ways to reduce the price of these drugs. In 2017, MSF announced it had been able to buy the same three-month treatment at a price of \$120, allowing the scale-up of treatment in selected countries (along with simplified diagnosis and treatment protocols). However, in many countries, this treatment remains unavailable for the majority of people who need it – particularly in middle- and high-income countries, where companies continue to charge unaffordable prices that put a major strain on health systems.

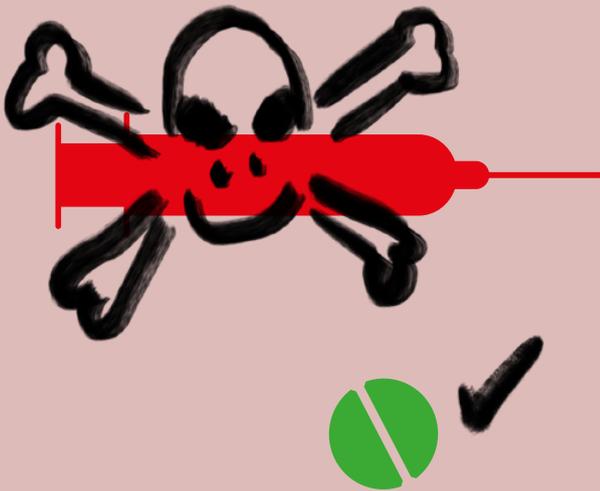
THERAPIES FOR EBOLA



MSF has responded to Ebola virus outbreaks since the 1980s. Back then, the only thing our medical teams could do was isolate patients to stop the spread of infections and ease patients' suffering until they died. No treatments were available at the time, which MSF highlighted starting in the late 1990s as the "fatal imbalance" in which only 1% of new drugs were for neglected diseases. When Ebola struck West Africa in 2014, this fatal neglect was made highly visible around the world – and MSF and others still

had nothing to treat or prevent the disease. Now we have some **promising vaccines and treatments** undergoing testing, as well as new global institutions and funding focused on R&D of better tools to respond to outbreaks of Ebola and other emerging infectious diseases. But such collective responses must be supported and accelerated, and they must be held responsible for delivering lifesaving tools that are available and affordable for the people who need them most.

SLEEPING SICKNESS CURE



Twenty years ago, MSF doctors needed to inject a potentially lethal arsenic-based drug called melarsoprol to save the lives of people with African sleeping sickness. The drug was so painful to receive, some patients called it "fire in the veins", and so toxic that one in 20 patients died during treatment. MSF helped develop a better treatment called NECT, using a combination of existing

medicines developed for other diseases, but it was still very cumbersome to use. Now, a **new simple oral pill** called fexinidazole has been developed and approved by our partner, the Drugs for Neglected Diseases *initiative* (DNDi). This new drug no longer requires patients to first undergo a painful spinal tap for diagnosis and is ready for use by people facing this deadly disease.

3 QUESTIONS WITH:



Shailly Gupta

Communications Advisor
MSF Access Campaign

What is your role in the Access Campaign as a Communications Advisor?

I provide strategic communications advice to further advocacy objectives based on MSF medical needs. This includes coordinating content development for different target audiences, and coordinating communications and Access Campaign initiatives with civil society, patient groups and the MSF communications network.

You worked on both the communications and advocacy sides of the Access Campaign's push to lower the price of hepatitis C drugs. What was the most important lesson you learned?

Building on a strong patient and community activist network, including people who inject drugs, who are disproportionately affected by hepatitis C, advocacy for affordable access to new hepatitis C drugs has been very impactful. Our continuous highlighting of the outrageous price of US\$1,000 a pill being charged by Big Pharma – making treatment unaffordable for millions of people – really helped in catching the attention of people and policymakers around the world.

In this age of media and information overload, how can we ensure MSF's public communications on access issues have an impact?

Our unique selling point is the fact that all our communications are rooted in people's medical needs and realities. Our voice is considered credible not just by the media but by policymakers, civil society, and international governing bodies. Our communications reflect the direct concerns of our patients and MSF medical teams in their struggle to access affordable and quality treatment and care.



HOW MANY PILLS DOES IT

TAKE TO TREAT ONE PERSON
WITH DRUG-RESISTANT TB?

PILL COUNT: 2,000

PILL COUNT: 4,936

PILL COUNT: 8,872

TOTAL PILL COUNT:
UP TO 14,600 PILLS

BHAKTI'S STORY

Strength to Survive Drug-Resistant TB

Bhakti Chavan, 24, is a graduate student from Mumbai, India. A young, bright mind, she recently completed her master's degree in biotechnology. In 2017, she was diagnosed with extensively drug-resistant tuberculosis (XDR-TB) and began treatment at MSF's TB programme in Mumbai. She is being treated with a combination of TB drugs, including delamanid, one of the first new TB drugs in 50 years. Her experience with long treatment and difficult side effects exemplifies the need for access to shorter, safer treatments for people with TB. This is Bhakti's story.

I was 23 and completing my final project for my master's degree in biotechnology when I started having stomach issues. My father took me to a gastroenterologist, who diagnosed me with irritable bowel syndrome. With medication, I managed to complete my project and exams. During this time, I started losing weight, but I thought it was all happening because of my stomach issues.

In June of 2017, I successfully completed my Master of Science degree with first class and was searching for a job when I observed swelling on the right side of my neck. I consulted my family doctor, and she prescribed me some antibiotics. Despite this, the swelling was not reducing. We went to a chest physician who examined me and told me to undergo a biopsy. He told me to send the samples for testing, including with GeneXpert [TB test]. Two days after my biopsy, my reports came back positive for multidrug-resistant TB (MDR-TB), with high resistance to rifampicin [TB drug].

I was so shocked. How could I get this dangerous form of TB? My doctor said I needed a second-line MDR-TB treatment regimen [second-line drugs are used to treat disease that is resistant to standard first-line treatments]. He told me I have to take daily injections for at least six months. [Treatment also requires taking many different pills for up to two years.] My family and I were so depressed after hearing about this rigorous treatment. Still, being a person with a science background, I knew in the back of my mind that this is the only treatment option I have.

Then, the drug-susceptibility testing report came with the most horrible results: I had not MDR-TB, it was XDR-TB [XDR-TB is a type of MDR-TB that is resistant to even more drugs]. I clearly remember the day when I was sitting in my doctor's cabin with my dad, and he told me that I have XDR-TB. He gave me the phone number of another doctor and



PHOTO COURTESY OF BHAKTI CHAVAN

asked me to visit there. It was the number of MSF's clinic in Mumbai. My doctor wanted me to start treatment with the new medicine bedaquiline or delamanid, which were provided by MSF free of cost.

The first day I visited MSF was so depressing for me. The doctor at MSF saw my reports and explained the side effects of the medicines, including one that can affect the heart, with risk of sudden death. But with the counselling and

support of the MSF team, I gathered all my courage and decided to undergo treatment.

Starting from August 2017, I was put on delamanid, cycloserine, ethionamide, clofazimine, moxifloxacin and linezolid, and daily injections of capreomycin. The side effects of the medicines started to appear soon – lots of vomiting, weakness, and neuropathy [nerve] issues. Due to the side effects of ethionamide, I was admitted to the hospital for seven days due to dehydration from severe vomiting. I used to cry while receiving the painful daily injections, which I took for eight months [requiring daily visits to the health centre, disrupting normal life]. But I feel proud of myself that, without missing even a single injection, I managed to complete that course of injectables.

As a young career-oriented person, it is so difficult to accept a situation like this. But I am so lucky that I have huge family support from my mom, dad and sister. They gave me confidence that whatever will happen, they will always be there for me, which also gives me a lot of strength. Also, talking with other survivors helps a lot. After a one-year break

from my studies, I decided to take a postgraduate diploma course to keep my mind busy with something. Now I have completed 18 months of my treatment and have two to three more months to go.

I am very happy today that due to the support of MSF, I can be cured. I wish for people who are suffering with drug-resistant TB to be diagnosed in a timely manner. New medicines are required to be available for larger numbers of patients with drug-resistant TB. Only then will we achieve our TB-free target in India by 2025.

**"NEW
MEDICINES
ARE
REQUIRED
TO BE
AVAILABLE
FOR LARGER
NUMBERS
OF PATIENTS
WITH
DRUG-
RESISTANT
TB"**

3 QUESTIONS WITH:



Jessica Burry

Pharmacist
MSF Access Campaign

What role do pharmacists play in MSF and the Access Campaign?

Our main role is to ensure people being treated in MSF projects get quality medicines and vaccines, regardless of what country they live in. This might mean supporting our supply centres to source quality-assured medicines, or negotiating with companies to make their medicines available and affordable in low-income countries.

One of your areas of focus is hepatitis C virus (HCV). Why has access to HCV drugs been so difficult, and how did your work lead to price drops?

The challenge in accessing HCV treatment has mainly been around price. Before, we only had access to the HCV drugs from Gilead and Bristol-Myers Squibb, which cost almost US\$2,000 per treatment in developing countries – meaning MSF could not really scale up treatment. We were able to work with several generic-drug companies in Egypt and India to do inspections and validate the quality of their medicines and saw the price drop to \$120 per treatment.

What do you hope for the access-to-medicines movement in the next 20 years?

I hope there is no need for an access-to-medicines movement in 20 years! While I love my job, at the same time, I find it quite sad to have to do the work that we do. So, I hope we find ways to make governments and corporations accountable and ensure access and R&D that addresses the real needs of people – and that we have worked ourselves out of a job.

TB TREATMENT AND SUPPORT IN MYANMAR

Sketches by artist George Butler

August 2013

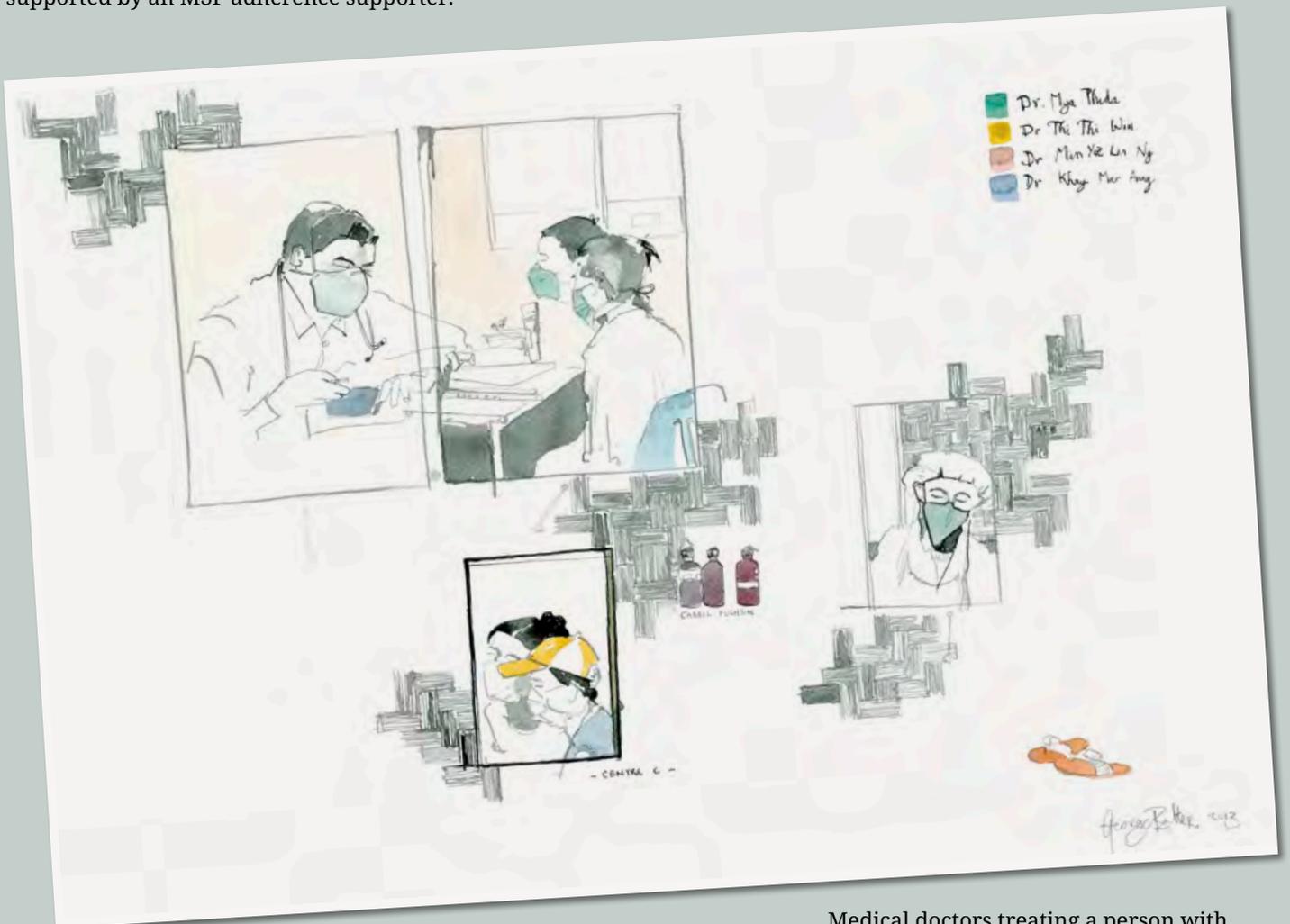


In Myanmar, MSF has supported the Ministry of Health since 2009 in the treatment of people with multidrug-resistant TB. Patients are treated in the community from the outset, enabling people to stay with their families. Rapid diagnosis and correct treatment increase a person's chance of cure and are the best form of prevention. A range of staff is involved in the treatment of people with multidrug-resistant TB. Everyone from doctors and nurses, to psychosocial counsellors, outreach adherence supporters, and peer support workers are essential to aid people through the long and painful treatments.

In 2013, artist George Butler documented life at the Insein and Hlaingtharyar clinics in Yangon, Myanmar.



Ko Myint Naing taking his DR-TB treatment, supported by an MSF adherence supporter.



Medical doctors treating a person with multidrug-resistant TB.

"I know what it means to be faced with the choice of being deaf or dead because the only drugs that can save your life will also rob you of your hearing. I wouldn't wish anyone to go through what I did with DR-TB. Pharmaceutical corporations should stop controlling the price of drugs that will restrict people's access to safer and more effective TB treatment."

TB survivor and activist, Phumeza Tisile, from Khayelitsha, South Africa, who completed treatment for extensively drug-resistant TB in 2013. She suffered hearing loss due to the toxic side effects of injected TB medication and is now a fierce advocate for TB treatment access and innovation.



© MARTA SOSZYNSKA/MSF

3 QUESTIONS WITH:



Sharonann Lynch

Policy Advocate
MSF Access Campaign

Why does MSF need to be involved in broader health policy?

We can't simply chase access to new emerging medicines or diagnostics one by one while ignoring the larger need to change the systemic way medical tools are conceived, developed, priced and delivered. We would do so at our detriment, and risk being blind to how global health politics affect our own ability as MSF to make a difference in the lives of the people in front of us.

How does the Access Campaign work to influence policies for access to treatment and care?

We prioritise, rightly, the needs of our patients, while working to provoke a paradigm shift in how medicines, diagnostics and vaccines are developed, priced and financed. Through analysis and advocacy, we bring evidence and arguments based on our medical experience to urge change by governments and policymakers regarding prices, operational

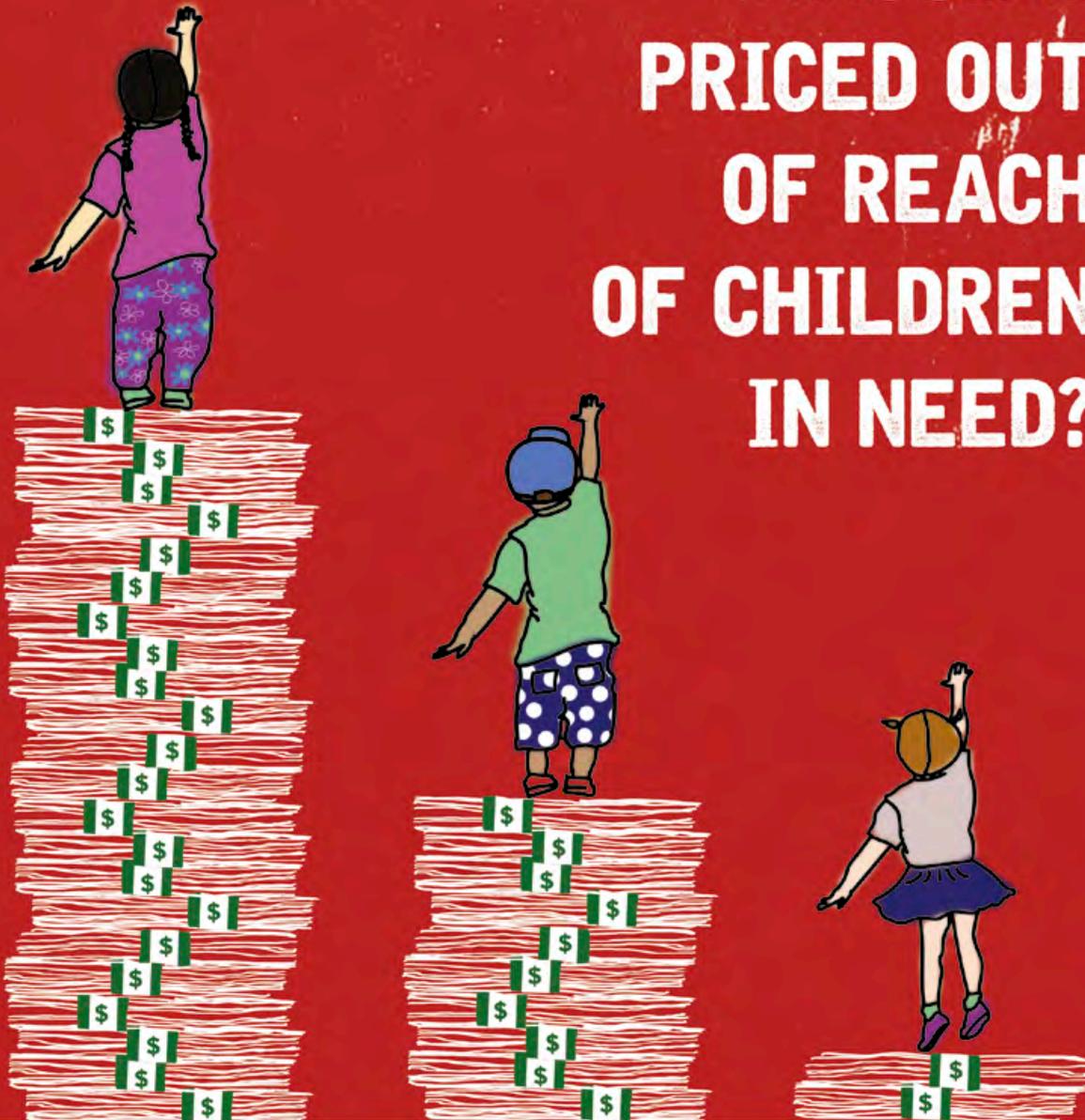
complexity and clinical benefits in order to scale up care to reach more people.

From your experience as a long-time health activist in HIV and TB, what are some of today's threats in access to treatment?

I fear that without sustained attention and funding, HIV becomes as poorly managed as TB, and TB's lethal mediocrity continues to be ignored. We also risk discarding the past 17 years of lessons of procuring affordable quality drugs and diagnostics, as seen in current shifts in Global Fund support. And in R&D, we risk repeating the problems of expensive medicines, inappropriate regimens, and long delays for new treatments if we think that the private sector will save the day.

HEY PFIZER...

WHY IS YOUR
LIFE-SAVING
PNEUMONIA
VACCINE
PRICED OUT
OF REACH
OF CHILDREN
IN NEED?



PROFILE OF A CAMPAIGN: FROM PUBLIC PRESSURE TO SAVING LIVES

Lessons Learned From “A Fair Shot”

Pneumonia is the top killer of children younger than five years of age, despite the availability of a vaccine – pneumococcal conjugate vaccine (PCV). For many years, and still the case today in some places, PCV was priced out of reach for many developing countries. In 2015, the Access Campaign embarked on a public campaign called “A Fair Shot” (www.afairshot.org), calling on the pharmaceutical corporations Pfizer and GlaxoSmithKline (GSK) to lower the price of PCV, so that MSF, countries and other healthcare providers could afford the vaccine and immunise many more children. Over 400,000 people signed a petition to demand a lower price.



In this interview, Kate Elder, the Access Campaign's Vaccines Policy Advisor who worked on the campaign, talks about what this public advocacy and action achieved, and the lessons learned.

What was the genesis of the “A Fair Shot” Campaign?

PCV is important in our medical operations because pneumonia is one of the leading killers of children we see. Around 2007, we started talking with Pfizer and GSK about purchasing it for our operations. These were long, drawn-out, unsuccessful discussions. The companies didn't want to lower their price but instead offered vaccine donations, which we didn't want to accept for the numerous issues brought by donations. MSF typically doesn't accept donations in the form of medicines because of restrictive conditions on use and the risks associated with unsustainable or unpredictable supply. There was a lot of internal discussion about accepting this donation versus children going without the vaccine. Finally, after about five years of trying to get affordable access to the vaccine, MSF made an exception to accept one donation while at the same time raising public pressure on the companies to obtain a long-term access solution.



What was the goal of the campaign?

We set an ambitious and aspirational goal of having both Pfizer and GSK lower the price of their PCVs to US\$5 for the three doses needed to vaccinate one child, for all developing countries and humanitarian organisations. We also called for both companies to publish the prices they charge countries, as well as the R&D costs, and for countries themselves to publish the prices they were paying for PCV.

“PEOPLE AROUND THE WORLD AGREE THAT ACCESS TO LIFESAVING VACCINES IS CRITICAL, AND WANT BIG PHARMA TO CHANGE THEIR WAY OF DOING BUSINESS”



How did the Access Campaign work together with MSF operations (medical programmes) to carry out such a public campaign?

In the long lead-up before the campaign, the Access Campaign supported MSF's medical operations at the highest levels in direct bilateral negotiations with the companies. I think this was why the MSF movement was ready to mobilise a public campaign, because the engagement with companies had already been done hand in hand with our medical operations. The Access Campaign brought the policy and campaigning expertise, and the medical teams brought the reality of kids dying from pneumonia in our projects and a very strong case of why PCV is needed.

What did the campaign achieve?

We finally had access to the lowest global price being paid by some countries, which was US\$9 for three doses, a price that had been inaccessible to us. Also achieved was the creation of the "Humanitarian Mechanism", whereby NGOs, regardless of where they are working, can purchase at this lowest global price. I'd say that was the biggest achievement. MSF has widely used the Humanitarian Mechanism now. By the end of 2018, MSF had used 360,000 doses

in 12 emergency vaccinations in Central African Republic, Nigeria, Niger, South Sudan and Syria.

What did we learn from doing this campaign?

We learned that there are hundreds of thousands of people around the world who agree that access to lifesaving vaccines is critical, and want big pharma companies to change their way of doing business to enable this. These people want to help and are looking for actions they can take to further the cause. If we can bring them ideas for these relatively small but meaningful actions in standing up to the pharmaceutical corporations, we can actually make a big difference.

▲ ON WORLD PNEUMONIA DAY 2015, MSF LAUNCHED THE "A FAIR SHOT" CAMPAIGN AND BROUGHT \$17 MILLION OF FAKE CASH - EQUIVALENT TO ONE DAY OF GLOBAL PROFITS FROM PFIZER'S PNEUMONIA VACCINE - TO PFIZER HEADQUARTERS IN NEW YORK.

© EDWIN TORRES

▲ HEALTH WORKER PREPARES PCV FOR A CHILD DURING AN MSF VACCINATION CAMPAIGN IN YIDA REFUGEE CAMP, SOUTH SUDAN, JULY 2013.

© YANN LIBESSART/MSF

3 QUESTIONS WITH:



Teri Roberts

Diagnosics Expert
MSF Access Campaign

Diagnostic tests often get overlooked in terms of access - why are these technologies important for people's health?

To quote Alain Mérieux, "without diagnostics, medicine is blind." You cannot provide someone with appropriate care, without knowing what the cause of the illness is. Diagnostics are the starting point for providing good quality care.

In what ways do the access barriers to diagnostic tools differ from that of drugs and vaccines?

Diagnostics are more challenging both in terms of supply and sustainable implementation. Most tests involve the purchase and stock management of multiple different components, from instrumentation to various reagents and controls. Service and maintenance is crucial for functionality, and staff must be trained to both perform the test and interpret the result correctly for appropriate clinical intervention.

What are the greatest needs in the near future regarding access to diagnostics?

There is a need for tests to meet public health needs. Much of today's innovation is either not reaching or not suitable for people in developing countries. Typically, when products are first launched, they are completely unaffordable. Also, new diagnostics often have not been tested in developing countries, so we need independent performance studies and quality assurance for tests.

Transforming Tomorrow into Today:

Imperatives for Change in the Future of Access

Despite some significant achievements in getting treatments to people who need them, the situation remains extremely dire. The access-to-medicines problem is still deep and pervasive, spreading and worsening across the globe. Too many people still suffer and die each day because they cannot get the drugs, vaccines or testing they need to survive.

Together we must drastically step up efforts and adapt strategies and tactics to keep up with – and ultimately overcome – the complex challenges limiting people's access to lifesaving health tools. Across the international community, all of us must demand change, political will and action to ensure access for all.

We need change now.

WE MUST:



Seize the global momentum for change

We must channel the current global outrage around expensive medicines and unnecessary deaths, build alliances with the growing numbers of people demanding change, and translate the successes from the past with present opportunities into sustainable, systemic change that ensures access.



Put an end to pharma's myths on high prices

Pharmaceutical corporations must be transparent and accountable in terms of their product price setting, research and development (R&D) costs, and research data. We must once and for all lay to rest the false narrative that medicines must be expensive.

Stop patent abuse

The pharma industry should no longer be given new frivolous patents on existing drugs, extending their monopolies and delaying access to affordable generic medicines.

Challenge the commercialisation of medical research

The economic model behind the development and distribution of medicines and other essential health technologies must change. Profit-maximising business strategies continue to fail sick people and are utterly unsuited to delivering the medicines we need in an affordable way. We should join forces with alternative health economics thinkers to explore sustainable ways forward that centre on people's needs.

Encourage and protect countries taking action for access

Countries wishing to exercise their legal right to put people before patents – like India, Thailand, Brazil, Colombia, Malaysia and others – must be allowed to produce or obtain affordable versions of lifesaving drugs and vaccines, without being bullied by pharma corporations or other countries.

Demand justice, not charity

Medical innovation must be fostered as a 'social contract' of open, collective effort between the public and private sectors, based on people's health needs, not on profit potential, and delivering beneficial public health tools, not luxury commodities. We must embrace open, collaborative R&D in the public interest, in which knowledge and new treatments are shared, not privatised. Medical R&D must address people's health needs no matter where they live, and must address priority areas of public health concern like drug-resistant TB, antibiotic resistance, outbreak diseases, and neglected diseases.

Pharmaceutical corporations and wealthy country governments serving their interests should not be allowed to decide if and when lifesaving drugs, vaccines and diagnostics are affordable or available to the people who need them. It is a collective public responsibility to ensure people's right to health and equitable access are put first.

Promote and organise R&D as a collective responsibility

Future Headlines

News > Health

Researchers Collaborate Across Continents to Develop Affordable New Class of Antibiotics

Medical researchers from six countries in Africa, Asia, Europe

When Vaccines Were Expensive: A Look Back

NEWS

Home Video World UK Bus

Short-Course Cure for TB Finally Available

The Micropharma Revolution: Small-Scale Co-op Apothecaries Produce Medicines at a Fraction of Big Pharma's Prices

WORLD

Open-Source Smart Insulin Revolutionizes Global Diabetes Control

We asked Access Campaigners what news headlines they hope to read in the years ahead...

21 min ·  
Locally Produced Ebola Vaccine Rolling Out in West
and Central Africa

● **Live** / Get Your
Annual ARV Shot:
HIV Treatment Now
Available as a Once-
a-Year Injection

BREAKING NEWS

GLOBAL RATES OF HEPATITIS C DROP
THANKS TO LOW-PRICED GENERIC DRUGS

REPORTAGE
WORLD'S LAST DRUG PATENT
TO EXPIRE PAGE 8

era English  · 9 min
Admitting For-Profit Model Fails Patients,
Governments Set New Rules for Pharma to
Shift to Public Health-Driven Partnerships



Incredible India



Don't shut down the pharmacy of the developing world!



MEDICINES
SHOULDN'T BE
A LUXURY

www.msfacecess.org/20years

