Dear Friends,

Long before high drug prices became a household issue in the United States, we were challenging pharmaceutical companies, governments, and international organizations to make medicines more affordable and accessible to the people who need them most around the world. And we haven’t stopped.

Twenty years ago, Doctors Without Borders/Médecins Sans Frontières (MSF) established the Access Campaign to bring down the barriers that keep people from getting the treatment they need to stay alive and healthy. The campaign advocates for effective and affordable drugs, tests, and vaccines suited to our patients and adapted to conditions in the places they live.

When MSF received the Nobel Prize in December 1999, MSF International President Dr. James Orbinski used his speech to draw attention to the structural reasons why medicines remain out of reach for too many people.

“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,” Dr. Orbinski said. He demanded “change, not charity.” The prize was used to set up the MSF Access Campaign, and that call to action is still what drives us to push for change on a global scale to meet the neglected medical needs we see every day in our projects.

In this issue of Alert, we reflect on the Access Campaign’s achievements over two decades of pioneering work—from expanding access to more effective testing and treatment for malaria, to securing dramatically lower prices for a lifesaving pneumonia vaccine. The campaign also works to transform the model of medical R&D to better meet public health needs. One of the early priorities of the team was to find a better way to treat sleeping sickness, or human African trypanosomiasis (HAT).

This pioneering research on sleeping sickness and other neglected diseases eventually led to the creation of a new organization, the Drugs for Neglected Diseases initiative (DNDi), to focus on research and development (R&D). In 2018, DNDi celebrated the launch of fexinidazole, a new all-oral cure for sleeping sickness.

Among the Access Campaign’s earliest fights was the groundbreaking effort to get affordable treatment to people living with HIV/AIDS in South Africa. In these pages, you’ll learn the inside story of how MSF joined forces with activists to bring down the astronomical costs of antiretroviral drugs and make treatment more widely available.

We’re now challenging Johnson & Johnson to drop the price on the breakthrough drug bedaquiline, so that people living with drug-resistant tuberculosis (DR-TB) can be treated effectively. In April, MSF-USA staff protested outside Johnson & Johnson headquarters in New Brunswick, New Jersey, during the company’s annual shareholders meeting, to demand action.

In May, the Access Campaign welcomed the WHO’s strategy on the prevention and control of snakebite envenoming, which kills more people than any other neglected tropical disease. Globally, more than 100,000 people die each year following bites from venomous snakes, and some 400,000 more suffer from disabilities and disfigurement. MSF has spent years calling for snakebite to be a priority on the global health agenda, because we know that lives can be saved with concerted action.

On a personal note, I’d like to wish you farewell as my term as president of the MSF-USA board of directors comes to an end. While I will continue to serve on the board, I am delighted to introduce MSF-USA’s new president: Dr. Africa Stewart, an ob-gyn and passionate advocate for women’s health who has completed five assignments with MSF. I know you’ll enjoy hearing from her in future issues of Alert.

It has been a great honor for me to lead MSF-USA during such a critical time, and I look forward to continuing to work with our staff in the office and with colleagues around the world responding to urgent medical humanitarian needs.

Sincerely,

John P. Lawrence, MD
President, MSF-USA Board of Directors
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Medikamente
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20 YEARS ON

THE FIGHT FOR ACCESS TO MEDICINES IS GOING GLOBAL

MSF activists protest for affordable medicines at the European Patent Office in Germany, September 2018. © Peter Bauza
When I first joined the Access Campaign in 1999, I understood both the enormous medical needs and intense frustration that led to its creation. 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 drugs were too expensive, ineffective, toxic—or simply did not exist at all.

I used my expertise as a biomedical researcher to coordinate a working group analyzing the lack of research and development (R&D) for neglected tropical diseases. Across the board, it was clear that these deficiencies were not solely due to scientific or technical limitations. They were the result of conscious political choices about how medical innovation and access to health tools are organized and financed globally. The multinational pharmaceutical industry, rooted in the economic and political systems of the richest countries on earth, decides which diseases merit R&D efforts and wields unchecked power over the pricing and distribution of essential medicines and vaccines everywhere. Big Pharma routinely prioritizes profits over people’s health.

“Medicines Shouldn’t Be a Luxury” was an early rallying cry for the campaign, and it remains a powerful message today. Over the past 20 years, we have achieved incredible victories. Working together with patient activists, MSF was part of a coalition that helped overcome the barriers to accessing lifesaving HIV antiretroviral drugs. Thanks to intensive advocacy as well as competition from generic producers, the price of these drugs dropped from more than $10,000 per person per year to less than $100. As a result, we’ve seen the massive scaling up of treatment for people living with HIV/AIDS to over 22 million at the end of 2018.

Other campaign 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, to fostering R&D for the most neglected diseases. A major outcome of the campaign was the creation in 2003 of the Drugs for Neglected Diseases initiative (DNDi), which I joined as a founding member. DNDi is a collaborative, non-profit drug development organization driven by patients’ needs, with which MSF continues to partner. Earlier this year, we celebrated the launch of fexinidazole, a new all-oral cure for African sleeping sickness developed with partners by DNDi. This landmark achievement shows that it is possible to develop new drugs outside the commercial pharmaceutical business model.

Despite some major wins, today the challenges for access to lifesaving medicines are greater than ever. Many new drugs, diagnostics, and vaccines are marketed at increasingly high prices. Drug corporation monopolies are even more entrenched, and their powers are more global. At the same time, we are missing the tools we need to control some of
Despite some major wins, today the challenges for access to lifesaving medicines are greater than ever. Many new drugs, diagnostics, and vaccines are marketed at increasingly high prices.

the major public health challenges of our time, such as the spread of antibiotic resistance and outbreaks of epidemic diseases like Ebola.

The crisis of access to medicines and medical innovation is truly global now, which presents enormous hurdles as well as opportunities for greater solidarity and coalition building. Finding solutions for exorbitant drug prices while fostering medical innovation is a topic of public and political debate in high- and low-income countries alike.

We are advocating for health needs-driven medical R&D and access to medicines as a collective responsibility. Given that medical R&D is largely financed by public funds, it is unacceptable that the fruits of these collective efforts are captured by unchecked monopolies that mainly enrich pharmaceutical corporations and their shareholders. Meanwhile, health systems collapse under financial burdens and people die for lack of medicines.

Together we must drastically step up efforts to expand people’s access to lifesaving health tools. Across the international community, all of us must continue to demand justice, not charity.
MSF ACCESS CAMPAIGN

TOGETHER WE MUST:

SEIZE THE GLOBAL MOMENTUM FOR CHANGE

We must channel global outrage over the high cost of medicines and unnecessary deaths, build alliances with the growing numbers of people demanding reform, and build on past successes to ensure sustainable, systemic changes that ensure greater access.

BUST PHARMA’S MYTHS ON HIGH PRICES

Pharmaceutical companies must be transparent and accountable in terms of their product pricing, R&D costs, and research data. We must counter 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. Patent abuse only enables companies to unfairly extend their monopolies and delay access to affordable generic medicines.

CHALLENGE AND TRANSFORM THE MEDICAL RESEARCH SYSTEM

The economic model behind the development and distribution of medicines and other essential health technologies must change. Profit-maximizing business strategies are failing sick people and do not deliver the affordable medicines we need. We must explore more sustainable ways forward that center on people’s needs, including treatments for drug-resistant TB, antibiotic resistance, outbreak diseases, and neglected diseases. We must embrace open and collaborative models of R&D in the public interest, through which knowledge and new treatments are shared, not privatized. Medical innovation must deliver goods supporting greater public health, not luxury commodities.

SUPPORT COUNTRIES TAKING ACTION FOR ACCESS

We should all defend countries exercising their legal right to put people before patents, such as India, Thailand, Brazil, Colombia, and Malaysia. Countries must be allowed to produce or obtain affordable versions of lifesaving drugs and vaccines without being bullied by pharmaceutical corporations or other countries.

DEMAND JUSTICE, NOT CHARITY

Pharmaceutical corporations and governments in wealthy countries should not get to decide if and when lifesaving drugs, vaccines, and diagnostics are affordable or available to the people who need them. We must work together to ensure that people’s right to health and equitable access are put first.

MEDICINES SHOULDN’T BE A LUXURY
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 categorizes “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 $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 are free-riding on public, taxpayer-funded research at government and university laboratories, from which most new drugs and health technologies originate. Pharma giants get tax credits and other financial incentives to “de-risk” their research investments, and to privatize and patent the resulting products. Then they come back for more by charging high prices to taxpayers and governments.

3. THE PHARMA INDUSTRY IS NOT THAT GOOD 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. MSF is working with other organizations to demonstrate that open models of innovation can actually speed up scientific research, reduce costs, address priority needs, and deliver affordable products to neglected patients.

4. PATENTS ARE EXTENDED—OVER AND OVER—TO PROLONG MONOPOLIES

Patent “evergreening” is a notorious pharma tactic in which corporations file for additional patents on small changes to existing drugs, thereby lengthening their monopolies and blocking the production of affordable generic versions. Evidence shows that evergreening and other abuses of the patent system hamper innovation across the industry.

5. PHARMA BULLIES LOW- AND MIDDLE-INCOME COUNTRIES

Time and again, Big Pharma uses pressure tactics or aggressive legal action against low- and middle-income countries like India, South Africa, Thailand, Brazil, Colombia, and Malaysia for prioritizing public health needs over corporate interests. Together with some wealthy countries, including the US, pharma works hard to influence international trade rules to benefit themselves—often at the expense of public health.

6. PHARMA POCKETS MORE THAN THEY REINVEST

Big Pharma says they need huge profits in order to pay for R&D and innovation. In reality, they spend more on share buybacks to boost their own stock prices and on sales and marketing than on R&D. Medicines shouldn’t be a luxury: it’s time to stop Big Pharma’s profiteering.
“WE HAD TO DO SOMETHING”

The beginnings of MSF’s Access Campaign

Doctors Without Borders/Médecins Sans Frontières (MSF) launched the Access Campaign in 1999, the same year we received the Nobel Peace Prize. The birth of the campaign happened at a pivotal moment in public health. Beginning in the mid-1990s, treatment for HIV/AIDS with new, effective drugs known as antiretrovirals (ARVs) was producing dramatic results for the patients who could afford them. As a result, mortality rates from AIDS—long considered a death sentence—fell sharply and steadily.

But in low- and middle-income countries, exorbitant drug prices charged by pharmaceutical corporations kept ARVs out of reach for the vast majority of people living with HIV. As a result, the number of AIDS deaths rose precipitously in countries like South Africa, where in the late 1990s and early 2000s as many as 250,000 people died from the disease yearly. The lesson was clear: if the best medicines and tests were available to people everywhere, many more lives could be saved.

It was for this reason that MSF launched the Access Campaign, which in 1999 was known as the Campaign for Access to Essential Medicines. As part of the international MSF movement, the Access Campaign works to bring down barriers that keep people from getting the treatment they need to stay alive and healthy. The campaign advocates for available, affordable drugs, tests, and vaccines that are suited to the people MSF cares for and adapted to the places where they live.

Dr. Bernard Pécoul was a co-founder and the first director of the Access Campaign when it was launched in 1999. He is now executive director of the Drugs for Neglected Diseases initiative (DNDi), which grew out of the campaign’s pioneering work. Here, he remembers the early challenges and successes.


ABOVE: A nurse injects melarsoprol, a drug derived from arsenic, to treat a patient suffering from sleeping sickness in Omugo, Uganda, 1998. © Serge Sibert/Cosmos
What led MSF to start the Access Campaign?

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

One example: In the 1980s and 1990s, MSF was confronted with sleeping sickness in Uganda. We knew existing treatments were terribly toxic—based on arsenic—and could kill 5 percent of people treated. But we had no choice [but to use it], as the disease is otherwise 100 percent fatal! A much better option existed, but this drug was no longer being produced, so our programs couldn’t access it.

For other diseases like kala azar [visceral leishmaniasis], meningitis, and shigella [a bacterial disease closely related to E. coli], we were confronted with a lack of products, or a lack of access to products, or both. After the twenty-fifth 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 research and development (R&D) barriers could be confronted and overcome—that was the role for the campaign.

What did the creation of the Access Campaign mean for MSF?

As a medical organization, MSF was not assessing the political or legal environment that governed access to medicines. 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.

What were the Access Campaign’s first achievements?

Getting rid of toxic sleeping sickness treatment was a first success. On a trip to the United States, I suddenly saw an advertisement on TV for a hair removal cream containing eflornithine, the drug we had tried and failed to access for many years to treat sleeping sickness. 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 [the CBS news program] 60 Minutes. This was the beginning of a long process that led to massive improvement in sleeping sickness treatment.

The campaign also led on malaria. In the 1990s, MSF programs were starting to observe that chloroquine [a drug introduced in the 1940s for the treatment of malaria] was not doing the job. But there was reluctance to change the status quo. MSF and Epicentre [MSF’s medical research arm] conducted a series of studies to document resistance to chloroquine, and on that basis the campaign came up with a strong message: “ACT NOW” to change treatment. [We wanted to] make artemisinin-based combination therapy [ACT]—newer, more effective malaria drugs—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. Publicly, [we led the] drive to reduce the price from $12,000 for a year’s treatment down to $1 a day. And within MSF, this contributed massively to overcome hesitancy to treat HIV, which previously was so expensive and complicated it seemed unfeasible.

And, by convening an expert group of idealists that thought we could do things better, the campaign also led to the creation of the Drugs for Neglected Diseases initiative (DNDi), a non-profit drug research and development organization that develops drugs to treat neglected diseases. After investigating the problems on the R&D side, we realized 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.
LIFE AFTER HIV/AIDS

The revolutionary struggle to bring lifesaving treatment to South Africa
In 1994, as South Africa celebrated its hard-won freedom from nearly half a century of apartheid, the country found itself gripped by a new crisis. A lethal and incurable virus was sweeping across South Africa like wildfire.

By the year 2000, an estimated 4.2 million South Africans were infected with the human immunodeficiency virus (HIV)—the virus that, left untreated, causes AIDS. Nearly a thousand people were dying from the disease every day.

In that same year, a confluence of unprecedented developments, including the newly fledged Access Campaign, would kick off an international movement to make lifesaving drugs accessible to people living with HIV/AIDS. A coalition of doctors, patients, and activists in South Africa and around the world worked together to transform public perception and treatment of the virus—and how Doctors Without Borders/Médecins Sans Frontières (MSF) responded to the public health crisis it posed.

“THE ONLY REASON WE ARE DYING IS BECAUSE WE ARE POOR”

Drugs to fight HIV existed in 2000 but were priced far out of reach for the vast majority of South Africans. Branded antiretrovirals (ARVs)—medications that people infected with the virus must take for the rest of their lives—cost upwards of $10,000 per year. The pharmaceutical companies manufacturing these essential medicines refused
to lower prices or allow generic competition. "The only reason we are dying is because we are poor," said Zackie Achmat, a South African activist and founder of the Treatment Action Campaign (TAC).

Treatment was also prohibitively complicated. Regimens required cocktails of expensive drugs that had to be administered by highly trained clinicians. Many public health authorities believed that, even if the sky-high prices of medications fell, the level of expertise and resources required to administer them properly would make it impossible to implement treatment projects in the countries that needed them most, like South Africa. Treating HIV appeared so difficult, in fact, that MSF was at first hesitant to tackle the growing health crisis.

Given these factors, most HIV/AIDS organizations had no choice but to focus almost completely on prevention rather than treatment. "It’s relatively difficult for an international medical organization to work only in prevention on this sort of disease, because you have to understand a lot of social and cultural aspects," said Dr. Bernard Pécoul, a former executive director of MSF in Paris who would go on to be a co-founder and first director of the Access Campaign. "So we felt that we were not the best organization to do it."

However, a growing movement within MSF disagreed. Though the organization was ill-equipped to work on HIV prevention, launching projects to treat the virus slowly began to seem more feasible. Promising scientific evidence from clinics in Thailand showed that the proper administration of a drug called AZT, or zidovudine, during pregnancy could cut the chances of transmission of HIV from an infected pregnant mother to her fetus by 50 percent. This treatment protocol came to be known as prevention of mother-to-child transmission, or PMTCT. Some within MSF also believed that AZT could be safely administered in South Africa, perhaps even outside a hospital setting.

However, South Africa’s health minister had blocked the use of AZT for pregnant mothers in the public...
The South African government, under the country’s second post-apartheid president Thabo Mbeki, had instituted a de facto policy of AIDS denialism. Government officials, skeptical after a lifetime of political violence and inequality, believed the virus was a political ploy—or worse. “All sorts of things came out,” said MSF doctor Eric Goemaere, who would eventually open MSF’s first HIV treatment program in South Africa. “That [ARVs] were toxic, that the drugs were killing people, problems with the tests . . . there was a lot of denial about ARVs.”

“PEOPLE WERE DYING IN THE WAITING ROOM”

Despite the massive challenges, as the crisis in South Africa wore on it became clear that MSF had no choice but to act. Although the central government was unwilling to implement ARV drugs, MSF was eventually able to secure local approval for a public ARV program in Khayelitsha, one of Cape Town’s largest—and poorest—townships, where rates of HIV infection were steeply on the rise. When the project opened its doors in 2001, the scale of the needs immediately became clear.

“The majority of people [coming to our clinic] could not walk anymore,” remembers Dr. Goemaere. “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 [that there had been] another death. Honestly, there was no single day without a death in the waiting room.”

The situation was so dire—and the drugs still so prohibitively expensive—that it would have been impossible for MSF to fill the needs in Khayelitsha, much less the city of Cape Town or South Africa as a whole. At first, the MSF team was only able to put 180 people on treatment with branded ARVs, forcing clinic staff to make wrenching choices of who would receive care—and who would die. Meanwhile, as the death toll rose, public pressure was growing in South Africa for the creation of a national HIV treatment plan.
The astronomical prices of ARV drugs were a major problem for the team in Khayelitsha, and for people living with HIV/AIDS around the world. New international patent agreements were a major reason why. Patents allow manufacturers to charge whatever they want for lifesaving medicines and block the sale of affordable generic versions of these drugs.

In 1997, the South African government led by President Nelson Mandela had passed an act that allowed the minister of health, under certain circumstances, to cancel patent rights to drugs or import generic versions in order to make low-cost medicines available to those who need them. Soon afterward, the Pharmaceutical Manufacturers’ Association (PMA)—a group representing 39 pharmaceutical corporations, including Bristol-Myers Squibb, GlaxoSmithKline, and Merck—sued the South African government. The PMA claimed that this act contradicted the country’s constitution and a new international agreement on intellectual property rights. This challenge began a protracted legal battle that would unite MSF and activist groups like TAC in a fight to bring cheaper generic drugs to patients in South Africa—and around the world.

The case dragged on for years, but a turning point came in 2001 when MSF launched a global advocacy campaign called “Drop the Case.” In a matter of weeks, MSF’s online petition collected 250,000 signatures from people in 130 countries, including many celebrities and public figures. MSF and TAC activists attended a PMA press conference the day before legal arguments in the case were set to resume. Dr. Eric Goemaere was in attendance with a printout of the petition signatures, thick as a phone book. “We are speaking on behalf of 250,000 people across the world,” he said. “And they are telling you: we don’t understand your position.”

The speech was picked up by the media and reported around the world. It had an immediate effect. In a court in the South African city of Pretoria on April 19, 2001, the PMA formally dropped the case. “The court was filled with people… and they started to sing,” remembers former Access Campaign advocacy director Ellen ‘t Hoen. “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 happened], the whole thing just broke out in one big dancing party.” South Africa now had the right to import generic drugs and break patents to improve access to medicines. Although the fight to bring these lifesaving drugs to the people who needed them would continue, a major hurdle had been overcome.

In 2002, the MSF team presented results from the Khayelitsha project at the Barcelona AIDS Conference. The findings were explosive: Two years after the program’s launch, 91 percent of patients were still adhering to their
treatment and had an undetectable viral load, allowing HIV-positive people to live longer, healthier lives and preventing transmission of the virus. Later that year, the Joint United Nations Program on HIV/AIDS and the World Health Organization published the “Khayelitsha model” as part of their best-practices series. The project now served as the bedrock on which resource-poor HIV/AIDS treatment programs could be built worldwide.

In 2003, the South African government announced the universal rollout of ARVs. That December, former president Mandela visited a new MSF clinic in Lusikisiki. “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.”

In the years since, the Access Campaign and activist groups around the world have continued to fight for affordable access to treatment for HIV/AIDS. Thanks in large part to these efforts, ARVs, which in 2000 cost $10,000 per patient per year or more, can now be purchased for around $1 a day. At the end of 2018, more than 22 million people living with HIV/AIDS received these lifesaving drugs.

While this progress has been heartening, the hard-earned gains of the past two decades risk being lost without continued support. Today, access and innovation are urgently needed in key areas including child-friendly medicines, second- and third-line drugs for people whose initial treatment fails, and drugs for AIDS-related opportunistic infections. Sustained attention and funding are required so that all people living with HIV/AIDS have access to lifesaving treatment and care.

“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 HAPPENED], THE WHOLE THING JUST BROKE OUT IN ONE BIG DANCING PARTY.” — Ellen ‘t Hoen, Access Campaign advocacy director

Parts of this article were adapted from the 2014 MSF book No Valley Without Shadows, the 2014 film Fire in the Blood, and the 2019 Access Campaign magazine 20 Years of Advocacy in Action.
## MSF Access Campaign: 20 Years of Advocacy in Action

### 1998

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 our projects and beyond.

### 2000

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

### 2003

MSF and partners create the Drugs for Neglected Diseases initiative (DNDi), a nonprofit that has since delivered eight new drugs.

### 2005

MSF stands with India to defend developing countries’ rights to protect access to affordable medicines in trade pacts and patent laws.

### 2006

MSF works to protect India’s production of affordable drugs from Novartis’s first attack on its patent law. The drug company’s campaign eventually fails.

### 2014

A massive Ebola outbreak in West Africa spurs research and development into vaccines and treatments; MSF later supports clinical trials and pushes for affordable, accessible tools to fight the spread of the disease.

### 2015

MSF’s A Fair Shot campaign launches to push for cheaper pneumonia vaccines. We later win a lower vaccine price for humanitarian use, but many countries still can’t afford it.
For 20 years MSF’s Access Campaign has advocated for medical research and development that prioritizes the needs of the patients we care for and delivers treatments that people can afford. Though the campaign has won important victories along the way, today the challenges we face are bigger than ever. As we prepare for the work—and fights—to come, it’s important to reflect on what the Access Campaign has achieved over two decades of advocacy.

2001
Big Pharma vs. Mandela: MSF’s “Drop the Case” petition adds to public pressure on pharmaceutical companies. South Africa wins the ability to import cheaper HIV drugs.

2001
A landmark $1-a-day price for antiretroviral medicine is publicly offered to MSF, boosting political will to treat HIV/AIDS in developing countries.

2001
MSF works with the World Health Organization to restart production of lifesaving drugs for sleeping sickness, which is fatal if left untreated.

2003
MSF’s ACT NOW campaign for more effective malaria treatments spurs change in sub-Saharan Africa.

2007
To prevent and treat malnutrition, MSF calls for a global scale-up of the use of ready-to-use therapeutic food.

2010
MSF proposes and campaigns for the creation of the Medicines Patent Pool to facilitate licensing of affordable generic HIV drugs.

2010
“Hands off our medicines!” MSF campaigns to remove provisions from the EU-India trade pact that would block access to medicines.

2013
An MSF doctor and an extensively drug-resistant tuberculosis survivor write the Test Me, Treat Me Manifesto and deliver their petition at the 2014 World Health Assembly.

2017
Patent challenges and pressure on companies by MSF and civil society lead to lower prices for hepatitis C drugs. MSF starts scaling up treatment.

2018
DNDi’s collaborative, public interest approach to research and development delivers a new oral drug for sleeping sickness, filling a long-standing medical need.

2019
After years of MSF advocacy, the World Health Organization releases long-anticipated global strategy on the prevention and control of snakebite envenoming.
Soon after celebrating her twenty-fourth birthday, Nandita Venkatesan woke up from a nap to a sharply altered reality. She had recently completed treatment for tuberculosis (TB) and was living at home in Mumbai, India. Suddenly, she could not hear anything.

“I woke up to complete silence,” she later told a TEDx audience in Jaipur. “I could see my brother talking to me. I could see the TV playing in front of me... But there was no sound in my world at all.”

Venkatesan lost her hearing due to a brutal side effect of kanamycin injections, one of the medications that was supposed to help cure her of drug-resistant tuberculosis (DR-TB). “I was devastated,” she said. “How many more people will have to die or go deaf, waiting to access safer and more effective drugs that can save their lives?”

TB is the world’s deadliest infectious disease, killing more than 1.6 million people in 2017, according to the World Health Organization. India has the highest incidence of TB, with more than a quarter of all TB cases, including drug-resistant forms of the disease.

In February, Venkatesan and another TB survivor, Phumeza Tisile, filed a patent challenge in India to try to block pharmaceutical giant Johnson & Johnson (J&J) from extending its monopoly on bedaquiline, a critical medicine in the treatment of drug-resistant tuberculosis (DR-TB). Both women survived DR-TB but lost their hearing because of the toxicity of their treatments. They are now fighting to ensure that newer drugs like bedaquiline—which are safer and more effective—are
made more accessible. Doctors Without Borders/Médecins Sans Frontières (MSF) is supporting this patent challenge as it winds its way through the Indian court system.

If India grants the new patent, J&J’s monopoly on bedaquiline would be extended from 2023 to 2027, delaying the entry of generic alternatives. This strategy of “patent evergreening” through filing of additional, often unmerited, patents is commonly used by corporations to extend monopolies on their drugs beyond the standard 20 years.

Access to and affordability of newer TB medicines is crucial at a time when the standard DR-TB treatment used by most countries has a cure rate of just 55 percent. That means that nearly one out of every two people don’t get better even after enduring a grueling treatment regimen: drugs that need to be injected daily and are associated with serious side effects including deafness and psychosis.

The World Health Organization (WHO) has now recommended bedaquiline as a core part of an all-oral treatment regimen for DR-TB, a move that should relegate older injectable drugs to options of last resort. However, the medicine can only reach the people who need it if J&J prices it affordably and registers it widely—or stops standing in the way of other manufacturers that want to make cheaper generic versions.


J&J currently sells bedaquiline for $400 per six-month treatment course to countries eligible to buy the drug through the Stop TB Partnership, affiliated with the United Nations. J&J has not disclosed prices for the drug in other countries. As of November 2018, only 28,700 people had received bedaquiline worldwide since it was approved for use in 2012, which is less than 20 percent of those who could have benefitted from it.

Researchers from the University of Liverpool have calculated that bedaquiline could be produced and sold at a profit for much less—as little as 25 cents per day if at least 108,000 treatment courses are sold per year. At $1 per day, the price would be $600 per person for the 20 months of treatment that many DR-TB patients require.

Bedaquiline was the first DR-TB drug to be developed in more than 40 years, and its development benefitted from considerable public investment. Evidence for the drug’s potential to improve cure rates with fewer side effects was also the result of joint efforts by the global TB research and treatment provider community.

MSF is one of the biggest non-governmental providers of TB care worldwide, especially for drug-resistant TB. Operational research carried out by MSF and others was key in generating evidence of bedaquiline’s effectiveness against drug-resistant forms of TB. Additional clinical trials by MSF are underway that could further inform treatment options containing the drug. Despite these joint efforts, J&J sets the price for bedaquiline at its own discretion, effectively deciding who can have access.

“It’s not complicated: drugs like bedaquiline that are created and developed together with the global TB community and using public money should be available to people who need them at the lowest possible price,” said Lynch. “The public has already paid for this drug. It’s time the public has affordable access to it.”
A FAIR SHOT
From public pressure to saving lives

Pneumonia is the top killer of children under five years old, despite the availability of a safe and effective vaccine against the disease. For years, the lifesaving pneumococcal conjugate vaccine (PCV) was priced out of reach for people in many low- and middle-income countries.

In 2015, MSF’s Access Campaign launched a public campaign to give children around the world “A Fair Shot” to get vaccinated. The campaign called on the pharmaceutical corporations Pfizer and GlaxoSmithKline (GSK), the only two manufacturers of the pneumococcal vaccine, to drop the price. We argued that lowering the price of PCV would enable MSF, national ministries of health, and other health care providers to protect many more children against pneumonia. More than 400,000 people around the world signed a petition joining our demand for a lower price.

In 2016, the campaign succeeded in getting Pfizer and GSK to significantly drop the price of the pneumonia vaccine for humanitarian organizations working in emergency settings. The story of “A Fair Shot” is just one example of how MSF’s Access Campaign uses public advocacy to speak out for our patients and help change global health policies for the better.

Here, Kate Elder, the Access Campaign’s vaccines policy advisor, shares some of the important lessons learned from this initiative.

ABOVE: On World Pneumonia Day 2015, MSF activists attempted to deliver more than $17 million in fake cash—the equivalent of one day of profits from Pfizer’s pneumonia vaccines globally—to the company’s CEO Ian Read. The same day, MSF launched a global petition to ask Pfizer and GlaxoSmithKline to reduce the price of the pneumococcal vaccine to $5 per child in developing countries.
“BY THE END OF 2018, MSF HAD USED 360,000 DOSES OF PCV IN 12 EMERGENCY VACCINATION CAMPAIGNS IN CENTRAL AFRICAN REPUBLIC, NIGERIA, NIGER, SOUTH SUDAN, AND SYRIA.”

What was the genesis of the Fair Shot campaign?

Around 2007, MSF started talking with Pfizer and GSK about purchasing PCV 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 because of the numerous issues brought by donations. MSF typically doesn’t accept donations in the form of medicines because of restrictive conditions on their 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 $5 for all developing countries and humanitarian organizations for the three doses needed to vaccinate one child. We also called for both companies to publish the prices they charge countries, as well as the research and development costs, and for countries themselves to publish the prices they were paying for PCV.

How did the Access Campaign work together with MSF’s medical projects to carry out this public campaign?

In the long lead-up before the campaign, the Access Campaign supported MSF’s medical operations at the highest levels in direct negotiations with the companies. I think this was why MSF as a movement was ready to mobilize 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?

Because of A Fair Shot, we finally had access to the lowest global price being paid by some countries, which was $9 for three doses, a price that had previously been inaccessible to us. Also achieved was the creation of the “Humanitarian Mechanism,” whereby nongovernmental organizations, regardless of where they are working, can purchase PCV 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 of PCV in 12 emergency vaccination campaigns in Central African Republic, Nigeria, Niger, South Sudan, and Syria. [In April 2019, MSF used the mechanism to launch a pneumonia vaccination campaign for refugee children stranded in Greece.]

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 lower prices. 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.

Learn more about the campaign at afairshot.org

BELOW: A child receives a pneumococcal conjugate vaccine in Yida refugee camp, South Sudan, in 2013. © Yann Libessart/MSF
Workey Mekonen was sleeping on the ground in a farm shed in northern Ethiopia’s Amhara region when she woke up to a sudden piercing pain in her forehead. She caught sight of a snake slithering away. Relieved at first that it was only a small snake, the pain and swelling soon made her fear for her life.

Workey, age 24, earns a meager living for herself and her four children by cooking for farm workers in the fields. Fellow laborers took Workey to her uncle, who took her to a clinic run by Doctors Without Borders/Médecins Sans Frontières (MSF) in nearby Abdurafi town. By that time, Workey’s face was so swollen that she could not see.

ABOVE: An MSF nurse begins antivenom infusion for Workey Mekonen, who was bitten by a snake while she slept in Ethiopia’s Amhara region. © Susanne Doettling/MSF
Workey’s test result showed no blood clotting, a clear indicator that the snake had injected its venom, and that this young woman needed urgent treatment. “The first ten minutes are critical and need close monitoring to ensure that she has no harmful reactions to the antivenom,” said MSF clinical officer Degifew Dires. “Over the coming hours, we will regularly check her physical condition and vital signs.”

Fortunately, she made a full recovery and was discharged from the clinic after five days. MSF doctor Ernest Nshimiyimana said Workey is one of the lucky ones. “Effective antivenom is either unavailable or is too expensive for the communities most affected by snakebite,” he said.

Every year, an estimated 2.7 million people are bitten by venomous snakes, resulting in death for more than 100,000 people and life-long disfigurement and disability for 400,000 more. MSF teams witness the devastating impact of snakebites on victims, their families, and communities. Victims can suffer a variety of immediate physical effects, including suffocation, bleeding disorders, kidney failure, and severe tissue damage that can require amputation. In 2017, more than 3,000 patients were admitted to MSF-supported hospitals for snakebite treatment, mainly in sub-Saharan Africa and in the Middle East.

And this may only be a fraction of the cases worldwide. Hospital records are an unreliable guide because many people bitten by snakes never make it to the hospital for treatment. Snakebite hits the poorest of the poor: farmers who work barefoot in the fields and people living in remote rural areas with limited access to health education and medical care. Displaced people fleeing conflict or violence who may hide out in snake habitats are also at risk. Children, due to their smaller body mass, are particularly vulnerable to death and disability from snakebite poisoning.

The vast majority of snakebite victims are unable to access affordable and effective treatment for a variety of reasons, including high prices for antivenoms, unavailability of effective antivenom in remote places when urgently needed, and lack of skilled health care workers. Many families are driven into debt and destitution in their attempts to get treatment. Death and disability can also spell financial ruin. Stigma and discrimination against disabled snakebite survivors are commonplace.

For years MSF’s Access Campaign has been calling for greater efforts to prevent and control snakebite envenoming. In 2017, the World Health Organization (WHO) recognized snakebite envenoming on its list of Neglected Tropical Diseases, and this May released its roadmap to address this major public health crisis. MSF is pushing for more attention to snakebite in fragile states and conflict zones, and for an adequate stockpile of quality-assured antivenoms.

MSF is cautiously optimistic that the WHO roadmap could be a turning point in tackling snakebite. The roadmap includes ambitious targets for reducing death and disability from snakebite, as well as outlining the funding needed to deliver on these plans. It finally provides a framework for MSF and other actors to mobilize governments and donors to respond to snakebite with the urgency and attention that this neglected public health crisis demands.

Now governments and donors need to pledge enough funds to scale up effective interventions, in particular technical assistance for countries to roll out the roadmap; procurement and supply of affordable, quality-assured antivenom products; and a dramatic reduction of out-of-pocket costs for snakebite victims, for whom access is a matter of life or death.

“Imagine how frightening it must be to be bitten by a snake,” said Dr. Gabriel Alcoba, MSF medical advisor on snakebite, “to feel the pain and venom spread through your body—knowing it may kill you and there is no treatment available, or that you can’t afford to pay for it.”

We can imagine a better future for snakebite victims, and working together we can ensure that they get the care and treatment they deserve.
The Keith Haring Foundation Supports MSF’s Access Campaign

MSF AND THE KEITH HARING FOUNDATION SHARE THE BELIEF THAT EVERYONE LIVING WITH HIV SHOULD HAVE ACCESS TO THE MOST EFFECTIVE TREATMENTS.

Celebrated American artist and social activist Keith Haring (1958–1990) captivated the world with his colorful, message-driven pop art and graffiti-inspired murals. For years, Haring created art for an audience of New York City subway commuters that tackled complex social topics like sexuality, violence, life, and death. He devoted much of his career to charitable causes, conducting art workshops for children and creating paintings that benefited health centers and disadvantaged communities.

In 1988, Keith Haring was diagnosed with AIDS. One year later, he established the Keith Haring Foundation, with a mandate to provide funding and the licensing of his images to nonprofit organizations that provide HIV/AIDS care and children’s programs. During the last years of his life, Haring spoke publicly about his own illness and became an activist to raise awareness about HIV/AIDS.

Haring believed that art should be accessible to everyone. Nearly three decades after his death, it’s fitting that the foundation he started supports MSF’s Access Campaign, which seeks to ensure that everyone—no matter where they live—has access to lifesaving drugs.

“The Keith Haring Foundation is fortunate to be able to support MSF, whose global reach and compassionate care poignantly illustrate that human beings truly are capable of selflessness,” said Julia Gruen, executive director of the foundation. “We wholeheartedly support MSF’s activities, which have saved the lives of millions.”

The Keith Haring Foundation was initially drawn to MSF’s mission in 2010 following the devastating earthquake in Haiti and made its first grant to support MSF’s emergency response to that disaster. This generous contribution paved the way for what would become a very special relationship. Through this connection, the foundation learned about MSF’s long commitment to ending the global AIDS crisis and the pivotal role that the Access Campaign has played in dramatically lowering the costs of HIV medications.

While the Keith Haring Foundation directs the majority of its funds to New York City-based programming, it recognizes that MSF’s groundbreaking work to shift public health policy on HIV/AIDS in countries like South Africa would not have been possible without the efforts of activists like Haring. MSF and the Keith Haring Foundation share the belief that everyone living with HIV should have access to the most effective treatments.

For these reasons, in 2016 the Keith Haring Foundation significantly increased its commitment to MSF by awarding a $1 million grant over four years in support of our HIV/AIDS projects and the work of the Access Campaign. This grant provides vital support to MSF pilot projects offering pre-exposure prophylaxis (or PrEP) to young, at-risk populations and to the advocacy work of the Access Campaign to increase access to HIV/AIDS drugs world-
wide, including drugs used to treat hepatitis C, a major killer of people with HIV/AIDS.

It is through our joint efforts—the generosity of the Keith Haring Foundation and the dedication of our teams—that we are developing better models of care and working to improve access to HIV prevention and treatment everywhere.

INCREASE YOUR IMPACT

Does your employer have a matching gift program? Many companies have matching gift programs that will double or even triple the impact of your gift. Companies will sometimes also match donations made by spouses, retirees, and board members. Because conditions and criteria for gift matching vary by employer, please check with your company’s human resources department for details.

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MSF-USA would like to thank all of our donors who have made commitments towards the Multiyear Initiative. With annual commitments of $5,000 or more, these generous supporters help provide MSF with a predictable revenue stream that better serves our ability to respond rapidly to emergencies and ensure the continued operation of our programs.

To date, we have received commitments totaling more than $60 million towards the initiative.

To find out how you can participate, please contact Mary Sexton, director of major gifts, at (212) 655-3781 or mary.sexton@newyork.msf.org. You can also visit www.doctorswithoutborders.org/multiyear.

JOIN OUR LEGACY SOCIETY

MSF is able to provide independent, impartial assistance to those most in need thanks to the dedication, foresight, and generosity of our Legacy Society members. Every day, legacy gifts help us keep our commitment made more than 40 years ago to assist people in distress regardless of race, religion, creed, or political affiliation.

To learn more about joining MSF-USA’s Legacy Society by making a gift through your will or other legacy gift that will save lives for years to come, please contact Lauren Ford, planned giving officer, at (212) 763-5750 or lauren.ford@newyork.msf.org.

SET UP A GIFT ANNUITY WITH MSF

MSF’s charitable gift annuities make it easy to provide for our future as well as your own. When you set up a gift annuity with MSF you will receive fixed payments for life and an immediate income tax deduction. The minimum age when payments begin is 65. We follow the ACGA suggested rates.

For more information, including a personalized proposal showing how a gift annuity can work for you, please contact Beth Golden, senior planned giving officer, at (212) 655-3771 or plannedgiving@newyork.msf.org.

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ALERT

is a quarterly newsletter sent to friends and supporters of Doctors Without Borders/ Médecins Sans Frontières (MSF). As a private, international, nonprofit organization, MSF delivers emergency medical relief to victims of war and disaster, regardless of politics, race, religion, or ethnicity.

ABOVE: Phumeza Tisile (center) celebrates her cure from extensively drug-resistant tuberculosis with friends and patients at Lizo Nobanda TB Care Center, Khayelitsha, South Africa, on August 16, 2013. © Sydelle Willow Smith