**Talking Points Social Forum**

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1. MSF aims to bring the best medical care possible to some of the most disadvantaged groups of society. But our medical teams are often hindered in delivering that optimised care due to the lack of adequate and effecive diagnostic tests, drugs and vacccines for those diseases that predominantly affect people in the places where we work. In response, therefore, in 1999, was when Médecins Sans Frontières launched the Access Campaign to alert the world about the desperate need to improve the medical tools at our and others' disposal.
2. The lack of urgently needed medical tools in the Ebola crisis in West Africa has definetely been a wake-up call on the need for R&D reforms. Ebola brought with it immeasurable suffering; destroyed the fabric of communities and devastated already fragile health systems.  More than 28,000 people were infected with Ebola, of whom more than 11,000 lost their lives, including more than 500 health workers, lost to countries where they are desperately needed.
3. From the very beginning of the epidemic, MSF responded in the worst affected countries – Guinea, Liberia and Sierra Leone - through setting up Ebola treatment centres as well as providing services such as psychological support, health promotion activities, surveillance and contact tracing. At its peak, MSF employed nearly 4000 national staff and over 300 international staff to combat the epidemic across the three countries. MSF admitted more than 10,000 patients to its Ebola treatment centres, of which half turned out to be confirmed Ebola cases. In total, we treated 1/3 of all confirmed patients during the outbreak.
4. During the outbreak, the ability of front-line doctors to respond was severely hampered by the lack of effective diagnostics, treatments and vaccines, thus the Ebola outbreak was not only a signal of a health systems failure and a failure for international agencies/governments to respond but also, as I was mentioning before, a failure of the system of R&D.
5. This failure can be considered in two ways:
	1. Ebola, like other epidemic prone infectious diseases, has not been prioritized over the last four decades in part because outbreaks are sporadic, in poor communities and not a commercial opportunity. With Ebola perceived as a disease causing small-scale outbreaks in poor rural communities in Central Africa, discovery and research and development efforts had been extremely limited. However, this also holds for far more ‘mainstream’ medical conditions including TB, paediatric diseases, rare diseases and drug resistant infections.
	2. Secondly, in the early 2000s, there was significant investment by a few governments, under the guise of counter bio-terrorism, to be able to anticipate an Ebola outbreak. This included R&D on new vaccines, drugs and diagnostics, none of which were completed.

6. When the Ebola outbreak occurred, despite the existence of Ebola for four decades and of significant research, we had no tools to protect, prevent and treat Ebola. So Ebola in the first instance is an important, though, specific example of how a lack of R&D for priority health needs costs lives.

7. In particular, it is worth noting that at least three vaccine candidates had been developed and were stuck in pre Phase I trials prior to the outbreak. When the outbreak occurred, none of these vaccines could be immediately deployed because no basic safety data had been collected. If even just Phase I trials, which could have been run in Geneva, and eventually were, had been conducted, these vaccines could have been used to help turn the tide of the outbreak at an earlier time and save lives.

8. One particular example worth noting is with the rVSV vaccine. It was developed by the Canadian government over a decade ago with public financing and showed enormous promise. The vaccine was then licensed to a small biotechnology company in the United States for 205,000 USD with no conditions really attached. The company was unable to continue development of the vaccine, including Phase I trials. When the outbreak occurred and the company was unable to respond, they were eventually compelled to sell the vaccine on to Merck for 50 million USD, which means the company was paid extravagantly for failure. Since then through significant public funding and some resources from Merck, the vaccine is now close to approval but has still not been approved.

9. So today, even after the end of the outbreak, we still have no approved drugs, vaccines and diagnostics to address Ebola. And this speaks to the fundamental failure of our current system of R&D - not only to produce affordable drugs and vaccines, but to prioritize and develop them in the first place.

10. Today there are significant efforts to now respond ahead of time in the future and avoid gaps and failures. This includes a coordination effort from the WHO called the WHO Blueprint and a particular R&D initiative, called the Coalition for Epidemic Preparedness Innovations, which is meant to accelerate the development of pipeline vaccines for these diseases through Phase II trials so that they can be ready for use in the next outbreak.

11. While we support both initiatives, we are concerned that the standards to promote access, relating to transparency, intellectual property and pricing, are not sufficient, in particular given that nearly all the R&D costs are being paid for by governments and philanthropies.

12. At the same time, we have to question why billions of USD were eventually raised during the Ebola outbreak and money has been raised since then to address these R&D issues, while many other therapeutic needs such as DR TB are left behind. The concern is that the broader interest in global health security amongst Northern governments and philanthropies - or to protect their own populations and economic interests - are being prioritized over the essential health needs of poor populations for a range of neglected and chronic conditions for which there is little or no R&D.