



MEDICINES  
SHOULDN'T BE  
A LUXURY

# Change, not charity

It's a bright October day. Around 200 activists are unified in chant and song in Midrand, protesting outside the South African headquarters of pharmaceutical corporation Johnson & Johnson: "Lives over profits." "Bedaquiline at one dollar a day!" "Drop the price!"

We are here because we want change – not charity. Bedaquiline is one of the best new medicines used to treat deadly drug-resistant TB in South Africa and elsewhere in the world. But drug maker Johnson & Johnson has priced it far beyond the reach of millions of people who desperately need it.

Twenty years ago, this same injustice prompted Doctors Without Borders (MSF) to launch its Access Campaign out of medical necessity and frustration. Dr Bernard Pécoul, an Access Campaign founder, explains: "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!"

MSF fieldworkers faced 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 resulted from conscious political and commercial decisions about how medical innovation and access to health tools are organised and financed globally.

For 20 years the Access Campaign has fought injustice and to bring change so people in the greatest need get the drugs and care essential to their survival. Back in 2000, the frontlines of the battle for affordable HIV treatment were drawn here in South Africa, when health activists confronted denialist government policies and pharmaceutical corporations'

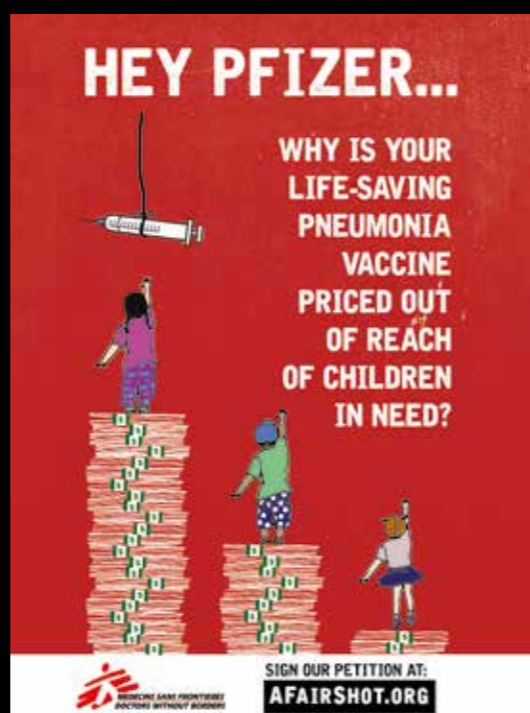
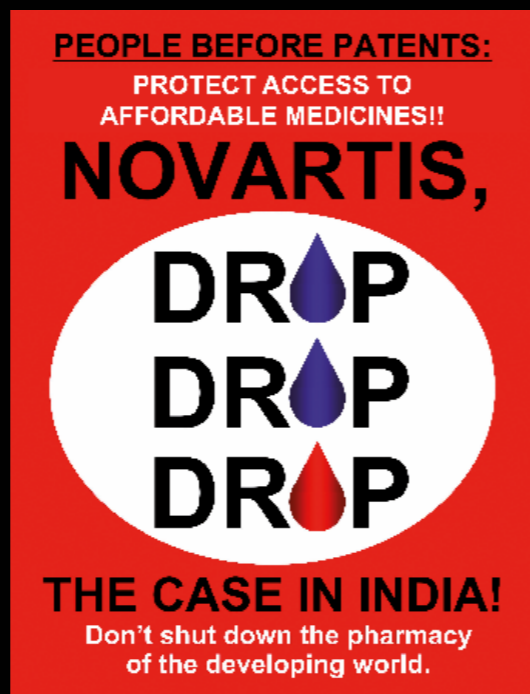
patents and exorbitant drug prices. Back then, antiretrovirals cost more than US\$10 000 a year to treat a single patient. International solidarity and activist alliances helped us win the fight to get HIV treatment costs down to less than \$100 per person per year. This was crucial to the scale-up of HIV treatment worldwide, particularly for South Africa, which now has the world's biggest HIV programme with more than 4.4 million people on treatment. Today we're engaged in the same battles over the costs of DR-TB drugs, vaccines and diagnostics.

I want to invite you on a journey with this edition of *Mamela*, exploring the Access Campaign's history, the landmark battles we won, and to understand the challenges that lie ahead in the future – a future we cannot fight for without your support.

**Candice Sehoma**  
MSF Access Campaign  
Advocacy Officer  
South Africa

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## CAMPAIGN POSTERS FROM THE PAST



# Revolt for access





Getting life-saving medicines to people with HIV/AIDS

In South Africa in the early 2000s, an unprecedented mix of events and developments unfolded. It was the first decade of post-apartheid rule but HIV/AIDS was killing alarming numbers of people – despite life-saving antiretroviral (ARV) treatment being available in wealthy countries. There was government denialism about the crisis – and even that HIV causes AIDS. MSF was beginning to treat people in the face of unaffordable ARV drugs and the Access Campaign had just launched. The watershed International AIDS Conference in Durban took place in 2000, and in 2001 the pharmaceutical industry withdrew its lawsuit against the Mandela-era government’s attempt to override patents to get 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 life-saving access to medicines for people living with HIV/AIDS in South Africa – told through the words of those who were there.

## 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 MUGYENYI, HIV/AIDS RESEARCHER AND PHYSICIAN

 [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\$10 000 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

## MSF’S DEFIANT INTERVENTION

 People were dying in our waiting room  
– DR ERIC GOEMAERE

Dr Eric Goemaere, HIV/TB Unit Coordinator, opened MSF’s first HIV treatment programme in South Africa in 2000, in Khayelitsha. The medical situation was dire: AIDS was killing hundreds of people daily. Sick people flocked to the MSF clinic seeking treatment. Access to ARVs and other essential drugs was very difficult due to high prices and patent barriers. Goemaere, patient activists 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.

“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.

“The majority of people could not walk any more. They were literally brought 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. This was a sign there was another death. And honestly, there was no day without a death in the waiting room,” Goemaere recalls.


People could not afford life-saving ARVs. “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.”


Goemaere, his team and activists from the Treatment Action Campaign banded together and developed a plan. “We shipped them [ARVs] 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.”




© Francesco Zizka/Moor


## SPEAKING OUT, TAKING ACTION

 The only reason we are dying is because we are poor – ZACKIE ACHMAT, FOUNDER OF THE 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 – VUYISEKA DUBULA, FORMER MSF PATIENT, STAFF MEMBER IN THE KHAYELITSHA PROGRAMME AND FORMER SECRETARY-GENERAL OF TAC

## 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

 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

© Christian Schwetz, South Africa




## TREATMENT FOR 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

© Eric Miller, South Africa



 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  
– FORMER PRESIDENT NELSON MANDELA

# From patient to activist

A brave young woman's journey is bringing change to thousands around the world



**T**hey lay there on a small saucer – five bright yellow capsules, a big white tablet and a brown capsule. And with one brave last gulp, Phumeza Tisile, then aged 23, put an end to her daily ritual of two years and swallowed the last of the 20 000 pills she had taken to cure one of the most severe forms of drug-resistant TB: extensively drug-resistant TB (XDR-TB). When it was done, she cried tears of joy.

“I never thought this day would come,” Phumeza said. “I’ve beaten XDR-TB! Getting cured at last is very exciting. It was scary at first. But you live in hope – hope that one day you will be cured. I didn’t want to be a TB statistic and that kept me going.”

Back in 2013, Phumeza beat XDR-TB against all odds. The disease has a less than 20% chance of cure, but because getting a proper diagnosis took so long, her chances of survival were even less to begin with.

Before being treated by MSF, an accurate diagnosis of Phumeza’s XDR-TB was delayed due to the lengthy process required to confirm XDR-TB infection using available diagnostic tests in the public sector.



I never thought this day would come – I’ve beaten XDR-TB!

Phumeza was also confronted with an impossible choice: death or deafness. One of the medicines she received cost her hearing – a serious side effect of older injectable TB treatments.

In 2013, Phumeza and her treating doctor, MSF’s Dr Jenny Hughes, wrote a DR-TB treatment manifesto which she took the UN’s World Health Assembly in Geneva. This was one of the steps to propel her into a life as DR-TB activist in South Africa and abroad.

Thanks to a crowd-funding campaign she eventually received two cochlear implants in 2015, restoring her hearing. She continued her fight for the need for shorter, less toxic treatment alternatives over the years while enrolling in university to complete her studies interrupted by lengthy DR-TB treatment.

In 2019, MSF supported Phumeza and Indian DR-TB survivor Nandita Venkatesan to challenge a patent by pharmaceutical corporation Johnson & Johnson on the tuberculosis drug bedaquiline. The patent could extend their monopoly on the drug, keeping it out of reach for millions.

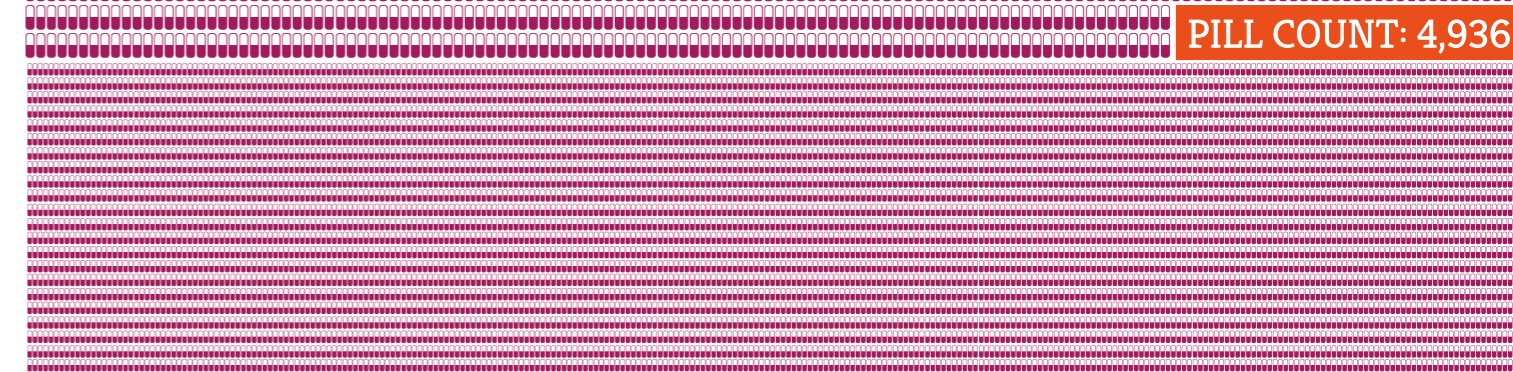
“I wouldn’t wish anyone to go through what I did with DR-TB. J&J should stop controlling the price of the drug that will restrict people’s access to safer and more effective tuberculosis treatment,” she said.



PILL COUNT: 2,000



PILL COUNT: 4,936



PILL COUNT: 8,872

TOTAL PILL COUNT:  
UP TO 14,600 PILLS

2013

## 1998

- Frustration mounts over people dying from treatable infectious diseases, and MSF publicly demands access to key life-saving 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

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

## 2001



- Big Pharma vs Mandela: MSF's "Drop the Case" petition adds 250 000 signatures to public pressure on pharma, and South Africa wins the ability to import cheaper HIV drugs
- MSF applauds the World Trade Organisation's Doha Declaration on the primacy of public health and access to medicines over commercial interests

Today, the challenges we face are bigger than ever. The crisis of access to medicines and innovation no longer affects only developing countries, but it is truly global. The MSF Access Campaign continues to advocate for medical research and development (R&D) that prioritises the medical needs of the people we care for. It delivers treatments that people can afford, for the global public good. As we prepare for our work ahead, we reflect on what we have achieved and how we got here

# 20 years of advocacy in action

## 2001



- The landmark US\$1-a-day price, publicly offered to MSF, boosts political will to treat HIV/AIDS in developing countries
- MSF works with the World Health Organisation to get life-saving drugs back into production for sleeping sickness, which is fatal without treatment
- Fatal Imbalance report: MSF and partners publish seminal evidence to highlight a crisis in neglected disease research



© Tom Stoddart, Uganda

## 2003



- MSF's 'Act Now' campaign for more effective malaria treatment spurs change in sub-Saharan Africa
- MSF and partners create the Drugs for Neglected Diseases initiative, a non-profit that has since delivered eight new treatments

## 2005



© MSF

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

## 2006



© Sheila Shertle

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

## 2006

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



© Ton Koene, Nigeria

## 2007



© Michael Goldfarb

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

## 2010



© Willi Hardy

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

## 2010



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

## 2013



- An XDR-TB survivor and MSF doctor writes the Test Me, Treat Me manifesto, and delivers the petition at the 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



## 2018

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





© Luca Sola, Malawi

# Big Pharma's failure

Scant progress in improving access to paediatric versions of HIV drugs for children

**M**eet Gloria Chipasula. She's small for her age but her smile still lights up her family's dark living room. Thirteen years ago she was born with HIV in Malawi's Chiradzulu district.

Here MSF treats complex HIV cases such as patients on second- or third-line antiretroviral (ARV) therapy and those with opportunistic infections or facing treatment failure. But our medical teams struggle to give children like Gloria, who also suffers from TB, a shot at survival and a healthy future because of a lack of appropriate treatments

"Pharmaceutical corporations simply don't consider children with HIV a priority, forcing us to use older, suboptimal treatments for the youngest people in our care that make it harder for them to stick to their treatment," Dr David Maman, Medical Coordinator for MSF in Malawi, explains. "Worse, increasing resistance to existing HIV medicines in sub-Saharan African countries means that the older treatments may not work for infants and children who are in urgent need of better treatment options."

"How long will children with HIV have to continue to suffer or die because of

pure indifference?", Maman asks.

Paediatric HIV remains a neglected disease, and the small market for paediatric HIV medicines means they have never been a priority for either

pharmaceutical corporations or generic manufacturers. Delays have plagued both the development and introduction of newer paediatric drug formulations, and the scale-up of existing formulations.

For example, the HIV drug dolutegravir – which is recommended by WHO as the preferred first-line treatment for infants and children, and was first approved for use in adults in 2013 – is still not available for children. Pharmaceutical corporation ViiV Healthcare has yet to finalise necessary studies and register a dispersible tablet (which dissolves in water) formulation for younger children. A paediatric granule formulation of another key drug, raltegravir, already exists, but pharmaceutical corporation Merck has been slow to register it in developing countries.

"Children need access to the best and most robust medicines possible given that they need to stay on HIV treatment for life," Jessica Burry, HIV Pharmacist for MSF's Access Campaign, explains. "Pharmaceutical corporations need to stop dragging their feet and start taking concerted action so that more young lives can be saved. Time's up for empty promises."

# 90%

PERCENTAGE OF CHILDREN WITH HIV GLOBALLY LOCATED IN SUB-SAHARAN AFRICA

# 52%

PERCENTAGE OF CHILDREN LIVING WITH HIV RECEIVING TREATMENT

# 110 000

NUMBER OF CHILDREN DYING FROM AIDS-RELATED ILLNESSES

# MILLIONS OF BABIES

# WON'T LIVE TO SEE THIS DAY.



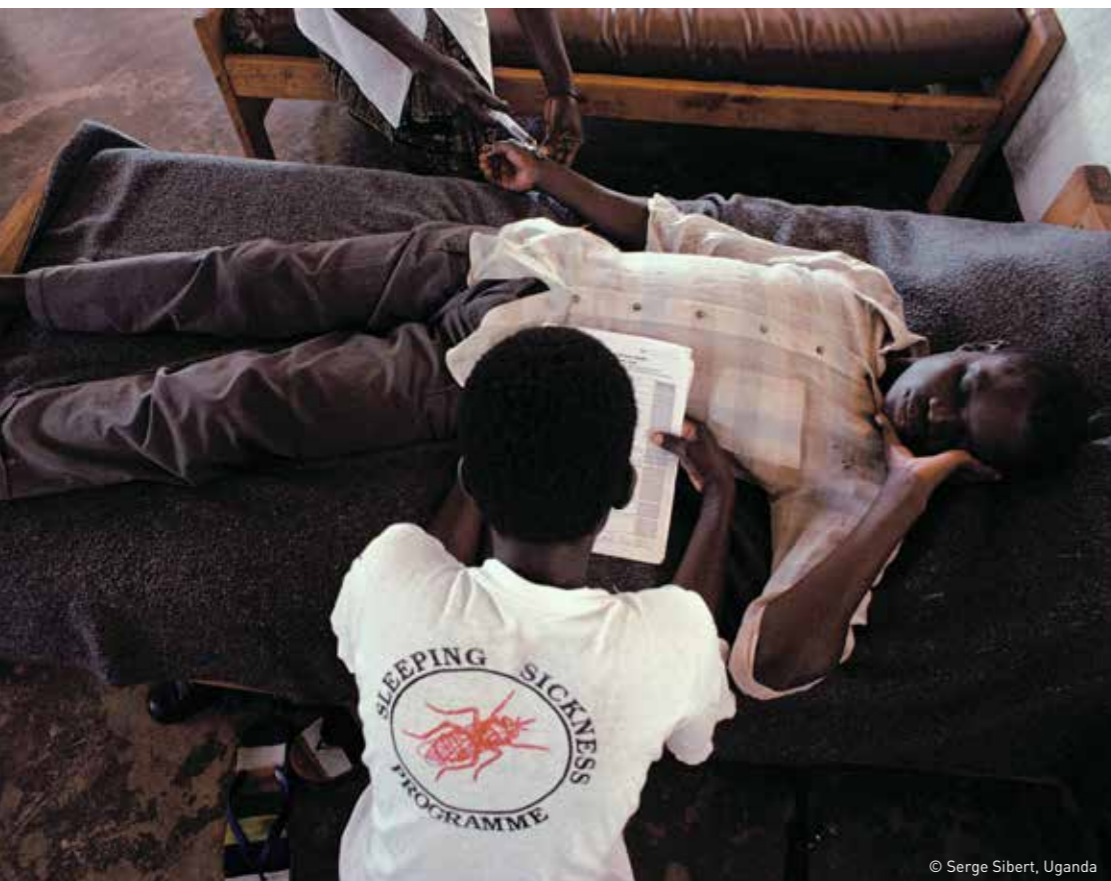
Without treatment, half of all children with HIV/AIDS in developing countries will die before their second birthday. **We desperately need diagnostic tests that work for babies, and pills that kids can swallow.** HIV/AIDS is treatable, but millions of children are still waiting.

2005



# Game changers

HIV/AIDS and TB aren't the only illnesses the Access Campaign has helped fight



© Serge Sibert, Uganda

## 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. 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.



© Pablo Garrigos, DRC

## THERAPIES FOR EBOLA

MSF has responded to Ebola virus outbreaks since the 1980s. Then, the only thing our medical teams could do was isolate patients to stop the spread of infections and ease their suffering until they died. In the late 1990s, MSF started highlighting the “fatal imbalance” in which only 1% of new drugs were for neglected diseases. When Ebola struck West Africa in 2014, this neglect was made highly visible around the world. 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 research and development (R&D) of better tools to respond to outbreaks of Ebola and other emerging infectious diseases. These collective responses must be supported and accelerated. And they must be held responsible for delivering life-saving tools that are available and affordable for the people who need them most.



© Garvit Nangia, India

## 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 find ways to reduce the price of these drugs. In 2017, MSF announced it had been able to buy the same three-month treatment for \$120, allowing the scale-up of treatment in selected countries, with simplified diagnosis and treatment protocols.

## TRANSFORMING TOMORROW: THE FUTURE OF ACCESS

We managed to get essential treatments to people who need them, but the fight isn't over yet. The lack of access to medicines is still deep and pervasive 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. We must keep up the fight. All of us must demand change, political will and action to ensure access for all. To do that, we must:

- 1 **Seize the global momentum for change**  
We must channel the current global outrage around expensive medicines and unnecessary deaths, build alliances with the growing number of people demanding change.
- 2 **Put an end to pharma's myths on high prices**  
Pharmaceutical corporations must be transparent and accountable in terms of their product price setting, R&D costs, and research data. We must stop the false narrative that medicines must be expensive.
- 3 **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.
- 4 **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 explore sustainable ways forward that centre on people's needs.
- 5 **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 life-saving drugs and vaccines – without being bullied by pharma corporations or other countries.
- 6 **Demand justice, not charity**  
Pharmaceutical corporations and wealthy country governments serving their interests should not be allowed to decide if and when life-saving 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.
- 7 **Promote and organise R&D as a collective responsibility**  
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. Medical R&D must address people's health needs no matter where they live, and priority areas of public health concern like drug-resistant TB, antibiotic resistance, outbreak diseases, and neglected diseases.

## PNEUMOANIA VACCINE PRICE

Pneumonia is the top killer of children under five years old, despite the availability of the pneumococcal conjugate vaccine (PCV). For many years, PCV was priced out of reach for many developing countries. In some, it still is. In 2015, the Access Campaign embarked on a public campaign called “A Fair Shot”, 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. More than 400 000 people signed a petition to demand a lower price. We set an ambitious 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.



© Edwin Torres, USA

# Never give up – that's how we do it

Claire Waterhouse, MSF Southern Africa fieldworker in the Democratic Republic of Congo, shares her proudest moments and lessons from working with the Access Campaign

**W**hat are your proudest memories while working with the Access Campaign?

In South Africa, my biggest victory was with the Fix the Patent Laws campaign (which seeks to reform intellectual property laws to increase access to essential medicines, making them more affordable). There really was no better feeling than on my last day working with the Access Campaign, to see the newly drafted intellectual property policy we had worked on for months. It contained so many of the important provisions we had fought for over the years. We made inroads by putting pressure on South African legislators to put people's lives over pharmaceutical corporations' profits. There's still a way to go for this process, but I'm proud of what we achieved and the commitment of my colleagues to keep up the fight.

**As an MSF fieldworker, when did you witness the direct impact of the Access Campaign's work for patients?**

I remember it like yesterday. Access Campaign colleagues worked really hard to reduce the cost of a new hepatitis C drug sofosbuvir. The manufacturer, Gilead, was charging US\$1 000 per pill. It was just staggering – none of us could believe how a company thought this was acceptable. It was revolutionary drug that would cut treatment time down to 12 weeks and it made it so much easier for patients since it had fewer side effects. It could change the way in which we treated hepatitis C.

Through negotiation and advocacy – and never giving up – the Access Campaign got the price down from \$84 000 to just \$120 for a 12-week course. That is just mind-blowing, really. The enormity of it only really hit home for me when I worked as project coordinator in an MSF programme treating hepatitis C in Meerut, India, using sofosbuvir.

I'll never forget walking into our pharmacy and seeing shelves upon shelves of the drug. I just stared. It was quite moving just to see this drug there, knowing how expensive it had been – far out of reach for people who desperately needed it. Seeing our doctors prescribing it to patients every day, and seeing the cure rates we achieved, was really exciting. That's the moment I saw how the Access Campaign really made a difference. When



## TREATING HEPATITIS C IN INDIA

MSF worked in Meerut because there is a very high prevalence of hepatitis C in this part of India. The infection is caused by a virus and leads to serious liver damage and chronic disease.

People get infected through contact with contaminated blood when unqualified medical practitioners often using unclean instruments treat them, or due to traditional tattooing. It is difficult to know you have hepatitis C unless you are actively tested or until the later stages when you see advanced effects, so many people are unaware of their status.

We showed how effectively and easily people can be tested and treated for hepatitis C, in just months – and at much lower cost, thanks to new, effective, affordable medicines.

Many of our patients came from very rural areas and could never afford treatment, so it was very important to be able to provide free, quality care to them.

We succeeded and in 2019 the local government rolled out its own hepatitis C treatment programme, largely based on MSF's Meerut model."



© Ravi Mishra, India

an Access Campaign colleague visited the project, she had exactly same reaction as I did. She had tears in her eyes. You really feel like: "Wow – what we're doing really means something!"

**What experiences or skills from your time with the Access Campaign helped you as a fieldworker?**

A huge thing for me was refining my advocacy skills. I really grew in areas of strategy building and the capacity to negotiate. Today, working as a field coordinator in the Democratic Republic of Congo, these skills help in my daily dealings with officials and during our negotiations for space to do humanitarian work in a very difficult environment. The other thing is to be tenacious, to never give up. My colleagues in the Access Campaign

never tire. They just keep going no matter how hard it is. They always manage to find new ways to approach the problem. And every time they do that, they find success.

**Why is the Access Campaign's work important to what MSF does in the field and beyond our projects?**

There are dozens of practical instances in South Africa where Access Campaign negotiations, advocacy and campaigning made an impact – especially on medicines to treat DR-TB, like linezolid, delamanid and bedaquiline. For me, in South Africa, it was a real and immediate experience. As a fieldworker from elsewhere, you could sometimes miss it. In several projects around the world we have the medicines to treat our patients because of the Access campaign's work.



## Ingenuity born from independence

Your support is essential for change, not charity. Let your **#ActionsSpeak**

**T**he success of MSF's Access Campaign over the past 20 years has depended on people like you. The commitment of individual private donors to support medical care and treatment for people who need it most, provides us with the required resources to act independently – from the influence of politics, governments and commercial business interests, especially pharmaceutical corporations.

We are heartened by MSF surveys in South Africa recently, finding the vast majority of respondents share our convictions on independence. For us access to health, including medicines, is a matter of justice, not charity. That is why we fight to reduce drug prices – instead of merely accepting drug donations from industry, as some would like to have it.

Drug donations from pharmaceutical corporations are not long-term solutions. Underfunded health systems and a lack of access to medicines to treat life-long illnesses in poor countries cannot be resolved with short-term donations. Often drug donations prevent, or delay finding long-lasting solutions through the import of affordable alternative medicines.

MSF researchers Guilloux and



Small but generous actions have a big impact. These small donations pay for medicines, equipment, and medical and humanitarian professionals to treat 11 million patients worldwide

Moon found that pharmaceutical corporations routinely gained more from drug donations than by reducing prices because tax incentives make it more profitable to donate drugs than to use differential pricing. Moreover, they also found that drug donations cost the donor country more than four times as much as other models that improve drug access.

To maintain our financial

independence, we launched a fundraising campaign called **#ActionsSpeak**, in September. The campaign depicts the ingenuity of turning negative situations into positive solutions when problems sometimes have part of the solution contained within them. All that is required is creativity and making an innovative but decisive, small change for action – such as making a donation to MSF.

We embarked on the campaign to remind South Africans of our work focused on HIV and TB, and medical emergencies such as sexual and gender-based violence. One of the adverts was shot on location near Eshowe in KwaZulu-Natal where MSF runs an internationally recognised HIV and TB project in the community.

"Small but generous actions have a big impact. These small donations pay for medicines, equipment, and medical and humanitarian professionals to treat 11 million patients worldwide. In South Africa, where we fight for access to affordable medicines, we treat nearly 23 000. We hope that more people will let their **#ActionsSpeak**, by taking a stand and donating to MSF," says Ludivine Houdet, Fundraising Director at MSF Southern Africa.



# SIX THINGS BIG PHARMA DOESN'T WANT YOU TO KNOW!

- 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. While they often say it costs US\$2-3 billion to develop a new drug, other estimates are at least 10 times lower.
- 2 You're paying twice for your medicines**  
Corporations free-ride off public, taxpayer-funded research at government and university labs, where 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 new drugs that arrive on the market are no better than what we already have. Big Pharma put more effort into developing so-called 'me-too drugs' than finding therapeutic breakthroughs.
- 4 Patents are extended, over and over, to prolong monopolies**  
A notorious pharma tactic is patent 'evergreening'. 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**  
Big Pharma uses pressure tactics or oppressive legal actions against low- and middle-income countries like India, South Africa, Thailand, Brazil and Colombia for prioritising people's health over pharma's interests.
- 6 Big Pharma pockets more than they reinvest**  
They say 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.

## mamela

Questions about donating to MSF?

Call the Donor Care team toll-free on **0800 000 331**  
or email us at [donorservices@joburg.msf.org](mailto:donorservices@joburg.msf.org)

Do you want to work for MSF in the field?

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letters directly to [recruitment@joburg.msf.org](mailto:recruitment@joburg.msf.org)