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Roundtable discussion on Global Health
Improve international Pandemic Prevention, Preparedness and Response

Equitable access to medical tools needed to ensure global Pandemic Prevention, Preparedness and Response

As a medical emergency relief organization active in more than 70 countries, Doctors Without Borders (MSF) sees time and again that low- and middle-income countries are at the back of the queue for access to life-saving medicines. From HIV and tuberculosis (TB) to Ebola and cholera: every day we see people die due to a lack of access to medicines, vaccines, and other medical supplies.

During the **COVID pandemic**, shortcomings in the global response hampered access to life-saving medical supplies for people in low- and middle-income countries. According to the World Health Organization (WHO), in 2021, only 3% of the COVID vaccines available at the time were delivered to African countries. A study in The Lancet shows that **due to the lack of access to vaccines in low-income countries, millions of lives were unnecessarily lost**. Yet, pharmaceutical companies made a profit of no less than 90 billion dollars. The delayed response has also led to decline in other health areas, such as HIV and tuberculosis, and the routine vaccination of children, losing years of progress across these areas.
MSF witnesses **more frequent and deadly outbreaks in contexts where health systems were already stretched** to a breaking point. In **conflict** settings, routine health services often break down entirely. Vaccination systems are disrupted, surveillance weakens, and response times slow. When outbreaks occur, we face deadly delays and gaps in response, allowing diseases to spread further and cause more harm. And these crises are not happening in isolation. They are overlapping, compounding one another, and placing immense strain on already fragile, and sometimes collapsed, health systems.

Today, MSF is deeply concerned by the impact of the outbreak of **Ebola disease caused by the Bundibugyo virus** officially declared by the Democratic Republic of the Congo on 15 May 2026. Following the Bundibugyo virus outbreaks of 2007 and 2012, experts clearly identified the need for broader diagnostics for Ebola disease. Yet nearly 15 years later, we still face **limited availability of diagnostic tools and a lack of authorized therapeutics and vaccines**, not because the science was beyond reach, but because the international community **did not sufficiently prioritize the people primarily affected by Ebola** in the years since the last outbreaks.
This is not the first time we have faced these challenges. During the 2014 ebola outbreak in West Africa, and at the start of the 2018 outbreak in DRC, there were **no approved therapeutics or vaccines**. In 2018, MSF was a partner in the PALM trials, which led to the development of two effective treatments for Ebola virus disease. And yet, eight years later, reliable and sustained access to these treatments remains highly **limited and inequitable**. The populations that suffered these outbreaks and contributed the biological materials, which allowed for the development of these products, still do not have guarantees to benefit from the products during the next outbreak. This falls short of our promises to these populations and does

not promote the trust we need from these communities during outbreaks like the one the region is facing now.
This outbreak once again exposes persistent failures to prioritize, fund, and produce accessible medical tools for diseases disproportionately affecting low- and middle-income countries. As the response scales up, it is critical to apply lessons learned from past pandemics, including COVID-19, and previous Ebola disease outbreaks.

This is where the **Pathogen Access and Benefit Sharing (PABS)** annex as part of the **World Health Organization (WHO) Pandemic Agreement** becomes urgent, not as abstract policy, but as a concrete mechanism determining whether what we learn from this outbreak actually protects affected communities in the future. A strong PABS agreement can bolster the delivery of reliable, equitable, and accountable access to vaccines, diagnostics, and treatments developed from shared samples and data. But it will require enforceable benefit sharing-terms to be agreed upfront, non-exclusive licensing on to WHO or WHO-supported initiatives to facilitate technology transfer and diversified production of medical products, facilitate coordinated stockpiling and equitable allocation, including for humanitarian needs, and, ensure transparency and public access to information. Yet, if we are serious about ensuring that what we learn from this outbreak benefits affected communities, our ambitions cannot stop with PABS.

When MSF works in conflict-affected areas, in fragile health systems, in remote regions, we see **communities doing the work that saves lives**. They are the ones identifying cases. They are preventing transmission. They are caring for the sick. They understand the terrain, the culture, and the trust networks that matter. Yet when R&D happens, when global health decisions are made, these communities are invited to listen, not to lead.

The 2023 UN High Level Meeting Political Declaration on Pandemic Preparedness and Response committed us to "whole of society approaches" and to meaningful participation. It is not enough to consult affected communities. They must be at the table making decisions about which tools get developed, how research happens in their countries, what happens with their contributions to research, and how the tools that are developed from such research are delivered to the places where outbreaks occur.
In conflict settings this is essential. And for this to work, **respect for international humanitarian law and unhindered humanitarian access must be non-negotiable**. Disease does not respect conflict lines, and our ability to respond depends on the ability of humanitarian personnel to reach those in need. **Outbreak response should never be politicized or dealt with as a matter of security only**. Hence, the most effective way to prevent, respond to, and stop outbreaks is to **respect the rights of affected communities and their needs and concerns at the center of the response**.

The international community has adopted **the Pandemic Agreement and amended the International Health Regulations**. These instruments have created the frameworks. Now we need the political will to genuinely **share power with the communities most affected.**

Recommendations to the Dutch government:

1. Affected people, communities and countries must be at the centre of decisions on R&D and access to medical products.

To strengthen preparedness for future outbreaks, R&D initiatives and investments need to continue beyond an initial emergency response period and build with and upon the collective knowledge and support from affected people, communities and countries.

R&D initiatives, especially **clinical trials**, should therefore be bound by **robust conditions on access to medical products.** These should include prohibiting the unilateral suspension of clinical trials so that participants have continued and safe access to medical tools; providing timely access to medical tools through compassionate use or emergency use mechanisms; guaranteeing continued and affordable access to medical products by trial participants and at-risk communities after trial completion; ensuring priority registration of trial products in host countries and regions most at-risk; and **supporting continued R&D beyond an initial emergency response period.**

2. **Make access conditions real and enforceable.**

To achieve equitable access, consistent and enforceable access conditions should be applied throughout R&D governance. These conditions can be applied along different pathways, including public funding and the sharing of pathogens, samples and data.

• **Public investment** in R&D for BDBV diagnostic, therapeutic and vaccine development should be accompanied by **binding measures to ensure equitable access**. Additionally, funding governments can retain legal rights over the technologies, enabling them to step in and set up access arrangements directly – using measures such as march-in rights – in cases where the funding recipient does not comply with access conditions.

• **Pathogen and data sharing**: When sharing pathogens, samples, specimens, biological materials and related data needed for R&D, **Access and Benefit Sharing (ABS) principles** could be used. Public institutions and governments in affected countries can leverage ABS to tie rapid sharing of pathogens, samples, specimens, biological materials, as well as related sequencing data, clinical, laboratory and epidemiological data to enforceable benefit-sharing obligations for recipients, ensuring that those contributing materials have access to the final medical products developed.

Public funding agreements and ABS arrangements should, where applicable, incorporate conditions such as **non-exclusive or open source licensing**, including open platform developments for diagnostics; **transparent and affordable pricing** (a cost-plus-reasonable-margin or no profit-no loss model); **technology transfer** with adequate financial support to potential manufacturers in LMICs; priority product registration in affected and endemic countries; compliance with ABS principles and obligations; timely access to end products needed for comparative studies, regulatory approvals and ongoing R&D; transparent clinical trial costs and outcomes; and **reliable supplies to meet international or regional stockpiling needs.**

3. Transparency and accountability should guide publicly funded response and coordination.

Transparency about prices, about stock and inventory, about where these tools are stockpiled, about timelines for production and supply, and how much it costs to make these products — all of this **information should be public**. Affected countries and communities need to know what's being promised to them, when they can expect to receive it, and how much it will cost them, if anything at all. **Accountability only works when there's transparency.**