

MSIF meeting report on Access to Treatment and Healthcare



11-12 July 2019, London

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Introduction

The barriers to accessing healthcare are many and complex. They vary from country to country, but also between demographics within countries.

Some can be addressed locally, but in an interconnected world sustainable solutions need to be international. Tackling them individually will duplicate effort and cost, and may just push the problem over a border or have no effect at all. MSIF has the global reach and experience to coordinate an international response.

Our work during the previous year has aimed to improve our understanding of the barriers and ongoing global initiatives in access by engaging with World Health Organisation (WHO) initiatives and building relationships with other stakeholders who are active in the field of global access to healthcare. We embarked on two projects: the first to put forward an application to add MS treatments to the WHO Essential Medicines List (EML); and the second to perform a scoping exercise to help better understand the regulation of follow-on MS disease modifying therapies (DMTs) in Latin America.

To shape our thinking on how we should follow on from these projects, MSIF convened a small think tank meeting 11-12th July with members of our international working group on access as well as selected global experts.

Topics identified in advance for discussion included:

- Pragmatic MS diagnostic and treatment guideline development for low-resource settings
- MS healthcare professionals in low-resource settings: training and models of healthcare provision
- Availability and affordability of safe and effective MS treatments

In the following meeting report, key challenges relating to improving access to MS healthcare are discussed, along with suggested actions the MS community might take to address them. These actions will be further developed and put into context to consider how we move forward on this topic.

The ethical case for access to treatment for the wider community

The moral obligation to improve access to DMTs globally was the main theme that ran throughout the meeting. There was a recognition that the time to tackle this topic is now and that the MS and neurological communities should act together, despite the complexity of the topic. MSIF has a key role to play in bringing these themes relating to access to MS healthcare together, as well as convening the MS community, inspiring them to take action. This meeting was an important step in advancing the MS access agenda.

Improving access globally is complex due to the different circumstances around the world. Whilst there is a generally accepted understanding of what aspirational looks like, with the aim of having a strategy to enable people to be treated to the target of 'no evidence of disease activity', our approach to access has to also be realistic and recognise the multiple challenges in different countries across the globe. Solutions are not simple – for example, if a very affordable off-label DMT with low effectiveness has a high risk of side effects, should it be advised against? What about countries where this is the only option? The need for more evidence to inform our approach, such as validation of criteria in different settings, was also raised several times. However, this could take a

number of years, and are we prepared to wait this long before acting, given the urgency of the situation? Cost of drugs has been identified as a critical barrier, but what else can we do alongside?

Suggested actions from the meeting

1) Start a conversation with the MS community about the ethical case to access and key challenges/barriers as well as possible solutions to widening access

Key figures from the MS community to produce a discussion paper that sets out our moral and ethical obligation to improve treatment options for people with MS around the globe. The paper should challenge the status quo, and convey the scale of the need – making the case for urgency of action. The paper could be published somewhere like the Multiple Sclerosis Journal (MSJ) or as a WHO Bulletin. The next edition of the Atlas of MS will gather data on the current global prevalence of MS as well as aspects relating to its clinical management. Depending on the timelines, some of these data could be used to illustrate the need for change.

It is important that the wider MS community work together to address access. The next step would then be to develop scientific consensus around which treatment options are appropriate in which contexts (linked to local circumstances), and to outline proposed models of care (see action 2 below).

2) Aspirational targets for global access to MS healthcare

The MSIF movement should further develop its position on access to MS healthcare, by producing a position paper for publication that sets aspirational targets relating to global access, accompanied by an action plan (based on the actions outlined below).

Finally, the aim would be to produce a set of guidelines that are appropriate for low-resource settings (see actions below).

Improving diagnosis of MS

Current diagnostic guidelines

The most recent diagnostic guidelines for MS are the 2017 McDonald Criteria, which in simple terms require evidence that damage has occurred in at least two separate areas of the CNS at different points in time (dissemination in time and space) and that there must be no other explanation (ruling out other diagnoses). It was acknowledged that the guidelines were developed with higher resource contexts in mind, and there is still a need to validate in other populations, although steps to do so are underway.

The specific needs of accurate differential diagnosis in different areas of the world is an area that particularly needs more attention. Some diseases may mimic or have complications that mimic MS symptoms. The need of differential diagnosis criteria may not have been considered in areas where the prevalence of these diseases is lower, e.g. NMO prevalence is higher in Asia, rates of HIV and TB are higher in Sub-Saharan Africa.

Diagnostic criteria, when implemented well, can speed diagnosis and lead to quicker treatment. The challenges of implementing the guidelines include the need for skilled healthcare professionals to perform the diagnosis (although tests such as MRI and oligoclonal bands are used, these are to support the *clinical* diagnosis); and the availability of infrastructure to perform the supporting tests. To address the former, better training for healthcare professionals in low resource settings is

therefore essential. In the case of the latter, consideration should be given to the local infrastructure and diagnostics available to ensure the best possible outcome can be obtained in different resource settings.

Routes to develop guidelines (diagnostic and treatment)

Many countries have developed their own guidelines relevant for their national setting (see example from Malaysia under 'Treatment guidelines' later in the report). The McDonald criteria (and its predecessors) were developed through a consensus process by the international clinical community. Organisations such as Clinton Health Access Initiative have developed flexible guidelines for specific regions taking into consideration the reality of the national infrastructure and availability of diagnostics, experts and treatment options (see cervical cancer guidelines for Sub-Saharan Africa in the pre-read).

Another route to consider is by working with the World Health Organisation (WHO) which has a variety of guidelines used by national ministries of health and other international organisations to guide diagnosis, treatment and procurement of medicines. WHO guidelines are not binding or mandatory, but often act as a model for developing local guidelines but can also be directly adopted. They are able to influence at the level of health systems, as well as, individual clinicians. The WHO guideline development process is very demanding and, the guidelines committee often rejects the proposed guidelines for a variety of reasons. Strong recommendations need high quality evidence (using GRADE-DECIDE), where less strong recommendations may be necessary for MS as the MS diagnostic criteria have not been validated for sensitivity and specificity. The output would end up being a lot of 'conditional' recommendations, which would reduce the overall impact. Working with the WHO to develop guidelines could be considered, although it would take a long time, but in any case we can learn a lot from their approach to ensure e.g. appropriate geographic, patient and technical representation and managing the conflicts of interest of the people involved.

Suggested actions from the meeting

- 3) **Update the 2008 paper on differential diagnosis for MS (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2850590/>), to include a wider global perspective**

This action was considered to be relatively straightforward due to an existing paper that could be updated and the potential high impact in areas where the diagnosis of MS can be complex. This activity needs to be led by a dedicated Chair, supported by a research fellow who has time and capacity to undertake the research and writing required. It will likely involve the McDonald criteria authors (2017), International Clinical Trials Committee and all the TRIMS¹. Careful consideration should be placed on involving experts from the right settings and relevant countries.

The distribution and subsequent implementation of this guide to differential diagnosis needs more consideration. It would need to involve the World Federation of Neurology (WFN), TRIMS, and may also be linked to work relating to improving knowledge, skills and expertise of healthcare professionals globally (see below).

¹ 'TRIMS' are the regional committees for Treatment and Research in Multiple Sclerosis, and include ACTRIMS, ECTRIMS, LACTRIMS, PACTRIMS and others.

Widening access to DMTs for treatment of MS

Essential Medicines List

In December 2018, MSIF applied to the World Health Organization (WHO) to add three MS treatments to its 2019 Essential Medicines List (EML). On Tuesday 9 July, the WHO announced that it would not be adding any of these treatments to the list. The WHO Expert Committee recognised the public health need for effective and affordable treatments for MS and requested a revised submission in two years' time.

Several meeting participants had been closely involved in the 2018 application. Discussion focused on the need to obtain greater clarity around the decision of the EML Committee, to help shape a potential revised submission. Concerns were raised around the ability to get more/better quality data in the ensuing two years that would enable a proper review of off-label treatments (e.g. azathioprine, rituximab), as has been requested. It was noted that even though affordability of treatment is not said to be the main criteria on which the decision is made, it is very important to justify how expenditure on the drugs put forward is related to the global burden of MS. In addition, the countries which the EML is most likely to positively impact have poorly resourced healthcare infrastructure, and this has to be taken into account in terms of administering/monitoring treatment.

It was agreed that even if a second application by MSIF to the EML is pursued, the urgency of the need for access is such that other activities must take place in parallel.

Experience of getting access to treatment

Personal experience of getting access to treatment is very varied. Our group of people affected by MS² noted that they often didn't have conversations with their health professionals about options for MS treatment, but this would sometimes have been limited by the very small number of treatments available in their country, and the costs of those treatments. The limited number of neurologists and the time they have available also prevents good quality discussions on treatment options. Funding for treatment varies not only between countries, but also within countries, and even different hospitals, depending on factors such as if the government covers the costs, budget allocation between regions or in hospitals, what type of insurance people have, whether that insurance covers DMTs or only specific DMTs, or whether people can afford to pay privately. The type of treatment that is covered by government or insurance may also vary; in some cases symptomatic treatment or rehabilitation therapy must be paid for privately.

Treatment guidelines

Please see section 'Routes to develop guidelines (diagnostic and treatment)' for different approaches. The benefit of creating guidelines for treatment should be to: inform decision-making by clinicians and patients; promote consistency of care and use of interventions with demonstrated benefit; and discourage the use of ineffective interventions. Guidelines should be seen as a tool to increase rather than limit access to therapy. The two major guidelines in use currently were produced in North America and Europe, and whilst they have a lot of similarity, they also recommend different treatment options in some circumstances. This can place the decision on the neurologist instead, potentially putting them in a difficult position, especially if they are not specialised in MS. There are several challenges involved in producing guidelines, due to first coming to global consensus on the key questions to be addressed, but also in addressing how to tackle gaps

² People affected by MS from Indonesia, Latvia, Morocco, Sri Lanka, Uruguay, US and Zambia were participating through a WhatsApp group

in evidence. Basing guidelines on clinical trial data only, and not real world evidence, can also lead to problematic outcomes.

Several countries have national treatment guidelines for MS; an example of this comes from Malaysia. Growing prevalence of MS in the country, along with better diagnostic tools, led to requests for an evidence based document to help in the diagnosis and management of MS and related disorders. The guidelines were developed by a group of Health Technology Assessment staff and key clinicians from the country, reviewing evidence and making recommendations, which were subsequently reviewed by an international panel. Every recommendation had to be tailored to the local situation, such as consideration of the complex monitoring required for certain treatments. The impact of the guidelines was to improve awareness and knowledge about MS among health care providers and patients; to improve stratification of patients for treatment; and to improve referral patterns between parts of the healthcare system. However, despite the increased awareness about the guidelines and knowledge about how to investigate and treat people with MS, it has not always translated into improved or immediate access to treatment due to economic constraints.

A global guideline for MS could serve as a reference point and provide evidence and leverage to improve access for treatment in a national setting. It could encourage consideration of low-resource settings in drug development and pricing, and provide guidance on use of appropriate, quality assured, off-label treatments where other treatments may not be feasible (see below). Improving and standardising diagnosis and treatment of MS may have great impact, as has been seen in some other diseases e.g. better treatment protocols for pediatric leukemia has improved treatment outcomes greatly. Guideline development itself is not enough, effective follow-on initiatives to address the gap between guidelines and context specific implementation will be crucial.

Off-label DMTs

The use of off-label treatments for MS due to cost or availability is an area with opportunity and challenge. Whilst off-label DMTs can widen the availability of treatment globally, it must not result in lowering standards of treatment overall. If a health system officially starts using off-label DMTs, they may be unlikely to swap to a more expensive on-label medicine in the future. Off-label use may also disincentivise pharma to enter specific markets with the newer drugs or the supply of cheaper generics due to a potentially smaller market opportunity. We need clarity around when off-label use (solely due to availability or cost) is appropriate and how the health system can ensure long-term planning towards on-label medications. Some treatments, e.g. azathioprine, have been thought to be less than ideal by some experts, but it is important to consider under what circumstances this kind of medication should or should not be used, e.g. if this is the only option available, is it better or worse than nothing? How can the community ensure the best possible treatment of MS in low resource settings right now, without undermining other principles around quality of data and need of early treatment with effective medication?

The types of off-label DMTs currently used to treat MS have varying levels of evidence of efficacy. Some are very similar to approved treatments (e.g. rituximab) but others are thought to have very low efficacy. To boost levels of evidence, Phase 3 trials could be undertaken (although this alone doesn't necessarily lead to adoption); or national registers could build up data on off-label use (this would be very challenging in resource poor settings, and data is more likely to be collected around safety rather than efficacy). MSIF could play a role in reviewing data on safety relating to DMTs, and disseminate relevant information globally through its member organisations and other professional bodies. For the purpose of reaching consensus within the MS community if an off-label treatment

could be recommended, the suggestion of a global process or a panel to review off-label products was discussed.

It would be interesting to consider how an alternative type of approval or licence for off-label use could be developed without the normal route of pharma applying for market authorization.

If consensus could be reached around appropriate use of off-label treatment for MS due to cost and availability, then it would be necessary to support and provide confidence to health care professionals in using such off-label treatments.

Generic and biosimilar DMTs

Several DMTs are going to come off-patent in the coming years (please see Patent Landscape section in the pre-read). Follow-on products of these DMTs are an important route to affordable DMTs as prices are normally expected to fall with competition. This may not always be the case as there may be a need for a large enough market to ensure profit. Many MS DMTs are either complex small molecules or biological products, which makes the production of follow-on products more challenging.

MSIF has recently commissioned research to better understand the regulation and use of biosimilar and complex generic versions of DMTs in Latin America due to concerns raised by the local MS organisations about their quality. Whilst this information is hard to obtain, findings suggest that there are issues in this region such as many products being licenced before adequate regulation came into force, a highly variable regulatory system based on differing guidelines, with a lack of transparency as to how drugs pass through the regulatory system; unclear labelling of originator/copy drugs; poor traceability of drugs; and inconsistent pharmacovigilance and monitoring. It might be useful to compare with the situation in Iran, where biosimilar DMTs have been used for over a decade. MSIF has a key role in supporting member organisations in Latin America, and it is important to ensure globally that attention to the quality of follow-on products are maintained when developing our access program.

A route to lowering prices of drugs that are still under patent is public health-oriented licensing. The Medicines Patent Pool (MPP) works with pharmaceutical companies to negotiate licences with originator companies on voluntary basis and subsequently sub-licence generic manufacturers to enable them to produce generic versions of patented medicines for use in low - and middle income countries (LMICs). The MPP model has proved to work well in HIV and viral hepatitis – most of LMICs got access to affordable quality assured (WHO prequalified or approved by SRA) generic medicines and combinations thanks to MPP licences. The average price reduction for essential treatments is 73% which has become possible due to generic competition facilitated by the MPP through its access-oriented licensing mechanism. Potential MS candidates the MPP has explored are fingolimod and cladribine. The product patent for fingolimod has not been filed in many jurisdictions, but there are formulation patents in force, which means that generic manufacturers may get around these. This makes fingolimod a less likely candidate as the voluntary licence may have less impact. Cladribine has the most potential, but the key issue would be whether there would be a sufficient market in the countries that MPP can get licences for. Production of a generic version would need to be accompanied by a substantial information campaign to ensure demand and increase uptake as the generic manufacturers would not have a budget for this.

It was suggested that MPP could also consider some of the pipeline DMTs as they would have a longer patent life ahead of them, e.g. Siponimod, Ozanimod, Ponesimod and the new fumarates

Economic issues

The economics of MS, like any other situation, needs to be considered from both demand and supply perspectives. Cost-effectiveness studies will, for example, compare benefits from treating people with DMTs to other scenarios, e.g. other forms of treatment or providing rehabilitation services and care for people with MS. As the health systems and services provided in different countries and economic contexts vary greatly, the comparative costs change. For example, if there are no or limited rehabilitation services available, no financial support for carers available, or family members responsible for caring would not be working in any case, the balance of cost-effectiveness of treating MS can change substantially. In addition, the drugs themselves are only one part of the picture as for MS to be treated, you will also need to consider health professional salaries, training, and infrastructure if these are not in place in the health system. Funds for these are likely supplied by a complex mix of taxation, insurance and paying privately. A large challenge comes in providing health services that are not just good enough quality, but allow equity of access within a country.

Suggested actions from the meeting

4) Application of MS treatments to the WHO Essential Medicine's List 2020

A revised application was requested by the WHO expert committee for 2020. Concern was raised on whether any new meaningful data would be available in such a short amount of time. It was clear that if we decided to go ahead with another EML application, other actions to improve access to treatment should not wait but be carried out in parallel.

5) Treatment guidelines

Flexible treatment guidelines that are appropriate for low-resource settings, depending on the infrastructure and resources available (e.g. using a decision-tree approach) would help countries by acting as a reference point for developing national MS guidelines. Global treatment guidelines would need to consider specific, quality assured, off-label treatments and be aligned with a potential EML application. A mechanism for 'approving' quality assured off-label may need to be considered.

MS organisations and professional communities would play a key role in advocating for the use of these guidelines as well as disseminating and training people on their implementation.

6) Panel to review off-label DMTs for MS

The treatment guidelines (action 5) and EML application (action 4) would require information and recommendations around off-label treatments for MS. A panel of experts could be used to review the data and determine the potential recommendations of use of off-label DMTs.

7) Work with the Medicines Patent Pool (MPP)

The MS Community should collaborate with the MPP, sharing MS-specific expertise and data where necessary, to evaluate opportunity for access-oriented licensing for certain MS drugs (e.g. cladribine) to facilitate availability of quality assured generic medicines and price reductions through generic competition.

8) Policy summit on the global market for MS drugs

MSIF could convene a high-level policy summit that engages all relevant pharmaceutical companies, along with other interested organisations, to discuss challenges and potential solutions relating to the global market for MS drugs, e.g. drug-pricing and availability.

Improving knowledge, skills and expertise of healthcare professionals³ globally

Availability of training for neurologists and other healthcare professionals in different regions

Multiple types of training relating to MS are developed and delivered across the globe, by higher education institutions, MS organisations, neurological organisations (e.g. WFN) and the regional TRIMS organisations. Examples of types of training include fellowships, travel awards, online resources, summer schools, workshops, certified courses, and also providing a platform for healthcare professionals in a region to come together and learn from each other, creating a valuable network. Funding for training comes from a variety of sources, including government and industry. Training is not just for neurologists, but for other specialisms such as nurses and physiotherapists. The multiplicity of training schemes means there is potential for duplication and reinventing the wheel; better alignment of activity could help counter this, and a better understanding may also help us to identify any gaps that need addressing from a global perspective.

A challenge identified with delivering training is the expectation of a number of fellowships or similar opportunities for the health care professional to receive their training outside of their home location. This could limit the accessibility of the training, or in some cases diminish the impact due to 'brain drain'. More creative models of training should be assessed and developed where there are gaps. The use of online and digital resources to support training is growing and could play an even larger role.

Teleneurology is a growing area of interest, with small pilots currently taking place. This allows healthcare professionals to seek advice from more experienced specialists and also to train and build the knowledge base of non-experts in more challenging settings, where training may not readily be available.

Experience of care – who delivers it?

The provision of care for MS varies widely across the world. Our group of people with MS were able to see neurologists, but indicated that nurses provided a large part of their care. Neurologists are usually not MS specialists, which can lead to a delay in diagnosis. Sometimes the nurses may be neurology specialists but MS specialist nurses were rare. In some countries, even getting access to nurses is problematic. In other cases, general practitioners may provide MS care through links with a neurological hospital. The urban/rural divide was very common, with concentrations of specialists only in the cities.

Suggested actions from the meeting

9) Resource Hub for MS-relevant clinical training

MSIF could act as a convener to collate freely available and online training resources linked to the provision of healthcare for MS. Such an activity would highlight opportunities (e.g. MS Nurse Pro <https://www.ms nursepro.org/>) and gaps in provision, for future work to commission new activity to meet the training needs.

³ Healthcare professionals includes but is not limited to: neurologists, primary care physicians, nurses, physiotherapists etc

10) Clinical peer-support

MSIF could review current models of peer support that allow health professionals to exchange knowledge and expertise, particularly in the context of MS experts supporting more general healthcare professionals in low-resource settings. We could explore opportunities to endorse/build on/expand successful models (e.g. UCSF's teleneurology service <https://neurology.ucsf.edu/gts>) and consider how regional hubs of expertise may be created, e.g. linked to TRIMS.

11) Clinical training fellowships

The models of clinical training fellowship offered by TRIMS and neurological associations should be reviewed and novel training models for healthcare professionals should be developed that can enhance provision of MS expertise especially in low-resource settings. The MS community could then act to influence fellowship providers and funders to consider tailoring their training models to better meet global needs. This work could be taken on by the TRIMS as a joint initiative as they are best placed to determining current and needed training for MS within the neurological community.

Appendix

Attendees

International Working Group on Access (IWGA)

Paolo Bandiera
Peer Baneke
Ava Battles
Georgina Carr
Timothy Coetzee
Benjamin Davis
Anne Helme
Joanna Laurson
Ceri Angood Napier
Nick Rijke

Apologies

Kathy Costello
Andrew Giles
Freddy Girón

Extra MSIF/MS organisation participants

Abdelfateh Ibrahim
Aidan Larkin
Luke Thomas
Cyndi Zagieboylo

MS experts from different regions

Brenda Banwell
Riley Bove [online]
William Carroll
Najia Chafai [online]
Jorge Correale
Robert Fox
Gavin Giovannoni
Bernhard Hemmer
Lekha Pandit
Mohammad Ali Sahraian
Deanna Saylor [online]
Shanthy Viswanathan Shanthakumar [online]
Martin Stevens
Del Thomas

Experts in access to healthcare

Anisah Alyahya
Neha Batura
Charles Gore
Caroline Middlecote
Jolene Skordis

People affected by MS WhatsApp Group

Kanya Puspokusumo
Maija Pontaga
Najoua Abkari
Najia Chafai
Nihal Uduwara
Shelby Kemper
Andrea Prato
Anthony Yamba

MS organisation

Italy
MSIF
Ireland
UK
US
Canada
MSIF
MSIF
MSIF
MSIF

US
Australia
Guatemala

MS organisation

MSIF, Capacity Building
Ireland, National Services Development Manager,
MSIF, Fundraising and Engagement
US, CEO

Region / Role

North America, Clinician
North America, Clinician
Asia-Pacific, Clinician
MENA region
Latin America, Clinician
North America, Clinician
Europe and Africa, Clinician
Europe, Clinician
Asia, Clinician
MENA region, Clinician
Sub-Saharan Africa, Clinician
South-East Asia, Clinician
MSIF, Chair of People Affected by MS Committee
International Organisation of MS Nurses

Organisation

Medicines Patent Pool [MPP]
Centre for Global Health Economics, UCL
Medicines Patent Pool [MPP]
Clinton Health Access Initiative [apologies]
Centre for Global Health Economics, UCL

Country

Indonesia
Latvia
Morocco
Morocco
Sri Lanka
United States
Uruguay
Zambia

Agenda

Thursday 11 July

Part A: IWGA with external experts

Introduction

- 8:15 – 8:30 **Coffee and introduction ice-breaker**
Together or small groups
Everyone to share a personal story around access or a specific angle of access that they have a special interest in.
- 8:30 – 8:45 **Welcome to the MSIF Access to Treatment and Healthcare meeting**
Peer Baneke
To cover MSIF strategy, its aims relating to Access and our last meeting outcomes. Current focus on way forward following the outcome of the EML application.
- 8:45 – 10:00 **Current projects and our objectives during this meeting**
Joanna Laurson
MSIF's application to add MS treatments on the WHO EML.
MSIF's scoping exercise on the regulation of biosimilars in Latin America.
Objectives
1. Identify the challenges and needs in access to treatment within the three topics
2. Explore possible solutions that could be taken forward following the EML application
3. Prioritise according to opportunity for impact and feasibility for MSIF to lead in this area
(a) Plan tactics for the next 1-2 years with current resources
(b) Thinking of ambitious growth in the next 5 years

Part I: Pragmatic diagnostic and treatment guideline development for low-resource settings

- 10:00 – 10:30 **Current diagnostic and treatment guidelines – key points**
Tim Coetzee
- 10:30 – 11:00 **WHO insight and initiatives in diagnostic and treatment guidelines**
MSIF
- 11:00 – 11:15 Coffee and tea
- 11:15 – 12:00 **Discussion on challenges and need in developing national guidelines in low-resource settings**
With Shanthi Viswanathan Shanthakumar, Deanna Saylor, Riley Bove and Najia Chafai.

12:00 – 13:00 **Structured activity to think about feasibility and opportunities with (a) current resource and (b) ambition**

13:00 – 14:00 Lunch

Part II: MS healthcare professionals in low-resource settings: training and models of healthcare provision

14:00 – 14:35 **Training neurologists: TRIMS and WFN current activity in different regions**
William Carroll, Bernhard Hemmer, Jorge Correale, Mohammad Ali Sahraian, Lekha Pandit, Bob Fox

14:35 – 14:55 **Beyond neurologists: rehabilitation, physiotherapy, occupational therapy**
Aidan Larkin

14:55 – 15:15 **What should be considered when trying to introduce new (costly) medicines to constrained healthcare systems?**
Neha Batura

15:15 – 15:30 Coffee and tea

15:30 – 16:00 **Discussion on need, opportunities and challenges on training healthcare professionals and different models of healthcare provision in low-resource settings**
With Deanna Saylor, Shanthi Viswanathan Shanthakumar, Riley Bove and Najia Chafai.

16:00 – 17:00 **Structured activity to think about feasibility and opportunities with (a) current resource and (b) ambition**

17:00 – 18.30 Free time

18.30 **Dinner at Vapiano** (near meeting venue). Meet 18.25 in hotel reception to walk over.

Friday 12 July

Part III: Availability and affordability of safe and effective MS treatments

- 8:30 – 9:00 Coffee
- 9:00 – 9:20 **Morocco – case study for access to treatment and affordability**
Najia Chafai
- 9:20 – 9:50 **MPP insight and initiatives in availability and affordability**
Charles Gore
- 9:50 – 10:20 **Off-label opportunities, barriers and risks in availability and affordability**
Gavin Giovannoni
- 10:20 – 10:45 **Discussion on challenges and need on improving availability and affordability in low-resource settings**
With Deanna Saylor and Shanthi Viswanathan Shanthakumar, Riley Bove and Najia Chafai.
- 10:45 – 11:00 Coffee and tea
- 11:00 – 12:00 **Structured activity to think about feasibility and opportunities with (a) current resource and (b) ambition**
- 12:00 – 12:30 **Summary of key opportunities identified, thank you to experts**
- 12:30 – 13:30 Lunch. Invited experts leave after lunch.

Part B: IWGA only

- 13:30 – 16:00 **Prioritisation exercise**
Led by MSIF
Summary of three days, prioritisation tools from last meeting
Plan tactics for the next 1-5 years with (a) current resources (b) ambitious growth
- 16:00 – 16:30 **How to fund and resource work in Access**
Luke Thomas
- 16:30 – 16:45 **Next steps and close**