

**Keynote address of Dr Peter Salama, Deputy Director General,
WHO at IFPMA General Assembly, 2018**

Thank-you to the organizers for inviting me to give this address- it is an honour to be here. The pharmaceutical industry is a crucial and intrinsic part of the global health architecture- our partnership is essential to reach our collective goals of improving global health, especially for the poorest and most vulnerable around the world. As we speak, we are battling the second largest outbreak of Ebola that the world has ever faced, in perhaps the most complex context we have known. And the partnership between WHO and your members is right at the centre of the response- I will return to that subject later.

Together we can be very proud of what has been achieved in recent years, especially in the period of the Millennium Development Goals. And it is with great pride that we can say that since 1990, the number of children dying before their fifth birthday, mostly of preventable causes such as malaria, pneumonia, diarrhoea and vaccine-preventable diseases, has been halved. In the same period, HIV has, through access to life saving anti-retro-viral medicines, been transformed from a death sentence to a chronic disease. The treatment of severe acute malnutrition has been revolutionized. And global life expectancy continues its steady, positive trajectory. Most of these gains were made with tools produced by the pharmaceutical industry. It has been my great privilege to serve with the UN at field level for much of my career, rolling out such programmes in countries such as South Sudan, Afghanistan, Zimbabwe and Ethiopia and to witness first hand, their tangible impact in some of the toughest places on earth.

Since joining WHO I have also been singularly impressed by our work together under the Pandemic Influenza Preparedness Framework- the only access and benefit sharing agreement of its kind. PIP is one of the untold success stories in global health- strengthening the long-standing WHO-coordinated GISRS network of more than 140 national influenza centres around the world, collaborating in real time to share more than 2 million virus samples every year in order to monitor changes in the virus, produce new vaccines and protect the world from the next pandemic. Through the partnership contributions with industry, which have raised more than 160 million USD since 2012, as well as material transfer agreements, the results are clear: the world is better prepared to respond to a future pandemic with secure access to 10% of vaccines which will be produced, and stronger capacities to prevent, detect and respond to new and emerging viruses. Almost 50 additional countries now have a fast-track regulatory approach to approval of pandemic influenza products during an emergency, more than 40 additional countries share influenza viruses systematically, we have new influenza mortality estimates and the world's first simulation portal.

And yet, still more than 5 million children under the age of 5, die every year, the vast majority in sub-Saharan Africa. Gains made in global measles control and elimination are being threatened. Two out of five people living with HIV do not have access to treatment. Anti-microbial resistance threatens to undermine our progress in treating bacterial infections.

In addition, this year marks 100 years since the Spanish flu pandemic which killed between 50 and 100 million people, - the threat of new and emerging diseases with their massive economic, social and political disruption is ever present. Over the past 2 years, WHO's emergency programme has developed a global surveillance system.

The system now detects 7,000 public health threats every month- through machine learning techniques and AI we are able to filter these down to 300, 30 of which require immediate field investigation. In the past year, the programme, which has become, to some extent, the world's emergency room, has responded to more than 50 outbreaks and other acute health emergencies whether infectious diseases outbreaks, chemical events or war-related trauma, in more than 50 countries. Unfortunately demand is constantly challenging our supply.

And while we have made tremendous progress tackling some stark global health inequities, there is a major fault-line that we have hardly begun to address. In recent decades it is not necessarily the poorest countries that have fallen behind the most, it is those countries or parts of countries that are facing conflict, insurgency or are fragile due to other reasons. In fact, more than three-quarters of the major outbreaks we see at WHO occur in these 20 or 30 places. Think, plague in Madagascar, wild polio on the Afghan-Pakistan border, yellow fever in Angola, cholera in Yemen, diphtheria among Rohingya refugees in Bangladesh, measles in Venezuela, meningitis in north-eastern Nigeria or Ebola in DRC. Conversely when we review our global goals under the Sustainable Development Framework, we see that the same set of countries accounts for more than 50% of most of the unmet targets- whether for under 5 mortality, maternal mortality or under-immunized children. Most of our global health battles will be won or lost in these countries. And we must review our progress through the prism of how our programmes and products will impact people in these countries.

Perhaps the poster-child for such countries is the Democratic Republic of the Congo, a country with a population of more than 80 million people that has faced decades of instability, exacerbated by

the fall out of the genocide in neighboring Rwanda in the 1990s. This year alone DRC has faced outbreaks of measles, malaria, monkey-pox, cholera, vaccine derived polio and rabies. Every year, in the DRC, 300,000 children under the age of 5 die from mainly preventable causes. The current outbreak is occurring in the context of what I have described as a 'perfect storm'- an outbreak of a terrifying viral haemorrhagic fever with case fatality rates between 50 and 80%, in the midst of a brutal civil conflict with more than 20 active armed rebel groups, in a dense urban setting with cities such as Butembo with its 1 million inhabitants affected, with a highly mobile population of refugees and internally displaced persons, close to international borders, in a province with an unregulated, mainly private and traditional health sector which has become a vector for disease transmission, and all this, during an election period.

Despite this context, so far the outbreak has been confined to 2 provinces within DRC and has not crossed international borders. One of the main reasons for this is the strong collaboration between WHO and your members under the Research and Development Blueprint. Every year, WHO releases a list of high threat pathogens for which no or limited medical countermeasures exist. WHO with academic partners is developing R and D roadmaps for each of these diseases. In addition, WHO works simultaneously to build regulatory and ethical pathways, formulate generic trial protocols and identify funding mechanisms to finance needed research that is now fully integrated into our work on outbreak and emergency response. Ebola is at the top of the Blueprint list of priority pathogens. Now you may think an Ebola outbreak in a war zone is an unlikely setting for cutting- edge research and science to occur. However, it is through the Blueprint that WHO, working closely with the Congolese MOH, has managed to vaccinate more than 40,000 people in North

Kivu under a research protocol with the investigational VSV-EBOV vaccine that has to be kept by means of an ultra- cold chain at between -60 and -80 degrees Celsius until close to the time of vaccination. It is also through the Blueprint and working with the NGOs, MSF and Alima, that more than 180 people have received investigational therapeutics under compassionate use -the drugs that you or I would want to receive were we to contract Ebola and be medically evacuated to our home countries. In addition, 2 weeks ago we launched with NIH and other collaborating partners, the first ever Randomized Clinical Trial for Ebola therapeutics. Collectively we have sent a very strong message to a marginalized community, traumatized by decades of violent conflict - that we believe that they should have access to the same type of medical products that others have around the world- in fact even more so, because they are at greater risk and should be the first to benefit.

Beyond the acute phase though, we must address national capacities to prevent, detect and respond to outbreaks and emergencies. We are doing this by integrating our preparedness portfolio around surveillance, laboratory strengthening, risk communication and emergency coordination into our work on health systems and by ramping up our work on ensuring an acute basic package of health services segues seamlessly into support for primary health care in fragile and vulnerable countries and settings. PHC as our first line of defence and building health systems that work for emergencies are our dual priorities, reflected in WHO's new strategic plan, the General Programme of Work. This is why our Director General, Tedros talks about Global Health Security and Universal Health Coverage being the twin sides of the same coin.

So where do we take our partnership from here. Some of you will have heard me say that our partnership needs to move from a

transactional approach to a strategic one. It is for this reason that I am not a big supporter of corporate social responsibility projects. I think the strongest and most sustainable partnerships are those designed for impact and aligned around common interests. The SARS outbreak cost the world between 30 to 50 billion USD; the impact of a pandemic of a novel influenza virus or new respiratory pathogen will likely be measured in the trillions. That we need to work together even more closely is self-evident.

So how do we do it? Industry needs to of course continue to do what it does best- to innovate, to bring the safest and most effective products to licensure and to market at the scale required, and to create value. However, I would argue that you will increasingly need to work even more closely with International organizations such as WHO to help define the public health priorities, to rely on us to provide the normative and enabling environment, to be an impartial broker and to help overcome market failures, in collaboration with GAVI, CEPI, GFATM and others, in order to ensure that your products reach the poorest and most vulnerable, in the fastest and most equitable manner, and therefore have the great public health impact. Importantly, we are on the ground in more than 150 countries- we can help you walk in the shoes of the people living in the most precarious settings on earth and the clinicians working without internet, electricity, or running water. We must remain relevant to their needs at all times. As WHO, we should also not be shy in asking you to support global public health goods from which you derive a direct benefit, such as PIP, the Blueprint or WHO's Contingency Fund for Emergencies, at a scale commensurate with your means, as major publicly listed companies. Not as a charitable contribution or CSD but as an investment. A safer world benefits everyone. UHC will benefit everyone.

And finally let's continue to challenge our assumptions, both epidemiological and commercial. We once considered Ebola to be a disease affecting only a few countries in central and east Africa with rural, isolated outbreaks that may have largely been self-limited. Now we see the transmission pattern is changing and changing dramatically. This will demand a different response from governments keen to protect their national security interests in a highly mobile, increasingly urban and inter-connected world. It will also have major implications for the markets for such products. As Ebola marches through the Kivus towards the east African transportation hub of Goma, the virus is exploiting social vulnerabilities and fault-lines nationally, regionally and globally, just as HIV and other diseases have done in the past. These are the issues, contexts and priorities for global health in the future. We count on our partnership with IFPMA to tackle them. Thank-you.