

Report by the Director-General to the Executive Board at its 120th session

Geneva, Monday, 22 January 2007

Mr Chairman, Members of the Executive Board, Excellencies, ladies and gentlemen,

1. I thank Dr Nordstrom for this comprehensive review of recent activities. As we know, Dr Nordstrom assumed responsibility abruptly, under tragic circumstances, and has managed the work of this Organization admirably. We are all most grateful.

2. Today is my 19th day in office as the Director-General of WHO. I was deeply honoured by the trust you placed in me in November and have kept one of my earliest promises: I am working tirelessly!

3. As we start this first year together, I would like to make a few announcements and clarify some of my commitments. I will then express some views about the agenda items we will be discussing in the coming days.

4. I will be listening closely to your debates. You will, of course, decide how we should move forward. But it is my responsibility to carry out those decisions. I look forward to your guidance.

5. As you know, I appointed Dr Anarfi Asamoah-Baah as my Deputy Director-General on 9 January. I have promised staff that I will continue ongoing reforms at WHO, but will not introduce changes that cause upheaval. Staff and the programmes they implement need continuity. There will be some changes, but these will be gradual and carefully managed.

6. I am holding discussions with Regional Directors on ways of improving the way the Organization functions across all levels, including the country offices. Our organizational structure in headquarters needs some fine-tuning. I am looking for ways to amplify the impact of our activities and I see some opportunities for bringing related programmes closer together. I have asked my Deputy Director-General to assume responsibility for the smooth management of these changes, and he has agreed to do so.

Mr. Chairman,

7. We begin our discussions in what I believe are optimistic times for health. Let me draw your attention to a spectacular success story.

8. Last week, WHO and its partners in the Measles Initiative announced that ambitious targets for the reduction of measles mortality were not only met, they were surpassed. By the end of 2005, we

aimed to reduce measles deaths by half compared with 1999. The statistics have been compiled: mortality went down by 60%.

9. Committed health officials in Africa – the region with the heaviest measles burden – led the way, reducing measles deaths by an impressive 75%.

10. Let's think about what this means. Cumulatively, from 2000 to end 2005, WHO estimates that accelerated measles immunization, boosted by this initiative, has averted 2.3 million deaths. The measles vaccine has been available for more than 40 years. But it took the commitment of leaders, and the caring – and cash – of a dedicated partnership, to turn things around.

11. The news gets even better. Increasingly, this Initiative is delivering a bundle of life-saving and health-promoting interventions: bed nets for malaria, vitamin A to boost the immune system, de-worming tablets that help keep children in school, polio vaccine, and tetanus vaccine for pregnant women.

12. I view this initiative as a model of what can be achieved through integrated service delivery. This is a value-added approach that amplifies the power of public health. Our profession is peopled with optimistic, innovative thinkers. Let us keep this great potential in mind as we discuss the work ahead.

Mr Chairman,

13. I have identified six issues that can guide the way we approach our work in the coming years. Two address fundamental health needs: for health development and health security. Two are strategic: we need to strengthen health systems, and we need better evidence to shape our strategies and measure our results. The last two are operational: our reliance on partners, especially those with an implementation role in countries, and our need to perform well as an organization, across all programmes and at all three levels. As I have said, this is a simple way of looking at a very complex task.

14. Let me first address health development. I have said that I want the relevance and effectiveness of our work to be measured by its impact on people, and two groups of people in particular: women and the people of Africa. To have an impact on the health of these two groups, we may need to do more in some areas of work. In other words, we may need to be more innovative and efficient.

15. Much of what we are already doing has an impact on women and the African people. This is not surprising. The threats to these two groups are multiple. Many of these threats are receiving high-level attention as we strive to achieve the Millennium Development Goals, to which I am fully committed.

16. We know that pursuit of the Millennium Development Goals is a pro-poor initiative. When we think about the health of women, we must also consider their role as agents of change. When women are given a hand up in terms of household income, we see improvements in their own health and that of families and communities.

17. When we think about health in Africa, we must never forget the links between poverty and health. Poor health anchors large populations in poverty. Better health allows people to work their way out of poverty and spend household incomes on something other than illness.

18. As with woman, people in Africa have capacities that need to be unleashed. We have seen the potential of African leaders realized in the measles success. The partnership provided the tools, but the victory belongs to Africa and its people.
19. One disease on our agenda causes immense suffering in large parts of the world, but does its greatest harm in Africa. This is malaria. Africa is home to the most efficient mosquito vector and the most deadly form of the parasite. In Africa, there is no malaria “season”. Transmission occurs year-round.
20. Malaria is an insidious disease that causes high mortality, but also creates a huge burden of debilitating illness that impedes human progress. When we consider that this disease consumes 25% of household incomes in Africa, we have a sense of the scale of the economic burden. The good news is the progress we are seeing in scaling up interventions.
21. In December of last year, I was privileged to attend the White House Summit on Malaria in Washington, DC. There, I saw first-hand what public-private partnerships and community goodwill can do to bring together resources from different sectors to help the people of Africa.
22. The neglected tropical diseases – which disproportionately affect the health and ruin the lives of women – are another example. WHO estimates that at least 300 million women are severely and permanently disabled by these preventable diseases, which take their heaviest toll in Africa. As Anders has noted, we are fortunate to have excellent initiatives and partnerships, and first-rate interventions for addressing these diseases.
23. We know that infectious diseases, especially AIDS, tuberculosis, and malaria, are significant impediments to development in Africa. But chronic diseases – cardiovascular diseases, cancer, chronic respiratory diseases, and diabetes – are on the rise there, as elsewhere in the world. In low- and middle-income countries, these diseases are another serious impediment to development.
24. Health systems can often manage the intermittent emergencies of infectious diseases, but are challenged by the demands – and costs – of chronic care, whether for HIV/AIDS or diabetes. The consequences for households can be catastrophic.
25. Once again, we have tools and strategies for taking action. As the report on chronic diseases makes clear, we have many excellent opportunities for prevention and a broad range of interventions that are cost-effective in all our regions. For these diseases, prevention is by far the best option. WHO must continue to convince health leaders in all regions that chronic diseases are part of the development agenda.
26. Health and security is the topic for this year’s World Health Report. It is also the theme for World Health Day, which we will celebrate around the world. I will join a high-level debate on the topic in Singapore. We will issue a background document for World Health Day to guide these discussions and issue the full report later this year. The report will focus on risks and dangers to health that arise from the ways in which nations and their populations interact internationally.
27. This is an extremely important area for WHO to address. SARS, for example, taught us how much our highly mobile, interconnected, and interdependent world has changed in terms of its vulnerability to health threats. Shocks to health – whether from emerging infectious diseases, natural disasters, or environmental change – can easily become major shocks to economies, societies, and

business continuity around the globe. I regard this year's report as the first part of what we have to say about health and security.

28. The World Health Report for next year will be the second part. It will be issued in a significant year: the 60th anniversary of WHO and the 30th anniversary of Alma-Ata. I have decided to focus the World Health Report 2008 on primary health care and its role in strengthening health systems. The report will address a second, more personal dimension of health security: community access to the fundamental prerequisites for health, including enough food, safe water, adequate housing and sanitation, and essential health care. Meeting these prerequisites is a critical public health function that should be performed in every country as a matter of good governance.

29. As my final announcement, I want you to know that I am setting performance objectives for myself. I must lead by example, and I must be held accountable to Member States. You expect me to deliver on my promises, and my performance should be measured. This is the foundation of accountability. This is what I expect of all my staff at all levels.

Mr Chairman,

30. I will now turn to items on our agenda. We have one item that covers our work in its totality, and does so well into the future. This is the Draft Medium-term strategic plan for 2008 to 2013, which includes the Proposed programme budget for the 2008 to 2009 biennium. I will be asking Anders to introduce this item. I know you will consider it carefully. Your views will be taken into consideration as we prepare the draft plan and proposed budget for submission to the Health Assembly in May.

31. Under technical and health matters, our first item is poliomyelitis. Polio eradication is one of our most important areas of unfinished business. The October report of the advisory committee on polio eradication reached a firm conclusion: it is technically feasible to interrupt polio transmission worldwide.

32. Here is the key question: are we now in a position to overcome the operational and financial obstacles? I believe we need to assess the country-level operations very carefully to ensure that we can indeed interrupt transmission globally.

33. I have decided to convene an urgent high-level consultation on this issue, which will take place in this room from 27 to 28 February. The expected outcome is a set of milestones that must be met if transmission is to be interrupted in the four remaining endemic countries. The consultation will also consider the funding required to meet these milestones. The conclusions will be communicated to the Health Assembly in May.

34. Apart from the Draft Medium-term strategic plan and the Proposed programme budget, the items before this Board cover only a selection of WHO activities. But these items are broadly representative in other ways.

35. Recent years have witnessed an unprecedented growth in the number of partnerships, initiatives, and funding agencies devoted to public health. Never before has health enjoyed such a high place on development and political agendas. The funding coming from private foundations and other sources is unprecedented. There will always be unmet needs, but health has never before enjoyed such wealth.

36. As guided by you, WHO has a great responsibility to channel this enthusiasm, activity, and money in ways that bring clear and measurable benefits to countries and their populations. Our public

health agenda should be cohesive and compelling for our partners, but above all must align with country priorities and capacities.

37. Single-disease initiatives have their place, but we need to pursue every opportunity to find synergies that bring multiple results.

38. Obviously, we must avoid duplication of efforts but we must guard against fragmentation as well. I believe that integrated service delivery, such as we see with measles and the neglected tropical diseases, is one way forward. I further believe that when we use an integrated primary health care approach, we will find ways to inter-relate programme activities, and thus amplify our impact.

39. Let me clarify what I mean by looking at three issues that appear time and time again in the reports and resolutions before us. These issues are **health systems, evidence for measuring impact, and access to essential care.**

40. **On health systems,** we have an item specifically devoted to this topic. But when you consider the other items under technical and health matters, you see that almost all contain a reference to health systems. Some reports on single diseases, such as malaria and tuberculosis, have strategies for contributing to the strengthening of health systems. Others bluntly state that further progress depends on stronger systems and services.

41. Here is the essence of our dilemma. We have a multiplicity of health initiatives focused on delivering outcomes. The ability to deliver these outcomes requires a functional health system. Yet strengthening health systems is not the core purpose of these initiatives. We need a common approach to service delivery.

42. None of this is news for public health. But I did want to make this point about the importance of health systems, as it reinforces my commitment to integrated primary health care.

43. As I have said, what gets measured gets done. **The second issue we see in several reports concerns the use of evidence to measure our results.** If we want to set out a compelling health agenda, we must look not only at the needs we are addressing, but also at the results we are achieving. We must keep track to stay on track.

44. A step forward for malaria control, as reported to this Board, is the development of country data profiles, supported by indicators. The report on tuberculosis control provides a model of the value of monitoring a programme's operational performance as well as its impact on an epidemic.

45. At the time when the global TB targets were set in 1991, no system existed for measuring the global burden of this disease. We can now say with confidence that progress has been tremendous. Monitoring becomes all the more important following the recent emergence of extensively drug-resistant tuberculosis.

46. For chronic diseases, WHO has initiated the STEPwise approach to risk factor surveillance, using standardized methods and tools. It is gratifying to note that every country in the African Region has adopted this standardized approach to data collection.

47. No one would question our need to measure performance and results. But we need reliable information to do so. Again, in the absence of well-functioning health systems, we are unlikely to get even the most basic population data on morbidity and mortality.

48. **The third issue concerns equitable access to essential care, including medicines and other commodities.** Among these essential commodities, I would include the information needed to avoid or minimize health risks.

49. When poverty is the root cause of poor access, we need approaches such as that seen with malaria, where bed nets are now being distributed free-of-charge or at heavily subsidized prices.

50. Another item on our agenda is a draft strategy on gender, women, and health. I welcome this item. We know that gender-related factors can expose a group to greater health risks, jeopardize health outcomes, or deny adequate health protection. Knowing about these problems allows us to design more equitable strategies.

51. Concerning fixed-dose drugs for children suffering from AIDS, tuberculosis, and malaria, we learn that these drugs are often not available because industry has no strong market incentive – these are not priority paediatric diseases in the affluent world. As you know, we are developing a strategy and action plan addressing public health, innovation and intellectual property.

52. We also learn that lack of availability of essential paediatric medicines, including antibiotics, is one reason why countries are not making adequate progress towards some Millennium Development Goals.

53. If we remain committed to the value system of primary health care, we must take a hard look at these and other issues pertaining to access and equity. The Commission on Social Determinants of Health is doing so as one of its tasks, and I look forward to the results.

54. These concerns about access and equity further reinforce my commitment to the primary health care approach.

55. Turning to performance, UN reform is on our agenda under managerial matters. We welcome the proposal for pilot exercises in selected countries to explore ways of improving UN system-wide coherence.

56. Let me assure you: WHO will be an active participant in UN reform. As the agency with the strongest country presence, we are well-placed to contribute and will bring our considerable experience to bear as the reform agenda moves forward. Your guidance on this important issue is most welcome.

57. Last week I attended the launch of the Consolidated Appeals Process for humanitarian assistance in crises. I saw good evidence of UN reforms that have led to much better strategic coordination of activities according to the unique mandates and strengths of individual agencies. I believe we are moving in the right direction.

Mr Chairman,

58. I will conclude with comments on avian influenza and the related pandemic threat. The message is straightforward: we must not let down our guard.

59. The whole world has lived under the imminent threat of an influenza pandemic for more than three years. These years of experience have taught us just how tenacious this H5N1 virus is in birds.

60. Countries have made heroic efforts, yet the virus stays put or comes back, again and again. Almost no country with large outbreaks in commercial or backyard flocks has successfully eliminated this virus from its territory.

61. As long as the virus continues to circulate in birds, the threat of a pandemic will persist. The world is years away from control in the agricultural sector.

62. This may mean that we have some more years in which to improve preparedness, or it may not. Influenza viruses are notoriously sloppy, unstable, and capricious. It is impossible to predict their behaviour.

63. But we do know some things. The virus does not, at present, transmit easily from birds to humans. H5N1 avian influenza is still essentially a disease of birds.

64. For humans, we also know that this virus has lost none of its virulence. As of today, 267 cases have been confirmed, of which 161 were fatal, representing a case fatality rate of 60%. More deaths occurred in 2006 than in the previous years combined. For 2006, the case fatality rate was 70%.

65. We are clearly much better prepared than three years ago, but have every reason to continue these efforts. The revised International Health Regulations come into force in June. That will help. You have a resolution before you that calls for routine and timely sharing of biological materials related to novel influenza viruses. That will help as well.

Mr Chairman,

66. I will now place this 120th session of the Executive Board in your competent hands.

Thank you.

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