LEE JONG-WOOK
LEE JONG-WOOK
A Life in Health and Politics

Desmond Avery

Orient BlackSwan
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Foreword

Dr. Lee Jong-wook, the sixth Director-General of the World Health Organization, is remembered by the world as 'the Vaccine Czar', 'the Schweitzer of Asia', or 'the Little Giant'. But to the Korean people, Dr Lee is most remembered as a proud figure who became the first Korean to lead an international organisation. Despite his global impact, surprisingly few records remain in and out of Korea as to what kind of person he was.

Dr. Lee was born in Korea in 1945, when the poorest country in Asia had just been liberated from the grip of colonial rule. He proved himself a man of great conviction and action, leaving behind what wealth and honour his profession as a medical doctor would have brought him in the newly industrialising and increasingly prosperous Korea. Instead, he opted to practise medicine for the good of public health by treating the poorest people in the world.

Despite his initial relative obscurity in the realm of international public health, his dedication made him the first technical staff of the WHO Secretariat to be appointed to the leading position of WHO in 2003. Only after his election to the post did the world start to pay attention to him, his unflinching work, and his substantial contribution to public health.

With the attention and expectations directed his way, history took up a pen to record his life as he lived it. But in May 2006, only halfway through his term as WHO Director-General, the pen abruptly dropped.

How a person is evaluated is bound to differ as the process of evaluation is inextricably linked to each viewer’s social and cultural background, as well as his or her knowledge. If even one person is inspired to continue the humanitarian work of Dr Lee,
then his legacy, and the different accounts of his life in this book, will serve as a valuable historical record when discussing what kind of person Dr Lee truly was.

May 2012

Han Kwang-su, MD, PhD
President
Korea Foundation for International Healthcare
Lee Jong-wook died on 22 May 2006. The day after his funeral, I was invited by email to write his biography. Having known him as a colleague since 1988 and then as his speech writer from 2003 to 2005, I welcomed the opportunity to continue our friendship in that way. In the process of finding out about him I became more and more aware of the paradoxes he embodied. He was often rated great but partly because he did not deny his limitations. He was often rated humble but he also boasted about his successes, and had few apparent inhibitions about being a top person. There was a kind of happy ending to his life in the sense that he won honour and approval that exceed most people's fondest dreams, but it was also a sad one in that he did not live to see the success of his efforts or to realise his full potential. If he had died later, on the other hand, he may have achieved more or he may not have, but in either case the moment for heartfelt applause on a grand scale may not have come.

Contradictions of this kind, which might appear in any life that is at all well known, defy efforts to ignore them or resolve them by settling for one side or the other, for instance by idealising or belittling the person concerned. In what follows I have tried to avoid both those errors and just assemble enough information about the man and the history of which he was a part to enable readers to come to their own conclusions. Out of respect for the dead and for those living who are still close to him, I have not delved into his private life, but out of respect for truth I have not tried to make a saint, genius or hero out of him. Every account is partial, however, in both senses of the word: it can only assemble part of the evidence that may be relevant; and it cannot help reflecting the opinions which guide the writer's choices of material.
An important restriction for the present writer which should be recognised at the outset is that I am English and Lee Jong-wook was Korean. He had lived more than half his life in what is now the Republic of Korea before he set foot outside it, whereas I have only spent a few days in that country and learnt only a very few words of its language, and even those I probably pronounce unintelligibly. Though we were born in the same year, so lived through the same period of world history, England and Korea are about as different as two countries can be, so there is room for plenty of incomprehension. To me and other westerners he was a thoroughly cosmopolitan English-speaking man with a Korean background, but the reality might be put more truly the other way round: he was a thoroughly Korean man with cosmopolitan ways of saying and doing things. The material in the following pages reflects this limitation in the writer by consisting only of what was available to me in English. This difference of language and background, for better or for worse, leaves an even vaster amount of potentially revealing material out of sight than would otherwise be the case with a discreet man involved in a large number and variety of confidential matters.

Lee Jong-wook did not keep a diary and was not much of a letter writer. He did not publish much either—only two or three co-authored research articles in his early days as a leprosy specialist, and policy articles written for him in his later days as a senior health official. So this account of his life and work depends mainly on other kinds of evidence: the memories of family members, friends and colleagues, press coverage, historical and institutional records, and the literature on matters in which he was involved. I did not spend a lot of time listening to him and drawing him out, as I might have done if I had known I was going to be his biographer. Even if I had, he would probably have still been hard to pin down.

A symptom of his elusiveness is the never entirely settled question of what to call him. In his medical student and early international days his English-speaking friends called him ‘Uggy’ and he signed his letters initially in Chinese characters, later
either with that name in Roman characters or its origin, ‘Jong-wook’, in Korean characters. In the 1990s he preferred his friends to call him JW. He was called officially Jong-wook or JW Lee in the World Health Organization (WHO) to start with, but when he became Director-General he decided his name should be written ‘LEE Jong-wook’, following the French practice of capitalising the surname in some cases. This was not always practical; for instance in lists of names, the rule would either have to be applied to all of them, which is not usually done in English, or be dropped to avoid bizarre ostentation. He continued to use ‘Jong-wook Lee’ as his signature though, so on official documents his name appears one way round in print and the other way round directly below it in his handwriting. WHO editors found the capitalised version of his surname unusable (or ‘bonkers’, as one daringly put it) in most cases, so quietly dropped it. His entourage at work cut through the uncertainty by calling him ‘the boss’, while the rest of the WHO staff called him ‘the DG’. In this book about him I have followed the convention of referring to him just by his surname, though in some places, especially during the first part of his story, ‘Jong-wook’ and ‘Lee Jong-wook’ seemed to work better.

In addition to reflecting a unique character, Lee’s life and work raise questions about health, international organisations and many other matters that are important in their own right. The following account attempts to cover some aspects of some of those issues, both for the light they shed on the man and for the light he sheds on them.
Acknowledgements

I am very grateful to the Korea Foundation for International Healthcare which commissioned this work, providing not only financial and moral support for it but first-rate assistance in Seoul with research on the early part of Lee Jong-wook’s life. The World Health Organization also generously provided access to information, support for travel, and guidance on selection of content. As well as these two institutions, there have been two moving spirits behind the work from beginning to end: Reiko Kaburaki with the wealth of memories and insights which she has shared so generously, and Ian Smith who first had the idea of a biography, then contributed a vast amount to the content, and then stuck steadfastly to the project through its many stages of drafting and redrafting. Without their help it would not have even been attempted.

Those who have contributed reminiscences, expertise, information and practical help are too numerous to list fully, but I would like to thank in particular Lee Chong-oh, Lee Chong-koo, Lee Chong-won, B. K. Kim and Kim Yun-nam for their help on the Korean years, Barry and Lili Kaufmann on the final year at medical school, John Hess and Lynn Stansbury on the time in Chuncheon, Honolulu and subsequently, Annie Worth and Jim Douglas on the time in Honolulu, Gisela Schecter on the time in American Samoa, and Denis Aitken, Bruce Aylward, Gini Arnold, Kenneth Bernard, Janet Bumpas, Patrick Chevalier, Dorine Da Re-Van Der Wal, Maria Dweggah, Bill Kean, Chen Ken, Gael Kernen, Peter Carey, Bjorn Melgaard, Shiguru Omi, Kidong Park, Thomson Prentice, Mario Raviglione, Alison Rowe, Alan Schnurr, Sally Smith, Shin Young-Soo, Steven Uggowitzer, Marie Villemin, and Tokuo Yoshida on the time in WHO. There were many others, and to all of them I am extremely grateful.
Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADG</td>
<td>Assistant Director-General</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CDD</td>
<td>Control of Diarrhoeal Diseases</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CVI</td>
<td>Children’s Vaccine Initiative</td>
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<tr>
<td>DANIDA</td>
<td>Danish International Development Agency</td>
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<tr>
<td>DHH</td>
<td>Department of Health and Human Services</td>
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<tr>
<td>DOTS</td>
<td>Directly Observed Therapy – Short Course</td>
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<tr>
<td>ECFMG</td>
<td>Educational Commission for Foreign Medical Graduates</td>
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<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>EXD</td>
<td>Executive Director</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance on Vaccines and Immunization</td>
</tr>
<tr>
<td>GPV</td>
<td>Global Programme on Vaccines</td>
</tr>
<tr>
<td>Hib</td>
<td>Haemophilus influenzae type B (vaccine)</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno Deficiency Virus</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>IUATLD</td>
<td>International Union Against Tuberculosis and Lung Disease</td>
</tr>
<tr>
<td>KNCV</td>
<td>Dutch Tuberculosis Foundation (Koninklijke Nederlandse Centrale Vereniging tot bestrijding der Tuberculose)</td>
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<tr>
<td>KOFIH</td>
<td>Korea Foundation for International Healthcare</td>
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<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<tr>
<td>NBME</td>
<td>National Board of Medical Examiners</td>
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<tr>
<td>OR</td>
<td>Operating Room</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>--------------</td>
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<tr>
<td>PAR</td>
<td>Post-Anaesthesia Room</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
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<tr>
<td>SHOC</td>
<td>Strategic Health Operations Centre</td>
</tr>
<tr>
<td>TAG</td>
<td>Technical Advisory Group</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Introduction: ‘This Great Doctor’

Lee Jong-wook, the sixth Director-General of the World Health Organization (WHO), and the first Korean to head a United Nations agency, died on Monday, 22 May 2006, which was the opening day of the annual World Health Assembly. His funeral took place on Wednesday the 24th at the Basilica of Our Lady in Geneva, Switzerland, celebrated by the Papal Nuncio with seven other priests, and attended by large numbers of ambassadors, ministers of health and other officials who were in town for the Health Assembly. Staff members who had taken the bus down the hill from the nearby WHO headquarters, family members who had flown in at short notice from the Republic of Korea, the United States and Japan, and colleagues and friends from other parts of the world, filled the remaining pews. There was standing room only for late-comers in the spacious Neo-Gothic Catholic church in the heart of the capital city of Calvinism, luxury goods and multilateral organisations. Flowers, candles, solemn music, ancient rites and eloquent eulogies combined to give due recognition to the event, which for many had been well summarised on Monday by the Secretary-General of the United Nations: ‘The world has lost a great man today.’ Kofi Annan did not get to the funeral himself but sent his deputy, Mark Malloch Brown, to represent him there.

At a gathering of friends and family that evening, a close Korean friend said to Reiko, Lee Jong-wook’s widow, ‘I didn’t
know he was a Christian! She answered simply and with a touch of humour, ‘Well, he is now.’

Bill Kean, whose job title was Executive Director of the Director-General’s Office, had said in his eulogy at the funeral: ‘This was a man who combined extraordinary intelligence with personal integrity.’ Recalling how well he got people to work, how strong his willpower was, how widely he read, how competitively he skied and played tennis, and what a large number of people were proud to count him as a friend, he concluded that ‘this great man had so much more to give. But if we could achieve any part of what he had accomplished—if we could influence and shape the world only a fraction as much as he did, this world would be a far better place.’

Lee’s son, known in Japanese and English as Tadahiro, and in Korean as Choong-ho, called him ‘an incredible and loving father, husband, brother and uncle’ whose ‘adventurousness made him great at work and at life. If ever he seemed stern or impatient, I believe it was because he had so much to accomplish in the time that he had. Whether it be solving every illness, hiking every hill or seeing every beautiful old church with my mother, he didn’t want to waste any time.’

Those two speakers were followed by Rhyu Si-min, Minister of Health and Welfare of the Republic of Korea, who said ‘Dr Lee was a towering figure in the world of health’ whose life had ‘touched millions and made them all that much better.’ With his death, ‘a shining light was unexpectedly extinguished.’

Celebrities also made their contributions to the tributes, condolences and obituaries. Jimmy Carter called him ‘an intense,
daring and accomplished person' who 'inspired us through his
grace, humility, and vision for a better world.' His death was 'a
personal loss for Rosalynn and me and a tragic loss for the whole
world.' Jacques Chirac called him 'this great doctor, a man of
vision and generosity in serving others,' through whom France
had enjoyed 'a relationship of friendship and trust' with his
organisation. George W. Bush wrote 'on behalf of the American
people' that he and Laura were 'deeply saddened to learn of the
sudden passing of Dr Lee, whose dedicated service to the World
Health Organization improved the lives of tens of millions of
people around the world.'

The British Medical Journal (BMJ) noted approvingly that Lee
had also been on friendly terms with Hu Jintao of China and
Vladimir Putin of Russia, and the latter had invited him to address
the G8 summit due to take place in St Petersburg that July. Sarah Boseley, writing in the Lancet, called him 'a consummate
politician' and quoted Jim Kim, a close colleague, comparing
him favourably to Jim Grant, the much admired former head of
the United Nations Children's Fund (UNICEF). She also quoted
Christine McNab, another member of his staff, calling him 'a real
leader. If he put his mind to something he would make it happen.'
Boseley went on:

Colleagues at WHO talk of Lee's formidable intelligence, his sense
of humour, and his love of the countryside. 'He spent his weekends
reading Shakespeare and listening to classical music and learning
languages and enjoying nature,' said McNab. Kim called him 'a
polymath who could talk intelligently about Russian history,
Shakespeare or particle physics'.

Boseley ends with Kofi Annan's statement, which she qualifies
as 'unequivocal', that his death was the world's loss of a great
man.5

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The messages sent that week by email and post and written into condolence books that were opened in WHO regional and country offices are hard to count because they were addressed to different recipients and did not all end up in the same place. Some are now with family members while others are stored in different systems and languages in WHO offices and those of the Korea Foundation for International Healthcare. Like those quoted above, the perhaps 1500 email tributes and condolences archived at WHO in Geneva made frequent use of the word ‘great’. Others tried to convey their sense of his significance with scenes from his life in which they had participated. A UNICEF worker wrote:

I would like to highlight the contribution he has made to reconciliation on the Korean peninsula. As well as being the first South Korean to be head of a UN agency, he was also the first South Korean UN international professional to visit North Korea. He came there as head of WHO’s tuberculosis control programme in 2001, along with then Director-General Gro Harlem Brundtland. I was the UNICEF Country Representative at the time. He so endeared himself to his North Korean hosts, as he did to the rest of us, that they invited him back again. This marked in my view a real turning point in WHO’s support for TB control and in the quality of WHO’s overall programme in North Korea. As we know, it also led to North Korea lending its decisive vote to Dr Lee in his election as Director-General of WHO. This is one of the lesser known but vital parts of the reconciliation of the divided people of Korea.

One final memory for me was of Dr Lee’s visit to Indonesia just after the devastating Indian Ocean Tsunami; I was there too as Acting UNICEF Country Representative. We had many VIPs come to see for themselves nature’s awful effects. But one man stood out for his truly human approach: Dr Lee Jong-Wook.6

The North Korean link, rarely mentioned during his lifetime, is confirmed by a press release on 23 May stating that the North Korean Ambassador, Chul Lee, had gone to see Lee at the hospital the day before he died, that they had often discussed current

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affairs at dinner together, and that an embassy official said they used to invite him round, and sometimes prepared Korean food for him to take home with him. ‘North and South Korea will be more sorrowful than any other country about this death. We had a very close relationship with the deceased,’ the official said.  

From Tashkent a staff member wrote:

I had the honour and privilege to be the WHO Representative in Uzbekistan (appointed by Dr Lee in Nov 2003) when Dr Lee came to Tashkent for an Official State visit. It is enough to point out that the meeting with the President was to have been for a few minutes (as a formality) and it actually continued for one and a half hours with an excellent rapport developed by Dr Lee with the President. I am certain that the many positive initiatives for health in Uzbekistan that followed owed much to Dr Lee’s visit and the high profile it gave to health in Uzbekistan. On a personal level Dr Lee was relaxed and very personable and the memory of the journey with him on the bi-plane trip across the ‘dying’ Aral Sea and his opening of the Multidrug-resistant Hospital in Nukus (where I am pleased his name and legacy will remain forever in the plaque that announces the opening of the first such hospital in central Asia) and the visit to the historic art museum in Nukus. 

A colleague from New Zealand who had recently been awarded the Order of Merit by his government wrote:

Dr Lee had a special place in his heart for New Zealand, many times referring to the large number of visits he made to the country during the period when he was a Medical Officer in Fiji, and later, when based in Manila.

Dr Lee was gracious enough to come to the award ceremony at the NZ Ambassador’s home, even in the midst of a busy schedule. He caught a bus from WHO to avoid the 6 p.m. traffic and, as a result, was the first to arrive. This type of action typified a special quality—his humbleness and his refusal to allow being the leader of a vast organisation dedicated to the health of the world’s people, to


detract from his essence as a genuinely warm hearted and expansive person.

He even made a speech which was spontaneous, light hearted and very funny, drawing attention to his accent: 'I have been to New Zealand two dozen times, so that is why I have such a strong Kiwi accent!' This wry sense of humour, and quick repartee, was a real gift. He started his talk in his own inimitable way as follows: 'I know this must be a serious occasion . . . (dramatic pause) . . . because I see that Robert has had a haircut!' He was still chuckling about these two jokes the next day (and so were we).9

Even making allowances for the strong feelings sudden death causes, such a profusion of warm-hearted remarks suggests an exceptionally likeable person. If he himself had tried to imagine a best-case scenario for what would be said about him when he died, he could hardly have come up with so much and such high praise. Indeed, since, as many people noted, one of his chief virtues was humility, he may not have been keen to be applauded quite so lavishly. Being a realist, he would probably not have expected it, and have found it pleasantly amusing. Whether he would have wanted a biography as well is hard to say, but the prominence of his position by the end of his life, and the drama caused by his death are probably sufficient reasons for attempting one.

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PART I
1945–1979
KOREA
Lee Jong-wook was born in Seoul on 12 April 1945. His father Myung-se and his mother Sang-kan had married in 1928, at the age of 20 and 19 respectively. Jong-wook had two sisters—Chong-sook who was sixteen years old, and Chong-won who was eight—and a brother, Chong-bin, who was fourteen. The family had recently suffered the loss of two children: a boy, Chong-ik, who had died of meningitis at the age of five; and a girl, Chong-hee, who had died of pneumonia at the age of three.1

As Chong-won was leaving for school on that morning in April, her mother asked her to call the midwife on the way, and when she came home in the afternoon, the birth had already taken place. Her father chose Wook for the new brother’s name, to express love and the hope for a long life. A dictionary definition of the word wook supplied by Jong-wook’s widow, Reiko, is: ‘To look clear and stand out, spotted and streaked charmingly and attractively, to be flourishing and successful, active and lively. He really was, wasn’t he? You need a Chinese-character dictionary to know the meaning of those letters.’2 A commemoration booklet about him says ‘Jong-wook’ means ‘Grow and prosper’.3 According

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1 The account of Jong-wook’s early days is taken mainly from an unpublished memoir by his elder sister Chong-won.
3 Korea Foundation for International Healthcare (KOFIH), Dr LEE Jong-wook (Seoul: KOFIH, 2008), 3.
to both his brother and his sister, Jong-wook became Myung-se's favourite son, and remained so for the rest of his life.

Chong-won recalls hurrying home from school each day, looking forward to holding her little brother in her arms. When she went on errands in town she carried him on her back, and felt safe to go wherever she needed to, authorised by her responsibility of child care. Even Japanese soldiers and policemen did not frighten her, as they were made tender-hearted by the baby she was carrying, seeing in him perhaps the hope for better times to come.

The time of his birth was an eventful one for global politics. On the day he was born, President Roosevelt died in Warm Springs, USA, from a brain haemorrhage, at the age of 63. The founding conference of the United Nations opened in San Francisco two weeks later, and Hitler shot himself in his bunker in Berlin on the last day of that April. In August, Hiroshima and Nagasaki were bombed, the ensuing devastation bringing the war in the Pacific to an end. This led immediately to the withdrawal of Japan from Korea after 35 years of harsh and bitterly resented rule. Following the withdrawal of Japan, many of the Koreans with government jobs remained in their posts. These included Jong-wook’s father, Lee Myung-se, who was a clerk in a local administration office.

As the Second World War ended and the Cold War began, the United States and the Soviet Union agreed to divide the Korean Peninsula into two occupation areas separated by the Thirty-Eighth Parallel, for the purpose of disarming Japanese forces. The two powers could not agree on the future of independent Korea, however, and Korean political activists failed to find an acceptable compromise for the ideological basis of the new regime. Political violence and armed conflicts ensued throughout the peninsula, with refugees and political exiles trying to move into safe areas. Jurisdiction for ‘the Korean Question’ was moved to the United Nations in 1947, but without the power to end the conflict. At last, the United States helped capitalists and democrats to establish the Republic of Korea in the south under Syngman Rhee, proclaimed on 15 August 1948, and the Soviet Union helped socialists to set up the Democratic People’s
Republic of Korea in the north under Kim Il-sung, proclaimed three weeks later on 9 September.\footnote{I am indebted to Lee Chong-koo for this summary of the political situation, in material sent by email on 2 September 2009.}

The United Nations saw the opening up of a more promising prospect for international cooperation during 1948: the inauguration on 7 April of its specialised agency, the World Health Organization. To promote ‘the happiness, harmonious relations and security of all peoples,’ the new multilateral institution was intended to uphold everyone’s right to ‘the enjoyment of the highest attainable standard of health.’\footnote{WHO, “Constitution of the World Health Organization”, in Basic Documents, forty-sixth edition (Geneva: WHO, 2007), 1.} The principle remains uncontroversial, just as the practical means of upholding it continue to raise contentious political and scientific issues. Meanwhile, national health services were launched in several countries in the same spirit, with the aim of making health care affordable for all at the point of delivery.

On 1 October 1949, Mao Zedong proclaimed the establishment of the People’s Republic of China, and four months later the Soviet Union and communist China signed a 30-year treaty of friendship, alliance and mutual assistance. Now unassailable from the north and the west, North Korean forces invaded South Korea with several armies advancing southwards on 25 June 1950. On 26 June, the UN Security Council adopted a resolution demanding their withdrawal, a decision that was uncontested formally since the Soviet Union was boycotting the Council’s meetings at that time over its refusal to recognise mainland China as a member of the UN. The major power with most troops available in the region to enforce the Security Council decision was the United States, which still had forces in Japan under General Douglas MacArthur. The military intervention in Korea by the US with countries allied to it under the aegis of the UN began in early July.

At first, the Lee family had expected to go on living as usual in Seoul while the war was fought at the Thirty-Eighth Parallel.
One morning, however, Myung-se left for work as usual, and discovered that they had been mistaken. As he approached the municipal building where his office was, he was shocked to see the North Korean flag flying over it. He headed back home as inconspicuously as he could. Meanwhile Chong-won had gone to the market to buy meat, and found the marketplace ominously silent and deserted, so she too had hurried home. The family had to decide quickly how to survive the war. Chong-won and her elder brother set off to stay with an uncle, Chong-sook went to the home of cousins in Yang-Ju, a rural area north-east of Seoul, the father went to stay with another uncle in Young-Chun, and the mother stayed at home with the small children—Jong-wook and a younger brother born in 1948, Chong-oh.

Some weeks later, Chong-won heard that Seoul was being bombed. Fretful about her mother and brothers, she decided to go back and join them. Taking with her a small supply of rice wrapped in pumpkin leaves and 100 won in cash, she got a ride for part of the way on an ox cart. After two days on the road, mostly walking and hiding, Chong-won did find her way home, where there was a joyful reunion with her mother and two brothers.

With no end to the war in sight, Chong-won and her mother looked for ways to make their limited resources last as long as possible. A staple dish at that time was pumpkin soup with some flour and egg-powder added. Buried in a nearby field, there was a supply of rice that Sang-kan had obtained in exchange for a gold ring. Children might not thrive on such a diet, but they could survive on it. The occupying North Koreans had impounded every movable item in their house, but had so far only had time to stick a label on it for its future removal, and forbid the family to take any of these objects out of the house. Sang-kan, like her neighbours, ignored this injunction, and used every opportunity to barter household goods for food.

One day, the husband of an aunt came to their house and told them Myung-se had been captured and imprisoned in a school near the police station. He had been told he would be executed, but then there was an air raid, during which he had escaped. He
was now hiding in that family’s cellar. Though the children were
told, they were perhaps unable to see the gravity of the situation,
and Jong-wook went on playing with his smaller brother in
the garden. As an adult Jong-wook told a friend that he had
been picked up by two North Korean soldiers the next day, and
questioned about the whereabouts of his father. Undeterred by
offers of sweets and threats of beating, he swore that he did not
know, and they finally believed him and let him go. Chong-won
did not remember the episode, but did recall how enemy soldiers
arrested Sang-kan a few days later while she was at the market
with Chong-oh on her back, and took her to a police station
for interrogation. Resisting their intimidation, she persisted in
saying, ‘If only I knew where he was! If only you could help me
find my husband! It’s very hard for a mother to take care of two
small boys without a man in the house!’ As the night wore on,
the soldiers began to feel sorry for her and her child, and at dawn
decided to let them go.

There was another joyful reunion when Sang-kan got home
and woke up Chong-won and Jong-wook. Breaking up some fruit
boxes for fuel, they lit a fire and boiled two handfuls of barley to
celebrate.

By 28 September 1950, the South Korean and UN forces had
recaptured Seoul after the battle of Incheon. For the Lees the
rejoicing was short-lived because it was then, when people were
free to circulate and pass on news again, that they learnt that
the eldest sister, Chong-sook, had died of kidney disease at the
home of relations in Yang-ju. Her funeral had already taken place
without her closest relations being able to attend, and she was
buried in the graveyard in a nearby forest. Her mother had put
aside some French fabric for her to wear for her wedding. Her
first act when she learnt of her daughter’s death was to burn it,
‘for the peace of her soul’, as Chong-won put it. In their grief, the
family could think of nothing to do but let her father go to Yang-
ju to touch her grave and say goodbye on their behalf. In 2006,
after Jong-wook’s death, Chong-won held a memorial service
for the sister who had died all those years ago, as well as for the brother who had just died.

Danger, hunger, grief, separations and reunions thus marked Jong-wook’s early years, and both failures and successes in later life are often attributed to such experiences. Researchers on resilience in children find that a sense of humour and the awareness of being loved are common factors in those who survive hardship and go on to flourish in later life.

Chinese forces joined the war to help the defeated North Korean army and drove the UN forces back to south of the Thirty-Eighth Parallel. In December 1950, there was a government announcement that a major assault on Seoul was imminent, so those who could move out and go south should do so without delay. Seoul municipal government workers were told to move to the southern city of Daegu. Lee Myung-se set out, telling his family to try to join him there when they could. A car was available from the Jae-Il Bank, and Chong-won, now 14 years old, was sent in it with some cousins to Kyo-Dong in Cheongju. Her mother and the two boys were to get there by ox cart. Chong-won was loaded with as many necessities as possible, which included bedding, a sewing machine, and some of the family’s money supply.

The route was through Jeon-Yee, the Lees’ ancestral home town, buried in snow at that time. It was there that the car got stuck in ice and snow. Attempts to dig it out failed, and the passengers eventually decided to abandon it there with some of their possessions, and arranged for an ox cart to take them the rest of the way to Cheongju. There they were warmly welcomed by their uncle. Chong-won waited for her mother and two brothers, as reports continued of the advance of the North Korean and Chinese armies on Seoul.

As the sun was setting on 20 December 1950, Chong-won saw her mother and two brothers arriving in Cheongju by ox cart. Their relief at being together again was mitigated by many fears, one of which was for Jong-wook’s ankle, which he had sprained when he jumped off the cart to greet his sister. It had quickly become swollen and painful.
The war news continued to be bad, and in early January enemy troops were advancing southward from Seoul. The only realistic option was to move on south as far ahead of them as possible. Daegu was some 90 miles further south. Like thousands of others in the same plight, they set off on foot, Sang-kan wearing a money belt and carrying a bag of belongings, Chong-won carrying Chong-oh on her back, with Jong-wook limping beside her. Bad though their situation was, she was aware that there were many others for whom it was worse. They at least had some money, and a loving father waiting for them with means of support. Jong-wook seemed to be aware of the need to be as brave and tough as possible. He kept going as well as he could, without complaining.

They walked for about four hours a day, with large crowds all heading south, some with cattle carrying luggage and pulling carts. When a cow died on the way, the owners had it butchered, kept some of the meat for themselves, and sold the rest. The meat was eaten boiled, with salt. Apart from that occasional luxury, the Lees lived mainly on sesame seeds, rice and red peppers they had brought with them from home, and kimchi which they bought on the way. Occasionally they would buy a sweet potato from a street food stand for the children. Chong-won would sing songs and tell stories to Chong-oh to stop him crying, and Jong-wook was fit enough to enjoy the adventurous side of the expedition, showing a keen interest in events such as the butchering of a cow. Fearing frostbite, Chong-won kept making sure his woollen helmet was securely fastened.

With so many people milling around, Chong-won, with Chong-oh on her back, got separated from her mother and Jong-wook, and spent a day desperately searching for them. Eventually she found a note in familiar handwriting, tied to a tree. It told her to wait there, and her mother would return to find her. After she had spent a few hours there, walking up and down to keep warm, the mother and Jong-wook reappeared, and the family continued their journey.
They arrived in Daegu on 26 January 1951, and checked into the first inn that would take them. Looking at her mother and brothers, and then at herself in the mirror, Chong-won saw that despite having had a rest and a wash they still looked like what they were: a family of refugees. She set off with Jong-wook for the Gyeongsangbuk-do government building, where their father and the other Seoul municipal government workers had offices. She remembers him being moved to tears at the sight of them, and taking his son in his arms.

He was able to rent a room for them in the house of the chief of police, and it was there that the Lees settled into their way of life as displaced people. They received government tickets for rice, and Chong-won attended a special class for refugees at the teacher training college in Daegu, where there were neither desks to work at nor chairs to sit on. Chong-won had learnt self-confidence at her school in Seoul, and worked hard and successfully to get good grades. It was there that she started learning English, an asset she valued for the rest of her life.

Jong-wook and Chong-oh enjoyed their time in Daegu, and had fond memories of playing by the river and catching frogs. At home when their mother or sister read comic books to them, they were absorbed in the stories and remembered all the details. Jong-wook liked to retell them, while Chong-oh preferred to draw battlefields and practise following the story from the pictures upside down. The family were worried about the elder brother, Chong-bin, who was suffering from anaemia and came on sick leave to Daegu from his posting on Jeju Island.

In August 1953, with Seoul back under South Korean control, Myung-se became a department chief in Seoul, with responsibility for public food and fuel supplies. Chong-won, her mother and two younger brothers followed him a month later in a rented lorry. After some more mishaps and fears, including a frantic search for the two boys, who went missing for a day, they made it back to their old home. The house was derelict and had no running water, but it was home, and to the boys such inconveniences were already the normal conditions of life. Being there again brought
back the memory of Chong-sook, but the pain of her loss faded with the challenges of remaking their home.

When Jong-wook enrolled in Bong-Rae primary school, the only thing he knew how to write was his own name. There were no decent clothes for him to wear to school, but Chong-won took their father’s old suits to the local tailor to cut down to size for him. She was delighted with the result and found her little brother looked like a model from a fashion magazine.

Two years later the family moved to a better house, with a new school for the boys. Chong-won was now at college, and she and her two brothers would set off for their studies every morning with their father by car, a rare privilege in the 1950s. As often as she could, Chong-won would ask the teachers about her brothers’ progress. It was her job to see that they did their homework, learnt discipline, and got good marks. When their father was not satisfied with their exam results he scolded her for failing in her role of guardian. This intensified her vigilance, and the brothers nicknamed her ‘the Leopard’ for her fierce attention to their progress.

Despite the rigours of school, Chong-won remembers it as a time of happiness, with a new baby brother to take care of, Chong-koo (born in 1953), and a big garden to play in. The house was usually crowded with relations, which may have helped to instil the gregarious spirit Jong-wook was known for in later life. Myung-se spent as much time as he could with his sons, and often took them for weekends in the country. His concern for their education was intense even by Korean standards, and their success was his dominant hope amidst the turbulence of the times.

He was glad to see that Chong-oh was careful with his pocket money, and concerned that Jong-wook was not. Their mother told him it did not matter because Jong-wook would be able to make lots of money when he grew up. There were some signs of promise to support this view, though his school grades were not outstanding. His class teacher noted on his report card that he was an ‘intelligent, warm-hearted’ child. He was selected for the
Lee Jong-wook

‘superior child’ group in the boy scouts, and was made vice-leader of his class on entering middle school.

His class teacher in middle school was famous for writing a song that was popular in the 1950s: *Our Longing is for Reunion*, referring to the reunification of North and South Korea. It was a feeling widely shared by Koreans at that time, irrespective of their other political views. Chong-oh and others who knew Jong-wook as an adolescent remember him as preoccupied with big ideas of travel and achievement rather than the more trivial tasks that doing well at school entailed. Later in life he confided to a colleague’s young son that his ambition as a boy had been to be a pirate. To get access to adventure stories he joined the voluntary service group for the school library. Family members recall him already reading stories in English such as *The Gold Bug* and *The Black Cat* by Edgar Allan Poe, the *Tom Sawyer* and *Huckleberry Finn* books of Mark Twain, and Dickens’s *A Tale of Two Cities*.

One of the most prestigious schools in Seoul was Kyungbock High School, and Jong-wook was enrolled there in 1960. Each class elected a president from among its members, and he was the president of his class for all three of the years he was there. This was evidently not due to exceptional physical or academic strength but to some other capacity to command respect. His pictures from that time suggest a tough, self-possessed boy with a good sense of irony. His classmates were from well-to-do families and many of them went on to do well themselves. Those who remembered him from those days and were available to reminisce included the Chief Executive Officer (CEO) of a major flour mill, an army general, and the president of a university. One of them explained that Kyungbok was for Korea what Eton was for England: where those with prestige sent their sons to school to keep it in the family and benefit from the old boys’ network.

In retrospect, the period from 1953 to 1960 was a kind of golden age for the Lee family. They had survived the Second World War and the Korean War, remade a home for themselves in Seoul, had a father in a good job as Ward Governor, academically inclined elder children, and three promising boys in good
schools. Chong-oh recalled that although their father was not highly educated he had a scholarly Confucian attitude and loved books and the arts, so there was always plenty to read at home. Jong-wook and Chong-oh read everything they could get their hands on, including the newspapers, and whenever they were given money by their parents or uncles and aunts they spent it on books. They read competitively, and fought over which one should read a new book first. Though in adult life they became close friends and confidants, Chong-oh recalled as boys they were rivals. They shared a room all the time they were growing up, but the elder brother did not confide in the younger one. Their political sympathies were at odds as well; Jong-wook wanted to get a Harvard PhD or find some other way into the world’s elite and to that end was already working hard at his English, while Chong-oh was more interested in human rights and the future of Korea.

The Republic of Korea was still a developing country struggling to recover from the war, but both at home and at school the boys could lead a full and rewarding life. Jong-wook wrote to a friend later in life, ‘At that time Korea’s per capita income was around $50 a year. . . . My father’s pay at that time was about $100 a month. But we had a car,\(^6\) drank nothing but Canadian whisky, smoked Lucky Strikes, and still could eat *bulkogi* [a beef steak dish] seven days a week.’\(^7\)

The family has happy memories of that time in spite of the increasingly draconian regime of Syngman Rhee. Then it ended abruptly. In April 1960, at the age of 85, following widespread protests inflamed by police attempts at control by shooting into the crowd, Rhee departed from Korea with his wife Francesca, and went into exile in Hawaii. Through these events and the political turmoil that followed, 1960 is said to mark the beginning of the democratic movement in South Korea, though many struggles and reversals were still to come.

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\(^6\) His father had the use of an official car.

\(^7\) Letter to Lynn Stansbury and John Hess, 14 February 1979.
That year also marks a turning point in the life of the Lee family. Myung-se, a heavy smoker like many of the men in his generation, resigned from his job during the protests, and was hospitalised with throat cancer shortly afterwards. He died that July. Though authoritarian in the traditional way, and apt to raise his voice, he had been a loving father, especially to his favourite son Jong-wook. He had also been the family’s only source of income. As Chong-won put it, the family now felt ‘like sheep without a shepherd in the wilderness.’ She was at graduate school at that time, studying pharmacology, and Chong-bin was convalescing in the mountains of south-western Korea from a bout of jaundice. Jong-wook’s strong opposition to smoking may have begun with this bereavement. ‘My own father died of a smoking-related condition when I was 14 years old. I saw the suffering caused,’ he recalled as head of WHO.8

In the months that followed, Chong-bin returned to Seoul and started a publishing business to rescue the family fortunes, but it failed, adding to their difficulties. To pay school and other bills and reduce the cost of living, Lee Sang-kan sold the house in Chung-Pa and moved her family into a smaller one. The mottoes she reverted to were the ones she had used when they were refugees: ‘Whatever happens we have to get through it,’ and ‘No pain no gain.’ Chong-won found her like Scarlet O’Hara in Gone with the Wind, the woman who does whatever is needed for her family. It was not until many years later that she even permitted herself to cry for her husband in front of the children. The boys admired her fortitude and did their best to help by studying hard at school. Jong-wook did not tell his school friends about his family disaster, and most of them assumed that he continued to be well-off like themselves. Up till then there had been plenty of room at home to invite them round after school and at weekends. He could no longer do that, but they scarcely noticed and were satisfied with his vague excuses.

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8 Address to Conference of the Parties of the Framework Convention on Tobacco Control, 6 February 2006.
For all his evident cleverness, Jong-wook did not glide effortlessly into Seoul National University, the most renowned one in Korea, as several of his classmates did. Instead he found himself in Hanyang University studying engineering and architecture but without a deep interest in them. So far, nothing much has come to light about this part of his life. All that is known for certain, at least to this writer, is that he was conscripted for military service after three years as a student at Hanyang.

Korean army training is reputed to be the toughest and most dangerous in the world, but he was spared some of its rigours by being assigned to an intelligence unit where his work was English-to-Korean translation. A colleague who knew him in the 1970s assumed that his duties included surveillance, since he was uncommonly well-informed on aircraft, and could tell at a glance the make and specifications of any plane that appeared in the sky. Lee himself reminisced that one of his responsibilities was to look after the stores, and another was to teach English to an officer’s son, both of which tasks gave him time to read.

Military service normally lasted three years, but Lee’s lasted three and a half, owing to a heightened security alert in 1968. By the end of it, if not before, he had decided to read medicine at Seoul National University. The way he put it in 1978 in a letter to American friends was,

I know well the penalty of not following the beaten track. But I can’t help it. It’s a disease. I was sillier [he had written ‘lonelier’ first but
crossed out that possibly self-pitying word in favour of the self-deprecating one] when I decided to be a doctor after three years architecture and three years army as an enlisted. We start med. from premedical course and I had to start from high school Math, English, Korean, German—nine subjects in all. High school subjects have their own tricks and holes to avoid. I even attended some of their classes.¹

Elsewhere he accounted for his eventual choice of medicine by saying that his mother convinced him that it was the surest route to security. She had noticed that during the war even communists did not kill doctors. He also joked that he thought being a doctor would be the best way to impress girls, but he never seems to have explained why he came to such conclusions so belatedly. If he was ambitious, even as a child, why did he take so long to start on a career? A possible explanation is that it took him a while to realise that he would have to work harder for success than he had expected. Getting into the institution of one’s choice might be easy for some people but for him it required extra effort, tuition and time. A more usual reaction to setbacks and difficulties is to adjust one’s sights and aim for something easier to get, but he was also known for his stubbornness, a quality he may have inherited from his mother. Although she apparently approved of his belated choice, it also entailed prolonging his dependence on her for food and shelter, which would have been a mixed blessing.

Those who studied medicine with him remember particularly that he was seven years older than them, being 25 when he started. This called for some humility on his part, but it also meant he was the natural leader of his group, and the one who would talk to the faculty when requests and concerns from the students came up. Even though they did their homework and ate instant noodle soup together as equals, his fellow students remembered finding it natural to defer to him and offer to carry his bag for him. In moments of absent-mindedness he would let

them do that, but retained a strong spirit of camaraderie with them even years after they had gone their separate ways. For the first two years as a medical student he could earn some money for self-support by giving private lessons to schoolchildren, but after that the medical school programme, with tests every month, was too demanding and he had to work full time on mastering the material. In later years he recalled how on one occasion the dissection room was closing before he was ready for a test the following day, but he needed to finish checking the details of a head, so he wrapped the head in a towel, put it in his book bag and took it home. When his mother was doing the housework the next day she found it on his desk, and, after a moment of horror, prayed for her son’s success in his exam.

The 1970s were a time of rising political tension for the Republic of Korea. Park Chung-hee, who had been head of state since the coup of 1961, enjoyed a good deal of popular support as industrialization forged ahead and prosperity grew, but changes in the international situation now exposed his regime to new risks. With the Nixon Doctrine of 1969, American dominance in the region began to recede, and one of the two combat divisions stationed in the country, consisting of about 20,000 troops each, were withdrawn in 1970. The US abandoned the gold standard in 1971 and this, combined with protectionist policies it adopted at that time, led to a recession. The continued hostility of North Korea added to the sense of insecurity, and Park declared a state of emergency in December 1971. This was followed by the Yushin Constitution, which was approved through public referendum in November 1972. It placed severe restrictions on political activities and civil liberties, and gave the president authority that was beyond the reach of any imaginable legal challenge. Park’s grip on power was thus strengthened but so was the discontent of those who saw their hopes for liberal democracy dashed. Anti-government feeling had been accumulating among the students since the beginning of Park’s regime, and the new situation added
to its energy and conviction. Dissidence became an enduring feature of student life at that time.\(^2\)

While Jong-wook was at medical school and Chong-oh was doing his military service, their youngest brother, Chong-koo was studying sociology at Seoul National University. In 1974 he was arrested for protesting. The following is from his own account of what happened:

The police arrested me on 31 March 1974, at home, for violating the President’s Emergency Decree No. 4, which made it an offence punishable by death to criticize the President or the Yushin Constitution. In fact that decree was issued on 3 April, three days after my arrest, so by law in the normal sense of the word I was innocent; but it was an era of madness under military dictatorship. I was interrogated by the KCIA [Korean Central Intelligence Agency] and convicted. The KCIA invented a fake organization they called the Confederation of Democratic Youth and Students, and urged people to confess they belonged to it. The military court sentenced me to 15 years’ imprisonment at the first trial, and reduced it to 12 at the second one. We could not recognize the authority of the judicial system so did not appeal to the Supreme Court.

Meanwhile, a mass movement against the brutal repression had been organized by Christian, Catholic and intellectual groups strongly demanding the release of political prisoners. On 15 February 1975 I was freed, together with other students and activists. But President Park continued to keep in custody those who were categorized as members of the ‘People’s Revolutionary Party’ which was a complete fiction invented by the KCIA. A few weeks later, on the 9th of April, the dictator had eight innocent men hanged. Thirty-three years later, in 2008, the Korean Supreme Court ruled that they were innocent and ordered the government to pay compensation to their families.

On the day of my arrest, the police fooled Jong-wook completely, and with no sense of the danger he allowed them to wait for me, persuaded me to cooperate with them, and even accompanied me and the plainclothesmen to the police station. Facing reality afterwards, he tried to get help for me from the university administration and academic staff, but to no avail. He provided shelter for one of my

fellows in the apartment of an American friend, an army surgeon. With the rising tide of the human rights movement in the autumn of 1974 demanding the release of political prisoners, Jong-wook helped foreign journalists to contact activists and the family members of prisoners. He managed to get an American reporter to our home and interview Chong-bin about the experiences of our family. The day after my release, Jong-wook introduced me to a British reporter, who wanted to hear what had happened with the KCIA and in prison.

Deprived of basic civil rights despite my release, I could not vote, travel overseas, get a job in government-related work, or study in university. In addition, my everyday life was under surveillance. President Park was assassinated by the head of the KCIA on the 26th of October, 1979. I returned to university and graduated in August 1981, but in May 1980 General Chun Doo-hwan had seized power by coup d'état and massacred protesters en masse in the Gwangju area. Repression against liberals was resumed. I tried to enter graduate school but the regime prohibited former activists from doing postgraduate studies at Seoul National University, to prevent them from influencing other students. So I applied to Tokyo University in Japan, was successful, and took up my studies there in 1983.3

Ten years later, Kim Young-sam, president from 1993 to 1998, granted amnesty to large numbers of political prisoners and annulled the earlier convictions of pro-democracy protestors. Chong-koo was among those cleared of blame and belatedly honoured for their efforts. What had been branded as a threat to society was now praised as a heroic contribution to it. Jong-wook was not an active dissident himself in his young days, his brother, Chong-oh asserted, but his colleagues remember him expressing pride in his brother’s courage at the time of his rehabilitation.

Like many medical students at that time, Lee was intending to extend his medical training in America and take up practice there. According to American figures, there were 32,158 Korean immigrants in the United States in 1975.4 The law gave preference

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3 Excerpted and edited from notes received from Lee Chongkoo on 2 September 2009.

to highly skilled professionals, which accelerated the brain drain afflicted Korea and other struggling economies at that time. In addition to the pull factor of a rich liberal economy abroad, there was the push factor of a poor and repressive one at home.

In 1974, to prepare themselves for emigration, a small group of medical students expecting to graduate at the end of the year approached the American military medical authorities in Seoul for help with English conversation practice. Their letter, signed by ‘Jong-wook Lee’ received the following answer:

Dear Mr. Lee,

I have received your letter from the commander of the 121 Evacuation Hospital where I am a surgeon. Although we have no training in teaching English, my wife and I thought we might be able to help you. I suggest that we get together one evening or on the weekend at my residence in Riverside Apartments. There would be no cost to any student interested. Please phone any evening and we can set up a convenient time to start. The phone number is 44-2057.

Sincerely,
Barry C. Kaufmann, M.D.
MAJ, MC
Department of Surgery

c: COL Odom

The letter marks the beginning of a relationship Lili Kaufmann was to describe 35 years later in the following way:

We knew Uggy in 1974–75 when he was a medical student at Seoul National University. He was the organizer and contact person for a group of medical students at SNU who wanted contact with American doctors as a way to dialog and connect with the western medical system.

My husband Barry was US Army Major and Surgeon at the 121 Hospital in Seoul. He brought home a letter from Uggy asking to possibly meet US doctors. We had recently arrived in country and were pleased to be able to have contact with ‘real’ Koreans not just our house maid.
We gladly invited the group to our small Riverside apartment on the Han River and thus began a year-long adventure of friendship and outings all over the city and countryside. We had a small yellow Toyota and we would squeeze into it, children on laps, and at times a taxi was also used. Initially, weekly meetings were set but often we would delay the activities depending on the students’ schedules. My husband would discuss medical issues taking place at the 121 and clarifying how the American system worked. They in turn taught us about Korean culture, society and Asian attitudes. We avoided politics due to the very oppressive Park regime and the risk of endangering the students. Uggy had a brother who had been involved in student protests and was under arrest at one time. We celebrated holidays both of our Jewish faith and participated in Buddhist events.

We shared our lives and our two sons were always a focal point for them. We went on a four day backpack to Seorak San and slept out under the stars and enjoyed incredible camaraderie.

Uggy was the group leader and was very fluent in English. He was older than his peers and had an incredible sense of presence and confidence in his future. It was obvious that he would not remain in Korea after his schooling.\(^5\)

The spirit of adventure and friendship characterises this part of Jong-wook’s life, and comes through in the letters he wrote to the Kaufmanns after their time in Seoul. The first, undated, is written the following autumn, not long after their return to the States, and is signed ‘Ugy’ with one ‘g’. His handwriting is untidy but easy to read, his English idiomatic and fluent. The main work of learning the language to an impressively high level had been completed long before his student days were over. In the extracts that follow I have left in the quirks that reveal a non-native speaker, but corrected occasional spelling and grammar errors.

This extract starts by apologising for not sending a tape recording; the group had gathered to make one but, Lee writes, apparently using a Korean metaphor, ‘with too many oarsmen the boat went to the mountain.’ Everyone in the group has done well in their exams, he reports, and now, ‘after one month in

operating rooms we are scattered—S. S. to emergency, S. D. to
X-ray, Chung-A to genetics, and I stick on O. R. We all feel this
exposure quite valuable and inspiring. I was given 6 spinal ones
and put a finger in those works of PAR, ICU & OR. An insight
how people being operated on can be cared for and killed.’

One of the group, Doun, he writes,

has analysed and weighed the pros and cons of going to the States and
staying here. He is likely to join the long olive-green line not because
he analysed his dream and got a conclusion but two guys in the class
with their powerful fathers decided to stay. We are somewhat cynical
about it. But what can we do? His father is merely professor, not
soldier–politician.

There is also some preoccupation with getting married, including
a reflection on the most fascinating member of the group:

She radiates some force that keeps me hanging around her. I know
prettier, brighter or more talented girls. Even more determined
girls. Still she is different. Honestly it has nothing to do with love or
something like that. I have been sometimes jealous but never fell in
love. She is a mystic. I reckon that’s a big part of the reason. I simply
couldn’t crack the code. Perhaps never will.

Changing the subject abruptly, he goes on:

It’s clean cool autumn. They finished the Highway from Seoul to Mt
Seorak. Now it takes only 3 and half hours. They all say the scenery is
breathtaking. The highway runs south of Seoul and runs east all the
way to the east coast, then turns northward to the hotel, Mt Seorak.

"Midnight Cowboy" is in Seoul now. I was scared off. In the movie
I could see Seoul through that impersonal New York. Not the Seoul
of S. S., Chung-A or me but Seoul of Itaewon, slum around Yong-san
compound, or down town back street. I don’t know but I am quite
philosophical tonight.

How are David & Peter doing [the Kaufmanns’ two small boys]?
Peter still keeps that Snoopy?

Last Saturday, the medical orchestra performed its annual
concert. On stage were Beethoven No. 8, Choriorum overture etc.
The fiddleress played 2nd violin.
We’ll gather up soon and record a cassette. Wait PLEASE.

Ugy.⁶

On December 22 he writes again, this time signing ‘Wook’ in Korean characters. After reporting that the final examinations are nearly finished and he has done well, he asks: ‘How do I feel? I feel pretty much stranded. Woman or children under strong husband or parents would feel more or less same way after their removal. The school’s been always tough to us even to the degree of cruelty, but what a security and shelter it provided us with.’

The sense of being a child guided and protected by strong grown-ups had been shaken when his father died, but apparently to some extent restored, both by medical school and by the American couple who had become friends and confidants. No doubt partly because they might be able to help, he tells them in some detail not only about his feelings but about his plans.

I still have to take examination (licensure) on 23rd Jan. Commencement ceremony on 26 Feb. Then I plan to work in a city health center till I get my visa. I may be able to make it till July. The immigration visa takes a couple of months longer. Change of exchange-visitor visa into immigration visa is extremely tedious and also basically a breech of contract. If I can’t make till July, with it goes my one year of training. So I have to make decision here now. Also I sent a letter to a relative in Canada to know how is that place after all. My logic is if I can do my internship in Canada and meanwhile I apply [for] an immigration visa to U.S. Perhaps too elaborate to be practical. Anyway I will try to be good to myself. If things really go bad for me, still I can fall back on my old 36 months of experience as a file. Anything I can endure and grateful too. I believe things will eventually fare well.

Also I need a girl to marry. One of my troubles here is that I contain a strong contemptuous feeling of that matchmaking business. . . . Lots of matchmakers chase doctors because of their presumed ability of making money. While I take reexaminations, do part-time jobs, prepare for this and that examination, what have they been doing? That selfish lot under that seemingly innocent stupidity obviously have no guts or refuse to share risks as well as benefits. As

⁶ Letter to Lili and Barry Kaufmann, undated, autumn 1975.
a compensation, they or rather their parents offer this or that, you
know, besides their daughter’s body. I want a girl who is equal in a
sense.

‘In a sense’ is striking. In what sense? And, by implication, in
what sense not equal then? On the political and cultural front:

‘Blowin’ in the wind’ & ‘If I get a hammer’ is prohibited along with 150
U.S. pop songs. They also published an official pronouncement on the
issue: ‘Blowing in the wind’ is an anti-war song, ‘If I get a hammer’
anti-system, according to the authoritative interpretation. Perhaps
they had that great insight to see that ‘If I get a hammer, I will crush
your egg head.’ Several days ago Doun was caught by Police in the
street and had his hair cut and paid fine. S. D. too. I almost forget.
Afterward Doun was furious at the incident. His hair was not really
long, you know his style, even compared with me. Me? I quickly got a
haircut from more seasoned barber. What a fatherly government we
have! After all, to care is to love.7

Writing again at the beginning of 1976, a year that was to aff ect
his destiny in more ways than one, he reverts to his complaints
about the marriage market and how it is controlled by mothers
and their eligible daughters, concluding, ‘Perhaps what we need
here is a men’s lib movement. Mothers and wives do everything
here.’ Then, in a rare moment of unguarded self-pity, he adds:
‘In summing up, looking into the core of the matter, I feel very
unhappy and empty in spite of my outward cheerfulness. I need
more and more energy to keep the façade the way it is.’ If what he
says is true, and not just another façade, his outward appearance
was probably more inscrutable than he realised, since no one who
has reminisced about how he seemed at any stage of his life has
referred to him as looking unhappy or seeming to feel empty. His
thoughts turning to his long-nurtured plan of escape to America,
he is not entirely reassured.

Naturally, if I go to New York, I’ll meet Seung Shin’s sisters. Seung
Shin’s mother told me at great length last night about difficulties
facing Korean couples in the States. The change of gender role,

7 Letter to Lili and Barry Kaufmann, 22 December 1975.
sudden sense of power of formerly docile women, etc. According to her, it seems the U.S. is littered with broken homes & wrecked marriages. I don’t care whether they are older than I or separated or very successful or not. I mean I’m quite open-minded about that kind of thing. However, if anything happens, it happens after I get to there. I don’t have slightest idea of using them as a means of establishing me there. However, I’m not so sure of my judgement. Anytime you find a good girl, please let me know.

Everything begins for me after I get my licence some time in Feb. or early March. I expect to untangle all this mess in time. Like I have been, I will continue to exercise my oriental patience. Meanwhile, I’m contemptuous of so many things and so many people—of course, I keep these things to my own. I really need a change of air. I’m afraid of showing signs of cracking after all these years in school and army. Before, I had experienced more than my share of frustrations and setbacks unlike most of the guys in my class, and I tried to use it as a stepping stone for something I cherish. Now, looking back, I wonder whether I paid too much for a whistle. It reminds me of a Korean folklore story of a guy who began to starve for the birthday party in 8 days. He died of hunger on the 6th day. I know it’s a transitional period for me. I assure you that I will do these jobs beautifully in time.

By ‘these jobs’, does he mean emigrating, getting married and becoming a medical practitioner? ‘Beautifully’ is an unusual way of imagining achieving such objectives. And what is the ‘something I cherish’ for the sake of which frustrations and setbacks can be taken as stepping stones rather than barriers? ‘Cherish’ is an odd word to use here too. It could imply something in the nature of a virtue, such as a truly independent mind, or perhaps some more external objective, such as a happy family or some contribution to human well-being by being a doctor, but whatever it is, he keeps it hidden. The question goes back to what prompted him to start studying to become a doctor at the age of 25 instead of the more conventional and convenient age of 18 or 19. Despite many enquiries, no answer has yet appeared. Meanwhile, the ‘oriental patience’ is comparatively easy to see and understand. It was a capacity he was sure of amidst many uncertainties, and was destined to be one of the strongest cards
in his hand. Moving briskly on, he ends his letter: ‘Wish you could find real nice practice in time. Thanks for your concern for me and all of us here. Of course I will not hesitate to wave my jacket when needs arise. Lili, long forgotten sister, thank you! Wish to join all of you soon. Please write!’

By the time Lee graduated, in 1976, the demand for Korean doctors in America had declined, following the end of the Vietnam War. The flow had been reduced to a trickle by making the visa qualifying examination harder to pass than before. Though he had recovered lost ground and was now as well-placed as anyone else in his generation for a brilliant career, the way forward was not clear. Eventually he could pass the new exam and get to America, he thought, but in the meantime he needed work.

He joined the Public Health Centre in Seoul, whose activities included support for the St Lazarus village in the southern suburbs. St Lazarus was founded in 1950 by a Catholic missionary from America as a refuge and care centre for people with leprosy. At the time when Lee started visiting there as a volunteer doctor, the village was being run by Fr Alexander Lee, a Korean priest who had lived in America. In addition to serving as chaplain to the community, he raised funds for the village from national and foreign charities, and coordinated voluntary support work for it. For Fr Lee, a young physician who was available to provide care and treatment free of charge for his flock was very welcome. Lee JW started visiting there as an unpaid doctor and by March of that year was able to write to the Kaufmanns, ‘In Korea there are about 80,000 leprosy patients. How many doctors who are actually treating them? Correct answer: two. I am one of these two.’

1 Letter to Lili and Barry Kaufmann, 26 March 1976.
It thus came about that Lee Jong-wook’s first job as a new member of his chosen profession was characteristically paradoxical: it was one of humble service although he was ambitious, unremunerated although he needed money, and in a Roman Catholic environment though he was, in his brother Chong-oh’s expression, an agnostic rationalist.

Fr Lee’s most valued assistant was a young Japanese lay missionary called Reiko Kaburaki, who had studied English literature at Sophia University, a Jesuit college in Tokyo. Inspired by her teachers’ dedication to a life of service, she had become a postulant for an order of nuns shortly after graduating, but had left a few weeks later, not finding what she felt called to in their way of life. While looking for an alternative, even if only temporary, she heard that St Lazarus Village needed a resident assistant, and offered her services. Warmly encouraged by the Jesuits, she had gone to the village in 1972, learnt to speak Korean fluently, and was now responsible for English and Japanese language fund-raising correspondence, as well as housekeeping and patient care.2

She was assigned to show the new volunteer doctor round the village and introduce him to the patients. He was impressed by how well she spoke Korean, and the mutual respect and affection between her and the patients. She was intrigued to find in him a man who, though belonging to the élite, seemed not to have the aversion Koreans usually felt for Japanese people as members of the race of their former oppressors. He spoke to her as an equal who wanted to learn from her. In addition, the fact of their being there to serve people who had a disease that had been feared and stigmatised for many centuries was a strong point in their favour in each other’s eyes. They could perhaps recognise something of their own best aspirations in each other.

Their friendship grew as they discussed English literature. She was pleased to hear that he had read Far from the Madding

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2 The following account of his work at St Lazarus and his relationship with Reiko is derived mainly from conversations and correspondence with her.
Crowd, in English, during his military service, sitting on a sack of American flour, minding the stores. He discovered that she knew in detail about Shakespeare plays such as *A Midsummer Night’s Dream* and *Macbeth*, and could quote from them in her pure brand of English learnt from a Jesuit professor from England, and explain their hidden meanings.

Soon she found that the most interesting part of her life consisted in Jong-wook’s visits. He often came much later than he had said he would, which made her wonder whether he was losing interest after all. In May he stopped coming altogether, but then, to her surprise, she received a letter from him saying that he had taken a job in Chuncheon at the emergency room of the Gangwon provincial hospital, in the north near the Thirty-Eighth Parallel, so he would only be able to get to St Lazarus Village occasionally. That letter has not survived the travels that were to follow, but one in August to the Kaufmanns paints a striking picture of his new situation.

I got a position here because of its SNU-only policy and recommendation from my classmates now doing internships here. They help a lot and I learn a lot. Chuncheon is one of the most beautiful cities in the nation—above all it’s a lake city. This city of 300,000 is also provincial capital of Gangwon-do, which contains Mt Seorak. This is the only general hospital here & has a dazzling array of disease, & patients demand its due respect every night. I work there nights – from 6 p.m. to 9 in the morning. With another fellow, I take turns. We so arranged that I work consecutively 3 days or four days and take leave the remaining half week.

At first I was scared a lot—I’m scared now—there is no resident on call, I’m on my own theoretically. One thing I learned is people don’t die easily. My alumni assure me it’s all difficult in the beginning and I will catch up in time. The other day I nearly drowned a pt. while lavaging her stomach by pumping water into her lung. Eventually she came around, but what a night! […]

Snakebite pts. have become a routine. E.R. is a sort of battlefield. At first I felt as if I were sent to Vietnam right after boot camp or rather given the handle of a Jumbo jet after a course of lectures on how to fly it. I will try to learn as much as I can before I go to the U.S. I’m eyeball to eyeball with a stark reality and could find no room for
pride or face saving measure. Funny thing is, in a particularly difficult situation I have to admit I don’t know first, to find a solution. This is one of the things the professors at the SNU used to tell me and though I forgot a lot of details of the lectures, I still feel the quality of SNU education. [...] 

Though it sounds very awkward even to me, I don’t know what specialty I should take yet. It’s like marriage. Perhaps I would take any subject if it is the only chance for me. But it would not mean that I fell in love with it. Perhaps I can choose a field with an eye for money, like marry for sex. Koreans are usually not in the habit of making decisions themselves. Actually I’m independent. I try to be. But I miss someone with whom I don’t feel the necessity of proving my independence. Sometimes I miss my long dead daddy—after all these years! I wonder if anyone can find a substitute even in a marriage for a good daddy. Family practice specialty—I don’t know much about that but it attracts me a lot. But perhaps I know I have to rule out other fields not for the prospect but for the sheer availability. (Going to the U.S. + a training + a wife to accompany me) I LOVE IT.

Will write soon again.

Uggy

It must not be unusual for a newly qualified doctor to make mistakes and feel overwhelmed at times, but the candour with which he admits it, to friends he would surely want to impress as favourably as possible, is striking. To end a review of his own sense of inadequacy and the daunting hazards confronting him by exclaiming in capital letters that he loves it conveys something of a surfer’s exhilaration: the bigger the waves the better.

After some weeks of attending patients at St Lazarus, a persistent red patch had appeared on his arm, and he was afraid it meant he had caught leprosy. He went to see a specialist to find out. After chatting over a cup of coffee, the specialist examined the patch and told him not to worry, it must be something else. Jong-wook was momentarily reassured, but as he was leaving the room he overheard the specialist telling his assistant to put his coffee cup in the steriliser. That made him even more

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3 Letter to Lili and Barry Kaufmann, 9 August 1976.
worried than before, so he looked for another specialist. A Japanese leprologist was visiting St Lazarus at that time, so he went there and consulted him. Tests revealed that the sore was caused by a fungus, probably caught while visiting his brother in prison.

Greatly relieved, he went to see Reiko that night, in her small room beside the kitchen. She was working at her desk and it was already dark when the dog barked and she realised someone was coming. She let him in enquiringly, and as soon as he had sat down he said, ‘Have you ever thought about getting married?’

After staring at him for a few moments she marshalled her thoughts enough to say, ‘What I had been thinking about was a hidden life of prayer and work in a contemplative order, but . . .’

He waited in case she was going to finish the sentence, and then said, ‘But supposing someone came along who loved you and wanted to marry you, a hard-working doctor say, wouldn’t that be a way to have a life of work, and prayer too, and hidden too, if you would like?’

After a long pause she said, ‘What if I was ill? What if I had leprosy? What if I was mentally unfit to be a wife?’ As she put it later, she did not love him yet, but she did like him as a bright young man, and was glad to hear that he liked her.

She explained her fears about her own health, and how she felt herself falling into an abyss of uselessness. Part of the fear was rational, in that her efforts at the leprosarium were less needed now than they had been. Government support was increasing, medical care was becoming effective, helpers were more numerous, and the village was turning from an inspiring mission into an institution running on the usual combination of bureaucracy, business and cynicism. She also had an irrational terror of leprosy, and the overall sense of doom was preventing her from eating and drinking. Loss of strength and peace of mind were clear evidence of the need for a different way of life but she was afraid the very urgency of that need would disqualify her from the kind of life she saw as the alternative.
After listening carefully he said, ‘If you’re not well you need someone to look after you.’

‘You mean you would?’

‘Of course! Everyone needs someone to look after them. This is our golden opportunity to meet that need.’ Many people have said about him that once he had set his sights on something he was persuasive and tenacious in pursuing it.

He seemed to understand her concerns and remain undeterred, and she gradually realised the radical implications for both of them of what he was proposing. The discussion ended on that first night without a definite ‘yes’, but with no indication of much of a ‘no’ either.

A nurse Reiko had worked with in the village had arranged an appointment for her at a nearby hospital the next day. When she arrived for it, Jong-wook was already there waiting for her, and accompanied her to see the nurse. On the way, Jong-wook said, ‘Why are you wearing those boots?’ Not expecting to meet him that day, she had put on blue rubber boots as the path from where she was living to the bus stop was muddy. Looking at them now, she could see that they were decidedly unromantic. Later he used to joke, ‘For our first date she wore rubber Wellington boots.’

After the nurse had administered intravenous feeding to Reiko, Jong-wook said, ‘Let’s go into town and get something to eat.’

‘OK,’ she said, ‘but I won’t be able to eat anything.’

He took her to a barbecue restaurant where, to her surprise, she discovered she was hungry after all, and ate quite a lot. ‘You see?’ he said triumphantly. ‘Much better than IV feeding!’

She was happy to be walking and talking in the late summer streets of Seoul with someone who liked her. He asked her again if she wanted to get married, but she was not sure, and they left it at that.

She had already made reservations for a trip back to Japan at the end of that week, to recover her health. They still had not reached a definite conclusion by the time she set off, but she asked Jong-wook to think it over and telephone her in Tokyo if
he changed his mind. She did not want to break the news to her father before she was quite sure of it herself.

In Tokyo she stayed with her father, whose efforts to make her eat were also successful. She was in suspense about whether the phone would ring, and on the third evening it did, and it was Jong-wook, to tell her that he had not changed his mind. She told her father, who congratulated her and was, in her words, happy about it. In view of the difficult past between the two countries, his reaction was a relief, and gave the new couple courage for what amounted to a radical departure from conventional Korean and Japanese attitudes at that time.

This is how Jong-wook broke the news of his engagement to the Kaufmanns:

Dear Lili & Barry, David & Peter too,

Here is one good piece of news of mine. I proposed to the Japanese girl I had mentioned in the tape and she accepted it. She went to Tokyo to ‘let her father know’ of her decision.

More than anything else you can catch a glimpse of her type by looking at one of her letters. Her Korean is perfect and I see no language barrier between us. However, perhaps I have to study Japanese soon. They invited me to Tokyo for a get acquainted meeting. Lots of people around me here don’t think it a groovy idea to marry a Japanese girl. As you might have known very well, I don’t mind her being a Japanese and her family seem not to care about my being a Korean. But as you know this is a rather extraordinary thing here. My mother’s initial reaction was ‘Why Japanese?’

She speaks good English. In fact she toured around England once. Also she is very modest. I’m sure you will be very fond of Reiko. She is coming to Seoul the day after tomorrow at 5.30 p.m. on C.P.A. I’m going to Seoul tomorrow morning to buy a ring. I would rather reserve this note only for this news.

It was a difficult decision and still is. Perhaps I should have chosen the easy way out through an able matchmaker. What a freedom I had I didn’t know until she accepted my proposal. I wonder if I’m doing some extremely stupid thing.4

4 Undated letter to Lili and Barry Kaufmann.
In this partly cool and partly jittery way, Lee Jong-wook announced the step that was to change his future more radically perhaps than any other he had taken or would take in his life. Up till then he may have been toying with the idea of an unconventional way of life, but from now on he was committed to it.

When Reiko went back to Korea after two weeks, Dr Lee, her fiancé, was at Kimpo airport to meet her. Fr Lee, her boss, was also there to meet her, and surprised that he was not the only one. It had never occurred to him that something like that could happen to Reiko, and it took him a while to come to terms with it, as she had been an important asset to his ministry. Jong-wook wrote afterwards to the Hesses, with whom he had become friends in Chuncheon:

One of Reiko’s jobs at the village was to prepare the priest’s speeches and sermons. Ha! Priest’s speechwriter! She prepared them in English, Japanese, and sometimes Korean too. I thought of it as an example of his exploitation of Reiko, but yesterday on my way from Seoul to Chuncheon, it occurred to me that he might have been a mere tool of Reiko’s. Reiko had been appealing to the public on behalf of her people by using his mouth and feet. I never thought of it in that way before. Perhaps it is because I have been reading too much Le Carré these days.5

Putting a brave face on his loss, Fr Lee offered to organise a big wedding ceremony at the chapel of the village, with himself as the celebrant. Reiko and Jong-wook turned down his offer, wanting to launch their new life in their own way.

As the autumn set in, the newly engaged couple met sometimes at the St Lazarus village, sometimes in Seoul, and sometimes in Chuncheon. He showed her round Seoul National University, founded by the Japanese. He also took her to a restaurant which served his favourite dish, maeun tang, a red–hot fish soup which he did not eat very often because he had seen the damage spices could do to stomachs. They agreed that if she was going to cook

it for him she should use less spice and make up the difference with bean paste. Sometimes they walked in the Secret Garden, the spacious park of a palace that has been preserved in the heart of Seoul, and there she learned about the life of the Japanese princess who married the Korean King and then lived for the rest of her life in that palace, even after the end of the Korean War and the death of her husband. Reiko continued to work at St Lazarus but went as often as possible to Chuncheon where Jong-wook introduced her to his friends. They went for walks in the mountains, and once they took a rowing-boat trip on one of the lakes.

In Seoul they went to see Archbishop Roh Kinam, to organise the wedding. He agreed to conduct the ceremony himself but said to Jong-wook, ‘You should become a Catholic, you know.’

‘I know, I know, I will, I will,’ he answered, but nothing came of it for the time being.

Reiko packed her suitcase and left St Lazarus Village without a farewell celebration, but when she turned the corner of the road leading out of the village, a small group of leprosy patients came up to her to thank her and say goodbye. They had organised a subscription, and presented her with a gold ring with her name and Jong-wook’s engraved on it.

For the engagement party, the couple had intended to invite only a few close friends, so that Reiko would not feel too isolated, but the Archbishop advised them to announce their engagement to the whole Lee extended family network and encourage Jong-wook’s mother to invite all its main representatives in the conventional way. They agreed, and for the wedding itself, which took place in Myeongdong Cathedral on December 18, there were two parties: one small, with the new couple, Reiko’s father, Jong-wook’s elder brother Chong-bin, a first cousin and an uncle; and one large hosted by his mother Sang-kan and his younger brother Chong-koo for the wider family.
Early in 1977, the Kaufmanns received the following news from Chuncheon:

Dear Lili and Barry,

Thanks for the cooking books and letter. Now I have been ex-bachelor almost 3 months and one thing I think of these days is that it must have been difficult for you to treat me and half a dozen boys and girls that many times for that period. We quite enjoy having guests but what a demanding job it is!

I rented a house – three rooms, one bath, one kitchen. It would be an understatement to say that it is quite adequate for us because it is actually better than my mother’s place.

It has been also very severe winter here but with heat, some money to spare and a wife to share it has been one of the best for years.

I finally got my passport last January, but I still don’t know when to leave or if to leave at all. U.S. embassy told me to secure this or that document for my visa to be issued last December. Then they changed the law and the embassy is waiting for instructions for the cases that had been caught during the changes. It seems that I have to take the National Board Exam Parts I & 2 here as part of Visa Qualifying Exam. Also I have to take ECFMG English test to prove my English is as good as two years ago. Everybody used to go, but it seems now they can afford to be a little more discriminating. Personally, I feel it is very exciting and challenging.

As to the National Board, I’m going to take it and not fail. I think I can pass language test. If anyone wanted to go, I wanted. But I’m quite philosophical about the whole thing. I have had rougher times.
As to our marriage, we made all decisions by ourselves. I saved my pay and bought ring, met all expenses together with Reiko and decided all those things—when, where, how. In the process we hurt a lot of people’s feelings who were all well prepared to give good advice. Even our parents were just asked to come to the ceremony. Reiko’s father came from Tokyo and stayed for five days. It is not a common practice here but we got immense pleasure.

Whatever happens with my future plan, so long as I can be independent and support my wife, I will not be influenced very much.

Peter and David must be taller and gentler boys now. Hope to meet them when we can still recognize each other.

The thought about the Kaufmann boys reflects his own sense of growing up. Just as the children might be hard to recognise the next time he sees them, so might he himself.

Chuncheon, the capital of Gangwon Province, is close to the demilitarised zone between South and North Korea. Lee continued to work at the provincial hospital there as an emergency-room physician, and the couple lived in one of the doctors’ flats behind the hospital. The working hours were long but the pay for doctors was relatively good, and they were able to save a little money for their hoped-for departure to America.

A vivid idea of what Chuncheon was like in the 1970s is conveyed by the following reminiscences written by Reiko.

After we married, we lived in Chuncheon, the capital city of the province. We lived in the hospital apartment for doctors. It is a medium-sized city with beautiful scenery. There was a man-made lake with a dam. JW used to take me to the lake and we rowed a boat. During my pregnancy we still went there, but I couldn’t row any more.

There was an American camp there and I heard that it was a very important one, with nuclear bombs. When the US decided to withdraw from there, I saw helicopters carrying bombs away from the camp, I don’t know where to. There were many prostitutes waiting

\(^1\) Letter to the Kaufmanns, 21 February 1977.
for the American soldiers to come out of the camp entrance at the end of the day. The Korean army had a big camp there as well. Once we were going to the lake in a taxi, and suddenly from somewhere a tank appeared with a gun pointing at us. I was surprised and afraid.

Once or perhaps even twice a day, I don’t remember now, everybody had to stop and sing the national anthem with a hand at the chest with the music from the loudspeakers that were everywhere in the city. There was evacuation training once a month, sometimes in the daytime and sometimes during the night. If it was the night-time training, we had to turn off all the lights. If one was in a bus or a train one had to get out of it and take refuge in designated places until the training was over.

One day his mother visited us and we took a sight-seeing boat trip on the lake. After that she stayed the night with us. In the morning I didn’t know what to prepare for my mother-in-law’s breakfast. I cooked kimchi chige, a kind of stew of kimchi with rice. It is a spicy food and I couldn’t eat it at that time, because my stomach got to be very sensitive to spicy food after I got pregnant and the smell of kimchi nauseated me. I just prepared bread and tea for myself, and she was not very happy to see that. JW was in a difficult position.

My mother-in-law visited us once a month. She always brought kimchi with her, travelling about two hours by bus and train. JW was not very kind to her, feeling that it was an interruption of our family life. He especially didn’t like what she said about the girls she had wanted him to marry. Graduates of the medical school of Seoul National University were the elite of the elite and many parents who had daughters wanted to marry them to the graduates of the school. There must have been some parents who wanted to marry their daughters to him with good prospects in mind, such as director of a private hospital. But he didn’t make his mother and the parents of some girls happy by marrying them as they wanted. He wanted to make his own life without anyone’s interference. Objectively, the marriage with me didn’t give him any advantage. I was not tall or pretty, wore glasses and had a gap between my front teeth. I was not a daughter of a rich person, and, worst of all, I was a foreigner.

After we married, he wanted to fulfil his hope of going to the United States as a physician, but with the change of the US policy for accepting foreign physicians after the end of the Vietnam war, he couldn’t get a visa for the category of foreign medical doctor. He
didn’t show me his disappointment, but now I know it was a big shock.

JW was in the reserve army and he had to go for training once a month or sometimes even twice a month when North Korean spies came down to the South. Chuncheon is close to the border with North Korea. After the night shift of the hospital, he looked very tired, but he had to go to the training. I worried so much when he had to work at night and do training in the daytime and then again take the night shift. He had a very strong body and he could do that. He was very confident about his strength, and it is clear in retrospect that its limits are what he ignored later in life.

Reiko had plenty of opportunities to see how her husband was getting on as a doctor, as the following recollections show.

**Dysentery**

One morning, after his night shift, he came home tired. I asked whether he had had a difficult patient. He said that a boy had been brought to the emergency room by his father. The boy was very dehydrated and feverish. He had dysentery. He treated him and he was better by the morning. A couple of hours later, the father visited us with a big live chicken which he had been keeping in his yard. He couldn’t help showing his gratitude in some special way. I felt uneasy, because the chicken was from the house where a dysentery patient had been living. Of course it was an unreasonable idea. We took it to a nearby market to have it prepared.

**Prisoner**

One day (it was in the daytime, so it must have been a holiday) he came home with a strange face. I asked what it was that had made him make such a face. A patient had been brought from a prison on a stretcher guarded by one or two prison guards. The prisoner’s mother was there too. After examining the patient, JW wondered why he had been brought to the hospital on a holiday. He told them to wait in a small room, and on their way to it, the prisoner’s mother came very close to him and touched his hand with something in her hand. As she did so, she whispered to JW, ‘Please tell the guards my son is very sick and has to be taken home, because his condition is so bad that he might die.’ JW was very surprised. Coming home, he told me the story and said, ‘Did she think I would accept her money in exchange for my medical license?’
Daughter-in-law

He told me that a woman was brought to the emergency room with severe anaemia. She had given birth more than ten days before that and she had been bleeding from the uterus. She had to do everything at home—washing, cooking, cleaning, everything. Her mother-in-law didn’t let her rest even the day after she had given birth, and the daughter-in-law couldn’t complain about it. Her husband didn’t stand up to his mother and his wife’s condition was getting worse and worse. There was nobody to take care of her at the hospital except her husband who visited her for a short time. JW asked a nurse to find out whether she had her own family. It turned out that she had a brother who lived with his family quite far from the hospital, but he came there when he was told about the condition of his sister. JW told him that she might die if she was taken back to her husband’s house. She stayed for a few days in the hospital, getting good treatment from the specialist, and then was taken to her brother’s house.

Appendicitis

We didn’t have a telephone, so we had to go to JW’s office to make calls, and wait for the line to be connected if it was an international call. When I went there to call Japan, I heard the wail of a woman as I went through the emergency room. She was crying ‘It hurts, it hurts! Please help me! It hurts!’ again and again. I asked JW why she was crying. She had appendicitis but she didn’t have money to pay for surgery. Her husband was in jail and no one in her family was helping her with anything. I asked JW how much surgery for appendicitis cost. It was a ridiculously small amount of money for me, and for anyone who had a job with normal salary.

When we married, my father had given me some money and I still had some left over after depositing most of it in dollars, as dollars were regarded as the most stable and strongest currency. I proposed that I, or we, should pay for her operation. JW talked with the office of the hospital and, surprisingly, they offered free surgery and treatment. I was so grateful. It was not a time in history when people with appendicitis should die. At that time in South Korea some health insurance systems were starting, and there were schemes for helping poor people, but it seems that she was not eligible for any of them, or if she was she had not taken the necessary steps to sign on. Anyway she was operated on and went home some days after that.
JW was very happy that I had offered it and that the office decided to help her.

**Asthma and dislocated jaw**

There was an asthma patient who suffered the disease with the changing seasons and levels of air pollution. He sold umbrellas at the market. After JW had seen him a couple of times in his clinic, the patient decided that he could cure him and he was the only doctor that could save him. He knew the time when an attack was coming on and came to the hospital entrance waiting for it to start. He was always right, and he came into the emergency room to see JW. He asked for JW only, even when he was not on duty. If he was at home, he always came to help him.

It was also around that time that a person came to his emergency room with a dislocated jaw and saliva coming out of his mouth which he couldn’t close. JW saw him and thought. The jaws were displaced so they should be able to get back in place. He put them back successfully. The patient had the same problem a few days later and went to a town doctor, but he couldn’t do what JW had done. He thought of operating on him, but he was not rich and he didn’t want it. So he came to the emergency room to see JW, but he was not in the clinic. The doctor on duty couldn’t put them back and called his colleagues to help him. They took an X-ray and started thinking of doing an operation. The patient was surprised and asked for JW to come to help him. He was out of town. When he got home, he was called to the emergency room for a very difficult problem. He saw the patient and did the same thing as before, again successfully. The patient was happy and went home calling JW a saviour.

**Leprosy**

One day when he was off-duty and in Seoul, a patient with leprosy came to the emergency room. The doctors on duty were scared and didn’t want to examine him, so he was kept waiting for a long time. As soon as JW came back he was called to the emergency room. Having worked at a leprosarium, he was not very scared of the disease, examined the patient and sent him home. It was still the time when leprosy was one of the diseases which people feared most of all.
Electrocution

We were at home in our doctors’ apartment on a warm and sunny day and had just finished lunch. Suddenly we heard a very loud noise, boom, from the hospital, but not in the hospital. He said something must have happened and ran back to the hospital. When he came back in the evening, he said that there had been an electrocuted person at the entrance gate of the hospital. When he arrived at the emergency room, that person was just being brought in. He was all black and smelled awful, he said. At that time already he was not breathing, but JW tried to resuscitate him. He massaged the heart and blew air from mouth to mouth. He said the smell of a burnt person was unimaginable.

In the hospital on 31 October 1977, Reiko gave birth to a son. They christened him Choong-ho for his Korean identity, and Tadahiro for his Japanese one. An effect of becoming a father is apparent from another of Reiko’s reminiscences:

Death of a Son

It was when our son was only two or three months old. One morning Uggi came back from the hospital and I prepared breakfast and put it on the table. He didn’t eat it but sat looking down at the floor. I asked him what the problem was. He looked up with eyes from which large drops of tears were falling and he couldn’t say anything. It was the first time I saw him cry. I worried so much, but soon he regained his composure and told me what had happened. During the night, a baby of about one year old was brought to the emergency room with dehydration and unconscious. He knew it was too late, but he tried every way he could think of to bring him to life. The baby died early in the morning. What he was thinking of was his own baby, Tadahiro. I had often been hearing that doctors shouldn’t get mentally involved, but I thought at that time that he was a good person. I heard more stories about babies after that, but he never cried.

Another Adventure of Friendship

John Hess, an American army doctor, was stationed at the 121st Evacuation Hospital in Seoul for a one-year tour of service before leaving the army and returning to the States for further study. He used to drive up from Seoul to Chuncheon in his red Nissan
sports car on Saturdays to help at a medical centre run by the Sisters of St Columban. One day in January 1978, Sister Zeta, the Irish nun who was in charge of the centre, told him, ‘There’s a new bright young doctor working at the hospital you must meet.’ By that time Jong-wook and Reiko had made friends with the sisters, who referred patients to his hospital and came to visit them there. So it was that the following week, while Hess was chatting with a patient and his interpreter in the consulting room, there was a knock on the door and Sister Zeta opened it, saying, ‘Dr Hess, I’d like you to meet Dr Lee.’

As Hess recalls, Lee was wearing jeans and a black and white sweater, and had a *New England Journal of Medicine* under his arm. They talked in English about the patient who was there, as well as with him in Korean, as Hess was learning the language. The patient and the interpreter soon left, and the two doctors went on to talk about other cases, their current work, the political situation, and common literary and other interests. Both 32 years old, both with a medical and military background and a sense of adventure, they took a liking to each other, and arranged to meet again to continue their discussions.

John Hess’s fiancée, Lynn Stansbury, was visiting him at that time from Hawaii where she was studying medicine. Lee gave them both a tour of his hospital, then took them home to meet Reiko and the three-month-old baby. The two couples enjoyed each other’s company, shared a common interest in English literature as well as their professions in health care, and became close friends. Lynn left for Hawaii and John joined her there some months later and they got married, but the couples kept in touch.

Meanwhile, the Lees’ plan of moving to America kept getting postponed by visa restrictions. At that point in their lives they might have given up the idea of emigrating, at least for the time being, but Reiko was not entitled to permanent residence in Korea. Her residence permit could not be renewed without a stay in Japan, and then only for six months. In December 1978, when her son was just over a year old, her visa had expired and she left
with him for Tokyo and rented a small flat near her sister’s home. Jong-wook was to join her and try and sort out the visa problem with the Korean Consulate there as soon as possible.

He reflected on his family’s predicament in a letter to John Hess dated 12 December 1978, just after Reiko and Tadahiro had gone to Tokyo. On the one hand, love was drawing them more and more closely together: ‘Five days plus today two years ago, we exchanged our “I Dos. Now in this time of her being away, I feel very much helpless and am in awe of Reiko more than at any other time of our togetherness. In the last few days, whenever I look for something it is there, neatly, thoughtfully like magic, an obvious sign of her quiet preparation.’ The difficulty of finding somewhere to live where they are not forced apart by immigration laws is becoming acute, and he goes into some detail about the obstacles they are encountering.

Meanwhile, the Hesses in Honolulu were looking for a way to help their friends in Korea. John was working on getting Jong-wook a place at the Hawaii School of Public Health as a postgraduate student, together with the financial means it would require. This involved a good deal of negotiating, filling in of forms, and strategising. The December 12 letter responds to Hess’s points and ends: ‘Reading your plan, I feel as if I am being briefed for a combat operation.’ He signs off ‘Numbed’, with ‘Jong-wook’ in Korean characters.

He was able to travel to Japan to join Reiko and Hiro in February 1979. It was the first time he had left Korea, and he was impressed by what he saw. He wrote to the Hesses a week after he had arrived, ‘Now in this sea of affluence, witnessing how the other members of Reiko’s family are doing normally well, has given me a new insight into her life in Korea. I feel I shouldn’t add extra insults to the pain that originated with her Korean mission.’

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3 Ibid.
John Hess’s efforts and his own were eventually successful, and Lee was accepted for a place at Hawaii University to read for a Master’s in Public Health, on a scholarship programme that would give him free tuition. That would solve the Japanese and Korean visa problem and be a good career move, but to obtain American visas for himself and his family Lee would have to prove that they would be able to support themselves. They had no substantial savings and no foreseeable income.

The Hesses came up with a solution for that as well, which was impressively generous. Instead of paying rent, the Lees could live with them, and to pay for daily needs Jong-wook would receive a stipend from the university of $500 a month, to be financed entirely out of John’s salary as a physician in Honolulu.

The Lees had qualms about imposing on anyone to that extent, but they were keen to survive as a family. So for them the offer was a kind of answer to a prayer, and as such could not easily be turned down in favour of something better but nonexistent. For the Hesses it was a way to help a family they really liked. As they reminisced later, they felt a strong affinity with the Lees. In traditional Hawaiian culture there was a variety of friendship called ohana, in which close friends saw each other as belonging to the same family without necessarily being related to each other by blood. It is similar to the German idea of Wahlverwandten, ‘chosen relations’. On that basis it was natural to offer support and a place in the home when the need arose. It was perhaps a romantic notion, but could also be seen as a more sensible tradition than many others. In addition, they had acquired quite a large house which they wanted to share with the Lees and another couple. None of them were hippies in search of a commune, but they belonged to that generation, and did have an open-minded approach to living arrangements. Likewise, they were no longer youths but they still felt young and adventurous.

As the project turned into a reality, Lee expressed his feelings about it in an undated letter to the Hesses.
Dear Lynn and John,

I who am making decisions for others every day couldn’t make this one. I tried to be logical, reasonable, practical or affable but still tough. Perhaps I could never file these papers without your friendly ‘pushing’. I talk about my frustration in everyday contact with these Gangwon-do patients, their efforts to save face when everything is so apparent to me. For all my external sophistication, I find myself very much one of them in my bones.

Then I hit on Lynn’s words, that you are speaking as a family. At every turn I look back on it. It comforts me. I am overcoming my fright and/or run-away instincts.

I have rarely caused this much trouble to anyone but my mother, Reiko and my sister in Singapore [Chong-won]. And now of course you.

Blessed are those who are patients! Thank John.

The letter shows how he was not taken in by his own façade of strength, but was not ashamed of the poor self behind it either. The fact that he can identify with his patients in both their helplessness and their pathetic attempts to conceal it suggests a well-balanced mind. Though not at all a pious man, he also offers insight about the Beatitudes: the poor in spirit and other kinds of sufferers can be called patients and are blessed, at least by truth, when they see the reality of their condition, and see it seen without malice by others.

Characteristically, he does not end the letter on that effusive note but goes on briskly to take care of some practical details:

One letter of recommendation is coming from Tampa.
I am sending the enclosed to you for your signature on page 7.
My transcripts are going to the school via Mr Kim tomorrow.
I enclose $20 and the application fee for expenses on the telegraph and extra application form. Please let the school cover its expenses.

Jong-wook [in Korean characters]

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Their military training probably helped to make Lee and Hess an efficient team, and by the end of July 1979 all the administrative details had been taken care of. The Lees set off to start their new American life that August. The tableware they took with them consisted, according to Reiko, of three bowls, three plates, and six chopsticks.
PART II

1979–2003

THE PACIFIC AND

THE WORLD HEALTH ORGANIZATION
The Lees arrived at Honolulu International Airport on 9 August 1979. Jong-wook’s student visa entitled his Korean son to one too, but not his Japanese wife, so Reiko had obtained a tourist visa, separately. On her immigration form she had put ‘Writer’ under ‘Profession’, and ‘Research’ under ‘Purpose of Visit’, as friends had advised them that this would make it easy to get an extension when the visa ran out in December.

Though Hawaii is 2000 miles from the mainland, it is a principal port of entry to the United States from the Pacific and Asia, and arrivals are filed past a row of immigration officials at their desks. Reiko joined a different queue from her husband and son, so as to seem more like an unattached writer than a dependent wife, but when her turn came and she was asked about her writing project, she was at a loss. After a silence, the woman checking her passport asked, ‘Are you married?’

‘Yes.’
‘Any children?’
‘One son.’
‘And where are they?’

‘Over there,’ said Reiko pointing to where Jong-wook and Tadahiro were waiting for her. She saw no way to keep up the fiction of her independence, but was now afraid she would be refused entry for making a false declaration. The official just nodded, however, made a note, stamped her passport and handed it back.
to her, wishing her a pleasant stay. So their arrival, although it was the fulfilment of a long-held hope, was not anxiety-free.

As Jong-wook made his way past customs with his wife, his child, and their suitcases, he could well have been having bad memories of his childhood refugee days. If so, they were pleasantly dispelled by familiar faces. The Hesses were waiting in the crowd at Arrivals to welcome the Lees and put a garland of red and white flowers around the neck of each of them in the traditional Polynesian way. There could no longer be any doubt that they had made it into the land of plenty, opportunity and goodwill.

The University of Hawaii at Manoa covers 320 acres of the valley to the north of Honolulu on Oahu Island. In addition to being a well-endowed American university with over 20,000 students, it claims special advantages over run-of-the mill places of learning in rich countries. With its Asian and Pacific connections it excels in areas such as tropical medicine and agriculture, volcanology, comparative philosophy, urban planning, international trade, and languages. It boasts a Japanese tea house and garden, a replica of a Korean king’s throne hall, a Hawaiian taro patch, the Cardinal Newman Center, the East-West Center, and the Center for Korean Studies. It is a prosperous environment by most standards, with the booming city of Honolulu and the splendid Waikiki Beach to back it up. Being a student there contrasted strongly with being an emergency-room doctor among the austerities and dangers of Chuncheon.

The standard course taught by Professor Bob Worth for a Master’s in Public Health consisted of epidemiology, health economics, disease prevention and control, and related subjects. In addition to taking this and a module on biostatistics for PhD students taught by Professor Chai-bin Park, Lee did research under the direction of Professor Jim Douglas on developing a serological test to detect the agent responsible for transmitting leprosy. It involved laboratory work in the Biomedical Sciences building and occasional travel to Ponapei in Micronesia to examine patients and collect blood samples.
Though he was an able student and researcher, and passed the necessary tests, he on one occasion loaded a centrifuge incorrectly, causing it to blow up. Perhaps because the wrecked machine was worth about $5,000, the accident made a lasting impression on him, and he mentioned it again, remorsefully, when he was with Bob Worth more than 20 years later. He took the American medical doctors’ visa qualifying examination again during his time in Hawaii, and failed it again.

One night he received an urgent phone call: the armadillo he and a fellow researcher kept in the laboratory had died. As a medical practitioner he needed to conduct an autopsy on it. The nine-banded armadillo has been known to carry the bacterium that causes leprosy in humans, and the animal had been kept for microbiological studies on the pathogenesis of the disease. Reiko remembered Jong-wook leaving the house in haste late at night to carry out this duty, but the causes of death appear to have been unremarkable, as no record of them is known to have survived.

Communal living at the house on Paty Drive had positive and negative aspects as the Hesses and Reiko recall it. Positively and predominantly there was an adventurous sense of strong friendship, bolstered by good career prospects in medicine for both of the Hesses and Jong-wook. Accepting financial support and living with the donors entails some risks, however, just as providing it and living with the recipients does. The way Reiko put it was, ‘Our friends were generous and we didn’t have real problems, but it was not easy and a bit humiliating.’ All of the household except Reiko and Tadahiro were out at work during the day—John as a physician in private practice, Lynn as an intern at the university hospital emergency room, Jong-wook as a graduate student. The other couple, called Sally and Joel, were teaching German and doing linguistics research respectively, at the university. Lynn explained:

Sally was my housemate—I had met her through Honolulu Friends Meeting, of which I was a member at that time—I through my third year of medical school while she was a TA in German Language at UH (and author of the line regarding teaching students: ‘I let them think
they have a choice.’) Tall, (imagine a Quaker Valkyrie) vegetarian
(tempura day-lily buds with honey and sour cream a specialty, along
with home-made yogurt and endless crock-pots of yummy lentils),
Rock of Gibraltar. J&S, J&I, all newlyweds, lived in classic Honolulu
cheek-by-jowl style in S&my flat through my senior year in med
school. When John and I bought the Paty Drive house at the end of
my senior year, we all just shifted over there. Joel was also a linguist,
though at a more basic-sciences of language level and also a rock,
classic Idaho pioneering kind of family. He was also the first bearded
individual Tadahiro had ever seen and, meeting him for the first
time, T was fascinated by this masculine accoutrement. As he patted
Joel’s beard, we kept saying ‘Joel’ and T kept saying ‘Beard’ and thus
was Joel rechristened for the household from that moment.¹

Tadahiro needed plenty of entertainment, and was energised by
the extra company in the evenings. Remembering those times,
Lynn wrote:

My intern year was a searing experience (including the death of two
of my fellow interns, one of whom was murdered, over the course of
the year, and a ‘flu epidemic that took another chunk of colleagues
out over a couple of weeks’ period in February) and I was distraught
and exhausted throughout. (Years later, Uggy apparently told John
that they could hear me crying myself to sleep on those nights that
I did get home from the hospital.) But the one bright thing out of
that year was our home and the people in it, John and Joel and Sally
and Reiko and Uggy, and, most particularly, Tadahiro.

When Uggy got back to Hawaii after one of his review courses,
he was taken aback by the sight of his wife and me manipulating his
classically ‘no’ stage two-year old son into the bath each night by my
running around downstairs telling Tadahiro that he couldn’t take a
bath, no, he had to take a shower because I was going to take the
bath. (The upstairs bathroom had only a shower; Uggy and Reiko’s
bathroom had the one bathtub in the house.) And, being a two-year-
old, he couldn’t resist opposing that and declaring that no, he was
going to take the bath and I would have to take the shower; at which
point Reiko would scoop him up and pop him into the bath, all amidst
much screaming and running around and laughter.)

¹ Email from Lynn Stansbury, 7 November 2008.
There is one incident I remember so painfully to this day of my asking Tadahiro not to run his toy car back and forth over the dining room table during dinner, and Reiko grabbing him from the table and rushing out. It has stuck in my head for years because of my guilt about having blown all of our efforts to make them feel welcome and at home and part of a family in that one moment of reverting to the formality of my own childhood. But my memory is of the joy, the sanity, the blessings of normal life that Reiko and Tadahiro brought into the horror of that year.2

Reiko used to take her child down the hill to the shopping centre about a mile from the house, preferring to walk rather than spend money on the bus fare. One hot day, however, Tadahiro’s face got alarmingly red and he was not sweating. Recognising the symptoms of heatstroke, she picked him up and ran with him to the drugstore fifty yards further down the road. Inside, she found an air conditioner, and held him in front of it till the cool air restored him. From then on she did not risk taking him for long walks in the heat of the day, but spending the bus fare entailed penny-pinching elsewhere. Eating at restaurants was not possible, and she recalled that there were times when she bought one hotdog for both of them, giving him the sausage and herself the bread.

The Hesses left at the end of the first year, for American Samoa, where John had been appointed as Director of Health. They left their house and their white Volkswagen Golf for the Lees to use. Hess had taught Lee to drive, and he had passed the test at the second attempt. The Lees enjoyed driving all over Oahu Island. Jong-wook gave Reiko driving lessons but these led to heated arguments, ending sometimes in her stopping the car and getting out. As a result, they both lost their enthusiasm for that project, and she did not get far enough along to take the driving test while they were in Hawaii. Tadahiro also took an interest in driving, and one of his favourite entertainments was sitting with his father by a speed bump on Maile Way and watching the cars

2 Email from Lynn Stansbury, 6 November 2008.
jounce over them, shouting with laughter, seeing it as one of the absurd games adults play.

As the second year in Hawaii drew to a close, there were two main options for the immediate future: stay on at the University of Hawaii as an assistant lecturer on public health, or take a job as a clinician in American Samoa. The doctor’s job offered independence and a proper salary, but on a smaller island with a less developed economy. The Hesses were returning to Hawaii, and it was through them that Lee had learnt of the opening in Pago-Pago. He applied for it successfully, and decided to take that option, resisting the charms of academic life.

American Samoa

The Samoan Islands in the South Pacific lie halfway between Hawaii and New Zealand. They have been inhabited by Polynesians for more than 2000 years, and European explorers began arriving there in the eighteenth century. Long-standing disputes over colonial control were settled in 1899 when the Germans and Americans agreed to split the archipelago into Western and American Samoa, which gave America the harbour of Pago-Pago on Tutuila Island, an important trade and military asset in the Pacific. Western Samoa was occupied by New Zealand at the start of the First World War, and became independent in 1962. The ‘Western’ was dropped from its official name in 1997. The Lyndon B. Johnson Tropical Medicine Center in Faga‘ula, near Pago-Pago, opened in 1968 following a visit to the territory by President Johnson two years earlier. With 120 beds, 31 physicians and a budget of US$115 million, it remains the best-equipped hospital in the South Pacific islands. The advantages of having such a facility probably helped to reduce the demand for independence during the time of worldwide decolonisation. The eastern group of islands has remained an American territory and its currency is American dollars, but technically it is neither an American state, like Hawaii, nor a colony. It is governed by a combination of village leaders and the US Congress, and defined legally as an ‘unincorporated territory’.
Near the hospital buildings there are some bungalows for staff and their families, and the Lees moved into one of them. With two bedrooms, a large living-room, kitchen, bathroom and attic all to themselves, they enjoyed having a place they could call their own. Their neighbours were Bill and Gisela Schecter, young Americans who were both doctors working at the hospital, and they had a son called Sam, the same age as Tadahiro. Gisela reminisced 27 years later:

JW was our nextdoor neighbour and our children were best friends, climbing their guava tree together and playing. JW and his wife were both very studious. JW was always studying about medicine, and his wife studied languages. She studied German with me. JW was studying to pass the Visa Qualifying Exam which is the test foreign medical graduates needed to pass in order to obtain a position in a residency in the US. He had failed before.

JW was the leader of the Koreans on Samoa. There was a Korean fishing fleet that had the Starkist factory on Samoa as their home base. He would invite us frequently to the Korea House for dinner, and was looked up to as the man for Koreans to go to if they had any problems or questions.

He was also a leader in the Emergency Room. There was a bus accident while we were there. A bus went over a cliff and 14 people were seriously injured. He was called to the hospital and organized the triage and care of the patients.3

The guavas, Reiko remembered, were very sweet. The families have remained close friends.

On ordinary days Lee worked at the outpatient clinic, seeing as many as 60 patients a day, with needs ranging from major surgery to authorisation for a day off work. At weekends and on holidays the family took as much advantage as they could of the blue water and beautiful shoreline, going for picnics on the beach, and snorkelling. It was in Samoa that Tadahiro learnt to swim, ‘like a fish’, his mother says, and Jong-wook learnt scuba diving. He was taught by John Flanigan, an American who was a lecturer in journalism at a college near Pago-Pago at that time,

3 Email from Gisela Schecter, 16 June 2008.
and ran a diving club. He remembers Lee not at all enjoying the part of the training in which you have to put on your equipment underwater in order to learn how not to panic. Like managing medical emergencies, it was probably good preparation for the stresses of being a director. Flanigan remembers him as stopping more frequently and for longer than most people to stare at plant and coral formations or watch shoals of fish going by. It was during this time that he took up underwater photography. Reiko also recalled an occasion when he and a friend were snorkelling, when he had been so absorbed in contemplation that he had not noticed his friend waving to warn him of a shark nearby. Fortunately the shark disappeared again, so the story of his life did not end there.

Anti-panic practice had more immediate uses as well. When Reiko was called to the preschool where Tadahiro was crying with pain, apparently in his stomach, she took him straight to the hospital. Neither Lee nor his fellow doctors could find the cause of the pain, however. Blood tests and X-rays produced no answer. The pain continued, and the surgeon was keen to take his appendix out in case that was the problem. There was no clear evidence that it was, but he argued that it would be better than doing nothing. Lee could see that that did not make enough sense, but just as his father had doted on him, he doted on his son, and was painfully aware of the need for action. Fortunately, while the tension between the doctors mounted the pain in the patient subsided, and he fell asleep. It turned out afterwards that he had early symptoms of tonsillitis, which was cured with two days on antibiotics.

When Korean fishing-boats came in, there were usually one or two of the crew who needed medical attention, and they were always sent to Lee, so they could communicate with their doctor. If he was off-duty they would either arrange to come back when he was there or, if it was urgent, try to get him there from home. He obliged whenever he could, and in return, they made presents of fish to the Lees, so their freezer was always full of tuna. When they got a whole one they took it to the market to be cut up, and
kept their friends well supplied with tuna as well. Reiko prepared some of it as sashimi, and boiled the head to make stock for kimchi.

One evening she had prepared the raw tuna dish for supper but her husband could not eat it. She asked him what was wrong, and reluctantly, he told her how a couple had come to the clinic that afternoon with something wrapped in newspaper and a piece of cloth. The woman was crying and touching the bundle tenderly while the man explained how they had last seen their son when he said he was going down to the beach. When he failed to return and no one had any news of him, they went to look for him by the sea, and found these pieces of flesh washed up on the sand. They had come to ask the doctor for a death certificate. He examined the contents of their package and had no reason to doubt their story. Sharks were common in the area. Though he prided himself on having acquired the physician’s detachment, the sight of sashimi reminded him too forcefully of what he had seen, and of what the parents were suffering.

Though the Schecters looked back on those two years of hard work and friendship with the Lees as an idyllic time in a glorious setting, the Hesses, from their time there the year before, remembered more about the difficulties. For the Lees it was always to be a transitional time, but they did not wait for the next exciting episode to present itself of its own accord.

Lee studied hard to pass the American visa qualifying exam at the third attempt. This time he would take it in Los Angeles. There were two flights a week to there from Pago-Pago, and he booked one that would give him a couple of days to get rested before the exam. In the event, that flight was cancelled owing to bad weather, so he took the next one, which arrived on the day of the test. Coming in straight from 12 hours of travel, he worked through the questions as best he could, without great optimism about the result.

After he had gone back to work and was thinking about other things, the letter eventually came, dated November 2, 1982: ‘The National Board of Medical Examiners (NBME) has forwarded
Lee Jong-wook

to ECFMG [Educational Commission for Foreign Medical Graduates] the results of the 1982 Visa Qualifying Examination and has requested that we report the results to individual VQE applicants. We are pleased to report that you have passed the Visa Qualifying Examination.

He wrote to tell John and Lynn, who by that time were in Colorado, and had just become parents.

Congratulations! So you have Aaron. I also have one piece of good news. I passed that VQE this year. I got the letter one week ago. Of all places, I made it from Samoa. We had a contingency plan: to evacuate to Japan at the end of this year.

Some excuses: I could not write any (almost) letter to anybody, including my mother. Simply I couldn’t. I feel as if I have survived a nasty dogfight in a crippled plane. Passing that lousy test was actually a very depressing experience. I could not afford to be depressed here until now.4

This contrasts with the Schecters’ memory of an idyllic time, and with the recollections of others who knew Lee then, all of whom say how positive and cheerful he was. His self-image as a fighter pilot in a damaged plane suggests both a dread of failure and a desperate struggle to avert it. Then why would he call his eventual success ‘depressing’? Maybe because he found it humiliating to have to work so hard for a position which others could take for granted. His apparent candour in this letter indicates a further twist in the tale of who the real Lee was: if he himself says the man behind the face was gloomy, may he not be just presenting another face, also misleading, rather than the real man behind it? To look too thrilled and relieved at such a small achievement—in comparison to his idea of becoming a world-class high flier, at least—would be a bit humiliating as well.

He steps quickly from the tricky subject of his spirits onto firm ground —with something he can be straightforwardly proud of:

Hiro is doing very well at school. He is the only one who reads in his kindergarten. Hiro has about 140 books including most of the Disney

books, goodies from Bob. The teacher at his school offered Reiko to send Hiro to South Pacific Academy. But we decided to keep him with his contemporaries believing he would be more comfortable that way. So teacher and Hiro take turns reading books to less knowledgeable creatures. Hiro’s Japanese is really flourishing. I don’t understand all of the Japanese conversation between Hiro and Reiko. In the athletic field, Hiro rides two-wheel bike, four-wheel roller-skates, and enjoys SWIMMING. Of course he has more toys than anybody else in the island.

He was evidently reproducing for his son the conditions of his own childhood full of books and paternal affection to compensate for the hardships of migration. After some gossip about promotions and demotions at the hospital, followed by speculation about training opportunities for himself in America, he reports another modest step forward in his career: ‘The ELISA research is going very well. Part of the result was published at the Japan-US annual scientific conference in Sendai this year. So I am going to have a couple of papers with my name on.’ He signs off this time as ‘Uggy, Reiko, Hiro.’

The ELISA (Enzyme-Linked ImmunoSorbant Assay) test was for the detection of preclinical leprosy. He had been working on it with Bob Worth and Jim Douglas in Hawaii and with patients in Micronesia. With his name appearing, eventually, in the International Journal of Leprosy and Proceedings of the Work on Serological Tests for Detecting Subclinical Infection on Leprosy, he had earned his credentials as a specialist. The specialisation that began in the St Lazarus Village had continued in Chuncheon and Samoa, where leprosy patients were usually referred to him.

It was at that point that a quite different opportunity appeared at the LBJ Hospital, in the form of the World Health

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Organization’s medical officer for leprosy. He was a Spanish doctor stationed in Fiji, the office responsible for WHO’s member states in the South Pacific, and he wanted to get back to Europe. That would be difficult to do without incurring the displeasure of his employer and thereby jeopardising his future job prospects, unless he could find a replacement for himself. Leprosy was still a major public health problem in that part of the world, and they really needed someone. Would Dr Lee by any chance be interested?
CHAPTER 6

WHO, Suva: ‘What a Change!’

There were at least five good reasons for being interested in working for WHO, ranging from lofty to practical. At the lofty end, ‘medical officer for leprosy’ had been the job title of Gerhard Hansen, the Norwegian doctor who had pioneered effective leprosy treatment, thereby winning worldwide renown. Second, WHO at that time was at the height of its prestige. The eradication of smallpox had been celebrated in 1980 as a triumph for global science and politics equally. The proclamation in 1978 at a global conference in Alma-Ata of ‘Health for All by the Year 2000’ had a ring of both truth and admirable idealism about it in the light of that achievement. Halfdan Mahler, the Danish Director-General of WHO who had led both efforts was still at the helm and at the height of his powers. Third, working as an international civil servant compared favourably to working as an immigrant in America, Japan or anywhere else. Fourth, it was a specific opening, rather than the many other possible but not yet tangible options. Fifth, the take-home pay and conditions of service were good, with education allowance, cost of living allowance, health insurance, and paid home leave. The Lees might well have considered these points in reverse order, but from every angle they pointed at an opportunity that should be seized.

Having fallen seven years behind in his youth for being indecisive about what to study, Lee was not about to make the same mistake again. Not content to fill in the standard personal history form and let his application follow the leisurely vagaries
of proper channels, he arranged a meeting with Dr Verstuyft, the WHO representative in Suva, Fiji, and flew there at the earliest opportunity. As usual, he came across as a pleasant and competent character, and had no difficulty in making a good impression. If it were up to him, Verstuyft assured Lee, it would be a done deal, which was a risk-free thing to say because it was not up to him. Only the regional director, stationed in Manila, Philippines, at the Regional Office for the Western Pacific, had the power to appoint new staff, and even he had to get personnel decisions cleared through Headquarters, in Geneva, Switzerland.

The regional director at that time was Dr Hiroshi Nakajima, a Japanese medical scientist who had helped to design WHO’s Essential Drugs strategy. He had been elected in 1978 by WHO’s regional committee, consisting of the health ministers of WHO’s member states in that region. Those states include China, Japan, the Republic of Korea, the Philippines, Australia, New Zealand, Malaysia, Laos, Cambodia, Vietnam, and most of the Pacific Islands. WHO is the only agency in the UN system that is divided into six regions each of which nominates its own director, who is then formally appointed by WHO’s executive board. The six regional directors are answerable to the director-general as well as to their respective regional committees, which, as we will see, produces interesting tensions in the decision-making process.

Nakajima was travelling extensively at the end of 1982, to canvas support for his re-election in 1983 for a second five-year term of office. An official photograph of the current regional director always hangs on the wall in the Fiji office, so Lee knew what he looked like, and on his way home from a visit to Honolulu saw him getting on the same flight as himself to Pago-Pago. Their seats were far apart, and during the flight Lee had time to realise that this too was an opportunity not to be missed. He introduced himself while they were waiting for their luggage. Nakajima was used to being recognised, so not surprised that a stranger should come up to him to talk about health issues. To add to Lee’s good fortune, Nakajima’s luggage did not appear on the conveyor belt, so he had time not only to explain to his potential boss in some
detail why he should be appointed to the leprosy post, but to
display his niceness and managerial ability by helping him find
his suitcase.

Lee’s mentioning that he had a Japanese wife, and displaying
some familiarity with Japanese language and culture, helped
to put the older man at his ease. Lee was also familiar with the
Sasakawa Foundation, which was funding part of the leprosy
research he had been involved in, as well as some of WHO’s work
in the region. By the time they parted to get into their respective
taxis, Nakajima could have been feeling that this might well be
a good man to have on the staff. A further providential factor
was that Nakajima’s deputy in Manila was a Korean, Dr Han
Sang-tae, director of programme management. He was eighteen
years older than Lee but as a compatriot and fellow graduate
of Seoul National University, collegially disposed towards him.
Long before his contract with the American Samoa Government
expired on 25 June 1983, all these factors had fallen neatly into
place, and he had secured his next job, in Fiji.

Lee needed to go to Manila for briefing before taking up his
new post, so he and Reiko took the opportunity to travel via
their home countries to visit their families. Tadahiro went with
Reiko to Tokyo while Lee went to Seoul. A prestigious advantage
of working for a UN agency is that it entitles you to carry a UN
laissez-passer, a document that looks like a national passport but
has a UN logo on it and facilitates the official travel of the bearer.
Lee was looking forward to getting one of those, after all the visa
problems he had had in the past. He had not yet got one, however.
At Seoul airport to catch his flight to Tokyo where he was to meet
up with Reiko and Tadahiro, he was asked to show some proof that
he was authorised to leave the country. He did not yet even have
a contract with WHO or a written assignment; that was what he
was going to Manila to finalise. The official was unimpressed by his
explanations, and waited silently while Lee rummaged through
his papers looking for some written proof of his employment.
The Korean government was going through another of its more
repressive phases under Chun Doo-Hwan, with bitter student
protests and correspondingly brutal suppression of them. As Lee searched, and the clock ticked on towards departure time, he had the sinking feeling that he might never see his wife and son again. Finally, he chose a telex confirming his itinerary and meeting schedule in Manila, and handed it to the official, who read it carefully, handed it back together with his passport, and, still poker-faced—waved Lee on through.

Being met at Manila airport by a WHO driver with air-conditioned Mercedes may have brought back pleasant memories of being driven to school in a government car, helping Lee to take to his new environment like a duck returning to water after a long time on dry land. Across the road from the WHO office on United Nations Avenue in Manila was the Hilton hotel, a five-star high-rise remnant of the American regime. The Lees stayed there for the few days needed for briefing, and were heartened by their new-found prosperity. When they went on to Fiji via Sydney they flew business class, for the first time.

WHO’s Fiji office, with its 30 staff, is a microcosm of the Manila office with its 300 or so, which in its turn is a microcosm of the Geneva headquarters with its 2,500 or so. Suva is the biggest city in the South Pacific islands and is thoroughly urban, with tall buildings, crowded shopping streets, security problems and traffic jams. David Narayan, the WHO driver, helped the Lees to find a house in a pleasant suburban area near a tennis court, a swimming pool and the International School. They quickly settled in, ‘full of good hope for our future,’ as Reiko put it.

The day after their arrival, Lee had to go to represent WHO at a meeting with the Leprosy Trust (now the Pacific Leprosy Foundation) in Christchurch, New Zealand. For that kind of meeting people wear a dark suit, he was told, an item he had not really needed up till then. He asked Narayan where he could buy one. ‘Yes, no problem, come with me,’ said the driver, and drove him, to his surprise, not to a department store but to a tailor, who measured him up, got him to choose the cloth, and promised to have the suit ready for him the next morning. After having to work hard to make a modest living, it was pleasant to have
people around who were eager and able to help, and be able to pay them.

In November 1983, Lee wrote to the Hesses in his untidy Roman characters on lined office notepaper. He was evidently writing it in the office, which he shared with an Australian chronic disease specialist, Kingsley Gee. When the phone rang, each of them would answer: 'Was it Dr Lee you wanted to talk to or Dr Gee?'

Greetings from Suva! What a change from LBJ-ER to WHO. I am slowly getting used to the idea that you work between 9 and 5 with 1½ hours of lunch break. I am a clean slate for administrative matters. One time I worried about not having enough matters to fill up 365 days. But now I am perfectly aware of the fact that I can create work out of nothing. By writing letters, answering letters, and ignoring some of them, you can create an avalanche of paperwork. Also there is a minimum of basic paper shuffling tasks all the time.

He is still the outsider looking in, and the overworked clinician who has not yet got used to the life of an official under less physical pressure. After some news of how the family are living and how Tadahiro is getting on at school ('very British, with uniforms, disciplines and accents'), he devotes a whole second page to the clinical details of a skin problem the assistant administrative officer has been suffering from for the last five months. 'This woman is 37 years old with a past history of allergic reaction to tetracyclin and Acromycin, and occasional sinusitis, but denies any past history of hay fever, asthma or skin problems.' He ends the letter: 'I enclose several pictures [of the patient’s rash—not family photos as one might expect] Please relay some relevant information on this problem. Say hello to Aaron!' He signs off just 'Uggy', and comes across as the normally busy doctor who is enjoying the life of a bureaucrat as a kind of amusing holiday or sabbatical.

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1 Kingsley Gee, email dated 3 June 2008.
His willingness to help a staff member as a physician also reflects the kind of professionalism and friendliness he projected at that time. Some of the Fiji staff who knew him then are still there, and remember him above all for his willingness to make friends with important and unimportant colleagues alike. There is a crude dividing line in the UN staff system between ‘Professional’ and ‘General Service’, with the former on a higher salary scale and more privileges than the latter. It is accentuated in WHO by the difference between doctors and ‘lay people’, as the medical and scientific community often put it. Lee never paid much attention to this dividing-line, and seemed to enjoy the company of secretaries and drivers as much as doctors, scientists and diplomats.

In a letter just before Christmas to ‘dear Lynn and John, last but not least AARON,’ he is a little more into the job, but not much. He types it at home on his old typewriter, though a Compaq computer is on the way from Hawaii, kindly procured for him by Bob Worth: ‘This job carries a lot of potential responsibilities,’ he writes. It is a premonition of things to come, but he quickly submerges it in irony: ‘Above all,’ he goes on,

I have been apprenticing in several survival tactics on the battlefield of bureaucracy. Bureaucracy is a very fascinating system, which defies the laws of thermodynamics and perpetuates itself. The secret fuel for this system is letter (or memo) writing. You have to reply. You can agree, disagree, or claim the mail has been lost. The other day Ponapei requested some drugs (dapsone), sending me one telex and one phone call. I sent two cables to Manila. Manila sent a cable to a drug company in Geneva. The Swiss company sent the tablets with a cash value of a grand total of $50—of course plus air freight and insurance. Of course Ponapei and WHO each spent several times $50 to get $50. Who is going to complain? Not us. We are all employed to do these things. These stories are for your entertainment only. I still need my job.

I have been to New Zealand two times, New Hebrides once, and the two Samoas once. Paul Turner had had strokes and in Straub Peter Lavao’s wagon crashed into a truck near the golf course, resulting in one death (his younger son), both femurs fractured for his wife and
chest contusion for Peter. Did I mention to you that they [ASG [the American Samoan Government] paid $8000 for my moving expenses from Pago Pago to Honolulu]? I did not complain at the time because I had no gut to stand up against a government decision. But it gave me some insight into why they were on the brink of bankruptcy.

I plan to apply for U.S. green card this year to secure some base. I hope this letter carries something of the South Seas to your holiday.

At this stage WHO was evidently still just an interim measure for him, and his expectations were still focused on America. The concern ‘to secure some base’ came partly from being on a short-term contract, which made it easy for the time being either for WHO to get rid of him if it turned out to be more convenient than keeping him on, or for him to leave if he found a more congenial opportunity.

The trip to the New Hebrides was to Espiritu Santo Island, Vanuatu. It included a hike lasting several days through bush to find leprosy patients in remote villages. Assuming that no one should be without access to the health system, he persevered in the trek for as long as he could, but eventually gave up without completing it, returned to the guesthouse in Santo and slept for a day from exhaustion.\(^3\) It may be that such exertions compensated for the sense of idleness from which he suffered in the Suva office.

The initial temporary contract was replaced with a fixed-term two-year one, and Lee gradually became a well-known face of WHO in the region. There are no more letters to the Hesses from this period. A Korean television company came to accompany him for a few days as he went about his work, so they could feature him in their series, ‘Koreans abroad’.\(^4\) There were many expatriate Koreans in the world to choose from, but apparently few with work as photogenic and interesting as travelling from one Pacific island to another by plane and boat, and going inland by jeep and on foot to find leprosy cases and get the patients onto

\(^3\) The episode is narrated in an unpublished memoir by Reiko Kaburaki.

\(^4\) Eventually broadcast in Korea on 27 January 1987.
Lee Jong-wook

treatment. In addition to filming him in Fiji, they went with him to the Solomon Islands.

Lee also became a familiar figure at the Twomey Hospital for leprosy patients in Suva, which was run at that time by missionaries called the Sisters of Mercy. Doctors and nurses from around the Pacific used to go there for two-week and three-week WHO-sponsored courses on how to organise and administer multidrug therapy, which WHO was promoting at that time. Multidrug treatment lasted from six months to two years, and rendered the disease permanently inactive. Previous regimens had been based on monotherapy with dapsone and had to continue indefinitely.

The new system presented the possibility, for the first time in history, of controlling leprosy definitively in individuals, and bringing its prevalence in populations down to low levels. That this should be happening just at the time when Lee was engaged as a specialist in that field helps to explain the aura of success and good morale he enjoyed in those early days, according to those who remember them now: it was an encouraging time for leprosy workers in general. Indeed, with the power and extent of the AIDS pandemic still not recognised, it was still an optimistic time in the history of health work itself.

By the end of the 1980s, WHO’s objectives for leprosy in the region had moved from ‘control’ (1983) to ‘total control’ (1989) and ‘elimination throughout the region by the year 2000’ (1991). The word ‘elimination’ was chosen because ‘eradication’ is not possible in the way it was for smallpox. The mode of transmission of leprosy is still not known sufficiently to devise a means of breaking it definitively. In addition, the bacterium can be carried for twenty years before the disease becomes manifest. ‘Elimination as a public health problem’ was the objective chosen. It was defined, with the help of Lee as a resourceful committee man, as a prevalence of less than one case per 10,000 people in a given population. It was considered achievable because once treatment renders *Mycobacterium leprae* inactive in an individual,

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that person can no longer transmit the bacterium, so the incidence of new cases can be brought to a minimal level by case-finding and treatment.

When an important Korean government official6 came on an official visit to Suva, Lee organised a dinner party for him at his home. It was the first time Reiko had had to cook for 30 people. She recalled how finding enough plates, dishes, glasses, cutlery, chairs and tables was already a big enough undertaking, quite apart from preparing the food. The party was a success, and helped to win Lee friends and supporters in high places.

He enjoyed company and was a talented host, and other such occasions followed, though on a more modest scale, most notably for the Japanese regional director, and his Korean deputy. Though she does not reminisce about it, staff members who were there in the Lees’ time remember how Reiko used to play the guitar and sing at parties. Occasionally, Tadahiro, aged at that time between six and eight, would come and see his father at the office, adding to the rather relaxed and convivial atmosphere that seems to have prevailed there during that period.

Lee completed his training in scuba diving and got his licence, while Reiko concentrated on swimming. After a while she was swimming two kilometres a day, which she had to reduce when she strained a tendon in her shoulder from overexertion. She suffered for several months from severe coughing with chest pains, diagnosed variously as bronchitis, asthma or pleurisy. No treatment proving effective, tuberculosis was also suspected, and she went for tests. The X-ray revealed a broken rib from coughing but no evidence of a recognisable infection. Lee reverted to his role as clinician and studied hard to find out what it could be. Eventually he discovered it was caused by filaria, the threadworm which causes elephantiasis, which had developed in her lung. It responded to standard drug therapy, but the memory of it remains as an indication of how the time in Suva was not uniformly one of

6 Reiko, from whom this memory comes, was not sure if it was Kwon E-hyock, known as ‘the godfather of public health’ in Korea, or a Korean senior World Bank official.
simple pleasure and success for the family. For Reiko, in addition to infections, there was the difficulty of finding meaningful occupations while her husband was at the office or travelling and her son was at school.

During their second year in Fiji, it was Reiko’s father who was in poor health, and she planned to visit him in Tokyo with Tadahiro. This raised the question of her son’s citizenship again. Up till then he had been Korean, but it meant that he could only enter Japan on a tourist visa, and only once a year. If for any reason she visited Japan again, whether for a holiday or for family needs, she would have to do so without her son. Since Lee’s work involved travel and longer hours as he accumulated responsibilities, it would not always be practical for him to take care of his son while his wife was away. In 1984 it was possible under Japanese law for children with one Japanese and one foreign parent to adopt the nationality of either one, rather than only the father, as previously. To avoid pitfalls, the Lees sought professional advice. The passport officer at the Korean Consulate was a friend, and his advice was for Tadahiro to get a Japanese passport and just keep quiet about his Korean one. Dual citizenship was against the rules at the time, but the rules could change, and in the meantime there was no need to raise the question. So that is what the Lees decided to do, and for the next ten years or so thought nothing more about it.

To advance in a bureaucracy, one needs easy access to the decision-makers, so Lee started working on getting moved to Manila. Nakajima had nothing against it, and Han Sang-tae could see advantages in having an able compatriot on hand to help him manage the office and maintain an equilibrium between the Japanese and Korean influence. Geographically, Manila was close to countries in which leprosy was prevalent, which included the Philippines itself, so the move made sense to those who could bring it about, and Lee moved to Manila in November 1986, followed by his wife and child in December.

Reflecting on the time in Fiji, during which her husband became a WHO man, Reiko wrote:
I don’t know how much he enjoyed his work and life while he was working in hospitals. I think he enjoyed the challenges each case offered him. In Korea, at the Chuncheon provincial hospital, he saw many patients whose illnesses were new to him. Sometimes he diagnosed some very rare diseases, sometimes he had to make difficult decisions, but those were the times he became lively and threw himself into attacking them. In American Samoa our future after the two-year contract was not yet in sight, but he had his hope that we would be able to live together as a family. He couldn’t drink alcohol before that time, but he started drinking beer during the Samoa time. After he joined WHO, I was worried to see so many hairs on the floor. Obviously it was from the stress he had in the office. He pretended that he didn’t feel it, but I knew that he was stressed very much. The social part was new to him, and it was also new to me. He wanted every dinner at our house with guests to be perfect, but I wasn’t and am not a good cook. I did my best just to make him happy. He poured his energy into every part of his new life as he had in hospitals for his patients.

Away from practice of medicine for a long time, he lost a lot of the medical part and became an office doctor, but I couldn’t but feel his frustration. His frustration was not only while he was new to an international society. He proved to be a very able person in it, but it also became the cause of a big frustration. Because of our mixed marriage, he had to choose the life of a WHO person. Would he have been happier if he hadn’t married me and continued his medical work in Korea or in the US? This is what he hated to think about; he had chosen that life, so he had to go forward in it; there was no “what if he had not?”

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7 Reiko Kaburaki, unpublished memoir.
CHAPTER 7

Manila: ‘An Astute and Capable Manager’

The Philippines consists of 7,107 islands and has a population of nearly 90 million. Eleven million of these live abroad, and 22 million of them live in Greater Metro Manila, a conurbation of 17 cities on Manila Bay on the western side of Luzon, the largest island. The archipelago was colonised by Spain in the sixteenth century, and then became an American territory in 1898 when Spain lost the Spanish–American War. During the Second World War the Philippines was invaded and occupied by Japan, and then liberated by American troops in 1945. America granted the country political independence in 1946, but continued to support it financially and maintain a large military presence there during the Cold War. Subic Bay was a major strategic asset as a base for American bombers during the Vietnam War. After three centuries of mediaeval Spanish Catholicism and half a century of modern Americanism, with a continuing lively Muslim community in the south, the original Australo–Melanesian and Chinese population had developed a complex mixture of traditions. This made it hard to govern, and dictatorship was seen by many as the only alternative to anarchy.

In 1986, however, the year the Lees moved there, the tyranny of Ferdinand Marcos was swept away by the tidal wave of political feeling that had become known as “people power”. Corazon Aquino, the widow of an assassinated popular opposition leader, together with Cardinal Sin, figurehead of Catholicism as the
dominant national moral force, led the uprising which brought the old regime to an end. Mrs Aquino, despite her modest self-definition as a housewife, became President of the Philippines in February 1986, and was for a while a much loved national heroine and international celebrity.

This pleasant surprise in the Western Pacific had implications for Korea, the Soviet Bloc, the Cold War, and WHO office politics. For the protestors in Korea it was proof that tenacity in fighting for what was so obviously desirable and necessary would meet with success in the end. For President Chun Doo-hwan and his supporters who were striving to continue to rule by force, it was a sign that the wind of political common sense was no longer blowing in their favour. America was putting strong pressure on Chun’s government to renounce its attempts to solve the escalating problem of popular dissent by means of a military crackdown. The Republic of Korea was preparing to be the centre of international attention in 1988 as host of the Olympic Games. It was Roh Tae-woo, leader of the government-backed Democratic Justice Party, who brought the protests to an abrupt end in June 1987 by announcing a programme of reform which included direct presidential elections in December, restoration of civil and human rights, a lifting of restrictions on the press, and the promotion of political parties. By the time the Olympic Games had been successfully held in the summer of 1988, the Republic of Korea was being fêted not only as an economic miracle but as a political one.

Lee bought a Mitsubishi Galant when he moved to Manila; a Mercedes was affordable thanks to tax exemption for international organisations, but politically the choice of a Japanese car made better sense, as well as being more economical. Although he had driven in Honolulu, Pago-Pago and Suva, the scale and intensity of traffic chaos in Manila were new to him, so during his first weeks there he sometimes got a Filipino driver or secretary to drive around town with him to instruct him in the art of avoiding crashes. At that time car ownership was still rare in China, so

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1 Eckert et al., Korea Old and New, 382–83.
Chinese doctors who came to work for WHO in Manila were often inexperienced drivers and had various expensive mishaps on the road. Lee was keen to avoid that kind of embarrassment, and adroit at doing so. In the same spirit of learning useful physical skills, he joined a staff ballroom dancing club, which also helped to make him popular and attuned to the concerns and opinions of staff members.

Bureaucracies generate anxiety, resentment and ambition, and in WHO this process normally goes in five-year cycles, with frustration and hopes for resolving it building up as the term of a director-general or regional director approaches its end, then gradually starting up again as the new term of office gets under way. Halfdan Mahler was wondering whether to try for a fourth term, which may seem excessive but had been achieved by his predecessor, the Brazilian Marcolino Candau. Meanwhile, Japan was keen to assert its leadership in the world by putting one of its own nationals in charge of a UN agency. The Republic of Korea too, after years of oppression, had won itself a place in the sun, and was looking for ways to make its mark on the global scene.

In January 1988, WHO’s executive board had to nominate the next director-general, and in September of that year the regional committee for the Western Pacific had to nominate its next regional director. Late in the race, Mahler decided to retire, but said subsequently that he would have stood again if he had realised how much support there was behind him. Hiroshi Nakajima with the backing of Japan was a strong contender for the director-general post, and if he succeeded, someone would need to replace him as regional director. Han Sang-tae with the backing of the Republic of Korea was keen to meet that need. Both men would be 60 that year, the official retirement age for UN staff members at that time (it has since been raised to 62), and neither of them were at all ready to retire; the rewards and stimuli of being in charge were too compelling for that. There is no statutory age limit for elected officers.

It thus came about that both the men who had recruited Lee and brought him to Manila were engaged in campaigns to get themselves elected during 1987 and 1988, his first two years there. In principle, staff members should not get involved in campaigning because international civil servants, like national ones, should be politically neutral. However, the practical implications of this principle in specific instances are often both debatable and hard to apply, especially when the candidates themselves are current or recent staff members.

The executive board consists of 34 members (at that time fewer), each designated by one member state of WHO on a geographical basis whereby none of the six regions of WHO has fewer than three board members. To be nominated for director-general entails winning a simple majority of votes from those board members at the executive board meeting in January. The board does the real work of choosing the candidate but their choice does not come into effect until all member states vote on it with a two-thirds majority at the World Health Assembly in May. To date, the Health Assembly has always accepted the executive board’s choice, so rejecting it would entail unprecedented diplomatic and procedural complications. The regional directors are elected in a similar way: by a simple majority vote in September by the regional committee, consisting, at the time of writing, of representatives of 30 member states with voting rights in the Western Pacific, with the successful candidate formally endorsed by the executive board at its meeting the following January.

Lee is thought to have applied himself with energy and flair to helping to ensure the success first of Hiroshi Nakajima as director-general, then of Han Sang-tae as regional director. It must be said,
however, that the nature and extent of his involvement would be hard to establish, and is asserted here as a matter of common assumption among WHO staff members who knew him at that time, rather than a verifiable conclusion based on the gathering of hard data. Hard data on such matters are hard to obtain.

In May 1988, the World Health Assembly had adopted the goal of eradicating poliomyelitis worldwide by the year 2000. The success with smallpox had helped to inspire the necessary confidence in the power of vaccine, money and determination. Also, 2000 still seemed reassuringly far away. As an impressive plank in his election platform, Han pledged to achieve polio eradication in the Western Pacific region by 1995. The regional committee, despite qualms and reservations expressed in a spirited debate, adopted a resolution to that effect in September 1988. At the same meeting, they nominated Han to succeed Nakajima as regional director.

By 1990, however, nothing much had happened on the polio eradication front, and Han needed to make good on his pledge if he was to go on enjoying the prestige his position had given him. He was not only proud of that position but determined to stay in it for as long as possible. ‘I may not be the best man for this job but now that I’ve got it I’m going to hold onto it like hell,’ he used to joke in his affable moments. In practical terms, that meant being re-elected in 1993, an outcome that would be less likely if by then he had lost credibility over polio eradication. To improve his chances, Han made one of his characteristically bold yet canny moves: he put his young compatriot in the position of director of Disease Prevention and Control, which included responsibility for mobilising the necessary funds and personnel to end the transmission of the poliovirus in the Western Pacific region. It was a way both to reward Lee for his past efforts and demand a great deal more from him. As it happened, this suited both men very well: Lee was keen to realise his own potential as a manager, and Han was keen to help him do so for as long as it worked to his own advantage. As Koreans they spoke the same language not only literally but metaphorically: they were graduates of the
same medical school and had the same national history behind them, in which the intricacies of power-management through bureaucracy played a central part.

So it was that during his seven years in Manila Lee rose first from the rank of responsible officer to programme director, roughly equivalent in chess terms to starting off as a pawn and ending up as a bishop. Lee’s new responsibilities included the whole expanded programme on immunisation (aimed at preventing tuberculosis, diphtheria, pertussis, tetanus, and measles, as well as polio), the new programme on AIDS, acute respiratory infections control, health laboratory services, and control of other communicable diseases. Clearly, then, he was not expected to do the legwork involved in running these programmes but to assemble the right team to do so, and give them the right instructions.

The key man Lee and Han selected to head the immunisation programme and therefore the polio campaign was Shiguru Omi, an energetic 41-year-old deputy director from Japan’s ministry of health and welfare. As well as being a medical doctor, Omi had a PhD in molecular biology, had studied law, and had served as a physician on remote Pacific islands. Though conscious of his own strengths, he was also modest and content to defer to his hierarchical superiors. Looking back on his experience of working under the two Koreans in those early days of his own career in WHO, his memories were of demanding but rewarding effort.

In 1990, when they first met, Lee was not yet confirmed in his position but already behaving like ‘a real director’, as Omi recalled. He was friendly, good-humoured and likeable, and his knowledge of Japanese helped to set up a good rapport from the start, but he was also intractable. There was to be a technical advisory group (TAG) meeting in Tokyo a few weeks after Omi took up his duties in Manila, and Lee without delay gave him sole responsibility for organising it. That meant making sure

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the right participants came, organising the agenda, the venue, accommodation, travel, materials, logistics and budget, and, of course, making sure the desired outcomes were achieved. While Omi was toiling under some pressure to get everything ready in time, Lee asked him at short notice to go to Vientiane to attend a meeting between UNICEF, Japanese and Laotian officials on unblocking the immunisation programme in Laos. Alarmed at the prospect of putting his TAG preparations on hold for a few days, Omi warmly recommended that his boss should send someone else to Vientiane.\(^6\)

Lee listened in a sympathetic way to Omi’s strong arguments and feelings about this but, when he had finished, said, ‘You go to Vientiane. Don’t worry about Tokyo.’ So he went, with no hard feelings on either side, according to Omi, and all went well except for his being even more overworked than before. Even being overworked took on a positive hue as a memory of the early days of polio eradication. An important ingredient of that sense of strength was that Lee, despite the subtleties of his intelligence, his modesty, and the newness of his position, had no doubt about his right and ability to tell people what to do. In later years, he acquired the nickname of ‘the boss’, a convention that was convenient for him and his colleagues alike.

The following year the TAG meeting was in Cebu, Philippines. Although the official purpose of these meetings was to agree on strategic aspects of polio eradication, the burning question was how it would be paid for, and those with the power to produce the money were still holding back. At the Cebu meeting, potential donors talked at length about the strengths and weaknesses of the campaign, its feasibility and their moral support for it, but with no sign of any real intention to support it financially. Late on the second afternoon, the Asian Development Bank’s representative was settling into his discourse of moral support when he was interrupted by Lee, saying loudly, ‘We don’t need any more bullshit, we need money!’ Whether he had lost

\(^6\) These and the ensuing reminiscences of Shiguru Omi were communicated in a series of conversations in Manila in July 2008.
his temper or done it in a coldly calculating way, the outburst helped to clear the air and concentrate minds on the urgency of the need, as Omi remembered it. It did not immediately trigger contributions, but it moved the discussions across the boundary between speculation and action. As many people have said about Lee’s participation in meetings, he was good at spotting the main issue.

In spite of displays of incisiveness, he could also seem rather absent-minded at times. The third TAG meeting was in Ho Chi Minh City, and during it, a breakfast meeting with the UNICEF representative was to take place, with Han, Lee and Omi in attendance. After waiting for a while for Lee to turn up, the other three decided to start their discussion without him. There was no sign of him till halfway through the morning, when he reappeared and explained that he had gone for a walk with some members of the Rotary Club, and the conversation had been so interesting that they did not notice where they were going and had got lost. That was his excuse, and it was in character, but since the Rotarians were the main source of funding for the polio campaign, it could also have been a choice of priorities. By 2005, Rotary International had contributed US $600 million to polio eradication globally. For the time being, however, Lee had to defer to the regional director, who was also highly conscious of who was in charge, and rebuked him loudly on this occasion for his negligence.

The synergy between Han, Omi and Lee continued to work, and by 1993 polio eradication had got going in a convincing enough way to help ensure Han’s re-election. As far as Han was concerned, they could go on indefinitely supporting each other in that way, but for Lee, now 48 years old, the subordination was becoming oppressive. He had remained on good terms with Nakajima, who had himself just managed to win a second five years as director-general in Geneva and so was well-placed to help.

At that time Nakajima was reorganising WHO’s immunisation activities as a single entity to be called the Global Programme on Vaccines. It was designed to complement the Children’s Vaccine
Initiative (CVI), which had been started a few years earlier by UNICEF, United Nations Development Programme (UNDP), the World Bank, WHO, and the Rockefeller Foundation to work with industry to meet vaccine needs worldwide. The new plan was to put one director in charge of both the WHO programme and the secretariat of the multi-agency initiative. The aims of the individuals and organisations involved covered the spectrum from benefiting mankind to maximising profits, and so needed a director who was both strong enough and endowed with a flexible enough intelligence to see the issues from several points of view. The position also called for someone who could win the trust of both western and eastern donors. It was a high-profile job, with authority over large numbers of people and dollars.

Although his experience of living outside WHO’s Western Pacific region was limited to Hawaii and American Samoa and he had only had three years of experience as a director in a regional office, Lee applied for this position, and, as he had when he joined WHO, made his case to Nakajima. The attempt itself to get that fairly huge promotion confronts us with a striking example of his opinion of his own abilities. On the one hand he was well aware of his limitations, had had to suffer their effects in getting qualified and employed, and was appropriately humble in his demeanour, as so many of his friends and colleagues have testified. On the other, he assumed he was as good as or better than all the high fliers and easy riders who might be eligible for the job he was applying for. How did he square the circle in his own head?

A possible hypothesis is that part of his intelligence consisted in scepticism about the apparent strengths of his competitors with their impressive academic or political track records. If he could see through his own plausible exterior he could see through theirs as well. A brilliant epidemiologist can be subnormal when it comes to everyday social interaction, a public health hero can be naïve politically, and he was well aware of such anomalies, usually in a sympathetic way. Common sense, emotional stability, friendship, courage, shrewdness, a knack of inspiring confidence are more useful in more situations than a double first in rocket
science. The fact that such elements are harder to measure does not make them less real or influential in decision-making. Lee did have gifts of that more elusive kind, and he actively cultivated them.

Perhaps not entirely separate from his administrative abilities, is this glimpse of him in his role as an uncle during his Manila days, provided by Yuriko, Reiko’s sister.

When my brother-in-law, Dr. Lee, was still in Manila, he often visited our house when he came to Japan during his duty travels to other countries. I was separated from my husband and my children had anxiety and loneliness which they couldn’t talk to me about. He had been always concerned about such situations and brought them presents such as an ornamental Indian cat or a stuffed Australian wombat.

There was also a particularly unforgettable gift. One day I and my daughter were going out to a nearby park to fly a kite which she had made at school when Dr. Lee arrived at my house unexpectedly. We were surprised, but then the three of us went to the park together to fly the kite which flew high in the blue sky and my daughter ran around with happiness. A few months after that, my daughter got pneumonia and was in hospital. When she was discharged after a week, a package from Dr. Lee arrived. In it was a traditional Chinese kite. He had been in China while my daughter was in the hospital. I think he sent it to her wishing she could fly a kite and be happy again. The kite hung at the front door of the house for some time and it is now carefully stored in the closet.

The park near our house is vast and always green, and it is one of the most famous places in Japan, with cherry blossom many people come to see. Usually though, it is quiet and many kinds of birds are seen in it. When he was staying at our house with my sister he got up early in the morning and enjoyed jogging in the park while my sister and I were still sleeping. I remember being very surprised to find a man standing at the door of our house soaked with perspiration.

It seems that his keenness to do some sports or training when he had time didn’t change until his last day.7

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7 Yuriko Sone, unpublished memoir.
The moral consensus that health was for all was inseparable from the ever-growing power of technology, and they had combined to produce high expectations for childhood disease prevention. The potential for a vast array of more efficacious and easier-to-use vaccines was widely recognised but the cost of developing any one of them was estimated in hundreds of millions of dollars. Those who could mobilise such resources were hesitant to put them at the disposal of other organisations, but unable to deploy them single-handedly. The pharmaceutical companies had the right kind of expertise and money, but their duty was to make their shareholders’ investments grow, and as things stood, saving children’s lives in poor countries was less profitable than making adults more comfortable in rich ones. Intergovernmental organisations had legitimacy but depended on the agendas of their member states, each of which had its own priorities. Non-governmental organisations had the necessary clarity of purpose but neither power nor money without the goodwill of donors. A modus operandi was needed which would enable the groups concerned to reinforce one another’s efforts rather than compete frustratingly with one another. Leaders of the United Nations Children’s Fund (UNICEF), WHO, and the Rockefeller Foundation worked out a proposal for such a way of working, and eventually called it the Children’s Vaccine Initiative. Its genesis and early struggles are described in William Muraskin’s
The Politics of International Health, to which the following account is much indebted.¹

James P. Grant was the Executive Director of UNICEF from 1980 to 1995, and won worldwide acclaim with ‘the child survival and development revolution’ which he launched in 1983. By the end of the 1980s, the effort ‘was estimated to have saved 12 million young lives’ through immunisation, oral rehydration therapy, and the promotion of breastfeeding.² Grant’s era in office overlapped with that of Halfdan Mahler at WHO (1973–88), and both leaders had visions of saving the world through projects of unprecedented grandeur. For Mahler, no sooner had the global eradication of smallpox been achieved than ‘Health for All by the Year 2000’ became the goal. The slogan was intended to convey the idea of making effective primary health care services easily accessible to everyone in the world as a way to start the approaching new millennium on a note of triumph for human goodwill and ingenuity. The movement, as it was called, was launched at the International Conference on Primary Health Care at Alma-Ata in 1978. Meanwhile, for Grant, as soon as the child survival revolution had taken hold, efforts were focused on the World Summit for Children, which brought 71 heads of state and senior officials of 88 other countries to New York in 1990 to pledge their support for ‘giving every child a better future’, than which there can be ‘no task nobler’³.

Grant wanted the summit to launch a bid to develop a vaccine that could protect children against six to twelve major diseases with a single shot, combining time-release technology with that of immunology. The idea had taken shape in the mid-1980s

in discussions involving Kenneth Warren, director of health services in the Rockefeller Foundation; William Foege who headed UNICEF’s Task Force for Child Survival; Gustave Nossal who headed WHO’s Scientific Advisory Group of Experts; and Donald Henderson, who had led WHO’s smallpox eradication campaign to victory.

The quest for this multipotent product called for a ‘Manhattan Project’ in the view of Jim Grant, who argued that ‘if we could build an atomic bomb we could create a children’s vaccine.’ The analogy had been used before for the effort which led to Jonas Salk’s polio vaccine, discovered in the early 1950s, ‘a feat of technological advance and social engineering that involved hundreds of scientists, technicians, and other workers.’ In the 1980s the Cold War was still being waged, and the idea of keeping ahead of the communists in biomedical science was still felt by many to be on a par with keeping ahead of them in physics. It was something on which politicians, businessmen, generals, carers and researchers alike could agree and help each other. Convenient though it was, however, the atom bomb metaphor had its downside as well. It was a discouraging reminder that the well-intended efforts of the most brilliant minds of a generation had led to nuclear proliferation, which far from saving the world had placed it in unprecedented danger for the foreseeable future.

At the instigation of Ralph Henderson, WHO’s assistant director-general for Communicable Diseases (no relation to Donald), Grant’s title was dropped in favour of a more reassuring one: the Children’s Vaccine Initiative (CVI). That phrase was broad enough to accommodate both high ambitions and plain practical concerns, such as the need to increase supply and improve quality.

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4 Muraskin, Politics of International Health, 37.
6 Allen shows how this worked with the sense of urgency generated in the West by early Russian and Cuban successes with polio elimination.
control for existing vaccines, improve the diphtheria, pertussis and tetanus vaccine, and develop a heat-stable polio vaccine.

When Nakajima succeeded Mahler as head of WHO in 1988, he took a keen interest in the initiative. His concern was partly to counteract the implied criticism that WHO was not up to the job of dealing with vaccine production and supply issues on its own, and partly to obtain the increased support WHO needed for its own immunisation activities. The founding agencies of the CVI were UNICEF, WHO, the United Nations Development Programme, the World Bank, and the Rockefeller Foundation. Its stated purpose was to foster product development, collaboration between the public and the private sectors, more involvement of the international health community in immunisation, and dramatically increased funding from the donor community.\(^7\) The executive secretariat for the initiative was to be located in WHO’s headquarters in Geneva, though in Muraskin’s account its structure had been worked out mainly at Johns Hopkins University by Dr Philip Russell, a retired army general of the United States Medical Research and Development Command.\(^8\)

As a prominent health scientist and leader, Russell was in some ways the best person to head the new initiative as its director, but, as it turned out, the position would be located within the WHO hierarchy and not near enough to the top of it for him to feel he could operate effectively there. Besides, General Russell was associated in some minds with US domination. Three of the five founding agencies were headed by Americans, and to put another one in charge of the whole thing would have defeated its multilateral purpose, reinforcing underlying suspicions that it was a conspiracy to extend the reach of the multinational drug companies. As Muraskin points out, business needs are not necessarily incompatible with those of the poor, and businessmen can be as keen as anyone else to do good, but mutual mistrust between the private and the public sectors is common, as is the competition between agencies for influence and money. Such

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\(^7\) Muraskin, *Politics of International Health*, 55.

\(^8\) Ibid., chapter 3, 55–91.
realities argued strongly for non-American leadership in the CVI.

When Nakajima won a second term as director-general in 1993, he was under political pressure to bring in reforms. Immunisation being one of the areas felt to be in urgent need of attention, Ralph Henderson invited Ciro de Quadros, the successful Brazilian leader of polio eradication in the Americas, to work out a detailed proposal for restructuring all of WHO’s vaccine-related activities. As well as being a senior official of WHO, stationed in Washington at the Pan American Health Organization (PAHO), de Quadros was a key member of the CVI’s Task Force on Strategic Planning, and a close colleague of Donald Henderson and Isao Arita. With these advantages and his proven competence, de Quadros was ideally placed to come up with the best possible plan.

He thought WHO should regroup its hitherto disparate immunisation activities, both at headquarters and in the six regions, as one entity, named the Global Programme on Vaccines (GPV), headed by a director with wide-ranging powers. At the same time, the CVI was felt to be badly in need of a strong leader, its various eminent advocates being unable to agree on basic issues such as whether vaccine research, production or delivery should be their main priority. Attempts to find such a director by means of discussion and consensus had failed, so de Quadros recommended that he (or she, but in the event no female candidate came into the picture) should be appointed directly by WHO, since WHO was the member of the Initiative responsible technically and politically for health. Rather than start a headhunt and a payroll allocation for two directors, he recommended that the two positions should be held by the same person. As the head of the CVI, that person would report to its management advisory committee, and as head of the GPV he would be answerable to WHO’s director-general.

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9 Arita was the deputy to D. A. Henderson in the smallpox eradication campaign, then representing the Japanese Agency for Cooperation in International Health.
De Quadros’s plan found favour with Ralph Henderson and Nakajima, but met with a mixed response from the CVI members and donors. Although there was no overwhelming opposition to it, there was no great enthusiasm for it either, so it remained a tangle of contentious issues in abeyance. De Quadros himself seemed like the ideal person to head both entities, but part of the trouble with his plan was just that: it came across as tailor-made to suit him, which would have deprived him of much-needed credibility. Either to prove that he had not designed the job for himself or realising that this was not the kind of struggle he wanted to live in, de Quadros made it clear that he would not be applying for the director position. UNICEF and UNDP thought Mark La Force, an American scientist, was the right man for the job, and made this known to Nakajima; others thought it should be S. Ramachandran, a well-respected Indian government official who was chairman of the CVI management advisory committee.

All such proposals were met with silence, as is often the case in UN agency personnel matters, until one day Nakajima announced that he was appointing Dr JW Lee to fill the two positions. Lee was not well known outside the Western Pacific region, but as a director of regional disease control activities he was well placed to follow discussions and negotiations on global strategy. It would not have been hard for him to see that his nationality and his unknownness were advantages that could help break the deadlock of incompatible agendas that threatened to immobilise the CVI and WHO activities. A carefully drafted letter from S T Han, regional director for the Western Pacific, to H. Nakajima, Director-General, recommends Lee for the job. Whether it was actually sent by Han or just drafted for him by Lee with the help of an editor10 is not clear from the file, the copy being unsigned and among Lee’s own papers. According to Reiko and colleagues close to both Koreans at the time, Han was not keen to let Lee go. Still, the persuasive words were written for him, and it could be that political considerations induced him to subscribe to them.

10 Unidentified—not the present writer, or his successor as editor in Manila.
After preliminary remarks about the many agencies now involved in immunisation and the importance ‘that WHO continues to assert its role as the directing and coordinating authority’ over all of them, the letter takes a position on the controversial priorities of the CVI: ‘The operational aspects of immunisation delivery must therefore remain the leading component of the CVI. If not, we risk developing excellent vaccines which are then not available to benefit those most in need in poor, less developed countries. With this in mind,’ it goes on, ‘I support the consideration of Dr JW Lee for the position of head of the new programme.’ In other words, the main challenge was delivery and that was what the candidate was good at. Though written more to convince than to inform, the letter provides insights into Lee’s strengths:

Dr Lee has served very capably and effectively in the Western Pacific Region since 1984 both in the field and in the Regional Office. During this time he has acted as Team Leader of our Regional Task Force for Poliomyelitis Eradication, getting this initiative off to a very rapid and effective start. Since May 1991 he became Director of Disease Prevention and Control, effectively leading a key division which includes some of the largest and most active programmes of the Regional Office. These programmes have important linkages to donors and other agencies such as UNDP, UNICEF, Asian Development Bank, Rotary International, Centers for Disease Control (CDC) and the major bilaterals. EPI, vaccine development and the CVI are all under his area of responsibility, in addition to AIDS, communicable disease surveillance, CDD [control of diarrhoeal diseases], ARI [acute respiratory infections], leprosy and TB control.

Dr Lee’s experience in drawing together the diverse funding and technical elements which have characterized the success of EPI is a resource many programmes would wish to share. The linkages demonstrated in his programme management are the shape of our work in the future, as we align and coordinate the resources and organizations around us, maintaining and substantiating WHO’s leadership in health-related matters.

Dr Lee has shown himself to be an astute and capable manager of a large team of professional and general service staff from diverse backgrounds. He has developed a keen understanding of the internal
workings of WHO. If appointed, he would be able to take charge immediately and to start developing the new programme.

This glowing reference, even if it was worked out by the applicant himself, does show how Lee had accumulated useful experience and met with some success during his time as a director in the regional office. Combined with his eagerness to get the job and his potential as a counterweight to western interests, his skills may have in fact made him the best person for the position. To see his selection as a good choice would not necessarily contradict Muraskin’s view, which was that it displayed masterful chess playing on the part of Nakajima, who had, as he saw it, ‘totally outmanoeuvred the Standing Committee, while laying the groundwork for an eventual take-over of the CVI by placing at its head a man whose chief loyalty was to WHO, and to Nakajima personally.’11 In any case it was ironical that the CVI, which had begun as a bid to free vaccine programmes from the restrictions imposed by multilateral agencies should now find itself firmly under the control of the one from which its founders most wanted it to be free.

The new job in Geneva started a new chapter in the family life of the Lees, which Reiko described in the following way:

JW travelled to Geneva from Manila frequently in early 1994. I didn’t know why. One day in February or March he said to me that he was to leave Manila soon. I was very surprised. I wasn’t the only person who was surprised. Dr Han, the Regional Director at the time, was very surprised also. Our son was to finish his high school in 1995, so what I said to JW on the spur of the moment was that I would stay in Manila one more year with Hiro. He said that it was good. I had said it but without thinking about it or Hiro’s school very carefully. I think perhaps I wanted to go on playing tennis.

JW looked as if he didn’t mind living alone in Geneva for a year. On the contrary, he looked rather happy about the idea. He left Manila with some necessary things. Then he came back to finish his work in the Manila office and collect some more of the things he needed to live in Geneva alone for some time.

11 Muraskin, Politics of International Health, 176.
During that time there were some farewell parties. One occasion I cannot forget was a farewell party held by the staff of the Manila office, who also invited the Regional Director, Dr Sang-tae Han. Towards the end of the party Dr Han said to JW that he must behave well in Geneva. I was very surprised, as it sounded as if he meant that JW didn't deserve the position, and he shouldn't behave like a person who deserved it. He and a Chinese director who had been in headquarters for some time were the same age. Dr Han said that the person who had been in a position longer should be respected more. ‘Don’t behave as if you were a more able person than him,’ Dr Han said. The bitter way in which he said it surprised me, although I knew he was a very arrogant person who always thought of himself as deserving of the highest position and more respect than anybody else.

JW was smiling and said he would respect him and behave well. As his wife, I was annoyed, and I knew that he was as well, more than I was, but what could we say? He could control himself when he had to, but he used to let himself go and shout while he was taking a shower.

He didn’t take many things with him. I prepared some towels, some china, clothes and some more small things. I bought a small rice cooker. He had to stay at a hotel before he found an apartment. A few months after he left Manila, he sent us some photos, and one of them was his new car. He had had a strong desire to own some car like a Volvo or a Jaguar. He bought a large red Volvo. Jaguars were too expensive for him. He didn’t want to have a Mercedes-Benz like so many other Korean diplomats.

At first he came to Manila to see us quite often, but little by little his visits became scarce. He wanted to concentrate on his work on vaccines. In 1994, while I was in Tokyo for a medical check-up and Hiro was in the US for a summer school at Stanford University, he visited me at my sister’s house. I asked him whether it was better for him that I and Hiro were not with him. He said yes. It was an honest answer, I still believe. He was enjoying a second bachelorhood, in a way. He made the same answer when I asked him again, after he became Director-General, but I am not sure it was an honest answer that second time.

He left Tokyo the next day for Kumamoto to see Dr. Arita, who had retired from WHO some years before. JW’s position as director of the Global Programme on Vaccines made it important for him to work
with people like Dr. Arita, who was one of the heroes of smallpox eradication. JW had something to do in Tokyo before taking the plane to Kumamoto. He got to the airport very late and the door of the plane was already closed. He asked the airport staff to open the door to let him in, and he succeeded in getting onto the plane. It must have been just one episode among many, as he was very often late. It seems that JW worked like a crazy person during this time, and his productivity was amazing.

In Geneva he stayed in a hotel for a short time and then moved to a hotel apartment in France just beyond the Swiss border. During that time he found a small apartment at the foot of the Jura Mountains. He invited his close friends to it for dinner several times, without hesitation, in spite of the mess and his poor cooking skill. He bought a bicycle and enjoyed cycling on narrow roads in vineyards and orchards, and went skiing in the winter.12

Meanwhile the Standing Committee of the CVI were favourably impressed when they met their new executive director, finding him ‘witty and personable’, Muraskin writes, but he adds that that may have been because of their ‘lack of any real choice. They desperately needed to believe in Lee.’13

To explain his scepticism, Muraskin refers to a description of the WHO working environment by another American, John Peabody, in *Social Science & Medicine* in 1995.14 Using research based on organisation theory, Peabody also drew on first-hand experience in WHO’s Regional Office for the Western Pacific, where he had worked as medical officer for AIDS from 1988 to 1991. He characterised WHO as both ‘a singular achievement in international cooperation’ and ‘a complex bureaucracy with an outdated organisational structure.’ He underscored the contrast between WHO’s ‘surrealistcally ambitious goal’ of ‘Health for All by the Year 2000’ and ‘the nearly unbounded worldwide burden of human disease and suffering.’

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12 Unpublished memoir by Reiko Kaburaki.
13 Ibid.
Positing these contradictions as a breeding ground for problems, Peabody enumerated some of the dysfunctions he was aware of. They included rigid compartmentalisation, substitution of output goals with process and self-maintenance goals, ‘trained incapacity’ (i.e., loss of technical acumen through dispersed responsibility), risk aversion, geographical representation undercutting professional competence and vice versa, the homogeneously medical background of staff, influence peddling, inertia, resistance to change, and ‘a seemingly limitless number of hierarchical levels’ which result in ‘a clearance procedure that can only be described as labyrinthine.’ In addition, staff serving internationally were overdependent on the goodwill of their director, and this was conducive to obsequious behaviour. It may be argued that some of these ills are inherent in bureaucracy itself, and as such are subject to control but not eradication, but in the case of WHO they were reflected, as Peabody stressed, by declining credibility and a concomitant shortage of funds.

Moving from diagnosis to prescription, he recommended closing the regional offices, thereby cutting out a layer of the hierarchy and giving more responsibility to the country offices. In this model there would still be an elected director for each of the six regions but they would serve as assistant directors-general at headquarters, replacing the traditional six at that time, five of whom were from China, France, the Russian Federation, the UK, the USA (like the permanent members of the UN Security Council), all selected and appointed by the director-general to be in charge of broad programme areas. Elections for these posts, and that of the director-general, would ‘need to be held publicly and in an open forum,’ thereby increasing WHO’s credibility, which would increase its funding. In addition, professional staff should be given specific outcome objectives with budgetary constraints and policy boundaries; staff tenure should be limited to ten years or varied in other ways to prevent homogenisation; and the goals of the organisation should be more realistically defined.

A seismic change of a kind that has not yet happened would have been needed to rewrite WHO’s constitution in the way that
Peabody implicitly recommended. Even then the new model would not necessarily work better than the old one; in particular, closing the regional offices would cut some costs, but retaining seven elected chiefs would leave intact the competition of loyalties—to the respective regional electorates on the one hand and the director-general on the other. Such tensions can work as beneficial checks and balances but they also spawn the kinds of delays, complexities and incompatible obligations that reformers were trying to tackle. Still, the proposals, carefully researched and peer reviewed, reflect the strongly felt demand for radical change at that time.

Having known Peabody well in Manila, Lee was aware of this perspective on WHO and its regional structure. ‘JW and I did discuss the SSM article while it was in prep once and then many times after it came out,’ Peabody recalled in 2009. ‘He contacted me several times after it was published to flesh out some ideas he had on making WHO more responsive to the poor and hoping to make WHO an efficient, outward looking organization. …What I always liked about JW is that he continued our friendship and he solicited advice when he was DG.’

One of Lee’s first moves as head of the two programmes was to hand over the management of the CVI Secretariat to a coordinator. For this he recruited Roy Widdus, a microbial biochemist and epidemiologist who had worked both in a pharmaceutical company in the UK and in the department of health in the USA. With his ability to see both points of view, Widdus was able to ensure that the CVI ‘maintained and even strengthened its attractiveness to industry as an indispensable place for the incubation of better public–private relations.’

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15 Their interactions included tennis. Peabody was the younger and more athletic player, but, as he recalled in later years, they made a winning team, his stronger backhand complemented by Lee’s stronger forehand.
Choosing vaccine *introduction* as the CVI’s specific contribution, he concentrated on making the recently discovered Haemophilus influenzae type B (Hib) vaccine available in developing countries. It had already almost eliminated meningitis in industrialised countries, but WHO’s Expanded Programme on Immunization had not yet made it a priority in Africa and Asia.

Lee also needed to find a leader for the Expanded Programme on Immunization (EPI), which was now under his responsibility. With the help of Ralph Henderson, he came to the conclusion that Bjorn Melgaard from the Danish International Development Agency (DANIDA) was the best man for the job. Melgaard did not want to join WHO, however, having formed a low opinion of its work in Africa and Asia during the years he had spent working for DANIDA in those regions. Lee persuaded him to spend a week in Geneva to see at first hand what the work would entail. Eventually Melgaard accepted the job offer. He said there were two reasons for the change of heart: ‘First, JW was very persuasive and I felt I could work well with him; second, EPI was one of the few programmes in WHO that I considered well run and successful.’

In Melgaard’s assessment, Lee was a ‘hands-off manager’ who did not get fully to grips with day-to-day issues. This may have deprived the programme of some of its potential but it may have also left him better placed to steer it clear of trouble and bring out the best in those working for it. ‘I liked JW’s style, which accommodated the quite seasoned senior-level managers and gave them relative autonomy. He was always available for discussions when we came to present problems to him. At times we would have wanted him to take a more direct interest in key planning and budgeting matters, but I don’t think they interested him. He was more engaged in more external activities like relations with donors and partner agencies.’

The most straightforward task for immunisation was to eradicate poliomyelitis. To help provide support from headquarters
for this undertaking, which up till then had consisted mainly of regional initiatives, Melgaard recruited Bruce Aylward, a Canadian physician who had spent several years working as a WHO consultant for polio immunisation campaigns in Egypt, Cambodia, Tajikistan, Kurdistan, ‘pretty well all the stans,’ as he put it, and in other difficult places. 19 With his combination of long experience and youthful energy (he was still only in his mid-thirties), Aylward was put in charge of the polio eradication programme, but he found it hard to make it work because someone else was also, to an extent not very clearly defined, in charge, in the role of a special adviser seconded from the US Centers for Disease Control and Prevention (CDC). This was a prolongation of the arrangement that had worked so well for smallpox eradication, masterminded by Donald Henderson who had come to WHO from CDC.

Lee, as head of the whole vaccine programme, was no longer directly involved in polio eradication, but Aylward thought it was he who was best placed to sort out the decision-making process, so he went to see him about it. As he recalled:

It was the usual WHO muddle, with nobody knowing who should be calling the shots.

So after about three months of this I went up to see JW. He had his feet up on his desk, with his shoes on, with this newspaper open, a Korean newspaper, at 11 o’clock in the morning. When you walked into that office you had no sense that this guy was running a programme. I can’t run a programme like that, but that says more about how good he was, because he could just get the right people, put his feet up, and let them run it while he would think about where to go next. People confuse it with goofing off, but you don’t claw your way into those positions to be able to goof off. He wanted to change the world. But anyway, there he was with his feet up like this.

So I sat across from him and I explained to him how ‘this just doesn’t work, so what do you think?’ I was actually asking him what I should do. ‘What is your advice, master, runner of things?’ He never even put down his newspaper, just lowered it a little bit, and looked at me over the top of it and let me talk. When I’d finished he just said, 19 Interview with Bruce Aylward, 24 March 2009.
'Never leave your enemies alive on the battlefield,' and then went on reading.

So I sat there and I thought, 'OK, so I guess I'm dismissed,' so I left. But then, you know, the CDC man was gone within a few weeks—it was over, he was gone. And I remember thinking, 'Does he do that with everyone? Or did I just get a rare glimpse into the real JW?' And years later I realized that was the real JW. That was the way he operated, in terms of ruthlessness—once he made a decision that that was the right way to go.

Lee's reason for not entering into a discussion with Aylward could have been to avoid undercutting Melgaard's authority. By just listening he could get a useful picture of what was going on without violating the principle of non-interference. In that case the impression of mysterious power behind a façade of immobility would have been a side-effect, though nonetheless useful and perhaps enjoyable. He had already been in the habit of sitting with his feet up on his desk when he was a medical officer in Fiji, as one of the secretaries remembered, and in those days he might have done it out of a feeling of relief after his physically demanding job as accidents and emergencies clinician which had kept him constantly on his feet.

Such reminiscences raise the question of what kind of leader Lee was, or on what basis he got himself into top positions. Aylward saw it like this:

Sometimes people are put in positions of power because it suits all the other players to have that person there, but JW was one of those incredibly rare people who seemed to have clawed his way there and fought his way into that, despite not being technically a master, not being known as a good manager, not being a recognized leader, not being a particularly charismatic individual—he was not any of those things. You know, the hero-worshippers would say he was but he didn't really manage us well, he was not a natural leader that people would get behind and follow into the jaws of death—no he was not—maybe because he wouldn't go into the jaws of death himself and everybody knew that, and never did he seem to apply himself to the details of any particular programme. But all of that is not to diminish the man but actually to demonstrate what a phenomenal person he
was because despite all of that he had this self-confidence that ‘I am the right person to do these jobs.’

On the other hand, it is worth noticing, Lee actually did go ‘into the jaws of death’, at least in the sense of exposing himself to dangers he could have avoided, for which he did pay the ultimate price.

Dubbed ‘Vaccine Czar’ by Scientific American, to his glee, Lee grasped some imaginative opportunities with good effect. He helped to get the Swiss tennis star Martina Hingis appointed as WHO’s Goodwill Ambassador for the immunisation programme in 1997—‘When young people like Martina show concern for the health of children in other parts of the world, it puts fresh energy into our work,’ he was quoted as saying at the time.\(^\text{20}\) He is also remembered for the launch, during this period, of a new publication, The State of the World’s Vaccines. Several of his advisers, including Melgaard, were opposed to this idea as it seemed merely to mimic UNICEF’s famous State of the World’s Children, but Lee was tenacious about it and it proved to be an effective way of making the programme better known and supported. Rather than competing with UNICEF, it made common cause with the more glamourised organisation and was thereby able to benefit from some of its visibility.

Nineteen ninety-eight was the year in which WHO was due to elect a new director-general. Although in the old days a director-general could go on indefinitely getting re-elected, a new rule had been introduced to prevent anyone from holding the job for more than two five-year terms. Nakajima was not bound by this rule but he did not have enough support to be re-elected, and Lee thought he himself might be the best person to replace him. He succeeded in getting some initial support from his own country and key executive board members, but when it became clear that Gro Harlem Brundtland was the front-runner by a long stretch, he withdrew from the race before he had formally joined it, and encouraged the Korean Government to support her instead.

When she was duly elected with a strong mandate for sweeping reforms, she appointed Lee as one of her senior policy advisers. It was a backhanded reward for his support, since although it appeared to honour him by placing him nearer the top of the hierarchy, it gave him little real authority and left him with no budget or staff of his own. Through his good offices, his position as vaccines chief was passed on to Melgaard. In line with the new administration’s policy of signalling change, the programme was renamed more modestly as ‘Immunization, Vaccines and Biologicals’. This was also designed to accommodate discussions then under way with the World Bank and others on setting up a new global multi-agency partnership on vaccines, eventually christened the Global Alliance on Vaccines and Immunization.
(GAVI). As the initiative could have been seen as a criticism of the existing programmes he had been heading, Lee would have been expected to oppose this innovation, so he was excluded from the discussions leading up to it.

Instead, he was asked to oversee the comprehensive overhaul of WHO’s information and communication system. By delegating that task to a consultant, he completed it within a year, and was then given a prestigious but ill-defined position in the external relations department. Since he was without pressing tangible obligations during the first two years of Brundtland’s hectic new regime, little of interest to report from these years in Lee’s life has come to light so far. His career might well have petered out at that point, in which case he would have played only an inconspicuous role in health history. In 2000, however, he was put in charge of a global effort to stop the spread of tuberculosis. As this disease exemplifies the unpredictable nature of medical progress, it is worth pausing here to look at its history. Although biomedical factors are the substance of that history, political ones directly affect its course, and so it provides a vantage point from which we can see how a long history affects and is affected by an individual’s life.¹

Though TB had been known for many centuries, it only came to the fore as a major killer in the crowded living conditions associated with industrialisation in the eighteenth and nineteenth centuries. It was thought to be responsible for one in four premature deaths in London in 1815, while autopsies in Paris hospitals attributed 40 per cent of deaths to it.² Called consumption because it seemed to kill its victims by consuming their flesh, and phthisis because that is the Greek word for wasting away, it was associated with fear intensified by the symptom of coughing up blood. The currently used name refers to the swellings or tubercles on the lungs associated with this disease.

¹ For the following account I am much indebted to the advice of Mario Raviglione, current director of the Stop TB Programme.

Robert Koch isolated the tuberculosis bacillus (a bacterium) in 1882 in Germany, but that did not settle the arguments about how to prevent or treat the infection.

It was not until 1906, in France, that a medical defence came into view, when Calmette and Guérin developed a non-virulent bovine strain of the bacillus that could be cultivated and used as a vaccine. This means of immunisation, still called BCG after them, came into widespread use in the 1920s, and was found in some circumstances to reduce tuberculosis incidence by 80 per cent by providing protection against the disease for up to ten years. Although BCG is thought to be the most widely used vaccine in history, it is not effective in all settings, and has had no verifiable impact on the incidence of tuberculosis in adults.

Tuberculosis thus remained a dreaded common lethal disease in Europe and elsewhere, and a cure for it was not discovered until 1943, in the United States. This was streptomycin, isolated from soil organisms by Albert Schatz, for which his supervisor at Rutgers University, Selman Waksman, received a Nobel Prize in 1952. The power of this antibiotic to kill tubercle bacilli led quickly to the belief that tuberculosis was a controllable or even eradicable disease. Effective treatment became widespread in industrialised countries after the Second World War.

In Paris in 1947, at WHO’s first meeting of experts on tuberculosis control, the strategy agreed on was prevention by vaccination with BCG and control by case management, mainly with streptomycin. It was during the 1950s that it became apparent that the effectiveness of BCG for preventing TB varied from zero in some developing countries to 70 per cent in some industrialised ones. For infants up to four years of age, however, it is still found to provide protection, and is recommended as soon as possible after birth in countries where TB is endemic. Meanwhile, two new effective TB drugs were discovered—isoniazid and pyrazinamide, so the realisation that TB was less preventable than expected was offset by a sense that it was more curable. Case management became the mainstay of WHO’s programme, and a steady decline in TB was noted up till
the late 1980s in most industrialised countries. This, however, did not happen in developing countries, where the drugs were unaffordable to the majority of those who needed them, there was insufficient health infrastructure for reliable diagnosis and treatment, and socioeconomic conditions continued to favour transmission and reactivation of the disease.

Even where the right medicine was available in developing countries, it commonly failed to achieve a cure because patients without adequate support from public health doctors did not persist in taking the full course of treatment. In search of solutions, Karel Styblo, a Czech physician working with the International Union against Tuberculosis, conducted important pilot projects in the late 1970s in Tanzania, Mozambique and Malawi. Styblo had suffered from tuberculosis in a Nazi concentration camp, and dedicated the rest of his life to controlling it. He died in 1998 at the age of 76. In Africa, by ensuring the regular supply of drugs, the administration of a multidrug regimen and the supervision of drug intake, he raised the cure rate from 43 per cent to 80 per cent, demonstrating that effective care was possible even in the poorest settings. By that time, a fourth drug, rifampicin, had been added to the means of treatment. However, Styblo’s systematic approach was not immediately taken up by WHO. The organisation was concentrating on the global campaign to eradicate smallpox, followed by primary health care and immunisation campaigns against several childhood diseases in the late 1970s and early 1980s.

In the 1980s, TB control was not a WHO priority, but the appearance of AIDS in the same decade not only jolted optimism for disease control in general but led to a steep rise in TB incidence, especially in Africa. With immunity destroyed by the new disease, the transmission of the old one increased. Multidrug-resistant tuberculosis spread rapidly, reaching very high levels in the 1990s, frequently making treatment ineffective. By 1990 an estimated 8 million new cases of TB were occurring globally each

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year, causing 3 million deaths. Having twice seemed defeated, first by prevention, then by cure, TB had rebounded, stronger than ever, as a leading threat to public health.

In 1991, the World Health Assembly at last responded by adopting a resolution to achieve an 85 per cent cure rate and a 70 per cent case detection rate worldwide by the year 2000. WHO reconstituted its tuberculosis programme and designed a new strategy. The strategy became known as DOTS, which stood for ‘directly observed treatment, short course’ and consisted of five components derived from the work of Styblo and others: (i) government commitment; (ii) diagnosis by sputum microscopy; (iii) standard short-course therapy under proper case management conditions and directly observed; (iv) a reliable drug supply system; and (v) a reporting and recording system to monitor progress. The strategy was achievable but it called for more money and political support than it obtained.

In 1993, WHO stated that the TB pandemic was a global health emergency, and in the same year a World Bank report entitled *Investing in Health* stated that providing TB chemotherapy was one of the most cost-effective health interventions in the world.

Awareness still spread slowly, however, and the belief persisted in wealthier countries that modern medicine had pretty well put paid to tuberculosis. The *Oxford Medical Companion* asserted comfortably in 1994 for this disease that ‘both its terrors and its prevalence have been vastly reduced by the discovery and application of tuberculostatic chemotherapy.’ Even in 1998, a London TB sufferer was told by a series of doctors that her complaint of coughing and chest pains was caused either by hypochondria, ‘too much stomach acid’, or asthma. She was prescribed steroids and sedatives, and was not correctly diagnosed until 2002, shortly before one of her lungs collapsed. She was subsequently cured and, looking back on the experience at the age of 29, said, ‘I missed out on three years of my life, three important years... I had all the classic symptoms. I was coughing

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up blood, sweating. I was so skinny, I had bedsores. But no! I’m a “silly girl.” I look back now and I’m not bitter—I was just dealing with a bunch of idiots.” An evident side-effect of the failure to control this disease is loss of respect for the medical profession.

During the 1990s, outbreaks of TB in American and European cities and Russian prisons made the need for strong control measures inescapably clear. WHO and the partner agencies involved recognised this but had difficulty in agreeing on strategy and a modus operandi. Cases continued to be undetected and untreated, on a scale beyond the capacity of national health services and international programmes to handle on their own, despite the fact that the means of control were widely known. The very strength of those means contributed to a false sense of security which slowed down organisation efforts and diverted the flow of funds towards needs considered to be more pressing. It was not until March 1998 that a realistic plan was formulated, by a WHO ad hoc committee that met in London. The plan, which became known as the London Declaration, focused on combining the efforts of non-governmental organisations, business, governments and donors. It called for the establishment of a coalition of partners, and of a drug facility to solve the problem of stock-outs that had been occurring in many settings.6

As part of the restructuring of WHO undertaken by Brundtland, WHO’s Global TB Programme was dismantled to accommodate the ‘horizontal’ managerial structures she had chosen.7 The TB experts either left WHO to continue in their own specialism or joined other teams to apply their skills to other problems. The idea was to replace the WHO programme with a multi-agency Stop TB Initiative, designed to establish,
expand and nurture a new international partnership of agencies, institutions, organisations and groups involved in tuberculosis control. The partners included international organisations such as WHO, the World Bank and UNICEF; representatives from high-burden countries; representatives from each of WHO’s six regions; financial donors; and technical agencies such as the International Union Against Tuberculosis and Lung Disease (IUATLD), the Dutch Tuberculosis Foundation (KNCV) and the US Centers for Disease Control and Prevention.

The initial mandate of the Stop TB Initiative was to implement the London Declaration. When Brundtland took over in 1998, she had asked all the existing directors to support her reform effort by agreeing to vacate their posts in case she wanted to replace them. Arata Kochi, who had been the director of the old WHO Global Tuberculosis Programme, was retained to coordinate a general disease programme, and then switched to the new Initiative. Like the Children’s Vaccine Initiative, Stop TB got off to a slow start, with a long-drawn-out transition period of uncertainties and disagreements. It became increasingly clear to the partners that a break with past ways of doing things was needed if they were going to get anywhere.

A ministerial conference on tuberculosis was held in Amsterdam in March 2000, which called for the formation of national and international coalitions to expand the use of DOTS, meet the targets of 70 per cent detection and 85 per cent cure rates by 2005, and fund an annual budget of US $1.2 billion. This is where the history of tuberculosis brings us back to the life of Lee Jong-wook. In December of that year, to bring about the necessary changes, Brundtland asked him to replace Kochi as leader of the programme, reasserting the leadership role of WHO in the coalition, and pledging her full support for it. Lee

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8 Raviglione and Pio, “Evolution of WHO Policies for Tuberculosis Control”, 779
was delighted to take up his new duties, which he considered to be a real job, after two years in a senior position but without much to do. The new position called for the kind of political, technical, psychological and managerial skills with which he felt particularly well-endowed. It also gave him the full support of a strong director-general. Considering that they had viewed each other as rivals only two years previously, this in itself was an impressive achievement on his part, and perhaps on hers as well.

Ian Smith, an English doctor who had joined WHO in Geneva after working on TB control with a non-governmental organisation in Nepal, had clear memories of the time when Lee took over from Kochi, which strikingly resembles his unexpected appearance at the helm of the vaccine programmes. There had been difficult discussions among the Stop TB partners, particularly over whether the secretariat of the TB drug facility should be housed in WHO or elsewhere, but Smith thought agreement had been reached.

And then quite extraordinarily on the 29th of November—at least extraordinarily to me and to others in Stop TB—we got this email from the DG saying Kochi had been moved to take on HIV/AIDS and JW Lee was to work on TB. But it wasn’t clear what he would be doing. He wasn’t appointed as Director of Stop TB at that stage because it didn’t exist as a department. The rest of that day we all spent in gossip in the corridors and frantic phone calls and lots of meetings with David Heymann and the rest of the TB staff. 10

Then there was a period of a few days where we all had an opportunity to meet with JW. Most of us had never met him before—I’d actually never even heard of him. If I remember correctly, there was quite a lot of concern about him coming to take over TB. I think those who did know him were concerned that this was replacing Kochi who had a tremendously clear understanding of TB and was respected for his technical knowledge of it and his leadership in the area, with JW who was obviously not, had no background in it. There was even I

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10 He was Brundtland’s executive director in charge of WHO’s communicable disease programmes, and had in fact recommended Lee for the Stop TB position.
think, in the corridors, talk of trying to get the decision changed and trying to make it clear that TB folks felt it would be important to have a TB person in charge—and moves to use the partners to try and get that message across to the DG. I don’t think that attempt was actually made, but some concerns were being expressed in that way.

Several of us senior staff had a few meetings with JW and went up to his room on the seventh floor. It was the first time I had been up there. It was a relatively Spartan room as I remember it. At the time we didn’t really know how he worked and looking back on it I can see how strategic he was being. He basically said ‘Right, you tell me what you think should be done,’ and we came up with lots of ideas over the next few days, while he knew full well what he wanted to do and was waiting for us to come to his decision as it were. Which we did, in time.

So the decision was to create a Stop TB department which would include the partnership and we did all sorts of organigram diagrams which we gave JW. That was the first time I saw his ability to get people to do what he wanted but without telling them to do it.11

Jim Kim, co-founder of the Harvard-based nongovernmental organisation, Partners in Health, was at a meeting in Peru on ‘DOTS-Plus’, for managing multidrug-resistant TB, when he first met the new director of WHO’s TB programme, in January 2001. ‘We had heard he was “a vaccine specialist” who had recently been working on a WHO telephone system and that he knew nothing about TB,’ Kim reminisced. ‘We had very low expectations.’12 He and his colleagues were pleasantly surprised, however, as Kim went on to recall.

At that conference he displayed one of his key strengths: the ability to listen intently and grasp both the political and the technical issues in any area of public health. He spent the entire meeting listening quietly to the proceedings with his arms crossed, observing with great intensity people as they spoke. At the end of the meeting we asked him to speak. It was typical JW Lee. He started with a joke about WHO itself. ‘Well, I’ve never been to a WHO meeting that was not

11 Ian Smith, Reflections on JW, sound memoir recorded in March 2009.
called successful at the end, but I would say this DOTS-Plus meeting was a successful-plus meeting.’ He then summarized the meeting in a way that showed he understood the issues and would support our efforts. We were relieved to learn that the new TB Director was extremely sharp and had a wry, self-deprecating sense of humour.13

Unlike many Korean Americans of his generation, Kim, aged 40 at that time, was able to introduce himself and chat with Lee in Korean, using the honorifics due to a distinguished confrère fifteen years older than him. Though distinguished himself as an academic and physician, he let Lee know that he would be ‘honoured to begin a classical Korean student–teacher relationship with him.’ Lee responded well to signals of respect, and found it easy to reciprocate. The two men became good friends, and the following year, when Reiko was looking for volunteer work, Kim with Partners in Health helped to make the initial arrangements for her to join their community-based project for people with TB and HIV, in a shantytown on the outskirts of Lima.

Still in the early stages of Lee’s time as head of Stop TB, a meeting to decide on the governing structure of the partnership was held in Bellagio, the Rockefeller Foundation’s international conference centre overlooking Lake Como in Italy. The agencies represented had strongly divergent opinions and agendas, and large amounts of money were at stake, as well as the future of the partnership itself. There was therefore nervousness on all sides about how the discussions would go. Lee spent time during the days leading up to the meeting sounding out the different partners and reassuring them about his intentions. He chose a neutral chairman who was respected without being domineering, and he himself kept quiet during the discussions. This helped to allay fears that WHO would try to force its own priorities onto the other partners. Surprisingly, the conversations were constructive. In a psychosocial move that was much admired for its wit, when the time came for evening drinks Lee put on a black bow tie and dinner jacket, and acted as barman. It was a way to say that he

13 Kim, Dr Lee Jong-wook.
saw himself and WHO as there to serve, but without sounding
tediously hypocritical about it, and without necessarily making
any substantial concessions. The meeting marked the beginning
of a more effective working relationship between the partners,
attributed to this subtler and more humorous approach.\textsuperscript{14}

Lee enjoyed getting the best out of people, and channelling
their energies into a common goal. Mario Raviglione, a prominent
member of the WHO TB team, remembers his way of working
during that time both for his readiness to lay down the law, and
for the sense of momentum and camaraderie he catalysed. As an
example of laying down the law, Raviglione kept the following
email, dated 11 January 2002, addressed to all the TB staff
with the attention-getting subject-line of ‘Want to be reassigned?’
Lee sent it out after the unexpected announcement by a staff
member that he had accepted the offer of another job. It displays
the care he took to maintain the balance between seeming nice
and seeming tough.

\textbf{Colleagues,}

It is a fact of life that we have to, or wish to, or work to, be reassigned
to other departments, regions, countries or organizations for
personal or official reasons. Periodic reassignment is a good thing for
career development as well as for the organization. Personally, I have
benefited greatly from my work in countries, regions and different
departments in HQ.

\textbf{How to make it happen smoothly?}

As far as I am concerned, involve me from the beginning. Staff
transfer is an issue of the highest importance because it affects all
our work. The team and department need time to think through the
consequences, and come up with measures in a positive sense. I will
be very supportive if you involve me from the beginning.

The other option is of course cook up everything and announce it
to me. Fine. In this case also you will get what you want. But I will be
very disappointed with your behaviour, and this impression will be
shared and passed on to up and down and left and right.

\textsuperscript{14} Reminiscence supplied by Ian Smith, \textit{loc. cit.}, March 2009.
If you are first line supervisors who are consulted by your staff on reassignment, I would also expect you to share it with me soonest.

thanks [sic].

JW

In a bureaucracy, the threat of being tagged with ‘disappointing behaviour’ can cause a good deal of anxiety to the person concerned, however rightly or wrongly, and can undermine confidence. The whole message, though carefully worded, can be read as ‘I will blacklist anyone who tries to leave unless it can be arranged in a way that causes me no inconvenience.’ This would make people feel either trapped in their job or determined to get out of it, neither of which is good for team spirit, though Lee thus attempted to offset the explicit threat with an implicit promise of support and advancement through friendly negotiation. Management by bullying was having bad effects on WHO during that period, and was not a method Lee really favoured, on the whole. A week later, he tried to dispel the bad vibes he had caused and compensate for the threatening tone of his message by apologizing to all concerned for having reacted too harshly.

He could also be irritable in a more impetuous way, however, as in this response to a message about some practical issues that needed his decision. It just reads: ‘thank you. I will never respond to this kind of email,’ with no salutation and no signature. The recipient still does not know what the problem was. When they met a few days later, Lee was constructively friendly about the same issues. In general, flashes of negativity followed by abrupt reconciliation could be explained by his belief, as he put it to a colleague, in the virtue of saying ‘no’ unreasonably at first so as to seem pleasantly reasonable after all when he said ‘yes’ later. This could easily go wrong and is surely not the best way to enhance mutual understanding, but in practice it appears to have often worked well enough.

On the other hand, a high level of camaraderie was also apparent in the messages that went back and forth in the course
of organising TB control activities in different parts of the world. From Peru, Lee wrote, ‘Mario, I found a gorgeous Amazon butterfly framed and sold here in Cuzco. I bought this for you as a souvenir.’ For an impending meeting in Havana: ‘On the social side, I would love to visit old Hemingway hangout and beaches, and beaches [sic]. And meeting too.’ For one meeting in Moscow, tickets for an evening at the Bolshoi Theatre had been bought. ‘This is really well organized. Why is Mikko complaining they have no agenda?’ Raviglione writes. ‘Beats me,’ Lee replies.

There were mutual advantages in coordinating the different inputs needed for a global effort: for Lee it provided a growing base of friends, co-workers and supporters who could like and trust each other; for the partnership he was a means of realising potential and channelling strengths into a common purpose. An independent evaluation of the Global Stop TB Partnership issued in December 2003 by the Institute for Health Sector Development, UK, came to the following conclusion:

The Partnership has scored some major achievements in only three years. It has built and is sustaining a broad network of partners; established a partnership architecture which commands broad support; heightened political commitment and marshalled widespread commitment to a detailed global plan to stop TB; made significant progress against TB, even in difficult environments; highlighted work on new diagnostics, drugs and vaccines which are critical but working to longer timescales; and operationalized in a remarkably short time the Green Light Committee for second-line TB drugs and a complex Global Drug Facility covering grant-making, procurement, and partner mobilization for technical assistance for first-line drugs. This is a formidable record.15

The positive impression was confirmed in 2007 when the Stop TB Secretariat reported to the World Health Assembly that after more than a decade of increase the global annual incidence rate of tuberculosis appeared to have stopped and may be declining, despite the rapid rise of multidrug resistance and extensively drug-

resistant strains of the disease. In 2005, there were an estimated 8.8 million cases of TB and 1.6 million deaths. Treatment success stood at 84 per cent as compared to the targeted 85 per cent, and case detection was 60 per cent as against the targeted 70 per cent, but the figures indicated that the programme, thanks to the efforts of partners and national governments involved, was getting results.\(^{16}\)

A key to these successes was the Global Drug Facility set up by the Stop TB partners in early 2001 to increase access to TB drugs and help expand the DOTS programme. Lee made good use of his experience and networks in the Global Programme on Vaccines to set up this facility. It consisted of businesses for drug production, quality control, procurement and distribution; funding sources such as the World Bank and donor organisations; and technical agencies such as WHO and the associations working against TB. These three elements were brought together by a team in the Stop TB Partnership secretariat, which was led by Jacob Kumaresan, an experienced doctor from South India, and managed by Ian Smith. An evaluation made by McKinsey & Co in April 2003 found that the facility had improved the quality and availability of drugs in 16 countries, and strengthened the work of the partnership. It needed grants amounting to at least US $20 million a year, however, and was US $7 million to $9 million short for that year. By that time, however, Lee had already moved on to his next assignment, which turned out to be his last.

PART III

2003–2006
DIRECTOR-GENERAL
'Head of WHO to stand down’ was a headline in the BMJ of 31 August 2002, with a picture of Gro Brundtland looking her formidable best but saying she would not seek a second term as director-general. She explained that she would be 69 by the end of a second term, and ’I don’t want to get into a situation in my life where I am not fully energetic and able to do my job.’ If she had wanted to stay on she could probably have done so on the grounds of needing to follow through on the reforms she had started and being a safer bet than some novice. Lee joked privately that until she made that announcement he had empathised with Macbeth, but as soon as she had made it he started empathising with Hamlet. He probably meant that he would have to act decisively if he was to have a chance of being elected to replace her, but, like Hamlet, he was intelligent enough to see the dangers involved. A failed attempt would probably end his career but a successful one would place him among pressures, responsibilities and publicity he had not yet known.

Eight candidates applied for the position and launched their campaigns for the support of the 32 executive board members. They were, in alphabetical order: Awa Marie Coll-Seck, health minister of Senegal; Julio Frenk, health minister of Mexico and a former right-hand man of Brundtland at WHO; Karam Karam, former health minister of Lebanon; Lee Jong-wook;  

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2 Lee JW, personal communication.
Pascoal Manuel Mocumbi, Prime Minister of Mozambique and former minister of health; Peter Piot, head of UNAIDS (the Joint United Nations programme on HIV/AIDS); Ismail Sallam, former minister of health of Egypt; and Joseph Williams, former prime minister of Cook Islands.³

Although Lee was not an obvious frontrunner, all of the other candidates fell by the wayside except himself and Peter Piot. When the votes were cast by the board members they both got 16 each repeatedly until eventually one of Piot’s supporters went over to Lee, giving him 17 votes and Piot 15.⁴ A press photo of Lee’s tired but delighted face when the result was announced became one of the most frequently used pictures of him during his time in office.

In his speech to the executive board about why they should choose him for director-general, Lee had promised a major attack on HIV/AIDS, a shift of resources from headquarters to the regions, more efficiency and accountability, and a working atmosphere that would make WHO ‘an even better place for people to work’. The commitment to shift resources was made in specific terms: ‘In the 2004 and 2005 budget, 36 per cent of the total [resources] are allocated to HQ. I will shift this HQ proportion to 25 per cent by 2005 and 20 per cent by 2008.’⁵

At the World Health Assembly on 21 May 2003, where he was duly elected and appointed, he reiterated those pledges, and specified another measurable target: 3 million people living with HIV/AIDS would be on treatment by 2005, which was known thereafter as the ‘3 by 5’ campaign. On that ceremonial occasion in May, with the drama of a change in regime in addition to the not yet known outcome of the SARS pandemic, there was a rare sense

⁴ That much of the procedure is well known by many people, but as the ballot takes place in a closed session there is no official record of it, to my knowledge.
of excitement in the air. Lee intensified that feeling by paying tribute to Carlo Urbani, who had died of Severe Acute Respiratory Syndrome (SARS) while attempting to stop its spread:

Shortly before Dr Urbani became ill, his wife worried about the danger in which he was putting himself. Dr Urbani replied: ‘If I cannot work in such situations, what am I here for—answering emails and pushing paper?’

Carlo Urbani has given us WHO at its best—not pushing paper but pushing back the assault of poverty and disease.

Today we are honoured to have Giuliana Chiorrini, Dr Urbani’s wife, present with us. I ask her and her family to accept the expression of our condolences and our profound gratitude for his work and life.6

Not everyone who takes up public health work does so with the idea of giving their life to save others from death, but in the circumstances it was easy for the whole spectrum of health officials present to applaud it. Would any of us have done the same? Most of us were unlikely to have the chance to find out, even if we wanted to, and in the meantime it was somehow encouraging to feel that some of us might. There was an emotional standing ovation for the colleague who had done so, and it implied respect and approval for the one who had drawn attention to it and would now be the face of the organisation. Exactly three years later, that word, ‘condolence’, would be one of those most frequently used at the Health Assembly.

Making the Transition

Now, however, Lee had the opportunity—and obligation—to turn inspiring ideas into reality. The McKinsey consulting firm was just completing its evaluation of the Global Drug Facility, and the Gates Foundation had provided a grant for the transition which enabled him to keep them on as facilitators. According to Ian Smith, Lee’s opinion of consulting firms was that ‘you pay them a lot of money to tell you what you already know,’ but he was

probably able to see that even that could be a valuable service; by marshalling the available expertise to produce the best possible agenda, the consultation could add value and credibility to the new administration. This would help to reassure WHO’s donors that they were getting value for money, and its staff members that they should do their best.

Lee asked Ian Smith and Jim Kim to coordinate the transition team. In addition to Smith, Kim, and the McKinsey consultants, the team included Michel Jancloes, a Belgian former WHO representative in Ethiopia; Tokuo Yoshida, a Japanese coordinator in WHO’s Drug Safety programme, both of whom were long-standing WHO colleagues; Sylvie Schaller, Lee’s French administrative assistant in Stop TB; and others on a part-time or ad hoc basis. To prepare the new regime, Lee started interviewing each of the directors at headquarters. One of these was the New Zealander, Ruth Bonita, who was working on monitoring noncommunicable diseases. She and her husband Robert Beaglehole had recently published Public Health at the Crossroads,7 setting out what they saw as the main choices facing health systems globally. Learning from her about her husband’s work, Lee asked to see him as well, and after a short interview told Ian Smith to add him to the transition team. With his expertise on international health issues, as well as his relaxed way of demanding excellence from his colleagues, Beaglehole added a sense of reliable wisdom to the activities. ‘It was extraordinary. JW’s capacity to quickly assess people and identify great people was just phenomenal. I think that was one of his greatest attributes,’ Smith commented later.8

With the directors Lee already knew, the interviews consisted of catching up on recent developments, not necessarily about their work. With those he knew only slightly or not at all, he used the opportunity to find out about their programmes and their

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8 Ian Smith, sound archive made during December 2008 and January 2009.
ambitions for them, often with optimism and enthusiasm on both sides. Not all of the interviews were so encouraging, however; sometimes there did not seem to be much sense of direction, or of ability to get the desired results. ‘He was very good at seeing how well people knew their area of work and how well they managed their department,’ Smith said, having participated in many of the interviews. A flurry of assignment changes occurs when a new term of office starts, and these conversations provided part of the rationale for them.

One of the changes that became necessary regardless of strategy was caused by the sudden death of Maryan Baquerot, who had been appointed by Brundtland as executive director for general management in May 2001. Previously he had served as the head of administration for the United Nations Mission in Kosovo, and chief of personnel in UNICEF. He died on 13 May 2003 from complications following knee surgery. He had been preparing WHO’s programme budget for 2004–05 to present to the Health Assembly. Lee needed to make sure that it was as compatible as possible with his own intentions for those years, so there was much discussion between Baquerot and the transition team, some of it by telephone from the hospital where he was working on the budget immediately after his operation. In the days that followed, an infection developed in the knee, which led to septicemia and septic shock, from which he died.

It was both a tragic event and an inauspicious start to the process of reorganising WHO’s budget to bring about decentralisation. Tokuo Yoshida, with the support of number crunchers and facilitators in the McKinsey team, was assigned to come up with a way to achieve the rapid reduction of spending at headquarters to 25 per cent of the total. They found that the shift would entail a staff reduction at headquarters by 33 per cent, and recommended criteria for reducing areas of work there accordingly. The criteria included impact of the activity, its duplication of efforts in other sectors such as academia, and the availability of expertise in the regions. Recommendations for streamlining headquarters administration activities to achieve these reductions included
outsourcing information technology and translation, moving the global accounts department to India, making efficiency savings, introducing an open plan office structure for better information sharing, making all new resolutions contingent on budget clearance, and increasing the authority entrusted to WHO representatives in countries. In Yoshida’s view, all this was possible and necessary if Lee was to make good on his commitment, which, unlike the ‘3 by 5’ pledge, did not depend on other agencies and so was easier to ensure. However, for a ‘softer landing’, he suggested spreading it over four years instead of two, in view of the difficulties some of the necessary measures would cause. Not least of these would be the instinctive resistance of staff members to anything that smacked of downsizing.

His recommendations were received with some discomfort by the transition team, and all those present looked relieved when Jim Kim suggested that instead of making big cuts at headquarters they should achieve the 25:75 proportion by making big increases in the regions in voluntary contributions from national and international bodies, such as those expected for the ‘3 by 5’ campaign. Lee was the only one in a position to decide between these approaches or call for a combination of them, but remained silent. Ian Smith’s view was that although the commitment had been made, it turned out on closer scrutiny to be impossible. Denis Aitken, while he was chief of cabinet for Brundtland, had said, ‘It is a fallacy to argue that because someone is working here [at headquarters] it isn’t benefiting countries.’ If that had been the main issue it would have been possible to change the proportion just by changing the accounting system to show more clearly which countries benefited from which programmes, without making any actual difference in the allocations and

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9 Tokuo Yoshida, Decentralization, Phase II Objectives, PowerPoint display, 7 July 2003.
11 Smith, sound archive.
distribution of activities. Lee did want a real slimming down at headquarters, though, and often said so informally, so was not interested in creative book-keeping as a way to seem to keep his promise, even if he could have got away with it. On the other hand, of course he did not want the pain which slimming down would cause.

After Lee had been elected and sworn in at the Health Assembly in May, the transition team rented twelve offices and two meeting rooms from the World Council of Churches, whose building was a five-minute walk from WHO. That summer was unusually hot, and there was no air conditioning in that building, so all the doors, as well as the windows, were kept permanently open. Information sharing was also enhanced by starting each day with a short meeting of everyone working there, each of whom had to say in a few words what they had done the previous day and what they were going to do on that day. No one was allowed to sit down and if the meeting went on for more than 15 minutes they all had to stand on one leg. The meetings included some physical fitness exercises led by a different person each day, and each working group was given a pedometer to encourage ‘management by walking around’, and they competed to see who could clock up the most miles. A member of the McKinsey team was caught sitting at his desk shaking the pedometer, but this was taken as part of the fun.

‘I think for all of us who were working there it was the most enjoyable, exciting and fulfilling period of our working lives,’ Ian Smith said.  

Tokuo Yoshida, on the other hand, wrote, ‘The transition period of JW reminds me of the painful brain exercise in the unbearable heat at Geneva in 2003, in vain.’

More exciting and less perplexing than financial planning was the need to appoint the incoming senior management team by July 21. A symbolic change Lee made soon after his election was to reinstate the job title of ‘Assistant Director-General (ADG)’.

13 Smith, sound archive.
It had been in use for the heads of clusters of departments for a long time in WHO, as in other UN agencies, until Brundtland had changed it in 1998 to ‘Executive Director (EXD)’. Her choice of title signalled a more businesslike approach, but it underemphasised the diplomatic and service-oriented aspects of managing WHO, which, for many, was better expressed by the traditional term.

Appointing the right ADGs of a new administration was a director-general’s best chance of getting off to a good start, and it had to be done during the two months between being elected by the Health Assembly in May and taking office in July. In some previous administrations the team of ADGs was called the ‘Cabinet’, and they do function to some extent analogously to that body in a national government.

To replace Maryan Baquerot, Lee approached Anders Nordström, the 43-year-old Swedish physician who had headed the interim secretariat of the Global Fund to Fight AIDS, TB and Malaria until Richard Feachem became its founding executive director in 2002. Nordström had earned a reputation for reliability and, equally importantly, had not worked previously with Lee. ‘He wanted to make it absolutely clear that the person he put in charge of the Organization’s resources had no personal links to him, was acceptable to the major donors, and had a reputation for being perfectly honest and straight,’ Ian Smith explained.\footnote{Smith, sound archive.} The other appointment agreed on before the Health Assembly in May was that of Vladimir Lepakhin as ADG for Health Technology and Pharmaceuticals. Lepakhin was a former deputy health minister of the Soviet Union and the Russian Federation. He had been an ADG briefly in 1998 before the Brundtland administration, and then became a fellow adviser with Lee, during which time they had got to know each other well.

Although Lee made it clear that those who had been executive directors in the previous administration should not expect to keep their jobs, he did not talk to them directly about it, preferring to keep his options open. This led to a good deal of anxiety for some of them, with fruitless attempts to find out what was in
store for them or to arrange a meeting with Lee through the transition team. 'It was the one time I would have wanted to do it differently and been quite clear and said, “I’ll meet with you and I’m going to tell you to move on,”' Ian Smith said, ‘but he didn’t. To my knowledge he didn’t meet with any of them. He just left it hanging. I suppose he was hoping some of them would do the noble thing and move on. Very few of them did choose to do the noble thing.'

One who did remain in place was Denis Aitken, whom Lee asked to continue in the role he had before, changing only the title of it, from chef de cabinet to director of the Director-General’s Office. Aitken, a Scot who had been a British civil servant before joining the International Maritime Organization, had originally been recruited from there to WHO as ADG for general management by Hiroshi Nakajima. Both by talent and experience, Aitken was probably better placed than anyone else to ensure that the organisation continued to run smoothly during the changes that were planned.

Anarfi Asamoa-Baah, from Ghana, was also retained as an ADG. He had been executive director for Health Technology and Pharmaceuticals under Brundtland, and Lee asked him to take over from David Heymann as ADG for Communicable Diseases. Heymann, who before joining WHO had worked for the US Centers for Disease Control and Prevention, had been at the forefront of controlling the SARS pandemic, and Lee asked him now to be his special representative for Polio Eradication. This gave Heymann what seemed like a job that was both relatively easy and of short duration, as polio eradication was thought at that time to be on the brink of completion. David Nabarro, a mercurial Englishman who had headed Brundtland’s Roll Back Malaria initiative and then the cluster on Sustainable Development and Healthy Environments, was put in charge of the Health Action in Crises department. The only other new ADG who had already been working for WHO was Kazem Behbehani, from Kuwait, a long-standing colleague of Lee’s, who was moved

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16 Smith, sound archive.
from Eastern Mediterranean Liaison to head External Relations and Governing Bodies.

The remaining five new ADGs, recruited from outside through a process of consultation and interviews, were as follows: Jack Chow (USA), formerly ambassador and deputy assistant secretary for health and science in the US State Department, to head the new HIV/AIDS, TB and Malaria cluster; Tim Evans (Canada), formerly director of Health Equity at the Rockefeller Foundation in New York, to head the Evidence and Information for Policy cluster; Catherine Le Galès Camus (France), formerly scientific adviser to the Director-General of Health, France, to head the Noncommunicable Diseases and Mental Health cluster; Kerstin Leitner (Germany), formerly UN resident coordinator and UNDP resident representative in China, to head the Sustainable Development and Healthy Environments cluster; and Joy Phumaphi (Botswana), formerly minister of health of Botswana, to head the Family and Community Health cluster.¹⁷

The thoroughly new team was introduced to a meeting of the staff at headquarters on 22 July 2003, Lee’s first day in office. Nine new directors were announced at that time as well, two of whom (Margaret Chan and Paulo Teixeira) were also from outside WHO. The assembling of nine new assistant directors-general plus nine new directors made it clear that major change must be imminent, but also that criticism of top-heaviness in the organization was likely to continue.

SARS and Avian Influenza

It was during the transition period that the worldwide epidemic of severe acute respiratory syndrome (SARS) broke out and was brought under control. The spread of the epidemic was traced to a medical doctor from Guangdong province in China who spent the night of February 21 in room 911 of the Metropole Hotel in Hong Kong. He was thought to have spread SARS to at least

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16 other travellers who then went on to Singapore, Toronto and Hanoi, as well as other parts of Hong Kong. During the next four months, 4000 cases and 550 deaths in 30 countries were traced back to that one visit.\textsuperscript{18}

The first WHO official to detect the new disease was Carlo Urbani, who was examining patients in Vietnam. He caused surveillance to be heightened and new cases to be identified and isolated before they infected hospital staff. Before joining WHO Urbani had been the president of Italy’s branch of Médecins Sans Frontières and was a member of the delegation that went to Oslo to receive the Nobel Peace Prize awarded to MSF in 1999.\textsuperscript{19} WHO issued a global alert on 12 March, after 55 cases of the disease had been identified. On 15 March it issued a second alert, naming the disease for the first time, and adding an emergency advisory notice for travellers and airlines. On 29 March, Carlo Urbani died of SARS in a hospital in Bangkok, at the age of 46. The outbreak reached its peak that May, when 200 new cases a day were being reported.

Just before the Health Assembly, Lee visited Beijing to assure the Chinese authorities of his support as the incoming director-general of WHO. He took with him a copy of Albert Camus’s \textit{The Plague} to read on the plane, in French. This was partly to improve his French but also to maintain a measure of detachment and be seen to be viewing the epidemic in a historical and moral perspective. Camus’s story of a doctor continuing to do his work in spite of danger and a strong sense of futility contained obvious messages for WHO and its member states.

Lee’s main helper in the Chinese Government was Liu Peilong, director-general of the department of international cooperation in the ministry of health, who afterwards joined Lee as a policy adviser in Geneva. On arrival in Beijing, Lee found that he had forgotten his suit jacket, but luckily he was about the same size


Lee Jong-wook

as Liu, who lent him a suit for his meetings. Lee had a knack of using mishaps of this kind to promote a relaxed, collegial way of working.

Expectation was growing at that time of an avian influenza epidemic that could spread as quickly as SARS. A highly pathogenic strain (H7N7) had claimed the life of a Dutch veterinarian on 17 April 2003 and resulted in the slaughter of more than 23 million chickens and other fowl in the Netherlands and Belgium. Since its discovery at six poultry farms in central Holland in February, the virus had also caused eye infections and influenza-like symptoms in more than 80 people, most of them workers involved in the culling operations. The culling of flocks in the Netherlands and Belgium dwarfed the well-publicised slaughter of all chickens—some 1.4 million birds—in Hong Kong in 1997 following an outbreak of avian influenza A(H5N1) that killed six people.20

The response to the Hong Kong outbreak had been managed by Margaret Chan, who since 1994 had been the Director of Public Health in Hong Kong, the first woman to occupy that position. Her decision to proceed with the cull of poultry in spite of strong political opposition to it was followed by an abrupt end to the outbreak. An experienced leader in two health emergencies, she was well acquainted with the region that was likely to play a central role in any future outbreak.

Taking Office

Five years to the day after Gro Harlem Brundtland had announced her programme of radical reform for WHO, Lee Jong-wook addressed the staff of WHO to unveil his own plans, as the sixth director-general. It was also twenty years, ‘almost to the day’, as he began by saying, since he had joined WHO. In that career perspective, the contrast between him and his predecessor was striking. She had become the first woman prime minister of Norway at the age of 42 and remained in the post for 15 years,

moving to WHO two years after that, famous both as a head of state and as chair of the World Commission on Environment and Development, known as the Brundtland Commission, which had pioneered the notion, now a household phrase, of ‘sustainable development’. Lee at the age of 42 had been a modestly placed WHO official in Manila, far away from any conspicuous position of national or international power. Even in his most senior previous position, as head of the TB partnership, he had been a comparatively unknown quantity. In addition, he was a WHO insider whereas she had been an outsider; his style was subtle, urbane and well attuned to eastern and western sensitivities alike, whereas hers was direct, forceful, and solidly western.

The executive board meeting room at WHO headquarters was the same, however, and as crowded with staff members and journalists on this occasion as it had been five years previously, many of them the same people. In 1998, Brundtland had been welcomed with a mixture of jubilation and apprehension as the bringer of much-wanted radical change, and now he too was welcomed warmly, if not quite so rapturously, as a bringer of much-wanted continuity. He had two kinds of continuity to offer: to maintain the prestige which Brundtland had won back for the Organization, and to build on the longer tradition of steady service in meeting health needs in countries.

Before introducing the new team, he outlined his aims as ‘doing the right things in the right places in the right way’, a formula whose tone of innocent good intentions found favour with his audience and was often repeated subsequently. The most prominent ‘right thing’ on his agenda, and the one he outlined most specifically, was ‘providing three million people in developing countries with antiretroviral therapy by the end of 2005’. The campaign was expected to give a sense of exciting swiftness and energy to the new administration, recover credibility lost with the moving of the HIV/AIDS programme out of WHO to a new multi-agency entity in 1996, and take advantage of the serious money at last being channelled into treatment and prevention of this disease. The dependence of Lee’s campaign on other
Lee Jong-wook

agencies—especially the Global Fund and UNAIDS—also went well with his profile as a successful leader of large partnerships.

The other ‘right things’ to do he named were the health-related Millennium Development Goals, which included controlling tuberculosis and malaria and improving maternal and child health; noncommunicable disease control; completing the eradication of polio, and building defences against the next global pandemic. The right places meant in countries more than at headquarters, with a corresponding shift in resources. The right ways meant better use of talent through staff mobility and rotation, better management and use of information technology, more rigorous auditing, the appointment of a technical ombudsman, and the introduction of open plan offices, starting with his own.

All of this combined to produce an atmosphere of fresh air and high expectations. Just as Brundtland had before him with her team, he then introduced his nine new assistant directors-general. By inviting Joy Phumaphi to speak for all of them, Lee achieved an additional sense of solemn solidarity in a good cause. By the time he had announced the other director-level appointments as well, and closed the meeting on a note of ‘humility and determination’, it really did seem that a bright future lay ahead.

Historical Perspective

The year 2003, in addition to marking the start of a new five-year period in the life of WHO, was the 25th anniversary of the Alma-Ata Declaration. Celebrations were held to mark the occasion in many parts of the world, including Alma-Ata itself, now Almaty. The Declaration made in 1978, agreed by the representatives of the 134 countries and 67 health-related organisations attending the conference in Alma-Ata, called for ‘urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world’. It marked a high point in the life of WHO and of Halfdan Mahler, who had vigorously promoted the concept of health for all through primary health care. Mahler had been strongly supported in this effort by UNICEF’s Director, Henry
Labouisse, who had been the one to receive the Nobel Peace Prize on behalf of UNICEF in 1965. ‘Health for All’ had strong moral authority behind it as a goal that was not only humane but apparently feasible. The three-syllable slogan also provided WHO with a concise and easy to grasp statement of its mission. In 1978, with 22 years in which to achieve it, the participants had felt well able to call convincingly for ‘an acceptable level of health for all the people of the world by the year 2000’.21

The rise of HIV/AIDS and the resurgence of tuberculosis and malaria, together with a widespread decline in health financing, were to follow in the 1980s, so the dominant feeling of power to bring health to all was short-lived. The ideal lived on, however, and Lee was keen to recapture the sense of goodwill and potential that went with it. For the quarter-century anniversary celebration in Geneva he invited his three immediate predecessors, Gro Brundtland, Hiroshi Nakajima, and Halfdan Mahler. The photograph of the four of them side by side is a classic in the history of public health. Representing thirty unbroken years of WHO leadership—potentially forty if Lee were to survive till 2013, as was widely expected—it also displays four entirely different kinds of leadership.

During her five years in office (1998–2003), Brundtland had exercised real power in health politics and displayed it especially by pushing through the Framework Convention on Tobacco Control and stopping the spread of SARS. During his ten years (1988–98), Nakajima had navigated through great upheavals in world politics and health, preferring to work inscrutably and behind the scenes. During his fifteen years (1973–88), Mahler had wielded moral power with eloquence, eradicating smallpox, championing the Health for All movement and standing his ground against the breast-milk substitute manufacturers and the pharmaceutical industry.

The only two missing from the complete set of directors-general were Marcolino Candau who died in 1983, and Brock Chisholm who died in 1971. Candau had held the position for twenty years (1953–73), during which his efforts at malaria eradication failed resoundingly but his management skills enabled WHO to grow into a large and strong organisation. Chisholm, a psychiatrist, had been the Director-General of Medical Services in the Canadian Army during the Second World War, and was well used to handling both hard power and moral authority in setting up the Organization and leading it through its first five years (1948–53). He is credited not only with being the Organization’s main founder but with helping to draft its controversially broad definition of health.

A new element that Lee brought to this series is hinted at in his bemused expression in the group picture: a sense of humour and perspective that he somehow managed to make compatible with the gravity of high office.
The Baghdad Bombing

One of the first tasks of David Nabarro as head of the new department called Health Action in Crises, was to broker support for rebuilding hospitals in Iraq following the American-led invasion in March 2003. A United Nations assistance mission headed by Sergio Vieira de Mello had just been established in Baghdad, housed in the Canal Hotel, a three-storey hotel training school that had been converted into UN offices in the 1980s. On 19 August, Nabarro was in the building when a cement truck packed with 1000 pounds of explosives was crashed into the back wall below the window of Vieira de Mello’s office on the second floor. The detonation caused a large part of the building to collapse, killing 22 people, most of them UN staff, including Vieira de Mello, and Nadia Younes of WHO who had been at a meeting with him in his office at 4.27 p.m. when the explosion occurred.¹

At that moment, Nabarro had been on his way upstairs to see her. He was cut by flying glass but not seriously injured, and managed to climb out of the rubble and help with the immediate rescue work. On his return to Geneva two days later, he talked to the press in some detail about what he had seen. He concluded:

¹ For these and other details of the attack see Samantha Power, Chasing the Flame: Sergio Vieira de Mello and the Fight to Save the World (London: Allen Lane, 2008), 451–516.
The people who do this kind of stuff have no understanding at all of what a man like Sergio, a woman like Nadia, a woman like Fiona Watson, what these people, and their Iraqi colleagues, who have also been so badly hurt, what they stand for, and what they are doing with their lives. It just hasn’t crossed their radar, because their radar is full of a number of other issues, which I don’t want to judge whether they are good or bad, but they just don’t know about absolute goodness. Because if they did, they’d never, ever think of killing these kinds of persons.2

After his state of shock had subsided he might have chosen some expression other than ‘absolute goodness’, but it remains on record to convey a hint of how he and others felt about the event and its significance at that time. In the light of it, it was easier than usual to see how the UN and its specialised agencies, for all their shortcomings, had ways to enlist goodwill that other kinds of organisation did not have.3

In addition to bombing, fears of bioterrorism had been fully aroused by the anthrax letters sent to media and government offices in the US shortly after the September 11 attacks in 2001. Only seven such letters had been sent, infecting 22 people and killing five of them, but the incident heightened awareness of the potential hazards. Brock Chisholm used to refer frequently to botulinus toxin and anthrax as examples of how exposed humanity was to biological weapons,4 but it turned out to be possible in his day to shrug off such concerns and hope for the best. Now fear had made them strongly felt. In addition, in December 2002 George W. Bush, as Commander in Chief of the United States Army had had himself vaccinated against smallpox and launched a campaign to immunise 10 million police

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3 See Power, Chasing the Flame for an exploration of this view.

4 See, for example, Brock Chisholm, “The Urgent Need to Reshape Education”, in Lectures by Brock Chisholm, M.D. (Chapel Hill: University of North Carolina, 1959), 4–9.
and health workers in 2003. This was to pre-empt the danger of enemies using smallpox as a terror weapon in retaliation for the imminent invasion of Iraq.\textsuperscript{5} There was no evidence that anyone in particular would or could do that, but there was none that they would not or could not either, whereas there was a high level of fear, so the usual evidence base criterion for medical decisions was not felt by the prevailing decision-makers to be applicable for the moment.

**Situation Room**

There was also the growing expectation of an avian influenza pandemic. In the global ‘Spanish flu’ outbreak of 1918 and 1919, the H1N1 virus had killed ‘at least 50 million—more than ten times as many as died in the Great War.’\textsuperscript{6} In 1919, a chief medical officer in the United Kingdom said famously, ‘I know of no public health measures which can resist the progress of pandemic influenza.’\textsuperscript{7} For the SARS outbreak of 2003, on the other hand, the public health measures of case isolation, contact tracing, travel restrictions, laboratory analysis, and information sharing had apparently not only resisted but stopped the progress of an influenza-like pandemic. WHO announced on 5 July that all chains of transmission had been broken, and the virus, after infecting 8,456 people in 30 countries and killing 809 of them, was no longer circulating in humans.\textsuperscript{8} The episode had shown that although disease could travel at unprecedented speed, control measures could work against it with unprecedented effectiveness. It had also shown the usefulness of a single multilateral organisation with the capacity to coordinate emergency measures. Such

\textsuperscript{5} Allen, *Vaccine*, 11.


\textsuperscript{7} Honigsbaum, *Living with Enza*, 57.

\textsuperscript{8} Fleck, “How SARS Changed the World in Less Than Six Months”, 625.
an entity was in fact indispensable for responding to health threats involving multiple countries. Individual governments are constituted to put national interests first, and so are not well placed to see the whole picture or take the necessary decisions. Even if they were to make the choices that were best for all countries concerned, they would lack the necessary authority to put them into effect.

National authorities do have situation rooms, however, with the best available technology to keep track of disease outbreaks and other emergencies, and coordinate responses. The need for such a facility had been strongly felt during the SARS outbreak. Lee made it one of his most immediate and tangible objectives when he came into office: to build an emergency management centre in WHO’s Geneva headquarters, preferably close to his own office. The idea took shape on a visit to the US in April, when Tommy Thompson, the US secretary for health and human services at that time, showed him around his department’s state-of-the-art facility in Washington.

Janet Bumpas, a young American consultant with a Harvard MBA and a track record in managing large high technology projects, was hired to get it built. ‘Dr Lee screamed at me to build it. I tried my best,’ she reminisced modestly later.9 The US Centers for Disease Control and Prevention had built their own situation room in a hundred days, and Lee challenged Bumpas to do the same for WHO Geneva. The project went through a series of names, including, in the early stages, the Alert and Response Operations Centre.

A planning document from that time explains: ‘The Alert and Response process is time critical and requires effective real-time communication and decision making within and outside the WHO system. The process depends on a broad range of professional support staff to act in a systematic and coordinated fashion. Information technology is critical to the success of the

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9 Janet Bumpas, email dated 8 July 2008.
A diagram shows the operations centre linked directly to WHO senior management, the regional offices and the country offices on the left and WHO field programmes, logistics, technical coordination, risk assessment, regional networks, dangerous pathogens, and fund raising on the right. A further direct link, shown in the middle of the diagram at the bottom, is with ‘Affected States’. At that level of abstraction it could be seen as something from which everyone would benefit.

For the physical reality, the old cinema room was chosen, a rarely used small auditorium in the basement eight stories down beneath the Director-General’s office and close to the executive board room. A planning document headed *Strategic Health Information Center—Section 1.01 Facility Physical Components* gives an idea of the kinds of tasks to be carried out. To start with:

- Complete demolition of ‘cinema room’ legacy components.
- All walls to be stripped to as bare an extent as possible.
- Existing sewage piping should be moved outside the facility, or raised to a less noticeable location higher in the ceiling. Piping should be covered with noise absorbing material as the existing installation produces a notable ongoing ‘dripping’ sound.
- Cable harnesses for electricity and other services not related to the facility should, when possible, be relocated outside the room.

Other items in the 12-page document include raising the floor, installing balanced lighting for videoconferencing, applying highly acoustical wall and ceiling tiling, structural room changes to include two breakout rooms, converting the upper deck, formerly the projection room, into a secondary conference room with dimmable viewing glass to main facility, hallway remodelling since ‘the approach walk from the elevator column to the facility is rather dreary’, a power room for structural and electrical components, a computer and communications room

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containing all of the indoor communications and IT equipment, a satellite and terrestrial antenna site, air conditioning and air cooling systems falling within required noise levels, computer hardware and software for 20 workstations, servers, local area network cabling, visual display systems for main digital video wall, telephony system, security system, and simultaneous translation facilities.

The budget for the facility was $5 million. As its function of crisis management, information sharing and information dissemination to the press and the public concerned most of WHO’s programmes, a large part of the funds needed came from their budgets. By October 2003, according to a document now calling the project the Director-General’s Situation Room, $3 million had been spent or committed, and the remaining sum of $2 million was requested from the US Department of Health and Human Services (DHH). The largest item in the budget funded by WHO was the construction work, including electrical wiring, at $1.8 million. The largest item the DHH was asked to fund was the server farm and control room at $1.15 million. Tommy Thompson, a strong advocate of the project from the start, came through with the money.

As the magnitude and reality of the project became more widely felt, a more significant-sounding name than Strategic Health Information Centre with its unsatisfactory acronym of SHIC was felt to be needed. Bumpas suggested Global Operating Database which spelt GOD, and that didn’t seem right either, but the ‘operating’ was partially retained. Calling the facility an ‘operations’ centre rather than an ‘information’ centre gave a more accurate sense of what it was for, as well as the suitably dramatic acronym of SHOC, so that was what it eventually came to be called.

After she had moved on to another project, this time with the World Bank, Bumpas looked back on the SHOC experience mainly in terms of team work:

One of the great things about working in teams is to see how diverse people come together. Our team was an eclectic group of folks who...
never worked together before—we had Steve, a young high end Canadian tech programmer and Campiche, an old-school Swiss architect. The two sides would stare at each other and one side would say, ‘tell me your requirements and I will find you a space that fits them,’ and the other side would say, ‘tell me the spaces and I will make the tech fit them.’ I don’t think we accomplished anything really for the first 3–6 months of the project—I go by the old metaphor about team building where every team goes through four stages—forming, norming, storming, performing. We spent a lot of time in the storming phase. At the end Steve and Campiche got along so well that they went rock climbing together on a Saturday. I take that as a vignette for how the team pulled together.11

Less enjoyably, there was some initial scepticism and resistance to the project by WHO staff. The only one entirely keen on it and consistently sure of its importance and possibility was Lee himself. He asked Bumpas eagerly about its progress on most days of the week, using his power to unblock bottlenecks and expedite decision-making. His wholehearted support was very good for effectiveness but not always for relaxed working relations with other staff.

Before being assigned to help set up the situation room, Steven Uggowitzer had been responsible for information technology during the SARS outbreak, travelling from country to country to solve problems of data gathering, analysis and sharing that were causing delays. He remembered the year he spent on the SHOC in glowing terms:

When we built this facility it was the first time ever that anything had gotten built in this organization where people in IT, people in building management, people in the Alert and Response network, people in Health Action in Crises were all talking to one another. We were all working together for something that would be good for the organization. It brought together forces that had rarely had the opportunity to find out about one another’s needs. Ambi Sundaram, the building manager, was the one who kept the clock ticking and brought us together for a meeting every week to keep the whole thing on schedule. We had literally hundreds of consultant contracts

11 Email dated 8 July 2008.
running at the same time. As you know, even to do one contract can be really challenging sometimes, but this was an occasion when we had to do everything at once, and get all these vendors and all these suppliers, and get everything going. There was a real vision to create not just a room where you could do presentations but really a nerve centre for the organization.\(^{12}\)

The facility was not completed in a hundred days, but was ready for use by the end of 2004, a feat considered definitely impressive by the normal standards of large intergovernmental organisations. It remains as tangible evidence that Lee was able to get things done.

\(^{12}\) Conversation with Steven Uggowitzer, 9 May 2008.
Three by Five

A global influenza pandemic with the human case fatality rate of SARS would have catastrophic consequences but it had not yet started. The global HIV/AIDS pandemic, on the other hand, with a case fatality rate of close to a hundred per cent, had appeared in the 1980s, and despite much effort within countries and internationally, still showed no signs of stopping. By 2003, 34 million to 46 million people were infected with the virus and 20 million had died of it, 3 million in that year alone.\(^1\) Unknown a quarter of a century ago, it was now the leading cause of death and lost years of productive life in the 15–59-year-old age-group worldwide, as well as of infant and child mortality. Two-thirds of the people affected were in Africa, but the virus was present in all countries. Although antiretroviral treatment, developed in the 1990s, had brought hope to many people, an HIV-positive diagnosis was still a death sentence for most. There was still no cure for anyone, and no vaccine, but now for those who could obtain the treatment, AIDS had become a chronic disease with which they could live and work for many years. The cost of the drugs, though now falling, remained prohibitive for most patients, however, and only 400,000 of the 6 million who needed them were getting them.

The existence of effective but unaffordable treatment made it clearer than usual that the challenge was not just for science to find a solution and for human fortitude to face suffering, but for society to function justly. This political dimension of health had also been brought to the fore by the Millennium Declaration made by the United Nations in the year 2000. One of the eight main Millennium Development Goals adopted at that time was to stop the advance of HIV/AIDS, malaria and other diseases; the other seven goals concerned poverty reduction, primary education, gender equality, child survival, safe motherhood, the environment, and international cooperation. Effective action to reduce the transmission of HIV and provide treatment for those already infected, the WHO argument ran, would contribute to achieving all of those goals; failure to do so would help to make them unattainable.² One in twelve adults in Africa was thought to be living with HIV/AIDS.³ Life expectancy, which had been gradually increasing in Sub-Saharan Africa, was now decreasing.⁴ Control of other diseases, especially tuberculosis, was being undermined by multidrug resistance in people with HIV/AIDS.

The target of getting 3 million patients onto antiretroviral treatment by the end of 2005 was presented as a first step towards universal access globally. It had been proposed at the International Conference on AIDS in Barcelona in 2002 and was strongly advocated by Jim Kim who, with Partners in Health, had achieved impressive results with treatment in rural Haiti. Lee had adopted this as a target for himself and WHO because, he said, the people who set targets are the ones who should be held accountable for hitting them. Longer-term campaigns had the disadvantage of seeming less urgent in the early stages, while those who inherit them as the deadline draws near are apt to find them less realistic than they had seemed originally.

³ Ibid., xv.
⁴ Ibid., 2.
Over ninety per cent of those receiving treatment for AIDS in 2003 were living in high-income countries. In Africa, only two per cent of those who needed treatment were receiving it. Brazil had introduced a policy of universal access to treatment in 1996, and the programme had led to a decline in infection rates. The former director of the successful Brazil National AIDS Programme was Paulo Teixeira, whom Lee had recruited and introduced in July as the new head of the HIV/AIDS department. In the early stages of the ‘3 by 5’ campaign, however, Teixeira withdrew for health reasons, and was replaced by Jim Kim, whose position up till then had been policy adviser to Lee.

The Global Fund to Fight AIDS, Tuberculosis and Malaria had been set up in 2002 as a mechanism to gather and distribute the unprecedentedly large amounts of money needed to keep these diseases at bay. Working with government and business organisations to raise grant money and evaluate proposals, it had awarded US$ 2.1 billion to programmes in 121 countries by the end of 2003. This fell far short of the $10 billion a year called for by Kofi Annan in 2001, but the trend towards increased funding looked set to continue. Lee persuaded Richard Feachem (now Sir Richard) who directed the Fund, and Peter Piot who directed UNAIDS, to join him on 22 September 2003 in declaring at a special session of the United Nations General Assembly that lack of access to AIDS treatment constituted a global health emergency which called for immediate action to get 3 million people onto antiretroviral treatment by 2005.

This had the desired effect of putting the spotlight on WHO, but some undesired ones as well. Part of Lee’s idea had been to ride the wave of rising financial support for disease control and increase the renown of WHO in the process. Peter Piot, however, who had been so narrowly defeated by Lee in his bid to become WHO’s director-general, was trying to do the same thing for UNAIDS. Richard Feachem likewise had the task of building the reputation of the Global Fund, of which he was the founding executive director. Both stood to gain by the treatment campaign, and in any case all three needed one another’s support, but the
two others could not afford to hand over the initiative to WHO and its new disconcertingly frisky leader. ‘Somebody has to do it and we are that somebody,’ Lee said to the global meeting of WHO representatives held that November in Geneva. It made sense if the ‘somebody’ and ‘we’ were stretched to include all the other organisations and individuals concerned. But then the appeal of being one of the happy few who rose to the challenge would be diluted, so a certain amount of unclarity was retained.

Laurie Garrett, writing in Newsday the following day, was quick to grasp the strategic essentials:

The strategy would be implemented swiftly, in an atmosphere of trial and error. WHO would work closely with other UN agencies and nongovernmental organizations such as Doctors Without Borders, WHO’s Dr Jim Kim, adviser to the director general, said.

Kim described his agency as leading the effort, with the UNAIDS Programme providing statistical support and the Global Fund acting as a financial conduit to poor countries.

Dr Nils Daulaire, executive director of the Global Health Initiative, an organization independent of UNAIDS and WHO, said in an interview he hopes the plan yields ‘a joint effort, joint leadership, rather than a jockeying for position and supremacy. We don’t care who is Number One, as long as the job gets done. This is certainly doable if the three organizations and the United States and local governments choose to work together collaboratively.’

At the beginning of that year, President Bush had announced in his State of the Union address that he was committing $15 billion over the next five years to tackling AIDS in poor countries, but directly, as bilateral aid, rather than through the Global Fund or any other international agency. Named the President’s Emergency Plan for AIDS Relief (PEPFAR), the project included getting 2 million people onto antiretroviral treatment by 2008. ‘Two by Eight’ was not necessarily incompatible with ‘3 by 5’ but some hard work was needed to reconcile the two approaches.

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UNAIDS subsequently worked with the Global Fund, the World Bank and other partners to dispel confusion by promoting an additional number-slogan: ‘Three Ones’, which was announced in April 2004. These were ‘three core principles’ agreed on by donors, developing countries and UN agencies: ‘one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad based multi-sector mandate; and one agreed country-level monitoring and evaluation system.’ It avoided the question of whether any one international AIDS coordinating authority was needed. ‘The agreement reached today will help all partners to exercise their comparative advantage in a manner that will enhance and not constrain our collective response,’ Ambassador Randall Tobias, US Global AIDS coordinator, said carefully.

Meanwhile, the expected money for ‘3 by 5’ had not yet begun to flow, whereas 2005 was drawing steadily nearer. It came as a great relief, therefore, when on 10 May 2004 the Canadian Prime Minister, Paul Martin, announced that his government was contributing 100 million Canadian dollars (US$ 72 million) to the ‘3 by 5’ initiative over the next two years. The donation more than doubled the amount of money available for ‘3 by 5’ until then, and was expected to encourage other donors to pledge. The training of 100,000 health care workers and the reorganising of 10,000 clinics in developing countries could at last begin in earnest.

WHO as an Engine of Progress

Although this effort was the one in the news during that time, WHO continued to serve ‘the full menu’ of health activities. While many were straining to get the treatment campaign moving,

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6 WHO, “‘Three Ones’ Agreed By Donors and Developing Countries”, The 3 by 5 Initiative; http://www.who.int/3by5/newsitem9/en.
7 WHO, “‘Three Ones’”.
a few were working overtime on the World Health Report for 2003, which came out in December of that year, followed by the one for 2004 only five months later, in May. The feat of swiftness was achieved by the editor-in-chief of both reports, Robert Beaglehole, urged on by Lee to contribute this further sign of vitality in the new administration. The titles of the two reports are in the same vein, in fact roughly synonymous: *Shaping the Future* for the first, and *Changing History* for the second, but the first is about a set of priorities whereas the second gives the detailed plan and rationale for achieving '3 by 5', with the red loop of the AIDS solidarity symbol dominating the cover.

As was the custom, each started with a ‘Message from the Director-General’, and each was accompanied by the same picture of Lee, tired but smiling with genuine cheerfulness, lit up by the aura of success one can see in people who have just won a tennis championship or an election. The printed caption under the photo reads ‘LEE Jong-wook’, while the signature scrawled under the message reads ‘Jong Wook Lee’. The theme of both reports was, naturally, progress, which in the one for 2003 took the form of increasing life expectancy by reducing health risks; helping to end poverty by achieving the health-related Millennium Development Goals; ‘confronting the killer’, HIV/AIDS; completing the global eradication of polio; learning the lessons of SARS by applying them to better security systems; acting to reduce cardiovascular disease, cancer and road traffic accidents; and building up health systems.

At that time, in the first years of the twenty-first century, the sense of inevitable progress in health that had prevailed into the 1980s had long since given way to what Roy Porter called ‘a certain malaise’. In the case of WHO the disease priorities in the 1950s had been tuberculosis, malaria and sexually transmitted infections and, with the modification of AIDS, they still were, half a century later. The greatest victory of all, over smallpox, had become a matter of perceived danger and strategic controversy.

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again, partly because of that very success. 'The atmosphere is one of hollow conquest,' Porter wrote in the 1990s. 'The age of infectious disease gave way to the age of chronic disorders. Longer life means more time to be ill, and medicine is more open to criticism.'

Expectations for medical technology continue unabated, however, and have the evidence of recent history on their side. In 2008, Paul Benkimoun argued, with a team of scientists to back him up, for the likelihood of the end of pandemic influenza in 2012, the introduction of an effective HIV vaccine by 2016, the end of polio vaccination by 2020, a malaria vaccine by 2026, and the commercialisation of an effective anti-ageing pill counteracting neurodegenerative disorders by 2025. For those who find the prospect of a very long life daunting, he proposes a treatment for depression that works by transcranial magnetic stimulation, available quite soon: in 2015,11 the target year for achieving the Millennium Development Goals. For some, this sense of inevitable progress may seem on the whole more like the coming of Aldous Huxley’s brave new world than anything more attractive, but it continues to generate well-founded hope for health workers and patients alike.

Despite the huge potential for good, the sense of hope can turn quickly into fear, as book titles like *The Coming Plague*,12 *Timebomb*,13 and *Six Modern Plagues*14 have shown, and such fears are often associated with scepticism about the notion itself of progress. Lee was a strong believer in the power of individual and collective human ingenuity to solve any problem, but whereas in earlier times the advance of human health could seem inexorable

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10 Porter, *The Greatest Benefit to Mankind*.
there was in many areas now a sense of disease control being in the balance. An all-out effort strongly led was felt to be needed to make it tip the right way.

The SHOC and ‘3 by 5’ were meant to enhance WHO’s capacity to lead sustained efforts and respond effectively to emergencies. Likewise, the set of programme areas highlighted in 2003 were seen as catalysts for the whole catalogue of others, from acute respiratory infections to zoonosis. With the programmes, projects and campaigns, there were all the other activities that administration entailed in the way of financial management, personnel management, translation, conference management, building maintenance, and information services, to name a few of them at random. The spectacular edifice of steel and glass opened in 1966 as WHO’s headquarters had long since become too small for the number of people working there, and other buildings had grown up around it, with chronic shortages of parking space both at ground level and underground. These facilities were supplemented during Brundtland’s time with rows and stacks of Portakabins as temporary office space, and construction work was just beginning in 2003 on the capacious new building on the other side of the WHO bus stop to be shared by WHO and UNAIDS.

This scene of continual expansion made it a matter of common sense to deploy a larger proportion of the available resources to other parts of the world, but the growth of headquarters had a momentum that was hard to resist. The Director-General was expected to appear at each of the six annual regional committee meetings held mainly in September, and these would have provided the ideal opportunity to announce the eagerly awaited plans for decentralisation. Nothing specific of that kind was forthcoming however, and the wording settled on for the Regional Committee for Africa, for instance, held that year in Johannesburg, was kept firmly in the realm of aspirations. Even these depended on other people: ‘At headquarters, all the Assistant Directors-General are looking at the departments under their responsibility, to see which of their activities could be better carried out in regional
and country offices. Overall I want to see these changes come through in the 2006-2007 budget.’ A lot could happen between 2003 and 2006.

To help recover the idea of health work as admirable service and not just a job or a business opportunity, Lee made as much as possible of the celebrations for the 25th anniversary of the Alma-Ata declaration. Attending ceremonies in Brazil, Kazakhstan and Switzerland was a priority, as was a meeting of the ministers of health of the six remaining polio-endemic countries who came to Geneva in January 2004 to pledge their commitment to completing the eradication of polio.

Another long-standing eradication target, which the World Health Assembly had adopted in 1991, was dracunculiasis, also known as guinea-worm disease. The *Dracunculus medinensis* enters the human body via contaminated water and can grow up to 80 cm long before emerging through an ulcer, usually in the leg, causing severe pain and disability in the process. The disease can be prevented by filtering household water supplies and treating pond water, and without a human host the worm would not survive. The cause of eradicating it had also been taken up by former US president Jimmy Carter and his centre for ‘Waging Peace, Fighting Disease and Building Hope’. In February 2004, Lee accompanied Carter, Ghana’s minister of health Kweku Afriyie, and UNICEF’s deputy executive director Kul Gautam on a field trip to Tamale, Ghana, where the control effort had been flagging. As in the case of polio, the most clearly perceived need was for political support for the effort. Carter, as a Nobel prize winner, former US president, and relatively independent individual, could use blunt language in challenging the Ghanaian government to do better: ‘It’s up to Ghana to commit to the challenge by taking swift and immediate action,’ he said.15

Jimmy Carter has a strong sense of his own worth, as Lee remarked with relish after returning from the trip. A health worker who was introduced to him enthused, 'Oh, Mr Carter you're the best ex-president!' After a moment of reflection, Carter had answered, 'Well, there ain't much competition.'

Management by Symbolism

Awareness of the power of symbols brought Lee’s talents into play in creative ways. Not long after he came into office, seventy Japanese flowering cherry trees were planted, to form two avenues, one shading the footpath running along the front of the WHO headquarters building, the other a footpath in the park behind it. Most of the trees were donated by the Nagasaki University School of Medicine, with current and former Japanese staff members also contributing. Lee paid for several himself. The administrative record states that they were planted by the OK Forêt company, on the instructions of Dr Lee Jong-wook. It quotes a note from the tree catalogue which says, 'Cherry blossom (Jakura nohana) announces the coming of spring. The Japanese gather beneath these trees to celebrate the new season when they are in blossom (O-Hanami), a symbol of the fragility and brevity of human life (short time of flowering).’ Though it was a cultural and aesthetic gesture it could be read politically as well, since his immediate predecessor had sent an early signal of change by having a large rose garden in front of the building dug up and grassed over. Nothing was said publicly about either modification to the landscape, so the various possible interpretations could coexist without difficulty.

A series of ceremonial tree plantings followed as Lee’s term of office proceeded. A white birch marks the visit of Kwon E-hyock, Chairman of the Korean International Foundation for Health and Development, former minister of health, minister of education, and president of Seoul National University, known affectionately in the Republic of Korea as the godfather of public

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16 A back-to-office anecdote recounted with glee by Lee to colleagues in his office.
health. A red maple was planted by Gro Harlem Brundtland in November 2004 on the occasion of the unveiling of her official portrait as WHO’s fifth director-general. The King and Queen of Spain planted a walnut tree in March 2005. Kofi Annan planted a maple in October 2005. The King and Queen of Norway planted an ash in April 2006. The last in that series was a white birch planted by the Prince of Wales on 23 May 2006, when he came to address the World Health Assembly. The tradition was continued after Lee’s death.

Lee explored the potential for symbolism in other ways too, with great pleasure, in his new position of power. He chose a Toyota Prius as his official car, a modestly sized hybrid that runs partly on a battery. In addition to displaying a sense of responsibility about climate change, it suggested that he was pleasantly free from the concerns about prestige that tend to weigh down people in high positions. Patrick Chevalier, the Director-General’s driver, recalled that Lee used to boast about his high tech car. At the World Economic Forum in Davos in January, Chevalier was able to get it all the way up to the hotel in the snow, while those with Mercedes 500s and 600s would not venture to drive them up there, so Lee enjoyed joking with his fellow dignitaries that they should take his example and get a better car. By that time his private car, the red Volvo he had bought in 1994, had done 350,000 km, and Chevalier urged him to get something more respectable. He held on to it however, saying that he wanted to put a million kilometres on the clock. The contradiction between a public car that was futuristically economical and a private one that was anachronistically uneconomical did not seem to bother him. At least it was his own money he was wasting on the Volvo, he might have argued, but the net effect may have been more of eccentricity than morality.

Halfdan Mahler had been noted for not sitting in the back seat of the official car like a grand personage but in front with the driver, and Lee adopted the same arrangement. In this way it was easier for him to practise his French with Chevalier. A friendship developed between them, and as Chevalier was a highly qualified
skier, they sometimes went skiing together at the weekends, so Lee could learn that from him as well. Chevalier rated him a good learner but prone to get himself into trouble by choosing slopes that were beyond his skill.17

A great opportunity for symbolic gestures was the World Health Assembly for which representatives of WHO’s 193 member states gather in Geneva for a week every year in May to make decisions on policy. In his first year as Director-General, Lee invited as guest speakers two former heads of state who were both Nobel Peace Prize laureates: Jimmy Carter of the United States and Kim Dae-jung of the Republic of Korea. In addition, during his own speech to the Health Assembly he gave the floor to Anastasia Kamylk, a young AIDS treatment campaigner from Belarus living with HIV, to let her cut through the abstractions of epidemiology and economics with her own irrefutable testimony of human need for the ‘3 by 5’ initiative.

The following year, he invited President Maumoon Abdul Gayoom of the Maldives to talk about his small island nation’s vulnerability to climate change, followed by Bill Gates on the achievements and plans of his gigantic foundation. This was arguably Lee’s most creative Health Assembly, with the drama of the contrasting guest speakers augmented by the Vienna Philharmonic Orchestra which he invited to play as part of the opening ceremonies. A fourth element of drama at that May meeting in 2005 was provided by Ann Veneman, the executive director of UNICEF who had just come into office at the beginning of that month. Lee invited her to speak during his own address to the Assembly, and as she came to the podium he took her hand and held it up high to proclaim what he called the ‘best friend’ relationship between UNICEF and WHO. Most of the audience would have been aware that relations between the two agencies were not always harmonious, so, whether premeditated or impetuous, the gesture gave a refreshing sense of shared adventure and goodwill to the proceedings.

17 Patrick Chevalier, interview, 16 May 2008.
By the end of 2004, it was clear that the target of 3 million on antiretrovirals ‘by 2005’ was not going to be hit in the next twelve months. The shift of a larger proportion of resources from headquarters to countries had given way to a less dynamic-sounding ‘review of strategic direction and competencies’ which was only just starting. The move to open-plan offices was meeting with more resistance than expected. Lee’s desk was not with the fifteen others in the big space occupied by his office staff as he had told the world it would be, but set well apart in the traditional way, with two or three secretaries between his office door and the rest of WHO.

On the other hand, implementation of the WHO Framework Convention on Tobacco Control was advancing more quickly than had been expected, and the fortieth state party had acceded to it in December, which meant it would come into force on 27 February 2005. The revision of the International Health Regulations, scheduled for adoption by the World Health Assembly in 2005, was in progress; an intergovernmental working group, consisting of delegations from all WHO’s member states and from the relevant international organisations, had met in November for ten days, and would meet again for a week in February. Bitter disagreements about priorities for national and international security notwithstanding, the need for a common rulebook was well recognised and the work was inching forward. Lee sat in on the discussions as much as he could, both to emphasise their
importance and to suggest ways to break deadlocks when possible. The Strategic Health Operations Centre had been completed and was ready for use, and Lee as the de facto commander-in-chief of those operations was getting ready to star in a discussion on ‘Preparing for the next global health panic’ at the World Economic Forum in Davos in January.

The Tsunami
On the morning of December 26, the biggest earthquake the world had seen for forty years occurred in the Indian Ocean and triggered the tsunami that devastated coastal areas of Indonesia, Sri Lanka, India, Bangladesh, Myanmar, Somalia, and islands such as the Maldives and the Seychelles. The death toll was eventually estimated at over 280,000. The Health Action in Crises department, headed by David Nabarro, moved into ‘the SHOC room’ as it was now called, to coordinate WHO’s emergency response in collaboration with the regional office in Delhi. Lee visited Banda Aceh in Indonesia and Galle and Ampara in Sri Lanka during the first week of the new year to assess needs and pledge support (see also page 176). Provision of essential medicines, water purification tablets, antibiotics, rehydration salts, temporary health services, as well as expertise on hygiene in crowded temporary accommodation, and management of dead bodies, gradually gave way to re-establishing health facilities and supporting health sector recovery.

The tsunami had happened without any warning and without a human cause, but the extent of its effects depended in large part on the human response. Flash appeals launched at the beginning of 2005 raised pledges totalling $7 billion, $67 million of which was contributed to WHO to help meet health needs in the worst-hit areas.

Commission on Social Determinants
While that emergency dominated health concerns around the world, preparations were under way to launch the Commission on Social Determinants of Health in March. The idea had come
from Tim Evans, assistant director-general for Evidence and Information, as a way to draw attention to an axiom of health policy: biomedical science had acquired unprecedented power to cure and prevent disease, but the extent of its ‘benefit to mankind’ depended on social choices. In addition, the new commission was to focus on health as an end in itself, rather than a means to some other end such as wealth. As Lincoln Chen put it later:

Intrinsically valuing health versus treating health as an instrumentality for other goals is reflected in the transformation of commissions in WHO. Earlier, WHO had launched the Commission on Macroeconomics and Health, chaired by Jeff Sachs, that viewed health as an effective instrument for economic growth. The goal here was not health but health as a means for economic growth. There were obviously tactical gains to be achieved by linking health to the economy. But under Tim Evans, WHO launched the converse, the Commission on Social Determinants of Health, chaired by Michael Marmot. What was transformative about the social determinants commission was its view of health as intrinsically-valued, an ultimate goal of development—not merely an instrument for other goals.1

Sir Michael Marmot had just published Status Syndrome—How Social Standing Affects Our Health and Longevity, with statistical evidence to prove not only that social injustice shortened lives and increased disability but that much could be done through health and broader policy to reduce such injustice.

With help from Tim Evans and others, Marmot put together a team of 20 leading academics, politicians and activists to form the commission, including William Foege of smallpox eradication fame, President Lagos of Chile, former president Mocumbi of Mozambique, Amartya Sen, Nobel Prize laureate for Economics in 1998, and other well-known figures from WHO’s six regions.2 From time to time, Tim Evans would bring the proposed list to

2 Complete list and information on the commission can be found at www.who.int/social_determinants/en.
Lee Jong-wook

Lee for his approval and he would suggest alterations according to what he called his ‘gut feeling’. For instance, at one point he suggested dropping one of the former heads of state proposed, since too many people used to being in charge and with a civil service and an army at their disposal were likely have problems with working as member of a team of equals.

In keeping with his principle of delegation, Lee left most of the task of defining the remit of the commission to others. Sonia Gandhi was in the news during the early stages of preparation of the commission, and in answer to Marmot’s request for more clarity Lee told him to be like her and ‘Follow your inner voice.’ Being a careful man who believed in the evidence base, Marmot was unsure whether to take this as a joke between men of science, carte blanche, or serious advice to be true to his own best insights.

The commission represented a return to the social justice principle of ‘health for all’ as the guide for policy, and the launch ceremony, hosted by President Lagos in Santiago, aimed to recapture that sense of global common purpose. Halfdan Mahler was a guest of honour, the heroic Chilean poets Pablo Neruda and Gabriela Mistral were invoked, and the final report was due in 2008, the 30th anniversary of the Alma-Ata Declaration, the 60th of the start of WHO. That would also have normally been an election year for WHO’s director-general, so the success of the commission would have affected Lee’s chances of re-election. A yet further source of inspiration was the venue for the opening ceremony: Avenue Dag Hammarskjöld, so Lee’s launch speech included a mention of the UN’s greatest hero as well, 100 years old that year.3

Public Speaking

Leadership itself is a social determinant of health, and those who want to exercise it usually feel the need for eloquence to help get them to the top and keep them there. Even a man of

action such as Julius Caesar took courses in rhetoric, in addition to practising the martial arts and riding a galloping horse with his hands behind his back. In our own times, politicians, whether good at it or not, still accept the need for talent or training in public speaking. Lee, though certainly keen to lead, was not a hard-working communicator in this conventional way. He did hire a speech coach for the week before he was nominated for the director-general post, but did not go back to work on it once he had got the job. He preferred instead to make the most of advantages he did have, one of which was a lively tactical imagination.

A tactic he used for getting attention was to take his audience by surprise. He sometimes did this by starting a set speech in an unexpected language such as French or Spanish. His pronunciation of those languages was not good, but he would practise enough to attain a certain amount of understandability. Then when he switched to English, which was much easier for everyone, the effect was one of both relief and added interest. His English was generally acknowledged to be excellent, especially for someone who did not live in an English-speaking country until he was 34. He had worked hard at learning the language since early in his school days and attained a high level of proficiency with it by the time he had grown up.

His use of French was particularly endearing to Jacques Chirac, perhaps partly out of compassion. When both of them made a speech in Paris on road safety, the theme of World Health Day in April 2004, the French President made warm references to ‘dear Dr Lee’, using this kind of friendliness as a special feature of his masterful oratory. The contrast between the two men was striking: Chirac tall, heavily and deeply versed in the subtle wiles of appealing to the public from a script, Lee quite short, reading his respectable words decently but in a modest way as part of his duties, and without apparent hope of having much effect on his audience. The impression was one of simplicity rather than impressiveness, but that too came across as a means of winning trust, both from the public and from the dominant star on the scene.
A week later, road safety was again the subject, this time at a special session of the United Nations General Assembly, and Lee hit on a quite different approach for the speech he was to make there. He would be one of several heads of agency to pronounce on road safety, and all of them were expected to cite some sobering statistics and draw obvious moral conclusions from them. Lee wanted to be different. Somewhere on the news he had heard about the first recorded motorised traffic fatality, and told me to start with that. As with his Health Assembly speeches, he liked to focus on something made of flesh and blood rather than a logical abstraction, so his script began:

The first person to be killed by a car was Bridget Driscoll. She was 44 years old and a mother of two. She was knocked down at London’s Crystal Palace on 17 August in 1896. The car was travelling at 12 km per hour. She never knew what hit her. The British coroner recorded a verdict of accidental death. Speaking at the inquest, he warned: “This must never happen again.” (see Annex p. 221)

Such devices worked well enough, and with his public image becoming more widely known and liked, he agreed to appear in May 2004 on HARDtalk, the BBC World News interview programme aimed at ‘getting behind the stories that make the news.’

His interviewer was Lyse Doucet, a Canadian law-school graduate and veteran television interrogator of Yasser Arafat, Hamid Karzai and other famous political figures. Introducing the programme with the Swiss mountains and the WHO headquarters building as a background, she proposed in a businesslike way to find out if ‘our global doctor has the right prescriptions to tackle diseases killing millions of people.’

Doucet began with the World Health Report on the ‘3 by S’ initiative, Changing History, and what the critics were saying about it. They were saying, she said, that it was too hasty, 60 per cent of WHO’s proposals for funding for it had been turned down,

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they weren’t going to get the money that was needed, WHO was behaving like an NGO, the campaign had been bungled and had already failed. Lee answered with a good-natured but perhaps slightly patronising smile that thousands of people were dying every day; if one waited for the perfect plan with enough money nothing would ever happen. That was how these things worked; it had been the same with the smallpox and polio campaigns. Besides the Canadian government had just contributed 100 million Canadian dollars, so it was all going ahead.

After rephrasing the Canadian contribution as having ‘bailed you out’ with ‘70 million [US] dollars’ Doucet hurried on to her next point: ‘Do you despair that although many countries give their political, their moral commitment to the fight against HIV/AIDS they don’t come up with the right kind of money?’ She cited President Bush as the prime example, having announced to the world ‘with great fanfare’ $15 billion for his AIDS relief in Africa project, ‘but then when he went to Congress he only asked for $2.1 billion.’

‘Well then we have to convince Congress and we have to convince other rich countries to . . . ‘

‘So the donors are not putting their money where their mouth is.’

‘Well, they . . . now they heard, also from WHO, that we have to present the compelling case to the world. Otherwise they wouldn’t know. So that if we said one million people by 2010, you know, it would be a boring number, everybody will yawn. But clearly we committed ourselves to this very ambitious almost impossible goal, that is we, just needed to tell them this is an urgent, this is an important issue.’

The interview went on to what Lee proposed to do about governments like that of Tabo Mbeki of South Africa which refused until recently to support antiretroviral treatment; what he had to say about the assertion of Médecins Sans Frontières that the DOTS strategy for TB did not work; what about the accusation that WHO’s recommendation of drugs that did not work for malaria was tantamount to medical malpractice? And
about the global problem of obesity, was he going to stand up to the big sugar companies or was he going to bow to pressure from them and alter the WHO experts’ recommendations? She did not argue with his technical and diplomatic answers to the first ones but on the one about sugar Doucet pushed hard:

‘You in effect are the world’s global doctor, are you going to stand up to the pressure?’

‘That, that . . .’

‘Are you going to stand the pressure?’

‘Yes, that is our line, that is . . .’

‘Yes?’

‘Yes. That is our line, that is our message. Because we’re very much concerned about child obesity. This is a really big issue, and everyone will agree this is a sensible strategy. We will change, you know, the wording here and there but the sense, the principle, the whole story, is intact.’

And for the ‘nightmare scenario’ of the expected avian influenza pandemic, was he going to stand up to big China if it refused to cooperate, the way it had initially with the SARS outbreak? That was easier; China was keen to cooperate now, so the question had passed its use-by date. Her overall concern, however, still appeared to be that Lee might not be the kind of guy who would stand his ground when the going got tough, and he did not entirely dispel that doubt.

None of the questions had wrong-footed Lee, and despite much chipping in and confrontation he had answers for all of them, though he sometimes produced them too fumblingly. He did not attempt to slug it out with her or drown her in technicalities as an ordinary head of a technical agency might have, but stuck to the broad common-sense aspects of his position, which came across as tenable. Less favourably, someone or something must have told him to keep smiling no matter what, as that is what he did, not always to good effect. On matters such as WHO’s limitations, heavy death tolls and grim prospects he would have done better to look troubled. Likewise, on being interrupted and needled by a presenter who seemed so dead set on pushing him
into an untenable position, he would have done better to look displeased from time to time.

The interview ended on a conciliatory note in the conventional way: ‘When you dealt with the eradication of polio campaign you said, “If you do your job right you could do good for tens of thousands of people.” But in fact is saving the lives of millions actually more difficult than you thought?’ Doucet asked, with a hint of pity.

‘Well of course, but, you know, I feel, it makes you feel warm. It’s a good feeling, I mean, you’re working, working to save lives.’

‘It must be frustrating too because it’s not just a medical job, it’s a deeply political job.’

‘It’s a political job, yes, it’s a . . .’

‘And it’s a begging job.’

‘Well yes it’s begging in a sense but we also have a fancy word for that, it’s raising funds, fundraising.’

‘But do you worry the world is more worried about problems in Iraq or sinking their money there, diverting funds from what you would regard as a much more deadly threat?’

‘Well there are people who are concerned about different problems, my duty is to be concerned about health problems and how to solve them.’

‘It’s going to be hard to “change history” as your report said.’

‘Well, I’m trying.’

No one could fault a man for trying to change history for the better. It was the end of the show, and as they leant forward to shake hands, they both looked glad it was over.

A friend from his medical school days remembered Lee saying after a lecture: ‘One day I’ll be standing up there at the podium while you guys are all down here scribbling away taking notes,’ and they had all laughed about it, Lee included, but it had turned out to be a real ambition, and was fulfilled on a bigger scale than could have easily been imagined.
Most of the invitations Lee received to speak at medical institutions after he became Director-General had to be turned down as too low in priority, but one he accepted was the annual Barmes Lecture in 2004, organised by the Fogarty International Center and the National Institutes of Health in Bethesda, Maryland, USA. Other speakers in the series have been leading scientists such as Harold Varmus, Barry Bloom, and Rita Colwell. Lee chose ‘Health Challenges for Research in the 21st Century’ as his topic, which enabled him to put WHO’s current efforts in the context of breakthroughs achieved by great men of the past. The lecture focused on James Lind who discovered a cure for scurvy in the eighteenth century, John Snow who discovered how to stop cholera in the nineteenth, and Jonas Salk who discovered a vaccine for polio in the twentieth.

His conclusion gives an idea of the kind of influence he hoped to have, both as an individual and as the face and voice of an institution.

The three researchers I have talked about were unusual individuals but they were also part of the social movements of their times. Lind was a man of the Enlightenment; Snow was part of a rising tide of alarm at the inhuman living and working conditions that had come with the industrial revolution; Salk was supported by the March of Dimes and a great popular movement of solidarity in the USA for the victims of polio.

As individuals they gave strength to those social trends, just as they drew strength from them. They were living in difficult and dangerous times, just as we are. Like them, we need to work with the positive trends in our own time.

They were great scientists, each in quite different ways, but they also had admirable human qualities, and those are an important part of the secret of their success. They were courageous, persistent and generous. Wherever people are thinking and working with that kind of intelligence, the necessary discoveries can be made.5

That was the way he saw things, and in his own way he did have the ability to win support and recognition for such views.

CHAPTER 14

Celebrity and Travel

Just as he sought success by entrusting areas of work to successful people, Lee Jong-wook sought fame from people who were famous. As he was now already somewhat famous himself by virtue of his position, others stood to benefit from his influence just as he did from theirs, so there were plenty of opportunities to choose from. To launch WHO’s World Report on Violence and Health in March 2004, he accepted an invitation to address a meeting of the health ministers of the Andean region, hosted by Hugo Chavez in Puerto Ordaz, Venezuela. Chavez responded warmly to Lee’s call for ‘commitment at all levels to reducing violence’, and, apparently taking a liking to the speaker, lent him his presidential jet to get him back to Caracas.

Another good meeting during that first year in office was with Hosni Mubarak, President of Egypt. Their appointment had been scheduled as a fifteen-minute slot, but Lee mentioned the role of the Egyptian Airforce in the 1973 Yom Kippur War, which propelled Mubarak into detailed reminiscing about that time and his own role in it, until 40 minutes later an aide discreetly reminded him that several ambassadors were waiting to present their compliments. Some of the ambassadors grimaced at Lee, pointing at their watches, as he sauntered back out through the waiting room with his assistant and the regional director.¹

¹ Reminiscence of Gini Arnold, executive officer for the Director-General’s travel schedule, 2 November 2009.
A traditional diplomatic duty of WHO directors-general is to make official visits to countries to review their national health situation. Lee was invited to the Czech Republic in May 2004 to do this, and accepted on the understanding that it would include a meeting with Vaclav Havel. Havel, hero of the Velvet Revolution of 1989 and president of Czechoslovakia from 1989 till its division in 1992, then first president of the Czech Republic from 1993 to 2003, agreed to this. Lee asked me to accompany him on the visit as he knew I was a fan of Havel’s. The meeting took place at the office of the foundation, Vision 97, set up by Havel and his wife Dagmar to encourage scientific research that ‘broadens people’s horizons by addressing fundamental questions of human existence’.2

We were accompanied by five or six government officials, so the meeting was not an opportunity for the cosy intellectual chat we would of course have preferred. Havel, then 67, was there with his wife. He was quite carefully dressed in a black jacket and bright but serious tie. Speaking in Czech with an interpreter, he welcomed Lee and said it was an honour to be visited by the head of a ‘planetary organization’. ‘What are the main health problems facing the world today?’ he asked politely, with apparent genuine interest, and perhaps a trace of irony. He had been a heavy smoker and was short of breath because of bronchitis associated with lung cancer. He seemed to choose his words carefully so as to keep the effort of speaking to a minimum. Lee made some judiciously brief remarks about HIV/AIDS, TB, malaria, new diseases, and disasters.

‘And do governments usually accept WHO’s advice?’ Havel asked. Lee gave the example of the big effect of travel advisories during the SARS outbreak. Havel observed that civilisation was bringing medical advances but at the same time was contributing to health problems, then joked that the changing health situation was also causing a rapid turnover of health ministers in his country at present. He told us about his foundation and

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I got him to sign my battered and marked-up copy of *Living in Truth*, a Faber paperback of 1989 which included his ‘Letter to Dr Gustav Husak’ and ‘The Power of the Powerless’. ‘A tremendous book,’ I told him. He thumbed through it, apparently not very familiar with that edition, wrote his name in it and drew a heart underneath, as he did on the booklets he signed at Lee’s request as well.

‘Come and see us in Geneva,’ Lee urged him several times, but Dagmar said quite firmly, ‘We haven’t got time,’ probably worried about his health. Afterwards, Lee speculated that in fact she may have meant that her husband did not have much more time left to live. As it turned out, he had a good deal more than his younger and fitter visitor.

In June 2005, Lee made a visit to the Prince of Wales at Clarence House in London. Roberta Ritson, the WHO official who accompanied him, remembered how the two of them seemed to hit it off immediately.

They were on the edge of their chairs, leaning forward, engrossed in conversation. I was really surprised—I suppose I shouldn’t have been—at how much Dr Lee knew about traditional medicine, and about the royal family. The Prince of Wales talked about how his whole family had always been interested in alternative approaches to health care, and his grandmother’s special interest in it, and all this sort of thing, and his own involvement, especially his concern that the National Health Service should recognize some alternative therapies. Dr Lee knew how to comment in just the right way on the family background and soon he was telling anecdotes about Chinese medicinal plants, Korean remedies, Indian treatments, and the Prince of Wales was just fascinated.3

It was during that meeting, which went on for half an hour longer than scheduled, that Lee invited Prince Charles to address the World Health Assembly in 2006. At first he demurred, saying he didn’t have the right expertise, but he was obviously interested, and could see it would be a good opportunity to win endorsement for his good cause. ‘The funny thing was that

although he was so much in the public eye, the Prince of Wales looked a little awkward sometimes in a way, and kept twisting the ring on his finger, whereas Dr Lee looked relaxed all the time. But they both seemed to be thoroughly enjoying themselves,’ Ritson observed. With a little coaxing from Lee, Prince Charles agreed to think about addressing the Health Assembly, and when the official invitation letter came from WHO a few days later, he accepted it.

Other prominent people with whom he established friendly personal relations included Hu Jintao of China, Vladimir Putin of Russia and George W. Bush of America, and, as we have seen, Jacques Chirac, which makes four out of the five heads of the permanent members of the UN Security Council. It is unusual for the UN agency chiefs to establish personal relations with the heads of the great powers, but a case could be made for it on the grounds of preparedness for global health emergencies. Lee also had a personal motive for doing so: a new secretary-general of the United Nations was due to be appointed in 2006, and he was keen to be Kofi Annan’s successor. Article 97 of the UN Charter states that ‘the Secretary-General shall be appointed by the General Assembly upon the recommendation of the Security Council.’ The General Assembly has consistently accepted the Security Council’s choice, and the five permanent members—China, France, the Russian Federation, the United Kingdom and the United States—have had a dominant say in making that choice. No official record of this attempt of Lee’s exists as far as I know, and it would not be useful to cite the many sources who have talked about it. It can remain in the realm of speculation if so desired, but is a prominent part of who Lee Jong-wook was and wanted to be, and as such helps to explain his motivation during the last months of his life.

There already was a favoured Republic of Korea candidate, Ban Ki-moon, but against him there was a potential argument to the effect that having Koreans in both positions—as director-general of WHO and secretary-general of the UN—would have produced an imbalance in the multilateral system. Moving Lee up to the
secretary-general post would have solved that problem while maintaining the principle of regional rotation which at that time favoured a Korean candidate. At that time too, however, measures were being introduced to make the appointment procedure more transparent, with more participation of the General Assembly and the non-permanent members of the Security Council. The chances of Lee winning the decisive Security Council poll that was eventually held on 2 October 2006 would be impossible to calculate even if he had been doing well until 22 May, which can probably not be known either. Rightly or wrongly, he himself did think he was doing well, according to two sources close to him.

A certain amount of physical fitness is needed to mix with people continually in every region of the world. ‘He should be young,’ wrote a group of former League of Nations officials in 1944 attempting to define the qualities needed for a Secretary-General of the United Nations. It was the one thing they seemed sure of, and in view of the packed schedule of official appointments considered to be the norm, the same could be said for a director-general of WHO. Brock Chisholm was 52 when he started, 57 when he stepped aside for a man more definitely in the recommended age-group; Marcolino Candau was 42 when he started, perhaps the ideal age, but 62 when he stopped. Halfdan Mahler started at 50 but went on till he was 65. Since him, all the incumbents have started on the older side. Nakajima was 60, Brundtland and Lee 58, and Margaret Chan 59.

The first six months of Lee’s time in office took him to Helsinki for a congress on tobacco control, to Johannesburg, Manila, Vienna, New Delhi, Washington and Cairo to address the WHO Regional Committees, to New York for a meeting with UNICEF,

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to London to the School of Hygiene and Tropical Medicine, to Brussels to meet members of the European Parliament, to the Hague for the centenary of the Royal Dutch Tuberculosis Foundation (KNCV), to Almaty for the 25th anniversary of the Alma-Ata Declaration, to Accra for a retreat with the WHO executive board, to Livingston for World AIDS Day, and to Brasilia for an international seminar on Primary Health Care.

The schedule tends to be fuller than usual in September because of the six regional committee meetings, but two to five countries a month was normal. Towards the end of 2005 he was feeling tired and found that his blood pressure was a little high, so he tried to cut his schedule down. Nevertheless, between November 2005 and May 2006 he went to Paris for a meeting on the Millennium Development Goals, Yaounde for malaria, Delhi for the Global Alliance on Vaccines and Immunization, London for a meeting on child survival, Beijing for a pledging conference on pandemic influenza, Paris for a meeting on financing mechanisms, Turkey, Madagascar, Mauritius and Kenya for country visits, Lusaka for World Health Day, Azerbaijan for a country visit, and Moscow for a meeting of health ministers of the G8 countries. So he went to several countries a month, and all such visits entail being the centre of attention at high-profile meetings interspersed with press conferences and media interviews. Naturally, being in the political limelight requires one to make safe but authoritative answers to demanding questions. When he was not travelling, such appearances were equally frequent or more so in Geneva, at WHO, at the Palais des Nations, at the headquarters of other international organisations, and at the consulates of member states. In addition, there was the main part of the job, which was to run a secretariat of over 8,000 employees. Such a way of life is liable to make punishing demands on a person, however strong and well-suited for it he or she may be.

At first, he travelled either alone or with a companion chosen on an ad hoc basis for their relevant expertise for the purpose of the visit. After a few months, however, the need for a consistent aide was strongly felt, to take care of briefings, schedules,
appointments, bookings, consistent records of what took place, any agreements or commitments made, and the many other practical details his programme away from the office entailed, so he asked his advisers to find someone. They thought the ideal person would be young, male, and from a developing country, but after considering a few options he chose someone young but female and from England. Gini Arnold was 31, a Cambridge anthropology graduate who had worked for Lee in the Stop TB department, and had taken over from Ian Smith as manager of the Global Drug Facility in 2003. Her memories of her year and a half of travels with Lee were dominated by the relentless demands of the schedule. ‘I found it exhausting and if it did that to me what must it have done to someone twice my age?’

A three-day visit to Russia that October brought out two aspects of Lee’s character that she thought were particularly revealing. The first was his kind-heartedness, which she saw in the sympathetic way he related to the children they visited at an AIDS orphanage in St Petersburg. These forty children were on antiretrovirals provided by the Ministry of Health, and living in an institution until foster families could be found for them. ‘He was really warm-hearted and affectionate with them,’ she said; ‘you can’t see it in the pictures because he got awkward as soon as people pointed cameras at him.’

The second was his mischievousness. He and his entourage of WHO and Russian government officials took the Red Arrow night sleeper train from Moscow to St Petersburg, but instead of settling down to rest after a long day’s work, he joined them in drinking vodka and encouraged them to sing the Internationale. This song, of which he knew some of the words in Russian, had inspired revolutionary socialist uprisings in many countries since the late nineteenth century, and was traditionally sung with right arm raised in a clenched fist salute. It had the added attraction of nostalgia now for most of those present, as well as hilarity in view of the contrast between the hopes it once stirred up and the realities that had ensued. Soon they were all singing

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6 Conversation on 2 November 2009.
it at full throttle with exaggerated fervour. Although this way of having a good time was not politically respectable on the whole, it produced a strong sense of camaraderie, a valuable asset for diplomacy.

A particularly arduous journey was the one occasioned by the tsunami in early January 2005 (see page 160): for site visits in Indonesia by jeep, and in Sri Lanka by helicopter. Information in Gini Arnold’s travel report from Aceh includes the following:

Military retrieving 3000+ bodies a day, 105 tonnes of food a day distributed, civilian contractors responsible for debris clearance . . . Field visits (coasts, hospitals, drive through city)—the team witnessed the extent of the devastation from both the tsunami and the earthquake; up to 7 km inland significant water damage, body bags lined the street and there is not one family who has not lost a member. We witnessed the strain on the health system—the largest hospital not functioning, 50 per cent of health staff were victims, so volunteers are staffing the remaining overcrowded hospitals. The major health problems witnessed included fractures, gangrene, respiratory infections, diarrhoea. Despite the devastation, the team also witnessed the determination of the survivors who had already started rehabilitation efforts (cleaning houses, debris clearance) and were attempting to rebuild their lives (market in force, traffic jams, kids on bicycles).  

Some of the facts could be recorded officially, but others, such as the psychological impact of the atmosphere with the smell of large numbers of decaying bodies and the sight of crowds of injured, sick and bereaved people, could only be approximated in conversation afterwards, or in a brief personal diary entry: ‘I have never seen such things in my life & hope I never will again.’ Her impression of Lee was that he too was shocked by the scenes they saw but at ease and authoritative at giving national leaders the right kind of assurances and advice.

Two weeks later they were at the opposite extreme of climate and comfort, at the World Economic Forum in Davos, where he

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Outstanding pupil (bottom right), dressed as UN peacekeeper. Photo from KOFIH.
Jong-wook with his father. Photo from KOFIH

Lively adolescent, Choongju, 1959. Photo from B. K. Kim
Class president
Photo from KOFIH

With his cousin Sung-Yap Choi. Photo from Reiko
New doctor and new father in Chuncheon. Photo from Reiko
John Hess at Mt Sorak, 1977. Photo from John Hess

The Lees at the house on Paty Drive, with Lynn Stansbury
Photo from John Hess
Reiko and Tadahiro / Chongho in Honolulu. Photo from John Hess
In the laboratory at the University of Hawaii. Photo from Reiko

Good rapport with fellow doctors. Field trip in China. Photo from Reiko
Field trip in South Pacific. Photo from WHO, Geneva

Ambitious doctor, Hygeia (the Greek goddess of health) and the WHO building
Photo from Reiko
Enlisting money and fame for health, with Martina Hingis. Photo from WHO

What’s so funny? The outgoing and the incoming Director-General
Photo from WHO, Geneva
Friend of the powerless, Angola, 2003. Photo from WHO, Geneva

Friend of the powerful, with Jacques Chirac, Paris, 2003
Photo from WHO, Geneva

With Vaclav and Dagmar Havel, Prague, 2004. Photo from WHO, Geneva

A shot in the arm against influenza, Geneva, 2005. Photo from WHO, Geneva
Secretaries or generals? With Kofi Annan, Geneva, 2005
Photo from WHO, Geneva
With Reiko in a vineyard near Geneva, 2005. Photo from Reiko

Official portrait. Photo from WHO, Geneva
had been invited to join a panel on ‘The Next Global Health Panic’. He had not wanted to go, Arnold recalled, but had been argued into it by his advisers in view of the political disadvantages of not going. ‘It wasn’t his scene; he didn’t want to be on display all the time, or hanging around hoping to meet some celebrity.’ His contribution to the panel discussion was modest, and as there was a free morning between two appointments, he invited her and Chevalier, the driver, to go snowshoe walking with him instead.

The well-known people whom he met formally and informally in the course of his extensive travels have little in common but he had a talent for getting on well with them. They are representative of large numbers of others, obscure and famous alike, who felt they knew him in a special way and liked him for one reason or another. It may be one of the principal ingredients of his success, that sense many people had of a kind of complicity with him through the interest he showed in their lives and ideas, and his apparent respect for them as human beings. He was widely respected himself, as a result. Two of his closer friends have asserted that he was approached to run for president of the Republic of Korea but did not see it as a possibility, being comparatively unknown in his own country.
With his aptitude for liking people and being liked by them, Lee might have been expected to bring in a golden age for staff morale, but after a few months of cheerful optimism the atmosphere returned to normal. By the end of his second year in office, relations between management and staff were arguably worse in some areas than they had been in earlier regimes. Unprecedented in the history of WHO, there was a work stoppage at the Geneva headquarters on 30 November 2005, involving 700 staff members according to its supporters, 350 according to its opponents.

As alleged by a leader of the protest,

The major problems leading to the staff–management crisis were lack of consultation and involvement in decision-making; mismanagement of staff and financial resources; removal of staff representatives from selection procedures (thus dismantling an essential mechanism to ensure respect of rules and procedures); refusal of a moratorium on external recruitment (hiring while firing); high levels of harassment; obstruction to internal justice; unacceptable levels of nepotism and cronyism; and continued abuse of temporary contracts.1

Such accusations had been common, with varying degrees of intensity, since the latter days of the Mahler regime, and played

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their part in the process of change and reform. All of them left room for honest disagreement about how things have to be done, and they reflect the lack facilities for legitimate questioning akin to an opposition party in national government or a union in industry. Be that as it may, the increasing dependence on short-term staff hoping for better contracts had gradually led to a high level of discontent. The UN system’s official solution was to stop making short-term contracts renewable, but this threatened a large number of people with loss of their livelihood, so it was met with an instinctively hostile reaction.

Ken Bernard, an American who became a policy adviser to Lee in 2005, put the opposite point of view from that of the strikers in these terms:

The Staff Association wanted to get rid of the category of short-term employees, the eleven-month contract thing, and so they said that this was cheating people out of their salaries, their benefits, their longevity, their retirement, which is true. Fine, but when New York said, ‘OK, then all of the eleven-month contract people who haven’t been assimilated will no longer be eligible for eleven-month contracts,’ the Staff Association thought, ‘Oh, this is great, everybody will be converted to full-time contracts. But what really happened was, the good ones were converted and the poorly performing ones were let go. This was the whole thing for some of the Staff Association activists: ‘I deserve a life-time job with WHO. I deserve it, I’m not getting it, therefore the system is screwing me.’ As far as I could tell, the uproar wasn’t any more than that. But it hurt JW. He said to the Staff Association, ‘Look, you guys asked for this. And now that you’re getting it, now that the four-year period is up, we’re telling you there’s no more money to hire any more people, now you’re telling us either you want your eleven-month job back or you should be hired on full time because you’re entitled to it. And JW said to me, ‘They’re not entitled to it, this is the UN, no professional staff are entitled to a job in the UN. Professional staff are supposed to come in, work for a while and then go back to their home countries.’ But that’s not how they viewed it. JW could never get past that. No one could get past that. The fact is the UN had a policy that the Staff Association didn’t
like. And they wanted it changed, and when you want something changed you fuss enough until somebody changes it.²

It is not usually clear in UN organisations how to differentiate between the management and the staff, since the only body akin to a union is the Staff Association and everyone belongs to it, including top management, and a large number of jobs, even at the lower levels of the hierarchy involve being a manager of one kind or another. So the channels for negotiation are ill-defined, and the staff association itself normally has difficulty in making a common stand. The threat to strike was a factor of uncertain importance, therefore, with some expectation that it might never come to anything. On the eve of the date announced, however, it was clear that some staff members were planning to participate in a work stoppage.

Lee was famous for his patience but in this case appears to have lost it, and issued an email ‘Message from Director-General to All Staff’, which may have made matters worse. It expressed some sympathy for ‘staff concerns and anxieties, in particular during this difficult period of change,’ but none at all for the idea of a strike. It would not be in the interests of anyone—neither those at headquarters nor ‘the hundreds of staff who are working in hardship posts around the world such as Darfur, Baghdad, and field stations in Africa and Asia, nor those whom we serve.’ Moving on to practicalities, he then set out three reasons for giving up the idea:

- We must ensure the continuation of our work. It follows that staff members who express an intention to go on strike may be informed by their respective ADG that they cannot do so if their work is of an essential nature.
- It should be noted that staff members who go on strike are not entitled to be paid for the period during which they do not work. Therefore it is important that staff members inform their ADG in writing by end of today if they intend to participate in the work stoppage.

² Ken Bernard, conversation on 30 April 2010.
In addition, other measures may be considered, including disciplinary measures—which could involve dismissal from WHO.

This approach was probably mainly an attempt to show the international community that he could handle UN personnel issues firmly.

Though it could have made sense from the outside, Lee’s tough message imposed incompatible obligations on his subordinates: it would be wrong to let fear prevail over claims to justice, but it would also be wrong to disrupt the system and harm oneself in the process. The result was that some were indignant and joined the strike although they had not been planning to before, while others who had been planning to were alarmed and changed their minds, so the number of people participating was not necessarily much affected by the message. Certainly, if it had been aimed at putting a stop to the strike altogether, the message failed.

There was no dramatic outcome, and discontent continued to simmer during the following months, though Lee adopted a more conciliatory tone and did not put his threats into practice. Matters did not come to a head again until May 2006, when the Staff Association was due to make a statement to the Executive Board. Some of its members were keen to report in strong specific terms on what they considered to be aberrations, others were for stating their concerns in more measured and general terms. The statement had to be approved by the Director-General’s Office before it was delivered, but agreement within the association had not been reached in time for the deadline, so two versions had been submitted, one a good deal more confrontational than the other.

On the evening of Friday 19 May, Lee called the chairman and members of the Staff Association, his assistant director-general in charge of administration (Anders Nordstrom) and some other advisers to his office to discuss the matter with them. Both sides had reasons to be nervous, but Lee displayed a relaxed and humorous attitude from the outset. A Staff Association member who was at the meeting reflected afterwards that the discussion
had been surprisingly pleasant. The upshot of her report, which was posted on the intranet a week later when the atmosphere had become completely different, was as follows:

He was of the view that all concerns from the Headquarters Staff Association as well as those of the Regional Offices staff associations should be addressed in such a way that global issues affecting staff be heard.

Jokingly, he added that, had he been given the chance to vote, he would have voted for version B [the milder statement to the executive board], as he is also a dues-paying member of the Staff Association. He invited the Headquarters Staff Association to reflect on his message [planned address to the Health Assembly] taking into account the talent, commitment, dedication and valour of staff in WHO, and the collective responsibility we all have in carrying forward the destiny of the organization. He hoped that this meeting would mark a start for a more constructive dialogue of all concerned.

Finally he stated that the atmosphere and spirit are equally important as words on paper. He particularly mentioned that he had been a staff member of WHO for over 20 years and he had dedicated most of his working life to its mission and he therefore cared deeply about the organization and in particular its people.

The meeting ended on a positive note. And for that I am forever grateful that the last meeting JW had with his staff ended this way. It is highly symbolic that his last official meeting before his untimely death was one of reconciliation.3

Grievances of the kind Lee had to deal with, regardless of where the blame for them should be placed, reflect a weakness in the UN system. It functions through a hierarchy, in which supervisors have some power to appoint, promote, reward and penalise subordinates, but all supervisors are also subordinates, including the director-general, who is supposed to carry out the instructions of the executive board, which in its turn acts for the Health Assembly, the representatives of each of whose member

3 Recollections of the Last Meeting of the Director-General, Dr LEE Jong-wook, with Members of the Staff Association. Written by Maria Dweggah. Posted on the intranet in May 2006; hard copy supplied by the author in March 2008.
states are supposed to do as they are told by their governments. Thus neither the chief nor any of the sub-chiefs down to deputy assistant team leader can say, ‘The buck stops here’; because the buck does not necessarily stop anywhere. Other pressures for keeping the machinery in good working order, such as market forces, Realpolitik, or well-informed media scrutiny are cushioned by administrative procedures and public indifference, so the art of making it work is complex in a way that demands rare talents.

As we have seen, WHO has a further challenge of its own, constituted by its regional structure. Each of the regional directors is, in practice, elected by the member states of that region and is accountable both to the director-general in Geneva and to that regional constituency through the annual regional committee. Global demands do not always coincide with national and regional ones, so the power both of a director-general and of a regional director often depends on how well they can negotiate with these disparate forces, which include each other. A potential outcome is that each of them has less authority than they need in order to run an effective service, and are more dependent than they ought to be on outmanoeuvring each other in pursuit of resources. In the dispute over conditions of service, Lee attempted to play off demands at headquarters against those in the regions, and at the same time win the approval of member states for being a tough manager.

Whether the reconciliation would have prevailed over hostility if he had lived longer is impossible to say, especially in view of his ability to switch back and forth unpredictably between conciliatory and harsh approaches. Reiko remembered a doubles tennis tournament in Manila which she and her husband thought they had won, only to discover that they had to win another set to win the match. Unable to make the adjustment needed for a further sustained effort, Lee started serving double faults and missing easy shots, losing them the next few games, and then the set and the match. The same kind of loss of the knack of winning could have set in at work, but he also had a track record of persisting in adversity and eventually succeeding.
The staff protests were occurring at the same time as the target year for ‘3 by 5’ was ending without anything like 3 million receiving treatment. His World AIDS Day message on 1 December was one of empathy with those in need of care. Giving the limelight to two campaigners for access to treatment, Carolina Pinto, an AIDS prevention worker in Angola, and Anastasia Kamyłk from Belarus who had spoken at the Health Assembly in 2004, he focused on their hopes and fears rather than his own. ‘Like all those who are living with HIV,’ he said of Anastasia, ‘she has a strong sense of her own mortality. Living with death postponed sharpens the urgency to make the most of skills and time left.’ At the same time he presented a report that was as upbeat as possible on how the campaign had turned out: ‘In just 18 months, the number of people on antiretroviral treatment in Africa and Asia has tripled. More than a million people in the developing world now have access to antiretroviral therapy.’ It means, though, that it was one million rather than the three so loudly proclaimed two years previously.

Partly to maintain resilience under pressure, Lee took sports and recreation seriously. Just as the Pacific Islands had been the place for scuba diving, Switzerland was the place for skiing, and he took it up with zest. That winter he was a familiar sight at Les Rousses and Les Contamines in orange jacket, helmet and gloves and with the latest ‘go-faster’ skis, taking the slopes at impressively steep zigzags. Sometimes he would go with Patrick Chevalier, sometimes with other friends, and sometimes on his own. He also rode his bike regularly around the Divonne Lake.

5 Alison Rowe, email dated 28 April 2008.
‘The Boss Has Collapsed’

On Sunday 14 May 2006, a week before the World Health Assembly, he suggested to Reiko a visit to Annecy. Once the Assembly started they would not have a chance to be together much before it was time for her to leave again for Peru. Although it was less than an hour’s drive from where they lived, Reiko was against the outing because he seemed so tired. He persuaded her, however, and they set off, but he soon got sleepy, so they stopped and he slept for twenty minutes. Reiko urged him to go home and rest properly but he insisted that he was all right, so they went on to the historic French town where they had often enjoyed relaxing and strolling by the lake. They parked near the lake as usual, but after they had walked about a hundred yards, he said: ‘Shall we go home?’

Tiredness is not necessarily an alarming symptom, and after some extra rest, Lee continued to work as usual in the days before the Health Assembly, with a crowded schedule of meetings and receptions. The following Saturday morning he enjoyed the rice balls, a favourite dish, that Reiko had prepared for him for breakfast. ‘Very good,’ he told her, looking well and cheerful as he got ready to leave for a busy day. As it turned out, that was the last thing he said to her. He had a lunch appointment with Gao Qiang, the Chinese minister of health, before which he spent the morning at the office on last-minute preparations for the Assembly that would open on Monday. While working with his speech writer on the address he was to deliver, he complained of a
headache but apparently assumed it was just due to the pressure of work, and took a paracetamol.

At 12:30, Gao Qiang and government officials with their WHO counterparts were waiting at the Chinese Mission for Lee. The lunch was an annual event to exchange views and information on issues that would come up during the Health Assembly. Lee arrived a little late complaining of tiredness. He had too many headaches, he joked, and took another paracetamol. According to Patrick Chevalier, his intention had been to put in a brief appearance, just to excuse himself from the luncheon, telling them he was feeling unwell and was going home to rest. He must have changed his mind, however, and was soon sitting down with the others at the lunch table. He was uncharacteristically quiet during the meal, and asked other WHO staff present to answer questions on Taiwan, the International Health Regulations and other matters. He was also not eating, and at the beginning of the third course, he asked to be excused so he could lie down for a few minutes in the adjoining room.1

Margaret Chan and Bill Kean, the two physicians present, hurried to help Lee as they saw him preparing to leave the room, and got him to a sofa where he could lie down. Before he could relax, he vomited, and then lost consciousness. By this time everyone had left the table and an ambulance was called. It came a few minutes later, and Chevalier, who was waiting outside with the car, said afterwards that he felt sure as soon as he heard it approaching that it was for Lee. It was soon speeding to the hospital, and Chevalier went to Nyon to pick up Reiko and take her there.

Ian Smith was at home working on preparations for the Health Assembly when he got a phone call from Bill Kean: ‘Ian, we’ve got a problem. The boss has collapsed.’ Part of the problem was simple: to cancel the two remaining appointments for that day and the nine for Sunday. Part of it was more complex: when the Health Assembly opened on Monday, who was going to be

1 This account of the sequence of events is based on conversations with WHO staff who were present: Liu Peilong, Denis Aitken and Bill Kean.
sitting in the Director-General’s chair, or would it be left empty? In either event, who would decide what the correct procedure was, and who would be in charge? Once when someone had asked him what the authorities would say, Lee had replied, ‘I am the authorities’, partly as a joke no doubt, but it was symptomatic of a weakness in the system which now came into full view.

While senior managers began to see what they should do about the vacuum he had left, Lee underwent surgery to remove a blood clot from his brain. In the night the surgeon broke the bad news to Reiko and two close friends who were waiting with her, Sally Smith and Ken Bernard: though the patient was still alive, it was only because his breathing was being maintained artificially by a ventilator, and he was not going to recover.

During the night, as Reiko sat by her husband’s bed in the intensive care unit she remembered how Lee had started coming to the St Lazarus compound as a newly qualified doctor, and how she had eventually decided to become his wife rather than a nun. She also remembered the Archbishop telling him ‘You should become a Catholic,’ and Lee agreeing with him, at least by word. During their married life, Lee had sometimes joked that he had ‘stolen Reiko from God,’ but it would be truer to say that she had linked him to a religious perspective he might not have had if they had not been married. Later she wrote:

I was told that JW wouldn’t recover on Saturday night and suddenly in the morning I thought about it. I thought it was the only way to get together with him after both of us have gone to the next world. Although of course the Bible says that in heaven we wouldn’t be husband and wife any more. I thought that I could do it as it is said that any believer could do it in the name of the Father and Son and Holy Spirit for an emergency case. But I asked Sally to try to ask someone whether any priest was available. The chaplain of the hospital could come.2

Ian Smith had told Sally that two months earlier he had been chatting with Lee about beliefs and Lee had said that in the past

2 Email dated 29 October 2009.
he used to consider becoming a Christian if things went well for him, and now things had gone well, so perhaps he should, but he made no attempt to specify what that might entail. To Reiko, Lee had made similar remarks, including, recently: ‘All those candles you lit for me and Hiro in all those churches we visited together, they seem to have done the trick.’ Such remarks could be quite in keeping with Lee’s usual manner of humorous ambivalence and his ability to adopt the point of view of the person he was talking to (others have asserted that he wasn’t interested in anything of that kind), but they also made it possible to speculate that he would not have been opposed to this last-minute acquisition of a religion, especially if he could see it would make life easier for Reiko.

After a few brief explanations, the priest performed the rite of baptism, in English, with the recipient, his head bandaged, lying unconscious, on a ventilator, and Ken Bernard, Sally and Reiko standing at his bedside. ‘At the end of the ceremony,’ Reiko wrote, ‘a candle should have been lighted but it was prohibited to use fire in the room, so I received it and asked for it to be lighted during the funeral mass. It was wonderful that Sally (Baptist), and Ken (Jewish) were there for a Catholic baptism.’

For the rest of the day and the night, he was kept on the ventilator so that he would be alive when his son got there from the United States. When Tadahiro had still not got there on Monday morning, the head surgeon decided that treatment should be stopped without further delay. Lee Jong-wook was pronounced dead at 7:43 a.m., and Tadahiro got there at 8:30. The following press release announcing the death was issued shortly afterwards:

Dr LEE Jong-wook, Director-General of the World Health Organization, has died.

He had been in hospital since Saturday afternoon, where he underwent surgery to remove a blood clot on his brain (a subdural

3 Ibid.
haematoma). He remained in intensive care. At 07:43 this morning, he was declared dead.

All of the staff of the World Health Organization extend their sincere condolences to Dr Lee’s family.

The sudden loss of our leader, colleague and friend is devastating. Dr Lee led WHO to continue its mission to help people to attain the highest possible level of health.

He was 61 years old. He is survived by his wife and son, two brothers and a sister and their families.

Condolences can be sent to DrLee-tribute@who.int

Continuing the Work of WHO

The World Health Assembly, with delegations from WHO’s 192 member states, opened in the Palais des Nations at 10:20 that morning, presided over by Elena Salgado, the minister of health of Spain. After declaring the meeting open, she carried out the difficult task of announcing the death of the Director-General. In a sometimes faltering voice, she praised his dedication to WHO, his efforts to tackle world health problems, and the friendly relations he had enjoyed with health ministers around the world. She called for a two-minute silence to honour his memory, then a half-hour break, followed by the Vienna Philharmonic Orchestra playing ‘a slow movement in honour of Dr Jong-wook Lee’.

4 So far, this is the only statement to have been issued on the cause of death. A haematologist I asked thought it was likely to have been an aneurism of an intracranial artery, and a neurosurgeon thought the same. Others say that in that case the bleed would have been subarachnoid, and subdural bleeding is usually caused by trauma or anticoagulants. Generalists nearly always link the bleed to stress, but this does not appear as a factor in the standard literature on subdural haematoma.


orchestra had come as in the two previous years to mark the opening of the Health Assembly, and had had to send back at short notice to Vienna for appropriate music.

When the meeting was resumed, Salgado announced that in 2003 Dr Lee had appointed Dr Anders Nordström, assistant director-general for Administration, as his deputy, but only in the eventuality that the Director-General should become unable to perform the functions of his office, or the office would become vacant. So, in accordance with the rules of procedure of the World Health Assembly, Dr Nordström, as the most senior official of the Secretariat, would be appointed as acting director-general. She added that there would be a meeting of the executive board as soon as possible, and moved straight on to the items planned for the assembly before the death of its central figure—the traditional opening addresses by an under-secretary-general of the United Nations and a conseiller d’état of Geneva.

It was not until the afternoon, after the usual speeches calling for and opposing Taiwan’s participation as an observer in the Health Assembly (this time only two for it and two against) and further administrative matters, that concerns were voiced about who should be the acting director-general. The occasion was an announcement by Denis Aitken for the secretariat that a special session of the executive board would be held ‘as soon as logistically possible and it concerns the recent events that we heard so tragically about this morning.” The delegate of Pakistan then cited Rule 113 of the Rules of Procedure of the World Health Assembly, according to which, ‘In any case where the Director-General is unable to perform the functions of his office, or in the case of a vacancy in such office, the senior officer of the Secretariat shall serve as the acting director-general, subject to any decision by the Board.’ His questions were whether a provision made confidentially by the Director-General two and a half years previously could overrule those set out in the Constitution and Rules of Procedure, whether an appointed officer (such as an assistant director-general) was senior to an elected one (such as

7 WHO, Fifty-Ninth World Health Assembly, 27
a regional director), and whether it was an interim incumbent or a successor that was taking over. In any case, the executive board should meet ‘without any loss of time,’ he said, to ‘rectify an interregnum which is developing.’ Seven delegates added their voices to these concerns, Legal Counsel explained the provisions of WHO’s Constitution, and the discussion ended with a decision that the executive board would meet at 6 p.m. the following day to clarify the situation, with interpreters for the six official languages on hand till midnight.

For the ensuing agenda item, entitled ‘Address of the Director-General’, Bill Kean read some highlights from the speech that had been prepared, the full text of which was distributed. The highlights selected touched on ‘the spirit of cooperation and wider purpose’ displayed by member states in negotiations during the past year; the health of the Palestinian population; finishing the job of polio eradication; universal access to treatment for HIV/AIDS; the need for strong WHO leadership in malaria control; and United Nations reform which called for ‘not words but action’. He then introduced Johnson Mwakazi. ‘Dr Lee heard this 19-year-old’s striking poetry in March this year during his visit to Kenya, Johnson’s home. He heard him speak on HIV and invited him here to the Health Assembly,’ Bill Kean explained.

Johnson Mwakazi then read his poem, which focused on the stigmatisation of people living with HIV/AIDS. He probably fulfilled Lee’s hopes, by both inspiring his audience and making them uncomfortable, saying, for instance, in one of his ten verses:

Anyway, I’m not begging you to understand me or even sympathize with me
Because I know some of you,
Oh yes, most of you,
Make money because of my status.
But I want you to know this

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8 Ibid.
If at all you think you are negative,  
You never know until you go for testing.  
And if you test negative,  
You never know, you might as well be in the window period  
Oh yes, in the window period.

His closing line was an appeal to ‘Jesus Christ, the sovereign Lord who reigns for ever and ever’—which may not have gone down well with everybody, given the variety of faiths assembled.

Speeches by many delegates ensued in the customary way, about the address of the Director-General and health activities in their own countries, all of them beginning with expressions of shock and sorrow at his death. The Prince of Wales, who spoke the following afternoon, began in the same way, and then presented his thoughts on alternative approaches to healing. This was followed by an award to Bill Sergeant for his work as chairman of the International Polioplus Committee of Rotary International, on the occasion of his retirement at the age of 86. The symmetry of the three guests—a very young Kenyan and a very old American with a 58-year-old English celebrity in between—reflects the creative pleasure Lee took in staging the Health Assembly. It is worth noting, however, that both the contribution of the Prince of Wales and that of Johnson Mwakazi could easily have misfired if the atmosphere had been the usual one of wariness tempered by conditional goodwill. After David Heymann had presented the award to Bill Sergeant on the Director-General’s behalf, the speeches by delegates continued till 5:35 p.m., leaving the executive board just enough time to get to their special session at 6 p.m.

At that special session, which began with a one-minute silence ‘to honour the memory of Dr Lee,’ agreement on whether to confirm Anders Nordström as the acting director-general was apparently hard to reach. All the board members from the Eastern Mediterranean region and most of those from the African Region argued against the validity of Lee’s memorandum appointing Nordström as deputy director-general, while those
from the other regions spoke mostly neutrally or in favour of it. As the relevant rule stated that the designation was ‘subject to any decision by the Board’, they had no choice but to come to a decision on the matter. Much of the discussion turned on the question of seniority, and culminated in a proposal that Dr Hussein Gezairy, regional director for the Eastern Mediterranean since 1982, should serve as acting director-general. This brought the tension between the authority of headquarters and that of the regions into sharp focus, and the meeting was suspended for 50 minutes. When it was resumed, the chairman announced that Dr Gezairy had advised him that he would not be a candidate, and there appeared to be a consensus that the board’s decision was ‘to appoint Dr Anders Nordström to serve as Acting Director-General until the appointment of, and assumption of office by, the new Director-General of the World Health Organization’.10 That decision was formally adopted without further discussion, together with one about clarifying the position of deputy director-general for the future, and one about establishing the procedures for electing the next director-general as soon as possible. The meeting ended at ten to 11 p.m.

The next day, the funeral was held, described in the opening chapter, bringing the story of Lee Jong-wook’s life to a close.

10 Executive Board, Special Session, 23 May 2006, EBss-EB118/2006/REC/1.
Epilogue

‘It is important to understand what you really want in your life and never stop moving to that goal,’ Lee said in one of his last speeches. He was quoting Anastasia urging those in need of treatment to stand up for their rights, but her advice could apply as well to himself as to anyone else. Did he understand what he really wanted in his life? It is easy to see that he was ambitious, but not so easy to see what his ambition was. In the script for his last address to the Health Assembly he presented himself as an actual or potential world leader, despite the fact that he had not made good on pledges boldly announced three years earlier such as ‘3 by 5’. Although he had learnt a great deal since his school days, he still seemed to be nurturing visions of grandeur that made getting good grades a matter of secondary importance to him.

That approach may not be the most likely to succeed but in the case of ‘3 by 5’ it is often said to have done so: the campaign fell far short of its target, but Peter Piot praised it for putting WHO back on the map in a field where it is supposed to work,¹ and in 2008, the year in which 3 million people were actually reached, Robert Beaglehole placed ‘3 by 5’ alongside ‘some of the greatest achievements in public health’, such as smallpox eradication.²

Epilogue

The fact that universal access to antiretrovirals is now the official goal of governments and health authorities is often seen as the outcome of Lee’s impossibly ambitious commitment. Even so, at least 5 million of the 9 million people in need of it were still without access to life-prolonging care at the end of 2009, so the achievement so far is more one of winning recognition for a responsibility than of fulfilling it.

The eradication of polio, when and if it happens, will be a victory that equals that of smallpox, and Lee might get some of the credit for it in spite of the setbacks that occurred during his time in office, but in the meantime it is proving much harder to achieve than had been expected. Here, as in the other challenges he took up, such as TB control, decentralisation of WHO’s resources, and health security, the question of what Lee Jong-wook achieved in practical terms is hard to answer. It may remain too early to tell for many years to come.

The aims that were most important to him could well have been the ones he kept most hidden. As a result of childhood experiences he could have been hoping for a role in bridging the chasm between North and South Korea, or in making the UN system more powerful and effective. Or the idea of being a leader may have been more compelling in itself to him than achieving the particular objectives it entailed.

He also had a reflective side from which he viewed the whole project of public success in a rather quizzical way, implying that even that was not what mattered to him most of all. He was impressed by Kim Ki-duk’s film Spring, Summer, Fall, Winter, Spring which came to Geneva in 2004, about a Buddhist monk on an island, training a boy in the virtues of compassion, silence and sitting still. Around that time he also found a CD of Albert Camus reading his own L’Étranger for French radio in 1955 and made time to listen to that dry, exact voice telling its story of shocking indifference. After watching a DVD of Charlie Chaplin’s The Great

Epilogue

Dictator, he chatted with great pleasure and laughter about the serious farce in which a brain-damaged barber is mistaken for Hitler and ends up addressing a huge belligerent rally with a message of peace and love.4

In a conversation we had about authority, he referred to George Orwell’s Shooting an Elephant, in which the narrator reflects on how he killed an elephant when he was a policeman in Burma, feeling compelled by an expectant crowd to do it although he was sorry for the animal and did not see it as much of a danger. Lee saw this as an amusing illustration of how there had to be someone in charge who seemed to know what he was doing because human beings are social entities, just as migrating birds have to have one in front to follow, which makes leadership look more like a matter of social mechanics than the mystique of special gifts in which it is customarily shrouded. His interest in literary miscellanea of this kind was wide-ranging and retentive. In our Manila days he had heard Douglas Hurd, then British foreign secretary, saying on the radio 'Thy wish was father to that thought,' finding it brilliant, and wanted to know where it came from. Learning that it was what the king says in Shakespeare’s Henry IV Part 2 when his son tells him he thought he was dead, not just asleep, he found the saying doubly impressive, and stored it away for future use.

His interest in Shakespeare was well known, and the plays, both in separate volumes and collections, were conspicuous among his books. There was also a scattering of classics by authors such as Walter Scott, Charles Dickens, St Exupéry, Mark Twain, Tennessee Williams, T. E. Lawrence, Albert Camus, Plutarch, and T. S. Eliot. More recent bestsellers were also there, including The God of Small Things, A Brief History of Time, The Clash of Civilizations, Sophie’s World, Wild Swans, One Hundred Years of Solitude, The Reader, The Road Less Travelled, and titles by P. D. James, John Grisham, John Le Carré, John Irving, Ken Follett, and Paul Theroux. Books about heroes and geniuses included several on Einstein, In the Footsteps of Churchill, The Triumph and

4 From casual conversations with the author at work.
Tragedy of J. Robert Oppenheimer—American Prometheus, Captain Scott, Shackleton, Brotherhood of the Bomb, and several others about the Manhattan Project, including some titles by Richard Feynmann. Inside Hitler’s Bunker was also there, as well as Sebag Montefiore’s Stalin, and Christopher Hibbert’s The Virgin Queen, about Elizabeth I. Books of that kind were interspersed with others on the wines of Burgundy, marine life in the South China Sea, commercial and financial French, Japanese verbs, the cathedrals and castles of Europe, more general travel books, the principles of medical statistics and miscellaneous other books about health though not more numerously than other subjects, and some ‘how to’ books, such as Public Speaking Made Simple, The Top Ten Mistakes Leaders Make, and The 48 Laws of Power.5

Time to read and ponder were increased with Reiko’s absence from 2002 onwards, and with it some eccentricities that may be associated with bachelorhood. She used to cut his hair, and when she was not there he used to go to the airport to get it cut, rather than shop around for a more exclusive service. To keep himself supplied with decent suits, he got Reiko’s sister Yuriko to order them for him in Tokyo and have them sent. From time to time he would invite all the Korean staff members out for a meal, apparently to enjoy the camaraderie of chatting in his own language. In the same vein, many friends and colleagues from earlier times recalled being pleasantly surprised by a phone call out of the blue from the Director-General who just wanted to chat. His habit of riding a bicycle or getting on the bus when it was more convenient than calling for his car was also seen as eccentric, in addition to being an intentional display of unpretentiousness.

All this reflects a rather solitary life. Being the head of WHO made him the centre of attention and the object of constant efforts to please, but it made natural friendship more difficult. The power to thwart or fulfil ambitions called for wariness on both sides, whether he was with equals, superiors or subordinates. If

5 Titles noted from books sent from the Lees’ flat in Nyon to the annual WHO staff charity book sale in 2006.
the adage that ‘solitude is the school of genius’ is applicable to Lee, it may be because of the very sense of isolation which made him aware of the sad fact of distance between the self and the other, especially when one or both are in a position considered to be high. Paradoxically, that awareness set up a current of humorous sympathy which made many people feel they understood him and were understood by him in a special way. That was perhaps the essence of what Reiko called ‘his genius for friendship’. It gave those who knew him a sense of adventure which he never lost and which in fact outlives him.
Presentation to the Executive Board

Mr Chairman, Members of the Executive Board, Ladies and Gentlemen,

It is an honour to be here today to present to you why I am seeking election as the next Director-General of this great organization. You must be very tired today after listening to all these presentations. But I am sure I can maintain your attention in the next half an hour.

I have worked for WHO for 20 years. And I am proud of it. I started in Fiji, working to control leprosy. It was a rewarding and a humbling experience. I was a young doctor, working and travelling alongside more experienced, wiser and older national physicians. But because I came from WHO, they always put up with me. Their understanding and good humour helped shape my career in public health. Since leaving them, I have worked at the Western Pacific Regional Office for 7 years and for nine years at headquarters. But it was the experience of working with doctors, patients, and public health officials in the field that has always been my reference point. These people have brought me here today.

As you know well, when WHO was established in 1948, we were given this mission statement: “The attainment by all of the highest possible level of health.”
Nearly 55 years later, we are still a long way from achieving this lofty goal. Millions of people continue to suffer and die unnecessarily, and billions lack the basic health necessary to raise themselves from abject poverty.

But this is not a reason to become disheartened. These noble goals we have set ourselves must not be abandoned. Setting apparently impossible goals drove us to eliminate smallpox and will soon rid the world of polio. These are the ideals which will drive the entire global health community to ever greater achievements.

In this presentation, I will answer three fundamental questions. WHAT needs to be done to fulfill our mission. HOW can we do it, and WHY I am the right person to make it happen.

Let me begin with the question of “WHAT” needs to be done.

Today, we have another set of ambitious goals that build on the WHO constitution and the aspiration of health for all, expressed in the Alma Ata declaration 25 years ago. These are the Millennium Development Goals agreed at the Millennium Summit by the members of the United Nations in September 2000. We must now focus our work on these global commitments to sustaining development and eliminating poverty.

The eight Millennium Development Goals have clear targets and indicators. Six of the goals, and many of the targets, are specifically related to health. What we now need is a massive and rapid scale-up of action and resources to meet these targets. WHO will have a crucial role in facilitating this scaling up.

As we all know, many parts of the world, especially Africa, are experiencing the devastating impact of the HIV/AIDS epidemic. HIV/AIDS threatens many areas of human social life in highly impacted countries. There is no question that the new Director-General will have to make it an extremely high priority. Together with UNAIDS and the Global Fund, I will forge a powerful and effective alliance to address this pandemic.

There are no easy answers to this problem, but in leading vaccine and TB programmes, I have learned much about organizing and delivering complex public health interventions in resource-poor settings. We will have to use all the lessons of past interventions, and invent many new ones. Our generation will be defined by what we do in response to HIV/AIDS. While we can’t allow it to overshadow other critical programmes, successful measures to combat HIV/AIDS could have extremely positive effects on all aspects of health systems.
We come now to “HOW”.

I have five priority areas for WHO that will turn commitment into measurable outcomes:

- Total commitment to achieving the Millennium Development Goals;
- Decentralizing WHO and its work;
- Enhancing WHO’s efficiency;
- Improving WHO’s accountability;
- Making WHO an even better place for people to work.

If I am elected, my first and over-riding priority as Director-General will be to meet the health-related Millennium Development Goals. I will advocate for a substantial increase in investment—both national and international—in public health systems and services.

The new resources flowing through the Global Fund to Fight AIDS, Tuberculosis and Malaria will make a substantial difference, and are most welcome. WHO will continue to work with the Global Fund Board and its Secretariat to ensure that the GFATM can manage existing resources well and disburse them rapidly. But we must also continue to make it clear that the financial commitments made so far are nowhere near enough, and do not adequately address the wider needs for scaling up AIDS, TB, and malaria control.

Despite the generosity of our supporters inside this room and elsewhere, WHO will never have resources to do everything that we want it to do. We must therefore focus our work on the things we do best—on setting high quality norms and standards in health, directing and coordinating international public health, on advocating for better resources and more efficient delivery, and on always providing the evidence to back up what we say.

I will focus on helping Member States to address the serious human resource problems that many currently face. I will therefore work with countries:

- to mobilize investment to increase their capacity for basic training of health workers;
- to develop sustainable reward systems for health workers;
- to improve long-term human resource planning in rich and poor countries to help alleviate the brain drain from the south;
- and to develop a mentoring system in WHO. This would involve recruiting and training young health professionals who would
gain valuable experience by working alongside more senior colleagues in WHO for a 2-year period before returning to their home countries.

I will promote specific health interventions that have clear impact on reducing both morbidity and mortality, particularly for the most vulnerable. Improving maternal health, child immunization, DOTS to cure TB, are some of the examples here. Having directed the campaign against polio for eight years, first at WPRO and later from headquarters, I will ensure that polio is eradicated during my tenure. In focusing on the Millennium Development Goals, I want to make it clear that this will not be at the cost of WHO’s broad scope and mandate. Our definition of health is a wide-ranging one. Our work must continue to encompass other priority areas, such as noncommunicable diseases, reproductive health, tobacco control, health systems, human rights, gender, violence, and mental health. We must continue to demonstrate leadership in all these areas.

The Framework Convention on Tobacco Control is a case in point. Signing of this important treaty is just a start, and its effectiveness must be carefully monitored over the coming months and years. My second and third key priorities are interlinked—decentralization and efficiency. I will devote more of WHO’s resources to the countries and regions where they can have the most direct impact. Today, the numbers of staff, long-term and short-term, at HQ are increasing steadily. In the 2004 and 2005 budget, 36 per cent of the total are allocated to HQ. I will shift this HQ proportion to 25 per cent by 2005 and 20 per cent by 2008. Shifting the HQ budget to the regions and countries will stop and reverse the trend of ever increasing numbers of HQ staff.

I will implement what I call “forward deployment” of specific technical programmes to the regions where they can have the biggest impact. For example, the Leprosy programme will be moved to the South-East Asia Regional Office, the Guinea Worm programme to the Eastern Mediterranean Regional Office, and the Traditional Medicine programme to the Western Pacific Regional Office. This “forward deployment” of programmes should not be interpreted as ‘regionalization’ of specific diseases. Rather, WHO’s technical experts will benefit from the rich local knowledge, as well as delivering programmes more directly to the people most likely to benefit from them. It will also produce cost savings. Together, we have to change both the way our work is done and the places where it is done.
We have to move to high technology. I will continue to invest in information technology and specifically in the communication infrastructure that links country offices with the regions and headquarters. Increased use of video conferencing will replace some meetings and duty travel.

We have to outsource whenever possible. Can’t we utilize our hundreds of collaborating centres around the world more effectively?

Some people do not believe that our regional and country offices can deliver. Their scepticism has contributed to the centralization of resources we see today. I strongly disagree with this assessment.

Country offices, regional offices, and headquarters are the three organizational pillars of WHO. Taking advantage of my personal experience in each of these three pillars, I will oversee a more effective distribution of resources among them.

Together with Regional Directors, I will undertake management reforms and capacity building in regional and country offices. With greater capacity and more resources, regional and country offices can take more responsibility for country support. The focus of work at Headquarters will be on setting, directing, monitoring and coordinating strategic directions on global health issues, and on the normative functions that support communities and countries as they strive to reach their health goals.

These changes will be an extension of what Dr. Brundtland started 5 years ago. I will introduce these changes through close consultation with you, the Members of our Board, with the Regional Committee and Regional Directors, and Member States.

Fourth, under my leadership, WHO will be more accountable and more transparent. We receive and spend large amount of public money. Even the poorest taxpayers in the poorest country contribute financially to the work of WHO. As Director-General, I will introduce a continuous process of programmatic and fiscal evaluation. I will always remember that the Member States are the reason for WHO’s existence.

The final priority I want to talk about today is the people who work for WHO—but by no means they are my last priority. None of the things I have talked about can be done without a fully engaged and committed staff. I am committed to making WHO a great place to work. I will do this by building clear career paths, by investing in in-service training, and by delegating authority to the skilled professionals who work here. Our people are the most valuable asset we have. Maintaining high morale
and keeping them focused and committed is not a simple task. I want to attract the best people. I want to provide the best possible working atmosphere for them. I want them to grow professionally during their time here.

Mr Chairman, Members of the Board, I would now like to turn to the key role of partnerships. WHO, essentially, is itself a specialized partnership of sovereign Member States.

For the past two years, I have been in charge of rebuilding Stop TB. During that time, the Stop TB partnership has grown into a complex and effective coalition of more than 250 international partners that includes WHO Member States, donors, NGOs, industry and foundations. We have developed innovative ways of purchasing and delivering much-needed drugs through the Global Drug Facility. We have brought global attention to a woefully neglected problem and we have made major measurable progress towards the goals of better detection and treatment of TB.

This is real progress. It was brought about by serious commitment to partnership. In all that we do, we must find ways to work beyond WHO. Building successful inclusive partnership cannot be an extra to our core work. It must be the core. However, any partnership in which WHO plays a part must earn our participation. If anyone worries about dilution of WHO’s leading role through partnership, I like to remind you that partners need WHO as much as we need them.

As you nominate the next Director-General of WHO, I ask that you consider three facts.

First I know this organization—probably better than most. I know the people who work here. I know our strengths and our weaknesses. As a Senior Adviser to the Director-General, I was closely involved in the reform process over the past years. That experience will be a vital asset in the coming months and years, as we build on the achievements of WHO in the past 55 years.

Second, I understand the opportunities and problems faced by many countries, both developed and developing. I grew up in what was then an extremely poor country. The Republic of Korea today has become an industrial and economic power house, but during my early life, Korea faced the problems of a developing country. I have not forgotten that experience.

Third, I deliver results. Over the past nine years, I have had the privilege of leading two key programmes, the immunization programme,
including the polio programme, and Stop TB. The key element for both is their impact in countries. The numbers of children immunized and protected from vaccine preventable diseases. The number of people cured of TB. Both programmes have shown substantial improvements in performance, and a significant increase in resources under my leadership.

I know this organization. I understand the opportunities and problems faced by many countries. And I deliver results. This is what I offer to you today.

Thank you very much.

Geneva, Switzerland         21 May 2003

SPEECH TO THE FIFTY-SIXTH WORLD HEALTH ASSEMBLY
Dr LEE Jong-wook, Director-General
Monsieur le Président, Mesdames et Messieurs les Ministres, Distingusés délégués, Mesdames et Messieurs,

En m’élisant comme premier Directeur-Général de l’Organisation mondiale de la Santé pour ce nouveau millénaire, vous m’avez confié une très grande responsabilité.

La responsabilité non seulement de poursuivre la tâche de mes distingués prédécesseurs, mais aussi de faire en sorte que l’OMS puisse répondre aux demandes toujours grandissantes qui lui sont posées.

Ce défi demande de l’excellence dans la connaissance, de la bonne volonté et de la détermination, de la part de chacun d’entre nous. Cela demandera aussi de la sensibilité politique, des compétences techniques et une vision éthique.

Today, I will briefly describe the main values that should guide us over the next five years, the global health situation, and how we must respond to current health challenges.

The world today needs leadership in the ongoing struggle for security from infections, and justice for those worst affected by diseases of poverty. The United Nations system was founded precisely to uphold these two principles of security and justice. They are interdependent. The world leaders who drafted the UN Charter saw that peace and security depended on establishing what they called “conditions under which justice . . . can be maintained.”
The WHO Constitution, signed in 1946, takes up this theme; if it is true for global politics, it is equally so for health. The Organization has an inclusive mission: to work for the highest attainable standard of health “for every human being without distinction of race, religion, political belief or economic or social condition.” Our Constitution commits us to solidarity. It warns that “unequal development in the promotion of health and control of disease” is a “common danger” for all peoples. These commitments are not naïve. They emerged from the most destructive war the world has ever seen.

Today, more than ever, it is clear that the values of the UN Charter and the WHO Constitution have to orient our work.

In many ways the global health situation has improved during the 55 years since WHO was founded. We have seen historic achievements, including the eradication of smallpox; significant reductions in childhood mortality; and much longer lifespans in many countries. But these successes present a sharp contrast with today’s unmet health challenges, and the suffering of millions of people still without access to the benefits of medical and scientific progress. The great infectious killers continue to spread. The HIV/AIDS pandemic is erasing decades of gains in life expectancy in some countries—25 per cent of adults in the hardest-hit areas may be killed by AIDS within 10 years. Partly because of the synergy with HIV, progress toward controlling tuberculosis is slow. Two million people die from tuberculosis every year. Meanwhile, malaria causes 3000 deaths a day, mainly among children.

We also face major new challenges. The SARS outbreak underscores the world’s vulnerability to new infections. Ten days ago I was in Beijing to discuss the situation there with the Chinese Government. I saw for myself the determined efforts now being made to control SARS. I also confirmed the urgent need for stronger disease surveillance and response mechanisms at local, national, and global levels.

At the same time, noncommunicable diseases are taking a heavier toll. Together, they accounted for more than 45 per cent of the world’s disease burden in 2001. That percentage is projected to rise. We see the unmet challenges in women’s health, including maternal health. There has been little progress in reducing maternal mortality rates over the last decade. We also see huge challenges in the area of mental health.

Behind such figures lie struggling health systems. Many countries face critical gaps in infrastructure, medical technologies, and human resources for health. Investment in health systems in developing
regions remains inadequate. Countries, donors, and international agencies have yet to work out a coherent and effective response.

As a result of these patterns, global health inequalities continue to widen. Consider two extremes. A girl born in Japan in 2002 has a reasonable chance of living to see the 22nd century. A child born in Afghanistan in the same year has a one in four chance of dying before the age of five.

Average life expectancy in some high-income countries is approaching 80 years. But in parts of sub-Saharan Africa, HIV/AIDS and other health threats are pushing average life expectancy down towards 40 years and less. A globalized society characterized by such extreme disparities is neither acceptable nor even viable.

The question of equity has special meaning for me. I come from Korea. When I was a boy, my country was impoverished and torn by war. Our people suffered the afflictions known to many other poor countries then and now. Koreans of my generation have not forgotten the lessons of an earlier time. We know what it means to face conflict, poverty, and widespread sickness. From this formative experience comes my determination to stress the health needs of the disadvantaged.

Mr President, let me speak now about how WHO and its partners will address global health challenges in the years ahead. The main directions of our work are already clear.

Twenty-five years ago, the Alma-Ata Declaration announced the goal of “Health for All by the Year 2000,” to be achieved by strengthening primary health care systems. We cannot turn back the clock to Alma-Ata. But we must renew the fundamental commitment to equity expressed by “Health for All.” WHO must work to translate this ideal into measurable results, through a new relationship with Member States.

The key to WHO’s work in the coming years will be a new commitment to results at country level. Five years from now, our operations will be significantly more focused in countries. We will be “closer to the ground,” working more intensively with national health authorities to respond to their priority health goals. We will focus on achievable objectives in areas where WHO can provide skills and resources.

What such dedication to results in countries can mean was shown by our WHO colleague Dr Carlo Urbani. Dr Urbani died of SARS on March 29. He was the first to recognize the significance of this new disease, and he treated the earliest cases in Hanoi. With other WHO doctors
and scientists, he initiated the worldwide alert that spurred efforts to contain the infection, saving numerous lives.

Shortly before Dr Urbani became ill, his wife worried about the danger in which he was putting himself. Dr Urbani replied: “If I cannot work in such situations, what am I here for—answering emails and pushing paper?”

Carlo Urbani has given us WHO at its best—not pushing paper, but pushing back the assault of poverty and disease.

Today we are honoured to have Giuliana Chiorrini, Dr Urbani’s wife, present with us. I ask her and her family to accept the expression of our condolences and our profound gratitude for his work and life.

Mr President, commitment to results at country level is the core of my vision for WHO. As I see it, this has five main implications. Let me briefly indicate the broad importance of each of these for our work together.

The first implication is aggressive pursuit of measurable health objectives, including the Millennium Development Goals, which were adopted at the United Nations General Millennium Summit in September 2000. They set clear objectives for countries in nutrition; access to safe water; maternal and child health; infectious disease control; and access to essential medicines. These goals are strategic focal points within a broad health agenda that builds on the Alma-Ata legacy.

Central to this agenda must be an intensified engagement against HIV/AIDS. Working with UNAIDS, the Global Fund, Member States, civil society, and other stakeholders, I will ensure that WHO provides leadership toward the bold “Three-By-Five” target: three million people in developing countries on antiretroviral treatment by 2005. As treatment is rolled out, HIV prevention efforts must also intensify. We will use the delivery of HIV/AIDS services as a way to build up health systems. We will work with partners to strengthen community involvement in HIV/AIDS prevention, care, and treatment.

We will also press forward towards other health targets. For eight years, I headed campaigns against polio, for four years in the Western Pacific Region, and later from headquarters. I pledge to complete the eradication of polio during my tenure as Director-General.

The commitment to results has a second implication for our work together, which is shifting more resources to countries. Decentralizing WHO’s work is a means of serving countries more effectively. It will be pursued in cases where it will promote positive results on the ground.
It is about building up our institutional strength wherever it can best serve countries’ needs, in the totality of WHO.

This is closely related to my third watchword, which is efficiency. Shortly, I will propose specific shifts in prioritization and cost-cutting measures. A key to increased efficiency is better use of new technologies. We have made progress on information technology, but much remains to be done. I propose to accelerate investment in IT and specifically in the communication infrastructure that links country offices with the regions and headquarters.

The fourth implication is a new emphasis on accountability. As Director-General, I will substantially strengthen the audit function at WHO.

Yet I understand accountability not just in terms of finances, but also in terms of the effectiveness of our contributions to health outcomes.

More broadly, all of the work of countries needs more reliable and timely health data. Accordingly, improving global health surveillance and data management will be a key WHO objective in the coming five years.

I will lead WHO and its partners in a major expansion and strengthening of the Global Outbreak Alert and Response Network. SARS is the first new disease threat of the 21st century, but it will not be the last. We will complete control of SARS and reinforce our defences against the next new infectious killer. Ninety per cent of resources will go to build disease surveillance capacity at country and regional levels. Substantial funding has already been committed, and the recent announcement of US support for this area of work is most welcome.

We will also expand and improve health measurement, with a strong emphasis on capacity-building in countries. Rationalized systems for health metrics are needed to track progress toward health targets, and to reinforce mutual accountability among countries, donors, and international agencies.

My fifth and final watchword for the years ahead will be strengthening human resources, both inside and outside the organization.

I am developing plans to create more coherent career paths that will clarify institutional expectations and enable professional growth throughout the span of a WHO career. I am also determined to see WHO’s professional staff reflect more fully gender balance and the diversity of our Member States.
Likewise, externally, we must help countries meet the challenge of human resources for health. I will use WHO’s expertise and influence to develop solutions to the personnel crisis facing many health systems.

Mr President, I began these remarks by recalling the core values of security and justice, which are inseparable. I spoke of the challenges of today’s global health situation. And I told you how I believe WHO can take the lead in confronting those challenges: through a new commitment to results-driven work in countries and five key themes.

In my work at WHO and as a physician before joining the staff, I learned the value of listening. I want WHO to become more of a “listening organization” with an emphasis on open communication. I will strive to model this attitude myself. Sharing ideas will be vital in the coming months. But our final test lies in action. Let us unite our strength for the work ahead.

Thank you.

Geneva, Switzerland  21 July 2003

ADDRESS TO WHO STAFF

Colleagues in our 147 country offices, six Regional Offices, here in Headquarters, and elsewhere,

Twenty years ago, almost to the day, I started working for WHO. Over two decades, I have had the privilege of witnessing many of our Organization’s accomplishments. You, WHO staff, made these achievements happen.

Diversity of skills and backgrounds make WHO’s strength. We bring together the wisdom of experience and the energy and enthusiasm of youth. The youngest of our colleagues were born not long before I entered the Organization. For example, Deepti Adlakha, who works in the library of the South-East Asia Regional Office in New Delhi, was one-year old when I began working for WHO in Fiji.

Youthful commitment can become a lifelong vocation. Joseph Ockana, an Administrative Officer in the African Regional Office in Brazzaville, joined WHO in 1964, when he was only 21 years old. He has now served this Organization for nearly 39 years.

These two colleagues represent the range of experience and some of the many skills on which WHO depends. Veterans and newcomers,
administrative, professional and maintenance staff: without all of your individual contributions, WHO’s work could not progress.

Today we begin a new chapter in WHO’s history. We will continue the work already under way. And we will make changes where these are needed to meet the test—results in countries.

Global health work must be guided by an ethical vision. WHO’s Constitution articulates our vision. At its heart is a commitment to respect for all human beings. That commitment sustains every part of our work.

The concept of Health for All reflects the quest for social justice and health equity expressed in WHO’s Constitution. The Alma-Ata Declaration still inspires us—because it puts the people at the centre of health and development. This May’s World Health Assembly resolutions and the activism of many health workers and communities around the world show that the Health for All ideal is alive. Slogans come and go. But the objective of Health for All will always be central to WHO’s work.

Colleagues, our work together in the coming years will be guided by three principles.

- We must do the right things.
- We must do them in the right places.
- And we must do them the right way.

First, doing the right things. Today, as the HIV/AIDS pandemic enters its third decade, fresh political will and new technologies have created an opportunity to turn the tide of this global killer. The international community must act now. We must scale up an integrated global HIV/AIDS strategy linking prevention, care and treatment, prioritizing poor and underserved areas. I am, therefore, constituting an HIV/AIDS leadership team to ensure that WHO, working with local, national and international partners, will be on the forefront of this effort.

The Global Fund and bilateral programmes have pledged increased resources to the AIDS fight. But, in order for these resources to bring results, countries are requesting technical cooperation in the design and implementation of comprehensive HIV/AIDS programmes. I will focus WHO’s resources on supporting countries on the forefront of the pandemic.

In May, the World Health Assembly took note of the goal of providing three million people in developing countries with antiretroviral therapy
by the end of 2005. The ‘Three By Five’ goal presents a great technical and political challenge. By 1 December this year, World AIDS Day, WHO’s HIV/AIDS Department, working with partners, will produce a global plan for reaching the ‘Three By Five’ target. Together with partners such as UNAIDS, WHO will use all available tools of advocacy to mobilize the political will and the additional resources needed to put this plan into action.

We will use the provision of AIDS treatment to strengthen HIV prevention and to build up health systems. Resistance to antiretroviral medicines must be closely monitored. I will work with WHO’s partners to establish a global network to monitor patterns of resistance to AIDS medicines.

In 2001, the Stop TB Partnership launched the Global Drug Facility and Green Light Committee to make quality TB medicines available at reduced prices. These facilities have promoted the standardization of TB treatment, paving the way for programme scaling-up and helping control drug resistance. Later this year, WHO will launch similar initiatives for malaria and HIV/AIDS.

To promote synergies in our work on major infectious diseases, the WHO departments working on HIV/AIDS, tuberculosis and malaria will be brought together in one cluster. This grouping will facilitate our work internally. It will also streamline our cooperative relationship with countries and partners such as the Global Fund.

Partnering with countries towards the Millennium Development Goals in health will be a key WHO objective in the years ahead. We see the Millennium Goals as milestones on the road towards health for all. Until now, WHO’s contribution to the Millennium Development Goals has largely focused on measurement. We will continue to emphasize reliable data and to cooperate in building country-level health measurement capacity. But, we will also strengthen technical cooperation with countries in designing and implementing national plans to reach the targets.

Threats to maternal health and child health demand intensified action. More than 500,000 women die each year during pregnancy and childbirth; millions more become ill or disabled. This year, more than ten million children in low- and middle-income countries will die before reaching their fifth birthday. Seven out of ten of these deaths are due to five preventable and treatable conditions: pneumonia, diarrhoea, malaria, measles and malnutrition. We can reduce this toll substantially
by working with countries to ensure that health delivery systems incorporate strategies such as Making Pregnancy Safer and Integrated Management of Childhood Illnesses.

Noncommunicable diseases and injuries account for a growing share—now about 60 per cent—of the burden of disease worldwide. We will develop and implement a comprehensive plan for fighting noncommunicable diseases.

We will sustain and intensify our work in areas including tobacco control; nutrition; violence and injuries; and mental health. The nutritional transitions now affecting all but the very poorest communities pose major challenges. Working with all stakeholders, we must develop integrated approaches that will respond to the critical needs of the malnourished, while avoiding the adverse health consequences of inappropriate diets. World Health Day 2004 will focus on traffic injuries, which are responsible for over one million deaths every year, the vast majority in developing countries. Most are preventable on the basis of existing knowledge and experience.

We will eradicate polio. A difficult struggle lies ahead. But with determination we can complete the global health community’s long effort to end this scourge.

We must also be ready for new threats. The SARS crisis illustrated WHO’s essential role in coordinating the international response to infectious disease outbreaks. SARS also revealed weaknesses in global disease surveillance. We will work with our partners in the Global Outbreak Alert and Response Network, and with bilateral and multilateral donors, to reinforce national and regional surveillance systems. We will strengthen the support and coordination functions of the Global Network. And we will revise the International Health Regulations to improve disease control.

Doing the right things is only part of the job. We must also focus our action in the right places.

That means putting countries at the centre. This idea is as old as the Organization itself. What has changed is the urgency of our commitment, and the determination to back this commitment with resources. We are putting countries where they should be—at the heart of WHO’s work.

In the coming months and years, we will strengthen WHO’s presence and impact at the country level. Working with Member States, Regional Directors and WHO country staff, we will ensure that our country offices
have the resources and the authority they need. We will empower WHO country offices to work more effectively and accountably with countries in responding to national and local health needs.

In recent years, WHO’s resources have become increasingly concentrated in Geneva. Concentration has enabled much excellent work at headquarters. Yet there has been a gradual drift away from programmes based on countries’ needs toward programmes driven by headquarters priorities.

I am asking all Assistant Directors-General to analyse the work of their respective clusters and to propose specific steps for moving resources from headquarters to regions and countries. I will begin deploying additional resources to priority country offices for building up capacity in HIV/AIDS control and health systems. These resources should be available by early 2004 to support the rapid scaling-up of HIV/AIDS technical cooperation and other top priorities.

Countries have expressed their desire for greater cooperation in health systems development. This will be the core mission of WHO’s Evidence and Information for Policy cluster. EIP’s new leadership will implement a strategic planning process to achieve this mission.

Health information is the glue that holds a health system together. In most countries stronger, more integrated information systems are required. One example is vital registration systems—the ability to count births and deaths. These systems are still missing for most of the countries’ population, especially in countries with high disease burdens. To make people count, we first need to be able to count people. To address this problem, I will develop WHO’s health information partnership with Member States and international organizations including the Gates Foundation, the World Bank and UNICEF. We will put in place a health metrics network to support countries in fullfilling critical health information gaps.

Many countries face a human resources crisis in the health sector. The shortage of skilled health personnel slows progress toward health goals such as “Three By Five” and the Millennium target on maternal mortality. Our cooperation with countries on this issue must intensify. Together, we must build the health work force using innovative methods of training, deployment and supervision of allied and community health workers. Community mobilization is a key to success. WHO’s engagement with civil society and communities must develop—both in international forums and on the ground at country level.
At the international level, WHO can contribute in direct ways to strengthening human resources for health. In early 2004, I will launch the Health Leadership Service programme. This initiative will recruit promising young health professionals from around the world and will provide them with the opportunity to work and learn for two years within WHO—in countries, regional offices and at headquarters. Mentored by senior WHO staff, these young professionals will form part of the next generation of international health leaders.

Global forces influence countries’ ability to build and maintain health systems that meet people’s needs. Putting countries at the centre of our work requires critical reflection on the factors influencing sustainable development and on the health consequences of development policies. As the world’s health advocate, WHO will be a strong voice in international debates on all issues that affect health. We will continue our analysis and advocacy on the health effects of global trade policies, intellectual property rights, environmental change, migration, conflict, and other institutions and processes related to development.

As we work to do the right things in the right places, we must also do things the right way. This means a new way of working together.

To serve Member States more effectively, we need to modify our human resources policies. I want to enable WHO people to perform better, with greater job satisfaction. I will initiate an Organization-wide talent review, to be completed later this year. The goal is to ensure that people’s skills and experience are being used effectively to reach our shared goal of improved results in countries.

I am instituting a new system of staff mobility, giving WHO staff the opportunity to work in different geographical and functional areas. The programme will enhance staff development, encourage the exchange of knowledge, and strengthen connections between countries, regions and headquarters. Within the next few weeks, I will discuss with all Directors and Regional Offices the preparation of plans for rotation and mobility with their staff.

Our staff appraisal mechanism is not always effective in helping people improve their work performance. We will base appraisal on a constructive dialogue, leading to a clear development plan for each staff member. I will commit increased resources to staff development. I am reviewing our recruitment and contracting processes to fulfil our commitment to equity and geographic and gender balance.
Along with specific policies, our overall organizational culture must evolve. Such a change cannot be imposed, but it can be modelled and supported at all levels, from country offices to Geneva. The climate within WHO must become more open and collaborative. We must work more closely together, in an atmosphere of trust and mutual respect. Decision making will become more participatory. Information sharing across clusters and departmental boundaries will intensify.

In some cases, the physical arrangement of our workspaces will change to facilitate new ways of working. For example, the Director-General’s Office here at headquarters will be set up on an open plan. My desk will be among other people’s. This is not just a symbolic gesture. It is a way of ensuring that the lines of communication stay open, and that I stay in touch.

As we work more collaboratively, we will also work more efficiently. I will review and rationalize our administrative processes. Our Management Support Units can be streamlined. We will combine units so that each MSU supports two clusters.

I will foster efficiency by making better use of information technology. IT is an important catalyst for reaching WHO’s goals—in particular, closer organizational integration and greater country-level impact. Currently, WHO’s talented IT professionals are hampered by insufficient resources and the lack of an overall institutional technology strategy. Later this year, I will release a comprehensive plan for knowledge management and information technology across the Organization. We will develop a clear, rational team structure for the IT department itself. We will streamline management functions through the Global Management System. We will develop flexible, “customer-driven” IT solutions that will facilitate collaborative work. For example, today I have introduced a pilot wireless network in the Director-General’s Office. We will strengthen information management in country offices and enhance the connectivity between headquarters, countries, and regions. We will find solutions to facilitate data management and use at the point of collection.

Over the last few years, we have shifted the emphasis in planning from resources to results. This shift must also occur in our evaluation and audit functions. I am strengthening our audit capacity. I am also appointing a technical ombudsman.

Colleagues, I am proud to say we have been able to recruit an exceptional group of women and men to join us and help guide the work
ahead. You have already read their names in the e-mail message I sent out last week.

I would like to introduce the team of Assistant Directors-General:

Denis Aitken (United Kingdom), formerly Chef de Cabinet, will be Director of the Office of the Director-General.

Liu Peilong (China), formerly Director-General, Department of International Cooperation, Ministry of Health, will be Adviser to the Director-General.

Anarfi Asamoa-Baah (Ghana), currently Executive Director for Health Technology and Pharmaceuticals, will head the Communicable Diseases cluster.

Kazem Behbehani (Kuwait), most recently DGO Eastern Mediterranean Liaison, will lead the External Relations and Governing Bodies cluster.

Jack Chow (USA) served most recently as Ambassador and Deputy Assistant Secretary for Health and Science, US State Department. He will head the new HIV/AIDS, TB and Malaria cluster.

Tim Evans (Canada), Director of Health Equity at the Rockefeller Foundation in New York, will take leadership of the Evidence and Information for Policy Cluster.

Catherine Le Gales-Camus (France), Scientific Adviser to the Director-General of Health, France, will lead the Noncommunicable Diseases and Mental Health cluster.

Kerstin Leitner (Germany), UN Resident Coordinator and UNDP Resident Representative in China, will have responsibility for the Sustainable Development and Healthy Environments cluster.

Vladimir Lepakhin (Russian Federation), most recently Head of the Department of General and Clinical Pharmacology at the Russian University of People’s Friendship, will lead the Health Technology and Pharmaceuticals cluster.

Anders Nordström (Sweden), Head of the Health Division, SIDA, will take charge of the General Management cluster.

Joy Phumaphi (Botswana), currently Minister of Health of the Republic of Botswana, will lead the Family and Community Health cluster.

Now I invite Joy Phumaphi to take the oath on behalf of the Assistant Directors-General.
I have asked four outstanding colleagues, who have completed their tenure as Cabinet Members with Dr Brundtland, to undertake important tasks.

I have named David Heymann to lead our work in Polio Eradication. I have charged Dr David Nabarro to lead our Health Action in Crises. Tomris Türmen will lead a team to assess the health implications of intellectual property rights structures and develop clear policy recommendations in this area. I have appointed Dr Derek Yach to design a comprehensive plan for strengthening WHO’s response to noncommunicable diseases.

I am also appointing the following directors:

Robert Beaglehole (New Zealand) to Evidence and Information for Policy; Margaret Chan (China) for Protection of the Human Environment; Graeme Clugston (Australia) as Technical Ombudsman; Marie Andree Diouf (Senegal/ France) to Cooperation and Country Focus; Hiroyoshi Endo (Japan) to Communicable Disease Prevention, Control and Eradication; Mario Raviglione (Italy) to Stop TB in the new HIV/AIDS, TB and Malaria cluster; Bernhard Schwartlander (Germany) to Strategic Information for HIV/AIDS, TB and Malaria; Ambi Sundaram (Sri Lanka) to Support Services, Procurement and Travel; Paulo Teixeira (Brazil) to HIV/AIDS, TB and Malaria.

Colleagues, the team members I have just introduced will be catalysts in moving our work forward. But, to meet the goals I have outlined, we need the commitment of all WHO’s staff, the support of Member States, and the efforts of our national and international partners.

With humility and determination we will carry on our work in the months and years ahead. WHO’s founding vision, its achievements, its partners and, above all, its people create a solid foundation. We will put countries at the heart of our efforts. Guided by our principles of loyalty, transparency and commitment to excellence, we will move forward towards the goal of Health for All. Together, learning from the past, we can change the future of global public health.

Thank you very much.
New York, USA
22 September 2003

PRESS CONFERENCE ON AIDS TREATMENT GLOBAL HEALTH EMERGENCY

Ladies and Gentlemen,

Our failure to deliver antiretroviral treatment for AIDS to the millions of people who need it is a global health emergency.

Today, we have medicines to treat AIDS patients for a dollar a day or less but these medicines are not getting to the people who need them.

To deliver antiretroviral treatment to millions of people we must change the way we think and change the way we act. Business as usual will not work. Business as usual means watching thousands of people die every single day.

To tackle the AIDS treatment emergency, we must take emergency measures. All of us here today—WHO, UNAIDS, the Global Fund, as well as our other partners, will take the lead in delivering these urgent actions. We will use the rapid response skills we have learnt in responding to complex emergencies in Afghanistan, Liberia, Iraq and in quickly controlling the SARS outbreak.

WHO will organize and lead emergency response teams to those countries with the highest burden of HIV/AIDS based on direct appeals from governments. These teams, made up of experts in AIDS treatment from international and non-governmental organizations, will work to speed up the delivery of antiretroviral drugs, diagnostic tests and other treatment, to the people who need them.

Already, we are working to develop simplified technical guidance for the delivery and use of antiretroviral medicines, based on fixed-dose combinations, basic laboratory exams, and simpler regimens.

We are building a global AIDS Drugs and Diagnostics Facility that will help developing countries to get quality antiretroviral medicines.

And we are developing rapid training for the thousands of health workers who will be needed to deliver the treatment.

I have committed the World Health Organization to meeting an extremely ambitious target: providing antiretroviral medicines to three million people by the end of 2005, the ‘3 by 5’ target.

At current rates, fewer than one million of these people will receive antiretroviral treatment by the end of the target year of 2005. To reach
our target will require an extraordinary effort, an extraordinary effort that is already under way.

About six million people in developing countries have HIV infections that require antiretroviral treatment. But fewer than 300,000 are being treated. In sub-Saharan Africa, where most of the people in need of treatment live, only 50,000 people are receiving it.

Last month, in Angola I met Carolina Pinto, a brave young woman who is one of the very few people in the country to receive antiretroviral treatment. She is being treated at the only centre in Angola that offers antiretrovirals, but the centre’s funding is uncertain and she told me she doesn’t know if her treatment will continue. We have to make sure that Carolina and the millions of people like her get the medicines they need.

Of course, on its own, providing medicines is not enough. Investing in treatment for AIDS also means strengthening health systems. This will benefit all those who require health care, for AIDS, for TB and for any other health needs.

We are now working out exactly how much money will be needed, both to provide the medicines and strengthen the systems to deliver them. We will be working very hard to make sure this funding is found as rapidly as possible.

What is needed is quite simple: a change in spending priorities. In Europe, for example, every single cow receives a daily subsidy of two dollars. Half of that amount would buy the drugs needed to treat an AIDS patient.

We know that AIDS is not a new disease. The possibility of treating people with antiretroviral medicines is not new. What must be new is our approach and our determination to meet this emergency. We must use all the skills we have learnt in responding to previous emergencies and controlling SARS to deliver these life-saving drugs to the millions of people who need them now.

WHO, UNAIDS and the Global Fund will be there with our partners to respond to this emergency. We call on governments, other international organizations, non-governmental organizations and all involved in the response to AIDS to join with us, to act with urgency, with commitment, and with the necessary words, deeds and resources, to tackle this global, human emergency.
UN General Assembly: Global Road Safety Crisis

Mr President, Secretary-General, Distinguished Delegates, Ladies and Gentlemen,

The first person to be killed by a car was Bridget Driscoll of the United Kingdom. She was 44 years old and a mother of two. She was knocked down at London’s Crystal Palace on 17 August in 1896. The car was travelling at 12 km per hour. She never knew what hit her. The British coroner recorded a verdict of accidental death. Speaking at the inquest, he warned: “This must never happen again.”

The world, to its great loss, has not taken his advice.

Twenty years ago, Michel Zoller was driving to work when his car collided with a truck. He was not killed but he was in a coma for six months. He attended our World Health Day celebration last week in Geneva, in a wheelchair, as his injuries have left him paralysed for life. His wife spoke on his behalf, because he has lost the use of his voice. She herself found it very difficult to speak—not because of any injury, but because of the trauma of recalling what had happened. Her message was that this must never happen to anyone again. On behalf of her family, and the millions of others who are afflicted in the same way every year, I bring you the same message today.

I thank the Government of Oman for taking a lead in bringing this topic today to the General Assembly.

The deaths, injuries and economic losses caused by road accidents can be prevented. The World Report on Road Traffic Injury Prevention, which we launched last week in Paris, sets out the known risk factors and the prevention measures that are known to be effective.

Some of these are: to set and enforce laws on seat-belts, child restraints, helmets and drink driving; and, to promote daytime running lights and improved visibility for all road users.

In addition to setting laws and raising awareness, countries need to make policies that promote safer vehicles, safer traffic management, and safer road design.

The countries that have been most successful at improving safety have been those that have engaged many different groups from government, civil society and industry, in a coordinated road safety
programme. Every sector—especially transport, education, health, and law enforcement—has a role to play in tackling the problem.

Public health needs to increase its contribution by strengthening emergency services for victims, improving data collection, contributing to policy-making, and promoting prevention activities.

International agencies, the donor community and nongovernmental organizations, all have an important role to play in promoting road safety. Each one of us, whether as pedestrians, drivers or decision-makers, can contribute to this effort.

Road safety is no accident. Traffic injuries decrease wherever people recognize that they can be prevented, and act accordingly. Let us all decide here and now to give road safety the priority it deserves.

Thank you.

Geneva, Switzerland              17 May 2004

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY

Address by the Director-General

Mr President, Honourable Ministers, Distinguished Delegates, Ladies and Gentlemen,

Many of you expressed concern during and after yesterday’s discussions in plenary that substantial time was being taken out of the agenda for this week. I share your concern. Some Member States expected the Secretariat to influence the process to reduce discussion. In recent years, there had been prior agreement on shortening the debate. This year, there was no such agreement. The extensive debate showed that such matters are of great importance to Member States, and when Member States do not have consensus, it is important that they hear one another. Over the coming year, I will look into ways in which to facilitate the smooth functioning of the Assembly, so as to ensure that sufficient time remains for Member States to discuss during the session the entire range of topics on its agenda.

Regardless of their view on the recommendations of the General Committee, I am sure all Member States share my appreciation for the steps announced by the Government of the People’s Republic of China to ensure Taiwan, China’s involvement in global health. These include the possibility of medical and health professionals from the island joining
the Chinese delegation to the Assembly, cross-Straits talks on Taiwan, China’s participation in relevant WHO technical activities, working with the Secretariat to promote participation of medical professionals from Taiwan, China in WHO technical exchanges, and technical support from WHO. The SARS epidemic showed us that we cannot afford any gap in our global surveillance and response network.

I look forward to working in the coming months to put these proposals into action.

Mr President,

In the world today:

- 2.8 billion people are living on less than two dollars a day;
- 480 million people are living in areas of conflict, fearing for their lives;
- 1.2 billion people are struggling to find clean water;
- 40 million women, men and children are living with HIV/AIDS;
- over half a million women die in childbirth every year;
- 1.3 billion people smoke, exposing themselves to illness and premature death;
- 1.2 million people are killed in road traffic incidents every year.

The amount of disease, suffering and death in the world can be overwhelming. There is a notorious saying that “when one person dies it is a tragedy, but when a million die it is a statistic”. For those exposed to danger and suffering, it is impossible to see things this way. They cannot be indifferent. As public health ministers, officials and workers we are constantly reminded that the statistics we use are significant because they represent individual children, women and men. It is their voices that need to be heard. I, therefore, invited Anastasia Kamyk from Belarus to this Assembly, and she will now tell us about her experience.

*Miss Anastasia Kamyk speaks in Russian.*

Thank you, Anastasia, for your courage, and for giving such a clear and specific reminder of the responsibilities of those taking part in this Assembly.
Mr President,

Advances in technology have profoundly changed the ways in which we live and work. They have brought many improvements, but our capacity to enhance health is matched by our capacity to damage it. The gap between rich and poor has widened and, in spite of surpluses, hunger and thirst remain widespread.

Despite commitments of nations to preserve harmony, peace and security, hundreds of millions are affected on a daily basis by wars and conflicts. Through our Health Action in Crises programme, WHO is active in most areas in the world affected by armed conflict.

I would like to use this opportunity to reassert that WHO is entirely opposed to any action that exploits health facilities, vehicles or personnel, in war or conflict zones. Equally, attacks on health workers have to stop. International humanitarian law imposes obligations on all combatants to protect civilians’ access to basic needs—water, sanitation, food, and functioning health facilities.

We see more and more examples of civilians being made the victims of conflicts which often continue for many years. It is the people who can no longer get food, clean water and health care who suffer most, particularly women, children, older people, and those with chronic conditions. Health agencies have to stand up for those whose lives and health are endangered in this way.

There are also many parts of the world in which major environmental problems cause health to suffer as a result of unsafe water, unmanaged solid waste and unsafe living conditions. These are often related to unplanned urbanization, climate change and uncontrolled development.

Even in areas not afflicted by these health hazards, preventable chronic diseases related to lifestyle severely limit individual and public health.

Nevertheless, there is evidence that the world’s desire and capacity to solve these problems is increasing.

Adoption of the Millennium Development Goals in 2000 demonstrated that the global community was serious about the need to reduce poverty and protect health. The most damaging inadequacy of today’s health systems is their inequity, both within countries and between them. Hopes of peace and security in the world fade where these inequities prevail. Adequate health services are not only essential.
for the three Millennium Development Goals that relate specifically to health, but make major contributions to the other five as well.

The increase in development assistance for health over the last few years is also a welcome sign. This went up by an average of 1.7 billion dollars a year between 1997 and 2002. Much of this increase has been caused by growing awareness of the devastation being caused by HIV/AIDS.

In some communities, close to half of young adults are infected with HIV. They will die in the next few years unless they receive effective treatment.

In December of last year, on World AIDS Day, WHO launched the strategy to accelerate access to antiretroviral treatment. The initial objective is to work with a broad alliance of partners to get three million people in developing countries onto treatment by the end of 2005. We are working with the health services in countries to achieve this, following a double imperative: there must be universal access to treatment by the earliest possible date, and ever more effective approaches to prevention.

With the help of our partners we have developed simplified treatment approaches and prequalified fixed-dose drug combinations of antiretroviral drugs. We will further develop and expand this work. I also welcome the announcement made earlier this week by the Government of the United States of America for a proposed rapid process for review of fixed-dose combinations and co-packaged products.

In March, the Government of Mozambique issued a compulsory licence for manufacturing a triple combination of antiretroviral drugs to meet national needs. In doing so, Mozambique became the first African country to take this important step in implementing the Doha Declaration. Canada was the first country to propose changes to its patent legislation to put into practice a decision made by the World Trade Organization in August 2003, allowing exports of generic medicines to countries with insufficient pharmaceutical manufacturing capacity. I welcome the announcement made last week that this legislation has been adopted.

The Millennium Development target for HIV/AIDS is to stop the spread of HIV and begin its reverse by 2015. The impact of treatment on prevention of new HIV infections is not yet known, but if, for each person receiving treatment, just one new infection is averted, the
'3 by 5' initiative will significantly speed up the achievement of the Millennium Development target.

The demand is clear. During February and March, WHO sent additional staff to 25 countries to assist in making national plans of action and applications for Global Fund grants. Over 90% of the countries we are working with have stated that they need expert help in capacity-building and training; 60 per cent need help with drug procurement and supply chain management; and 50 per cent need help with monitoring and evaluation. We are responding to these requests.

An unprecedented amount of political will and financial resources are now focused on the fight against HIV/AIDS, tuberculosis and malaria, particularly through the Global Fund and other multilateral and bilateral support.

Last week, the Prime Minister of Canada announced a grant of 100 million Canadian dollars to support our work in '3 by 5'. Together with the earlier funds provided by the Government of the United Kingdom of Great Britain and Northern Ireland, this will enable us to rapidly accelerate our support to countries in scaling up access to treatment.

We will make our first detailed progress report on '3 by 5' to the International AIDS Conference in Bangkok in July. In the meantime, this year’s World Health Report, entitled “Changing History”, explains how we are now in a position to save the lives of millions of people from HIV/AIDS, and why we must seize this opportunity.

Viruses are unpredictable and they have no respect for national boundaries. There is, as yet, no way to say whether SARS has finally been brought under control, or whether avian influenza will make a comeback in Asia or elsewhere. Since the SARS epidemic was contained last July, there have been four further outbreaks in Asia. Three of these arose from laboratory accidents, emphasizing the need to strengthen bio-safety. In January, there was a historically unprecedented outbreak of avian influenza (H5N1) in eight Asian countries, with 34 human cases and 23 deaths. WHO experts provided prompt support for the authorities to contain these epidemics. Their combined efforts have been successful so far, but sustained vigilance is required.

Our other long-term disease control programmes include poliomyelitis eradication. Here, the key to success will be tenacity, both in our colleagues running the immunization campaigns and maintaining surveillance, and in our donors. We are on the verge of eradication, with
just 22 cases to date this year in all of Afghanistan, Egypt, India and Pakistan.

On the other hand, we have had setbacks in west and central Africa, with an explosive outbreak that has paralysed over 500 children. The leaders in these areas have now planned to restart synchronized mass immunization campaigns across 22 countries. If we do not lose our nerve in these last stages of the campaign, where so much can be either lost or gained, we will soon have kept the pledge, made by this Health Assembly in 1988, to eradicate poliomyelitis.

The Framework Convention on Tobacco Control, adopted by this Assembly one year ago, has now been signed by 112 countries plus the European Union, and ratified by 14. When 40 countries have ratified it, the Convention will come into force and further help governments and health authorities to protect the public from one of today’s most serious and most unnecessary health hazards.

Mr President, I believe we continue to improve our capacity as an organization to respond to the challenges facing us. Last year, at this Assembly, in addition to my pledge to close the treatment gap for people living with HIV/AIDS, I made specific commitments in four other areas, designed to enhance our effectiveness in countries.

I set specific targets for decentralization. Since then, we have increased the budget allocation to regional and country offices for the current biennium to 70 per cent.

I recognized the need to improve efficiency. We have developed a strategic framework for general management and launched initiatives to promote collaboration, strengthen financial management and streamline work processes.

I committed myself to improving our accountability. I am pleased to report that a draft of the performance assessment report for the 2002–2003 biennium is already available. With results-based budgeting, we are now reporting on our achievements against expected results. The development of this report has also assisted us in planning for the next biennium.

I stressed the need to improve our staffing situation by promoting greater equity in gender and geographical representation, and promoting mobility and career development, to get better results in countries. We continue to make progress in these areas and a mobility and rotation scheme was launched last month. I am also pleased to announce that the Bill & Melinda Gates Foundation has committed funding for the
Health Leadership Service. This new initiative will provide a two-year structured learning experience in WHO for young health professionals, primarily from unrepresented and underrepresented developing countries.

But I would also like to highlight four areas of health work in which we need to do more.

We have yet to get to grips with the links between health, equity and development. The underlying theme of my first year as Director-General is equity and social justice. To support our work in this area, I am setting up a new commission to gather evidence on the social and environmental causes of health inequities, and how to overcome them. The aim is to bring together the knowledge of experts, especially those with practical experience of tackling these problems. This can provide guidance for all our programmes.

We have yet to make significant progress in reducing maternal deaths and protecting the health of children. I am, therefore, making this a major priority for the coming year. The World Health Report and World Health Day for 2005 will share a common theme: the health of women and children. This will bring together a large number of WHO’s activities and those of our partners, particularly, immunization, safe motherhood, and nutrition.

We have yet to reduce substantially the gross inequity in health research funding. Every year more than US$70 billion is spent on health research and development by the public and private sectors. Yet, less than 10% of this is used for research into 90% of the world’s health problems. We are cosponsoring with the Government of Mexico a ministerial summit on health research in November. The summit will examine this issue, and focus on the knowledge and action needed to achieve the Millennium Development Goals.

Finally, we still have gaps and delays in health information systems. We have, therefore, set up a Strategic Health Information Centre at WHO headquarters. It consists of the most rapid and powerful information and communication facilities currently available for the management of crises and outbreaks. This technology will enable individuals, teams and Member States to take more effective action in emergencies. The Centre will also provide ongoing support for information management
and dissemination. At the technical level, it is important to be sure that there is no hole in the global outbreak alert and response network. The Director-General continues in French.

Mr President, the agenda of this Fifty-Seventh World Health Assembly demonstrates our common concern to address the major health challenges facing the world today. You will be discussing global strategies to promote healthy diets and physical activity, and to improve reproductive health. In round tables, you will discuss action to limit the impact of the HIV/AIDS pandemic. In technical briefings, you will hear updates of our work in crises, and in mental health. These are just a few of the many important topics you will be facing this week.

This World Health Assembly has a great responsibility in leading the world in action for health. The deliberations and decisions reached over these six days can have a profound impact on the health of every individual in this world.

I began with several numbers. I would like to end with some more.

- The five million children who otherwise would have been paralysed who will be walking in 2005 because of the effort to eradicate poliomyelitis.
- The three million tuberculosis patients now being treated every year under DOTS.
- The 600,000 cases of blindness prevented through the Onchocerciasis Control Programme.

The key difference is that these last numbers demonstrate what this Organization can achieve. They bring hope. Hope for individuals like Anastasia and the millions of people living with HIV.

Mr President, honourable ministers, distinguished delegates, ladies and gentlemen,

The staff of this Organization share your commitment to improving the health of the world, and we are determined to continue serving those most in need of better health.

Thank you.
Introduction
David Barmes worked for WHO from 1967 to 1992, and is remembered as a highly capable Chief of the Oral Health Programme, an excellent scientist, and an effective global strategist for health. It is people like him who give WHO its strength and makes it work. I am happy to be continuing his work by contributing a lecture to this series.

My aim in this presentation is to put some of our present concerns about global public health into their historical context, so that we can think as clearly as possible about our present and future responsibilities.

It was already clear, to at least one person, 24 centuries ago that scientific enquiry could improve human health. Hippocrates, around 400 BC, not only introduced the method of diagnosis based on systematic observation but recommended carefully tested diets and physical activities as the first line of treatment.

It took a long time for this enlightened approach to take hold, however, and I will argue that it still has not done so as much as we need it to. In fact progress in applying scientific intelligence to health did not really start to pick up speed until about 21 centuries after Hippocrates had started it.

There have been three kinds of breakthrough we can use as reference points for our current concerns: a cure, a prevention method, and a vaccine. They are discoveries associated with individuals, but they also reflect the efforts and talents of many people, both before and after the event. I will use one example from each of the three centuries preceding this one:

- James Lind’s publication of a cure for scurvy in 1753;
- John Snow’s demonstration of a way to stop cholera in 1854;
- and Jonas Salk’s discovery of a vaccine for polio in 1954.

I will end by mentioning some current research needs. My main point is that research has already been giving us the means to control
and prevent most of the major disease threats of today. The challenge before us now is also to make good use of them.

_A cure for scurvy in 1753_

In the 18th century, scurvy was killing thousands of people every year. More sailors in the British Royal Navy were dying of it than from enemy action. James Lind published his *Treatise of the scurvy* in 1753. It has been called one of the earliest accounts of a prospective clinical trial, comparing six commonly used treatments of scurvy. It also includes a systematic review of what had previously been published on the diagnosis, prevention and treatment of scurvy.

While serving as a naval surgeon in the Channel Fleet in 1747, Lind selected 12 sailors who were all at a similar stage of scurvy, had the same basic diet and were accommodated in the same part of the ship. To two each he allocated one of six of the many different treatments for scurvy then in use:

- a quart of cider a day;
- 25 drops of elixir of vitriol three times a day;
- two spoonfuls of vinegar three times a day;
- half a pint of sea water a day;
- a concoction of nutmeg, mustard and garlic three times a day;
- and two oranges and a lemon a day.

Lind reported: ‘The most sudden and visible good effects were perceived from the use of oranges and lemons; one of those who had taken them being at the end of six days fit for duty... The other was the best recovered of any in his condition; and being now deemed pretty well, was appointed nurse to the rest of the sick.’

Lind left the Navy after that voyage and returned to Edinburgh University, where he reviewed the literature on scurvy. He identified 54 books on it worthy of critical appraisal, and wrote an abstract of each of them. The evidence that fresh fruit and vegetables both prevented and cured scurvy was overwhelming.

During the following years, Lind’s 450-page treatise was published and republished, in English, French, Italian and German. Enlightened individuals like Captain Cook were strict about taking in fresh fruit and vegetables at every opportunity and making sure that every man on board ate them. As a result, the mortality rate for his voyages was outstandingly low. But it was only a year after Lind’s death, in 1794, that the Admiralty provided lemon juice for its sailors on a large scale. The
effect was dramatic. Within two years, scurvy more or less disappeared from the Navy.

The necessary information and knowledge was there for all to see, but it took the British naval authorities 40 years to get around to applying it.

In our own time we see the same delays, or arguably worse. Richard Doll and Bradford Hill published their landmark study showing the link between smoking and lung cancer in 1950. It was neither the first nor the last such study, but is seen as the one which ‘launched the case against tobacco as a leading cause of disease’. Concerted international action on a large scale to curb tobacco use in Europe and the United States did not take place until decades afterwards. Globally, we still have a very long way to go to apply non-smoking as a simple measure to prevent 5 million deaths a year. This number is expected to grow to 10 million by 2020.

The WHO Framework Convention on Tobacco Control will enter into force on 28 February 2005. Last week the 40th country, Peru, became state party to it. This means that it will become binding as law for all its parties. It is a great achievement and we are celebrating. But even with this support, there is an urgent need for decisive action by governments, and by the public, if tobacco-related diseases are to be reduced.

The WHO Global Strategy for Diet and Physical Activity was adopted last May by the World Health Assembly. It recommends measures that are easy to follow and provides inescapable evidence for their efficacy. Such measures can save large numbers of lives of men and women in the prime of life and at the height of their abilities. They can also save health services and national economies large amounts of money.

Where the ingenuity and systematic approach of Lind are urgently needed now is in finding ways to ensure that the knowledge of nutritionists and noncommunicable disease researchers is fully synthesized, understood, and applied.

Stopping cholera in 1854
Asian cholera entered England in 1831, through the seaport of Sunderland. John Snow was an apprentice physician at that time, and assigned to help patients in the Newcastle area. He quickly discovered that existing medicines were powerless against this disease, which killed within hours of onset. By studying that outbreak and subsequent ones
in London, he became convinced that the transmission of cholera was faecal–oral and spread mainly by contaminated drinking-water.

In the outbreak in London in 1854, as we all know, he set out to prove this theory by studying the death registers, making door-to-door enquiries to track down chains of transmission, and analysing London’s water supply and sewage system. Snow marked each death on a street map, together with the location of each public water pump. Within 10 days there had been 500 deaths in one small area, 50 of them within 50 feet of the Broad Street pump. He also found out that most of the people who had died in the neighbourhood drank water from that pump. Households that used other pumps suffered no casualties.

Snow noted that a sewer line ran within a few feet of the pump. In addition, microscopy was sufficiently advanced at that time to show that the water from that pump contained a good deal of organic matter.

Snow took his findings to the Board of Guardians of St James’s Parish on September 7, 1854. They took his advice and removed the handle of the Broad Street pump. As Snow had predicted, within a few days the outbreak began to subside.

It could be that the epidemic had peaked out anyway. But the main point is that 29 years before Koch’s microbiology identified the *vibrio cholerae*, Snow’s epidemiology had produced a powerful body of evidence for preventive action. The parliamentary committee to which he later presented his findings was not convinced by them initially, however, and stuck to the traditional view that cholera was an airborne disease caused by miasmas. It took several more years and thousands more deaths for enough evidence and political pressure to accumulate before the decision was taken to construct a proper sewage and drinking-water system for London.

One moral of this story is that public health can save more lives than individual medical interventions. Cholera was a frightening mystery in an individual patient, but a great deal could be done to stop its transmission. It just needed someone brave enough and persistent enough to gather the evidence.

The same was true of SARS last year. It was stopped by the same basic methods of epidemiology that John Snow used: mapping cases, investigating transmission, analysing findings, drawing conclusions and taking action. In 2003 that was made possible by rapid information exchange on a worldwide scale and the willingness of scientists like yourselves around the world to pool their knowledge and skills.
A second moral of the Broad Street pump story is that local authorities can often act much more swiftly and appropriately than larger government bodies. Where people are well enough informed they do not have to wait for large-scale action. Disabling a pump does not require a degree in rocket science, or a national or international consensus, or meetings. Knowing that it was necessary did require excellent and sophisticated research, and that had been done. The next step, of making that knowledge available where it was urgently needed, is equally important. That is why in WHO we do everything we can to support local action based on reliable information.

But self-help still needs a functional society in which to operate, so our mandate is to work with governments to build national and international health systems. This dimension of health work is often seen as beginning in 1851 with the first International Sanitary Conference. It met in Paris to agree on shipping and docking regulations for disease control. The main objective was to stop the spread of cholera, which was killing people by the thousand across Europe and causing massive financial losses.

Last month, just 153 years later, representatives of our Member States met for two weeks in Geneva to agree on the next revisions to those regulations. The last major rewrite was in 1969, when the world was quite a lot different from what it is now (for instance, smallpox was still a concern, and AIDS was not yet known). For the current revisions the centre of attention is the danger of an influenza pandemic. The revised regulations will be considered by the World Health Assembly in May next year. The world’s health depends increasingly on such agreements and arrangements, but it equally depends on individual and local initiative. We do not have to wait for the perfect solution. In many cases we cannot afford to.

A third moral I would like to mention from the story about John Snow is that the determinants of health are social as well as biological. It was mainly the poor who were devastated by the cholera epidemics. Disease and the effort to control it revealed the need to build a safer and more just society. That meant adequate water, sanitation and living conditions for everyone, as well as reliable health care systems. Otherwise everyone was at risk.

Exactly the same is true for the diseases of poverty today. To speed up the process of making this clear and acting accordingly, we are launching a Commission on the Social Determinants of Health in March next year.
It will be examining some of the social disadvantages that cause health problems, and what to do about them. The health sciences have found ways to prevent or control most of the diseases that are killing children and younger adults today, but they are powerless without the necessary social support. History shows that support comes when there is a clear enough understanding of how living and working conditions affect people’s health.

We need people with the courage and persistence of John Snow to gather the evidence, interpret the findings, and make them clear to policy-makers.

_A vaccine for polio in 1954_

I’ve brought Jonas Salk into this because he too started something that is still waiting for us to finish.

Salk embarked on systematic research for a polio vaccine in 1947, when he was 33, working at the University of Pittsburgh Medical School and with the National Foundation for Infantile Paralysis. He discovered and developed inactivated polio vaccine in 1952. Two years later 1.7 million children in this country participated in the field trials for this new product.

Many western countries, as well as the US, had been trying to fight epidemics of this disease, which killed or crippled people for life. In spite of precautions such as closing swimming pools and movie houses in the summer, children and adults in their thousands were paralysed, either lying in iron lung machines or struggling to walk with crutches and in leg braces. Polio was a major source of grief, anxiety and panic in those days.

The news of Salk’s achievement caused an international sensation. He added to his own glory with his famous answer to the question of patenting. When asked who owned the new vaccine, he said, as I am sure you all remember: ‘The people! Could you patent the sun?’ Opinions differ about Jonas Salk, but that was indeed a famous answer.

Of course, his discovery was soon followed by that of Albert Sabin, of oral polio vaccine. With these highly effective and affordable products, hundreds of millions of children were protected. Polio was gradually recognized as an unnecessary affliction, and in 1988 the World Health Assembly launched the Global Polio Eradication Initiative.

Poliovirus transmission is still occurring in Afghanistan, Egypt, India, and Pakistan, where it can be stopped by the middle of next year,
and in Africa where it can be stopped by the end of next year. The end is in sight, but we still need a very high degree of mobilization and persistence to complete this task.

Salk showed how with a strong social movement, faith in science, and generosity, it was possible to solve one of the toughest and most dangerous public health problems of his time. We still need that spirit to finish his work.

That is also the kind of strength we need very urgently to tackle HIV/AIDS. Treatment for this disease has existed since the 1990s, but six million of the people who need it are not getting it, and are consequently dying. They are dying not because there are no effective drugs but because they are too poor to obtain them, and there are no health systems to provide them.

Last year WHO and UNAIDS launched the initiative to get 3 million of those people onto treatment by the end of 2005. We see this as a first step to universal access and an indispensable support for activities to prevent HIV transmission. It is an emergency initiative. AIDS is destroying whole societies in some parts of the world.

Treatment requires not only affordable drugs but functioning health systems. Last month I attended the Ministerial Summit on Health Research, in Mexico. The aim of the summit was to direct research efforts at tackling the diseases of poverty. The participants found that there already is a wealth of innovation at country level, waiting to be used and built on. They also found that many of the challenges to health systems are the same in poor countries as they are in rich ones. Some of the most pressing needs are for quality, safety, equity and fairness.

There was a large amount of agreement on the areas of research that are most needed now. They include diagnostics, drugs, vaccines for the priority diseases, of course. But equally important if not more so now, they include the social and environmental requirements for good health. Most importantly of all, these factors need to be understood as part of a coherent system and set of approaches.

That is why at the centre of most people’s concern was the need for research on health systems that will meet the needs of our own century—the 21st. These systems will not just evolve of their own accord. They have to be designed and built, with just as much expertise as an urban water supply system. Effective and reliable international and national health systems are urgently needed now.
The people who run them have to be well-informed, and make full use of the available technologies. They also have to take fully into account the social and economic factors involved, as well as the medical ones.

Conclusion

The three researchers I have talked about were unusual individuals but they were also part of social movements that were characteristic of their times. Lind was a man of the Enlightenment; Snow was part of a rising tide of alarm at the inhuman living and working conditions that had come with the industrial revolution; Salk was supported by the March of Dimes and a great popular movement of solidarity in the USA for the victims of polio.

As individuals they gave strength to those social trends, just as they drew strength from them. They were living in difficult and dangerous times, just as we are. Like them, we need to work with the positive trends in our own time.

They were great scientists, each in quite different ways, but they also had admirable human qualities, and those are an important part of the secret of their success. They were courageous, persistent and generous. Wherever people are thinking and working with that kind of intelligence, the necessary discoveries can be made.

David Barmes was an excellent example of this approach. He represents many others who usually remain unrecognized. I would like to use this opportunity to remind us of the importance of working in this spirit. With the combined expertise and roles of our organizations we can meet today’s health challenges, and continue the work of our great predecessors.

Thank you.

Santiago, Chile 18 March 2005

Commission on Social Determinants of Health

Official Launch of Raúl Prebisch Auditorium, ECLAC

Mr President, Members of the Commission, Honourable Ministers, Colleagues, Ladies and Gentlemen,

“Dadme un punto de apoyo y levantaré el mundo” — “Give me a place to stand and I will lift the earth”, Archimedes said. All of us who work
for health say the same today to our new Commission on the Social Determinants of Health. Give us a place to stand and we will lift the burden of ill health that is crushing so many people so unnecessarily in the world today.

Archimedes meant that with a long enough lever and the right place to exert pressure, he could lift any weight, however heavy. He is known as the man who discovered mechanics and physics about 22 centuries ago. That knowledge continues to change the way we live. The commissioners may need to discover something equally important in their turn. Each of them with their own outstanding ability and expertise is looking for better ways to work for health. By combining their talents they are multiplying their chances of success.

Medical science has achieved an impressive amount and we expect it to go on achieving more. But now we need some breakthroughs in what we might call social determinant science. Otherwise we could find ourselves as exposed to health hazards as our ancestors were. The challenges we now face include antimicrobial resistance, emerging disease pandemics, and the continued spread of existing epidemics. They require social solutions now just as urgently as biomedical ones.

From WHO’s point of view there are two public health needs in the world: to improve health security globally, and to improve health status within countries. It is not possible to achieve one without the other.

We are fully engaged in initiatives to meet these needs. The activities include developing a global outbreak alert and response network, getting treatment to people living with AIDS, preventing infectious disease, eradicating polio, protecting the health of mothers and their children, and a large number of others. All such efforts have a strong social component.

If you take just one example, polio eradication, this is not hard to see. Polio prevention depends on a vaccine, but that vaccine itself exists because a very strong social movement funded and motivated the research for it in the 1950s. The same social impetus made the vaccine, once it had been discovered, available without delay and on a large scale. Furthermore, the fact that polio has not yet been eradicated globally is due almost entirely to social challenges rather than medical ones.

In the same way, national health programmes in rich and poor countries alike are grappling with social factors, such as education, living and working conditions, and economics. However good a health technology is, it cannot work if people are denied access to it. Where
health workers struggle blindly with these social factors their projects are liable to fail. Where they work with open eyes, using what is known and uniting their efforts with those of colleagues in other sectors, they can be highly effective.

A great deal is known around the world about the social determinants of health, but that knowledge needs to be drawn together, more clearly understood and put more systematically to use. To help achieve this, all regions of the world are represented on the Commission. In addition, some members are more from the world of action and others more from the world of knowledge. Our hope is that they will inspire each other to enlighten their action and activate their knowledge even further, to make them highly effective and applicable in many situations.

Being here in Avenue Dag Hammarskjöld is an inspiring reminder of Chile’s global vision. Dag Hammarskjöld, who was the second Secretary-General of the United Nations, was born 100 years ago this July. His life was devoted to international service and solidarity, which he saw as indispensable for the future of the world. Our new commission can help to recover and strengthen that understanding.

The fullest recent expression of the UN’s social purpose is the Millennium Development Goals, adopted by the General Assembly in 2000. Those eight goals place a strong emphasis on health. Health indicators are perhaps the best means we have of assessing human well-being.

Many other promising initiatives are in progress, in addition to the Millennium Goals, and they will add to the Commission’s strength. I think in particular of the Africa Commission and the current G8 and European Union efforts to reduce poverty through debt relief, new financing mechanisms and increasing development aid. I think also of national initiatives such as the Chile Solidario system and all the programmes we saw on yesterday’s site visits; Chile’s achievement of universal access to antiretroviral treatment and its progress towards building a strong health system; and the Regional Programme on Bioethics, whose centre is here at the University of Chile. Activities such as these are the ones that can contribute most directly and effectively to improving and protecting people’s health.

The Commission on Social Determinants of Health can be a powerful means of catalysing and strengthening such activities in all countries. It will complete its initial work in 2008. That will be 30 years after the Declaration of Alma-Ata (in 1978), and 60 years after the beginning of
WHO (1948). Those were moments of great clarity about the needs and opportunities for health in the world. We should now start preparing, with the help of this Commission, for another such moment of clarity.

On behalf of health workers everywhere, and of all those who need them, I thank the Commissioners for joining this effort. And I wish them every success.

Thank you.

Geneva, Monday 22 May 2006

REPORT BY THE DIRECTOR-GENERAL TO THE FIFTY-NINTH WORLD HEALTH ASSEMBLY

Mr President, Honourable Ministers, Distinguished Delegates, Ladies and Gentlemen.

First, I thank all countries for their support. You have given us crucial cooperation in the many important negotiations concluded over this last year. For example in the Conference of the Parties to the WHO Framework Convention on Tobacco Control and the revision of the International Health Regulations 2005. Any of these delicate processes could have stalled. But they didn’t. I thank you for your spirit of cooperation and wider purpose.

WHO is always open to our Member States. In the past year we were honoured by visits from the King and Queen of Norway and from the First Ladies of Egypt and Senegal. In 2005, heads of state, ministers, ambassadors, NGOs, parliamentarians, and representatives from the private sector and other partners have visited us at headquarters. It is always an honour to receive you. We listen to you all with close attention. When we know what your needs are we can work to meet them.

Many health issues need our rapid response. Our outbreak and emergency teams are in high and increasing demand. We are there when you call us. When the Government of Pakistan and Minister Khan sounded the alarm after the South Asia earthquake we immediately put our resources into the team effort.

Concerns have been expressed about the health of the Palestinian population. WHO is monitoring the situation closely, and continues

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1 Distributed posthumously
to provide support to health services for the Palestinian people in the West Bank and Gaza.

This year saw a hugely effective reply to the largest multi-country epidemic of polio since the eradication initiative began in 1988. The collective action of more than 25 countries got this international effort back on track.

As avian flu has spread throughout the world, we have sent experts within hours of your request for support. Since the start of this year, we have sent assessment and response teams to more than 20 countries in Africa, Asia, Europe, and the Middle East.

The Strategic Health Operations Centre continues to play a key role in coordinating action and providing information.

This connectivity is a vital part of our relationship with you. We want WHO to be a source of reliable information, strategy and wisdom—you have to deal not only with wild viruses, but also with wild rumours. Only straight talking and good science will do.

Straight talking is what my guest speaker does very well. I heard this 19-year-old’s striking poetry in March this year during my visit to Kenya, his home. I heard him speak on HIV and I invited him here. Ladies and gentlemen, please give your full attention to Johnson Mwakazi.

This is a voice that must be heard. He speaks for the 40 million people living with HIV. Those living in the shadow of stigma. Johnson, you are welcome here.

Johnson Mwakazi reads poem

Johnson, on behalf of all of us here, thank you. There can be no “comfort level” in the fight against HIV. We must keep up the pressure to get prevention, treatment and care linked and working.

A key outcome of ‘3 by 5’ was the commitment to universal access to treatment by 2010.

But what does universal access mean?

To me, this means that no one should die because they can’t get drugs. It means that no one will miss being tested, diagnosed and treated because there aren’t clinics. It means that HIV positive mothers will not unwittingly give a death sentence to their babies. Their parents will live to look after them instead of making them AIDS orphans.

There must be a relentless push to make sure that everyone who needs testing, counselling, treatment and care, gets it. At the same
time, we will fully support every effort to make sure people know how to prevent HIV infection and are able to do so.

‘3 by 5’ helped to build the sure foundations for this. It drove the construction of a physical and management infrastructure of supply chains, prequalification systems, protocols for treatment, diagnosis, and case management.

But, universal access still faces significant challenges. Six million people are in urgent need of antiretroviral treatment today. Drug shortages are frequent in many parts of the world. It is outrageous that children can’t get effective treatment—simply because so few paediatric preparations are available. And not just for HIV. The same is true for TB and malaria. To add a further problem, second-line treatments for these diseases are expensive and in short supply. This calls for bold action and new resources.

I warmly welcome the initiative of several countries, led by the Governments of Brazil, Chile, France, and Norway, in proposing an International Drug Purchase Facility to help to meet these needs. The IDPF will use predictable and innovative funds from airline and other taxes to provide sustainable funding. By pooling financing and procurement, the facility will be able to decrease the prices of drugs, rapidly improve the quality of products circulating in the world and ensure that patients can access these products. WHO is committed to support the IDPF in any way we can.

Treatment is essential but so is protection from disease. Immunization remains a cornerstone of our work in infectious disease control. Measles deaths have been almost halved over the last few years. The number of polio-endemic countries has been cut to just four—the lowest in history.

Let’s look at those last four countries.

India and Pakistan are on track to complete eradication by the end of this year. Only a few cases remain. This is a fantastic achievement. Afghanistan is also making excellent progress in stamping out the last cases, although this is complicated by the security situation in the southern region. Conflict stands between children and the polio vaccine.

Now the world is looking to Nigeria. Up to half of children are still being missed in northern states. This represents the last uncontrolled reservoir of polio in the world.
We have great partners. Rotary International, the US Centers for Disease Control and Prevention, and UNICEF are spearheading support for the Nigerian authorities. Together we are implementing a new strategy to get polio vaccination to all the unreached children. We are attracting parents to the immunization points through, for example, also offering mosquito nets.

The world has invested US$ 4 billion so far in polio eradication. I appeal to you all to continue your support—both political and financial—until the job is finished.

Some have questioned whether polio eradication is possible. Let there be no doubt. We can do it. And we will.

Turning to avian influenza. To date, highly pathogenic H5N1 has been reported in domestic or wild birds in more than 50 countries in Asia, Europe, Africa, and the Middle East. Ten of these countries have now reported human cases.

Unfortunately, we have already had more fatal human cases this year than in all of 2005. We must not let down our guard. The threat from avian flu is not over. It is not going away.

We are—and we must remain—alert to every hint that the virus may be changing its behaviour.

Right now, our epidemiologists are investigating the largest cluster of human cases so far reported, all in one extended family in Indonesia. This cluster was identified by effective surveillance. But there are still hundreds, maybe thousands, of disease blind spots around the world—where no one knows what they have to watch for, or what they must report. And there may also be no one there for them to report to. We must fill those gaps. We must know about every cluster of cases, no matter where it is.

Overall, more than 200 million birds have either died or been destroyed. Livelihoods have been destroyed. Vital nourishment has been lost.

My message to countries which have not yet been touched by this devastating virus is: think hard. If you feel you have a breathing space, use it well. Preparation is never really finished. We must speed up work on vaccine development, build manufacturing capacity, improve early warning systems, share business continuity plans, and help others to get ready.

I greatly appreciate the vital role played in this effort by President Bush of the United States who launched the International Partnership
on Avian and Pandemic Influenza. The governments of Canada, China and Japan quickly took up the cause, and hosted meetings to develop the leadership and funding to take this work forward. I thank you all for commitment to this important work.

This week you will be considering a resolution calling for immediate voluntary compliance with relevant provisions of the revised International Health Regulations. This is a clear indication of the priority countries are giving to the pandemic influenza threat. Substantial funding has been promised, but it has been slow to arrive in the places where it is needed most urgently. The funding pledges made in Beijing need to be delivered.

Turning to malaria, clearly things are not going well with malaria control. So many lives could be saved with simple tools for vector control and treatment like insecticide-treated bednets, and the use of artemisinin combination therapy. Many researchers are pursuing the ultimate goal of an effective vaccine against this disease. Yet malaria remains the biggest cause of death for children under five in Africa. We accept our responsibility for this. Now is not the time for shyness. WHO will exercise much greater leadership in malaria control. We respect the excellent work of many partners fighting this disease, but we must get back on track very quickly.

We have to live up to the expectations of Member States. That is why the WHO Global Malaria Programme was launched earlier this year. We will report on progress at the next Health Assembly.

Our experience with the ‘3 by 5’ initiative showed how useful incremental targets are. Those “in between” targets force us to be accountable. The Millennium Development Goals, on their own, are not enough. In each of the areas where there is a health-related MDG, there must be clear targets.

TB control takes this approach to its logical conclusion. The new Global Plan to Stop TB is comprehensive and well structured and therefore measurable and accountable. Every year, the global annual TB report tracks the course of the epidemic, and the progress made in stopping it. This approach—of tracking not just process indicators, but successful impact on people’s lives—is important.

A similar approach has been useful in monitoring newborn and child health. There is an urgent need for an equally competent model for maternal mortality reduction.
I would like to thank President Putin of the Russian Federation for including health so prominently in the agenda of the G8 Summit this year. Health, security, and education. Each dependent on the other. Progress in each is fraught with difficulty.

We have to address these difficult issues now. If not, the MDGs and poverty reduction are a pipe dream. To reach the MDG targets, we need to link better health care coverage with action on social factors such as poverty, women’s empowerment, social exclusion, living conditions, and the public health effects of trade policies and environmental hazards. The Commission on Social Determinants of Health, launched a year ago, is showing how this can be done. A growing number of countries are partnering with the Commission to identify and implement effective multisectoral policies.

This week you will review the Report of the Commission on Intellectual Property Rights, Innovation and Public Health. Let me again express our thanks to Madame Dreifuss, former president of Switzerland, who used her formidable diplomatic skills to find a common pathway for the Commission. You will need to consider what action, arising from this report, should now be taken to improve the sustainability of efforts to develop and make available the vaccines, diagnostics and medicines urgently needed in developing countries. I am sure that we can make real progress towards this objective.

The World Health Report 2006 describes another deep-seated problem that has no quick solutions—the crisis in the health workforce. I want to acknowledge the many African countries who have been driving forward this important issue. You convinced this forum to table two resolutions on the subject. You have kept up the pressure for change.

When I launched the world health report in Lusaka, Zambia, I met a nurse in the hospital there. She works 18 hours a day. She told me that she could not continue like that. I saw a hospital that was supposed to be staffed by 1000 professionals. It was run by less than 400. I met nursing students. I praised their decision to choose this noble profession. But I also wondered how many of them were already planning to emigrate upon graduation.

Together with our partners, we will launch the Global Health Workforce Alliance this Thursday.

It is clear that without health workers there can be no development progress.
The lack of properly trained midwives to attend births is one area which needs swift action. The health of mothers and their babies during and just after delivery is a critical focus for improvement.

Pregnancy related deaths are a leading cause of mortality for girls aged between 15 and 19. Last year there were 1.2 billion adolescents in the world. The most ever, and numbers are predicted to grow. That group of young people is also especially hard hit by HIV. Nearly half of 4.9 million new HIV infections each year occur among those aged 15–24. And again, women are worst affected, with a higher rate of incidence than men.

If a problem can be solved by money alone, it is not really a difficult problem. So how do we approach those difficult problems? We must change expectations. And create a climate that helps to bring about change.

Our work in guidelines and standards can do just that. For example, the recently published child growth standards show that all children have the potential to grow at the same rate, despite differences in ethnicity and genetics. That means a new era of growth expectations. The implications are enormous. We now have to work to support the changes in feeding and childrearing generally that will allow children to reach that potential.

Publications like the global report Preventing Chronic Diseases are also part of changing expectations and supporting change. The report's analysis for the first time articulated clearly the scale of the damage from diseases like cancers, diabetes, or cardiovascular disease. It also proposed an ambitious goal—to reduce chronic disease deaths by a further 2% annually until 2015. This would prevent 36 million premature deaths.

Change also happens when we raise issues, and build understanding and consensus on them. For example, the Global Strategy on Sexually Transmitted Infections and the Eleventh General Programme of Work were developed through broad consultation.

Evolutionary pressure changes the way that organisms evolve. We are using that knowledge for predictive and preventive work on avian flu. We use it to isolate and stamp out transmission of the polio virus. But when we apply that knowledge to ourselves, what do we learn? How do we change our environment?

When I was elected, I made a commitment to improve our transparency and accountability.
At the beginning of this year we issued an ‘accountability framework’ for WHO. This outlines responsibility and authority throughout the Organization.

It also stresses the results we want to achieve. In other words: we don’t want to look only at the process—we want to know what actually happened to people’s health status.

This is what the TB annual report does, for example. It doesn’t say how many consultations and meetings were held. It says that in 2004, 4.8 million TB cases globally were treated under the DOTS strategy. Eighty percent of these are now cured.

As part of this accountability we have made an assessment of the way that we used the budget for the last biennium.

I said earlier that if money alone solved the problem then it was not a difficult one. But there are many areas where we are pleased to report that money did solve the problem.

Thank you for your continuing generous financial support. Of course, we would no longer continue to operate if we did not have it. Your continuing support is a very welcome signal of your approval and endorsement of WHO’s action.

Our resources are—first and foremost—our people.

I would like to make three points on the financial situation:

First, total income from extrabudgetary contributions in 2004–2005 was just over two billion dollars. A record amount. There was a 61% increase in voluntary contributions.

Second, the trend is for WHO to be financed predominantly from such voluntary sources. Currently these provide nearly three quarters of overall financing.

Third, in 2004–2005 the Organization’s work shifted in emphasis. The trend of steep increases at headquarters has been broken. We are moving decisively towards my commitment to place resources where they are most needed—in countries. The total expenditure in regions and countries increased from US$1.3bn in 2002–2003 to US$1.9bn in 2004–2005. That is an increase of 46 per cent. The increase in countries alone went from 30.0 per cent of total expenditure to 35.5 per cent.

I have stressed the need to have interim targets when we set an ambitious long-term goal. That is the role of the new Medium-term Strategic Plan. The detailed content of this Plan for 2008–2013 will be presented for consultation at the regional committee meetings in just a few months’ time.
I have described today the ways in which WHO is responding to your needs. I have talked about the need to listen to you. The need to structure our response so the health results are measurable. The need to be completely transparent about how we spend your money. The need to make short-term as well as long-term plans.

And the need to remember always that what we are doing is not implementing plans and executing strategies—it is about people. About improving lives and protecting people’s health.

There is a lot of talk about UN Reform. In my view, UN reform is not an annual event but the work of every day.

What matters in reform is not words but action.

I hope that the actions of the Organization speak for themselves.

As I said at the start of this speech, I am deeply conscious of the relationship between us, the staff of WHO, and you, the Member States. Our role and purpose reflects your public health needs. I believe that one of my important functions as Director-General is to be sensitive to your needs, and to make sure that WHO is a fully flexible instrument that does what you need it to do.

Sixty years ago, in July 1946, the International Health Conference adopted the Constitution of WHO. The two first countries to sign were the United Kingdom and China. Their support to the Constitution was reported to be ‘without reservation’.

It would be presumptuous to imagine that, six decades later, no reservations had crept in. But one thing has not changed. That is the clarity with which we see and understand our role.

WHO was created to serve its Member States as the ‘leading organization in international health work’.

Without hesitation, I say to you that continues to be our central driving force.

Thank you.
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