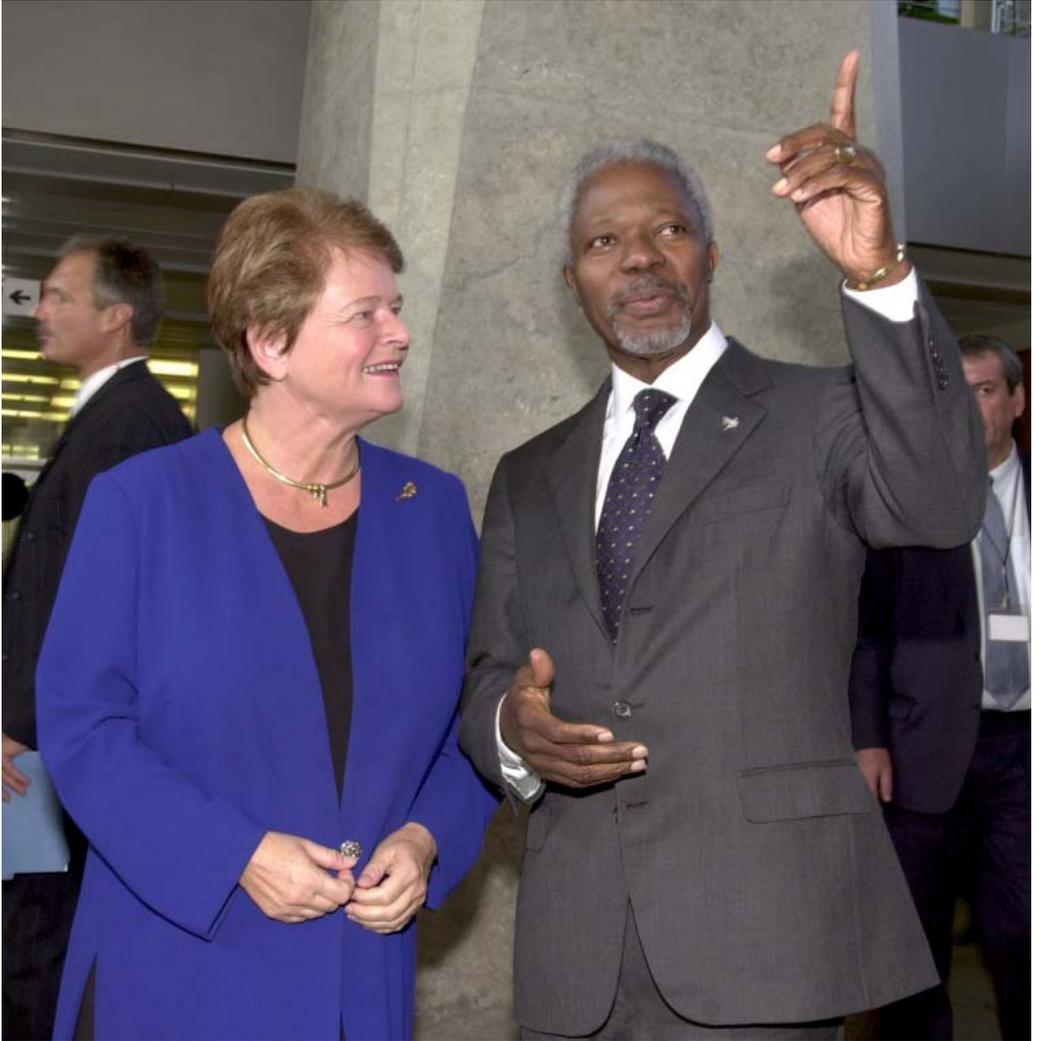


Report of the Director-General

2001



World Health Organization



The Director-General with the United Nations Secretary-General during his visit to WHO headquarters on 2 November 2001

Report of the Director-General 2001

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I. Introduction

1. In this annual report I review the efforts of WHO to advance the health agenda, and point to the future directions of our work. The report highlights major events during the past year, noting both the achievements and the challenges that still need to be addressed. It also gives an account of how we are currently implementing our corporate strategy.

2. During 2000, the Executive Board endorsed four strategic directions for WHO's contribution to efforts to advance health at country level and globally.¹ These form the basis of the General programme of work 2002-2005, and the Programme budget 2002-2003 adopted by the Fifty-fourth World Health Assembly.²

3. The first direction is **to address the burden of ill-health among very poor populations**, taking account of the big contrasts in healthy life expectancy – between and within countries – giving particular emphasis to childhood illness; reproductive ill-health, including maternal mortality and morbidity; nutrition; communicable diseases; mental ill-health; injury and noncommunicable diseases.

4. The second, is **to track and assess risks to health, and to help societies to take action to reduce them**. The emphasis is on enabling people to understand, then to limit, the risk factors for health. Risks may be associated with individual behaviour, dietary practices, use of tobacco and its products, exposure to violence, or influences within the environment.

5. The third, is **to improve the performance of health systems**. This means being able to assess how well a health system is performing in relation to expectations, and to establish the reasons for differing performance of health systems. The methods need to be robust enough

¹ See document EB105/2000/REC/2, summary record of the first meeting.

² Resolution WHA54.20.

to enable the examination of health systems within a country, or the comparison of different national experiences. It also means a focus on options and means to improve the health system, concentrating on service delivery, resource management, financing mechanisms and stewardship.

6. The fourth, is **to encourage national policies which promote health**, with contributions from the economic, political and societal domains. The challenge is to find optimal means for investing in healthy futures through intergovernmental, national and local action.

7. The following report shows how we have contributed to improved health outcomes within each of these strategic areas, focusing on different aspects of our work.

II. Strategic direction 1: reducing excess mortality, morbidity, and disability, especially in poor and marginalized populations

Tackling communicable diseases

8. **HIV/AIDS.** At the end of 2001 we reported, once again, that the estimated number of people living with HIV has increased. The number of children living with HIV is now far larger than previously known. But we have, during the past year, seen the start of a real change in our collective ability to confront the epidemic. The agreements reached at the United Nations General Assembly special session on HIV/AIDS in June 2001 provide a strong platform from which different public, civil-society and private-sector groups will work together; learning from those who have blazed a trail, scaling up best practice, and improving the well-being of millions of people.

9. Prime ministers, finance ministers, planning ministers and health ministers are all focusing on the devastating effects of HIV and AIDS. Civil society, in particular people living with HIV, have greatly contributed to improving knowledge and to strengthening the moral imperative for action. Taboos are starting to erode. Governments are confronting the epidemic with a new openness. New information provides solid scientific evidence for the benefits of investing in poor

people's health – including efforts to stem the spread of the HIV/AIDS epidemic. There is intense and widespread political commitment to act.

10. Within several countries we have seen examples of ways in which political commitment in support of focused and imaginative programmes is leading to reductions in the incidence of HIV. We have seen that communities and countries can turn the tide on HIV/AIDS. The reduction of prevalence in Cambodia, following earlier success in Thailand, has been noteworthy.

11. There are signs that a comprehensive response to the epidemic is at last becoming possible within poor countries. Lower-cost medicines for treating people infected with HIV are becoming available. Health systems that are providing essential services for people affected by, and at risk of, HIV infection in resource-poor settings are being studied and characterized. This creates exciting new opportunities for those seeking to invest in effective action to confront HIV/AIDS.

12. The priority now is to ensure wider access to reliable diagnosis and effective care. To this end, health staff is being trained to attend to people at risk of HIV infection and AIDS.

13. WHO is building up its contribution to national efforts to tackle HIV/AIDS. It is drawing upon its strengths and its expertise in the health sector to make optimal use of available resources. It works in close cooperation with the other cosponsors of UNAIDS, academic groups, nongovernmental organizations and private entities. WHO offers information about best practices and provides support to national efforts in the areas of voluntary counselling and testing, prevention of mother-to-child transmission of HIV, provision of care to mothers, and prevention of sexually transmitted infections.

14. WHO offers guidance on the care, treatment and support of people living with HIV/AIDS, including their nutrition, their access to antiretroviral and prophylactic drugs, diagnostic technologies, palliative care and psychosocial support. It also advises on blood safety and prevention and treatment of sexually transmitted infections. It collaborates with countries in strategically targeting interventions, including harm reduction and work with young people. The

interventions are supported through a programme of surveillance, monitoring, and evaluation.

15. In all this work WHO helps to define norms and standards, and encourages and supports the development of new prevention technologies, especially research on microbicides and vaccines. WHO promotes the development of candidate vaccines based on HIV strains present in developing countries, facilitates their evaluation in clinical trials, and provides coordination of the international research effort on HIV vaccines. WHO is deeply involved in developing the agenda for HIV/AIDS research and in research and development related to new medicines in the context of conditions prevailing in developing countries.

16. **Rolling back malaria.** The Roll Back Malaria partnership, launched in 1998, is committed to implementing a new strategy to tackle malaria effectively. The strategy for rolling back malaria is based on the best available evidence, uses four cost-effective interventions, and – where possible – encourages their incorporation into health systems. These interventions are: ensuring that those affected by malaria have rapid access to diagnosis and effective antimalarial medicines; using insecticide-treated materials to reduce the frequency of mosquito-biting in or near the home, supported – where appropriate – by environmental control measures; treating malaria intermittently during pregnancy to prevent consequences for the newborn child and mother; and rapidly detecting – and managing – possible malaria epidemics.

17. Heads of State – particularly in Africa – have made firm commitments to implementing the strategy and to halving the malaria burden within the next decade. Governments have concentrated on providing support to national movements of public, voluntary and private-sector groups in order to implement the strategy.

18. WHO's role is to provide support to Roll Back Malaria partners, particularly at country level. It offers consistent technical guidance, and helps local institutions to undertake the applied research necessary to assess the national malaria situation, to investigate the ecological, social and economic determinants of illness, and to implement effective action

which responds particularly to the needs of women and children, poor people, and vulnerable groups.

19. With WHO support, the Roll Back Malaria partnership has enabled over 30 countries (21 in Africa) to draw up strategies for increasing their investment in support of rolling back malaria. Investment plans call for multisectoral action based on the four essential interventions, including encouragement of the widespread use of insecticide-treated mosquito netting in the home. The results are palpable. A recent report from the United Republic of Tanzania shows that the introduction of insecticide-treated bednets in a community of 480 000 people reduced mortality by 25% in children under five. African Heads of State, when meeting in Abuja in April 2000, made a commitment to reduce taxes and tariffs on nets and insecticides to make them more affordable. Benin, Côte d'Ivoire, Kenya, Nigeria, Uganda and Zambia have changed their policies – lowering the price of treated nets. The United Republic of Tanzania has been a pioneer, as it abolished taxes and tariffs as early as 1994.

20. Chloroquine has been the mainstay of malaria treatment for years, but evidence shows a rapid increase in parasite resistance, even in sub-Saharan Africa. WHO is working with the Roll Back Malaria partnership to review the experience of artesunate-based combination therapy (ACT) in treating malaria and reducing the intensity of epidemics. It has already proved to be particularly effective in South-East Asia. The current debate relates to the speed with which ACT should be recommended for introduction in Africa. On behalf of the partnership, WHO is working with a major pharmaceutical company to enable people in malaria-endemic countries to have access to an ACT preparation at a price 30 times lower than the sales price in Europe. The Special Programme for Research and Training in Tropical Diseases is collaborating with pharmaceutical companies to study and develop other similar combinations as part of its contribution to the partnership. The Medicines for Malaria Venture is providing support for the development of novel malaria therapies through strategic public-private cooperation, in preparation for the inevitable development of parasite resistance to the currently effective therapies.

21. Public-private partnerships are vital to the development of better technologies for insecticide use within the domestic environment. The WHO Pesticide Evaluation Scheme coordinates the testing and evaluation of pesticides for public health use. It undertakes this activity through a formal relationship with the pesticide industry. An important new development is the long-lasting treated mosquito net that remains active for years, even when washed.

22. There is welcome evidence of the reform of malaria control programmes so that they provide support and encouragement to multisectoral movements at local level, of higher government spending on the essential interventions of increased donor support for malaria control, and of greater commercial investment in malaria control technologies. This action is now being reflected by the significant number of applications for additional support for action to combat malaria – from both national treasuries and such international sources as the Global Fund to Fight AIDS, Tuberculosis and Malaria.

23. **Stopping tuberculosis.** In November 1998, I launched WHO's Stop TB Initiative at the Global Conference on Lung Health in Bangkok and pledged WHO's strong support for an emerging collaboration known as the Stop TB Partnership. I am delighted to report that today over 120 organizations are working together against tuberculosis. They share common values and principles, a clear vision, a mission, and a comprehensive plan for control of tuberculosis: the Global Plan to Stop TB. The Partnership has broken the mould with its innovative approach to development. And we have learned more about what it takes to make partnerships work: transparency, imagination, trust and, above all, shared responsibility for jointly agreed goals. Our role in the Partnership is to secure agreement to application of evidence-based strategies and to promote best practice.

24. The Global Plan to Stop TB has four clearly defined objectives: to expand our current strategy: directly observed treatment, short course (DOTS), so that all people with tuberculosis have access to effective diagnosis and treatment; to adapt this strategy to meet the emerging challenges of HIV and drug resistance; to improve existing tools by developing new diagnostics, new drugs and new vaccines; and to

strengthen the efforts of Stop TB Partners so that proven tuberculosis control strategies can be effectively applied.

25. These objectives provide direction for individual Stop TB partners. Most importantly, the Plan ensures a monitoring mechanism, allowing different partners in, and donors to, tuberculosis control to assess progress and redirect efforts as needed. Strategic interventions like DOTS provide us with an opportunity to strengthen health systems and contribute to sustainable development. DOTS relies on secure routine delivery of health services through clinical facilities, health promotion activities, laboratory networks, community volunteers, drug and reagent supplies, and good management and administrative support.

26. The Global TB Drug Facility was launched in 2001 with the full involvement of WHO. It operates as a unique mechanism for ensuring the uninterrupted provision of quality-assured antituberculosis drugs for implementing DOTS. In a move to tackle the dual problems of insufficient treatment of active cases and the spread of drug resistance, the Facility grants free supplies of drugs only to those governments and nongovernmental organizations that adhere to proven and effective diagnostic, treatment and disease monitoring practices encompassed in the DOTS strategy.

27. In order to improve access to second-line antituberculosis drugs in countries where multidrug resistance is widespread, a partnership was established in 2001 with the pharmaceutical industry to provide these drugs at preferential prices. A mechanism known as the “Green Light Committee” reviews project applications and determines whether projects can benefit from this system. To date, the Committee has reviewed six potential projects for participation in the pooled procurement of concessionally priced second-line antituberculosis drugs.

28. The dual epidemic of tuberculosis and HIV, which is severest in the African Region, has been one of the challenges facing many governments in sub-Saharan Africa. With up to 80% of tuberculosis patients co-infected with HIV in some countries, health systems in several countries are struggling to cope with this problem. In collaboration with UNAIDS and other partners, WHO has developed a

strategic framework to provide guidance to Member States to address this challenge.

29. The Stop TB Partnership estimates the five-year cost of tuberculosis control to be US\$ 9.3 thousand million, with a funding gap of about US\$ 4.5 thousand million. The 22 most-affected countries will contribute their share, but it is clear that a major injection of development assistance is needed to achieve global goals. The Plan is only as good as the action it produces. It is, therefore, flexible and adaptable. Nearly all the most-affected countries have prepared national plans to control tuberculosis, and in many cases the availability of resources is the principal factor that inhibits their implementation.

30. **Combating other communicable diseases.** Partnerships between national governments, and voluntary and private entities are proving to be crucial to the success of programmes to control, prevent and eradicate different communicable diseases. Support has been provided to several time-limited programmes to eliminate diseases through the donation of medicines. The partnerships to eliminate leprosy and lymphatic filariasis were established some years ago and are achieving promising results. In 2001 a collaboration was initiated with African countries to build sustainable programmes to combat African trypanosomiasis. Part of this collaboration involves donations both in cash and in kind from industry. In one case three medicines are being donated and US\$ 25 million has been provided for logistics and service delivery over the next five years; in another, two specific drugs have been donated for five years; in a third, a drug has been donated for one year, together with funding over two years for disease management.

31. Within WHO we have recently integrated all aspects of research and development in vaccines against infectious diseases under a single umbrella, the Initiative for Vaccine Research.

Improving health in poor communities

32. **Gender and women's health.** Gender considerations, as well as concern for human rights and economic justice, are crucial elements of efforts to achieve the long-standing goal of equity in health. Work on gender issues has become more prominent throughout WHO in ways

that reflect varying needs and interests in different regions. WHO's contribution to the elimination of female genital mutilation and mitigation of its impact among those already affected was stepped up in 2001. Several publications were produced, both for frontline health workers and for trainers of nurses and midwives. WHO's policy on gender – integrating gender perspectives in the work of WHO – is being disseminated throughout the Organization and is subject to regular review.

33. **Reproductive health.** Too many women die in childbirth. In many poor countries the lifetime risk of pregnancy-related death is as high as one in 10. In developing countries women's health is strongly influenced by their role as mothers. Nearly half a million women die each year of pregnancy-related causes, and up to 20 million suffer associated illness and other health problems. Yet most of this suffering could be avoided if all women had the assistance of a skilled healthcare worker during delivery.

34. The Making Pregnancy Safer initiative is WHO's contribution to the global Safe Motherhood movement, which aims at reducing maternal and neonatal morbidity and mortality to meet the targets adopted by the United Nations General Assembly in its Millennium Declaration. Making Pregnancy Safer is a health-sector strategy that focuses on a systematic and integrated approach to increasing access to key clinical and health-system interventions, including family planning services. The strategy places particular emphasis on skilled attendance during pregnancy, delivery and the postpartum period, and provision of an appropriate and effective continuum of care with full involvement of families and communities. Ten "spotlight" countries are currently participating in the initiative: Bolivia, Ethiopia, Indonesia, Lao People's Democratic Republic, Mauritania, Moldova, Mozambique, Nigeria, Sudan and Uganda.

35. Women's health also means a focus on specific conditions that particularly affect women. In 1980 20% of the adults infected with HIV were women. By the end of 1999, 47.5% of HIV-positive adults were women. In some parts of Africa, rates of HIV infection among adolescent girls are now three to six times higher than boys of the same age. During pregnancy malaria is particularly dangerous, causing severe

anaemia and contributing substantially to maternal death. In parts of Africa where it is common, women are only about half as likely to survive bouts of the disease when they are pregnant, yet they are more than four times as likely to suffer clinical attacks of malaria during pregnancy than at other times.

36. **Child health.** In recent years child mortality rates and life expectancy have greatly improved throughout the world, with the exception of sub-Saharan Africa. Child mortality rates are a barometer of the state of a society. High rates of child mortality are a sign of social inequity. Children from poor households, living in dismal environmental conditions, and whose parents do not have access to essential health services, are most at risk. Nearly 11 million children under five years of age died in 2000, 97% of them were in developing countries. Many of these deaths are associated with feeding practices during the first years of life.

37. Mortality due to measles is an example of health inequity. It is estimated that every year nearly 30 million children suffer from measles and 777 000 die, despite the availability of an effective and safe vaccine for over 30 years. Each year, measles is responsible for about half the deaths due to vaccine-preventable diseases in childhood; most of those deaths occur among children in developing and least developed countries in the African, South-East Asia and Eastern Mediterranean regions. In response to requests from countries, several bodies – including UNICEF, the United States Agency for International Development, and the Centers for Disease Control and Prevention, have joined with WHO to develop a new strategic plan for measles control between 2001 and 2005. The aim is to reduce global measles mortality by half by 2005. The strategy recognizes varying needs of countries and sets out principles for optimal programme design and implementation. WHO has a major role in helping to ensure its successful implementation.

38. When I travel to countries I see the results that can be achieved if the main causes of child mortality are tackled. Countries do best if they give priority to ensuring that the basic needs of children are met – exclusive breastfeeding for at least six months, good complementary

nutrition, prevention and care of common illnesses, easy access to water and sanitation, and to provision of school health-services.

39. Along with Carol Bellamy, Executive Director of UNICEF, I convened a global consultation on child and adolescent health and development in March 2002, hosted by the Government of Sweden. The consultation helped to lay the foundation for the important debate on child and adolescent health to be held at the United Nations General Assembly special session on children in May 2002, and sketched out a course to be followed for fulfilment of the Millennium Development Goals that relate to child health.

40. **Infant and young child nutrition.** Malnutrition is an underlying factor in 60% of child deaths, and stems largely from poor feeding practices. During 2001 WHO, in response to requests from Member States, drew up a new global strategy for infant and young child feeding on the basis of six regional consultations involving over 100 Member States. Its integrated, comprehensive approach reflects the urgent need for interventions at national and local levels to ensure that children receive the nutrients they need through food that is safe. In preparing the strategy, WHO undertook a systematic scientific analysis of the significance and optimal duration of exclusive breastfeeding. Following an expert consultation, I presented a new series of WHO recommendations to the Health Assembly, which included promotion of exclusive breastfeeding for the first six months of life, and appropriate support to mothers who were unable to breastfeed for this period.

41. **Immunization: the global alliance.** During the 1980s the number of children vaccinated with six antigens so as to increase their immunity to common – yet serious – childhood illnesses increased dramatically. This was the result of the intense efforts of national governments and nongovernmental groups, with the support of international organizations (notably UNICEF and WHO). It has not been possible, however, to sustain this coverage during the past 10 years. Moreover, newer, cost-effective vaccines – such as those which encourage immunity to the hepatitis B virus – have not been accessible to the world's poorest communities. Two years ago, WHO and UNICEF joined national governments, development agencies,

foundations, voluntary organizations, and several committed private companies to respond to this challenge. We formed the Global Alliance for Vaccines and Immunization (GAVI) to contribute to reducing poverty and improving the well-being of disadvantaged societies by sustaining better immunization coverage.

42. The Alliance supports national immunization strategies that are based on the best available scientific evidence, and draw on the strengths of different partners at local and national levels to offer sustained immunization services for all children. Even though the interests of national governments are at the centre of the GAVI strategy, the Alliance focuses on the setting of realistic objectives and the careful monitoring of achievements in order to sustain the increased levels of funding required. At the same time, it offers resources for strategic efforts to discover, develop and apply new vaccines that could have a significant impact on children's well-being.

43. The governments and foundations that have provided millions of dollars to the Alliance want to see a clear link between the funds they donate and increases in numbers of children protected against damaging illness. Hence, when reviewing applications for funds, GAVI's Board pays special attention to the effectiveness of in-country action, and to ensuring that the health systems receiving additional resources are performing adequately. Evidence suggests that this "results-based" approach to international development is an essential prerequisite for securing *additional* resources.

44. GAVI's Board encourages the use of best practices within national programmes, but does not micromanage the resources it provides. It looks for opportunities to use those resources to strengthen national health systems, avoiding advancement of "vertical" programmes and unnecessary additional work for national authorities as they seek funds or manage grants.

45. With GAVI we sought to break new ground and to pioneer innovative ways of working. Looking back on the past two years, I conclude that the collective effort of the Alliance has been rewarded. In 2001 the 74 poorest countries were invited to submit financing proposals. Before the end of the year funding had started to reach those

which were successful. Vaccines started to arrive in countries at the turn of the year. To date, 54 countries have responded and GAVI and the Vaccine Fund together have made commitments amounting to US\$ 600 million.

46. GAVI's Board recognizes that WHO plays a unique and crucial role in collaborating with countries as they seek funds, then use them within their immunization programmes. WHO also provides support to country-level task forces on coordination, convenes regional groups that focus on immunization issues, and offers technical support to countries on immunization needs and programme strategies, including the role of new vaccines and training.

47. WHO is also called on to provide technical guidance to the Alliance on such matters as strengthening national regulatory authorities and assuring the use of good-quality vaccines. WHO is making efforts to improve immunization safety, including research and development into new vaccines and design of immunization strategies.

48. **Eradication of poliomyelitis.** An alliance of committed governments, international organizations, foundations, agencies and voluntary bodies is now deeply involved in the final stages of the epic battle to eradicate poliomyelitis. When UNICEF, the Centers for Disease Control and Prevention, and WHO joined together with Rotary International to launch the Global Polio Eradication Initiative in 1988, the disease was paralysing children in 125 countries. About 1000 children were paralysed every day – totalling 350 000 children every year. They could no longer walk as a result of their infection and were forced to crawl, or hobble, on withered legs. We have come far since then. In 2001, less than 1000 cases were reported corresponding to more than a 99% reduction in the incidence rate.

49. When I visited Pakistan in February and the Democratic Republic of the Congo in July last year I saw the remarkable commitment of national authorities to eradication, often under extremely difficult conditions. I saw the unique efforts of national coordinators to build teams that reach millions of children in a single day, to establish functioning laboratory networks in war-torn areas where no one thought they could ever exist, to mobilize millions of

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volunteers and organize them so that they work for health as a single body. I saw the efforts being made to find and immunize those children at highest risk of being missed: children in urban slums, nomad children and others on the move, whether inside the country, or crossing international borders. I learned how vaccinators were working hard to reach and respond to children in remote and inaccessible areas.

50. The Member States of the Western Pacific Region were certified free of poliomyelitis in 2000. The Region joins that of the Americas, certified in 1994. The European Region, which includes the whole of the former Soviet Union, is on track for certification in mid-2002.

51. Progress over the past three years leaves no doubt about the efficacy of the recommended strategies, and our ability to stop the spread of wild poliovirus. In 1999 there were approximately 50 countries where the disease was endemic. In 2000, there were 30. By the end of 2001, there were no more than 10. Our efforts mean that by 2005, 5 million people in the developing world, who would have been paralysed, will be walking. Together, we can finish the task and reach our target of eradicating poliomyelitis by the year 2005. We can make eradication a great chapter in our world's history.

52. **Contending with noncommunicable diseases.** Last year, when I visited Cuba and the Islamic Republic of Iran, I saw how countries that have made good progress in tackling communicable diseases face big challenges in responding to noncommunicable conditions. The growing burden of noncommunicable diseases poses a major challenge to national health systems. They are becoming leading causes of mortality and disability in many countries – even the poorest. Within countries, risk factors for these diseases are increasingly concentrated among poor and disadvantaged groups. WHO's proposals for strategies to prevent and control noncommunicable diseases within populations at risk were adopted by the Fifty-third World Health Assembly (2000).¹ They offer cost-effective, evidence-based and sustainable approaches for countries

¹ Resolution WHA53.17.

to tackle the challenge of these diseases in an integrated manner. Countries within the different WHO regions have started to implement the strategies, and to share experiences through a global forum on the prevention and control of noncommunicable diseases that held its first meeting in Geneva in December 2001. Prevention efforts are combined with disease management in a way that encourages new approaches to development of health systems, especially in resource-poor settings. WHO is giving higher priority to supporting national approaches to prevention, control and surveillance of these diseases. We collaborate with countries in adapting their health systems so that they focus on promotion of healthy lifestyles with a view to reducing the epidemic of noncommunicable diseases.

53. **Mental ill-health.** Today, more than 400 million people throughout the world are estimated to be suffering from some kind of mental and neurological disorder, including those related to alcohol and substance abuse. Mental ill-health accounted for more than 10% of the burden of all disease in 1999. Too few people realize that mental illness is one of the dominant causes of years lost to disease. Globally, depression, schizophrenia, bipolar disorders, alcohol dependence, and obsessive-compulsive disorders currently make up five of the 10 leading causes of disability. In 1999 mental illness accounted for 23% of the disease burden in high-income countries, and 11% in middle-income countries. Overall, the burden of disease due to mental illness is expected to increase to 15% over the next 20 years.

54. Depression is ranked fourth in the list of conditions that contribute to the global burden of disease. It is predicted that by 2020, depression will be ranked second. Globally, twice as many women suffer from depression as men. Between 10 and 20 million people are estimated to attempt suicide each year; one million die. This is as many as the number who die each year from malaria.

55. In 2001, mental health was the subject of both World Health Day and *The world health report*. World Health Day was celebrated in many countries with mass events, often with the participation of Heads of State and other government leaders. In addition, half a million children across the world participated in contests on the theme of mental health.

I marked World Health Day at the Mathari National Mental Hospital in Nairobi. I saw how a combination of appropriate community care and the right use of medication meant that only a few patients needed hospitalization, and the average duration of their stay could be reduced from months – or even years – to a few weeks. The experience of the Mathari Hospital is an example that could well be followed by other national institutions.

56. During the Fifty-fourth World Health Assembly, ministers of health from over 130 countries participated in a round table on the challenges they face in addressing the mental health needs of their populations and considering how they might improve their response.

57. In October, I participated in the European Union Mental Health Conference organized by the Government of Belgium. We recognized the advances made in approaches to helping people to tackle mental ill-health. For example, it is now commonplace that 60% of people affected by depression recover with a combination of antidepressant drugs and psychotherapy. Studies in some northern European countries show that if general practitioners are trained to recognize and treat depression, suicide rates fall by 20% to 30%.

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58. WHO has launched the mental health Global Action Programme, a five-year initiative aimed at closing the gap between the resources needed to reduce the burden of mental disorders, and those which are currently available. The programme collaborates with countries to carry out a strategy to improve mental health by enabling people to have better information about mental illness, framing mental health policies and developing responsive, accessible services; raising awareness of the extent of mental illness and the potential for both treatment and prevention; and undertaking research to improve the effectiveness and impact of interventions.

59. **Injuries and violence.** Road-traffic injuries are the leading cause of death by injury and the tenth leading cause of all deaths. They represent a rapidly growing problem that particularly affects poor people in developing countries (who account for nearly 90% of all traffic-related deaths). WHO is working with national institutions and other international bodies to encourage intensification of activities to

prevent road-traffic injury. As a first step, WHO has developed a five-year strategy which countries could adapt to their needs and then implement in ways that reduce the incidence of injuries and the consequences with which they are associated.

60. Every day, around 4500 people die violent deaths. These include over 2200 suicides, more than 1400 homicides, and nearly 850 war-related deaths. Countless more individuals who survive violence in one form or another are left with physical and psychosocial scars that last a lifetime. The human, social and economic costs of the consequences of violence are staggering. In November 2001, WHO was invited to act as facilitator for a collaborative effort within the United Nations system (involving 11 organizations) to prevent interpersonal violence.

61. WHO will cosponsor the Sixth World Conference on Injury Prevention and Control (Montreal, Canada, May 2002). The conference will provide the opportunity to share knowledge about the extent of injuries, groups at risk, policy options and best practice for the prevention of injuries, self-harm and violence.

62. The forthcoming world health report on violence and health will call for implementation of evidence-based actions to prevent violence. When the report is released in September 2002, WHO will launch a global campaign advocating a multidisciplinary approach to the prevention of violence and the treatment and care of victims.

III. Strategic direction 2: promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes

Reducing tobacco use

63. At the same time as the third round of negotiations opened on the framework convention on tobacco control, Adolf Ogi, Special Adviser to the United Nations Secretary-General on Sport for Development and Peace, and representatives from the International Olympic Committee, the Fédération internationale de Football Association, the Fédération internationale de l'Automobile, and Olympic Aid joined me to launch the campaign for Tobacco Free Sports. My message was

straightforward: tobacco and sport do not mix. Sports must not be used to spread messages that are associated with disease and death. We need to break the dependence of sport on tobacco and tobacco sponsorship. At the same time, support must be provided for a worldwide increase in people's involvement in sport and physical activity.

64. WHO is linking up with many other groups to plan tobacco-free events in 2002 in order to highlight the importance of physical activity and sport as a means of improving people's health and promoting well-being. These events, which began with the 2002 Salt Lake City Winter Olympics, will include the 2002 FIFA World Cup to be held in Japan and Korea.

65. The Fifty-fourth World Health Assembly adopted a resolution calling for greater transparency in tobacco control, and asking WHO to keep Member States informed of activities of tobacco companies' undermining public health.¹

66. A record number of 168 Member States took part in the third session of negotiations on the framework convention on tobacco control (22 to 28 November 2001). Regional preparatory consultations, hosted by Algeria, Bhutan, Brazil, Estonia, Islamic Republic of Iran, New Zealand, and Russian Federation, enabled countries to develop common negotiating positions. As a result, significant progress was made during the third session. Consultations before the fourth session, were hosted by Côte d'Ivoire, Egypt, India, Malaysia and Peru. Additionally, I attended the WHO European Ministerial Conference for a Tobacco-Free Europe (Warsaw, February 2002) where 48 of our European Member States had gathered to discuss the proposed text. Data released at the conference showed that young people in Europe – especially girls – are now smoking more than their parents, indicating that tobacco control is one of Europe's major health challenges.

¹ Resolution WHA54.18.

67. It is clear that governments are not waiting for the convention to be adopted before they act. Member States are informing us of legislative action, fiscal initiatives, and educational programmes designed to control the use of tobacco at national level. In adopting these new policies, they have been able to draw on the advocacy of WHO's pathfinder Tobacco Free Initiative. Its communications work is designed to mirror the social, political and legal context within which the convention is being negotiated. Examples include the "Tobacco kills – don't be Duped" media advocacy initiative, broad-based communications work with nongovernmental organizations, and the first public hearings on tobacco control within the United Nations system. In the course of its work, the Initiative has confronted difficult issues such as accuracy in scientific reporting, transparency in public health policy-making, the need for surveillance of tobacco companies' activities, and the responsible reporting and dissemination of news.

Diet and physical activity for better health

68. At the Fifty-fourth World Health Assembly we described the changes in diet, physical activity and tobacco use in many parts of the world, and presented evidence which links dietary patterns, nutrition and physical activity to the origins of noncommunicable diseases. We highlighted the great potential for disease prevention among populations and in individuals, and proposed a series of responses that would help countries to reverse these unhealthy trends. In January 2002, together with FAO, we convened a large and well-prepared experts' meeting in Geneva that agreed on the latest evidence on diet, nutrition and prevention of chronic diseases. At a consultation in April 2002, representatives of industry, consumers, and the health profession commented on the experts' recommendations and shared views on possibilities for working together to promote better health. We propose to continue this work in alliance with appropriate organizations of the United Nations system, the World Bank, nongovernmental organizations, and private entities, in order to provide support to countries in stepping up their work on diet and nutrition in the prevention of noncommunicable diseases.

69. Reduced physical activity at work and leisure is a major contributor to the increasing rates of obesity reported from many regions. Obesity contributes to the risk of diabetes, hypertension and severe cardiovascular diseases. We know that by increasing their level of physical activity, individuals have an affordable means of reducing the incidence of these diseases. Increasing opportunities for physical activity is a cost-effective approach to promoting population health and well-being. For that reason, I proposed at the Fifty-fourth World Health Assembly that the topic for World Health Day 2002 should be physical activity. Since then, the campaign “Move for Health” has been prepared and well received by both countries and numerous health promotion groups around the world. In April 2002, I had the pleasure of attending, together with the President of Brazil, the main World Health Day event in Sao Paulo, which focused on the good work undertaken by the *Agita Mundo* movement.

Effect of alcohol abuse on health

70. Worldwide, 5% of all deaths of young people between the ages of 15 and 29 are attributable to alcohol misuse. In Europe, one in four deaths of men in the age group 15 to 29 is related to alcohol. In parts of Eastern Europe, the figure is as high as one in three. Globally, 140 million people are suffering from alcohol dependence. Around the world, alcohol misuse takes a heavy toll – damaging public and private life with countless traffic fatalities and injuries, fires in the home, drownings, suicides and violent crimes. It can also lead to indebtedness, ruined careers, divorces, birth defects, and children with permanent emotional damage.

71. We have established a WHO task force on alcohol policy and the Alcohol Policy Strategy Advisory Committee. Experts meeting in Valencia, Spain, in May 2002 will recommend policy options for addressing the aggressive marketing of alcohol products to children.

Genomics and human health

72. During the past few years there have been intense debates on expectations, possibilities for, and concerns about, using new knowledge on the human genome to improve health. In 2001 I asked

the WHO Advisory Committee on Health Research (ACHR) to prepare a report, which would help both decision-makers and concerned members of the general public to assess these issues for themselves. After a period of intense scholarship and several expert consultations, the report has now been published.¹ It recognizes the potential for new research on the human genome to improve health. It also encourages the development of basic genetic services and research in developing countries in order to ensure that all countries have the capacity to respond to emerging issues related to genomics. It recommends international advocacy for policies that lead to the benefits of genomics being shared widely, so reducing health risks for all, an endeavour in which WHO would play a central role. In this regard, the recent five-year joint initiative of WHO and the United States National Institutes of Health will provide support to developing countries in strengthening research capacity in genetics and genomics.

73. Recent developments in cloning have unprecedented ethical implications and raise serious concerns for the safety of individuals and subsequent generations. The Health Assembly has affirmed that the use of cloning for the replication of human individuals is ethically unacceptable and contrary to human dignity and integrity.² Related research and development should be carefully monitored and assessed, with the rights and dignity of patients respected. In November 2001 WHO participated in discussions at the United Nations General Assembly to explore the possibility of negotiating an international convention to ban the use of cloning in human reproduction.

74. Scientific research involving stem cells, especially those derived from fetal and embryonic tissue, has the potential to yield treatments for medical conditions and diseases for which none currently exist. However, such research raises ethical and social issues. WHO

¹ Genomics and world health: report of the Advisory Committee on Health Research, Geneva, World Health Organization, 2002.

² Resolution WHA50.37.

recognizes that a full and open debate among a broad range of interested parties is needed in order to reach conclusions on the utility, safety and desirability of scientific research involving stem cells.

75. No discussion of genetics can be complete without including some of the associated ethical issues. At the meetings of regional committees in 2001, I launched a new initiative on ethics and health throughout WHO that focuses on ethics in public health and health research, and the application of ethics to biotechnology. The initiative is designed to build up the competence of Member States in handling ethical issues, and to provide support for intergovernmental action on health and ethics.

Potential health effects of depleted uranium

76. In 2001 we prepared a monograph on the health effects of depleted uranium summarizing all known health effects of exposure.¹ In addition, we joined other organizations of the United Nations system to undertake field studies of the potential health effects of depleted uranium. Although the levels of depleted uranium in the environment and their public health impact in the Balkans suggested that they were not significant enough to affect health, further studies will be undertaken. In addition, we continue to work on the impact of ionizing and non-ionizing radiation on the health of all vulnerable populations.

Making our food safe

77. WHO's Member States recognize the importance of reducing the potential of food to cause harm. Food safety is now seen as a worldwide challenge to public health. Resolution WHA53.15, adopted by the Health Assembly in May 2000, focuses on the need to develop sustainable, integrated food-safety systems for reduction of health risk along the entire food chain. WHO is carrying out this work in collaboration with FAO, notably within the FAO/WHO Codex

¹ Document WHO/SDE/PHE/01.1.

Alimentarius Commission, and we have over the past year substantially increased our resources in this area.

78. Assessment of microbiological risk – the process to assess microbiological hazards in food – was initiated in 2000 in collaboration with FAO. While participating in the Food Chain 2001 Conference, (Uppsala, Sweden, March 2001) I emphasized the need to focus on direct risk to humans of contaminated food. We need to begin with the epidemiology of foodborne diseases and track them back through the food chain, all the way to the farm. This represents a tremendous challenge for all governments, and WHO is gearing up to respond to their needs.

Risks to health

79. Risks to health is the theme of *The world health report 2002*. It will contain new information on the magnitude of major risks to people's health, including consumption of tobacco and alcohol, high blood pressure, physical inactivity, poor quality drinking-water, lack of access to sanitation, indoor-air pollution, inappropriate dietary patterns, certain sexual practices, and high cholesterol levels. It will set out options for reducing these risks, and stress the importance of surveillance as part of public health and health promotion. WHO is working with countries to establish systems for the surveillance of risk factors in order to yield information necessary for disease prevention and control. The goal is to achieve comparability of data over time and between countries, using common definitions of variables to be studied, and standardized instruments for data collection.

IV. Strategic direction 3: developing health systems that equitably improve health outcomes, respond to people's demands, and are financially fair

Framing health policy and developing health systems

80. Throughout the world, health systems are adapting to the challenges of responding to the conditions that have the greatest human and economic impact. At the same time, they are readjusting to the demands of chronic conditions, such as treatment of people with

HIV/AIDS or noncommunicable diseases. This means developing health systems that encourage long-term, often lifelong, adherence to therapy, and linking hospital treatment to community care, emphasizing the critical role of families and community groups in the process. WHO is making available descriptions of best practice in building up health systems that maintain effective contact with people in need of care.

81. We are working with many countries to examine their health systems in order to make them more effective and efficient. Several have adapted the national approach to assessing the performance of health systems to local level.

82. I launched a consultative process in 2001 on the framework and methods for assessing the performance of health systems. Consultations were held in each WHO region, involving scientific experts and members of government. Eight technical consultations on specific topics were also held involving internationally renowned scientific experts.

83. I also set up a group to advise me on how WHO should apply the assessments of health systems' performance. In November 2001 it made recommendations to me on the consultative process, and the timing and conduct of future assessments. It supported the process through which both the international scientific community and the governments of Member States had been engaged in consultation.

84. The Scientific Peer Review Group, which I also established in 2001, provides support to WHO in developing the methodology for assessing health systems' performance. It is addressing a range of difficult methodological and scientific issues. Taking account of its work, and the recommendations of the advisory group, I have decided that the next report on performance of health systems should focus on country experiences and new approaches. I plan that quantitative analyses of performance of countries' health systems will be produced for *The world health report 2003*.

85. One of the encouraging outcomes of the assessment of health systems' performance is that more and more countries see the value of generating and using evidence in health-policy debate and decision-

making. For example, more countries than ever before are undertaking national exercises on health accounts and using the information as the basis for decision-making.

86. Three new emphases guide our support to health systems. First, we are generating locally applicable information for national decision-makers on the costs and consequences of key interventions. This is being made available through WHO's CHOICE project. Secondly, we are preparing a world health survey, that will enable Member States to obtain important information on the coverage of key interventions, levels of health and risk factors, and health expenditure. It will provide a sound basis for evaluating progress towards the United Nations Millennium Development Goals (see paragraphs 105 and 106), as well as helping local health managers when they have to make difficult decisions. More than 70 Member States have asked to participate in the survey. Thirdly, we are starting to analyse ways to improve the resources available to health systems. We are drawing up technical guidance both for health-system financing and for use of human resources for health action.

Improving access to health information

87. A key component of WHO's effectiveness is the quality and timeliness of the health information it makes available to countries. How WHO internally manages health information is as important as the way in which the information is disseminated. In 2001 I approved changes to production processes within WHO. These involved transferring responsibility for the quality of health information products to the various programmes, and the formation of an Organization-wide capacity for information dissemination. I intend in the future to improve planning of health information products so that each one responds directly to an identified health information need and to evaluate the effectiveness of products in communicating health information.

88. Moreover, WHO is the keeper of diverse and often unique sets of health data, which have to be preserved. WHO's internal information assets will be surveyed and catalogued in 2002 in order to make them more accessible and to increase use of health data within WHO and, particularly, within countries.

89. The *Bulletin of the World Health Organization* has been turned into an international journal of public health. All research articles are now subject to scientific review. Recent evaluations suggest that its articles have a significant impact. Agreement has been reached with a number of publishing houses to make available to developing countries, on the Internet, 1000 medical and scientific journals at no, or low, cost. At the same time, WHO's own web site has been substantially remodelled, and we have participated in international initiatives on the communication of information.

Strengthening national disease-surveillance systems

90. WHO plays a continuing role in strengthening national preparedness for disease outbreaks, and providing support for effective public health response. Support is provided by WHO teams from country and regional offices, headquarters, and the WHO Project Office for Global Surveillance and Response to Communicable Diseases in Lyon, France. Surveillance of harmful chemical incidents is undertaken within the framework of the International Programme on Chemical Safety. The outcome is a network of networks – an efficient and proven global alert, verification and response system.

91. In 2001 WHO convened an expert group to prepare a second edition of its publication, *Public health response to biological and chemical weapons*. The guide provides information on preparedness for, and response to, the deliberate use of biological and chemical weapons. Demand increased after events that took place in the United States of America in September 2001. A prepublication version was immediately made available to Member States on WHO's web site and the subject was debated by the Executive Board in January 2002. WHO's capacity to respond was strengthened, particularly in the epidemiological and laboratory techniques needed to detect, investigate and contain any outbreak.

92. WHO's response is designed to cooperate with national governments to contain any new – or long-standing – threat, particularly from emerging infectious diseases, epidemics, and drug-resistant infectious agents. This capacity is strengthened through links with the international public-health community. WHO helps to build up

national resources for epidemic alert and response by improving capacities for laboratory services and epidemiology. In February 2001, with the assistance of the Government of France, the City of Lyon, France and the Mérieux Foundation, I opened the new office for global surveillance in Lyon, which will provide national officials in developing countries with training in detection of, and response to, epidemics.

93. By defining the core variables for surveys, surveillance and monitoring instruments, we have also developed a common approach for use by countries to monitor the distribution of noncommunicable diseases. It will enable low- and middle-income countries in particular to establish the importance to be given to control of noncommunicable diseases, while facilitating comparability of data over time and between countries.

Expanding access to essential medicines

94. Since 1975, the Health Assembly has asked for definition of essential medicines and an improvement in people's access to them. During the past two years we have witnessed some promising developments. Many companies are now offering differential prices for their products with substantial discounts (and below-cost prices) for least developed countries. Moreover, the question of access to essential medicines was prominent at the Fourth WTO Ministerial Conference (Doha, November 2001). The Ministers declared that WTO's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all. The declaration provides welcome clarification on some of the flexibilities within the TRIPS agreement. Countries continue to require elucidation of the health implications of implementing WTO agreements, and WHO will continue to respond. It will pursue its work on access to essential medicines and health care technologies, focusing on ways to ensure equitability while respecting intellectual property rights.

95. The WHO Model List of Essential Medicines is a guide for drawing up national and institutional lists. Most countries have national

lists and some also have provincial or state lists. Every two years since 1977 the Model List has been revised by the WHO Expert Committee on the Use of Essential Drugs. Over the past two years WHO has reviewed the procedures for updating its Model List in collaboration with Member States, WHO collaborating centres, members of expert advisory panels, organizations of the United Nations system, nongovernmental organizations, professional associations, national essential drugs programmes, academic groups, the pharmaceutical industry, and patients' associations. The main components of the revised procedures are strengthening the evidence base; broadening the global review process; linking selection to clinical guidelines; ensuring the independence of the Expert Committee in its scientific, normative and public health functions; and creating an essential medicines library which links the Model List with clinical guidelines, the WHO Model Formulary, and other normative information.

96. The capacity of health systems to respond to infectious disease is limited by increasing pathogen resistance to antimicrobial products. To meet this growing challenge, WHO launched a global strategy for containment of antimicrobial drug resistance in September 2001. Addressed to policy-makers and managers in a range of sectors and organizations, the strategy sets out interventions that can slow the emergence of antimicrobial-resistant microbes in a diverse range of settings.

Improving health systems in emergencies

97. WHO provides the most up-to-date information and the capacity to coordinate health-related responses to emergencies on the part of a range of groups involved in health action. In Afghanistan this task is taken on by the Regional Health Coordinator, who is helping to ensure that throughout WHO the best possible response is offered to meet the health needs of the people of Afghanistan (wherever they currently may be). WHO works closely with the national authorities in Afghanistan, other governments within the region, organizations of the United Nations system, nongovernmental organizations, and donors to help ensure availability of optimal information on the health and nutritional status of different population groups, synergy of strategies, coordinated

action, and careful monitoring of results. The emphasis is on reconstruction of the country. Together with UNICEF, WHO is responsible for assessing needs and coordinating responses for improving health, and gives this task the highest priority.

98. In November 2001, I visited the Democratic People's Republic of Korea, a country that for several years has suffered a crippling food shortage. An unknown number of people died of hunger and diseases related to malnutrition. But the world community stepped in and provided assistance. By doing so, we have helped to save thousands of lives, prevented a humanitarian catastrophe of enormous proportions, and promoted the stability of an entire region. But the emergency is having familiar long-term consequences. The health system is hampered by a failing infrastructure and lack of basic medicines and equipment. People weakened by years of malnutrition are vulnerable to diseases. Malaria has taken hold and is spreading rapidly. Tuberculosis is widespread. Overall mortality has increased by nearly 40%. It is clear that unless the country receives substantial assistance for its health sector, it will be struggling with serious health problems for decades. In the year 2001, we appointed the first WHO Representative in the Democratic People's Republic of Korea.

99. Assistance on its own cannot solve emergencies. It is not a substitute for concerted international action to mitigate conflicts. Assistance does save lives – thousands of lives; that is the justification for providing it. It also leads to better coordination of multiple actions. It can prevent an emergency from turning into a major catastrophe. It can prepare the ground for a sustained solution. It is a bridge to peace: a vital foundation for a safer, more secure and more peaceful world.

100. Emergencies occur throughout the world; in some places on a large scale right now. Often those affected are forgotten – their plight does not induce significant responses from the international community and, as a result, whole families suffer. Their ill-health delays their emergence from poverty and their achieving self-sufficiency. WHO must respond, consistently and effectively: we will do what we can to ensure that there is adequate capacity within the Organization to respond, despite the unpredictable nature of the demand for emergency

and humanitarian action. At the same time, we will continue to invest in strengthening national capacity in emergency preparedness.

101. We are currently reviewing ways to expand the impact on health of organizations working in emergency situations. This includes WHO's role in policy, operations, technical and administrative support. We are assessing how WHO mobilizes resources, expertise and finances to achieve its objective: to reduce avoidable deaths and illness that result from any type of natural or man-made disaster.

Impact of ageing populations on health systems

102. In April 2002, I took part in the United Nations Second World Assembly on Ageing in Madrid, an important global event which reflected on the multiple implications of ageing for all aspects of society. Ageing is the silent revolution of our time. Never before in human history have we experienced such a rapid ageing of our population, both in the developed and the developing world.

103. If the growing ranks of older people are to continue to make a useful contribution to their families, their communities and the economies of their countries, they must remain active and healthy. This was clearly recognized by the international plan of action on ageing adopted in Madrid, a large part of which is devoted to policy recommendations on how to maintain health and well-being at older ages. Complementing those recommendations, WHO has drafted its own background paper and policy framework on what we term "active ageing". They are based on the assumption that nations can manage ageing populations if individuals remain healthy as they grow older. Maintaining good health requires above all efforts to promote health throughout the life span and to prevent noncommunicable diseases, combined with appropriate management of chronic conditions. This should make it possible to reduce unnecessary morbidity and disability.

104. The ultimate goal is to ensure good quality of life for the highest number of individuals, whatever their age. WHO is firmly committed to implementing the policy it has set, and for this purpose has started to collaborate with different sectors and partners.

V. Strategic direction 4: developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy

Impetus for health

105. **United Nations Millennium Development Goals.** The United Nations Millennium Summit Declaration and its related targets and indicators, cover several areas that are of direct relevance to the work of WHO, including goals to reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases; and provide access to affordable, essential drugs in developing countries. These Millennium Development Goals provide a framework for charting our progress towards fulfilling commitments related to the Declaration.

106. To reach the Millennium Development Goals we need a fundamental change in the way we work together. This means shared agendas, new partnerships, funding mechanisms and monitoring, such as GAVI and the newly-formed Global Fund to Fight AIDS, Tuberculosis and Malaria. We are responding vigorously, with renewed will, to support effective action by all and to achieve results, with a stronger WHO presence in countries and increased capacity to provide support for effective local action. WHO will ensure a reporting process that does not overburden its technical programmes, yet ensures an appropriate and timely response from the entire Organization.

107. The International Conference on Financing for Development (Monterrey, Mexico, March 2002) provided a crucial opportunity to strengthen further the international commitment to achieving the Millennium Development Goals, to mobilize support for increased resources for development, and to agree on strategies for the effective, efficient and transparent use of those resources. WHO focused on evidence and experience from the health sector that can help to reach these goals, and on ways in which better health that should result from development can best be achieved *and* sustained.

108. **Health and human rights.** WHO strengthened its focus on health and human rights, building internal-capacity and advancing

health on the international human-rights agenda. We have compiled an annotated bibliography and a global database of those involved in health and human rights. Training modules have been developed to raise the awareness of WHO staff. WHO contributed actively to the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance (Durban, South Africa, September 2001), the United Nations Commission on Human Rights, and the different bodies concerned with United Nations human rights treaties.

109. Sustaining development and reducing poverty: the health contribution. The World Summit on Sustainable Development to be held in Johannesburg, South Africa in September 2002 is the culmination of a 10-year review of progress in the field of sustainable development. A major objective is to find ways of tackling obstacles to implementation of Agenda 21;¹ notably with regard to integrating trade, investment and finance issues into efforts to achieve sustainable development, and addressing the causes of growing poverty and inequalities. Health will play a more prominent role in the Summit than it did in the Conference on Environment and Development. Agenda 21 provided us with an important entry point into action for sustainable development, and we will stress the linkages between health and poverty reduction, health in development policies and practices, health risks and determinants beyond communicable diseases, health hazards of the human environment, and the impacts of economic globalization on health. We will present the case that health is central to the overall process of achieving sustainable development in its three dimensions: social, economic and environmental.

110. The correlation of ill-health and poverty is becoming more widely understood, and we see an increasing interest in human health within national strategies for reducing poverty. In these strategies, it is crucial for countries to give due prominence to investments in health. WHO has been supporting this effort in two ways. First, we have been

¹ The Plan of Action adopted at the United Nations Conference on Environment and Development (Rio de Janeiro, Brazil, 1992).

monitoring poverty reduction strategy papers from a global health perspective, and recently analysed 10 papers prepared for review by the World Bank and IMF. The review highlighted the limited degree to which growing understanding of the links between poverty and ill-health is translated into national strategies. None the less, in some countries preparation of these trends is leading to availability of more funds for health; the challenge is to ensure that they are used in ways that benefit poor people. On the basis of experience in 2001, the monitoring will be expanded in 2002 and 2003. Second, together with the regional offices and partner organizations, we have been building the capacity of national authorities to shape the health component of poverty-reduction strategies, part of the effort to strengthen WHO's country operations.

Investing in the health of poor people

111. **The Commission on Macroeconomics and Health.** During the 1980s, economists tended to maintain that developing countries could only afford to invest in health once they had reached a higher level of income. I was convinced that this was wrong; there is an interaction: a healthy population is a prerequisite for growth as much as a result of it. When I joined WHO, I set up the Commission on Macroeconomics and Health, chaired by Professor Jeffrey Sachs, to examine this relationship; I received its report in December 2001.

112. The report is a turning point – for health, and beyond. The Commission argues for a comprehensive, global approach to sustainable development, with concrete goals and specific time frames. The proposed investments in health involve well-tried interventions that are known to work. They can be measured, in terms of the disease burden and performance of the health system. The emphasis throughout is on results: on investing money where it makes a difference. WHO will work with countries as they request, taking action and pursuing the ideas in this report. Indeed, I believe the report will have a profound influence on how we all go about our work.

113. We will collaborate with countries in assessing options for setting up time-limited national commissions on macroeconomics and health, or similar entities. These bodies would contribute to formulating

a national long-term programme for scaling up essential health interventions within the context of preparation of poverty reduction strategy papers. Together with other partners, we will work with national commissions to establish epidemiological baselines, operational targets, and a framework for long-term donor financing.

114. In addition to the support provided for improving the performance of national health systems (see strategic direction 3) we will collaborate in preparing national health plans and funding proposals. We will fund operational studies to assess feasibility of community health-financing mechanisms. We will strengthen ties between debt relief and increased health spending, working with such initiatives as Heavily-Indebted Poor Countries, and with countries not in the initiative, to design national strategies and organize round tables for donors and other international partners. We will coordinate both existing and new mechanisms geared to increasing access to global public goods.

115. The report also encourages us to carry out existing work programmes with renewed vigour. Hence, we will help to set up mechanisms that can improve access to life-saving drugs and stimulate development of new drugs and vaccines. We will advise and give guidance on best practices for import, distribution and retailing systems for medicines. We will provide best evidence and technical advice on prevention, treatment, care and the performance of health systems to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. We will explore the feasibility of setting up a global fund for health research.

116. The report has identified prerequisites for more efficient financing of health systems, including more international support for health systems in low-income countries. All development partners have also recognized that expanding the action of health systems is limited by severe constraints in the area of human resources. Through an intense process of consultation within WHO and with experts from all regions, we are preparing evidence-based policies and guidance for building sustainable and efficient health-financing systems and developing human resources, that will enable us to respond to requests from Member States for high-quality technical advice.

117. Part of the message of the report is that increased resources, guided by the most cost-effective strategies, can improve the health of poor people and act as a catalyst for economic growth. Valid and regularly updated information on the costs and consequences of key health interventions is an important input for revitalizing national health policy. WHO's CHOICE project, launched three years ago, will provide such locally relevant information for national decision-makers. The first results, on interventions related to child health, blindness, and mental health, will be released in April 2002, with further instalments at regular intervals.

118. The momentum for new investments in health will be maintained only if the first disbursements make a real difference to the health of poor people. We must all be accountable for achieving better health outcomes. The world health survey will provide important information for this purpose (see paragraph 86). Variants of the survey's modules are being developed to help local managers of health programmes to monitor and manage delivery of services to particular communities.

119. We recently released a report entitled *Scaling up the response to infectious diseases: a way out of poverty*,¹ that builds on the work of the Commission on Macroeconomics and Health. It provides a road-map for channelling fresh investment into existing interventions for combating infectious diseases, and methods for strengthening countries' health systems. The report also broadens the public-health paradigm, stressing that prevention as well as treatment is now fully accepted as a means of promoting health and attacking poverty.

120. **Economic impact of ill-health.** A few conditions, such as malaria, HIV/AIDS, tuberculosis, traditional fatal childhood illnesses, reproductive health conditions and nutritional disorders, are directly biting into the economic growth of poor countries. At the same time, poor communities are affected by a rising incidence of cardiovascular diseases, mental illness, tobacco-related conditions, cancers and

¹ Document WHO/CDS/2002.7.

injuries. Surveillance of all these conditions and their impact within poor communities, and information on current levels of risk, provides vital support for framing optimal health policies and choosing the means to make programmes more effective.

121. Analysis of data from 31 African countries, from 1980 to 1995 showed that the annual loss of economic growth due to malaria has been as high as 1.3% per year. If this loss had been compounded for that 15-year period, it means that gross national product is 20% lower than it would otherwise have been. When HIV prevalence reaches 8% of the population – as is the case in at least 21 African countries – per capita growth is reduced by 0.4% each year. Given that annual per capita growth in Africa for the past three years has averaged 1.2%, this is a significant reduction.

122. Several of the Millennium Development Goals call for increased action to tackle global ill-health. However, it is becoming clear that health systems which spend annually less than US\$ 60 per capita find it very hard to deliver a reasonable minimum of services, even when they have been subject to extensive internal reform. If health professionals do not receive adequate salaries, and if essential diagnostics, medicines and vaccines are not available, the health system will not perform at a reasonable level.

123. Yet a number of health interventions that are effective at local level can dramatically reduce mortality and contribute substantially to achieving global health goals. Already described under strategic direction 1, they include supervised medication regimes (based on the DOTS strategy) to tackle tuberculosis; nets impregnated with insecticide against mosquitos, and wide access to effective malaria treatment among those at risk (particularly children and pregnant women); deliveries attended by skilled attendants and supported by emergency obstetric services; childhood immunization; and prevention programmes for HIV/AIDS, and access to care that delays death of persons living with HIV/AIDS. World leaders are starting to recognize the potential of these interventions and are committing themselves to making them more accessible, particularly to the world's poorest populations.

124. **A new global funding mechanism for health.** One sign of the increased commitment to investing in health is the newly formed Global Fund to Fight AIDS, Tuberculosis and Malaria. Creation of the Fund reflects the need for a massive and sustained increase in the resources allocated to tackling diseases that drive and are driven by poverty. Work to establish the Fund started less than a year ago in response to calls by heads of government of developing countries, supported by heads of the G8 nations and many other OECD countries. The Secretary-General of the United Nations has been a powerful advocate of the Fund since early 2001, and has encouraged organizations of the United Nations system to make every effort to support its rapid creation.

125. The Fund is not a programme; it is a financial instrument designed to attract, manage and disburse additional resources to scale up the fight against HIV/AIDS, Tuberculosis and Malaria. It will base its work on programmes that reflect national ownership and are formulated and implemented by countries. It will promote partnerships and alliances among all those involved in the country and across all sectors of society. The Fund will adopt a novel approach to international health issues, emphasizing public-private alliances, achievement of results, independent review of proposals, and efficient programming and use of resources. WHO shares and supports the objectives of the Fund. Assisting establishment of the Fund's structure and actively supporting Member States in taking advantage of this new opportunity falls within WHO's core strategic directions. WHO is currently providing a range of administrative services to the Fund's interim secretariat and is negotiating a service agreement for the permanent secretariat that is being formed.

126. Commitments to the Fund currently stand at over US\$ 2 thousand million. Of this, some US\$ 700 million to US\$ 800 million should be available for disbursement in the first year of its existence. Used wisely, these resources can make a significant difference to the impact of national policies and programmes, by expanding coverage, engaging new partners, and initiating new activities. When preparing applications for submission to the Fund, it will be crucial to show how the additional resources will add value to what is being done already, and to indicate

how results will be assessed. WHO will collaborate with Member States as they respond to the invitation to submit applications to the Fund. We will pay particular attention to the needs of countries that receive grants from the Fund, or which require support when making their applications to the Fund. We are committed to ensuring the success and sustainability of this mechanism or bringing additional resources into international health.

127. As with all our work with Member States in building health partnerships, the first point of contact is WHO's country offices. As a support for the WHO Representatives, I have established a team at headquarters, with focal points in all the regional offices, to ensure that country offices have access to the information and advice they need for providing support to the Fund's country coordination mechanism. The team includes both staff with expertise in health systems and those with specialized knowledge on individual conditions. In addition, we offer web-based support through a bulletin board on which country groups can receive information and exchange experience and advice. Providing support to governments and their development partners as they gain access to resources from the Fund will become an important component of strengthening WHO's presence in countries.

128. Establishment of the Fund is a milestone in collective efforts to combat disease and to make a significant contribution to the reduction of poverty. As in any new venture, sharing and learning from experience will be crucial for the Fund's success.

Working with others: improved links between WHO and the European Commission

129. In this endeavour, as in others, WHO is working closely with international and intergovernmental bodies, seeking to ensure consistency of advice and support. In particular, cooperation between WHO and the institutions of the European Union, notably the Commission of the European Communities, has been strengthened at all levels. An exchange of letters between WHO and the Commission, concluded on 14 December 2000, sets out a new framework for intensified cooperation that identifies objectives, priority areas, and

activities, as well as procedures and arrangements for implementation, making WHO and the Commission partners in global health.

130. As a consequence, recent policy dialogues have covered health and poverty, accelerated action on major communicable diseases, health and environment, tobacco control, and sustainable development. Specific events have included a joint round table on major communicable diseases and the development of programmes for action; a joint statement on research on international public goods; participation of the European Commission in the negotiations on the framework convention on tobacco control; a joint statement on tobacco control; and a joint seminar on health and environment. Increasing collaboration with the European Commission at all levels is set in the context of the effective partnership that is currently being built up between the United Nations and the Commission.

VI. Implementing WHO's strategic programme: administrative and managerial processes

131. Through the joint efforts of staff in different parts of WHO, a strategic programme was drawn up for the whole Organization for the biennium 2002-2003, using 35 distinct (but overlapping) areas of work, 11 of which have priority status. Work plans were then prepared for each area of work, setting out expected results and milestones. The work plans are based on single budgets which indicate how both regular budget and voluntary funds would be used.

132. Organization-wide monitoring has been initiated in order to examine the achievement of expected results. Achievements within each area of work and future work plans were communicated to Member States and others at the last Meeting of Interested Parties (June 2001).

133. The Financial Regulations of WHO were revised in 2000 in order to introduce a more modern approach to budgeting and accounting. The positive impact of these changes was perceptible in 2001. Reform of human resources policy continued. In the area of staff development, work focused on three areas: enhancing communication and negotiation or mediation skills; improving access to development and training

opportunities at all levels of the Organization through the use of new technologies, and emphasizing the value of self-development, on-the-job training and mentoring as an adjunct to formal training activities. Some aspects, including a new approach to appraisal of staff performance, were introduced in 2001; the remainder, including reform of contractual arrangements for staff, will be completed in 2002. Particular attention was given to staff security worldwide, upgrading the Organization's capacity to plan and respond to security needs. Work also began on updating the Organization's information system. Stocktaking and analyses of programme implementation during 2001 revealed the emphasis given to the monitoring of activities and expenditure.

134. During 2002, the new strategic programme budget and work plans will help to ensure that the whole Organization is working consistently and effectively. Our performance within countries is variable; there is a need to bring all up to the standard of the best. Similar consistency is needed on the degree to which activities are synchronized – between areas of work, and between different regional and country offices. To this end, we will further develop our administrative and management systems.

135. In March 2002 Ministers of Health of the Eastern Mediterranean Region, the six Regional Directors and I participated in the formal opening of the new Regional Office for the Eastern Mediterranean in Cairo. I subsequently participated with Ministers of Health of the African Region in the reopening of the Regional Office for Africa in Brazzaville.

136. The table below shows the extent to which the Organization depends on extrabudgetary, or voluntary, funding. During 2002, activities supported by voluntary funds will be subject to similar management processes as those financed from regular budget resources.

Financial highlights

	1998-1999 US\$ million	2000-2001 US\$ million	Increase %
Income			
Total	2 200	2 700	23
for WHO programme activities	1 800	2 300	28
Expenditure			
Total	2 000	2 500	25
for WHO programme activities	1 700	2 100	24
Regular budget (assessed contributions)			
Appropriations	843	843	-
Extrabudgetary resources (voluntary contributions)			
Total	931	1 450	56

137. Planned developments for the management system include:

- new mechanisms to implement the lines set out in the corporate strategy, such as a broad approach to health, poverty reduction, international trade arrangements that do not undermine public health, health within the context of sustainable development and macroeconomic processes, and health and human rights
- regular review of the total portfolio of WHO's activities, as reflected in the 35 areas of work, and reallocation of resources between them depending on the outcome
- better focus of work on the needs of countries, and – in the process – improved performance at country level
- intensive efforts to further upgrade WHO's administrative systems.

VII. Conclusion

138. This annual report indicates that we are moving ahead to improve and support health action as we build on the continued efforts of our staff in country and regional offices and at headquarters. The more detailed reports of the six WHO regions on their work and of the programmes on their activities supplement the information I have provided.

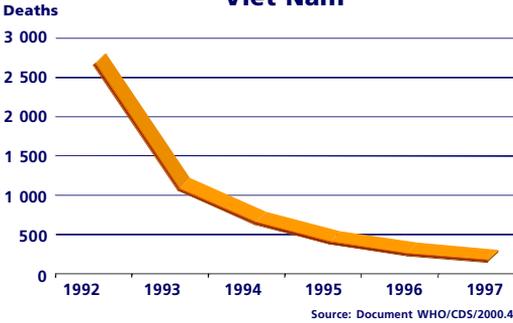
139. We know what needs to be done to achieve equity in health. Since the launching 25 years ago of the movement towards health for all through primary health care, we have seen the importance of using science to devise essential health interventions, of bringing them directly to the poorest and most vulnerable people – those who need them the most – and of working for health across different sectors.

140. We know how it can be achieved. WHO has secured agreement for global strategies to tackle the major health issues of our time. Many of these strategies have been endorsed at the highest political levels. They have concrete goals and specific time frames. Their costs are not unreasonable, and are dwarfed by the potential benefits. The strategies propose a range of cost-effective and well-tried interventions that are known to work. Their impact can be measured – in terms of reducing the burden of disease and improving the performance of health systems.

141. WHO is helping to ensure that precious investments in people's development lead to health equity and well-being. This is essential in order to maintain confidence and increase aid flows. Within WHO we know how to make investments in health yield extraordinary outcomes. They can make the difference between death and life, poverty and prosperity.

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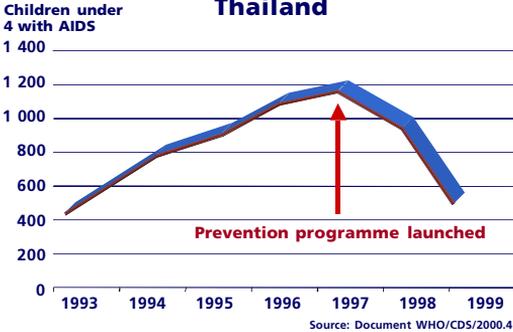
Reduction in malaria mortality through increased access to bednets and antimalarials Viet Nam



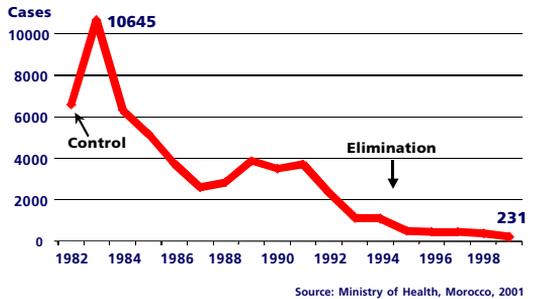
Reduction in reported cases of tuberculosis through increased access to multidrug treatment Peru



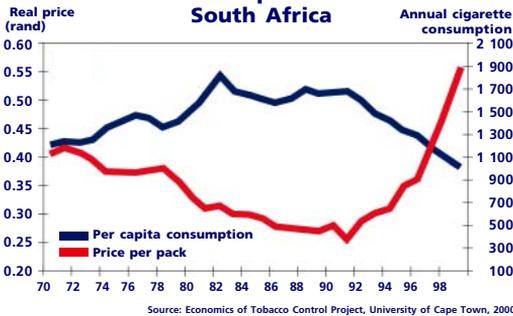
Reduction of mother-to-child transmission of HIV through use of antiretrovirals Thailand



Reduction in cases of schistosomiasis after introduction of control Morocco



Reduction in cigarette consumption as a result of price increases South Africa



Eradication of poliomyelitis Estimated and reported cases

