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Towards a strategic agenda for the WHO Secretariat

Statement by the Director-General to the Executive Board at its 105th session

Geneva, Monday, 24 January 2000

Mr Chairman,

In the first week of the new millennium, in New Delhi, I watched as 30 young Indian boys and girls paralysed by polio each lit a candle for the 30 new children who would fall victim to the disease that day.

Yet, this was not a sad event. Ten years ago, we would have needed a thousand children to send the same message! The 30 candles were a powerful reminder of how far we have come in the past decade in our efforts to eradicate polio. Hopefully, by this time next year, there will be no more candles to light.

With UNICEF, Rotary International and our many partners, WHO is entering the final year of the polio eradication campaign. We are committed to let polio join smallpox in the history books. But the battle will be hard. It will require the full commitment of the whole of the international community and I count on our Member States to rise to this historic occasion.

Another major health challenge was on my agenda in India – a challenge which will unfold into the 21st century and one which requires new methods – but the same determination and dedication.

I am talking about tobacco. Together with the Prime Minister, I opened an international conference on tobacco regulation. I applaud India for taking this initiative, bringing together lawyers, legislators, finance experts and health officials.

The developing world has limited time to raise its guard in the face of the tobacco epidemic. Developing countries urgently need to put in place legislative instruments to protect themselves and especially their younger generations. This goes right to the core of global public health.

Polio, looking back – tobacco, looking ahead; at the same time, in the same capital of a country of a billion people – a country with such long traditions – rising to seize the opportunity of development, and the potential for better health.

And then a third theme binding the two together: research and knowledge.

In New Delhi I also visited the All India Institute of Medical Sciences, one of the most distinguished medical research centres in the world. Knowledge underpinned the health revolution of the 20th century and knowledge will be the vehicle to bring that revolution to those who did not enjoy the benefits of progress. To succeed we need to build capacity in the developing world itself, and WHO is committed to contribute.

Next week, Dr Ade Lucas and Dr Tore Godal, the two past Directors of the joint programme on tropical disease research, TDR, will receive the prestigious Prince Mahidol of Thailand Award. In addition to honouring these two individuals, I see this prize as an acknowledgement of WHO and TDR's efforts to build capacity in developing countries.

Over the years TDR has been able to spur progress where the market forces did not respond. In health there are vital goods, services and values that the market will not deliver. In no other area is the need for a modern, vigilant and effective public sector response stronger. WHO has to be in the forefront in arguing the case for global public goods.

Mr Chairman,

Eradicating polio, curbing the tobacco epidemic, stimulating research in the developing world – this is our **corporate strategy** in practice.

We are dealing with the prime public health concerns of our times. We are focusing on conditions with a major impact on the poor and disadvantaged. We do so on the basis of solid evidence. And we are working alongside a broad range of partners, maximizing what we can achieve together.

Over the last 18 months we have worked on a corporate strategy for the WHO Secretariat by pursuing two approaches.

First, we have established procedures for corporate decision-making which gradually allow us to take more informed and evidence-based decisions for One WHO.

Cabinet at headquarters has given us the opportunity to see every new initiative in a broader context – inviting comments, criticism and improvements from a broad range of colleagues. The Global Cabinet is binding together what must be one – headquarters and the regional offices in their dealing with strategic decisions.

Second, beyond the organizational structure there is the process of priority-setting itself. We needed a more solid framework for defining our priorities, large and small, a framework spelling out our strategic directions and broad principles underpinning how we work.

The corporate strategy is not a product in itself. It is a process of organizational development and institutional change which will lead to products and informed decisions.

One such product is a sharper and more focused General Programme of Work, which will provide a policy framework for the Secretariat during the period 2002-2005, and which we will present to the Board in May. Another product will be the 2002-2003 programme budget, which will reach the Board a year from now.

Today I would like to highlight what I see as the major political significance of the corporate strategy in terms of strategic choices for WHO. And I will share with you how I see these choices unfold in specific priorities towards a new biennium.

The main message of the corporate strategy is to place health in a broader context – acknowledging that better health depends on contributions from outside as well as within the health sector.

- Our mission is clear; it remains the attainment, by all people, of the highest possible level of health.
- Our value base is solid – taking its inspiration from the ethical traditions of equity, solidarity and respect for human rights as expressed in the global commitment to health for all.
- Our core functions – the list of our specific efforts and interventions – have been further focused on the basis of those set out in our Constitution.
- Our four strategic directions have been developed and refined with input from throughout the Organization.

I have been outlining them in my many meetings across the regions this year – and let me briefly mention what they are:

1. To reduce the excess mortality of poor and marginalized populations.
2. To effectively deal with the leading risk factors.
3. To strengthen sustainable health systems.
4. To place health at the centre of the broader development agenda.

All of this comes together in an increased level of ambition to enable WHO to make the greatest possible contribution to world health through developing its technical, intellectual, ethical and political leadership.

In this broader context we have put a greater focus on poverty and health.

Why have we shifted our focus? Because we are taking our mandate and our values seriously. A thousand million fellow humans did not reap the benefits of the health revolution of the 20th century. People who are poor experience neglect of fundamental human rights. Health is key among them. But health is at the same time part of the solution – a new and potentially powerful exit route out of poverty.

The world has committed to halving the number of people living in poverty by 2015. The major development conferences of the 1990s have defined a set of concrete targets for how to get there, and many of them focus on health – on child and maternal health and access to primary and reproductive health care.

To me it is clear that we should strengthen our focus on how health actions, including those that affect the broader determinants of health, can help reduce poverty.

Last week WHO launched the Commission on Macroeconomics and Health. Under the chair of Professor Jeffrey Sachs, leading economists from around the world, including representatives from other agencies, the World Bank, IMF and OECD, have started work to provide new insight into the key links between better health and improved economic performance. The Commission will work for two years – it will meet in different parts of the world and will broadly disseminate its findings.

We may be standing at the threshold of a major shift in thinking. Until recently, many development professionals have argued that the health sector itself is only a minor player in efforts to improve the overall health of populations. And the overwhelming majority of finance officials and economists have believed that health is relatively unimportant as a development goal or as an instrument for reducing poverty. Health was seen as a consumption rather than investment cost.

But this is changing. Health may be far more central to poverty reduction than our macroeconomist colleagues have previously thought.

Poverty breeds ill-health – that is nothing new. But we now know much more about how ill-health also breeds poverty, triggers a vicious cycle, hampering economic and social development and contributing to unsustainable resource depletion and environmental degradation. The persistent problem of malnutrition and the unfolding AIDS crisis in Africa tells this story in its most stark form.

This is our message to decision-makers: Investing in health to reduce poverty could provide the kind of sharp, focused message we need to mobilize resources and the attention of the international community.

Together, let us turn the power of ideas into the ideas of power.

It is our role to provide key elements of the intellectual and technical basis for that message – through the Commission and our own work in-house coordinated by a Health and Poverty Task Force.

Mr Chairman,

Based on the guidelines from the World Health Assembly, defining WHO's particular role in world health is the centre-piece of the corporate strategy. We have to ask:

- What is our comparative advantage? Given our mandate and our human and financial resources, what are the functions that WHO is best placed to carry out more effectively than others?
- How can we shift the balance of our work to focus even more forcefully in areas where our comparative advantage really lies?
- And most importantly, how can we increase the impact of our contribution by engaging a variety of partners who can supplement and complement our contribution?

I would like to share with you how I see our major priorities unfold as we move towards the next biennium. But first let me reflect briefly on the notion of priority.

When we talk of priorities, we refer to a limited number of areas of work where we will strengthen our focus, increase our efforts and provide additional resources. These are areas which hold a potential for significant changes in the burden of disease with the use of cost-effective interventions,

health problems with major socioeconomic implications, or which have a disproportionate impact on the lives of the poor, and areas where we see a real opportunity to act.

But the notion of priorities is a complex one in an organization like ours. Critically important areas of work will continue even if they are not singled out as specific priorities. Delivering global public goods is in itself a priority – be it expanding the network for surveillance of communicable diseases, updating the International Health Regulations, taking forward the Essential Drugs List or keeping up to date an evidence base available to all. These are core activities and they cut across all areas of work.

The principles that lead to the definition of specific priorities must be clear. To me they are: values, evidence, strategy, specificity and continuity.

Values – because we seek to deliver on our mandate, to help build healthy communities and fight ill-health with a special emphasis on the situation of the disadvantaged.

Evidence – because we depend on solid analysis of the challenge and the likely impact of our contribution.

Strategy – because we need to map the road towards the goals we are fixing.

Specificity – because we need work plans that translate into budget allocations and expected results.

And finally – continuity – because priorities cannot change at every crossroads.

We used these principles when we selected five specific areas to benefit from the casual income transfer at last year's World Health Assembly, and we did it when I decided on how to allocate the first tranche of funds from efficiency shifts.

Together they represent the priority areas towards 2002-2003, and let me list them:

Health systems: without well performing health systems technical interventions have limited impact and strengthening health systems has to be at the heart of everything we do.

Malaria, HIV/AIDS and TB: they are major killers, they have disproportionate impact on the lives of poor people and there are huge development stakes involved.

Tobacco: a major killer in all societies and a rapidly growing problem in developing countries.

Maternal health: the most marked area of difference in health outcomes between developed and developing countries, and in itself a key milestone in the International Development Targets.

Safe blood: a neglected area in many countries, and key to many dimensions of human health.

Mental health: a major, often forgotten contributor to the growing global disease burden.

Cancer, cardiovascular disease, diabetes and chronic respiratory diseases: the leading causes of the growing tide of noncommunicable diseases.

Food safety: a problem with potentially serious economic and health consequences and an area of increasing public concern.

And finally; **investing in change in WHO;** keeping this high on our agenda in search for better results and a more inspiring and productive working environment.

Mr Chairman,

We will come back to all of these areas as we present the programme budget for the next biennium. Today I wish to comment on a few – and I will begin where the drama is the greatest – with **HIV/AIDS**.

A disease which has killed over two million people in Africa in a single year – more than 10 times the number that perished in wars and armed conflict during the same period. A disease which has already left 11 million orphans – 90% of them in Africa. A disease which threatens to reverse hard-won gains in child survival and life expectancy, and which looms as a potential threat to national and regional security.

HIV/AIDS is now the leading cause of death in sub-Saharan Africa, but in other parts of the world the threat is also devastating. The number of people in the Newly Independent States living with HIV/AIDS has doubled in the last two years. In Asia more than six million people are infected. If the epidemic is not controlled in the Indian Subcontinent, the consequences for that region will be truly appalling.

HIV/AIDS calls for unprecedented responses from all stakeholders. It has never been higher on the international agenda: as a development issue but also as a crisis at the top of the world's security attention as reflected by the unique discussion in the United Nations Security Council. We must capitalize on the momentum provided by this renewed international attention.

And let us not despair: despite the gravity of the situation, we are not powerless. We must learn lessons from those countries where infection rates are falling such as in Uganda and Thailand – countries that have shown how strong political leadership, an openness to confront sensitive issues, and a multisectoral response which links efforts across government and civil society, can start to turn the tide.

As a founding cosponsor of UNAIDS, WHO has an unshakeable commitment to the global response to HIV/AIDS. At the heart of our commitment is the objective of ensuring that the health sector – particularly in the worst affected countries – is technically and institutionally equipped to play an effective role in a society-wide response to the epidemic.

Work on HIV/AIDS cuts across many parts of WHO. Today I want to touch on three areas which merit particular attention, areas which are all key to an effective health sector strategy.

Firstly, care for the more than 30 million people currently living with HIV/AIDS. A few countries have made major strides in improving quality of life and prolonging life expectancy – but most have not.

We cannot accept the argument that because most of these 30 million will die in the next 10 years that somehow their needs should be neglected. We cannot watch while fragile health systems break down under the strain of massive additional demands. We need to recognize the critical synergy that exists between care and prevention in the overall response to the epidemic.

We know what people living with AIDS and health care providers need: clinical management, nursing care, counselling, social and psychological support. The challenge is to help national authorities make these plans a reality. We will intensify our efforts in this area, and in Africa we will do so as part of the International Partnership against AIDS.

Secondly, mother-to-child transmission, which accounts for 90% of HIV infection in children, is a problem for which effective interventions exist. Research has demonstrated the effectiveness of different drug regimes, in combination with changes in feeding practices and, when favourable conditions prevail, elective caesarean section.

Pilot projects which link these interventions with primary prevention and access to information are under way in several countries, with support from WHO, other United Nations agencies and other partners.

WHO will focus initially on a limited number of countries where conditions on the ground, and support from donors allow for more widespread application from the lessons learned from pilot studies. Which brings me to the issue of drugs.

Treatment in developed countries has led to a dramatic fall in deaths due to AIDS. But in Africa many people have no access to palliative medicines, let alone antiretroviral therapies or drugs for treating opportunistic infections. Squarely put: the drugs are in the North and the disease is in the South. This kind of inequity cannot continue.

Access to drugs is a critical component of a health sector strategy. Governments face difficult choices: they cannot invest in a few costly drugs and ignore all the other aspects of care. It is our role to help make those choices less difficult.

WHO is working, with UNAIDS and other partners, to make HIV drugs more affordable. I wish to invite the pharmaceutical industry to join us in taking a fresh and constructive look at how we can considerably increase access to relevant drugs. There should be progress so that we can report on our findings to the upcoming AIDS conference in Durban in July.

We will seek lessons from successful drug donation programmes for diseases such as river blindness, lymphatic filariasis, leprosy and trachoma. But these are short-term solutions: we also need to look for more sustainable arrangements.

WHO is working with others to negotiate with the pharmaceutical industry on the cost of individual drugs and different approaches to drug pricing. Where appropriate we support the promoting of generic competition and bulk purchasing. We are including priority HIV drugs in the regular revisions of the WHO Model Essential Drug List and we are monitoring the positive effects of growing competition in the market for antiretrovirals.

In line with the Revised Drug Strategy we are ready to provide advice to ministries of health on how to assess the public health consequences of international trade agreements and to inform them on their rights in relation to the public health safeguards included as part of the TRIPS agreement.

Mr Chairman,

Access to HIV drugs is part of a broader issue of access to drugs, medicines and vaccines. Let us be frank about it: essential and life-saving drugs exist while millions and millions of people cannot

afford them. That amounts to a moral problem, a political problem and a problem of credibility for the global market system.

The end-point of international consensus should be that the poor would not have to pay the same price for life-saving drugs as those who are better off.

Many factors determine the complex question of access; among them distribution systems, financing and prices. WHO will support any measure which realistically and sustainably improves access to essential drugs. I hope we can take the discussion forward in the year to come and together search for innovative approaches.

On intellectual property rights WHO's position is clear: they must be protected. We depend on them to stimulate innovation.

But we also need to study how the global rules and regulations work in practice. One assumption of strengthened intellectual property rights was that more research, development and production would take place in developing countries and that prices would come down.

We have to ask: is this happening?

This is not the time for simplistic solutions and there are no magic bullets. But the current international agreements cannot be seen to provide the final answer. There are new chapters that we need to explore. WHO will take this public health debate forward, with our Member States, with our other United Nations partners, with civil society and with industry.

I have offered to WTO to have WHO organize a joint working group on access to drugs and to include major stakeholders in its work, and I hope we will be able to move forward on this issue.

Mr Chairman,

Let me now touch on some of the other proposed priority areas.

The international community is committed to a 75% reduction in maternal mortality by the year 2015. Yet, throughout the world, women and newborn babies – particularly those who are poor – do not benefit from cost-effective health care that would reduce the dangers they face. It is therefore appropriate that **making pregnancy safer** should be a priority for WHO working with partners inside and outside the United Nations, and living up to our commitment that has been strengthened since the population summit in Cairo six years ago.

Our strategy focuses on results – improvements in maternal and newborn health, and an increase in the proportion of women whose deliveries are attended by skilled attendants. It involves actions within the health sector, among families and communities, by midwives, obstetricians and other professional groups, with national and international political leaders. It draws on current research and best practices from countries over the last 10 years.

Above all, it responds directly to the needs of millions of women for whom pregnancy and childbirth are hedged with uncertainty, with results that – all too often – are quite devastating for women, babies and their families. Making Pregnancy Safer is now ready to be presented to Member States and partners and I hope to see intensified action in a number of countries before the end of the year.

Prioritizing HIV/AIDS, malaria, TB or safer pregnancy makes little sense unless we are equally concerned to strengthen the systems through which interventions are delivered. **Health systems strengthening** is one of the four strategic directions and in itself a priority.

Health systems performance is the subject of this year's World Health Report, to be published in May. This report will include an innovative approach for assessing the effectiveness of health systems. We know that with similar levels of resources some countries achieve higher levels and more equitable distribution of health for their people than others.

The report will show that the way services are provided, organized, managed and financed can account for a large part of this difference. This new body of work will provide a strong base for advice to Member States – not just as they strive to ensure better health care, but also to protect people from financial losses when a family member falls seriously ill.

Primary health care is an important feature of the health system. Over the years, it has drawn attention to the needs of the many, and has been a powerful instrument for making governments and their partners recognize that the provision of health care cannot be left to the professionals alone. Our focus on the diseases of the poor and our work on health systems is consistent with the messages of primary health care. But many countries face new economic, institutional and social challenges. Over the course of the next year we will be carrying out a review which will focus on the challenges to primary health care in the changing context of international health.

Mr Chairman,

We are suggesting two new priority areas, **safe blood** and **mental health**.

Eighty per cent of the world's population still does not have reliable access to safe and affordable blood. We have to intensify our efforts in this area. Blood safety is as important to public health as it is to the health of individuals. I have therefore decided that this year's World Health Day will be devoted to safe blood.

For the first time we are inviting a partner to share World Health Day with us. Together with the International Red Cross and Red Crescent Federation we are engaging in a major campaign of information and mobilization. Working as partners we truly complement each other.

The World Health Day dedicated to safe blood will not be a single event – it will be a stepping stone for an intensified investment in blood safety activities in WHO – striving towards building capacity in all Member States.

I have wanted to see a closer coupling of World Health Day and the World Health Report. Both are well established ways of deepening our understanding of issues and bringing them to the world's attention.

Today I am pleased to announce that the theme of the World Health Report for 2001 will be mental health and that the work on that report will begin shortly. Accordingly, the theme of World Health Day 2001 will be mental health.

The case for this is strong: five out of 10 leading causes of disability worldwide are mental problems. Major depression ranks fifth in the 10 leading causes of the global disease burden. By 2020 it will have jumped to second place according to the projections.

I launched our global strategy in Beijing last November. We are now working to take this work forward with a major emphasis on mental care, community support, a strengthened evidence base, strengthened capacity of the health worker and better access to effective essential drugs.

Mr Chairman,

I wish to conclude on the priorities by addressing the **Tobacco Free Initiative** and **Roll Back Malaria** – the two priorities from day one.

Next week the Global Roll Back Malaria partnership will meet to review progress towards halving people's malaria burdens by the year 2010. National Roll Back Malaria partnerships are already helping to reduce malaria-related suffering in more than 20 countries. These efforts will have a direct impact on the health and well-being of millions of poor people.

I am pleased with the way that different parts of WHO – country and regional offices, and headquarters departments – are supporting the work of these partnerships. During the last year we have seen the coming together of malaria research and control communities, the gradual fusion of health systems and disease control thinking, the development of a WHO-wide work plan for malaria, and a cross-cluster approach to reducing reliance on DDT. New public-private alliances – such as the now independent “Medicines for Malaria Venture” – have been launched.

I am inspired by the commitments being made by President Obasanjo as he plans an April Summit in Nigeria to agree targets and mobilize resources for the next decade. I am reassured, too, that *increased financial support* is being made available for countries' efforts to Roll Back Malaria, though much more is needed. We have a window of opportunity here: given the real progress made in the last 18 months, I know that we can succeed.

By the end of 2003, I believe the Tobacco Free Initiative will have led to measurable changes in tobacco control at global and national levels. International attention is already increasing, and new policies are being adopted with the aim of curbing consumption growth, enhancing health and reducing costs for Member States.

WHO is the driver of this change process. We are now entering the negotiating phase of the framework convention on tobacco control. Towards the end of the next biennium the initial protocols should have been adopted, leading to better and more effective national and global action.

We are seeing changes in industry behaviour. CEOs of tobacco multinationals are now admitting that smoking is dangerous. They do so after having denied it for years and years when the evidence was compelling.

A tactical shift is taking place, and we need to study it closely. Fear of litigation is changing the way the tobacco industry works. We are already seeing less competition between companies and brands. In another two to three years we can expect the large merged tobacco multinationals to be openly making claims about the health and safety benefits of their new products. Those claims will be evaluated by a vigilant public health community and form the basis for regulatory approaches to tobacco products that not long ago were inconceivable.

In all of the priority areas we are working on strategies for One WHO, linking up our global, regional and national efforts. You will see this illustrated in the next budget which will be One budget for One WHO – not seven separate parts.

Succeeding will largely depend on how we perform in countries. Financed by the Renewal Fund, the Project on Strategies for Cooperation and Partnership has been mandated to test out new planning and working methods in countries – called country cooperation strategies for one WHO.

It is in countries that global initiatives and country needs meet, where we examine our comparative advantage in relation to other partners. Working closely with the WHO Representatives and regional offices we are testing out such approaches in all regions. The country office is our window on the world of national policy-makers, and the Country Cooperation Strategy is our instrument for becoming a key resource in that world.

Mr Chairman,

Today we are reaping the benefits of our new structure – our clusters and departments, our special projects, work in Cabinet, in Global Cabinet, new information technology facilities, rotation and mobility policies and gradually more modern rules and regulations. The updated financial regulations are of particular importance.

Major structural changes are behind us, but the process of reform will continue as we seek to achieve better results by working more effectively and redirect even more resources to our priority technical areas. Taken in totality we have redirected about 70 million dollars in 18 months.

On the budget side, we are now trying out new methods to link operational plans with the resources we are spending on them, regular and extrabudgetary. A new scheme for evaluation and monitoring is being developed and will be presented to you in a year.

We have delivered on the budget resolution of the Assembly and I am proud of my staff for the way they rose to the challenge.

Some say: look at how they managed – it proves that the nominal growth budget was no problem after all. Let me be very clear. The net result of the zero nominal growth budget is that we can deliver 25 million dollars less worth of WHO services. We would have gone for the efficiencies anyway. And we will continue to look for more as long as we can redirect the gains to health.

I wish to thank staff and the Staff Association for a close working relationship during recent months of challenging change. The dialogue has improved our decisions and I wish these consultations to continue here at headquarters, but also in every regional office.

We are now moving forward with a Task Force on Human Resources Management Reform. The Task Force will review the whole area with a clear aim: to simplify procedures and strengthen the productivity, efficiency and job satisfaction of all staff. The recommendations of the Task Force will come to the Executive Board in January 2001.

After some initial delays, we are also moving ahead with a comprehensive offer of training to staff. At headquarters and at several regional offices we offer leadership training of technical staff and WHO Representatives, often using regional expertise, thus contributing to regional capacity-building. The new satellite-based Global Private Network, financed by the Renewal Fund, provides additional opportunities to actively use distance learning.

These management reforms are an integral part of the corporate strategy – personnel policies, information policies and resource mobilization policies – the way they are tailored and carried out determines our ability to succeed in delivering on our mandate.

Information technology holds a real potential for further efficiencies. Taking full advantage of this technology will depend both on our creativity and on access to the necessary financial resources.

Mr Chairman,

Few organizations have a mandate with such direct impact on the daily life of men and women across the globe. For few organizations does effective communication matter more.

WHO is a multicultural and multilingual organization. Our regional structure gives us a unique capability to adapt the delivery of our advice and expertise in a variety of languages. Few organizations have such widespread and effective use of all official United Nations languages.

Multilingualism is a quality – a sign of diversity – a source of different cultural expression. This diversity needs to be actively nurtured because health cannot be expressed in only one language.

Our biggest challenge is to find means of reaching more people, more health authorities and more partners with our messages.

Succeeding will require innovation in the way we use our information technologies. The future does not belong to tons of printed materials in a number of official languages coming out of Geneva, so often gathering dust in cellars. It belongs to flexibility, broad availability and support at local levels to downloading, distribution and translation.

Here in Geneva, French and English are the leading working languages. In the regional offices, there are other mixes, tailored to regional specificities.

Our task is to facilitate communication in a way that secures high quality technical dialogue. I will be appointing a senior staff member to help coordinate and advise on the way we take issues of language diversity forward.

Free language courses have not been offered to staff since 1986. We shall now be returning to full reimbursement for staff who wish to pursue training in an official language while working at WHO.

We are also looking into how we can expand our interpretation services so that we can attract competent experts from Member States for technical consultations here in Geneva.

The importance of communication will be increased by the Internet. There are 11 millions hits on WHO's Homepage every month, and the number is rising sharply. We will develop and enrich our Website in order to make it accessible in more languages.

Last year we merged several WHO publications into the *Bulletin of the World Health Organization*. The ambition of this year is to provide the *Bulletin* in English, French and Spanish and to work towards translations into other languages at a local level. And in addition to English and French, the World Health Report of this year will also appear in Spanish, and we are ready to help facilitate translation into other major languages.

Mr Chairman,

Today I have touched on some major features of the corporate strategy, during the rest of this week we will have the opportunity to look into others.

Opportunity can stand as a leading motivation for WHO and its partners as we enter a new century. Some opportunities are there for us to grasp, others will emerge if we do our work well.

We are seizing opportunities when we help safeguard health as a key component of emergency and humanitarian assistance. We are doing it in Kosovo, in East Timor and in the flooded areas in the Americas, to mention but a few examples.

We have seized the opportunity of the new initiative on debt relief and the increased emphasis on health and education that may follow.

We seize the opportunity to call the world to renewed action against tuberculosis at the upcoming ministerial meeting in Amsterdam.

We seize the opportunity of increasing world attention to the safety of food and good nutrition as we sharpen our focus and step up our activities in this important field.

Next week we will seize a major opportunity in the field of immunization as we launch the Global Alliance for Vaccines and Immunization – or GAVI.

We need new knowledge, but let us not forget the major opportunities inherent in existing knowledge. By applying available tools and interventions we can massively reduce the disease burden of the poor and thus chart a course out of poverty.

During the coming months we will seize the opportunity to strengthen the place of health in the broader development agenda as we take part in preparations for Copenhagen plus 5 and Beijing plus 5.

In the era of globalization the mandates of several United Nations organizations are interrelated. We have renewed our dialogue with organizations such as WTO, UNCTAD, ILO and WIPO. I believe we can serve our Member States better by working much more closely together.

Health is in itself opportunity – for each individual and the community we live in. In a world torn by economic, ethnic, religious and cultural divisions, health remains as one of the few truly universal values. All major systems of belief and all mainstream political movements give primacy to the preservation of life, the promotion of well-being and the respect of the intrinsic dignity of the human being.

Health can be a unifying power that stops civil strife to allow vaccination campaigns to reach all sides. Health is a bridge to peace, an antidote to intolerance, a source of shared security.

In building the 21st century we need anchor points for a better common future.

Health is one such vital anchor.

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