

Report by the Director-General to the Executive Board at its 128th session

Geneva, Monday, 17 January 2011

Mr Chairman, members of the Executive Board, excellencies, ladies and gentlemen,

1. This past year has been one of big events for public health.
2. In December, I participated in the launch, in Burkina Faso, of a new meningitis vaccine that has the potential to end devastating epidemics in Africa's meningitis belt.
3. The launch of this vaccine is a triumph for public health on several levels. It gives us a ground-breaking new model for product innovation driven by public health needs, and not by market forces.
4. The vaccine was developed in response to the expressed needs of African leaders, including an affordable price. The project was coordinated by WHO and PATH, with core funding from the Bill & Melinda Gates Foundation.
5. At the target price of 50 cents a dose, no large pharmaceutical company was interested. That prompted a unique partnership involving public-private, north-south, and south-south collaboration.
6. A consortium of academics and scientists developed the vaccine. Technology was transferred from the United States of America and the Netherlands to the Serum Institute of India, which agreed to manufacture the vaccine at the target price.
7. African scientists contributed to the design of study protocols and conducted the clinical trials. Canada assisted the Indian National Authority in regulatory approval. WHO prequalified the vaccine last June, providing assurance that the product meets the highest international standards of safety and efficacy.
8. The vaccine was developed, from start to finish, in less than a decade, in record time, and at about one-tenth of the cost usually needed to bring a product through development to the market.
9. African countries frequently have to wait years, if not decades, for new medical products to trickle into their health systems. Not this time. For once, the best technology that the world, working together, can offer is being introduced in Africa.
10. Thanks to GAVI Alliance support, the first country-wide vaccination campaign in Burkina Faso is being followed by similar campaigns in Mali and Niger, the three hyper-endemic countries in the

meningitis belt. But there are 25 countries in this belt, and funding shortfalls jeopardize much-needed campaigns elsewhere.

11. This situation raises a question that recurred throughout the year and continues today. How much will the financial crisis and economic downturn affect public health, both internationally and within individual countries?

12. Will progress stall? Will powerful innovations, like the meningitis vaccine, like the vaccines for preventing diarrhoeal disease and pneumonia, like the new diagnostic test for tuberculosis, fall short of reaching their potential?

13. Public health has been on a winning streak. But will we still have the resources to maintain, if not accelerate, these gains? Many organizations in global health, like the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, and WHO itself, now face serious funding shortfalls.

14. Treated bednets need to be replaced. Antiretroviral therapy for AIDS is a lifeline, for a life time. Case-finding and treatment for tuberculosis are a constant undertaking that needs to intensify. Every new generation of babies must be protected from vaccine-preventable diseases.

15. Last year, we launched an aggressive new strategy for polio eradication. Does the international community have the stamina, and the resources, to reach the milestones? The map of areas where guinea worm disease is endemic has shrunk to its smallest size ever. Will we finish this job as well?

16. The financial crisis was a jolt. Climate change looms. Last year, records for extreme weather events were broken a record number of times. The trend continues this year, most notably with the flood crises in Australia, Brazil, and Sri Lanka.

17. Our hearts go out to those who have lost loved ones, and the many thousands who have lost their homes and their livelihoods.

18. Last year, the response capacity of the international community was stretched to its limits by two mega-disasters: the January earthquake in Haiti and the August floods in Pakistan. Support will be needed for some time to come.

19. Cholera is on your agenda. As the report notes, this is a disease that exploits weak health systems and infrastructures, especially in water and sanitation. Given the short incubation period, explosive outbreaks, like the one we are seeing in Haiti, can occur when the warning system is weak.

20. Both of these mega-disasters make an obvious point: poverty and weak infrastructures increase the health impact of disasters and extend recovery time. This simple observation underscores the wisdom of the Millennium Development Goals as a broad-based attack on poverty.

21. It also underscores the wisdom of WHO's current emphasis on building fundamental health capacities. Doing so increases resilience and self-reliance. It also provides the foundation for equitable and sustainable improvements in health outcomes.

Ladies and gentlemen,

22. Decades of experience tell us that health initiatives survive long enough to deliver sustainable results only when they are nationally owned and aligned with national priorities and capacities.

23. Self-reliance is realized only when programmes are delivered in ways that strengthen existing systems, infrastructures, and capacities. Doing so helps countries reduce their dependence on aid and gives donors an exit strategy.
24. You will consider reports on health system strengthening, where trends, challenges, and the need for WHO support at the country level, and especially at the policy level, are described. The kind of integrated service delivery promoted by primary health care is put forward as a model for organizing health care. This need is reflected in several other reports.
25. The report on the health-related Millennium Development Goals concludes that success depends heavily on the integration of health programmes and the strengthening of underlying health systems.
26. The report on immunization cites the weakness of health systems in many countries as a fundamental obstacle to progress. That report also shows how outreach and routine immunization activities are increasingly delivering integrated primary health-care services, often bringing these services to the most remote and hard-to-reach areas.
27. The report on malaria notes how the drive to prevent and control this disease contributes to stronger health systems and benefits from these improvements.
28. The draft HIV/AIDS strategy marks a turning point in the global response to this disease. The proposed strategy articulates a more integrated and balanced approach that depends on the performance of other health programmes and contributes to their success. The draft strategy also places the HIV/AIDS response in the context of broader public health and development agendas.
29. I personally welcome these trends.
30. Last year also saw the launch of WHO's first report on the neglected tropical diseases.¹ The striking progress documented in the report is a big blow to some ancient diseases, a big blow to the seemingly endless grip of poverty, and a big triumph for the power of strongly led partnerships.
31. Some of the biggest leaps forward have come through WHO strategic policies aimed at simplification, consolidation, streamlining, and integration. This guidance has unquestionably increased operational efficiency and relieved the burden on countries where many of these diseases overlap.
32. The launch of the report was accompanied by further commitments from the pharmaceutical industry to donate drugs in massive quantities. When the goal is to reach very large numbers of very poor people, no drug price, however low, is affordable.
33. Thanks to these donations, many millions of poor people are receiving the best-quality medicines the world can offer.
34. Public health has long struggled to achieve greater equity in access to quality medical products. This is happening, also with the new meningitis vaccine, and I strongly welcome this trend.

¹ *Neglected tropical diseases, hidden successes, emerging opportunities*. Geneva, World Health Organization, 2009.

35. I also welcome the African network for drugs and diagnostics innovation (ANDI), which is working to create a sustainable platform for research and development innovation in Africa.

Ladies and gentlemen,

36. In August, on the advice of the Emergency Committee set up under the International Health Regulations (2005), I declared an end to pandemic H1N1 (2009).

37. At that time, we warned that the H1N1 virus has by no means gone away and would likely take on the behaviour of a seasonal virus, circulating for some years to come. During this winter season in the northern hemisphere, some countries continue to see cases of severe H1N1 disease in a comparatively young age group.

38. In some cases, persuading the public to seek vaccination has become even more problematic than during the pandemic. As documented in the report on immunization, the problem of public mistrust extends well beyond influenza vaccines.

39. We may need to accept the fact that public perceptions about vaccine safety can be permanently changed by unfounded fears, to an extent that no amount of evidence can change the public's mind. This is a worrisome new trend that needs to be addressed.

40. As you know, a Review Committee, set up under the International Health Regulations (2005), is conducting a rigorous review of WHO's performance during the pandemic, together with an assessment of the overall functioning of the International Health Regulations. The Committee will report in full to the Health Assembly in May.

41. A truly worldwide event, like pandemic H1N1 (2009), highlights weaknesses in health services and inequities in access to commodities. This is a matter of continuing concern, which you will likewise be addressing.

42. At the same time, the H1N1 pandemic response confirmed the value of preparedness and capacity building. This, in turn, says much about the value of global solidarity when confronted with a universally shared threat.

43. Commitment to pursue health as a poverty reduction strategy was strongly affirmed at the United Nations Millennium Development Summit in September.¹

44. I participated in that event and can assure you that health enjoyed a very high profile.

45. As noted in several of your documents, that occasion also saw the launch, by the United Nations Secretary-General, of a Global Strategy for Women's and Children's Health. Countries and partners pledged some US\$ 40 billion over the next five years to support the strategy.

46. In a closely related undertaking, the Secretary-General called on WHO to facilitate a high-level Commission on information and accountability for women's and children's health. This initiative breaks new ground in terms of global health governance.

¹ United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, 20–22 September 2010).

47. I have asked the Commission to propose, within a six-month timeframe, expedient ways to improve the tracking of financial and other commitments from partners, the measurement of results, and the capacity of developing countries to collect and analyse basic health data.
48. The practical outcome is twofold: making sure that investments deliver the intended results, and doing so in ways that strengthen, rather than overburden, national health capacities.
49. To this end, the Commission is also being asked to propose a set of core indicators for measuring women's and children's health. These should help streamline and standardize reporting requirements while also improving the international comparability of data.
50. In addition, the Commission will be looking at ways to take advantage of information and communication technologies to build health information capacity. Without this capacity, we will never know if investments produce results.
51. In September of this year, the United Nations General Assembly will hold a high-level meeting on the prevention and control of noncommunicable diseases. You will be looking at preparations for the meeting during this session.
52. Prevention of these lifestyle-related diseases often depends on actions beyond the direct influence of the health sector. The same is true for road safety and the prevention of unintentional childhood injuries. The health sector can gather evidence of the harm, including the costs to society, but it is up to other sectors to introduce the policies, and the legislation, that confer protection.
53. The need for multisectoral action is nothing new for public health, dating back, as it does, to at least the Declaration of Alma-Ata more than 30 years ago. At that time, collaboration was sought with friendly sister sectors, like nutrition, water supply and sanitation, housing, and education.
54. This is no longer the case. The sectors, and the policies, that are driving the rise of noncommunicable diseases are influenced by the actions of powerful industries and multinational corporations, like tobacco, alcohol, food corporations, and the agribusiness giants.
55. The objective of incorporating health concerns in all government policies, especially for controlling noncommunicable diseases, faces some tough opponents. But this must be done. The rise of these diseases clearly contributes to the rise of health-care costs.
56. Last year's World Health Report¹ offers practical advice on the financing of health systems. It aims to put more countries on the path towards universal coverage and help others maintain their gains.
57. The report simplifies some complex economic arguments and theories, and distils a vast amount of country experiences into a menu of options and policy choices.
58. It proposes answers to the three biggest questions facing any move towards universal coverage: how to raise more money for health, how to extend financial protection to the poor and sick, and how to deliver health services more efficiently.

¹ *The world health report 2010: health system financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

59. As noted, better policies for the purchasing, prescribing, and quality control of medicines are a major source of savings in every country, with the use of generic medicines singled out as especially effective.

60. Apart from its practical value, the report delivers an especially timely message. When money is tight, improving efficiency is a far better option than cutting services.

Ladies and gentlemen,

61. You have a packed agenda. WHO has a packed agenda. This Organization is over-extended. We are constantly asked to do more and more. This has a limit. We are there.

62. We are not functioning at the level of top performance that is increasingly needed, and expected. From the review of events I have just provided, I think we can conclude that WHO is effective, sometimes strikingly so, in some areas. But this is not the case in all the areas covered by our vast programme of work.

63. WHO needs to change at the administrative, budgetary, and programmatic levels. We do not need to change the Constitution, but we do need to undergo some far-reaching reforms.

64. You will be considering an item on the future of financing for WHO. Any discussion of financing and budgeting needs to go hand-in-hand with a close look at the purpose and unique contribution of WHO.

65. The level of WHO engagement should not be governed by the size of a health problem. Instead, it should be governed by the extent to which WHO can have an impact on the problem. Others may be positioned to do a better job.

66. Part of the need for reform comes from external events and trends. The determinants of health are broad and interactive. The list of factors that influence health outcomes continues to grow.

67. The challenges have become far more complex, often entangled with thorny trade issues and the interests of large and powerful industries.

68. The landscape of public health is crowded with an ever growing number of partnerships, initiatives, and implementing agencies. The demands on WHO, and on countries, have become overwhelming.

69. Let me illustrate. In 2009 alone, Viet Nam dealt with more than 400 donor missions to review health projects or the health sector. Rwanda has to report, to various donors, on 890 health indicators.

70. Though the causes are external to WHO, the Organization needs to address this problem. There are two main ways.

71. As noted in your documents, national health strategies and plans are one way to achieve better alignment with national priorities and reduce some of the demands, duplication, and fragmentation. Support for this approach requires changes in the way WHO country offices function and in the way their staff are recruited and trained. It also requires changes in the behaviour of partners and donors as they work to support health development in countries.

72. A second approach is through strong technical leadership on the part of WHO. The Stop TB Strategy provides a good example. The strategy has a plan, with budgeted activities, a strong partnership, and strong technical guidance from WHO.

73. Mechanisms are in place to facilitate the procurement of quality-assured drugs at the best possible prices, including drugs for resistant forms of tuberculosis. Implementation, monitoring, and reporting take place in the context of the country-led framework of national tuberculosis programmes. Partners implement the strategy in a unified and coordinated way.

74. The strategy is dynamic and responsive. A research component means that technical and policy guidance is constantly fine-tuned in line with the latest evidence or innovations, such as the new diagnostic test.

75. This is a powerful innovation in terms of its speed and its sensitivity, particularly in detecting drug-resistant tuberculosis and tuberculosis- associated with HIV infection. Results come in around 100 minutes instead of up to three months.

76. WHO endorsement of the tool resulted in a price reduction of 75% for developing countries. Again, developing countries, with support from WHO and partners, will be among the first to introduce this breakthrough tool.

77. More recently, the Global Malaria Programme has begun to provide similar technical support to the Global Malaria Action Plan. I personally believe that much recent progress in malaria control can be attributed to the fact that disease-endemic countries and partners have united behind WHO technical recommendations.

78. As I have mentioned, the programme on neglected tropical diseases has been providing this kind of leadership for some time. Again, we see the results.

79. Of course, WHO cannot provide the same kind of high-profile, high-impact leadership in every area of work. In some areas, WHO engagement should be that of a watchdog, supported by our constitutional function of monitoring health trends and determinants.

80. Because the determinants of health are so broad and interactive, we need to keep an eye on everything. But we do not need a programme for everything.

81. Another problem is the simple fact that much of the core work of WHO is largely invisible, with an impact that is difficult to measure. Donors are impatient. They want rapid, conspicuous, and measurable results.

82. WHO is a specialized technical agency. We deliver expertise. We are positioned to deliver state-of-the-art consensus advice that guides policies or settles controversies.

83. Does a chemical contaminant in food cause cancer? It is safe to sleep under an insecticide-treated bednet? Do growth charts send false alarms to breast-feeding mothers?

84. Is a family planning device safe in malnourished women with multiple infections? Can treatment regimens for a given disease be safely shortened and simplified?

85. Can clinical signs and symptoms reliably substitute for guidance from expensive and demanding laboratory tests? Why are iodine deficiency disorders, so easily and cheaply prevented, on the rise in the African Region? What needs to be fixed?

86. This is the kind of vital, yet low-profile work that keeps public health running smoothly, with a strong bias towards needs in the developing world. Countries depend on WHO to do these jobs, but they are not well-funded.

87. International norms and standards also contribute to equity. Everyone in the world deserves the same assurance that the air they breathe, the water they drink, the food they eat, the medicines they take, and the chemicals they encounter will not harm their health.

88. This is the ideal. The reality, of course, depends, once again, on capacity, including regulatory capacity. What good are norms and standards if countries lack the capacity to implement them?

89. And we are back to the basic question. How far do the duties and responsibilities of WHO extend? How much are we obliged to ensure that our work actually has an impact on health outcomes? This is clearly happening in some areas, but not all.

Ladies and gentlemen,

90. I have concentrated on programmatic issues. The document you will be discussing has a much broader scope.

91. I will not make decisions about changes at WHO on my own. I have some personal views, of course. This is part of my job as the chief technical and administrative officer of this Organization.

92. The guidance must come from Member States, in close consultation with WHO staff. I will be listening very attentively to your views when we open this agenda item on Wednesday.

Thank you.

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