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ADDRESS
BY
DR GRO HARLEM BRUNDTLAND
DIRECTOR-GENERAL
TO THE
FIFTY-FOURTH WORLD HEALTH ASSEMBLY

GENEVA,
MONDAY, 14 MAY 2001

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BRIDGING THE HEALTH DIVIDE: THE WAY FORWARD

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Introduction

This **is** a year of hope.

People's health is the subject of intense public debate.

Healthy lives are now a core goal of development.

Health features in newspaper editorials, summit meetings, popular assemblies and parliamentary debates.

New resources have been promised and they are starting to appear.

New partnerships are bringing vital support to country action.

WHO staff are working even harder.

The contribution of civil society is vital, and welcome. We seek ways to build on it.

The involvement of the private sector evolves, with exciting new milestones: Access to new medicines at lower prices.

New drugs for sleeping sickness, and new vaccines. Combination antimalarials. The price of treating people with HIV is coming down.

We are gaining speed. The move towards wider access to life-saving health care is now unstoppable.

So – at the start of this Fifty-fourth World Health Assembly – we have new reason to be optimistic. We are working together with renewed energy. A renewed will to act. A determination to walk down unexplored paths to get results.

The demands for effective action are ever more intense.

Our fundamental challenge is to respond to the billions of people whose potential is so cruelly extinguished by avoidable ill-health.

How can we best convert this new energy, interest and commitment into equitable health outcomes – pursue our collective commitment to achieve results?

This Assembly is an opportunity to share experiences. To define new steps. And to rally to the cause.

Political agreement on the need to scale up

Mr President,

We all know that good health is vital for economic and social development. There is increasing recognition by key decision-makers – in government, in the private sector and in civil society – that healthy individuals, communities and societies are crucial for the future well-being of nations and of our planet. Health of a society is seen as one of the first prerequisites for the development of its people.

There has been a real change in development thinking. There is a new realization about the state of the world's health.

Fifty years after the link between tobacco and ill-health was demonstrated, decision-makers at last understand the real global threat of tobacco. Not only in wealthy nations, but among poor people **everywhere**. The threat is greatest for the new generation in developing nations. Tobacco will cause more of them to die than any other single reason – and health systems will not be able to afford the long and expensive care in its wake.

After 30 years of making the case, the dire social and economic consequences of diseases such as malaria and tuberculosis in the poorest communities are being understood at the highest levels of decision-making everywhere. After 15 years of analysis, prediction and intense advocacy, the extreme damage caused by HIV has become apparent to all.

And, at last, the world is waking up to the enormous burden of mental illness and neurological disorders: By applying the knowledge available today we can reduce the stigma, improve the quality of life for millions of people and help them increase their productivity.

The challenge, now, is to respond to this growing public perception of a deep health divide – the gap between those who enjoy

good health, and feel that they can control their destiny, and the millions more whose lives are undermined by serious illness.

When speaking in public, on the radio or television, through the web, or in parliament, decision-makers increasingly acknowledge concerns about the current health situation for many of their people. They know that solutions exist. That interventions are available. That strategies to improve the situation are known. They also know how best to implement them. But they recognize that much more must be done if the divide is to be bridged. They seek the commitment and resources to make this happen.

We are here at a time of unprecedented opportunity for global health. We must act now. This window of opportunity may close at any time.

We cannot wait another decade while HIV/AIDS affects more and more of the people from Africa, China, India, the former Soviet Union, and Eastern Europe. If we do not act now, drug-resistant tuberculosis will have become far more widespread, requiring costly treatment that is difficult to provide. Malaria treatments will have lost their potency due to the increase of drug-resistant strains.

Change in WHO's ways of working

Mr President,

During the last three years, we have concentrated on sharpening WHO's strategies and contribution to health and well-being.

As I took up this position in July 1998, I said that the global health agenda is too big for any one entity. To work effectively, we need to pull together. Since then, we have reached out to different parts of government, civil society, professional associations, the research community, foundations and bilateral agencies, encouraging intensive and focused partnerships.

Improving access to vaccines and immunization. Rolling back malaria. Stopping tuberculosis. Helping to reduce HIV infection. Accelerating access to treatment for AIDS. Tackling epilepsy and mental ill-health. Eradicating poliomyelitis. Eliminating leprosy and guinea worm. Improving child and adolescent health. Making pregnancy safer. Reducing injuries. Improving food safety. Developing effective health systems. It is all done in partnerships.

Within any partnership WHO retains its core values and its integrity. The goals are always the same: To improve health outcomes and promote health equity. Partnerships have greatly enhanced our reach and ability to make a difference.

Two years ago, when I introduced WHO's budget for the current biennium, I committed WHO to work differently. Selecting priorities, and reducing the emphasis on – or even closing – non-priority programmes. Concentrating resources on the priorities, and cutting back on administration. Improving our capacity to work together, strategically, at country as well as global level, and increasing our income to enable us to do this.

We developed a corporate strategy and prepared a strategic programme budget. The next stage is to intensify country action, within the context of country cooperation strategies, in ways that reflect the needs and intentions of Member States *and* agreed global priorities for health action.

All our staff worked hard to increase efficiency and focus their work: to make sure that WHO adds the greatest possible value to investments in world health – wherever they are made.

Our efforts have been recognized: Voluntary contributions to WHO's work have increased by 40% in 2000.

We still have to invest more in our information technology, so that we can track income and expenditure in real time, and demonstrate a clear link between funds provided and results achieved. This will

become easier in the next biennium as we move to programming by areas of work, across the whole Organization.

We have to accept the reality of voluntary funding. Often funds are provided on a year-by-year basis, and are tightly earmarked. Because continuation of such funding cannot always be guaranteed, we are often reliant on short-term staff, and this creates challenges for our human resource policies.

The use of all resources within areas of work, across the Organization, will – for the first time – be reviewed at the remodelled Meeting of Interested Parties that will take place in June, each year.

Last week, I have appointed a new Executive Director for WHO's General Management – someone who has extensive experience in handling the complex challenges of administration in a United Nations system under reform. I have also decided to upgrade the post of Human Resources Director to a Cabinet position. The person selected will help to take forward human resource reforms and be responsible for an enhanced programme of staff development, as well as the important task of relating to the energetic and constructive staff associations throughout the Organization.

In 1998, our review of WHO's administrative systems suggested that financial and personnel management functions should be streamlined and standardized, while – at the same time – being brought closer to the technical programmes in the Regions and Geneva. Management Support Units were created in each of the Geneva clusters. This innovation has been appreciated by the programmes, and has proved – overall – to be effective. However, internal audit has highlighted the need for further standardization of procedures, and we are now implementing such changes.

Capacity and contribution of country teams

During the past year, the Regional Directors and I have strengthened the ability of all parts of the Organization to work as one. In March, I called the second meeting of WHO Representatives here in Geneva. We agreed that the time had come to focus on strengthening the capacity and contribution of our country teams. Regional Offices have reviewed their capacity to support country programmes, and established new intercountry programmes. The newly constituted Global Programme Management Group – which includes Programme Management Directors from each Region – will take this work forward, together with the Regional Directors.

Budget

A major item on this year's Health Assembly will be the review of the Proposed programme budget for 2002-2003. It is a key instrument in the reform process towards One WHO, and one which will serve as the underpinning for WHO's strategic plan for the next biennium.

The preparation of this budget is significantly different in several ways: first, it has been prepared in a truly collaborative spirit between the Regional Offices and Geneva; secondly, it applies principles of results-based budgeting through the identification of expected results and performance indicators for all of the Organization's strategic areas; and thirdly, it has for the first time been reviewed in its entirety by the Regional Committees before being transmitted to the Executive Board.

Over the last three years we have attempted to increase the effectiveness and efficiency of WHO's work with a declining regular budget. We have made extensive savings, and redirected resources to priority programmes. The demands on the regular budget – for our administration, our core programmes, our normative functions and our country programmes – are intense.

This year we invite the Assembly to take account of the net increases in our costs and consider a 1.9% increase in the regular budget for the 2002-2003 biennium – equalling US$ 16 million. We also anticipate an amount of US$ 10 million from miscellaneous income that I believe is required for certain selected priorities, linked to the ongoing reform process in the Organization. One example is the investment required in strengthening the capacity and contribution of our country teams.

There are also unexpected demands being made on the Organization. For example, during the last year we have been asked by Member States to do more to assess the possible health impact of the use of depleted uranium in munitions. We appealed for extrabudgetary funding to undertake essential field work and support research – particularly in the Balkans and the Gulf States. The response – from France and Switzerland – has been much appreciated but is far below the cost of doing this work. We hope that it will increase in coming months.

Evidence and health systems performance

Mr President,

Three years ago, I pointed to the need for an increased focus on ensuring a strong evidence base for world health action. The initial focus was on identifying and quantifying the various reasons why healthy life years are lost in different countries, establishing which interventions are effective in different settings, and standardizing means through which guidelines are developed and disseminated.

During the last two years we have followed similar principles in developing methods for analysing and comparing the performance of health systems worldwide. We set out desirable goals and functions of national health systems. We went on to develop a group of indicators for measuring health system performance, and to make quantitative performance assessments for all the world's health systems. The results

were expressed as indices in the annex to the World Health Report 2000.

There has been considerable public debate about both the methods used and results obtained. At the 107th session of the Executive Board in January, I indicated that WHO would encourage a wider examination of the issues. The Executive Board addressed such an approach through a resolution.

I have now established a group to advise me on this important work. It will be led by Dr Mahmoud Fathalla of Egypt, the Chair of the Advisory Committee on Health Research.

The Regional Directors and I have moved ahead with plans for regional and international consultations which will enable WHO to receive and reflect on a wide range of views about optimum means for assessing health systems performance. The consultations are timed to take place between May and July this year.

I am also establishing an expert team to peer-review health systems performance methodology, following the technical consultation process.

I expect that the technical consultations and peer reviews will enable us to update the methodology and data sources relevant to the performance of health systems, leading to a plan for further research. It will also enable us to develop the framework and relevant indicators for performance assessment, and improve data quality, as identified by the Executive Board resolution. The modifications will serve as the basis for the next report on the performance of the world's health systems, to be issued in October 2002.

Tobacco

Mr President,

Another important innovation during the past three years has been the process through which governments are negotiating a framework convention on tobacco control. The second round of the negotiation process was completed earlier this month under Ambassador Amorim's excellent stewardship. His first draft was discussed and debated at length. This is the normal negotiating process that will go forward to the next session in November. I am confident that we will end up with a strong and effective Convention – one that can help countries confront the threat of tobacco to their people.

As we move forward, we must keep the alternative firmly in mind: millions of needless and preventable deaths around the world each year. Deaths caused not by microbes or virus – but by an unhealthy hunt for profits. Profits for some which will burden societies dearly through the cost of treatment and lost productivity. Tobacco steals from society. It steals life and scarce resources. The framework convention is an important tool to protect our societies – and especially the poor ones – from this pillage.

Let me be clear: Tobacco use is a communicated disease. Tobacco should not be advertised, glamorized or subsidized.

The health divide

Mr President,

We are living in a world in which the divide between the haves and the have-nots continues to widen; a world in which only a privileged few have access to the fruits of the technological revolution. Our challenge is to bridge that divide. We can do it through improving access: Access to resources. Access to commodities. Access to information and technology. Access to health systems, together with infrastructure and institutions that make this possible.

Bridging the health research divide

One of the big challenges is to improve the technologies available to tackle the illness experienced by poor communities. Market forces on their own do not create an environment which favours the development of essential public health goods that are needed by the world's poorest people. They certainly do not encourage the delivery of these goods at a price which poor people – or their health systems – can easily afford.

During the last three years, we have seen a powerful effort by groups focusing on health research, together with staff from WHO and other development agencies, assisted by data from the Commission on Macroeconomics and Health. Nongovernmental organizations, researchers, and the private sector have stepped up their efforts too. We consider the kinds of incentives that encourage innovation of the kind needed by poorer communities. We have proposed alternative approaches to meeting the cost of research and development for diseases that drive poverty. We are starting to see imaginative answers to these difficult questions.

We have drawn on the experiences of existing programmes for tropical disease, for human reproduction, and related research to bridge the divide in access to technologies. We have worked through public-private partnerships to develop new medicines, diagnostics and

vaccines in areas where they are badly needed. At all times, we have championed the ethical development and application of new technologies and their widespread availability among the world's poorest communities.

We have started to examine the implications of advances in genomics and other critical areas of biotechnology. They clearly have a huge potential for improving human health.

The basic knowledge on the human genome is, of course, already in the public domain. The challenge is to harness this knowledge and have it contribute to health equity.

However, most biotechnology research is now carried out in the industrialized world, and is primarily market-driven. This is ethically unacceptable. Unless this pattern is changed, the knowledge and technology gap between industrialized and developing countries will widen. The health needs of poor nations will fail to get the attention they deserve.

WHO's research programmes help bridge this divide through building international networks that involve researchers from all over the world, working together in ways that maximize the probability of success. One promising example is the new initiative to develop anti-tuberculosis drugs, based in Africa, Europe and the United States of America.

Intercountry partnerships are vital for the proper application of genome science, as well as for other disciplines. So we actively seek means to involve developing country scientists in innovative biotechnology. Only by their participation can we reap the full health benefits and contribute to health equity. WHO will work with Member States on the ethical, social and legal issues. The Advisory Committee on Health Research is expected to report on some of these issues within the next year.

The information resulting from research is a "global public good" just as health technology must be considered a global public good. Yet the information divide stands in the way of health equity. WHO is contributing to dissemination of health information so that it becomes unrestricted and affordable worldwide.

Responding to the resource gap

Mr President,

The underlying cause of the health divide is a shortage of resources. This is the fundamental reason why the new partnerships cannot yet fulfil their full potential. Over the last three years, Heads of State have argued coherently for a rapid and sustained increase in the level of resources invested in human health.

There is growing impatience for more resources, and for their effective use. The Non-Aligned Movement issued a landmark declaration earlier this year following their meeting in South Africa, calling for a major increase in resources for health – as a global priority. There have been many similar calls from a wide spectrum of voices, including African Heads of State, who came together at the invitation of the OAU and the Nigerian Government to assess the impact of ill-health on their people in Abuja last month.

At summits over the last few years, political leaders have set targets, and have made public commitments to their people. Halving the burden from malaria and tuberculosis within 10 years. Reducing HIV infections by 25%. Cutting child and maternal death rates. Reducing tobacco use. The targets have been reiterated. In Abuja. In Durban. In Amsterdam. In Okinawa. In Brussels. In Delhi. In New York at the Millennium Summit last year.

The call to action is clear. A massive effort is needed. Step up the fight against devastation caused by malaria, HIV, tuberculosis, maternal illness, tobacco. Broaden access to life-saving medicines. Ensure that health systems perform as they should, responding to people's needs,

increasing healthy life expectancy, and are financed fairly. Rolling back the illnesses that perpetuate poverty means investing more, investing it well and tracking these investments with care.

We see the response unfolding as we meet here this week.

Developing country governments **are** in the lead, changing their spending priorities to give higher priority to their people's health. But the bulk of the new resources required must come from the wealthy world.

G8 nations have given increasing importance to health issues in the last four of their annual meetings, culminating in a major declaration to contribute more in Okinawa last July. The European Union, too, have made a major commitment to do more, and President Prodi of the European Commission has indicated his impatience to see real results, soon. OECD countries have pursued the cause actively. Some have indicated that they intend to make public commitments soon. Many more are coming on board.

The President of the United States of America signalled the importance of global health, and the importance of working with the United Nations as a partner, with the announcement last Friday when he stood with the United Nations Secretary-General and President Obasanjo of Nigeria on the White House lawn. The United States has a key role to play in the United Nations and in the betterment of world health.

The framework for action

We see a growing commitment to a new international framework which links the availability of new resources to the ways in which they are used.

The first requirement is that there really is a steep **increase in resources:** in Abuja, Heads of State, together with Government Ministers, and representatives of civil society, indicated the need for

more resources. The United Nations Secretary-General spoke of an additional US$ 7 billion per year for HIV/AIDS. I believe we should be looking toward a progressive increase in funding – from all sources, both national and international – toward a total of about US$ 10 billion a year to cover the investments needed to tackle HIV, tuberculosis and malaria.

There is much that can be done by increasing investments through existing international channels. Savings from debt relief can make a significant contribution to national budgets. But we also believe there is need for something new. We have worked hard to maintain the necessary momentum for a new international fund.

United Nations Secretary-General Kofi Annan has now personally taken a leading role advocating, and coordinating the United Nations contribution to, a **global AIDS and health fund**. WHO has been working with Member States, with United Nations agencies and others on the design of such a fund, taking account of the evidence produced by the Commission on Macroeconomics and Health.

Within the framework for action, a significant proportion of the new money is needed to build the systems in health and other sectors needed to deliver results. This means working through a diversity of public, not-for-profit and private providers, with clear targets and better means for assessing progress. WHO will intensify its support for Member States as they scale up and streamline their health systems.

We will continue to draw on experience to date – including the Primary Health Care and Health for All movements, as well as initiatives for heath sector reform and sector-wide approaches. We are doing more to help Member States better monitor coverage, accessibility and use of services, and to assess the effectiveness of health care providers. We will also increase our capacity to help on health financing and human resources for health systems, which will also help to meet the needs of chronic disease management. This will be as important for HIV/AIDS and tuberculosis as it will for diabetes, cancer and schizophrenia.

We anticipate that the opportunities posed by the 3rd Conference on Least Developed Countries, as well as the upcoming United Nations General Assembly Special Sessions, will encourage all sectors to examine how their policies can help bridge the health divide. This applies particularly to education, finance and revenue, trade, environment, local government, and social development. We will continue to encourage approaches that promote the realization of all people's human rights.

Within the framework, we will continue to encourage long-term political support for intensified health action, advocating our cause and describing results achieved to decision-makers within governments and funding agencies.

We need new mechanisms to spend resources from the new Fund quickly, and well. This means establishing means to bring both cash and commodities rapidly to where they can contribute directly to better health. I would like to see decisions in relation to programme and policy options being based on country and community realities. Approaches for resource allocation should build on existing country processes, such as national poverty reduction strategies, with United Nations agencies coming together through the United Nations Development Assistance Framework. We should build on the effective elements of partnerships like Roll Back Malaria, Stop TB and the International Partnership against AIDS in Africa.

Do we know how to deliver swiftly? Take the Global Alliance for Vaccines and Immunization as an example. Last year we invited the poorest 74 countries to submit proposals to the GAVI secretariat. Before the end of last year, financial support started to flow. Vaccines started to reach countries early this year. To date 54 countries have responded and the fund has commitments amounting to US$ 375 million.

The pathfinder partnerships are showing the way forward. They have given us the know-how and are ready for scaling up.

As more countries become involved in the development of a Global AIDS and Health Fund, there will be a need for WHO's Member States to work together. They need opportunities for detailed deliberations and frank discussion. I believe that delegates will take advantage of such opportunities at this Assembly, focusing, perhaps, on the collection of resources, the ways in which they are used, and means for monitoring results. I will review progress in an informal briefing session at lunch-time tomorrow. WHO does have an important role to play in the Fund, and I solicit your advice as we continue to refine this role.

We are lucky that on Thursday, the United Nations Secretary-General plans to be here to give his perspective on progress and next steps. The WHO Executive Board will discuss WHO's involvement in scaling up health action next week. We anticipate that there will be extensive consultations on the AIDS and Health Fund, involving a broad range of Member States, over the next few weeks.

HIV/AIDS

Mr President,

HIV is the biggest health challenge of our time. It is vital that we work together to confront the epidemic effectively. A much better response is needed.

In close coordination with other UNAIDS cosponsors, WHO is scaling up its efforts to play our part in the action against HIV/AIDS. We do so through our normative excellence, through technical support, through mobilizing additional resources. We do it through responding to Member States' requests to help with prevention and with improving access to care for people affected by HIV. Our actions are based on the best evidence, joint work, and the need to secure lasting results.

Indeed, we focus relentlessly on better health outcomes. They are key to the fate of our peoples and the health of our economies.

We are responding to the urgent calls for intensified action, from Heads of State and the United Nations Secretary-General, from civil society and the international community.

- We concentrate on the needs of young people through helping increase their access to preventive measures – including condoms and microbicides, information and services for other sexually transmitted infections;

- We do more to ensure prevention of HIV transmission among mothers and their children;

- We promote a comprehensive response by increasing access to voluntary counselling, testing, blood safety and safe injection practices, and better access to care and support for those affected by HIV, on management of opportunistic infections and of tuberculosis and treatment with antiretroviral compounds. We pay special attention to the needs of health workers.

- We invest widely in research to establish the best options for prevention, diagnostics and care.

- We support communities who have been devastated by HIV – particularly children who have been orphaned.

Within WHO, our vital task is to establish the ways in which the available interventions can be made as effective as possible in different country settings. We want to help ensure that all health systems everywhere are scaling up their efforts and empowering people to better confront HIV. If the health systems cannot do this, limiting the spread of HIV becomes virtually impossible.

At the beginning of last year, I was outspoken about inequities in people's access to life-prolonging therapies. I asked why so many millions of people should be denied the hope that is available to a fortunate few. The offer of treatment will increase testing for HIV.

Increased testing is essential for prevention strategies to work. We must create a positive spiral of hope.

In this effort, people with HIV are powerful partners.

During the past year, the face of the epidemic has changed, dramatically.

HIV-affected people and advocacy groups have strengthened the public debate. WHO, together with other United Nations system agencies, has provided technical support for effective action. Companies are responding to the United Nation's call by reducing prices of medicines to treat people infected with HIV.

For many governments, the new reality raises difficult challenges. Of priority setting. Of capacity. Of equity. Of balancing public expectation with resources.

Many commentators have said that the pace of change over the last year has been too slow. But no one will thank us if – in our haste – we promote patterns of care that are unsafe – or even dangerous. We are working hard, with Member States and other interested parties, to establish health systems that offer care which is safe and sustainable, as well as affordable. For WHO, this means making clear how diagnostic tests and laboratory services, antiretroviral medicines and other treatments can best be made available in resource-poor settings.

We must be responsible and realistic, but that does not mean we cannot begin improving access to treatment quickly. In every country in the world, there is already the capacity to reach at least some HIV-affected people with better medical care. As our experience improves, we can expand.

We must also do what we can to establish consistent funding: it would be a tragedy if people who start antiretroviral therapy are forced to quit because funds dry up. Good systems, and sustained funding will

create new market forces. I am sure that costs of effective triple ARV therapy could still go much further down.

I have been outspoken about the absolute need for health systems to scale up preventive efforts. Let us all take note of the example of your country, Mr President. Cambodia experienced a rapidly escalating HIV epidemic during the 1990s. The Government's vigorous efforts to combat HIV/AIDS involved a national policy for "100% Condom Use", through a well organized health campaign, with coordinated action in other sectors. The HIV infection rates have shown declining trends in recent years. For example, the rate of HIV infections among young sex workers – below 20 years of age – dropped from more than 40% in 1998 to 23% in 2000.

Essential drugs

Mr President,

The debates about access to essential – yet expensive – medicines have led to calls for a review of the concept of essential drugs. Since 1977, WHO has updated a model list for essential medicines to be used in both national and institutional settings. Now, more than 150 Member States have their own national lists of essential drugs.

The maintenance of such lists is no easy matter. The stakes are high – in light of the potential to improve health outcomes, the need to contain health care costs, and the different commercial interests involved. It is crucial that the process is open, clear to all and based on accepted principles of scientific analysis. We would like the selection process used by WHO to be a model for all Member States to follow.

When the Executive Board meets next week, it will receive a summary of a proposed new process to update essential drug lists. After the Board meeting, all Member States – and then a broad range of partners including United Nations agencies, the World Bank, members of WHO Expert Advisory Panels, nongovernmental organizations, and

the pharmaceutical industry – will be able to examine the proposals in full and make their contribution.

Further consultations will take place during the June 2001 WHO Meeting of Interested Parties and – to reduce costs and widen participation – through a Web-based discussion forum. After further internal review within WHO, involving the Expert Committee on Essential Drugs, I will propose the new process to the Executive Board, in time for its meeting in January 2002.

In this way we will ensure that the Model List of Essential Drugs remains a key reference point and guide for Member States in their work to ensure access to life-saving medicines for all who need them.

Infant feeding

Mr President,

Exactly 20 years ago, in 1981, this Assembly adopted the International Code of Breast-milk Substitutes. This pioneering instrument is being implemented by at least 170 Member States. It is being used as the basic platform for action to improve infant and young child nutrition.

Last year, I initiated work on a new global strategy for infant and young child feeding to provide a framework for intensifying action. The work has been guided by two principles: first – the strategy should be focused on science and evidence, and second – a broad range of interested parties should be involved in its development. Consultations are under way within WHO's Regions, and six more are due to take place between now and October. They will draw on experiences of more than 100 Member States. The proposed strategy will be presented to the Executive Board and the Health Assembly in 2002.

Over a year ago, I commissioned a systematic scientific review of all published literature on the optimal duration of exclusive

breastfeeding. The analytical work was examined at an expert consultation here in Geneva at the end of March.

Based on this evidence, I encourage Member States to protect, promote and support exclusive breastfeeding for six months as a global public health recommendation.

Of course, we must consider how health workers can best respond to the specific needs of individual infants whose mothers are unable to, or choose not to, breast feed for six months. Many mothers need help to optimize their infants' nutrition. Experience suggests that this should include improving the nutritional status of women to reduce intrauterine growth retardation; preventing micronutrient malnutrition among infants in areas with high prevalence of deficiencies; and ensuring better access to primary health care for individual infants.

As we develop a new global strategy for infant and young child feeding, let us take on board this careful, science-based analysis, encouraging its application in ways that meet the needs of all the world's infants wherever they live.

Polio

Mr President,

I said earlier that the time to act is now. There is one window of real opportunity that will close quickly if we do not act forcefully. I am talking about the eradication of polio.

In the last 24 months we have made tremendous progress. In that period, we have fallen from 50 to fewer than 20 countries infected with polio. In October last year the Western Pacific Region was declared polio-free. By the end of 2000, there were fewer than 3500 cases reported throughout the world. That is a 99% decline since the World Health Assembly resolved to eradicate polio in 1988.

Despite the tremendous progress to date, events in several Regions over the last 12 months also remind us of the fragility of our gains so far.

An outbreak caused by a vaccine-derived poliovirus in Hispaniola last year underscores in particular the need to carefully map out the polio "end-game" – how we will be able to sustain a polio-free world. WHO is now leading a programme of work which will define specific options and report these to the World Health Assembly at a later stage.

We have a hard task in front of us. Preventing the last 3500 polio cases may be as difficult as eliminating the other 346 500. At the country level – our biggest challenge is ensuring high-quality polio immunization activities and high-quality surveillance.

At the global level, the greatest threat to realizing this historic goal is the US$ 400 million funding gap. Without the money, we cannot finish the job.

Now, when the end is in sight, it is easy to waver. One may think, "what are a few cases of polio compared with all the other diseases we have to struggle with?" But the recent outbreaks – as well experience with other diseases that were at one time almost eradicated but now have rebounded – show us that it is all or nothing. We cannot relax now.

By contributing to polio eradication, you are also contributing to improved health systems worldwide. WHO will be working within the Global Alliance for Vaccines and Immunization to ensure that the resources spent on eradicating polio today will benefit immunization and health systems well into the future.

Food safety

Mr President,

Ten years ago, food safety was not much of an issue for people in general. Incidences of chemical or microbiological contamination were local in nature. So was the reporting about them. In the industrialized countries, there was a general expectation that food was safe – and in many developing countries, foodborne diseases were often grouped with the other diseases of poverty, like malaria. There is, without doubt, a serious "food safety divide".

What a contrast with the present. Today, food safety is one of the highest priority issues for consumers, producers and governments alike, certainly in Europe, but increasingly throughout the world.

Based on evidence, it is clear that the main food safety problems are not the spectacular outbreaks which make their way into the media. In fact, the problem is a vast number of sporadic cases. Foodborne diseases amount to an enormous global health problem.

Millions of children die every year from diarrhoea, mostly because they consume food and water that are contaminated with pathogens. In industrialized countries it is estimated that one third of the population suffers from foodborne disease every year, and out of these, maybe up to 20 per million die.

As I look at the vast area of food safety from the vantage point of the World Health Organization, I see three major challenges to protect the health of the consumer:

- We need to accept that the systems we use to ensure food safety are not as good as we have come to believe. We must reassess them all the way from the farm to the table;

- We need to ensure reasonable food safety standards that apply throughout the world and assist all countries to reach these standards; and

- We must develop global standards for pre-market approval of genetically modified food to ensure that these new products not only are safe, but also beneficial for consumers.

To ensure global food safety, developing countries should be key players. Thus, participation of developing countries in the process of international rule setting, such as the Codex Alimentarius Commission, is important. Industrialized countries will find it is in their interests to ensure that this happens sooner rather than later.

Last year, the World Health Assembly passed a resolution identifying Food Safety as an essential public health issue. WHO is following up the resolution in collaboration with FAO, and within the FAO/WHO Codex Alimentarius Commission. Over the past year, the level of WHO's resources that are applied to this area of work has increased substantially. But additional finance and technical expertise are urgently needed to promote food safety, and so protect the health and the trading capacity of many low income countries.

Mental health

Mr President,

This year, the theme of the World Health Day was mental health. Many countries and communities marked the theme of "Stop exclusion: Dare to care".

The challenge ahead is clear. We must attack stigma and the damage it does. We must work to eliminate the violation of the basic human rights of patients, especially those in large psychiatric institutions. And we must reduce the tremendous gap between the number of people who are ill and those who actually get the treatment they need.

The message we can bring to the world is one of optimism. Effective treatments are there. Prevention and early detection can drastically reduce the burden. As we will hear today, families of those who suffer with mental ill-health, and their local communities, can play a key role. Given the proper support, they can help patients in the struggle to regain their full mental health and re-establish their role in society.

Our way ahead is one of integrating mental health care and prevention into general health services. Those who need hospitalization should be able to stay in ordinary hospitals with other patients who suffer physical illness – and not be separated in special institutions, surrounded by ignorance and fear.

This year's World Health Day gave hope to millions who celebrated it in thousands of venues around the globe. Hope based on a sense of change. Change of perceptions and realities. We must keep up this momentum.

Next year's World Health Report is on the theme of "Risks to Health". I propose that the theme for World Health Day 2002 is "Fit for Health". This will give particular visibility to ways in which individuals and communities can influence their own health and well-being.

Complex emergencies

Mr President,

We remain concerned about the current insecurity and suffering in West Africa, in Gaza and the West Bank, in Afghanistan and in other troubled areas of the world. We will continue to work tirelessly in pursuit of world peace, and contribute in a practical way to conditions that result in the better health for all people.

The concerns of consumer organizations

Mr President,

Many groups join us in expressing their frustration that more is not being done to promote equitable health outcomes. They have achieved widespread coverage of their concerns about the potential power of the tobacco convention; about the links between intellectual property rights and access to essential medicines. They have focused on the potential for – and dangers associated with – increased understanding of the human genome. They have spelt out links between environmental degradation and human health. They have drawn attention to the specific health needs of women and children. They have spoken of the need for a greatly increased investment in research into health problems that most affect poor people. They have also commented on the involvement of private entities in international health action.

It is vital that such views are clearly expressed in an open, transparent debate. However, it is not at all obvious that WHO should opt to establish an advocacy position in all such debates.

It is not WHO's role to take sides, unless – as in the case of tobacco – a particular approach is clearly associated with the promotion of ill-health and suffering. At the same time, WHO has a vital role in informing health debates, analysing available evidence, seeking the best policy positions and trying to establish consensus around them.

In all partnerships between the public sector, civil society and the private sector we would like to see the optimal balance of power, representation and influence in order to achieve the best and most sustainable health outcomes possible. To this end, we will encourage a stronger relationship between those responsible for the stewardship of health action and groups within civil society. For example, I have studied the declaration of last year's People's Health Assembly, and expect to hear more about it this week. Last Friday I launched a new initiative to strengthen WHO's links with civil society, and I shall watch its development closely.

In the world of the 21st century, the private sector in all Member States plays an important role – not only as a producer of needed commodities, but also by developing technologies and knowledge. We therefore must engage some private entities in the effort to advance global health. Their contribution is appreciated. Their role is important.

The potential for different parties working together to do good is high. But we also have to be clear about our different roles, and how these roles shape and limit our collaborations. Such insights are needed if we are to work together productively and avoid conflict of interest.

For example, WHO and WTO last month convened a workshop in Norway on differential pricing and financing of essential drugs. Discussions showed how groups from industrialized as well as developing countries, from pharmaceutical companies – both research-based and generic manufacturers – and nongovernmental organizations, **could** find ways to work together. They showed how they can agree on the need for a differential – or equity-based – pricing system for key drugs and other pharmaceuticals.

The Norway workshop took place against the backdrop of a legal dispute between a number of pharmaceutical companies and the Government of South Africa on legal provisions for improving access to essential life-saving medicines. I believe that there is widespread relief after the settlement of a very controversial struggle involving people's lives and futures. WHO provided the South African

Government with technical information on the relevant issues and is contributing to continued dialogue among all parties within other fora.

Conclusion

Mr President, colleagues,

The prospect for bridging the health divide depends on the extent to which we can show collective leadership.

It depends on our ability to work better together.

It depends on strong partnerships that enable all people to access essential, technically sound, quality services to prevent, as well as to treat, suffering.

We will debate many difficult issues in this Assembly.

But we must rise above the debates to new ways of working that enable us to pursue our vital mission. Only then can the hopes of today become the reality of the future.

We have no choice: the well-being of future generations depends on how we act today.

Thank you.

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