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Report of the Director-General 1998 - 2003

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I. The broader context

1. When I took office as Director-General in July 1998, the World Health Organization was at a crucial point in its history: 50 years old and faced with **complex processes of transition in a rapidly changing world context**. Globalization was not only opening new avenues of growth and progress, but also creating new and critical threats to health.

2. The twentieth century had seen remarkable advances in health and human development: life expectancy at birth had increased by more than 30 years, access to health services had improved significantly, high global coverage rates for immunization had been achieved, smallpox had been eradicated, and scientific research and development had shown extraordinary progress. We had considerable understanding of the different determinants of health – molecular and societal – and of the conditions necessary for a healthy life.

3. Yet the world was far from its goal of ensuring that all peoples attain the highest possible level of health. **Many critical tasks remained unfulfilled**: absolute poverty was spreading, with one-third of all children suffering from hunger and malnutrition; inequities were growing, between and within countries; the world's climate was changing and posing new threats to health and the environment; people were still facing deadly threats from diseases such as human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), tuberculosis and malaria; noncommunicable diseases were becoming more and more prevalent; the position of women was still vulnerable in many parts of the world; and armed conflicts continued to hamper advances in health and development. Access to health services remained very inequitable: while the developing countries carried 90% of the world's disease burden, they had access to only 10% of the resources dedicated to health. One-fifth of humanity had no access to modern health services and one-half lacked access to essential medicines.

4. It was imperative to define a clear strategy to address these critical challenges. And for this, there was a need to move the health agenda closer to the development debate; **to place health in a broader perspective**; to promote the understanding that health investments are

sound investments for global security, poverty reduction and economic growth; and to convey this message to the political leaders of the world.

5. I wanted to be sure that WHO was properly positioned to provide the best possible technical guidance for action to improve the health of the world's peoples. This meant that WHO needed to build a sound understanding of risks to people's health, the burdens imposed by disease, the challenges faced in improving the performance of health systems, and the political and institutional context for health action. WHO needed to strengthen its role as a source of reliable information about interventions to prevent and respond to different health problems; and that information needed to be based on the best available evidence. As well as being a reliable source of high-quality advice based on up-to-date and relevant evidence, we had to help others – who did not necessarily have a detailed knowledge about health – to make good use of that information. This meant that WHO had to be ready – and able – to bring together the different groups with a stake in health, particularly within countries, and to be a broker and negotiator for better health. WHO has been able to do this in ways that enable different stakeholders to develop strategies for implementing concerted action for health, and to measure progress – particularly among the world's poorest people.

6. Given the extreme limitations on WHO's budget – with its zero nominal growth – and WHO's dependence on voluntary funding, these increased demands have required the Organization to make particular efforts to maximize its impact, with proper cohesion between country teams, regional offices and headquarters departments. This called for WHO to be more effective and efficient, more accountable, more transparent and more responsive to a changing world.

7. To achieve our goals it was necessary **to reach out to other partners**: to other agencies of the United Nations system, to governments, to the private sector, to civil society. I saw WHO as a strong lead agency in health, entering into creative and innovative partnerships with the various key players in the field of health and human development. I established two Cabinet projects – Roll Back Malaria and Tobacco Free Initiative – as pathfinders for these new ways of working, throughout WHO and with partner organizations.

Building a corporate strategy for the World Health Organization

8. The fulfilment of the tasks before me also required considerable **internal reorganization**. I felt that there was an urgent need to pull WHO together into one entity and create unity of purpose by focusing our efforts around our core businesses; to reconnect the Organization through a flatter structure, better communication, more transparency and a clearer distribution of responsibilities; and to create an organizational culture driven by results, efficiency, productivity and job satisfaction.

9. My aim was to devise a corporate strategy that would enable WHO to be more effective in its work for and with countries, to be more focused, to select priorities, and to be more creative and innovative in building partnerships.

10. It was with this in view that I presented the corporate strategy to the WHO Executive Board in January 2000, which endorsed four strategic directions for WHO's activities. These strategic directions form the basis of the General Programme of Work 2002-2005 and the Programme budget 2002-2003 as well as the Proposed programme budget 2004-2005:

- reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;
- promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes;
- developing health systems that equitably improve health outcomes, respond to people's demands, and are financially fair;
- framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

11. The core functions of the WHO Secretariat were defined in the corporate strategy as articulating consistent, ethical and evidence-based policy and advocacy positions; managing health information and stimulating research; technical and policy support to stimulate action and help build national capacity in the health sector; negotiating and sustaining global partnerships; setting, validating, monitoring and pursuing the proper implementation of norms and standards; and stimulating the development and use of new technologies and guidelines for disease control, risk reduction, health care management and service delivery.

12. It is with these strategic directions as a basis that the various activities and programmes of WHO since 1998 have been conceived and implemented, within the larger objective of pursuing health for all.

United Nations Millennium Development Goals

In September 2000 at the United Nations Millennium Summit in New York, world leaders agreed on a set of global development goals. Three of the eight Millennium Development Goals, eight of the 18 targets, and 18 of the 48 indicators cover areas that directly concern the work of WHO. These include reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, and providing access to affordable essential drugs in developing countries. Others, such as eradicating extreme poverty and hunger, and promoting gender equality and empowering women, have a health dimension. The achievement of these goals requires a concerted, global strategy aimed at increasing the access of the world's poor to essential health services.

Resolution WHA55.19, adopted in May 2002, urged Member States to strengthen and scale up efforts to achieve the goals of the Millennium Declaration. I strongly believe that improving the health of the underprivileged is not only a goal of sustainable economic development, but also a means of attaining it. The Goals are being taken into account both in the current work of WHO and in setting priorities for the strategic Proposed programme budget for 2004-2005. By building new partnerships, developing new funding mechanisms, strengthening our presence in countries and our support to local initiatives, and improving our reporting mechanisms, WHO continues to cooperate with the international community in contributing to the attainment of these goals.

Our commitment to the Millennium Development Goals was reinforced at the International Conference on Financing for Development held in Monterrey, Mexico, in March 2002, where I called for increased and more effective investments to tackle the burden of HIV/AIDS, tuberculosis and malaria. In Monterrey, it was agreed to start mobilizing the funds needed to do this. Donor governments showed a new willingness to support national development efforts that are effective and deliver results.

Country focus

13. In January 1999, I initiated a Cabinet project to re-examine the way in which different parts of WHO work with each other, with countries and with development partners. One of the main outputs of the project is a corporate instrument for formulating and agreeing on WHO's strategic agenda at country level – the **country cooperation strategies**.

14. Following the second meeting of WHO's country representatives in 2001, I started to plan a new initiative to increase WHO's focus on countries. At the Fifty-fifth World Health Assembly (2002), I described how this country focus initiative would improve WHO's capacity to work with countries as they seek both to scale up action for health equity and to exert a greater influence on global and regional public health action. The country cooperation strategies are key instruments in improving our effectiveness within each country. Work on 50 of these strategies is under way; in some countries the strategies have been completed. Developing a strategy calls for joint work between national authorities and WHO. The development of a country cooperation strategy brings together a realistic assessment of national needs, requests from national authorities, the interests of other stakeholders, and WHO's regional and global priorities as endorsed by Member States in WHO's governing bodies.

15. The initiative draws on the work now being undertaken by WHO and countries to establish strategies for cooperation. It involves the Organization as a whole in responding to the strategic agenda for health in each country. Its purpose is to ensure that WHO focuses better on the needs of countries, supporting effective health action through both standard-setting and technical cooperation. It will improve the core competencies of country teams so that they are better able to pursue the agreed strategy, and will enhance the way in which regional and Geneva-based WHO programmes support country action. It will transform WHO's administrative systems to allow more effective operation of WHO country offices. And it will improve the sharing of information between WHO and countries, and increase the ability of

WHO to work with other parts of the United Nations system, the World Bank and other development partners and national mechanisms.

16. Six key priority areas have been identified for the country focus initiative: extending the use of country cooperation strategies; improving the core competencies and capacity of country teams; enhancing integrated programmatic and technical support to country activities from regions and headquarters in response to the country cooperation strategies; enabling effective operations in WHO country offices; collecting and collating country-specific information and intelligence; and better working with organizations of the United Nations system and development partners.

17. The objectives and expected results of the country focus initiative and country-focused investments are reflected in the Proposed programme budget 2004-2005. The initiative will be monitored, reviewed and amended to ensure continuous improvement in our efforts to tackle health challenges and poverty within Member States.

Health and human rights

When I took office in 1998, I called upon the international community to uphold the enjoyment of the highest attainable standard of health as a fundamental right of every human being, as enshrined in WHO's Constitution. Since then, WHO has been actively engaged in increasing understanding of the linkages between health and human rights. Overall, there are three broad areas of work: developing a health and human rights approach within WHO, advancing health as a human right and supporting countries in integrating human rights in health policies and strategies.

Projects have been undertaken to explore human rights in the context of mental and physical disabilities, reproductive health, tuberculosis, essential drugs, and water and sanitation. A publication series has been launched on health and human rights. Training has been conducted to improve understanding of health and human rights across the Organization. WHO forged close links with the newly appointed United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and worked to ensure more consistent WHO input to the human rights treaty monitoring bodies of the United Nations system. WHO is now equipped to support Member States in advancing the right to health and integrating human rights in health development.

Investing in the health of poor people: the Commission on Macroeconomics and Health

18. I took the initiative to set up the Commission on Macroeconomics and Health to study the interaction between health and economic development. The Commission, chaired by Professor Jeffrey Sachs and comprising a total of 18 of the world's leading economists, public health experts, development professionals and policy-makers, submitted its report in December 2001, confirming

my belief that better health can act as a catalyst for growth and poverty reduction.

19. The report concluded that economic losses from ill-health have been underestimated and that countries with the weakest health and education conditions have greatest difficulty in achieving sustained growth. It noted that the large majority of deaths are caused by communicable diseases, maternal and perinatal conditions, childhood infections, tobacco-related illnesses and nutritional factors. It argued for increased investment in essential health interventions and global public goods, and estimated that an annual investment of US$ 66 000 million over 15 years could save eight million lives each year and create sixfold returns in terms of economic growth. It also advocated the setting of concrete goals and well-defined time frames for cost-effective and efficient interventions.

20. The findings of the report encourage us to keep up our work to increase access to life-saving medicines, to stimulate the development of new vaccines and medicines, to provide guidance and technical advice to countries on health issues, and to provide locally relevant evidence-based information to political decision-makers. On the issue of funding, the Commission identified the prerequisites of efficient funding of health interventions. It emphasized the need for a "health pact" – a mechanism that brings together ministries of finance, ministries of health, development agencies, the private sector and civil society – to scale up essential health interventions, providing further impetus to WHO's work in this respect.

21. The report underscores the need to invest in human resources, including leadership development. WHO is preparing evidence-based guidelines in consultation with experts from all the regions to respond to the requests of Member States for technical advice on how to carry forward the work of the Commission at country level.

22. In order to help countries implement the Commission's recommendations, WHO is collaborating in the establishment of national commissions on macroeconomics and health where required. These commissions will work with WHO to analyse the health situation in the country and the performance of their health systems, to define

epidemiological baselines, and to draw up strategies for essential health interventions. WHO is helping countries prepare community and national health plans and funding proposals. We also work with the World Bank, International Monetary Fund and other organizations of the United Nations system, as well as with the international donor community, to ensure that health and poverty-reduction programmes are placed at the heart of the development agenda and contribute effectively to the achievement of the Millennium Development Goals.

Ethics

23. The rapid advances in science in the past decade are raising new ethical issues. At the sessions of WHO regional committees in 2001, I announced the ethics and health initiative to provide a focal point for support to Member States on the ethical aspects of health care, biotechnology, and human genetics and genomics. The initiative also assists in the examination of ethics issues arising in the course of WHO's activities and coordinates with other United Nations and regional organizations on bioethics.

II. Scaling up the response to disease

24. A number of health interventions can dramatically reduce mortality from the main killer diseases: supervised medication regimes for tuberculosis; bednets impregnated with insecticide against mosquitos, and wide distribution of malaria treatment among children and pregnant women; prevention programmes for HIV/AIDS and care programmes that can substantially prolong life among those living with AIDS. WHO's approaches in these areas are described below, together with other efforts related to, for example, tobacco control and the Integrated Management of Childhood Illness.

HIV/AIDS

25. HIV/AIDS is the major cause of death in Africa today. It is a serious problem in the Caribbean and is on the rise in Asia and in large parts of Eastern Europe. Despite falling prevalence in some countries and significant advances in treatment and care, 42 million people are today infected with HIV, the majority of them in the developing world

and half of them under 25 years of age. Each day, more than 15 000 people become infected. In the absence of a massive scaling-up of efforts, it is estimated that a further 45 million people will be infected with the virus by 2010 and almost 30 million will have died.

26. The consequences of the HIV/AIDS epidemic go beyond the loss of lives and the health care costs directly associated with the disease. It is an obstacle to development and has wide-ranging social and economic impacts. A recent study from southern Africa has shown that AIDS, in combination with other factors – droughts, floods, even short-sighted national and international policies – is causing a decline in agricultural production and placing a greater burden on household income. HIV is undermining development gains in several countries in Africa, as life expectancy and child survival rates decline.

27. I was convinced that WHO, as a cosponsor of UNAIDS, needed to strengthen its technical mandate. WHO has to lead the health sector response to the disease by providing normative tools, such as guidance on the prevention and treatment of HIV infection, setting standards, providing strategic information, promoting research and development, and providing technical support and sustained advocacy. The Fifty-third World Health Assembly (2000) adopted resolution WHA53.14 requesting WHO to develop a global health-sector strategy to combat the epidemic, to give priority to the prevention and control of HIV/AIDS in WHO's regular budget, to mobilize funds in support of national programmes, and to promote and support research and development. It also urged Member States to match their political commitment to the magnitude of the problem by allocating an appropriate budget to HIV/AIDS prevention and care, to strengthen public education and to implement key strategies.

28. Activities related to HIV/AIDS at WHO headquarters were strengthened in December 2000 in order to coordinate a strategic, Organization-wide response to the epidemic and to enable WHO to provide better technical support to regions and countries.

29. We are witnessing political commitments throughout the world to scale up the response to HIV/AIDS. Governments, private sector enterprises, nongovernmental organizations and civil society are

coming together in a global effort commensurate with the scale of the epidemic. In June 2001, the United Nations General Assembly held its first-ever special session dedicated to HIV/AIDS. The Declaration of Commitment adopted by Member countries represents an unprecedented global political commitment to tackle the epidemic.

30. There are several promising examples of how political commitment, a clear strategy against AIDS and multisectoral responses are resulting in reductions in the incidence of HIV. In Uganda, infection rates in pregnant women in urban areas have dropped from 30% to less than 10%. In Thailand, comprehensive prevention efforts have significantly reduced the number of new HIV infections compared with a decade ago. HIV incidence has also dropped in Senegal. It is important to encourage these efforts and promote best practices in other countries.

31. At the same time, we have addressed the need for people living with AIDS to have access to treatment, including clinical management of their illness, nursing care, counselling, and social and psychological support. A growing body of evidence shows that it is possible to deliver care and treatment for people living with AIDS in resource-poor settings. Many of the treatments for the associated opportunistic infections have been available for many years for just a few United States cents. Recent advances in research, simplified treatment schemes and drastic price reductions now make it possible to envisage that the millions of poor people who need antiretroviral therapies could indeed obtain them – and thus have a chance of living a full life. Efforts are needed to make antiretroviral medicines more easily accessible to all.

32. Treatment in developed countries has led to a dramatic fall in deaths due to AIDS. But in Africa and other parts of the developing world, many people have no access to palliative medicines, let alone antiretroviral therapies or drugs for treating opportunistic infections. In short, the medicines are in the North and the disease is in the South. Access to medicines is a critical component of a health sector strategy. Governments face difficult choices: whether to invest in a few relatively costly drugs or focus on other aspects of care. It is WHO's role to help make those choices less difficult. WHO is working with

UNAIDS and other partners, including the research-based pharmaceutical industry and the producers of generic medicines, to make HIV drugs more affordable. Through constructive dialogue, we seek to negotiate with the pharmaceutical industry on the cost of individual drugs and different approaches to drug-pricing. Where appropriate we support the promotion of generic competition and bulk purchasing. We have included priority HIV drugs in the WHO Model List of Essential Medicines and we are monitoring the effects of growing competition in the market for antiretrovirals.

33. Expanding access to these drugs is a high priority for WHO – not just through reduced prices but also reliable supply systems, laboratory back-up, patient supervision, monitoring of drug resistance, and the need to set clear, ethical priorities for public subsidies. Ten antiretroviral drugs were added to the WHO Model List of Essential Medicines in 2002. Guidelines have been published on simplified antiretroviral use and clinical monitoring. On 12 December 2002 the International HIV Treatment Access Coalition was launched to boost efforts to extend access to antiretroviral drugs to a larger number of people in developing countries. This Coalition brings together more than 50 partners, including nongovernmental organizations, donors, governments, people living with HIV/AIDS and their advocates, the private sector, research institutions and international organizations.

34. WHO is strongly committed to promoting measures to prevent HIV infection, especially among young people. For this, it is important to spread awareness about the causes and consequences of the epidemic and to ensure access to means of prevention. Studies show that people's understanding of how to protect themselves is increasing.

35. WHO is also expanding its programmes to control mother-to-child transmission of the virus, which currently accounts for 90% of HIV infection in children. Research has shown that certain drug regimes, in combination with changes in feeding practices and, when conditions are favourable, elective caesarean section, can prevent transmission from infected mothers to their infants. WHO is also committed to the promotion of safe and appropriate use of injections, through education of health workers, ensuring the availability of safe

injection equipment, and sound management of clinical waste. WHO also continues to promote national blood programmes to ensure the safety, quality and adequacy of blood supplies. World Health Day 2000 was dedicated to safe blood.

36. It is equally important to build public awareness and fight the taboos associated with the virus. HIV testing is critical, and voluntary testing must be made easily available and free from stigma. Counselling must be easily accessible, confidential and non-judgemental. HIV is very much a societal issue. Changing the practices and behaviours that contribute to the infection calls for intersectoral action – tackling violence against women and the social environment of young people. This is particularly relevant when efforts are made to reduce drug use by young people.

37. To this must be added the crucial question of the resource challenge. It has been estimated that the total additional sum required each year for an adequate global response to AIDS is US$ 10 000 million. It will take a concerted international effort to mobilize the funds needed to increase the capacity of health systems in communities affected by HIV and AIDS, and to help ensure that resources are properly used. To this end, WHO has worked closely with the international community in the establishment and operation of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The Roll Back Malaria partnership

38. The Roll Back Malaria partnership was presented to the Fifty-first World Health Assembly (1998) and launched in October 1998 with the aim of halving the world's malaria burden by 2010. Its founding partners – WHO, UNICEF, UNDP and the World Bank – are sharing their resources and expertise in a concerted effort to reduce the burden of malaria worldwide, to provide technical and operational support to countries, to stimulate research and development, and to monitor progress and outcomes. WHO houses the secretariat of the partnership and provides technical leadership.

39. The project was developed as a pathfinder. It pulled in all parts of WHO – the tropical disease experts, the child health experts, the

environmental health experts and the pharmaceutical experts. It was based on partnerships with other organizations of the United Nations system, the private sector, the research community and nongovernmental organizations. It put emphasis on the strengthening of national health systems.

40. In April 2000, the partnership sponsored the first International Summit on Malaria, held in Abuja, Nigeria. Senior government officials from 44 African countries, together with representatives from the founding partners, adopted the Abuja Declaration and Plan of Action, reiterating their commitment to the programme and to meeting the partnership's targets. They expressed their resolve to improve access to treatment, to provide preventive measures such as insecticide-treated mosquito nets, and to provide chemoprophylaxis or presumptive intermittent treatment for pregnant women. International development partners have since pledged an additional US$ 750 million to African resources over the next few years.

41. New and effective partnerships have been developed with governments, international organizations, nongovernmental organizations and private sector groups. A notable one is the Medicines for Malaria Venture, a public-private partnership for the development of novel antimalarial therapies through strategic collaboration, launched in November 1999. The Venture represents a strategic response to the serious problem created by the rapid spread of resistance to existing drugs. Its projects engage industry, academia and other public sector institutions, with industry providing in-kind contributions (tools, personnel, expertise, etc.). The Venture provides funding for research and assists in technical aspects related to project management. The new antimalarial drugs will ultimately be marketed by a pharmaceutical company partner at affordable prices. In the first three years of its existence, the Venture has built up its research portfolio from four planned projects to 11 fully operational projects, most with a pharmaceutical industry partner. On a broader scale, international spending on malaria research increased from approximately US$ 84 million in 1984 to over US$ 1000 million in 2002 largely as a result of a significant rise in investment in malaria vaccine research.

42. An extensive external evaluation of the Roll Back Malaria partnership was conducted in 2002. It concluded that the first phase (1998-2002) had seen significant achievements in rolling back malaria, but that there was a need for increased country action. The partnership was judged not to have a sufficiently well-defined structure and means of operation. Country-level studies revealed uneven progress in action to tackle malaria within affected communities.

43. Close to one-third of African countries, representing almost half the population at risk, have shown their commitment to rolling back malaria and completed the initial phase of strategic planning. Strategic global advocacy has resulted in the problem of malaria getting more attention than ever before.

Stop TB

44. The epidemic of tuberculosis is growing and is killing approximately two million people every year, the biggest burden in terms of numbers being in South-East Asia. Tuberculosis is a curable disease. Life-saving drugs exist and a critical mass of health workers is trained to use them. It is unacceptable then that we cannot make sufficient supplies of antituberculosis drugs available to combat the spread of this disease. In 1993, WHO declared tuberculosis a global emergency and made the fight against the disease a priority.

45. In order to combat the disease, WHO and its partners developed the DOTS (directly observed treatment, short-course) strategy, a comprehensive strategy for detection and cure of tuberculosis, which incorporates five elements: political commitment, case detection through microscopy services, standardized treatment regimens provided under direct observation, regular and uninterrupted drug supplies, and surveillance and monitoring systems. This strategy has proved to be highly effective, producing cure rates of up to 95% even in the poorest countries. The World Bank has ranked the DOTS strategy as one of the most cost-effective of all health interventions.

46. At the Global Congress on Lung Health in Thailand in November 1998, I launched WHO's Stop TB initiative and pledged WHO's strong support for an emerging public-private collaboration known as the

Stop TB Partnership, with the following objectives: to promote wider and wiser use of existing strategies to interrupt transmission of tuberculosis; to adapt existing strategies to address the challenges posed by emerging threats; and to accelerate elimination of tuberculosis by promoting research on new and improved diagnostic tests, drugs and vaccines, and promoting the adoption of new and improved tools.

47. The targets set by the Partnership were: by 2005, 70% of people with infectious tuberculosis will be diagnosed and 85% cured; by 2010, the global burden of tuberculosis (deaths and prevalence) will be 50% lower than levels in 2000; and by 2050 the global incidence of tuberculosis will be less than one case per million population.

48. The role of WHO in the Partnership is to provide guidance on global policy. WHO also houses the secretariat of the Stop TB Partnership, and provides an efficient and effective management framework for the activities of the Partnership.

49. To strengthen commitment to the global partnership, a ministerial conference on tuberculosis and sustainable development, organized by WHO and the World Bank, was held in Amsterdam in March 2000. Organizations of the United Nations system, governmental and nongovernmental organizations, donors and the private sector pledged to ensure that tuberculosis gets priority in budget allocations and that all people who need treatment have access to it, to tackle multidrug-resistant tuberculosis, to work in partnership and to respond positively to requests for support to fight the global epidemic. In May 2000, the Fifty-third World Health Assembly encouraged all Member States to endorse the Amsterdam declaration and to commit themselves politically and financially to achieving the tuberculosis targets set by previous Health Assemblies.[1]

50. Research is being carried out aimed at reducing the total length of treatment and frequency of drug administration, as well as the level

[1] Resolution WHA53.1.

of supervision of patients by health workers. Such advances could significantly lower the cost burden on developing countries. New drugs are also required to combat the rise of multidrug-resistant tuberculosis. To support such research initiatives, a public-private partnership called the Global Alliance for TB Drug Development was launched in October 2000. The Bill & Melinda Gates Foundation and the Rockefeller Foundation have already contributed to this Alliance.

51. Equally important is improved access to available drugs. In 2001, WHO and the Stop TB Partnership launched the Global TB Drug Facility as a mechanism to expand access to, and availability of, high quality antituberculosis drugs to facilitate DOTS expansion. A partnership was also established with the pharmaceutical industry in 2001 to provide drugs at preferential prices. Called the Green Light Committee, this new partnership is helping improve access to second-line antituberculosis drugs in countries where multidrug resistance is widespread. Through these mechanisms, the price of first-line drugs has been reduced by 30% and the price of second-line drugs has dropped by 95%.

A new global funding mechanism to fight HIV/AIDS, tuberculosis and malaria

The **Global Fund to Fight AIDS, Tuberculosis and Malaria** is a new mechanism to support action at country level, and has been developed as a partnership between rich and poor countries, organizations of the United Nations system including WHO, the private sector and civil society. It was formally established in January 2002. The aim of the Fund is to attract, manage and disburse additional resources to mitigate the impact of HIV/AIDS, tuberculosis and malaria in countries in need, thereby contributing to poverty reduction as part of the United Nations Millennium Development Goals.

WHO shares and supports the objectives of the Fund and actively supports its Member States in obtaining resources from the Fund for health projects. A team has been created at headquarters, with focal points in regional offices, to ensure that country offices have access to information and advice on the Fund. WHO also provides a range of administrative services to the Fund. We are committed to ensuring the success and sustainability of this funding mechanism and increasing the resources generated and disbursed by it.

The first funding round, in April 2002, disbursed US$ 616 million to 40 countries. Today, financial commitments to the Fund stand at over US$ 3000 million. These resources can make a significant difference to the impact of national programmes by improving coverage and making new initiatives possible.

Combating other communicable diseases

52. **The Global Alliance for the Elimination of Leprosy** was launched in November 1999 bringing together governments of affected countries, WHO, foundations, pharmaceutical companies and bilateral agencies with the aim of ensuring that all leprosy patients have free and equal access to treatment. WHO's elimination strategy, based on the widespread use of multidrug therapy, has led to a 90% reduction in leprosy prevalence over the past 15 years. In May 2001, WHO

announced that the overall global target for leprosy elimination of one case per 10 000 inhabitants had been reached. Efforts are continuing in the remaining endemic countries that have not yet achieved control.

53. The **Global Alliance to Eliminate Lymphatic Filariasis** was launched in May 2000, with the aims of interrupting the transmission of infection and alleviating and preventing the suffering and disability caused by the disease. It has poverty reduction as an explicit focus. The number of at-risk persons reached and treated rose from 2.9 million (in 12 countries) in 2000 to 65 million (in 34 countries) in 2002.

54. Efforts have also intensified to control **African human trypanosomiasis**. A partnership was concluded between WHO and the private sector in May 2001 to fight against trypanosomiasis in the most affected countries of Africa, covering drug donation, disease management and control, and research and development. In 1998, the World Health Assembly approved a resolution[1] calling on all Member States with populations still affected by **Chagas disease** (the Andean and Central American countries) to elaborate plans of action towards elimination of disease transmission by the year 2010. WHO supports countries in surveillance, programme development and implementation, and good progress is being made.

Tobacco is a killer

55. On the basis of the trends found in the global burden of disease study, I identified **tobacco as a key concern**, and launched a new initiative in 1998.

56. It is estimated that, with current smoking patterns, about 500 million people alive today will eventually be killed by tobacco. Currently, an estimated 4.9 million deaths per year are caused by tobacco. Without further action, it is predicted that by 2020 the mortality burden attributable to tobacco will have doubled. Approximately 70% of the deaths will occur in developing countries.

[1] Resolution WHA51.14.

After HIV/AIDS, tobacco use is the fastest-growing cause of death in the world and is set to become the leading cause of premature death in the 2020s. More and more women and children are smoking today. The tobacco epidemic is a communicated disease – communicated through advertising and through the glamorization of smoking. Children are particularly vulnerable to environmental tobacco smoke. Tobacco burdens health systems and reduces the productivity of economies. Tobacco control is a global challenge, and a concerted effort is required on three fronts: legislation, taxation and education.

57. There is also mounting evidence that a number of tobacco companies have subverted science, public health and political processes to resist all tobacco control activities and continue selling their products. In 1999 I called for an inquiry into whether the tobacco industry had exercised undue influence over WHO's tobacco control activities. Following the publication of the report, the Fifty-fourth World Health Assembly adopted a resolution on transparency in tobacco control and urged Member States to be aware of affiliations between the tobacco industry and members of their delegations to the Health Assembly and other meetings of WHO.[1]

58. In 1999, the Health Assembly decided unanimously to establish a body to draft a proposed **framework convention on tobacco control**.[2] The negotiations were formally launched at the Fifty-third World Health Assembly.[3] The convention will set basic global standards for tobacco control and will address a wide range of issues, such as bans on advertising and promotion, taxation and prices, illicit trade, product regulation, treatment of tobacco dependence, and packaging and labelling. Six sessions of the Intergovernmental Negotiating Body on the WHO framework convention on tobacco control have been held. At the end of the sixth session in February

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[1] Resolution WHA54.18.

[2] Resolution WHA52.18

[3] Resolution WHA53.16.

2003, Member States agreed to transmit the final draft of the convention to the World Health Assembly in May 2003. The subsequent negotiation of early protocol agreements in the areas of advertising, promotion and sponsorship, and illicit trade is being considered by WHO's Member States.

59. In 1998, the Secretary-General of the United Nations agreed to the designation of a United Nations Ad Hoc Interagency Task Force on Tobacco Control under WHO's leadership. The Task Force is comprised of 15 organizations of the United Nations system, the World Bank, the International Monetary Fund, WTO, and the World Customs Organization. This initiative provides a multisectoral mechanism to tackle the tobacco problem and, in its four years of work, has provided unparalleled opportunities for information-sharing, as well as for extending multisectoral collaboration across the United Nations system and developing interagency projects to address the tobacco epidemic. WHO is actively working in collaboration with ILO, FAO, UNICEF, the World Bank, and the World Customs Organization on tobacco control issues.

60. In order to raise public awareness of tobacco-related health issues, the **Tobacco Free Initiative** has organized many campaigns and events in partnership with other stakeholders. The theme for World No Tobacco Day 2002 was Tobacco Free Sports, to highlight the fact that tobacco and sports do not mix and to campaign against tobacco in sports in the form of consumption, exposure to second-hand smoke, advertising, promotion, marketing and sponsorship of events. This initiative was supported by the International Olympic Committee, the Fédération Internationale de Football Association (FIFA), Olympic Aid and other regional and local sports organizations. Tobacco-free events were organized all over the world, including at the 2002 Winter Olympic Games and the 2002 FIFA World Cup.

61. The theme for the 2003 World No Tobacco Day is the advocacy of tobacco-free films and fashion. Special campaigns have also been organized to draw attention to the growing use of tobacco by children and adolescents.

Tuberculosis patients register for DOTS therapy in an integrated health clinic, Rabat, Morocco

Delhi, India

Immunization, Bolivia (photo courtesy of PAHO)

Immunization against poliomyelitis, Côte d'Ivoire, April 1999

62. Many Member States have already taken steps to control the use of tobacco at the national level, including legislative and fiscal action, and educational programmes. Several countries have taken steps to limit tobacco advertising and to strengthen the protection of children. Many have raised the taxes on tobacco products. The Tobacco Free Initiative supports and encourages all such initiatives. The negotiation of the framework convention on tobacco control has already stimulated a powerful process of multisectoral cooperation within and between countries, which can only be expected to intensify with the entry into force and implementation of the convention.

Mental health

63. The number of people suffering from some form of mental illness is on the rise. It is estimated that one in every four persons seeking health services has at least one mental, neurological or behavioural disorder, most often neglected or even undiagnosed. Depression, schizophrenia, bipolar disorder, alcohol dependence and Alzheimer disease are among the leading causes of disability. These problems are aggravated by rapid socioeconomic transitions, ageing of populations, violence, social unrest and war, physical disease, and of course poverty. Every year, between 10 and 20 million people attempt suicide. Alcohol abuse is an increasing problem among young men. Mental problems are common to all countries; yet in most countries there are barriers to the care and reintegration of people with mental disorders.

64. Since 1998, WHO has given mental health a high profile. At the ministerial round tables during the Fifty-fourth World Health Assembly (2001), the situation of mental health care and obstacles faced in meeting the mental health needs of populations were discussed. On World Health Day 2001, the theme of mental health was marked in over 155 countries. *The world health report 2001* also focused on mental health. The **Mental Health Global Action Programme**, a five-year initiative adopted by the Fifty-fifth World Health Assembly, [1] focuses

[1] Resolution WHA55.10.

on forging strategic partnerships to promote the mental well-being of populations and to reduce the burden of mental disease. The Programme focuses on prevention, treatment and rehabilitation, especially of the most vulnerable populations. It aims to increase government awareness and responsiveness, enhance the quality and cost-effectiveness of services, and focus on research in neuroscience and behavioural medicine. It also calls for action to reduce stigmatization, discrimination and violations of the rights of persons with mental illness. Mental health must be an integral part of the general health care system and treatment costs made affordable for all those in need. Special attention is also given to the needs of rural, remote and dispersed populations, refugees and disaster-stricken populations, as well as children and adolescents.

Immunization and the Global Alliance for Vaccines and Immunization

65. Immunization is one of the most cost-effective interventions available. Yet immunization coverage has slipped to dismally low levels in many countries. In parts of Africa, coverage is now well below 50%. The progress achieved in the 1980s was reversed or stagnated in the 1990s. Every year, vaccine-preventable diseases cause an estimated two million deaths; one in every four children born remains unimmunized.

66. In 1999, WHO and UNICEF, together with national governments, development agencies, the vaccine industry, philanthropic organizations, nongovernmental organizations and research institutions, established the Global Alliance for Vaccines and Immunization (GAVI). The strategic objectives of the Alliance are: to improve access to sustainable immunization services; to expand the use of all existing safe and cost-effective vaccines and promote delivery of other appropriate interventions at immunization contacts; to support national and international accelerated disease control targets for vaccine-preventable diseases; to accelerate the development and introduction of new vaccines and technologies; and to accelerate research and development efforts for vaccines needed primarily in developing countries.

67. WHO is co-chair of the GAVI Implementation Task Force, which supports countries in their coordination efforts, in monitoring and evaluation, and in the further integration of immunization programmes in health systems. WHO also co-chairs the GAVI Task Force on Research and Development.

68. GAVI is unique in its innovative way of working. It awards performance-based grants, giving special attention to ensuring that the health systems receiving the resources are performing adequately. The GAVI Board also encourages the use of best practices within national programmes, which means that countries have to monitor the effectiveness of their action and document their success over time. Care has been taken to keep the administration light, to avoid high transaction costs and to ensure that GAVI does not become caught up in complex, laborious processes.

69. In 2000 GAVI invited 74 of the world's poorest countries to submit grant proposals to the secretariat; 54 countries responded, and funds have started to flow and vaccines to reach the countries. This has been possible thanks to an early, substantial and multiyear commitment from the Bill & Melinda Gates Foundation, as well as from the Governments of the Netherlands, Norway, the United Kingdom of Great Britain and Northern Ireland and the United States of America. More than 30 million vaccine doses have already been delivered to 27 countries and funds transferred to national immunization programmes in 34 countries. Efforts must continue to increase immunization coverage, through improved management, innovative and effective strategies to reach currently unreachable populations, and efforts to make immunization safer and to reduce wastage. WHO will collaborate with eligible countries that are seeking GAVI assistance.

Eradication of poliomyelitis

70. When I started my term as Director-General, poliomyelitis was still a concern and the world was still some way from the goal, set in May 1988, of eradicating the disease by the year 2000. The global initiative, launched in partnership with UNICEF, the Centers for Disease Control and Prevention, and Rotary International, has made outstanding progress. The number of poliomyelitis endemic countries

fell from 125 in 1988 to 50 in 1998 and seven today. The Region of the Americas, and the European and Western Pacific regions have been declared free of poliomyelitis. The numbers of cases in Africa and South-East Asia are falling. National governments are showing remarkable commitment in mobilizing the human and financial resources necessary to deliver the poliovirus vaccine to millions of children, including those not easily reachable but highly prone to infection. Immunization days have been held in the priority countries, many with the support of GAVI. The success of these initiatives has shown that we can overcome adverse conditions on the ground – the overwhelming majority of countries are now free of poliomyelitis. The critical factor is the political commitment to eradication at all levels of government in the remaining endemic countries, and the funds to finish the job. We cannot afford to lose time.

Child health

71. Children and adolescents are the fundamental resource for human, social and economic development. They are among the groups most vulnerable to suffer the consequences of unmet health needs; around 40% of the global burden of disease falls on them. Despite remarkable reductions in child mortality, 10.8 million children under five years of age died in 2000, over half of the deaths being caused by just five preventable communicable diseases, compounded by malnutrition. In many countries the progress in reducing deaths has slowed and in some, past gains have been reversed. One reason is failure to address effectively neonatal mortality. Others include the limited progress in tackling determinants of ill-health such as malnutrition, unhealthy environments, and low levels of access to, and utilization of, good-quality health care services. Knowledge about the management and prevention of childhood disease and injuries has increased, but coverage of essential interventions is still modest.

72. **Integrated Management of Childhood Illness** is an integrated approach to child health that focuses on the overall well-being of the child. The approach aims to reduce death, illness and disability, and to promote improved growth and development among children under five years of age. In health facilities, it promotes the accurate identification

of childhood illnesses in outpatient settings, appropriate combined treatment of all major illnesses, counselling of carers, and speedy referral of severely ill children. In the home setting, it promotes appropriate care-seeking behaviours, improved nutrition and preventive care, and the correct administration of prescribed care.

73. To achieve further reductions in childhood deaths and long-term disabilities, the health of mothers and neonates needs to be given higher priority. The health and survival of the child, especially in early infancy, are intricately linked to the health of the mother, her nutritional status, and the reproductive health care she receives. The reduction of child mortality is dependent on the reduction of maternal mortality. A set of essential care practices has been identified to ensure healthy outcome of pregnancy, and a limited number of low-cost interventions can ensure that both mothers and newborn infants receive the best possible care.

74. A strategy for child and adolescent health and development has been formulated and will be considered by the Fifty-sixth World Health Assembly in May 2003.

Making pregnancy safer

75. Pregnancy is a normal part of human development and should be a time of joy and happiness. Tragically, around the world, every minute of every day, a woman dies from complications of pregnancy or childbirth. These women die because there is no skilled person to handle complications during delivery, or because they have been referred to hospital too late. They may even die in hospital, because they do not receive the treatment they need. The majority of these women suffer and die from one of five problems – bleeding, infection, hypertension, obstructed labour or complications of induced abortion. In addition, more than 20 million women experience ill-health as a result of pregnancy. The problem is more severe in rural and remote areas than in the cities, especially in areas where the basic infrastructure and services remain inadequate. Many of these deaths are preventable, yet previous efforts to reduce maternal mortality have met with only limited success in many countries.

76. As part of the global Safe Motherhood movement, which aims to reduce maternal and neonatal mortality to meet the targets set out in the United Nations Millennium Declaration, WHO launched the **Making Pregnancy Safer** initiative in 2001. The key message of the programme is that safe motherhood is not just a health issue, but a social and moral one. It is an investment in future health and development. Every pregnancy should be wanted and all pregnant women and their infants should have access to skilled care. New partnerships are being forged between health care providers and women's groups at country, regional and global levels in three key areas: access to family planning information and services; access to health care during pregnancy and childbirth; and mobilization of families, communities and nations to support pregnant women and young mothers. Ten "spotlight" countries are currently implementing the initiative: Bolivia, Ethiopia, Indonesia, Lao People's Democratic Republic, Mauritania, the Republic of Moldova, Mozambique, Nigeria, Sudan and Uganda.

77. WHO has intensified activities to promote adolescent sexual reproductive health with a prominent focus on pregnancy, to ensure that adolescents are not forgotten in the increased efforts to reduce maternal mortality.

III. Risks to health

78. While in many ways the world has become a safer place as a consequence of advances in medical knowledge and in public health systems, technology and legislation, in other ways people today are living more dangerously, as a result of unhealthy lifestyles, inappropriate dietary patterns, consumption of tobacco and alcohol, unsafe sex, environmental pollution, and other risks.

79. To bring to light the magnitude of the major risks to people's health today, and to encourage governments to intensify public health responses to these risks, I decided to focus *The world health report 2002* on risks to health. This report is the result of one of the largest research projects WHO has ever undertaken. We began with two simple questions: what are the main risks to health – not only for one

population or one group of people, but for the world as a whole? And what can we do to reduce these risks?

80. We selected 25 major preventable risks for in-depth study. Among these, we found that the top 10 together account for about 40% of the 56 million deaths that occur worldwide annually and one-third of global loss of healthy life-years. These 10 risks are: childhood and maternal underweight; unsafe sex; high blood pressure; tobacco consumption; alcohol consumption; unsafe water, sanitation and hygiene; iron deficiency; indoor smoke from solid fuels; high cholesterol; and obesity.

81. One of the most striking findings of the report is that the majority of risks are related to consumption, and arise either from excessive consumption or from undernutrition. This finding dramatically illustrates the disparity between developed and developing countries. The report makes a strong case for concerted international action to promote better public health and risk surveillance worldwide, and helps countries identify the most cost-effective measures that they can adopt to reduce the risks to the health of their populations. It provides a road map of how societies can tackle a wide range of preventable conditions that are killing millions of people prematurely and robbing tens of millions of a healthy life. WHO is working with countries to establish risk surveillance systems to gather comparable data over time using common definitions and standards.

Risks to infants and young children

82. Since its inception, WHO has been committed to the promotion of good nutrition and the prevention and elimination of malnutrition among infants and young children. An estimated 174 million children under the age of five in the developing world are malnourished. Child malnutrition leads to poor physical and cognitive development, as well as lower resistance to illness. Malnutrition contributes directly or indirectly to 35% of young child mortality in developing countries. While malnutrition is clearly associated with poverty and underdevelopment, inadequate feeding practices are often also a determinant. WHO provides support to countries in assessing and monitoring basic nutritional indicators in childhood, and in establishing

interventions to protect, promote and support appropriate infant and young child feeding, including management of malnutrition.

83. In 2000, WHO, in collaboration with UNICEF, organized a consultation to assess infant and young child feeding policies, review key interventions and develop a comprehensive strategy for the next decade. A new Global Strategy for Infant and Young Child Feeding was drawn up in 2001 on the basis of regional consultations, and endorsed by the Fifty-fifth World Health Assembly[1] and by the Executive Board of UNICEF. Progress was also made in expanding the evidence base for the optimal duration of exclusive breastfeeding and for complementary feeding with continued breastfeeding, leading to revised recommendations. Attention will also be given to improving the nutritional status of young women before they become mothers, as well as during pregnancy and lactation. In working with other agencies, progress has been made in decreasing micronutrient malnutrition especially in reducing vitamin A deficiency and iodine deficiency disorders.

84. Efforts are continuing to reduce mortality from **measles**. Despite the major impact made on this disease by successful immunization programmes, measles still infects nearly 30 million children every year, and takes the life of 750 000 children. Most of these deaths occur in poor countries in the African, South-East Asia and Eastern Mediterranean regions. Wider immunization coverage, rapid referral of serious cases, prompt recognition of and action against other conditions that arise in association with measles, and improved nutrition are essential to combat the disease. WHO is working in collaboration with UNICEF, USAID, the Centers for Disease Control and Prevention and others to develop a new strategic plan for measles control and to reduce global measles mortality by half by 2005. Remarkable progress has been made in the Region of the Americas in reducing measles prevalence and deaths.

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[1] Resolution WHA55.25.

Gender, risks to women' s health and reproductive health

85. Reproductive health is a priority area for WHO, especially in the developing world. Half a million women die each year from pregnancy-related complications, the causes of which are exacerbated by poverty. In parts of Africa, women face a one in 16 risk of death associated with pregnancy and childbirth. Improving women's health necessarily includes reducing the risk of dying when giving birth to a child. All women should have the help of a skilled health worker during delivery.

86. While contraceptive use among married women has increased from less than 10% in the 1960s to over 60% today, an estimated 123 million women still have an unmet need for family planning. WHO is continuing its long-standing efforts to increase access to high quality family planning services through the development of new and improved contraceptive methods, evaluation of the safety and effectiveness of existing methods, assessment of the social and behavioural determinants of successful contraceptive use, and the creation and implementation of evidence-based norms and tools for family planning.

87. Gender issues are closely linked to health and poverty. Of the 1200 million people living in poverty, 70% are female. Protein-energy malnutrition and iron deficiency are significantly higher among women than men. Poverty is also a significant factor behind stress and depression among women, with domestic violence being a contributing factor. Discrimination, combined with poverty, limits women's access to health care. Women must be empowered to make healthy choices for themselves and their children. WHO is now contributing significantly to gender, health and poverty issues through research, advocacy and programmes adapted to the needs of regions and countries.

88. Another crucial issue for women's health today is HIV. Women are more vulnerable to HIV infection biologically, economically, socially and culturally. In some parts of Africa infection rates of adolescent girls are now three to six times higher than those of boys of the same age. Women also often bear the psychological and physical burdens of AIDS care and suffer particular discrimination. Changes in attitudes and sexual practices are necessary. Women must be given the right and the means to protect themselves against infection. As the chief

recipients of blood transfusions, they must have access to safe blood especially during and after delivery. WHO's Making Pregnancy Safer initiative includes the incorporation of services for HIV/AIDS and sexually transmitted infections into district-level maternal and child care.

89. The number of women who have undergone female genital mutilation is estimated at between 100 and 140 million, mostly in Africa. It is also estimated that, each year, a further two million girls are at risk of undergoing mutilation. Besides the immediate complications, which include severe pain, shock and haemorrhage, this practice can also lead to the transmission of HIV, other physical complications, and psychological and psychosexual trauma. WHO advocates the elimination of female genital mutilation and is strongly opposed to the medicalization of all such practices. Following a joint WHO/UNICEF/UNFPA policy statement on mutilation, a regional plan to accelerate the elimination of female genital mutilation has been published to promote development of policy and action at the global, regional and national levels. WHO has also published documents and developed training materials aimed at community workers, nurses and midwives to generate knowledge and promote the prevention of mutilation at the grassroots level.

Diet-related risk factors and physical inactivity

90. The Fifty-fifth World Health Assembly in May 2002 adopted resolution WHA55.23 launching a broad and inclusive consultation process to formulate a **global strategy on diet, physical activity and health**. The guiding principles of this process are the need for stronger evidence on the relationship between diet, physical activity and health for policy-making, advocacy for policy change, stakeholder involvement to implement the global strategy, and the development of a framework for action with tailored policies and interventions for countries. The strategy itself is being prepared for consideration by the Fifty-seventh World Health Assembly in 2004.

91. A report of the Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases provides further evidence for us to use as a basis for preparing the global strategy on

diet, physical activity and health in collaboration with Member States and other partners, including other organizations of the United Nations system, the World Bank, nongovernmental organizations and the private sector.[1]

92. Physical activity is as important as diet for good health. Prolonged inactivity leads to heart disease, hypertension, diabetes, osteoporosis and obesity. In order to bring this issue to the forefront, the theme chosen for World Health Day 2002 was "Move for Health". The day was launched in Brazil where the *Agita São Paulo* movement had already been advocating physical activity for better health. The key message of the Move for Health campaign is that increased physical activity is the most cost-effective way of promoting good health. Policy-makers, health professionals, teachers and town planners are encouraged to give physical activity a higher priority.

Noncommunicable diseases

93. Concern has arisen in recent years over the potential threat posed by inadequate attention being given to the prevention of noncommunicable diseases, especially in low- and middle-income countries. The major noncommunicable diseases, which include cardiovascular diseases, cancer, diabetes, chronic rheumatic and respiratory diseases, and genetic disorders, are often associated with urbanization and changing lifestyles, and are posing an increasing challenge to national health systems in many developing countries today. These countries are facing the double burden of communicable and noncommunicable diseases. Current estimates are that such diseases account for almost 40% of deaths in developing countries, and 75% in industrialized countries.

94. WHO is increasingly active in the **prevention of noncommunicable diseases**. Our work has focused on the following

[1] *Diet, nutrition and the prevention of chronic diseases: report of a joint WHO/FAO expert consultation*. Geneva, World Health Organization, 2003 (WHO Technical Report Series No. 916).

priority areas: advancing school and youth health globally, regionally and nationally, emphasizing the importance and feasibility of healthy ageing, promoting surveillance of health behaviours and risk factors, nutrition and the prevention of noncommunicable diseases, oral health promotion and the promotion of physical activity.

95. WHO is combining efforts with leading organizations working in cancer prevention and control to create an alliance on global cancer control in order to reduce the cancer burden throughout the world. The second edition of *National cancer control programmes* was published last year. It provides guidance to countries on the implementation of comprehensive cancer control programmes. The cardiovascular diseases programme has launched a multicentre project on secondary prevention of major cardiovascular diseases in low- and middle-income countries, focusing on bridging gaps between evidence-based knowledge and practice. In addition we are promoting an integrated and cost-effective approach to management of cardiovascular risk. Models and tools to facilitate the implementation of this comprehensive approach, even in settings with limited resources, have been developed and released recently. In partnership with nongovernmental organizations, WHO has also embarked on a global diabetes advocacy and awareness campaign. We are working to provide people who are living with chronic respiratory disease self-management tools such as programmes for tobacco cessation, allergen avoidance, appropriate pharmaceutical management, and rehabilitation.

96. In May 2000, the Fifty-third World Health Assembly adopted WHO's Global Strategy for the Prevention of Noncommunicable Diseases;[1] a global forum on integrated prevention and control of noncommunicable diseases was also launched. The goals of the Global Forum are to develop national integrated programmes for the prevention and control of such diseases, to prevent them by tackling the major risk factors, to reduce morbidity and premature mortality and to

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[1] Resolution WHA53.17.

improve quality of life. Emphasis is laid on developing cost-effective, evidence-based and sustainable approaches for countries.

Active ageing

97. The ageing of populations is an impressive testament to the achievement of better standards of health worldwide; it is also a challenge that will have an impact on all aspects of society in the twenty-first century. WHO has developed a policy framework on active ageing, which aims to ensure the highest attainable standard of health and well-being for older people. Their numbers are growing both worldwide and as a proportion of the population in many countries. The policy framework was WHO's main contribution to the United Nations Second World Assembly on Ageing, held in Madrid in 2002. To highlight the issue of ageing, World Health Day 1999 focused on the theme "Active Ageing Makes the Difference". Resolution WHA52.7 adopted the same year called for intersectoral action towards active and healthy ageing; relevant research; fostering of healthy lifestyles; and actions to address the needs of ageing populations for disease prevention and service delivery, and to ensure that the different needs of men and women are taken into consideration. The implementation of the resolution and the Madrid Plan of Action on Ageing were discussed at the Fifty-fifth World Health Assembly in 2002.

Substance abuse

98. Alcohol consumption poses a serious threat to health and to the social and economic fabric of families, communities and nations. Globally, 76 million people are dependent on alcohol. It is estimated that 5% of all deaths of young people between the ages of 15 and 25 are attributable to alcohol abuse. WHO plays a leading role in supporting countries in preventing and reducing problems related to substance abuse, including through advocacy, sharing information on the epidemiology of alcohol and drug abuse, interventions and regulation of psychoactive substances. A global Task Force on Alcohol Policy was set up to study and recommend policy options on primary prevention of alcohol abuse. Special attention is given to the issue of alcohol abuse among young people, including legislation, regulation, counselling and

community action programmes, as well as checks on aggressive marketing of alcohol products to young people.

Sustaining development and reducing environmental risks

99. The close correlation between health, poverty alleviation and sustainable development is today undeniable. At the United Nations Conference on Environment and Development held in Rio de Janeiro, Brazil, in 1992, countries adopted Agenda 21, a global plan of action on sustainable development. Ten years later at the World Summit on Sustainable Development in Johannesburg, South Africa, countries reaffirmed their commitment to the goals laid out in Agenda 21 and agreed that health is both a resource for, and an outcome of, sustainable development. The key message of WHO at the Summit was that investments in health have overall long-term benefits for social, economic and environmental development. We emphasized the need to build an evidence base to assess the impact of development policies and practices on people's health, and to forge partnerships and alliances as a means of addressing threats to health and promoting sustainable development.

100. At the World Summit, WHO founded a new partnership: the **Healthy Environments for Children** alliance. This alliance brings together a range of groups from governments, private entities, nongovernmental organizations, academia, development agencies, banks and other organizations of the United Nations system to give effect to the increasing number of international and national calls for action, to encourage political commitment at the highest level, to build on the complementary strengths of various stakeholders and to serve as a hub in a wide network of partners addressing the issue of healthy environments – safe water and food, universal sanitation and clean air – for children.

Making food safe

101. Foodborne diseases are a growing public health problem in both developed and developing countries. Consumers, public health professionals and policy-makers are increasingly concerned about the safety of food, particularly with the emergence of new food products

derived from biotechnology. The Fifty-third World Health Assembly recognized that foodborne diseases significantly affect people's health and urged Member States to establish and strengthen food safety programmes, to develop and maintain surveillance mechanisms, and to integrate food safety matters into health and nutrition education and information programmes for *inter alia* consumers, farmers and agro-food industry personnel.[1] In 2002, WHO finalized a global food safety strategy with a strong, new message of looking at food safety throughout the food production chain from farm to table. WHO, together with FAO, provides the Secretariat of the Codex Alimentarius Commission, which develops international guidelines on food safety standards and surveillance of chemical and microbiological contaminants in food. The first evaluation of Codex in 40 years has recently been completed and is being taken up by WHO's and FAO's governing bodies.

102. In January 2003 WHO published guidelines on establishing national mechanisms to counter potential terrorist acts against food supplies.[2] The booklet describes how countries can establish basic prevention, surveillance and response capabilities. It also emphasizes the need to strengthen existing emergency alert and response systems through improved links with all relevant agencies as well as the food industry.

103. International collaboration in strengthening food safety systems and sharing experiences among countries was the theme of the first Global Forum of Food Safety Regulators, organized by WHO and FAO in Marrakesh, Morocco, in 2002.

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[1] Resolution WHA53.15.

[2] *Terrorist threats to food: guidance for establishing and strengthening prevention and response systems*. Geneva, World Health Organization, 2003.

Injuries and violence

104. Violence is one of the leading causes of death among people between the ages of 15 and 44 years. Every day, an estimated 4500 people die from acts of violence; others are left with physical and psychological consequences that often persist a lifetime. Contributing factors to violence can include substance abuse, a history of being a victim of aggression, domestic conflict, the availability of firearms, the absence of social networks, illicit trade and income, and gender inequalities. As with other causes of ill-health, poor people bear a disproportionate share of the burden of violence.

105. In 2002, WHO launched a broad campaign on violence and health, the main message of which is that violence should be prevented. The first *World report on violence and health* was published in October 2002, and documents the magnitude, consequences and responses to violence – self-inflicted, interpersonal and collective – across the world, aiming to raise awareness about the problem of violence as a public health issue. The report recommends that governments should create, implement and monitor a national action plan for violence prevention, enhance their capacity to collect data on violence, promote primary prevention, strengthen responses for victims of violence, increase collaboration and exchange of information on violence prevention, and integrate violence prevention into social and educational policies.

106. Traffic injuries are now the ninth leading cause of death globally. In 2000, WHO, in close collaboration with many others, developed a five-year strategy for prevention of road traffic injuries. This will form the basis for our future actions in the field. The theme for World Health Day 2004 has been selected as "Safe roads", to draw more attention to road safety as a public health problem. This will be a major opportunity to focus global attention on the growing but preventable human and economic costs of road traffic injuries and deaths. A *World report on road traffic injury prevention* is also in preparation.

IV. Framing health policy and developing health systems

107. One of the four core strategic directions of WHO has been to promote the development of equitable and responsive health systems.

Health systems in rich and poor countries alike have undergone significant changes in the past decade, becoming more complex. With the commitment by Member States to the Millennium Development Goals, there has been renewed attention on improving health outcomes for the poor. This requires political commitment to increase investments, forge new partnerships and implement advocacy. The Fifty-second World Health Assembly in 1999 urged Member States to continue to develop equitable, affordable, accessible and sustainable health care systems and requested the international community and multilateral institutions to support efforts aimed at strengthening the health systems of developing countries.[1] Ministerial round tables were held during the Fifty-third World Health Assembly to review the major challenges faced by health systems.

108. Improving health systems requires reliable evidence, and for this we need to be able to measure how health systems perform; otherwise, vocal but narrow interest groups may have more influence on policy than more marginalized and less articulate members of our societies, who often have greater needs. To improve performance we need to apply the lessons of experience of what works, where, when and how.

109. *The world health report 2000* focused on health systems and their performance and set out a framework for analysing national health systems. It showed that, while improving population health is the defining goal of any health system, people expect the system to contribute to other social goals, by responding to the expectations of the population, ensuring that the financial burden of paying for health care is distributed fairly, and improving the level and distribution of health. It introduced the first measurement exercise of these three goals, which found that performance varies greatly, even between countries with similar levels of health spending.

110. The report identified four functions of health systems: service provision, financing, the generation of resources, including human and

[1] Resolution WHA52.23.

intellectual capital, and the overarching function, stewardship. Stewardship of the health system is essentially the responsibility of the government and is in many ways the most important function. It is about providing leadership to all involved, setting the rules to help the various actors behave in ways that reflect public interest, monitoring how they behave, and ensuring that corrective action is taken when required. This is the case even where ministries of health do not have direct control of health services – because they are either controlled by local government or in private hands. Good stewardship is based on clear standards, applied well within the local context, in ways that are as effective and efficient as possible.

111. This report was controversial, but I believe it was important in increasing the attention paid to health systems. There is much progress to report. The assessment framework has been rigorously reviewed with inputs from the international academic community and from policy-makers, through regional consultations, a scientific peer review process, and a special advisory group that I appointed. As a result it is now much more robust.

112. We have also worked with countries to improve the performance of their health systems. Financing and human resource problems, and ways to solve them, tend to be a key concern of ministers of health. Our work has shown that countries that spend less than around US$ 60 per capita on health face particular difficulties in delivering even a minimum of services. Work has been initiated to provide guidance on health care financing in different settings. We are working with ILO, the World Bank and others to analyse the effects of strategies such as community health insurance. We are documenting evidence on basic issues such as how much should be spent on health, and criteria for resource allocation. We are generating systematic reviews of the cost-effectiveness of many interventions. A public database known as WHO-CHOICE (*Choosing Interventions that are Cost Effective*) can now be adapted by Member States as one input to the policy dialogue on ways to make better use of scarce resources. In a number of countries we are working with ministries of health to develop health financing policies.

113. The Fifty-fourth World Health Assembly in 2001 adopted resolution WHA54.12, which recognized the importance of **nursing and midwifery services** as the core of any health system, and urged Member States to establish comprehensive programmes that support the training, recruitment and retention of a skilled and motivated nursing and midwifery workforce. With broad partnership, WHO launched a strategy in 2002 to support countries in strengthening nursing and midwifery services.

114. Lack of sufficient numbers of appropriately trained **health workers** is a significant constraint on the delivery of services. WHO is working with other agencies and foundations to devise practical ways of reducing the impact of this constraint. A critical objective of health programmes is to deliver health interventions to poor and vulnerable populations. This is often hampered by barriers in the health system itself. WHO has developed an approach that provides support to countries in identifying the magnitude of gaps in coverage and analysing the causes (access, affordability, availability, acceptability).

115. WHO is also collaborating with countries to respond to the shift towards chronic conditions. Our project on innovative care for chronic conditions works closely with health professional bodies around the world to provide models, methods and tools for assisting health systems to deal with this shift. Improving adherence to long-term therapy is a significant challenge in the management of diseases like hypertension, diabetes, depression, chronic lung disease, tuberculosis and HIV/AIDS. Low-cost approaches are being developed that will improve the quality of life of patients and reduce health care costs considerably.

116. Country cooperation strategies (see paragraph 13) have repeatedly identified health systems as a priority area in which greater technical support is needed from WHO. Health systems issues cut across all departments and all levels of the Organization. Strengthening WHO's capacity to provide high quality and prompt technical advice is a key part of the country focus initiative.

117. Lastly, as part of WHO's commitment to global development, *The world health report 2003* will focus on health systems and their contribution to achieving the Millennium Development Goals. The

World Health Survey, in which over 70 countries are participating this year, measures 13 of the health-related Goals. It will significantly enhance countries' capacity to monitor the effects of their health policies. WHO is also undertaking a detailed analysis of health policies in many different countries to increase understanding of what constitutes a "pro-poor" health policy in different settings – still an area of considerable uncertainty.

Expanding access to essential medicines

118. Essential medicines form one of the most cost-effective elements of modern health care. Yet over one-third of the world's population, and over half the population of the poorest countries in Africa and Asia, still lack access to essential medicines. In over 30 countries, public spending on medicines is still less than US$ 2 per person per year. When I took office in 1998, WHO as an organization was embroiled in a heated debate on the future directions of the WHO programme on essential medicines, which was facing the challenges of globalization, free trade, the privatization of health care services, the development of increasingly sophisticated health care technologies, the revolution in information technology, and the protection of intellectual property rights. Following broad consultations with Member States, academic institutions, WHO collaborating centres, other international organizations, nongovernmental organizations and experts, a new WHO medicines strategy was articulated in 2000. The mission of the programme remains the same – to maximize the potential of essential medicines to save lives and improve health status.

119. Key to the rational use of drugs is rational selection of drugs with the best combination of safety, efficacy, quality and health impact. Since 1977 WHO has regularly published a Model List of Essential Drugs, which is used by countries to draw up their own national lists. The Model List is updated every two years. To make the Model List more relevant to Member States and the process of selection of medicines more transparent, measures have been adopted to strengthen the evidence base, broaden the review process, link selection to clinical guidelines, ensure the independence of the WHO Expert Committee on the Use of Essential Drugs and create an essential medicines library.

During 2001, clinical guidelines were issued on treatment of malaria, sexually transmitted infections, tuberculosis and some noncommunicable diseases. The first-ever WHO Model Formulary, which provides independent information on drugs to prescribers, was published in 2002.

120. WHO's work on the quality and safety of medicines received a boost with an increased emphasis on strengthening national drug regulatory authorities, in addition to the work on defining norms, developing international reference materials, and producing guidelines on good manufacturing practices. Many national drug regulatory authorities are now part of WHO's network of collaborating centres. Pharmacovigilance and the challenges of counterfeit medicines are receiving more attention in many countries. Together with sister organizations of the United Nations system, WHO has established a prequalification scheme for antiretroviral drugs, first-line medicines for tuberculosis, and antimalarials.

121. Expanding access to essential medicines also requires affordable prices, reliable supply systems and sustainable financing. I have therefore instituted an ongoing dialogue with the research-based pharmaceutical industry and manufacturers of generic drugs to find ways of reducing prices with a view to making medicines more accessible to the people who need them. Together with Member States and industry, WHO is exploring a number of mechanisms to make existing products more affordable, including bulk purchasing agreements, tiered pricing, corporate donations, and voluntary licensing. These arrangements have been labelled "differential pricing" arrangements. WHO and WTO held a workshop on differential pricing in Høsbjør, Norway, in April 2001, which brought together some of the most important actors concerned with access to essential drugs in the world. The discussions in Høsbjør laid the groundwork for a number of possible actions. For example, the Government of the United Kingdom has established a Prime Minister's working group to advise on how to take forward the ideas discussed in Høsbjør, and the European Commission has developed a programme of work on differential pricing.

122. The Fourth WTO Ministerial Conference in Doha, Qatar, in November 2001, issued a Declaration on the Agreement on Trade-Related Aspects of Intellectual Property Rights and Public Health, which was an important landmark in the work of WHO. It provided further clarification and impetus for WHO's guidance to Member States on the consequences of, and the opportunities opened by, the trade negotiations.

Strengthening national surveillance systems

123. With globalization – and the consequent escalation in population movements, through migration and tourism, the growth in international trade in food and biological products, and social and environmental changes linked with urbanization – the spread of infectious diseases is growing in importance as an international public health issue. In order to contain the spread of infectious diseases, international cooperation on epidemic surveillance, alert and response is indispensable.

124. WHO plays a key role in containing the global public health threat caused by emerging and potentially epidemic infectious diseases by collecting information, coordinating an international strategy for disease control, setting international standards, and supporting countries in disease surveillance and response. This commitment was reaffirmed by the Fifty-fourth World Health Assembly in 2001, which expressed its support for the development of a global strategy for containment and, where possible, prevention of antimicrobial drug resistance, and urged Member States to participate actively in the verification and validation of surveillance data concerning health emergencies of international concern.[1] The *WHO global strategy for containment of antimicrobial resistance* was published in 2001.

125. Since partnerships are a key factor for effective disease surveillance and control, WHO in 2000 created the Global Outbreak Alert and Response Network, a collaborative effort of networks and

[1] Resolution WHA54.14.

institutions for rapid identification, confirmation and response to disease outbreaks. WHO provides secretarial support to the Network, and coordinates international outbreak response activities using resources from the Network. Information on verified disease outbreaks is made immediately available on the WHO web site.

126. Emphasis is laid on developing surveillance and alert mechanisms at the national level with a particular focus on poor countries. An efficient and cost-effective multidisease approach is used. In February 2001 I inaugurated a new WHO office in Lyons, France, for training in field epidemiology and laboratory techniques. This office has been set up in collaboration with the Government of France and the Mérieux Foundation, with the aim of building capacity in high-risk countries to detect and respond to epidemics.

127. By defining the core elements of surveillance, we have also been able to develop a common approach for use by countries in monitoring noncommunicable diseases and environmental, chemical or nuclear risks. Surveillance of noncommunicable diseases and their risk factors is becoming increasingly important in many countries as they struggle to control rising health care costs for an ageing population. Specifically, data on risk factors are crucial for predicting the future burden of chronic disease and also for identifying potential interventions to reduce that burden. While some developed countries have national health surveys that include selected risk factors, for many the information comes from small, costly one-off surveys, if at all. We have developed a set of survey instruments that produce valid and comparable trend data – the Global Youth Tobacco Survey, the STEPwise approach to surveillance of noncommunicable disease risk factors (STEPs), and the World Health Survey. The Youth Tobacco Survey, which is implemented in collaboration with the Centers for Disease Control and Prevention, is the largest global surveillance system for any major public health risk. It is operational in 150 countries and questionnaires have been completed on over one million children between the ages of 13 and 15 years in randomly selected schools. The approach of the Youth Tobacco Survey is now being expanded to surveillance of other major risks that can be effectively measured in the school setting.

128. In response to numerous requests for information on the **deliberate use of biological or chemical agents to cause harm**, specially after the events of 11 September 2001 in the United States of America, WHO prepared a second version of the document on public health response to biological and chemical weapons. Relevant information was made available on the WHO web site. In May 2002 the World Health Assembly adopted resolution WHA55.16 on the global public health response to natural occurrence, accidental release, or deliberate use of biological and chemical agents or radionuclear material that affect health. Member States were urged to have in place national disease surveillance plans and to collaborate and provide mutual support in order to enhance national capacity in field epidemiology, laboratory diagnoses, toxicology and case management. In response to this resolution, WHO developed a strategy covering four main areas: international preparedness, global alert and response, national preparedness, and preparedness for selected diseases and intoxication.

Improving health systems in emergencies

129. Health is the cornerstone of any humanitarian assistance. In emergency situations, WHO provides up-to-date information and coordinates inputs from governments, other organizations of the United Nations system and nongovernmental organizations to address core health issues: assessment of health risks, epidemic and nutritional surveillance, control of preventable causes of illness and death, basic preventive and curative care, prevention of malnutrition, management of health risks in the environment, protection of health workers, services and structures, health as a human right and reduction of the impact of future disasters. WHO is committed to supporting Member States in developing health systems that are more resilient during emergencies, that are able to absorb humanitarian assistance, and that can move towards recovery once the crisis is over.

130. In 1999 in East Timor, WHO set up a country office to support local authorities in rebuilding health services. In Afghanistan, WHO is working closely with the national authorities, other organizations of the United Nations system, nongovernmental organizations and donors to

maintain basic health care facilities, to help ensure that accurate information is available on the health and nutrition needs of the people, to develop synergies among various interventions and to monitor results. In Kosovo in 1999, WHO played a role in the development of a policy for the rehabilitation of the health sector. In 2001, after the earthquake in Gujarat, India, WHO undertook the initial needs assessments and collaborated in the immunization of children and improvement of environmental health. In the same year, WHO appointed its first representative to the Democratic People's Republic of Korea to give support and guidance in the reconstruction of the health system and help ensure better access to basic medicines and equipment. During the most recent crisis in the Great Lakes Region of Africa, WHO provided support to the coordination of the health response, in particular for the Democratic Republic of the Congo. In Sierra Leone, WHO has a wide range of programmes covering HIV/AIDS, poliomyelitis and malaria. In December 2002, WHO shipped 164 emergency health kits to Ethiopia in response to the severe drought. In the current humanitarian crisis in southern Africa, WHO is working to strengthen the health system and to ensure that the health of people is acknowledged as an important factor in sustainable recovery. In the past five years, WHO has been able to maintain a technical and humanitarian presence in the West Bank and Gaza Strip.

131. The protection of health personnel, hospitals, health facilities and infrastructures used for humanitarian purposes is indispensable to the success of any intervention in an emergency situation. The Fifty-fifth World Health Assembly called upon all parties to armed conflict to adhere to the rules of international humanitarian law protecting civilians and combatants who are *hors de combat*, as well as medical, nursing and other health and humanitarian personnel.[1] A humanitarian supply management system called SUMA, developed as a collective effort by the countries of the American Region, is a pathbreaking tool in the area of emergencies. More than 3000 volunteers in over 30 countries have

[1] Resolution WHA55.13.

been trained to use the SUMA software, which is now recognized as the standard in post-disaster supply management.

132. We also believe that health can contribute to the prevention of, and preparedness for, humanitarian emergencies. WHO has begun to look at what we can do for countries and populations that are on the brink of crisis. By placing health and social services high on the political and economic agenda, we are helping to reduce the vulnerability of populations and eventually the need for humanitarian assistance. For this, a concerted international commitment is required to mobilize resources and expertise.

V. Research and health information

Research

133. Research is a critical element of all actions to promote better health. It provides tools, knowledge, understanding and evidence for policy and programme implementation. It is important that research results become available rapidly and accessible globally to ensure the widespread application of their benefits. Many of the fundamental challenges in international health research defined in the past decade remain: only 10% of the resources available for global health research are being spent on improving the health of 90% of the world's population (the 10/90 gap); too few medicines are being developed for neglected diseases; research capacity in developing countries is limited. WHO's work in health research is central to the growing interest in defining priorities and methods of financing global public goods. Developments in biotechnology and genomics offer the prospect for many new tools and technologies.

134. All WHO's programmes promote and support research and knowledge management. The **UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases** and the **UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction** bring together organizations of United Nations system, the World Bank, donors, industry, private and public research institutions, and foundations to foster and support research in neglected

infectious diseases and reproductive health. A global vaccine-research forum, which meets annually, allows key private and public sector players to share information on the development and application of new technologies and approaches in vaccines and to contribute to setting global priorities.

135. The focus of all our research work is to develop new and improved tools and approaches for prevention, diagnosis, treatment and control, especially for conditions that impose a high health burden, those that are neglected by the commercial sector, and those that disproportionately affect developing countries. I have supported the participation of developing countries in the governance, priority-setting and implementation of research. We use the evidence provided through our research and that of others to set global health policy. WHO also supports Member States in translating research results into applicable, acceptable and affordable strategies that can be readily integrated into health services.

Genomics and human health

136. In the past 20 years, genomics research has progressed at a remarkable speed, transforming our understanding of human genes and the underlying pathology of disease, and opening new opportunities for prevention, diagnosis and treatment. This revolution, highlighted by the completion of the sequencing of the human genome, has also brought forth new issues of debate regarding the scientific and ethical consequences of gene manipulation.

137. WHO has a crucial role to play in providing international leadership in genomics research, bioethics and the resulting impact on global health equity. In 2001 I requested the **WHO Advisory Committee on Health Research** to prepare a report on genomics and world health. The report, published in 2002,[1] gives a detailed account of the advances in research and warns of the potential risks, including

[1] *Genomics and world health,* Report of the Advisory Committee on Health Research. Geneva, WHO, 2002.

the widening of health inequalities, and ethical issues. It recommends that WHO should support Member States in establishing regulatory systems to safeguard against the risks and hazards of genomics research and its applications. It also recommends that developing countries begin to develop appropriate technological capacities to make best use of the potential of genomics for their own health needs, and advocates equitable sharing of the benefits of genomic research.

Health information

138. Significant progress has been made on a number of fronts. Information available on the **WHO web site** has been greatly improved in terms of organization, design, data storage and publishing standards. Several WHO periodicals were merged to form the new monthly *Bulletin of the World Health Organization*, which is published in print, online and CD-ROM formats. Since its launch in 1999, it has become a leading international journal of public health as attested by its increasing citation rates and impact factor. Arrangements with outside publishers, both commercial and noncommercial, have brought WHO books and reports to many new audiences in more than 50 languages. At the same time, agreements with commercial information providers and database services now enable WHO information to be delivered electronically to the desktops of hundreds of thousands of educational institutions, libraries, and companies.

139. The **WHO Library** has been providing progressively better access to health information, including: the introduction of electronic access to the full text of over 1000 journals for WHO staff in regional and country offices; public access through the Internet to the full text of thousands of WHO information products; and the continuing development of the Library's collections which are used by both WHO staff and visitors.

140. In July 2001, WHO, together with the world's leading medical journals, launched the **Access to research** initiative, to make almost 2000 of the world's leading medical and scientific journals accessible free or at heavily subsidized rates to medical schools and research institutes in developing countries. By January 2003 over 100 countries had this access. Research and discussions around best practices in

knowledge management, knowledge-sharing, collaborative communities, and learning organizations are recent cross-cutting activities.

VI. Management reform

141. An important product of the corporate strategy was the elaboration of a General Programme of Work for 2002-2005. It was decided that the Programme would cover a period of four years (rather than six as in the past) and would take the form of a short policy document which would guide the programme budget and subsequent operational work plans.

142. The **Programme budget** for 2002-2003 was drawn up jointly by regional offices and headquarters – and not separately as in the past – within the framework of the new corporate strategy. It focused on 35 distinct areas of work for the whole Organization, with 11 well-defined priority programmes, derived from the goals defined in the General Programme of Work. It thus reflected the interdependence of the different parts of WHO within agreed global objectives and strategies. The concept of results-based budgeting was introduced for the first time, making budgetary allocations to each area of work dependent on achievement of predetermined objectives and expected results. Organization-wide monitoring was introduced to track the achievement of results. The Financial Regulations were also revised in 2000 in order to introduce a more modern approach to accounting.

143. The Proposed programme budget for 2004-2005 further refines the process of results-based budgeting and provides measurable indicators for each of WHO's objectives.

144. A task force on reform of human resources management was set up in 2000 in order to review human resources policy, and make recommendations on simplifying procedures and strengthening productivity, efficiency and job satisfaction for all staff. Emphasis was placed on staff development: enhancing communication and negotiation or mediation skills, improving access to development and training opportunities at all levels of the Organization through the use of new technologies, and promoting self-development, on-the-job training and

mentoring. I also took measures to achieve gender parity within the Organization. A new approach to appraisal of staff performance was introduced. Our capacity to respond to the security needs of our staff worldwide was strengthened. We are also working on the elaboration of conflict-of-interest policies for staff members.

145. In order to ensure that our interaction with the private sector is effective, transparent and protected from conflicts of interest, we revised our guidelines on interaction with commercial enterprises in July 1999.

146. A range of steps were taken to improve internal communication and management. A global cabinet comprising the Director-General and the Regional Directors meets six times a year. A cabinet of the Executive Directors was established. The first-ever meeting of all the WHO Representatives was held and is now a biennial feature. An improved telecommunications network was set up; global videoconferencing and an internal global telephone network are now fully operational. Management support units have been set up with delegated authority closer to the technical programmes. Retreats of the Executive Board were held for the first time. Global Health Leadership fellowships brought young people to WHO. A global staff/management council meets annually.

147. The battles against ill-health and disease continue. To fight these varied battles on so many fronts, WHO needs to be strong. There are increasing demands on us to support national authorities as they work to improve health outcomes for their populations. We are also asked to help countries to have greater influence on global and regional public health action. A strong foundation has been laid. A lot has been accomplished and WHO has much to be proud of. But more remains to be done. I am sure that WHO will continue to play its rightful role in leading the world to become a healthier and better place.

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The closing of the final session of the Intergovernmental Negotiating Body
on the WHO Framework Convention on Tobacco Control, Geneva, February 2003