

## **Address by Dr Margaret Chan, Director-General to the Sixtieth World Health Assembly**

**Geneva, Tuesday, 15 May 2007**

Madam President, honourable ministers, distinguished delegates, ladies and gentlemen.

When I took office at the start of this year, I described these times as optimistic for public health. Four months and many experiences later, I still hold this view.

Less than a decade ago, public health was struggling to gain visibility in national and international development agendas. Health was fighting to be heard when priorities were fixed and budgets were decided.

Today, health enjoys support from many partnerships, foundations, and implementing agencies. The number of innovative funding mechanisms continues to grow, as does the size of resources they command.

Health is now seen as a key area of engagement for foreign policy. Health has become an attractive focus for corporate social responsibility.

There will always be unmet needs, but health has never before received such attention or enjoyed such wealth.

I am fully optimistic, but these four months in office have deepened my understanding of the challenges.

Madam President,

This past November, I spoke about six issues that provide a simple way of looking at the complex task before us. I have discussed this framework with my senior colleagues, and they are in full agreement.

We have mapped these items against the objectives set out in the Medium-term strategic plan. They fit together well.

This is now our six-item agenda.

The first two items address fundamental health needs: for health development and health security.

The second two items are strategic: strengthening health systems and using evidence to define strategies and measure results.

The remaining two items are operational: managing partnerships to get the best results in countries, and improving the performance of the World Health Organization.

Health development is familiar territory for WHO. It is our most extensive area of engagement.

The very first Health Assembly, in 1948, agreed on six priorities for international action. Three were for diseases: sexually transmitted diseases, malaria, and tuberculosis. The remaining three were maternal and child health, environmental sanitation, and nutrition.

If you replace sexually transmitted diseases with HIV/AIDS, these are now the health-related Millennium Development Goals.

It is no surprise that WHO has strong and experienced programmes for addressing each of these Goals.

In making this comparison, I do not mean to suggest that the situation has remained the same over these decades. The changes have been dramatic.

The disease burden has changed. We have made progress against many diseases. But society has never experienced a disease as deadly and destructive as HIV/AIDS.

The distribution of the disease burden has changed.

Today, the overwhelming burden of disease is borne by the African people. We must not allow Africa to become the continent left behind by development.

In addition, we must not neglect the special challenges faced by small island states, countries in transition, and middle-income countries with a high disease burden.

The landscape in which health programmes operate has become far more complex than it was just a decade ago.

The landscape is crowded. More international actors are working in health than in any other sector. In many cases, efforts overlap, results are fragmented, and activities do not align with country priorities and capacities.

Chronic diseases, long considered the companions of affluent societies, now impose their greatest burden in low- and middle-income countries.

The globalization of the labour market has contributed to the mass exodus of health workers from the countries that invested in their training.

The distinction between the health problems of rich and poor countries is no longer absolute.

Many wealthy countries have growing urban slums that drain health resources and strain the social welfare system. More developing countries now have pockets of wealth that attract the lion's share of spending on health.

In many places, rapid urbanization outpaces the ability of governments to provide essential services.

We see this in teeming urban shantytowns that have no safe water, sanitation, electricity, roads, and often no law enforcement. These are ideal conditions for diseases of filth to flourish. They are also ideal for epidemics of violence and the misery of mental illness.

We see the results of rapid modernization on the roads. Of the 1.2 million deaths caused each year by road crashes, 90% now occur in low- and middle-income countries.

These countries are already shackled by the double burden of infectious and chronic diseases. They do not need a third burden of high morbidity and mortality from crashes, accidents, injuries, and violence.

Madam President,

The problems are great, but so is the determination to tackle them.

Part of this determination arises from evidence that health can drive socioeconomic progress. This is recognized in the Millennium Development Goals, which give health a central role in poverty-reduction strategies.

Health development includes the chronic diseases and the neglected tropical diseases. Both groups of diseases are strongly associated with poverty. They deepen poverty and hold back economic progress.

For the treatment of chronic diseases, we now have packages of interventions that are effective and affordable in every part of the world.

The Framework Convention on Tobacco Control is supported by more than 140 countries, making it one of the most widely embraced treaties in the history of the United Nations. This is really primary prevention at its best.

To reduce tobacco use, we are now moving from advocacy to a scaling up of interventions.

I am therefore grateful for the financial support, from the Bloomberg Foundation, for a new stop smoking initiative announced last year. This contribution has greatly increased the resources devoted to fighting tobacco use in the developing world, where most smokers live.

As you heard yesterday, this is the first Health Assembly held in a smoke-free environment. May this be an example for the rest of the United Nations system.

Last month, the first meeting of global partners for the neglected tropical diseases was held. This was a turning point. Prospects for reducing the burden of debilitating diseases for at least one billion people have never looked brighter.

The eradication of a disease is the ultimate contribution to sustainable health development. We have two such initiatives under way: for polio and for guinea-worm disease.

Two weeks ago, I visited Afghanistan and Pakistan, two of the four remaining countries where indigenous transmission of wild poliovirus has not yet been interrupted. I spoke with the President of Afghanistan and the Prime Minister of Pakistan, and received their full commitment.

Following an urgent consultation with stakeholders in February, we developed a new case for completing polio eradication. Finishing the job is our best buy. We must do it. We are leaving a perpetual gift to generations of children to come.

Guinea-worm disease has seen a dramatic decrease. Cases have declined from 3.5 million in 1985 to only 25 000 today. Like polio, we must finish the job.

Madam President,

Health security has two dimensions in this agenda: one at the individual and community level, and a second at the international level.

Health security at the individual and community level will be addressed in next year's World Health Report. It will concentrate on the role of primary health care in providing access to the essential prerequisites for health.

International health security is addressed in this year's World Health Report, which is now in press.

At the international level, several acute risks and dangers can threaten health security, sometimes globally.

Some acute shocks to health arise from the way nations and their populations interact. The emergence and spread of new diseases is one example. Another example is exposure to toxic substances, whether following illicit dumping or after an accident.

Other shocks to health take on international dimensions because of the need for humanitarian assistance. These threats to health security arise from conflicts and natural disasters.

We have solid evidence that climate change, which contributes to natural disasters and heat waves, is yet another threat.

All of these events are destabilizing, disruptive and costly. All have effects that are felt internationally, either directly or indirectly. All reveal our shared vulnerability, and call for collective action.

On 15 June of this year, the revised International Health Regulations will come into force. Pro-active risk management is the strategy behind these Regulations. They aim to stop an event at source, before it has a chance to become an international threat.

This is our best insurance policy.

WHO has strong and well-tested mechanisms for responding to outbreaks. In the last few years, we have had teams on site less than 24 hours after an alert. This is a tribute to the agility of WHO and our partners.

Here I would like to honour the memory of Dr J.W. Lee, my predecessor and mentor, for his foresight in establishing the Strategic Health Operations Centre. Many of you have visited it. It is now named in his memory.

Madam President,

We must increase the number of laboratories that support the Global Outbreak Alert and Response Network. We need this expertise much more broadly distributed throughout the world. In an outbreak, every hour counts. This will help us move faster.

Many activities undertaken to prepare for an influenza pandemic are improving our collective defence against other outbreaks. These improvements are a permanent strength, whether this H5N1 virus causes the next pandemic or not.

An influenza pandemic is a global event. I am personally engaged in several efforts to ensure access to vaccines in all countries.

The first agreements to transfer technology to vaccine manufacturers in developing countries have been signed. We have initiated work on establishing a stockpile of H5N1 vaccine. Advance procurement mechanisms for pandemic vaccine are under development.

I am in dialogue with development partners and with executives from all the leading influenza vaccine companies. I am greatly encouraged by their commitment.

The health of people in areas of conflict presents a different challenge. Our activities include emergency preparedness, the provision of essential services, the prevention of outbreaks, and rehabilitation.

I want to pay tribute to all those working in these exceptionally difficult situations. Your commitment is inspiring. Your sacrifice is real.

Only ten days ago, Dr David Dofara was killed in the Kenya Airways crash in Cameroon. He was returning to his demanding job as head of the WHO sub-office in South Darfur. He was deeply committed and will be greatly missed. I am sure you would want to join me in offering our condolences to his family and his colleagues.

Madam President,

The strengthening of health systems is the first of two strategic items.

We face a fundamental dilemma. Multiple initiatives have formed to deliver specific health outcomes. The ability to deliver these outcomes depends on a functioning health system. Yet the strengthening of health systems is not always a core purpose of these initiatives.

As a result, we have parallel delivery systems reaching targeted populations at a time when we need comprehensive systems reaching all in need.

One of the biggest challenges facing health development is to scale up population coverage with existing interventions. If we want health development to work as a poverty-reduction strategy, we must have health systems that reach the poor.

Numbers of maternal deaths will not fall until more pregnant women have access to skilled birth attendants and emergency obstetric care.

To make a further reduction in childhood diseases and deaths, emergency care must reach more neonates and children suffering from acute respiratory infections.

Inadequate numbers of staff and weak infrastructures have been identified as the single greatest obstacle to universal coverage, whether for HIV/AIDS, tuberculosis, malaria, or reproductive health.

I do not need to remind you: these are precisely the conditions targeted by health-related development goals.

I am using every opportunity to speak with partners about the need to make the strengthening of health systems an explicit component in disease strategies and funding grants.

For all of these reasons, we are placing renewed emphasis on primary health care as an approach to strengthening health systems.

Decades of experience have taught us that integrated service delivery is the best route to universal access. It is the best way to reach under-served populations with essential and sustainable care.

We are not starting from scratch.

And I am not reopening the debate about horizontal versus vertical programmes. We need both, but they need to work better together.

For example, the river blindness control programme began as a vertical programme, but eventually developed the community-directed approach for drug distribution.

We also have to look at the reality of systems and services that already exist. We cannot ignore the role that traditional medicine plays in large parts of the world. It can be an important resource for health.

Next year marks the sixtieth anniversary of WHO and the thirtieth anniversary of the Declaration of Alma-Ata.

As I mentioned, primary health care will be the topic for next year's World Health Report and also the theme for World Health Day.

Many countries have extensive experience with primary health care. As a contribution to the anniversary events, several countries will be holding international and regional conferences to share these experiences.

I am encouraged by this enthusiasm.

A commitment to equity is central to the value system of primary health care. People should not be denied access to life-saving and health-promoting interventions for any reason.

Yet today, more than one third of the world's population has no access to essential interventions.

In addition, we badly need new drugs, diagnostics, and vaccines, especially for diseases of the poor.

The challenge is to get the right balance: the right balance between the immediate need for equitable access to quality, affordable medicines, and the long-term need to stimulate innovation.

This is the challenge being tackled by the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, which will hold its second meeting in November.

Madam President.

Evidence is the second strategic item.

Reliable health data and statistics are the foundation of health policies, strategies, and evaluation and monitoring. The confidence of donors, nationally and internationally, depends on our ability to show measurable results.

Evidence is also the foundation for sound health information for the general public. Public advice on health-promoting behaviours is an intervention in its own right. It makes a huge contribution to prevention.

Setting norms and standards is a traditional WHO function, and we have performed well. I am referring, for example, to standards for the quality of drinking-water, the safety of food, and the quality of medicines and vaccines.

I regard the generation and use of health information as the most urgent need.

In many cases, basic health information is simply not available. This is not surprising. In areas where health systems are weak or virtually non-existent, basic data will not be collected.

Many countries do not have the ability to generate vital statistics. In other cases, abundant data are generated, but never feed into the decision-making process.

To improve this situation, innovative approaches to the standardized collection and use of health statistics have been developed, and implementation has begun. Direct technical and financial support to countries is being provided by the Health Metrics Network, which is hosted by WHO.

I want WHO to help countries make maximum use of advances in information technology.

We need to explore innovative ways to make the revolution in information technology work for health, but we also need to coordinate existing activities. For example, the use of uniform information technologies and computing platforms would simplify work within health districts.

Madam President,

Coordination also applies to the remaining two items, which are operational.

Performance within countries improves when the multiple activities of partners are harmonized with national priorities, and led by governments. WHO can encourage a more coordinated approach using the strategic power of evidence.

One of my jobs is to convince our partners to align their activities with country priorities and capacities, but also with WHO-recommended strategies and best technical practices.

In the interest of better coordination, WHO is participating fully in the eight “one UN” pilot projects.

In my four months in office, I have held discussions across the full spectrum of our partnerships. These include sister United Nations agencies, bilateral agencies, development banks, nongovernmental organizations, civil society, and academia.

We are looking for engagement and synergies but above all for greater coordination and cohesion.

A similar search for alignment will take place this July, when I meet the heads of the main health-related international agencies.

I am also speaking with executives in multiple industries except for one – the tobacco industry. We are not on speaking terms, and never will be.

The final item concerns the performance of WHO at all levels.

Madam President.

It is my responsibility, as the chief technical and administrative officer, to manage this Organization efficiently.

We have checks and balances in place to ensure transparent and accountable management. In some cases, these are not working as well as they should. I am taking corrective action.

We have embarked on a process of contract reform. This reform will make conditions of service for staff more equitable. It will streamline some of the administrative procedures, and improve human resource planning.

The introduction of the global management system next year will further streamline administrative work.

You have before you the Proposed programme budget for 2008 and 2009 and the draft Medium-term strategic plan. Both demonstrate a results-based approach. Many of you have told me that WHO leads the United Nations system in this area, and I thank you.

In the interest of efficiency and consistency, WHO headquarters, its regional offices and country offices must work in a cohesive and coordinated way. In the past four months, the regional directors and I have met together on three occasions to discuss organizational strategy and policy.

I have visited four regional offices and six country offices. I have talked with staff. I am pleased to say: we are working well together.

Madam President,

As I have said, what gets measured gets done. The most important measure of our performance is the impact on health outcomes.

I have identified the health of two populations as indicators of our overall performance: the people of Africa and women.

Last month, Africa's health ministers, under the leadership of the African Union, approved the continent's first overarching health strategy. It is comprehensive, and it is far-sighted, covering the years 2007 to 2015.

You heard about this strategy yesterday from the outgoing President. Let me highlight some key points.

First, the strategy acknowledges that Africa will not experience economic growth until the burden from infectious diseases is reduced.

Second, the main focus of the strategy is on the urgent need to strengthen health systems. The ability to deliver essential interventions to those in need is regarded as the greatest challenge facing health care in Africa.

The strategy further emphasizes the need to revitalize the primary health care approach, and calls for a minimum package of core interventions that can be made available to all.

There is strong agreement between this strategy and the six-item agenda for WHO. I want these honourable African ministers to know: you have my full support.

Madam President,

The challenges are different for women. Women need special attention in health agendas for three main reasons.

First, their role as care-givers makes them an important resource.

Second, they are susceptible to special health problems and a heightened risk of mortality.

Third, and most important, women are agents of change. They can lift households and communities out of poverty.

But women will not realize their potential, also as agents of change, unless they are given opportunities. And most especially: opportunities to improve their economic status.

For women, economic capital is social capital. It earns respect.

When these opportunities are provided, health-promoting behaviour follows.

When women earn an income, the extra money goes to school fees, better nutrition, routine health care, and other investments that promote better health.

The most successful and sustainable projects use an entry point that matters most to women.

In Pakistan, earlier this month, I had a chance to see and hear, first-hand, how piped water has revolutionized the lives of impoverished rural women. With the burden of collecting and carrying water gone, health-promoting behaviours have followed.

WHO needs to do much more for women, to protect their health, and to realize their enormous potential.

As a first step, we are looking at evidence of the impact of microfinancing schemes on women's health. The results I have seen show an impressive and rapid impact on health outcomes. There are also some unexpected results, such as a decline in domestic violence.

I am glad to see that the forthcoming G8 summit will be looking at microfinancing, especially for women, as a poverty-alleviation strategy for Africa.

Second, I have called for an inventory of initiatives that affect the health of girls and women throughout the life-course. We are looking for gaps in care, and ways to find operational synergies. We need a cross-cutting approach that stretches from water supply to basic surgical skills.

Third, I am asking all programmes to collect and report data disaggregated by sex. This is another way to pinpoint problems and detect unmet needs.

The new gender strategy will enable us to mainstream gender awareness throughout the work of the Organization.

Finally, I look forward to the findings and the recommendations of the Commission on Social Determinants of Health, which will be made available next year. This report will give us a better idea of what needs to be done to promote equal access to health services for all people, irrespective of gender or social and economic backgrounds.

Madam President,

This, then, is my view of the landscape in which public health operates today. It is a landscape of enormous complexity, but with enormous opportunities.

It is one of shared threats, collective responsibility, mutual support, and global solidarity.

The progress we have made in global health in recent decades has not come about by accident.

It has come about because our predecessors dared to dream, and dared to question the status quo. They not only had a vision for a better and brighter future. They worked enthusiastically towards it.

I would like to recognize Dr Mahler in the audience as one of my predecessors.

We, too, have an opportunity. The forces of globalization have drawn the world together as never before.

We have the tools, the commitment, and the determination to create a healthy legacy for the whole world.

Let this be our goal as we work together – with enthusiasm and optimism.

Thank you.

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