

## **Address by Dr Tedros Adhanom Ghebreyesus, Director-General**

### **HIGH-LEVEL WELCOME (First plenary session, 22 May 2022)**

Your Excellency Minister Wangmo, President of the Seventy-fourth World Health Assembly, Excellency President Kenyatta, Your Excellency President Masisi, Excellency President Milanović, Excellency President Abinader, Excellency Vice-President Borrero, Excellency Federal Councillor Berset, excellencies, dear colleagues and friends,

Before I continue, I would also like to recognize the video message from President Macron, Prime Minister Hasina and Secretary-General Guterres.

It's good to see you. It's been a while. For more than two years, technology has allowed us to continue meeting, and to continue our work together. But there is no substitute for meeting face-to-face. I look forward to this week; to our conversations, and to moving ahead on the challenges that confront us all.

The coronavirus disease (COVID-19) pandemic has turned our world upside down. Our world has endured great suffering – and endures it still. I know how difficult the last two years have been for you and the people we serve together.

People have lost their lives, loved ones and livelihoods; health systems have been strained to breaking point, and in some cases, beyond; health workers have laboured under extreme circumstances. Some have paid the ultimate price, and we have lost others to stress and depression; communities have faced great disruptions to their lives, with schools and workplaces closed, and the burden of isolation and anxiety.

You, as governments, have been at the centre of the storm, facing multiple challenges: to protect both the health and rights of your populations; to give reassuring advice in the face of uncertainty; to counteract misinformation and disinformation; to access vaccines and other tools; and you confronted so much more.

I thank all of you for your efforts to protect your communities, and to work with the WHO Secretariat and our partners to protect others around the world.

More than two years into the most severe health crisis in a century, where do we stand? More than 6 million COVID-19 deaths have been reported to WHO. But as you know, our new estimates of excess mortality are much higher – almost 15 million deaths. Reported cases have declined significantly from the peak of the Omicron wave in January of this year. And reported deaths are at their lowest since March 2020. In many countries, all restrictions have been lifted, and life looks much like it did before the pandemic.

So is it over? No, it's most certainly not over. I know that is not the message you want to hear, and it's definitely not the message I want to deliver. There's no question we have made progress, of course we have: 60% of the world's population is vaccinated, helping to reduce hospitalizations and deaths, allowing health systems to cope, and societies to reopen.

But it's not over anywhere until it's over everywhere. Reported cases are increasing in almost 70 countries in all regions – and this in a world in which testing rates have plummeted.

And reported deaths are rising in my continent – the continent with the lowest vaccination coverage.

This virus has surprised us at every turn – a storm that has torn through communities again and again, and we still can't predict its path, or its intensity. We lower our guard at our peril.

Increasing transmission means more deaths, especially among the unvaccinated, and more risk of a new variant emerging; declining testing and sequencing means we are blinding ourselves to the evolution of the virus; and almost one billion people in lower-income countries remain unvaccinated.

Only 57 countries have vaccinated 70% of their population – almost all of them high-income countries. We must continue to support all countries to reach 70% vaccination coverage as soon as possible, including 100% of those aged over 60; 100% of health workers; and 100% of those with underlying conditions.

Vaccine supply has improved, but absorption has not kept pace. In some countries, we see insufficient political commitment to roll out vaccines. This was impacted by the initial lack of political commitment for equitable access to vaccines, as President Kenyatta said. In some we see gaps in operational or financial capacity; and in all, we see vaccine hesitancy driven by misinformation and disinformation.

WHO's primary focus now is to support countries to turn vaccines into vaccinations as fast as possible. However, we still see supply-side problems for tests and therapeutics, with insufficient funds, and insufficient access.

The pandemic will not magically disappear. But we can end it. We have the knowledge. We have the tools. Science has given us the upper hand.

We call on all countries that have not yet reached 70% vaccination coverage to commit to achieving it as soon as possible; and to prioritize the vaccination of all health workers, all people over 60 years and everyone at increased risk.

We call on those countries that have reached 70% to support those that have not.

We call on all countries to maintain surveillance and sequencing.

We call on all countries to be prepared to reintroduce and adjust public health and social measures as necessary.

We call on all countries to restore essential services as rapidly as possible.

And we call on all countries to work with your communities to build trust.

But of course, the pandemic is not the only crisis in our world. As we speak, our colleagues around the world are responding to outbreaks of Ebola virus disease in the Democratic Republic of the Congo, monkeypox and hepatitis of unknown cause, and complex humanitarian crises in Afghanistan, Ethiopia, Somalia, South Sudan, the Syrian Arab Republic, Ukraine and Yemen. We face a formidable convergence of disease, drought, famine and war, fuelled by climate change, inequity and geopolitical rivalry.

As you know, this Health Assembly marks the end of my first term as Director-General. I am humbled by the Executive Board's decision to nominate me for a second term.

As I have reflected on the past five years, I realized they have been flanked by two visits to war zones. I made my first trip as Director-General to Yemen in July 2017, a country which was, and remains, mired in civil war. While I was there, I met a mother and her malnourished child who had travelled for hours to reach the health centre I was visiting in Sana'a. The woman was skin and bone, begging the medical staff for care – not for herself, but for her child.

Then two weeks ago, I was in Ukraine, visiting bombed hospitals and meeting health workers. I visited a reception centre for refugees in Poland, where I met another mother, from the Mariupol area, who told me that when the shelling began, her young daughter was very scared. "Don't worry," her mother told her. "It's just a thunderstorm. It will pass."

At our warehouse in Lviv, I held a paediatric crutch that WHO was preparing to deliver – a crutch for children – a tool that children should only need if they are injured playing sport or climbing trees – children being children – not if they are hurt by bombs. I met people who have lost loved ones; lost their homes; lost their sense of security – and yet somehow, have not lost hope.

In both Yemen and Ukraine, and in other countries I have visited in between during my first term, I saw the profound consequences of conflict for health systems and the people they serve. More even than pandemics, war shakes and shatters the foundations on which previously stable societies stood.

It deprives whole communities of essential health services, leaving children at risk of vaccine preventable diseases; women at increased risk of sexual violence; expectant mothers at risk of an unsafe birth; and people who live with communicable and noncommunicable diseases without access to the lifesaving services and treatments on which they depend.

And it leaves psychological scars that can take years or decades to heal. For me, this is not hypothetical or abstract; it's real, and it's personal. I am a child of war.

The sound of gunfire and shells whistling through the air; the smell of smoke after they struck; tracer bullets in the night sky; the fear; the pain; the loss – these things have stayed with me throughout my life, because I was in the middle of war when I was very young.

Like the mothers I met in Yemen and Ukraine, my mother's concern was to keep me and my sisters and brothers safe. When my mother heard gunfire at night, she would make us sleep under the bed, and lay more mattresses on top of that one bed, with all children crammed under the bed, in the hope we might be protected if a shell fell on our house.

I felt that same fear as a parent myself again in 1998, when war returned to Ethiopia, and my children had to hide in a bunker to shelter from the bombardment. That's when I returned from Nottingham where I was doing my PhD, because I was worried about my family and the rest of the

country. Maybe you remember what happened in 1998. I feel the same pain and loss again now, with war in my homeland once again. I was not only a child of war, but it has followed me throughout.

But my story is not unique. It is like so many others – the story of a family who did not start the war, who were not responsible for it, but suffered because of it.

War is bad enough. But it is made worse because it creates the conditions for disease to spread. Indeed, war, hunger and disease are old friends. In the Napoleonic wars and the American Civil War, more soldiers died from disease than in battle.

It was no coincidence that the 1918 influenza pandemic – the greatest pandemic – coincided with what was then the greatest war the world had known – the First World War. It's no coincidence that the final frontier for eradicating polio is in the most insecure regions of Afghanistan and Pakistan.

It's no coincidence that in 2018, the Ebola virus disease outbreak in the relatively stable Equateur province of the Democratic Republic of the Congo took two months to control, while the outbreak in the insecure regions of North Kivu and Ituri took two years. Where war goes, hunger and disease follow shortly behind.

The COVID-19 pandemic did not cause the war in Ukraine; and the war did not cause the pandemic. But they are now intertwined. Until this year, Ukraine was among the countries that was making the most rapid progress towards universal health coverage.

We are deeply concerned about the impact of the war on these gains. Already we have seen many clinics and hospitals closed, health workers displaced and services disrupted.

I visited a hospital in the town of Makariv, west of Kyiv. Its inpatient department had been damaged by a missile strike, and its primary care department was completely destroyed. And it's not just Ukraine.

So far this year, WHO has verified 373 attacks on health in 14 countries and territories, claiming the lives of 154 health workers and patients, and leaving 131 injured.

Even WHO is targeted. In 2019, our colleagues Dr Richard Mouzoko and Belinda Kasongo were murdered in the Democratic Republic of the Congo while working to protect others from Ebola virus disease.

Attacks on health workers and health facilities are a breach of international humanitarian law. But they are also an assault on the right to health.

In Ethiopia, the Syrian Arab Republic, Ukraine, Yemen and elsewhere, WHO is working in conflict zones to deliver medicines, equipment, training and technical advice to support care for those who need it: to treat the wounded, to give pregnant woman the conditions for a safe and supportive birth, to make sure children receive routine vaccinations, and to support health workers who continue to deliver life-saving services in the most difficult circumstances.

Last year I travelled to Afghanistan, where I met a group of women nurses who told me they had not been paid in three months, but would continue to serve their patients. WHO paid their salaries so they could continue to deliver the care on which their communities depend.

But ultimately, the one medicine that is most needed is the one that WHO can't deliver – peace. Peace is a prerequisite for health.

During El Salvador's civil war, one-day ceasefires called “days of tranquillity” were declared three times a year, to allow the vaccination of children against polio, measles and more. In 1990, 159 nations signed a declaration and plan of action endorsing the need for Days of Tranquillity, which have been used in Afghanistan, Côte d'Ivoire, Peru, Uganda and elsewhere.

There can be no health without peace. But equally, there can be no peace without health.

The authors of the WHO Constitution knew this, when they wrote that the health of all peoples is fundamental to the attainment of peace and security and is dependent on the fullest co-operation of individuals and States.

Health can contribute to peace by delivering services equitably to all people in a society, especially disadvantaged groups. This can help address the triggers of conflict, such as unequal access to health care, which can often lead to feelings of exclusion and resentment.

Equitable health services strengthen community trust, which in turn contributes to strengthening health systems and peace building.

For example, in Tunisia in the aftermath of the Arab Spring, and with WHO support, a Societal Dialogue for Health was established as a platform for Tunisians to express their needs and ideas on health. In Sri Lanka, WHO has supported a community-based psychosocial intervention called “Manohari”, aimed at violence reduction. In Colombia, WHO-PAHO supported the reintegration of former combatants with health expertise into the health system, through medical training.

The resolution on health and peace that you will consider this week, if adopted, will further support the Secretariat's efforts to deliver health programmes in conflict-affected areas – programmes that also help to build peace.

Health is one of the few areas in which nations can work together across ideological divides to find common solutions to common problems, and build bridges.

You have a full agenda this week – from designing the health workforce of the future, to finishing the eradication of polio, to building a new architecture for global health security, and renewing the drive towards universal health coverage.

But none of it can truly succeed in a divided world. It can only succeed if countries work to put aside their differences; to seek common ground where it can be found; to collaborate where possible; to compromise where needed; to seek peace.

As John Lennon said, “You may say I'm a dreamer, but I'm not the only one.” Because unless we dream of a better world, we will keep waking up in this one. Unless we aim higher, we will land lower. Unless we sow solidarity, we will reap division. Unless we seek peace, we will find war.

Today, and every day, we have a choice – we make the choices. And today, and every day, we must choose health for peace, and peace for health. Peace, peace, peace.

## **OPENING ADDRESS (Second plenary session, 23 May 2022)**

Your Excellency Ahmed Robleh Abdilleh, Minister of Health of Djibouti and President of the Seventy-fifth World Health Assembly, excellencies, ministers, heads of delegation, dear colleagues and friends,

Yesterday, I made my remarks on the theme of health for peace and peace for health, which Member States will discuss in the general debate. I want to start today by looking back, to where we have been over the past five years.

You elected me five short years ago, with an ambitious agenda for universal health coverage; health emergencies; women's, children's and adolescents' health; the health impacts of climate and environmental change; and a transformed WHO. Those priorities evolved into the 13th General Programme of Work and the "triple billion" targets, which the Health Assembly adopted in 2018.

The WHO Results Report for 2020–2021 provides a detailed and interactive presentation of our work over the past two years against each of the "triple billion" targets. I commend it to you. But I also want to reflect on everything we have achieved together over the past five years.

Progress isn't always fast or easy to measure. But in ways small and large, seen and unseen, I am proud to say that this Organization is making a difference.

Let me start with our efforts to see 1 billion people enjoying better health and well-being. Our projection is that we will almost reach this target by 2023, but progress is only about one quarter of what is required to reach the relevant Sustainable Development Goal targets.

Still, there are encouraging trends and successes to celebrate. In addressing the risk factors for noncommunicable diseases, many countries are making progress by reducing the use of health-harming products.

Tobacco use continues to decline. Since 2018, the number of countries on track to meet the target of a 30% reduction in tobacco use between 2010 and 2025 almost doubled, from 32 to 60 countries.

We also see encouraging progress against our target to eliminate industrially-produced trans fat from the global food supply by 2023. Since we launched our REPLACE initiative in 2018, mandatory policies prohibiting the use of industrially-produced trans fat have been introduced in 58 countries accounting for 40% of the world's population.

And in the past five years, more than two thirds of Member States have either introduced or increased excise taxes on at least one health-harming product, such as tobacco, alcohol or sugary drinks.

At the same time, WHO has supported countries to create the environment and living conditions in which health can flourish. At the 26th Conference of the Parties to the United Nations Framework Convention on Climate Change (COP26) last year, more than 50 countries agreed to take concrete steps to develop climate-resilient, low-carbon health systems. We issued new air pollution guidelines, setting new limits for air quality based on mounting evidence of the harms to health of air pollution at even lower concentrations than previously thought.

Seventy-one countries are now using WHO guidelines or tools on the health response to violence against women. Road deaths have stabilized, despite a continued rise in the number of cars. And the

Global Network for Age-friendly Cities and Communities was expanded, supporting more than 1300 cities in 52 countries to become better places in which to live and age.

Now to our efforts to see 1 billion more people benefiting from universal health coverage by 2023.

We are far behind, and progress is less than one quarter of what is required to reach the billion target. Even before the pandemic, we estimated that only 270 million more people would be covered by 2023 – a shortfall of 730 million people against the target of 1 billion. Disruptions to health services during the pandemic have sent us backwards, and we estimate the shortfall could reach 840 million.

Nevertheless, we have many achievements to be proud of over the past five years in our work to strengthen health systems and respond to communicable and noncommunicable diseases.

At the political level, we saw two major commitments, with the Astana Declaration on Primary Health Care in 2018, and the political declaration of the high-level meeting on universal health coverage at the United Nations General Assembly in 2019.

WHO's Special Programme on Primary Health Care is now supporting 115 countries, compared with 30 five years ago. Since 2015, 95% of these countries have made progress towards increased service coverage.

We have also seen encouraging trends in our work to strengthen the global health workforce. Between 2013 and 2020, the number of health workers globally increased by 29%. Previously, we projected a global shortage of 18 million health workers by 2030. That projected shortage has now shrunk to 15 million – but it is still a massive shortage.

In the past five years, we have also made significant progress in expanding access to medicines and other essential health products. We have prequalified 53 vaccines, 50 in-vitro diagnostics and 288 medicines, including important new therapies for HIV, hepatitis, tuberculosis, malaria, neglected tropical diseases and COVID-19. We also prequalified two biosimilar cancer medicines and launched a pilot programme to prequalify human insulin, to make these life-saving but expensive therapies more affordable and accessible.

During the pandemic, we gave Emergency Use Listing to 12 COVID-19 vaccines and 28 in-vitro diagnostics. Within 15 days of Emergency Use Listing of vaccines, 101 countries issued their own regulatory authorization, illustrating the weight that these countries place on WHO's stamp of approval.

We have assessed regulatory systems in 80 countries, and supported 10 new countries to develop to higher regulatory levels, including four in Africa: Egypt, Ghana, Nigeria and Tanzania.

Recognizing that almost 90% of Member States report the use of traditional medicine, just last month we established the Global Centre for Traditional Medicine in India, to create a reliable body of evidence and data for practices and products that many millions of people use.

On communicable diseases, WHO guidelines have supported major gains in HIV testing and treatment, resulting in a 32% decline in HIV mortality since 2016. We have validated 15 countries for the elimination of mother-to-child transmission of HIV and/or syphilis.

The Sustainable Development Goal target on hepatitis B has been met, and since 2015 the number of people who have received treatment for hepatitis C has increased 9-fold to 9.4 million, reversing the trend of increasing mortality for the first time.

On tuberculosis, 33 countries have reached the target for a 35% reduction in tuberculosis deaths since 2015, and 86 have achieved a 20% reduction in incidence. Since 2012, nine more countries have been certified as malaria free, and cases in the Greater Mekong have dropped by almost 90%.

And for the first time, we have a malaria vaccine. More than one million children in Ghana, Kenya and Malawi have now received at least one dose. Widespread use of this vaccine, as WHO recommended last year, could save tens of thousands of young lives, especially in Africa, every year.

In the past five years, 14 additional countries and territories eliminated at least one neglected tropical disease. Cases of African trypanosomiasis have declined by 90% in 10 years. Only 15 cases of Guinea worm disease were reported last year, compared with 3.5 million in the mid-1980s. Just two cases have been reported so far this year.

Our dream of a polio-free world is tantalizingly close, with four cases of wild poliovirus reported so far this year in Afghanistan and Pakistan – although two new cases in Malawi and Mozambique are a setback.

Since 2017, WHO and our partners in the Global Polio Eradication Initiative have provided 1.4 billion doses of polio vaccines to Member States at no cost. Our investments in polio will not end when polio ends. The infrastructure and expertise we have built is already being used to deliver other vaccines and health services, including for COVID-19.

And we have made significant progress in our response to antimicrobial resistance. High-level political leadership is essential to address the threat of antimicrobial resistance, which is why we established Global Leaders Group on Antimicrobial Resistance, chaired by Prime Minister Mia Mottley of Barbados and Prime Minister Hasina of Bangladesh.

Through WHO's Global Antimicrobial Resistance and Use Surveillance System (GLASS), the number of countries collecting and sharing data on antimicrobial resistance has tripled, and we have seen a six-fold increase in the number of samples collected and analysed globally.

The Antimicrobial Resistance Multi-Partner Trust Fund was established, and is now supporting 11 countries to implement their national action plans. And in 2020, the Antimicrobial Resistance Action Fund was set up to overcome funding barriers for antibiotic development. This year it made its first investments in the development of two antibacterial medicines.

On noncommunicable diseases, over the past five years WHO has supported 36 countries to integrate services to prevent, detect and treat noncommunicable diseases into primary health care programmes, and we have supported 25 countries with rehabilitation services.

More than 3 million people in 18 countries have gained access to treatment for hypertension, with increasing use of the WHO HEARTS package of interventions. More than 30 countries have developed policies or programmes to improve access to childhood cancer care. We've supported more than 40 countries to introduce human papillomavirus (HPV) vaccines for the first time, as part of the Cervical Cancer Elimination Initiative. And we have supported 31 more countries to integrate mental health services into primary health care. Child survival has improved dramatically over the past 20 years,



although 54 countries are off track to meet the child survival targets of the Sustainable Development Goals.

Now to our work on emergencies. It's clear that the world was – and remains – unprepared for a pandemic.

Every month, WHO processes more than 9 million pieces of information, screens 43 000 signals, reviews 4500 events, and verifies an average of 30 events. In the past five years, WHO has responded to more than 120 emergencies – cyclones, volcanoes, earthquakes, outbreaks, wars – and a pandemic. Some last a few months; some last for years. As we speak, my colleagues are responding to more than 50 emergencies around the world. In many cases, WHO is the first to arrive and the last to leave.

Since 2017, we have shipped more than US\$ 1.6 billion worth of medical supplies all over the world, working with partners to support critical health emergency supply chains. The WHO Logistics Hub in Dubai has expanded 10-fold.

Through the Access to COVID-19 Tools (ACT) Accelerator, WHO and our partners have delivered more than 1.5 billion vaccine doses, enabling 40 countries to begin their COVID-19 vaccination campaigns, as well as 159 million tests and US\$ 222 million worth of therapeutics.

For the first time, we established a Division of Emergency Preparedness, which supported countries to prepare for thousands of mass gatherings, from the Olympic and Winter Olympic Games, to COP26 and the Dubai Expo.

We have introduced the universal health and preparedness review, which has now been tested successfully in four Member States: Central African Republic, Iraq, Portugal and Thailand, with support from a further 21 Member States.

And just last year, we created the Division for Health Emergency Intelligence and Surveillance, which has created the WHO Hub for Pandemic and Epidemic Intelligence, in Berlin. This will build on our existing work by harnessing cutting-edge technologies and innovations in data science, and by fostering greater sharing of data and information between countries with a “collaborative intelligence” approach.

The Secretariat remains committed to supporting all Member States technically, operationally and logistically to continue responding to this pandemic, and to prepare for future health emergencies.

All of these achievements, across the “triple billion” targets, have been supported by the new Divisions of Science and Data and Delivery for Impact, which we created in 2019.

The Science Division has supported the development of hundreds of guidelines and other normative products. During the pandemic, WHO introduced a “living guidelines” approach, which cut the average time to production of guidance from as much as nine months to as little as five weeks. WHO also established the mRNA technology transfer programme in South Africa to support countries to build local manufacturing capacity, using cutting edge technology.

The Division of Data and Delivery for Impact has supported countries to improve their data systems through WHO's SCORE technical package, and consolidated data in the World Health Data Hub.

Last year, we broke ground on the WHO Academy in Lyon. Already the Academy is offering several training courses, attracting strong interest. For instance, the Academy's mass casualty management programme has now been successfully delivered in 14 countries, reaching more than 100 hospitals.

The Global Action Plan for Healthy Lives and Well-being for All has helped strengthen collaboration among 13 multilateral agencies on primary health care and other areas in more than 50 countries.

Underpinning all of these achievements is the transformation journey that we have been on for five years. There have been many calls for WHO to change. And there is no question that more change is needed. But this is an Organization that has changed, and is still changing, introducing the concept of continuous improvement.

We have built a new strategy, moving from a focus on outputs to outcomes; new processes, to make us more effective, efficient and agile; a new operating model, moving from a fragmented organization to one that is more integrated, aligned and agile; a new approach to partnerships, moving from risk aversity to risk management; a new approach to financing, towards more sustainability and predictability; and a new culture, based on shared values of service, professionalism, integrity, collaboration and compassion. The pandemic has put our transformation to the test. It has shown the value of the changes we have made, and areas where we must continue to improve.

We have more work to do to deliver the results, the efficiency, the accountability, and the transparency that you, our Member States, expect – including being an Organization with zero tolerance for sexual exploitation, abuse and harassment, and zero tolerance for inaction against it.

I provide regular and full updates on our work on the prevention and response to sexual exploitation, abuse and harassment to Member States regularly, and a detailed report on our management response plan is in my report to this Assembly. Be assured of my complete personal commitment to this issue. We are implementing wide-ranging changes to our Organization, which you will hear more about in my report on this issue later this week.

Looking back, we have achieved so much together over the past five years. We have many reasons to be proud. But we still face many challenges. So we must look down, to see where we are now.

As I said yesterday, the pandemic is far from over. And even as we continue to fight it, we face the task of restoring essential health services, with 90% of Member States reporting disruption to one or more essential health services.

One of the most common is immunization. The number of children receiving no doses of DTP vaccine has barely changed for a decade, until 2020, when it jumped by more than 25%, taking us back to the 2005 level.

Progress on sexual and reproductive health, including maternal mortality, remains slow. One in three women will suffer physical or sexual violence in their lifetime. Hypertension causes one third of all deaths, but only half of cases are diagnosed, and less than half of those are treated. The pandemic has led to a massive increase of 28% in depression and 26% in anxiety disorders globally.

Malaria-related deaths have been increasing since 2015, and tuberculosis deaths rose last year for the first time in a decade. In 2020, the number of people receiving treatment for a neglected tropical disease fell by 25% as a result of health service disruptions caused by the pandemic.

Only 20% of national antimicrobial resistance action plans are fully funded, most in higher income countries. Since 2000, the number of people globally who face financial hardship because of out-of-pocket health spending has increased by 75%, to close to 2 billion people.

The needs of our world remain daunting and complex. But none of these challenges are insurmountable. For every challenge, there are solutions. If there is a will, there is a way.

So how will we harness those solutions to overcome the challenges we face, and accelerate progress towards the “triple billion” targets and the Sustainable Development Goals?

We have looked back, to where we’ve come from; we have looked down, at where we are. Allow me now to look forward, to where I believe we need to go in the next five years.

At the meeting of the Executive Board in January – thank you to our Chair of the Board, Dr Patrick Amoth – I outlined my five priorities for the next five years.

Since then, the Secretariat has been further developing how we will work with Member States to deliver on these priorities, which we are now describing as follows:

Promoting health – by addressing the root causes of disease and creating the conditions for good health and well-being;

Providing health services – by reorienting health systems towards primary health care as the foundation of universal health coverage;

Protecting health – by strengthening the global architecture for health emergency preparedness, response and resilience;

Powering progress – by harnessing science, research, innovation, data, and digital technologies;

And performing – by building a stronger WHO that delivers results, and is reinforced to play its leading role in global health.

First, promoting health. Realizing our vision for the highest attainable standard of health starts not in the clinic or the hospital, but in schools, streets, supermarkets, households and suburbs.

Much of the work that you do as Ministries of Health is dealing with the consequences of poor diets, polluted environments, unsafe roads and workplaces, inadequate health literacy, and the aggressive marketing of products that harm health. We need an urgent paradigm shift, towards promoting health and well-being and preventing disease by addressing its root causes.

Globally, only 3% of health budgets are spent on promotion and prevention. And yet increased investment in these areas could reduce the global disease burden by half, generating massive returns for individuals, families, communities and nations. We are calling on every government to put the health of its people at the centre of its plans for development and growth.

In the next five years, WHO is committed to supporting all Member States to focus attention on the highest-impact transformations: to decarbonize your health sectors; to implement air quality standards; to reduce car dependence and promote public transport; to ensure all health facilities have electricity, and safe water and sanitation; to improve diet, nutrition and food safety; and in particular to stop the rise in obesity in 24 high-burden countries by 2025; and to reduce consumption of health-harming products.

The second priority is providing health services – by reorienting health systems towards primary health care as the foundation of universal health coverage.

At present, health spending in most countries is imbalanced towards secondary and tertiary care, with huge amounts spent on expensive equipment and medicines that often deliver modest health gains. By contrast, 90% of essential health services can be delivered through primary health care; and we estimate that investing in primary health care could increase global life expectancy by as much as 6.7 years by 2030.

We need a radical shift to accelerate progress towards universal health coverage, with a significant increase in investments in primary health care in all countries – high-, middle-, and low-income. We have seen globally that the weakness is in primary health care.

Crucially, we call on all Member States to ensure that seeking health care is never a source of financial hardship. The Secretariat's proposed target therefore is to support 25 countries to halt the rise in financial hardship caused by out-of-pocket health spending by 2025.

The third priority is protecting health – by strengthening the global architecture for health emergency preparedness, response and resilience.

In response to the request from the Executive Board, and in consultation with Member States, the Secretariat has prepared a proposal for a more equitable, inclusive and coherent global architecture. This proposal synthesizes and builds on more than 300 recommendations from the various reviews of the global response to the pandemic. The international accord, which Member States are now negotiating, will provide a vital overarching legal framework, under which we make 10 recommendations, in three key areas.

First, we need governance that is coherent, inclusive and accountable. Second, we need stronger systems and tools to prevent, detect and respond rapidly to health emergencies. And third, we need adequate and efficient financing, domestically and internationally.

Underpinning these proposals, we need a stronger and sustainably financed WHO at the centre of the global health security architecture. I will return to this in a few moments. The Secretariat looks forward to your feedback on this proposed architecture, but more importantly, to building it with you.

Our fourth strategic priority is powering progress – by harnessing science, research, innovation, data and digital technologies.

Advances in science and research are constantly pushing back the boundaries of the unknown and the impossible, increasing our understanding, and opening new possibilities. Innovations in health products and service delivery offer give us hope of overcoming challenges that once seemed insurmountable.

Developments in big data and machine learning are helping us to see who is being left behind and where the biggest gaps are, and to track progress against our targets. And digital technologies offer huge potential for delivering health services in new ways, to more people, especially in hard-to-reach areas.

To pick up the pace towards the “triple billion” targets and the Sustainable Development Goals, we must pick up the pace and scale at which science, research, innovations and digital technologies are adopted and implemented.

Equity is key: the best science and innovations are those that make the biggest difference to people who are furthest behind. This cannot be left to chance, goodwill or market forces. The Secretariat’s proposal for the next five years is to support the scaling of at least five innovations that reach at least five million people each.

The fifth priority is performing – by building a stronger WHO that delivers results, and is reinforced to play its leading role in global health.

The pandemic has demonstrated why the world needs WHO, but also why the world needs a stronger, empowered and sustainably financed WHO. Many of you have said it more eloquently – thank you so much.

I welcome the recommendation of the Working Group on Sustainable Financing to increase assessed contributions to 50% of the core budget over the next decade. I would like to use this opportunity to thank Björn Kümmel for his incredible leadership, all members of the Working Group’s bureau, and all Member States for your support.

I also welcome the recommendation to consider a replenishment model, to broaden our financing base, and to provide more flexible funding for the programme budget.

These recommendations could completely transform this Organization. For many months I have said that fixing WHO’s financing was a case of now or never. If adopted by this Health Assembly as I hope they will be, you will have given your answer. You have chosen now.

I thank all Member States for their commitment over the last year and their engagement in the negotiations. It has been tough, but you have made it. We recognize and agree that with increased trust comes increased responsibility.

The Secretariat welcomes the Working Group’s recommendation to further strengthen governance, transparency, accountability, efficiency and compliance, and we look forward to working with the Member States task team to move this forward. We will work day and night to deliver on these issues.

A key priority for the next five years is to further strengthen our work in our country offices. I assure you that all roads will lead to the countries, based on country priorities.

Mr President, excellencies, dear colleagues and friends,

We have looked back, at where we have been. We have looked down, at where we are. And we have looked forward, to where we must go.

Now, I invite you to look up. How will we overcome the many challenges we face, and reach the targets we set for ourselves? It takes good data; it takes good planning; it takes good science; it takes strong political commitment. But more than anything else, it takes hope – the belief that things can be better.

As President Milanović of Croatia said yesterday, the President of the very first World Health Assembly, held in 1948, was a Croat, Dr Andrija Štampar. Dr Štampar was a visionary, and one of the architects of the WHO Constitution, including its timeless preamble. In his address to that first Health Assembly 74 years ago, Dr Štampar said this:

It is obvious that we cannot proceed to the solution of health problems in the same way in all countries. Each country has its own peculiarities, and what may be good for one may not be so good for another. But one basic truth applies to all of them, and that is that every individual has a fundamental right to health.

It is that right to health for which this Organization has been striving for three quarters of a century. And it is that right to health for which we will continue to strive; for which I will continue personally to strive, because health is a fundamental human right. It's an end in itself, and a means to development.

Thank you so much and I look forward to working with you. Thank you for your confidence and support.

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