World Health Organization

SEVENTY-SIXTH WORLD HEALTH ASSEMBLY **A76/3**
Agenda item 3 **26 May 2023**

Address by Dr Tedros Adhanom Ghebreyesus, Director-General

HIGH-LEVEL WELCOME (First plenary session, 21 MAY 2023)

Your Excellency Ahmed Robleh Abdilleh, President of the Seventy-fifth World Health Assembly, Excellency Alain Berset, President of the Swiss Confederation, Excellency Filipe Nyusi, President of Mozambique, Right Honourable Jacinda Ardern, former Prime Minister of New Zealand – between jobs, Gianni Infantino, President of FIFA, Renée Fleming our brand new Goodwill Ambassador for Arts and Health, who is joined by Pretty Yende from South Africa, Members of the Global Scrub Choir, Excellencies, Ministers, heads of delegation, dear colleagues and friends,

First, let me begin by thanking Your Excellency President Berset for your personal support and partnership, and for Switzerland's continued support and partnership for WHO and global health.

My thanks also to Your Excellency President Nyusi, for being with us today, and for your commitment to health, including your championship on malaria and your country's journey towards universal health coverage.

My thanks to Your Excellency former Prime Minister Ardern, for your leadership in global health, and especially for your humble leadership. That's what we want from all our leaders – humble leadership. Thank you so much for being the model of that.

Thank you, Your Excellency Minister Abdilleh, for your leadership of the Seventy-fifth World Health Assembly, which is very historic.

Thank you, Mr Infantino, for your partnership in harnessing the power of the beautiful game for health, and my congratulations on the 119th birthday of the Fédération Internationale de Football Association today. Happy birthday FIFA.

And my thanks to Renée Fleming and the Scrub Choir for inspiring, moving and entertaining us, through the powerful medium of music.

Thank you all for being with us today, for this historic World Health Assembly in WHO's Seventy-fifth year.

Excellencies, dear colleagues and friends,

In 1977, Ali Maow Maalin was a 23-year-old working as a hospital cook in the port of Merca, Somalia. In addition to his duties in the kitchen, Maalin had worked as a vaccinator in WHO's smallpox eradication programme, which had hunted down the last remaining cases of smallpox among groups of nomads along Somalia's border with my country Ethiopia.

In October of that year, two children with smallpox from a nomadic group, or pastoralists group, were sent to an isolation camp near Merca. The driver who was transporting them stopped at the hospital where Maalin worked to ask for directions. Maalin offered to accompany them, and the driver asked if he was vaccinated. Maalin said, "Don't worry about that, let's go." He wasn't vaccinated.

Maalin was in contact with the infected children for 15 minutes. But that was enough. Nine days later he started to feel sick and developed a rash. He was diagnosed with chickenpox and sent home. But Maalin knew it wasn't chickenpox. He was too scared to go to the isolation camp, but a hospital nurse reported that he was sick.

The hospital stopped taking patients while everyone inside was vaccinated and put in quarantine. Meanwhile, a team started vaccinating everyone surrounding Maalin's home – more than 50 000 people in two weeks.

Ali Maow Maalin was the last recorded case of naturally occurring smallpox. He went on to work with WHO in the polio eradication campaign in Somalia. He used to say that Somalia was the last country to get rid of smallpox, and he wanted to make sure it wasn't the last to get rid of polio, and he was right. In 2013, during a campaign to counter a flare-up of polio, he contracted malaria and died a few days later, aged 59.

The campaign to eradicate smallpox was launched in 1959 by WHO Director-General Dr Marcolino Candau, and ended officially in 1980 with the Health Assembly's declaration "that the world and all its people have won freedom from smallpox". Dr Candau is from Brazil, by the way, and today I wanted to use my speech to recognize all our former Directors-General. I will talk about Dr Gro Harlem Brundtland later. It remains the greatest achievement in the history of public health, and the only human disease to have been eradicated to date.

But today we stand on the threshold of eradicating two more diseases: polio and Guinea worm. When the Global Polio Eradication Programme was launched in 1988 under Director-General Hiroshi Nakajima of Japan, there were an estimated 350 000 cases a year. So far this year there have been just three cases. And when the Guinea Worm Eradication Programme began in 1986, there were an estimated 3.5 million human cases in 21 countries. Last year, just 13 cases were reported from four countries. We will finish the job. We must. But our work will not be done.

I grew up next door to Maalin, in Ethiopia. In Africa, we are all neighbours. One of my earliest memories is walking with my mother through the streets of Asmara – then Ethiopia, now Eritrea – and seeing posters about a disease called smallpox and an organization that was eradicating it from our communities.

I had never heard of smallpox before. I had never heard of the World Health Organization. I couldn't have pointed to Geneva on a map. But I knew that sometimes, diseases could sneak up on children and snatch them away.

I knew, because that's what happened to one of my brothers, my younger brother. I don't know what disease took him. Maybe measles. But most probably he was taken by a disease that could have been prevented with a vaccine.

Vaccines drove smallpox into oblivion. But millions of children across Africa and around the world – children just like my brother – continued to be snatched away by diseases for which children in other countries were immunized.

That's why, in 1974, WHO launched the Expanded Programme on Immunization, to ensure all children, in all countries, benefited from the life-saving power of vaccines, initially for six major diseases: diphtheria, pertussis, tetanus, polio, measles and tuberculosis.

At the time, only about 10% of the world's children received three doses of DTP vaccine. Thanks to the Expanded Programme on Immunization, or EPI, it reached 86% in 2019, but has slipped since then owing to the disruptions of the coronavirus disease (COVID-19) pandemic, and the very big campaign of anti-vaxxers.

Today, more than 30 diseases are vaccine-preventable, and EPI recommends 12 as essential for every country. Through WHO's support for countries to ensure access to vaccines for all children, we are helping to avert more than 4 million deaths every year.

Vaccines are among the most powerful innovations in human history. Thanks to vaccines, once-feared diseases like diphtheria, tetanus, measles and meningitis can now be easily prevented.

Vaccines now give us hope of eliminating cervical cancer; vaccines are helping us to snuff out Ebola virus disease outbreaks faster; for the first time, we can say that malaria is a vaccine-preventable disease; vaccines were critical in ending COVID-19 as a global health emergency; and vaccines have brought us to the threshold of eradicating polio.

For more than 20 years, millions of children around the world have enjoyed the benefits of vaccines thanks to the work of Gavi, the Vaccine Alliance. And for the past 12 years, that work has been led by my friend and brother Seth Berkley, who is stepping down in August.

Under his leadership, Gavi introduced new vaccines against cervical cancer, malaria, pneumonia, meningitis, polio, and reached the incredible milestone of immunizing 1 billion children. During the pandemic, Seth was a champion of vaccine equity through Gavi's partnership in COVAX, which supplied nearly 2 billion vaccine doses to 147 countries. I offer Seth my deep gratitude for his leadership and partnership, and I look forward to working with his successor, Dr Muhammad Pate, to realize the power of vaccines for even more children. So I would like to say welcome to my brother Muhammad Pate.

The demise of smallpox coincided with the realization that achieving the founding vision of WHO for the highest attainable standard of health for all people could not be achieved one disease at a time. It would require a holistic approach that delivered the health services people need, where and when they need them, but that also improved health literacy, nutrition, water and sanitation and other drivers of disease.

It was an approach we now know as primary health care, and its chief architect and advocate was WHO's third Director-General, Dr Halfdan Mahler. By the way, he has a T as his middle initial, which stands for Theodore, so we share the same name.

Under Dr Mahler's leadership, the term "Health for All" was first coined as the theme of the World Health Assembly in 1977. And under Dr Mahler's leadership, the Declaration of Alma-Ata was negotiated and adopted in 1978 – a landmark commitment to primary health care as the platform for achieving a bold vision: Health for All by the year 2000. It was a milestone in public health that changed the way countries thought about, designed and delivered health services – and continues to do so.

Although the vision of Health for All by 2000 was not realized, its spirit and ambition persisted, and today the concept of primary health care remains the bedrock of our shared commitment to universal health coverage.

Five years ago, I had the honour to join our colleagues from UNICEF and Ministers of Health from around the world in Kazakhstan, the birthplace of the Declaration of Alma-Ata, to renew our commitment to its vision in the Declaration of Astana. Dr Mahler later described the adoption of the Declaration of Alma-Ata as a "sacred moment" and a "sublime consensus".

But in 1981, just three years after Alma-Ata, and just one year after the World Health Assembly declared smallpox eradicated, a new threat emerged, the likes of which the world had never seen before. In the United States, the first cases were reported of a mysterious new illness – an illness that appeared first in gay men, and within months was reported around the world, affecting people of all ages and sexualities. It was not for another two years that the cause of this new disease was identified – a retrovirus we now know as HIV.

HIV presented a new challenge for WHO; a challenge it did not always meet successfully. It highlighted the fact that a global health challenge of this scale and speed could not be met by one agency alone, but required WHO to work with partners across the United Nations system and beyond. It also highlighted in a new and stark way the vast inequities in global health. When the first antiretroviral treatments became available in 1987, only high-income countries could afford them.

By the turn of the century, the severity of the global HIV epidemic prompted the United Nations Security Council to adopt a resolution on HIV, the first time it considered a health issue as a threat to global security.

But the inequities continued. By 2003, only 400 000 people were receiving antiretroviral medicines in low- and middle-income countries. Since the smallpox eradication campaign, WHO had developed proven know-how in getting essential medicines to people who needed them, wherever they were. And so, under the leadership of then Director-General Dr LEE Jong-wook, from the Republic of Korea, WHO launched the "3 by 5" initiative – to get antiretroviral medicines to 3 million people by 2005.

It took an extra two years to reach the target, but "3 by 5" laid the platform for the dramatic expansion in access to antiretroviral medicines that has turned the tide on HIV. Sadly, Dr LEE did not live to see the accomplishment of his vision. Tomorrow marks the anniversary of his passing, in May 2006.

For most of the first 50 years of its history, WHO's work was focused mainly on infectious diseases afflicting low-income countries. But throughout those decades, a new pandemic was spreading almost unchecked, fuelled by the deadliest non-infectious agent in history – tobacco.

The link between smoking and lung cancer was proved by the British researcher Richard Doll in 1952, shortly after WHO was founded, but smoking prevalence continued to climb for decades. Indeed, some of the photos from WHO's early years show men in offices – and yes, they were mostly men – sitting at their desks, smoking.

It was not until 1988 that Dr Mahler banned smoking inside WHO buildings. He smashed his own ashtray with a hammer in the WHO lobby, and pledged to stop smoking. And it was only in 2013 that our entire headquarters campus became smoke-free. The manager of the Tobacco Free Initiative at the

time, Dr Armando Peruga, was even roughed up a couple of times by WHO staff for telling them not to smoke on campus.

Some countries made their own efforts to curb the harms of tobacco, but it became clear that unlike localized disease outbreaks, tobacco was a global threat that demanded a global response. WHO's founders had foreseen this need in Article 19 of our Constitution, which enabled Member States to adopt conventions or agreements on any health threat.

But it was a provision that lay dormant until the mid-1990s, when an American lawyer, Dr Ruth Roemer, first proposed the idea of an international treaty on tobacco control. Dr Roemer had herself been a heavy smoker, and for a short time her husband had worked for WHO. Dr Roemer proposed her idea to Neil Collishaw, who was then the head of WHO's tobacco control unit. Collishaw was supportive, but skeptical. Adopting a convention would require a two thirds majority of Member States, and at the time, only about 10 countries had strong tobacco control policies.

But Dr Roemer wouldn't take no for an answer. That's how many of the best ideas in global health happen, and there's often a woman behind them. Bit by bit, the idea gained traction, and in 1996, the Forty-ninth World Health Assembly adopted a resolution calling for an international framework convention on tobacco control.

However, like too many resolutions, it was slow to become a reality. It was another two years before the idea began to move forward, driven by a new Director-General with a strong commitment to the fight against tobacco, and political experience as Norway's Prime Minister – Dr Gro Harlem Brundtland. No sooner had Dr Brundtland taken office than she established the Tobacco Free Initiative and began advocating relentlessly for the framework convention.

But she was up against a wily and well-resourced enemy. You know what I'm saying. In 1999, it emerged that for many years tobacco companies had been infiltrating WHO by paying consultants to undermine WHO's work. Staff at the Tobacco Free Initiative even began checking for wire taps. The tactics were unnerving, but they did not work.

Negotiations on the framework convention began in 2000 and went on for two-and-a-half years. Finally, twenty years ago today, on 21 May 2003, and almost 30 years after Dr Roemer first proposed the idea, the Fifty-sixth World Health Assembly adopted the WHO Framework Convention on Tobacco Control, or FCTC.

In the 20 years since then, thanks to the WHO FCTC and the MPOWER technical package that supports it, smoking prevalence has dropped by one third globally. Two thirds of the world's population is now protected by at least one MPOWER measure. The WHO FCTC is living proof of the power of global agreements to drive a paradigm shift in global health.

Dr Brundtland is with us today, and I would like you to join me in thanking her for her leadership, and the legacy she has left. Thank you Gro, tusen tak.

The adoption of the WHO FCTC coincided with the first of a series of outbreaks, epidemics and pandemics that have marked the first two decades of the 21st century, and that have been significant in shaping the WHO of today.

In February 2003, the first cases were reported of a strange new respiratory disease caused by an unknown pathogen that later proved to be a coronavirus. Sound familiar? It was the outbreak of severe

acute respiratory syndrome (SARS). Around the same time, the first human cases of avian influenza A(H5N1) were reported, sparking fears of an influenza pandemic caused by a virus that killed six in 10 it infected. Although SARS and H5N1 both caused global panic, neither caused a global pandemic, thanks in no small part to Dr Brundtland's strong leadership.

Her leadership was also instrumental in the major revision of the International Health Regulations that followed, which included the provision for a Director-General to declare a public health emergency of international concern. Although she never needed to use that provision herself, her successor, Director-General Dr Margaret Chan, from China, did four years later, when a new influenza virus sparked the first pandemic of the 21st century: influenza A(H1N1).

While H5N1 was highly pathogenic but not highly transmissible, H1N1 was the other way round. Although it spread rapidly around the world, it caused largely mild disease and, for a pandemic, relatively few deaths. Nevertheless, H1N1 exposed a dangerous breach in the world's defences against pandemics. Vaccines were developed rapidly, but by the time the world's poor got access, the pandemic was over.

That experience led to the development, under the leadership of Dr Chan, of the Pandemic Influenza Preparedness (PIP) Framework, a historic commitment between Member States to work together in the face of an influenza pandemic to share virus samples and vaccines. But the ink was barely dry on the PIP Framework when a new and deadly epidemic erupted, caused not by influenza, but by one of the most feared viruses on earth – Ebola.

For more than two years, the world watched in horror as Ebola laid siege to West Africa. And although it never became a global pandemic, the West African Ebola virus disease outbreak highlighted the need for substantial reforms of WHO's work to prepare for and respond to emergencies.

That led, in 2015, once again under the leadership of Dr Chan, to the creation of the WHO Health Emergencies Programme, and the Contingency Fund for Emergencies – a flexible financing instrument that has enabled WHO to release more than US$ 350 million to respond rapidly to hundreds of emergencies over the past eight years.

Each of these outbreaks, epidemics and pandemics taught the world new lessons and resulted in new agreements and new tools to keep the world safer. But even so, the world was taken by surprise and found unprepared for the COVID-19 pandemic, the most severe health crisis in a century.

Over the past three years, COVID-19 has turned our world upside down. Almost 7 million deaths have been reported, but we know the toll is several times higher – at least 20 million. The pandemic has caused severe disruption to health systems, and severe economic, social and political upheaval.

COVID-19 has changed our world, and it must. In 2020, I described COVID-19 as a long, dark tunnel. We have now come out the end of that tunnel. To be clear, COVID-19 is still with us, it still kills, it's still changing, and it still demands our attention, but it no longer represents a public health emergency of international concern.

The end of COVID-19 as a global health emergency is not just the end of a bad dream from which we have woken. We cannot simply carry on as we did before. This is a moment to look behind us and remember the darkness of the tunnel, and then to look forward, and to move forward in the light of the many painful lessons it has taught us.

Chief among those lessons is that we can only face shared threats with a shared response. Like the WHO Framework Convention on Tobacco Control, the pandemic accord that Member States are now negotiating must be a historic agreement to make a paradigm shift in global health security, recognizing that our fates are interwoven.

This is the moment for us to write a new chapter in global health history, together; to chart a new path forward, together; to make the world safer for our children and grandchildren, together.

In the three quarters of a century since WHO was founded, the world has seen major improvements in health. Life expectancy globally has increased from 46 to 73 years, with the biggest gains in the poorest countries. Forty-two countries have eliminated malaria, we have pushed back the epidemics of HIV and tuberculosis, driven polio and Guinea worm to the brink of eradication and expanded access to curative treatment for hepatitis C. I would like to use this opportunity actually to thank the former President of the United States Jimmy Carter for his leadership and commitment to eradicating Guinea worm, which is very close.

In the past 20 years alone, maternal mortality has fallen by a third and child mortality has halved. In just the past five years, new vaccines against Ebola virus disease and malaria have been approved and are now saving lives.

Of course, WHO can't claim sole credit for these successes – the very nature of what we do involves working with partners to support innovation and countries as they implement policies and programmes that drive change. But it's difficult to imagine the world would have seen the same improvements had WHO not existed.

The challenges of today are very different from those we faced in 1948. Noncommunicable diseases now account for 70% of all deaths globally; tobacco still kills 8.7 million people every year; obesity rates have skyrocketed; the COVID-19 pandemic highlighted the huge burden of mental health disorders and the weakness of health services; antimicrobial resistance threatens to unwind a century of medical progress; vast disparities persist in access to health services, between and within countries and communities; and the existential threat of climate change is jeopardizing the very habitability of our planet. A climate crisis is a health crisis.

WHO also faces its own institutional challenges. Over the past 20 years the world's expectations of WHO have grown enormously, but our resources have not. Then there is the challenge of being a technical, scientific organization in a political – and increasingly politicized – environment.

These are daunting and complex challenges. We will not solve them at this Health Assembly, and we may not solve them in our lifetimes. But bit by bit, we are building a road that our children and grandchildren will walk down, and which they will continue to build. Sometimes the building is slow. Sometimes the road is meandering and rough. But the destination is sure, and is closer now than when our forebears began in 1948.

It is the destination that was envisioned by WHO's first Director-General, Dr Brock Chisholm from Canada, one of the fathers of the WHO Constitution: the highest possible level of health for all people.

I thank you.

OPENING ADDRESS (Second plenary session, 22 MAY 2023)

Honourable Chris Fearne, Deputy Prime Minister of Malta and President of the Seventy-sixth World Health Assembly, congratulations on your election, and I look forward to working with you very closely. Your Excellency, Excellencies, Ministers, heads of delegation, dear colleagues and friends,

As you know, just under three weeks ago I declared an end to COVID-19 as a public health emergency of international concern. It was a moment of relief and reflection.

It's encouraging to see life return to normal – to be able to hug a friend, to travel freely, and to meet together. We have been hostages of this virus for some time, so as I said, it's a relief. But at the same time, many of us continue to carry grief in our hearts – grief over those we have lost, grief at the terrible toll the pandemic has taken on families, communities, societies and economies, and grief that it didn't need to be this way. In particular, the pandemic has taken a heavy toll on mental health, including on many of our own staff, who like so many health workers around the world, have experienced severe stress and burnout.

The pandemic has confronted us with unprecedented challenges. And it has also demonstrated what our WHO is capable of.

Throughout the pandemic, your WHO has mobilized global expertise to provide technical and logistical tools to support you in your efforts to save lives. And through the Access to COVID-19 Tools (ACT) Accelerator, WHO and our partners delivered nearly two billion doses of COVID-19 vaccine, as well as tests, therapeutics, oxygen, personal protective equipment and other medical supplies.

The end of COVID-19 as a global health emergency is not the end of COVID-19 as a global health threat. Earlier this month, the Secretariat published the fourth edition of the global Strategic Preparedness and Response Plan for COVID-19, which outlines critical actions for countries in five core areas.

The threat of another variant emerging that causes new surges of disease and death remains. And the threat of another pathogen emerging with even deadlier potential remains. And pandemics are far from the only threat we face. In a world of overlapping and converging crises, an effective architecture for health emergency preparedness and response must address emergencies of all kinds.

This year's high-level meeting on pandemic prevention, preparedness and response is a valuable opportunity for leaders to chart a clear path forward towards that future. We cannot kick this can down the road. If we do not make the changes that must be made, then who will? And if we do not make them now, then when? When the next pandemic comes knocking – and it will – we must be ready to answer decisively, collectively and equitably.

The COVID-19 pandemic has had significant implications for the health-related targets in the Sustainable Development Goals, and each of the triple billion targets. More than 1 billion more people are now enjoying better health and well-being since 2018, but progress is insufficient to reach the related targets of the Sustainable Development Goals by 2030.

On universal health coverage, we have made progress and closed gaps, and since 2018, 477 million more people are enjoying the benefits of universal health coverage. But on current trends, fewer than half the world's population will be covered by the end of the Sustainable Development Goals era in 2030, meaning we must at least double the pace.

And on emergencies, the COVID-19 pandemic has shown that it's not 1 billion people but 8 billion people who need to be better protected. The pandemic has blown us off course, but it has shown us why the Sustainable Development Goals must remain our north star, and why we must pursue them with the same urgency and determination with which we countered the pandemic.

Despite the many setbacks we have faced, we also have many achievements of which to be proud. Last week the Secretariat published its Results Report for 2022 on the WHO website, presenting a comprehensive, detailed and interactive account of our work, with country stories from around the world. I commend it to you. It's impossible to do justice to the huge range of accomplishments in 2022, but the Results Report highlights key achievements that are symbolic of our work in all its diversity.

I would like to highlight a few, according to each of the "five Ps" that I outlined at last year's Health Assembly: promoting, providing, protecting, powering and performing for health. The first set of highlights relate to the first P, promoting health, by preventing disease and addressing its root causes. One of the key ways in which countries are doing that is through the use of health taxes in the fight against noncommunicable diseases.

Between 2017 and 2022, 133 Member States increased or introduced a new health tax on products that harm health, including tobacco and sugary drinks. For example, with advocacy and technical support from WHO, Timor-Leste last year increased its tax on tobacco from US$ 19 a kilogram to US$ 50 a kilogram, and already this year has increased it again to US$ 100 a kilogram – one of the largest tobacco tax increases achieved anywhere.

Elsewhere, Mauritius and Finland introduced plain packaging, Oman will do so this year, and Tunisia increased health warnings to 70% of the front and back of tobacco packaging. Sierra Leone introduced some of the toughest tobacco controls in the world, Ukraine expanded its smoke free laws to ban the use of e-cigarettes and heated tobacco products in public places, and Kazakhstan introduced a new tax policy on heated tobacco products. Well done to each of these countries.

We also see encouraging progress in eliminating industrially-produced trans-fats from the global food supply. Since we launched our REPLACE initiative in 2018, we have seen a six-fold increase in the number of people protected by WHO-recommended policies on the use of industrially produced trans-fats, from 550 million people to more than 3.7 billion. Just in the past six months, Bangladesh, Nigeria and the United Arab Emirates have implemented trans-fats policies, and Argentina, Egypt, Mexico, Paraguay, Philippines and Ukraine are all preparing to introduce their own policies in the next two years.

Many countries have also made impressive progress in reducing salt intake, a leading risk factor for cardiovascular disease. For example, over the past 10 years, Sri Lanka has reduced average salt consumption per capita by almost 20%, with support from the WHO country office.

On climate change, at the 27th Conference of the Parties to the United Nations Framework Convention on Climate Change last year, we launched the Alliance for Transformative Action on Climate and Health, which is supporting 65 countries to build climate resilient and climate-friendly health systems. For example, with support from WHO, Guinea has begun assessing emissions from its health sector and is developing a plan to reduce them.

In addition to all of this work, we continue to support countries to build healthier populations by increasing physical activity, improving road safety, fostering healthy ageing, and so much more.

Now to the second set of highlights, which relate to the second P, providing health, by reorienting health systems towards primary health care as the foundation of universal health coverage.

The high-level meeting on universal health coverage at the United Nations General Assembly in 2019 was a historic commitment by world leaders to realize the vision of health for all. Little did we know then that COVID-19 was just around the corner. The second high-level meeting on universal health coverage at this year's United Nations General Assembly is therefore a vital opportunity to refocus political attention and financial investments on accelerating progress.

Strong primary health care is especially vital for delivering life-saving services for maternal and child health, including routine immunization. Between 2019 and 2021, an estimated 67 million children missed out on at least one essential vaccine, including 48 million children who missed out entirely. In response, WHO and our partners have launched "The Big Catch-up", a global effort to increase vaccination levels in children to at least pre-pandemic levels by the end of this year, and to protect those who missed out.

Despite the setbacks of the pandemic, many countries have continued to make progress in maternal and child health. The Democratic People's Republic of Korea, Indonesia, Maldives, Sri Lanka and Thailand have all achieved Sustainable Development Goal targets in reducing neonatal mortality, under-five mortality, and the same five countries, plus Bhutan, also achieved the 2030 target on stillbirths.

We are also proud to note the impressive progress countries have made in the promotion, protection and support of breastfeeding. In 2022, 48% of children below 6 months were exclusively breastfed, getting close to the target of 50% set by the Health Assembly.

And we continue to support research to improve care for pregnant women. Last year, WHO reviewed evidence from trials in 20 countries that showed for the first time that immediate skin-to-skin care, or kangaroo mother care, can save almost one third of children born preterm. And a WHO-led study showed that implementing a set of interventions at the same time, instead of consecutively, was able to reduce severe postpartum haemorrhage by 60%, and reduce the chance of death.

The new WHO compendium Promoting the health of refugees and migrants: experiences from around the world showcases dozens of country case examples from 44 Member States that demonstrate real progress in addressing the unmet health needs of refugees. Over the longer-term, it is a priority to mainstream care for refugees and migrants into broader national plans, supported by partnerships within countries and internationally.

One of the most important investments in primary health care and universal health coverage is investment in health workers. Five years ago, WHO projected a shortfall of 18 million health workers globally by 2030. That projected shortfall has now reduced to 10 million, but the African and Eastern Mediterranean regions bear an increased share of the shortage.

If we are to get anywhere near the Sustainable Development Goal target of universal health coverage by 2030, we must close that gap, by supporting all countries to build the health workforce they need. This is not something that each country does on its own; it's something countries must do together. We call on all countries to respect the Global Code of Practice on the International Recruitment of Health Personnel, and in particular to protect the 55 countries on the recently updated Support and Safeguards List against international recruitment, which is draining those countries.

We're also working hard to support countries to deliver lifelong training to continuously improve health worker competencies and quality of care. Just last month we launched the global 25x25x25 campaign, which aims to provide access to basic emergency care training for 25% of nurses and midwives from 25 countries by the end of 2025.

And with the strong support of France, we continue to achieve key milestones on the establishment of the WHO Academy, with our new building scheduled to be completed in seven months, and the first release of learning programmes scheduled for later this year. This will have a significant contribution to building country capacity.

One of the other most important elements of universal health coverage is access to essential medical products, and 2022 saw the introduction and rollout of several important new tools. For tuberculosis, we launched new WHO guidelines recommending the first all-oral treatment regimens for multidrug-resistant tuberculosis, reducing treatment time from 18 months to 6 months. So far, 109 countries have started using these new regimens, based on WHO guidelines.

But recognizing that we can only end tuberculosis with effective vaccines, earlier this year we also established a ministerial-level TB Vaccine Acceleration Council, to bring new vaccines to market as quickly as possible. If there is a will, there is a way. It was done for COVID-19; it can be done for tuberculosis.

As we approach the high-level meeting on tuberculosis at this year's United Nations General Assembly, we are asking leaders to commit to concrete targets over the next five years, on diagnosis, treatment, vaccine development, social protection, financing and research and innovation.

Last year we also published new guidelines on the use of long-acting injectables for preventing HIV – a potential game-changer for those most at risk. So far, based on WHO guidelines, six countries have approved the use of long-acting injectables – Australia, Botswana, Malawi, South Africa, the United States and Zimbabwe – and approval is under way in another 12 countries, plus in the European Union.

And following WHO's recommendation for widespread use of the RTS,S malaria vaccine in 2021, more than 1.5 million children have now received it in Ghana, Kenya and Malawi. Among those vaccinated, we see a 30% reduction in severe malaria, and a 10% drop in child deaths. We estimate that one death is prevented for every 200 children vaccinated. Put simply, this vaccine is changing the course of malaria, and as a malariologist, I'm really happy. At least 28 more countries in Africa are planning to introduce it, starting this year. A second vaccine is under review by WHO, and if recommended for use, could help to close the gap between demand and supply, and reduce costs – so more accessible than the one we have.

As I said yesterday, vaccines are among the most powerful innovations in history. Vaccines have extinguished smallpox, pushed polio to near eradication, and tamed multiple other diseases. And vaccines are bringing the dream of eliminating cervical cancer within reach. Since WHO's Call to Action to eliminate cervical cancer in 2018, nearly 50 more countries introduced the human papillomavirus vaccine into their national immunization programmes, including 41 lower-middle income countries. We continue urging all countries to scale up services to meet the 90-70-90 targets by 2030.

Even as we work to expand access to essential medicines and vaccines around the world, we are also continuing our work to protect precious medicines against the threat of antimicrobial resistance. For the first time, Ministers of Health and Ministers of Agriculture from around the world came together

in Oman last year to agree on a target to reduce the use of antimicrobials in the agri-food system by 30% by 2030.

Next year's high-level meeting on antimicrobial resistance will be crucial for mobilizing political and financial commitment to meet those and other targets. I would like to use this opportunity to thank the Prime Minister of Barbados for her leadership of the Global Leaders Group on Antimicrobial Resistance, and also Deputy Prime Minister Chris Fearne of Malta.

Finally, as I mentioned earlier, the pandemic has exposed the huge burden of mental health. The WHO Special Initiative for Mental Health has supported nine countries to increase access to mental health services for over 5.2 million people who previously were not able to access them.

The third set of highlights relate to the third P, protecting health by strengthening the global architecture for health emergency preparedness and response. In addition to COVID-19 and mpox, last year WHO responded to 70 graded health emergencies from floods in Pakistan, to Ebola in Uganda, the war in Ukraine, cholera outbreaks in more than 30 countries and complex emergencies in the greater Horn of Africa, northern Ethiopia and the Sahel.

A crucial enabler of our response was the Contingency Fund for Emergencies, which was established following the West African Ebola virus disease outbreak in 2014 and 2015. Last year, the Contingency Fund released almost US$ 90 million in as little as 24 hours to support the rapid response to emergencies.

Already this year we have allocated more than US$ 37 million to fund our response to the earthquakes in the Syrian Arab Republic and Türkiye, the conflict in Sudan and more. Our Global Logistics Hub in Dubai, United Arab Emirates processed almost 600 shipments to 90 countries, and I would like to use this opportunity to thank the United Arab Emirates for its support, starting with His Highness the President. Last year we also launched the first consolidated WHO Global Health Emergency Appeal, and in January we launched this year's appeal, for US$ 2.5 billion.

Just as we continue to respond to emergencies around the world, so we are continuing to work with Member States and partners to strengthen the global architecture for health emergency preparedness and response. One of last year's key achievements in this regard was the establishment in November of the Pandemic Fund at the World Bank, with technical leadership from WHO. The Fund has an initial budget of US$ 1.6 billion, and has already approved US$ 300 million for the first round of funding, to support catalytic and gap-filling financing for pandemic preparedness and response around the world.

The Pandemic Fund is just one of many initiatives that WHO and Member States are undertaking to make our world safer against health emergencies: for enhanced accountability, the Universal Health and Preparedness Review; for enhanced surveillance, the WHO Hub for Pandemic and Epidemic Intelligence, and the newly launched International Pathogen Surveillance Network; for an enhanced emergency response workforce, the Global Health Emergency Corps, launched just last night with my good friend Minister Lauterbach and Chris Elias from the Gates Foundation; for enhanced sharing of biological samples, the WHO BioHub System; for enhanced monitoring, the Global Preparedness Monitoring Board; for enhanced governance, amendments to the International Health Regulations (2005); and for enhanced international cooperation, the pandemic accord – a generational commitment that we will not go back to the old cycle of panic and neglect that left our world vulnerable, but move forward with a shared commitment to meet shared threats with a shared response.

That's why we say the pandemic is a generational commitment: a commitment from this generation is important because this generation experienced how awful a small virus could be.

The end of COVID-19 and mpox as public health emergencies of international concern means polio remains the only official global health emergency. After an all-time low of five polio cases due to wild poliovirus in 2021, we saw an increase last year, with 20 cases in Pakistan, two in Afghanistan and eight in Mozambique. So far this year, there have been three reported polio cases due to wild poliovirus, including one from Pakistan and two from Afghanistan just last week.

WHO and our partners remain steadfastly committed to finishing the job of consigning polio to history. Last year, 3 million children previously inaccessible in Afghanistan received polio vaccines for the first time. And in October, donors pledged US$ 2.6 billion to support the push for eradication.

At the same time, as part of the transition of polio resources, more than 50 countries have integrated polio assets to support immunization, disease detection and emergency response. We must make sure that the significant investments in polio eradication do not die with polio, but are used to build the health systems to deliver the services that these communities so badly need. After all, we haven't truly helped a child if we protect her from polio but she dies from measles.

The fourth set of highlights relate to the fourth P, powering health, by harnessing the power of science, research, innovation, data and partnerships to deliver impact.

The mRNA vaccine technology transfer hub in South Africa is a perfect example, as part of our commitment to strengthen local production and enhance pandemic preparedness and response globally. I visited the mRNA hub in 2021, shortly after it was created, and had the opportunity to return for the official launch just one month ago. The progress is remarkable. The hub has now started transferring technology to manufacturers in 15 countries, supported by the biomanufacturing training hub in the Republic of Korea, which has trained 300 staff in low- and middle-income countries. The mRNA technology transfer programme holds huge promise, not just for vaccines against COVID-19, but also for other diseases including HIV, tuberculosis, malaria and more.

Vaccines are powerful tools, and so are data. Central to our efforts to track progress towards the health-related Sustainable Development Goals is our work to strengthen health information systems in countries, to generate and analyse reliable data to inform the best health policies and programmes.

One of last year's key data products was our estimate of excess mortality from COVID-19. Based on consultations with Member States, and working with partners across the United Nations and scientists around the world, we estimated 14.9 million excess deaths in 2020 and 2021. Last year we completed the beta version of the World Health Data Hub, providing a single source for publishing health data – the first time in our history. And during this Assembly we will be launching DataDot, the public-facing portal of the World Health Data Hub.

The final set of highlights relates to the fifth P, performing for health, by building a stronger and sustainably financed WHO. Your decision last year to transform WHO's financing model was a landmark towards strengthening and empowering WHO to fulfil its role as the leading and directing authority on global health.

Thank you so much for that truly historic decision, which will bring a huge return to saving lives. In return, you asked the Secretariat to implement reforms on budgetary, programmatic, finance and governance processes, and accountability. Working with you, we developed the Secretariat

implementation plan, with 96 actions, which the Executive Board endorsed in January. So far, we have implemented 42 actions, and 54 are ongoing, and I assure you of my commitment to be more aggressive in implementing the remaining actions.

We are also continuing in our efforts to transform the way this organization prevents and responds to sexual misconduct, and to achieve gender equality. For the first time in WHO's history, we have reached overall gender parity for staff across all appointment types and categories of positions.

At the end of last year, we held a global management meeting involving all our country representatives, Regional Directors and headquarters leadership. The main outcome was the establishment of an Action Results Group, led by country representatives, which has developed an ambitious 100-day plan with 100 actions, in seven critical areas, including a core country presence, delegation of authority, and adequate financial and human resources, including through mobility.

To support these efforts, I have squeezed US$ 100 million from our budget to allocate to country offices. But in order to sustain this commitment, we look to Member States to approve the 20% increase in assessed contributions at this Health Assembly.

Your Secretariat is making the changes you asked for. Now, we ask you to honour your commitment to increase assessed contributions, to enable us to deliver the long-term predictable programming in countries that will deliver the results we all want to see.

Many of my colleagues will be disappointed that I was not able to mention their area of work. The highlights I have given you, though extensive, barely scratch the surface of everything we have achieved across the world in the past year, or everything that we're doing.

Some of it makes the headlines; most of it doesn't. Some of it attracts the attention of donors; and some of it doesn't. But in so many ways and in so many places, your WHO is working to promote, provide, protect, power and perform for health – the five Ps.

I leave you with three requests. First, I urge every Member State to work with the Secretariat to identify concrete ways to pick up the pace of progress on the triple billion targets and health-related Sustainable Development Goals.

Second, I urge every Member State to engage constructively and urgently in negotiations on the pandemic accord and the International Health Regulations, so that the world will never again have to face the devastation of a pandemic like COVID-19.

And third, I ask you to support the increase in assessed contributions, as well as plans for an investment round in 2024.

As we celebrate WHO's 75th anniversary, let us commit to do even more together to promote health, keep the world safe, and serve the vulnerable. Thank you so much.

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