Director-General

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Report to the Executive Board, 122nd session

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Mister Chairman, members of the Executive Board, excellencies, ladies and gentlemen,

First and foremost, let me wish you, your families, and the populations you represent all the best for a healthy new year. On balance, I believe we have some good reasons to be optimistic about the prospects ahead.

However, we are seeing right now some stark evidence of the threat to health arising from instability and civil unrest. Such conditions disrupt routine health services and compromise special initiatives, as we have seen repeatedly with polio eradication.

I am concerned, in particular, about the situation in Kenya, where support is urgently needed to ensure the continuity of routine health services and programmes for HIV/AIDS, malaria, tuberculosis, and other diseases.

I am also concerned about the grave situation in Gaza. Infectious diseases are not the only problem. Disruptions in the continuity of essential services take a heavy toll on people needing emergency care and those suffering from conditions such as cancer, heart disease, and diabetes.

I want to take this opportunity to commend the Iraqi government for its survey of health conditions conducted under extremely challenging conditions. Data from this survey of family health help draw the attention of world leaders to the impact of conflict on health services and patterns of morbidity and mortality, including deaths from violent causes.

Mr Chairman,

In my report, I will review some of the main events and trends over the past year that have shaped the challenges we face, both within countries and as an international community. I will then discuss specific agenda items for this session in terms of their place within this broader context of events and trends.

Before doing so, I must address, head on, a matter that concerns you greatly, as we have just heard from the Chair. This is the late release of documents. We rely on the January session of the Board to prepare the way for an efficient Health Assembly. You cannot do this work properly when so many key documents arrive late.

You have heard some explanations. Let me emphasize one. In the last half of 2007, WHO hosted three intergovernmental meetings, including one held in Bangkok in July and two held in Geneva, almost back-to-back, in November. This is an unprecedented number of formal governance meetings. Servicing these meetings placed an unprecedented strain on our capacities.

As I said, there are some explanations. But in the end, there are no excuses. As the chief administrative and technical officer of this Organization, I must accept personal responsibility. I look forward to reviewing this important issue, with your help, so that we can have timely documentation in the future.

That said, let me turn to a review of recent events and trends.

For the high-mortality diseases, we had some good news last year, but much of this news is qualified. For HIV/AIDS, new estimates from UNAIDS and WHO indicate that global HIV incidence peaked in the late 1990s. Moreover, the number of people dying from AIDS-related illness declined over the past two

treatment. We are not doing enough to prevent mother-to-child transmission. Some governments are still closing their eyes to infections in high-risk groups.

For tuberculosis, control efforts are paying off. After more than a decade of steady increase, the global annual incidence of the disease appears to have stabilized in some parts of the world and may now be declining. Again, this is good news but let us put it in perspective. TB remains a major killer, responsible for around 1.4 million preventable deaths each year.

The spread of multi-drug resistant TB is a cause of particular concern, especially in Eastern Europe, parts of Central Asia, and China. Even more alarming is the recent emergence of extensively drug-resistant TB worldwide. This form of TB is difficult to detect, even with sophisticated laboratory tests. It is extremely difficult and expensive to treat. Its emergence reminds us to be prepared for setbacks arising from the constantly changing microbial world.

We need to remember that both of these high-mortality diseases now impose their greatest burden on Africa. The same is true for malaria. Progress will not be measured by global averages. It will be measured by how well we improve the health of the African people. For malaria, we have many reasons for optimism. About a decade ago, observers of the malaria situation had one positive comment. The malaria situation is stable, they said. It could hardly get any worse.

This no longer applies. In just the past few years, the political and public profile of malaria has risen to unprecedented heights. I see solid reasons for optimism in the strength of international commitment, in the power of existing interventions, and in the coherence of evidence-based strategies for implementation.

But the best reason for optimism comes from the results we are seeing in some African countries, particularly following better coverage with bednets and use of the newer strategy for home-based management. New tools, most notably a vaccine, would allow us to raise the bar of expectations, but we are already seeing solid progress using existing tools.

I believe this is the right way to move forward for malaria and many other diseases: use existing tools for an immediate impact, while stimulating R&D to develop the tools that can support far more ambitious goals.

Again, this sense that the stage is set for malaria results must be qualified. We have strong evidence demonstrating the superior efficacy and safety of artemisinin-based combination therapies, but ACT drugs cost 20 to 40 times more than conventional treatments. For a disease that takes its heaviest toll on impoverished rural families in Africa, price can be an absolute barrier to access. For me, one of the most encouraging trends in public health today is the power of commitment to unleash the best of human ingenuity. Let me give just one example. UNITAID, which draws funds primarily from a levy on airline tickets, began operating in 2006 as a facility for purchasing drugs and diagnostics for AIDS, TB, and malaria.

This facility is not only purchasing large quantities of interventions. It is already showing additional benefits arising from the guarantee of a large and predictable market. UNITAID has provided an incentive for product improvements, including paediatric formulations for AIDS and TB drugs.

Establishment of a rotating stockpile of second-line drugs for TB serves as an incentive for manufacturers to increase their production capacity and develop pre-qualified products. Large procurement volumes have secured substantial price reductions. In partnership with the Clinton Foundation, UNITAID has brokered average price reductions of 40% for HIV/AIDS drugs.

Several partners are now considering an innovative funding facility for making ACTs more affordable. This approach involves heavily subsidized prices at the point when these drugs leave the manufacturer, thus cutting prices for both the public and private sectors.

This is the kind of hard-nosed pragmatism that gets results in public health. It looks at the reality of conditions in the developing world, identifies the forces that shape the reality, and then outsmarts them. If price affects access, make the price of the best products competitive, and thus drive ineffective, substandard or counterfeit products off the market. We must keep such approaches in mind as we consider broad ways to improve access to essential medicines.

Progress in combating the neglected tropical diseases – the high-disability diseases – brings us more good news. The strategies are increasingly consolidated, streamlined, and cost-effective, and they are

China and Egypt announced the elimination of lymphatic filariasis, a disease that currently disables some 40 million people. Other countries are on the verge of similar achievements. These are victories, not just for health, but also in our struggle to free people to live productive lives.

For many other priority diseases, trends such as globalization and urbanization have introduced a commonality to health problems seen in every part of the world. More and more, health problems are being shaped by the same powerful forces. This similarity in health challenges was readily apparent during the Regional Committees, where certain items appeared on every agenda.

Countries in all regions are concerned about emerging and epidemic-prone diseases. All recognize the significance of the revised International Health Regulations. All regions know we have moved a big step forward in terms of our collective security, but they also recognize the responsibility this places on countries, as well as on this Organization at all three levels.

Many Regional Committees also addressed the threat posed by avian influenza. This season has again given us some stark reminders that the threat of an influenza pandemic has by no means diminished.

Countries in all regions are very deeply concerned about the rise of chronic diseases. The impact is now being felt in very poor countries, where we see morbidity from conditions such as hypertension and diabetes side-by-side with high mortality from infectious diseases. We see severe malnutrition and stunting side-by-side with obesity.

The health-related Millennium Development Goals were on every agenda, usually together with progress reports. Progress is mixed, but all regions see difficulty in meeting the goal set for reducing maternal mortality.

This concerns me deeply. We must continue to make the health of women a high priority. As a cause for optimism, last year’s major conference, on Women Deliver, held in London, brought together the energy, the commitment, and the knowledge for change.

We should not be surprised that improved maternal health is such a difficult goal to reach. Maternal mortality will not go down until more women have access to skilled attendants at birth and emergency obstetric care. The need for a well-functioning and inclusive health system is absolute.

Moreover, the causes of maternal mortality are broad and closely linked to social and economic factors. There is no single pill, bednet, or vaccine that can guarantee results. In this regard, I look forward to the report of the Commission on Social Determinants of Health, which will be released later this year.

Fortunately, countries in all regions have recognized the need to strengthen health systems and are giving this issue high priority. They understand the reality: money, good intentions, and good interventions are not enough. If we want health to work as a poverty-reduction strategy, we must reach the poor. Countries desperately need better delivery systems to do so.

There is a closely related problem: the financing of health care, the lack of schemes for social protection, and the growing reliance on private-sector providers. Again, if we want health to reduce poverty, we cannot allow the costs of care to drive impoverished households even deeper into poverty. Many Regional Committees addressed the severe problem of reliance on out-of-pocket payment to cover health care costs.

Mr Chairman,

If I were asked to pick the events during the past year that meant the most to me, I would chose three.

First, development partners, UN agencies, and funding facilities now recognize the necessity of investing in health systems. This is a striking and welcome change from the past. We saw this new emphasis most explicitly during the September launch of the International Health Partnership. We also see it in policy shifts at the Global Fund, the GAVI Alliance, and the World Bank. Clearly, the problem of weak health systems includes the shortage of human resources as well as issues of infrastructure and financing.

Second, climate change is now accepted as a reality by world leaders. It was the job of scientists, and not of public health, to make the case for taking this threat seriously. But now that the case has been convincingly made, public health must move onto the scene in full gear. Up to now, the polar bear has been the poster child for climate change. We must use every scientifically sound and politically correct mechanism in the book to convince leaders that humanity really is the most important species

This is just a dozen years away. Our sector has good evidence about what droughts, floods, storms, heatwaves, air pollution, malnutrition, displaced populations, and water-borne and vector-borne diseases mean for health.

My third reason for personal encouragement is this: primary health care is making a comeback on the development agenda. It is being revisited, partly in the context of stalled progress in meeting international goals. Hopefully, it is also being revitalized.

Last year I attended the first in a series of regional conferences devoted to primary health care. Primary health care will be addressed in this year's World Health Report, which marks the 30th anniversary of the Declaration of Alma-Ata and the 60th anniversary of WHO.

This revival of interest in primary health care pleased me most especially. I believe we will not be able to reach the health-related Millennium Development Goals unless we return to the values, principles, and approaches of primary health care. I believe we must reach these Goals, as the ability of countries to adapt to climate change will depend on the state of population health and the systems in place to protect it.

Mr Chairman,

Let me turn now to some internal changes that will take place this year. These are reforms mandated by Member States with the aim of improving the Organization's performance. I know these matters are important to you. I have followed the discussions of the Programme, Budget and Administration Committee with great interest and I am grateful for this guidance.

First and foremost, I wanted during this first year to get all three levels of the Organization working together in seamless harmony. This is the very foundation for efficient performance, and I believe we have made some good progress on this front. In this regard, I want to thank the Regional Directors and all country representatives for their commitment and hard work.

I have previously expressed my commitment to results-based performance and financial discipline. The planning framework for the new biennium is an improvement over past years, as it reinforces the results-based approach this Organization has taken.

My predecessors set the course to modernize managerial and administrative procedures. I fully appreciate the need to make WHO a fit-for-purpose organization, with the flexibility and efficiency demanded by rapidly changing challenges.

The Global Management System will become operational this year. This system will vastly increase transparency and accountability. It is a unifying tool for work at all three levels. And it is an efficiency tool for the management of programme and human resources.

I am aware that implementation of a change of this magnitude carries risks. Implementation will not take place in seamless harmony. There is a bumpy road ahead. I have put in place mechanisms to ensure close monitoring of implementation, and risks will be managed as they arise. I accept this responsibility as part of my job.

Mr Chairman,

Let me make some comments about items on our agenda. Public health has only a few opportunities to improve this world in permanent ways. You will be considering reports on two of these opportunities: the eradication of polio and the eradication of guinea worm disease.

Both initiatives have pushed previously widespread diseases into just a few small corners of the world. Indeed, we have these diseases cornered in a final stand-off. We must finish the job.

Let me thank our many partners, in both initiatives, for their steadfast commitment and support.

For both efforts, we face a substantial funding gap. For polio, as you will know from the report, this is one milestone in the final stretch that has not been met.

For guinea worm disease, the report gives an estimate of the funding needed to finish the job. Eradication of this disease is being achieved not by a powerful drug or vaccine, but by behavioural

encouragement becomes all the more important given the rise of chronic diseases, where behavioural change is vital for prevention.

You have before you two reports on the progress of international negotiating bodies. Both are addressing highly complex issues.

The intergovernmental meeting on pandemic influenza is seeking a timely, fair, transparent, and equitable system for the sharing of viruses and the sharing of benefits.

The intergovernmental working group on public health, innovation and intellectual property is seeking to influence the dynamics of supply and demand in industries that are largely driven by market forces. That is a tall order.

It is good that these complex issues are being considered so thoroughly with such broad participation in the intergovernmental bodies.

I have already referred to the importance of the International Health Regulations, our need to respond to climate change, and the alarming rise of chronic diseases.

You will consider a report on strategies to reduce the harmful use of alcohol. As a starting point for your discussions, this report catalogues the broad range of damage, at many levels of health, associated with the harmful use of alcohol. This is a problem we need to take very seriously.

Items on the international migration of health personnel and on female genital mutilation have been considered by previous sessions of the Board. For both, we still have some important problems to solve.

You will also consider the health needs of people who leave their home countries seeking refuge or a better life abroad. This is another trend influenced by globalization.

Mr Chairman,

I have saved what I believe is the most exciting and encouraging report for last. This is the global immunization strategy, developed jointly by WHO and UNICEF in collaboration with many Member States and immunization partners.

As we all know, childhood immunization has long been one of the biggest success stories in public health. In the 1980s, coverage reached a high level and then stagnated, facing stubborn obstacles like those we see in the last stretch of polio and guinea worm eradication.

These obstacles have been overcome and the results have been spectacular. The figures set out in the report speak for themselves. Progress in 2006 was record-breaking. I believe it is useful to look at what lies behind this achievement and what it promises for the future.

Immunization generally does the best job of delivering interventions to hard-to-reach populations, even in the absence of a well-functioning health system. Progress has been most impressive in low-income countries, especially in sub-Saharan Africa.

Immunization programmes are increasingly delivering other essential interventions, such as bednets, vitamin A supplements, and deworming tablets. This is a value-added approach that reduces the operational costs per child reached.

We see strong support from governments and from the GAVI Alliance. We have a range of proven strategies, such as the reaching every district, or RED strategy. Innovative ways have been devised to generate substantial new funds. We see impressive progress in the introduction of new and underutilized vaccines, with even more new vaccines expected within the next 10 years.

Increasing population coverage has reinvigorated the vaccine market. It has also stimulated R&D for new vaccines for diseases prevalent in the developing world. The entry of more manufacturers from developing countries, with products pre-qualified by WHO, is also changing the dynamics of the market. The immunization strategy has provided an incentive for building stronger and more comprehensive systems for disease surveillance and programme monitoring.

With these thoughts, Mr Chairman, I will now place this 122nd session of the Executive Board in your competent hands.

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