

**Report by the Director-General to the
Executive Board at its 126th session
Geneva, Switzerland, 18 January 2010**

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

Thank you, all around this table, for honouring the memory of our colleague, Dr Ali, Somalia's minister of health. This tragedy touches us in yet another way. The bombing occurred during a graduation ceremony at a medical school in Mogadishu. Six years of medical training vanished together with several of those lost lives. WHO has been supporting that medical school, and we will continue to do so.

I know you will join me in expressing our deep condolences to the people of Haiti and our gratitude to the many who are rushing to provide assistance. The loss of life cannot be reliably estimated at present, but is at least 50,000 and rising. Already, this disaster ranks among the most devastating and logistically challenging in recent history. We are seeing the difficulties that arise when disaster strikes an already disastrous public health situation.

Many of the problems we try to prevent after a disaster were already present in Haiti. These include diseases associated with poor water and sanitation systems, low immunization coverage and widespread malnutrition, outbreaks of infectious diseases, a high prevalence of HIV/AIDS and tuberculosis, and erratic delivery of medicines and care.

The almost unbelievable damage to infrastructure extends to hospitals and health centres. The WHO premises were damaged, but we are operational. A WHO/PAHO team of specialists is on the ground and is spearheading the health response to the earthquake.

The first priorities are to assess the nature and magnitude of emergency health needs, to treat the injured, to recover bodies, and to set up surveillance for infectious diseases. Offers of help continue to pour in. But aid must closely match urgent health needs and be tightly coordinated. This is part of WHO's job. We have every reason to be concerned about the health of survivors.

Making hospitals safe during emergencies was the theme for last year's World Health Day. One point is obvious. When infrastructures are already weak, the vulnerability of populations to disasters is vastly increased.

This strong link between weak infrastructures and capacities and the vulnerability of populations applies to many other areas of public health.

Ladies and gentlemen,

We are at the start of the second decade of the 21st century. And we are just five years away from 2015. A report on progress towards the health-related Millennium Development Goals is on your agenda.

Several other reports describe activities that are contributing to achievement of the Goals or point to specific challenges that need to be addressed. As these reports show, progress in individual countries tends to be greatest in the better-off populations. We are still not doing enough to improve life for the most vulnerable and the poorest of the poor.

At the international level, the picture is mixed, and the African region must continue to be a focus of particular concern. But there are many bright and motivating examples of success everywhere.

Some of these examples come from big-picture trends. Towards the end of last year, WHO and other agencies issued substantial reports on trends for HIV/AIDS, tuberculosis, malaria, vaccines and immunization, and the health of children.

You will be familiar with the positive trends in all these areas. The progress is sometimes fragile, threatened by factors ranging from drug resistance to uncertain funding for the future. But the trends are definitely positive. While optimism about the malaria situation must be cautious, this is the first time, in decades, that we are getting some good news. This, too, is progress.

We can all be proud that the drive to reach international health commitments has never faltered, even at a time of multiple global crises on multiple fronts.

Apart from these big-picture trends, reports prepared for this session cover many specific indicators of progress. Vitamin A supplementation has been implemented as a life-saving measure in 66 of 68 countries with a high burden of child deaths. Since 2000, measles deaths have dropped by 78%. As the report on this item concludes: measles eradication is achievable. If we want to do this, we can.

By 2007, 98% of reported tuberculosis cases were being diagnosed and treated in DOTS programmes. WHO Child Growth Standards have been adopted by more than 100 countries. This, in turn, has led to increased investment in programmes to reduce undernutrition, but also to tackle the growing problem of childhood obesity. As I have said on many occasions, what gets measured gets done.

Ten years into this new century, we are seeing signs that aid for health development can bring solid results. Equally important, in the drive to reach a limited number of time-bound health goals, fundamental problems are being uncovered, and solutions are being found that benefit public health across the board.

We are making progress, as the reports before you show. We need to keep on setting our sights higher, aiming to do more, for more and more people.

Ladies and gentlemen,

For me, the best health news of the previous decade is the fact that the long overdue influenza pandemic has been so moderate in its impact. Had the pandemic taken another course, the agenda for this session would have looked very different. Had the virus mutated to a more virulent form, we would not be talking about forging ahead. We would be standing still or dealing with serious setbacks.

We have been fortunate since the very emergence of the new H1N1 virus, and have remained fortunate up to now. The virus initially spread in countries with good surveillance systems. The honesty and speed of early reporting set the standard for the international response.

The virus did not mutate to a more virulent form. Resistance to oseltamivir did not become widespread. The vaccine proved safe and a close match with circulating virus. Things could have gone wrong in any of these areas.

We were fortunate in other ways. This is the first pandemic to occur since the revolution in communications and information technologies. For the first time in history, the international community could watch a pandemic unfold, and chart its evolution, in real time.

The amount of data that have been collected since April of last year, and the number of research reports and studies that have been published, have been remarkable. This quick collection of information has allowed WHO to issue treatment guidelines, track the epidemiology, and keep a close watch for mutations, including those that confer resistance to antiviral drugs.

When the history of this pandemic is written, I believe that the speed of actions taken by governments to protect their populations will earn the highest marks. Though the burden on emergency rooms and intensive care units has been heavy, nearly all health systems have coped well. Let me pay tribute to all the health care workers who have worked tirelessly to care for patients.

The early standard of rapid and transparent reporting was upheld, and the sharing of information, diagnostic support, test kits, and viruses has been commendably generous. To date, well over 23,000 viruses and other specimens have been submitted to WHO network laboratories for analysis.

During any public health emergency, health officials must make urgent, often far-reaching decisions in an atmosphere of considerable scientific uncertainty. Given our duty to safeguard public health, the tendency of officials facing such a situation is nearly always to err on the side of caution. I believe we would all rather see a moderate pandemic with ample supplies of vaccine than a severe pandemic with inadequate supplies of vaccine.

In some countries in the northern hemisphere with good surveillance systems, the pandemic appears to be easing. The worst may be over. But it would be unwise for anyone to reach firm conclusions before April, when the normal influenza season usually ends. There is still quite a lot of winter left.

In addition, we cannot predict what will happen between now and later in the year, when the southern hemisphere enters its influenza season and the virus becomes more transmissible.

Data for most parts of Africa are sparse. We are concerned that some countries in the western part of the continent remain susceptible to intense waves of transmission. We do not know for sure, but we are keeping a careful watch.

Population susceptibility to infection by a new virus drives the dynamics of an influenza pandemic. This is the critical question. Are there enough susceptible people left to sustain further waves of community-wide transmission? At present, we simply do not have enough data to answer this question with certainty. Studies are, however, under way.

We can estimate how much immunity has been conferred through vaccination. But knowing how much natural immunity has been acquired through infection is more difficult, especially given the very mild nature of illness in the vast majority of patients. Some infections produced no symptoms, and quick surveys of influenza-like illness will not capture these infections.

In short: I believe that what most countries are doing, that is, urging their populations to get vaccinated, is the prudent public health approach. Each country has to assess its own epidemiological situation and the needs and concerns of its citizens. For developing countries concerned about their lack of access to pandemic vaccines, WHO is ramping up its donation programme.

This pandemic has also been the first major test of the revised International Health Regulations. They have given the world an orderly, rules-based way to respond, and this has been an asset. With few exceptions, social and economic disruptions have been far less significant than feared. Another strength of the International Health Regulations is its system of checks and balances. They ensure that no one, myself included, has unfettered power.

Although the virus has not yet delivered any devastating surprises, we have seen some surprises on other fronts. We anticipated problems in producing enough vaccine fast enough, and this did indeed happen. But we did not anticipate that people would decide not to be vaccinated.

I mentioned the revolution in communications and information technologies. In today's world, people can draw on a vast range of information sources. People make their own decisions about what information to trust, and base their actions on those decisions.

The days when health officials could issue advice, based on the very best medical and scientific data, and expect populations to comply, may be fading. It may no longer be sufficient to say that a vaccine is safe, or testing complied with all regulatory standards, or a risk is real.

In my view, this is a new communications challenge that we may need to address. As the items on your agenda show, persuading people to adopt healthy behaviours is one of the biggest challenges in public health.

In terms of managing public perceptions, part of the problem arises from the big difference between what was expected, after watching the highly lethal H5N1 virus for so long, and what fortunately happened. An event similar to the 1918 pandemic was feared, when what actually happened is probably closer to the 1957 or 1968 pandemics.

Let me introduce a word of caution. Reliable estimates of the number of deaths and the mortality rate during the current pandemic will not be possible until one to two years after the pandemic has ended.

Let me reassure you on a final point. This has been the most closely watched and carefully scrutinized pandemic in history. We will have a wealth of new knowledge as a result. It is natural that every decision or action that shaped the response will likewise be closely and carefully scrutinized.

WHO can withstand this scrutiny.

Ladies and gentlemen,

I began this report with several examples of progress. Let us turn to some of the problems you will be addressing during this session. Despite the diversity of topics, the problems, the main obstacles to further progress, are remarkably the same.

The funding to sustain progress is precarious, and even more so for scaling up. The shortage of doctors, nurses, and other personnel needed to do the job is measured in the millions.

Countries lack fundamental laboratory capacity. Unsafe practices in hospitals abound, contributing, among other things, to the spread of viral hepatitis. Blood supplies are likewise often unsafe, of poor quality, or inadequate.

Countries lack critical support from regulatory and enforcement bodies. Countries lack reliable systems for data collection and information management. This is the absolute foundation for setting national priorities and monitoring progress.

Health services in the public sector are plagued by stockouts, poor working conditions, and staff shortages. In the private sector, the price of generic medicines is, on average, more than 600% higher than their international reference price. This is not a pretty picture, but this is the reality. This is what insufficient capacity means, also in costs.

Delivering interventions, like vaccines, medicines, condoms, bednets, and vitamins, clearly brings mortality down, sometimes very quickly. But this is not enough, and your reports make this point convincingly.

We face a dilemma. The Millennium Development Goals are results-oriented and time-limited, and have unquestionably spearheaded much progress. Donors are impatient, but capacity building takes time.

Ladies and gentlemen,

Last week, I convened an informal consultation of experts to look at the future of financing for WHO. Participants considered funding needs together with a very frank assessment of WHO's unique roles and functions, and its comparative advantages in today's crowded landscape of public health.

We are beginning to get a better grip on what countries expect from WHO, what WHO does well, some things that only WHO can do, and some things that are best left to others. This, in turn, could guide future financing decisions.

A report of the meeting will be circulated to all Member States and made publicly available for a web-based consultation. We anticipate that a paper reflecting the results of this consultation will be submitted to the Board within a year.

Global governance of public health was part of the discussions during that meeting. Many items on your agenda address transnational threats or deal with problems that are best managed at the international level.

This is true for public health, innovation, and intellectual property, and for the code of practice for the international recruitment of health personnel. This is true for the item on noncommunicable diseases, which includes recommendations on the marketing of foods and non-alcoholic beverages to

children. This is a world where an estimated 44 million pre-school children are overweight or obese. We have to take action.

This is true for the harmful use of alcohol. The report documents a wide and alarming range of harms, and also gives you a range of policy options and intervention measures, including at the regulatory level.

With the industrialization of food production and the globalization of its marketing, efforts to ensure food safety likewise take on an international dimension.

I know very well that you have come to the table with a diversity of views on these issues. Finding an agreed way forward is not easy. There are some strong economic dimensions as well as strong public health concerns, and many competing interests.

But WHO, I believe, is the right forum for these discussions and the right agency to take your decisions forward. Rest assured of full support from the Secretariat in these and all other deliberations.

Thank you.