

# **Keeping promises**

Accountability of Dr Margaret Chan  
during her first term as WHO  
Director-General



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## **Accountability of Dr Margaret Chan during her first term as WHO Director-General**

During 2006, to support my candidacy for the post of WHO Director-General, I issued a manifesto with a six-point agenda for leading the Organization forward. Specific commitments were made under each agenda item. I promised results and am holding myself accountable.

This document sets out my frank and personal assessment of achievements, setbacks, and remaining challenges, structured around the 22 specific promises I made prior to my election.

These commitments were personal and are not always formal WHO priorities, which are established by Member States. Some commitments addressed neglected problems. Others aligned with internationally agreed goals. Still others were “natural” choices as they reflect the traditional technical strengths of WHO.

Given the large number of agencies and initiatives working to improve health, many of the achievements described in this document cannot be attributed solely to the efforts of WHO. At the same time, WHO has unquestionably shaped the health agenda and gathered the technical expertise and guidance that have paved the way for other initiatives to move forward towards their goals.

Across the board, the greatest gains were made when governments gave health objectives high-level political support. In such cases, the job of WHO, at country, regional, and head office levels, has been to follow the country's lead, stepping in with technical support and guidance whenever needed or requested.

I am proud that WHO, as a custodian of vast technical expertise, can be called upon to provide this kind of support, and trusted to deliver it well.

Midway through my term, the world was rocked by financial, fuel, and food crises, all highly contagious and all with disruptive and lingering effects. I am equally pleased that the determination to improve health remained steadfast despite these jolts, though the task has, in some areas, become harder as funding has fallen.

As my first term in office draws to a close, I humbly submit this personal account of my promises made nearly six years ago, and the extent to which these promises have been kept.



Dr Margaret Chan  
Director-General, World Health Organization

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## 1. Development for Health

***Commitment:*** Accelerate existing initiatives to make pregnancy safer, integrate the management of childhood illness, and immunize children against vaccine-preventable diseases.

At the start of 2007, most experts agreed that progress towards the Millennium Development Goals for reducing childhood and maternal deaths had stalled. In some parts of the world, deaths during pregnancy and childbirth were actually increasing. The number of under-five deaths looked stubbornly stuck at more than 10 million, as had been the case for nearly six decades.

To its great credit, the international community faced this grim outlook, analyzed the causes, shifted gears, and redoubled its efforts, also on new fronts.

To expand the power of vaccines to save lives, innovative mechanisms were established to purchase more vaccines and guarantee a market for new vaccines that protect against pneumonia and severe diarrhoea, the two biggest killers of young children. With GAVI support, many countries added yellow fever, hepatitis B, rotavirus, and pneumococcal vaccines to their routine immunization programmes. For the rotavirus vaccine, the impact in early-adopting countries was dramatic, in some cases halving deaths from diarrhoeal disease.

The Decade of Vaccines was launched in 2010. The following year, leading drug companies announced significant slashes in vaccine prices for the developing world, including a 95% price reduction for the new rotavirus vaccines. Also in 2011, donors pledged more than \$4 billion to support the work of GAVI, an amount that exceeded expectations.

Despite these positive developments, several countries were reluctant to introduce expensive new vaccines into their routine immunization programmes, especially in the absence of an evidence base demonstrating their efficacy. To guide sound policy decisions, WHO supported research, funded in part by GAVI, to establish an evidence base, published in a 2012 supplement to the journal *Vaccine*, assessing the efficacy of oral rotavirus vaccines in a range of epidemiological settings.

Other research conducted by WHO established that childhood pneumonia could be more safely and effectively treated with antibiotics in communities and homes than in hospitals.

On another front, many countries heeded the WHO call to revitalize primary health care as an efficient and effective way to improve health outcomes while also tackling the broader determinants of health and disease. More than 100 countries are now using the Integrated Management of Childhood Illness approach as their principal strategy for child survival. The strategy has

recently integrated the management of HIV as part of child survival in Africa, the Americas, and South-East Asia.

Under the pressure of such a multi-pronged attack, under-five mortality dropped below 10 million deaths and continued to decline, year after year, with current estimates at 7.6 million.

This progress contrasts sharply with that for maternal and neonatal mortality. Neither group has a single powerful intervention, like vaccines or oral rehydration salts, that can make a path-breaking, game-changing difference in their chances for survival. This reality contributed to growing awareness that powerful interventions and the money to buy them will not improve health outcomes in the absence of well-functioning systems for their delivery. It is now well-established that maternal mortality will not go down until more women have high-quality clinical care at birth, delivered by skilled attendants, and access to emergency obstetric services when problems arise.

Recognizing the need to do more, the UN Secretary-General launched the Global Strategy for Women's and Children's Health in September 2010. The initiative generated \$40 billion in commitments, prompting a need to hold donors accountable for their promises and all partners accountable for results.

In a new model for global health governance, WHO established a commission charged with rapid preparation of a framework for ensuring accountability. The framework puts a multitude of stakeholders in a position to work in unison according to uniform methods, uniform operational approaches, and a small but balanced set of indicators for measuring results. In another ground-breaking innovation, the building of information capacity within countries, and especially systems for vital registration, goes hand-in-hand with the objectives of tracking resources and measuring results. Accountability means counting. Without this capacity, money for development assistance disappears in a black hole.

As a welcome by-product, commitment to the UN Global Strategy, also known as *Every woman, every child*, launched a wave of simple, ingenious innovations that can save lives in resource-constrained settings, including the Odon device for assisted delivery and the Safe Childbirth Checklist, both developed by WHO.

Viewed together, all of these developments and trends augur well for continuing progress.

***Commitment:*** Enhance WHO commitment to the target of universal access to HIV treatment, prevention and care.

The number of people in low- and middle-income countries receiving antiretroviral therapy for AIDS moved from an estimated 300,000 in late 2002 to more than 8 million at the end of 2011, an achievement unthinkable just a decade ago. Over the past nine years, HIV treatment expanded more than 25-

fold, representing the fastest scale-up of a life-saving intervention in history. Today, 47% of those in need are receiving antiretroviral therapy.

While WHO does not purchase or distribute these medicines, the Organization is widely credited with making this achievement possible. WHO advocated for action among countries and development partners, developed the technical guidelines and clinical protocols that made safe and effective treatment possible in low- and middle-income countries, and used the WHO prequalification programme to promote access to quality medicines and diagnostics. WHO also helped countries adapt their national guidelines and services to deliver treatment, and monitored and reported on progress. Today, low-income settings are achieving clinical outcomes equal to those in the most affluent societies, setting a new benchmark for quality care.

In 2011, the World Health Assembly approved a new HIV/AIDS strategy, which marked a turning point in the global response to this disease. The strategy articulates a more integrated and balanced approach that depends on the performance of other health programmes and contributes to their success. The strategy also places the HIV/AIDS response in the context of broader public health and development agendas.

Evidence continues to mount that antiretroviral therapy not only saves lives but is also a powerful preventive tool, giving the world its first real chance to get ahead of this devastating epidemic. New research indicates that early antiretroviral therapy reduces sexual transmission of HIV in serodiscordant couples by a striking 96%. The opportunity is further widened by evidence of the effectiveness of male and female condoms, harm reduction, behaviour change, and male circumcision.

Supported by WHO technical guidelines, initiatives have been launched to ensure that every baby is born HIV-free by 2015 and that their mothers are kept alive.

Unfortunately, funding shortfalls threaten to put a brake on continuing progress. The UN target of having 15 million people on treatment by 2015 can be met only if treatment scale-up is accelerated and people are retained on treatment.

***Commitment:*** Accelerate the momentum to control malaria, tuberculosis and ancient tropical diseases that anchor large populations in poverty.

Two decades ago, the only positive thing that could be said about malaria was that the situation was stable, as it could hardly get any worse. That assessment no longer applies. In recent years, malaria has experienced several “billion dollar” moments, measured as investments in research as well as in the purchase of medicines, treated mosquito nets, and insecticides for indoor residual spraying.

Over the past decade, scaling up the delivery of these interventions is estimated to have saved more than one million lives in Africa alone, with the majority of these deaths averted since 2007. Since then, more than 300 million treated mosquito nets have been distributed in Africa, enough to protect at least 600 million people.

High-level political commitment in endemic countries has contributed significantly to this success, as embodied in the African Leaders for Malaria Alliance. WHO supports their leadership with technical and policy advice as the malaria situation changes, the burden goes down, and national and regional goals become more ambitious. For example, Namibia is now leading a group of eight neighbouring African countries in a drive to eliminate malaria by 2015.

In 2010, WHO introduced a major policy change: testing to confirm malaria in all suspected cases should be done before initiating treatment; medicines should be dispensed only following diagnostic confirmation. This policy marked a striking departure from previous practice, when malaria was so common that every child with fever was presumed to have the disease and was given antimalarial drugs. The availability of sensitive and specific diagnostic tests, so simple they can be used at the community level, made this policy change possible.

Countries that have implemented this recommendation detect and manage other life-threatening childhood diseases that were previously missed, save the costs of unnecessary treatment courses, guard against the emergence of drug-resistant parasites, and have a much more precise understanding of the true disease burden and its geographical foci. Senegal, for example, has introduced the policy nationwide and is now saving a quarter of a million treatment courses each year.

Reflecting this progress and growing optimism, international conferences have been held to assess the prospects for eliminating, possibly even eradicating malaria, and to set out a research agenda that can help make this happen. In the meantime, WHO has issued a complete set of manuals for using existing tools to test, treat, and track cases. These manuals support country efforts to move towards universal access to diagnostic testing and antimalarial treatment, and to build stronger surveillance systems.

The results have been impressive. In 43 endemic countries, the number of malaria cases has been cut in half. The malaria map is shrinking. Since 2007, four countries have been certified as malaria-free by WHO. In 2009, for the first time, not a single case of falciparum malaria was reported in the European Region, and this trend continues.

WHO has consistently accompanied reports about progress in malaria control with warnings about the fragility of this progress and the need to stay one step ahead of this ancient, extremely complex, and stubborn disease, particularly in monitoring resistance to artemisinin and pyrethroid insecticides and

preventing the further spread of resistant parasites. WHO operates sensitive monitoring programmes for both forms of resistance.

Progress has also been good for tuberculosis, though again, this progress is fragile. The epidemic, declared a global emergency by WHO in 1993, has peaked and begun a slow but steady decline, demonstrating the effectiveness of the Global Plan to Stop TB. However, the yearly number of TB deaths remains unacceptably high at nearly 2 million, and inadequate diagnosis and care, in the private and public sectors, continues to drive the rise of multi-drug resistant and extensively drug-resistant strains. These resistant forms of TB are more difficult to diagnose, are around 200 times more costly to treat, and are far more likely to be fatal.

In response to these concerns, the Stop TB Strategy has recently undergone some important modifications. First, the failure to control TB is now recognized as a failure of the entire health system in which TB programmes operate, again placing emphasis on the critical need to strengthen health systems. A second shift is a stronger emphasis on the social determinants of TB and on the need to extend services to the most vulnerable and excluded groups.

Co-infection with HIV is another major concern. Between 2007 and 2008, 1.4 million TB patients were tested for HIV, representing an increase of 200,000 from the previous year. Of those who tested positive for HIV, one-third benefited from antiretroviral therapy and two-thirds were enrolled in chemoprophylactic therapy to reduce the risk of fatal bacterial infections. In people living with HIV, screening for TB and access to preventive therapy for TB more than doubled. Once again, however, the number of people being missed by these interventions remains too high. WHO estimates that 3 million people fail to access accurate TB diagnosis and high-quality treatment every year.

In an mHealth project supported by the Stop TB Partnership's TB REACH, with funding from the Canadian government, mobile phones and financial incentives helped a network of private clinics serving poor communities in Pakistan detect twice as many TB cases and ensure their timely treatment. The report of this project, published in June 2012, concluded that mHealth is emerging as one of the most potent weapons in the fight against TB.

Progress in controlling the neglected tropical diseases continues to accelerate thanks to the commitment of endemic countries, the leadership of WHO, and the generosity of the pharmaceutical industry. During 2010 alone, nearly 700 million people received preventive chemotherapy for at least one of these diseases. On current trends, several of these ancient diseases could be eliminated by 2015.

These "Cinderella" diseases, long ignored and underappreciated, have become a rags-to-riches story. In January 2012, a pharmaceutical company pledged to step up its contribution of preventive treatments for schistosomiasis 10-fold, reaching 100 million treatments per year by 2016. WHO administers the distribution of the majority of drugs donated to control

the neglected tropical diseases. This commitment puts WHO in a position to protect all school-age children in Africa at risk of schistosomiasis.

***Commitment:*** *Ensure that interventions, including new drugs, that arise from these initiatives are affordable and accessible to those in need.*

The Global Strategy and Plan of Action for Public Health, Innovation and Intellectual Property was successfully negotiated by Member States as an agreed way to broaden access to the benefits of research and development for new health products to combat diseases that disproportionately affect the poor. The Global Strategy set out the framework, and laid the groundwork, for multiple ways to improve access to essential products.

Moral pressure on industry, also using flexibilities in the TRIPS agreement, contributed to dramatic reductions in the price of antiretroviral therapy, with the annual costs of treatment dropping, within a decade, from \$30,000 to \$200.

WHO endorsement of new products can likewise stimulate dramatic price reductions for developing countries. In 2010, for example, WHO endorsement of a new molecular diagnostic test for TB brought an immediate 75% reduction in the price offered to developing countries. The test delivers results in around 100 minutes instead of up to 3 months, reliably detects TB in children and in persons co-infected with HIV, and detects the most common drug-resistant strains. Such features give control programmes a powerful new tool for case detection and immediate follow-up with the most appropriate medication. In June 2012, the Executive Board of UNITAID approved funding of \$30 million to scale up access to the test and reduce the cost of its use. The Stop TB Partnership's TB REACH initiative, supported by the Canadian government, will fund an additional \$10 million for the implementation of tests in countries.

Several public-private partnerships established to develop new products for the neglected diseases of the poor have matured. Vaccines for malaria have reached the most advanced stage of clinical trials ever experienced for this disease. The Medicines for Malaria Venture has recently licensed new products and has a promising portfolio of novel molecules in the R&D pipeline.

The Meningitis Vaccine Project, coordinated by WHO and PATH, culminated in December 2010 with the introduction of a new conjugate vaccine, priced at only 50 cents per dose, in the most hyper-endemic countries among the 25 countries that make up Africa's Meningitis Belt. Coverage was expanded in 2011, when more than 35 million people were protected, promising to end the terror and havoc of recurring seasonal epidemics. The payback will be enormous. A single case of meningitis can cost a household the equivalent of three to four months of income. Mounting a reactive emergency response to epidemics can absorb more than 5% of the country's entire health budget.



African countries frequent have to wait years, if not decades, for new medical products to trickle into their health systems. For once, the best technology that the world, working together, can offer was introduced in Africa.

The WHO prequalification programme allows manufacturers from low- and middle-income countries to enter the market on an equal footing with established manufacturers, provided they produce products that meet international standards for quality, efficacy, and safety. Expansion of the programme continues to change the dynamics of the market for public health vaccines. By assuring the quality of products manufactured in developing and emerging economics, the programme has increased competition as well as supplies, getting prices down and augmenting the purchasing power of investment dollars.

As yet another innovation, the framework for pandemic influenza preparedness, approved by the Health Assembly in 2011, extends traditional cooperation in the health-related public sectors to include annual contributions and firm commitments from private industry, in the name of health and in the interest of fairness.

In May 2012, the World Health Assembly approved a way forward for exploring innovative ways of financing R&D to produce new products for neglected diseases of the poor.

The relentless rise of chronic noncommunicable diseases, especially in the developing world, is certain to create new challenges for access to affordable medicines. While many essential medicines for managing these chronic conditions are off-patent and available in low-cost generic form, the millions of people now affected, and the duration of needed treatment, take these products beyond the reach of health budgets in most developing countries.

***Commitment: Complete polio eradication.***

This commitment has not been met. Though progress towards polio eradication has been made, the goal remains elusive. At the request of the World Health Assembly, an Independent Monitoring Board was convened to monitor and guide the progress of the Global Polio Eradication Initiative's 2010–2012 Strategic Plan. The plan aims to interrupt polio transmission globally by the end of 2012.

The Board's reports have been frequent and hard-hitting. They are consistently frank in their assessment of obstacles and strident in their demands for better programme performance. This public and critical prodding, which has included some bold proposals for doing things differently, brought several significant changes in both operational aspects of the initiative and signals of government commitment in the remaining countries where transmission continues.

In May 2012, the Health Assembly approved a resolution declaring the completion of poliovirus eradication a “programmatic emergency for public health, requiring the full implementation of current and new eradication strategies, the institution of strong national oversight and accountability mechanisms for all areas affected by poliovirus, and the application of appropriate vaccination recommendations for all travellers to and from areas affected with poliovirus. ”

In June 2012, the Independent Monitoring Board issued its most optimistic report to date. As noted, polio is at its lowest level since records began and the virus is gone from India, “a magnificent achievement and proof of the capability of a country to succeed.” The report also stressed the magnitude of remaining challenges, pointing out that 2.7 million children in the persistently affected countries have never received even a single dose of polio vaccine. While recent successes have created a unique window of opportunity, the current funding shortfall threatens to undermine the increasing containment of the virus. As the report concluded, “the prize of a polio-free world is drawing closer, but is far from secure.”

***Commitment:*** *Support full implementation of the WHO Framework Convention on Tobacco Control.*

The WHO Framework Convention on Tobacco Control now has 175 parties committed to implementing the treaty’s articles and obligations. These parties govern nearly 90% of the world’s seven billion people. Despite this widespread commitment, implementation falls short, for many reasons, in many countries.

To scale up implementation, WHO introduced the MPOWER policy package in 2008, setting out best-buy and good-buy measures that are known to be effective in reducing tobacco use.

The biggest threat to full implementation of the Framework Convention arises from the open and extremely aggressive tactics being used by the tobacco industry to subvert control measures. The high-profile legal actions targeting Australia, Norway, Turkey, and Uruguay are deliberately designed to instill fear in countries wishing to introduce similarly tough tobacco control measures. Numerous other countries are being subjected to the same kind of aggressive scare tactics. The measures known to work best are the ones most vigorously opposed by the tobacco industry. What this industry wants, and WHO fears, is a domino effect. When one country’s resolve falters under the pressure of costly, drawn-out litigation and threats of billion-dollar settlements, others with similar intentions are likely to topple as well.

WHO devoted World No Tobacco Day 2012 to this kind of interference from industry, aiming to alert governments, the public, and the media to the sleazy tactics now being used to subvert provisions in the treaty. WHO directly supports countries in their efforts to counter these tactics.

***Commitment:*** Accelerate comprehensive action to implement the Global Strategy on Diet, Physical Activity and Health.

Awareness of the need to prevent and control chronic noncommunicable diseases peaked in September 2011, when heads of state and government agreed on a political declaration during a high-level meeting held during the UN General Assembly. That declaration gave WHO a number of responsibilities and assignments with tight timelines.

Outcomes of this meeting and a previous First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control were discussed during the May 2012 Health Assembly, which also considered a report on progress in meeting WHO commitments as set out in the political declaration. The methodology used to establish targets and indicators for an accountable implementation of *Every woman, every child* is serving as a model. Likewise, capacity building, especially to measure results and monitor trends, is an explicit objective.

In line with the need for a multisectoral approach to control, WHO has made NCDs a cross-cutting issue, engaging all relevant departments across the whole Organization.

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## 2. Security for Health

***Commitment:*** Support countries in building capacity in prevention, preparedness, response and rehabilitation.

The capacity of all countries to respond to outbreaks and epidemics was put to a severe test in 2009, when WHO declared the start of an influenza pandemic. Together with partners, WHO had invested years of work to build an extensive network of influenza laboratories, and this work paid off. The rapid dispatch by WHO to developing countries of stockpiles of oseltamivir and pandemic vaccines unquestionably reduced public anxiety and saved some lives.

The response to the pandemic was also the first major test of the revised International Health Regulations. At its January 2010 session, the Executive Board agreed to establish an independent Review Committee to examine the functioning of the IHR, with particular reference to the influenza pandemic and the way it was managed by WHO.

In its report to the May 2011 Health Assembly, the Review Committee concluded that the IHR helped make the world better prepared to cope with public health emergencies, but that the core national and local capacities called for in the IHR were not yet fully operational and not on a path to timely implementation worldwide.

The report further concluded that the world is ill-prepared to respond to a severe influenza pandemic or to any similarly global, sustained and threatening public health emergency. Building these core capacities must become an even higher priority for WHO in the immediate future.

***Commitment:*** *Further strengthen WHO mechanisms for responding rapidly and effectively to public health emergencies.*

WHO has greatly strengthened its systems for the electronic real-time gathering of disease intelligence, risk assessment, outbreak verification, and the pre-positioning of logistical supplies. Responses are rapid, with teams usually on the ground within 24 hours following a country request for assistance.

In May 2009, the WHO global Event Management System went live as a web-based tool that supports event-based surveillance, risk assessment, and the management of acute public health events. It was widely used during the H1N1 influenza pandemic. The system provides an historical database of more than 4,000 acute health events detected by WHO. Of these events, more than 65% were substantiated as outbreaks through a rigorous verification procedure undertaken by WHO experts, often supported by epidemiologists in WHO country offices. The Event Management System is now linked to business intelligence software which generates real-time statistics for risk assessment and management.

WHO has introduced a second system, its Event Information Site, for real-time confidential communication of epidemic intelligence. The system ensures that National Focal Points, as established under the International Health Regulations, are immediately alerted to potential outbreaks anywhere in the world.

In 2010, the international humanitarian community was overwhelmed by two mega-disasters following the earthquake in Haiti and the massive floods in Pakistan. Events in Haiti, and earlier in Zimbabwe, dramatically illustrated the impact of cholera on vulnerable populations. No one anticipated the cholera outbreak in Haiti, a country that had not seen a case of this disease for more than half a century.

The international humanitarian community needs to anticipate that, as the climate continues to change and extreme weather events become more common, more mega-disasters will occur, often accompanied by outbreaks of infectious diseases. As part of the reform process at WHO, capacity to lead the health cluster during humanitarian emergencies is being strengthening, also by relying on mechanisms and operational protocols that have been so successful in outbreak response.

Mechanisms that worked well against epidemics of meningitis and yellow fever are now being used to strengthen WHO's response to cholera outbreaks. The deaths in Haiti were way too high and tragic, but each and

every year in Africa, similar numbers of people, sometimes more, die from cholera.

Much controversy has surrounded the role of vaccines in bringing a cholera outbreak under control. In April 2012, WHO brought the world's top cholera experts to Geneva for an urgent consultation. They advised WHO to establish a 2-million dose stockpile of oral cholera vaccines, under the same umbrella mechanism as used for vaccines for epidemic meningitis and outbreaks of yellow fever. WHO will do so, also as a way of stimulating increased vaccine manufacturing capacity.

At the same time, vaccines will not solve the cholera problem. Evidence of the impact of vaccines during cholera outbreaks is incomplete. This is another objective of the initiative: to gather the evidence to support well-informed policy decisions when responding to future outbreaks of cholera.

***Commitment:*** *Persuade senior foreign policy, diplomatic, defense, and private sector officials that health is an integral and necessary part of what they do.*

Individual countries have taken the lead in this area, most notably through the Oslo Ministerial Declaration – global health: a pressing foreign policy issue of our time, signed by the ministers of foreign affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand. A central message of this initiative is that a country's foreign policy should be judged by its effect on global health.

Such initiatives are likely to gain in importance as world leaders are compelled to do more to prevent obesity and noncommunicable diseases, also by looking at agricultural policies and systems for the international trade of food and beverages. Prevention of NCDs will likewise depend on the responsible behaviour of the food and beverage industries in product formulation and marketing practices, especially to children.

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### 3. Capacity for Health

***Commitment:*** *Revitalize the WHO health systems agenda, in collaboration with development partners, to support countries in building their sustainable national capacities.*

The drive to reach the health-related Millennium Development Goals drew attention to the urgent need to strengthen health systems. Doing so is now recognized as an absolute prerequisite for progress that is both sustainable and fair in its distribution of benefits. As poverty alleviation is the overarching

goal of the Millennium Declaration, health initiatives that miss the poor miss the point.

The 2008 World Health Report set out the evidence and laid the foundation for a revitalization of primary health care. As the report argued, primary health care is the most efficient and fair platform for addressing today's complex health problems, including most especially the rise of chronic noncommunicable diseases. Building resilient health systems, with strong community participation, is also the best way to prepare for future disasters, including those associated with climate change.

During the previous decade, global health initiatives established to combat single diseases rarely made the strengthening of health systems an explicit objective, even though good results depended heavily on a well-functioning health system. This situation has changed. Nearly all global health initiatives, including funding agencies, incorporate a platform for strengthening health systems. Support for the purchasing of interventions, like medicines, vaccines, and bednets, continues to be a priority. Health systems that lack commodities for managing high-mortality diseases, like AIDS, tuberculosis, malaria, and the main killers of mothers and young children, will have neither an adequate impact on health outcomes nor credibility in the eyes of citizens.

The 2010 World Health Report gave governments a menu of policy options for financing health systems as a path to universal coverage. The report presented evidence-based options for raising sufficient resources, reducing several common causes of waste and inefficiency, and removing financial barriers to access, including user fees, which punish the poor. By mid-2012, and despite a nearly global mood of severe financial austerity, more than 50 countries had requested WHO technical support for their plans to move towards universal coverage.

***Commitment:*** *Improve the quality and effectiveness of WHO technical support to Member States.*

WHO country offices, which are usually located near or within ministries of health, are a unique asset that facilitates direct dialogue with, and support to, countries. The Director-General continued the practice of bringing the heads of country offices to Geneva every two years to jointly look for ways to improve direct support to countries. These meetings have resulted in a number of policy changes, including policies for the recruitment of appropriately qualified staff, and refinements in the expectations for WHO collaboration with countries.

As part of the WHO reform process, ways are being sought to increase support to countries by harmonizing the work of multiple development partners and securing more predictable financial resources in line with national health priorities. More WHO support during the formulation of national health strategies and plans is considered central to better performance within countries, also on the part of development partners. WHO continues to regard

good development assistance as a contribution to national self-reliance, which is most likely to be achieved when aid is channeled in ways that strengthen existing infrastructures, systems, and capacities.

***Commitment:*** *Promote coordination with the education, labour and finance sectors to build and sustain a health workforce in developed and developing countries.*

In 2010, after extensive negotiations, the Health Assembly approved a global code of practice for the international recruitment of health personnel. Progress in implementation of the code is under constant review.

WHO hosts the Global Health Workforce Alliance, which was established in 2006 as a common platform for responding to the critical worldwide shortage of more than 4 million health workers, with 1.5 million needed in Africa alone. The Alliance has published a number of strategic documents, including innovative examples of ways that countries, in different resource settings, are solving problems.

Most recently, WHO, in collaboration with the US President's Emergency Plan for AIDS Relief, or PEPFAR, together with the US National Institutes of Health and the Health Resources and Services Administration, launched a five-year initiative aimed at strengthening medical education in Africa.

Building a workforce of appropriately trained staff, in adequate numbers, takes time. A crippling shortage of appropriately trained health staff continues to undermine the effectiveness of health services. In the absence of an adequate workforce, particularly in Africa, many countries will not be able to meet the health-related MDGs, especially those for reducing maternal and childhood deaths.

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#### 4. Information and knowledge for health

***Commitment:*** *Establish a global health observatory to collect and collate data on priority health problems.*

At present, some 85 countries, representing 65% of the world's population, do not have reliable cause-of-death statistics. This lack of fundamental information capacity means that causes of death are neither known nor recorded, and health programmes are left to develop their strategies, and monitor the results, using crude and imprecise estimates.

In response to increased demand for accountability at country and international levels, WHO has established a Global Health Observatory with the aim of improving access to health data, statistics, and analyses. The Observatory is an organization-wide resource with strong links to countries

and regional offices. It aims to enhance the efficiency, quality, and transparency of WHO's work in monitoring health trends and measuring results.

A single portal and data repository allows access to more than 50 datasets on WHO priority statistics. Theme pages highlight the global situation, trends, and analyses in selected areas of particular concern or high priority for international public health. Similar functions continue to be performed by the yearly World Health Statistics reports.

Together with several partners, WHO is exploring the use of information technologies to address persistent data gaps. The readily availability of mobile phones throughout the developing world has been described by some as the most democratic technology revolution in history. Many countries are already using mobile phones to collect vital health information from communities, to remind patients to follow treatment regimens, or to transfer vouchers that pay for the emergency transportation of women experiencing problems during childbirth. To move these experiences from anecdotal reports to a solid evidence base, innovative uses of information technology are being systematically assessed by an independent Expert Review Group, which monitors progress in implementing recommendations of the Commission on Information and Accountability for Women's and Children's Health.

***Commitment:*** *Integrate WHO activities across the health research spectrum to promote health and to prevent and control disease.*

In May 2010, the Health Assembly approved a WHO strategy on research for health. However, this commitment has not been fully met. In 2013, the World Health Report will be devoted to health research, with a particular focus on research that improves access to essential medicines and services and supports the goal of reaching universal health coverage.

***Commitment:*** *Promote national and global mechanisms to apply existing knowledge and technology and increase local capacity to conduct research.*

WHO supports, and in some cases has initiated, a number of public-private partnerships established to develop new products for diseases of the poor. WHO also supports the African network for drugs and diagnostics innovation, or ANDI, which is working to create a sustainable platform for R&D innovation in Africa.

In its traditional role of supporting capacity building in the developing world, the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, or TDR, continues to support local research aimed at discovering new ways to combat tropical diseases. The emphasis has recently shifted to operational research that helps develop new products, or adapt



existing ones, to conditions in hot and humid climates with limited resources and erratic electricity supplies.

For malaria, TDR and the Global Malaria Programme have conducted a series of comprehensive evaluations of rapid diagnostic tests, in collaboration with the Foundation for Innovative Diagnostics, or FIND. The results of these studies are guiding WHO, the Global Fund, and national procurement officers in their selection of the most reliable and cost-effective diagnostic tests. Use of these tests supports the new WHO policy that advises countries to dispense antimalarials only after testing has confirmed infection with malaria.

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## 5. Partnerships for health

***Commitment:*** *Engage strategically in partnerships for health, strengthening relationships with civil society and the private sector, and create greater alignment between health partnerships.*

The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action set out principles, based on decades of experience, for improving the quality of aid and making development assistance more effective. A growing number of partnerships are implementing these principles in a spirit of mutual accountability and with an emphasis on delivering measurable results. In 2011, a meeting in Busan took these commitments a step further with the concept of domestic accountability, in which country ownership matures to the point that governments are held accountable, by citizens and civil society organizations, for safeguarding public health.

WHO has supported the International Health Partnership and Related Initiatives, or IHP+, since its inception in 2007. IHP+ was created to accelerate better health results in low- and middle-income countries by putting the principles on aid effectiveness into practice. The initiative has grown from 27 to 56 signatories to the IHP+ Global Compact, including 25 countries in Africa.

IHP's central concept of uniting partners behind a single national health strategy has matured. The challenge now is to instill confidence in that strategy. Along the way, IHP+ has developed and refined tools for improving the quality of national health strategies and plans and for conducting joint assessments of these strategies. It has also helped bring civil society into these processes at country level and give them a greater voice in policy formulation.

Work on harmonization and simplification of financial management has accelerated through collaboration between the World Bank, GAVI, and the Global Fund. Other development partners are now getting involved. Through IHP+, a single monitoring and evaluation framework with a limited number of indicators was developed, based on consultations with countries and development partners. Boosted in part by the achievements of the

Commission on Information and Accountability for Women's and Children's Health, the framework is being used by a growing number of countries as the basis for strengthening their health information platforms.

The environment in which IHP+ operates in 2012 differs from that in 2007. The economic downturn has changed assumptions about development assistance. The growth in development assistance for health has slowed since 2009, with data for 2011 showing a 3% real decline in aid as a whole. At the same time, the number of providers of aid has continued to increase, and with it the transaction costs of fragmentation. Assistance is characterized by less political willingness to take risks and an increased focus on value for money. These trends reinforce the need for WHO to continue to play an active role in initiatives that aim to improve aid effectiveness. WHO is well-positioned to do so as, together with the World Bank, it jointly coordinates IHP+.

***Commitment:*** *Introduce and accelerate reforms leading to greater effectiveness and coherence with other UN agencies and development partners at the global and country level.*

In 2007, the Director-General established an informal group, often referred to as the "H8", of seven health-related international organizations, namely WHO, UNICEF, UNFPA, UNAIDS, the Global Fund, and the GAVI Alliance, and the Bill and Melinda Gates Foundation. The group meets on a regular basis to harmonize activities, reduce duplication, and ensure that each agency works, according to its unique strengths, in a coordinated response to shared problems. The group also works to ensure systematic and robust knowledge management and to seize opportunities opened by the renewed interest in health systems.

***Commitment:*** *Listen closely to grassroots voices.*

During her first term in office, the Director-General visited more than 50 developing countries, ranging from the Democratic Republic of Congo, to flood-stricken Pakistan, to small island nations already experiencing the effects of climate change. Apart from the desire to witness health conditions first-hand, an objective of these visits has always been to hold discussions with grassroots initiatives and view their work.

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## 6. Performance for health

- ***Commitment:*** *Accelerate human resource reform to build a work ethic within WHO that is based on competencies, collaboration and pride in achieving results for health.*
- ***Commitment:*** *Introduce a corporate communication and information strategy that promotes accountability to the public and to Member States..*

- **Commitment:** *Engage with Member States and partners to ensure effective financing for WHO.*

These commitments are being met, in a Member-State driven process, as WHO undergoes the most extensive reforms in its history. Three main areas are being addressed by these reforms:

- Programmes and priority setting
- Managerial reforms aimed at improving organizational effectiveness, strengthening technical support to countries, improving WHO's financing, and increasing WHO's accountability and transparency
- Governance, including both the internal governance of WHO by Member States and the role of WHO in global health governance

Human resource reform and a corporate communication and information strategy are being addressed as part of managerial reform.

At the start of her term, the Director-General established a Global Policy Group, which gives all Regional Directors a formal platform for jointly shaping WHO policies, solving problems, and promoting greater coherence throughout the Organization. The Global Policy Group also allows Regional Directors to profit from experiences in other regions, sometimes resulting in joint regional programmes or the sharing of experienced staff.

WHO was among the first international agencies to introduce managerial safeguards shortly after the financial crisis of 2008, rightly anticipating that budgetary discipline would be needed. Despite this budgetary discipline and a correspondingly increased burden on staff, WHO managed to service a growing number of intergovernmental negotiating bodies. These were convened, at the request of Member States, to reach agreement on some especially challenging issues, often with strong economic dimensions. This trend, though demanding on WHO resources, can be interpreted as a sign of trust in WHO, of confidence that agreements negotiated under the auspices of WHO will be fair in their outcome, fully mindful of the consequences for health everywhere, but most especially so in the developing world.