Sixty-third World Health Assembly

http://www.who.int/mediacentre/events/2010/wha63/en/index.html

Date: 17–21 May 2010
Location: Geneva, Switzerland

The 63rd session of the World Health Assembly will take place in Geneva during 17–21 May 2010. At this session, the Health Assembly will discuss a number of public health issues, including:

- implementation of the International Health Regulations (2005);
- monitoring of the achievement of the health-related Millennium Development Goals;
- strategies to reduce the harmful use of alcohol; and
- counterfeit medical products.

The Health Assembly will also discuss the programme budget, administration and management matters of WHO.

NEWS

Daily notes on proceedings

MULTIMEDIA

Photographs
Selected photographs from each day, high-resolution versions also available

DOCUMENTATION

World Health Assembly Journal, Number 3, 19 May 2010

Provisional agenda [pdf 33kb]

Medium-Term Strategic Plan 2008-2013 Amended (draft), including the proposed Programme Budget 2010-2011

Complete documentation

SPEECHES

Dr Margaret Chan
WHO Director-General
Opening address
Watch the video [wmv 00:27:10]
Smallpox eradication

TOPICS

Alcohol

International Health Regulations

Millennium Development Goals (MDGs)

Pharmaceutical products

Time to get back on track to meet the Millennium Development Goals

Dr Margaret Chan
Director-General of the World Health Organization

Mister President, honourable ministers, excellencies, distinguished delegates, Dr Mahler, ladies and gentlemen,

Public health must never cease to learn from its successes, and its failures.

Thirty years ago, the World Health Assembly declared that "the world and all its people have won freedom from smallpox". That official death certificate for an ancient scourge marked an unprecedented achievement in the history of public health. It provided dramatic proof of the power of collective action to improve the human condition in a permanent way.

This is worth remembering at a time when the international community is engaged in the most ambitious attack on human misery in history, with just five years left until 2015.

Smallpox eradication was a single-disease initiative. That killing, blinding, disfiguring disease never had a cure. The cornerstone of the campaign was prevention at a time when most health systems around the world were designed to deliver curative care.

An initiative that broke every single chain of virus transmission in every corner of the world was the ultimate example of universal coverage. This tells us what collective action for a common cause can achieve.

Related links

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63rd session of the World Health Assembly

Among its many legacies, the eradication campaign spawned the Expanded Programme on Immunization at a time when less than 20% of children in the developing world were covered by immunization programmes.

Throughout the 1980s, the so-called "lost decade for development", the expansion of childhood immunization was a robust and inspiring success story in the midst of an oil crisis, a recession, a crushing debt crisis, and structural adjustment programmes that slashed national spending for social services, including health. This reminds us of how greatly health can suffer from policies made in other sectors.

The point I want to make is this. As we enter the second decade of the 21st century, and the homestretch for reaching the Millennium Development Goals, we need to draw on every lesson, every approach, instrument, and innovative way of raising funds or collaborating together, from heads of state to civil society. We have very little time left, and little space for unproductive debates. We need to move forward fast.

We need horizontal and we need vertical approaches. We need to scale up the delivery of commodities, and we need to strengthen the fundamental capacities that allow us to do so. We need coherence in policies, within and beyond the health sector, and we need

complementarity of efforts.

Reaching the health-related Goals is not about national averages. It is about reaching the poor, who are almost invariably the hardest to reach. This is the challenge, and the measure of success.

The Millennium Development Goals promote health as part of an overarching strategy for poverty reduction. To put it bluntly, if we miss the poor, we miss the point.

We have a long way to go, especially for maternal and newborn mortality, and we welcome the efforts being made, on multiple fronts, to accelerate progress in this area. But let us take heart from what has already been achieved.

Success in public health nearly always saves lives. But it also has symbolic value. Recent progress tells us that when the international community is fully committed to a goal, creative solutions can be found and obstacles, including financial ones, can be overcome.

Since the start of this century, the number of under-five childhood deaths dropped below the 10 million mark for the first time in nearly six decades, and then dropped again to below 9 million.

The number of people in low- and middle-income countries receiving antiretroviral therapy for AIDS moved from under 200,000 in late 2002, to 3 million, then beyond 4 million, an achievement unthinkable a decade ago.

The rate of people newly ill with tuberculosis peaked and then began a slow but steady decline. For the first time in decades, we are seeing signs that the steadily deteriorating malaria situation might be turned around.

Progress in controlling the neglected tropical diseases continued to make impressive strides. By the end of 2008, some 670 million people had been reached with preventive chemotherapy for at least one of these diseases. Cases of guinea worm disease are at their lowest level ever, now confined to only four countries.

I think we can conclude: increased investment for health development is working.

Like the smallpox eradication campaign, the drive to reach the Millennium Development Goals has already left some legacies that benefit public health across the board. Let me mention a few.

First, the Millennium Declaration and its Goals turned thinking about development upside down. For a long time, factors such as access to safe water and sanitation, literacy rates, infant and young child mortality, and maternal mortality were regarded as indicators of a country's level of socioeconomic development.

According to the logic at that time, living conditions and health status would gradually improve as economies developed and prosperity increased. That happened, of course, but frequently not to the benefit of society's poorest and most marginalized people. All too often, economic growth has meant wealth creation for some, and increased poverty for others.

The Goals turned this thinking around. Instead of waiting for living conditions and health

status to gradually improve, the Goals called for a direct attack on the conditions and diseases that anchor people in poverty. This was put forward as the best, and probably the fastest, route to equitable and more balanced progress.

Indicators of development became engines for development. A quest for economic development became a quest for social development. The report of the Commission on Social Determinants of Health has taken this thinking forward.

Second, the MDGs changed thinking about aid effectiveness, as reflected in the Paris Declaration and the Accra Agenda for Action. An almost fashionable scepticism about the value of aid, with blame placed on weak capacities and governance in recipient countries, was replaced by recognition that the policies and behaviours of donors could also be at fault. Accountability for results must be mutual.

Good aid honours the priorities, capacities and responsibilities of recipient governments to their citizens. Good aid aims to eliminate the very need for aid. It does so by investing in the capacities and the infrastructures needed to move towards self-reliance.

If aid does not explicitly aim for self-reliance, the need for aid will never end. For obvious reasons, breaking the cycle of dependence on aid contributes to equity among nations in a fundamental way.

Third, the drive to reach the health-related MDGs unleashed the best of human creativity, bringing a host of innovations for improving health, especially among the poorest.

The list is long: the GAVI Alliance, the Global Fund, UNITAID, new partnerships to develop medicines and vaccines for diseases of the poor, advance market commitments as an incentive for industry, a finance facility for immunization, a facility to reduce the costs of malaria drugs, and the International Health Partnership as a new way of working within countries.

We have all contributed in some way to these innovations for international health cooperation.

The great spirit of collaboration and consensus-seeking seen in recent Health Assemblies has added to this list, notably through the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property.

The trend continues. Earlier this year, the Bill and Melinda Gates Foundation launched the Decade of Vaccines by pledging $10 billion over the next ten years to help deliver existing vaccines and develop new ones.

This commitment is most welcome. Vaccines are one of the best life-saving buys on offer, preventing an estimated 2 to 3 million deaths each year.

WHO and UNICEF, in close collaboration with the Gates Foundation, countries, and partners, are initiating a process to define the ambitions and scope of this Decade of Vaccines.

The momentum that has been growing since the start of this century must continue. Last month, WHO launched simultaneous immunization weeks in more than 100 countries. These

events are building public and professional awareness of the value of immunization as well as saving lives.

You will be well aware of the setbacks that occur when people decide that vaccines are risky, unnecessary, or even part of a conspiracy. This has been a problem for measles, for the uptake of pandemic vaccines, and most especially for polio.

Vaccines touch your agenda at several points. You will be considering accelerated action to reduce deaths from pneumonia, the feasibility of measles eradication, and the prevention of hepatitis B virus infection through immunization of infants.

As requested by the 61st Health Assembly, you will also be considering an aggressive new strategic plan to complete polio eradication. The plan incorporates several new strategies that respond to different transmission dynamics in different settings, make use of a new bivalent vaccine, and address head-on the problem of international spread that has made progress so fragile.

Significantly, the plan maps out a more systematic engagement of the initiative in the broader effort to strengthen immunization systems. This is a most welcome emphasis.

The polio initiative knows how to deliver interventions to hard-to-reach populations. This know-how becomes broadly beneficial in the homestretch to 2015, where the greatest challenge lies in reaching underserved populations.

Last month's polio outbreak in Tajikistan, in a region certified as polio-free since 2002, is a stark reminder that finishing eradication is the only viable option for responding to this disease. A resurgence of polio, of deaths, and childhood paralysis is the predictable consequence if we fail to stay the course. Collectively, countries and partners have a moral duty to finish the job.

Ladies and gentlemen,

Good news for public health usually arises from factors like political commitment, sufficient resources, strong interventions and implementation capacity, equitable delivery, and alignment with national priorities and capacities. Sometimes, though, we are just plain lucky.

This has been the case with the H1N1 influenza pandemic. The virus did not mutate to a more lethal form. Cases of resistance to oseltamivir remained few and isolated. The vaccine closely matched circulating viruses and showed an excellent safety record.

Emergency wards and intensive care units were often strained, but few health systems were overwhelmed and the effects were usually short-lived. Schools closed, but borders remained open, and disruptions to travel and trade were far less severe than feared.

Had things gone wrong in any of these areas, we would have a very different agenda before us today.

This has been the most closely watched and carefully scrutinized pandemic in history. It is normal that every decision and action, especially on the part of WHO, will likewise be closely scrutinized and critically assessed. We welcome this process.

The pandemic has also been the first major test of the functioning of the revised International Health Regulations, which entered into force in 2007.

During the January session of the Executive Board, I proposed that a previously scheduled review of the functioning of the Regulations could also be used to assess the international response to the influenza pandemic. The Board agreed to this proposal. A report of the Review Committee's first meeting is before you.

When I opened that meeting, I stressed the need for a frank and critical assessment of performance, including WHO's performance, in a process that is independent, credible, and transparent. We want to know what worked well. We want to know what went wrong and, ideally, why. We want to know what can be done better and, ideally, how.

We are seeking lessons, about how the International Health Regulations have functioned, about how WHO and the international community responded to the pandemic, that can aid the management of future public health emergencies of international concern. And I can assure you: there will be more.

The report of the Review Committee's first meeting summarizes issues and questions repeatedly raised and likely to guide the review. The Committee further agreed to look into criticisms that have been levelled at WHO for its management of the pandemic. As I said, we welcome this review.

Ladies and gentlemen,

We have some solid evidence that aid for health development is working. But it needs to work much better. The drive to reach the health-related MDGs has taught us a major lesson, and this is a lesson about failure.

For decades, we have collectively failed to invest adequately in basic health systems, infrastructures, training of staff, information systems, regulatory capacity, and systems for social protection. This is an absolute barrier, and trying to bypass it by building separate single-purpose systems is not the answer.

International donors, partners, and governments themselves have failed to rally around national health policies, strategies, and priorities. This contributes to fragmentation, duplication, added demands and costs, and defeats national ownership. We have learned this.

How can we scale up interventions or aim for universal coverage when health systems in so many countries are on the verge of collapse? Or when the world faces a shortage of 4 million doctors, nurses, and other health personnel?

Weak health systems blunt the power of global health initiatives to reach their goals. Weak health systems are wasteful. They waste money, and dilute the return on investments. They waste money when regulatory systems fail to control the price and quality of medicines or the costs of care in the private sector.

They waste training when workers are lured away by better working conditions or better pay. They waste efficiency when needless procedures are performed, or when essential procedures are precluded by interruptions in the supply chain.

They waste opportunities for poverty reduction when poor people are driven even deeper into poverty by the costs of care or the failure of preventive services. Above all, weak health systems waste lives.

This problem is now recognized by countries and donors alike, and it is being addressed by a range of new and existing initiatives, including several global health initiatives. Though designed to deliver specific health outcomes, these initiatives now recognize that meeting their goals depends on a well-functioning health system. In my view, this shift of attention is nothing short of revolutionary.

Equity and social justice are at the heart of the Millennium Declaration and its Goals. They were always at the heart of the primary health care approach. As last year's resolution on primary health care noted, principles such as universal access to services, multisectoral action, and community participation form a solid basis for strengthening health systems.

Efforts to reduce maternal and newborn deaths have shown the slowest progress of all the Millennium Development Goals in all regions. This should come as no surprise, as reducing these deaths depends absolutely on a well-functioning health system.

In preparation for the September UN summit on the Millennium Development Goals, the Secretary-General's office is finalizing a Joint Action Plan to accelerate progress in reaching the health-related MDGS, with a special focus on maternal and child health. I encourage you to participate in the technical briefings on the Millennium Development Goals, as your views will be decisive in shaping the development of this plan.

Health systems are an issue for other items on your agenda. Drug-resistant forms of tuberculosis arise because of shortcomings in general health services, including years of neglect of laboratory services, inadequate regulatory capacity to ensure the supply and quality of medicines, and a dire shortage of health personnel.

In the so-called virus importation belt in sub-Saharan Africa, the spread of polio has become predictable, as the virus travels by exploiting weaknesses in health systems.

Strong regulatory capacity underpins efforts to reduce the harmful use of alcohol, to control tobacco, to protect children from harmful marketing practices, and to assure the safety and quality of medical and blood products.

Some 85 countries, representing 65% of the world's population, do not have reliable cause-of-death statistics. This means that causes of death are neither known nor recorded, and health programmes are left to base their strategies on crude and imprecise estimates.

On the positive side, work to improve facility-based health care, which is critical for reducing maternal and newborn deaths, will increase the capacity to respond to the vast new challenges that come with the rise of chronic noncommunicable diseases.

These are some of the issues you will be discussing this week. Improving fundamental capacities helps reach international commitments, increases efficiency as well as fairness, improves health outcomes in sustainable ways, and moves countries towards greater self-reliance.

We have failed to do this job properly in the past. As we enter the homestretch, we must get

back on the right track.

Thank you.

http://www.who.int/topics/millennium_development_goals/en/index.html

Millennium Development Goals (MDGs)

The United Nations Millennium Development Goals are eight goals that all 191 UN member states have agreed to try to achieve by the year 2015. The United Nations Millennium Declaration, signed in September 2000 commits world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. The MDGs are derived from this Declaration, and all have specific targets and indicators.

More about the MDGs

GENERAL INFORMATION

20 ways that the World Health Organization helps countries reach the Millennium Development Goals

Fact sheet on Millennium Development Goals

RELATED TOPICS

World Health Survey

Health and development

Health systems

Primary health care

Social determinants of health

PARTNERS

United Nations Millennium

TECHNICAL INFORMATION

MDG 1: Eradicate extreme poverty and hunger

MDG 3: Promote gender equality and empower women

MDG 4: reduce child mortality

MDG 5: improve maternal health

MDG 6: combat HIV/AIDS, malaria and other diseases

MDG 8, target 8.E: access to affordable essential medicines

PUBLICATIONS

World Health Statistics 2010
Special section on Millennium Development Goals

Development Goals

Addressing violence against women and achieving the Millennium Development Goals [pdf 308kb]

WHO PROGRAMMES AND ACTIVITIES

WHO programmes

MDGS IN WHO REGIONS

Region of the Americas
European Region
Western Pacific Region

MDG 1: Eradicate extreme poverty and hunger

Target 1C. Halve the proportion of people who suffer from hunger

Globally, there is evidence of improvements in children's nutritional status. The percentage of underweight children is estimated to have declined from 25% in 1990 to 16% in 2010. Stunting in children under five years of age has decreased globally from 40% to 27% over the same period. In Asia, the number of stunted children is estimated to have halved between 1990 (190 million) and 2010 (100 million). However, in Africa the number of stunted children is projected to increase from 45 million in 1990 to 60 million in 2010. Despite these overall gains, around 104 million of children under five are estimated to be underweight in 2010.

WHO activities

WHO is working with countries:

- to build capacity in using standard growth assessment tools;
- to assist in planning and conducting nutritional surveys;
- to support the analysis and interpretation of nutritional survey results;
- to support the development of nutritional surveillance systems;
- to ensure that nutrition is an integral part of care and support for people with HIV and TB;
- to develop national nutrition plans and policies; and
- to strengthen the delivery of essential nutrition actions.

Related links

Nutrition

The WHO Child Growth Standards

MDG 3: Promote gender equality and empower women

The MDG 3 indicators track key elements of women's social, economic and political participation and guide the building of gender-equitable societies.

All the MDGs influence health, and health influences all the MDGs. The MDGs are inter-dependent. For example, better health enables children to learn and adults to earn. Gender equality is essential to the achievement of better health.

Target 3.A. Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education by no later than 2015

Girls' education is critically linked to self-determination, improved health, social and economic status as well as positive health outcomes for the mother and the child. Yet, girls still account for 55% of the out-of-school population.

Maternal deaths and pregnancy-related conditions cannot be eliminated without the empowerment of women. Maternal mortality is the number one cause of death for adolescents 15–19 years old and in many countries, sexual and reproductive health services tend to focus exclusively on married women and ignore the needs of adolescents and unmarried women.

Empowerment of women, including ensuring access to health information and control of resources such as money, is important for achieving gender equality and health equity. However, the ratio of female-to-male earned income is well below parity in all countries for which data are available.

Up to one in three women worldwide will experience violence at some point in her life, which can lead to unwanted pregnancy and abortion, among other things.

WHO key working areas

In partnership with Member States and others, WHO:

- furthers the empowerment of women, especially as it contributes to health;
- supports the prevention of and response to gender-based violence;
- promotes women's participation and leadership, especially in the health sector;
- defines ways in which men can be engaged to promote gender equality and to contribute more to their own health and that of their families and communities;
- builds the capacity of WHO and its Member States to identify gender equality-related gaps; and
- provides support for gender-responsive policies and programmes.

Related links

Gender, Women and Health

Engendering the Millennium Development Goals [pdf 151kb]

KEY WHO INFORMATION

Director-General
Director-General and senior management

Governance of WHO
WHO Constitution, Executive Board and World Health Assembly

Media centre
News, events, fact sheets, multimedia and contacts

International travel and health
Publication on travel risks, precautions and vaccination requirements

World Health Report
Annual report on global public health and key statistics

MDG 4: Reduce child mortality

Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Nearly 9 million children under five die every year. Almost 90% of all child deaths are attributable to just six conditions: neonatal causes, pneumonia, diarrhoea, malaria, measles, and HIV/AIDS. During 1960-1990, child mortality in developing regions was halved to one child in 10 dying before age five. The aim is to further cut child mortality by two thirds by 2015.

Reaching the MDG on reducing child mortality will require universal coverage with key effective, affordable interventions: care for newborns and their mothers; infant and young child feeding; vaccines; prevention and case management of diarrhoea, pneumonia and sepsis; malaria control; and prevention and care of HIV/AIDS. In countries with high mortality, these interventions could reduce the number of deaths by more than half.

WHO strategies

To deliver these interventions, WHO promotes four main strategies:

- appropriate home care and timely treatment of complications for newborns;
- integrated management of childhood illness for all children under five years old;
- expanded programme on immunization;
- infant and young child feeding.

These child health strategies are complemented by interventions for maternal health, in particular, skilled care during pregnancy and childbirth.

Related links

- Child health
- Infant, Newborn
- Immunization
- Children's environmental health
- Breastfeeding
- Nutrition

MDG 5: improve maternal health

Target 5.A. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Target 5.B. Achieve, by 2015, universal access to reproductive health

More than half a million women die each year in pregnancy and childbirth. Most of them die because there is not enough skilled routine and emergency care. Some South-East Asian and North African countries with high maternal and newborn mortality, have made progress in providing skilled care to women during pregnancy and childbirth. However, in sub-Saharan Africa, one in 22 women has the risk of dying during pregnancy or childbirth over a lifetime, compared with about one in 8000 women in the developed world.

WHO key working areas

- Strengthening health systems and promoting interventions focusing on policies and strategies that work, are pro-poor and cost-effective.
- Monitoring and evaluating the burden of maternal and newborn ill-health and its impact on societies and their socio-economic development.
- Building effective partnerships in order to make best use of scarce resources and minimize duplication in efforts to improve maternal and newborn health.
- Advocating for investment in maternal and newborn health by highlighting the social and economic benefits and by emphasizing maternal mortality as human rights and equity issue.
- Coordinating research, with wide-scale application, that focuses on improving maternal health in pregnancy and during and after childbirth.

Related links

More about MDG 5

Sexual and reproductive health and the Millennium Development Goals

Gender, women and health

New UN report confirms ongoing lack of access to essential medicines

The UN report *Strengthening the Global Partnership for Development in a Time of Crisis* highlights the existence of large gaps in the availability of medicines in both the public and private sectors, as well as a wide variation in prices which render essential medicines unaffordable to poor people.

Launched on September 16th as the second report of the MDG Gap Task Force, the report describes progress towards achieving MDG 8 (Develop a global partnership for development) and its related targets in the areas of essential medicines, official development assistance, trade, external debt and technology.

MDG 8, Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential medicines in developing countries was measured using nine indicators for measuring access to medicines using data collected by WHO and its partners. The report found that in the public sector, generic medicines are only available in 38.1% of facilities, and on average cost 250% more than the international reference price. In the private sector, those same medicines are available in 63.3% of facilities, but cost on average about 610% more than the international reference price. High prices often render medicines unaffordable, with common treatment regimens costing a low-paid government worker several days' wages. The cost of treatment for chronic diseases is particularly unaffordable because of the need for lifelong treatment which is less amenable to short-term financial coping strategies.

UN - MDG Gap Task Force report 2009
Arabic [pdf 1.60Mb] | Chinese [pdf 2.71Mb] | English [pdf 1.67Mb] | French [pdf 2.47Mb] | Russian [pdf 1.87Mb] | Spanish [pdf 2.46Mb]

UN - MDG Gap Task Force report 2008
Arabic [pdf 1.56Mb] | Chinese [pdf 2.02Mb] | English [pdf 1.67Mb] | French [pdf 1.42Mb] | Russian [pdf 1.45Mb] | Spanish [pdf 1.56Mb]