WHO leadership priorities

- Universal health coverage
- The International Health Regulations (2005)
- Increasing access to medical products
- Social, economic and environmental determinants
- Noncommunicable diseases including disabilities, mental health, violence and injuries
- Health-related Millennium Development Goals
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The confirmation of an outbreak of Ebola virus disease in Guinea earlier this year brought to four the number of severe emerging viruses that are currently circulating, including the H5N1 and H7N9 avian influenza viruses and the Middle-East Respiratory Syndrome, or MERS, coronavirus. The recent upswing in the number of MERS cases shows how quickly a previously stable situation can change.

WHO’s leadership role in outbreak alert and response is well known. WHO also administers the International Health Regulations, which were significantly strengthening following the SARS outbreak of 2003. The Regulations bring rules-based order to the procedures of disease detection, reporting, and containment, with clearly defined obligations and timeframes. The objective is to proactively detect and stop outbreaks at their source, before they have a chance to spread internationally. The absence of fundamental capacities to do so in several countries is the greatest barrier to reaching this objective. WHO leadership is needed here as well.

One of the objectives of WHO reform is to give this Organization the flexibility it needs to respond quickly to evolving situations. The volatile microbial world is certain to provide many such challenges in the future.

The debate about the post-2015 development agenda continues. I have no doubt that the health-related Millennium Development Goals will be given a second life in this agenda. Niger’s success story, as summarized in this issue, shows how any country, no matter how poor, can achieve dramatic health gains if it really wants to.

Margaret Chan
Director-General
This issue of Change@WHO highlights two of these leadership priorities: building the capacities needed to implement the IHR and fulfilling the health-related MDGs.

The International Health Regulations came into force in 2007. This legally binding instrument is the primary means of protecting the world from new and re-emerging diseases, microbial shocks, and other threats to public health and global health security.

Countries are obligated, by 2016, to establish a series of functions to ensure that they can detect, verify, assess, and respond to public health threats. The core capacities needed to fulfill these functions include national legislation, policy and financing; coordination and communication through a national focal point; surveillance; response; preparedness; risk communication; human resources; and laboratories.

For many countries, implementing all of the IHR’s provisions is a challenge. They are asking for support to ensure that they can fulfil the requirements. One example of support for building risk communication capacity is described in these pages.

Ensuring that countries are at the heart of WHO’s work has been one of the main objectives of reform. This issue of Change@WHO examines a critically important success in one country that serves as a model of another leadership priority, which is to finish the job of the health-related MDGs.
Focus on the IHR: Risk communication training

Sudan, like many other countries, faces a long list of potential public health threats – cholera, Rift Valley fever, droughts, floods, and chemical hazards to name a few. And the country’s capacity to deal with them has limitations, a situation also not unique to Sudan. As one national expert put it, during a recent outbreak of Rift Valley fever, the only available tools were the bare hands and communication skills of only a few people.

The government of Sudan is aware of its obligation, under the International Health Regulations (2005), to assess, notify and respond to public health threats. The IHR specifies eight core capacities that are essential to public health response; one of the eight capacities is risk communication.

Risk communication is a process that helps minimize death, disease and disability by engaging the public through rapid and transparent information exchange, taking into account their particular social, religious, cultural, political and economic concerns. Helping countries fully implement the IHR is one of WHO’s six leadership priorities. The Government of Sudan asked WHO’s Eastern Mediterranean office (EMRO) for support in strengthening its capacity for risk communication, especially through expanding the number of people with those skills.

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A series of training courses, led by a multi-disciplinary IHR team from EMRO, and risk communications and capacity-building experts from Headquarters and the WHO Country Office in Khartoum, together with Sudanese counterparts, was held in February 2014. Participants included the IHR focal point (the office designated to liaise with WHO on IHR matters and events of public health concern) and a few others working in surveillance, zoonotic diseases, and points of entry. None of these people were trained communicators, but all were working in areas where communication is critical.

From this small group, the training was expanded to include 200 other technical officers, staff in the Ministry of Health, and animal health and agriculture officials, as well as those responsible for food, chemical and nuclear safety, points of entry and civil defence.

Initially, the training focused on basic communication skills, especially on how to build trust in communities. Participants learned how to analyse the needs of their public and build on tools already developed by the Federal Ministry of Health, from maps and posters to radio and text messages and a telephone hotline that citizens can use to get information and advice and to give their opinions. The country has a huge appetite for health information; “they consume health,” one trainer said.

As a result of this training, Sudan is now developing a national risk communications plan that will encompass a wide range of public health concerns. A second national meeting, which will review the plan and train media professionals, health workers and other partners, is in development.
One country that has made significant progress in child mortality rates is Niger. Although it is one of the poorest countries in the world, with one of the highest fertility rates – 7.1 children per woman – it has been able to achieve some excellent results in reducing child mortality.

In 1990 Niger had the highest child mortality rate in the world; in 1998 the rate of death in children under five years was 274 per 1000 live births. But by 2012, this number had fallen to 127 per thousand, an average annual rate of decline of 6%, well above the threshold of 4.3% needed to achieve MDG 4, with gains that exceeded those of its neighbours. And this decrease was seen across all income levels, in rural and urban areas, for girls as well as boys.
How was this enviable reduction achieved?

First, the country decided to concentrate on primary health care for women and children, through the creation of a national policy on the use of the Integrated Management of Childhood Illness (IMCI), an integrated approach that includes both prevention and treatment of illness, especially in outpatient and home settings.

Paid community health workers were trained jointly by WHO and UNICEF in integrated case management in the community. Further, the government took a decision to make health care free of charge for all children and pregnant women: when user fees were abolished, use of services increased dramatically. Care was provided mainly at community health posts that were constructed in rural and remote areas far from existing health facilities.

Second, mass campaigns were initiated for interventions such as measles vaccination and the distribution of insecticide-treated bed nets against malaria. Finally, nutrition became an area of strong public health emphasis.

These three strategies combined are what made the difference, along with a focus on the regular collection of high-quality data. Those data were then used to guide the revision of programmes and policies, in collaboration with many partners.

The overall result is that Niger is on track to achieve the MDG on child mortality by the 2015 deadline, thanks to political will and leadership, and support from donors, but most of all through a determined strengthening of one country’s capacity to improve the health of its people.
Q  How were the leadership priorities decided?

A  We started off with quite a long list of about 26 priorities, in categories suggested by Member States. Since 26 was clearly too many, we then asked, “What are the most important areas where WHO really needs to exercise its leadership over the next 6 years?” These are cross-cutting areas where WHO wishes to influence the global debate and that draw together work across all levels of WHO.

Q  Were there other contenders that didn’t make the list?

A  No, I think not. The priorities are aligned with the Director-General’s manifesto for her second term. They are also closely linked with what is going to happen in the post-2015 agenda. One of the clearest messages we got from Member States, both North and South, was that we need to complete the job of the MDGs; that naturally became the first priority. NCDs clearly need to be part of the global health agenda and is an area where WHO’s leadership is critical. That in itself became a second priority.

Universal health coverage is a flagship issue of the current leadership and of the Organization, and one that has gained a huge amount of support from Member States, so that found its place fairly easily. Access to medicines is a good example where WHO has a real comparative advantage. It is of concern to the whole Organization to make sure that people have access to medical products they need.

The issue of health security is something for which WHO is well recognized, but we thought that there is a particular focus within that priority to make sure countries have the capacity to implement
“Member States are concerned that WHO should clearly show that it gives priority to the broader causes of ill health and inequity.”

primarily wanted to give highest priority to WHO’s presence in countries – for hands-on support, helping as a neutral broker, given all the different sorts of advice they receive. A second group of Member States saw WHO’s priorities much more in terms of its normative and standards-setting role.

As the reform has progressed, a third group, particularly from the large emerging economies, proposed a third way of thinking about WHO – as an effective political actor in support of health, whether that is in the environmental sphere or in terms of access to medicines, trade, etc. – where WHO seeks to be a much more effective advocate. So my sense is that this is where the real focus of the work on social determinants will lie.

Q Might these priorities change before 2019?
A I suspect not, though the balance between them may change. There may well be a situation where the social, economic and political determinants of health becomes more focused, with WHO being more involved in some than in others. With respect to the other priorities, I think that the change is likely to be within WHO’s role rather than the priorities themselves, given that they are fairly broad.

“Universal health coverage is a flagship issue of the current leadership and of the Organization.”
WHO’s relationships with non-State actors, such as nongovernmental organizations, the private sector, academic institutions and philanthropic foundations, are increasingly critical to WHO’s work. In 1948, WHO stood mainly alone on the global health stage. But in the more than 60 years that have passed since WHO’s founding, the number of organizations in this field has dramatically increased.

Clearly, it is in the best interest of the health of people around the world for all these groups to share resources, experience and expertise, and to eliminate overlap and redundancies – in short, to work together effectively. WHO’s six leadership priorities cannot be fulfilled without the cooperation and partnership of all global health actors.

Exactly how these relationships should be defined has been the focus of discussions in recent months, following meetings held in 2013. The Executive Board, in January 2014, asked for an informal consultation with Member States on 27–28 March 2014, chaired by Professor Thomas Zeltner, WHO’s Special Envoy on engagement with non-State actors.

Nearly 200 participants attended in person or observed by WebEx. They discussed a draft document on how WHO should engage with non-State actors, including methods of interaction and engagement that require development of new policies or revision of existing ones. Member States showed that they were ready to move beyond a debate on broader conceptual issues towards the development of policies.

Although the meeting participants supported one overarching framework for engagement, they noted a need to differentiate among certain types of non-State actors through the development of additional policies. Different policies were needed for philanthropic foundations and academic institutions, not only for private sector entities and nongovernmental organizations.

Member States have expressed a clear wish for comprehensive policies that are as inclusive of different actors as possible, while safeguarding the reputation and work of the Organization from conflicts of interest.

In some cases, this will involve strengthening our procedures to ensure that due diligence is undertaken more consistently, that risk assessments are done properly, and that an online register of non-State actors is created to make all aspects of engagement more transparent.

Professor Zeltner said he was grateful to the participants for helping define the foundations of the framework and to clarify its overall structure. “This debate,” he said, “will allow the Secretariat to presents a new version of the framework to the May Health Assembly that is in line with the expectation of Member States.”

www.who.int/about/who_reform/non-state-actors
Annual meetings of WHO Regional Committees

WHO Regional Committees will meet in 2014 to set policy and approve budgets and programmes of work for each of the six WHO regions.

**WHO African Region**
Sixty-fourth session of the WHO Regional Committee for Africa
Benin
1–5 September 2014

**WHO South-East Asia Region**
Sixty-seventh session of the WHO Regional Committee for South-East Asia
September 2014

**WHO European Region**
Sixty-fourth session of the WHO Regional Committee for Europe
Copenhagen, Denmark
15–18 September 2014

**WHO Region of the Americas**
Sixty-sixth session of the WHO Regional Committee for the Americas
Washington D.C., United States of America
29 September – 3 October 2014

**WHO Western Pacific Region**
Sixty-fifth session of the WHO Regional Committee for the Western Pacific
Philippines
13 – 17 October 2014

**WHO Eastern Mediterranean Region**
Sixty-first session of the WHO Regional Committee for the Eastern Mediterranean
Tunisia
19 – 22 October 2014

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