Madam President, excellencies, honourable ministers, distinguished delegates, ladies and gentlemen,

This is the sixth time I have addressed the **Health Assembly** in my capacity as Director-General. I still get nervous. But I do have some important messages to convey.

In public health, decades sometimes acquire labels. The 1970s were a decade of hope, culminating in the Health for All movement under Dr Mahler's leadership.

That hope was quickly followed by an oil crisis, a debt crisis, an economic recession, and the imposition of structural adjustment programmes, which forced governments to cut budgets for social services, including health.

The 1980s became known as the "lost decade for development". After a long span of steady progress, large parts of the developing world slid back into deeper poverty. Health services, starved of funds, began to crumble.

That damage was inherited by the next decade. With few exceptions, progress in public health was slow during the 1990s, with health viewed as an expenditure rather than an investment.

The first decade of the 21st century has also acquired a label. Many describe it as the "golden age for health development". And rightly so.

For the first time, health moved to the top of the development agenda, thanks to the work of Dr Brundtland, including the report she commissioned on macroeconomics and health.

At the start of the decade, the Millennium Development Goals showed how much the perception of health had changed, from a drain on resources to a driver of socioeconomic progress.

In that golden decade, governments, in both donor and recipient countries, made the health agenda a top priority. Money for health development more than tripled. Substantial results followed, with a particularly strong impact on deaths from HIV/AIDS, tuberculosis, malaria, and childhood illness.

The Millennium Development Goals unleashed the best in human ingenuity and creativity, leaving a legacy of innovations. The list is long. It includes new vaccines, medicines, and diagnostics, new ways of stimulating R&D for diseases of the poor, and new ways of financing health development, like GAVI, the Global Fund, and UNITAID.

The decade is over, and some observers will tell you that the golden age for health development has also come to an end.

Bitter observers say what many suspect may be true. A financial crisis derailed the best chance ever to alleviate poverty and give this lopsided world greater fairness and balance.

I strongly disagree. I believe the best days for health are ahead of us, not behind us.

It is true that money is tight and the future of the world economy looks uncertain. Health officials, development partners, and WHO are watching money closely. Money is important, but many other factors drive progress in public health.

During my recent visits to countries, I have seen inspiring examples of success. Striking achievements within countries make me optimistic.

The unprecedented momentum for better health that marked the start of this century continues, though on a different footing, sometimes on an even surer footing.

Ladies and gentlemen,

Time and time again, we see the importance of national ownership and leadership. India would never have been able to dramatically change the prospects for polio eradication without full government ownership of the programme.

The government of India deserves our congratulations for this monumental achievement.

Ghana's commitment to guinea worm eradication shrunk the map to its last outpost, in South Sudan. During the first quarter of 2012, cases of this disease dropped 67% compared with last year, and now number just over 100.

I visited Namibia in April. That country's minister of health, an expert in vector control, is leading a group of eight neighbouring African countries in a joint effort to eliminate malaria within the next few years. WHO has produced a complete set of technical manuals, for testing, treating, and tracking, to guide them on their way.

These countries are ambitious. They are determined. Their eyes are wide open to the challenge, but the chances of success are good.

Last month, I also visited Oman, where I learned about the outcome of an EU/WHO initiative to build the country's capacity to respond to outbreaks and natural disasters. This is a splendid example of a whole-of-government approach, with more than 30 government sectors and departments working together to build resilience.

In its fight to wrap a deadly product in a plain package, Australia leads resistance to the tobacco industry's latest onslaught of aggressive tactics.

During negotiations on pandemic influenza preparedness, Indonesia, joined by many others, pushed for a fairer and more equitable system that shares responsibilities and access to benefits, on an equal footing. The result is a pioneering framework that extends traditional cooperation in the health-related public sectors to include annual contributions and firm commitments from private industry, in the name of health.

Given my commitment to women, I am grateful to the Nordic countries and Canada for their unwavering promotion of women's empowerment, gender equity, and human rights, and for leading by example.

Several recent studies have advised the international community to look to BRICS countries, namely Brazil, the Russian Federation, India, China, and South Africa, as a way to maintain the momentum for better health.

These countries have become the biggest suppliers of essential medicines, in affordable generic form, to the great benefit of the developing world. BRICS countries also offer an alternative model for health development, including technology transfer, based more on equal partnerships than on the traditional donor-recipient model.

Some of these countries need support in upgrading quality standards and improving regulatory control. WHO is providing this support. Last year, after extensive technical collaboration, WHO prequalified China's State Food and Drug Administration.

Once individual vaccines are prequalified by WHO, the country's capacity to produce a large number of vaccines at very low prices will revolutionize vaccine supplies and their prices.

I am further encouraged by the high place health is given in many regional political and economic unions, and by international organs.

Last November, I addressed members of the UN Security Council. I drew their attention to the

threat posed by emerging and epidemic-prone diseases, and reassured them.

WHO uses a sophisticated electronic surveillance system to gather disease intelligence in real time. We are rarely taken by surprise.

WHO can mount an international response within 24 hours. This is because of WHO's Global Outbreak Alert and Response Network, but also the capacity of our country offices to get visas, move supplies through customs, and coordinate every step with the ministry of health.

No other agency can do this.

You will be reviewing progress in building the capacities needed to implement the International Health Regulations.

Ladies and gentlemen,

We see WHO leadership at work, often bringing outsized results for small but smart investments.

Africa's new meningitis vaccine, developed in a project coordinated by WHO and PATH, is being rolled out, promising to end seasonal epidemics in Africa's meningitis belt. The payback will be enormous. A single case of meningitis can cost a household the equivalent of three to four months of income. Mounting an emergency immunization campaign to control an epidemic can absorb as much as 5% of a country's entire health budget.

WHO leadership brought the neglected tropical diseases from obscurity into the limelight. These Cinderella diseases, long ignored and underappreciated, are a rags-to-riches story.

In January, a pharmaceutical company pledged to step up its contribution of preventive treatments for schistosomiasis10-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. With the January commitment, WHO is now in a position to protect all school-age children in Africa at risk of schistosomiasis.

We can blanket this part of the world with medicines that rid every schoolchild of worms and eggs, parasites that interfere with their learning, impair cognitive development, and compromise their nutritional status.

This is a gift to their health, but also to the education and nutrition sectors.

Last year, WHO recommended a ban on inaccurate and costly commercial blood tests for diagnosing active tuberculosis. Last week, the country with the largest use of these tests, especially by private practitioners, announced legislation banning the tests nationwide.

More than a million of these misleading blood tests are carried out each year, often at great danger and great cost to patients, who may have to pay up to $30 per test.

Think of what we are saving.

Following publication of the 2010 World Health Report on health system financing, more than 60 countries have approached WHO seeking technical support for their plans to move towards universal coverage.

What we are seeing goes against the historical pattern, where social services shrink when money gets tight. I think this drive to expand coverage is a powerful signal. Despite deepening financial austerity, the will to do the right thing, the fair thing, for people’s health prevails.

All of these examples, all of my personal experiences over the past five years, bring me to one overarching conclusion. Universal health coverage is the single most powerful concept that public health has to offer.

Universal coverage is relevant to every person on this planet. It is a powerful equalizer that abolishes distinctions between the rich and the poor, the privileged and the marginalized, the young and the old, ethnic groups, and women and men.

Universal health coverage is the best way to cement the gains made during the previous decade. It is the ultimate expression of fairness. This is the anchor for the work of WHO as we move forward.

Ladies and gentlemen,

These examples give me, personally, great cause for optimism during what many regard as an especially dismal time. They also provide guidance on strategies and approaches that help maintain the momentum for health.

I can suggest three general lines of advice.

First, get back to the basics, like primary health care, access to essential medicines, and universal coverage.

Shift to thrift. Develop a thirst for efficiency and an intolerance of waste.

When a government commits itself to universal coverage, it takes a hard look at waste and inefficiency. It shifts to thrift.

At the international level, this means making good use of initiatives like the International Health Partnership Plus and Harmonization for Health in Africa.

This means streamlining and integrating health programmes, as is being done with plans to ensure that every baby is born HIV-free.

This means putting countries in the driver's seat, giving them full ownership of what is being done for the health of their people. This is how a government earns the trust and confidence of its citizens, the voters.

This means using WHO country offices as a resource for policy dialogue and coordination, and for ensuring that aid for health development moves the country towards self-reliance.

Good aid is channeled in ways that strengthen existing infrastructures and capacities. Good aid aims to eliminate the need for aid.

Second, as public expectations rise, costs soar, and budgets shrink, we must look to innovation as never before. And I mean the right kind of innovation.

Innovation does the most good when it responds to societal concerns and needs, and not just to the prospects of making a profit.

These days, the true genius of innovation resides in simplicity.

This is not rocket science. This is frugal, strategic innovation that sets out to develop a game-changing intervention, and makes ease of use and affordable price explicit objectives.

We are seeing a new wave of innovation that, I believe, the commissioners on Social Determinants of Health would welcome. It looks not just at the causes of preventable deaths, but at the real reasons behind these causes.

Obstructed labour is a major killer of young women and adolescent girls. The real reasons are these: poverty and health systems that are impoverished by lack of medicines, equipment, skilled staff, and transportation.

The Odon device, developed by WHO and now undergoing clinical trials, offers a low-cost simplified way to deliver babies, and protect mothers, when labour is prolonged.

It promises to transfer life-saving capacity to rural health posts, which almost never have the facilities and staff to perform a C-section.

If approved, the Odon device will be the first simple new tool for assisted delivery since forceps and vacuum extractor were introduced centuries ago.

As we promote primary health care and universal coverage, we must not let a deteriorating economic outlook compromise the quality of clinical care.

Primary health care is not cheap, and it must not be a B-team version of what people get when they pay for private care.

We must never forget the importance of high-quality clinical care. Here, too, frugal innovation helps.

Just a few years ago, WHO estimated that surgical errors were killing around one million people worldwide each year. To address this problem, WHO adapted a simple checklist used by pilots in the airline industry, one of the safest industries in the world.

The WHO Safe Surgery Checklist was introduced in 2008 and has since been widely applied, significantly reducing surgical errors.

Studies suggest that, if fully implemented, nearly half of those one million deaths would be averted.

Building on this success, WHO has developed a Safe Childbirth Checklist to address the huge burden of preventable maternal and newborn deaths, especially in low-income settings.

What good does it do to offer free maternal care and have a high proportion of babies delivered in health facilities if the quality of care is substandard or even dangerous?

A pilot study of the checklist, conducted in India and published last week, demonstrated a 150% increase in adherence to accepted clinical practices for maternal and perinatal care in an institutional setting.

No additional resource investments were made. Just a paper checklist, like pilots use.

A large randomized controlled trial is under way to quantify the impact on reducing morbidity and mortality, but results will take some years. In the meantime, WHO will soon release the checklist as part of a call for collaborative research.

There is another good reason to promote frugal innovation.

Unlike other areas of technology development, like computers and mobile phones, advances in medical products nearly always come with greater complexity and a much higher price. The complexity increases the price further, as highly skilled staff are needed.

At some point we come up against a brick wall, where delivering care for NCDs, especially cancer, or care for people with mental disorders, especially elderly people with dementia, becomes unaffordable, even in the world's wealthiest countries.

To counter this trend, WHO has launched an initiative to develop appropriate assistive devices for the developing world's rapidly ageing populations. These are things like mobile phones adapted for the visually impaired and robust low-cost hearing aids.

Affordability is important, but so are simplicity and ease of use, as this relieves some of the pressure on specialized care and further reduces costs.

Imagine the impact on well-being and quality of life. In developing countries, WHO estimates that nearly 40% of people older than 65 years have a disabling hearing impairment.

My final advice is brief.

Use research. Use science. Shape the research agenda and seize every opportunity opened by new findings.

WHO does this most conspicuously when it revises policy and technical guidance for HIV/AIDS, tuberculosis, and malaria.

As just one example, evidence indicates that the elimination of mother-to-child transmission of HIV is entirely feasible, and this is now our operational goal.

This is part of efficiency. Science makes the breakthroughs. Public health operationalizes them and leaps ahead.

Ladies and gentlemen,

The past year has seen some good news for health and we are right to be encouraged. But there are at least two danger zones, and they are big ones.

Our traditional financial donors are under intense domestic pressure to demonstrate that official development assistance is being wisely invested.

Taxpayers and parliamentarians want to see quick, tangible, and measurable results that demonstrate payback for the money.

This can be dangerous, especially for a disease like HIV/AIDS.

In a sense, we are in the best position ever to get ahead of this devastating epidemic and put its heavy burden behind us. Evidence continues to mount that antiretroviral therapy not only saves lives but is also a powerful preventive tool, reducing sexual transmission of HIV by as much as 96%.

Unfortunately, it is highly unlikely that the established goal of universal access to antiretroviral therapy will be met. We have good reason to believe that the UN target of having 15 million people on treatment by 2015 will not be met.

In these difficult financial times, I see an extremely dangerous tendency to measure how much health can be bought for a given amount of money.

Saving a life with a vaccine is unquestionably far cheaper and more immediate than keeping someone with AIDS alive. It is also less demanding on health services.

In my view, human life cannot be valued, or devalued, or discounted in this way.

These medicines are a lifeline for a lifetime. The only ethically acceptable exit strategy is to stop new infections in the first place.

We have that opportunity, opened even wider by evidence of the effectiveness of male and female condoms, harm reduction, behaviour change, and male circumcision.

The critical question is this: will we seize this opportunity or let it slip away?

The second danger zone should be obvious to anyone who pays attention to WHO's monitoring of global health trends.

This monitoring tells us where we are making progress, but also which health threats cast the biggest shadow over that progress.

And this is the biggest one, the longest black shadow: the relentless rise of chronic noncommunicable diseases.

Last week's World Health Statistics report created a stir, and rightly so.

WHO data show that rates of obesity nearly doubled in every region of the world from 1980 to 2008. Worldwide, one in three adults has raised blood pressure. One in 10 adults has diabetes.

These are the diseases that tax health systems to the breaking point. These are the diseases that break the bank.

These are the diseases that can cancel out the gains of modernization and development. These are the diseases that can set back poverty alleviation, pushing millions of people below the poverty line each year.

Last year's political declaration on NCDs assigned a number of responsibilities to WHO. You have before you a report on the multiple steps WHO has taken to meet these expectations.

I can assure you: we are giving these diseases, and our role in their prevention and control, the utmost priority.

Ladies and gentlemen,

I have a final comment as we think together about WHO reform.

I see the role of WHO as that of a global health guardian, a protector and defender of health, including the right to health. WHO is a custodian of technical expertise, but also of values, like social justice and equity, including gender equity.

We must never forget our value system. Never forget the people. Public health is trained in compassion and driven by passion. This will always be our strength, our true comparative advantage.

Persuading others to share this value system is another way to maintain the momentum for better health.

This happened most recently with human African trypanosomiasis. Late-stage sleeping sickness is invariably fatal.

Drugs are donated for treatment, but what good do they do if cases are detected too late?

Understanding this, the company donating the drugs also gives WHO the funds needed to support active screening: that is, to pay for the facilities, equipment, logistics, staff, and their training.

Industry commitment continues because my staff took the company's CEO and senior executives on a field trip to Africa last month.

These executives saw the people, the illness, the lumbar punctures under the mango trees, the cases detected, and the medicines given.

Seeing the people, being eye-to-eye with their misery, has great power to motivate the right kind of public-private partnership. Results build trust, and with trust, commitment escalates.

Let me conclude by thanking Member States for so carefully and diligently shepherding change as this Organization undergoes the most extensive reforms in its history.

We all know that this is not an easy process. But it must be done and it must be done right.

I would also like to thank Regional Directors and staff for their good work, dedication, commitment to the Organization, and support for its reform.

I thank as well the Permanent Missions here in Geneva and their ambassadors for investing so much time in supporting the work of this Organization.

I personally believe that WHO does great good in this world. By improving the Organization's operational effectiveness and strategically positioning its work, we can do more.

The world expects this, and needs this, from WHO.

We will not let the people down.

Thank you.