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FAILED STATES AND GLOBAL SECURITY: HOW HEALTH CAN CONTRIBUTE TO A SAFER WORLD

An Address by:

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THIS IS AN UNCORRECTED TRANSCRIPT

LAEL BRAINARD: Good morning. It's a great privilege for Brookings to welcome the Director-General of the World Health Organization this morning. Director-General Brundtland.

Strobe Talbot unfortunately, I think, is on airplanes and was deeply disappointed not to be here for this important event. I as asked to introduce the Director-General, but I think she hardly needs introduction I think to everybody here. We all recognize her as a real standout in the pantheon of global public servants.

In addition to the public service that she rendered Norway as Minister of Health, as Minister of Environment, and as Prime Minister for ten years, Dr. Brundtland has rendered great public service to the world as a whole.

She initially came to great prominence on the world stage chairing the Brundtland Commission which back in 1987 put forward the concept of sustainable development that I think has shaped all of our thinking ever since and which led ultimately to the Rio Conference in 1992. Her contributions since, if anything, have been even greater.

As Director-General of the World Health Organization since 1998 she's credited with putting that organization back on the map and establishing the primacy of basic health in the fight against international poverty as an integral contributor to growth, not just a humanitarian concern.

I was able to observe the importance of her vision first-hand when I worked in the White House and Vice President Gore and President Clinton both were really inspired by her vision but also given kind of concrete direction by her very pragmatic proposal. Her fingerprints are all over the International Tobacco Control Initiative, the Global Alliance for Vaccines and Immunization, efforts to make HIV/AIDS treatment drugs affordable in the poorest nations, and of course the Global Fund to Fight AIDS, Tuberculosis and Malaria, in all cases pioneering new partnerships between the private and public sectors and really changing the way that we do health internationally.

The international policy agenda I think came full circle for Dr. Brundtland when earlier this month the Johannesburg Summit made the connection between health, environment and development -- something she's been stressing now for over two decades.

I have the privilege also of being able to plug her new book, which I gather is coming out to a bookstore near you. I gather from it that you'll learn not only a great deal about policy but also about this phenomenal human being.

Over the past year the salience of the WHO's work on surveillance and epidemiology has risen even further as Americans, finally, have awoken to the painful realization that infectious diseases, whether manmade or caused by bioterrorism, do not respect national borders, and that health and governance crises in failed states far from our shores can have repercussions way too close to our own homes.

The contribution of health to overall economic growth and to state viability are areas of deep interest to Brookings scholars so it is doubly a pleasure for us to have her here today. And I hope you will join me in welcoming her.

[Applause]

DIRECTOR-GENERAL GRO HARLEM BRUNDTLAND: Thank you very much for that generous introduction. I'm happy to see all of you here, and the Norwegian Ambassador Vollebaeck is here and I want to mention that especially.

So ladies and gentlemen, countries in crisis, failed states and weakened states I believe are crucial to the peaceful development of our world. The way we as a world community work to prevent such crises and stabilize and rebuild these states will determine whether we succeed in our quest for global security as well as in our struggle for global, economic and social development.

And health will not only play a necessary part in such an effort, which is obvious, but it can also provide an effective tool by which to succeed.

We do face a formidable challenge. In many parts of Africa, some parts of the Middle East, and some countries in Latin America and Asia people have seen decades, in some places more than a generation, of stagnation. They are certainly not progressing, sometimes even moving backwards. Many are living in countries where too many people cannot meet their basic daily needs for food, water and shelter. They cannot access services that they need for survival including essential health care and personal protection. They are vulnerable, they are insecure. And I'm not talking about small numbers.

Between 1990 and 2000 the Human Development Index declined in nearly 30 countries. Well over a billion more than one-fifth of the world's population are unable to meet their daily minimum needs. Almost one-third of all children are undernourished.

In many countries which had seen economic growth increasing inequality means that the poorest part of the population has seen little or none of the benefits from this growth. The average African household consumes 20 percent less today than it did 25 years ago.

Over the past 15 years the populations in many of the poorest countries have also become much harder to reach. As the iron hand of the Cold War loosened its group the result in some areas was armed conflict which seriously weakened states.

Of course this trend is far from universal. Mozambique, Uganda, and Cambodia are only three examples of countries, which have seen peace, stability, and functional government appear out of the ashes of war over these last 15 years.

In countries in crisis people are suffering, locked in a vicious cycle of poverty and insecurity. Rates of severe illness and death are high. In some settings the daily death rate is at least double the expected level in that kind of country.

The crises are caused by violent conflict often over decades, by natural disasters like drought, by economic collapse, or by poor governance, or of course a combination of them. Often these causes work together and they make a deadly combination.

Today nearly a third of the population of sub-Saharan Africa live in countries one can define as weak and failed states, or which are ravaged by complex emergencies. Development or humanitarian work in such states is therefore a very difficult task. As Robert Rockberg [ph] of Harvard recently described in *Foreign Affairs*, one of the key signs of a failing state is its growing inability to provide even basic services to its population. A descent into poverty and lawlessness leads to rapid decline in health indicators such as infant mortality and life expectancy.

Now southern Africa is a case in point. You mentioned Johannesburg. And as we all were there the crisis in southern Africa was happening just around the conference itself. A number of political, economic and social factors have played a role in creating a situation where more than 12 million people in this region are now affected by famine, but there is no sudden event, which has caused the crisis. Rather it comes as a result of a long process of under-investment in human resources.

This process has been compounded by the AIDS pandemic which, for example, has reversed much of the tremendous progress Botswana has achieved and is now becoming a profound burden on South Africa as well as Zimbabwe, Zambia and Malawi.

These underlying causes form a downward spiral, which is making countries increasingly weak. The important challenge is to address the underlying causes and arrest the descent before we are forced to deal with the ultimate consequences -- famine, unrest, and human suffering.

The experiences over the past year show, I believe, that we neglect countries in crisis at our peril. All over the world extremists use popular frustration to justify their actions. It is no accident that they take refuge in the debris of failed states where the consequences of crisis fuel frustration and insecurity.

A world where a billion people are deprived, insecure and vulnerable is an unsafe world. The despair of stagnation and regret provides openings for extreme ideas and can be exploited as a justification for action that undermines society and terrorizes its people.

Now we must counter this manipulation of despair. We should seek to engage even more strongly with countries in crisis to promote the values of freedom, democracy, and justice.

There is, however, another compelling reason for engaging in support and rebuilding weak and failed states. Diseases are spreading, mainly as a result of a reduced efforts to control them and health systems weakened by poverty. We cannot afford to have large neglected areas where the population is left to fend for themselves against diseases.

Take Ebola, for example. So far it has been contained because it has been confined to small villages far from big cities. Health systems like that of Uganda have done a fine job in isolating patients and restricting spread. They could do this with the help of international specialists from WHO and CDC Atlanta because the security situation in the area was good.

What if an outbreak takes place in a devastated Central African country where there is no local health care? What if the security situation was so bad that we could not send in international experts to advise and assist in containing the outbreak? What if infected people start fleeing into cities, to neighboring countries, and eventually out of the region?

These, unfortunately, are not solely hypothetical questions. They are issues WHO's self-surveillance experts are already grappling with.

Nothing, not even war or famine, has such an undermining and destabilizing effect on destabilizing societies, however, as has HIV/AIDS. As The Brookings Institution's own scholar, Dr. Peter Singer, has convincingly shown, AIDS depletes countries of their most valuable and productive people. Teachers, civil servants, health professionals, key industry workers such as miners and soldiers. HIV attacks primarily those between 15 and 40, leaving orphans and the elderly to fend for themselves.

Now the recent decision of the South African stock exchange to demand that listed companies declare the percentage of their workers who are HIV positive is but one illustration of how the disease is now eroding the core economic foundation of countries.

Failed states function as reservoirs for a number of diseases like polio, malaria, sleeping sickness, to mention only a few. And as Dr. Singer has shown in his work, complex emergencies are prime spreading ground for HIV/AIDS because people move and through the deployment of peacekeepers and other military and police staff.

But this also holds true for other communicable diseases. A strong state is needed to sustain the public health function, to prevent disease outbreaks, win battles for eradication, create conditions which reduce disease transmission and promote health for all.

Now in public health we often say that if one person is infected the whole world is at risk. And I mean the idea of smallpox gives you the right imagination about that. This is literally true for polio now, which we are on the verge of eradicating. Only when every child in every country is vaccinated and there are no more cases of polio anywhere in the world for three years can we draw a real sigh of relief like we did with smallpox 20 years ago.

But we are not talking only about polio. Seen from WHO headquarters in Geneva the world looks like a very vulnerable place. Despite enormous economic and technological progress, large populations are still as vulnerable to killer diseases as several centuries ago in our own countries. Profound changes in lifestyles, in communication and movement of goods and people have changed the way diseases and health risks are spread and contained.

An example of such changes is the repeated occurrences of West Nile Fever in this country, first in New York City and most recently in the south.

There is the recent sharp rise in tuberculosis in countries, which for decades have considered the fight against TB a victory. This new wave of TB often in forms resistant to all normal treatment comes as a large extent as a result of the movement of people from endemic countries into Europe and Northern America.

The rapid spread of Denghi Fever and its deadly hemorrhagic strain to large areas of Asia, Africa and Latin America over the past decade is a sign of how increased urbanization and movement of people can provide opportunities for a disease to thrive. And the disease is now endemic in more than 100 countries. Before 1970 only nine countries had experienced epidemics of the deadly Denghi Hemorrhagic Fever. By now that number has increased to more than 50. WHO currently estimates there may be 60 million cases of Denghi infections worldwide every year.

The problem is even greater for malaria. A decline in funding, insect resistance to DDT, and environmental concerns related to DDT led to the malaria eradication campaign being abandoned, more or less, in 1972. After a lot of success but leaving Africa and some other places behind.

Malaria has been rebounding ever since and is now reappearing in some countries that had previously eliminated it. The number of annual deaths from malaria is now 1.1 million, nearly back to the 1950s level, and hundreds of millions fall sick every year -- a drain on families, communities, and nations. Economically, a devastating drain.

Global health matters for each one of us and for the security and future of our children. Conditions of ill health around the world directly and indirectly threaten the lives of large numbers also of Americans.

The separation in fact between domestic and international health problems is losing its usefulness as people travel, as goods travel across continents. More than two million people cross international borders every single day, about a tenth of humanity each year. And of these, more than a million people travel from developing to industrialized countries each week.

Now it is not only the infections that spread with globalization. Changes in lifestyle and diet prompt an increase in heart disease, cancer, and diabetes. More than anything, of course, tobacco is

sweeping the globe as it is criss-crossed by market forces. Only weak after the old socialist economies in Europe and Asia open up to Western goods and capital more than ten years ago now, Camels and cowboys began to appear on buildings and billboards. This is why we need to conclude international agreements to effectively contain a major threat to global public health.

Last year's anthrax incident has taught us how vulnerable even the most sophisticated societies are to the deliberate use of chemical and biological agents to cause harm. But through the impressive effort by the U.S. Center for Disease Control and the U.S. national agencies, we have seen that the wakeup call has been heeded.

WHO works globally to improve awareness and assist other countries in building up their preparedness. Unlike most defense investments, disease surveillance and control has immediate civilian benefits since it improves protection against all diseases, no matter the cause.

So as CDC Director Dr. Julie Gerberding recently was quoted as saying, "Thanks to the experiences of last year health authorities were better prepared to detect and deal with the West Nile Virus as it appeared in states with no previous experience of that disease."

So what is emerging today is a new and wider notion of human security, or national security in the traditional sense. Something we, for want of a better word, perhaps can call human security.

The levels of ill health in countries constituting a majority of the world's population pose a direct threat to their own national, economic, and political viability. And therefore to the global economic and political interests of all countries.

Territorial dispute is no longer the prime source of conflict. It is increasingly ruthless in battles over resources, mismanagement, aftermath of humanitarian crisis, shortage of food and water, and the spreading of poverty and ill health.

Health, however, can also be a bridge to peace. Let me give you just one such example.

After a pilot workshop on health at the Bridge for Peace held in Sri Lanka in 1999, health staff on both sides were given negotiating skills to use in their day-to-day work and educate their colleagues in the military. The outcomes were encouraging. Even before any cease-fire, Sri Lankan army medical services were instructed to cater to "enemy" communities. Enemy in quotation marks.

The Minister of Health could run mobile units, health services, in areas that were not under government control and Shinawa [ph] and Tamil [ph] villages were involved in joint projects in conflict areas to deal with health challenges.

Now a main lesson over the last ten years, therefore, is that only peace reveals -- not therefore, but as we look at the total picture, that only peace in the end reveals all the health needs of a country

and that reestablishing health care is a major factor of civilization. It is crucial to invest early in health to be able to consolidate peace.

So investing in global health is investing in national security. So is investing in weak states. Or as my fellow countrymen and the world's first High Commissioner for Refugees Fridjt of Nansen put it in the language of his time -- "Charity is [real] politics."

But global health trends have wider consequences for global security.

As the 18 leading economists and health experts who form my commission on macroeconomics and health have argued, disease holds back development and weakens society. Malaria alone taxed Africa's GDPs by about $100 billion compared to what it could have been if that disease had been tackled 30 years ago when effective control measures first became available.

The commission has now presented us with a definite argument for the need to invest in health as part of a basic development strategy. It shows quite simply how investments in health are an important prerequisite for economic development. People who are ill cannot produce. People who are ill cannot be educated easily. It's a drain on the economic potential of a country.

The commission has concluded that health systems spending $10 or $12 per capita on health are simply not able to provide even the most basic health services to the people they serve.
Their report calls for a six-fold increase in health expenditures in the developing world and they have calculated that half of that increase can be covered by the countries themselves in a gradual scaling up. The other half has to come from the industrialized world.

The commission focuses on a few key diseases and issues, which if tackled can give huge improvements in health outcomes for the poorest -- AIDS, TB, malaria, children's diseases and maternal conditions.

As many as eight million lives saved each year and a six-fold return on the investment in terms of economic growth would be the result if we managed to channel enough resources into health for the poorest countries to achieve the millennium development goals.

In fact competition in a global marketplace will not provide enough stimulus or enough opportunity for poor countries to move out of poverty. The idea that little help should be given to any country apart from supporting free market reforms and democracy is now fortunately being seriously challenged.

But even among those of us who share the belief that development assistance is a crucial part of any attempt to create a better and more secure world, strict prioritization of AIDS has become a matter of necessity after a decade of shrinking resources for international development. Donors have become increasingly focused on achieving measurable results. I am myself a strong proponent of this approach.

We do need to direct aid into activities and intervention that give concrete and measurable outcomes if we are to build a momentum for increasing development cooperation, and more aid is needed if we are to meet the millennium development goals to which all countries now have committed.

Humanitarian aid and development assistance have contributed greatly to reduce suffering and increase security. I say that because I hear now again and again that people believe that what has been done has been wasted. We should expect even more.

After a decade of shrinking resources for international development assistance, donors have become increasingly focused on support for quality programs that promise to yield measurable results. And it is a sign of hope that key donors have made commitments to raise and not lower their level of official development assistance. It happened in Monterey, Mexico with both the U.S. and the European Union announcing not great but increases instead of flat or reducing patterns.

Through the Global Alliance for Vaccines and Immunizations, through the Global Fund to Fight AIDS, Tuberculosis and Malaria, and a number of other alliances and partnerships we have developed a new set of tools to turn resources into effective action, working with the private and public sector together with NGOs and having common goals and indicators to measure where we move.

The common denominator for these new tools are that they respond to the country's own priorities. They process funds rapidly, they reward results, and they are transparent.

The last decade brought a wealth of experience of how to strengthen weak states, prevent failures and rebuild countries wrecked by conflict. It also brought some examples of how not to do it. What we learned in Cambodia, in the Balkans and in East Timor and are learning again in Afghanistan is that it takes a combination of feasible political solutions, basic justice and stability, and humanitarian intervention.

Unless all these elements are working together it will be so much harder to reestablish a viable government and functioning services. This is why it is so important in Afghanistan today to ensure that security is extended beyond the capital Kabul, and that donor nations fulfill their pledges for humanitarian and development assistance which are needed to rebuild the country's shattered services.

In fact today in the Washington Post there is an article on the first page about the situation on the ground for women giving birth in Afghanistan. It's shocking reading.

These lessons were built into recommendations from the Carnegie Commission on preventing deadly conflicts which I was involved with during the mid 1990s. The commission emphasized the importance of early measures such as early warning and response, preventive diplomacy, sanctions, and economic rewards, and finally the use of force. But importantly, it also stresses the extremely important role of development and humanitarian assistance to maintain and strengthen basic services for the population.

Within WHO we grapple with these issues every day. We cannot turn our backs on countries in crisis or on the AIDS virus as it undermines the capacity to respond. We've refused a prioritized and disciplined response using our resources to encourage coordination and maximum efficiency.

So friends, my final comment, I believe we are all concerned with improving security and reducing threats to our home countries. These days the discussion is focused on the possible benefits, dangers, the whole issue of war to achieve security.

So my plea to day based on what I have just gone through with you is to see the issue of security also as a wider agenda and to invest in development to reduce the glaring injustices that are kept perpetuated by poverty.

We will only obtain, I believe, global security when we mean security for all, not only from terror and war but also from hunger and disease.

Thank you very much.

[Applause]

LAEL BRAINARD: I think that Dr. Brundtland would be happy to entertain your questions. If you would identify yourself and your home institution before asking your question that would be great. We have a mike in the back.

QUESTION: Thank you, Dr. Brundtland. My name is Grunita Vostava and I represent the Tartar Energy Research Institute in Washington, D.C.

I was wondering if you could perhaps say a few words on the importance of multinational companies to carry out research and development of vaccines and development of pharmaceuticals which will help in alleviating the types of health problems and the spread of disease, especially in developing countries. Because clearly, a lot of the incidents, increasing incidents of disease in developing countries has to do with their inability to pay for the treatment that is required to alleviate the problem of health in this country. Thank you.

DIRECTOR-GENERAL BRUNDTLAND: Absolutely. The challenge that you have 90 percent of the effort to prevent or treat disease is used for the 10 percent richest in the world and the 10 percent for the 90 percent others. That's the picture in broad terms. Those gaps are so great that what you are saying is a very relevant problem.

Now what we are trying to do is on several fronts. One is to create alliances again between the private and public sector, to use the strength of both to develop new technologies, new medicines,

which are needed for diseases linked with poverty. Diseases where the people who will be affected do not have the capacity to pay much, or pay anything in many cases.

We therefore have created institutions that deal with, for instance, looking at how do we get new malaria drugs onto the market as the existing drugs are losing their effectiveness? No pharmaceutical company invests in it on its own and with its own funds because of the market outlook. So we need to create global public goods. These medicines are needed. So we are trying to bridge that market failure by putting government money, public money into a pot to inspire pharmaceutical companies to compete about getting that support for their own basic research and competing between them who has the best potential concept we can help create the market which is not there without public effort involved.

We have the same kind of situation with sleeping sickness, with a number of vaccines which are needed but are expensive or we need new ones for diseases which are problems only in poor parts of the world.

So we have to overcome these market failures or these gaps in different ways by working with others and putting common goals that we can pursue by putting the creativeness of the private sector, their capacity in investing in new medicine but also supporting their calculus so that it makes sense for people to do so.

Now this is the same, we're looking for the malaria vaccine, also looking for the AIDS vaccine. It doesn't only happen on its own just by the private sector investing. It's not sufficient. It takes too long a time and you have no guarantee that we will be moving at a reasonable pace on it. So there is the combination of public and private effort.

The other part is the price situation. The people in poor countries or the government of those people cannot pay the kinds of prices that we pay for normal medications that we find in any pharmacy here in Washington or in Oslo or in any other place in the industrialized world. So we have been moving to say differential pricing is needed. Those prices have to be lowered to such a level that there is a possibility for those countries to be able or those people who are poor to be able to get access to these medicines.

However, if you look at the AIDS situation, even with having been able with the pharmaceutical industry to help push the medicines down to 10 percent of what the price was three years ago, that price is still $500, $600, $800 a year. Much too much for a country that spends $10 or $20 per capita in the whole of the health service.

That means that gap has to be filled, and that has to be filled by funding from development corporations or from foundations or others who want to be helpful, or from industries who want to see that their workers get treatment so that they don't lose them and have to train new workers as more and more people get affected by AIDS.

These are just some of the examples of what we are trying to do to bridge the gap.

I mentioned the Global Fund to Fight AIDS, TB, and Malaria. Those funds are used to bridge some of these gaps. Help the poor countries build their services and make medicines available in programs which are funded by industrialized countries or by foundations. So these are some of the aspects, the principles that they are using.

QUESTION: Nancy Cummings. I'm Emeritus at NIH.

I have a question that's related to that plus a couple of others. I think nutrition and education are the terribly important bases, and the problem with the pharmaceutical industry is that they don't see the profits and I don't even see with your suggestion the major amount of money that's needed. Because if you look right out during World War II and after, there were major efforts to look at anti-malarials and malarial treatment and there was an increase in treatment, but even with money being put in it's not enough for a disease like malaria and some of the aspects would be education as well as better nutrition.

How do you see bridging this gap because the pharmaceutical companies in this country are against even having generic drugs to make things cheaper. They're trying to extend patents. And certainly drugs against malaria, schistosomiasis and all those diseases aren't profit-makers. I wonder how you have real influence on them when even foundations and WHO don't give enough money to satisfy greedy groups like the pharmaceutical companies.

DIRECTOR-GENERAL BRUNDTLAND: Our international institutions like WHO don't have budgets which have anything to do with filling funding gaps. What our budget is used for is to have sufficient expertise and people who have direct access and advisory roles with our member states and with others who are active on the ground in different parts of the world so that the knowledge base of health is shared and can be used by those who are able to support funding.

Just to simplify it because people often ask me what can WHO do to see that medicines are cheaper, as if we had a budget that could pay for these things. However, the advice that we give, the experience that we share, and the feeling of security by those who are willing to fund or looking at what they can fund, that there is an evidence base and there is a systematic approach to see that money is spent in a good way that reaches results. That is a very important part of our role, as of course the NIH also has that kind of role in the American society as well, and globally to the extent that also knowledge is shared and available to everybody.

But the other questions you raised about generics and patents are really part of what I was answering partly earlier, about having to fill some gaps in a system where you don't only have generic medicine and poor people need access also to the new medicines and we need to inspire new products coming onto the market.

So you have to combine a basic principle of patents as part of a global system, but seeing to it that the patent time and the conditionalities about poor countries, how they are able to have exceptions to this. That's what we are struggling with in the trade realm and where we have been advising before the so-called Doha meeting, and we succeeded in getting, I mean with others and NGOs and others fighting this issue, to see that compulsory licensing and other exceptions to the general rules there can be used by poor countries so that they can make generic medicines or import generics from countries which give much lower price.

But these are difficult balances and the pharmaceutical industry, of course, is looking very strongly at exactly how these rules are being developed.

But there has been a change in mindset, at least in several American countries and European ones of the bit multinational pharmaceutical companies being part of trying to find solutions, not only trying to fight change. So there are signs of hope.

QUESTION: Dr. Brundtland, I'm Charlene Porter with the State Department.

If you would, is there a connection between the World Bank meeting and your visit in Washington? Would you comment on expectations for this upcoming meeting as a consideration of these issues as the next logical international forum after the Johannesburg Summit and a consideration of all of these health care issues?

DIRECTOR-GENERAL BRUNDTLAND: I think the World Bank meeting is always, every year, an important meeting because what policies and guidelines are developed within the World Bank and what experiences there are shared and what is pushed forward always has a great impact for all who deal with the development questions around the world.

However, the fact that I'm here exactly this week is linked to our American region, [PAVL], Pan American Sanitary Bureau, having it's so-called regional committee meeting or its conference, its yearly conference, and even this year a centennial. It's 100 years anniversary for the Pan American Health Organization which is why I am in Washington. And we have elected, by the way a new leader of [PAVL] a woman leader yesterday and moving on to CU today and in the morning I was in CSPAN talking about health problems and also talking about the book that was mentioned. So this week has a number of issues. Also on Friday, tomorrow now, I'm going to Harvard for a meeting which focuses on the global challenge of health inequities.

So I'm here in parallel with what happens in the World Bank, but as you say, it is very important and we do work very closely with the World Bank on development issues.

In Johannesburg by the way, I launched with others an alliance on healthy environments for children. Why? Because many people are focusing on the health and future of our children as part of sustainable development, and environment is where children live and grow up. The soil, the water, the

air they breathe, all these, their close environment influences their lives, their health and their future.

So trying to bring people together under an agenda of looking at how the environment affects people's health, but specifically how it affects children's health because children are most vulnerable, with a certain level of toxic components affecting them the result is more danger in a small child than in a grown-up individual, relatively. So as we focus on children we have to move forward on trying to improve the factors from nutrition as the lady from NIH mentioned, to safe water, air, and the child who sits on the mother's shoulder as she is bending over a stove that fills her little room with smoke. It creates respiratory infections and is one of the main causes of premature death in children -- diarrhea and respiratory infections. Very closely linked to environment.

The Johannesburg conference made very clear that water and then increasingly during the conference member states were moving also on sanitation, that they are crucial as we look at the commitments for the coming decades to improve the health and environment certainly of our children.

QUESTION: Thank you, Dr. Brundtland, it was a delight to listen to you.

My name is Viji Melnick. I come from the University of the District of Columbia as well as the Georgetown University Immunology Center.

We are going to conduct a conference precisely on vaccines this coming November 1st where we are going to discuss some of these issues, but a number of concerns come to my mind. One is that whereas we are asking the pharmaceutical companies and other organizations, research organizations, to develop new vaccines there have also been concerns raised in the way clinical trials have been conducted in developing countries to develop some of the vaccines and the way people have been recruited into the trials and the concept of informed consent, etc. That is something that one has to address before you can plunge into sort of a bridge between the developing and the developed countries' efforts.

Second, there are a scarcity of vaccines right here. In the last two years the pediatric vaccines have been so scarce that children were not able to receive the full complement of vaccines they were expected to receive over the first two years of their lives. This is because most of the vaccines are developed by one particular company and when they don't see the kind of profits they may not produce the appropriate amount of vaccine, or something may happen to their production and vaccines stop being manufactured. So there are problems right here in the so-called developed countries and in the infrastructure where we have practically everything that we need.

The other concern that I have is that in improving health such that the education of the mother is the single most indicator, the best indicator of a child's health. Without educating the mother and otherwise empowering the mother, I don't think that we can do very much, and I think this is very eloquently laid out by the book that Amarcia Sen had in which he calls the empowering of women is going to be the answer for the development as in all areas including national development and in security

and in health. What is your opinion?

Thank you.

DIRECTOR-GENERAL BRUNDTLAND: I certainly do agree. As I talk about maternal and childhood conditions as one of the challenged areas, it is clear that both what happens to the mother as she grows up, her nutritional status before even she has her first pregnancy, her knowledge level to have some influence on when she has those pregnancies, and to be able to deal with the number of children she chooses to have. These all illustrate how many of the causes of mortality for children and also maternal deaths which are high above what is in any way reasonable in many countries around the world, is very much linked to the level of conditions around the mother. Not only education but her nutritional status, her health status, her education. They are all intrinsically linked and they are very crucial. And in many countries, of course, women have not been given equal opportunities with men, even in basic things like nutrition or access to education. And the article I mentioned from Afghanistan is kind of just one symbol of this, that in some cultures and in many countries where poverty is prevalent and where the attitudes are different, really the role of women has had major problems. So it's a big challenge and it is linked both to health and education and the children's future.

So I agree. I couldn't agree more. Amarcia Sen is a big hero.

QUESTION: Dr. Brundtland, my name is Lorraine Jensen. My home state is Minnesota, which is probably one of the largest populations of Norwegian-Americans I think in this country and I just want to -- Oh, and Wisconsin. [Laughter] We don't recognize them, though.

I just want you to know how much I appreciate you and I think that women all over the world appreciate you as a role model. I particularly feel that I am very respectful of what you symbolize to me as someone with Scandinavian heritage. So just personally, I want to thank you for who you are and what you represent to me. But I do have a question.

DIRECTOR-GENERAL BRUNDTLAND: Good.

QUESTION: I'm an intern here at the Brookings Institute in mid-career, and I am studying non-profit organizational management. As you know, the tragedy of September 11th has impacted our economy and it has significantly impacted the amount of money that charitable organizations have available to them to give to the kinds of health priorities that you've been talking about.

I wondered if you could respond to how the World Health Organization is assessing how that's going to impact the priorities that you would like to see moved forward in the world.

DIRECTOR-GENERAL BRUNDTLAND: Well let me say this. In the aftermath of September 11th in the first few weeks or even days we were concerned about the potential new threats, as such, and very quickly the anthrax episodes started to happen. We focused on broader thinking

about what other threats could be there from smallpox to other biological weapons and the surveillance and the preparedness activities that needed to be done. That was one aspect. And we entered into that very quickly to help countries prepare themselves.

But the second issue was exactly what you are talking about, the fear that this tragic situation would lead to a number of negative spirals going downward with regard to the world economy, to the whole atmosphere that was at that time moving in the right direction with the G-8 countries listening more to the importance of development aspects and the fight against poverty and also health issues involved.

All that had been established before September 11th on a positive trend so we were concerned what is going to be the net effect even for these important long-term issues?

Today, one year later -- Well, let me say. The risks that it would have a negative effect were obvious and you are explaining some of those negative effects in what you are seeing in funding for good causes in this direction.

On the other hand, I was hoping that as a balance to those potential negative aspects there would be an increasing awareness about our interdependence in the world, and that as I have been describing today, that when you have devastation and terrible conditions and human suffering around in the world and failed states and countries in crisis, the breeding ground for terrorism and for things that will threaten all of us at the global security level, is a challenge to all of us that has to be addressed.

So where are we now a year later? What of these two? Is there an increased awareness that in fact the world is more closely knit together and dependent on each other, and that there needs to be more willingness to come forward to help those who are in desperate conditions.

I don't know what the right answer is at this moment on that balance but it certainly has two aspects and we still have to be trying to explain and to move people to understand how we are so fundamentally dependent on each other that we need to be able to contribute more than what has been the case until now to help people out of poverty. And I do believe that -- The Johannesburg conference in a --

First of all the Monterey conference in Mexico as I mentioned was a certain positive sign because there were increased commitments, not as much as I would have liked, but still in the right direction. And Johannesburg, although it was declared before the meeting to be already a failure, things were happening during that conference and in the preparation of it that after all were positive. So I am, when I have to choose looking objectively and analyzing issues, and then where do I hear, it's not obvious what way we are moving. Then I tend to opt for the optimistic part saying the only thing that can help is to continue believing that things can change in a positive direction and that people can grasp and politicians and countries and interested citizens can rise to the occasion. So I still hope that we will see positive trends after all coming out.

QUESTION: Joe Farrill from UN Wire.

Speaking of Johannesburg, Dr. Piatt said there that he thought AIDS was much too low on the agenda and it was a bit neglected. Do you share his view? Do you think that AIDS has remained as much on the world's radar as it should? Particularly in the year after 9/11 and so forth?

DIRECTOR-GENERAL BRUNDTLAND: Certainly it doesn't get the attention it deserves, AIDS. We have a situation where the Global Fund has a little more than $2 billion to be used in some cases over several years and what we called for with Kofi Annan was $7 to $10 billion, which is what is needed. So we are far below that mark. Frankly, it is not impossible to mobilize $7 to $10 billion a year. It is a minute fraction of the GDP of the rich countries to do this. So there is a cap which is large, and we can calculate that 29 million people, that is our calculation now, will die unnecessarily from AIDS between now and 2010 unless that kind of investment is made.

Also if we do invest in trying to save the teachers and the doctors and the nurses and everybody else of course, by also gradually getting medication to people in poor countries who have AIDS already. Saving their lives maybe for ten years so that their children can grow up and so that they can continue living a productive life for a number more years, that is very important because they are losing some of their best-educated people in many of these countries.

But to do that we have a big gap in funding at the moment which is why I think [Peter] Piatt said what he did. But I think the countries there who were kind of questioning that comment, they were saying we just were in Barcelona. We had the big AIDS conference in New York a little more than one year ago. The program is clear what is needed. We have calculated the funding that is needed. The commitments are in a way there, indirectly at least, but there is a big gap in funding so people will be dying unnecessarily from AIDS and people will be getting, the 29 million, are the ones that will acquire the disease. That's the number. When I said, I was stating it wrong. Twenty-nine million will acquire the disease before 2010 unless the preventive efforts are made to avoid it happening or to curb the curve of increasing numbers of AIDS infections. So big challenge.

QUESTION: Ann Bravier with the Vital Voices Global Partnership. Dr. Brundtland, welcome back to Washington albeit briefly.

I just want to follow up on the question from the questioner from Georgetown about the empowerment of women and you very articulately indicated the importance of the correlation between investments in women and the social outcomes from nutrition, family planning, poverty alleviation, etc., and all of the indicators in increasing studies support that as well.

My question has to do with whether or not during your tenure in recent years you have observed an increased awareness of the importance of these investments, and more importantly from the broader donor community, the reality of making those kinds of investments.

DIRECTOR-GENERAL BRUNDTLAND: I think already in the aftermath of the big global conferences in the '90s, including Cairo and Beijing, donors were much attuned and much aware of the importance of the empowerment of women. So what was needed more than anything was the scaling up of making it happen. It's not the lack of understanding about the issues that count, but it is the inability to get to a level of action that fits with that awareness, which is why I have seen it as one of my roles now in these years to try to add the security and the economic dimension to the general humanitarian aspect because I know that unless you reach the minds of the Finance Ministers and the Prime Minister's office you will not have basic policy change which is what is needed here.

So trying to put health, which means health, education, empowerment of women, to be able to take care of future generations, unless you get health onto the political agenda at the highest level, there will not be this kind of change.

So I don't think it's that people don't know but it is the amount of action taken about that knowledge which is the problem.

QUESTION: Dr. Brundtland, Penny McDonald with CNN International.

We have been following the framework convention on tobacco control and given that May next year I think is the deadline for it and several key countries seems to have weakened their position on the convention, what do you think that convention is going to look like by May next year, and how sort of confident are you that it's going to be a good mechanism for the tobacco industry?

DIRECTOR-GENERAL BRUNDTLAND: We have now two or three weeks ago the first full text of the convention which has been prepared on the basis of the former meetings between nations that have been already carried through. And I am reasonably happy with that text.

If we have sufficient support from each region of the world, of the World Health Organization member states, to rally around the text that is on the table I think we have achieved quite a success story.

Now we don't know at this moment -- The Brazilian Ambassador who has been the chair now, been working very closely with my Secretariat on preparing that text, but he is the one now putting it forward as the negotiating basis for the negotiation. And I think in his wisdom and with our advice I think we have found something which has a real chance to get sufficient support.

The thing is the NGO community, the media, everybody I feel should be trying to rally around that text and protect every bit of it because if we succeed there then we have come to a situation in May 2003 which really is a major step forward. So it's avoiding that text being watered down which is a key challenge for everyone.

QUESTION: Dr. Brundtland, I'm Brenda Wilson with National Public Radio.

I'm sort of curious. You've held very many important positions, one of them as Prime Minister of your country and also with the Brundtland Commission and now with the World Health Organization. My sense of it from just living here in the U.S. is that most Americans probably don't have a huge awareness or consciousness of the World Health Organization.

As the Director of this organization have you found it more difficult to gain an audience to say the President of the United States or others? Where did you have more access and where were people more responsive? And have you seen that change during the time that you have held this position? Has access improved in terms of, especially with industrial countries? I know that people in developing countries are much more open to you, but I just wonder if in industrial countries whether there's that same sort of receptivity to the World Health Organization and a recognition of its importance? Do they listen? Do they invite you in?

DIRECTOR-GENERAL BRUNDTLAND: You know it's a difficult call to answer the question for the following reasons. I can never separate fully in my analysis of, to answer your question, my background, my previous roles and positions from my present one because in my access to political forces, to political decisionmakers, to others in any country, my whole background is what they see and respond to. So this Norwegian Prime Minister of ten years and the leader of the Brundtland Commission and all of that means that being Director-General of WHO but with all this baggage gives me quite a lot of access and influence which not necessarily would be given to anyone. But of course I see this as a benefit for the causes that I am fighting for and I use it because my whole life has been trying to make a difference and trying to make change, and there is a long, consistent thread in my own life in this.

So now many things come together from my own original choice to become a doctor because I wanted to do good not only to people one by one as individuals, but to my own society and to the world. As you think of a child, what can you do, how should you educate in order to make a difference? Choosing to be a doctor was kind of a public health perspective in my mind and from then on to an Environment Minister, all of a sudden being asked to take on that challenge, and then on to becoming Prime Minister and leading the world commission and all this work has been one thing of trying to make change not only in my own country but globally. So I have the luck that I know the people in decisionmaking power in industrialized countries because of the whole of my career and my work, including your present administration, I know people there because of the history. So it helps in getting the messages through.

LAEL BRAINARD: You mentioned that at Monterey America came out with what we consider here to be a very substantial increase in funding. It may look small for a developed country but the reality is it's doubling our development aid. Yet when we got to Johannesburg we were, the U.S., was clearly seen again as sort of the deadbeat, the target.

I'm wondering is the problem from your perspective, where you sit, one of perception or of substance? And what is it that the U.S. could fundamentally be doing differently to be more of a partner in the globalization process to developing countries?

DIRECTOR-GENERAL BRUNDTLAND: I think -- When you double something which is relatively low -- [Laughter] I agree that that can seem dramatic in the domestic scene, but I think that's part of the answer to your question. And I'm sure that the American administration and political system was wondering, do we come with this initiative in the financing for development context? I remember I was glad they did, because it helped that conference shape a better result and both Europe and the U.S. came forward on a positive note.

It helped that conference have good conclusions, including the leaders of poor countries signing up to their responsibility to improve the governance, the transparency, the systems of their own efforts because this is a deal which has several components. It's not only asking for money but it is the performance of the poor countries themselves which is involved.

So it helped that conference.

However, when countries then move on to Johannesburg and they see the whole of Agenda 21 and all that has not been done, not only with regard to funding but changes in the international economic system, the trade system, access to markets, it's a much broader agenda of course also in the financing for development work. But in Johannesburg all this was on people's minds.

The subsidies which in European countries and in the U.S. go to farming was an important aspect. I haven't mentioned it because it's even beyond what -- I would have to have two lectures then. But there are so many issues which are linked with only the development assistance part which have to do with the opportunities of poor countries on the global scene economically which were shot as issues in Johannesburg.

So they were not only angry with the U.S., they were angry, the developing countries were angry also with the European Union because of their reluctance to make any move as they saw it on this basic fairness agenda about markets.

LAEL BRAINARD: Thank you all for being here today.

[Applause]

DIRECTOR-GENERAL BRUNDTLAND: Thank you very much.

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