



UN Special

THE OFFICIAL MAGAZINE OF INTERNATIONAL ORGANIZATIONS

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**DIGITAL HEALTH
FOR GLOBAL GOOD**

**INTERVIEW WITH
DR. TEDROS,
WHO DIRECTOR-GENERAL**

**MAKING THE UN
SMOKE-FREE**

**TRANSFORMING WHO
INTO A GLOBAL FORCE
TO IMPROVE HEALTH**

789 - MAY 2019



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GARRY ASLANYAN

Deputy Editor-in-chief/Rédacteur en chef adjoint

The global force to improve health

Firstly, I am very happy to be back editing the May issue of the magazine, which focuses on the work of WHO. Ideas for these editorials come from threads of thoughts and information gathered over the two months spent putting the next issue together. Interaction with staff who propose ideas, discussion on the focus, brainstorming on what would be the best angle on a story to interest the reader, etc. A lot of creative thinking goes into the process. Then there is fact-checking, on which I have put increased emphasis this time around. This has nothing to do with grandstanding or pedantic joy. The facts in the stories come from informed discussion, which is the underlining goal of the magazine – to create a space for discussing and sharing the experiences of UN staff.

You will see that we have followed up with WHO's Director-General to understand the progress made in the process of transforming the Agency that Dr. Tedros initiated at the assumption of his term as D-G. We have also brought you stories on the direction that WHO is taking, with a focus on digital health, working in emergencies and making the UN smoke-free. The integration of approaches to communicable and noncommunicable diseases with the goal of achieving universal health coverage is another critical change in direction that the Organization has recently undertaken. Enjoy reading! ■

La force mondiale pour améliorer la santé

Tout d'abord, je suis très heureux de revenir à la rédaction du numéro de mai du magazine qui porte sur le travail de l'OMS. Les idées pour ces articles sont issues de réflexions et d'informations recueillies au cours des deux mois de préparation de ce nouveau numéro. Ainsi, échanges avec le personnel proposant des idées, discussion sur le thème principal, réflexion sur le meilleur aspect du récit pouvant intéresser le lecteur, etc. Le processus fait appel à beaucoup de réflexion créative. Ensuite, il y a la vérification des faits, sur laquelle j'ai mis davantage l'accent cette fois-ci. Cela n'a rien à voir avec la démagogie ou la joie pédante. Les faits présentés dans les articles proviennent d'une discussion éclairée, ce qui est l'objectif principal du magazine, qui est de créer un espace de discussion et de partage d'expériences du personnel de l'ONU.

Vous verrez que nous avons assuré un suivi avec le Directeur Général de l'OMS pour comprendre les progrès réalisés dans le processus de transformation de l'agence que le Dr Tedros a initié au début de son mandat. Nous vous avons aussi présenté des articles sur l'orientation que prend l'OMS en mettant l'accent sur la santé numérique, le travail dans les situations d'urgence et l'interdiction de fumer à l'ONU. L'intégration des approches des maladies transmissibles et non transmissibles dans le but d'atteindre l'objectif d'une couverture médicale universelle est un autre changement d'orientation crucial que l'organisation a récemment entrepris. Bonne lecture à tous! ■

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Director-General and six Regional Directors of WHO.

Interview

Dr. Tedros, Director-General, World Health Organization

UN Special was privileged to have the opportunity to interview WHO Director-General Dr. Tedros Adhanom Ghebreyesus for this issue.

DR. GARRY ASLANYAN, WHO, DEPUTY EDITOR

Thank you allowing to come back to you a year after the May 2018 issue of the magazine where you outlined your plans and hopes for the organization. A year after, what are the major achievements and what are the remaining challenges?

There are many achievements. Most importantly, our new five-year strategic plan – the General Programme of Work – anchors our work in the Sustainable Development Goals and was approved by the World Health Assembly. At its heart are three ambitious targets: 1 billion more people benefit ing from universal health coverage; 1 billion more people better protected from health emergencies; and 1 billion more people enjoying better health and well-being.

We've already made real progress in the last year. Several countries, including Kenya, India, the Philippines and South Africa, made important strides towards universal health coverage. We launched major new initiatives against cervical cancer, malaria and tuberculosis. And we held the first global conference on air pollution and health.

We responded to 66 emergencies in 49 countries, including two Ebola outbreaks in the Democratic Republic of the Congo, the largest ever Yellow Fever outbreak in Brazil, as well as ongoing humanitarian crises in Yemen, Syria and Bangladesh.

We launched WHO's first investment case last year; it estimates that if the world achieves the "triple billion" targets, we

can prevent 30 million premature deaths and add 2-4 percent of economic growth in low-income countries by 2023.

To support countries, we recognize that the world needs a more modern and agile WHO. As soon as the Assembly adopted our new strategy we embarked on a radical redesign of all major process. By 6 March we announced the most comprehensive, far-reaching set of reforms in WHO's history. Our new structure is designed to break down silos and enable us to work in a much more integrated and timely way, both vertically across our headquarters, regional offices and country offices and horizontally within offices

Now we have to maintain momentum as we implement the transformation agenda while driving progress on the targets.

The transformation agenda you have mentioned and initiated has had positive reviews overall. Where do you see the organization in another year's time? Some questions remain on how the existing regional office configuration will allow for the transformation to happen and make real difference, what is being done to prevent that risk?

WHO has a unique and powerful governance structure because our Regional Directors are elected by Member States, rather than appointed. We work closely together and have met monthly over the past year to design and roll out the new WHO. We are truly on the road to 'One WHO'.

For the first time, we are aligning the structure of headquarters, regional offices and country offices. Four "pillars" that will run through the organization: Programmes; Emergencies; External Relations and Governance; and Business Operations. We've also clarified the roles of the three levels to make us more effective and efficient

We are creating a new division, the Office of the Chief Scientist, which will anticipate and stay on top of the latest scientific developments and ensure the scientific excellence and relevance of WHO's products.

A new Department of Digital Health will drive a comprehensive digital health strategy, while enhancing WHO's role in assessing digital technologies and supporting countries in deciding how to prioritise, integrate and regulate them.

We are overhauling the way we work with countries through a new strategic dialogue process. We will make country-specific SDG projections based on robust data; identify weak points in health systems; and provide tailored support on how countries can change course and improve outcomes on the road to the SDGs.

A new WHO Academy will serve as a state-of-the-art digital learning platform to leverage the expertise of the world's best health experts and make it available for people all over the world.

We're changing how WHO generates resources. A new WHO Foundation and innovative financing mechanisms will help us diversify our funding, make us less reliant on a handful of major donors, and ensure our important normative work is truly driven by public health needs.

In one year's time, we will be a very different, stronger WHO, working seamlessly across 3 levels to drive measurable impact in people's health on the road to 2030.

The staff are ready to embrace the idea of not working in silos. How will the new leadership help ensure this actually takes place?

We are taking a broad-based approach to make us a more agile organization and eliminate barriers to collaboration. We will establish 3-level delivery teams, combining staff from headquarters, regions and countries into single teams with joint goals and accountability for achieving results.

For example, we plan to create a 3-level delivery team programme for our new "High Burden, High Impact" initiative on malaria, with staff from across WHO.

For some initiatives that require expertise from multiple departments, we will build cross-cutting teams with joint accountability for specific projects.

Primary health care and antimicrobial resistance are good examples of issues that will require the input of many different parts of WHO, which we can deliver with agile cross-cutting teams.

For short-term projects that require expertise from multiple disciplines, we will create agile product delivery teams with fully seconded and co-located staff.

For example, if a new guideline is needed quickly, a dedicated product delivery team will come together under an empowered leader with a budget and authority.

Several new policies, such as on mobility and teleworking are directly linked to transformation agenda - how do you see this unfolding in the next year?

Mobility is a key tool for increasing diversity and performance. But our commitment to diversity is not about ticking a box, it's about improving the quality and impact of everything we do.

When staff experience new places, the organization benefits. To help incentivize mobility we are making it a key criterion for career progression.

I support teleworking because it can increase productivity while helping staff maintain work-life balance. At the same time we need to address challenges to how we currently work. Only then can we exploit tools like teleworking to help achieve our objectives. I look forward to expanding options for teleworking once our new operating model, new teams and new ways of working have been cemented.

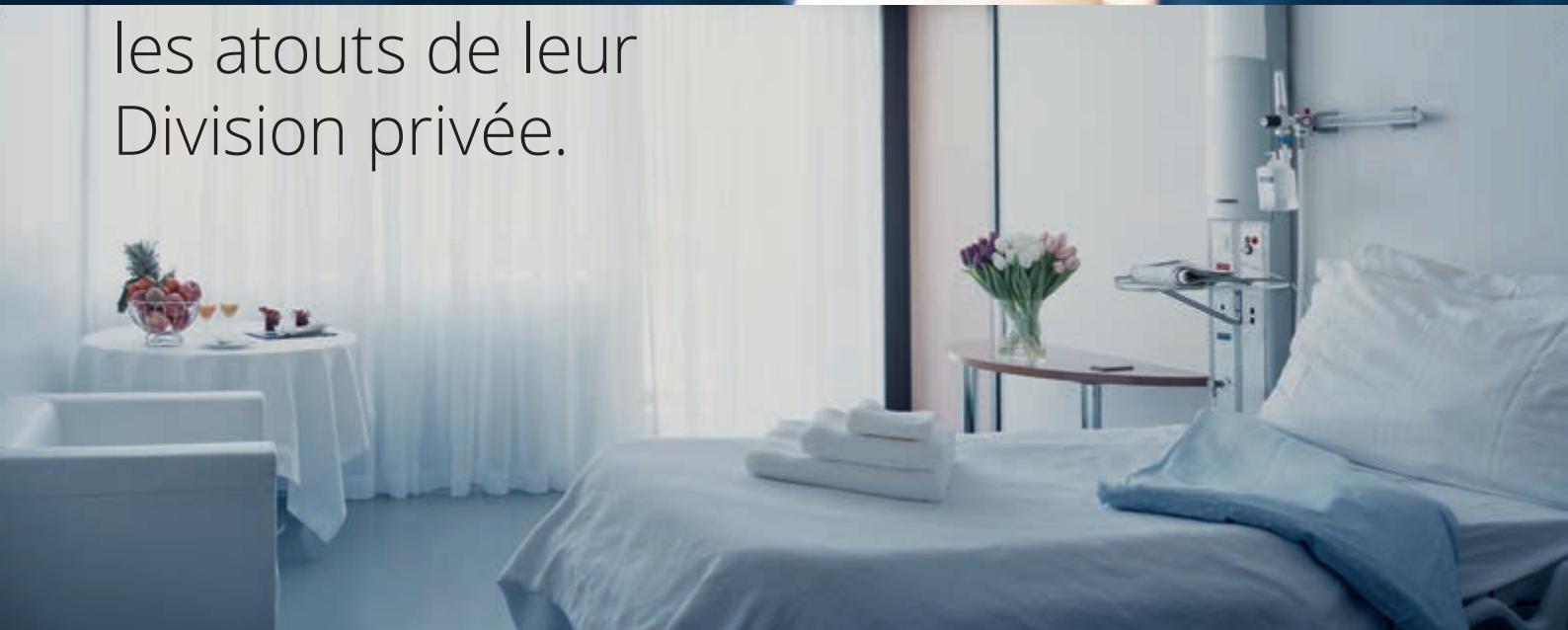
Are there any specific messages that you would like to leave with staff at this exciting time?

Yes – thank you! Many of the ideas we are now implementing came from the staff themselves. I have always believed that staff are an organization's best asset. WHO has amazing people doing amazing work all over the world, every day. I understand that periods of change can cause disruption and uncertainty, but I know that most of our staff are as excited by our new mission and transformation as I am. I'm looking forward to working with them to make it a reality. ■



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Digital health for global good: a holistic vision

Digital health provides opportunities to accelerate our progress in attaining Sustainable Development Goal 3 and achieving the “triple billion” targets in WHO’s 13th General Programme of Work for 2023. Most importantly, it provides the opportunity to fulfill a holistic vision: with WHO’s sound commitment to ethical and evidence-based policies, good governance, and accessible and affordable solutions, we can seal the deal for global goods without leaving anyone behind.



“These messages help me manage my condition”.

© Baye Omar GUEYE

LAXMI PANICKER, WHO

For the past two weeks, Mariam has woken up to this mobile message: “Remember to check your blood sugar, and drink 2 liters of water before you start fasting today.”

It’s the holy month of Ramadan in Senegal, and her day begins before dawn. It starts with the morning prayer, then the daily chores of sending her six children to school, before heading to the fish market to collect her supply, which she then sells on the small street near her home.

This is the family’s sole income. The job is physically demanding. Mariam will typically spend six to eight hours in the market, haggling with her customers. It is not unusual for her to suffer several attacks of dizzy spells during the day when her blood sugar drops. Drinking water is essential to keep her blood sugar in check and to prevent cardiac accidents related to diabetes. As the days start busy, she often forgets to tend to herself.

But today, as has been the case in the past two weeks, she has not forgotten to drink water before setting out for the day. Thanks to mDiabetes, a digital health initiative supported by WHO and the International Telecommunication Union, she receives a text message at daybreak, reminding her to keep her blood sugar in check.

“These messages help me manage my condition,” she says. Despite the altered eating schedule of Ramadan, Mariam find it easier to cope with her condition and have the energy needed to work and care for her family.

mDiabetes, a part of Be He@lthy, Be Mobile, is one of the many digital health initiatives supported by WHO. mDiabetes connects target patients, local practitioners, and community health workers. It supports the design, implementation, and scale up of digital health programmes for the prevention and management of noncommunicable disease (NCDs) by using SMS to deliver advice to patients.

A Paradigm Shift

As in Mariam’s case, digital health is a paradigm shift in the delivery and management of healthcare. WHO is already active in this field and we are set to move ahead rapidly. Recognizing the potential, the World Health Assembly has called for a global health strategy to embrace this wave of change and untapped opportunities. The potential is massive, from artificial intelligence assisting with remote diagnoses to the advancement of Sustainable Development Goals. However, for WHO, real success will be determined by our capacity to leverage innovation in delivering equitable, accessible, and affordable

digital health solutions, leading to universal healthcare for all.

But what will this success look like in Mariam’s life?

WHO’s commitment to ensuring proper governance, evidence-based policies, accessibility and affordability for digital health services, aligned to the needs of the national health system, is set to benefit people like Mariam all through her life.

1. Mariam will have access to affordable treatment and medicine

Data analytic solutions, like WHO’s Medmon app, can indicate the availability and price of medications in public and private health facilities, including private pharmacies – providing economic and safe options to choose from. While individual providers can develop such technologies independently, WHO can provide countries frameworks and evidence-based guidance to vet potential technologies to ensure they fit with the country’s needs, are people-centric, and integrated into the national health system in ways that are transparent, reliable, and secure.

2. Mariam will have access to innovative and quality health care services locally

Currently, teleconsultation solutions like WHO-supported telemedicine provide a range of options to support the diagnosis

and treatment of noncommunicable diseases (NCDs) in rural settings. However, a technological leap, like artificial intelligence, can aggregate, predict, and scale up the potential for wider reach, bringing much-needed services to people and regions that have formerly been left out or underserved. As part of our convening role, WHO can work with Member States and innovators to connect specific country needs with digital solutions, that make an impact on the ground.

3. Mariam will receive safe and regulated medicines.

Solutions like blockchain can track the origin of medical products to eliminate counterfeit medicines from the market, providing safer options for health care practitioners.

However, digital services such as these are launched into a largely unregulated space, sometimes without operational maturity. In its regulatory role, WHO can introduce the governance model to ensure digital health solutions are ethical, clinical, legally validated, and affordable to those who could benefit the most.

4. Mariam will receive preventive care.

Mobile health applications, such as WHO's Be He@lthy, Be Mobile initiative, can help empower patients to change their health behaviors, self-manage their health and reduce national health care spending. WHO can use its technical capacity to design and implement patient-centered digital health solutions that address the health delivery demand from Member States.

Central to this vision is our triple-pronged approach to digital health delivery.

1. Policies – Support policymakers at the national level to ensure the safe and ethical use of technology.
2. Practitioners – Facilitate the capacity for practitioners to use digital technologies to deliver healthcare benefits effectively.
3. Population – Improve the health and well-being of people, with the interventions of digital health.

As the first step towards creating a mechanism for wider collaboration, in support of this vision, commitment from all players that share the current digital health arena (tech giants, corporations, governments, startups, and international bodies) is



mDiabetes campaign in Senegal.

essential. The operational motto for such a partnership should shift from digital health production to one focused on co-creation for the common good.

We understand the potential; we understand the challenges. And we are committed to kick-starting our actions and initiatives so that people like Mariam need not wait too long to see the benefit in their everyday lives. ■

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DG's interview

Digital health for the global good: reaching everyone, everywhere

LAXMI PANICKER, WHO

How do you see WHO's role in digital health? How can digital health initiatives help reach the "triple billion" targets?

Digital technologies are changing health in numerous ways. They enable us to test for diabetes, HIV and malaria on the spot, instead of sending samples off to a laboratory. 3-D printing is revolutionizing the manufacture of medical devices, orthotics and prosthetics. Telemedicine, remote care and mobile health are helping us deliver care in people's homes, instead of in hospitals and clinics. And before any of us ever sit down in a doctor's office most of us have Googled our symptoms and diagnosed ourselves – perhaps incorrectly.

Harnessing the power of digital technologies is essential for achieving the Sustainable Development Goals, including universal health coverage and the "triple billion" targets in WHO's 13th General Programme of Work. Digital technologies can strengthen health systems by simplifying and improving the quality and coverage of care, increasing access to health information, and reducing the economic burden on health systems through preventive care.

Digital technologies are evolving rapidly and hold great promise for transforming the health of individuals and entire nations. But a key bottleneck



Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization (WHO), briefs journalists on the Ebola Virus Disease outbreak in the Democratic Republic of Congo.

for maximizing their use is scale and sustainability. That's where WHO can play a key role. We can bring together different actors in the digital health arena to ensure digital health development and implementation are driven by evidence-based and ethically sound policies, good global governance, and are accessible and affordable. Based on that, we can advise countries on how to maximize the opportunities of digital technologies, while avoiding the pitfalls with appropriate regulation.

You have recently announced the transformation agenda. How will this shape the digital health goals of the Organization?

In at least three ways. First, because digital technologies

will play such a key role in health, WHO is creating a new Department of Digital Health to enhance our role in assessing digital technologies, and in supporting countries to make decisions about how to prioritise, integrate and regulate them.

Second, we are also setting up a Department of Data, Analytics, and Delivery, to build a modern data "backbone" in WHO that allows sharing and analysis of data between the three levels of the organization and countries.

And third, we have also established an Innovation Hub to identify innovations with the potential to make significant improvements in health, but which face barriers in being taken to scale.

At the regional level, we will establish a framework for promoting dialogue, innovation, and best practices with digital health by mid-2020. As a trusted advisor to governments, and to leverage our country and regional offices, we will then work with countries to scale and sustain evidence-based innovations.

How will WHO support countries to strengthen their digital health efforts?

WHO has offices in 149 countries, territories and areas. That global presence, allied with our global mandate as the world's leading authority on health, mean we are uniquely positioned to make a difference by matching the supply of promising innovations with

demand from countries. We can use our normative role to ensure that countries use digital health technologies that are evidence-based, sustainable, and aligned to their needs. We can also support national regulatory bodies and ministries of health to adapt their practices and capacities in regulating and adopting digital health to maximize its benefits and we can work with innovators around the world to meet the specific needs of the Member States and implement tailored solutions that make an impact on the ground.

What measures are we taking to make sure that “no one is left behind,” especially people living in remote areas or resource-limited settings, like Mariam, the protagonist in our story?

We all need to make sure that innovations such as digital

technologies work for everyone, and help to reduce inequalities instead of exacerbating them. But we also need to think about innovation in its broadest sense, beyond digital technologies. We need innovation in every area of health systems – including the way services are delivered, the way health workers are trained, and the way health systems are financed. We should not forget that at the center of the digital health delivery chain is an individual, like Mariam, who in industry terms, is the ‘consumer’ of these innovations. The best innovations are those that respond to needs of people and their circumstances. So we encourage innovators to know their market, identify where the needs are greatest, and be clear about how their ideas could make the biggest difference. It’s equally important to supplement technologies with evidence-based policies at

the global, national, and community level so that solutions are affordable, accessible, and fully integrated into national health systems.

Digital health is an arena with multiple players (like tech giants, corporate entities, academic institutions, and pharmacies). Some of them may have a financial interest in this partnership. How can WHO ensure an ethical and moral commitment from all players?

Active engagement with the private sector is essential to achieve the Sustainable Development Goals. Of course, we need to pay careful attention to conflict of interest, but I believe strongly that we need to move from a culture of risk aversity to a culture of risk management. We must be guided by some key principles. First, countries must make careful, targeted investments based on

national health priorities. We can support them with the most up-to-date evidence and advice to make the smartest investments and achieve the biggest gains in health. We can also leverage from our experience in pre-qualification of medicines to certify the adherence to global standards of quality and ethics of digital health innovations.

Ultimately, our aim is to ensure evidence-based technologies are scaled in the most effective and sustainable way. We will look into partnering in open source and open collaboration models to develop egalitarian solutions. Another key measure is for governments to support local ownership, development, and implementation of digital health innovations, rather than relying on imported solutions. ■



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MedMon App

A new addition to WHO's digital health portfolio

SWATHI IYENGAR AND
LAXMI PANICKER, WHO

Approximately one million Rohingyas have fled violence in Myanmar's Rakhine State and crossed into Cox's Bazar, Bangladesh – one of the country's poorest districts. This vulnerable population needs an uninterrupted supply of essential medicines. However, the rapid influx of medicines from various sources and limited regulatory oversight increases the risk of substandard or falsified medicines infiltrating the local market. It also increases the complexity of supply, distribution, storage systems, and the risk that safe, affordable, and effective medicines may not be accessible to those who need them urgently.

In October 2018, WHO introduced its mobile application, "MedMon," in a joint project with the United States Pharmacopoeia Convention (USP), and the Bangladesh National Medicines Regulatory Authority (DGDA) to assess access to essential medicines required to treat critical illnesses in the Rohingya refugee camps. WHO Essential Medicines and Health Products Price and Availability Monitoring Mobile Application (MedMon), first piloted in 2016,



Essential medicines' assessment at a health facility pharmacy in the Rohingya Refugee Camp (Teknaf).

is an innovative, multi-language tool that enables rapid data collection and analysis of the price and availability of medicines, procurement methods, quality and safety risks, and appropriate use from local health facilities, pharmacies, and procurement centers.

MedMon allows users to routinely monitor medicines' access in a sustainable, cost-effective, and timely manner, regardless of the users' access to internet or cellular data. It accelerates our operational decision making and improves policy interventions to increase patients' access to medicines.

Before the development of MedMon, similar assessments would have taken months for data collection, validation, and analysis and would have cost upwards of 25,000 USD. The time, labor, and cost of such assessments were key barriers to the sustainable routine monitoring of medicines' accessibility. With MedMon, countries without comprehensive logistics management and information systems can now collect and analyze data quickly and cheaply to track medicine prices and availability and identify areas for policy intervention to improve patients' access to medicines.

Some countries, including Bangladesh and Thailand, will implement MedMon nationally to produce data for national policy-making and monitoring Sustainable Development Goal Indicator 3.b.3, i.e., the availability and affordability of a basket of tracer medicines for primary health care.

MedMon has been piloted in 25 countries in four regions. ■



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Catherine Kirorei Corsini, President of the WHO/HQ 67th Staff Committee (SC67)

CATHERINE KIROREI CORSINI, WHO

Several years ago, I did not know well what the SC did, nor did I understand how I could be of help. Nevertheless, I put my name forward and was trusted by the HQ colleagues who voted for me. Initially, I worked as a Selections Coordinator, learning about WHO policies, HR rules and hiring mechanisms. Later in 2018, I was elected as one of the Vice-Presidents of the 66th SC; and here I am now – trusted again by colleagues, this time to serve as the HQ Staff Association President.

Intense, complex, with a lot of responsibility

This is what the work of the President is. One needs to be a spokesperson – for the SC and staff, interacting with the office of the Director-General, management and even liaising with the Regional Staff Associations for issues that touch global WHO. This entails taking decisions, representing staff at high-level meetings and speaking on their behalf. It is not easy when one speaks for over 2,500 colleagues, bringing to light issues related to staff rights and interests. One has to remember: it is not about you as a President, but about everyone working at HQ and WHO as a whole.

It is important to constantly keep abreast of WHO rules and policies and follow them to make sure they reflect the interests of both staff and the Organization. The President is responsible for enabling constructive relations with management. He / she oversees the smooth running of the Committee and its secretariat, chairs the SC meetings, facilitates or takes lead in decision-making. Unlike working for a department or unit, being the SA President also means you handle a wide range of subjects, meeting staff of all categories across the hierarchy within the Organization. This requires essential skills in listening and analysing situations and advising staff on the correct solutions. A President – as well as any SC member – should not be judgemental. We are always there for all HQ staff.

The President's work is impossible without the commitment and full support of the whole Committee. I am so grateful to all

SC members – those who served in the past, those yet to join and especially those serving now and giving me the full support required to carry out this important task. This is voluntary work. It is not by default that people volunteer to serve others; it takes courage and a big heart to do that. They do everything possible, and beyond, to make sure our work is done, and this is on top of their normal work. This group is a very diverse group. We range from G4 to P5; the youngest is 26 years old and the oldest 59. These nine women and eleven men speak a rich range of languages: English, French, Russian and Spanish (from the UN official languages); we also cover among ourselves languages such as Portuguese, German, Swahili, Masaai, Bulgarian, Greek, Tagalog, Visayan, Fanti, Twi and Ga... We are from 11 different countries: Australia, Bulgaria, Canada, Djibouti, Germany, Ghana, Kenya, Switzerland, The Philippines, Portugal, and the USA. We are from a diverse range of backgrounds. Yet, we serve all WHO staff, across categories, functions, geographical and economical origins, cultural and religious beliefs. We are diverse, but we serve as one.

Staff need and deserve support

Even when an organization functions perfectly, employees are not 100% safe from problems that might arise at work. Our diverse cultural backgrounds, religious beliefs and geographical and economic origins inevitably have an impact on how we relate to each other in the office. In addition, we all have phases in life when we may face personal issues that cause stress and hinder relationships at work. In addition, there may always be misunderstandings or diverging viewpoints between a staff member and the Organization, or within teams. We hear about such situations, and the SC does its best to support colleagues. We are flag bearers on behalf of staff, while also advocating for staff to respect and adhere to the WHO rules and policies. Other issues that are cause for a lot of concern are open office space, parking spaces, the introduction of new policies like mobility, transformation or realignment and shared utilities like the fitness centres or the cafeteria, etc.



Catherine Kirorei Corsini.

Listening. Engaging. Communicating.

To bring their concerns forward, staff talk and write to us, come to us, or visit the clinics that we hold once every month. The SC also conducts surveys when necessary to get the feel of and feedback from staff so that we can correctly represent them. We are proud of the trust staff have in us!

An exceptional year

During my service, I have seen storms – like the new mobility policy and the pay cut for Professional staff (both launched in 2016). I witnessed how previous Presidents gave their best, empowering the SC to work with staff while collaborating with management to defend staff interests.

2019 is the year in which WHO is going to implement the Transformation, to enable our Organization to deliver on the 13th Global Program of Work (GPW13). As previously, changes may cause anxiety and worries amongst staff. This year, SA will need to collaborate closely with management to make sure staff concerns are heard and taken into consideration. I am involved in discussions and take part in several working groups and committees discussing the transformation implementation phase. I also ensure continuous collaboration with regional SAs, as we believe in the value of sharing information across all levels. This is a process led by our Director-General, who is committed to a global WHO, one WHO. SAs are also coming together along this thinking, making sure we all work as WHO staff, regardless of where we serve.

Our priorities for 2019

- **Managed Mobility:** implementing a feasible and sustainable mobility policy (geographical and functional), supported by incentives and effective HR policies
- **Burn the Red Book Initiative:** identifying and drawing attention to inefficiencies in order to improve the Organization and increase the impact of our work
- **Transparency and Internal Justice:** increasing openness and accountability throughout the Organization
- **One Big Association:** representing the shared and unique needs of all personnel
- **Working Conditions and Well-Being:** protecting and advancing the interests of staff on all fronts
- **Greening the Blue:** promoting and enacting changes for our environment and health

Acting on behalf of staff

The President holds face-to-face meetings with the Human Resources Director, bringing individual staff queries to the attention of HR. The SC also meets with senior management each week, to discuss broader, systemic issues and WHO policies and rules. There are also monthly meetings with the

Director-General. At the global level, we have WebEx coordinated calls with the regional SAs and an annual meeting with the heads of the regional SAs. Very importantly, we participate in the Global Staff and Management Council (GSMC) – a group that brings together global WHO SAs with all WHO HR and top management, to discuss and agree on policies and any other issues of concern to both management and staff. This council delivers reports, with recommendations, that are submitted to the DG for approval.

A constructive, trustful collaboration

Management is both a partner and an adversary. We press on issues where we see that management needs to better integrate staff concerns, but we do it with confidence that we will be heard and that whatever is reasonable and feasible, will be done. We, as the HQ Staff Association, enjoy the privilege of good collaboration with Human Resources and the Office of the Director-General. The monthly meetings with the Director-General are exceptionally beneficial formats of engagement. The DG values staff, and expects his Management team to do so too. At these meetings, we bring forward issues of concerns to staff, systemic issues and any other issues that could make WHO a better working place.

A lot accomplished, a lot more to do

2019 is especially challenging. I feel an enormous responsibility to help the Committee and staff get through it well. We get a lot done through the engagements described above.

My own experience confirms that the good collaboration with him and his office makes the SC work more easily and helps us move fast. We have been challenged to be more agile, so we have gone out to all HQ staff with our Agile April initiative – broadly embraced by many colleagues. The SC is grateful for this great collaboration and we believe a lot more can be achieved when minds, hearts and actions are concerted across all staff – from the most junior person in the system up to our Director-General.

I want to finish by thanking my whole team in the IVB department for their encouragement and full support during the years I have served on the Committee and especially this year, in which I was elected President. I also thank the SC67 members for their trust in electing me as their President, their commitment to the work of the Committee and their full support. ■

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Interview

Dr. Ren Minghui, WHO Assistant Director-General

Dr. Ren Minghui serves as Assistant Director-General for Universal Health Coverage, Communicable and Noncommunicable Diseases at the World Health Organization (WHO). We sat down with him to discuss progress towards health-related SDGs and ongoing collaboration with key partners.



Dr. Ren Minghui, WHO Assistant Director-General for Universal Health Coverage, Communicable and Noncommunicable Diseases, speaking with Garry Aslanyan and Zsafia Szilagy in his office at WHO Headquarters in Geneva.

DR. GARRY ASLANYAN, WHO, DEPUTY EDITOR AND ZSOFIA SZILAGYI

In early 2016 you swapped the role of Director-General for International Cooperation in China's National Health and Family Planning Commission for a leadership position at WHO's Geneva-based headquarters. Was that transition easy?

The transition was generally smooth although it was challenging in some ways. Prior to joining WHO, I worked extensively on international health cooperation and served on the executive boards of WHO, the Global Fund and UNAIDS. My priorities included overseeing the expansion of health cooperation with Africa, BRICS countries and other key partners. So when I arrived at WHO, I was aware of the complex dynamics in global health and knew all the key actors really well. But at the same time, I had to learn a lot about the multicultural working environment and the very different administrative system.

You are currently in charge of infectious and non-infectious disease programmes at WHO. Both areas of work are vast and complex. How do you rate progress towards the health-related SDGs?

Countries are making progress in many areas, including on reducing deaths within the under-five age group, as well as on reducing mortality due to HIV, tuberculosis (TB) and homicide. However, overall progress on health is not fast enough to meet the 2030 targets. The relevant tools, policy instruments and technical recommendations are available to all countries but there are many roadblocks on the way. These range from a lack of adequate financial resources to fund or reform health programmes, to challenges in health service delivery during humanitarian emergencies, structural weaknesses in health systems such as health worker shortages, and biological challenges such as antimicrobial resistance.

I expect the first UN SDG summit in September to draw clear conclusions on where we are and what we need to do differently to accelerate the pace of progress.

WHO is undergoing a major transformation to maximize its impact at country level. What do you consider to be the most critical elements of the reform? WHO is being transformed into a modern, agile organization that works seamlessly across programmes, major offices and its three levels, to reach our five-year strategy's triple billion targets by 2023. Among others, we are redesigning and standardizing our core technical, business and external relations processes, centralizing the resource mobilization function, and strengthening our country presence. Our goal is to deliver measurable impact on the health of people in all countries. We are also aligning our ways of working with other organizations and developing a

Global Action Plan on Healthy Lives and Well-being for All.

Tell us more about this Global Action Plan. How did this come about and when will it be ready?

WHO began coordinating the development of the Global Action Plan last year following a request by three heads of state: Germany's chancellor, Angela Merkel, Ghana's president, Nana Akufo-Addo, and Norway's prime minister, Erna Solberg. The Global Action Plan is an historic commitment by 12 global health and development organizations to accelerate progress towards the health-related SDG targets. Our aim is to unite the organizations under a joint vision and align efforts to reduce inefficiencies and duplication at country level. The first-phase document was presented to key global health actors last October and the final document will be launched during the high-level week of the UN General Assembly in September 2019.

We will begin implementation at global, regional and country levels later this year.

How will this affect your existing collaborations, for example with key partners in the fight against infectious diseases?

WHO enjoys a close collaboration with the Global Fund, Unitaid, UNICEF, UNAIDS, UNDP and Gavi – who are all signatories to the Global Action Plan. Let me illustrate this with an example. A few years ago, treating children with TB was very challenging as no medicine formulation was available that was adapted to their needs. Caregivers had to crush adult tablets into small pieces to administer them to children. This often resulted in incorrect doses and poor treatment outcomes. To address this problem, Unitaid launched a project to increase access to quality-assured, affordable TB medicines in suitable

formulations and correct dosing for children. WHO received funding, together with the TB Alliance, to implement the project and to guide generic manufacturers in the development of child-friendly formulations. As a result, the WHO Prequalification Programme approved two child-friendly TB medicines in 2017, and this cleared the way for partners and countries to bulk procure the medicines at reduced prices. The child-friendly medicines are now available and used in over 80 countries. So with some partners, we already collaborate very closely, but with others we need to further align our work.

If we could fast-forward to three years from now, where do you hope we will be in terms of health-related SDGs?

I hope we can put elimination programmes for diseases such as HIV, TB, malaria, hepatitis and neglected tropical diseases

on a sustainable footing. Most countries should adopt integrated approaches to health promotion and disease prevention and achieve strides in strengthening their health systems. I have high hopes that the UN High-level Meeting on Universal Health Coverage, which will take place in September, will generate concrete commitments and follow-up actions in countries. Overall, I hope that most countries will increase their health spending and have a strong plan in place to move towards universal health coverage.

Finally, because you are from China, we would like to ask: does China's Belt and Road Initiative offer opportunities to improve health outcomes?

Yes, absolutely. The economic development projects, scientific collaboration and targeted health programmes under the Belt and Road Initiative (BRI)

could lead to tangible improvements in health outcomes in BRI beneficiary countries and help to reduce poverty rates. Further, I think that China's own experience in strengthening its primary health care system and expanding essential health service coverage to over 95% of the population will be invaluable to these countries. WHO is working closely with China and BRI beneficiary countries to ensure that the Initiative's health component yields visible and sustainable results. ■



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Her Excellency Ms. María Fernanda Espinosa Garcés, President of the 73rd session of the UN General Assembly, opens the high-level meeting on TB.

#ItsTimeToEndTB

TB is a treatable and curable disease that still kills millions. Governments and heads of state have agreed that an accelerated and tougher response is needed to end tuberculosis (TB).

**DR. TEREZA KASAEVA, DIRECTOR,
WHO GLOBAL TB PROGRAMME**

“It’s time for action – it’s time to end TB!” this was the rallying cry on 24 March this year, as governments, affected communities, civil society organizations, health-care providers, and, national and international partners came together to commemorate World TB Day. This follows the historic UN high-level meeting on TB held last September that brought together for the first time heads of state and other leaders to make commitments to accelerate the TB response.

This high-level spotlight has been long in coming. Progress in combatting this ancient disease that has been around for millennia has been far too slow. While 54 million lives have been saved since 2000 through our collective global efforts, TB remains the top infectious killer causing far too much suffering. Every day, 30,000 people fall ill and 4,500 die from a disease that is preventable, treatable and curable. Drug-resistant TB remains a global public health crisis that threatens gains made in the fight to end TB.

This is why the political declaration of the UN high-level meeting is so critical as it calls for an urgent surge in the TB response, and sets out concrete targets to achieve by 2022, including diagnosing and treating 40 million people with TB, scaling-up access to preventive treatment to 30 million people most at risk of contracting the disease, and scaling up investments in TB implementation to USD 13 billion and USD 2 billion for TB research annually. Along with world leaders, the voices of those affected by TB and civil society were vibrant at the UN high-level meeting in calling for these bold commitments. Work towards achieving these

2022 targets will drive the acceleration needed to reach the 2030 target of ending the TB epidemic as set in the Sustainable Development Goals.

To ensure these promises are kept and the response to end TB is accelerated, the WHO Director-General will support UN Secretary General in delivering a progress report in 2020, ahead of a more comprehensive review by heads of state and government at the next UN high-level meeting, expected in 2023.

The good news is that countries, including India, South Africa, the Russian Federation, Vietnam, Philippines and the Dominican Republic are well on their way to translating commitments into actions. WHO is working with them and other high burden countries to intensify efforts and ensure access to tools and support. Notably, WHO released a special package of actions to help countries increase the pace of progress to end TB on the occasion of World TB Day. The package includes:

- An accountability framework to coordinate actions across sectors and to monitor and review progress

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Dr. Tedros Adhanom Ghebreyesus, Director-General of WHO, speaks at the high-level meeting.

affected with TB. The 1 + 1 initiative calls for people to support at least one other person affected or at risk of TB which could in turn multiply to reaching millions with care.

We now have the commitments and tools – it’s time to rapidly translate these into action and empower those at the frontline – working towards ending the suffering and death caused by this disease to millions worldwide. As expressed by WHO Director-General Dr. Tedros Adhanom Ghebreyesus, “In the end, we must remember that the war against TB will not be won at meetings in Moscow, Delhi or New York. It will be won in communities. It will not be won with declarations. It will be won by nurses, doctors, community health workers and others at the frontlines. Our job is to give them the resources they need to find every last person with TB, to diagnose them, to treat them, and to cure them. That’s the measure of success.”

- Key new WHO guidelines on multidrug-resistant TB treatment, infection control and preventive treatment for latent TB infection.
- Tools such as a guide for effective prioritization of planning and implementation of impactful TB interventions based on analyses of patient pathways in accessing care; a dashboard to help countries know more about their own epidemics through real-time monitoring – by moving to electronic TB surveillance systems and roadmaps to scale up action to address child and adolescent TB and private sector engagement.
- An overview of important initiatives led by WHO in collaboration with partners, such as the “Find.Treat.All.#EndTB” flagship initiative with Global Fund and Stop TB Partnership to reach 40 million people with quality care by 2022; and the WHO civil society task force to ensure effective and meaningful civil society engagement.

In addition, WHO launched a collaborative multi-stakeholder and multisectoral platform with partners to coordinate the TB response and review progress, as well as a 1 + 1 initiative with youth advocates to support those

WHO is committed to action for a world free of TB, working closely with those affected, and those at the frontlines of the fight against TB. Together we will succeed in wiping out this ancient disease. Join us. It’s time to end TB. ■



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Safety and health at work

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Deaths and accidents at work exact not just an economic cost but an immeasurable human price, affecting hundreds of millions of people. It's therefore not surprising that Occupational Safety and Health (OSH) has been a priority of the International Labour Organization (ILO) since its foundation.



Construction workers in France.

© ILO/S. Legoupi

MANAL AZZI, OSH TECHNICAL SPECIALIST, ILO

When the Organization's structure and Constitution were being negotiated, in 1919, OSH was specifically included in the preamble. "An improvement of those [working] conditions is urgently required; as, for example...the protection of the worker against sickness, disease and injury arising out of his employment".

These diplomatic negotiations were swiftly followed by concrete action. At the first session of the member States' meeting, the International Labour Conference (ILC), three of the six recommendations adopted related to OSH; the Anthrax Prevention Recommendation, 1919 (No. 3); Lead Poisoning (Women and Children) Recommendation, 1919 (No. 4); and White Phosphorus Recommendation, 1919 (No. 6).

Early ILO instruments tended to regulate single issues (such as exposure to hazardous materials or dangerous machinery) or sectors of industrial activity (including mining, the maritime industry, construction and manufacturing). The focus was on prescriptive rules and the role of governments in protecting workers.

There are now more than 40 international instruments dealing with OSH. A particular strength of these instruments came from the ILO's unique tripartite structure, which meant that representatives of the governments, employers' and workers' organizations of its member States all played an equal role in negotiating and drawing them up at the ILC. This unique characteristic also helped to ensure that ILO member States extended their work to address key social policy issues that relate to OSH, such as sickness insurance and pensions.

Other early OSH milestones included the establishment of the ILO's Industrial Hygiene Section (IHS) in 1920, which acted as a repository of information on occupational medicine and hygiene, and the Industrial Safety Section (ISS) in 1921.

The next major advance, in 1930, was the creation of the ILO Encyclopaedia. Thanks in part to the contributions of literally thousands of experts, this publication helped to establish the multidisciplinary nature of occupational safety and health at work. In 2012 the encyclopaedia went on-line, making global and immediate access far easier.

The Second World War and its aftermath triggered another transformation in the way that OSH issues were seen and addressed. Interest in OSH grew and began to extend into newer disciplines associated with safety design and engineering. The advent of new substances and chemicals, with possibly harmful effects on workers, created a demand for more research and countermeasures.

Against this background new global institutions with an interest in health issues emerged, including the United Nations (UN) and the World Health Organization (WHO). The ILO also entered the post-war years with changes, in particular the 1944 Declaration of Philadelphia that set out the aims and purposes of the ILO for the new era. As well as reasserting the core ILO principle, that labour was not a commodity, the Declaration also addressed the issue of workers' health; "the solemn obligation of the International Labour Organization to further among the nations of the world programmes which will achieve [...] adequate protection for the life and health of workers in all occupations" .



© ILO/M. Crozet

Men work at great heights with no safety equipment in Beijing, China.

In 1950 the ILO and WHO convened their first Joint Committee on Occupational Health. The overlap between the remits of the two agencies subsequently led the ILO to move away from the strictly medical aspects of OSH and towards prevention, combining matters of safety and health into one programme. In line with this new approach the IHS and ISS were merged in 1953 to become the Occupational Safety and Health Division.

The post-war de-colonization movement also brought changes to the ILO's membership profile in particular an increase in the number of developing countries. In response, the ILO introduced a programme of technical assistance to support the creation of national OSH policies, institutions and labour inspection systems.

Work also began on the development of OSH Codes of Practice. While not legally binding, these provide guidance on meeting acceptable standards.

The late 1980s saw another shift in attitudes towards OSH, following the Chernobyl nuclear disaster. The focus shifted from a prescriptive, government-led approach towards the development of a 'safety culture' focused on risk assessment, prevention and mitigation. OSH began to encompass not only workers' physical condition but their mental health too.

The adoption of the ILO's Global Strategy on Occupational Safety and Health, in 2003,

reflects these new attitudes, placing less emphasis on prescription and more on prevention. 2003 also saw the first celebration of the annual World Day for Safety and Health at Work, on April 28, an acknowledgement that OSH was of direct interest to the general public.

In the ILO's second century its OSH work is no less important – every year around 2.8 million workers still die from occupational accidents and work-related diseases and more than 370 million others are injured – and is once again evolving.

Technology, demographics, sustainable development, and changes in work organization are among the new headline

challenges. Psychosocial risks, work-related stress and non-communicable diseases are also attracting increasing attention. But these challenges also bring opportunities for improvement; for example, applying tech to risk assessment and dangerous jobs, and re-shaping working schedules to create a better work-life balance.

OSH strategies will need to respond with a broader, multidisciplinary, public health approach and a stronger culture of prevention and risk anticipation. One thing that will not change, however, is the human-centred approach that was outlined in the ILO's 1919 constitution. That guided the ILO's first century of progress and will continue to guide its second. ■

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Surgery for All: Social Justice for All

The WHO, UNITAR and the Harvard Medical School Program in Global Surgery and Social Change are developing a new platform to help build capacity in Global Surgery.

GEOFFREY C. IBBOTSON, UNITAR, JOHN G. MEARA, PGSSC, WALTER JOHNSON, WHO

A Story from the Field

Late one night, a 29-year-old mother of two was carried into the emergency department of our hospital by her family members. At that point, the group had already travelled for two days from another, more remote hospital in the Himalayan foothills where she had spent the past two weeks. They had tried their best to access a surgeon there but to no avail until arriving at our hospital. The emergency physician on duty quickly diagnosed a perforated peptic ulcer. We were shocked to learn that the X-ray that confirmed her diagnosis had been taken three weeks earlier. Over the following three days, our surgical team worked overtime to make up for the severity of her late presentation. Despite having surgery, blood transfusions and all the necessary antibiotics, she did not improve and finally passed away.

Unfortunately, outcomes like this are far too common. Patients present late because they are unable to access a functional, safe surgical service. Thankfully, and more commonly, our surgical department saw better outcomes and witnessed the significant impact they had on the community that they serviced. Shortly after the case of the 29 year-old mother, a man from the next valley, who came with his wife and three children, presented with a complete bowel obstruction that had been ongoing for five days. During his surgery, we found dead bowel that was near perforation. The obstruction was due to a massive

infestation of round worms. Following a routine bowel resection, he went home six days later in good condition and with worm medicine for the whole family. His outcome would have been the same as the other patient if surgery had not been available in a timely manner.

The sad reality is that stories such as these are all too common in low and middle-income countries (LMIC). However, these same stories can help bring the important human element to the dialogue as world leaders look for solutions on how to provide appropriate surgical care globally along with Universal Health Coverage (UHC). Indeed, the personal stories illustrating the frontline realities are an important reminder as to why the world needs to persevere in its efforts to achieve the UN Sustainable Development Goals (SDGs) and the 2030 Agenda. The most vulnerable and impoverished of our world still face tremendous challenges accessing good health care, which is one of the most important factors in improving their life and avoiding poverty. There is increasing evidence to show that without a significant increase in the availability of safe and affordable surgical care, the world will be hard pressed to achieve UHC and many of the SDGs.

The Numbers

The global burden of non-communicable diseases (NCDs) and traumatic injury is increasing at an alarming rate and completely eclipsing communicable diseases. Recent data shows that almost 30% of the world's total burden of disease is caused by conditions that require surgical, obstetric or anaesthesia expertise and training. Worldwide, roughly five billion people do not have access to safe, affordable and timely surgical care. More shockingly, approximately 90% of people living under the poverty line do not have access to surgery. As a result, a staggering 17 million people die each year from surgically preventable causes, the greatest of these in the most vulnerable countries. This reality makes it imperative for the world's leaders to focus more attention on the tremendous need for building up surgical care in the countries that need it most (figure 1: the scale of the challenge).

It is also well recognized that if the world does not address the enormous needs in surgical care, this inaction will cost LMICs approximately US\$12 trillion in lost outputs (total GDP losses). When countries invest in surgical capacity, they are also investing in the economic development of their country. Furthermore, as countries build up surgical services, there is a concurrent rise in the overall capacity of that health system since surgical care (surgery, obstetrics and anaesthesia) has an impact across all sectors of health care.

Looking Back

In 1980 at the World Congress of the International College of Surgeons in Mexico City, Dr. Halfdan Mahler, the Director-General of WHO at the time, gave a profound and prophetic address. He outlined the importance of surgery in achieving the main health target set at the 1977 World Health Assembly (WHA) of "Health for All by 2020". He clearly stated that "Social injustice is socially unjust in any field of endeavour, and the world will not tolerate it for much longer. So the distribution of surgical resources in countries and throughout the world must come under scrutiny in the same way as any other intellectual, scientific technical, social or economic commodity. The era of only the best for the few and nothing for the many is drawing to a close."¹

Almost four decades later, we are still grappling with the same challenges, albeit with an increasingly complex, changing and inter-related global environment. Over the last several decades, the world has met many of the health challenges of the time with vigour and resolute determination in their efforts to overcome the seemingly insurmountable problems. The greatest example of this is seen with the success in dealing with HIV, TB and Malaria. Many lessons can be learned from that experience. As we face the new challenges of a quickly changing disease burden profile it is important for the world health policy leaders to rapidly adapt to find new solutions to meet the changing needs. This is especially true as we see the quickly increasing need for strong surgical capacity around the world, and especially in LMICs.

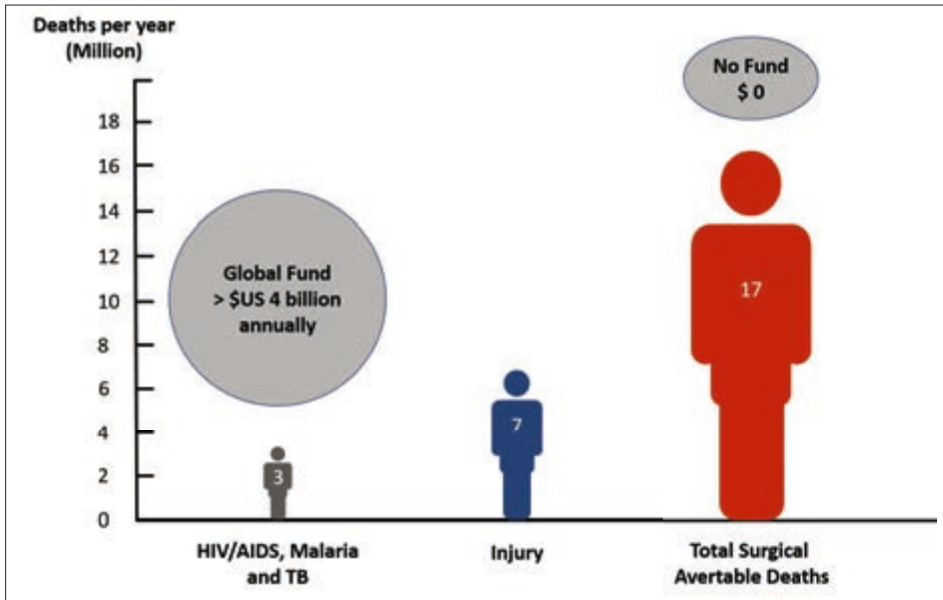


Figure 1: the scale of the challenge.

The simple truth is that without increasing access to safe and affordable surgical care, the world will struggle to achieve UHC or many of the SDGs.

In 2008, Drs. Paul Farmer and Jim Y Kim coined the term describing surgery as the “neglected stepchild of global health”. In their landmark paper, they outlined the reality for surgical care globally and offered suggestions for moving this important agenda forward, including the importance of UHC². In the years following that, momentum continued to build as more surgeons and public health specialists realized the importance of surgery in meeting the global health needs. Two watershed events occurred in 2015 with the unanimous passage of WHA 68/15 on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage and the Lancet Commission on Global Surgery with its findings and recommendations. Both set

the stage for what has now grown into an increasing global awareness of the great need for surgical care to be addressed in order to achieve the SDGs. Indeed, 9 of the 13 targets of SDG3 are directly or indirectly related to surgical care and will only be achieved with improved surgical, obstetric and anaesthesia care service delivery.

The Way Forward

With this new realization, many countries are making efforts to incorporate robust national surgical, obstetric and anaesthesia plans (NSOAP) into their national strategic health plans. Indeed, five countries have completed their NSOAPs, with 11 others well along in the process. In March 2019, the Harvard Medical School Program in Global Surgery and Social Change and the WHO Emergency and Essential Surgical Care Programme hosted a regional meeting in Dubai³ for governments, academics and funding agencies to further explore how to expand the NSOAP process. There was

an excellent representation from Africa, Asia and the South Pacific, including delegates from the World Bank and other significant stakeholders. The general consensus of the conference participants was that the time was long overdue for the world leaders and health policy makers to act in response to the challenges spoken years ago by Drs. Mahler, Farmer and Kim. This sentiment was well summarized in the special address to the conference by Dr. Tedros Adhanom Ghebreyesus, Director-General of WHO, when he said, “No country can achieve Universal Health Coverage unless its people have access to safe, timely, and affordable surgical services... It’s therefore vital that countries invest in surgery.”⁴ This message echoes that of the Lancet Commission on Global Surgery which stated that “the delivery of surgical services and essential procedures must be embedded within the targets for the SDGs and UHC.”

In summary, the message is clear: Universal Health Coverage, and indeed most of the targets of SDG 3, are not attainable without increasing the global surgical capacity. The target date for the SDG agenda is only 11 years away. Time is short. There is an urgent need for world leaders to join the efforts and make this a global priority. The growing enthusiasm and resolve from surgeons, government policy makers, academics, and more recently funders to meet these needs has started the process. Let us reach for this goal together. ■

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- 3 <https://www.pgssc.org/2019-national-surgical-planning>
- 4 <https://www.youtube.com/watch?v=P1XLthxQs7g>

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MAKING THE UN SMOKE-FREE

UNOG Tobacco sales ban

Before ban



After ban, effective 3 Feb 2009



The WHO Geneva headquarters offices were the first among all United Nations facilities to be smoke-free for all the indoor workplaces. These measures were taken on April 7 1987 accompanied by the ashtray-smashing ceremony performed by the WHO Director General Dr Halfdan T. Mahler. Following this event, in 1993, resolution WHA 43.16 was adopted at the 43rd session of the World Health Assembly (WHA) proposing all UN organizations to be smoke-free. In the late 1990ies by utilizing the momentum of the WHO Framework Convention on Tobacco Control treaty negotiations, even terraces and balconies of WHO offices were made smoke-free. Another significant milestone following the WHO best practice was the adoption of the resolution on smoke-free United Nations premises by the United Nations General Assembly in December 2008. The resolution includes making all indoor UN premises smoke-free and banning the sale of tobacco products.



WHO HQ staff and visitors enjoying a smoke-free campus



Healthy/ Smoke-free Workplace

1986
Ottawa
Charter

1996
Global Strategy on
Occupational
Health for All

1997
Luxembourg
Declaration on
Workplace Health
Promotion in the
European
Union

2008
Barcelona
Declaration on
Developing Good
Workplace Health
Practice in
Europe

Making the work environment healthy and productive is a social responsibility for health

Looking back at the history of occupational health, many declarations, resolutions and charters in favor of making the workplace a healthy and productive environment were put in place. The smoke-free concept is an integral part of a healthy workplace.

Globally, tobacco use kills more than 8 million people a year including more than 1 million people as the result of non-smokers being exposed to second-hand smoke. United Nations' staff spend a large proportion of their time at work and they including children and guests should be protected from the exposure to second-hand smoke at UN both for health and safety reasons.

WHO went beyond the smoke-free United Nations premises resolution by declaring WHO headquarter campus in Geneva smoke-free on World No Tobacco Day, May 31st 2013, and by implementing the smoke-free campus policy at the regional level as appropriate.



WHO Director-General engaging in physical activity on the WHO smoke-free campus in Geneva

Learning from experiences and recommendations in making the campus smoke-free

Tobacco use is the most preventable single cause of death. Yet, despite some achievements already made by the UN, big efforts are still needed to make all the UN campuses 100 percent smoke-free not only inside, but also on the outside premises. In its recent meeting, the UN Inter-Agency Task Force on NCDs agreed that UN agencies would assess their respective implementation of the UN smoke-free resolution.

It is our common duty to protect UN staff and their families from second-hand smoke and to promote the health, safety and well-being of us all. It will be the combined efforts of the employees and employers!

UN smoke-free milestones

Process of making the WHO Geneva campus smoke-free

- ✓ Forming a planning committee (2011)
- ✓ 3 working groups with specific tasks
- ✓ Engaging key stakeholders such as staff association and senior management
- ✓ Developed strong implementation plan (campaign + communication materials and activities)
- ✓ Providing cessation support for free
- ✓ Information note 8/2013 on WHO HQ smoke-free campus was issued on 8 April 2013
- ✓ Declared as smoke-free campus on 31 May 2013

*Make all
UN campuses
smoke-free*



Cyber Hygiene for Programme Delivery, Like Hand Hygiene for Health

Cyber hygiene is as important to programme delivery as hand hygiene is for optimal world health. The International Computing Centre offers cyber security services to over 30 UN Agencies and related international development organizations.



© UN Women/Mai Thi Thanh Nga

Cyber security hygiene and safety is fundamental to a UN Agency's ability to get their programme work done safely and efficiently.

WILLIAM ALLEN, UNITED NATIONS INTERNATIONAL COMPUTING CENTRE (UNICC)

The United Nations International Computing Centre (ICC) is working with UN agencies for improved cyber health and safety around the world.

Health workers, hospital chief executives, administrators and policy makers all agree that preventing antibiotic resistance through hand hygiene is a World Health Organization (WHO) priority.

In a similar fashion, cyber security hygiene is fundamental to any UN Agency's ability to get their work done, preserve business continuity and streamline effectiveness in programme delivery. One malicious phishing attack, once clicked on by an unsuspecting user, can bring down an institution, greatly risking financial and operational health.

Gartner reports that consumption of cyber security products and services rose by more

than 7% in the past years and it continues to grow, with a rising awareness about the impact of security incidents, data protection security awareness and an evolving regulatory landscape, including the EU General Data

Protection Regulation (GDPR) which entered into effect in 2018.

UN Agencies and related international development organizations, working to promote key and humanitarian missions related to the Sustainable Development Goals, are recognizing the rise of cybercrime and cyber-attacks world-

wide and recognize the importance of risk mitigation and cyber hygiene.

ICC has been growing its cyber security services over the past several years as organizations see the value in risk mitigation and security preparedness. ICC has over 30 United Nations Clients and a growing list of subscribers, as well as a global team of over 13 experts working

in New York, Geneva, Rome, Valencia and Brindisi, Italy. Just this March, ICC opened the United Nations' first Inter-Agency Common Secure Operations Centre at its Centre of Excellence hub in Valencia, Spain.

ICC is helping to protect the United Nations family, its friends, users and their data, from cloud security assessments to CISO-as-a-Service. Some of ICC's Clients include ADB, CTBTO, GGGI, IAEA, ICAO, IFAD, ICJ, IMO, OCHA, OHCHR, PAHO, UNCTAD, UNDP, UNHCR, UNICEF, UNJSPF, UNOG, UNRWA, UN Women, WFP, WHO, WMO and WTO.

With over 30 Clients today, ICC offers Common Secure governance and Information Security Management System (ISMS) services, Threat Intel Network, Common Security Incident and Event Management (CSIEM) and Common Security Operations Centre (CSOC), policies, controls and enforcement, awareness, SWIFT assessments, Public Key Infrastructure and digital identity services, cyber security operations and incident management and response.

Organizations can improve their security posture significantly by addressing security and risk-related hygiene through

good governance, threat intelligence networking, security event management and professional incident response, vulnerability and penetration testing, centralized log management, internal network segmentation, backups and system hardening, not to mention cyber security awareness for business stakeholders.

Cyber security health and safety is fundamental to any UN Agency's ability to get their work done, preserve business continuity and streamline effectiveness in programme delivery.

ICC's services include governance and CISO support services, such as Framework Program and Structure, Information Security Policies, Controls and Information Security Enforcement, ISMS Risk Management, Security Incident Management and Coordination, Access Control Management, Information Security Awareness and SWIFT Security Assessments.

They also offer Common Secure Threat Intel Services, an inter-Agency Common Secure Security Operations Centre (CSOC), Common Secure Information and Event

Management (CSIEM), Phishing Simulation Services and Vulnerability Management Services, Penetration Testing Services and Incident Response and Forensic Services and Network and Infrastructure Support Services.

While the expert team continues to monitor and proactively prevent

cyber security issues, Tima Soni, Head of Information Security Services at ICC, continues to build the program and provide visibility on the various initiatives that continue to build in strength. Some of these activities over the past year include:

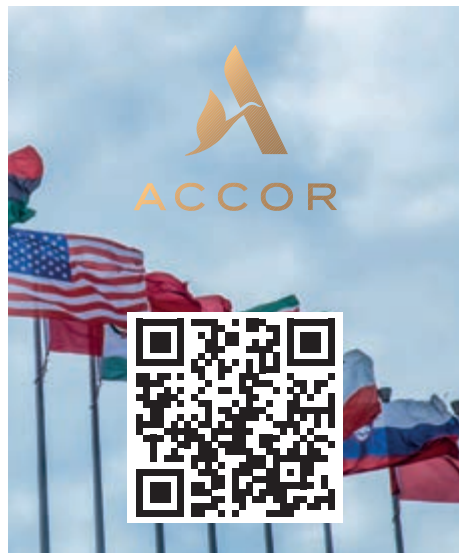
- ICC Helping with UN Global Pulse's UN Principles on Personal Data Protection and Privacy
- ICC Keynote Speaker at Cloud Security Alliance Congress 2018
- Women and Children First: A Cyber Event with UNICEF, UN Women and ICC
- Cyber Security Training for Women in Developing Nations, in Ukraine
- ITU WSIS forum on Cyber Security Best Practices for SDGs
- Moderated two sessions at the UN Information Security Special Interest Group
- Mission-driven Cyber Security Conference – A UNICEF, UN Women and ICC Event
- UN ICT Network Security Summit with Microsoft Tech for Social Impact.

In working to build a model of an Inter-Agency hub for cyber security expertise, ICC has partnerships with many cyber experts worldwide:

- Center for Internet Security (CIS), a forward-thinking, non-profit entity that harnesses the power of a global IT community to safeguard organizations against cyber threats
- Cloud Security Alliance (CSA), dedicated to defining and raising awareness of best practices to help ensure a secure cloud-computing environment
- ID2020 Alliance, a unique public-private partnership committed to improving lives through digital identity
- Forum of Incident Response and Security Teams (FIRST), a global leader in incident response. ICC's membership in FIRST enables its incident response teams to more effectively respond to security incidents as well as be more proactive
- SWIFT, a global member-owned cooperative and a leading provider of secure financial messaging services, providing a platform for messaging, standards for communicating and products and services to facilitate access and integration; identification analysis and regulatory compliance.

This model of increasingly optimised cyber security hygiene is reaching across many in the UN family with the shared solutions and services at ICC, just as WHO's hand hygiene is helping to prevent antibiotic resistance for improved health across the globe. ■

Improving security is not just about new technologies. Recent incidents remind us that delivering the basics has never been more important.



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Dear WHO, welcome to the digital era!

SURABHI JOSHI, PER ERLEND HASVOLD, NATALIA WROBLEWSKA

Digital information and communication technologies are infiltrating and disrupting almost all aspects of our lives. Traditionally healthcare services have been slow to adopt new technologies, but the transformation into a digital world will not wait. Can WHO respond to this shift in healthcare delivery to best support the Member States?

Digital health already benefits millions of people around the globe. Health information is stored in electronic health records instead of on paper; communication has shifted from phone calls and fax to messaging, apps, emails and cloud storage. These shifts are known as “megatrends”, happening in multiple sectors, regardless of existing guidance.

Once digital, data from different sources can be combined with other information and further analyzed. With use of technologies such as machine learning or artificial intelligence this analysis can happen anywhere, supporting decision making of healthcare providers, ministries, international organizations including WHO, and other public and private sector players. The power of digital information lies in the way that the information can be generated and accessed independent of the location in space and time.

The positive impact this shift can create is enormous, but so are the potential challenges. The infamous Cambridge Analytica scandal, in which millions of Facebook users were profile and classified according to political preferences, has shown the world the power of data.

Personal health information can be used to determine the individual’s health status and their behavioural risk profiles. This can revolutionize personalized preventive care and self-management of disease, but it can also put individuals at risk. Health data is vulnerable and must be adequately protected.

Since incorporation of digital into healthcare is unavoidable, one must focus efforts to ensure that it achieves its maximum potential without any compromises. Healthcare services rely on evidence-based products and procedures. Traditionally, randomized control trials (RCTs) ensure the highest level of confidence which in case of drug treatment can add up to more than 10 years from discovery to full implementation¹. Digital health poses a challenge to this rigorous process, as it is a fast moving, complex and cross-cutting field therefore the body of evidence supporting it is still limited².

Over the past decade, in order to strengthen the quality of digital health research, WHO has developed a number of normative documents, including the mERA checklist³, the MAPS toolkit⁴, the recent Classification of digital health interventions⁵ as well as the National eHealth strategy toolkit⁶. A number of further guidance documents has been developed to support implementation of digital programs⁷ and several WHO regions have already adapted various digital health interventions.

The field of digital health calls for an approach that supports quick integration of digital technologies, while addressing the need for appropriate governance and regulations.

For a normative organization this means enabling faster decision making and strengthening cross-sectoral collaborations, across all three levels of the organization: countries, regions and headquarters. Moreover, effectiveness of digital interventions depends not only on the solution itself, but the whole ecosystem it is embedded in^{8,9}. The guidance provided must therefore also discuss appropriate implementation.

With the Digital Health Resolution unanimously passed at the 71st WHA in 2018, WHO now has a mandate to assist Member States within the area of digital health. To meet the demand, over the course of recent transformation, WHO is establishing a department of Digital Health and Innovations, situated under the Chief Scientist, a new division that re-emphasizes WHO’s continued commitment towards scientific integrity and innovation. The announcement has been warmly welcomed by the global digital health community which has been waiting for WHO to provide leadership in this area for a long time.

According to Dr. Takeshi Kasai, the Regional Director of the Western Pacific Region, the department “will harness the power of digital health and innovation by supporting countries to assess, integrate, regulate and maximize the opportunities of digital technologies and artificial intelligence”¹⁰. A Department of Digital Health can help accelerate the progress towards UHC, but we can reach even further if all of us embrace digital in our work.

The organization now embarks on an exciting, but also challenging journey within the dynamic digital environment.

The decisions made today will affect the future of digital health in an unprecedented way and WHO is ready to take the giant leap forward! ■

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Evelyn Kortum, incoming General Secretary of FICSA

JOELLE MARX¹

Evelyn Kortum, a fun-loving mother, wife, friend and expert in work psychology, is very excited about her new role as General Secretary of FICSA (Federation of International Civil Servants Association.) I am so grateful for the opportunity to sit down and chat with her!

Ever heard of using Tai Chi to relieve your stress? This week, I had the opportunity to sit down with Evelyn Kortum, incoming General Secretary of FICSA, to learn about her passion for practicing mindfulness, as well as about how she ended up where she is today.

Evelyn was born and raised in Hamburg, Germany. Growing up, she always wanted to learn languages and incorporate that into her professional life. Evelyn moved from Germany in 1986 to spend a year in London, and since 1987 has lived almost everywhere in the Pays de Gex. She then moved to Geneva in 2008. She absolutely loves Geneva's weather! In Hamburg, the weather was often dreary and grey, and usually drizzly. She very much enjoys living in an area surrounded by beautiful mountains and learning how to ski was a special treat for her.

Evelyn started her career at the World Health Organization (WHO) in 1989 in Personnel (today called HR). She returned to her studies to earn a Bachelor's degree in Psychology and a master's in Organizational Psychology while earning her living at WHO. In 2007, Evelyn decided to do a PhD in Applied Psychology also via distance courses. Her academic passions have always been centered around the workplace, with a particular focus on mental health. Many of Evelyn's personal passions are also focused on practicing mindfulness and meditation.

Before work, Evelyn loves to do Tai Chi sessions to center herself. She also enjoys practicing yoga two to three times a week, as well as Nordic walking, exploring nature, doing Reiki, watching the birds in her garden, travelling and reading. On beautiful days or even gloomy ones, you can find Evelyn riding her bike to work! She told me that she is inspired by her husband – not only is he the love of her life, but he is also the best teacher and mentor. He has always been encouraging and supportive of her progress in life and at work.

As a student, it is important to me to find ways to relieve my

stress. Because Evelyn seems like the expert on recharging from her stress, I asked her to give me a few pieces of advice. She recommends finding a way to ground yourself through the techniques that she mentioned before. She told me that “at work it is really important to prioritize your work, use your social support network and get the help you need from colleagues and friends. It is best to talk about what you need and why you think you feel stressed. Often you may find that you have too high expectations of yourself when the locus of control lies with others. This can put us under undue pressure and we need to either accept and deal with it, or try to change it, if that is a possibility.” She believes that proper work organization including good managers is key, but that is too complex to discuss in depth in this interview. If you need advice on approaches to address stress at work from a systemic or even a personal perspective, Evelyn would like to invite you to visit her in the Villa Bocage.

At FICSA, Evelyn is excited about the promotion of fair, equitable and predictable conditions for staff in their respective organizations. This includes prevention of




Evelyn Kortum and Joelle Marx in front of Villa Le Bocage.

© Yuthee Oly/FICSA

work-related stressors that can cause mental and physical diseases, as well as unacceptable behaviors including nepotism and lack of solidarity. She is particularly concerned with the erosion of staff contract conditions and the unacceptable increase in precarious working conditions which dehumanizes our working environment. To effectively combat this, strong collaboration with FICSA members and the International Civil Service Commission (ICSC) is necessary.

Evelyn is ready to go! ■

1 Spring 2019 FICSA Intern from Colgate University



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Participatory governance as the means and the end of development

Engaging artisanal gold miners and traders in developing Sierra Leone's National Action Plan under the Minamata Convention on Mercury.



Jorden de Haan.

JORDEN DE HAAN, UNITAR

Artisanal and small-scale gold mining (ASGM) has been estimated to employ over 16 million people and accounts for up to 20% of the world's gold production.¹ The majority of these people are young, and approximately one-third are women. Besides direct employment, the sector creates indirect employment through the cash it injects into rural economies – thereby creating demand for food, goods and services and stimulating further livelihoods. Altogether, more than 100 million people are considered to depend directly or indirectly on the sector.²

While the sector is important for socio-economic development, it is associated with a range of other social, economic, health, environmental and human rights issues. Poor occupational health and safety, child labour, and the involvement of armed groups are some of the most noted issues. However, a closer examination shows that, for a large part, these issues are mere consequences of the sector's widespread informality, which deprives miners and

traders of access to technical assistance, finance the global market, and, importantly, decision-making.

The Minamata Convention on Mercury

One issue that has recently attracted global attention – and has effectively put the sector back on the map of policy makers – is the sector's use of mercury. In short, many artisanal miners use mercury to separate gold from sediment and ore. The resulting mixture, or amalgam, is heated to isolate the gold from the vaporized mercury, which harms miners and their communities and contaminates the environment. Exposure to mercury, such as through ingestion or inhalation of mercury vapours, may cause toxic effects on the nervous system, the digestive system, and the immune systems, and on lungs, kidneys, skin and eyes. Since mercury vapours travel freely through the atmosphere, this is an issue of global concern.

In response, Member States of the United Nations have

negotiated the Minamata Convention on Mercury, a global treaty with the objective of protecting human health and the environment from mercury. The Convention identifies ASGM as the main source of human-caused mercury releases. It includes an obligation for countries with ASGM activity on their territory to develop a National Action Plan (NAP), “to reduce, and where feasible eliminate, the use of mercury” in the sector. The Convention entered into force on 16 August 2017 and had been ratified by 107 Member States by 24 April 2019.

Developing Sierra Leone's NAP

Sierra Leone ratified the Convention on 1 November 2016, under the leadership of Environment Protection Agency-Sierra Leone (EPA-SL). With technical support from UNITAR, EPA-SL has embarked on a journey to develop the country's NAP, funded by the Global Environment Facility (GEF) and UN Environment.

A key starting point for the NAP development was a field study

to develop understanding of the sector from the perspective of those within it. Between January and February 2018, an EPA-SL and UNITAR team undertook a comprehensive field study, visiting the country's main ASGM communities.³ They spoke with more than 300 stakeholders, including the stakeholders directly involved in the gold supply chain such as miners, mineral processors, small-scale operators, gold traders, goldsmiths, and exporters. In addition, wider stakeholders in the communities were interviewed, including paramount chiefs, health workers, community leaders, youth leaders, farmers, and local shop holders.

Engaging stakeholders for developing a national vision for ASGM

The next step was to set goals and objectives for mercury reduction and for the sustainable transformation of Sierra Leone's ASGM sector. But how should these objectives be set and what should this “sustainable transformation” include? What is the overarching vision?



Participants interacting in the workshop in Makeni.

The NAP would only be a *national* action plan if it includes the interests and priorities of the key stakeholders involved in the sector. Therefore, EPA-SL and UNITAR organized two stakeholder engagement workshops in collaboration with the National Minerals Agency (NMA – the institution mandated with regulating Sierra Leone’s mining sector) in March 2019. One workshop was held in Makeni, a city close to ASGM communities, where stakeholders at the local level were engaged (similar to the ones engaged in the field study); and one workshop was held in Freetown, where relevant government ministries, departments and agencies (MDAs), donors, NGOs and academia were engaged.

The main purpose of these workshops was to develop a national vision for the ASGM sector that articulates where

Sierra leonians would like to see the sector in the future. Following a process described in UNITAR & UN Environment’s Formalization Handbook, which suggests a human rights-based approach to formalization, workshop facilitators first organized an exercise to map ASGM’s positive and negative impacts on a range of development indicators. Subsequently, participants were asked to rank these impacts in order of importance in a short survey, on an individual basis. After that, participants were asked which changes they would like to see in the sector in 10-15 years from now, and what would be the required short-term steps.

In addition, a local geologist moderated discussions with miners about what could be suitable as improved mining methods and technologies that could be introduced to decrease miners’ dependence



Artisanal miners washing ore in Makong, Sierra Leone.

on mercury (in relevant areas) and mitigate other negative impacts. Similarly, the Director of Mines from the NMA and the UNITAR representative (author of this article) jointly moderated discussions to obtain inputs for developing a formalization strategy as a critical component of the NAP. Other significant issues, such as awareness raising, protecting children, gender equality and women’s empowerment, were also discussed with interventions from local experts.

The way forward: participatory governance as the means and end of development

Based on the inputs obtained during the field study and workshops described above, EPA-SL (with UNITAR’s support) is currently drafting the NAP, which will be shared with key stakeholders for their review and subsequent endorsement. Once it is endorsed, the NAP will be

submitted to the Minamata Convention Secretariat. As required by the Convention, an important element of the NAP concerns a strategy for the continued engagement of ASGM communities during the process. It is therefore very positive that ASGM is mainstreamed in Sierra Leone’s *National Development Plan for 2019-2023*, with the formalization of artisanal mining as a policy priority, and that the new *Artisanal Mining Policy for Sierra Leone* places greater emphasis on community consultation.

Indeed, notwithstanding the challenges ahead, the application of participatory governance as both the means and the end of development can go a long way in kickstarting the inclusive and sustainable transformation of ASGM and similar informal sectors worldwide. ■

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Better understanding for better prediction

WHO Collaborating Centre for Humanitarian Medicine and Disaster Management (CHMDM)

Tsunamis, floods, earthquakes, storms, landslides, but also disease outbreaks and armed conflict; the urgency in the aftermath of a disaster calls for large-scale, multi-faceted humanitarian assistance

MARINA GIACHINO, OLIVIER HAGON, FRANÇOIS CHAPPUIS¹

This is where the Division of Tropical and Humanitarian Medicine (DTHM) of the Geneva University Hospitals (HUG) comes in. In October 2017, the DTHM was designated by WHO as Collaborating Centre for Humanitarian Medicine and Disaster Management (CHMDM). A WHO Collaborating Centre (CC) is an institution that participates in the strengthening and support of the Organization's programmes. This

designation is initially agreed for a four-year period.

Using national institutions for international purposes facilitates the development of new partnerships. This win-win relationship between WHO and its CC makes a significant difference to public health globally.²

The World Health Organization had already designated the HUG for five other CCs.³

The main focus of the CHMDM is to support the

implementation of the Emergency Medical Teams (EMT) initiative, to develop collaboration and partnerships, to train the emergency teams to provide adapted care to victims caused by disasters, with a special focus on Mother and Child health in emergency settings. Dr. Olivier Hagon and Prof. François Chappuis are co-heads of the CHMDM.

EMT initiative: "save lives – preserve health – alleviate suffering"⁴

The earthquake in Haiti, the Indian Ocean tsunami or the Pakistan floods – the EMT has a long history of responding to sudden onset disasters. CHMDM promoted and supported the WHO EMT initiative all around the world. The EMT highlights the importance of local capabilities. Every EMT member must follow the national regulations. The

emergencies are complex and can raise several challenges for the team such as safety and security as well as the ability to adapt their capacities to the type of disaster. Continuous adaptation to needs during the different phases in the aftermath of a disaster is a key condition for an adequate and reliable response.

International Geneva: discreetly at the centre of humanitarian initiatives

The HUG are engaged in various causes worldwide, and lead or participate in cooperation projects in over 30 countries. The role of International Geneva is to enable collaboration with other organizations. The HUG's geographical location predisposes openness by working closely with the Swiss Agency for Development and Cooperation (SDC), the Swiss Federal Department of Foreign

Education / enseignement



Prof. François Chappuis and Dr. Olivier Hagon, Heads of the new WHO Collaborating Centre at the Geneva University Hospitals.

Affairs, the ICRC, Médecins Sans Frontières and others on different humanitarian projects during disasters.

The CHMDM reinforces the capacity of the HUG to conduct operational and research activities abroad, with the main objectives of building or reinforcing local capacity. Its international projects include activities that facilitate equitable access to health and care. These projects can be divided into four categories: human resource development; humanitarian response; Neglected Tropical Diseases (NTDs) and Non-Communicable Diseases (NCDs).⁵

The forgotten population: Mother & Child

35 to 40% of the population are women and children in most disaster-prone countries. This particularly vulnerable and often neglected population needs continuous and appropriate care throughout a disaster. Based on the experience of the Haiti earthquake (2010), the first deployment of the module Mother & Child took place after the earthquake in Nepal at Gorkha District Hospital in 2015 under the authority of Swiss Humanitarian Aid. A year later, the CHMDM returned to Gorkha hospital to run a workshop on M&C in disaster settings.⁶

Patients with non-communicable diseases may also be considered as part of the forgotten population. During a disaster, these patients remain in need of care, but the collapse of the usual facilities and the rupture of the cold chain block access to medicines. The combination of the CHMDM's skills enables to raise awareness and develop good intervention practices.

Lastly, sharing experiences, coordinating teams and improving quality standards are essential. By using the scientific aspect and experience of the centre, it is possible to better anticipate needs and identify gaps that can improve the quality of care for victims. ■

- 1 Heads of the new WHO Collaborating Centre at the Geneva University Hospitals.
- 2 Guide for WHO collaborating centres: <http://www.who.int/collaboratingcentres/information/en/>
- 3 HUG-WHO centres: <https://www.hug-ge.ch/en/leading-swiss-university-hospital-group>
- 4 WHO Vision about EMT: <https://extranet.who.int/emt/content/about-us>
- 5 BERAN, David, et al. Partnerships in global health and collaborative governance: lessons learnt from the Division of Tropical and Humanitarian Medicine at the Geneva University Hospitals. *Globalization and Health*, 2016, vol. 12, no.1
- 6 HUG, Nepal-Gorkha Hospital video: <https://www.youtube.com/watch?v=rN1E7Txxf8>

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Health partners and Geneva public to Walk the Talk for Health for All on 19 May

Thousands of people are expected to take to Geneva's streets on Sunday 19 May 2019 in a celebration of physical activity and to promote the need for all people to have access to health.



More than 4,000 people participated in the inaugural WHO Walk the Talk: The Health for All Challenge in 2018.

PAUL GARWOOD, WHO

The second *Walk the Talk: The Health for All Challenge* is being organized by the World Health Organization (WHO) in conjunction with Geneva authorities, the governments of Switzerland and the Netherlands, the European Union, the Association of Southeast Asian Nations (ASEAN), the Graduate Institute, and multiple United Nations organizations and nongovernmental local and international partners.

In 2018, more than 4000 people joined the event's first ever edition in Geneva, walking, running, dancing, moving and playing for health. There were further events in Astana, Bishkek, Budapest, Copenhagen, Dakar, Djibouti, Khartoum and Manila.

"We look forward to people of all walks of life and ages joining us for the Walk the Talk: The Health for All Challenge," said Dr. Tedros Adhanom Ghebreyesus, WHO Director-General. "The event is a celebration of healthy lives and partnership for health. It is also a powerful platform to promote the need for all people to have access to health."

The upcoming edition is taking place on the eve of the seventy-second World Health Assembly.

Starting at Place des Nations at 9.30 a.m. on 19 May, the non-competitive and non-political event offers participants three connected routes of three, five and eight kilometres to walk, jog, run, or use their wheelchair. Other major Geneva landmarks along the courses include WHO's headquarters, Jardin Botanique, Villa Barton on Lac Lemman (Geneva) and Bains des Pâquis.

The event is focused on promoting "health for all," particularly a healthy lifestyle, for a healthier humanity. It is open to all people, from delegates to the World Health Assembly and organizations committed to promoting health and development, to local school students and their families.

Key participants are expected to include the Mayor of Geneva Mr. Sami Kanaan, First Lady of Kenya Ms. Margaret Kenyatta, leading female marathon runner Ms. Mary Keitany and Eritrean-born Swiss athlete Mr Tadesse Abraham.

The event aims to profile the work and goals of WHO and other health agencies in Geneva and highlight the city's role as the global health capital in improving health. A particular goal is to demonstrate the strong connection between "international" and "local" Geneva.

In 2019, particular attention is also being given to key health subjects, particularly promoting the health of women, advancing mental health and wellbeing and providing services and support for people with intellectual disabilities. ■

More information can be found at www.who.int/walk-the-talk-2019-Geneva

Have you ever checked your hearing?



DR KAREN REYES MPH

PREVENTION OF DEAFNESS AND HEARING LOSS, WHO

Our sense of hearing keeps us connected with the people around us and facilitates many aspects of daily life. As such it is essential that we assess our hearing from time to time and intervene early in case of hearing loss. These messages were highlighted by the World Health Organization (WHO) on World Hearing Day observed on 3 March 2019 with the theme: Check your hearing!

In advance of World Hearing Day, WHO launched a mobile application: hearWHO which makes it possible for anyone with a smartphone to easily check their hearing in a matter of minutes. Hearing checks are especially important for those who are at a higher risk of hearing loss. These include people who often listen to loud music, work in noisy environments, use medicines that are harmful to hearing or are over 60 years old.

As per WHO estimates, 466 million people live with disabling hearing loss around the world and another 1.1 billion of young adults (12-35 years) are at risk of hearing loss due their practice of listening to loud music over prolonged periods. Unaddressed hearing loss is one of the leading causes of morbidity and poses an estimated annual cost of US\$ 750 billion globally. It is expected that the prevalence of hearing loss will rise considerably in coming decades due to changing population demographics, increasing exposure to risks such as loud sounds, as well as persistence of untreated ear conditions such as otitis media.

Despite the high prevalence of hearing loss, ear and hearing health care services are very scarce or unavailable in low- and middle-income countries. This is due to a lack of proximity to health care services and a lack of trained health care professionals. hearWHO aims to help improve the identification of people with hearing loss, determine their need for a formal hearing test, and serve as a tool to raise awareness about the importance of hearing generally.

Dr. Etienne Krug, Director, Department for the Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention notes that “Many people with hearing loss are unaware of it and they miss out on educational, professional and everyday-life opportunities. Once lost, hearing does not come back. Through hearWHO, we encourage people to ‘Check your hearing!’ in order to help preserve this valuable gift that helps us to enjoy life.”

The hearWHO app is based on validated digits-in-noise technology. The speech-in-noise tests measure the signal-to-noise ratio where a listener recognizes 50% of the digit triplets. (i.e. 4-7-2) correctly. This easy-to-use app not only gives users access to a hearing screener to check their hearing status, but also clearly displays the users’ results and keeps a personalized track record of their hearing status over time.

So, why should you check your hearing? It’s because early identification is the key to effective management and rehabilitation of hearing loss. It is crucial to identifying the risky behaviors that should be changed and ascertaining the most appropriate interventions needed. These are identified by hearing care professionals and can range from captioning and sign language to hearing aids and cochlear implants. Interventions to prevent, identify and address hearing loss are cost-effective. ■

Since its release on 25 February 2019, the hearWHO app has been downloaded 77,000 times in 165 countries, and over 76,000 people have tested their hearing. WHO recommends that you find a few minutes to take the test now.

More information can be found at www.who.int/deafness/news/hearWHOApp-news/en/



WHO Solidarity chain during World Health Day 2019.

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Engaging communities in a simulation exercise at pre-deployment training piloted in Kintele, Congo.

© WHO/Lianne Gutcher

Ready, willing and able

A new learning culture for health emergency work to save lives.

DR. GAYA GAMHEWAGE AND MELISSA ATTIAS, WHO

Even the world's best experts, regardless of their qualifications, need to keep learning. No one is too smart, no one is exempt. That's the main thinking behind WHO's new approach to learning that is challenging the traditional concept of a technical agency staffed by experts.

This year, 28 response leaders from the World Health Organization (WHO) – already experts in their fields – have been enrolled in a 12-month learning programme, in addition to the challenging and often life-threatening work they are doing in the field. This first cohort is part of the new approach being used by WHO to create a workforce of excellence towards protecting a billion people from emergencies by 2023.

So, what's new and will it really make a difference?

Buy-in for a first-ever strategy

First and foremost, the WHO Health Emergencies Programme invested in an intensive consultation process involving 100 of its key staff across the Organization at the headquarters, regional and country levels. This resulted in the first-ever learning strategy for WHO aimed at creating a ready, willing and able workforce – within and outside WHO – to meet the ever-challenging needs in health emergencies.

Second, the learning strategy dragged the programme into the 21st century, framing learning as a journey based on competencies to fulfil the Organization's role in health emergencies, and harnessing the power of digital technologies.

Learning as a journey, not an event

The strategy now enables all staff and external partners working with WHO in health emergency response to pick one of three learning pathways: public health, operations or leadership.

The paths are still being defined, but personnel can have access to three types of learning: education or training online or face to face; exchange and social learning with peers; and experiential learning. In a recent perception survey, WHO health emergency staff said they preferred experiential learning.

Protecting the vulnerable as the goal

The learning strategy has introduced a fully competency-based approach to learning needs assessment, learning activity



© WHO

Dr. Ibrahima Socé Fall, Assistant Director-General for Emergency Response, WHO, at a global simulation exercise.

design and delivery, and the assessment of learning.

“Our staff and external experts we deploy in emergencies are all extremely qualified and experienced. However, it’s not only about technical expertise. Working in complex operations in a big team under huge pressure to protect vulnerable populations is what they need to do in today’s emergencies,” says Dr. Ibrahima Socé Fall, the new WHO Assistant Director-General for Emergency Response. Dr. Fall, a seasoned public health leader, served for many years in Africa and was the Regional Emergency Director immediately prior to this promotion.

“We need to train personnel in how to work in the Incident Management System which now forms our operational setting for health response, such as in the ongoing Ebola disease outbreak in northern Democratic Republic of Congo. We need to train them to gain leadership skills so that they can manage the ever-changing teams they are leading, to work effectively with national authorities, other agencies and partners,” he explains.

“This is hard at the best of times, but in emergencies, when lives are at stake, and you are facing danger yourself, we need

personnel who are performing at super-human levels. Mediocrity kills in emergencies.”

To focus on performance, WHO has selected 49 key behaviours under six core competencies for WHO health emergency personnel. All learning activities will now be designed to help personnel acquire, maintain and excel in these 49 behaviours.

In addition, each of the key functions in a standard health response will have its own “function-specific” competencies.

Simulating reality to test competency

In face-to-face training, the WHO Health Emergencies Programme will use two powerful and related tools: competency-based assessments and simulation exercises.

The competency-based assessments involve observation of learners in practical exercises and simulation exercises to help identify strengths and learning needs. This process is also used to assess which staff and external experts are ready to be deployed, which need to be deployed with more skilled practitioners and which need to complete further learning before they are sent to emergency response operations.

The goalpost keeps on moving

This broader core competency approach will continue alongside the subject-matter training that will be required to keep abreast of developments and to deliver on specific areas of the response.

For example, the response to the Ebola outbreak in the Democratic Republic of the Congo (2018 and ongoing) is very different from that of West Africa (2014). We need to train response teams and partners on the ground on using the new field laboratory diagnostic tests, vaccinating the population and providing new treatments to patients – all of which were unavailable in the West Africa Ebola outbreak.

Health knowledge is thought to double every few months and the challenge will be to transfer that knowledge to where it is needed quickly and effectively.

Getting know-how to the frontline

Modern disease outbreaks occur frequently (Africa experiences a new disease outbreak on average every three days) and demand fast knowledge transfer (adapted to educational and cultural needs) to reach massive numbers of responders on the front lines.

In 2017, WHO created its first open platform using low bandwidth for learning, targeted even for remote areas where outbreaks happen most frequently. The OpenWHO.org learning platform offers free online courses to improve the response to health emergencies.

The platform is available to anyone, anywhere, which allows WHO to transfer critical knowledge to large numbers of frontline responders, including its own deployees. It has more than 100,000 course enrolments from 190 countries across the globe just two years later, with 50 active courses in 21 national and local languages. The OpenWHO App enables download of knowledge when internet is available to be used offline later on.

Personnel from UN country teams, health ministries and national health institutes and external experts are the biggest users of the OpenWHO platform. ■



Vice-Minister of Health Dr. Checheibaev together with Working Group members.

© WHO Regional Office for Europe

Awareness-based transformational change in Kyrgyzstan

An experiment in building trust, strengthening relationships and catalyzing change.

NURLAN ALGASHOV, ANNE MADSEN, MARTIN KRAYER VON KRAUSS, WHO, REGIONAL OFFICE FOR EUROPE

So many of us in the United Nations have been there: we are called in to provide advice on a policy matter or a technical issue, only to realize that the main bottleneck is not technical knowledge but the ability of our counterparts to catalyse and implement change. This realization is leading to increased attention to the art and science of transforming complex systems. This article relates some of the highlights

of our experience with facilitating the transformation of public health services in Kyrgyzstan, experimenting with awareness-based change methods in practice.

In May 2018, the WHO Regional Office for Europe received a request from Kyrgyzstan's Ministry of Health to support the production of a concept on transforming public health services in the country. Kyrgyzstan has a high degree of fragmentation and an urgent need to upgrade infrastructure and strengthen the services targeting noncommunicable diseases, and the need for reforming public health services has thus been apparent for many years. Despite several attempts to reform and decades of support from the international development community, progress remained elusive, mainly

because consensus is lacking among key stakeholders within public health. The WHO team therefore decided to experiment with a novel approach to change management inspired by Otto Scharmer's Theory U – a framework for learning, leading, innovating and profound systems change. Scharmer's Presencing Institute summarizes the gist of Theory U as follows: “the quality of results produced by any system depends on the quality of awareness from which people in the system operate. The formula for a successful change process is not ‘form follows function’ but ‘form follows consciousness’”.

So, how do we foster increased awareness? The first step is to bring people out of their usual context and mindset of “I know it all” and “I am right and you

are wrong”. The second step is to invite them into facilitated space, where not knowing is perfectly fine and where we can engage in authentic dialogue among the stakeholders with trust, openness and genuine curiosity. The third step is to explore together and co-create possible solutions and the way forward based on the collective intelligence of the whole system rather than the selected few.

The WHO team deployed a suite of collaborative methods based on the art of hosting approach – methods such as circle, world café, appreciative inquiry, open space technology, storytelling and more. Although our team had had very positive experiences using these methods at international meetings, this was the first time we tried them at the national level.

Between September and December 2018, the WHO team together with art of hosting experts conducted three missions to Kyrgyzstan. As a result of these missions, the following tangible outcomes were achieved:

- A working group, representing a variety of public health stakeholders, was established.
- An advisory group, representing public health leaders, was established.
- The draft vision, mission and goals of the concept were produced.
- Seven alternative scenarios for developing public health services were produced.

Even more importantly, however, were the intangible outcomes that began to emerge:

- Trust among the stakeholders was strengthened.
- A shared sense of purpose began to take root between the members of the Working Group and the members of the Advisory Group.
- Change management processes were better understood, and there was first-hand experience with authentic dialogue practices.

In other words, the key public health stakeholders started an open conversation among themselves, which helped them to see and understand different viewpoints. The art of hosting methods were instrumental to fostering the dialogue, which in turn was instrumental to building trust.

This endeavour is clearly just beginning, and there is still



Working and Advisory Groups at work.

© WHO Regional Office for Europe

some way to go before reaching consensus on the optimal model for reform. Nevertheless, the preliminary results are promising, and it appears safe to conclude that awareness-based transformational change methods are also applicable in different cultural settings such as that of Kyrgyzstan's civil service. That

said, our experience has also been that it is too much to expect national counterparts to start using these methods on their own, and continued accompaniment is therefore necessary, not entirely unlike the challenges encountered in reforming our various United Nations organizations. ■

WHO / OMS

Telling the Time at the Palais des Nations

The Palais des Nations has over 350 clocks in-sync throughout its corridors, conference rooms and offices.

DAVID WOODS AND GUSTAVO MONASTERIOS

The clocks were a donation from the Patek Philippe Foundation. The donation includes the adjustment of the central clockwork mechanism, and the repair and maintenance of the entire system free of charge until December 2050. There are a few different models: including worldtime models which tell the local time of many cities globally, and, the most prevalent model, which features a hobnail-style (“clous de Paris”) detailing on the bezel, similar in design to the Calatrava, one of Patek Philippe’s best known models. Each clock gets its power and time-signal from a cable that is linked back to the central clock, just like railway platform clocks. ■



A view of the central clockwork mechanism in the basement of the Palais des Nations.

© Gustavo Monasterios and David Woods



The clocks are an interesting detail in the rich architectural setting of the Palais des Nations.

© Gustavo Monasterios and David Woods



A typical scene: staff members going about their work, with the familiar clock overhead.

© Gustavo Monasterios and David Woods



The Cherry blossoms at the WHO Headquarters.

© WHO/Christopher Black

On Cherry Blossoms, Appia, and the ephemeral boundaries to well-being

A reflection on local boundaries, the social forces revealed through the ephemeral existence of an evolving building, and the inhabitants that make of an urban space a living one.

HEBER GÓMEZ-MALAVÉ, WHO

The transient quality of health remains a challenge to public health. The attainment by all peoples of the highest possible level of health seems utopian, particularly in the context of a global landscape that keeps redefining itself. However, as advocates for well-being-oriented practices, we are always engaged in a battle for reaching utopia.

The World Health Organization (WHO) headquarters, based in Avenue Appia, experienced firsthand the effects of the ephemeral, very much as we see life (and health) come and then fade. And as the cherry blossoms facing the WHO headquarters mark the peak of the springtime, the ephemeral social interactions among international civil servants and many other users of the urban space highlighted the contingency of existence and bonds.

In August 2015, as the eyes of the world contemplated an unprecedented migratory crisis in Europe, the announcement of the arrival of 180 asylum seekers to a previously empty administrative building located

in the international neighborhood provoked a set of complex reactions from the inhabitants of the zone. If the limits of the international neighborhood in Geneva extend throughout different communities in the city, making its administrative borders somehow inexistent, during the past two years, the *Appia Center* (previously known as *Bâtiment V*) remained a focal point.

A reflection on boundaries

Although boundaries persist as strong separating artifacts, recent migration phenomena could be interpreted as a manifestation of the contested solidity of imposed material separations between territories, particularly in the context



© Heber Gómez-Malavé

Bâtiment V during the renovations (2016).

of an already described liquid modernity allowing for a more fluid shaping of space, and its daily uses. An issue of the journal “Social Anthropology” published in 2001, offers an eloquent analysis by the sociologist Zygmunt Bauman, reflecting on our modern and very fluid behavior. In his article “Identity in the globalizing World”, the reshaping of territories and identities are described as follows:

“This is, precisely, what distinguished the ‘individualisation’ of yore from the form it has taken now, in our own times of ‘liquid’ modernity, when not just the individual placements in society, but the places to which the individuals may gain access and in which they may wish to settle are melting fast and can hardly serve as targets for ‘life projects’. This new restlessness and fragility of goals affects us all, unskilled and skilled, uneducated and educated, work-shy and hard-working alike.”

These liquid properties of reality, in allowing incoming forces to reshape the previously existing forms, illustrate

how borders as separating artifacts are being slowly erased from the collective imaginary world. However, the extent to which this feature immediately translates into the daily uses of urban space, remains to be evaluated according to each particular context.

The urban order, reinforced by imaginary boundaries in the neighborhood, creates a set of rules, reinforcing separations otherwise inexistent. One interpretation of the concept of social boundaries allows the analysis of the effects of this separation as “following a double performative dimension, both as affordances for social judgement and also as scripts framing how to interact within the delimited context”, as proposed by Lucca Pattaroni and Hossam Adly in their 2013 publication *Boundaries and Urban Worlds. The Contested Ethnoscape of Expatriates in Geneva*.

The international neighborhood in Geneva, and the arrival of a group of asylum seekers to a previously empty office building, offers an example of how imaginary boundaries

are reinforced by daily uses of urban space. But if we could intuitively think that territorial boundaries are less and less evident in our *liquid* modern experience of the urban space, imaginary limits opposing otherwise more fluid interactions can be as constraining as the material ones in more solid structurally limited contexts.

Universal access and the imaginary borders to well-being

On April 29 2016, during an activity for initiating the integration efforts among neighboring organizations and the new residents of the *Appia Center*, the cherry blossoms were at their peak. After talking to one English-speaking asylum seeker about the beauty of the cherry blossoms, he asked: “can we go there?”. This question seemed surprising, given the proximity to the trees, and the absence of walls that could imply a separation, a physical barrier.

This question remained as heartbreaking evidence of how imaginary boundaries persist in our urban space. The park, frequently enjoyed by other users, seemed somehow out

of reach for the asylum seeker. Whether the reason for his hesitancy was born out of a formal rule established by the local authorities, or was simply born out of spontaneous individual concern, the imaginary wall existed, and it manifested itself in this person’s question about the possibility of going there.

The *Appia Center* was demolished in 2018. Evidence of the social interactions that took place within and beyond those walls lays in the testimonials of several international civil servants that were deeply engaged in transforming this ephemeral experience into a beautiful one. But the commitment remains. We must continue with our collective effort to grant universal access to the cherry blossoms before they fade, making the borders to beauty and the boundaries to well-being, more permeable ones. ■



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As the world *lingua franca*, English must accommodate everyone

Throughout human history, people have always needed to communicate, whether through the use of signs, verbalized sounds, or cave paintings.

GUILHERME SANCHES LIRA¹

Throughout human history, people have always needed to communicate, whether through the use of signs, verbalized sounds, or cave paintings. This necessity to communicate feelings and ideas gave birth to what we recognize as modern language, which consists of basic sounds (linguists call them “phonemes”), which can be combined to form meaningful words and, in turn, organized according into logical sequences (or “syntax”), and even more specific patterns known as grammar, which vary from language to language.

Despite the sophistication of human communication in the form of language, humans eventually faced language barriers. One historical parable interprets the emergence of multiple languages – and

the challenges their multiplicity poses for effective communication – as a lesson about human hubris: the story of the Tower of Babel. According to the Merriam-Webster Dictionary, Babel was an ancient city where the building of a tower described in the Book of Genesis was halted by God’s punishment, which was the confusion of tongues, sounds and the voices of its builders, thus causing them to be unable to communicate and achieve the final result – the completion of a tower high enough to reach heaven. This myth illustrates the need of human beings to use a common language; a *lingua franca*, a language spoken by all.

First, the Greek alphabet and language emerged as an early means of communication in the western world during antiquity. Then, in the Middle Ages,

educated Europeans learned to read, write and speak Latin, regardless of their native language. The use of Latin during this historical period reflects the widespread influence of the Catholic Church, which used this language for its official communications. The advancement of Latin as a *lingua franca* meant that many people in the western world learned to communicate in a common language. With the passage of time, the English language spread around the world and replaced Latin as the common linguistic medium in which the masses could communicate. Undeniably, English has become today’s *lingua franca*.

But does English accommodate everyone who speaks it as a second language or as their *lingua franca*? There is probably no one answer to this, as those who use English as a *lingua franca* come from various cultures.

To answer this question, I have reflected on my own experience of language. I am someone who not only speaks

English as a second language but also teaches it as a foreign language. This comes as a surprise to many because there exists a theory that non-native English-speaking teachers are not the same as native English-speaking teachers. This belief, in turn, leads to a form of prejudice referred to as Native Speakerism. This prejudice against non-native speaking teachers is grounded in a presumption that those who come from countries such as the UK, Canada, Australia or the US are ideal representatives of the language and, more importantly, that people from these anglophone countries are the ideal representatives of global institutions. It is probably not a surprise to those of you who work in various UN agencies that a native English speaker tends to be the one who people turn to for help in finalizing a report, or for assistance in coming to a consensus on the wording of important documents that are created during a negotiation process, or to make an important presentation. But English is also the mother tongue or a second language to many

people in places like Africa and Asia. Yet many people do not consider them to be native speakers, perhaps because they do not perceive them to be ideal representatives of the English language. However, the idea that being an English native speaker implies possession of deep linguistic knowledge or preferable linguistic aesthetic is a misconception: the level of literacy ranges among native speakers of any given language, be it English, Armenian, Portuguese or Quechua.

English is everyone's tool for international communication and should be inclusive of a broad range of users. I admit

that, at some point, I almost bought into the myth of native speaker superiority. In hindsight, I suffered from what the brilliant Nigerian writer Chimamanda Ngozi Adichie refers to as *The Danger of a Single Story*. I became convinced that language teachers had to be native speakers to be good teachers. Had I not disabused myself of this misguided notion, I would have regrettably overlooked the rich cultures of more than 60 countries in the world where English happens to be a widely-spoken language.

If you have heard of Esperanto, which loosely translates into English as “the one who

hopes”, or “the one who has hope”, you will know it was artificially created as a neutral language, therefore not belonging to a certain group or being representative of one people. Of course, while it may be too late for Esperanto to become today's world *lingua franca*, its essence does convey a powerful message: equality and, above all, unity and tolerance. While the solutions to overcoming linguistic prejudice and discrimination are not easy, it is important to increase awareness of the need for the English language to evolve to become more accommodating. As a *lingua franca*, English should help unite the world, not further divide it. ■



Guilherme Sanches Lira.

© Guilherme Sanches Lira

1 Cambridge Certified teacher of English as a Second Language, Geneva, Switzerland

WHO / OMS

The global development dance ensemble

The world is looking for development solutions.

MARISELA PONCE DE LEÓN VALDES¹ AND MELECKIDZEDECK KHAYESI²

The world is looking for development solutions
Diverse actions crisscross the global development space
High and low swings occur daily
Agents of change come and go
Discourses show up, disappear and resurface
Many new initiatives parade the dance floor

The orchestra sets the rhythm for the world to dance
The dance has nothing to do with where we were born
Unity, richness and beauty stalk our differences
Don't be shy to reveal your movements and feelings
We all add to the flavour of the tempo

The dance connects us in space and time
Shakespeare reminds us that
“all the world's a stage
And all the men and women merely players
They have their exits and their entrances”
Let us join the great global development dance
with our talents
Let us strive to leave positive imprints on this stage

Let us join the dance of protecting the Amazon rain forest
Guarding the lungs of the world is a great honour
Let us nurture the Nile as it is the lifeline of many

Let the graceful Ganges and Rhine peacefully unite nature and humanity
Do no harm to the glaciers of the world
Let us raise our voices to save the Ozone layer
The global village, where are you now?
Why don't you continue with the chorus of the Sustainable Development Goals?
Translate them into practical solutions for the small rural village

Let us enjoy dancing in our ordinary micro spaces
Let us vigorously perform our local dances to become global best practices
Participate in the dance instead of Waiting for Godot
Let us dance with the surprises life throws at us

Embrace life
Break predefined boxes
Create alternative boxes
Dance change
Dance solutions
Dance possibilities
Dance the future we want ■

1 Inter-American Development Bank

2 World Health Organization (Meleckidzedeck Khayesi)

World Health Day

Countries across the world join hands in solidarity for Health for All

Imagine that your son was struck down with a serious illness and you were unable to pay for the treatment he desperately needed... Or that your mother, now in her 80s, was unable to get an appointment with a doctor within 50 km of her home... Or that medical supply chain problems meant that your best friend had to manage without the drug that she had been prescribed for her high blood pressure...



Staff of the Pan American Health Organization joined with health partners in a solidarity chain in Bolivia.

ALISON BRUNIER AND PIPPA HAUGHTON, WHO

Today, at least half of the people in the world do not receive the health care they need. About 100 million people are pushed into extreme poverty each year because of out-of-pocket spending on health. And unsafe and low-quality health care costs the world trillions of dollars every year.

This is why the World Health Organization chose to focus on universal health coverage as the theme for this year's World Health Day and to highlight that quality, accessible primary health care is its foundation. In the days leading up to World Health Day and on World Health Day itself, we brought people from across the world together to show their support for universal health coverage and Health for All. In more than 30 solidarity chains, on all continents, WHO staff stood together with partners,

policy-makers, health workers and friends as a symbol of their commitment to working collaboratively towards universal health coverage.

Hundreds gather at the Place des Nations

During a sunny lunch hour on Friday 5 April, more than 600 people from WHO, other Geneva-based public health organizations and government embassies joined hands in a giant circle at the symbolic Place des Nations in Geneva. They were joined by WHO Director-General, Dr. Tedros Adhanom Ghebreyesus, who highlighted the importance of investment in primary health care as the bedrock of universal health coverage, together with Alain Kolly, from the University Hospitals of Geneva, Philippe Cori from UNICEF and Clemens Adams from the United Nations Office in Geneva. The lively drumbeat and dynamic dancers of the multinational group

“United Colours of Dance’n Drums” added to the festive atmosphere of the event.

A global Chain

The global nature of the Chain became apparent over the following weekend, as photos and videos of solidarity chains the world over began to appear on social media. Chains of varying lengths, from a few dozen to hundreds, were formed in countries including Azerbaijan, Bolivia, Congo, Cuba, Cabo Verde, Denmark, Egypt, India, Mexico, the Philippines, the Russian Federation, Somalia, and the United States of America.

Said Sarah Russell from WHO’s Department of Communications, who came up with the idea for the Solidarity Chain: “There was a tremendous atmosphere at the Place des Nations and it was really energizing to see so many people out together demonstrating their commitment to Health for All.”

A petition for the UN General Assembly

World Health Day also provided the opportunity for us to launch a global petition for Health for All. In just one week, more than 7500 people from over 100 countries had added their names to show their support. The petition will be presented to global leaders participating in the High-level meeting on universal health coverage at the United Nations General Assembly in New York in September this year. The petition, which should by then include over a hundred thousand names, will send a clear signal of public desire to ensure that in years to come, lack of access to quality health care will be a thing of the past. ■

To add your name to the Health for All petition, visit www.who.int/petition.

For more information on this year’s World Health Day, visit www.who.int/whd19

Voyage sur le Toit de l'Afrique

PASCALE TOUYÈRE, WHO

Parce que la vie est un cadeau extraordinaire, il faut la vivre à fond et faire l'expérience, si on le peut, d'aventures magiques et hors du commun!

Après avoir réalisé mon rêve de gravir les 4810 m jusqu'au sommet du Mont-Blanc, point culminant de l'Europe occidentale, je décide quelques mois plus tard de tenter le plus haut sommet d'Afrique.

Arrivée en Tanzanie, je découvre les camarades avec lesquels je vais passer 7 jours, avec l'espoir d'atteindre le sommet du Kilimandjaro qui culmine à 5895 m.

Le trek, dans le Parc National du Kilimandjaro, commence par la traversée d'une forêt très dense, sous une fine pluie. Instant magique, quelques colobes gue-reza (singes au pelage noir dont les flancs depuis les épaules jusqu'aux reins, sont ornés de longs poils blancs), passent de branches en branches devant nos yeux.

À l'arrivée au premier camp de base, il fait très froid, je me change rapidement car mes vêtements sont détrem-pés. C'est ici que nous passerons notre première nuit, à 3000 m d'altitude.

Je me réveille fatiguée, on ne dort pas très bien en altitude, surtout tant que le corps n'est pas acclimaté. Je n'ai heureusement aucun mal de tête, ce qui peut arriver fréquemment en haute montagne. Aujourd'hui nous avons une marche de 4h pour arriver jusqu'à notre deuxième camp de base à 3840 m. Je passerai une nuit glaciale, il y a une humidité terrible à

l'intérieur de ma tente, ce qui ne m'étonne pas, car une fine couche de gel est venue se coller sur la toile, et tout est complètement givré autour de nous. Je crois n'avoir jamais eu aussi froid la nuit sous une tente, c'est assez désagréable et en même temps, cela me fait plus que jamais réaliser à quel point nous vivons dans un confort inouï dans nos vies de tous les jours.

C'est le troisième jour d'ascension aujourd'hui. Nous allons monter jusqu'à Lava Tower (4640 m), où nous prendrons une collation rapide, avant de redescendre au camp de base Barranco à 3960 m. Le périple est tantôt ensoleillé, tantôt brumeux, et nous cheminons parmi les séneçons géants (espèce de plante que l'on trouve en Tanzanie, notamment dans le Parc national de Kilimandjaro). Je vais être prévoyante cette fois, et enfilez directement une veste polaire supplémentaire pour passer la nuit, et ainsi essayer de garder une chaleur toute relative dans mon sac de couchage.

Un nouveau jour se lève, nous allons remonter jusqu'à la grande muraille de Barranco, où quelques passages nécessitent de s'aider des mains. Ce sera une longue traversée, faite de montées et de descentes sur les flancs du Kilimandjaro. Nous passerons notre dernière nuit avant notre but ultime, à Barafu Camp, 4640 m, soit presque au niveau du Mont-Blanc! La journée fut longue et difficile je me sens très fatiguée, l'acclimatation ne se fait pas suffisamment, car nous passons d'un camp à l'autre trop rapidement à mon avis. Demain sera une journée encore plus dure, la plus difficile et la plus

longue de notre expédition, car nous enchaînerons la tentative du sommet tant convoité, puis la descente pour revenir à une altitude plus raisonnable pour passer notre toute dernière nuit avant le retour à notre point de départ, soit 16 heures de marche d'affilée. Il est 19h, il faut se coucher, car cette nuit nous allons nous lever à 23h, soit dans 4 heures à peine. Un petit miracle se produit, un des porteurs qui fait parti de notre équipe gratte à ma tente en annonçant «hot water for sleeping». Je ne comprends pas sur le moment et pense que c'est une boisson chaude, mais c'est en fait un bouteille en aluminium rempli d'eau bouillante prête à être glissée dans mon sac de couchage pour le réchauffer! Cet instant restera un des petits moments de bonheur que j'ai vécu sur cette magnifique montagne. À 23h, il est temps de sortir de la tente, après un court sommeil. Surprise! Il a neigé, et c'est 10 cm de poudre blanche que je découvre tout autour du camp. Commence alors une longue et éprouvante montée, dans la nuit noire, juste à la lueur de nos frontales et en lutte perpétuelle contre les éléments, le vent, le froid... Quelques heures après le début de l'ascension, un des camarades nous fait remarquer que nous passons le seuil mythique des 4810 m, soit le sommet du Mont-Blanc. Mais le chemin est encore long, très long... Notre progression continue jusqu'à Stella Point (5700 m), notre dernier stop avant le sommet Uhuru Peak et le dernier endroit pour faire demi-tour, et «rendre les armes». Trois membres de l'équipe, à bout de force, décident d'arrêter ici (nous apprendrons plus tard qu'un de ces membres a eu le Mal des



Pascale Touyère.

Montagne, et a fait un début d'œdème cérébral, qui est heureusement resté sans séquelle). Nous marchons depuis 7h. La pente est raide, et l'ambiance irréal au milieu des glaciers suspendus. Je n'arrive plus trop à réfléchir, je suis exténuée, mon esprit est confus, mais quelque chose me pousse à continuer, encore une heure de souffrance, il ne faut pas lâcher maintenant. Le jour se lève doucement. Le paysage qui se dévoile à nous est grandiose... Quelques mètres encore et nous voilà au sommet du Kilimandjaro à presque 6000 m d'altitude! L'émotion est intense, nous nous prenons dans les bras les uns les autres, les larmes nous montent aux yeux... Nous passerons 20 minutes au sommet, le temps de prendre quelques photos pour d'immortaliser ce moment unique... mais il est temps de repartir, car à une telle altitude, le corps humain est très éprouvé et il faut amorcer la descente qui durera encore 7 heures pour revenir jusqu'au camp de notre dernière nuit sur les flancs du mastodonte. Dans l'avion du retour, je pense déjà à la prochaine aventure, pourquoi pas l'Elbrouz (Caucase, Russie), le sommet de l'Europe, et pourquoi pas aller y porter haut les valeurs de l'OMS? L'appel est lancé! ■

Mens sano in corpore sana (4)

It doubles your well-being!

Around a year ago, I launched a well-being column, in which I wrote about the benefits of healthy eating, healthy breathing and Ayurveda.

EVELINA RIOUKHINA, UNECE

Let me offer you a new testimonial: “tested on myself”, I hope you will find it beneficial for your well-being, your work performance, and much more...

It is not the first time I have undergone Ayurvedic immersion, and if you decide to do the same, then definitely chose Kerala in India. There are many healthy resorts and clinics where you will get wonderful treatment, or simply combine your holiday there with wise and healthy care of yourself.

However, if you want something special or more than that, there are several specific places to go. One of these is Bethsaida Hermitage Ayurvedic resort and healing centre, and it is indeed a special place. You will not find it in any commercial tourist catalogue as its purpose is not commercial, and it is not only about healing. Its purpose is also highly humanitarian, as the owner of this place gives all he gets from a patient's stay to helping those who are in need. It is a fascinating story and human experience, and knowing that you are not only pampering yourself, but also doing something useful for others in need doubles the benefit

The atmosphere of the place is very serene. There is no luxury,

but there is care – and you will feel it in every small gesture. When you enter the premises, you will see the steps and “feel like coming home”. The moment you put your foot on these steps, the welcome is tangible as the atmosphere, hospitality and care are so cordial. People from all over the world come here. I met patients from the UK, Switzerland, Germany, Italy, Russia, Kazakhstan, Iran, Saudi Arabia, Israel, and Australia. All have the same feeling and many return to this place over and over again. And this has been going on for 20 years already!

What and who contribute to this feeling? Four doctors are available for a personalised check-up to determine the best possible treatment for you. My doctor prescribed an absolutely fantastic combination that within two weeks had totally recharged me. All the treatments are performed diligently, using special Ayurvedic techniques by two therapists with “four hands”. These simultaneous movements help to relieve tension and fortify the nervous system and immunity. A detailed meals programme was elaborated for my Dosha type and specially prepared juices and Ayurvedic drinks complimented my daily rations. Advice on how to eat better was also provided, which I have followed rigorously since. Yoga is also an integral part of the treatment, as well as meditation, as there is no Ayurveda without healing the mind. Follow three daily courses with Asans (sun salutations) and singing mantras – and you are in a different world.

Breathtaking sights, a magnificent territory – it is as if you



At Bethsaida Ayurveda Resort. Kerala typical round houses.

are in paradise. But there is a person behind all this. His name is Frederick Thomas. He has been an international teacher and philosopher for the last twenty years with professional experience in India and abroad. With his multiple educational disciplines, he has influence many students and continues to attract and inspire people to adopt socially responsible and sustainable eco-friendly policies. His vision, his creativity and his hospitality are defined with the motto “feels like coming home”, which is exactly what you feel there. He personally attends to each guest/patient during their stay, and it is not only through courtesy but also a gesture of generosity – he welcomes you, he listens to you, he is there with you, it is his home and he makes your feel at home too!

He is very modest, does not speak much, but does a lot. The philanthropic projects he is involved in serve humanitarian purposes and include orphanages and schools, day care for elderly people, clinics, etc. His project started out helping 15 children and today many hundreds of orphans and children in need from surrounding villages live and study in premises specially designed for that

purpose. Thomas is committed to supporting all socially disadvantaged children, paving the way to college education. He is a person who makes a difference.

Staying there for me turned into not only “feeling like coming home”, but feeling part of this philosophy too. Not only did I recover, but it made me feel like I was making a difference too. It is my second cure there, and long after the treatment, not only can I live without any medical help and manage to cope with an extreme workload, but have also maintained a high morale and been able to support others in difficult situations. And all this is thanks to my stay at this place, where I belonged to something high and important.

There are many factors that make this place so special: doctors, some of the best in Kerala, for the treatment programmes, qualified therapists, a caring atmosphere, the generosity of the owner Frederick Thomas, or just knowing that by being there you are not only healing yourself but also doing something important for somebody else, or making a difference. For me it definitely “doubled” the well-being. I hope it will be the same for you too! ■

Message du rédacteur en chef

Vous aimeriez partager votre opinion sur le magazine et son contenu?

N'hésitez plus et écrivez-nous !

Nous serions heureux de recevoir votre avis. Les plus pertinents, les plus intéressants, les plus originaux seront publiés dans le magazine.

Si vous souhaitez proposer un article, n'hésitez pas à me contacter à tout moment.

Et maintenant, à vos plumes !

Adressez vos commentaires à:

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Message from the editor-in-chief

Would you like to share your opinion about *UN Special* and its contents ?

Write to us!

We will be glad to hear from you. The most interesting, relevant, or even ingenious responses will be published in the magazine.

Should you wish to submit an article, please do not hesitate to contact me at any time.

Now, put pen to paper!

Send your thoughts to:

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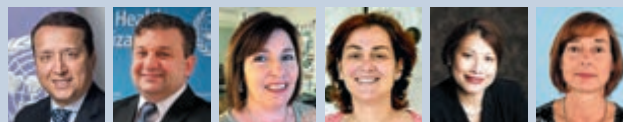
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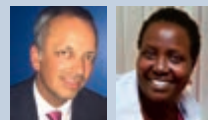
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