Raising a moral voice to reach health targets

WHO Director General **Dr Gro Harlem Brundtland** talks to **Mahfuz Anam**

"You cannot come in and tell a country what they are supposed to do. You can tell them why certain methods work, why it is a good idea to give service to the poor people because then it is a basis for economic growth. You can do it on an ethical basis or you can also argue economically, which I do. I do that because I know as a politician that any government will be looking not only at ethical questions, but also at practical, economical questions – how can I get returns?"

DR. Gro Harlem Brundtland – who chaired the World Commission of Environment and Development producing *Our Common Future* in 1987 that to such global conferences as the Earth Summit in Rio – was here in the city. Now director general of World Health Organisation, the former prime minister of Norway is defining the WHO agenda in new terms and changing the 52-year-old institution's ways of operation. She spoke exclusively to The Daily Star on Tuesday at her Sheraton Hotel suite. Excerpts:

The Daily Star (DS): What is your view of the health situation of Bangladesh? What do you think we are doing right and what do you think we are doing wrong?

Dr. Gro Harlem Brundtland (GHB): I think that the basic philosophy, the basic guideline of the programmes, is that it is aimed at reaching the poor. That has been the basis since the start here. That I think is the right philosophy because one of the major problems of the world today is poverty and that there are 1.2 billion people that globally are left out of the health revolution that has happened in this century. If we want to fight poverty and overcome poverty, we have to see that there is equity and that people have the access to the knowledge and the technology that the world has developed, so we can bring this to the 1.2 billion on board. Half of that number of people live in this region and in Bangladesh there is the policy of trying to reach everyone. That doesn't obviously mean that everything is perfect here. But if you don't even have that philosophy, how can you ever reach those goals? So that's the positive side of it.

For many years, the international agencies, donors, the government and NGOs have been working here in the field of health, focusing on fighting disease, preventing disease. Still there is a major problem of nutrition, anaemia, too high maternal mortality, a lot of tuberculosis, which has been increasing. So what the government is doing and planning with the help of WHO, the World Bank and the other donors, is having a sector-wise approach to develop the health system. I think that is the right way to go because that is in accordance with the philosophy of a primary health care perspective of reaching all -- immunising, giving preventive efforts so that every child is given a chance. So we think that the plan that has been developed is a right one, a sector-wise health and population approach which is supported by WHO and the other agencies.

DS: The problems we face here are that countries like Bangladesh are very good at taking up policies. We are the first one to go to the UN and sign the charter on child rights, the charter on discrimination against women. We sign all of that, but the reality on the ground is that there are policies, good plans, but these are not implemented in their letter and spirit.

GHB: Wherever this is the case, it concerns me. But we are in the business of creating the evidence based on which to act. So the WHO philosophy and policy is not based on declarations alone. It is really looking at the health indicators, looking at maternal mortality, which, as I said, is too high here, and it should be lower. It can be done. So, making pregnancy safer is something we work on in many countries, including Bangladesh because the health indicators show that not sufficiently or in the right way are things being done to prevent maternal deaths. That is an example of checking the implementation, looking at what happens and then seeing how one can change.

I was speaking with your government functionaries today and yesterday about the fact that there has been, and still is, a separation of management within the government between family welfare and health directorates. In this case, with regard to the guidelines and implementation in making pregnancy safer and reducing maternal mortality, that has been a barrier to improvement. Now they tell me that this is going to change, that they are going to bridge them to avoid the problems that we have seen through the detrimental results. So we are practical people. We look at what happens on the ground and we will know more so when we are doing it. We are in the WHO now improving our capacity and ability to analyse and to give advice about the development of health systems, about health financing because there is nothing like a free service. Somebody is going to pay -- the government, taxpayers or those in a pre-payment system. So we have studied these things. We compare countries, we share the knowledge, we give examples, sharing between governments and by that we can give the answers on what works and what does not work. Why does this country have better health indicators than this country although it is in the same development range?

We are trying systematically to focus on how to invest in health, to improve the development pattern and to alleviate poverty. We know that it is not only poverty that leads to ill health. But ill health breeds poverty. These are the things I discussed with your people.

DS: What, at present, are the major programmes that WHO has for Bangladesh? Is your visit going to initiate some new one?

GHB: I would say, generally so, that WHO offers support for government programmes. It is not that we deliver programmes. This was the case more than 20 years ago, maybe even 10 years ago. Now it is a clear philosophy that we are giving technical advice and technical support to government plans that are developed with the input and the advice of WHO and others. But it is government owned.

You can take one example. I am much concerned about how we implement programmes such as the one on polio eradication. In India and Bangladesh, there are two examples globally of important remaining sources of the wild polio virus. The two countries themselves are dependent on making their efforts with the support of the international community -- with WHO, the NGOs, Unicef and others. We have a campaign to eradicate polio. But the government has to be in the lead in making decisions about the programme, while we can give a lot of input, especially in these kinds of eradication campaigns.

Both in India and Bangladesh there are big numbers of sources of the wild polio virus still active, and we want to get rid of this in 15 -16 months – January 1, 2001 is our aim.

Now, we feel this country has been a little slow in getting the surveillance system in place. Every country needs a laboratory service or unit with WHO credentials that we can trust it, that can test whether polio virus is still active in the population. Otherwise we don't know where to go in the so-called mop-up. You have national campaigns, national immunisations days which are very important. And Bangladesh has had some of those and is going to continue. But there are all those we don't reach because people have to go to a place where immunisation is given. To finish an eradication campaign which then can rid the whole world of polio and the disability of polio, you know what kind of crippling condition it is, we have to have the mop-up. We have to go from hut to hut, into the homes in those areas where wild polio virus is still there and where too few children have been immunised. So we have to survey. We have to count how many are there and have to go after them, like a military operation in a way. There you need the government actively supporting the efforts.

DS: One of the new phenomena in Bangladesh is the high growth of urbanisation. This was perhaps not so 10-15 years ago. The city has grown tremendously. Is it your view that urban areas offer different challenges than rural areas? Or is it the same? For example, big cities like Dhaka or Calcutta have 10 million people living without any sanitation or water supply. This is a new phenomenon.

GHB: Yes, this has happened in the past 20 years or so. In this case, this is a major infrastructural challenge and remember that more than 20 years ago, there was the so-called Habitat Conference in 1976. I was a young Environment Minister at that time. I led the Norwegian delegation to that Habitat Conference. Now, why did we have the Habitat Conference? Because the world had started to see what you are now talking about. So in the five years proceeding that conference, human settlement, organisation, how to deal with water and sanitation, were part of the challenge. This was an enormous UN conference. They made a Habitat Unit, an institution in Nairobi afterwards. So it was seen to be closely connected with environmental policy.

Naturally, as you were saying, it involves sanitation, infrastructure, water, housing, all the basics. So that illustrates that we are not only into a health issue, it is a broad development issue. But of course, since water and sanitation and health are basic for human life, it is important for World Health Organisation. However, there are many agencies involved in this area. So it's not like a core area for WHO. It's really across the board. One has to find the infrastructure solutions in these megacities. You can't deal with it as if people were still living in rural areas. When they move more densely together, they communicate more infectious diseases, and sometimes increase poverty because they don't have the opportunity to grow food.

However, you can, by building the economy and giving the opportunity for education, have investment from society into infrastructure and you can have economic growth. But you have to tackle the basic requirements of human settlement.

DS: What do you suggest ...

GHB: I would say this is a major development challenge and WHO would be one of the several agencies that would give technical advice in the more definite field, addressing the minimum standards that are needed for quality of water, quality of sanitation, explaining what is necessary, but as for the investment and the money, we are not a funding agency. We are basically a technical agency.

DS: Do you see WHO as a part of the international effort to help Bangladesh in this regard?

GHB: We already are.

DS: Do you think there should be a special programme for Bangladesh? Like the one when the world responded together to the massive floods in 1988, trying to help Bangladesh find out ways to fight the recurrent natural disaster? Because the fact remains that our capital Dhaka is a city where the slum population is larger than national population of many countries. So do you think there should be a major international initiative to help Bangladesh?

GHB: I think there should be special programmes for every developing country. We are an international organisation of 191 member states and what we are doing is gathering the evidence working in collaboration with NGOs and others, trying to give support in the public health field to all our member countries, both rich and poor. We are taking more money from the rich and giving more money to the poor. So, for instance, in my country Norway, there is not one WHO staff. Here, I don't know the number, but there are 60 or 70 people even in the Country Office of Bangladesh.

DS: In your discussions with the government, what were the points you raised with Bangladesh officials?

GHB: I was giving strong support to the implementation of the programme that has been developed for a sector-wide approach, because we don't want it to be on paper. We want it to be implemented step by step.

DS: What do mean by the sector-wise approach?

GHB: As I told you earlier, the polio eradication campaign is an example where you go in a big exercise. You get funding from big organisations worldwide. It's an eradication campaign. However, as it happens, we have to build up the laboratory capacity of a country like Bangladesh in order to be able to survey the situation and to learn what's happening on the ground. Now that ensures a capacity building in Bangladesh to deal with other viruses and other health problems, not just the polio issue. This is what we call a vertical approach. We go in to fight polio because we have technologies that work. A little drop in the mouth of child and you are immune for life. It's workable, it's necessary and it's a right policy, but it gives a broader capacity building effect. In this case, the laboratory capacity, the knowledge of how to work at the community level to do things, organising people to do things that are based on knowledge.

What I am saying by sector-wise approach is that instead of having certain number of different programmes in different areas, people have to get a health system in place where people can come with a sick child, get to learn how to prevent diarrhoea, get reproductive health services. You need such an approach, otherwise you will never be able to build it for the whole of the population. This is not only Bangladesh, but it is the experience now in many countries. Until you have that basic thing in place, it will not happen, like seeing the nutrition advice is given to women and children, especially to girls, so they don't enter adulthood anaemic, which will reduce the rates of maternal mortality. Their children are born without a future. So it's a capacity building question.

Do you know what percentage of your national budget goes into health and education? We made a global agreement 2020 at the social summit in Copenhagen. To what extent is Bangladesh moving towards 20 per cent of its budget going into health and social services? This is what I am talking about. You cannot come in and tell a country what they are supposed to do. You can tell them why certain methods work, why it is a good idea to give service to the poor people because then it is a basis for economic growth. You can do it on an ethical basis or you can also argue economically, which I do. I do that because I know as a politician that any government will be looking not only at ethical questions, but at practical, economical questions – how can I get returns?

DS: While we have been improving on immunisation front, Dhaka has become the most lead-polluted city in the world. The lead content in the air is so high.

GHB: I have been talking about this with your Health Minister and with my own people. This is typical of third world country cities. This cannot continue. Again, it's a question of infrastructure, gradually phasing out the cars that don't have clean engines. As long as the people were using cycle rickshaws, it was okay, but then they had bad motors spreading this bad smoke. People are breathing this, and it is dangerous. You have to gradually take higher standards in environment and health, but you cannot of course do it overnight.

DS: We cannot do it overnight, but we got into it literally overnight. We were quite disappointed by the role WHO played at least in Bangladesh. We in the press are writing huge articles about this lead pollution in Dhaka and how children are getting affected. I would have hoped that there would be some kind of declaration that, look here, Bangladesh is going dangerously below accepted standards, but nothing like that came. We thought that the lack of pro-activeness on the part of WHO ...

GHB: That may be, but when are you talking about? Five years ago?

DS: No, it's very recent.

GHB: In my country they would not turn to the UN or WHO or anyone else. They would turn directly to the government.

DS: That's what we did. What we are saying is about the partnership. Because the fact remains that international organisations have a lot of impact on policy makers of the developing countries.

GHB: Of course, because you have a lot of development efforts which are based on donors and agencies.

DS: Yes, if WHO says, look here, it's very dangerous. When Unicef says, our nutrition level for children has gone down very much, then everybody takes note.

GHB: What you are saying is if we could play a more pro-active role in the matter. Do you know the level now? Has the lead content in the city increased? Have you looked at the international picture?

DS: We in Bangladesh are in the worst lead-polluted city of Dhaka.

GHB: You have to go to the government, go after the sources, make a plan about which sources are the most dominating ones, the ones that you can get rid of and then make an implementation plan over a few years, and finally getting it systematically done.

DS: In fact it was the media basically which made this issue into a national issue and forced the government to make some promises.

GHB: So you succeeded.

DS: But the promises are not being turned into action. The main source is the auto-rickshaws. The government allows import though these have been banned all over the world.

GHB: Why? How can you explain it?

DS: Vested lobbies. You know how governments go along with them. So, it was the media which single-handedly made them promise. Now they are saying they are going to ban it in 2004.

GHB: When I started asking about it while driving in a car, asking what are you planning to do, I got the answer that the decision has been made that within three or four years these will be banned. This is also the only way one can do this kind of thing because not in any country can you suddenly say that all the people who bought cars last week are not allowed to use them. You have to stop the new ones coming in and then say you have to change the motors, this and that before you go on. That's what happens all over the world. This has to happen. You can't just sit there and register the increase of the lead.

DS: You will be happy to note that the media in Bangladesh ...

GHB: Strong NGOs and strong media are a very good thing for this country, isn't it? We are working with UNEP, the environmental agency, to work on city pollution. So we have a concept about cities. There is at least one example of that in Bangladesh.

DS: As you talk about raising a moral voice, bringing up issues that are essentially related to broad development agenda, campaigning against conflict and strife, how have the responses been so far? On a visit to a region where a nuclear race is on between two countries, how do you feel about it? Have you ever raised this issue in your discussions with political leaders of India and Pakistan?

GHB: There are many different channels for discussion with government. You have the daily contact of people working in the field, or in this case, in the WHO office, and dealing with programmes and issues, telling the government what happens and what is done in other countries and how things can be done. So there are so many levels and types of communication all the time. If you see my speech, I have given positive remarks about development here in this country and the region. But I also gave critical remarks about what is lacking. I had said to the (Bangladesh) government that I am waiting for the plans for polio because I think we have to gradually be more outspoken and transparent, able to discuss issues, seriously and directly. This has to be done, increasing the confidence that there is a serious and objective organisation that is there to help people basically. And one way of helping is also explaining how changes in policies can be necessary. So we have to play this role of supporting and sometimes giving critical remarks.

DS: What do you think will be the challenges for the next century?

GHB: I should mention one thing. Beyond the issues we have discussed, the problem I have also discussed with all of the ministers that I met is the tobacco issue. This is a pandemic problem and it's hitting the developing world worse than anything else. In the developed world, the knowledge about the danger of tobacco is rapidly increasing and it is going out of fashion in many countries. And we have strong policies against it, high taxation for instance. In many developing countries, they are now being focused, advertised, invited, inspired by money and all. It is going to be a major burden on developing countries 20 years from now. People who are young now start smoking. They will have heart disease, cancer, things that are costly to society, not only to the individual. So if the health system in Bangladesh is going to be dealing with all the diseases of the tobacco epidemic in 20 years from now, you certainly will not have sufficient resources to deal with the diseases that are not as easily preventable. It is easily preventable now. Just get rid of smoking. It's one of the biggest killers here and in many countries.

DS: So what are the challenges you think there are for WHO in the 21st century?

GHB: I think we have talked about them. The challenges for the first decade in the next century will be getting the 1.2 billion poor to have access to basic health technology with the knowledge that we have against disease. It will help them out of poverty and I think that is the major challenge.

DS: Madam, you have been the pioneer, we would say, in terms of raising the whole issue of environment at the global level. We remember your report called Our Common Future. So at the international level, what is you assessment? Has there been a successful effort?

GHB: Yes, there is no doubt about it, I mean in terms of the awareness, the knowledge, the research level, the NGO commitment etc. Many of the governments have made a lot of efforts which wouldn't have come about without the awareness raising campaign. However, there is a long way to go and that is the problem. The environmental problems are still great. They are still increasing in some places like China and probably in Dhaka. So that illustrates the case. There is a lot more to be done.

DS: The follow-up to the Rio conference, globally how is it going?

GHB: In the Rio Conference, we made Agenda 21. This is really about sustainable development including health, education, democracy, free press, really a programme for the right world development. We are far from it in many places.

DS: Thank you very much for your time.

"It is not that we deliver programmes. This was the case more than 20 years ago, maybe even 10 years ago. Now it is a clear philosophy that we are giving technical advice and technical support to government plans that are developed with the input and the advice of WHO and others."

The Brundtland profile

DR Gro Harlem Brundtland was born in Oslo, Norway, on 20 April 1939.

A medical doctor and Master of Public Health (MPH), Dr Gro Harlem Brundtland spent 10 years as a physician and scientist in the Norwegian public health system. For more than 20 years she was in public office, 10 of them as Prime Minister. In the 1980s she gained international recognition, championing the principle of sustainable development as the chair of the World Commission of Environment and Development (the Brundtland Commission).

Dr Brundtland's first choice of career was neither environmentalist nor politician, but to become a doctor like her father. He was a specialist in rehabilitation medicine, a skill much in demand following the Second World War. When Gro Harlem was 10 years old, the family moved to the United States where her father had been awarded a Rockefeller scholarship. A few years later the family moved again, this time to Egypt where her father was serving as a United Nations expert on rehabilitation. The seeds of internationalism were sown in the young Gro.

Dr Brundtland inherited another passion from her father – political activism. At the age of seven, she was enrolled as a member of the Norwegian Labour Movement in its children's section and has been a member ever since, leading the Labour Party to election victory three times.

The sense of global awareness that began in her childhood developed when, as a young mother and newly qualified doctor, Gro Harlem Brundtland won a scholarship to the Harvard School of Public Health. Here, working alongside distinguished public health experts, Dr Brundtland's vision of health extending beyond the confines of the medical world into environment issues and human development began to take shape.

Returning to Oslo and the Ministry of Health in 1965, the next nine years were to be very hectic for Dr Brundtland. At the Ministry she worked on children's health issues including breastfeeding, cancer prevention and other diseases. She worked in the children's department of the National Hospital and Oslo City Hospital and became Director of Health Services for Oslo's schoolchildren. All this at the same time as bringing up her own family, representing Norway in international conferences and working her way up through the Labour Party hierarchy.

Such energy, enthusiasm and commitment brought an unexpected change of career. In 1974, Dr Brundtland was offered the job of Minister of the Environment. At first, believing she did not have enough experience of environmental issues, she was reluctant to accept the post. But her growing conviction of the link between health and the environment changed her mind.

During the 1970s she acquired international recognition in environmental circles and a political reputation at home. In 1981, at the age of 41, she was appointed Prime Minister for the first time. Gro Harlem Brundtland was the youngest person and the first woman ever to hold the office of Prime Minister in Norway. With two other periods as Prime Minister from 1986-1989 and 1990-1996, Dr Brundtland was Head of Government for more than 10 years.

Throughout her political career, Dr Brundtland has developed a growing concern for issues of global significance. In 1983 the then United Nations Secretary-General invited her to establish and chair the World Commission on Environment and Development. The Commission, which is best known for developing the broad political concept of sustainable development, published its report Our Common Future in April 1987.

The Commission's recommendations led to the Earth Summit - the United Nations Conference on Environment and Development (UNCED) in Rio de Janeiro in 1992.

Dr Brundtland finally stepped down as Prime Minister in October 1996. In her successful bid to become Director-General of the World Health Organization her many skills as doctor, politician, activist and manager have come together.

Dr Brundtland was nominated as Director-General of the World Health Organization by the Executive Board of WHO in January 1998. The World Health Assembly elected her for the position on 13 May 1998.

In her acceptance speech for the World Health Assembly, Dr Brundtland said: "What is our Key mission? I see WHO's role as being the moral voice and the technical leader in improving health of the people of the world. Ready and able to give advice on the key issues that can unleash development and alleviate suffering. I see our purpose to be combating disease and ill-health - promoting sustainable and equitable health systems in all countries".

Dr Gro Harlem Brundtland took office on 21 July the same year.

-- Courtesy: WHO