

DR. SANIA
NISHTAR

10 PLEDGES
FOR ACTION

A NEW VISION FOR WHO

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World Health Organization

Nominated by the Government of Pakistan

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“My vision for WHO is one in which WHO reclaims its primacy and earns the world’s trust as its lead health agency, and has the ability to foster and sustain partnerships to achieve the vision for health – universal attainment of the highest possible level of health and well-being.”

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Statement of my candidacy

As the World Health Organization (WHO) nears its seventieth anniversary, the mood is not yet celebratory. While some Member States still express support for and confidence in the organization, others openly debate WHO's merits and consider the case for its continued survival. In a world brimming with unprecedented opportunity for health improvement, WHO faces structural limitations and reputational damage. The next Director-General must usher in an era of renewal.

Against this backdrop, I present my vision, centered on the firm belief that as the world's only universal membership multilateral agency in health, WHO has critical mandates and that its relevance matters today more than ever in the face of a multitude of pressing health challenges. My conviction is that the organization has the potential to re-emerge as the world's most trusted and leading health agency. However, a renewal is more than a simple matter of reorganization; it must run deeper and touch every aspect of the organization. This requires bringing reforms to rapid fruition, embracing meaningful and timely transparency, institutionalizing true accountability, ensuring value for money, and driving a culture based on results and delivery. These have featured saliently in my 10 Pledges to achieve a renewed and reinvigorated WHO.

Universal attainment of the highest possible level of health and well-being is an undisputed goal. The new vision for WHO reiterates its importance and flags that its achievement is a collaborative effort. WHO exists in a rich landscape of global health actors, where sectors other than health influence health outcomes, and other stakeholders have a role to play. The systemic interlinkages between the economic, social and environmental determinants of sustainable development require a profound change from the prevailing sectorial view of health. In order to affect change, I pledge to focus WHO on its core and exclusive mandates and to exercising WHO's leadership by establishing a shared vision, through effective coordination, building on comparative advantage and by establishing a partnership-fostering culture.

My programmatic Pledges center on delivering effective operational readiness in outbreaks and emergencies; strengthened action on global public goods; focus on supporting countries to reduce the health risks of climate change; and country-relevant support to achieve the SDGs, with an emphasis on Universal Health Coverage and multisectoral action.

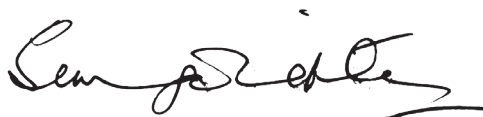
My mix of civil society, governmental, medical, multilateral and grass-roots experience and professional expertise will enable me to deliver a renewed WHO. My experience demonstrates my ability to relate to a wide range of partners and to understand WHO and its challenges from a diverse range of perspectives. If elected, I will lead a WHO that leverages stakeholders' contributions and inspires increased engagement and accountability.

I bring a track record of finding solutions. I bridge divides, speak truth to power, drive change, deliver results in resource-constrained environments and have demonstrated commitment to

transparency and accountability. I have the resolve, ability, and experience to provide strong and decisive leadership for WHO – and the ability to listen carefully to stakeholders and adapt decisions to a rapidly changing global health environment. I will focus on fulfilling WHO's mandate and holding it accountable for delivering results.

I have committed to voluntarily making my electoral campaign financing public to demonstrate that there will be no hidden influence of campaign financing during my term in office.

It is critical for WHO to reclaim its primacy. As Director-General, I would drive action to achieve this, regain trust and reestablish WHO as the world's lead health agency, fit for purpose to identify and address the pressing and urgent challenges ahead.



September, 2016

Summary of the 10 Pledges

One Vision

My vision for WHO is one in which WHO reclaims its primacy and earns the world's trust as its lead health agency, and has the ability to foster and sustain partnerships to achieve the vision for health – universal attainment of the highest possible level of health and well-being.

Ten Pledges

Under my leadership, WHO will demonstrate and deliver:

1. **Transparency and accountability in all areas of its work:** WHO will adopt an accountability framework that is straightforward to enforce and is guided by independent voices. As a starting point, I will voluntarily make my own electoral campaign financing a matter of public record and scrutiny.
2. **Leadership for action:** Leadership will not be subject to special interests, but will rather focus on fulfilling the mandate of the organization, such that it becomes accountable for results and delivers.
3. **Operational readiness in outbreaks and emergencies:** WHO will continue to develop the financial, technical, institutional, and technological capacity to detect, lead, manage, and coordinate the response to outbreaks and emergencies with health consequences, including supporting countries to enhance preparedness and resilience.
4. **Country-relevant support to achieve the SDGs:** Countries will be supported to achieve the Sustainable Development Goals, particularly Goal 3 to “ensure healthy lives and promote well-being for all at all ages,” with the understanding that the goals are interlinked, and with full realization of the importance of gender equality and poverty reduction as critically important measures for health.
5. **Strengthened action on global public goods:** WHO will live up to its core mandate for collective action to produce global public goods in health – as producer of health norms and standards, as steward of the world's health knowledge, and as bulwark against threats such as antimicrobial resistance.
6. **Focus on health-climate interaction:** WHO's actions will support adaptation to and mitigation of climate change, capitalizing on the co-benefits of action for health.
7. **Accelerated pace of reforms:** WHO will evolve to tackle its systemic constraints, and will reform into an effective, well-managed, transparent, accountable, and cohesive organization, which achieves value for money, and where robust evidence guides decision-making. WHO will exploit to best effect, the synergies between its headquarters, regional offices, and country offices, and will develop the capacity to look beyond the horizon to anticipate global health trends and what is required to respond.

8. **Management for results:** A culture of management for results will be fostered throughout the organization. Amongst other things, this also means creating a performance-enabling environment, and breaking intra-organizational silos.
9. **A culture of partnerships:** WHO will develop the institutional capability to work with all appropriate partners in a transparent, accountable, efficient, and effective manner to improve global health while upholding the principles enshrined in WHO's constitution, and with safeguards against undue influences.
10. **New models for financing:** WHO will deliver value for money through a combination of efficient and cost effective working. Through innovative financing measures, WHO will strive for a budget that is proportionate to its scope of responsibility.

WHO Leadership

The World Health Organization (WHO) was created in 1948 in the aftermath of World War II, as the health sector's contribution to peace and security and lead agency, globally. Since its creation, WHO has contributed significantly to the achievement of health improvements, disease eradication, capacity development, and knowledge generation for health. Although the nature, scope, and complexity of issues confronting WHO have radically changed over the decades, its relevance as the world's only universal membership multilateral agency in health, remains undiminished. Its mandate, centered on norm and standard setting, management of outbreaks and emergencies with health consequences, international coordination, and technical leadership in global health remains exclusive. Today, in the wake of disease outbreaks and emergencies, widening inequalities in health outcomes and overarching threats such as antimicrobial resistance (AMR), climate change, and Non-Communicable Diseases (NCDs), WHO's functions and principles, clearly articulated in its Constitution,¹ are more relevant than ever.

WHO is the world's only universal membership multilateral agency in health. The new Director-General must lead WHO reform to address its structural limitations

The incoming Director-General will step in at a critical juncture in WHO's history. Although WHO's prestige has been dented over time, the situation has worsened recently due to its handling of the West African Ebola outbreak, as a result of which the relevance of WHO and its capacity to deliver have been questioned. As a response, Dr. Margaret Chan has put in place the much needed reform of the emergencies program. This reform is in its early stages of implementation, and it is clear that further work is still needed. There is, therefore, an urgency to accelerate the pace of reform and to ensure its effectiveness in order for WHO to play its critical leadership role, as required.

Beyond the emergencies imperative, WHO has other critical mandates in health—and the world needs it to fulfill these mandates effectively and to achieve reform in these areas as well. However, over the past two decades, new needs and opportunities for action in global health, coupled with a lack of confidence in WHO, have led to the establishment of new institutions. In most cases, these institutions offered a means to bypass WHO's structural limitations, which have hampered its ability to deliver and have contributed to weakening of performance despite its legitimacy. However, cross-border issues, in particular disease outbreaks and emergencies, and threats such as AMR, necessitate urgent collective multilateral action, now. WHO is the only multilateral agency in health with the legitimacy to intervene. The new Director-General must lead WHO reform to address its structural faults so that it can effectively deliver in these and other areas.

A transformation is possible with bold and innovative leadership and clear priorities. As a

starting point, WHO's new leader must differentiate between the **vision for health**, the overarching health goal "universal attainment of the highest possible level of health and well-being," and the **vision for WHO** as a preeminent institution dedicated to achieving that vision for health, worldwide.

Achievement of the vision for health is a collaborative effort in which Member States and many national and international organizations play a critical role. WHO's leadership must be grounded in its core and exclusive mandates, and collaborative division of labor. It must exercise leadership by establishing a shared vision, effective coordination, forging partnerships, and building on comparative advantage and complementarity.

My vision for WHO is one in which WHO reclaims its primacy and earns the world's trust as its lead health agency, and has the ability to foster and sustain partnerships to achieve the vision for health – universal attainment of the highest possible level of health and well-being. Partnerships are critical to achieving this vision. With the Sustainable Development Goals (SDGs), an ambitious agenda has been agreed, globally. Health as enabler, determinant and outcome of development is at the center of this agenda. The systemic interlinkages between the economic, social and environmental determinants of sustainable development require a profound change from the existing sectorial view of health. This entails a major operational and knowledge challenge that will require corresponding adjustment for the work of WHO.

The achievement of my vision for WHO, therefore, requires a concerted effort across all the institutional pillars including governance and management, financing, information systems, service delivery, and human resource, amongst others. To this end, I have outlined 10 Pledges grounded in WHO's constitutional parameters, its exclusive mandates, recent global commitments, a universal outlook for health, country systems strengthening, and commitment to build further on the progress currently underway.

I humbly suggest that I have the resolve, ability, and experience to provide strong and decisive leadership for WHO. In this document, in addition to the 10 Pledges, I have also outlined some examples from my past work as evidence of my capacity and track record to deliver in these areas. Should I be accorded the honor to serve as Director-General, I commit to leading a WHO that will aim to deliver on these 10 Pledges. I respectfully submit these to Member States and the general public – as the DG has an equal responsibility to both.

10 Pledges for Action

Transparency and accountability, guided by independent voices

Transparency and accountability are vital for safeguarding WHO's role and achieving the vision for WHO. To signal my commitment from the outset, I aim to set a standard of transparency by making public, financial statements of my campaign, including all sources of funding. This is essential to demonstrate that there will be no hidden influence of campaign financing during my term in office. Throughout my career, I have been a staunch advocate for accountability, transparency, and good governance. As Federal Minister in the Government of Pakistan, I set precedent by being the first minister to publish the Handover Papers,² which served to make my decisions and conduct in public office open for public scrutiny and accountability. I have also disclosed all information about my work on a publicly accessible website.³

**Transparency and accountability are
vital for safeguarding WHO's role**

Transparency and accountability are mutually reinforcing. Accountability is not only, or even primarily a punitive concept, but rather has a preventive function and is essential to reestablishing trust in WHO. My commitment to accountability is also evident in my recent decision to step down from my position as Chair of the United Nations' Every Woman Every Child Independent Accountability Panel (IAP), following the announcement of my candidature for Director-General. The IAP is meant to be independent and impartial, and it is critical that there be neither real nor perceived conflicts of interest.⁴ As such, the act of stepping down also signals the respect I have for the role of independent institutional arrangements to inform decision-making.

Under my leadership, WHO will deliver transparency in all areas of its work, and will adopt an accountability framework that is straightforward to enforce and is guided by independent voices.

Leadership for action

Leadership for action involves fulfilling the mandate of **WHO despite all difficulties**. The organization, therefore, needs a strong leader who has the technical skills to understand complex issues in health, and the political and diplomatic skills to drive change. This requires working with Member States to make difficult choices, and challenging the status quo. To cite an example, in 2013, when I was a Federal Minister, I did just this—by re-establishing Pakistan’s Ministry of Health. In 2010, a constitutional amendment ushered devolution in Pakistan’s federal system. The mandates of 17 sectors including health were devolved from the federal to provincial governments, and their respective federal ministries were abolished. All federations, even those that are decentralized, have central bodies, responsible for certain key functions, including infectious disease control. As Minister, I led a multi-pronged strategy, which resulted in the Ministry being reestablished. The structure I put in place stands today, and is the foundation of how Pakistan’s health sector is now governed at the federal level. I have shown repeatedly that I have the ability to be decisive and lead on hard issues. My leadership will not be subject to special interests, but will rather focus on fulfilling the organization’s mandate, such that it delivers on results and is accountable.

Leadership must focus on fulfilling the mandate of the organization

Leadership for action also involves **standing up for the right causes**. As an advocate and civil society leader, I have stood for pro-poor policies, anti-corruption and systems strengthening measures. I have also fought to increase attention to neglected health areas, and improve efficiency in health care delivery, demonstrating my commitment to drive and lead change for positive outcomes.

Leadership for action also involves **forward thinking**. I can press for progress even if it is not the popular thing to do at the time. My leadership to institutionalize an integrated approach to NCDs dating back to 2003, is an example,⁵ where forward thinking was needed to achieve the long-term payoff.

Leadership for action involves **resolving impasses on polarized issues**. WHO has to deal with many such issues and deadlocks. An example of my ability to build trust and bridge divides includes my role as Chair of the drafting committee of the WHO Venice Statement on Global Health Initiatives and Health Systems in 2009,⁶ where I was able to build consensus in a highly polarized environment. As Director-General, I will respect the mandate of Member States and will aim to proactively build consensus. During discussions on deadlocked issues, I will exercise leadership to find constructive solutions.

Leadership for action also involves **listening to varied voices**. To this end, I have worked with people from every region of the world and have convened widely diverse constituencies, building bridges across different cultural, social, economic, and political perspectives.

Recently, as co-Chair of the WHO Commission on Ending Childhood Obesity,⁷ I ensured broad consultation and stakeholder engagement throughout the process, which led to a successful outcome.

Finally, leadership for action requires **resolve**. I make clear decisions, communicate them at all levels, motivate stakeholders to stand behind them, monitor their effectiveness, and try to mitigate any negative consequences.



Announcing the establishment of Pakistan's Ministry of Health during the Pakistan Statement at the 66th World health Assembly, 2013

Operational readiness in outbreaks and emergencies with health consequences

At the beginning of the last century, an estimated 50 million people died due to a flu pandemic. A flu pandemic in today's inter-connected world could still kill an estimated 80 million, even with the advanced medicines and technologies at hand.⁸ Apart from pandemics, even today, Dengue Fever, Yellow Fever, and more recently, Zika outbreaks, affect millions of people worldwide, every year. Handling outbreaks and emergencies with health consequences is one of WHO's foremost priorities. In addition to infectious disease outbreaks, this also includes conflicts, disasters, and other catastrophes leading to widespread public health emergencies. Health is one of the top concerns of the 130 million people who are affected by humanitarian crises across the globe today. This includes the 60 million people who have fled their homes and are seeking refuge elsewhere.⁹

I applaud Dr. Margaret Chan's vision and tenacity in leading the reform of WHO's Health Emergencies Program, which was approved by the 69th World Health Assembly. With the political work completed and the program designed, the phase of implementation has just commenced, and it is not surprising that many things are yet to be addressed, including mobilization of large scale resources for the program, which Member States have committed to raise. I strongly support the new program, including its "all hazards" approach, and new response mechanisms, in particular the humanitarian system-wide coordination of the response to large-scale health hazards using the UN's Inter-Agency Standing Committee mechanisms and UN's Office for the Coordination of Humanitarian Affairs. I fully realize that these arrangements place the onus of strategic and technical leadership responsibility on WHO. I will work closely with the regional offices and regional directors to ensure that all WHO offices align their structures, staffing, and processes with the "One Program" centered on the full cycle of health emergency management, and that timely and effective capacities are established at all levels of the organization.

WHO must also work more effectively with Member States to enhance their core public health capacities as demanded by the International Health Regulations (IHR). Improvement in disease surveillance will improve health planning, and quick detection and response to outbreaks will save lives and assist national and local health systems to build their capacity for implementing the IHR, as I have outlined in my analytical work.¹⁰ To this end, in all high-level engagements with countries, I will emphasize the importance of implementing the IHR and investments in building core public health capacities. There are also low-cost "quick wins" – like a cell phone-based alert system for ministers of health and other stakeholders to keep them abreast of emerging threats and progress. Simple measures like this also can promote accountability of WHO to its stakeholders. Based on my past experience I know these simple monitoring measures can be highly effective.

WHO must work more effectively with Member States to enhance their core public health capacities as demanded by the International Health Regulations

The success of the WHO Health Emergencies Program is interlinked with many other areas of work within and outside WHO. Long-term technical and program strategies can frame needed priorities for action. Implementation of the SDGs, UHC, and health systems policies can step up routine vaccination and enable increased investment in laboratory and integrated disease surveillance systems, as well as human resource and infrastructure. These capacities are critical, both for building resilience as well as responding to emergencies. Some emergencies can be prevented or mitigated by addressing their underlying determinants. Public health measures are amongst the most cost-effective preventive strategies in that regard. In addition, multisectoral approaches involving mobilization of governments' disaster management systems are needed for an effective response. Furthermore, partnerships matter deeply. For example, the Global Health Security Agenda, Field Epidemiology and Laboratory Training Program and Global Outbreak and Response Network (GOARN) play important roles. The civil society, communities, volunteers, and private sector all contribute, particularly during the response phase. WHO must strengthen its leadership role through improved coordination to better leverage the skills, experiences, and resources of partners. Coordination must also involve building of appropriate cross-country, cross-regional, and cross-institutional linkages, and ensuring collaborative capacity building, particularly at a regional level, to pool resources and catalyze solidarity. I, therefore, commit to mobilizing all stakeholders in support of the Health Emergencies Program.

It is also important to strengthen WHO's role as Health Cluster lead. Coordination is a key priority in humanitarian settings as it has a direct impact on response and effective delivery of services. Further, it is essential for optimizing resources in a fiscally constrained environment and preventing further emergencies. I have seen first-hand, how the 2005 earthquake and 2010 floods in Pakistan presented huge coordination challenges, and how coordination played a key role in minimizing loss of life.

Country-relevant support to achieve the SDGs

The era of the Millennium Development Goals (MDGs) has left a strong legacy of progress in health, but has also passed on a number of challenges to a new generation of policy-makers. In many parts of the world, poverty, illiteracy, and inequity are the root causes of disease and suffering. Each year, millions of women and children die needlessly from preventable causes, despite the existence of lifesaving interventions, which range from family planning and safe delivery, to increasing access to vaccines and treatment for HIV and AIDs, malaria, tuberculosis, pneumonia, and other neglected diseases. In many parts of the world, limited health systems infrastructure and critical human resource shortages lead to insufficient coverage of essential health services. For this reason, WHO must remain vigilant with regard to the unfinished business of the MDGs in particular ending preventable child and maternal deaths and the epidemics of AIDS, TB and malaria and help countries prioritize the needs of people who have had little or no access to the progress that has been made in the 21st century.



With Roya, Islamabad, 2015. Her story will be accessible later at <http://www.rockhopper.tv/films/detail/choked-pipes>

In 2015, world leaders embraced a new form of cooperation on a global scale by adopting the universal agenda of the SDGs. While SDG 3, “Ensure healthy lives and promote well-being for all at all ages,” is directly health-related, most SDGs deeply impact health and well-being through their focus on bridging inequality, and fostering inclusive economic growth and environmental protection. The SDGs have a focus on strengthening country institutions and systems, so that international actors can focus on areas where they have a comparative advantage. They signal policy direction for deeper linkages among development, humanitarian and climate change-related work and for integrating social, economic and environmental objectives. Partnerships, intersectoral and multisectoral action have been flagged as an imperative. This necessitates a new approach to leadership, new institutional competencies, systemic innovations to break silos, and a partnership-fostering culture. An international coordinated effort is needed to re-energize institutions, broaden intellectual formation and improve future leadership. I would aim to lead a transformation so that WHO can be ahead of other agencies in responding to the Sustainable Development Agenda.

I believe WHO is uniquely placed for both technical and political activism in support of the SDGs. This will be a priority for me as Director-General. WHO can contribute by supporting the ministers of health to make the case for investment in health more compelling and can assist countries to initiate or step up implementation. Since country needs differ substantially, I will strive to make WHO's technical assistance country-tailored, taking advantage of its three-tier structure, especially WHO's unique 150-country-strong footprint. I will also focus on strengthening WHO's technical assistance to countries in terms of quantum, quality, and relevance. As the global community and countries look at a full (sometimes overwhelming) suite of interventions, I believe WHO must promote the ones that are high "value for money," and have the potential to maximize synergies across silos, align with a rights based approach and create impact in terms of gender equality and equity in outcomes. Overall, I will adopt a life-course approach to health, as it cuts across all areas of WHO's work including the health of women before, during and after pregnancy, and of newborns, children, adolescents, and older people, taking into account, environmental risks, social determinants of health, gender, equity, and human rights.



At the High-Level Dialogue on Health in the Post 2015 Development Agenda, Botswana, 2013

Universal Health Coverage is the central pillar in the health SDGs. UHC saves lives by promoting healthy life expectancy, reducing poverty, and protecting household incomes. Under my leadership, WHO will promote UHC as a health policy goal for all countries, and will help ministries of health galvanize commitment at the head of state level. Just as the emergencies stream of work centers on the conventional notion of "collective" health security, the SDGs, and in particular UHC, is indispensable for "individual" health security. Embracing UHC means building on previous commitments to Primary Health Care and including long-term social policy commitment, domestic resource allocation, and a move linking coverage for essential services to financial risk protection. UHC must also be inclusive of prevention, health promotion, palliative care and public health, and should focus on achieving equity.

WHO is uniquely placed for both technical and political activism, in support of the SDGs

However, the success of UHC hinges on effective health systems. These can also enable achievement of disease-specific targets, building of resilience against the health effects of climate change, preventing and managing disease outbreaks, and implementing IHR. I have been a proponent of country-specific health systems solutions, and have effectively led health systems initiatives in my country.^{11,12,13} WHO must embark on a major initiative to strengthen the international framework to coordinate and consolidate efforts towards the achievement of UHC, with health systems strengthening as one of its key features.

Health systems strengthening must also include efforts to overcome systemic barriers and address corruption, a pervasive universal problem. In my own work, I have been a vocal advocate against corruption, as evidenced in my book 'Choked Pipes.'¹⁴ As Director-General, I will forge strategic partnerships with agencies fighting corruption, to assist countries in their efforts to strengthen institutions. Game-changing solutions such as the use of mobile phone technology, which is now ubiquitous in many parts of the world, offer great potential. WHO should establish new partnerships to tap these 'disruptive' opportunities, and evaluate them rigorously. One of the programs in my organization, Heartfile, has built an access to treatment program using mobile phones at every stage of the process to safeguard against collusion.¹⁵ Innovations are a key feature of this program and include new ways of organizing people, processes, and resources to protect the poorest of the poor against catastrophic health expenditures or foregoing care, thus contributing to UHC objectives.^{16,17} Implementing lessons learnt from evaluation has been a key part of the program's success.



Asian Development Bank, Manila, 2013 where I was honored on the International Anti-corruption day

WHO must also provide countries with strategic guidance to tap the potential within the private sector, which plays a dominant service delivery role in many countries. In the coming years, hopefully, the number of people seeking health coverage will increase exponentially. For many countries, it will be impossible for the public sector to do this job alone. A massive shift is needed in health employment, with public and private sector investment to deliver UHC and power economies as envisioned by the High-Level Commission on Health Employment and Economic Growth. In describing the "mixed health systems syndrome,"^{18,19} I have attempted to draw attention to the need for effective public stewardship of "mixed health systems" – that is, systems in which public and private actors co-exist. Proper stewardship – "setting and enforcing the rules and incentives that define the environment and guide the behaviors of health system players, including the complex range of formal and informal providers" – is a crucial state role. WHO must play a stronger role to overcome the current massive deficiencies

in stewardship in many countries, and help build technical capacity of stewardship and regulatory agencies. WHO must augment its capacity, for example, in technical areas dealing with contracting, purchasing, and regulation. It is important that WHO cascades knowledge in these areas to countries. WHO must also provide Member States and partners with knowledge to make healthcare, especially primary and community care, more quality-oriented.

Non-Communicable Diseases are the leading cause of death worldwide, accounting for an estimated 38 million deaths annually, and are projected to incur economic losses of US\$ 7 trillion over the next 15 years.²⁰ Fortunately, it is possible to stem this tide by addressing their main lifestyle-related modifiable risk factors, and adopting multisectoral policies. I have been actively involved with WHO's NCDs-related work, both technically and politically. More recently, I was part of the WHO technical advisory group, which oversaw development of the Global Action Plan on NCDs (2013-2020).²¹ As Minister, I co-chaired its resolution drafting committee. I also currently serve as co-chair of the WHO Ending Childhood Obesity Commission. I am deeply committed to working with stakeholders to scale up WHO's work in the area of NCDs. It is important to implement agreed NCD action plans, strategies, recommendations, and frameworks such as the WHO-Framework Convention on Tobacco Control (FCTC), and to support national plans and provide catalytic funding to strengthen capacities for primary prevention, screening, and surveillance. Within and beyond this work, we also need to recognize the need to move past the notion of only focusing on premature mortality and instead create health for longer lives—or “healthy ageing”—as an explicit and essential global agenda.

Mental health issues impose an enormous disease burden on societies across the world. Depression alone affects 350 million people globally, and is the leading cause of disability worldwide. The issue is becoming ever more urgent in light of the forced migration and sustained conflict we are seeing in many countries of the world today. I will push for the inclusion of mental health into country health policies. I believe it is possible to address NCDs, mental health, violence, and injuries through integrated public health approaches as we did in 2003 in the ‘National Action Plan for Prevention and Control of Non-Communicable Disease Prevention, Control and Health Promotion in Pakistan,’ which I authored.²² The aim was to prevent a siloed approach to these public health issues. Its design was spotlighted as the model Public-Private-Partnership approach to NCDs by WHO.²³ As Director-General, I will promote adoption of integrated approaches in dealing with NCDs, mental health, and injuries.

Malnutrition will be an important area of focus under my leadership in line with the outcomes of the second International Conference on Nutrition (ICN2), during this Decade of Action on Nutrition.

Unhealthy diet is the top contributor to the global disease burden. Malnutrition, in all its forms, poses a threat. Today, 800 million people face food insecurity while 2 billion are overweight and obese, globally. By improving diet and nutrition through a common set of health and food sector policies, both maternal and child as well as NCD outcomes can be impacted. For every



Closing plenary, First Global Ministerial Conference on Healthy Lifestyles and Non-Communicable Disease Control, Moscow, 2011

\$1 spent to avert malnutrition, \$16 in returns can be gained.²⁴ WHO must work collaboratively with other UN agencies and civil society to address the malnutrition challenge. It must support governments in their dialogue with the private sector, providing them with best practice solutions and the tools to handle conflict of interest in order to bring about changes in the food system. I have been committed to making changes at both ends of the malnutrition spectrum. My global policy level work with the WHO Commission on Ending Childhood Obesity evidences my commitment to this area of work, as does my recent decision to serve on the Scaling-Up Nutrition (SUN) Lead Group.²⁵



Ending Childhood Obesity Commission Regional Consultation, Mexico, 2015

Malnutrition in all its forms is an example of an urgent issue requiring a fully integrated approach that breaks traditional silos

As founding chair of the Every Woman, Every Child Independent Accountability Panel, I realize that the 2030 Sustainable Development Agenda lays stress on country review processes as the basis for accountability. It has major implications for health monitoring for all countries, in an integrated manner and with much greater focus on data disaggregation so that “no one is left behind.” Member States must develop appropriate institutional arrangements to collect, consolidate, analyze, interpret, and communicate health information for timely actions at appropriate levels. In 2005, under a Memorandum of Understanding with the Government of Pakistan and WHO,²⁶ I committed a year pro-bono to review health indicators (dating back to my country’s creation in 1947), analyze weaknesses in the health information system, and author the first national compendium of health statistics.²⁷ This effort served as a template for monitoring health trends and has been institutionalized. Under my leadership, WHO will support countries to strengthen their health information and statistical systems. I will promote use of data and information for decision-making and monitoring of the SDGs. This will include efforts to improve data accuracy and quality, and bridging of data gaps. I will emphasize the importance of data disaggregation by age, gender, capability and income level to facilitate design and implementation of strategies to tackle discrimination and ensure achievement of health for all.

Strengthened action on global public goods

As the world's only universal membership multilateral agency exclusively devoted to health, WHO must exercise stronger leadership for collective action solutions, and production of global public goods in health. In addition to infectious disease outbreaks and emergencies with health consequences, other important collective action solutions include establishment of norms and standards, dissemination and management of knowledge derived from research and evaluation, and action against AMR. WHO also has the exclusive mandate to frame health-related conventions, agreements, and regulations. I will ensure WHO strengthens its position and leadership role with regard to these roles and its unique convening power through my own leadership, and by engaging expertise and experience in these areas.

Establishment of the Guidelines Review Committee in 2007 to promote high methodological standards and “a transparent evidence-based decision-making process” has strengthened the quality of advice.²⁸ More can and should be done to continue in this direction. In a world overwhelmed with data and evidence, WHO must convene the highest level of expertise and act with neutrality vis-à-vis the interpretation of evidence. Under my leadership, WHO's work in setting **norms and standards** will be defensible, scientific evidence-based, and free of political, special interest group, or commercial influence.

In the 21st century, one of the greatest threats to human health is the continued expansion of **antimicrobial resistance**. This occurs naturally over time, usually through genetic changes. However, the misuse and overuse of antimicrobials in people, animals, and plants is accelerating this process. Use of antimicrobials as growth promoters in animals and fish, and their use in viral infections, are examples of misuse. Patients with infections caused by drug-resistant bacteria are at increased risk of worse clinical outcomes and death, and consume more health-care resources than patients infected with non-resistant strains of the same bacteria. Treatment failure is common among infections like urinary tract infections, tuberculosis, and malaria. WHO must demonstrate leadership in reducing AMR to much lower levels, and make sure that effective new medicines are developed and made accessible for developed and developing countries alike. WHO must also exercise leadership to mobilize the needed multisectoral political commitment at the highest level and actions from Member States and its partners in the scientific community and pharmaceutical industry. In close collaboration with FAO and OIE, WHO should support countries as they develop and implement their own national action plans on AMR.

In the 21st century, one of the greatest threats to human health is the continued expansion of AMR

At the high-level meeting of the President of the UNGA on AMR there was overwhelming political support to combat AMR. I will ensure words are put into action and will develop a clear roadmap with commitments. Under my leadership, the AMR program would remain a special initiative under the Director-General's Office.

Research and knowledge are important public goods in health. WHO can play a key role in determining research priorities, building national capacity for research, and knowledge management and dissemination. WHO should serve as a knowledge lighthouse, which is solution- and context-specific. Amongst other things, that also requires enhancing communities of practice, strengthening country-to-country and cross-regional collaboration, and facilitating joint learning processes among Member States. I also learnt through my former role as Chair of GAVI's (independent) Evaluation Advisory Committee, that country specific research can help with effective remedial action at the policy and operational levels. To support the role of research in action, I will establish a Knowledge Solutions Club featuring weekly meetings in which senior staff, including the Director-General, will participate; an annual WHO Expo on the sidelines of the WHA; and a Solutions Challenge Award to bring together a wide constituency of stakeholders to demonstrate how multidisciplinary knowledge translates into practical solutions. I will also institutionalize a culture of the Director-General's regular virtual roundtables with Member States to seek specific needs and ensure timely technical support leveraging WHO's own technical repository and its convening capability. Amongst other things, this will require proactively tapping digital capabilities to map and connect knowledge communities with governments, practitioners and investors in search of solutions that can improve health.

In relation to knowledge management and technical support to countries, but also more broadly, WHO must lay greater emphasis on integrating and harmonizing its work programmatically as well as across the three levels of the organization. Doing so requires continuing the momentum around improving management processes. Institutionalizing matrix management, program area networks and category networks are examples of promising beginnings.

WHO should serve as a knowledge lighthouse, which is solution- and context-specific

Major innovations are driving change in health – new therapies and technologies, personalized medicine, big data, genomics, myriad uses of cellphones, new frontiers in research and vector control, and process innovations, amongst others. Through appropriate knowledge management and other means, WHO can play a major role in harnessing the potential of innovations to drive change and ensure the goal of health for all. Process and partnership innovation are as important as innovations in technology. For work in this area and the ability to link the three, I received the Global Innovation Award from the Rockefeller Foundation in 2011. Under my leadership, WHO will play a role in shaping research incentives to promote innovation and will lead development of technical guidance to inform policy and regulatory decisions. This will also require a major rethink of how we incentivize the development of new medicines, diagnostics and health technologies in a way that keeps them accessible and affordable for all who need them.



Global innovation award, New York, 2011



Panel discussion on "Making the Case for Investing in Health, Again", Tokyo, 2012

Through appropriate knowledge management, WHO can play a major role in harnessing the potential of innovations to achieve health for all

Behavior change is one of the most cost-effective collective action interventions in health (if not public good). It can impact family planning, help prevent diseases such as HIV and AIDS, reduce the spread of infectious diseases, improve newborn and maternal health, and can be critical in the approach to preventing NCDs. I believe there is great potential in harnessing digital technology and social media for health behavior change, especially when coupled with knowledge management and the right partnerships. As Director-General, I will proactively engage with stakeholders to tap this potential.

Finally, as almost goes without saying, **disease eradication** should be viewed also as a global public good. Consigning polio to the history books and developing a lasting legacy will be one of WHO's greatest milestones in improving human health. Despite ongoing challenges, the world still has the opportunity to end polio—I will be fully committed to seeing that through. In addition, I will continue to work with partners to build on the strengths and infrastructure of the global polio program for wider health gains, in particular to tackle emerging threats and will promote further investment to upgrade surveillance networks.

Focus on health-climate interaction

A recent United Nations Environmental Program publication,³⁰ has outlined a range of environmental threats to health, and how addressing environmental challenges can also protect and promote health. Many measures to reduce greenhouse gas emissions result in near-term co-benefits to health e.g., from reduced air pollution, which is an important risk factor for a number of NCDs. Policies to increase resilience of populations to climate change, such as by enhancing food security and access to safe water, also yield benefits to health. Many health issues are directly linked to climate change, such as shifts in the distribution of tropical diseases and disease outbreaks.

Addressing environmental challenges can protect and promote health

Over two years (2014-15), I served on the Planetary Health Commission and contributed to a report,³¹ which highlighted existing evidence to show how the health and well-being of future generations is being jeopardized by the unprecedented degradation of the planet's natural systems. My country, Pakistan, is particularly vulnerable to climate change and variability. In 2010, for example, floods affected 20 million people, incurring huge economic losses. As such, I have a close understanding of country level grass roots dynamics, and the threat faced by many countries such as the Small Island Developing States, or large ocean states, that risk losing past development gains due to environmental challenges. Droughts, floods, other extreme climate events (hurricanes and typhoons), and changes in disease vector distribution can also wreak havoc in many other countries. It is, therefore, critical to build linkages between SDG 3 and other goals relevant to health and sustainability. WHO must facilitate access of vulnerable countries to the climate mitigation/adaptation funds. It must also play a stronger role, coordinating development and humanitarian and climate change-related work as it relates to the right to health for all.



Speaking at the fourth Climate and Health Summit, Paris, 2015

Accelerated pace of reform, focusing on systemic constraints

WHO has launched an internal reform program in three areas—program and priority setting, governance, and management. Reform of WHO’s emergency operations and the modalities governing stakeholder engagement have already been approved by the 69th WHA. Changes in both these areas are urgent and critical. Other reforms underway, such as those centered on agenda management, budget alignment, monitoring, information management, and financing, however, are largely focused on process issues and do not address WHO’s inherent structural and managerial problems, which are deep-rooted.

I will adopt a four-pronged approach to dealing with reform. The first builds upon and **accelerates reforms underway**. Within 30 days of assuming office, I will convene a “stock-taking” reform workshop to develop a plan to accelerate the pace of agreed reforms. For example, the potential exists to overcome process constraints, which hamper functioning of WHO’s governing bodies. Adopting a forward-looking structure, adequate preparation by the Secretariat, and involvement of Member States between meetings, can improve the quality of governance. I will aim to bring experience from the national and international boards on which I have served, to actively seek ways to make the governance discourse more meaningful for Member States and the Secretariat, as a starting point.

I will adopt a four-pronged approach to dealing with reform

Secondly, I will fully explore options to exploit **synergies between headquarters, and regional and country offices**, and will make every effort to make WHO’s decentralized structure work. As an entry point, I will institutionalize the Senior Management Global Policy Group. I will propose formal compacts between the Director-General and each of the regional directors for clearer responsibilities and accountability. I have collaborated with WHO’s regional offices and value their relevance and leadership within the regions. I will proactively work towards harnessing and drawing upon their resources and knowledge, distributing functions when a region has a specific added value, and harmonizing and aligning their efforts within a more streamlined organization. This needs to be done with the understanding that the approach to engagement with regional offices may vary from region to region.

While I fully support regional approaches to solution building and have also led such activities in the past,³² I also realize from first-hand experience of planning and executing the distribution of functions in multilayered governance systems, that in the exercise of some functions, a centralized approach is needed.³³ My country and WHO share a common ‘federal’ structure, with shared authority between a center and sub-units. With the re-establishment of Pakistan’s Ministry of Health, I centralized responsibility for infectious disease control, while leaving most other functions decentralized. Responsibility and accountability for emergencies is centralized under the new Health Emergencies Program in WHO—a framework I will fully implement.

Thirdly, I will seek Member States' support for an objective and **knowledge-driven reform to tackle WHO's structural and managerial problems**. As a first step, I will commission an organization-wide independent evaluation and will set forth bold questions for the evaluators. I will also draw insights from existing evaluations.

Lastly, under my leadership, **capacity for forecasting** will be institutionalized so that WHO looks beyond the horizon and hones its ability for response to emerging threats. A number of options exist to institutionalize this intent—establishment of a forecasting and strategy unit, an expert advisory group, or embedding this function within existing WHO units. As Director-General, I will convene an options-consultation to explore the best way forward.

Management for results

Good management is not just a personal skill. **Institutional prerequisites** facilitate effective and efficient management. These include strategies matched with appropriate program budgets and well-defined implementation plans, effective systems and processes, and an institutionalized cycle of planning, priority setting, execution, learning, and remedial action. I have always focused on building this infrastructure in the institutions that I have founded, and have been involved with and will ensure the same for WHO. In tandem, I will establish Priority Metrics for WHO and a Delivery Unit, reporting directly to the office of the DG, to drive a culture of management for results throughout the organization. The new unit will also work to address intra-organizational silos across diseases and areas of work, and build teams across large departments to maximize coherent approaches. Noting that the varied quality of WHO staff is frequently cited as one of the key limitations of the organization, performance management will be one of the key areas of focus of the Delivery Unit.

Good management is not just a personal skill. Institutional prerequisites facilitate effective and efficient management

WHO's staff is its foremost asset. It is critical to create a **performance enabling environment** with clear responsibilities, the right incentives to perform, performance reward mechanisms, and accountability frameworks. I have previously given these attributes high priority in my analytical work and ministerial role.³⁴ Given the nature of work, staff safety and security, especially in hardship stations, in outbreak and emergency response, and in protracted emergencies, also needs to be a priority. Supporting staff to give the best possible advice, even when they are under pressure from powerful interests, is equally critical.

Transparency in recruitment processes, merit-based hiring, gender parity, balanced regional representation, and balance of staff skills are critical for organizational performance. As Director-General, I will accord due attention to these attributes. I will also strive to make WHO an exciting place for bright young health professionals to work and will proactively select, guide, nurture and channel the talents of the world's best practitioners in public health. Instituting paid internships would be an entry point to bring greater focus to this area.

Also, as Director-General, I will deliver **value for money in a fiscally-constrained environment**. Over the years, I have demonstrated my ability to do this in institutions operating at different scales from local to global, and I am committed to bringing the same culture to WHO. In my role as President of Heartfile,³⁵ an organization I built from scratch into a widely respected entity, I am responsible for all aspects of organizational management and have built systems for change and safeguards against abuse.

A culture of partnerships

Partnerships are crucial for achieving a WHO fit for purpose in the 21st century. The SDGs' framework strongly supports broad-based partnerships in support of sustainable solutions. This translates into four partnership imperatives for WHO.



Representing Government of Pakistan at the 2013 European Union Day reception, Islamabad

The first partnership imperative requires inter-linkages with the many **factors outside of the health sector's purview**. Macroeconomic management, governance effectiveness, and social policies matter deeply for health. Per-capita income and maternal level of education are the strongest determinants of health status achievement. The social and environmental determinants of health play a critical role in addressing inequities and achieving desired health outcomes. WHO must recognize that it cannot address all these issues by itself. In many important areas, WHO's goals are dependent on action entirely outside of the health sector. Girls' education, women's economic empowerment, and reproductive rights are particularly critical for improving health, globally in that regard. The achievement of UHC necessitates a massive change in employment, and social policies. Road traffic injuries are a leading cause of death globally, particularly in young people (age 15-29 years). Injuries and violence prevention more broadly, as well as action against drug abuse are critical for safeguarding the health and well-being of millions of people, worldwide, but their relevant scope of responsibilities are outside of the purview of the health sector. The well espoused notion of 'whole of government' and 'whole of society' at WHO must, therefore, translate into WHO's concrete ability to influence other actors (within and outside the health sector, both governmental and non-governmental) and shape their behaviors in such a way that the political, economic, and commercial objectives of these actors are reconciled with public health goals. Under my leadership, WHO will hone its ability and outreach to advocate for action outside the health sector, both within the UN system and beyond and will leverage expertise and commitment of stakeholders through various means including through the appointment of WHO ambassadors.

Girls education, women's economic empowerment, and reproductive rights are critical for improving health, globally



I strongly support girls education

The second partnership imperative is driven by WHO's **co-existence with other global health institutions**. These should not be perceived as a threat to WHO, but rather as entities vital to WHO's mission. As the world's only universal membership multilateral agency in health, certain critically important global health functions can only be performed by WHO—it must, therefore, focus on its core and exclusive mandates. WHO should not attempt to take on every global health function on its own as other global health institutions, have specific roles and comparative advantage. To cite examples from the areas of financing, the World Bank, Global Fund to fight AIDS, Tuberculosis and Malaria, and Gavi, the Vaccine Alliance have specific competencies. WHO can gain by maximizing synergy. If public-private partnerships seek to stimulate research and development of new vaccines, diagnostics and treatments for neglected diseases of poverty, (particularly those with complete market failures), WHO can become a force multiplier through norm setting. Additionally, by leveraging partners' efforts strategically and effectively, WHO can help mobilize resources to further its own mission — as in the case of the Pandemic Emergency Financing Facility and the Global Health Security Agenda in relation to WHO's operational role in emergencies. There are many opportunities to tap the wide constituency of knowledge stakeholders and draw on their strengths to further WHO's technical mission. Similarly, many other UN agencies have comparative advantage in areas that matter deeply for WHO's work. In fact, through clearer collaborative division of labor and better understanding and acceptance of comparative advantage, gains in global health can be achieved much faster. This complex but rich institutional environment in global health is also an opportunity for WHO to hone its much-needed coordinating role. I will, therefore, invest in a Coordination-centered Capacity Building Initiative, which will aim for WHO's excellence in this area, with the understanding that coordination is one of WHO's key mandates.

Thirdly, in the era of the SDGs as WHO's work becomes more intersectoral, engagement with Non-State Actors (NSAs, a collective name used for non-governmental organizations,

private sector, academic and philanthropic organizations) becomes an imperative. Member States have agreed on the rules of engagement with NSAs during the 69th WHA by approving the Framework of Engagement with Non-State Actors (FENSA). Under my leadership, WHO will promote strategic engagement with NSAs, efficiently and effectively, while enforcing all procedures of FENSA to build safeguards against undue influences, which can undermine public confidence and create a reputational risk.

Without question, non-governmental organizations are critical partners for WHO. NGOs play varied roles including service delivery, technical support, advocacy, awareness creation, monitoring and accountability, both in development and humanitarian settings. In many parts of the world, there is also increasing acceptability of public accountability and increased response to inputs from civil society. My career to date speaks of my extensive experience in this area and demonstrates the feasibility of constructive engagement and partnership.

Finally, the need for **multisectoral engagement** constitutes yet another partnership imperative. Multisectoral governance arrangements are necessary to impact desired health outcomes in many areas. For example, policies to address NCDs need all sectors to work together – including health, finance, foreign affairs, education, agriculture, planning, and others. Tackling AMR necessitates action to address crosscutting issues in animal and human health, agriculture, food, and environment. Similarly, dealing with emergencies has a major interplay with broader disaster management systems. I believe I have both the understanding as well as the experience to lead this transformation. I have served as a Federal Minister in a country of 200 million people, where I had multisectoral responsibility for Health, Education, Science and Technology, Information Technology and Telecom; I have previously outlined the systemic absence of incentives and structures to forge multisectoral collaboration in government systems as one of the key issues plaguing the functioning of governments.³⁶ I will work proactively to lead a strong call for sectorial cooperation at the government level as Director-General of WHO.

Under my leadership, WHO will embody a partnership-fostering culture, invest in new competencies to enable asset allocation mapping, establish incentives for collaborative division of labor, and develop partnership-sensitive metrics.



At a ministerial panel on “Ensuing Equitable Universal Coverage” during the World Conference on the Social Determinants of Health; Rio de Janeiro, 2011

New models for financing

To reiterate once again, WHO is the world's only multilateral agency in health with exclusive mandates, and as such, it has a critical role. Its strategic plans relevant to its core mandates must be adequately funded. Under-resourcing of WHO has been one of the drivers of its under-performance and expectations from WHO to deliver must come with the commitment to resource it adequately. As already stated, interlinked reform of governance and financing can provide a lasting solution. To drive incremental change in that direction requires the establishment of four financing 'compacts'.

Financing consensus compact: Member States and donors must address the current imbalance between assessed and voluntary contributions, which is currently skewed towards the latter. Over the last decade, we have seen increases in WHO budgets, but not assessed contributions. Assessed contributions reflect confidence in the multilateral character of WHO; an increase will enable more strategic and predictable use of resources, better investments for capacity building to respond to emergencies, as well as longer term attention to the SDGs. There is a clear opportunity to increase assessed contributions, which I will actively pursue. Core resources must be used for the most strategically important areas.

Value for money compact: WHO must institutionalize the culture and systems to 'buy results' of the desired quality at the lowest price. This will be part of the tools within the Delivery Unit, already referred to and will necessitate action at various levels. On the one hand, strategic measures would include governance reform, stepping back in certain areas where other agencies have a comparative advantage, tapping human resources in WHO Collaborating Centers more effectively, dealing with corruption, reducing duplication across the three levels of the organization, and utilizing the technical expertise outside of WHO more actively, for efficiency and effectiveness in the provision of technical cooperation. On the other hand, simpler measures would be prioritized. For example, scaling down printing, better use of technology to cut down on meetings and conferences, better negotiated contracts, etc. Unless one has created organizations from scratch in a resource-constrained environment, the potential of these approaches is difficult to tap. This type of "value for money" approach has been a central feature of my management efforts—adopting highly effective cost-saving approaches while upholding the quality of deliverables.

**WHO must adopt a value for money approach and
get attuned to getting better at buying 'results'
of the desired quality at the lowest price**

I believe it is possible to reaffirm donors' trust through a combination of measures—meaningful fiscal transparency and accountability, cost saving measures, and demonstration of additional results with a given fiscal envelope. This should make it possible to secure predictable and potentially multiyear commitments, in terms of assessed contributions and increased allocations. I regard innovations in transparency as a powerful lever to build donors' trust.

I have experienced this in my work with Heartfile Health Financing, where I make details of micro-transactions available for donors.

Solidarity financing framework: Under my leadership, WHO will also explore other channels of resource mobilization. For example, providing organizations with details on ways to charge and channel voluntary micro-leaves to support WHO's assessed contributions. If the fruits of WHO's effectiveness benefit everyone, then financing could potentially be a shared responsibility, as well. However, this will require scrupulous attention to conflict of interest and other safeguards. In addition, WHO should also explore the potential of direct funding appeals to mobilize funding from individuals, and leverage the potential of philanthropy.



Date	Procedure	Cost
21 Apr 2015	Diagnosics for bone marrow transplant PIM2	12338.00
20 Apr 2015	BM2	62290.00
20 Apr 2015	Laparoscopic laparotomy NICH pediatric surgery	34250.00
20 Apr 2015	Laparotomy major NICH pediatric surgery	34250.00
16 Apr 2015	Diagnosics for bone marrow transplant PIM2	11235.00
16 Apr 2015	BM2	38220.00
08 Apr 2015	Ventriculoperitoneal shunting LUH NS	27060.00
07 Apr 2015	Renal blood therapy (Haemaphysa) 20 kg	10000.00
06 Apr 2015	PIM2 BM2	42050.00
06 Apr 2015	Satter's procedure NICH pediatric surgery	27060.00

Ensuring full transparency for donation use in Heartfile Health Financing



Opening speech at the launch of the Pandemic Emergency Financing Facility, Washington, 2015

Emergencies financing compact: Outbreak and emergency financing disappeared from the risk discourse after 2009, only to re-emerge as an issue during the West African Ebola epidemic. However, existing funding is inadequate, unpredictable, unsustainable, and highly fragmented. This compact will drive agreement at all levels of the organization to consolidate funding instruments and to work together to mobilize full financing for the Contingency Fund for Emergencies. I will also strive to leverage partners' efforts strategically, such as the Pandemic Emergency Financing Facility and the Global Health Security Agenda. In addition, I will urge Member States to mobilize domestic resources for IHR implementation.

Beyond these four compacts, financing innovations must be part of the broader WHO strategy to mobilize funding for health. **Beyond the traditional understanding of 'innovative financing,'** which encompasses raising funds through innovative projects, I also envision innovation in financing as embodying many other approaches. For example, by playing its normative role and partnering with initiatives aimed at stimulating research and development for neglected diseases of poverty and in the context of AMR, WHO can make resources available for a critical area in global health. Another example is resource mobilization through WHO's "Geographically Dispersed Offices" model. These are extensions of Regional Offices, based in a host country that agrees to fund them for a minimum number of years, conducting a specific technical function approved by the Regional Committee, and serving the whole of a region. These currently exist in the WHO European Region. WHO can simultaneously tap countries' interest and more resources for WHO through this approach, and should assess the application of this model to other regions.

As Director-General, I will set up a Task Force of relevant stakeholders and experts to seek expert guidance on maximizing the potential of innovative approaches to address the resource gap at WHO, and to make resources more widely available for health, more broadly.

A concluding note

A Vision for WHO: 10 Pledges for Action aim to reaffirm WHO's global leadership. I am committed to delivering on these pledges. But I also offer them as an invitation to others to contribute ideas, expertise, and good will to develop the thinking further and to assure diverse perspectives.

Part of this Vision is focused on present needs, given the urgency of improving the agency and meeting the challenges before us today. But I would lead WHO proactively, not just reactively. I believe WHO must increase resilience and remain forward-looking to seize opportunities and respond effectively, in real time, to the world's evolving health needs.

The points I raise are not exclusive. I will be looking to consider others' views on this Vision, and to lead by listening and collaborating. Leadership of WHO requires agility and ability to respond to the unexpected. Building an open-minded institutional culture of mutual respect and debate is critical to remaining nimble, efficient, and creative. Since some of the pledges are bold and game-changing, I realize they would need further diligence and consultation if I have the honor of being elected.

I believe I am uniquely suited to lead WHO in this increasingly challenging environment. I bring, not only a combination of major institutional leadership from both governmental and non-governmental perspectives, but also credibility as a physician, researcher, driver of change, and global thought leader. I also offer extensive experience especially in areas relevant to the SDGs. I bring a track record of finding solutions; bridging cultural divides and differing global perspectives; delivering results in resource-constrained environments; and demonstrating ironclad commitment to transparency and accountability. I have reaffirmed my unwavering commitment to transparency, accountability, and a collaborative management approach, both during the campaign, and should I have the honor of being selected as the DG of WHO.

I firmly believe that WHO must deliver on both its purpose and on value for money, and to do so, it must engage with Member States and partners and garner broad support from the global community it serves. Then it must hold itself accountable to all stakeholders. I bring extensive experience in building broad cross-sector and international coalitions, and in holding the institutions I lead, accountable to all stakeholders. My mix of civil society, governmental, and medical experience allows me to relate to a wide variety of partners and participants, and to understand WHO and its challenges from their perspectives. If selected, I will lead a WHO that leverages each of these stakeholders' contributions and inspires them to increased engagement.

It is truly an honor for me to participate in this process. My entire life's work has prepared me for this role. I passionately believe in WHO as the world's most significant leader in shaping the future of human health. WHO is an extraordinary organization with unprecedented opportunity to improve global health, to change the models of worldwide cooperation in problem-solving, and to innovate for the 21st century. WHO is also uniquely positioned to contribute to achieving the SDGs.

The application process and campaign have allowed me to signal critical priorities and to advocate for the institutional change and global cooperation I believe will undergird a renewed WHO for the future – a WHO that becomes a model for other global institutions. I hope Member States interpret this Vision as an offer to listen, support, and address your priorities.

I wish to express my gratitude to Member States for consideration of my candidacy.

Note from the Government of Pakistan

Dr. Nishtar's credentials are uniquely suited to leading WHO for the following reasons:

WHO is a technical agency and should be led by a leader with a strong professional background – Dr. Nishtar's technical excellence is evident from her resume. She has a unique combination of experience as minister, civil society trailblazer, leader in multilateral institutions, physician scientist, thought leader, and founder of institutions. Dr. Nishtar is a research-trained medical doctor, which is a critical strength for leading WHO. Her expertise is broad-ranging – health systems, public health, and sectors outside of health such as social protection, governance, and public-private engagement.

WHO is a multilateral organization and needs a leader who understands its dynamic – Dr. Nishtar's erudition in the multilateral system is well established. For instance, recently as co-Chair of the WHO Commission on Ending Childhood Obesity, she was instrumental in achieving global consensus on a complex public health strategy. She has a long-standing working association with WHO and knows the organization from many perspectives.

Dr. Nishtar has a proven track record of leadership to bring change and deliver results. This, combined with her wide experience, charisma, and excellent communication skills, make her a unique candidate.

WHO is currently undergoing a reform and change process to ensure it stays technically and institutionally relevant and ahead as a top technical agency to deal with evolving global health-related challenges and crises – Dr. Nishtar's work with systems reform, and her ability to navigate and implement reform and deliver results are well known. These capabilities would be crucial for the reform process.

Accountability for results is a key area of focus in the reform process – Dr. Nishtar's selection by the UN Secretary General as founding Chair of a UN independent accountability panel is evidence of her accountability credentials. As federal minister, she undertook the widely acclaimed accountability approach through publication of the 'Handover Papers.' In her civil society role, she has campaigned to promote accountability and has institutionalized it while building institutions. She will bring the same accountability ethic to WHO.

As an organization, WHO needs strong management – as someone who has founded institutions from scratch, and taken them to scale, Dr. Nishtar has unique and strong management experience. She understands governance from her diverse experience as chair and member of boards, both nationally and internationally. Through her work building institutions, she has gained extensive experience in strategy formulation, fund mobilization, partnership building, and use of innovations for systems-building.

WHO needs to be well-resourced in today's financially-constrained milieu – Dr. Nishtar has proven resource mobilization skills. She has singlehandedly sustained an NGO and a charity in Pakistan over a decade and a half. She has learned to leverage transparency as a tool to

mobilize donors, and ensure accountability for use of funds. She is familiar with innovative financing whilst being sensitive to the need to address legitimate concerns about conflicts of interest. Establishing institutions in a resource-constrained environment has made her adept at efficient utilization of resources and building strong systems for change.

WHO is committed to the 2030 Agenda for Sustainable Development with Non-Communicable Diseases and Universal Health Coverage as two major additional areas of focus—Dr. Nishtar would have an advantage due to her professional expertise related to health systems and Non-Communicable Diseases. She also has a strong track record of intersectoral action for health, which is a crosscutting theme of the SDGs. With a universal approach to health and sustainability, the SDGs are framing a context where Dr. Nishtar can act as a bridge between national and global perspectives.

Partnerships and innovations can be force multipliers for WHO—Dr. Nishtar has led public-private partnerships with governments and has effectively mobilized many stakeholders in her civil society role. She is noted for her collaborative approach and her ability to engage a wide variety of governmental and non-governmental stakeholders to address complex problems and lead transformations. She has been globally decorated as an innovator.

It goes without saying that with her developing country background and proven pro-poor record, Dr. Nishtar is well-placed to represent the views of, and be responsive to, the needs of the underprivileged. As a woman leader and change agent, she is particularly gender-sensitive. With a long track record and broad acceptability in international civil society, and experience engaging with the private sector through her work on obesity prevention, she can bring diverse voices to the negotiating table. Dr. Nishtar is a bridge between the Muslim world and the West and has the confidence of both developed and developing countries. She effectively speaks on behalf of all, irrespective of gender, race, creed, colour or nationality. She has been involved with leading peace-building initiatives, and is a vocal promoter of increasing Western-Muslim engagement.

Dr. Nishtar's credentials are evident from her resume. However, a resume does not outline personal attributes, which are critical for leading complex organizations—her inter-personal and leadership skills, ability to multitask, and the combination of her creativity, agility, drive and commitment coupled with her humility. Her clear-headedness and empathy evoke consensus building and trust. The combination of her knowledge of micro—understanding people's needs—to influence the macro in terms of policy reform and institutional change is unique. Dr. Nishtar's professional experience is complemented by an exceptional work ethic, a deep sense of moral purpose, and flawless integrity. Her personality and temperament exemplify diplomacy. She is just the kind of leader WHO needs.

Bibliographic highlights

- 1963 Born in Peshawar, Pakistan
- 1986 Graduated in medicine from Khyber Medical College. Declared best graduate of the year with 16 distinctions and gold medals
- 1994 Passed the Membership examination of the College of Physicians and Surgeons of Pakistan (MCPS)
- 1996 Passed the Membership examination of the Royal College of Physicians of London, MRCP (UK)
- 1996 Founded Heartfile, a globally recognized NGO, a powerful and respected health policy voice in Pakistan
- 2000 Appointed Executive Council Member, South Asian Association for Regional Cooperation (SAARC) Cardiac Society
- 2002 Awarded PhD in Medicine from Kings College, London
- 2002 Published the first case control study on coronary risk factors in Pakistan and became an advocate for disease prevention and health promotion, using study findings to develop public awareness campaigns
- 2003 Founded the tripartite partnership between the Ministry of Health, WHO and Heartfile
- 2003 Appointed Member of Steering Committee of the WHO's Mega Country Network on Health Promotion
- 2003 Authored the National Action Plan for Prevention and Control of Non-Communicable Diseases and Health Promotion in Pakistan.
- 2003 Appointed Chair, Steering Committee of the World Heart Federation's World Heart Day initiative
- 2003 Appointed Chair, Foundations Advisory Board and Member of the Board, World Heart Federation
- 2004 Appointed Chair, global 'Go Red for Women' campaign
- 2004 Appointed Member of the Program Committee of WHO's Global Forum IV
- 2004 Appointed Chair, International Consortium on Community Health Promotion, IUHPE
- 2004 Appointed Member, Board of Trustees, International Union for Health Promotion
- 2005 Awarded Fellowship of the Royal College of Physicians of London
- 2005 Authored The Gateway Paper: Health Systems in Pakistan: A Way Forward
- 2005 Awarded the Population Science Award by the European Society of Cardiology
- 2005 Founded Pakistan's Health Policy Forum

- 2005 Appointed Member, Board of Governors, Trust for Voluntary Organizations, Pakistan
- 2006 Appointed Member, Board of Directors, Infrastructure Project Development Facility, Ministry of Finance, Pakistan
- 2006 Appointed Member, Health Committee, National Commission on Government Reforms, Pakistan
- 2007 Founded Heartfile Health Financing, an award-winning access-to-treatment initiative to support Universal Health Coverage in mixed health systems
- 2007 Received Pakistan's Presidential Award Sitara-i-Imtiaz [the star performer]
- 2007 Appointed Chair, Expert Panel on Women and Heart Disease, World Heart Federation
- 2007 Selected to serve as Member, World Economic Forum Global Agenda Council initiative
- 2007 Authored the first compendium of health statistics in Pakistan: Health Indicators of Pakistan
- 2007 Inducted as Member, Clinton Global Initiative
- 2008 Appointed Member, WHO Consortium on Maximizing Positive Synergies between Health Systems and Global Health Initiatives
- 2008 Appointed Member, WHO Director General's High-Level Task Force on Health Systems
- 2008 Appointed Member, Aspen Institute's High-Level Task Force, Ministerial Leadership Initiative for Global Health
- 2008 Appointed Member, Working Group, Private Sector in Health Systems. R4D and Rockefeller Foundation
- 2008 Appointed Member, WHO Director General's Expert Working Group on R&D and Financing
- 2008 Appointed Member, WHO Expert Advisory Panel on Health Promotion (2008-2013)
- 2008 Appointed Board Member, [WHO's] Alliance for Health Policy and Systems Research
- 2009 Appointed Member, WHO's Strategic Advisory Committee for Stewardship on Research on Infectious Diseases of Poverty
- 2009 Appointed Chair, Drafting Committee, WHO's Venice Statement on Global Health Initiatives and Health Systems
- 2009 Appointed Member, Global Health Policy Advisory Committee. PepsiCo, New York
- 2009 Appointed Member, Board of Governors, Pakistan Institute of Legislative Development and Transparency
- 2010 Published Choked Pipes, an Oxford University Press published book on health reform
- 2010 Appointed Panel of Advisors, Center for Health Market Innovations R4D
- 2011 Appointed Member, US-Muslim Engagement Initiative
- 2011 Received the Global Innovation Award by the Rockefeller Foundation

- 2011 Inducted into the University of Toledo's Medical Mission Hall of Fame
- 2011 Appointed Member, International Steering Committee, First Global Ministerial Conference on Healthy Lifestyles and Non-Communicable Diseases
- 2011 Appointed Member, Healthcare Advisory Council, Pakistan American Foundation
- 2011 Appointed Member, Partners for a New Beginning, Pakistan Chapter, Aspen Institute
- 2011 Appointed Chair, GAVI's Independent Evaluation Committee
- 2011 Appointed Member, Board of Governors, Islamabad Electric Supply Company
- 2011 Appointed Council of Deans, First Global Symposium on Health Systems Research
- 2012 Appointed Member, Board of Governors, Chal Foundation
- 2013 Appointed Federal Minister, Government of Pakistan (portfolios: Education and Training, Science and Technology, Information Technology and Telecommunications, and Health)
- 2013 Published the Pakistan Lancet Series on health reform
- 2013 Conferred an iconic status by the Asian Development Bank in Manila as part of ADB's international campaign, "iACT: I fight corruption" on the International Anti-Corruption Day
- 2013 Appointed Member, WHO Expert Review Group on an Integrated Response to Mental Health
- 2013 Appointed Member, Advisory Group, WHO Health Systems Research Strategy
- 2013 Appointed Member, Senator Group for the WHO Ashgabat European Ministerial Conference on NCDs
- 2013 Appointed Member, Network of Health System Experts for WHO EMRO
- 2013 Appointed Member, Technical Advisory Committee to the Regional Director, WHO EMRO
- 2013 Appointed Member, EAT Advisory Board, Stockholm Resilience Centre
- 2013 Appointed Member, Board of Governors, Pakistan Center for Philanthropy
- 2014 Appointed Member, Expert Advisory Council, NCD Alliance
- 2014 Appointed Member, National Commission on Science and Technology, Pakistan
- 2014 Appointed Member, Board of Governors, Benazir Income Support Program
- 2014 Listed in the top twenty Most Influential Women in Science in the Islamic World
- 2014 Appointed Chair, Ministry of Finance's Task Force on Strengthening Social Safety Net Institutions in Pakistan
- 2014 Appointed Co-Chair, WHO Commission on Ending Childhood Obesity
- 2014 Appointed Member, Economic Advisory Council, Ministry of Finance
- 2014 Appointed Member, Advisory Committee of the Planning Commission of Pakistan

- 2014 Appointed Member, Advisory Committee, Federal Tax Ombudsman of Pakistan
- 2014 Appointed Member, Lancet and Harvard Commission on Pain and Palliative Care
- 2014 Appointed Member, Steering Committee, the Emerging Markets Symposium, Green Templeton College, Oxford University
- 2014 Appointed Member, Advisory Committee, Lancet Global Health
- 2014 Appointed Member, Lancet and Rockefeller Foundation Commission on Planetary Health
- 2015 Appointed Chair, Independent Accountability Panel for the Global Strategy for Women's, Children's and Adolescents' Health by the United Nations' Secretary General. Stepped down after announcement of candidacy for the post of WHO DG to avoid perception of conflict of interest
- 2015 Appointed Member, High Court of Pakistan's Commission on Pakistan Medical and Dental Council
- 2015 Appointed Member of the GAVI Board
- 2015 Nominated as Pakistan's candidate for The United Nations High Commission for Refugees and was in the shortlist
- 2016 Appointed Council Member, Pakistan Medical and Dental Council
- 2016 Appointed Member of the Board, UN University International Institute for Global Health
- 2016 Appointed Trustee, The Future of Health Global Challenge Initiative, World Economic Forum
- 2016 Appointed Member, SUN Movement Lead Group
- 2016 Appointed Co-Chair, Global Future Council on Health and Healthcare, World Economic Forum

End notes

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3. Official webpage of Dr. Sania Nishtar. www.sanianishtar.info
4. Statement of Sania Nishtar. Chair of United Nations' Secretary General's Independent Accountability Panel. <http://www.everywomaneverychild.org/news-events/news/1371-independent-accountability-panel-leadership-transition>
5. Government of Pakistan, WHO and Heartfile. National Action Plan for the Prevention and Control of Non-Communicable Diseases and Health Promotion in Pakistan. <http://heartfile.org/pdf/NAPmain.pdf>
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