BRITISH BROADCASTING CORPORATION *RADIO 4*

TRANSCRIPT OF - IN FAILING HEALTH? THE INSIDE STORY OF THE WHO

CURRENT AFFAIRS GROUP

TRANSMISSION: *Tuesday 6th September 2005 2000 - 2040*

REPEAT: *Sunday 11th September 2005 1700 - 1740*

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PROGRAMME NUMBER: *05VQ3409LHO*

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"IN FAILING HEALTH? THE INSIDE STORY OF THE WHO"

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ACTUALITY IN KENYA

URRY: Here in Kenya, when people get sick, they may have to walk many miles on dusty tracks to the nearest clinic or hospital, if there is one. They may or may not be given drugs by a medic, who may or may not have the proper training, which may or may not cure them from the many diseases to which they can fall victim. For most Kenyans and for the many millions more in developing countries beyond Africa, this is what healthcare means for them.
Nearly sixty years ago, the World Health Organisation, an Agency of the United Nations, was formed to change that. It's crowning achievement, a successful campaign to eradicate smallpox.

EXTRACT FROM ARCHIVE

MAN: Wanted: smallpox reports in Southern Somalia. Two hundred shilling reward. News of the reward spreads quickly and it helps the searchers. On the spot vaccination for everyone guarantees that the virus will not slip through the net.

URRY: But today other infectious diseases are on the march across Africa. AIDS, malaria and tuberculosis are killing millions every year. The gap between life expectancy in parts of Africa and an industrialised nation like Japan has now reached five decades - the widest it's ever been. In the light of this, we ask if the World Health Organisation is up to the challenge posed by this global health crisis.

ACTUALITY IN HEADQUARTERS

URRY: We're deep inside its headquarters in Geneva, where there's a special emergency room.

RYAN: We're below sea level here, so this is flood protected in case we ever have a flood. Secondly we've got very sensitive equipment in here. Video feeds from all of the major news channels in the world, so we have every satellite channel you could hope to imagine, so we can monitor what's going on in the world.

URRY: This is part of a communications centre packed with cutting edge technology. It keeps experts in Geneva right up to date with emergency teams working in the field. Dr Mike Ryan heads this unit, which is geared up to respond to emergency outbreaks.

RYAN: We now have the capacity to mobilise not only the people, but we can actually rapidly now mobilise dedicated logistics resources to the field. An operation centre in a box, which is basically everything you need in the field, including a wi-fi lan, three different kinds of satellite phone, video conferencing, telephone, fax, scanners, printers, and they all come in a 60 kilogram box, and you open that box, plug it in and you basically have the capacity to support an office of twenty to thirty people in the field. So we as an organisation are having to maintain our ability to do good policy work, to do good evidence-based public health. But at the same time, having the capacity to come rapidly to the assistance of an affected state.

URRY: On the day we visited, an outbreak in Angola of deadly Marburg haemorrhagic fever was still being contained.

ACTUALITY OF TELEPHONE CALL

It's said to be worse than Ebola and experts in Geneva were in daily contact with those at hospitals in the affected area.

TELEPHONE CALL CONTINUED

RYAN: Even during, for example, on the Marburg outbreak, you can imagine in Angola, it's a very large oil-producing country, there were a large contingent of expatriates working there, and the European Union asked us to have a conference, teleconference with them. And we were able to go online with 27 countries in real time and present our risk analysis.

URRY: And you were confident about that assessment, were you, based on what you'd already got in?

RYAN: Absolutely. One has to make a public health judgement, everything is a judgement. You can't stand back as an organisation and say, well, we're not sure so we can't say anything. That's not helpful, and I think WHO has that capacity to be a trusted source of the right information and the right guidance.

URRY: But that isn't always the case. The World Health Organisation has become involved in a row with the British Government about the accuracy of its data.

EXTRACT FROM ARCHIVE

REPORTER: In a tent that's thick with the stench of illness and death, the children lie in rows. Most of them are still, their bodies emaciated, their eyes staring into space. Their mothers sit by, powerless.

URRY: Civil war in Sudan has created a catastrophe in the western province of Darfur.

REPORTER: Darfur's people are lost in an immense calamity. This place is desolate, its people are tortured and many more will die before this is over.

URRY: Since 2003 the government, based in Khartoum, has deployed counter insurgency tactics against rebels in the region. Although the government denies it, those tactics appear to include helicopter gunships attacking schools and the use of mounted militiamen, known as janjaweed, to spread terror. Eric Reeves, a leading researcher and analyst of Sudan, says the militias have been brutal.

REEVES: They kill as many males, boys and men, as they can. They rape women. They destroy foodstuffs, seed stocks, agricultural implements. They destroy water supplies, irrigation systems. They cut down fruit trees. Clearly the effort is to make these villages uninhabitable, not places to which people can return. So the counterinsurgency strategy has succeeded, ambitions which have been realised not only in the huge displacement figures, but also in huge mortality.

URRY: More than two million people fled their homes. Many made their way into makeshift camps. These Internally Displaced Persons, or IDPs, as they are categorised, have been living in appalling conditions. But there've been few reliable estimates of the numbers who've died because of violence, which drove their families there. Then, last autumn, the WHO published the results of a mortality survey it had conducted in parts of Darfur. It was based on information gathered in some IDP camps. The WHO decided the death toll in camps was running at about ten thousand a month, mostly from disease. The agency extrapolated that figure to seventy thousand to cover seven months. But the survey has been dogged by misunderstanding and a lack of clarity. The Sudan researcher, Eric Reeves, noted its limitations.

REEVES: We need to bear in mind how much is excluded here. This is a mortality assessment essentially of death from disease and malnutrition …

URRY: But that's important to know about though, isn't it?

REEVES: Extremely important. But most analysts would tell you that certainly through summer 2004, the primary source of human mortality was violence, and this did not show up in the WHO study. Khartoum was very very sensitive to mortality assessments, has given all those who have attempted to do mortality studies a great deal of difficulty.

URRY: But the problem was the figure of seventy thousand began to be used by the media and by governments as the accepted death toll for mass murder in Darfur. Eric Reeves' own estimates, which are now widely accepted, put that figure much higher, between three hundred to four hundred thousand. He says journalists shouldn't have got it wrong, but the WHO should then have put it right.

REEVES: Where I fault the World Health Organisation is in how they represented this data, and once it began to be represented as global mortality rather than as an extremely circumscribed study, I think it was incumbent upon the WHO to do much more to explain what their data meant and what it did not. I think the World Health Organisation, which caught a great deal of flak from Khartoum because of this study, was unwilling to go out on any limb and say, 'This is only a very partial picture. We know that mortality in Darfur is actually a great deal greater than this seventy thousand.'

URRY: Dr David Nabarro, who heads the WHO's crisis management team, confirmed the Sudanese government had been displeased.

NABARRO: Colleagues in the government of Sudan were extremely unhappy with our estimate of seventy thousand deaths, and they made representations to very senior officials in the United Nations system and also suggested that if we went on making statements about mortality estimates in that way, we might be invited to cease operations in Sudan altogether.

URRY: You were put under pressure from the Khartoum regime?

NABARRO: Well, Sudan is a member of the World Health Organisation, and it is their right as a member of our organisation to express their view. The Ministry of Health and other groups within the government of Sudan felt that it was inappropriate for WHO to be extrapolating from the results of the mortality survey to produce an estimate for deaths due to conditions in the displaced people camps.

URRY: The misunderstanding escalated. Earlier this year, the International Development Committee of the House of Commons published a report based on its inquiry into the crisis in Darfur. During one session, the Secretary of State for International Development, Hilary Benn, had to apologise to the committee for stating that the seventy thousand figure included deaths caused by violence. He'd been basing his conclusions on the figures published by the WHO. After that, the committee decided it wanted absolute clarity about the survey and about what it regarded as references to violence, the nature of which was unclear. In February this year, a special advisor wrote to Dr David Nabarro at the WHO to try to clear matters up.

READER IN STUDIO: The seventy thousand estimate is, as you know, the most quoted figure and is often used without qualification, so the committee, in its report, want to make it very clear what the figure includes and excludes.

URRY: The advisor then went on to ask questions about the part of the survey which did touch on violence. Was it related to what was happening in the villages? But the WHO says it wasn't in a position to give further detail on the nature of the violence associated with deaths in their sample. The confusion rumbled on. The Conservative MP Tony Baldry, who chairs the International Development Committee, believes the UN agency mishandled vital information.

BALDRY: We've said in our report it demonstrated, at best, extreme naivety and otherwise gross incompetence.

URRY: That's a pretty stinging criticism of a UN agency.

BALDRY: Well, the fact of the matter is that people rely on the WHO figures and if their figures are open to misinterpretation, as these clearly were, then they deserve to be criticised. They should have recognised that statistics of this kind, if you're not careful, become a sort of weapon themselves in the PR battle because, of course, throughout all of this, the government of Sudan in Khartoum had been seeking to say that various agencies have been grossly overestimating the figures, so statistics can be used as political weapons. So the WHO has got to ensure that its statistics are not open to misinterpretation and abuse.

URRY: Whilst the WHO's Dr David Nabarro doesn't accept the mortality survey was flawed, he does concede it could have been presented more clearly.

NABARRO: Presentationally, we probably should have been even more explicit in the statements we made about the start and finish time of this estimate. So I think that there may be a presentational difficulty, so were I doing it again, I think I would be more explicit about the start time and the finish time of the estimate.

URRY: Yes, but when the UK's International Development Committee says that this was either extremely misleading or gross incompetence, which one was it?

NABARRO: Neither.

URRY: Well that's certainly not the position of the committee or its chairman.

NABARRO: No, but it's just possible that they might be wrong. We did a crucial piece of work, produced a report, produced some data. Those data were misrepresented by certain journalists.

URRY: But you didn't fall over yourself to correct that, did you?

NABARRO: Now, I want to be very precise with you about what life is like. Have you been to Darfur yourself?

URRY: No, but I don't think that's the point really.

NABARRO: Well, just listen to me then, before you go on with this. We've had one of our staff members shot, we've had numerous staff members threatened, vehicles hijacked, people's accommodation burgled. We want to stay working in Darfur and when people misrepresent information for their own purposes that we put out very clearly, it's not in the interests of our staff or of the communities that we're seeking to serve that we go into print repeating a piece of information that we've already put into the public domain that is not relevant to our business. As far as I'm concerned, I'm interested in one thing only, which is good quality public health that leads to reduction in deaths of suffering people.

URRY: But politics and their influence are never far away.

ACTUALITY OF WOMAN SPEAKING IN SPANISH

URRY: Elena Salgado, the Spanish president of the World Health Assembly, welcomes delegates to this year's gathering in Geneva. The Assembly is made up of 192 member states, setting policy and providing funding for the WHO. Some believe this leaves it even more vulnerable to political pressure.

ATTARAN: It's certainly politicised to the extent that because it is constituted by member governments, it will be very slow to slap member governments on the wrist for doing the wrong thing.

URRY: Professor Amir Attaran of the Royal Institute for International Affairs in London.

ATTARAN: South Africa is probably the best example. South Africa has an enormous age pandemic. 25% of adults are now HIV positive, they will be dead within a decade, and it's a human tragedy for a country that already had the human tragedy of

ARRARAN cont: apartheid before it. And although South Africa has repeatedly put forward false statistics of its AIDS problem, WHO has simply taken those numbers, attached a few caveats to them and let them be published. In my idea of a meaningful WHO, WHO would refuse to publish those statistics, would hold a press conference in Johannesburg and announce to the South African press that their government was not telling them the truth about AIDS.

URRY: What has the WHO done about this then?

ATTARAN: WHO has done exceedingly little about the AIDS situation in countries where the statistics on AIDS are factually untrue. In South Africa they have said nothing.

URRY: But Dr Ian Smith, special advisor to the director general of the organisation, says one of its strengths is its ability to overcome political differences and to build consensus.
When a country like South Africa is in constant denial about, until very recently, its levels of HIV and AIDS, what does the WHO do about that?

SMITH: I'm not sure that there's been much denial about the levels of HIV and AIDS. It's been, I think, internal disagreements about the appropriate response, the nature of the epidemic and the response to it. We've always kept a firm position on the nature of the epidemic and we've made that very clear to all countries, including South Africa.

URRY: Well, what has been that position with South Africa then?

SMITH: Well, as we would for all countries, we make it very clear where, what evidence there is, in terms of the cause of HIV and the appropriate responses that need to be taken to address the epidemic. Clearly in some instances the country doesn't necessarily agree. Our responsibility is to provide the best possible advice based on the best evidence as to what should be done.

ACTUALITY AT WHO BUILDING

URRY: To get a sense of the sheer diversity of the work of the World Health Organisation, and the physical size of the building which is its nerve centre, it's best to come out onto the roof of its headquarters. From here, three hundred or so feet up, you can see Lake Geneva in the distance and the mountains beyond. Rather closer at hand is Dr Ian Smith.
You've got this commanding walkway that stretches the entire length of your building. What's the sort of work that's going on in these offices we're passing?

SMITH: Well as we're just passing, the group working on our left through the windows, this is the HIV department, the team working on HIV prevention, care and treatment. Just on the other side of the corridor we've got the senior staff working on HIV as well as TB and malaria.

URRY: How much of a priority do those sorts of initiatives get?

SMITH: We've got about thirty-five different areas of work, which are our sort of prime focus, such as chronic diseases, which would include, for example, cancer, heart disease. Others are more specific, like TB, malaria, HIV.

URRY: What about your budget? Do you struggle?

SMITH: Our budget is only about $1.7 billion a year. It's tiny compared with the total amount that is spent on health globally, and tiny really compared with what's needed. However, we can use that resource, we think, very efficiently to help coordinate the global response to a disease and the global response to promoting health.

URRY: Given that health priorities are so pressing, why do you have such a low budget?

SMITH: Partly I think because it's recognised that most of the money should be spent by governments themselves on the healthcare services that they

SMITH cont: provide for their people. There's a lot of money flowing now from international organisations through other mechanisms, through international funds, through the World Bank, global funding for HIV, TB and malaria, governments themselves giving funds bilaterally to governments, and we don't take on the responsibility to be the sort of Ministry of Health for the world.

URRY: That's just as well, because for Laurie Garrett, senior fellow for global health for the US-based Council on Foreign Relations, the World Health Organisation's budget is so small, and so prescribed, it offers very little room for manoeuvre.

GARRETT: WHO's budget is abominable. In fact, its core budget, the guaranteed tithing of the 192 nations, so it's essentially like a dues process, constitutes about one-quarter of the annual budget of the city of New York's health department. The WHO gets an additional about 70% of its budget is in very soft money, specifically targeted by wealthy donors.

URRY: So it can't move vast amounts of money around, because it hasn't got that money?

GARRETT: It not only can't move the money because it doesn't have it, but it can't move what it does have, because almost all of it is very narrowly earmarked and targeted by the donors. So, for example, your government might decide that it's very very keen on dealing with HIV prevention and say, 'We're giving another $2 million to very narrowly carry out this set of HIV prevention campaigns in these targeted countries.' That doesn't give the leadership of WHO much leeway. It cannot rapidly adapt to changes in the world and move resources around, even when it has resources.

URRY: Despite this, the WHO undertakes major global health campaigns. The most prominent under the current leadership is a drive to get more people in the developing world on treatment for HIV and AIDS. A key phase is called Three by Five. Launched two years ago, its objective is for three million patients, by the end of 2005, to get the drugs they need to keep them alive. The frontline in this battle is sub Saharan Africa, in places like Kibera in Kenya, one of the world's largest slums.

ACTUALITY IN KIBERA

URRY: This is an area where poverty exists on an almost unimaginable scale. Slums which are perched on the rolling hills, just here on the outskirts of Nairobi, and from where I'm standing, for just about as far as I can see, stretching way into the distance are the broken-down, rusty roofs of these corrugated iron shacks. People living cheek by jowl, right next to each other, where only the most basic sanitation exists. And even that is nowhere near adequate enough. It's also a place where disease is rife, where it spreads easily and where the need for the most modern and the most effective of drugs is the most apparent.

There's a little clinic here dispensing some of those drugs for patients with HIV. The humanitarian organisation, Medicins Sans Frontieres, is helping to provide treatment. MSF's medical co-ordinator for Kenya, Dr Moses Massaquoi, agreed to show us around.

ACTUALITY IN CLINIC

MASSAQUOI: This is actually the visiting block, so you have the counselling room. This is the reception and Carolyn is the nurse in charge.

URRY: How many people are you seeing on average in a day?

NURSE: An average of sixty patients a day.

URRY: That's a lot.

NURSE: Yes. Fifty-five to sixty.

URRY: This is a very small clinic really, isn't it? I mean, it's much needed, but it's a very small place.

NURSE: Yes. It's quite a small place but with many patients.

URRY: But even sixty patients a day is not enough.

URRY cont: Dr Massaquoi says many more are going without treatment, and Kenya won't meet its part of the Three by Five target.

MASSAQUOI: To date we have about 26,000 on treatment, which is about 38% of our target, so we still have to go 62%. And we're about six months away from the target deadline, so I will think it will be a miracle to achieve this.

URRY: Why do you think that target is unlikely to be met then? What's gone wrong?

MASSAQUOI: First and foremost, I think, is the issue of human resources.

URRY: Haven't got enough doctors, basically?

MASSAQUOI: They haven't got enough doctors, enough nurses, enough clinical officers at the moment to roll out the treatment plan that they have made.

URRY: Kenya's problems are reflected elsewhere. The WHO has admitted its global Three by Five target will not now be met. Although the numbers on treatment have more than doubled since its launch, from four hundred thousand to a million by June of this year, and the rate at which that has been happening has shown an increase, it's still two-thirds short of the target. Bottlenecks in procurement of drugs, supply chain management and trained health workers are said to be some of the factors involved. And there's a further warning of an $18 billion shortfall in pledges by big donor organisations and countries in the coming two years. At its Geneva headquarters, Dr Ian Smith remains optimistic.

SMITH: It was always clear from the beginning that this was going to be an extraordinarily difficult target to reach. That doesn't mean we shouldn't aim to do it. It was an appropriate target to set.

URRY: So what's gone wrong?

SMITH: The resource needs have not been entirely fulfilled. There are still challenges in creating the healthcare infrastructures in countries to reach those who need treatment, and there are still concerns about the availability of drugs. All of those have to be addressed. Nevertheless …

URRY: But shouldn't those be addressed before targets are put in?

SMITH: No, you can't wait, you've got to set a target in order to stimulate that development. If you wait until everything is in place before saying, 'Right, now let's set our target,' we'll be waiting forever. In a sense, you could actually argue that seeing only three million out of the six million that needed it was an inadequate target and we should really be aiming for far more people to be treated.

URRY: But Professor Amir Attaran of the Royal Institute for International Affairs in London, argues the organisation is undermining its own credibility by setting targets it doesn't meet.

ATTARAN: It's important that we have a strong and credible WHO. I couldn't possibly disagree. But as part of that, it's important we have a WHO that does not on its own set targets that it will fail to achieve, or the fault for damaging its credibility lies with itself, and that's unfortunately what has happened. The WHO has an awful penchant of setting targets that it does not have the means to achieve, and it knows that, and it believes that by setting the target it will exhort us all towards that achievement. But when judgement day comes, WHO dodges the bullet and washes its hands of the very target that it's set. That is not an honest way to do public administration, and in fact, in the long run, it will cost you more credibility and it will cause fewer people to respect the WHO name than any other strategy one might calculate.

URRY: For Dr Ian Smith, there are good reasons for ambitious goals, and he's unrepentant about missing targets.

SMITH: I think one of the things that's come out of Three by Five is giving a much higher priority to the interventions that really make a difference in HIV, not just in treatment, but also in counselling and testing and prevention and in care. Simply saying we've not got to this intermediate target means we'll never get to the goal, we should give up, would be an extraordinarily negative and devastating position to take, particularly for the millions of people around the world who need treatment.

URRY: It sounds a bit like you keep moving the goalpost, you know, we haven't hit this one, so what we'll do is we'll redefine the objectives, we'll call it a catalyst for change rather than a target, and then we'll drag the goalposts across the pitch and we'll put them over there.

SMITH: No, I think it's being realistic. It's saying, if we have the resources, if we have the infrastructure, this is what we could do and we should do.

URRY: One of the difficulties with the drive to get treatment to the six million who ultimately need it most is access to reliable, efficiently-managed supplies of quality medicines at sustainable costs. That in itself is a big undertaking, and it's an area in which the World Health Organisation has run into problems.

ACTUALITY IN CLINIC

DOCTOR: How are you feeling today?

MAN 2: ….

URRY: At the clinic in Nairobi's Kibera district, where they are trying to treat those with HIV, they've been using anti-retro viral therapies, or ARV's as they're known. These slow down the progress of the virus, helping to strengthen the immune system.

DOCTOR: I'm going to give you monthly ARV supply. Sixty tablets.

URRY: According to those who are given these drugs, like Seamon Sine, they can make a big difference.

SINE: It's been helping me, but will have side effects, but to try and kill the virus and reduce the multiplication of the virus in the body, they really help me, see how healthy I am.

URRY: Well you look healthy.

SINE: [LAUGHS]

URRY: You're all smiles and you look pretty healthy to me. But last year, staff at this clinic and at many others like it elsewhere were thrown into confusion.

Medicins San Frontieres which supports the work of this and other HIV clinics, had been buying ARV drugs on a list drawn up by the World Health Organisation. Some of those drugs are generics, ones said to be as effective as those developed by big pharmaceutical companies, but sold at much cheaper prices. They are supposed to be assessed according to stringent standards, and if they pass, the WHO puts them on what it calls a pre-qualifying list. That list aims to be a reliable international reference to countries and humanitarian organisations purchasing essential medicines like ARVs.

But last year, eighteen pre-qualified generic drugs, manufactured by two Indian companies, were withdrawn or de-listed. Concern had been raised about whether they behaved in the same way once released into the bloodstream as the commercial brands, because a system of tests using independent laboratories put into place at the insistence of the WHO showed discrepancies. The problem was though they'd already been pre-qualified, and so Medicins Sans Frontieres and others had bought in bulk. For MSF's Dr Moses Massaquoi it caused consternation.

MASSAQUOI: This is not very easy for us, working in the field, to have drugs that are pre-qualified, listed and then delisted. I think this was a big mistake. We must have quality drugs. This is a problem of the WHO. They have to move this programme ahead.

URRY: MSF carried on using the drugs in Kenya. The WHO's advice was that, in principle, patients should switch to other pre-qualified drugs, but that those might be difficult to find straightaway, so they were told to keep on using them, because the risk of coming off outweighed the risk brought to light by the test results. Professor Amir Attaran of the Royal Institute for International Affairs in London, believes the matter shows the WHO is out of its depth in this complex and difficult area of safety and efficacy of medicines. He argues that's best left to the experienced regulators of the developed world.

ATTARAN: Ultimately, if WHO says the end product is a good product and it turns out to be false, WHO bears responsibility for that. Certainly what the rest of the world was looking at was WHO's seal of approval, not the seal of approval of somebody else. And unfortunately the seal of approval of WHO, after having been given in many cases, was shortly thereafter taken away.

URRY: This, nevertheless, was a well-meaning attempt. The organisation recognises, doesn't have any regulatory powers it can impose on the countries where medicines are being made, but nevertheless also saw a need for a sustainable source to developing countries that would otherwise might not be able to afford it.

ATTARAN: It was a well-meaning attempt by WHO and I would say that most of WHO's attempts are well-meaning. But you have to be technically competent and not just well-meaning. And, let's face it, WHO has never done drug regulation in the past, whereas the UK government has, the French government has, the Canadians have, the Americans have, the Japanese have. And so it would have been much more reasonable to, for instance, put together a European or a North American or even a worldwide coalition of drug regulators who have between them hundreds of years of experience in this job, to ask them to pass judgement on the safety and effectiveness of the medicines in question. But WHO is also a turf conscious organisation and it did not want to share its turf with those others.

URRY: The WHO says the problems arose in contract laboratories which were carrying out checks to make sure manufacturing and other procedures met international standards. It also points out that there are no problems with any of the drugs currently on its list and says its pre-qualifying process is very rigorous, and that

in its view as good as the world's best regulatory authorities. For Professor Attaran, his concerns about the pre-qualifying list highlight one of the World Health Organisation's big weaknesses - it tries to do too much.

URRY cont:

ATTARAN: My belief is, and if I were Director General of WHO, what I would do is I would make the organisation probably smaller, not larger. I would give up its advocacy organisation, I would give up the campaigning totally and I would focus on making WHO an auditing and a statistical organisation and a reservoir of information on how to fight diseases for those countries that had the interest to do so.

ACTUALITY AT WORLD HEALTH ASSEMBLY

MAN: The capacity to respond to health threat quickly with a well coordinated action is indispensable for public health in the 21st century.

URRY: But at this year's World Health Assembly, the body which sets policy for its UN agency, there was little sign of any lessening of ambition.

MAN: For all the major health problems before us now, the solutions are available, but we have to put them into practice. Our task here, this week and next, is to decide on the ways to do this. Let us make full use of the historic opportunity we have now to meet this double need. Thank you very much. [APPLAUSE]

URRY: According to Dr Ian Smith, special advisor to the WHO's Director General, the big objectives it strives to meet are driven by its founding philosophy.

SMITH: If we assume that the highest attainable standard of health is a basic human right, which is within the constitution of the WHO, we should be setting these ambitious targets. What the targets do is stimulate much more action. That's what helps drive forward real progress, that's what helps make, turn these into real movements of change that do affect and improve the health of millions of people. Confidence will only come when people see that people are helping to build the infrastructures in

SMITH cont: countries, that we are training the health workers that are needed in health centres and in the communities to reach people who need treatment, and that we're ensuring that drugs are being manufactured in the quantities that are required. We're working in all of those areas to make a difference. But we as an organisation certainly are not solely responsible. This is a shared responsibility by international organisations, by countries themselves.

URRY: In these two programmes we've heard evidence that major campaigns to tackle infectious diseases have fallen short of their targets. That some data which the organisation uses to measure the performance of those campaigns and to inform international debate, is badly flawed. It's been muddled when clarity was required, and accused of naivety, even incompetence. The World Health Organisation's tiny budget removes much of the control it might otherwise have over some of these issues. None of this can be good for its patients, the millions in many parts of the globe facing a crisis of health and who turn to the world's doctor for the right prescription. Laurie Garrett, senior fellow for global health at the US-based Council on Foreign Relations, believes the time is now right for the doctor to go for a check-up.

GARRETT: I think you have to think back to the post World War II period, when there was a sense of let us bring much of the world up with us. There was really a very strong belief that it was possible to carry out crusades against disease, that entire campaigns could be mounted, targeting specific disease problems and if you had the right scientific tools, you could do it. It was a very optimistic time. You flash forward to today. It is a totally different world. WHO needs to find its role. It is not the role that was appropriate to WHO forty or fifty years ago. It's not even the role that probably was appropriate ten or fifteen years ago.

URRY: So what is that role?

GARRETT: I don't pretend to have that answer in my head. What I do pretend to have is a notion that we need to have that discussion. We have set a set of targets for the world, but we're not going to make them if we continue to use these old-fashioned, post-colonial health structures in poor countries to funnel money down old stove

GARRETT cont: pipes with disease-specific targets, and to force programmes to compete over human resources, talent and skills at a time when the wealthy world is trying to suck those talents and skills away as fast as they can.

URRY: Do we still need a World Health Organisation?

GARRETT: Desperately. Desperately. If it didn't exist, we'd have to invent it. But we need it to rethink much of what it does.