Good afternoon everyone. Dean Saloner, thank you for that kind introduction. I’m honored to be here for this inaugural conference on Global Development and Poverty.

It’s great to look out at all of you and see students, faculty and professionals from so many disciplines coming together to think about shared prosperity and health.

You know, I’ve been both an infectious disease physician working in some of the poorest places in the world and a university president, and if you asked me which was more difficult – treating multi-drug resistant tuberculosis in the slums of Lima, Peru, or getting faculties to work together across disciplines on big problems – it would be a very close call.

But that’s precisely your mission here at the Global Development and Poverty Initiative. Seeking transformative solutions to challenges of development and poverty that are necessarily cross disciplinary is exactly what a great university should be doing.
This collaborative approach to solving the world’s toughest challenges is something we’ve worked to institutionalize at the World Bank Group because, without collaboration that is both broad and deep, we have little hope of accomplishing our twin goals – to end extreme poverty by 2030 and to boost shared prosperity.

To accomplish the first, we must reduce the proportion of the global population living on less than $1.90 a day to below 3 percent. To accomplish the second, we must grow the incomes of the bottom 40 percent of people in developing countries at a rate equal to or faster than the national average. These goals were endorsed by all 188 member countries of the World Bank Group in April of 2013, eight months after I began my tenure. I was both delighted and a bit surprised that there was such unanimity around these goals – they are the most ambitious in the history of the Bank.

Over my career, I’ve learned that setting time-bound targets is one of the most important steps in achieving ambitious goals. This is true in the field of health and even more so when it comes to the health of the poor. When I was working at the World Health Organization, we set a target of treating 3 million people living with HIV/AIDS in low- and middle-income countries with antiretroviral medicines by the end of 2005 – just two and a half years after setting the target. At the time the target was set, there were less than 100,000 people in all of Sub-Saharan Africa who were receiving treatment. This 3 by 5 campaign may not sound like much now, especially to the students in the room, but back then, people thought we were crazy.

Critics told us it couldn’t be done. There wasn’t enough money, they said; there wasn’t enough infrastructure; some even suggested that treatment was too complex for African societies because many African people didn’t have watches, and wouldn’t be able to follow complex medical regimes. But along with extraordinary commitments by President George W. Bush to the President’s Emergency Plan for AIDS Relief, which has saved millions of lives, and the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria, this clear target helped unify a diverse set of actors – we stopped spending all of our time arguing about whether HIV treatment was possible and focused on scaling up treatment.

By measuring success according to the number of people being treated, the 3 by 5 campaign also encouraged accountability among both donors and recipients. By the end of 2005, the number of people receiving HIV treatment in Sub-Saharan Africa had increased eightfold – and while we didn’t reach the target, we reached it two years later, a record for the United Nations system. Approximately 10.7 million people in the region now have
access to ART and the global goal for 2015 is 15 million – five times higher than what we aimed for just 10 years ago – and we expect to exceed it. It’s hard to imagine what Africa would look like today if we hadn’t fought so hard to set that original target just 12 years ago.

As with all ambitious targets, the global health community was forced to fundamentally rethink what it was doing and focus on the things that mattered most in expanding treatment access. Access to drugs was a huge challenge as many developing country procurement and supply chain management systems were not prepared to deal with the sheer volume of medicines that treatment scale up required. New strategies and alliances were required, drug regimens and diagnostics had to be adapted to local conditions, new infrastructure had to be built, and whole new cadres of health workers had to be trained.

But that’s the beauty of a time-bound, ambitious target – it forces you to change. I remember visiting a local health official in South Africa prior to 3 by 5, who proudly told me that his team had met all its targets for the last five years. I humbly suggested that perhaps his aspirations were too low. As Paul Batalden, the great health systems improvement guru has said, “Every system is perfectly designed to get the results it gets.” In order to do the right thing for poor patients in poor countries, health systems throughout the world have to change; ambitious targets are a great way of making this happen.

We find ourselves in a similar place today when it comes to ending extreme poverty and boosting shared prosperity. We now have the targets but what are the changes we need to make in how we work together to reach them?

The good news is that the world has made substantial progress already. In 1990, when the world population was 5.2 billion, 36 percent of people lived in extreme poverty. In 2012 – with 7.3 billion people in the world – 12 percent lived in extreme poverty. In the last 15 years, we’ve gone from nearly 2 billion people living in extreme poverty to less than a billion. And this year, we expect the extreme poverty rate to drop below 10 percent for the first time in human history. This is the best news in the world today.

But we’re humbled by the challenges ahead. By 2020, half of all the extreme poor will be living in fragile and conflict affected settings. The prospects for economic growth in developing countries are lower than at any time in the last decade. Rising global temperatures will have devastating impacts on poor countries and poor people – and, as we saw with Ebola, major pandemics are likely to disproportionately affect the poor.
Inside the World Bank Group, for the past 50 years, we’ve continuously distilled and analyzed our global experience in fighting poverty and boosting shared prosperity. As a result, our advice to governments has evolved over time. We’ve taken a new look at the drivers of progress over the last 15 years and know that our approach must continue to evolve. Our strategy to end extreme poverty and boost shared prosperity, based on the best global knowledge now available, can be summed up in three words:


Decades of experience have taught us that economic growth is the primary driver of increased personal income and poverty reduction. Sustained growth requires macroeconomic stability in the form of low inflation, manageable debt levels and reliable exchange rates. Government policies and investments must prioritize growth in sectors that increase the incomes of the poor.

But the global economy is now facing significant headwinds, especially for emerging markets – growth is slowing; commodity prices are lower and may stay depressed for some time; and there is an exodus of capital from developing countries that is likely to accelerate with the increase in the Federal Reserve’s funds rate target.

While promoting growth has always been a Bank priority, at times, it seemed that it was the only priority. Other development goals, including the health of people and the environment, were not on the front burner. This was one reason why, 20 years ago, I was part of a movement called “50 Years is Enough,” which aimed to shut down the Bank on the occasion of its 50th birthday. Well, I have to admit that I’m glad we lost that fight because the Bank has learned from its mistakes and, 20 years later, we take a much broader approach to development, because we know that growth in GDP alone is not enough for us to achieve our twin goals.

One of the most important things I want all of you to know about the World Bank Group is that we are extremely committed to evidence. We have been a producer of evidence for many years. We are also an institution that has made fundamental changes in our operations and policy advice based on evidence.

And the evidence is increasingly clear that, in addition to growing their economies, developing countries must make investments in their people, especially in health and education; they must also support programs and policies that insure people against risks
that threaten to plunge them into poverty because of events and circumstances beyond their control.

Among the investments that developing countries can make in the health and education of their people, the most important ones start when a woman becomes pregnant. It’s the combination of health, nutrition and education, of investment and insurance, known as early childhood development.

Twenty-six percent of all children under five in developing countries are stunted, a condition in which children are not only malnourished and under-stimulated, but risk a loss of cognitive abilities that lasts a lifetime. In Sub-Saharan Africa, some 36 percent of children are stunted. That’s nearly four in 10 of Sub-Saharan Africa’s children with limited prospects in life. This is a disgrace; a global scandal and, in my view, akin to a medical emergency.

Children who are stunted by age five will not have an equal opportunity in life. It’s difficult to imagine a path to the end of poverty or shared prosperity without proper antenatal care for mothers; or appropriate stimulation, nurturing, and nutrition for infants and young children. If your brain won’t let you learn and adapt in a fast changing world, you won’t prosper and, neither will society. All of us lose.

The World Bank Group is committed to effective action on early childhood development. We’ve identified five packages of 25 services for families with young children all based on strong evidence. From 2001 to 2013, we invested $3.3 billion dollars in early childhood development programs around the world – in Haiti, Indonesia, Jamaica, Lesotho, Mozambique, Russia, and Vietnam. Using innovative policymaking and development finance tools, we recently helped Peru cut its rate of child stunting in half to 14 percent in just eight years. Progress is possible and it can happen quickly. But we must do even more.

What we need now is an ambitious global goal that will help drive our work in early childhood development. For childhood stunting, the world set a target in 2012 – to reduce stunting in children 40 percent by 2025. But that would still leave 100 million stunted children – this goal, in my view, is just not ambitious enough.

If equality of opportunity is a value that we indeed all share, and we’re serious about boosting shared prosperity, we need to work together to set a target to end stunting for all children well before 2030. This goal will enable us to hold each other accountable, forcing us to change the way we do our work. We need to formulate a plan to end stunting and use innovative financing mechanisms to make it happen.
Ensuring that children have the neuronal connections to learn is only half the battle – we have to make sure they’re in school and actually learning. Today, 91 percent of children in developing countries attend primary school, up from 83 percent in 2000. Over that 15 year period, attendance rates in Sub-Saharan Africa rose 20 percent! The number of out-of-school children of primary school age worldwide has fallen by almost half, to an estimated 57 million in 2015, down from 100 million in 2000.

We won’t rest until every child is in school; at the same time, we’ve got to move beyond our focus on access and focus on quality – the evidence on learning outcomes among young people in many countries is simply alarming. An estimated 50 percent of young people in Kenya who have completed six years of schooling cannot read a simple sentence. International assessments show that the average eight grade student in the Middle East and North Africa region performs below the international average in science and math – and in some cases, far below. These low achievement levels have devastating implications when people look for jobs.

I expect that many of you have heard of Khan Academy, which I think presents a good model for boosting educational outcomes globally. It gives students and teachers access to some of the best instructors in the world through technology. Teachers can learn how to teach important lessons and students can absorb the content directly. We’re already exploring ways of using Khan Academy content in rural Guyana and India.

Pilot programs we have underway are showing the potential for technology to transform learning outcomes. For example, in Lagos, Nigeria, eReaders are helping to improve student performance in secondary schools. Data shows these devices have had significant positive impact on students’ non-verbal skills and reading and math scores, especially among students who do not own textbooks.

Recent analyses also show the positive development impact of investing in people’s health. In 2013, the Lancet Commission on Investing in Health – a team of global economic and health experts led by Larry Summers – concluded that between 2000 and 2011, better health outcomes accounted for fully 24 percent of growth in “full income” in low- and middle-income countries. The Commission also determined that the economic return on investment in health in low- and middle-income countries could be as high to 10 to 1. Even here in Silicon Valley, that’s a good use of your money.
With the right investments, we could achieve a “grand convergence” of health outcomes among all countries – meaning a child in Cambodia and a child in California could have the same chance to survive and live a long and healthy life. This makes improving the quality of health systems everywhere a critical development issue that is essential to boosting shared prosperity. In the calls that we and many others have made for universal health coverage, we see the potential for a transformative approach to achieving this grand convergence.

But we have many challenges ahead. The depth and breadth of these challenges were never more evident than during the Ebola crisis. We learned that we were unprepared to respond to an epidemic – we still are. The outbreak also showed that our failure over many years to build effective health systems in every country meant that we were unable to prevent terrible tragedies – the deaths of more than 11,000 people and billions of dollars of economic losses in Guinea, Liberia and Sierra Leone. These are three of the poorest countries in the world that, prior to Ebola, happened to be three of the fastest growing economies in the world.

We need a robust response capacity to tackle epidemics and contain them wherever they occur. We also need stronger health systems that can diagnose and treat the sick wherever they live. Stronger health systems can extend the reach of doctors and nurses, and serve as disease outbreak alert and response networks critical to containing infections.

Just imagine what could have happened if, in December 2013, the small Guinean village where two year-old Emile Ouamouno fell ill had trained health personnel linked to a disease surveillance system – like there was in the Democratic Republic of Congo and Uganda, where previous Ebola outbreaks were limited to a small number of infections. What first looked like cholera or diarrhea would have been recognized as something far more serious and a quarantine would have been established. Instead, we didn’t even begin to figure out what was going on until three months later when a doctor who had been treating the sick died; by then, the infection had spread to three countries.

One of the most important interventions during the fight against Ebola was behavioral change, which was critical to stopping transmission. Local customs dictated that people care for victims at home, rather than sending them to a hospital, and that they touch corpses before burial, precisely the point at which the deceased was most infectious to others.
The many western doctors and dollars that ultimately supported the containment effort would have been far less effective had it not been for people who could speak the local language, were sensitive to local customs, and had enough cultural capital to persuade others to change their behavior. Trained community health workers have been vital to improving outcomes in many different areas of public health and medicine. We believe that they can form the backbone of a community based approach to effective global pandemic response.

Investments in community health workers generate other development dividends as well. They offer formal employment for women and unemployed youth. They can also become pathways out of poverty and informality for low-income and low-skilled workers. In India and Ethiopia, the World Bank Group is supporting programs that train these front line health responders and give them incentives to continue on careers paths in health care and other related social sectors, such as early childhood development. Overall, our financing is expected to support programs that train and deploy close to 1 million mostly women community health workers to areas in need, including rural and underserved communities.

There is so much we still need to do to build an effective global pandemic response system. First and foremost, a robust response capacity will require a stronger and better resourced WHO to lead the effort. Proper incentives for appropriate vaccine and drug development, and prearranged agreements with drug, transport, communications and other companies, can ensure we have life-saving medicines that get to where they’re needed quickly. Rapidly disbursing financing arrangements can help trained professionals and medical equipment reach those in need without delay.

We’re developing a concept that would help provide this financing called the Pandemic Emergency Facility or PEF. This innovation would disburse funding immediately to national governments and responding agencies to support a surge in health capacity in the context of an outbreak. By providing financing for action within hours and days, rather than months, the PEF would eliminate the availability of finance as a constraint to a response, saving lives and protecting economies.

We’re examining a variety of ways to provide this funding. One possibility is for the PEF to leverage resources from (re)insurance and capital markets, spurring the creation of a new market for pandemic insurance in developing countries. Payouts would be disbursed immediately in the event that a certain epidemic threshold is met or surpassed. This arrangement could help bring market discipline to crisis response by creating positive
incentives for data reporting and monitoring of diseases, and promote increased country-
level investments in pandemic preparedness. Another possibility is for donors – public and
private – to pre-commit to providing funding to accounts that are already linked to the global
financial system, and for these commitments to come due as soon as an outbreak occurs.

As my friend Larry Brilliant has said, “Outbreaks are inevitable, epidemics are optional.” We
hope that the PEF will become part of a system that proves him right. Building universal
health coverage on top of this structure will improve our ability to prevent pandemics and
increase the opportunity for everyone, everywhere to live a healthy, productive life.

The momentum for this movement is growing. Germany, which hosted the G7 leaders
conference in June, issued a new framework in September for global cooperation to
strengthen health systems. Next year, we expect to have a substantial platform to advance
these plans. Japan, which will host the G7 leaders conference in May 2016, has been a
long time champion of universal health coverage and disaster risk management –
institutional frameworks that are extremely relevant for robust pandemic response
capabilities.

But we have to move now on building effective health systems in every country. That’s why,
with partners, we’ve made a commitment to provide smart, scaled and sustainable funding
for developing countries seeking to provide every woman and every child the health
services they need. Our Global Financing Facility or GFF is a joint effort that takes an
innovative approach to delivering on this promise. All of its funding will be “results based,”
meaning funds will only disburse when countries achieve agreed upon, measurable
outcomes. We’ll provide technical assistance to governments to help them meet these
metrics.

GFF funding will support cost effective health interventions and health system
improvements, such as universal immunization and task-shifting to community health
workers, which evidence shows can increase results by up to 20 percent. Because the GFF
will link its financial support to countries’ decisions to use financing from our concessional
grant and low-interest loan accounts to fund results-based health programs, the GFF has
the potential to dramatically increase funding for health. For concessional grants, GFF
support will add to the amount of the grant; for low-interest loans, GFF support will be used
to buy down the interest rates so countries will receive financing on more concessional
terms. In the case of Kenya, GFF financing is expected to help reduce the country’s funding
gap for maternal child health by over 66 percent!
Ultimately, ending poverty and boosting shared prosperity will depend on insurance schemes that cover more than health related costs. Conditional cash transfer programs, for example, can cushion the impact of unemployment and poverty, while also promoting better health outcomes. Peru’s Programa Juntos, which began in 2005, has reached half a million poor families with conditional cash transfers worth $38 dollars each month based on regular health and nutrition check-ups for young children.

We also need recurring financing that prompts the world to prepare for or reduce the risks related to climate change. At our Annual Meetings in Lima a few weeks ago, we set a target of providing $29 billion dollars in climate finance to developing countries annually by 2020. This puts the World Bank Group front and center in finding a credible pathway to the $100 billion dollars that developing countries were promised in Copenhagen. Developing countries have made it clear that reaching $100 billion dollars a year by 2020 will be critical to securing a climate change agreement in Paris a month from now.

Poverty and pandemics, climate change and catastrophes like illness or unemployment, are major obstacles to a world where everyone, everywhere can reach their full potential. But there are many tools – from aspirational time-bound goals to new ways of delivering timely, smart, scaled and sustainable financing – that can help us tackle these challenges. The World Bank Group’s strategy of “grow, invest, insure” aims to help countries overcome these obstacles so that we can end extreme poverty by 2030 and boost shared prosperity.

There is so much evidence today which demonstrates that investments in people’s health are critical to ending extreme poverty and reducing the enormous levels of inequality in the world today. What does it mean that we live in a world where, since December 2013, more than 11,000 people in Guinea, Liberia and Sierra Leone have died from Ebola, but every American treated for the virus in the United States has survived? Eliminating obstacles to care within countries and equalizing health outcomes across countries is arguably every bit as important to tackling inequality as raising the incomes of the poorest.

At the World Bank Group, we are devoting all of our resources – our development knowledge and experience, our financial expertise and our capital – to tackle inequality and ensure that the bounty of global prosperity can be shared by all.

In difficult times, when we’re concerned about growing inequality, worried about the health of our planet and future pandemics, and outraged that one-quarter of all children in
developing countries are stunted, we must tackle the biggest problems with only the highest aspirations. Only then will we be successful.

I've said it many times: When you’re fighting extreme poverty, optimism is a moral choice. Pessimism in the face of extreme poverty can become a self-fulfilling prophesy that is deadly for the poor. Our goals of ending extreme poverty by 2030 and boosting shared prosperity are not just slogans. We’re serious about them.

It starts with the pregnant woman who lives in a conflict zone. We must do whatever it takes to support her so that her newborn child will have a world of opportunity, equal to that of any child in the world.

With partners like the Global Development and Poverty Initiative and the entire Stanford community, I'm full of hope that we can indeed be the first generation in human history to end extreme poverty and create a more just and prosperous world for everyone on the planet.

Thank you.