Minister for Health and Social Welfare of the Kingdom of Swaziland and Chairperson of the Commonwealth Regional Health Ministers’ Conference for East, Central and Southern Africa, Honourable Dr. Phetsile Dlamini;
Tanzania Minister for Health, Honourable Anna Abdallah, MP;
Honourable Ministers for Health from East, Central and Southern African Countries;
Your Excellencies Heads of Diplomatic Missions;
The Regional Secretary, Commonwealth Regional Health Community Secretariat, Dr. Steven Shongwe;
Representatives of Cooperating Partners;
Distinguished Delegates and Guests;
Ladies and Gentlemen.

Let me begin by thanking you, Chairperson, and the Regional Secretary for inviting me to officially open the 34th Commonwealth Regional Health Ministers’ Conference.

As Ministers you are politicians, but I note that most of you are doctors. And it is not often that I get to talk to doctors. Usually it is the doctors telling me, and telling others like me who are not medical doctors, how to, or rather how not to, live our lives, if we want to live long. Most of what they tell us is not pleasant, yet they still expect to get paid for the bad news. As the late American satirist and literary critic, H. L. Mencken, once said: “One of the chief objects of medicine is to save us from the natural consequences of our vices and follies.” There is only one exception I recently read about, based on a conversation between a patient and his doctor.

“Do you think I shall live until I’m ninety, doctor?”
“How old are you now?” the doctor asked.
“Forty.”
“Do you drink, gamble, smoke, or have you any vices of any kind?”
“No. I don’t drink, I never gamble, I loathe smoking; in fact, I haven’t any vices,” the conceited patient proudly answered.
“Well, wottinell do you want to live another fifty years for?”

Be that as it may, it gives me great pleasure to welcome you all – doctors and mere politicians like me – to Tanzania. I hope you were all received well, and that adequate facilities have been made available to make your stay comfortable, and your important work here successful.
Regional Co-operation in Health

Honourable Chairperson,

We in Tanzania feel greatly honoured to host this Conference. We are equally honoured to host the Headquarters of the Commonwealth Regional Community Secretariat for East, Central and Southern Africa in Arusha. I should like to assure you, Honourable Ministers, that the United Republic of Tanzania will continue to host the Secretariat for the benefit of our people in the region, and fulfill our obligations as host state.

As pointed out by those who spoke before me, one of the key objectives of the Commonwealth Regional Health Community is to foster regional co-operation in the health sector. The Community encourages collaboration and exchange of knowledge and information to enable member states respond collectively to the challenges and problems affecting the health of our people. Tanzania fully associates itself with the ideals and objectives of the Regional Health Community, convinced that the Community remains relevant – perhaps even more relevant today than when it was established – relevant to the welfare of our people.

From the moment it was established, the Regional Health Community has been an illustration of needed co-operation in health in our region; a healthy strategy in facing the similar health problems and challenges we all face. As developing countries – some least developed countries – we need to work together. We have to pool our will, our resources, our knowledge and our experiences and make them work for all of us. Tanzania’s commitment to such co-operation is firm and will continue.

This organisation, established by member states in 1974, has over the years evolved into a credible and competent regional body, which fosters co-operation in the multi-faceted challenges we all face. I am also aware that the Secretariat has initiated internal institutional reforms to respond more efficiently and effectively to the needs of the member states.

It is also gratifying to note that some of these reforms are already bearing fruit in the form of improved management and focused programmes. This is commendable, and I ask you Mr. Regional Secretary and your staff to keep up the good work. The Secretariat can count on the continued support of my government as it discharges its noble functions. I also urge my fellow Heads of State and Government, through you Honourable Ministers, to give the Community the support it needs and deserves.

In commending the Secretariat, I also wish to encourage them to play a leading role in addressing the health challenges our region faces. The Secretariat should also address the issue of visibility, and increasingly monitor the impact of its programmes in member states. It should also promote the sharing of best practices in the region for the betterment of the community and our people.

Honourable Ministers, Ladies and Gentlemen,
The theme and sub-themes of this Conference are compelling and appropriate. For, we should all be concerned about strengthening health systems in our region. Health and access to health services are issues that are embodied or implied in all our Constitutions, as well as the United Nations Charter of which we are all members; and which recognises health as a basic human right.

Moreover, a healthy population and a sound health environment are prerequisites for economic development. A healthy labour force will produce a healthy economy. The challenge before our development partners and us is to provide our people with access to quality, affordable and acceptable health services. We should exchange knowledge and experiences in this important area.

Regional Health Situation and Challenges

Honourable Chairperson,

Our countries in this region have resolved to address health as a basic human right. Priority areas such as poverty, illiteracy and disease have been given due prominence in our respective National Development Plans. We have achieved significant progress in some of these areas. For example, immunisation coverage and access to health services has improved over time. Important indicators of development, such as life expectancy, had gone up (before the onset of HIV/AIDS), and infant mortality had gone down in most of our countries, including Tanzania.

Sadly, some of these achievements are being undermined by high rates of population growth amidst low rates of economic growth. The HIV/AIDS pandemic, coupled with the resurgence of infectious diseases such as tuberculosis and malaria, are eroding our previous successes. Non-communicable diseases such as diabetes, cancer, hypertension and other heart diseases, hitherto considered diseases of the developed countries, are on the increase in our region. All these factors combine to increase the burden and demands on our governments in general, and the health sector in particular.

In response, most countries in the region have initiated various reform processes including designing and implementing Health Sector Reforms, the primary goals of which are to improve the efficiency of health systems and enhance equity in health delivery. While there has been some progress, recent reviews show a need to further strengthen the health systems so as to respond better to the new challenges.

Honourable Ministers, Ladies and Gentlemen,

In addressing the theme of this Conference, you will also have to address several other key issues, such as the role of, and relationships between, governments, the private sector and non-governmental organisations, (NGOs), in health service delivery, and improving health systems in our region. For, the challenges we face require the widest possible level of co-
operation and mutual support among all stakeholders. You will also have to examine the major challenges facing the health sector, such as the increasing diseases and managing health systems, in the context of limited resources, and the ensuing question of setting priorities.

As we plan for the strengthening of the performance of our health systems we must also seriously discuss the question of resource availability, and alternative health care financing programmes. For, government resources, particularly financial resources, are never sufficient in relation to the increasing burden of disease and medical care.

The onslaught of the HIV/AIDS pandemic has compounded the problem. Increased demand for health care from people with HIV-related illnesses is already over-stretching public health systems in our region. Judging from present trends, the pressure will increase before it decreases. In 1997, public health spending on AIDS alone exceeded 2 per cent of GDP in 7 out of 16 African countries, in a situation where the total health expenditure from public and private sources amounted to 3-5 per cent of GDP. In recent years, patients underlined with HIV infection have occupied half the beds in major city hospitals in our region.

At the same time, tuberculosis, which before the HIV/AIDS epidemic had been brought under control, has now become the leading cause of death among HIV-positive people, accounting for about a quarter of all AIDS deaths worldwide. In this regard, health sector costs such as infrastructure, drugs, and human resource development will continue to rise, especially as new palliative therapies are introduced to treat HIV-infected persons.

Meanwhile, there are several other competing demands on the finite resources available to us, such as education, poverty reduction programmes, infrastructure, public utilities, and other social development related sectors. Against these setbacks, we must evolve innovative ways and means to effectively finance our health systems in the region. These and other related questions should be addressed at this Conference.

International Co-operation

Honourable Chairperson,

It is also necessary that appropriate policies be developed to guide our countries in the implementation of the commitments we made in various international conferences and meetings such as the Abuja Declaration, the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), and the Commonwealth Heads of Government Meetings (CHOGM). These are solemn commitments we must live up to as Africans, and towards which the rich industrialised countries must also fulfil their obligations.

Both the developing countries and their development partners have now to show a demonstrable commitment to making health a priority human rights issue. In our region we have begun to show such commitment. If there are shortcomings, it is not for the lack of trying, or for the lack of political will. The costs involved are too high for our countries to bear alone. The case and plea for more development assistance, more debt relief, and more concessional loans cannot be made more stridently. The rich industrialised countries that are always urging us to
move faster on political rights, should likewise empower us to move expeditiously to make health a human rights issue in practice.

For, without good health, all other basic human rights are not of much use, even when fully guaranteed. We talk of a common humanity, but the global and sometimes national inequalities in access to affordable and quality health care are so staggering as to make a mockery of the concept of common humanity. The global and national health gap must be addressed if we are to be members of a common humanity. As the World Health Organisation (WHO) Director-General, Dr. Gro Harlem Brundtland, correctly said soon after taking up the position in 1998:

“Never have so many had such broad and advanced access to healthcare. But never have so many been denied access to health. The developing world carries 90% of the disease burden, yet poorer countries have access to only 10% of the resources that go to health.”

Honourable Chairperson,

It is also important to bear in mind the causal relationship between poverty and health. Poverty is at the heart of most of the shortcomings in the health delivery systems in our countries. I repeat. The shortcomings are not reflective of insufficient political will. And, poor health exacerbates poverty, not only by reducing productivity through ill health, but also by increasing the cost of medical care, including on easily preventable diseases.

Too many of our people, including children and young persons, are dying of preventable or treatable causes. Sub-Saharan Africa continues to be the worst HIV/AIDS affected region, with 70 per cent of the over 23 million infected people worldwide. Most of our people are getting infected, or are infecting others, out of ignorance; or because we cannot provide reliable and accessible testing and blood screening facilities, as well as counselling services to all parts of our countries. I am told that a staggering 90 – 95 per cent of our people who carry the virus do not even know they are infected.

The WHO last year estimated that globally we need USD 1.5 billion each year up to 2010 for the medicine and prevention tools needed to stop the spread of the six big killer infectious diseases. That makes a total of only USD 15 billion dollars to prevent these diseases, which account for over 90 per cent of the total infectious disease deaths worldwide.

But, globally, we spend far more resources on war, and preparation for war, even though these infectious diseases kill many more people than wars. The World Disaster Report released last year by the International Federation of Red Cross and Crescent Societies shows that the death toll from infectious diseases (such as AIDS, malaria, respiratory diseases and diarrhoea) is 160 times greater than the number of people killed in the 1999 national disasters, including the massive earthquakes in Turkey, floods in Venezuela and cyclones in India combined.

The Report also points out that since 1945, an estimated 150 million people have died from AIDS, tuberculosis and malaria, compared to 23 million people who died from war. Every hour, 300 people die from AIDS. Each year, 2.6 million of our fellow human beings die from malaria, 75 per cent of them children. I need not remind you that most of these deaths have
occurred, and will continue to occur, in Sub-Saharan Africa, unless there is a concerted global initiative to save our people.

It is possible to save our people. For as the report shows, in 1995, global military spending reached USD 864 billion, compared to an estimated USD 15 billion spent annually on prevention and control of AIDS, tuberculosis and malaria combined. An extra USD 15 billion redirected from military expenditure to prevention and control of infectious diseases is an achievable goal if there is the necessary political will.

And there are other areas where international co-operation can help to reduce unnecessary deaths. According to the WHO, of the 500,000 maternal deaths that occur every year in the world, 99 per cent are in the developing countries. It is not that our women are of less value than women in rich industrialised countries; or that we do not care. The unsafe abortions, the haemorrhages, the infections, the high blood pressure and the obstructed labour that cause these deaths have their roots in our poverty, and the poor access to quality medical care it engenders. Those that prod us on gender issues should also help us invest in improved reproductive health to ensure safe motherhood. We have to ensure our women are alive first before we can guarantee them their other rights.

Malaria kills more than 1 million people a year worldwide, 90 per cent of them in Africa. But malaria is not a high priority research area for the large pharmaceutical companies, because malaria is an affliction of poor people who cannot afford new and expensive drugs. Yet, malaria can to a large extent be prevented using safe insecticides and impregnated mosquito nets. A greater partnership between governments in poor countries, donor countries and agencies, and international civil society, can together help to make much headway in this area.

Honourable Chairperson,

There are many areas where international co-operation is needed to improve health delivery and care in our region, and the developing world as a whole. I cannot do justice to all of them with the time available. But let me mention the issue of capacity for correct diagnosis. The Economist magazine of 2 September 2000, stated as follows regarding this matter:
“Every day, thousands of people in poor countries are condemned to death without due process or a thorough investigation of their cases. If this were a miscarriage of justice, then human-rights activists would be up in arms. But it is a miscarriage of medicine instead, and until recently it has passed largely unnoticed by outsiders.

In much of the developing world, diagnostic tools that practitioners in rich countries take for granted, such as sophisticated laboratory tests for serious infections, are too expensive or impractical for local conditions. As a consequence, patients are given inappropriate drugs – which can promote drug-resistance among nasty bugs – or, even worse, are not treated at all. According to Médecins Sans Frontières, an international medical aid-agency, up to a fifth of patients in some African hospitals are misdiagnosed as HIV-infected on the basis of symptoms alone, and left to die because the drugs required to treat AIDS are too costly.

The need is therefore for simple, rapid and cheap diagnostic assays which can screen the large numbers of the world’s poor who are at risk of debilitation or death from HIV, malaria, tuberculosis and some of the nastier tropical diseases such as lymphatic filariasis.”

I could not agree more; and I urge for a stronger partnership between governments, aid organisations, international civil society, and donor agencies to work together to improve the diagnostic capacity of our region. And having correctly diagnosed the diseases that afflict, debilitate and kill our people, patents for medical knowledge and drugs should not stand in the way of saving lives by the thousands.

Honourable Chairperson,

I would like at this point to extend my special gratitude to our co-operating partners including the World Health Organisation, USAID/REDSO (Regional Economic Development Services Office for Eastern and Southern Africa), Rockefeller Foundation, European Union, United Kingdom Department for International Development (DFID), the Support for Analysis and Research in Africa Project of the Academy for Educational Development (SARA/AED), and many others for their continued support to the Commonwealth Regional Health Community Secretariat. I should like to assure you that your support is most useful and greatly appreciated.

I have, Chairperson, a reputation in this country of railing against the frequency of meetings in the form of seminars, workshops, retreats, conferences, you name them. But this is one meeting I commend for its practicality. Ministers of Health are sort of doctors, and, as one wit has put it, there are only two sorts of doctors: those who practice with their brains, and those who practice with their tongue!!

It is now my pleasure and privilege to declare the 34th Commonwealth Regional Health Ministers Conference officially opened, and to wish you successful deliberations.

I thank you for your kind attention.