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Kigali, Republic of Rwanda, 31 August–4 September 2009

ADDRESS BY HIS EXCELLENCY MR PAUL KAGAME, PRESIDENT OF THE REPUBLIC OF RWANDA

Leaders and heads of Rwandan higher institutions,
Your Excellency Festus Mogae, former Head of State of the Republic of Botswana and Chairperson of the Champions for an HIV-Free Generation,
African and Rwandan ministers,
Dr Margret Chan, WHO Director-General
Dr Luis Gomes Sambo, WHO Regional Director for Africa,
Heads of international organizations,
Development partners,
Distinguished delegates,
Ladies and gentlemen.

A very warm welcome to all delegates attending this important Conference organized by the World Health Organization's Regional Committee for Africa.

Although the meeting comes at a critical time due, among other things, to the ongoing global economic crises and influenza pandemic, I am certain that we will have a productive discussion that advances innovative modalities for improving the health of African people.

We should therefore use this opportunity to reflect deeply on Africa's social sector, especially the state of our health systems which any unbiased observer would readily describe as "gravely unhealthy" – a not-so-new verdict.

I am pleased that over the next five days we will be considering issues that are key to sustainable solutions, among them, inclusive and holistic health care systems; and the required scientific and technological base to permit domestic, regional and continental health research capabilities.

And so as we discuss these and other health issues at this conference, we should concentrate on the fundamental questions and solutions.

For instance, how do we reverse the decades-long poor state of Africa's health system and the meagre research capability – issues that are continuously analyzed, re-assessed and reconsidered to an extent that discussion at times appears to have become an end in itself.

We should strongly resist the tendency to oversimplify this failing and reduce it to financial constraints and poverty – for indeed as someone has rightly put it, "Africa is not poor, it is poorly only managed".

Yes – money is essential for achieving development objectives, but greater challenges lie elsewhere – including strong and multi-level leadership, robust policy ownership, appropriate strategy, forward-looking, commitment, hard work, being innovative, and accountability.

Put differently, no amount of material or financial resources can transform a nation without a clear political and policy purpose, and a deliberate strategy and commitment to continuously improve the conditions of its most important national asset – people.

My point here is that we have it within ourselves on this continent to work harder, more creatively, and faster for good results overall, including to improve substantially the health of Africans.

We are convinced of this in Rwanda – our efforts and modest achievements in general and in the health sector in particular provide ample evidence.

Take, for example, the case of our community-based health insurance in which citizens, central government and local governments contribute to ensure that even the most vulnerable in our society have basic health insurance coverage.

We continue to make significant progress towards universal coverage – from 7% in 2003 to 85% in 2008.

In another example, considerable gains were made between 2005 and 2008 through an important innovation, namely, the implementation of performance-based financing in our country's health sector.

This experiment took place in the broader context of other national reforms, not least IMIHIGO, performance contracts between the Head of State and Rwandan mayors representing and working with citizens, as well as the sustained decentralization process of human resources for health.

The main lesson from performance-based financing is that facilities utilizing it have outperformed those with conventional mindset and operations.

This is primarily because the financial and human resources transferred to the health facilities are treated differently – in the case of performance-based financing, it is the results that matter more.

There is, in other words, no single magic solution to achieving this success – and most certainly, it is not merely a result of money.

Local leaders, health facility managers, district health officials, and the community at large no longer engage routinely because they "have to" but because it is in their own interest to achieve better results.

Citizens develop a direct stake in health – and can no longer afford to stand on the sidelines precisely because they now realize that they can contribute considerably to the improvement of the lives of their children, siblings, parents, or their very own lives.

Local communities begin to take a keener interest in the professionals hired by their health facilities.

And they have a say in their hiring and firing based on clear performance indicators such as the number of children delivered, immunized, or receiving treated mosquito nets; people receiving HIV treatment or counseling – among others.

The same factors – leadership, accountability, community empowerment – account for the significant achievements in our national antimalaria campaign.

At the national leadership level, we undertook an ambitious but achievable campaign for resources, but, once again, we did not leave it at that.

We had to have an effective preventive and curative strategy that emphasized public and private partnerships; assertive community mobilization; and a consistent focus on strengthening our national health system, especially at the district and local levels.

It is very clear that without the extensive involvement of local leaders, we could not have achieved the ninety-seven-percent household coverage for indoor residual spraying for malaria.

The successful mobilization of Rwandan household and community workers was singularly due to this factor.

And so I return to my earlier point: we have it within ourselves in Africa to do much better and faster to improve the health of Africans.

It is not preordained that our continent must remain impoverished, illiterate, and in poor health – and if we can make the noted modest achievements in Rwanda, a country that is by no means rich, we can do even better regionally and continentally.

I conclude by thanking the development partners that have played an invaluable role in Rwanda's achievements.

We have also learnt important lessons from our partnerships, especially on ways to jointly render aid most effective.

We have learnt that aid works best if conceived and executed as a transitional measure, and not as an end in itself – with the following key features for maximum impact:

- First, national policy ownership with a clearly-defined purpose for aid – understood and shared by the provider and receiver;
- Second, shared oversight and accountability mechanisms with well-defined indicators to systematically monitor the impact;

- Third, embedding aid into the execution of national development strategies and policy priorities, and therefore, disbursement through national institutions including budgeting and programming;
- Finally, built-in human and institutional re-enforcement to increase and sustain capacity and competence beyond aid – as opposed to parallel donor structures that undermine these very systems.

The Rwandan health cases cited earlier on convincingly demonstrate that aid defined and executed with these features achieves by far more positive and sustained results.

We are fortunate to be working with development partners who increasingly share this vision, and have placed the burden of responsibility for our future where it belongs – on our own shoulders.

It is now my pleasure to wish us all – delegates at this Conference – successful deliberations.

We look forward to practical and innovative recommendations on the important subject matter at hand – improving the health of African people.

I now declare open the Fifty-ninth session of the WHO Regional Committee for Africa, and thank you for being here and for your kind attention.