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Held at the Palais des Nations, Geneva, on Wednesday, 8 July 2009, at 9.30 a.m.

President: Ms. Lucas ..... (Luxembourg)

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10-48441 (E)

Ms. Lucas took the Chair.

The meeting was called to order at 9.40 a.m.

Annual ministerial review: "Implementing the internationally agreed goals and commitments in regard to global public health" (*continued*) (E/2009/81)

National voluntary presentations (*continued*) (E/2009/88 and E/2009/97)

The President invited Mr. Mettan, Head of the Club Suisse de la Presse, to act as moderator for the national voluntary presentations.

Mr. Kahandaliyanage (Observer for Sri Lanka), welcoming the fact that the Council was playing a more active role in helping to achieve the Internationally Agreed Development Goals (IADGs), said that Sri Lanka was one of the first developing countries to recognize the importance of investing in human resources and promoting gender equality and social development. A large share of its public spending had been on measures to improve living standards and ensure minimum consumption levels, in the framework of a firm commitment to democratic values. Those investments had borne fruit and, in general, Sri Lanka was making good progress towards attaining the Millennium Development Goals.

Sri Lanka's recent history belied the claim that countries in conflict or emerging from conflict were the least likely to attain the MDGs. Despite almost three decades of terrorism, recently ended, Sri Lanka had continued to make gains in human and social development, particularly in the area of social determinants of health. Both its democratic political system, based on universal franchise and regular multiparty elections, and its economy had withstood the threat posed by the conflict.

For the past 30 years, Sri Lanka had been a liberal, market-oriented society, with a strong commitment to social welfare. The proportion of individuals below the national poverty line had decreased from 26 per cent in 1990 to 15.2 per cent in 2006. The number of children enrolled in the formal education system had been gradually increasing, and primary-school enrolment and completion had nearly reached 100 per cent. Both life expectancy and literacy rates were high.

A series of socio-economic, political and institutional factors had bolstered Sri Lanka's success in the health sector, despite relatively limited resources. The Government had systematically invested funds to develop human and physical resources in the public health sector, which had the capacity to treat 5 million inpatients and 43 million outpatients per annum. The overall health of the population had improved significantly, and there was growing awareness about the benefits of good health.

Public-sector health care was provided free of charge and within facilities located close to users, making universal access a reality. The private sector had been allowed to expand in order to provide alternative treatment sources, thereby reducing public health-care costs. Indigenous systems of medicine, dominated by the ayurvedic tradition, accounted for a large portion of the health-care system and had been receiving an increasing amount of public funding.

Health care had contributed to human development through both preventive and curative care. Prevention campaigns had helped to reduce communicable and parasitic diseases. All vaccine-preventable diseases had either been eliminated or brought under control through the country's immunization programme. Improvement of sanitation facilities had helped to promote healthy lifestyles. Measures had been taken to reduce malnourishment among children, and to educate pregnant women and mothers. The Government had also implemented a national maternal and childcare programme.

A series of reforms had been undertaken to improve public health care, including the development of existing facilities and the setting up of countrywide facilities offering varying levels of care. The decline in infant mortality, under-five mortality and maternal mortality rates was a sign that Sri Lanka was well on the way to achieving the health-related MDGs. Life expectancy, as of 2006, had risen to an average of 74 years. Diseases such as leprosy, polio and measles had been eradicated. The combat against HIV/AIDS had been relatively simple owing to its low prevalence and limited spread. However, more needed to be done to improve the health conditions of social groups in all regions, notably by ensuring that housing, water supply and sanitation played a role in creating a positive environment for health care.

In a period of demographic transition marked by an increasingly aged population, the epidemiological picture was changing: while levels of morbidity arising from communicable diseases remained high, non-communicable diseases accounted for a growing share of health expenditure, placing a double burden on health-care funding. Regional imbalances in health-care delivery represented another challenge and health authorities had developed a health-sector master plan to improve access to quality services.

The health sector in Sri Lanka was financed by private and public funds — private sources accounting for a slightly higher proportion than public sources, which were derived mainly from tax revenues. Public health facilities served lower and middle income groups, while the wealthier classes were encouraged to use private-sector facilities.

His country had a record of dealing effectively with health care in emergency and crisis situations. Its response to the 2004 tsunami had demonstrated how well prepared the health sector was to deal with natural disasters. Throughout the 30 years of conflict with the terrorist group Liberation Tamil Tigers of Ealam (LTTE), Sri Lanka had continued to provide health-care delivery in areas controlled by that group. The Government was now mobilizing its resources, in cooperation with United Nations agencies and international NGOs, to provide health care to the civilian populations displaced during the conflict and to rebuild the health infrastructure in the northern and eastern regions.

The main lesson to be learned was that significant advances in human development could be made, even in low per capita income countries, by the use of systematic and well-planned State interventions, supported by strong economic growth.

Mr. Kazi (Observer for Bangladesh) said that Sri Lanka had demonstrated a clear commitment to ensuring basic health care for all its citizens. The country's impressive human development indicators showed that sustained investment in human capital, even with limited resources, paid off. Despite three decades of violent conflict, Sri Lanka had consistently ranked high on the human development scale in relation to other countries in the region. Its crowning achievement was its sustained high literacy rate, which had had a positive impact on its health care system. It had demonstrated an impressive capacity to meet challenges, as evidenced by its steady progress towards achieving most of the Millennium Development Goals.

While the tsunami disaster of 2004 had put the entire Sri Lankan health system under serious strain, proper management of the crisis had helped to avert any major health crises. He was particularly interested in learning how Sri Lanka had integrated its health strategies into its overall risk reduction and disaster preparedness scheme.

The coexistence of public and private health-care delivery in Sri Lanka offered both opportunities and challenges. He would appreciate knowing what public-private partnership models were being envisaged to ensure effective health-care delivery. Was the Government giving consideration to establishing health insurance systems as a means of tapping into private resources?

In Sri Lanka, 97.6 per cent of births had been handled by skilled birth attendants in 2006 and 2007, significantly reducing maternal mortality. How had that high proportion been achieved? More information would be welcome on Sri Lanka's strategy for combating non communicable diseases and its health-sector master plan, a best practice that might be replicated in his own country.

Mr. Alviarez (Observer for Cuba) said that Sri Lanka's report gave a clear picture of the efforts it had made to achieve greater social justice and equity, combat poverty and foster development. All that had been achieved despite the numerous obstacles facing the country, including natural disasters, a prolonged internal conflict costing many lives, and its status as a developing country operating under an unjust international economic and financial system. Sri Lanka had systematically implemented policies aimed at ensuring universal access to health and education services and social welfare programmes, and deserved high marks in the field of human development.

In the field of health, Sri Lanka had brought communicable diseases under control and had made HIV/AIDS prevention and treatment a priority. It had above all launched a

health sector master plan, the objective of which was to guarantee access for all to modern and high-quality

health services, with special emphasis on the needs of vulnerable and low-income groups.

The Sri Lankan health system had proved its resiliency during the crisis provoked by the tsunami in 2004. He wished in that regard to stress the importance of international cooperation, not only in mitigating the impact of natural disasters but also in promoting the full exercise of the right to development.

Sri Lanka had made good progress with respect to most of the Millennium Development Goals. Its Government had acknowledged, however, that progress varied within the country depending on region and income status and was taking steps to rectify that situation. He noted with satisfaction that the Government had implemented measures for attaining MDGs 1, 3 and 7 and was well on the way to developing strategies for achieving the remaining goals.

The significant progress made by Sri Lanka in the area of social development, including health, could not have been achieved without the political will shown by its Government and adequate financial resources. He wondered in that connection whether the level of international assistance to Sri Lanka was sufficient for its needs, what the impact of the international financial and economic crisis had been on the funds allocated for health care, and what solutions the Government had in mind for ensuring adequate funding to meet future challenges. He would welcome more information on the measures taken in Sri Lanka to ensure health services in the aftermath of the recently ended conflict and, in particular, on the level of international assistance that had been received to help the country meet that challenge.

Mr. Gopinathan (India) commended Sri Lanka on its effective efforts to achieve the internationally agreed development goals. Its achievements in the health sector — in the context of a long internal struggle — were outstanding, not only in the region but also in comparison with some developed countries. He wished to know what were the key ingredients of the country's success in the health sector, and what the trend in public health-care expenditure had been in recent years?

Sri Lanka now faced even greater challenges in the post-conflict phase, which included caring for thousands of displaced persons, providing appropriate medicine and equipment, and finding trained personnel. He would welcome information on how Sri Lanka planned to meet those challenges. As financial resources were crucial to those efforts, he would also appreciate information on the amount of assistance Sri Lanka was receiving from the international community.

Mr. Chen Zhu (China) said that Sri Lanka had overcome significant challenges to meet the Millennium Development Goals in such areas as women's and children's health, and was an example for other developing countries. Like Sri Lanka, China faced the problems of controlling non-communicable diseases and of an ageing population. He wondered what strategies Sri Lanka had developed to deal with those problems. His delegation looked forward to exchanging information and ideas for further progress towards the Millennium Development Goals.

Mr. Alviarez (Venezuela) congratulated the Government of Sri Lanka on the situation of economic, social and cultural rights in that country, and especially the right to health — a fundamental and inalienable right inherent in the right to life. He encouraged the Government to continue on its present path, and to focus especially on nutrition, health, education, full employment and improving its infrastructure. What kind of financial and humanitarian assistance had Sri Lanka received from the international community, and especially from the developed countries and the relevant international agencies, to place the recent peace agreement on a secure footing and overcome the effects of an armed conflict which had lasted over 30 years?

Mr. Khan (Pakistan) said that, thanks to its sustained investment in public services and the provision of free education, free health services, food subsidies and subsidized credit, Sri Lanka had achieved almost universal primary education, literacy rates above 90 per cent and increasing life expectancy, and was well on track to achieve the MDGs in those areas. The return to normalcy after decades of conflict would hasten that process. His delegation was impressed to note that everyone in Sri Lanka had access to a health-service facility within a radius of 3 km, and that almost all vaccine-preventable diseases had either been eliminated or brought under effective control. He asked what steps were being taken to bring the indigenous traditional ayurvedic medicine system into mainstream national health care, and to enhance its safety and efficacy; how the Government of Sri Lanka planned to balance competing demands for health financing in a context of an ageing population and a

growing burden of non-communicable diseases; and whether its consistent pattern of spending on health and education was due to any particular constitutional requirements or long-term strategy, or rather to decisions taken by successive governments.

Mr. Chebihi (Algeria) said many countries could learn from Sri Lanka's success, which had been achieved despite some 30 years of conflict. He asked for more information on how much international assistance Sri Lanka was receiving and called on the international community to increase its support in order to help Sri Lanka deal with such challenges as the many persons displaced as a result of conflict, as well as natural disasters.

Ms. Jameel (Observer for Maldives) said Sri Lanka had shown that if the necessary political will existed, virtually any challenge could be overcome. It had for example dealt much better with the effects of the tsunami than Maldives. She was confident Sri Lanka would rise to the challenge of meeting the needs of persons displaced by conflict. She suggested that Sri Lanka should share its experience in other forums for the benefit of countries facing similar challenges. Lastly, she asked how Sri Lanka had integrated traditional ayurvedic medicine into the health-care system and how it had managed to provide free health care to its population.

Ms. Skalli (Morocco) noted Sri Lanka's exemplary progress towards meeting the Millennium Development Goals and asked for further explanation of the achievements made in reducing maternal mortality. She wondered whether some of that success could be attributed to efforts to eliminate violence against women and gender equality policies. She asked for information about the current situation regarding voluntary termination of pregnancy. Turning to the political sphere, she wondered if women were well represented at the national and local levels and whether there was a true participatory approach to governance.

Ms. Basilio (Philippines) said that Sri Lanka had made impressive progress towards providing health care to all its citizens and towards the Millennium Development Goals. She was sure it would rise to the challenge of meeting the needs of the displaced populations in the north and east of the country and asked for information on what needed to be done and how the international community could help.

Mr. Kahandaliyanage (Observer for Sri Lanka) said that his Government, with the assistance of such partners as the World Bank and the World Health Organization (WHO), had made health promotion and the prevention of non-communicable diseases a priority. As for the structure of the health system, he said that private health care was available for those who could afford it but that a public health safety net was likewise available. Sri Lanka's commitment to building a comprehensive health-services infrastructure had played a major role in reducing maternal mortality; for example, the ratio of midwives to the general population was 1:3,000. Maternal mortality had fallen from 4.3 per 10,000 live births in 1991 to 1.97 in 2003 and the relevant Millennium Development Goal would almost certainly be met. Gender equality was encouraged; there was a ministry for women's affairs and development and women were very well represented in political life and at all levels of Government.

With the help of international partners, his Government was meeting the health needs of the internally displaced population and intended to resettle them within six months. Traditional ayurvedic medicine had been integrated into the health system and there was even a separate ministry for traditional medicine. The health system was financed by the private and public sectors, 52 and 48 per cent respectively, with approximately 5 per cent of the public share coming from external sources.

He stressed that Sri Lanka had cultivated a system based on free education and health care and universal suffrage and democracy since the 1930s. It also benefited from a culture that had always valued good health practices, encouraged by traditional leaders, even before the introduction of Western medical practices.

Mr. Mettan, Moderator, thanked participants for a most instructive exchange. He invited Sudan to make its presentation to the Council.

Mr. Salih Fedail (Sudan) thanked the Council for its support for Sudan's efforts to meet the many challenges it faced and for the opportunity to make a presentation. He stressed however that challenges could also provide opportunities; the end of the conflict in the south of Sudan had for example provided an opportunity to promote development and strengthen education and health care.

He affirmed his Government's commitment to peace as the foundation for development in all areas of Sudan. Even in areas torn by conflict his Government had made every effort to mitigate the effects of conflict; for example, it was thanks to such efforts that there had been no epidemics in Darfur. Assistance from the United Nations was essential to help manage the post conflict situations in Sudan yet less than a third of the assistance promised following the 2005 peace agreement in the south had been provided. Likewise, although nearly 5 billion dollars had been promised at the 2008 Oslo donors' conference, to date very little had been received. He said that the Sudanese people should be able to live in peace, but required international assistance to achieve that goal.

Ms. Al Basher (Sudan), accompanying her statement with a computerized slide presentation, recalled that Sudan was a large country that shared generally open borders with nine countries; its population was scattered across the territory with few major population centres. There was massive internal movement of populations caused by conflict, drought, desertification and flooding. There was a high rate of illiteracy, especially among women and there was a generally low level of awareness of health issues.

The health system was divided into three levels: the federal government formulated policies and strategies, mobilized resources and was responsible for monitoring, coordination, training and external relations; the 25 States implemented national policies based on federal guidelines using federally supplied funding; the more than 200 local and district governments implemented national and state policies and ensured delivery of primary health-care services.

Expenditure for health care was low, approximately 5 per cent of the national budget. The health-care system was fragmented, with multiple providers. Her Government had however established Health Coordination Councils at all levels of the health system, with representatives from all health-care partners, to improve coordination, oversee policy development and monitor implementation. There was a serious lack of health-care personnel, with only 1.5 health-care providers per 1,000 population. Many more doctors, nurses, midwives and other health workers were needed. The situation was further exacerbated by high turnover rates, in particular for doctors, and by the concentration of health-care workers in Khartoum State. In the other States the percentage of the population living within 5 km of a health facility ranged from 32 to 98 per cent.

Turning to the specific Millennium Development Goals, with regard to Goal 1, eradicate extreme poverty and hunger, she said that the percentage of children in the various regions who were severely underweight ranged from just under 4 per cent to 20 per cent, with a national average of 9.4 per cent. As for Goal 2, achieve universal primary education, she said that primary-school attendance rates ranged from approximately 12 per cent to 95 per cent, with a national average of 53.7 per cent. An average of 90.3 per cent of children reached grade 5 nationally, with rates ranging from 10 to nearly 100 per cent across the country. In the related area of Goal 3, promote gender equality and empower women, the ratio of girls to boys in primary education was 0.93.

As for Goal 6, combat HIV/AIDS, malaria and other diseases, she said that only 4 per cent of the population had adequate knowledge of how to prevent HIV transmission; at the national level an average of 49.4 per cent of children under 5 slept under insecticide-treated nets, with averages around the country ranging from 28.8 per cent to 82.5 per cent. With regard to ensuring environmental stability, Goal 7, she said that 56.1 per cent of the population had access to improved drinking water, with regional averages ranging from approximately 22 to 80 per cent; the national average for access to sanitation facilities was 31.4 per cent, with regional averages from 12 to 83 per cent.

The statistics she was quoting were taken from the Sudan Household Health Survey 2006, which was in fact the only source of nationwide data available. Previously only regional data had been available. That lack of data, especially updated data, made it difficult to measure trends and indicators. Turning to Goal 4, reduce child mortality, she said that child mortality ranged from 52.37 to 150.7 per 1,000, with a national average of 80.77; under-five mortality ranged from approximately 60 to 200 per 1,000, with a national average of 112.18.

As for Goal 5, improve maternal health, she said that there was little use of contraceptives, ranging from 2.1 to 22.4 per cent by region, with a national average of 7.8 per cent. On average 58.1 per cent of births were attended by qualified personnel, with rates ranging from under 20 to nearly 100 per cent. In that regard she

explained that the level of training provided to midwives in Sudan was not sufficient to qualify them as skilled birth attendants. The national maternal mortality rate, 1,106.7 per 100,000, was the highest in the region and one of the highest in the world, with rates across Sudan ranging from 93.6 to 2,327.2.

In order to improve that situation her Government was implementing various national health, reproductive health and child health policies. It had for example begun offering free life saving care for children under 5, childbirth and cases of Caesarean section. It was also revising training programmes for midwives to qualify them as skilled birth attendants: students could train for two years to become midwifery technicians or follow a full 4-year qualifying programme. Until such time as all midwives were skilled birth attendants, the current midwife system would continue in order to avoid a reduction in coverage for attended births.

A number of initiatives were under way to improve child and maternal health care. Under the United Nations Children's Fund (UNICEF) Accelerated Child Survival Initiative (ACSI) jump-start and pulse campaigns, children and women of childbearing age would be provided with interventions in such areas as vaccinations, nutritional supplements and health education. A project for sending mobile health clinics to underserved areas had been launched and more than 200 hospitals and health centres were being modernized. A project to provide centralized ambulance service had likewise been launched in various districts and 115 ambulances were currently operating.

There was a growing political commitment to maternal and child health. A Higher Council for Child and Maternal Mortality Reduction had been created, which included representatives from all stakeholders and similar councils had been established in the individual Walis, or States. Much more support was however required from international partners, including with regard to coordination and allocation of meagre resources. A workshop had been held in February 2007 to make recommendations on how to improve maternal and child health.

Effective interventions to reduce maternal mortality did exist: at Omdurman Maternity Hospital, for example, the maternal mortality rate had been reduced from the equivalent of 216 per 100,000 births in 2003 to 28 per 100,000 live births in 2007. She therefore called on the international community to help Sudan provide effective health care to all mothers and children and in so doing pay tribute to those Sudanese who had died earlier than they should have.

Mr. Chen Zhu (China) noted with appreciation the efforts made by Sudan to prevent and control infectious diseases and to improve individual health. It had made considerable progress towards achieving the health-related MDGs, in spite of the problems it faced in terms of infrastructure and human resources. Much effort was still needed to build up its medical services. China's experience had shown that reform and economic growth did not automatically lead to health-service developments. Sudan should make use of its current economic opportunities to improve its health-care and health institutions, and to build basic health-care services. That would enable it to deal with new infectious diseases and to control chronic diseases. What percentage of gross domestic product was accounted for by physical inputs into Sudan's health service, and how were medical professionals distributed among the population? The international community should increase its assistance to Sudan to overcome the problems it was facing in the health sector.

Mr. Jazaïry (Algeria) said that although it had made some progress, as in the matter of access to clean drinking water, Sudan continued to face problems in achieving the MDGs, and especially in overcoming poverty. In the north of the country about 50-60 per cent of the population were poor, and the figure was much higher in the south. Maternal mortality remained high, and the country had difficulty providing adequate health services for a scattered population. Nevertheless, he paid tribute to the great efforts made by the Government in adverse circumstances, and expressed full support for its national development strategy and its five-year medium-term development plan for the period 2007-2011. The conflict in Darfur had distracted the Government's attention from the need to reduce regional disparities and levels of poverty, and had slowed development. He encouraged it to pursue its efforts to eliminate poverty and hunger and its goals of achieving universal primary education, gender equality and women's rights, reducing infant mortality and improving maternal health, combating HIV/AIDS and other diseases, preserving the environment and creating an international partnership for development. The benefits of the remarkable

increase in gross domestic product, 11 per cent in 2007, had not been evenly distributed so as to bring about a lasting reduction in poverty. Additional financial resources must be devoted to making good the shortage of institutional and human capacity and ensuring universal health coverage, improved access to health care and improvements in the health system itself. The international community must provide Sudan with sufficient assistance to meet the challenges mentioned in its report.

Mr. Pino Álvarez (Observer for Cuba) said that in spite of the conflict which had devastated the country for many years, the Government of Sudan had made great efforts to eliminate poverty, reduce maternal and infant mortality and combat infectious diseases, including HIV/AIDS. Political will was the key to achieving the MDGs. In the developing countries, official development assistance and international cooperation were also important means of achieving them. In which specific areas of its health programmes would Sudan benefit from more international cooperation and resources? He welcomed the information given in the slide presentation about the mobile clinics project, which would be a good example for other developing countries to imitate. How did it work in practice?

Mr. Miyagawa (Japan) suggested that the United Nations Trust Fund for Human Security (UNTFHS), which had carried out a number of projects through the United Nations Development Programme, could be of assistance in launching a "safe motherhood" project in Sudan through the United Nations Fund for Population Activities (UNFPA). In the view of the Government of Sudan, would such a project be viable?

Ms. Basilio (Philippines) welcomed Sudan's policies for improving nutrition. She noted that its expanded immunization programme now reached a commendable 83.9 per cent of its population. She also welcomed the reforms which had been put in place to enhance the skills of health personnel, such as the revised curriculum for trainee midwives. She encouraged the Government of Sudan to continue cooperating with the international community and the various United Nations agencies in its efforts to improve the health of its people.

Ms. Bered De Corms (Brazil) said Sudan's difficulties in improving its health sector were understandable, given its vast territory and the scattered nature of its population. She hoped it would persevere in improving access to health services, and especially in pursuing the MDGs relating to infant and maternal mortality. What additional measures could the international community take to help Sudan in those areas?

Mr. Hackett (Barbados) said Sudan had chosen its priorities wisely in focusing on the delivery of primary health care, and had made remarkable progress in spite of the enormous challenges facing the country. The Council should perhaps call for a wider partnership between Sudan and the international community as a means of helping it to achieve the health related MDGs.

Mr. St. Aimee (Saint Lucia) recalled that Sudan, presiding at the recent summit meeting of the African Union, had emphasized the need for security within the country. A preventive approach to nutrition and education would also help to improve security.

Ms. Aitimova (Kazakhstan) said that Sudan was making heroic efforts to alleviate its social needs in spite of grave insecurity. She endorsed the appeal by its delegation to Member States to fulfil their commitments towards Sudan. Should the coordinated assistance sought by Sudan come primarily from the international community, or from United Nations agencies?

Mrs. Al Basher (Sudan), replying to the comments and questions from other delegations, said that coordinated support was needed for the health system from the agencies and programmes referred to in the slide presentation in the context of attracting external resources, such as the Global Alliance for Vaccines and Immunization (GAVI). Reducing maternal and infant mortality was high on Sudan's agenda. As for the distribution of health personnel around the country, Sudan had recently begun a process of "task shifting" with a view to ironing out the inequalities between areas and achieving universal coverage.

Mr. Salih Fedail (Sudan) added that the information provided in the report had been gathered in 2006, only one year after the end of a long war, and the interval was too short to make much difference. Moreover, some areas had been worse affected by the war than others, resulting in considerable variation in the findings across the country in all sectors, including health. The next household survey, due in 2010, would

provide new and reliable indicators. The Government was now striving to achieve balanced development. He appreciated Japan's contribution, and the form that contribution took should be the model for others.

Special event on Africa and the least developed countries: partnerships and health — matching health outcomes with human development

The President invited Mr. Diarra, Under-Secretary-General Special Adviser for Africa and High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States, to co-chair the Special Event on Africa and the Least Developed Countries, and Ms. Mafubelu, Assistant Director-General, Family and Community Health of the World Health Organization, to act as Moderator. He welcomed the panellists, Mr. Daraloy, Minister of Health of the Lao People's Democratic Republic and Mr. Yankey, Minister of Health of Ghana.

The President said that the United Nations system was particularly concerned by the health outcomes and development needs of Africa and the least developed countries (LDCs), which were not on track for meeting the target date for achieving the Millennium Development Goals (MDGs) by 2015. Slow progress on the health-related goals was undermined by critical gaps in all other development areas, owing in large part to fragile and fragmented health systems, a crisis in the health-sector workforce, and persisting inequalities in access to life-saving support.

The impact of the global economic crisis on public health would be felt even more keenly in Africa and the LDCs should official development assistance (ODA) and other financing for development decline. The shortage of skilled and adequately remunerated health workers required urgent attention, as did the need for sustained procurement of medicines and vaccines and reliable information systems for tracking health trends and epidemics. Effective health systems depended on user-targeted service delivery at every level, as well as equitable and participatory governance and the rational use of resources. The international community had a unique opportunity to maximize global partnerships to help Africa and LDCs respond to major health challenges. Multi-stakeholder partnerships were key to advancing the MDGs and ensuring a coherent and concerted response to health challenges.

Mr. Diarra (Under-Secretary-General, Special Adviser for Africa and High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States), said that the international community was well aware of the pressing needs of the poorest and most vulnerable countries as well as the enormity of the challenges facing them in pursuit of the health-related MDGs. Despite the steady progress made in that connection, and despite extraordinary coordination efforts, the broader MDGs would remain elusive without a sharp focus on the health needs of the poorest.

A candid discussion on the state of health care in Africa and the LDCs was central to any debate on global public health. Debate would focus on: the need to strengthen health systems; critical health access gaps necessitating the implementation of poverty-eradication and national development strategies for the MDGs; the crisis in the health workforce, exacerbated by the brain drain to richer countries; and the imperative for multi-stakeholder partnerships focusing on the needs of Africa and the LDCs. It was also vital that donor commitments should be honoured despite the global economic downturn.

The international community should pursue its response to HIV/AIDS, malaria and tuberculosis, yet not lose sight of chronic non-communicable diseases and disease brought on by climate change. The latter would only increase the already heavy burden on health-care systems in Africa and the LDCs.

The Council was in a unique position to act as a catalyst at the ministerial level by promoting implementation of the health-related MDGs and a vision of health care as an enabler of socio-economic progress.

Ms. Mafubelu (World Health Organization, WHO), Moderator, said that time was running out before the target date for the achievement of the MDGs, all of which impacted on public health. The international community should not lose sight of the fact that some 97 per cent of maternal morbidity and infant mortality cases occurred in the developing world, mostly in Africa and the LDCs. It was vital, therefore, to focus on: strengthening health systems; addressing access gaps; and maximizing partnerships. She encouraged the two panellists to restrict their presentations to five minutes in order to leave time to engage in interactive dialogue with Members.

Mr. Dalaloy (Observer for the Lao People's Democratic Republic) said that sustainable development in a globalized and post-industrialized world depended on integrated policies on health and the environment. Many countries had wisely invested in both despite the global economic crisis. Global health initiatives required appropriate resources, organization and infrastructure; however in developing countries, health systems and local participation remained fragile.

The Lao People's Democratic Republic had managed to build health capacity and achieve set targets thanks to the clear scope, comprehensive goals, appropriate strategies and implementation arrangements of the Global Fund to Fight AIDS, Tuberculosis and Malaria working at country level. The Government, for its part, had done its best to promote a spirit of ownership, transparency, efficiency and accountability. However, constraints included a lack of integration of global health initiatives within the country's own health system, a weak sense of ownership, difficulties harmonizing criteria with other countries, and problems with the composition of the country coordinating mechanism.

The situation was complicated by the fact that the country had a small, multi-ethnic population with diverse levels of development, languages, customs and ways of life. Some 80 per cent of Lao people lived in rural, mountainous and remote areas difficult of access. In the post-conflict transitional period, poverty was still rife owing to lack of market access and inadequate education and health provision. Local superstition and taboos further complicated efforts to address health emergencies. There was a vital need to strengthen health literacy to deal with pre-existing as well as the emerging health challenges associated with changes in lifestyle. Information, education and communication were key to enhancing local participation and strengthening health systems from the "bottom up". Strategies had been devised to put an end to slash-and-burn agriculture and promote rural development. Agriculture, Communication, Education and Health had been identified as the country's development pillars, and health as vital to reducing poverty and superstition. A Healthy Model Village project focused on the mother and child in families and schools and involved providing village medicine kits to volunteers from nomadic communities, replacing traditional birth attendants with skilled midwives, providing family planning and antenatal care, and promoting breastfeeding, Integrated Management of Childhood Illness, clean water and sanitation. As part of efforts to encourage healthy living, people were advised not to engage in animal husbandry under or inside homes and to use impregnated bed nets for preventing malaria and dengue fever. Malnutrition would be tackled as part of initiatives to prepare for natural disasters and epidemics, with health literacy and local participation being crucial to that end. Schools, civil society, religious leaders, opinion makers and the media also had a critical role to play in conveying public-health messages.

The child health MDG was achievable for the Lao PDR, whereas the maternal health MDG remained a serious challenge owing to the need to complete the training of midwives. Although the Lao health system was organized correctly, there continued to be a severe shortage of skilled personnel especially at the village level. Technical and financial support were required to strengthen the public health system and his Government was ready to cooperate with new global health initiatives to that end.

Ms. Mafubelu, Moderator, invited the second panellist, Dr. Spia-Adjah Yankey, Minister of Health of Ghana, to make his presentation.

Dr. Spia-Adjah Yankey (Observer for Ghana) said that Africa and the rest of the developing world would have to make strategic use of science and technology in order to achieve the MDGs. Technology could be seen as the application of knowledge in order to meet basic human needs. There had been dramatic strides in basic and advanced medical knowledge, treatments and technologies, but the question was whether those developments had enhanced health-care delivery to all and, if not, how they could be so applied. While such advances had improved health care in developed countries, it was not clear that the same could not be said for Africa and the rest of the developing world. Many children continued to die from preventable and easily treatable diseases, and mothers continued to die in childbirth and from diseases long eradicated in some parts of the world.

Hope for Africa and other developing countries lay in their ability to appreciate the relevance of simple, currently available technologies for their health policies and programmes. Obviously, the reason why those nations were struggling to meet the MDGs was

because they lacked the resources to acquire and deploy the necessary technology. The huge disease burden facing the LDCs drained their resources, yet there was no option other than to spend more on disease control. In Ghana, malaria alone cost the country 732 million dollars every year, including the cost of treatment and the related losses to the economy. Development of health infrastructure had lagged behind because of an inability to invest more in the sector, and that situation had been aggravated by the global recession. Many communities continued to lack basic health services and that seriously interfered with the country's ability to meet the MDGs.

The world had woken up to the need to support Africa and LDCs in their efforts to develop health systems and deploy disease-specific interventions. Global health partners had been very helpful in providing Ghana and other countries in Africa with financial and technical support, and they were to be commended for their efforts. They should now perhaps take a second look at how they could best support those countries in developing their health systems, since without such systems there was no foundation from which to tackle specific diseases.

The time had come for Africa and the LDCs to use the full range of available technologies to attain the MDGs. Simple technologies, such as insecticide treated nets and malaria vaccines now on trial, could be used to contain diseases that were killing children all over Africa and thus reduce infant mortality. In Ghana, one third of all deaths of children under 5 were malaria related; thanks to the large-scale use of such interventions, the infant mortality rate fell between 2003 and 2008 by 30 per cent; and, if interventions were stepped up, it could be reduced much further. Ghana was also working to promote community health-planning systems that involved the local population in the provision of health care to rural areas. Compounds had been set up in rural areas where health workers undertook outreach activities and provided treatment; and plans existed to build 1,000 compounds countrywide over the next few years.

Ghana was also making progress in combating AIDS: thanks to its efforts to educate people about the disease, people were more willing to seek treatment and to take protective measures. Under the National Health Insurance Scheme, the payment of a small yearly fee gave people access to treatment and medication free of charge, and there were plans to shift to a one time premium soon. Thus, Ghana was working to build a scheme to make health care available to all. It also was running a programme to encourage lifestyle changes to help protect against non-communicable diseases.

Yet the problems Ghana faced were formidable, and resources were insufficient to deal with them, so that it would continue to rely on its global health and donor partners' assistance. It was requesting the developed countries to support Africa and LDCs in their efforts to meet the MDGs and bring better health to their people, thereby enabling Africa and the LDCs in turn to support the advanced countries in protecting the future of the world.

Ms. Mafubelu, Moderator, invited Mr. Leisinger, President and Chief Executive Officer of Novartis Foundation for Sustainable Development, to comment on the issues raised in the preceding presentations. Mr. Leisinger's extensive professional experience in Africa and outstanding academic work on health and social policy for LDCs placed him in a unique position to provide input for the present debate.

Mr. Leisinger (Novartis Foundation for Sustainable Development) said that remarkable progress had been made in the past decade in improving the health of the poor in low- and middle-income countries through a coalition of motivated actors from the international community, United Nations agencies, organizations such as the Global Fund, Governments, NGOs and the private sector. However, the advances had not been equally distributed among or within countries. Differences in governance, in the allocation of scarce resources and in cost effectiveness had led to significant disparities in health-development performance. Moreover, many rich countries had not lived up to their commitments. In view of the impact of the current crisis and the fact that the world's population would grow by 3 billion people in the next 50 years, there was reason for concern that insufficient progress would be made.

It was therefore important to apply best practices and lessons learned, to be aware of the responsibilities of developed societies, and to optimize cooperation in order to take advantage of synergies and the range of available resources, skills and experience. The private sector was expected to be part of the solution by competing with integrity and ensuring environmental sustainability, while maintaining profitability. The

pharmaceutical industry's role in combating poverty and helping to achieve the MDGs involved the development of better medicines and new vaccines. Enlightened companies would offer preferential pricing systems for essential drugs and would contribute pro bono research and funding, while enlightened nations would give incentives to companies that delivered much-needed solutions in cooperation with other actors. If all actors were to "walk as they talked" at international conferences and in their public statements and were to cooperate in good faith, the MDGs would be attainable.

Ms. Mafubelu, Moderator, invited Mr. Boyd, Acting Director General of the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), to comment on the challenges and opportunities facing the international and local pharmaceutical community in sub-Saharan Africa and LDCs.

Mr. Boyd (IFPMA) said that over the last decade the links between the developed world and Africa, especially in the area of health, had been growing stronger, and the research based pharmaceutical industry's involvement in improving health in LDCs had been growing similarly. Between 2000 and 2007, pharmaceutical companies had provided enough medical assistance to reach 1.75 billion people, mostly in Africa, and in 2005 had provided assistance valued at US$ 1.5 billion, equivalent to 11 per cent of all health development aid supplied that year by all OECD Governments.

The industry was running a large number of programmes in different countries: in Uganda, for example, it was providing antiretroviral medicines at preferential prices and was running programmes to prevent mother to child AIDS transmission, treat affected children and teach African health workers to treat the disease effectively. Throughout Africa, the industry had programmes to combat malaria and other tropical diseases. Its research and development efforts regarding developing-world diseases were also on the rise: in 2005, pharmaceutical companies were working on 32 new medicine projects for the 10 main diseases of the developing world; and in 2009, the number of projects had climbed to 75. Pharmaceutical firms had also been starting up programmes to address child and maternal health and chronic diseases and were working to strengthen primary health care and health infrastructure in Africa through capacity building and other initiatives.

Mr. Omaswa, (Executive Director, African Centre for Global Health and Social Transformation (ACHEST)) said that poor people in Africa commonly cited poor health as both cause and consequence of their poverty. A healthy body was often the only asset a young man or woman possessed to support themselves and their dependants. The time lost through personal and family illness should instead be used to increase economic productivity and educational opportunity and to engage in social activity. The disease burden in Africa from both chronic and acute illnesses was incredibly high. As a former member of a group of surgeons travelling to remote rural hospitals to hold surgical camps, he recalled being overwhelmed by patients with deformities, women with fistula and huge uterine fibroids, and young children with grotesque untreated birth defects. Such people accepted the frequent deaths in their communities as normal, even seeing them as acts of God. But those deaths represented failures in the health system; they did not occur in better organized societies such as Japan. Achieving the health-related MDGs meant transforming the mentality which saw them as inevitable.

He suggested several interventions to secure better health outcomes in Africa. First, there must be a vigorous advocacy campaign to reject rampant ill-health and premature death and to support strong pro-poor health systems. Second, Government leadership and stewardship in the health sector must be strengthened, and ministers of health be enabled, through institutional reform, to take command of the sector. Third, the health workforce in African countries needed urgent attention, so as to build up a critical mass of appropriately skilled health professionals who would serve in rural areas and be well paid for their work. Lastly, the financing instruments for channelling funds to health programmes should support both the integrated delivery of individual and public health care, and the capacity for planning, implementation, monitoring and evaluation. In addition, countries should find innovative ways to raise local funds for priority health programmes.

Mr. Kazatchkine (Executive Director, the Global Fund) said the enormity of the disease burden in Africa fully justified the Council's special attention to the continent. Two thirds of the 33 million people with

HIV/AIDS lived in Africa, as did three-quarters of all those living with an AIDS-related disease, 33 per cent of women with HIV/AIDS and 90 per cent of AIDS-infected children. The Global Fund had already allocated US$ 9.2 billion in grants to 40 countries in sub-Saharan Africa to fight HIV/AIDS, malaria and tuberculosis. It was also supporting 75 per cent of people in Asia undergoing treatment for HIV/AIDS. As a result, there had been significant decreases in mortality from all three diseases in the past three years. Reductions in mortality from malaria in over 10 endemic countries in sub-Saharan Africa ranged from 40 per cent to 80 per cent, and owing to the expansion of the DOTS programme treatment rates for tuberculosis had doubled over the past five years.

The world economic and financial crisis now posed a grave risk that donors might renege on their commitments and that developing countries would be unable to maintain their own social investments. That would jeopardize the prospects of treatment for HIV/AIDS for the 4 million people still in urgent need, and the programmes for increasing the provision of bednets and of ACT (artemisinin-based combination therapy) for all those at risk of malaria, and for expanding DOTS coverage and diagnosis of drug-resistant tuberculosis.

Among the lessons learned during the lifetime of the Global Fund were the feasibility of large-scale interventions against infectious diseases and the power of partnerships to make things happen. Partnerships worked well when the countries took the lead, designing their own national plans and strategies to be supported by the multilateral system and through working with the World Health Organization, the World Bank, UNFPA, GAVI and UNAIDS. Public-private partnerships could also be effective, and so could civil society and patient involvement and task shifting by the health workforce. It was important to strengthen the capacity of health systems and the health workforce to conduct monitoring and evaluation and procurement, to empower countries to help deliver health care and to build up social protection networks, focusing especially on health insurance. Of the Global Fund's resources, 35 per cent was being spent on support for health systems, and 25 per cent on support for the health workforce. The Fund was due to be replenished in 2010. In conclusion, he emphasized that reaching the health-related MDGs was by no means a utopian endeavour.

Ms. Skalli (Morocco) said that the development potential of the least developed countries was hampered by the shortage of funds from official development assistance (ODA), inadequate infrastructures, a low level of participation in world trade, increased vulnerability to climate change and the spread of endemic diseases. She urged the international community to fulfil its ODA commitments and its pledges to cancel debts and open developed-country markets to the goods of the least developed countries, especially those in Africa. Morocco had launched several partnership initiatives with African least developed countries in infrastructure, agriculture, health, education, transport and communications. It had cancelled its bilateral debts with all of them, and had given them duty-free access to its markets. She hoped that by the time the United Nations held its Fourth Conference on the Least Developed Countries in 2011, specific measures would have been taken to achieve their development objectives.

Ms. Kaur (India) said that the Delhi Declaration and the Africa-India Framework for Cooperation, adopted at the India Africa Partnership Forum Summit in April 2008, focused on the priority areas of health, food security, capacity-building, agriculture, infrastructure development and cooperation in technology. India had donated a dedicated satellite for e connectivity in sub-Saharan Africa, in order to provide quality tele-education and telemedicine. It served the pan-African e-network project, already joined by 30 countries, which would link 53 hospitals and 53 university centres in Africa to 12 specialist hospitals in India and 7 Indian universities, to provide online and offline medical consultations, diagnosis, medical education and clinical skill training every year to over 100 practising doctors and 200 paramedical staff in Africa. The Africa-India Framework for Cooperation aimed to strengthen cooperation in health through training and capacity-building for health professions; sharing experiences of health-care systems and community health programmes; linking centres of excellence in the health sector; enhancing universal access to adequate medical services through telemedicine infrastructure and technology; strengthening indigenous manufacturing capacities to make pharmaceuticals and essential medicines affordable and available; controlling HIV/AIDS, tuberculosis, malaria and other communicable diseases; and the local production of oral rehydration therapy and cooperation in combating counterfeit medicines.

India was the largest producer and exporter of generic drugs, and over 60 per cent of African imports of generic drugs came from India. Unfortunately, consignments of generic drugs manufactured in some developing countries and destined for others had recently been seized at European ports, so impairing their availability in the countries of destination contrary to the Doha Declaration on the TRIPS Agreement and Public Health, and the concept of territoriality in the TRIPS Agreement. She called upon all countries to respect territoriality as defined in the Agreement, and not to hinder critically needed improvements in public health. India stood ready to cooperate with African countries in strengthening their drug regulatory authorities. Anti counterfeit legislation should not be allowed to impact adversely on the availability of genuine, affordable generic medicines.

Mr. Abdalhalee Mohamad (Sudan) referred to the increased globalization of health problems, in light of the fact that most of the least developed countries, being those most at risk, were in Africa. Special attention should be given to the development of traditional medicines and the promotion of indigenous medicinal and aromatic plants. Other key aspects were communications, satellite connectivities and telemedicine. Achieving the health-related MDGs should be a standard item in all conferences dealing with the MDGs, and should feature on the agenda of the Fourth United Nations Conference on the Least Developed Countries.

Ms. Matsau (Observer for South Africa) emphasized the importance of improving health systems. E-health was a valuable tool for that purpose, but required careful coordination of telecommunications and clinical equipment in different places. Progress had been made in reducing the prices of essential medicines, but it was important that drugs should be manufactured locally wherever possible. Another question for debate was the patent legislation on drugs; there was no good reason for research-based drugs remaining in patent for as long as 20 years. Finally, the progress made by developing countries in training health personnel was being undermined by their recruitment for work in developed countries. The WHO code of practice on the international recruitment of health personnel should be respected.

Mr. Kazi (Observer for Bangladesh) said that the presentation by the Lao Minister of Health had made clear that the least developed countries had made some limited progress towards achieving the millennium development goals (MDGs), while emphasizing the need to engage with the international community in order to maintain momentum. The Ghanaian Minister of Health had also raised a highly pertinent issue, namely, that basic technology could empower people in poor countries. Bangladesh had direct experience of the fact that simple technologies, such as oral rehydration therapy or solar water filters, could protect and save lives on a vast scale.

However, while development assistance was a topic often discussed in the context of African and least developed countries, technology transfer was not. The international community could consider developing the capacities of those countries to engage in their own research and development activities. In that connection, the current negotiations on the Global Strategy on Public Health, Innovation and Intellectual Property should take into consideration the issue of Africa and least developed countries. Although the present discussion was focused on the MDGs deadline of 2015, least developed countries should keep in mind that the exemption that they enjoyed under Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement would expire in 2016. Ensuring universal access to medicines and developing the capacity of least developed countries to manufacture their own drugs were equally important goals to which the international community could lend its support.

Lastly, the speaker pointed to a positive aspect of the migration of health professionals, namely, that it could create diasporas that could be used to mobilize expertise and resources, to the benefit of their country of origin.

Mr. Kenneth (Observer for Kenya) said that the present meeting was an important platform from which to lobby for the needs of people in African and least developed countries and should be repeated. The panellists had all agreed on the issue of resources; a strong message must be sent to the Group of Eight (G-8) and Group of Twenty (G-20) countries that substantial additional resources, comparable to the bailout facility offered to private sector companies, was needed in order to achieve the MDGs. When the resources had been available, as in the case of Ghana, significant progress had been made. It was the responsibility of the middle-income and developed countries to put together such a facility in order to

address the problems of Africa and the least developed countries.

Mr. Mwakyusa (Observer for the United Republic of Tanzania) said that the meagre national budgets of many developing countries in sub-Saharan Africa depended on donor funding; health was often not a priority. The Abuja Commitment had set a target of 15 per cent for national health budgets; currently, health spending in his country had reached 11.6 per cent of the national budget. It was important to emphasize the need for self-reliance in that regard: donors provided more than 38 per cent of the health budget in his country despite the introduction of a number of fees, schemes and funds.

It was also important to spend the scant resources effectively, efficiently and with the maximum transparency. Sub-Saharan African countries had their own plans, programmes and agendas and sought to bridge the budget gap with donors in order to increase their capacity. Donor countries should recognize and exploit the considerable local knowledge and existing structures in those countries and ensure that their donations were spent accordingly, in the recipient country.

Mr. Chebihi (Algeria) said that the world's poorest populations were suffering the consequences of the global financial and economic crisis more keenly than others. The crisis had revived the spectre of exclusion, extreme poverty and hunger, eclipsing the hopes of recent years and making the lives of a billion people yet more precarious. The means available to the least developed countries to achieve the MDGs continued to shrink, with the rise of protectionism, the contraction of development assistance, the growing scarcity of credit and the decline of remittances. The countries concerned faced many difficulties, not least a lack of solidarity on the part of their development partners. Algeria welcomed with any action to counter the negative effects of the global crisis on Africa and the LDCs and appealed to the developed countries to demonstrate greater commitment to achieving the MDGs, which were essential to a more stable, fair and equitable world.

Mr. Albuquerque (Portugal) emphasized the importance of convening a special event on Africa and least developed countries with a focus on health systems. Development aid alone was insufficient to achieve the MDGs; progress was being obstructed by shortages of human resources and the brain drain of health workers, especially in sub-Saharan Africa. His country considered cooperation on health to be a key element of overseas development assistance and had established the Strategic Health Cooperation Plan for the Community of Portuguese Speaking Countries 2009-2012 (PECS-CPLP) in June 2008.

In partnership with the Portuguese College of Physicians, CPLP had launched an important initiative by establishing a centre for specialist medical training in Cape Verde, which would offer further education and training for doctors and health workers as well as certification in clinical techniques and technology transfer. Such partnerships could be a creative and cost effective way of going beyond the limitations of official development assistance.

Mr. DIARRA (Under-Secretary-General, Special Adviser on Africa and High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States) said that most of the 68 priority countries accounting for maternal and infant deaths were African and least developed countries. Although health issues were covered by MDGs 4, 5 and 6, all MDGs were interlinked and should be addressed simultaneously. African and least developed countries had to contend with a considerable burden of diseases and other health challenges with meagre resources. Although medical technology had advanced substantially in recent years, progress was unevenly distributed between and within countries. Moreover, commitments in terms of assistance had not always been delivered.

There was a need for strong leadership at the national level to make good policy choices and exercise ownership of those policies. In addition, communities should be involved at all levels in organizing structures for health-care provision, raising awareness, prevention and health literacy. Furthermore, pro bono research and development should be promoted and low-cost medication should be developed. In that connection, he commended the contribution made by the Global Health Council to more than 3 million people living with HIV/AIDS and for contributing 30 per cent of its resources to Africa.

There was a continuing need for pharmaceutical industries to be mobilized to focus on tropical and neglected diseases. Two related issues concerned the development of generic drugs by other developing

countries and the need to discuss the issue of drug patents, in the context of developing local manufacturing capacity. At the same time, emphasis should be placed on the reinforcement of health systems, to include health providers, resources, infrastructure and consumables. Efficient use should be made of health technologies, including the basic ones. Prevention capacity and social nets for vulnerable people should be expanded and partnerships including public-private, bilateral, multilateral and civil society partnerships should be strengthened. Finally, he commended the commitment of certain developing countries, including Morocco and India, to supporting African and the least developed countries.

The meeting rose at 2.10 p.m.