

**KEYNOTE SPEECH TO THE COMMONWEALTH HEALTH
PROFESSIONALS MEETING
COMMONWEALTH PEOPLE'S FORUM, KAMPALA
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Ladies and gentlemen,

It is a pleasure to be here and to have the opportunity to address you this morning. I bring you greetings and apologies from my fellow Director, Ann Keeling, who was scheduled to give this Keynote Address. Ann is unable to be here due to the ill health of her mother and has asked me to deliver this address on her behalf.

Ann asked me to begin this morning by paying tribute to Julia Champion from the Commonwealth Dental Association, who was one of the organisers of this meeting. Sadly, Julia died suddenly a few days ago and her death came as a great shock to Commonwealth Secretariat colleagues who had worked closely with Julia for many years. Julia worked tirelessly for the CDA and for health in the Commonwealth and will be sorely missed. Our sympathies are with Julia's family, friends and colleagues.

Now let me turn to the presentation today. This promises to be a very exciting week in Kampala. A meeting of Commonwealth Heads of Government is always a significant and influential gathering but this week a new Commonwealth Secretary General will be chosen, and directions will be set for the Secretariat's new Strategic Plan 2008 - 2012. As ever, the policy agenda for CHOGM is a crowded one. We expect that Heads will discuss climate change, trade, education, and respect and understanding – and we

know that health is relevant to all of those. We also expect some Heads to raise Non Communicable Diseases, which was the theme of this year's Commonwealth Health Ministers Meeting and a subject I will return to.

And we know that the Millennium Development Goals will be high up on the agenda at CHOGM because member states have asked the Secretariat to draft a separate statement on the MDGs for the CHOGM Communiqué. This is both timely and appropriate. Timely because we are now at the half way point to the MDG end date of 2015, so this is the right time to take stock. And it is appropriate because the 53 countries of the Commonwealth are critical to achievement of the all the MDGs but particularly those in health. Our 53 Commonwealth countries with 1.8 billion people bear a disproportionate burden of global poverty, ill health and deprivation. The Commonwealth is home to one-third of the world's population but two-thirds of global HIV/AIDS cases, two-thirds of maternal deaths, two-thirds of children under 5 suffering from malnutrition, and nearly half of infant deaths in the world. And that burden of suffering is concentrated in Sub-Saharan Africa and South Asia – and borne most heavily by women and children.

This is why the Secretariat adopted the MDGs as the overarching framework for our development work and the reason why Heads of Government will pay very close attention this week to progress made on the MDGs. As you will know, three of the MDGs are health specific – covering maternal and child health, HIV/AIDS, Tuberculosis and Malaria – and at this midway point to 2015, they are seriously off track in many countries. Achievement of the health related MDGs globally, will be made or broken in the Commonwealth.

At the Secretariat our approach is to support health systems strengthening rather than take a narrow focus on particular diseases. We know that health is a development issue and therefore cannot be separated out from other

MDGs covering income poverty, gender equality, education or the environment. It is a major concern that income inequality is increasing in many low income and middle income countries with the result that gains from economic growth are not necessarily reflected in better health and life chances for the poorest. Poverty remains the single greatest killer in the Commonwealth, with differential life chances between rich and poor starkly reflected in maternal mortality statistics.

As we approach the MDG target date of 2015 none of the poorest regions of the developing world is currently on track to reduce maternal mortality by three quarters and child mortality by two thirds by the target date of 2015. And these are not ambitious targets. They do not say 'eradicate maternal and child mortality', only that deaths should be cut by a percentage. We have 300,000 largely preventable maternal deaths each year in the Commonwealth. The causes of these deaths are known and low cost solutions are available. The persistence of such unacceptably high maternal and child mortality remains a serious challenge not only for national governments but also the international community. We know that the low social status of women and girls is a strong contributory factor in maternal and infant deaths. I am pleased to note therefore that the Secretariat also works on the MDGs to promote quality education for all children, equality between women and men, the rights of women and girls, and poverty alleviation. Our work in conflict resolution and good governance also helps to provide the socio- political environment conducive for health and health care delivery.

At this mid point in the MDG cycle, the Commonwealth still faces major challenges in health but there is good news: 50 of the 53 countries of the Commonwealth have eradicated the wild Polio virus, of the remaining three, India and Pakistan are making excellent progress. We believe that a Polio

free Commonwealth is within sight. Secondly, a number of countries in Africa, including Uganda, have made serious inroads into the spread of HIV/AIDS. In the last 5 years the percentage of infected Commonwealth people receiving anti retroviral treatment has increased from 2% to 28%. Those figures are nowhere near good enough but they are moving in the right direction.

In the Secretariat, one of our greatest preoccupations in health is the shortage of trained health workers. Last year the World Health Organisation estimated there is a global shortage of 4.2 million trained health workers and that 17 Commonwealth countries face critical health worker shortages. We estimate that the Commonwealth needs at least another 2 million health workers if it is to meet the three health related Millennium Development Goals. Health worker migration within the Commonwealth is a longstanding tradition. But a global shortage combined with rising demand for health services both in the poorest and the richest countries has fuelled migration of health professionals from rural to urban areas, from the public to the private sector and from developing to developed countries. The Commonwealth countries with the highest burden of disease and most vulnerable health systems have been at the end of this migration food chain, with catastrophic impact on health services. Health worker shortages in key countries have impeded the roll out of Anti Retroviral Treatment in some countries with epidemic levels of HIV/AIDS. Elsewhere in Africa particularly, health sector reforms and structural adjustment programmes have led to public sector recruitment and pay freezes making it impossible to hire much needed health workers. Some countries have been exporting unemployed health professionals whilst having severe domestic shortages. Elsewhere, health workers have been lost to HIV/AIDS and others simply lost to the profession, unhappy with terms and conditions, or lack of professional development

In 1998 Commonwealth Health Ministers raised concerns about health worker migration and asked the Secretariat to study trends. This work led to the Commonwealth Health Ministers adopting a Commonwealth Code of Practice for the International Recruitment of Health Workers in 2003 which aims to balance the rights of health workers to migrate with the right to health of the people left behind in their country of origin. The Code is sensitive to the needs of the recipient countries and the regulatory rights of the individual health professionals. It proposes an ethical framework within which recruitment should take place. In the Secretariat, we recognise a positive and enabling working environment as very much part of the rights of the internationally recruited health worker.

The 2003 Commonwealth Code has been the basis for several bilateral agreements between Commonwealth countries on recruitment, which we believe is a positive outcome. It has also influenced the development of regional codes. A new Code recently agreed by Pacific countries draws heavily on the Commonwealth Code. The Commonwealth Secretariat sits on a high level Global Policy Advisory Council on Health Worker Migration which is drafting the framework for a Global Code for the 2009 World Health Assembly. We expect that Global Code to be heavily influenced by the Commonwealth Code.

Ethical recruitment of health workers is critical but there is also an urgent need to plug that 4.2 million hole in global health worker numbers, or else we will just continue to move the same scarce resource around the world with inevitable consequences for low income countries. The Secretariat is supporting work to scale up health worker numbers in partnership with the Global Health Workforce Alliance, and will be part of a major meeting in Kampala next March when we hope that the recommendations for scaling up health worker numbers will be adopted as concrete plans with funding

attached. We hope that the Commonwealth professional and civil society associations will be part of this major initiative.

Next, I want to mention some major challenges already with us or on the horizon that impact upon our work in health.

The first of these is urbanization. This year for the first time in history, the number of people living in cities has equaled the number living in rural areas. At the same time, it is estimated that one third of the 3 billion people living in cities globally are living in slums. The Commonwealth contains some of the world's largest cities and some of the world's most deprived slum areas. Urbanisation changes the context for health care delivery and also the pattern of disease. In particular, environmental pollution in many major Commonwealth cities is impacting negatively upon health. Breathing the air in the Indian city of Mumbai, for example, is the equivalent of smoking 30 cigarettes a day. Urbanisation presents us with both opportunities and challenges.

The second challenge, related to city living, is the increase in non communicable diseases such as diabetes, heart disease, stroke and cancers in low and middle income countries. These diseases, considered previously as diseases of the rich world, are now becoming endemic in poorer countries and are already the major burden of disease in India and China. Some of these diseases are largely avoidable by changes in lifestyle such as diet, physical activity and reducing tobacco consumption. Others, such as diabetes and specific cancers, are also related to incidence of other diseases such as HIV/AIDS. This increase in non communicable diseases is putting an additional burden on the poorest countries still struggling with infectious diseases and coping with high rates of injuries from causes such as road

traffic accidents.

The third challenge is posed by changing demographics. 68 countries globally have almost half their population aged under 16 years. Many low income Commonwealth countries are in this category with very young populations. We currently have the largest cohort of young people in history, particularly in Africa, providing a window of opportunity to invest in their future as healthy adults. In particular, there is an opportunity to put in place the sexual and reproductive rights and services they will need as young adults. Missing this opportunity will have serious consequences for their future health. At the same time, the richer countries of the Commonwealth have ageing populations requiring very different health services and social care. And it is worth noting that the most populous country on the planet, China, also has an ageing population.

These three challenges together will require resources and policy innovations to turn them into opportunities. The Commonwealth network of countries has the potential to share lessons between societies at different stages of development which may help countries avoid some of the pitfalls already experienced by others. This is very clear in the case of the lifestyle related non communicable diseases.

Finally, I would like to close by saying that it is imperative that as the Commonwealth we stick with the MDG agenda in health until the job is finished. And that will mean rapidly scaling up effort in most MDG health areas and focusing on strengthening health systems. A critical step will be expanding trained health worker numbers and providing incentives, as some countries have done, to get them into rural and remote areas where they are most needed. Meeting the health MDGs will also mean addressing the social determinants of health particularly, inequality and social exclusion and the

rights of women and girls plus the stigma and discrimination attaching to certain diseases such as HIV/AIDS. The WHO has established a Commission on the Social Determinants of Health which I hope that Commonwealth civil society organizations are engaging with, as it promises to be both authoritative and influential in this area. Finally, there is no doubt that health systems in the poorest countries need more resources to face current and future health challenges. The good news is that funds for health have increased through special funds such as GAVI and the Global fund for AIDS, and also through philanthropic organizations and the private sector. But not all countries in the G8 have made good their pledge to contribute at least 0.7% of their gross national income to overseas development assistance. These funds are still vital to meeting the MDGs in health. Recipient countries must also put in place the systems to use external funds effectively to target the health needs of the poorest people. As Commonwealth professional and civil society organizations you have a critical part to play in raising awareness of critical health issues both nationally and globally and in supporting delivery of health services. Your support and partnership is essential to the success of everything we do in the Secretariat Health Programme. I trust that Commonwealth Heads of Government will listen to the messages you send them this week in Kampala and that Health will continue to be a priority in the next Secretariat Strategic Plan. I will leave you with a statistic from the World Health Report of 2006:

A child born in Japan has a chance of living 43 years longer than a child born in Sierra Leone.

I wish you a successful meeting and say that we cannot rest until we have evened up the life chances of the poorest children on the planet.