Approved for tabling
SNA
14/11/18

REPUBLIC OF KENYA

THE NATIONAL ASSEMBLY

TWELFTH PARLIAMENT- SECOND SESSION 2018

THE NATIONAL ASSEMBLY
PAPERS LAID
DAY. Thursday
DATE: 15 NOV 2018
TABLED BY: Hon. Sabina Chege
CLERK-AT-THE-TABLE: Jerusha Moses.

DEPARTMENTAL COMMITTEE ON HEALTH REPORT

ON

THE 73RD SESSION OF THE UNITED NATIONS GENERAL ASSEMBLY

NEW YORK, USA

20TH – 30TH SEPTEMBER, 2018

Published by:-
The Directorate of Committee Services
Clerk's Chambers
Parliament Buildings
NAIROBI

NOVEMBER, 2018

Table of Contents

ABBREVIATIONS

AMR	Antimicrobial Resistance
CVD	Cardiovascular Diseases
HIV	Human Immunodeficiency Virus
MDR	Multi-Drug Resistant TB
NCDs	Non-communicable Diseases
NTSA	National Transport and Safety Authority
SDG	Sustainable Development Goals
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNGA	United Nations General Assembly
WHO	World Health Organization

1.0 PREFACE

Hon. Speaker,

This is a report of the delegation from the Departmental Committee on Health's trip to New York, USA for the 73rd Session of the United Nations General Assembly that was held from 20th – 30th September, 2018.
The Departmental Committee on Health received invitation from the Ministry of Health to form part of its delegation to the conference.

Hon. Speaker,

This year's Session had among others, two full days on Tuberculosis and Non Communicable Diseases. You will note that the National Assembly sent participation to the World Health Organization's First Global Ministerial Conference on ending Tuberculosis. This meeting was a precursor to the High-level UN meeting on TB, AND Kenya was well represented.

The delegation also attended the speech by H.E Uhuru Kenyatta, President of Kenya where he urged for inclusion of African countries as permanent members of the UN Security Council and the pursuit to combat illicit financial trade to alleviate poverty among other issues.

1.1 Delegation

The following Members of the Departmental Committee on Health comprised the delegation to the 73rd Session of the UN General Assembly;

i) Hon. Sabina Wanjiru Chege, MP – Chairperson/ Leader of the Delegation
ii) Hon. Stephen Mule, MP - Chairperson, African Parliamentarians TB Caucus
iii) Mr. Victor Weke Imbo – Clerk Assistant I/ Secretary to the delegation

Included in the wider delegation representing Kenya also included the Committee's counterpart in the Senate, Kenya Women Parliamentary Association and officials from the Ministry of Health and Office of the President.

1.2 Appreciation

Hon. Speaker,

In conclusion, the delegation is grateful to the Offices of the Speaker and the Clerk of the National Assembly for facilitating the trip. The delegation views such trips as important in learning of best practice in medicine and healthcare in general, especially in a fluid medical environment, and furtherance of Kenya's footprint in championing global agenda of the Sustainable Development Goals (SDGs). Resolutions and recommendations herein if adopted and domesticated will go a long way towards eliminating Tuberculosis and Non-communicable Diseases in the country.

Hon. Speaker,

Pursuant to Standing Order no. 199(6), it is now my pleasant duty to table the Departmental Committee on the 73rd Session of the United Nations General Assembly in New York, USA, 20th – 30th September, 2018, for consideration and adoption by the House.

Signed ..... **Date** 13/11/18

Hon. Sabina Chege, MP
Chairperson, Departmental Committee on Health

2.0 BACKGROUND

2.1 United Nations General Assembly (UNGA)

Established in 1945 under the Charter of the United Nations, the General Assembly occupies a central position as the chief deliberative, policymaking and representative organ of the United Nations. Comprising all 193 Members of the United Nations, it provides a unique forum for multilateral discussion of the full spectrum of international issues covered by the Charter. It also plays a significant role in the process of standard-setting and the codification of international law.

The Assembly meets from September to December each year and thereafter from January to August, when need arises. Also during the resumed part of the session, the Assembly considers current issues of critical importance to the international community in the form of High-level Thematic Debates organized by the President of the General Assembly in consultation with the membership. During that period, the Assembly traditionally also conducts informal consultations on a wide range of substantive topics, including on UN reform-related matters. It is against this backdrop that the 73rd Session held High-level meetings on Tuberculosis and Non Communicable Diseases.

Functions and powers of the General Assembly

The Assembly is empowered to make recommendations to States on international issues within its competence. It has also initiated actions; political, economic, humanitarian, social and legal, which have affected the lives of millions of people throughout the world. The landmark Millennium Declaration, adopted in 2000, and the 2005 World Summit Outcome Document, reflects the commitment of Member States:

- to reach specific goals to attain peace, security and disarmament along with development and poverty eradication;
- to safeguard human rights and promote the rule of law;
- to protect our common environment;
- to meet the special needs of Africa; and
- to strengthen the United Nations.

In September 2015, the Assembly agreed on a set of 17 Sustainable Development Goals, contained in the outcome document of the United Nations summit for the adoption of the post-2015 development agenda. SDG No. 3 intends to ensure healthy lives and promote well-being for all at all ages.

2.2 Tuberculosis

Tuberculosis (TB) is an infectious disease usually caused by the bacterium Mycobacterium tuberculosis. It generally affects the lungs but can also affect other parts of the body, and is the leading infectious disease killer worldwide today and one of the top 10 causes of death worldwide. It is spread through the air when infected persons cough, spit, speak or sneeze. The symptoms include fever, night sweating, loss of appetite, weight loss, fatigue and typically incessant coughing.

TB carries with it profound economic and social consequences. WHO's latest collated data in 2015 documents that 10.4 million people fell ill with TB worldwide, while 1.8 million people died from it.

Prevention of TB generally involves screening those at high risk, early detection and treatment of cases and vaccination for infants.

The fight against the disease has been complicated by Multi-Drug Resistant (MDR-TB); WHO's 2015 data captured that 0.5 million people developed MDR-TB. These are people that are resistant to treatment with at least two of the most effective first-line anti-TB medications, isoniazid and rifampin.

Kenya is among the 14 high burden TB countries in the world today. These are countries that account for over 80% of all cases worldwide. These 14 countries are rated on the basis of TB infections, TB/HIV infections and prevalence of Multi drug resistant TB.

The disease remains a major cause of mortality in Kenya, and has its greatest toll among the productive age group of 15 to 44 years. In Kenya, the major factor responsible for its high burden is the concurrent HIV epidemic. Moreover, high poverty levels and social deprivation has led to mushrooming of high density slums, providing fertile ground for its spread. Prison congestion, influx of refugees and limited access to general healthcare services have also conspired for this state of affairs.

TB prevalence in Kenya currently stands at 558 per 100,000 persons, with about 20% of victims having HIV/AIDS as well. Ministry of Health records indicate that about 4,735 people died of TB in Kenya in 2016, indicative of progress towards the fight against the disease.

2.2.1 The First WHO Ministerial Conference on ending TB

Although 49 million lives have been saved through global efforts since 2000, actions and investments fall far short of those needed to end the TB epidemic. Thus, a high level multi-sectoral action was envisaged to concert efforts towards combating the disease. It is towards these efforts that the first WHO global ministerial conference was held. It was

informed by the need to actualize the 'End TB Strategy' adopted by the World Health Assembly in May 2014. The strategy aims to reduce global TB incidence by 90% before the year 2035, and will be tackled through the following five steps;

- Successfully find and treat at least 10 million people for TB per year by 2022;
- Close the TB funding gap and ensure sufficient and sustainable domestic and donor financing
- Renew global support for TB innovation, including supporting mechanisms to fast track the development and uptake of new drugs, diagnostics, vaccines and interventions for TB
- Ensure all countries adopt and implement WHO standards and guidelines and adopt people-centered models of care
- Commit to a robust, independent accountability mechanism at the Head of State level to monitor progress towards ending TB.

Participants in this high level ministerial meeting held in Russia on 16th & 17th November, 2018 included Ministers of Health (and other sectors e.g. Finance, Social Development etc.), leaders of UN agencies, other development agencies and regional bodies. It also included Parliamentarians, NGOs, philanthropic foundations, civil society groups, affected people and communities, academic and research institutions and the private sector.

Based on the Sustainable Development Goals (SDG) agenda, WHO developed eight thematic areas for the conference to brainstorm on ways which will provide immediate action in addressing gaps in access to care and the MDR-TB crisis. These thematic areas resulted in the signing of the Moscow Ministerial Declaration on TB, to inform the UN General Assembly High Level meeting on TB in 2018.

2.3 Non-Communicable Diseases (NCDs)

Globally, member states have a running agenda for the prevention and control of NCDs contained in the NCD Global Action Plan 2013-2020 within which is an intention to reduce the premature mortality from NCDs by 25% by the year 2025 through nine voluntary global targets.

Kenya developed the national NCD prevention and control strategy 2015-2020 that was based on Kenya Health Policy 2013-2030, which outlines the overall sector direction in health and prioritizes NCDs prevention and control through 4 out of the 6 policy directions aimed at supporting the halting and reversing of the rising burden of NCDs.

Non communicable Diseases account for over 55 percent of hospital deaths in Kenya while more than 50 percent of all the hospital admissions are due to NCDs. These diseases are associated with multiple negative effects in low income countries given that they decrease economic productivity and drain family resources, becoming a major threat to economic and social development.

NCDs and Injuries are emerged as conditions of great public health concern in Kenya. Thirty percent of all deaths in the country are as a result of NCDs primarily diabetes, cancers, cardiovascular diseases and chronic respiratory diseases. Other smaller NCDs yet with a big burden include neurological conditions like Epilepsy, sickle cell and other genetic conditions, endocrine conditions, congenital anomalies and degenerative conditions.

NCDIs are responsible for over 37% of all disability adjusted life years and cause significant economic impact on households by causing a significant decrease in household income (28.6%) and subjecting families to catastrophic expenditures spiraling them in a vicious cycle of poverty.

Amongst the leading NCDs wreaking havoc in Kenya are discussed hereunder;

Cancer

Cancer is estimated to be the second leading cause of NCD related deaths after cardiovascular diseases and accounting for 7% of overall national mortality. Existing evidence shows that the annual incidence of cancer is close to 37,000 new cases with an annual mortality of over 28,000 making cancer the third leading cause of death. The leading cancers in Kenyan women are breast, cervical and esophagus. In men, esophageal, prostate cancer and Kaposi sarcoma are the most common cancers with incidence rates of 17.5, 15.2 and 9.2 per 100,000 men respectively.

The KDHS 2014 and STEPS survey show very low levels of cervical cancer screening among women between 25-49 years at 18.8% and 14.2% of women respectively. The coverage of cervical cancer screening was equally low (17%), ranging from 0% in Wajir and West Pokot to 54% in Mombasa county.

While early detection ensures a favorable outcome and prognosis of most cancers, about 80% of reported cases in Kenya are detected at an advanced stage when very little can be achieved and outcomes are very poor.

Cardiovascular diseases (CVD)

Cardiovascular diseases, which includes hypertension, ischemic heart disease (Heart attach), cerebrovascular disease (stroke), cardiomyopathy, valvular heart disease and pericarditis currently constitute the leading cause of death in the world, with 80% of all CVD-related deaths occurring in low- and middle income countries

Hypertension is an important risk factor for CVD and remains the single biggest risk factor for stroke (WHF 2014). Estimates of mortality due to CVD in Kenya ranges from 6.1% (NHSSP) to 8% (WHO NCD fact sheet 2014), while autopsy studies suggest that more than 13% of cause-specific deaths among adults could be due to CVDs.

The prevalence of hypertension has increased over the last decade with the STEPs survey 2015 showing that close to a quarter of Kenyans had hypertension. This prevalence increased with age with more than half of those above 40 years being hypertensive. Sadly, only 4% had of the patients under treatment achieved control portending a big risk of long term complications like heat attacks, strokes, blindness and renal failure.

Diabetes

This rise in diabetes is associated with demographic and social changes such as globalization, urbanization, aging population and adoption of unhealthy lifestyles such as consumption of unhealthy diets and physical inactivity.

In Kenya, the prevalence of people living with diabetes or various degrees of deranged blood glucose control in adults is estimated to be 5% according to IDF, amounting to almost 750,000 persons and 20,000 annual deaths. With low levels of awareness and opportunities for screening, approximately 60% of people living with diabetes are unaware and thus present to the health care facility late with long term complications of diabetes.

The hall mark of diabetes is long term complications like foot, cardiovascular, eye, nerve and renal complications that are driven by poor glycemic control.

3.0 GENERAL ASSEMBLY HIGH LEVEL MEETING ON TUBERCULOSIS (TB)

On 26th September 2018, The United Nations convened a high-level meeting on the fight against TB. The meeting's theme was 'united to end Tuberculosis: an urgent global response to a global epidemic.'

The meeting focused on the current state of efforts and needs to accelerate responses to combat TB, including experiences and best practices around the world, highlighting specific challenges facing various stakeholders and the need for stronger accountability at all levels.

The meeting commenced with an opening statement by Mr. Miroslav Lajcak, President of the General Assembly amongst other speakers. Discussions were thereafter organized into four panels under various thematic areas as below;

i) **Reaching the unreached: closing gaps in TB diagnosis, treatment, care and prevention;**

The focus of this panel was to reach persons contracting TB annually, estimated at 10.4 million as at 2016. It is estimated that 40 million people globally will need quality care between 2018 and 2022. These include people with multi-drug resistant (MDR) TB, pediatrics, those with HIV co-infections and complexities, vulnerable and marginalized segments of the society including those needing preventive treatment.
Panelists and discussants pursued strategies for a global response to achieve *End TB* targets and ensure access to quality TB prevention, diagnosis, treatment and care for all.

ii) **Innovation to end TB: new tools and approaches;**

The panel discussed the urgent need to invest in new tools, including drugs, diagnostics and vaccines and their effective access for those who need them. It was noted that the only vaccine available is 97 years old and diagnosis uses the same technology since 1882. Research and innovation will help combat the current strains of the disease including the multi-drug resistant strain.

iii) **Investing to end the world's leading infectious killer;**

It was estimated that TB would cost the world economy nearly USD 1 trillion by 2030. The panel focused on significant investment in the fight against the disease to fill the funding gap for TB care and prevention estimated at USD 2.3 billion and for research and development at USD 2 billion, as well as build support for investment in underfunded health systems.

iv) **Partnerships for success- the role communities in an equitable, person-centered, rights-based response.**

This panel focused on synergies to bring together affected communities and enable a model of person-centered care and prevention. This would be attained through empowering communities through education and advocacy, and a people-centered model of service delivery such as integrated, decentralized and ambulatory care.

The General Assembly adopted resolutions emanating from the discussions, attached to this report as Annex 1.

4.0 GENERAL ASSEMBLY HIGH LEVEL MEETING ON PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES (NCDs)

The meeting discussed scaling up action for the prevention and control of non-communicable diseases. Herein, discussions were on the role of identifying and implementing effective national responses for the prevention and control of NCDs, including by achieving universal health coverage.

The meeting also discussed financing for the prevention and control of NCDs, focussing on the disproportionate burden of NCDs in low and middle income countries. It was highlighted that funding should entail a mix of domestic and international funding.

Further, promotion of multi-sectoral partnerships for the prevention and control of NCDs was discussed. Discussants pushed for opportunities and challenges of synergy with the private sector, civil society, academia and affected communities, towards concerted efforts to curb NCDs.

Moreover, the role of political leadership and accountability came into focus as discussions sought ownership and firm political will by governments and a global accountability framework.

The General Assembly adopted resolutions emanating from the discussions, attached to this report as Annex 2.

5.0 DELEGATION OBSERVATIONS

5.1 Challenges faced in combatting NCDs In Kenya

The delegation observed that efforts to curb NCDs were hampered by several shared risk factors;

1. Obesity and overweight is one of the major drivers of the NCD pandemic and has been on the rise across all the age groups. 24.8% of women and 13.2% of Kenyan men are overweight while 12.6% of women and of 4.3% of men are obese portending a great risk of complications that come with obesity. Child hood obesity is also on the rise coexisting with residual malnutrition.
2. Tobacco is major cause of death, disease, disability and poverty. Tobacco use and exposure to second hand tobacco smoke is a major preventable risk factor for Non-communicable diseases. The prevalence of tobacco use in Kenya is 11.6% among adults and 9.9% among the youths. Other risk factors for NCDs include heavy episodic drinking at 12.7%, poor diets with only 6.0% of Kenyans consuming a minimum of the recommended five servings of fruits and vegetables daily, 23% of adults adding excessive salt to food at the table and 28% using excessive amounts of sugar in beverages.

3. Violence and Injury also emerged as a major contributor towards NCDs. NTSA reported about 3,000 deaths per year during the period 2010-2015, indicating a sharp decline in fatalities per 10,000 vehicles. New outpatient road traffic injuries was 2.5% against a target of 3% for 2015 while other injuries, most commonly cuts and falls, accounted for about 1% of all OPD diagnoses with little change over time. The STEPs survey showed that 10% of Kenyans reported to have been involved in a serious injury in the preceding 12 months. The percentage of facility deaths due to injuries was 5.1% against a target of 6%.

4. Other than the above, the delegation noted various challenges of NCD prevention and care in Kenya;

    - Poor prioritization/Neglect of NCDs traditionally with more focus on infectious diseases.
    - Few strategic partnerships and low level of involvement of the private sector in the NCDs sphere.
    - Poor funding and investment in capacity building for NCD prevention and control.
    - Low levels of awareness and poor health seeking behavior among the population resulting in late presentation and poor outcomes.
    - Lack of funding for wellness and health promotion in upstream interventions like awareness, education, screening and early detection as well as downstream interventions for treatment, referral and palliative care.
    - Policy incongruence with poor coordination across the sectors given the multi-sectoral nature of NCDs
    - Poor infrastructure of NCD data collection and surveys
    - Lack of integration of NCDs into other primary care platforms.

5.2 Challenges faced in ending TB In Kenya

Kenya is among the 14 high burden TB countries in the world today. These are countries that account for over 80% of all cases worldwide. The disease remains a major cause of mortality in Kenya, and has its greatest toll among the productive age group of 15 to 44 years. Kenya falls here because of many factors;

- TB/HIV co-infections have complicated treatment of the disease due to opportunistic infections; Kenya has a high prevalence of Multi drug resistant TB;
- Moreover, high poverty levels and social deprivation has led to mushrooming of high density slums, providing fertile ground for its spread.

- Prison congestion, influx of refugees and limited access to general healthcare services has also conspired for this state of affairs.

6.0 RECOMMENDATIONS

6.1 Combatting NCDs

Other than full implementation of the conference resolution on NCDs, the Committee makes the following recommendations to be implemented in Kenya to complement global efforts;

1. Legal and legislative Actions

These include sustained enforcement of laws that aim at reducing the burden of NCDs and injuries including the Traffic amendment act, Tobacco Control Act (2007) and Regulations (2014), Cancer Prevention and Control Act 2012, Alcoholics Drinks Control Act.

The tobacco Control Act 2007 imposes a 2% levy on tobacco manufactures and importers. This levy should be implemented and the funds channeled to the tobacco control Fund, also established by the Tobacco Control Act, and these funds be used to implement UHC.

Further, the Ministry of Health should introduce legislation to control exposure to NCDs risk factors such as regulation of salt and sugar content of food produced in industries, appropriate taxing of sweetened sugar beverages tobacco and alcohol, restriction of advertising of unhealthy foods especially those targeting young children, increasing physical education e.g. introduction of safe pedestrian walkways among others. This should go hand in hand with providing guidelines for healthy school diet.

2. Restructuring of health systems

Health management systems should integrate NCD management in the primary health-care services through development of efficient structures to prevent and manage NCDs.

These systems should also strengthen human resource for prevention and management of NCDs and injuries including the development and review necessary treatment guidelines for management of NCDs and conducting trainings.

Further, there should be established innovative ways to ensure patient follow along a streamlined referral pathway with a robust surveillance platform, allocation of more resources to NCDS at both policy and service delivery levels and integration of

prevention and management of NCDs with other programs such as maternal and reproductive health, HIV/AIDs management, TB.

3. Monitoring and Evaluation systems

The Ministry of Health being the custodian of policy should establish clear M&E systems to track NCD indicators for policy formulation and evaluate progress at the national, regional and global levels. Development and Incorporation of indicators that properly capture NCD data, provision of harmonized tools, streamlining the reporting systems and training of relevant staff to properly code and capture NCD data is urgently needed to improve the quality of NCD data.

NCD indicators should also be integrated in other National surveys including establishing mechanisms to link road traffic injuries data from the Police/NTSA with Health facility data to capture delayed hospital based mortality and disability.

NCD interventions should be strengthened at community levels through enhanced health promotion programs targeting such areas as regular screening, healthy diets and lifestyles using a variety of public channels and media. This should also be done through training of Community Health Volunteers on NCDs prevention and management.

6.2 Ending TB

The Committee recommends full implementation of the conference resolutions on ending TB, and makes the following further recommendations to be implemented in Kenya;

1. The Ministry of Health should cultivate strong collaboration between various stakeholders, i.e. government, the private sector, civil society organizations, donors and research institutions.

2. Treasury should observe the Abuja declaration of 2001 that called for at least 15% of national budgets to be dedicated to health and sanitation initiatives. It is clear that those countries that have Universal Health Care coverage have low incidence rates of TB, in appreciation of the interlinkages between TB and other health dynamics. This also calls for political commitment from the highest levels in implementing national guidelines on TB management.

3. Out of the 15% recommended allocation for health mentioned above, a minimum cap should be devised by Treasury and the Ministry of Health to be dedicated towards the fight against TB. This is more so in appreciation of the fact that Kenya

will stop receiving funding from the Global Fund to Fight AIDS, TB and Malaria come the year 2020 due to its new found status of being a middle income country.

4. The government should maintain proper documentation of all births in the country, with 100% compliance enforced on all infant vaccines. All expectant mothers should be screened for TB as part of their pre-natal examinations. Further to this, research institutions should dedicate efforts towards development of a TB vaccine for adults. The existing vaccine, BCG is devised for infants.

5. Diagnosis of TB in Kenya is currently based on examination of sputum and use of x-rays. These however only identify pulmonary TB, leaving patients of other forms of TB vulnerable. Part of the solution would be to have gene experts at health centre levels in addition to advance forms of diagnosis. To increase scope of reach, health professionals should be allocated certain quotas or zonal areas to fully screen members of the public throughout the country, for among others, contact tracing.

6. To improve compliance by patients, the Ministry of Health should encourage short course therapies and affordable medication. This will replace the current criminalization of skipping medication by patients, a practice that has been found unethical, ineffective and has been challenged in courts as infringing on human rights.

7. MDR-TB has been a major concern in the fight against TB in Kenya. Research efforts by the Ministry of Health in collaboration with research agencies and institutions to combat this phenomenon must be intensified.

8. An effective fight against TB will be possible if the government takes stock by having proper records. For instance, what data does the country have as regards surveillance of MDR-TB? How many children are immunized at birth and how many are not? What collaborative efforts with various stakeholders are currently present? How many health professionals dedicated to TB are there? It is only through proper database of all TB facts that we can effectively fight the disease.

9. Being a major host of refugees from the region, the government should secure the country's borders by having strong surveillance systems to stop the spread of the disease. This will enable proper management and those cases that exist in these refugee camps. Health and sanitation amenities are also a key concern in these camps. Related to this, other vulnerable groups should also be deliberately targeted. These groups include alcoholics, drug addicts, migrants, minors and even health workers who are exposed.

10. The Ministry of Health should improve on effective monitoring of the disease by creating awareness amongst groups, *chamas*, schools, etc.

ANNEXURES

Annex 1: Political declaration of the high-level meeting of the General Assembly on the fight against tuberculosis

Annex 2: Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

ANNEX 1

United Nations A/RES/73/3

General Assembly

Distr.: General
18 October 2018

Comment [Start1]: <<ODS JOB NO>>N1831553E<<ODS JOB NO>>
<<ODS DOC SYMBOL1>>A/RES/73/3<<ODS DOC SYMBOL1>>
<<ODS DOC SYMBOL2>><<ODS DOC SYMBOL2>>

Seventy-third session
Agenda item 129

Resolution adopted by the General Assembly on 10 October 2018

[*without reference to a Main Committee (A/73/L.4)*]

73/3. Political declaration of the high-level meeting of the General Assembly on the fight against tuberculosis

The General Assembly

Adopts the following political declaration approved by the high-level meeting of the General Assembly on the fight against tuberculosis on 26 September 2018:

Political declaration of the high-level meeting of the General Assembly on the fight against tuberculosis

United to end tuberculosis: an urgent global response to a global epidemic

We, Heads of State and Government and representatives of States and Governments, assembled at the United Nations in New York on 26 September 2018, with a dedicated focus for the first time on the global tuberculosis epidemic, reaffirm our commitment to ending the tuberculosis epidemic globally by 2030 in line with the Sustainable Development Goals target, commit to ending the epidemic in all countries, and pledge to provide leadership and to work together to accelerate our national and global collective actions, investments and innovations urgently to fight this preventable and treatable disease, affirming that tuberculosis, including its drug-resistant forms, is a critical challenge and the leading cause of death from infectious disease, the most common form of antimicrobial resistance globally and the leading cause of death of people living with HIV, and that poverty, gender inequality, vulnerability, discrimination and marginalization exacerbate the risks of contracting tuberculosis and its devastating impacts, including stigma and discrimination at all ages, such that the disease requires a comprehensive response, including towards achieving universal health coverage, and one that addresses the

social and economic determinants of the epidemic and that protects and fulfils the human rights and dignity of all people, and we therefore:

1. Reaffirm the 2030 Agenda for Sustainable Development,[1] including the resolve to end the tuberculosis epidemic by 2030, and the Addis Ababa Action Agenda of the Third International Conference on Financing for Development,[2]

2. Further reaffirm the 2016 political declaration of the high-level meeting of the General Assembly on antimicrobial resistance, as reflected in its resolution 71/3 of 5 October 2016, the 2016 political declaration on HIV and AIDS, adopted in its resolution 70/266 of 8 June 2016, the 2014 outcome document of the high-level meeting of the Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of non-communicable diseases, adopted in its resolution 68/300 of 10 July 2014, and its resolution 72/139 of 12 December 2017, in which the Assembly decided to hold a high-level meeting on universal health coverage in 2019, and take note of World Health Assembly resolution 69.2 of 28 May 2016, entitled "Committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health",[3] and Human Rights Council resolution 33/11 of 29 September 2016 on preventable mortality and morbidity of children under 5 years of age as a human rights concern,[4] and further reaffirm the World Health Organization End TB Strategy, as approved in World Health Assembly resolution 67.1 of 21 May 2014,[5] and its associated targets,

3 Acknowledge that the Millennium Development Goals[6] and associated strategies, plans and programmes for the prevention and care of tuberculosis helped to reverse the trend of the tuberculosis epidemic and, between 2000 and 2016, reduced tuberculosis mortality by 37 per cent, which saved 53 million lives, and that investment in care and the prevention of tuberculosis brings some of the largest gains in terms of lives saved and economic benefits from development investments;

4 Welcome the convening of the first World Health Organization Global Ministerial Conference on Ending Tuberculosis in the Sustainable Development Era: A Multisectoral Response, held in Moscow on 16 and 17 November 2017, and take note with appreciation of its Moscow Declaration to End TB, with its commitments and calls for urgent action, notably on advancing the response to tuberculosis within the 2030 Agenda, ensuring sufficient and sustainable financing, pursuing science, research and innovation and developing a multisectoral accountability framework, which contributed to this meeting,

5 Recognize other recent high-level commitments and calls for action against tuberculosis, including its multidrug-resistant and zoonotic forms, made by global, regional and subregional bodies and meetings, including the Delhi End TB Summit, held from 12 to 17 March 2018,

6. Recognize that, while the World Health Organization declared tuberculosis a global emergency 25 years ago, it is still among the top 10 causes of death worldwide, and that it is a critical challenge in all regions and countries and disproportionately affects developing countries, where 99 per cent of tuberculosis-associated deaths occur, and furthermore recognize that the epidemic is exacerbated by the rise of multidrug-resistant tuberculosis and the heavy burden of tuberculosis,

[1] Resolution 70/1.
[2] Resolution 69/313, annex.
[3] See World Health Organization, document WHA69/2016/REC/1
[4] See *Official Records of the General Assembly, Seventy-first Session, Supplement No. 53A* and corrigendum (A/71/53/Add.1 and A/71/53/Add.1/Corr.1), chap. II
[5] See World Health Organization, document WHA67/2014/REC/1
[6] See resolution 55/2.

HIV and AIDS, and other co-morbidities such as diabetes, that one quarter of the world's people are infected with the bacterium that causes the disease, and that millions of people ill with tuberculosis are missing out on quality care each year, including on access to affordable diagnostic tests and treatment, especially in developing countries;

7. Express serious concern that, despite these commitments, tuberculosis remains a cause of an enormous burden of illness, suffering and death, and that stigma and discrimination because of the disease bring enormous costs for individuals affected by tuberculosis and their families, and acknowledge that an adequate multisectoral and intersectoral engagement in the fight against the disease is needed, and that the world needs to refocus efforts on actions and investments, including in research, needed to achieve the Sustainable Development Goals target of ending the tuberculosis epidemic by 2030;

8. Recognize that tuberculosis affects populations inequitably and contributes to the cycle of ill health and poverty, that malnutrition and inadequate living conditions contribute to the spread of tuberculosis and its impact upon the community, and that tuberculosis is fundamentally linked to a majority of the leading development challenges addressed by the 2030 Agenda;

9. Further recognize that tuberculosis is both preventable and curable, yet 40 per cent of people newly affected by tuberculosis are missed by public health reporting systems, and millions do not receive quality care each year, and that tuberculosis can only be eliminated through prevention efforts and access to quality diagnosis, treatment and care, including access to affordable diagnostic tools and drug treatment, effective people-centred and community-based models of care supported by integrated care services, as well as financing innovations, and additional investments in research and development and in the affordable delivery of tuberculosis programmes, especially in developing countries, and recognize that countries that are transitioning from donor to domestic funding face new challenges that may have a negative impact on earlier gains in the fight against tuberculosis;

10. Recognize that, even though tuberculosis is the leading global cause of death of people living with HIV, in 2016 less than half of the estimated number of cases of tuberculosis in people living with HIV were found and notified, and less than 60 per cent of known tuberculosis patients were tested for HIV, precluding treatment and resulting in preventable deaths;

11. Recognize that multidrug-resistant tuberculosis is estimated to account for one third of deaths due to antimicrobial resistance globally, and that many of the Sustainable Development Goals may not be attainable if we fail to address antimicrobial resistance, that the grave risks to individual and public health posed by multidrug-resistant tuberculosis are cause for alarm, that only 25 per cent of the estimated number of multidrug-resistant tuberculosis cases were diagnosed and notified in 2016, such that the vast majority of those in need still lack access to high-quality prevention, treatment and care services and that inadequate investment in tuberculosis case detection is a key obstacle to meeting tuberculosis treatment goals, and furthermore acknowledge that the response to multidrug-resistant and extensively drug-resistant tuberculosis to date has been insufficient, despite the introduction of new rapid diagnostic tests, efforts to scale up disease management and international financing, such as from the Global Fund to Fight AIDS, Tuberculosis and Malaria, including to help support drug supply, yet globally just over 50 per cent of patients enrolled in treatment for multidrug-resistant tuberculosis are successfully treated;

12. Acknowledge that multidrug-resistant tuberculosis is a key component of the global challenge of antimicrobial resistance, and express grave concern that the

scope and scale of multidrug-resistant and extensively drug-resistant tuberculosis illness and mortality place an additional burden on health and community systems, especially in low- and middle-income countries, and thereby pose a critical challenge that could reverse the progress made against the disease, against antimicrobial resistance and towards the Sustainable Development Goals, and that there is a profound gap in access to quality diagnosis, treatment and care for those affected, and there is still a low treatment success rate for those who are treated, and therefore acknowledge that it is necessary to ensure global collaboration, sustainable and sufficient political buy-in and financial investment from all sources, a strong public health response, including strong and resilient health systems, and additional investment in research, development and innovation, recognizing that innovation has the potential to benefit society at large;

13 Note with concern that the protection and promotion of the right to the enjoyment of the highest attainable standard of physical and mental health, as well as access for millions of people to tuberculosis health services and to quality, safe, efficacious and affordable tuberculosis diagnostics and treatment, remains challenging, especially in developing countries,

14. Recognize the profound socioeconomic challenges and financial hardships faced by people affected by tuberculosis, including in obtaining an early diagnosis, in being subject to extremely long treatment regimens, with drugs that could involve severe side effects, as well as in securing integrated support, including from the community, and therefore affirm that all these people require integrated, people-centred prevention, diagnosis, treatment, management of side effects, and care, as well as psychosocial, nutritional and socioeconomic support for successful treatment, including to reduce stigma and discrimination;

15 Recognize the role played by the Stop TB Partnership/Global Drug Facility, which has, since its creation in 2001, increased access to high-quality and affordable tuberculosis treatment and diagnostics for populations in need and is open as an option to be considered for use by all nations, and therefore encourage all nations to use the Stop TB Partnership/Global Drug Facility,

16 Recognize the potential of digital technologies to be used in a variety of ways for tuberculosis prevention, treatment and care, including to support health systems by improving the accessibility, quality and affordability of health services and to help with adherence, surveillance, logistics management and e-learning;

17 Recognize the enormous, often catastrophic, economic and social impacts and burden of tuberculosis for people affected by the disease, their households, and affected communities, and that the risk and impact of tuberculosis can vary depending on demographic, social, economic and environmental circumstances, and, in order to make the elimination of tuberculosis possible, prioritizing, as appropriate, notably through the involvement of communities and civil society and in a non-discriminatory manner, high-risk groups and other people who are vulnerable or in vulnerable situations, such as women and children, indigenous peoples, health-care workers, migrants, refugees, internally displaced people, people living in situations of complex emergencies, prisoners, people living with HIV, people who use drugs, in particular those who inject drugs, miners and others exposed to silica, the urban and rural poor, underserved populations, undernourished people, individuals who face food insecurity, ethnic minorities, people and communities at risk of exposure to bovine tuberculosis, people living with diabetes, people with mental and physical disabilities, people with alcohol use disorders and people who use tobacco, recognizing the higher prevalence of tuberculosis among men,

18. Recognize the various sociocultural barriers to tuberculosis prevention, diagnosis and treatment services, especially for those who are vulnerable or in vulnerable situations, and the need to develop integrated, people-centred, community-based and gender-responsive health services based on human rights;

19. Commit to promoting access to affordable medicines, including generics, for scaling up access to affordable tuberculosis treatment, including the treatment of multidrug-resistant and extensively drug-resistant tuberculosis, reaffirming the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), as amended, and also reaffirming the 2001 World Trade Organization Doha Declaration on the TRIPS Agreement and Public Health, which recognizes that intellectual property rights should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to medicines for all, and notes the need for appropriate incentives in the development of new health products;

20. Recall with concern that, until recently, no new medicines for tuberculosis treatment had been approved for over 40 years, and acknowledge that innovative approaches, including greater engagement between the public and private sectors, will be necessary to develop new vaccines, drugs and other health technologies to respond to the tuberculosis epidemic;

21. Recognize the lack of sufficient and sustainable financing for the tuberculosis response, including for the implementation of integrated, people-centred prevention, diagnosis, treatment and care of tuberculosis, including community-based health service delivery, and for tuberculosis research and innovation, including for the development and evaluation of better diagnostics, drugs, treatment regimens and vaccines, as well as other innovative care and prevention approaches, such as addressing social and economic factors of the disease;

22. Recognize that, to end the tuberculosis epidemic by 2030, reliable data on incidence, prevalence and mortality, where appropriate, disaggregated by income, sex, age and other characteristics relevant to national contexts, as well as the strengthening of national capacity for the use and analysis of such data, would be needed to ensure that collective knowledge is transformed into effective and timely action, and that progress at both the global and national levels needs to be reviewed regularly to ensure that we remain on target;

23. Take note with appreciation of the ongoing process of drafting a multisectoral accountability framework to accelerate progress to end tuberculosis, as agreed in World Health Assembly resolution 71.3 of 26 May 2018;[7]

24. Commit to providing diagnosis and treatment with the aim of successfully treating 40 million people with tuberculosis from 2018 to 2022, including 3.5 million children, and 1.5 million people with drug-resistant tuberculosis, including 115,000 children, bearing in mind varying degrees of the burden of tuberculosis among countries, and recognize the constrained health system capacity of low-income countries, and thereby aiming to achieve effective universal access to quality diagnosis, treatment, care, and adherence support, without suffering financial hardship, with a special focus on reaching those who are vulnerable and the marginalized populations and communities among the 4 million people each year who have been most likely to miss out on quality care;

25. Commit to preventing tuberculosis for those most at risk of falling ill through the rapid scaling up of access to testing for tuberculosis infection,

[7] See World Health Organization, document WHA71/2018/REC/1.

according to the domestic situation, and the provision of preventive treatment, with a focus on high-burden countries, so that at least 30 million people, including 4 million children under 5 years of age, 20 million other household contacts of people affected by tuberculosis, and 6 million people living with HIV, receive preventive treatment by 2022, and with the vision of reaching millions more, and further commit to the development of new vaccines and the provision of other tuberculosis prevention strategies, including infection prevention and control and tailored approaches, and to enacting measures to prevent tuberculosis transmission in workplaces, schools, transportation systems, incarceration systems and other congregate settings;

26 Commit to overcoming the global public health crisis of multidrug-resistant tuberculosis through actions for prevention, diagnosis, treatment and care, including compliance with stewardship programmes to address the development of drug resistance in line with General Assembly resolution 71/3 on antimicrobial resistance, improved national, regional and global pharmaco-vigilance, and improved treatment adherence for people with drug-sensitive tuberculosis, universal, equitable and affordable access to quality diagnosis, treatment, care and support for people with drug-resistant tuberculosis; global collaboration to ensure accelerated development of accessible and affordable diagnostic tools, and shorter and more effective oral regimens, including those that meet the unique needs of children; and through an urgent response to multidrug-resistant tuberculosis and the scale and severity of local and national epidemics of the disease;

27. Ensure that tuberculosis programmes actively contribute to developing national antimicrobial resistance strategies, capacities and plans and that lessons learned from global, regional and national efforts to combat drug-resistant tuberculosis inform the design and implementation of both global antimicrobial resistance strategies and national action plans according to national contexts;

28 Commit to address tuberculosis prevention, diagnosis, treatment and care in the context of child health and survival, as an important cause of preventable childhood illness and death, including among children with HIV and as a co-morbidity of other common childhood illnesses, especially pneumonia, meningitis and malnutrition; to enable child-friendly policies and an integrated, family-based approach to tuberculosis care and services, address the vulnerabilities faced by children affected by tuberculosis, support their caregivers, in particular women and the elderly, and provide related social protection; to promote equitable access to child-friendly formulations of medicines to optimize the prevention and treatment of drug-sensitive and drug-resistant tuberculosis among children, including through addressing national regulatory and policy barriers;

29. Given the strong association between the two diseases, and associated high mortality, commit to coordination and collaboration between tuberculosis and HIV programmes, as well as with other health programmes and sectors, to ensure universal access to integrated prevention, diagnosis, treatment and care services, in accordance with national legislation, including through promoting testing for HIV among people with tuberculosis and screening all people living with HIV regularly for tuberculosis, and providing tuberculosis preventive treatment, as well as to eliminate the burden faced by affected people, to leverage resources to maximize impact, and to address the common social, economic and structural determinants of tuberculosis, HIV, viral hepatitis, non-communicable diseases, in particular diabetes, and the complex biological factors that increase tuberculosis incidence and mortality, worsen treatment outcomes and increase drug resistance;

30. Commit to finding the missing people with tuberculosis, and integrating tuberculosis efforts more fully into all relevant health services to increase access to

tuberculosis services, recognizing that reaching undetected and untreated men, as well as empowering women and girls through community health care and outreach, is a critical part of the solution, and to considering responses appropriate for men and women, boys and girls;

31. Commit to systematic screening, as appropriate, of relevant risk groups, as identified in World Health Organization guidance documents, for active and latent tuberculosis, to ensure early detection and prompt treatment in groups disproportionately affected by tuberculosis, such as people living with diabetes and people living with HIV, and to implementing primary prevention in high-risk occupations by reducing silica dust exposure in mining, construction and other dusty workplaces, and worker tuberculosis surveillance and infection prevention and control in health-care settings;

32. Commit to adapting and implementing rapidly the End TB Strategy to ensure that current guidance from the World Health Organization and other relevant international entities, relevant to the tuberculosis response in each country, is rapidly adapted and implemented and scaled up, where necessary, in taking forward the commitment to quality prevention, diagnosis, treatment and care of tuberculosis;

33. Commit to developing community-based health services through approaches that protect and promote equity, ethics, gender equality and human rights in addressing tuberculosis by focusing on prevention, diagnosis, treatment and care, including socioeconomic and psychosocial support, based on individual needs, that reduce stigma, and integrated care for related health conditions, such as HIV and AIDS, undernutrition, mental health, non-communicable diseases including diabetes and chronic lung disease, and tobacco use, harmful use of alcohol and other substance abuse, including drug injection, with access to existing and new tools;

34. Commit to related improvements in policies and systems on each country's path towards achieving and sustaining universal health coverage, such that all people with tuberculosis or at risk of developing tuberculosis receive the quality, accessible and affordable prevention, diagnosis, treatment and care services they need without suffering financial hardship, with stewardship of antimicrobials and prevention and infection control, within public and community, including faith-based, organizations, and private sector services;

35. Given the global nature of the tuberculosis epidemic and the critical public health challenge of multidrug-resistant tuberculosis, commit to strengthening public health systems as an essential pillar of the tuberculosis response, including health workforce capacity-building for public and private sector care, as well as community-based care services, and related robust multisectoral partnership frameworks in countries where the non-public sector is the leading tuberculosis care provider, laboratory networks, infection prevention and control, medicines procurement, distribution and regulatory capacity and access to diagnostic technologies for drug resistance; cross-border collaboration; and robust health information systems comprising integrated case-based electronic surveillance, reliable data, including at the national and subnational levels, with disaggregation by age, sex, disability and other characteristics relevant to national contexts, for monitoring the level of and trends in the epidemic, treatment outcome monitoring, and improvements in national vital registration systems;

36. Commit to considering, as appropriate, how digital technologies could be integrated into existing health system infrastructures and regulation for effective tuberculosis prevention, treatment and care, reinforcing national and global health priorities by optimizing existing platforms and services, for the promotion of people-centred health and disease prevention and in order to reduce the burden on health systems;

37. Commit to protect and promote the right to the enjoyment of the highest attainable standard of physical and mental health, in order to advance towards universal access to quality, affordable and equitable prevention, diagnosis, treatment, care and education related to tuberculosis and multidrug-resistant tuberculosis and support for those who become disabled due to tuberculosis, integrated within health systems towards achieving universal health coverage and removing barriers to care; to address the economic and social determinants of the disease; and to promote and support an end to stigma and all forms of discrimination, including by removing discriminatory laws, policies and programmes against people with tuberculosis, and through the protection and promotion of human rights and dignity, as well as policies and practices which improve outreach, education and care;

38 Commit to providing special attention to the poor, those who are vulnerable, including infants, young children and adolescents, as well as elderly people and communities especially at risk of and affected by tuberculosis, in accordance with the principle of social inclusion, especially through ensuring strong and meaningful engagement of civil society and affected communities in the planning, implementation, monitoring and evaluation of the tuberculosis response, within and beyond the health sector, we further acknowledge the link between incarceration and tuberculosis and therefore reaffirm the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) as defined in General Assembly resolution 70/175 of 17 December 2015;

39 Commit to enable and pursue multisectoral collaboration at the global, regional, national and local levels, across health and nutrition, finance, labour, social protection, education, science and technology, justice, agriculture, the environment, housing, trade, development and other sectors, in order to ensure that all relevant stakeholders pursue actions to end tuberculosis and leave no one behind;

40. Strengthen support and capacity-building in low-income countries and lower-middle-income countries, many of which have high rates of tuberculosis combined with health and social protection systems that have limited resources, including to support implementing multisectoral approaches in their response to the tuberculosis epidemic;

41. Commit to foster cooperation between public and private sector entities in furthering the development of newly approved medicines for multidrug-resistant and extensively drug-resistant tuberculosis and for additional new drugs in the future, as part of Member States' efforts to contribute appropriately to research and development,

42 Commit to advancing research for basic science, public health research and the development of innovative products and approaches, which may include evidence-based, regulated medicines, including traditional medicines as adjuvant therapies, including in cooperation with the private sector and academia, without which ending the tuberculosis epidemic will be impossible, including towards delivering, as soon as possible, new, safe, effective, equitable, affordable, available vaccines, point-of-care and child-friendly diagnostics, drug susceptibility tests and safer and more effective drugs and shorter treatment regimens for adults, adolescents and children for all forms of tuberculosis and infection, as well as innovation to strengthen health systems such as information and communication tools and delivery systems for new and existing technologies, to enable integrated people-centred prevention, diagnosis, treatment and care of tuberculosis;

43. Commit to create an environment conducive to research and development of new tools for tuberculosis, and to enable timely and effective innovation and affordable and available access to existing and new tools and delivery strategies and

promote their proper use, by promoting competition and collaboration, removing barriers to innovation, and working towards improving regulatory processes and capabilities;

44. Further commit to advancing that new research and innovation environment through global collaboration, including through existing World Health Organization mechanisms and initiatives; strengthening research capacity and collaboration through improving tuberculosis research platforms and networks across the public and private sectors, noting such platforms and networks as the Brazil, Russian Federation, India, China and South Africa (BRICS) Tuberculosis Research Network and the Life Prize; in basic science, clinical research and development, including pre-clinical and clinical trials, as well as operational, qualitative and applied research, to advance effective tuberculosis prevention, diagnosis, treatment, and care and actions on the economic and social determinants and impacts of the disease;

45. Promote tuberculosis research and development efforts aiming to be needs-driven, evidence-based and guided by the principles of affordability, effectiveness, efficiency and equity and which should be considered as a shared responsibility. In this regard, we encourage the development of new product development partnership models and, for multidrug-resistant tuberculosis, continue to support existing voluntary initiatives and incentive mechanisms that separate the cost of investment in research and development from the price and volume of sales, to facilitate equitable and affordable access to new tools and other results to be gained through research and development, and we acknowledge the need to establish additional incentives for the research and development of new products to treat multidrug-resistant tuberculosis and to encourage stewardship, conservation, and global access to such products in addition to rewarding innovation, welcome innovation and research and development models that deliver effective, safe and equitable solutions to the challenges presented by tuberculosis, including those that promote investment by all relevant stakeholders, including Governments, industry, non-governmental organizations and academics, and continue to support existing voluntary initiatives and incentive mechanisms that avoid reliance on high price or high sales combinations and explore ways to support innovation models that address the unique set of challenges presented by tuberculosis, including the importance of the optimal use of medicines and diagnostic tools, while promoting access to affordable medicines and other health technologies;

46. Commit to mobilize sufficient and sustainable financing for universal access to quality prevention, diagnosis, treatment and care of tuberculosis, from all sources, with the aim of increasing overall global investments for ending tuberculosis and reaching at least 13 billion United States dollars a year by 2022, as estimated by the Stop TB Partnership and the World Health Organization, according to each country's capacity and strengthened solidarity, including through contributions to the World Health Organization as well as voluntary mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, including its replenishment, which provides 65 per cent of all international financing for tuberculosis; and to align within overall national health financing strategies, including by helping developing countries to raise domestic revenues and providing financial support bilaterally, at regional and global levels, towards achieving universal health coverage and social protection strategies, in the lead-up to 2030;

47. Commit to mobilize sufficient and sustainable financing, with the aim of increasing overall global investments to 2 billion dollars, in order to close the estimated 1.3 billion dollar gap in funding annually for tuberculosis research, ensuring that all countries contribute appropriately to research and development, to support quality research and development of new and the effective implementation

of recently approved health technologies, and to strengthen the academic, scientific, public health and laboratory capacity needed to support research and development for prevention, diagnosis, treatment and care, inter alia through the engagement of national, international and innovative financing mechanisms;

48 Commit to develop or strengthen, as appropriate, national tuberculosis strategic plans to include all necessary measures to deliver the commitments in the present political declaration, including through national multisectoral mechanisms to monitor and review progress achieved towards ending the tuberculosis epidemic, with high-level leadership, preferably under the direction of the Head of State or Government, and with the active involvement of civil society and affected communities, as well as parliamentarians, local governments, academia, private sector and other stakeholders within and beyond the health sector, and promote tuberculosis as part of national strategic planning and budgeting for health, recognizing existing legislative frameworks and constitutional arrangements, so as to ensure that each Member State is on track to achieve the Sustainable Development Goals target to end the tuberculosis epidemic;

49 Request the Director General of the World Health Organization to continue to develop the multisectoral accountability framework in line with World Health Assembly resolution 71 3 and ensure its timely implementation no later than 2019,

50. Commit to establishing and promoting regional efforts and collaboration to set ambitious targets, generate resources, and use existing regional intergovernmental institutions to review progress, share lessons and strengthen collective capacity to end tuberculosis,

51 Recognize the need to strengthen linkages between tuberculosis elimination and relevant Sustainable Development Goals targets, including towards achieving universal health coverage, through existing Sustainable Development Goals review processes, including the high-level political forum on sustainable development,

52. Request the Secretary-General, in close collaboration with the Director General of the World Health Organization, to promote collaboration among all stakeholders to end the tuberculosis epidemic and implement the present declaration, with Member States and relevant entities, including funds, programmes and specialized agencies of the United Nations system, United Nations regional commissions, the Stop TB Partnership, hosted by the United Nations Office for Project Services, UNITAID, hosted by the World Health Organization, and the Global Fund to Fight AIDS, Tuberculosis and Malaria,

53 Also request the Secretary-General, with the support of the World Health Organization, to provide a progress report in 2020 on global and national progress, across sectors, in accelerating efforts to achieve agreed tuberculosis goals within the context of achieving the 2030 Agenda for Sustainable Development, including on the progress and implementation of the present declaration towards agreed tuberculosis goals at the national, regional and global levels, which will serve to inform preparations for a comprehensive review by Heads of State and Government at a high-level meeting in 2023

18th plenary meeting
10 October 2018

ANNEX 2

United Nations A/RES/73/2

General Assembly

Distr.: General
17 October 2018

Comment [Start1]: <<ODS JOB NO>>N1831540E<<ODS JOB NO>> <<ODS DOC SYMBOL1>>A/RES/73/2<<ODS DOC SYMBOL1>> <<ODS DOC SYMBOL2>><<ODS DOC SYMBOL2>>

Seventy-third session
Agenda item 119

Resolution adopted by the General Assembly on 10 October 2018

[*without reference to a Main Committee (A/73/L.2)*]

73/2. Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

The General Assembly

Adopts the following political declaration approved by the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases on 27 September 2018:

Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

Time to deliver: accelerating our response to address non-communicable diseases for the health and well-being of present and future generations

We, Heads of State and Government and representatives of States and Governments, assembled at the United Nations on 27 September 2018 to undertake a comprehensive review of the challenges and opportunities in the implementation of our existing commitments for the prevention and control of non-communicable diseases and the promotion of mental health, which constitute a major challenge for the health and well-being of our peoples and for sustainable development,

1. Strongly reaffirm our political commitment to accelerate the implementation of the 2011 political declaration and the 2014 outcome document of the previous high-level meetings of the General Assembly on the prevention and control of non-communicable diseases,[1] which continue to inspire our action and catalyse our

[1] Resolution 66/2, annex, and resolution 68/300.

efforts, and, in line with the 2030 Agenda for Sustainable Development,[2] reduce by one third premature mortality from non-communicable diseases by 2030 through prevention and treatment and promote mental health and well-being, by addressing their risk factors and the determinants of health;

2. Reaffirm General Assembly resolution 70/1 of 25 September 2015, entitled "Transforming our world the 2030 Agenda for Sustainable Development", and the Addis Ababa Action Agenda of the Third International Conference on Financing for Development,[3]

3. Reaffirm the right of every human being, without distinction of any kind, to the enjoyment of the highest attainable standard of physical and mental health and recognize that health is a precondition for and an outcome and indicator of all three dimensions of sustainable development,

4. Recognize that action to realize the commitments made for the prevention and control of non-communicable diseases is inadequate and that the level of progress and investment to date is insufficient to meet target 3.4 of the Sustainable Development Goals and that the world has yet to fulfil its promise of implementing, at all levels, measures to reduce the risk of premature death and disability from non-communicable diseases;

5. Acknowledge the progress achieved by some countries in the implementation of their commitments made in 2011 and 2014 for the prevention and control of four major non-communicable diseases, namely, cardiovascular diseases, diabetes, cancer and chronic respiratory diseases, by reducing their main common risk factors, namely, tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity, and by addressing the underlying social, economic and environmental determinants of non-communicable diseases and the impact of economic, commercial and market factors, as well as by improving disease management to reduce morbidity, disability and mortality,

6. Recognize that many countries still face significant challenges in the implementation of their commitments, and remain deeply concerned that the burden of non-communicable diseases continues to rise disproportionately in developing countries and that every year 15 million people between the ages of 30 and 69 die from non-communicable diseases and that 86 per cent of these premature deaths occur in developing countries;

7 Express grave concern that the huge human and economic cost of non-communicable diseases contributes to poverty and inequities and threatens the health of peoples and the development of countries, costing developing countries over the next 15 years more than 7 trillion United States dollars;

8 Welcome the fact that the General Assembly proclaimed 2016–2025 as the United Nations Decade of Action on Nutrition and encourage its implementation;

9. Welcome the convening of the World Health Organization Global Conference on Non-communicable Diseases, hosted by the Governments of Finland, the Russian Federation and Uruguay and the World Health Organization, from 18 to 20 October 2017 in Montevideo, and its outcome document, entitled "Montevideo road map 2018–2030 on non-communicable diseases as a sustainable development priority", as a contribution to the preparatory process leading to the third high-level meeting and recall World Health Assembly resolution 71.2 of 26 May 2018,[4]

[2] Resolution 70/1

[3] Resolution 69/313, annex

[4] See World Health Organization, document WHA71/2018/REC/1.

10. Welcome the report of the World Health Organization Independent High-level Commission on Non-communicable Diseases entitled "Time to deliver", and take note of its recommendations;

11. Recognize that mental disorders and other mental health conditions, as well as neurological disorders, contribute to the global burden of non-communicable diseases and that people living with mental disorders and other mental health conditions may face stigma and discrimination, being more susceptible to having their human rights violated and abused, and also have an increased risk of other non-communicable diseases and therefore higher rates of morbidity and mortality, and that depression alone affects 300 million people globally and is the leading cause of disability worldwide;

12. Acknowledge the significant impact of non-communicable diseases on children, which is of major concern, in particular the rising levels of obesity among them, recognizing that children who are given the opportunity to grow and develop in a healthy environment that is responsive to their needs, including breastfeeding, and that, at a young age, fosters and encourages healthy behaviour and lifestyles, including healthy dietary choices and regular physical activity, and promotes the maintenance of healthy weight, can greatly reduce the risk of non-communicable diseases in adulthood;

13. Acknowledge the impact of non-communicable diseases on older persons, which is of particular concern, given the growing proportion of older persons and recognizing that they have an increased risk of multiple non-communicable diseases, which constitutes a major challenge for health systems;

14. Acknowledge that mainstreaming a gender perspective into the prevention and control of non-communicable diseases is crucial to understanding and addressing the health risks and needs of women and men of all ages, giving particular attention to the impact of non-communicable diseases on women in all settings;

15. Reaffirm the primary role and responsibility of governments at all levels in responding to the challenge of non-communicable diseases by developing adequate national multisectoral responses for their prevention and control, and promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and underscore the importance of pursuing whole-of-government and whole-of-society approaches, as well as health-in-all-policies approaches, equity-based approaches and life-course approaches;

16. Acknowledge that other stakeholders also share responsibility and can contribute in creating an environment conducive to preventing and controlling non-communicable diseases, and recognize the need to bring together civil society and the private sector to mobilize all their available resources, as appropriate, for the implementation of national responses for the prevention and control of non-communicable diseases;

We therefore commit to scale up our efforts and further implement the following actions:

17. Strengthen our commitment, as Heads of State and Government, to provide strategic leadership for the prevention and control of non-communicable diseases by promoting greater policy coherence and coordination through whole-of-government and health-in-all-policies approaches and by engaging stakeholders in an appropriate, coordinated, comprehensive and integrated, bold whole-of-society action and response;

18. Scale up the implementation of the commitments made in 2011 and 2014 for the prevention and control of non-communicable diseases through ambitious multisectoral national responses and thereby contribute to the overall

implementation of the 2030 Agenda for Sustainable Development, including by integrating, across the life course, action on the prevention and control of non-communicable diseases and the promotion of mental health and well-being,

19 Implement, according to own-country-led prioritization, a set of cost-effective, affordable and evidence-based interventions and good practices, including those recommended by the World Health Organization, for the prevention and control of non-communicable diseases, that can be scaled up across populations to promote health, treat people with non-communicable diseases and protect those at risk of developing them, with a particular emphasis on the needs of those in vulnerable situations,

20. Scale up the implementation of the commitments made in 2011 and 2014 to reduce tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity, taking into account, as appropriate, World Health Organization-recommended interventions for the prevention and control of non-communicable diseases,[5] in line with national priorities and targets,

21. Promote and implement policy, legislative and regulatory measures, including fiscal measures as appropriate, aiming at minimizing the impact of the main risk factors for non-communicable diseases, and promote healthy diets and lifestyles;

22. Accelerate the implementation of the World Health Organization Framework Convention on Tobacco Control [6] by its States parties, while continuing to implement tobacco control measures without any tobacco industry interference and to encourage other countries to consider becoming parties to the Convention;

23 Implement cost-effective and evidence-based interventions to halt the rise of overweight and obesity, in particular childhood obesity, taking into account World Health Organization recommendations and national priorities;

24 Develop, as appropriate, a national investment case on the prevention and control of non-communicable diseases to raise awareness about the national public health burden caused by non-communicable diseases, health inequities, the relationship between non-communicable diseases, poverty and social and economic development, the number of lives that could be saved and the return on investment;

25 Establish or strengthen national multi-stakeholder dialogue mechanisms, as appropriate, for the implementation of the national multisectoral action plans for the prevention and control of non-communicable diseases in order to attain the national targets;

26. Share information with global and regional partners on experiences, including successes and challenges related to the implementation of national policies and programmes to prevent and control non-communicable diseases and promote health, in order to further strengthen the global knowledge and expand the evidence base on best practices and lessons learned, including on traditional medicines, to promote informed action;

27 Invest in research, including in public health measures, on health promotion and disease prevention and the health sector's role therein, and in new treatment options for prevention and cost-effective therapies;

[5] Such as the World Health Organization Global Action Plan for the Prevention and Control of Non-communicable Diseases 2013–2020, the comprehensive mental health action plan 2013–2020, the global strategy and action plan on ageing and health 2016–2020, the global action plan on physical activity 2018–2030, the Global Strategy on Diet, Physical Activity and Health and the Global Strategy to Reduce the Harmful Use of Alcohol, as well as the World Health Organization Framework Convention on Tobacco Control

[6] United Nations, *Treaty Series*, vol 2302, No 41032

28. Take the necessary measures to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health across the life course, in respecting human rights obligations and addressing the specific health needs of children, women, older persons, persons with disabilities and others who are more vulnerable to non-communicable diseases;

29. Take measures to better prepare the health systems to respond to the needs of the rapidly ageing population, including the need for preventive, curative, palliative and specialized care for older persons, taking into account the disproportionate burden of non-communicable diseases on older persons, and that population ageing is a contributing factor in the rising incidence and prevalence of non-communicable diseases;

30. Scale up efforts to use information and communications technologies, including e-health and m-health and other innovative solutions, through, inter alia, the promotion of public-private partnership to accelerate ambitious action towards the prevention and control of non-communicable diseases;

31. Increase global awareness, action and international cooperation on environmental risk factors, to address the high number of premature deaths from non-communicable diseases attributed to human exposure to indoor and outdoor air pollution, underscoring the particular importance of cross-sectoral cooperation in addressing these public health risks;

32. Promote healthy communities by addressing the impact of environmental determinants on non-communicable diseases, including air, water and soil pollution, exposure to chemicals, climate change and extreme weather events, as well as the ways in which cities and human settlements are planned and developed, including sustainable transportation and urban safety, to promote physical activity, social integration and connectivity;

33. Encourage the adoption of holistic approaches to health and well-being through regular physical activity, including sports, recreation and yoga, to prevent and control non-communicable diseases and promote healthy lifestyles, including through physical education;

34. Empower the individual to make informed choices by providing an enabling environment, strengthening health literacy through education, and implementing population-wide and targeted mass and social media campaigns that educate the public about the harms of smoking and/or tobacco use and second-hand smoke, the harmful use of alcohol and the excessive intake of fats, in particular saturated fats and trans-fats, sugars and salt, promote the intake of fruits and vegetables, as well as healthy and balanced sustainable diets, and reduce sedentary behaviour;

35. Strengthen health systems and reorient them towards the achievement of universal health coverage and improvement of health outcomes, and high-quality, integrated and people-centred primary and specialized health services for the prevention, screening and control of non-communicable diseases and related mental health disorders and other mental health conditions throughout the life cycle, including access to safe, affordable, effective and quality essential diagnostics, medicines, vaccines and technologies, and palliative care, and understandable and high-quality, patient-friendly information on their use, as well as health management information systems and an adequate and well-trained and equipped health workforce;

36. Promote increased access to affordable, safe, effective and quality medicines and diagnostics and other technologies, reaffirming the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), as amended, and also reaffirming the 2001 Doha Declaration on the

TRIPS Agreement and Public Health, which recognizes that intellectual property rights should be interpreted and implemented in a manner supportive of the right of Member States to protect public health and, in particular, to promote access to medicines for all, and notes the need for appropriate incentives in the development of new health products,

37. Implement measures to improve mental health and well-being, including by developing comprehensive services and treatment for people living with mental disorders and other mental health conditions and integrating them into national responses for non-communicable diseases, and addressing their social determinants and other health needs, fully respecting their human rights;

38. Promote access to affordable diagnostics, screening, treatment and care, as well as vaccines that lower the risk of cancer, as part of the comprehensive approach to its prevention and control, including cervical and breast cancers;

39. Integrate, as appropriate, responses to non-communicable diseases and communicable diseases, such as HIV/AIDS and tuberculosis, especially in countries with the highest prevalence rates, taking into account their linkages,

40. Strengthen the design and implementation of policies, including for resilient health systems and health services and infrastructure to treat people living with non-communicable diseases and prevent and control their risk factors in humanitarian emergencies, including before, during and after natural disasters, with a particular focus on countries most vulnerable to the impact of climate change and extreme weather events,

41 Pursue all necessary efforts to mobilize the full, active and responsible engagement and participation of all relevant stakeholders for the prevention and control of non-communicable diseases,

42. Promote meaningful civil society engagement to encourage Governments to develop ambitious national multisectoral responses for the prevention and control of non-communicable diseases, and to contribute to their implementation, forge multi-stakeholder partnerships and alliances that mobilize and share knowledge, assess progress, provide services and amplify the voices of and raise awareness about people living with and affected by non-communicable diseases;

43 Engage with the private sector, taking into account national health priorities and objectives for its meaningful and effective contribution to the implementation of national responses to non-communicable diseases in order to reach Sustainable Development Goal target 3 4 on non-communicable diseases, while giving due regard to managing conflicts of interest,

44. Invite the private sector to strengthen its commitment and contribution to the implementation of national responses to prevent, control and treat non-communicable diseases to reach health and development objectives by:

(a) Promoting and creating safe and healthy working environments, by implementing occupational health measures, including by establishing tobacco-free workplaces, and through good corporate practices, workplace wellness programmes and health insurance plans, as appropriate;

(b) Encouraging economic operators in the area of alcohol production and trade, as appropriate, to contribute to reducing harmful use of alcohol in their core areas, taking into account national religious and cultural contexts;

(c) Taking concrete steps, where relevant, towards eliminating the marketing, advertising and sale of alcoholic products to minors;

(d) Further producing and promoting food products consistent with a healthy diet, making further efforts to reformulate them in order to provide healthy and nutritious options, reducing the excessive use of salt, sugars and fats, in particular saturated fats and trans-fats, as well as providing appropriate content information of those nutrients, bearing in mind international guidelines on nutrition labelling;

(e) Committing to further reduce the exposure of children to and impact on them of the marketing of foods and beverages high in fats, in particular saturated fats and trans-fats, sugars or salt, consistent with national legislation, where applicable;

(f) Contributing to further improving access to and the affordability of safe, effective and quality medicines and technologies in the prevention and control of non-communicable diseases;

45. Establish or strengthen transparent national accountability mechanisms for the prevention and control of non-communicable diseases, taking into account government efforts in developing, implementing and monitoring national responses for addressing non-communicable diseases and existing global accountability mechanisms;

46. Commit to mobilize and allocate adequate, predictable and sustained resources for national responses to prevent and control non-communicable diseases and to promote mental health and well-being, through domestic, bilateral and multilateral channels, including international cooperation and official development assistance, and continue exploring voluntary innovative financing mechanisms and partnerships, including with the private sector, to advance action at all levels;

47. Call upon the World Health Organization to continue to exercise its leadership, as the directing and coordinating authority on international health, in order to contribute to Member States' efforts to prevent and control non-communicable diseases by continuing and strengthening its normative and standard-setting work and its capacity to develop and provide technical cooperation, assistance and policy advice to Member States, as well as to enhance its multi-stakeholder engagement and dialogue, including through the World Health Organization global coordination mechanism on the prevention and control of non-communicable diseases and the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases;

48. Also call upon the World Health Organization to continue to promote and monitor enhanced global action to prevent and control non-communicable diseases by coordinating work with other United Nations agencies, development banks and other regional and international organizations, including by exploring new financing, implementation, monitoring and evaluation and/or accountability mechanisms;

49. To implement these actions, we commit to act in unity to create a just and prosperous world where all people can exercise their rights and have equal opportunities to live healthy lives in a world free of the avoidable burden of non-communicable diseases;

50. We request the Secretary-General, in consultation with Member States, and in collaboration with the World Health Organization and relevant funds, programmes and specialized agencies of the United Nations system, to submit to the General Assembly, by the end of 2024, for consideration by Member States, a report on the progress achieved in the implementation of the present political declaration, in preparation for a high-level meeting on a comprehensive review, in 2025, of the progress achieved in the prevention and control of non-communicable diseases and the promotion of mental health and well-being.

18th plenary meeting
10 October 2018

Approved for tabling.

SNA
2/10/18

Paper Laid
at the Table & Ltd
House by Hon. Mrs. MP
on 3/10/2018

REPUBLIC OF KENYA

THE NATIONAL ASSEMBLY

TWELFTH PARLIAMENT- SECOND SESSION

DELEGATION REPORT

REPORT ON THE JOINT EAST AFRICAN COMMUNITY HEADS OF STATE RETREAT ON INFRASTRUCTURE AND HEALTH FINANCING AND DEVELOPMENT

KAMPALA, UGANDA

21ST – 22ND FEBRUARY, 2018

Published by:-
The Directorate of Committee Services
Clerk's Chambers
Parliament Buildings
NAIROBI

OCTOBER, 2018

Table of Contents

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CoE	Centre(s) of Excellence
EAC	East African Community
HIV	Human Immunodeficiency Virus
NCDs	Non Communicable Diseases
SDGs	Sustainable Development Goals
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Program
UNEP	United Nations Environmental Program
WHO	World Health Organization

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CoE	Centre(s) of Excellence
EAC	East African Community
HIV	Human Immunodeficiency Virus
NCDs	Non Communicable Diseases
SDGs	Sustainable Development Goals
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Program
UNEP	United Nations Environmental Program
WHO	World Health Organization

1.0 PREFACE

The EAC Heads of State Summit on Investment in Health is the first and biggest ever event of the EAC Heads of State on matters of health. Convening of the First Summit on Investment in Health was recommended in June, 2016 by the 12th Sectoral Council on Health and subsequently adopted in April, 2017 by the 35th Meeting of the EAC Council of Ministers.

Convening of the event is in recognition of the fact that the EAC region is undergoing major public health transformations fueled by changing human, animal and environmental interactions, population dynamics and socio-economic development. The region, like other low and middle-income regions, is experiencing a burden of common infectious diseases such as malaria, HIV/AIDS and TB as well as maternal and child health complications; NCDs such as high blood pressure, diabetes and cancers; and epidemic and pandemic diseases related to increasing globalization, trade and climate change.

1.1 Delegation

The following Members of the Departmental Committee on Health were nominated to attend the Meetings of the Joint EAC Heads of State Retreat on Infrastructure and Health Financing and Development in Kampala, Uganda on 21st and 22nd February, 2018;

1. Hon. Mercy Gakuya, MP - Leader of the Delegation
2. Hon. Tongoyo Gabriel Koshal, MP
3. Ms. Christine Odhiambo – Delegation Secretary

1.2 Appreciation

Hon. Speaker,

The delegation is grateful to the Offices of the Speaker and the Clerk of the National Assembly for facilitating the trip. The summit was geared towards incorporating separate infrastructure and health sector investors and donors' roundtable and international exhibition. The meeting also provided a high-level political push for investments in major infrastructure and health projects in the region, all of which are aimed at advancing the health and wellbeing of East Africans.

Hon. Speaker,

Pursuant to Standing Order no. 199(6), it is now my pleasant duty to table the Report of the Parliamentary Delegation on the Joint EAC Heads of State Retreat on Infrastructure and Health Financing and Development, for consideration and adoption by the House.

Signed..... **Date**.....2/10/18.....

Hon. Sabina Chege, MP

Chairperson, Departmental Committee on Health

2.0 INTRODUCTION

The East African Community (EAC) is a regional intergovernmental organization of six Partner States: the Republics of Kenya, Burundi, Rwanda, South Sudan, the United Republic of Tanzania and the Republic of Uganda. The headquarters of the EAC is in Arusha, Tanzania.

The work of the EAC is guided by its Treaty which established the Community, known as the Treaty for the Establishment of the East African Community. It was signed on 30 November 1999 and entered into force on 7 July 2000 following its ratification by the original three Partner States - Kenya, Tanzania and Uganda. The Republic of Rwanda and the Republic of Burundi acceded to the EAC Treaty on 18 June 2007 and became full Members of the Community with effect from 1 July 2007. The Republic of South Sudan acceded to the Treaty on 15 April 2016 and become a full Member on 15 August 2016.

As one of the fastest growing regional economic blocks in the world, the EAC is widening and deepening co-operation among the Partner States in various key spheres for their mutual benefit. These spheres include political, economic and social.

3.0 BACKGROUND

The Joint East Africa Community Heads of State Retreat on Infrastructure and Health Financing and Development brought together two events namely the 4th EAC Heads of State Retreat on Infrastructure Financing and Development as well as the 1st EAC Summit on Investment in Health and Health Sector Investors and Donors Round Table and International Exhibition. The Heads of State Retreat aims at accelerating the attainment of the objectives of the EAC Development Strategy, Agenda 2063 and the Sustainable Development Goals in the infrastructure and health sectors.

The theme for the Retreat was "Deepening and widening regional integration through infrastructure and health sector development in the EAC Partner States".

Under the health sector pillar, the Retreat addressed itself to the following issues–

a) Building consensus on regional health sector investment priorities for the attainment of Universal Health Coverage and the Sustainable Development Goals;

b) Showcasing the major health sector investments and opportunities in the Partner States;

c) Mobilizing investment in the health sector in identified priority areas; and

d) Revitalizing regional partnerships and linkages for improved health outcomes for EAC Partner States.

4.0 PRESENTATIONS

The following are the key highlights of the presentations made at the Retreat;

4.1 Opening remarks by Sicily Kariuki, Cabinet Secretary in the Ministry of Health, Kenya

The Cabinet Secretary noted that there had been great strides made towards achieving better health outcomes. She stated that the Government of Kenya had undertaken to make Kenya globally competitive by the year 2030. One of the key priorities to achieve this is the Universal Health Coverage, which is grounded on three pillars namely to ensure financial protection, to increase access to health services as well as to develop sustainable financing.

She further stated that Kenya strives to increase domestic health financing so as to ensure the affordability and accessibility of health services for all. She noted that the Government had created an enabling environment for investment in health, and that local, regional and international investors were encouraged to take advantage of the opportunities available in health investment.

4.2 Opening remarks by Ambassador Liberat Mfumfeko, Secretary General, EAC

The Secretary General noted that communicable and non-communicable diseases were on the rise in Africa, and that there was need to put in place sustainable measures to curb this menace. He stated that the primary health objective was to provide quality healthcare through strengthening health services.

He however noted that there had been significant progress made in the delivery of high quality health services, training and research. He noted that the attainment of the Universal Health Coverage is critical for having a healthy population and a healthy East Africa in general.

He also stated that there was need for regional cooperation for the attainment of Universal Health Coverage. To this end, he emphasized the need to foster good relations with development partners as well as among the Partner States. He also stressed the importance of the need to

strengthen the research capacity of Partner States so as to curb the communicable and non-communicable diseases.

He further noted that the major challenge in the health sector was the emergence of new diseases. He finished by stating that expenditure in health should be looked at as an investment in the long run.

4.3 Promoting private sector contribution towards achieving UHC and ending extreme poverty by 2030, by Tim Evans, Senior Director of Health Nutrition and Population, World Bank

The forum was informed that;

A pluralistic health system is a reality and private sector administers more than half of all healthcare in Africa, if informal providers are included. The role of the private sector in UHC is not a new phenomenon. There is at present a wide range of ongoing roles and activities which include direct provision of healthcare, training of human resources, management of health care institutions, manufacturing of healthcare goods (pharmaceuticals; equipment) and services (rehabilitation), as well as financing. There is also growing evidence on the substantial role played by the private sector in advancing UHC, with examples of countries such as Thailand and Turkey.

The typology of the private sector mainly involves Informal Providers, Non-profit Providers, Small to medium Providers as well as Large corporate or Commercial Providers.

The informal providers are characterised by single/ solo practitioners or traditional healers having their own retail outlets. The approach applied by the informal providers involves beneficial competition rather than control, linking to systems and incentives for referral; expansion of pharmacy chains as well as the strict enforcement of law, especially prescription laws.

The NGOs and Faith based Providers are characterised by the fact that they are not for profit.

The faith based networks in EAC are an important source of healthcare and they deliver specific services to the people within the community, and are usually supported through external financing for particular services for vulnerable groups. This therefore ensures that faith-based healthcare is sustainable. However, hospital services charged on fee for service basis to cover costs could make them inaccessible to the poor and vulnerable unless external subsidy is available.

Registered Small to medium providers on their part form a substantial share of the private sector and perform better on client satisfaction. There is better cost containment through strategic purchasing, equity and cost effectiveness, but may impact contribution to health outcomes.

Corporate and commercial providers are experienced mainly in the growing in middle income countries. They are characterised by a business model catering for the rich and low cost base for international market, commonly known as health tourism. The high cost of medical services offered under this category makes it inaccessible to the poor.

The key global lessons in achieving equity within the health sector may therefore be said to be;

- Taking advantage of political opportunities and using supportive social movements;
- Starting incrementally and expanding the coverage;
- Public Financing is critical for achieving UHC. There is therefore need to explore different sources of revenue to support UHC expansion;
- Being cautious about early decisions, including payment arrangements, private sector role and number of risk pools; and
- Building analytical capacity to assess and find best options including negotiation skills.

4.4 Digital Reach Initiative: Digital Regional East African Community Health Initiative, by Prof. Gibson Kibiki, MD, MMed, PhD- Executive Secretary, East African Health Research Commission

Towards regional commitment to improve health and outcomes through digital technology

The forum was informed that;

The East Africa Community is leading in Africa on the use of ICT for communication and financial transactions. However, the EAC still lags behind in digital health as evidenced by its high disease burden, low life expectancy and weak health systems.

The Vision for the Digital Reach Initiative is towards interconnected health systems for a healthy and prosperous Africa. The mission statement on the other hand is to maximize the power of digital health in East Africa by ensuring an enabling environment and by implementing scaled, coordinated, transformational and innovative approaches.

The digital reach initiative is applied in various areas. In the area of public health education and awareness, digital reach initiative is applied to support individual wellness, disease prevention, public health and behavior change through the various channels. In terms of diagnostic and treatment support, it is used to diagnose at the point-of-care and treat patients remotely, including maintenance of health provider appointments and medication regime adherence.

Data collection and surveillance involves collection of real-time patient data, including healthcare data related to vital statistics, disease incidence, outbreaks, and public-health emergencies. Resource allocation and management on the other and involves allocation of resources according to population and health indicators.

In regards to the opportunity for digital health in East Africa, there is need for shared regional infrastructure, capacity and learning to create large-scale cost efficiencies, as well as faster and better implementation mechanisms.

The digital reach initiative, once fully implemented, will result in economic efficiencies and improved health systems. It will also enable the region to position itself as a new leader in digital health implementation.

4.5 East Africa's Centres of Excellence for Skills and Tertiary Education in Biomedical Sciences, by Patience Kuruneri, Manager- Public Health, Security and Nutrition Division, African Development Bank

The forum was informed that;

The Centres of Excellence (CoEs) focus on significantly enhancing and upgrading biomedical sciences education and training, as well as research capacity in existing institutions of higher learning in the EAC.

The aim of the CoEs is to contribute to the development of relevant and highly skilled workforce in biomedical sciences to meet EAC immediate labour market needs and support the EAC regional integration agenda in Higher Education and implementation of EAC Labour Mobility Protocols.

The African Development Bank is supporting the creation of a network of CoEs within the EAC, as follows;

1) ***CoE in Nephrology and Urology Sciences- East Africa Kidney Institute (Kenya)***

   The aim of this CoE is to address the labour market shortages for skilled professionals in the biomedical specialities of nephrology and urology within the EAC.

   The Institute will provide higher education programs and clinical training; scientific and operation research; and preventative, curative and service delivery. A complex for the Institute will be built at Kenyatta National Hospital (KNH) grounds with facilities for education, research, and service delivery.

   The expected outcomes of the Institute are the training in masters and doctorate courses, as well as building capacity in research and implementing initiatives to facilitate and strengthen applied research activities.

2) ***CoE in Oncology Sciences- East Africa Oncology Institute (Uganda)***

   The aim of the CoE is to transform the existing Uganda Cancer Institute (UCI) from a modest

specialized health facility to a higher Institute in collaboration with the Makerere University College of Health Sciences.

The institute will provide leadership in postgraduate education, clinical training, research and clinical services to cater for oncology demands in the region. The expected outcomes are to provide cancer treatment facilities using chemotherapy, radiotherapy and other forms of modern cancer treatment; provide scholarships for 60 post-graduate training in cancer and related research for 5 years; establish an e-learning centre, e-library to support research and continuous medical education; and to develop and implement a regional integration strategy on higher education and research.

3) ***CoE in Biomedical Engineering and e-Health- East Africa Biomedical Engineering Institute (Rwanda)***

The aim of this CoE is to address the labour market shortages for skilled professionals in biomedical specialties specifically biomedical engineering and e-Health.

The Center of Excellence in Biomedical Engineering and e-Health will be housed at the University of Rwanda. The Institute will provide leadership in training, research and preventive maintenance services to cater for regional needs.

The Institute will strengthen the synergy between academia, the Government and the private sector while harnessing the transformational power of biomedical engineering and ICT for cost-effective service provision and job creation.

4) ***CoE in Cardiovascular Sciences- East Africa Heart Institute (Tanzania)***

The aim of this CoE is to address labour market shortages for skilled professionals in cardiology and cardiovascular surgery in Tanzania and to expand biomedical higher education to help reduce the burden of cardiovascular diseases and risk factors in the East African population. The CoE is hosted at the Muhimbili University of Health and Allied Sciences (MUHAS), Mloganzila Campus.

The CoE will train highly qualified human resources, provide quality multifaceted patient care, and conduct cutting edge research and innovation in cardiovascular sciences.

The expected outcomes of the CoEs will be to directly benefit the EAC citizens; development of

relevant biomedical skills and thematic research as well as data generation that will aid in finding biomedical solutions.

5.0 OBSERVATIONS

The Heads of State observed that there was need for certain immediate investment priorities, namely;

1) Expansion of access to specialized health care and cross border health services;
2) Strengthen the network of medical reference laboratories and the regional rapid response mechanism for health security threats;
3) Expansion of capacity to produce skilled and professional work force for health in the region based on harmonized regional training and practice standards and guidelines;
4) Increase access to safe, efficacious and affordable medicines, vaccines, and other health technologies focusing on malaria, TB, HIV/AIDS, NCDs and other high burden conditions;
5) Upgrading of health infrastructure and equipment in priority national and sub national health facilities/ hospitals Establishment of strong primary and community health services as a basis for health promotion and diseases prevention and control;
6) Expansion of health insurance coverage and social health protection;
7) Improvement of quality of healthcare, health sector efficiency and health statistics; and
8) Strengthening of health research and development.

6.0 RECOMMENDATIONS

At the conclusion of the Retreat, the partner states were urged to;

1) Ensure that investments made in the EAC regional CoEs for higher medical education, health services and research are prioritized so as to achieve the ultimate goal of attaining self-sufficiency in specialized healthcare;
2) Progressively increase domestic financing of health services, research and development priorities in line with the WHO recommended targets and taking into account the rapidly growing population;

3) Emphasize equity, efficiency and accountability in the efforts to attain universal health coverage;
4) Take decisive actions towards the elimination and control of infectious diseases such as malaria, HIV&AIDS, Tuberculosis; NCDs; and preventable reproductive maternal and child deaths and complications as per global commitments;
5) Scale up investments in human resources for health as the cornerstone for enhancing health sector performance in terms of planning, development, recruitment and retention and introduce innovative needs-based training programs;
6) Institutionalize quality improvement initiatives at all levels of the health system to enhance health service delivery, efficiency and returns on investment;
7) Increase investments in interventions addressing social determinants of health including water, sanitation, and hygiene;
8) Harness the potential of digital technology and e-Health to address current and emerging health threats through stronger health management information systems, capacity building, diagnostics and treatment;
9) Establish stronger partnerships with the private sector including in areas of local manufacturing of health products through effective incentives such as affordable financing and enabling legal frameworks; and
10) Ensure meaningful engagement of key stakeholders during the development of the detailed projects arising from the priorities framework.