It is an honour to address you this morning.

Good health is what we wish most, all of us, for our loved ones and without it nothing else matters.

Health is also the currency of progress.

I want to begin by underlining that Universal Health Coverage is Africa's priority and it is the world's priority.

The Africa Health Strategy recently adopted by the African Union, in the context of Agenda 2063, defines Universal Health Coverage by 2030 as the continent's top strategic objective in this area.

The Sustainable Development Goals include the very same target. Since last July there is also consensus on how to measure progress. The World Health Organisation is the custodian of those indicators.

These developments have created an unprecedented political opportunity to anchor the huge global public health gains realised over the past generation in national health systems that are sustainably-financed and people-centered.

I commend the Director General, Dr Tedros, for seizing this momentum and placing the World Health Organisation squarely at the centre of this global priority.

He brings a fresh energy and a hands-on approach, which is not surprising given the

tremendous progress his country has made. He is the right person, in the right place, at the right time.

The World Health Organisation's proposed 13th General Programme of Work designates Universal Health Coverage as the first of its three strategic imperatives for the next five years. It is therefore fully aligned with the decisions already taken at the continental and global levels.

Specifying an interim goal of an additional one billion people getting coverage by 2023 is a good innovation. This may sound like a lot, but the truth is that it reflects the minimum pace required to meet the 2030 goal, and we are already behind schedule.

According to the latest Global Monitoring Report, the greatest variation among regions is in service capacity and access, where Africa lags behind. We simply lack the personnel and the facilities required for Universal Coverage. Addressing this gap has to be main focus of African Member States and our partners.

The data also show that catastrophic out-of-pocket health expenditures are an increasing source of impoverishment in Africa, though not yet to the extent seen in other regions.

However, that may simply reflect the fact that many life-saving services are not yet widely available. As service coverage in Africa expands, the financial risks for citizens will also increase unless adequate protection measures are in place for the most vulnerable.

There are also some bright spots. For example, Africa ranks highly on the sub-index for Non-Communicable Diseases (NCDs) service coverage because of low levels of tobacco use.

But let's not take this for granted and continue working with the World Health Organisation and other partners to keep tobacco use in check.

Achieving Universal Health Coverage is feasible for countries at every income level.

It is also the right thing to do. Strong political leadership will certainly be necessary at every stage. It is therefore helpful to regularly remind ourselves why Universal Health Coverage is so transformational.

First, and most importantly, it works.

All around Africa, and beyond, whenever countries have put universal, community-based, primary health systems in place, the results have been good.

For example, in Rwanda, a combination of community-based health insurance, community health workers, and good external partnerships led to the steepest reductions in child and maternal mortality ever recorded.

The key was an approach that put individuals and communities at the centre. In choosing this path, Rwanda learned from others who preceded us, and we also benefited greatly from advice and support from the World Health Organisation.

Integrating digital applications and new technologies into our health system has also made a difference, and we are now using drone aircraft to quickly deliver blood and medical supplies to rural hospitals.

More than 90 per cent of Rwandans are enrolled in health insurance today. Two-thirds of the costs are covered by contributions from beneficiaries, with government subsidising the remaining one-third.

At one point, we realised that enrolment was falling because the reliability of services in some places had declined.

The challenge was addressed, and confidence restored, by shifting to electronic payments for insurance premiums and segregating health funds from other accounts at the local level.

At the same time, we continue to expand our network of volunteer Community Health Workers, who are present in every village and serve as an essential link between the population and health facilities.

A second reason for Universal Coverage, is that the impact on women and girls is disproportionately positive. This has been critical to making gender equality a reality.

Third, Universal Health Coverage is affordable for countries at every income level, as examples from all over Africa show.

Ghana, Kenya, Morocco, and Senegal all offer a subsidy to insurance. Ethiopia is a pioneer in the use of Community Health Workers as the frontline of primary healthcare, and Ghana is also deploying them with great success.

And in Tunisia, we have seen an effective example of the importance of involving citizens in the planning and evaluation of health provision.

In many cases, these programmes can be scaled up using national resources, even as direct partner funding addresses other important health needs.

When the means to succeed, and the responsibility for doing so, are put directly in the people's hands, not only are lives saved, but it is also sustainable.

Fourth, our experience in Rwanda is that an early emphasis on primary healthcare was one of the most effective strategies for re-building trust between citizens and government, in the aftermath of our national tragedy.

The trust that was earned became the foundation for other essential services and proved to be the key ingredient for long-term stability and security.

Fifth, Universal Health Coverage leads to future-mindedness and entrepreneurship. It frees people to plan for the future with confidence. Families invest the savings in businesses and in better-quality education for their children, for example.

These items should really be enough to cement the political case for Universal Coverage. But it doesn't hurt to add two more arguments in favour that are often overlooked: Jobs, and women's economic empowerment.

The International Labour Organisation estimates that Africa's health economy workforce today is missing almost 17 million workers in both health and non-health occupations. Under Universal Health Coverage, that shortage is projected to increase to 26 million by 2030.

Indeed, half of the funding needed to achieve U.H.C. by 2030 will go to training and employing workers in the health sector. These are high-quality jobs that are not easily displaced by technology.

Building the health workforce can also radically transform women's lives, and this will benefit all of us.

One-quarter of the health workforce globally consists of unpaid labour by women, particularly providing long-term care. But this labour is not really free. It comes with tremendous opportunity costs as tens of millions of women forego employment.

Universal Health Coverage is therefore an opportunity, not a burden, in every respect.

Resources undoubtedly matter. The world has come together and done the right things. That includes government donors, and also transformational philanthropies, such as the Gates Foundation, as well as sister organisations, like the Global Fund, and Gavi, the Vaccine Alliance.

Working together, intractable problems become less daunting. Historic progress has already been achieved, and so we cannot afford to see any decline. Too many lives would be at stake.

When it comes to resource mobilisation, a sense of shared ownership of success makes all the difference.

As it embarks on its eighth decade, the World Health Organisation is as essential and central, as ever. It has a unique role in developing important new norms and standards, and sharing life-saving tools and technologies.

It works at the country-level, where, for example, we need the World Health Organisation's support to increase Africa's emergency preparedness by meeting the International Health Regulation core competencies.

The World Health Organisation is aligned with Africa and with my country, Rwanda. It is a trusted source of technical advice and helps keep our people safe from harm.

We should return that trust by ensuring that the World Health Organisation has the resources needed to carry out the missions that Member States have assigned to it. This means diversifying funding sources, so that costs are more equitably shared. It also means reducing earmarks in favour of untied contributions. We must also commit to paying our assessments on time and in full.

It is entirely appropriate for Member States to expect value for money and accountability for results. The Director General has committed to providing us with this data and that is reflected in the new General Programme of Work.

I believe that he and his team merit our full confidence and support in this endeavour.

The World Health Organisation's renewed emphasis on preparedness is of great significance for all of us. Whatever dangers the future might hold, we will come out of it better if threats are met by organised institutions that react quickly.

I would like to close by commending Dr Tedros and the entire staff of this organisation for the quick and effective response to critical health emergencies in Africa over the past year, most recently in the Democratic Republic of Congo.

Indeed, we all owe a debt of gratitude to all the front-line health workers and advocates around the world, whose heart and spirit of selfless service make our world safer and more just.

I thank you for your kind attention and wish you a very positive and productive Assembly.