Thank you very much. Let me first start by expressing our appreciation to Paul Allen, and the Family Foundation and for all those who put this together. I bring you warm greetings from the Chairperson of the African Union Commission, Dr. Nkosazana Dlamini Zuma who insisted on our participation. She herself would have loved to be here but she is currently in Brussels, also attending to another equally important engagement. Let me also express appreciation to Honorable Madina and to our good friend and collaborator Dr. Nabarro, who we have been on this long journey together.

I’m just going to focus quickly on six areas of lessons we have learned and we will continue to learn. The first one is early and timely response. In April 2014 when our ministers of health meeting under the joint ministers of health meeting organized to get our WHO in Luanda, and Guinea had highly fulfilled its obligation by reporting the outbreak of disease, some ministers did volunteer to go to the front, then we thought well if we throw money at this it will go away. Looking back, we were wrong. We did throw money at it, some of the ministers who are health personnel did go to Guinea, volunteered, but we now know that it wasn’t enough. It wasn’t until August 8th when WHO declared Ebola a public health of international concern, that we all became serious. The first lesson is that we should have had a timely response. We took it all from there. On August 19th, 11 days after our Peace and Security Council acting under Article 684 protocol, declared Ebola as a threat to peace and security.

But within less than four weeks we put gloves on ground; in other words, we were able to deploy. So the second lesson we’ve learned is the logistics of response and deployment. And we have, looking back, we ask ourselves, how did we do it? Within less than four weeks we were able to put our first set of health volunteers, hard target was a hundred but within four weeks of the establishment, by September 15th, we put health workers on the ground in Liberia, and few days later we were able to send people to Sierra Leone and Liberia. We’re still asking ourselves, how did we do it? Again, in consultation with the member states effected, it was just like reading from General Petraeus’ book, we need to have a surge. Again within a month we scaled up from one hundred health volunteers to almost nearly a thousand. We are still asking ourselves, how did we do that within a month? With very limited resources, it is a lesson we are trying to document.

The third area of lesson is in our concept of operation and support – our philosophy, the principle is that we cannot know better than the people of Sierra Leone. We cannot know better than people of Liberia nor can we know better than people of Guinea. And we do not have intention of going there to dictate to them. And I’m glad to listen to the Honorable Madina, I’m glad about some of the films and documentaries we have watched because the greatest error of all this struggle are the people of Liberia, people of Sierra Leone, and people of Guinea themselves. They should be recognized because they are the front line – we supported them, so our philosophy is that we are going to put these health workers, they were the first line to be decimated by Ebola. Our philosophy then was get African health workers in the contest of African solidarity, African helping Africans, and putting them at the disposal of the African government. It worked. I remember we had a bit of this discussion with Dr. Nabarro when
he visited us in Addis Ababa that we must learn the lessons from HIV and AIDS, when we go all over the place telling people as if they don’t know what to do the reality is that these people live on the continent, they are in better position to fight infectious disease. They need assistance, they need help, which the international community did provide and are quite appreciative of.

The third lesson here is in terms of collaboration and coordination among different actors. I’m glad to see Dr. Nabarro here, we had various actors in the field, everyone having their own idea. Well, the African Union under ASEOWA was able to bring together ECOWAS and other African countries to have a bit of coordination. The UN tried the same thing with UNMEER. Dr. Nabarro will tell you how successful they were in that. There were other organizations on the ground whose defining characteristics is that they will never be coordinated. Medecins Sans Frontieres, the Red Cross and so many others; you cannot coordinate the United States, nor can you coordinate the United Kingdom, as some other member states did. So it was a nightmare coordinating in the field. I’m sure the Deputy Minister of Health here will also say more about that but the lessons to be learned is that there is need for proper coordination on the field. At a later stage, we were able to have that semblance of coordination and I’ll cite an example: where we coordinated very well with the United States and Center for Disease Controls in areas of Sierra Leone in training and in data management.

Five is in the area, the role of technology and innovation: looking back we are able to say, how did we do it, how did we put close to a thousand people on the ground – in terms of recruitment, in processing, checking their background, checking their qualifications. We were able to develop internally within the African Union Commission, software that enabled us to do this. What about their rapid test? We heard from Paul this morning talking about the rapid diagnostic test. The interesting thing is Nigerians, Ugandans, have also been developing this test; some of the research is coming from the partners and when Nigerians brought their mobile laboratory to Sierra Leone, it was for the rapid diagnostic test they brought with them, and from the experience of some of the people we were able to quickly diagnose, given the sensitivity of the rapid diagnostic test, to offer more treatment and care and support.

Finally, is a medium to long term program to build Africa’s capacity. We’re, as Dr. Nabarro would say, the approach to zero is bumpy. Yes, but we’ll get it. The experience and defining characteristics of places like Uganda and DRC is that you’re going to be having those bumps pop up here and there; we have to have a flexible response on ground now and we are starting to withdraw mobile units that can quickly go after them but we’re already talking in terms of recovery to make sure in future we are able to rapidly, to have a good surveillance, detection, and response. This is in the contest that we’re putting in the place the African Centers for Disease Control and Prevention that we call the Africa CDC. Thanks to our colleagues at the US CDC and others, who have been supporting us in this. We hope that when the center starts operating in July, it will take seriously the issue of international health regulations and give capacity building to the member states who have been lacking in even the core capacities of the IHR and also will continue to monitor development; we know that once Ebola has arrived in that part of the continent it’s not going to go away any time soon. The challenge we’ll face is preparedness to detect and respond. We’ve demonstrated that we’ll be keeping the core of the health workers on the continent to make sure that we have well trained health workers that we can draw upon so that we’re never caught napping. I am going to stop here; I’ve taken more than my time. I hope to answer more questions on the African Centers for Disease Control and some of the great work that people of Sierra Leone, the people of Liberia and the people of Guinea with the support of close to a thousand of their own brothers and sisters who are the front line.
Thank you very much.