Meeting Report

High Level Forum on the Health MDGs in Asia and the Pacific

20–21 June 2005 • Tokyo, Japan

Government of Japan

Asian Development Bank

World Bank

World Health Organization

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MEETING REPORT

Hosted by the Government of Japan
in cooperation with
the Asian Development Bank, World Bank and World Health Organization

The World Health Organization Regional Office for the Western Pacific prepared this report on behalf of the co-organizers and participants at the High-Level Forum on the Health MDGs in Asia and the Pacific, held in Tokyo, Japan on 21 and 22 June 2005.

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1. INTRODUCTION

In the United Nations Millennium Declaration of 2000, world leaders agreed to a set of measurable goals and targets for combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. Known as the Millennium Development Goals (MDGs), three of the goals deal with health: Goal 4, reduce child mortality; Goal 5, improve maternal health; and Goal 6, combat HIV/AIDS, malaria and other diseases. Three other goals are health-related: Goal 1, eradicate extreme poverty and hunger; Goal 7, ensure environmental sustainability; and Goal 8, develop a global partnership for development.

The High Level Forum on the Health MDGs in Asia and the Pacific, hosted by the Government of Japan, in cooperation with the Asian Development Bank, World Bank and World Health Organization, was held in Tokyo from 21 to 22 June 2005 (see Annex 1 for the Agenda). Participants included ministers of development, finance and health, as well as high-ranking officials from 24 countries in Asia and the Pacific, bilateral and multilateral donor agencies, United Nations agencies and nongovernmental organizations (see Annexes 2A and 2B for lists of participants).

The objectives of the Forum were to:

- review progress and challenges faced by countries in the Asia Pacific Region as they seek to achieve the health Millennium Development Goals;
- from this review, identify best practices and opportunities to accelerate progress at the country level;
- highlight strategies for cooperation between countries and for strengthened regional collaboration; and
- consider options of increasing domestic and international resources for health in efficient and equitable ways including through regional cooperation and South-South cooperation.

The Forum focused on actions that can be initiated at the country level and strengthened through regional cooperation. The lessons from experience and good practices in Asia and the Pacific shared during the Forum and summarized in the Chair's Summary (see Annex 4) are an important contribution to the global review of progress taking place in 2005, in various forums, including the High Level Plenary Meeting of the 60th Session of the General Assembly (the 2005 World Summit). It was also significant that ministers and high level officials in charge of health, development and finance reconfirmed their political commitment to achieving the health MDGs.

The Forum was opened by two officials of the Government of Japan, Mr Ichiro Aisawa, Senior Vice-Minister for Foreign Affairs, and Mr Hiroyoshi Nishi, Senior Vice-Minister of Health, Labour and Welfare, and by Dr Shigeru Omi, World Health Organization Regional Director for the Western Pacific. Their opening remarks are attached (see Annexes 3A, 3B and 3C). A background paper, *Turning Promises into Progress: Attaining the Health MDGs in Asia and the Pacific,* was distributed at the Forum. In the discussion during the opening session, many participants welcomed the new Health and Development Initiative (see Annex 5) announced by the Government of Japan on this occasion.

2. PROCEEDINGS

2.1 Overview of progress

The first plenary session, chaired by Mr Shigekazu Sato[1], reviewed progress on the health MDGs in Asia and the Pacific.

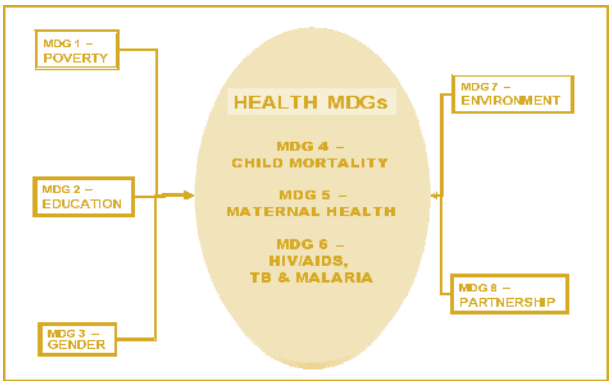
In his overview presentation on issues and challenges, Dr. Andrew Cassels[2] emphasized the critical importance of tackling the health problems associated with the MDGs in Asia and the Pacific, given the region's contribution to the total global burden of disease and mortality. Aggregate data can be misleading, since progress is uneven within countries and areas in the region. It is important to ensure that the goals are achieved equitably—that is, without ignoring the poor and the marginalized.

The technical interventions for many diseases and health problems are known. But many of these effective interventions fail to reach those who need them. A key challenge is to define a clear and practical agenda to strengthen health systems development. This requires effective stewardship, ensuring adequate and sustainable financing, as well as addressing human resources issues such as adequate staffing, improved motivation and retention through better conditions of work, more balanced deployment, and reduced migration. Region-specific health challenges include noncommunicable diseases, new and emerging communicable diseases, and the impact of disasters and conflicts. Achieving the health MDGs also requires coordinated actions to address the non-health determinants of health across a range of other sectors or areas, including education, agriculture, infrastructure, water and sanitation, and gender equality. Finally, the effort needs greater resources in developing countries, raised both domestically and through international assistance. Aid should be more predictable, better coordinated and harmonized with national priorities.

2.1.1 Successes

Malaysia has achieved or is very likely to achieve the health MDGs, according to Dr Chua Soi Lek[3]. For example, it reduced its under-5 mortality rate (U5MR) by 85% in three decades, falling from 57 per 1000 live births to 17 per 1000 live births between 1970 and 1990, and to 9 per 1000 live births in 2000. Reductions in infant and maternal mortality have been of similar magnitude. In the same period, poverty has declined from 49% to 5%; universal education has been assured for all up to age 11 and the vast majority of the urban and rural population have access to clean piped water and adequate sanitation.

Figure 1. Links among MDGs



Malaysia attributes its successes to three major factors, namely: non-health factors; the overall development in health services; and specific maternal and child health initiatives. Among non-health factors, strong political will for health and socio-economic development is reflected in policy formulation, resource allocation and infrastructure development. Since all the MDGs are closely linked (see Figure 1), another success factor is good intersectoral cooperation from sectors such as education, rural development, information, transport and housing, as well as technical support from regional and international partners.

Second, large investments were made in health infrastructure development. Over 90% of the population lives within 5 kilometres of a health facility. Mobile services cater to the more remote areas. Malaysia has also trained allied health professionals, such as community nurses, medical assistants and dental nurses, to be responsible for basic health care, especially in rural areas. Many quality improvement initiatives have focused on the health

[1] Director-General, Economic Cooperation Bureau, Ministry of Foreign Affairs, Japan

[2] Director, Sustainable Development and Healthy Environment/MDGs, Health and Development Policy, World Health Organization, Geneva

[3] Minister of Health, Malaysia

of mothers and children. Since 1985, the National Quality Assurance Programme monitors the performance of health programmes against national and professional standards.

Initiatives specific to maternal and child health include addressing high-risk cases, auditing of maternal death, growth monitoring of infants, nutritional surveillance, use of oral rehydration salts for acute diarrhoea, and training in neonatal resuscitation. Training of traditional birth attendants has increased the proportion of births attended by skilled health personnel from 20% to 99%.

Other successes and success factors

Thailand has achieved the MDG targets for poverty, hunger, gender, HIV/AIDS, and malaria more than 15 years ahead of schedule. Further reductions in child and maternal mortality will be difficult. Thailand has set more ambitious "MDG-plus" targets for itself. Its success owes partly to the sustained internal resources mobilized to reduce poverty through health actions.

Myanmar, a low-income country of 54 million people of whom 70% live in rural areas, has made some progress. It eliminated poliomyelitis by 2000 and leprosy by 2003. Life expectancy has increased, and maternal and child morbidity and mortality have declined.

Pakistan, whose experience was presented by Mr Muhammad Nasir Khan[4], has recently seen more than a three-fold increase in public sector health allocations and expenditures. However, three fourths of health expenditures are still funded out of pocket. Prioritizing programmes for children and mothers, the Government will increase the number of Lady Health Workers (LHW) from 85 000 to 100 000. LHW form a bridge between the community and health facilities bringing basic health services to the doorstep. Oxford Policy Management's evaluation of the programme found that it has a significant impact on child and maternal mortality rates.

2.1.2 Challenges

Changing disease burden

Pakistan typifies many countries in the region that face a double disease burden. Communicable diseases, reproductive health and malnutrition issues still dominate, but non-communicable diseases, injuries and other conditions are increasingly important (see Figure 2).

Figure 2. Pakistan: Burden of disease

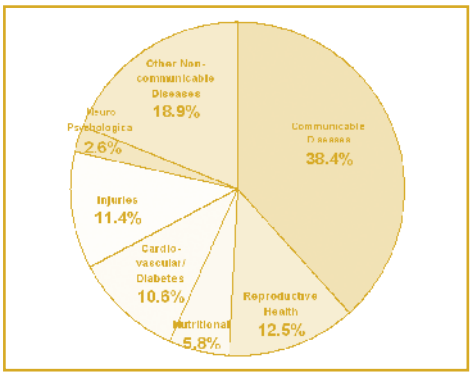
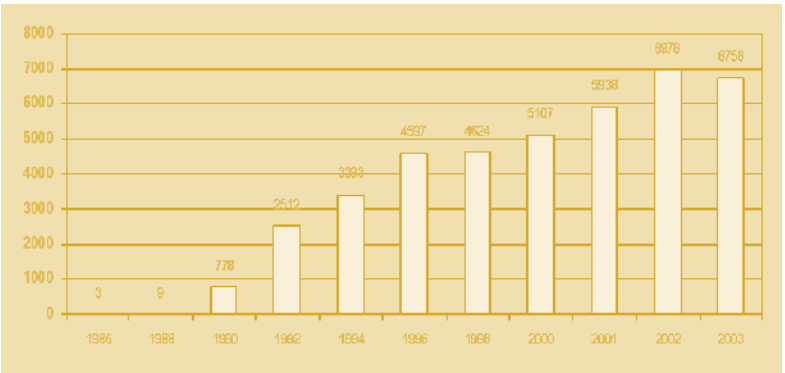


Figure 3. Malaysia: reported HIV infections (including AIDS) 1986-2003



HIV/AIDS poses a special threat to public health as well as to development progress (see Figure 3). Its progress has been unrelenting in the region, except in Cambodia and Thailand, which have successfully reduced the number of new infections. At current rates, its spread is unlikely to be halted and reversed by 2015. Addressing the challenge requires strong political commitment and coordinated action by a range of stakeholders. In Malaysia, where injecting drug use is a key mode of transmission, an inter-ministerial committee oversees national efforts on HIV/AIDS.

[4] Minister of Health, Pakistan

Weak health systems

The *Lao People's Democratic Republic* was discussed by Dr Ponmek Dalaloy[5]. Despite having made significant progress on the MDGs, the country has weak health system capacity and inadequate health infrastructure. Developing adequate workforce skills, ensuring essential medicine supply and tapping the rich potential of indigenous medicinal plants are key challenges. Decentralization has proved to be a mixed experience. The National Growth Poverty Reduction Strategy identifies the following priorities: 1) reduce maternal and infant morbidity and mortality; 2) enhance the skills of health workers, particularly in remote areas; 3) develop sustainable health financing, including various forms of health insurance, as well as equity funds for the poor; 4) develop institutional mechanisms to steer cross-sectoral actions; and 5) develop regional cooperation, particularly with neighbouring countries.

Thailand faces health system challenges including inadequate health information system capacity and inadequate and unevenly distributed human resources, especially physicians.Financial incentives did not have much success in encouraging retention of health staff in rural areas. A special project seeks to ensure an adequate number of rural doctors through rural recruitment, local training and hometown placement.

Myanmar struggles to ensure access to affordable essential medicines. Prices rose after the country signed patent agreements, but negotiations with the pharmaceutical industry were not fruitful. Using provisions of Trade-Related Aspects of Intellectual Property Rights (TRIPS) for non-commercial purposes, *Malaysia* has reduced antiretroviral drug prices from about $1000 to $200 per month.

In *Pakistan*, 78% of births take place at home and skilled birth attendants assist in only 24% of births. One child dies every minute, mainly from diarrhoea, acute respiratory infections and vaccine-preventable diseases. Key health system challenges include improving access to services in less developed areas; integrating fragmented health services; reforming institutional and management systems; upgrading infrastructure; strengthening monitoring and surveillance; and building capacity among management and health providers.

Limited cross-sectoral actions

Participants agreed on the need for cross-sectoral actions to improve health. The challenge lies in developing the institutional mechanisms to ensure this. One participant noted the absence of sexual and reproductive health from the MDGs.

Insufficient and inefficient use of resources

Countries fund a major part of their health expenditures through domestic resources. However, many countries need substantially more resources to meet the health MDGs. For the poorest countries, progress is not possible without external financial resources. The quality of aid is as important as its quantity. Another challenge lies in improving resource allocation and management. Currently, a large share of funding usually goes to urban areas, often supporting costly curative services.

Inequity a threat to progress

Despite successes, there is wide variation in progress, both between and within countries. Inequities have widened in recent decades, with the poor increasingly unable to access health services. In *Viet Nam*, for example, the maternal mortality rate (MMR) fell from 200 per 100 000 in 1990-1995 to 85 per 100 000 in 2003. However, the MMR in remote and mountainous areas is two times higher than that in other areas. The country recognizes the importance of providing better reproductive services to the disadvantaged and those residing in mountainous and remote areas. Malaysia and Thailand also recognized the need to reduce differentials between states.

[5] Minister of Health, Lao People's Democratic Republic

Participants also raised other issues in discussions during this session, including:

- role of the health sector in promoting intersectoral actions on health;
- need for better alignment of donor policies to national priorities in developing countries;
- need for special attention to fragile states;
- production of medicines by developing countries to reduce costs and the feasibility of differential pricing for essential medicines; and
- the importance of peace to achieving the health MDGs.

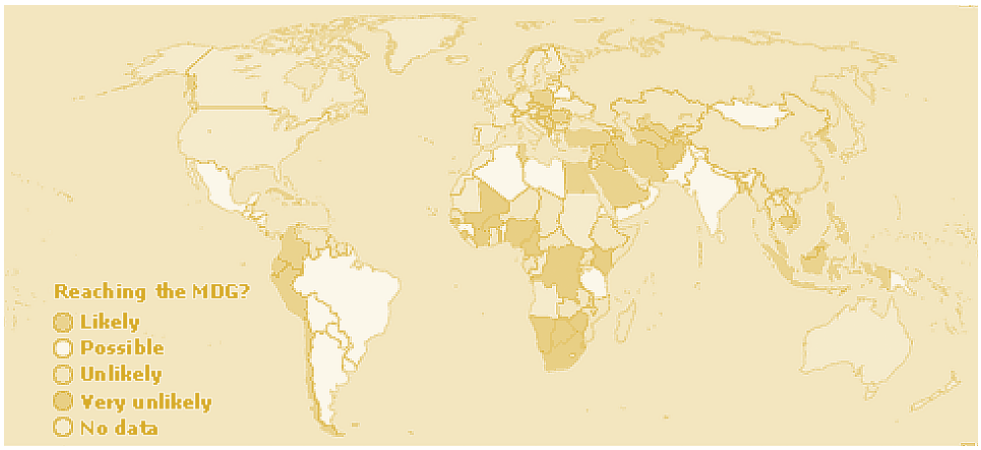
2.2 Strengthening health systems through capacity development

An analysis of the current situation and key challenges in achieving the health MDGs suggests that effective health systems, which can ensure that available interventions are delivered to those most in need, are not always in place. In particular, effective interventions are failing to reach the most vulnerable groups. Participants explored the key health systems challenges facing countries in the region in their efforts to achieve the health MDGs in a parallel session chaired by Dr Andrew Cassels.

2.2.1 Progress, constraints and challenges

In his overview of key health systems constraints, challenges and opportunities, Dr David Evans[6] pointed out that progress on the health MDGs is often slower than that for other MDGs. For example, a World Bank study of 78 low-income countries shows that 68 are not on track for the maternal and child mortality goals (see Figure 4). By current trends, 55 countries will not achieve the malnutrition goal, and only a handful of countries will halt and start to reverse the spread of HIV/AIDS.

Figure 4. Prospects of meeting the child mortality MDG



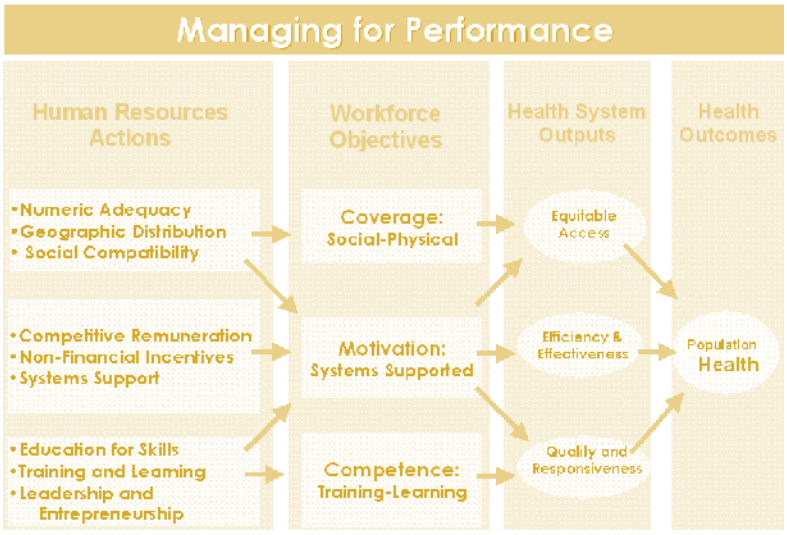
Note: Countries need an average of 4% decline per year in child mortality

Key health systems barriers to scaling up interventions for malaria, HIV/AIDS, tuberculosis, maternal and child health include: social, economic and cultural influences; human resources availability; management; drug and supply systems; financial constraints; resource allocation; and monitoring and evaluation systems; and the use of information.

The health workforce, which accounts for up to 50% to 75% of government health spending in many cases, is too often perceived as a cost, not an asset. Rigid professional boundaries, poor working conditions and weak leadership frequently result in low morale among health workers. Growing demand in some countries has triggered ongoing migration, resulting in shortages elsewhere. Some governments have been increasing budget allocations for health. Nevertheless, available resources are still insufficient. While the annual investment needed for health is estimated at $50 to $100 per capita, up to 66 countries spend less. Reliable, valid and timely information on inputs, outputs and outcomes is often lacking. Analysis of equity is often not possible, since information is not disaggregated according to age, sex, geographical area, rural or urban residence, income and other indicators of social exclusion. Capacity to analyse information and use it for policy-making is usually weak. Inequalities in access, affordability and outcomes persist and may be increasing.

[6] Director, Health System Financing, Expenditure and Resource Allocation, WHO

Figure 5. Managing for performance



2.2.2 Approaches to strengthen health systems

Under a systems approach, various health systems actions, such as strengthening human resources for health (see Figure 5), contribute to a hierarchy of outcomes. Participants discussed several health systems strengthening approaches to accelerate the achievement of the health MDGs.

Effective policies

Governments need to ensure that health is encapsulated in a clear set of widely understood development policies and strategies. These should be discussed with finance and other key ministries. For example, *Sri Lanka* prepared a master plan to strengthen the health system, with support from Japan. The project built capacity and local ownership of the process. As a result of regular consultation with various stakeholders, the strategy and priority interventions identified in the plan were widely accepted and guided future project design by the World Bank and the Japan Bank for International Cooperation. At the same time, health policies need to be supported with adequate resources so as to ensure financial risk protection and universal access, especially for vulnerable groups. For example, in *Myanmar*, essential drug funds and health funds, available in every town hospital, provide financial protection to the poor during illnesses. The United Nations Millennium Project's proposed "quick wins" include rationalization of health service delivery to ensure safe services at the lowest level of service provision, provided by adequately trained and appropriately supervised personnel; and elimination of user fees for the poor.

Health policies need to better link vertical programmes with more integrated health systems-focused approaches. Linking vertical programmes, such as sexual and reproductive health and HIV/AIDS, can mutually reinforce the strengths of each programme, such as confidentiality of services and behaviour change communication.

Human resources for health

Health infrastructure should be complemented by appropriate human resource development policies. Long-term commitment and planning are required to address human resource shortages, improve work conditions, and strengthen the management and implementation capacities of the health workforce. Country-specific approaches are important. At the same time, international action is needed on issues such as migration, to ensure that health workers are not pulled out of developing countries at a pace that is detrimental to their country of origin.

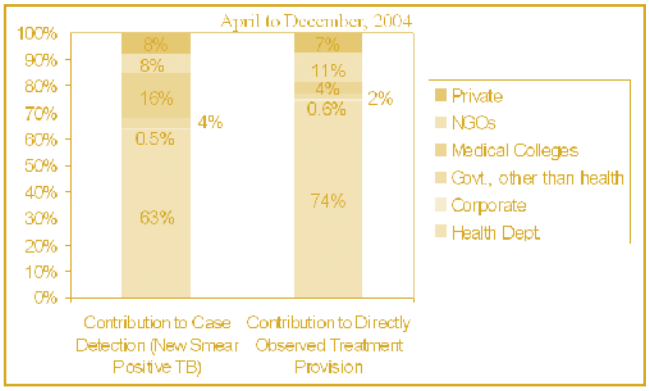
Mr Tsuisugaletaua Aveau Sofara[7] presented *Samoa*'s experience in human resources for health. In the context of prioritizing primary care, Samoa has tried to ensure an optimal skill mix and strengthen the leadership and management capacity of health professionals. These steps were undertaken within the framework of a national public sector reform programme, while adhering to the core values of equity, sustainability, quality and cultural appropriateness. The Health Leadership and Management Development Programme in Samoa and the South Pacific is a concrete example of how a sub-regional approach with multi-agency support can strengthen the capacity of mid-level managers. Samoa's experience demonstrates that an appropriate skill mix can promote service delivery in far-flung areas and can be particularly important for improving service quality and ensuring retention. Similarly, *Myanmar* provides services through paramedics at rural health centres, where deployment of doctors is a challenge. Developing the skills of workers at multiple levels can strengthen referral.

[7] Minister of Natural Resources, Environment and Meteorology

Strengthening partnerships

An example of public-private partnership in directly observed treatment, short course (PPM DOTS) from *India*, presented by Mr. G. V. Srinivas[8], illustrates the potential role of the private sector in improving access to good quality diagnosis and treatment, with strong support from the public sector. Many tuberculosis (TB) patients prefer private health facilities, even when public facilities are available. However, private providers often follow non-standard diagnosis and treatment practices, at relatively high cost, whereas public TB services are provided free. Under PPM DOTS, the government provides training and medicines and laboratory supplies free of charge. Private facilities may refer TB suspects for diagnosis to a designated centre or diagnose TB themselves and then provide directly-observed treatment. Nongovernmental organizations (NGOs) are also involved in the programme, which has reached about 4 million patients so far. Case detection and treatment success rates are comparable to those under the public sector (see Figure 6). Challenges in scaling up include the heterogeneity and unorganized nature of private providers and their reluctance to sign formal agreements with and be supervised by government. These challenges are being addressed through local innovative approaches.

Figure 6. Contribution by different providers in 12 intensified PPM DOTS sites, India, Apr-Dec, 2004



There was discussion about the role of global initiatives, such as the Global Alliance for Vaccines and Immunization (GAVI), in supporting health systems. Participants agreed on the importance of donor coordination for effective use of human and financial resources. The challenge for governments is to exercise a leadership role and foster national ownership.

Access to essential drugs

Sri Lanka's experience, presented by Dr Nihal Jayathilaka[9], exemplifies the role of government in responding to market imperfections to improve access to affordable essential drugs. These policies were introduced under a broader effort to improve access to health services in general. As early as the 1970s, Sri Lanka pioneered the concept of an essential medicines list. It set up a state monopoly for manufacturing as well as importing and distributing essential drugs, although gradually permitting the private sector to import multiple brands. As a result, the public sector provides essential medicines free of charge and has kept quality and prices under control even in the private sector. A critical factor for success has been the high literacy rate, which has heightened people's awareness of the importance of health and their demand for services. On the supply side, medical professional education and training were tailored to the national drug supply policy and system, including the essential drug concept. Future challenges to address include waste, resulting from free provision of drugs, and ensuring effective monitoring of the use of standard treatment guidelines. Years of civil conflict have eroded social sector budgets. Changes related to TRIPS may also threaten the existing system.

Myanmar's measures to make drugs affordable include an essential drug fund, tax exemption for sales of essential drugs and partial use generics in procurement.

A project for strengthening district health systems in Sulawesi, *Indonesia*, supported by Japan, aims to strengthen the blood supply system through the construction of a blood bank, provision of equipment and supplies, training for blood laboratory technicians and doctors, and supporting policy formulation and legislation for expansion to the national level.

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[8] First Secretary (Political & Consular), Embassy of India, Tokyo

[9] Additional Secretary, Ministry of Health, Nutrition and Uva Wellasa Development

Health information and research

The formulation of effective health policies and the measurement of progress require timely, accurate and disaggregated information. Many countries have weak capacity to produce and use quality evidence. Collecting and analysing information that is disaggregated by various indicators of social exclusion can support the analysis of equity in health efforts and outcomes. Health systems research should focus on important domestic challenges. In translating evidence into decision-making, information must be user friendly.

Lesson learned: no universal model, country-specificity crucial

No single model of a health system is suitable for universal adoption. Even within countries, an overall guiding framework is needed, but there need not be a single system dominated by the public sector. What is important is for each country to decide and act on four basic questions: 1) How is the health system being financed? 2) How are services planned and organized? 3) What is the best mix of providers? and 4) How are services regulated and quality assured? System performance may be assessed based on four criteria: 1) The system has identified priority actions to improve the health of vulnerable groups; 2) It has the capacity to formulate evidence-based policies; 3) It can train, utilize and motivate staff; and 4) It has adequate resources. Another way to assess performance is to measure the extent to which the health MDGs and other health outcomes are achieved.

2.3 Promoting cross-sectoral actions to achieve the health MDGs

It is well recognized that health is significantly determined by social and other non-health determinants. However, the corollary notion that non-health sector actions are needed to successfully address health challenges is not always equally well appreciated. In a parallel session chaired by Ms Khempheng Pholsena[10], participants examined how synergies in health outcomes can be achieved by a range of interventions across non-health sectors. In particular, they considered examples where the institutional mechanisms have successfully been put into place to steer cross-sectoral actions to improve health.

2.3.1 Priority sectors for promoting cross-sectoral actions

Participants were in agreement that health is a shared responsibility. For example, construction of sanitation facilities alone is not sufficient; improvement in hygienic behaviours is a must. Thus, the Punjab Community Water Supply and Sanitation Project in *Pakistan* combines water and sanitation infrastructure development and hygiene education.

Japan's Official Development Assistance (ODA) has made efforts to undertake projects with a cross-sectoral or multisectoral approach, combining health, nutrition, education, agriculture and infrastructure. For example, an ODA loan project in Mindanao in the southern *Philippines* was designed to reduce poverty among farming families by providing comprehensive assistance in basic infrastructure for agriculture and social infrastructure, including health services. The health service component includes construction and rehabilitation of clinics and purchase of equipment and supplies for medical examinations. Through its multisectoral approach combining health, education, irrigation and farm management, the project is expected not only to alleviate poverty but also to contribute to better health.

The education-for-all approach integrates the provision of safe water and sanitation in schools, skills-based health education, and school-based health and nutrition services. After World War II, *Japan* provided school meals and educated children on sanitation and parasitic diseases. To promote healthy diets and reduce obesity, *Brunei Darussalam*'s school health programme targets children between 6 and 14, referring identified children to facilities that assess nutritional status and recommend appropriate interventions. Guidelines on the sale of food in school canteens have also been issued.

[10] Vice President, Finance and Administration, Asian Development Bank

Infrastructure development can have a mixed health impact. An analysis of road transport in Asia by the Asian Development Bank (ADB) documents increased air pollution (leading to about 500 000 premature deaths every year), respiratory ailments and accidents. About 44% of the world's road deaths occur in Asia.

On the other hand, infrastructure development can significantly increase the impact of interventions in the health sector. For example, sample interviews of more than 200 women in the Japan Bank for International Cooperation's (JBIC) evaluation of a completed rural road project in *Indonesia* found that improved access through paved roads greatly contributed to increasing the use of antenatal facilities by pregnant women and, thereby to safe deliveries. Projects not directly related to the health sector might incorporate components to mitigate the negative impacts on health resulting from implementation of the project. For example, a JBIC-funded bridge construction project over the Mekong River to connect *Thailand* and the *Lao People's Democratic Republic* generated concern about the spread of HIV/AIDS resulting from the influx of migration workers and sex workers catering to them. In response, AIDS prevention programmes were conducted before and during construction. These programmes included education, voluntary counseling and testing, and the strengthening of health centers at the construction companies and surrounding communities. In Yunan, *China*, ADB supports efforts to prevent the spread of HIV/AIDS among workers involved in road projects. Similar HIV/AIDS prevention activities are included in a project to rehabilitate the Sihanoukville road in *Cambodia*. Similarly, Health Without Borders health promotion programme of the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) conducts research on working conditions and health needs of long-distance transport workers to help identify appropriate policies and pilot interventions, such as health stops along highways. To prevent a possible increase in malaria incidence resulting from newly built irrigation facilities, the Japanese ODA-funded Rengali Irrigation Project in *India* included the provision of insecticide-treated bednets, malaria testing, and capacity-building for community participation, in collaboration with the state health department.

The broad concept of human security can promote cross-sectoral actions. Cross-sectoral needs and impact assessment should be promoted. Rather than being externally driven, research and analysis should be nationally owned. Programmes designed with a focus on outcomes may generate more cross-sectoral approaches.

Health can also form an entry point to address non-health sector issues. For example, in *Nepal*, health is a possible starting point of the integrated approach to rehabilitation and resettlement of internally displaced communities.

National mechanisms

National governments need to provide a policy, regulatory and legislative environment conducive for cross-sectoral actions and facilitate inter-ministerial policy formulation, planning and budgeting. For example, *Nepal*'s Poverty Reduction Strategy Paper (PRSP) process includes development of a midterm expenditure framework and annual planning. The National Health Sector Implementation Plan is being linked with funding. The Ministry of Finance is moving towards zero budgeting and programme performance budgeting, with standards and norms for outcomes expected.

Ms Ishenkul Boldjurova[11] described the policy instruments developed in *Kyrgyzstan* to partner with the private food industry in improving the health of children and mothers. The Concept of Healthy Food National Policy (2003) promotes domestic capacity to produce food fortified with vitamins, mineral and other micronutrients. Recognizing the need for clear laws and regulations, the Parliament amended the law on the prevention of iodine deficiency diseases to establish conditions for industries that produce fortified food. In 2004, the Committee on Public Health of the Jogorku Kenesh (parliament) approved a law requiring enterprises to fortify at least one half of the baking flour they produce. Flour in the state reserves is also subject to mandatory fortification. State standards for iodized salt and fortified flour have been developed and approved.

[11] Vice Prime Minister, Kyrgyzstan

In *Indonesia*, all local governments are required to provide a minimum package of health services. They are also free to provide more services, depending on local priorities. In *Myanmar*, members of the National Health Committee, the highest health policy-making body, include health-related ministries and NGOs. To avoid overlapping, funds from international partners to support HIV/AIDS control have been pooled.

Public-private partnerships

The experience of *Kyrgyzstan* in preventing iodine deficiency disorders provides examples of institutional strategies for engaging the private sector. This partnership has resulted in nationwide access to fortified flour and iodized salt and improvement in the quality of fortified food. Early on, the Government defined its role in preventing micronutrient deficiency to include coordination across public and private sectors and civil society; providing a level playing field for private industries through laws and regulations, and creating an enabling environment. Members of the National Food Fortification Alliance, chaired by the vice-prime minister, includes representatives from health and other ministries, the sanitary-epidemiological supervision office, associations of private producers, academic institutions, international partners and NGOs. Enterprises participating in food fortification receive various concessions, including exemption from customs duties, exemption or deferment on VAT for various items, and preferential loans. The private sector, for its part, engages in fair and trusting dialogue with the Government. For example, the association of salt producers recently raised concerns about the efficiency of the partnership. NGOs, working with health and education staff, raise public awareness on iodine deficiency and the benefits of fortified food.

The not-for-profit private sector can also help introduce innovations. In *Nepal*, a missionary hospital outside the capital has attracted patients from Kathmandu because of its leadership and effective management. Its nursery school generates funds for better staff salaries and it has started community health insurance schemes. Another multisectoral programme initiated by an NGO addresses issues such as poverty, migrants, HIV/AIDS, and trafficking of drugs for cross-border populations in *China,* the *Lao People's Democratic Republic, Myanmar* and *Thailand*.

Cross-sectoral actions, decentralization and good governance

Decentralization, in which decision-making power is transferred to local officials and communities, can create opportunities for increased cross-sectoral actions.

Mr Arum Atmawikarta[12] described the institutional mechanisms for intersectoral coordination and local conflict resolution under decentralization in *Indonesia*. The process for formulating medium- and long-tern development plans promoting cross-sectoral actions was institutionalized by presidential decree. Joint Health Councils, with both health and non-health members, were established to assess proposals, with support from technical review teams composed of representatives from local governments, NGOs and academia. Criteria were developed to ensure eligibility of poor villages for development projects. Monitoring and evaluation are organized at community as well as district, provincial and central levels.

Indonesia's Intensified Iodine Deficiency Control Programme provides an example of multi-level integration of responsibilities and inter-ministerial policy coordination across health, industry and trade, home affairs, and the Food and Drug Control Agency. The National Plan of Action delineated the lines of accountability and responsibility. Central ministries are responsible for setting standards, developing regulations and policy guidelines, and monitoring and evaluation. Local governments are responsible for local enforcement, distribution of iodized salt, quality control at distribution and consumption points, education of salt farmers, and dissemination of iodization technology.

Strengthening the capacities of the local authorities and the communities can promote cross-sectoral actions. The cross-sectoral institutional arrangements employed in

[12] National Development Planning Agency (BAPPENAS), Indonesia

response to the December 2004 tsunami provide another example. Rehabilitation and reconstruction agencies (RRA) were set up in Aceh and Nias, consisting of an executing agency and two independent oversight boards reporting directly to the President of Indonesia. The RRA coordinates reconstruction efforts and matches donor funds with community needs, through a rigorous, well-monitored and locally responsive process. In *Thailand*, local authorities fund health personnel education and training, and construct health facilities. The primary health care concept integrates sanitation, basic health services and essential medicines at the community level. In *Myanmar*, health committees at the district, township and village levels coordinate health matters, including monitoring and evaluation.

Decentralization also provides an opportunity for increased stakeholder participation, enabling local authorities and communities to identify health priorities and participate in decision-making, based on local needs. However, decentralization requires significant investment in building local capacity to manage health and use participatory approaches.

2.3.2 Lessons learned in promoting cross-sectoral actions

Effective partnership is the foundation of successful cross-sectoral actions

Cross-sectoral action involves partnership. Influential individuals or groups should be brought on board. Strengthened analysis of the economic benefits of health will contribute to raising the priority of health. Governments may consider establishing a high level, multisectoral national steering committee that monitors and evaluates programmes to facilitate cross-sectoral actions and coordination. For example, in *Tonga*, church leaders were invited to participate in a dialogue on their resistance to the use of condoms. Over time, the church has become a core member of a committee to discuss broader health issues.

Ownership is needed at all levels

Ownership of cross-sectoral actions and involvement in decision-making need to be cultivated at all levels with all the stakeholders or target populations. In *Tonga*, communities did not regard health clinics as their own, and thus the facilities were neglected. The Minister of Health then convened a dialogue, initially with advisers, senior officials and Ministry staff, and eventually with the communities. This has generated an increased feeling of ownership of health facilities. Several communities have set up health committees.

2.4 Securing resources and improving effectiveness to achieve the health MDGs

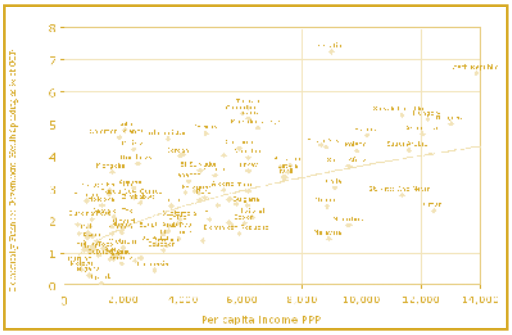
Current resources for health fall far short of actual needs. Even available resources are not always optimally allocated. This comes at a time when the need for the scaling-up of programmes is putting already weak health systems under increasing strain. In the plenary session, many participants emphasized the importance of economic growth for generating funding for health. In a parallel session, chaired by Dr Fadia Saadah[13], participants discussed issues of resource mobilization, aid effectiveness and harmonization.

In his overview, Mr George Schieber[14] presented a framework for analysing health financing in terms of its three core functions: revenue collection, revenue pooling, and purchase of services. Domestic revenues need to be adequate and sustainable and allocated efficiently and equitably to ensure a package of essential services and financial protection against catastrophic health expenditures. Efficient pooling of health risks promotes predictability of health expenses and unlinks the use of services from the ability to pay.

[13] Health Sector Manager, East Asia and Pacific Region, World Bank

2.4.1 Need for more resources for health and their more effective use

Figure 7. Government health spending by per capita income



Current spending

Many governments spend less than optimal amounts on health, often less than that required to meet critical social and infrastructure needs. Figure 7 shows the wide variations between per capita income and health spending. Most health spending comes from out-of-pocket private sources, which is regressive and therefore the least desirable source.

Future needs

Financing needs are determined by underlying demographics. For example, in East Asia, the total population will increase by 15 %-17% between 2000 and 2020, with the elderly population increasing by 50%. Even without new technology or improved coverage, health financing needs will rise by at least 15%-17% during the same period, and another 15% or 16% because of ageing (see Figure 8), which is an annual increase of 1.5%.

In South Asia, the population will increase by about 30%, and the elderly population by 25%, entailing the need for an additional 40% in health spending, which is 2% a year (see Figure 9).

Potential sources of additional domestic revenues

Figure 8. Effect of ageing on health expenditure, selected East Asia and Pacific countries

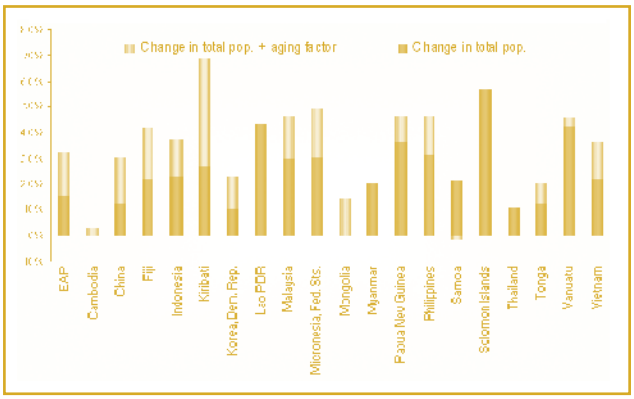
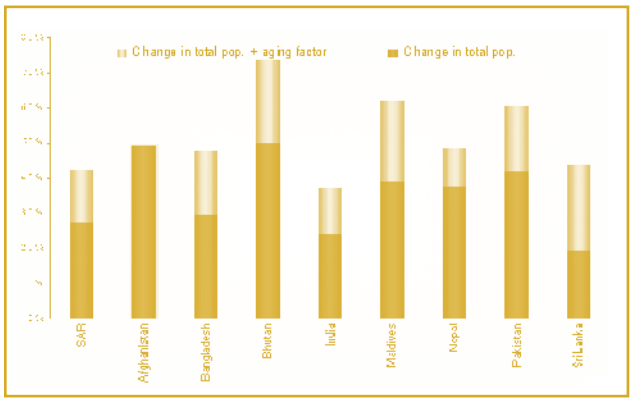


Figure 9. Effect of ageing on health expenditure, selected South Asia countries



Mr. Peter Heller[15] provided an overview of the options for mobilizing additional revenues and the concept of fiscal space. At 6% for East Asia and the Pacific and 5% for South Asia respectively, future GDP growth is unlikely to generate sufficient revenues to meet demand. Countries can borrow internally or externally, as long as they can create the capacity to repay. In low-income countries, more fiscal space may require reliance on donors for concessional loans or better yet for grants. Some countries need to exercise better fiscal discipline to maintain credibility in external capital markets. Figure 10 shows that some countries face difficult external debt repayment problems. Fiscal consolidation could reduce deficits and slow down the growth of public debt. The savings generated from reduced interest payments could then be channelled to health. Debt cancellation is another option on the international agenda.

Resources can also be mobilized through taxation. As income increases, countries' ability to raise revenues increases. Figure 11 shows the revenue-to-GDP ratios plotted against the GDP per capita of countries. The tax base can be expanded by changes in tax policy (e.g., reducing tax holidays and exemptions) or strengthening tax administration. Criteria for a good tax system include revenue adequacy and stability, efficiency, equity, ease of collection and political acceptability.

[14] Health Policy Adviser, Health, Nutrition and Population, World Bank

[15] Deputy Director, Fiscal Affairs Department, International Monetary Fund

Figure 10. External debt as share of gross national income, 2003

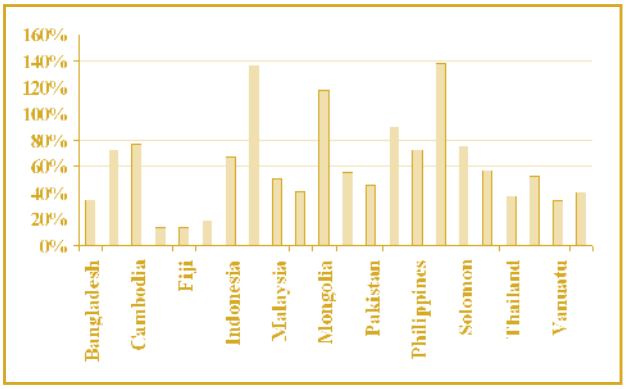


Figure 11. Central government and tax revenues as share of GDP, 2001

In some cases, privatisation can be used to create fiscal space. For example, in *Indonesia*, the proceeds were used for infrastructure spending. Other innovative options include:

- levy on air tickets to finance development and health programmes as part of the solidarity contribution elaborated in the Berlin Declaration by Algeria, Brazil, Chile, France, Germany and Spain;
- exploring an International Finance Facility for development;
- International Development Assistance (IDA) buy-downs to transform loans into grants; and
- passing a portion of taxes paid expatriate persons from developing countries to the country of origin.

Reprioritizing expenditure

Although social sector outlays are insufficient in many countries, there is room to reduce unproductive spending and thereby free up resources for health. For example, poorly targeted subsidies (such as those on fuel in India, the Lao People's Democratic Republic, Pakistan and Viet Nam, and fertilizer in India) can be cut back. Strengthening public expenditure management through privatization, reduction in inefficiencies, or reduction in subsidies or transfers can reduce state enterprise losses such as those in energy and manufacturing in *Bangladesh*, railroads in *India*, airlines in *the Lao People's Democratic Republic*, and energy in *Pakistan* and the *Philippines*.

Dr Khandaker Mosharraf Hossain[16] shared experiences from *Bangladesh*. The Bangladesh government is prioritizing outlays for an essential services package and shifting resources from the tertiary and secondary to the primary level, especially in poorer districts. Identification of beneficiaries will help better target services to the poor. Demand-side financing pilot projects include vouchers for maternal health. Similarly, *Thailand* shifted budget allocations in the 1980s to invest more in rural primary health facilities.

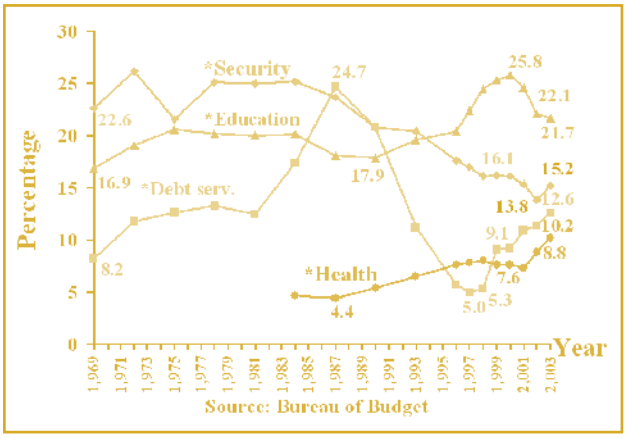
Risk-pooling

Risk-pooling helps channel spending away from out-of-pocket expenditures by households to more efficiently purchase services and provide financial protection.

Private insurance provides financial protection, but is usually unaffordable for the poor. Social health insurance (SHI) may be worthwhile, particularly in countries with a growing formal sector where revenue collection is relatively strong. Enabling conditions for SHI include: a growing economy; large payroll contribution base and, thus, small informal sector; concentrated beneficiary population and increasing urbanization; adequate administrative and supervisory capacity; ability to manage market failures such as moral hazard and adverse selection; and political will.

[16] Minister of Health and Family Welfare, Bangladesh

Figure 12. Sources of funds for universal coverage

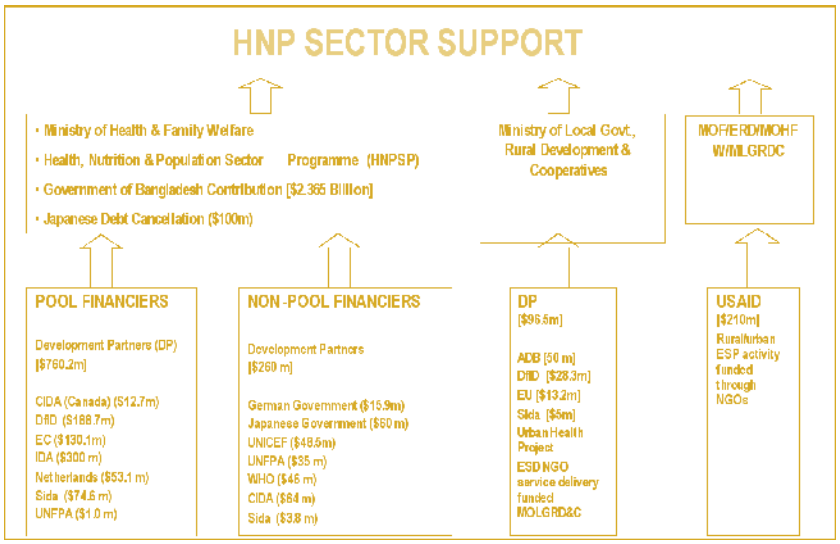


The experience of *Thailand* in introducing universal coverage through the "30 Baht Scheme" in 2001 was presented by Dr Suwit Wibulpolprasert.[17] The scheme, targeted to the poor, young and elderly, people with disabilities, and veterans, demonstrates the benefit of resource-pooling. The scheme pays three quarters of a dollar per episode of illness (see Figure 12). The government spends 4000 baht per year for each civil servant and his/her dependents through the Civil Servants Medical Benefits Scheme. Only 1800 baht per member per year is paid through the capitation system of the Social Security Scheme. The scheme benefited from a "peace dividend", through a 10% reduction in the defence budget. Double-digit economic growth in the 1980s to 1990s also reduced public debt repayments by 20%. The government is now contemplating earmarking two thirds of taxes on tobacco and alcohol for the 30 Baht Scheme.

Following the 30 Baht Scheme, surveys revealed that the share of the poorest population quintile pushed into deeper poverty as a result of health expenditure was only 2% and 0.8% among the richest quintile. The differential between the two quintiles was reduced from 11 times to less than 3 times over three years.

Improving aid effectiveness

Figure 13. Bangladesh: Resources for health, nutrition and population, 2005-10



Health investments need to be aligned to broader national policies and development processes, such as the Poverty Reduction Strategy Paper and the Health Master Plan (HMP). UNICEF proposed 10 principles for developing MDG-oriented health systems and policies and poverty reduction strategies, namely: multisectoral; synergistic, evidence-based, ambitious yet realistic, balanced, outcome-driven, system-enhancing, accountable, strengthening of partnerships and empowering of communities. *Bangladesh* adopted the sector-wide approach (SWAP), which puts the Government in the driver's seat with financial and technical support from partners. The Programme Support Office (PSO), located in the Ministry of Health and Family Welfare (MOHFW), coordinates contributions from development partners. A Health, Nutrition and Population (HNP) Development Partners Consortium facilitates coordination among partners. The five-year financing of the HNP programme (see Figure 13) comprises $2.3 billion from the government, $760 million from a pool of financiers and $260 million from non-pool financiers to the Ministry of Health and Family Welfare, $96.5 million to the Ministry of Local Government, Rural Development and Cooperatives, and $210 million from USAID to the Ministry of Finance for rural and urban essential services packages. Pooled funds represent 57.2% of the total.

The criteria being used in evaluating the HNP pooled fund include: share of total government expenditure to MOHFW; proportion of MOHFW expenditure allocated to the 25% poorest districts; utilization rate of ESD by the two lowest income quintiles; proportion of contracts awarded within initial bid validity period; proportion of births attended by skilled personnel; and TB case detection rate.

[17] Senior Adviser on Health Economics, Ministry of Public Health, Thailand

In *Viet Nam*, the Poverty Reduction Support Credit, co-financed by the World Bank and Japan, supports (i) private sector reforms and infrastructure development to help complete the transition to a market economy; (ii) social sector development including health, education, water and environment; and (iii) public sector financial management to strengthen governance. To improve access to health care by the poor, the health component provides support for the Health Care Fund for the Poor, targeting selected populations in all 64 provinces.

2.4.2 Lessons learned

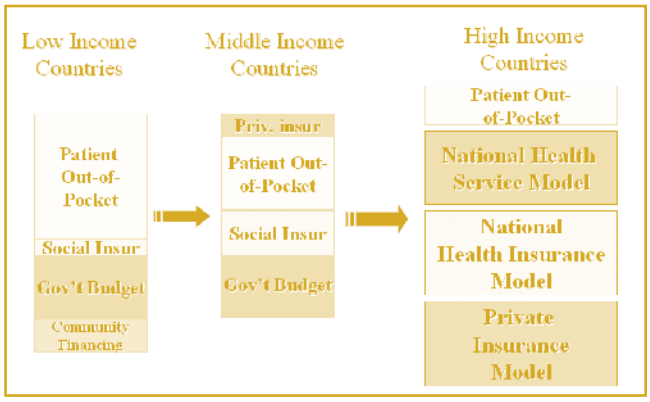
Health improvement is possible in low-income settings and economic downturns

During a period of slow economic growth in the early 1980s, *Thailand* invested a large share of resources in rural areas, freezing the budget for urban hospitals. In *Malaysia*, dramatic decreases in maternal mortality were achieved through fiscal prudence, investment in safe deliveries and motivation of health staff through better salaries. Both Thailand and Malaysia protected, and increased, the health budget during the 1997-1998 financial crisis.

No single model for securing resources and improving effectiveness

Although the issues may be similar, their magnitude and contexts differ across countries. Mr. Schieber proposed a model for the evolution of health care systems (see Figure 14). In a study of 25 high-income countries, 13 have adopted the national health service approach, nine the social health insurance approach, and three have mixed systems. Mobilization of resources and improving effectiveness need to be coupled with improvement in the quality of service delivery and management.

Figure 14: A model for the evolution of health financing systems



2.5 Ensuring equity in access to quality health services

Many countries in the region are making good progress in achieving the health MDGs. However, recent decades have also witnessed a widening of health inequalities and increasing inequities in access to quality health services. Hence, it may be possible for some countries to achieve the health MDGs while still having areas or populations experiencing poor outcomes. At the same time, analysis suggests that increasing inequalities may themselves hamper the efforts of countries to achieve the MDGs. In a parallel session, chaired by Mr. Shigekazu Sato,[18] participants discussed key dimensions of equity in relation to the health MDGs and considered ways to close the widening gaps.

2.5.1 Dimensions of disparities

In his overview Mr. D. Gwatkin[19] presented evidence on the need to address inequities and better reach the poor. For example, basic maternal, nutrition and child health services are typically undertaken in the name of poverty alleviation. However, evidence shows that these programmes are not being reached as well as the better off (see Figure 15). Differentials between poor and rich are higher for non-clinical facility-based services, which absorb the majority of expenditures for health services. Without social

Figure 15. Use of maternal and child health services by income quintile, Central, South, and South-East Asia

[18] Director-General, Economic Cooperation Bureau, Ministry of Foreign Affairs, Japan

equity, it will be very difficult to maintain social cohesion and experience continued development of a society.

Disparities in access and use of health services are multiple, and can be based on income, location (see Figure 16), ethnicity and gender (see Figure 17). Often these dimensions overlap. For example, many rural residents are poor and some belong to minority ethnic groups. While the poor have higher morbidity and mortality burdens, their use of services is lower than that by the non-poor.

Figure 16. Rural and urban coverage rates of maternal and child health services, Central, South & South-East Asia

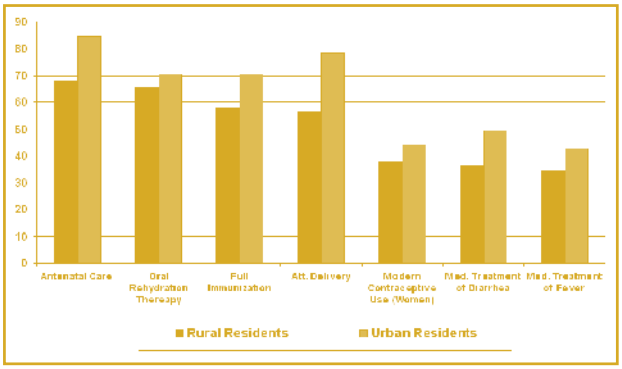
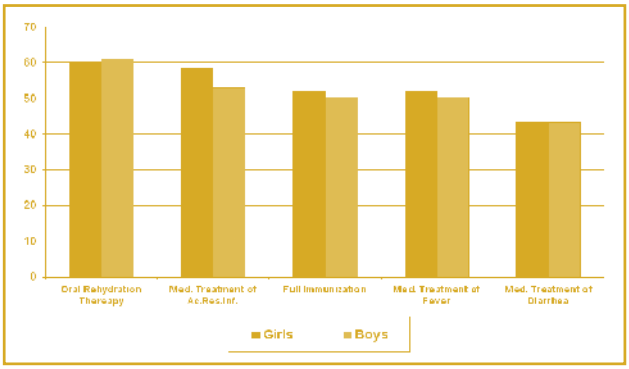


Figure 17. Use of maternal and child health services by sex, South and South-East Asia



Fragile states, including those emerging from conflicts, have particular needs. In these countries, there is a failure by government to provide basic health services to the general population or specific groups.

2.5.2 Strategies to narrow the gap and reach the unreached

Targeting interventions and investments

Programmes need to be targeted for priority population groups. The poor may be identified through means testing, and the demand for services generated through social marketing programmes may also be designed to be more pro-poor. *Sri Lanka* converted its comprehensive Health Master Plan, based on broader national policies, into project proposals with detailed costing and monitoring. Targeted interventions require consistent commitment.

Risk-sharing and other safety nets

Mr Keat Chhon[20] presented the experience of *Cambodia* in ensuring equity in access to quality health services, where an equity fund aims to protect the poor from catastrophic health expenditures and improve the quality of care through the provision of targeted, demand-side subsidies. The fund covers expenses for major health emergencies—such as road accidents, obstetric interventions and debilitating illnesses—for the poor in 10 health operational districts where the ADB-supported Health Sector Support Project is being implemented. Financed by the Government of Japan, the equity fund encourages early care-seeking. The fund faces four challenges: involving stakeholders from the local to national levels in programme development, implementation and monitoring; defining the national criteria for selecting pilot areas, beneficiaries, service coverage, and expected results and outcomes; encouraging existing equity funds to operate within the national framework; and ensuring that good services are accessible and attractive to the poor, particularly those in rural and remote areas.

Dr Francisco Duque III[21] presented the experience of the *Philippines*. The Philippine Health Insurance Corporation (PhilHealth) aims to promote financial access to health services. In collaboration with national and local governments, PhilHealth introduced a sponsored programme for the poor, based on the principle of social solidarity and

[19] Lead Poverty and Health Specialist, Health, Nutrition and Population, World Bank

[20] Senior Minister, Ministry of Economy and Finance, Kingdom of Cambodia

cross-subsidization of the poor, elderly, sick and vulnerable by the employed, active and healthy. Members of PhilHealth are entitled to the basic services from almost all hospitals in the country. PhilHealth is now taking steps to lower the prices of drugs. In the future, it will take advantage of the increasing revenues to improve health facilities and services nationwide.

Viet Nam strengthened the primary health care network and set up the Health Care Fund for the Poor in 2002. To date, 14 million people have benefited from the fund, 75% of which is financed by government. Children under six years of age receive free services. The Government of *Singapore* subsidizes health expenses of the elderly at private doctors or general practitioners whose clinics are within walking distance of their homes. It also subsidizes the Voluntary Welfare Organizations that provide home medical and home nursing to the elderly poor. Community health screening programmes have been set up to reach out to the poor. The MediFund is a financial safety net enabling the poor to access basic medical care because of their inability to pay. In 2004, $34.5 million was paid by the MediFund to hospitals to help low-income Singaporeans.

Improving quality of services

Governments have a stewardship role to play in improving the quality of services. For example, the Strengthening EPI in the Pacific Region Project, supported by Japan, aims to improve the quality of EPI (Expanded Programme on Immunization) services in 13 countries and areas in the Pacific through the development of national "Reach Each Island" guidelines for outreach activities, in line with the "Global Reach Every District" strategy set by WHO. In addition, it provides training to outer island health staff on cold chain and vaccine management. In *Viet Nam*, the National Standards for Health Services at Commune Level have been developed to improve the quality and effectiveness of commune health services. By 2010, 70% of communes will have reached this standard. Promoting a service orientation among health staff and providing incentives for good quality care to different population groups are other ways to improve service quality.

At the facility level, participatory planning between decision-makers, providers and users can lead to positive attitude changes among health workers and promote better understanding among all sectors. In *Nepal*, for example, participatory planning facilitated an increase in the use of emergency obstetric care services in four districts over a period of five years among women needing care from 5% to 25% and among Dalits (people from the lower castes) from 0.9% to 9.2%.

Promoting civil society participation and empowerment

An approach based on the perspective of human security, which places the focus on individuals and emphasizes protection from threats and fears as well as empowerment of the people, is important in addressing disparity. In *Thailand*, for example, the comprehensive HIV/AIDS Prevention and Care Project, supported by Japan, aimed to empower communities and people living with HIV/AIDS (PHAs), their families and communities to cope with HIV/AIDS through comprehensive care and services, including counselling, treatment of opportunistic infections, setting up of community volunteer care networks and income generation activities, capacity-building of health staff, and the improvement of quality of services. The project contributed to the dramatic decline in the HIV infection rate in the region from 10.6% in 1994 to 2.3% in 2001.

Governments and development partners need to partner with NGOs and civil society, particularly those with good track records. NGO contracting of health services in *Cambodia* is a promising innovation in partnerships between governments and -NGOs. Promoting women's empowerment and gender equality are important to address health disparities related to wealth and gender.

Health information

There is a need to disaggregate data and information to document inequities, monitor

[21] Secretary, Department of Health, Philippines

progress on reaching the intended recipients, and evaluate the impact on narrowing the gaps. There is also a need to share the results of monitoring as well as good practices and approaches. The inclusion of differentials and access in the measurement and monitoring framework of the MDGs was proposed to attract the attention of decision- and policy-makers and have them address these issues. There was a specific suggestion to add the target of universal access to reproductive health by 2015 and the differentials in the proportion of demand for family planning that is met as indicators of improved maternal health.

3. SUMMARY

In the final plenary session of the Forum, participants discussed themes such as regional cooperation and building partnerships. Building partnerships at the community, national and international levels can help mobilize resources and increase effectiveness. Strengthening regional cooperation can promote the sharing of experiences and know-how. For example, the Asian Center of International Parasite Control (ACIPAC), established in *Thailand* in 2000 through cooperation between the Governments of Thailand and Japan, supports the efforts of neighbouring countries, such as Cambodia, the Lao People's Democratic Republic, Myanmar and Viet Nam, to promote school-based deworming and health care. The centre serves as a regional hub for information, research, training, field visits, pilot projects and information networks.

The final session of the Forum produced a Chair's Summary, synthesizing the key points in the discussions. The full text of the Chair's Summary is attached as Annex 4.

Annex 1

High Level Forum on the Health MDGs in Asia and the Pacific
Tokyo, Japan, 21-22 June 2005

Agenda

Tuesday, 21 June 2005

09:30-10:00 Opening session

Chair: Mr Shigekazu Sato, Director-General, Economic Cooperation Bureau, Ministry of Foreign Affairs, Japan

- Statement by Mr Ichiro Aisawa, Senior Vice-Minister for Foreign Affairs of Japan
- Statement by Mr Hiroyoshi Nishi, Senior Vice-Minister of Health, Labour and Welfare of Japan
- Statement by Dr Shigeru Omi, WHO Regional Director for the Western Pacific

10:00-12:15 Review of progress on health MDGs in the Asia Pacific region

Chair: Mr Shigekazu Sato, Director-General, Economic Cooperation Bureau, Ministry of Foreign Affairs, Japan

- *Meeting the Health Millennium Development Goals: Issues and Challenges in Asia and the Pacific*: Dr Andrew Cassels, Director, Sustainable Development and Healthy Environment/MDGs, Health and Development Policy, World Health Organization, Geneva
- *Lao PDR's Experience*: Dr Ponmek Dalaloy, Minister of Health, Lao People's Democratic Republic
- *Malaysia's Experience in Health MDGs*: Dr Chua Soi Lek, Minister of Health, Malaysia
- *Pakistan Millennium Development Goals: Status, Challenges and Future Directions*: Mr Muhammad Nasir Khan, Federal Minister of Health, Pakistan

12:30-14:00 Lunch

14:15-17:30 Parallel group sessions on key cross-cutting issues

Group Session A: Strengthening health systems through capacity development

Chair: Dr Andrew Cassels, Director, Sustainable Development and Healthy Environment/MDGs, Health and Development Policy, World Health Organization, Geneva

- *Building Health System Capacity to Meet the Health MDGs*: Dr David Evans, Director, Health System Financing, Expenditure and Resource Allocation, WHO, Geneva
- *The Experience of Samoa in Building an Appropriate Skill Mix of Health Providers at the Primary Care Level and Strengthening the Leadership and Management Capacity*: Mr Tsuisugaletaua Aveau Sofara, Minister of Natural Resources, Environment and Meteorology, Samoa
- *Improving Access to Affordable Essential Drugs: The Experience of Sri Lanka*: Dr Nihal Jayathilaka, Additional Secretary, Ministry of Health, Nutrition and Uva Wellasa Development, Sri Lanka
- *Expanding DOTS Coverage through Public-Private Partnerships: India's Revised National TB Control Programme*: Mr G. V. Srinivas, First Secretary (Political & Consular), Embassy of India, Tokyo

Group Session B: Promoting cross sectoral actions to achieve the health MDGs

Chair: Ms Khempheng Pholsena, Vice President, Finance and Administration, Asian Development Bank

- *Iodine Deficiency and Food Fortification in Kyrgyz Republic*: Ms Ishenkul Boldjurova, Vice Prime Minister, Kyrgyz Republic

- *Integrating Health and Non-Health Sector Planning in Indonesia*: Mr Arum Atmawikarta, National Development Planning Agency (Bappenas), Indonesia

18:00-20:00 Reception
Hosted by Mr Ichiro Aisawa, Senior Vice-Minister for Foreign Affairs, Japan

Wednesday, 22 June 2005

09:30-12:45 Parallel group sessions on key cross-cutting issues (cont.)

Group Session C: Securing resources and increasing effectiveness to achieve the health MDGs

Chair: Dr Fadia Saadah, Health Sector Manager, East Asia and Pacific Region, World Bank
- *Sustainable Health Sector Financing*: Mr George Schieber, Health Policy Adviser, Health, Nutrition and Population, World Bank
- *Is There Room for Additional Spending in Social Sectors: Examining Fiscal Space Issues in 7 Countries of South and South-East Asia—Bangladesh, Laos, India, Indonesia, Pakistan, Philippines and Viet Nam*: Dr Peter Heller, Deputy Director, Fiscal Affairs Department, International Monetary Fund
- *Bangladesh Resource Mobilization and Sustainability in the HNP Sector*: Dr Khandaker Mosharraf Hossain, Minister of Health and Family Welfare, Bangladesh
- *MDGs and Universal Coverage of Essential Health Services: Experiences from Thailand*: Dr Suwit Wibulpolprasert, Senior Adviser on Health Economics, Ministry of Public Health, Thailand

Group Session D: Promoting equity in access to quality health services

Chair: Mr Shigekazu Sato, Deputy Director-General, Ministry of Foreign Affairs, Japan
- *Reaching the Poor with Health, Nutrition and Population Services to Ensure that They Share Fully in Progress Toward the MDGs*: Dr D. Gwatkin, Lead Poverty and Health Specialist, Health, Nutrition and Population, World Bank
- *Promoting Equity in Access to Quality Health Services: Cambodia Health MDGs*: Mr Keat Chhon, Senior Minister, Ministry of Economy and Finance, Kingdom of Cambodia
- *The Formula for Health: Health Insurance as Driver of Health Sector Reforms in the Philippines*: Dr Francisco Duque III, Secretary, Department of Health, Philippines

13:00-14:00 Lunch

14:15-15:45 Way forward to achieve the health MDGs

Chair: Mr Shigekazu Sato, Director-General, Economic Cooperation Bureau, Ministry of Foreign Affairs, Japan
- Presentation of session summaries by Group Session Chairs
- Comments on session summaries
- Adoption of Chair's Summary (draft)

15:45-16:00 Closing remarks by Mr Shigekazu Sato, Director-General, Economic Cooperation Bureau, Ministry of Foreign Affairs, Japan

Annex 2A

List of Participants, Countries

Country	Head	Name	Title/Designation
Australia	√	Mr Mark Palu	Counsellor (Development Cooperation) Australian Consulate, Ho Chi Minh City
Bangladesh	√	Hon. Dr Khandaker Mosharraf Hossain	Minister, Ministry of Health and Family Welfare
		Dr Khandaker Rashedul Haque	Joint Secretary, Ministry of Health and Family Welfare
		Mr Mohammad Mizanur Rahman Majumder	Additional Secretary, Ministry of Health and Family Welfare
		Mr Mozzammel Hoque	Joint Chief, Ministry of Health and Family Welfare
		Mr M. Serajul Islam	Ambassador of Bangladesh
		Mr M.D. Jashim Uddin	Counsellor, Embassy of the People's Republic of Bangladesh
		Mr Mohammad Monirul Islam	Third Secretary, Embassy of the People's Republic of Bangladesh
Bhutan	√	Mr Nidup Lham	Chief Budget Officer, Ministry of Finance
Brunei Darrusalam	√	Hon. Pehin Dato Suyol Osman	Minister of Health
		Mr Serbini All	Permanent Secretary
		Dr H.S. Md Rahmah Said	Acting Director of Environmental Health
	√	Dr Zainai Ariffin Yahya	Acting Assistant Director (Human Resource Development)
		Dr Anie Haryani Rahman	Acting Senior Medical Officer
		Mr Mohammad Jeffry Tamit	Statistician
		Mr Abdul Rahim Ismail	Second Secretary, Embassy of Brunei Darussalam in Japan
Cambodia	√	Hon. Mr Keat Chhon	Senior Minister, Ministry of Economy and Finance
		Mr Chhieng Yanara	Deputy Secretary General
		Mr Sok Saravuth	Director of Budget Department
		Mr Chhau Sothira	Second Secretary
		Mr Lim Thearith	Attaché
		Mr Pou Sothirak	Royal Embassy of Cambodia
China		Mr Mingzhe Piao	First Secretary
Fiji	√	Hon. Mr Tomasi N Sauqaqa	Assistant Minister of Health
France	√	Mr Jean-Pierre Thebault	Minister Counsellor-Charge d'Affaires, Ambassade de France
		Mr Christian Dumon	First Secretary
India	√	Mr S.K. Mandal	Deputy Chief of Mission, Embassy of India, Tokyo
		Mr G.V. Srinivas	First Secretary, Embassy of India, Tokyo
		Mr N.P. Singh Azad	First Secretary, Embassy of India, Tokyo
Indonesia	√	Dr Arum Atmawikarta	Director, Directorate for Health and Community Nutrition
		Mr Mirza Nurhidayat	First Secretary for Economic Affairs, Indonesian Embassy
		Mr Dominicus Supratikto	Counsellor for Economic, Indonesian Embassy

Country	Head	Name	Title/Designation
Japan	√	Hon. Mr Ichiro Aisawa	Senior Vice-Minister for Foreign Affairs
		Hon. Mr Hiroyoshi Nishi	Senior Vice-Minister of Health, Labour and Welfare
		Mr Shigekazu Sato	Director-General, Economic Cooperation Bureau, Ministry of Foreign Affairs
		Mr Kazuo Kodama	Deputy Director-General, Economic Cooperation Bureau, Ministry of Foreign Affairs
		Mr Ken Okaniwa	Director, Aid Planning Division, Economic Cooperation Bureau, Ministry of Foreign Affairs
		Dr Yasutaka Iwasaki	Director, International Cooperation Office, Minister's Secretariat, Ministry of Health, Labour and Welfare
		Mr Teruyuki Tanabe	Director General, Sector Strategy Development Department, Japan Bank for International Cooperation
		Mr Kazushio Hashimoto	Director General, Development Assistance Department, Japan Bank for International Cooperation
		Mr Akira Hashizume	Executive Technical Adviser to the Director General, Human Development Department, Japan International Cooperation Agency
Republic of Korea	√	Mr Lee Jong Koo	Director-General, Bureau of Health Promotion, Ministry of Health and Welfare
		Mr Park Ki Dong	Director of Infection Control, Korea Centre for Disease Control and Prevention
		Mr Jung Tong Ryuong	Researcher, Korea Institute of Health and Social Affairs
Kyrgyzstan	√	H.E. Ms Ishenkul Boldjurova	Acting Vice Prime Minister
		Mr Sabirjan Abdikarimov	General Director, State Department of Sanitary and Epidemiology, Ministry of Health
		H.E. Dr Askar Kutanov	Ambassador, Embassy of Kyrgyz Republic
		Mr Esen Saliev	Minister-Counsellor, Embassy of Kyrgyz Republic
		Mr Yuri Dvorjak	Interpreter
The Lao People's Democratic Republic	√	Hon. Dr Ponmek Dalaloy	Minister of Health
		Mr Khonepheng Thammavong	First Secretary, Embassy of the Lao PDR
Luxembourg	√	H.E. Ms Michèle Pranchere-Tomassini	Ambassador Extraordinary and Plenipotentiary
		Mr Lèo Faber	Head of Luxembourg Cooperation Office in Hanoi
		Ms Mirellie Guden	First Secretary
Malaysia	√	Hon. Dr Chua Sol Lek	Minister of Health
		Dr Teng Seng Chong	Director, Institute of Health Management
		Dr Narimah Awin	Director, Department of Family Health Development
		Dr Maimunah Abdul Hamid	Director, Institute for Health System Research
		Mr Thean Ming Fatt	Senior Confidential Secretary to Minister of Health
		Eideen Hussaini	Second Secretary, Embassy of Malaysia

Country	Head	Name	Title/Designation
Mongolia	√	Hon. Mr Chimeddorj Ganzorig	Vice-Minister of Finance
		Hon. Mr Shagdarsuren Enkhbat	Vice-Minister of Health
		Ms Baasal Bulganchimeg	Deputy Director, Financial Economical Planning and Management Department, Ministry of Health
		Ms Tumendemberei Bolormaa	Director, International Cooperation Department, Ministry of Health
		Ms O. Enkhjargal	First Secretary, Embassy of Mongolia in Japan
Myanmar	√	Hon. Prof. Mya Oo	Deputy Minister, Ministry of Health
		Mr Aung Kyaing	Deputy Director General, Department of Health Planning
		Mr Thant Kyaw	Minister-Counsellor, Myanmar Embassy
		Mr Soe Han	First Secretary, Myanmar Embassy
		H.E. U Saw Hia Min	Ambassador
Nepal	√	Hon. Mr Madhukar Shumshere J.B. Rana	Finance Minister
		Mr. Lava Kumar Devacota	Secretary
Pakistan	√	Hon. Mr. Muhammad Nasir Khan	Minister of Health
		Mr Syed Iftikhar Hussain Shah	Deputy Chief of Mission
Papua New Guinea	√	H.E. Mr Michael Maue	Ambassador
		Mr Stephen Barampataz	Minister, Embassy of Papua New Guinea
The Philippines	√	Hon. Dr Francisco Duque III	Secretary of Health
		Mr Ruben John Basa	Manager, Corporate Planning Department, Philippine Health Insurance Corporation
		Mr Alan L. Deniega	Second Secretary and Consul, Philippine Embassy, Tokyo
Samoa	√	Hon. Mr Tulsugaletaua Sofara Aveau	Minister of Natural Resources and Environment
		Mr Soolalo David Fong	Assistant of Chief Executive Officer, Ministry of Natural Resources and Environment
Singapore	√	Dr Mohamad Maliki Osman	Parliamentary Secretary (Health and Community Development, Youth and Sports)
		Ms Chua Boon Loy	Senior Health Economist
		Ms Geraldine Goh	Senior Health Policy Analyst (International Cooperation)
		Mr Terence Heng	First Secretary, Embassy of the Republic of Singapore
Sri Lanka	√	Hon. Dr Nihal Jayathilaka	Additional Secretary, Ministry of Health, Nutrition and Uva Wellassa Development

Country	Head	Name	Title/Designation
Thailand	√	Hon. Dr Vichai Tienthavorn	Permanent Secretary, Ministry of Public Health
		Dr Suwit Wibulpolprasert	Senior Adviser, Health Economics, Ministry of Public Health
		Dr Borworn Ngamsiriudom	Deputy Director-General, Department of Health
		Dr Orasa Kovindha	Policy and Plan Analyst, Bureau of Policy and Strategy, Office of the Permanent Secretary, Ministry of Public Health
		Ms Sirinad Tiantong	Foreign Relations Officer, International Health Group, Bureau of Policy and Strategy, Office of the Permanent Secretary, Ministry of Public Health
		Mr Pichai Israbhakdi	Minister and Deputy Chief of Mission, Royal Thai Embassy, Tokyo
		Mr Pisanu Sobhon	First Secretary, Royal Thai Embassy, Tokyo
Tonga	√	Hon. Dr Viliami Tangi	Minister of Health
United Kingdom	√	Dr Jenny Amery	Senior Health Adviser, Department for International Development
United States of America	√	Dr Charles R. Aanenson	US Embassy Counsellor for International Development
		Dr Tim Meinke	Senior Adviser for Donor Coordination (USAID-Global Health)
		Dr Alfred Bartlett	Senior Adviser for Child Survival (USAID-Global Health)
		Ms Rie Yamaki	Development Assistance Assistant, USAID/Tokyo
Viet Nam	√	Hon. Dr Le Ngoc Trong	Vice-Minister of Health
		Dr Tran Thi Giang Huong	Deputy Director General, International Cooperation Department

Annex 2B

List of Participants, Partner Agencies

Country/ Agency	Head	Name	Title/Designation
Asian Development Bank (**ADB**)	√	Ms Kempheng Pholsena	Vice President (Finance and Administration)
		Mr Jacques Jeugmans	Principal Health and Nutrition Specialist
		Ms Ma. Virginia Capulong	Senior Sector Officer Regional and Sustainable Development Department
		Mr Jerry Silverman	Consultant, Regional and Sustainable Development Department
		Mr Yuri Vladimirovich Dvorjak	Interpreter
Economic and Social Commission for Asia and the Pacific (**ESCAP**)	√	Ms San Yuenwah	Chief, Health and Development Section, Emerging Social Issues Division
European Commission (**EC**)	√	Mr Ulrich Jochhelm	Second Secretary, Political & Economic Section (Tokyo Delegation)
Global Alliance for Vaccines and Immunization (**GAVI**)	√	Mr Bo Stenson	Principle Officer, Technical & Policy, GAVI Secretariat, c/o UNICEF
		Mr Andrew Jones	Senior Regional Officer, Anglophone & Pacific, GAVI Secretariat, c/o UNICEF
International Monetary Fund (**IMF**)	√	Mr Peter Heller	Deputy Director, Fiscal Affairs
International Planned Parenthood Federation (**IPPF**)	√	Dr Steven W. Sinding	Director-General
		Dr Raj Karim	Regional Director, East & South East Asia and Oceania Regional Office
		Ms Sumie (Ishll) Yamaguchi	Executive Director, Japanese Organization for International Cooperation in Family Planning (Tokyo Liaison Office)
		Ms Yuri Nakamura	Resource Mobilization Officer, Central Office
Joint United Nations Programme on HIV/AIDS (**UNAIDS**)	√	Mr Prasada Rao	Director, Regional Support Team for Asia and Pacific
United Nations Children's Fund (**UNICEF**)	√	Dr Pascal Villeneuve	Chief of Health, Programme Division
		Ms Suomi Sakai	Representative, Nepal Country Office
		Dr Rudolf Knippenberg	Senior Adviser, Health Programme Division
		Dr Stephen Atwood	Regional Adviser, Health & Nutrition, Regional Office for East Asia and Pacific
		Mr Yoshiteru Uramoto	Director, Office for Japan
		Mr Yasushi Katsuma	Programme Coordinator, Office for Japan
		Ms Kyoko Okamura	Assistant Programme Officer, Office for Japan

Country/ Agency	Head	Name	Title/Designation
United Nations Development Programme (**UNDP**)	√	Mr Murali Balasubramaniam	Programme Officer & Special Assistant to UN Assistant Secretary General, RBAP
		Ms Akiko Yuge	Director, Tokyo Office
		Mr Takashi Kondo	Deputy Director, Tokyo Office
		Ms Akiko Fujil	Programme Manager, Tokyo Office
United Nations Population Fund (**UNFPA**)	√	Mr J. Bill Musoke	Deputy Director, Asia and Pacific Division
		Mr Stan Bernstein	Policy Adviser, UN Millennium Project
		Ms Kiyoko Ikegami	Director, Tokyo Office
		Ms Fuyo Ueno	Assistant to the Director, Tokyo Office
		Ms Keiko Otsuka	Intern, Tokyo Office
		Mr Satish Mehra	
World Bank (**WB**)	√	Ms Fadia Saadah	Health Sector Manager, East Asia and Pacific Region
		Mr George Schieber	Health Policy Adviser, Health, Nutrition and Population
		Mr Rafael Cortez	Senior Health Economist, South Asia Region
		Mr Davidson Gwatkin	Lead Poverty and Health Specialist, Health, Nutrition and Population, World Bank
		Mr Naoya Ooka	Operations Analyst, World Bank Tokyo Office
		Ms Yoshiko Maruyama	Team Assistant, World Bank Tokyo Office
World Health Organization (**WHO**)	√	Dr Shigeru Omi	Regional Director, Western Pacific Regional Office
		Dr Andrew Cassels	Director, SDE/HDP, WHO, Geneva
		Dr David Evans	Director, EIP/FER, WHO, Geneva
		Dr Quazi Monirul Islam	Director, FCH/MPS, WHO, Geneva
		Dr Than Sein	Director, HSD, South East Asia Regional Office
		Dr Anton Fric	Regional Adviser, EHI, South East Asia Regional Office
		Dr Soe Nyunt-U	Director, DHS, Western Pacific Regional Office
		Ms Anjana Bhushan	Technical Officer, HCF, Western Pacific Regional Office
		Dr Yojiro Sato	Medical Officer, PTT, Western Pacific Regional Office
		Ms Mangai Balasegaram	Short-term Consultant, Western Pacific Regional Office
		Dr Francisco Flores	Short-term Professional, Western Pacific Regional Office

Opening Remarks: Mr Ichiro Aisawa
Senior Vice-Minister for Foreign Affairs, Japan

Your Excellencies, distinguished colleagues, ladies and gentlemen.

It is my great pleasure to welcome you and open the High Level Forum on Health MDGs in Asia and the Pacific. I would also like to express my sincere gratitude to the World Health Organization, the Asian Development Bank and the World Bank with whom we have prepared this Forum.

As you are aware, 2005 is an important year in which the international community will review the progress on the Millennium Development Goals (MDGs) and take further actions needed to achieve the MDGs. Among the 8 MDGs, three goals are related to health, a reflection of the crucial importance of health to promote freedom from sickness and poverty.

A general overview of the situation regarding in Asia and the Pacific shows that there is relatively good progress on poverty reduction. Rising incomes have brought about improvements in health-related indicators such as nutrition, life expectancy at birth and child mortality. In this connection, I would like to pay tribute to the participants for making progress on health despite various difficulties.

On the other hand, it is also true that the Asia- Pacific region, which accounts for about two thirds of the world's poor population, is still confronted with various challenges. Many people are under miserable conditions without access to adequate health services. It is an urgent challenge to address disparities among and within countries. This region also accounts for 55% of the death toll from tuberculosis. It is predicted that the number of HIV/AIDS positive in the region will increase up to 20 million people within 10 years. In addition, emerging infectious diseases such as SARS (Severe Acute Respiratory Syndrome) and avian flu are becoming a new threat in recent years.

This Forum aims to strengthen actions at the country level and regional cooperation by sharing good practice and discussing regional cooperation. In view of the need to take cross-sectoral actions in health as well as other related areas in order to make progress on the health MDGs, it is significant that we have the participation of ministers in charge of health, development and finance.

Japan is among the largest donors in the sectors that are closely related to the MDGs such as health, water, education and environment, and it is committed to actively contribute to the achievement of the MDGs. Japan has decided to convene this Forum because, in the effort to support the developing countries, sharing of experiences is just as important as cooperation on the ground.

Excellencies, at this Forum, we will first have an overview of progress on the health MDGs in the Asia-Pacific Region. After this, we will address four key themes, namely, resources, health systems, cross-sectoral actions and equitable access.

Needless to say, ensuring necessary funding and its effective use is fundamentally important for strengthening our efforts. Generally speaking, it is remarkable that countries in the Asia-Pacific have funded a major part of their health expenditures through domestic resources. However, in many countries further increase in resources is required through efforts such as tax reform, health insurance and additional budget allocation to the health sector.

The international community must also strengthen its support to the efforts of the developing countries. Japan has implemented assistance under the Okinawa Infectious Diseases Initiative amounting to 4.1 billion US dollars in the four years between 2000 and 2003. A large part of this assistance was directed towards Asia and the Pacific. In order to strengthen its contribution to the health MDGs, Japan will implement the "Health and Development Initiative". Japan will further enhance its support to the efforts of the developing countries to achieve the health MDGs based on ownership and partnership.

At this Forum, we have the presence of donor countries and organizations which account for about 80% of ODA in the Asia-Pacific region. It is my hope that these donors will also

strengthen their cooperation. In this connection, I would like to emphasize the effectiveness of South-South cooperation. South-South cooperation can effectively transfer technology and know-how more suited for the recipient country. Several countries in Asia and the Pacific are promoting South-South cooperation. Japan highly appreciates such efforts. Japan actively supports South-South cooperation as an important activity under its ODA Charter. To cite one example, Japan supports cooperation provided by Thailand in the area of parasitic diseases and HIV/AIDS to other countries in the Mekong region. I hope that South-South cooperation will expand further and other donors will strengthen their support to such cooperation.

Excellencies, to achieve the health MDGs, it is essential that we adopt effective interventions and strengthen capacities for implementation together with infrastructure development. Japan's huge progress in the health situation after the war was made possible not only by funding but also due to such efforts as capacity building of health workers, effective collaboration of government and the local community, and development of social and economic infrastructure. Based on such experience, Japan, for instance, attaches importance to building human resources that support the health systems of developing countries. Under the Okinawa Infectious Diseases Initiative, Japan provided training to more than 15,000 personnel in health-related sectors of 146 developing countries during the 4 years between 2000 and 2003.

Excellencies, to achieve effectively the health MDGs, we need to promote cross-sectoral actions in the health-related areas such as poverty reduction, education, water/sanitation and infrastructure along with actions in the health sector. In Japan, cross-sectoral actions such as the use of Maternal and Child Health (MCH) handbooks, school health program, clean water supply and development of health systems have contributed considerably to drastic reduction in child mortality and extension of life expectancy at birth to highest levels. In addition, preventive activities against parasitic diseases in primary schools played an important role in containing the spread of parasitic diseases in Japan. Based on such experience, Japan's Health and Development Initiative emphasizes effective collaboration between assistance in the health sector and assistance in other closely related areas.

Excellencies, despite improvements in health indicators for the country as a whole, there are cases in which the situations of certain poor areas or for people who are disadvantaged such as women or minority groups have not improved. In the effort to achieve the health MDGs, the problem of disparities arising from a various reasons such as income, gender, geography or social factors must be addressed. As part of such efforts, it is extremely important to promote women's empowerment, gender equality and access to reproductive health services in accordance with the Beijing Platform of Action and the ICPD Program of Action. Japan is committed to make further efforts to address disparities in the health sector based on the perspective of human security.

Excellencies, I am convinced that the results of the Forum will be an important contribution to the major international conferences such as the Mid-term Review of the United Nations Millennium Declaration by presenting the viewpoint of the Asia-Pacific region. While the effective approaches and lessons learned coming out of the discussions cannot be simply transferred to other countries and regions, I believe that they will provide important ideas for countries in the Asia-Pacific region and also for other regions including Africa. Therefore, in order to make this Forum meaningful, I would like to kindly ask all the participants to have frank and active discussions today and tomorrow.

Thank you.

Opening Remarks: Mr Hiroyoshi Nishi
Senior Vice-Minister for Health, Labour and Welfare, Japan

Good morning honoured guests from overseas. It is my great pleasure to have this opportunity to present Japan's position on international health issues on behalf of the Ministry of Health, Labour and Welfare. I would like to express my sincere gratitude to our co-organizers, WHO, ADB, and the World Bank.

As globalisation progresses, health issues become globally shared, with increasing threat from new and emerging infectious diseases. We face the risk of health crisis in one country directly affecting another. The growing ease and frequency of cross-border movements have greatly facilitated the spread of infectious diseases. Now is the time for all of us to treat health threats as a common problem. We work together in the spirit of international solidarity to ensure the well-being of people everywhere.

At present, one-quarter of the world's population is living in poverty. Sadly, the disparities have grown in recent years. No need to mention, poor health is a factor to aggravate poverty. To alleviate poverty, we must strengthen efforts towards promoting health measures above all. The international community agreed on setting up UN MDGs, disease control is set as one of the key issues. It is to be achieved by the year 2015.

Global cooperation towards alleviating poverty through setting up MDGs is itself a significant achievement. It is wonderful that global efforts are now being made to achieve these goals. As it happens, the Seventh International Conference on AIDS in Asia and the Pacific will be held next week in Kobe, Japan. Since the advent of the HIV/AIDS epidemic in the 1980s, the disease has rapidly spread worldwide. Millions of challenges have been made to control the disease. There have been success stories. In several countries we can see a downward trend in the spread of HIV. Through WHO's leadership, three million by 2005, it has launched this 3 by 5 Initiative which has increased the number of those receiving therapy, and has shown the effectiveness of antiretroviral therapy. At the same time, global initiatives such as the Global Fund to fight AIDS, Tuberculosis and Malaria is pushing forward with HIV/AIDS programmes.

Some of the brightest intellects in the world are now dedicated in initiatives combating HIV/AIDS globally. In Japan, we have held the view that prevention, cure, and care are an essential part of support packages. Good health systems form the basis for carrying out comprehensive interventions. To tackle the problem of HIV/AIDS comprehensively, we believe that a thorough understanding of social backgrounds and cultural traditions is also necessary.

The global priorities are clear. Needs have been assessed and we know what has to be done. It is now time to move forward and meet those needs. To improve people's health it is essential that we not only seek to achieve MDGs in health but ultimately to provide quality health services. Concerted actions during the next 10 years are critical if we are to achieve our goals. If we are to overcome the barriers to human resource and health system development, we will need a road map. Improved governance is essential if we are to make the most of contributions from development partners and increase efficiency.

Development partners must provide the sort of comprehensive support such as medicines, health facilities, and health information systems, and those should be integrated into cohesive and sustainable public health systems in the recipient country. Let us build on the capacity to succeed.

Our Ministry of Health, Labour and Welfare has emphasized international cooperation in health. We recognize the importance of infectious disease control and maternal and child health in light of our experience of post-war rehabilitation attaching great importance to Asia and the Pacific. We will continuously work towards achieving MDGs through both bi and multilateral channels in collaboration with respective organizations and our development partners.

Many challenging health issues lie ahead. Through this high level forum, we share good practice and experience with our friends from Asia and the Pacific. It is a great opportunity to learn from our friends what we need to do from listening to their experiences and applying the lessons learned. This is a time when the international community needs to share ideas, reach

agreement, and to take action based on those agreements. We believe that the MDGs will act as a catalyst, stimulating discussion and action and that they will help us to meet the global challenges we all face.

Thank you very much for your kind attention. Thank you.

Opening remarks: Dr Shigeru Omi
WHO Regional Director, Western Pacific Region

Good morning everybody. Honourable Senior Vice-Minister for Foreign Affairs, Mr Aisawa, honourable Senior Vice-Minister of Health, Labour and Welfare, Mr Nishi, Madam Kempheng Pholsena, Vice President of ADB, Ms Fadia Saadah, Health Sector Manager from World Bank, honoured ministers from the Asia and Pacific region, distinguished guests, colleagues, and ladies and gentlemen, thank you very much for giving me this opportunity to speak on this very important occasion.

First of all, on behalf of the World Bank, ADB, and WHO, I would like to express my sincere, and our sincere, appreciation to the Government of Japan through Mr Aisawa, honourable Senior-Vice Minister for Foreign Affairs, and Mr Nishi, honourable Senior Vice-Minister of Health, Labour, and Welfare, for taking this initiative to organize this very important meeting.

As we all know, Japan has been promoting the concept of human security which encaptures the major component of the MDGs. More specifically, Japan is one of the key players in the international community to help promote health through various initiatives such as the Okinawa Summit, which has developed into the Global Fund to fight AIDS, Tuberculosis, and Malaria. Therefore it is very timely and appropriate that this meeting is now taking place here in Japan.

The reason as to why we are here today is that across Asia and the Pacific, even in this age of the Internet, globalisation, and rapid economic growth, 700 million people live in extreme poverty and they struggle to survive on a daily basis on incomes of as little as $1 or less a day. Often, they go to bed hungry, suffer without treatment when they are sick, and do not have safe water to drink, and many indeed are too poor to even stay alive.

This is in striking contrast to the situation of the better off. The gap between the rich and the poor is unacceptably wide. For example, the poorest 20% of the world population are roughly 10 times more likely to die before the age of 14 than the richest 20%. Similarly, in many developing countries women have limited access to reproductive health services, and nearly 40% of all births worldwide are not attended by a skilled health worker.

Health is central to fighting poverty. Thus it is fitting that health is a pre-component of the MDGs which aim to halve global poverty by the year 2015. The health goals cover the very fundamentals such as survival of mothers and young children. They also address diseases that predominantly affect the poor. HIV/AIDS, tuberculosis and malaria are not just leading killers, but are an economic deathblow for poor families.

Achieving the health goal is certainly a daunting challenge for all of us, but most of the goals we already know what to do. The technical interventions are already available. For example, the cure for Tuberculosis has been available for more than half a century, and many interventions are also inexpensive. It costs less than $2 to immunize a child against key diseases.

Therefore it is now time for us to build our solidarity in Asia and the Pacific, and strengthen our commitment to turn our promises into real action. So what must we do?

I would like urge all of us to take action in four main areas. Firstly we have to strengthen health systems. Indeed, significant progress will not be achieved without this. For example, sometimes drugs are available in the capital city but do not reach people in far-flung areas who need them most. In many settings, trained health workers are not available to provide services. When health services and systems are weak, it is usually the poor who suffer the most.

Secondly, we need additional funding. Health is often woefully underfunded, but additional funding alone will not suffice. We also need to better allocate and manage these resources, and currently the bulk of funding usually goes to urban areas, often to costly curative services at the expense of essential services in rural areas. International partners also have a key role to play in providing more funds, and there also needs to be better coordination and alignment of aid to national priorities.

And thirdly there is a need for stronger multisectoral collaboration, involving not just the health sector but also education, environment, infrastructure, gender equity, and even law enforcement. For example, recent evidence suggests that holding other factors constant, significant declines in child mortality can result from such diverse actions as improved access to drinking water, and increasing years of schooling among particularly women.

Fourth, we need to ensure greater equity so that the benefits of our efforts are enjoyed by all. Alarmingly, inequities have widened in recent decades, with the poor increasingly unable to access or afford healthcare. And because of lack of health prepayment schemes, the poor often pay out of their pocket at the time of sickness pushing their families further into a vicious cycle of poverty, and such inequity is just unacceptable.

Honoured ministers, colleagues, ladies and gentlemen, Asia Pacific countries have already achieved a lot, and I would like to thank all of you for your leadership and excellent progress so far. But, much more needs to be done. The rich-poor gap continues to widen, and good health should be a universal right not a privilege. And I am sure that this meeting will provide an excellent opportunity to accelerate our joint effort on health MDGs. In closing I would like to thank all of the honourable ministers and colleagues for joining this very important meeting, and also thank the Government of Japan once again for initiating this meeting, and I hope that this meeting will mark a turning point in uniting our effort to fight poverty, and achieve health for all in Asia and the Pacific.

Thank you very much.

CHAIR'S SUMMARY

Better health is central to the achievement of MDGs, both as an end in itself and as a major contributor to the overarching goal of reducing poverty and to economic growth.

Asia and the Pacific, as a group, have fared relatively well in reducing poverty (Goal 1 of MDGs). However, most countries will miss the target under current conditions regarding reducing child mortality (Goal 4), poor progress is observed on improving maternal health (Goal 5), and majority of the countries are not doing well in combating HIV/AIDS and only modest progress is being made in controlling malaria and other diseases (Goal 6). If countries of the region do not take adequate measures on prevention and care for combating HIV/AIDS and reduce the new infections to at least 50% of the present level, not only would Goal 6 become unattainable, but Goal 1 on poverty may also be delayed in some countries.

The participants acknowledged the progress made by countries in the region, but there remain many challenges. The participants resolved to strengthen efforts to achieve the health MDGs based on ownership and partnership.

The Forum focused on four key cross-cutting issues that are crucial for achieving the health MDGs in Asia and the Pacific, namely, (1) strengthening health system through capacity building, (2) promoting cross-sectoral actions to achieve the health MDGs, (3) securing resources and increasing effectiveness to achieve the health MDGs, and (4) ensuring equity in access to quality health services.

Session A: Strengthening health systems through capacity building

Analysis of the current situation and key challenges in the achievement of the health MDGs shows that the technical interventions are, in fact, available. What are often critically missing are effective health systems that can ensure that these interventions are delivered to those most in need. In particular, effective interventions are failing to reach the most vulnerable groups. Countries need to ensure sustainable public investment in the essential public health functions.

Key dimensions of health systems

- Health systems are a means of achieving health outcomes.
- Health system performance should be measured by the extent to which it is able to achieve the various health MDGs and other health outcomes. These could be taken as evidence of the overall success of the health system.
- In many countries, weak health systems pose a considerable obstacle to the achievement of the MDGs. National and international support to strength these systems are urgently required.
- Linking various health programmes can promote synergies to accelerate progress towards the health MDGs. For example, sexual and reproductive health and HIV/AIDS programmes could be more successfully integrated, offering women a confidential location for voluntary counselling and testing (VCT) and family planning services, giving the opportunity to intervene in the early stages of the HIV epidemic.

Appropriate health systems model to deliver the health MDGs

- Clearly there is no single model—countries vary enormously. Even within countries, there may be an overall guiding framework, but there certainly need not be a single system dominated by the public sector.

Planning, organization and delivery

- Governments have to take the responsibility to ensure the availability of a minimum package of essential health services, especially for the poor. Services can be augmented by public-private partnerships or other strategies.
- Health systems operate in different kinds of settings—for example, fragile states. Getting health systems right in those circumstances may require different approaches.

Health services regulation

- Governance and stewardship are important. The question of regulation of the health sector is more relevant where government is not the sole provider.
- Ensuring the quality of health services is a key challenge. The example of PPM-DOTS India demonstrated how regulation and stewardship role of governments could ensure this.

Financing the health system

- We have good estimates of the minimum investment needed to establish an adequate health system. Countries need to ensure adequate financing, including pro-poor health care financing. However, in poorer countries, external assistance will continue to play a vital role.
- Donors need to deliver on their internationally agreed commitments. The quality of donor assistance is as important as quantity and can improve health system performance.

Ways to strengthen health systems

Country-level actions

Health policies

- Health should be encapsulated in an overall clear set of widely understood and known development policies and strategies.
- There is a need to ensure national ownership of health systems policies, around which donors should align. Political commitment is important in this regard.
- Setting clear priorities is critical. Policies should lead to clear and effective strategies for implementation.
- Strengthening the referral system at multiple levels is critical for overall health system development. Health infrastructure development should be complemented by appropriate human resource development policies.

Human resources

- Addressing human resource shortages and work conditions is a priority within the health systems agenda and requires long-term commitment and planning.
- Samoa demonstrated that an appropriate skill mix can promote delivery of services in far-flung areas and can be particularly important for improving service quality and ensuring retention.
- Even with a clear commitment to achieving the MDGs, managerial and implementation capacity are often weak and need strengthening.

Pharmaceuticals and vaccines

- As the *Sri Lanka* case study shows, governments have a role to play in effectively regulating the supply of affordable essential drugs and vaccines and their prices and quality. Governments must also ensure effective drugs storage and distribution system.
- Countries also face challenges in keeping prices of drugs and vaccines down, particularly in the context of countries' entry into agreement with the World Trade Organization (WTO) and the opportunities created under Trade-Related Aspects of Intellectual Property Rights (TRIPS).

Health information, knowledge management and research

- There is a need to strengthen capacity in the production and use of quality evidence to support policymaking.
- Health information needs to be timely and reliable. Disaggregation of health information by various indicators of social exclusion enables the analysis of equity.
- In translating evidence into decision-making, information needs to be packaged in a user-friendly way and factors that push managers to use evidence need to be analysed.
- Health system research can help address important health challenges.
- There may be imbalances in the use of research resources, with a large share of the resources being devoted to the health research priorities of developed countries.

- It is sometimes more cost-effective to use research capacity in developing countries to undertake health systems research related to their needs and priorities.
- Donors have a role to play in supporting health systems research.

Role of international partners, harmonization and global partnerships

- Clear domestic polices are important, but they need to be supported by concerted international action in accelerating the achievement of the MDGs.
- It is critical for donors to align their support to the national government's mandate and priorities.
- There is need for a more coherent architecture of international support that addresses coordination. Donors should use existing national structures rather than set up new ones.
- Global initiatives, such as Global Alliance for Vaccines and Immunization (GAVI) or the Global Fund to fight AIDS, Tuberculosis and Malaria, have a role to play in strengthening health systems as part of their core business. Harmonization between these initiatives and among the various stakeholders is important.

Session B: Cross-sectoral actions to achieve the health MDGs

It is well recognized that health is significantly influenced by social and other non-health factors. Achieving the non-health MDGs will have a direct impact on the health MDGs. Progress on Goal 1 poverty reductions and Goal 2 on primary education affect progress on Goals 4, 5, and 6. In addition, progress on Goals 4, 5 and 6 are dependent on Goal 7 on environmental sustainability and Goal 8 on global partnership for development. However, the corollary notion that non-health sector actions are also needed to successfully achieve health sector objectives is not always equally well appreciated. This session discussed governance issues, especially how systematically integrating non-health sector actions in support of desired health outcomes can be achieved through institutionalizing appropriate procedures and organizational arrangements. In particular, it considered examples where institutional mechanisms have been established, in *Indonesia* and in the *Kyrgyz* Republic, to achieve cross-sectoral integration with regards to policy, planning and implementation in support of health sector objectives.

A cross-sectoral approach combining health, nutrition, education, agriculture and infrastructure, as well as addressing cross-cutting issues such as gender, environment and governance, is needed and highly effective in achieving health MDGs through shared responsibility.

- The Kyrgyz Republic established an effective partnership among government, commercial private producers and other interested parties to address the specific health objective of reducing iodine deficiency.
- Indonesia has developed a broader approach in planning and implementation that integrates health and non-health concerns across all relevant sectors in the context of decentralization.
- Incorporating components addressing health issues in projects that are not directly related to the health sector is an effective way to improve health indicators and avoid any adverse effects on health. For example, transport infrastructure is essential for ensuring access to health services in terms of both supply (provision of quality health services/ supplies) and demand (user's accessibility to such services), but could also have negative impacts that need to be mitigated , such as the spread of HIV/AIDS and communicable diseases.
- In another example, there is a possibility that a micro-credit project involving women might inadvertently affect children's health because it demands too much time from the mothers without offering alternative support for the children in the short-term.

Leadership and ownership

- Leadership and ownership at all levels are essential to raise the priority attached to the health MDGs. Strengthened analysis of the economic benefits of health will contribute to raising the priority of health. Capacity for research and analysis needs to be developed.
- Health is more than the absence of disease; it includes physical, social, mental, and

spiritual well-being. Therefore, health should be the concern of everyone.
- Cross sectoral actions in support of health MDGs need to be integrated in strategic planning and budgeting at the macro level, where competing national priorities are identified and selected.
- Governments may consider establishing a high level, multi-sectoral national steering committee that monitor and evaluate programmes to facilitate cross-sectoral actions and coordination.

Economic growth
- Significant investments needed to meet the MDGs require appropriate domestic resources -- including from the private sector.
- Economic growth is ultimately the only road to financial self-sufficiency on a sustainable basis.
- In the meantime, increased ODA aligned with national priorities will still need to be mobilized, particularly by the low-income countries in our Region.

Participation
- The peoples' will to be healthy is often underestimated. An approach that takes the perspective of human security and emphasizes protection from threats and empowering people is essential.
- People's lives are multi-sectoral. People are making multi-sectoral decisions for themselves every day. Therefore, a decentralized cross-sectoral approach most closely conforms to peoples' actual lives.
- Decentralization facilitates participation of all stakeholders in decision making at the local level, thereby strengthening local ownership and sustainability. Joint health committees established at local levels in Indonesia are examples of institutionalisations by the government of a participatory process. Involvement of NGOs and civil society plays an important role.
- The bottom-up approach implies that lower levels influence decisions at higher levels. Health and education can be entry-points for promoting rural development based on participatory approaches, particularly in fragile states.

Sharing knowledge/building capacity
- There is a need for more knowledge generation, management and sharing about effective cross-sectoral actions for health.
- Focusing on health outcomes inherently leads to a cross-sectoral focus while focusing on inputs tends to emphasize individual sectors.
- Identifying good practices requires evaluation to assess the outcomes and determine the factors of success and failure. This requires appropriate tools; for example, health impact assessments.
- Evaluations will enable us to scale-up successful interventions through sharing our experiences in the region and in other regions.
- Least developed countries, island states, fragile states and states emerging from conflicts need particular attention.
- Regional and South-South cooperation should be encouraged as an effective way of sharing knowledge and experiences.

Session C: Securing resources and increasing effectiveness to achieve the health MDGs

Current resources for health fall far short of needs in most countries. Countries are challenged to afford basic health services for their populations, assure financial protection, and achieve the MDGS. High levels of out-of-pocket spending dominate and are indicative of limited risk pooling and financial protection. As a result of the economic structures in many countries, domestic resource mobilization efforts are frequently severely constrained, and are not efficient, equitable, or sustainable. Moreover, available resources are frequently not used effectively. This comes at a time when the need for scaling up programmes is putting already weak health systems under increasing strain. Health sector specific bottlenecks and other institutional and macroeconomic absorptive capacity constraints often preclude effective use of available external funding. Moreover,

the health and nutrition transitions are putting new cost pressures on countries in terms of growing populations, ageing, and higher dependency ratios. Thus, it is important to improve domestic resource mobilization efforts, obtain external grant funds, and to assure that funds are spent in an equitable and efficient manner. Health investments need to be guided by clear and effective strategies linked to outcomes, closely aligned to broader national development processes, such as in PRSPs and SWAps/PBAs, and be consistent with medium term expenditure frameworks (MTEFs). Effective macroeconomic management is a critical concomitant for providing the 'fiscal space' needed to absorb large new external investments in health and laying the bases for sound future financing of Asia's health systems.

The cases of Thailand and Bangladesh provide important examples of countries that are effectively grappling with these financing issues. In the case of Thailand, the Government has now achieved universal coverage by extending coverage to 18 million uninsured for a basic package of essential services under the '30 Baht Scheme' and increasing the Ministry of Health's budget in a strongly pro-poor manor by focusing on rural primary health facilities including community hospitals and health centres. Political will and leadership were critical concomitants of implementing the reform as were peace and economic growth which provided the fiscal space for increased allocations to the health section. As a result of these policies, Thailand has achieved universal coverage and better financial protection for the poor, improved allocative efficiency through a more effective focus on primary care and the poor, and has increased public health spending to over 10 per cent of the national budget. The country is also earmarking tobacco and alcohol taxes for health in order to assure long-term sustainability.

In the case of Bangladesh, the government has not yet achieved universal coverage of health services but has over the past five years focused spending on the Essential Services Package (ESP) - thus shifting resources from tertiary and secondary to primary the level. It has increased its budgeting allocation in real terms by about 17 per cent and donor support has increased by some 60 per cent. The proportion of public health expenditure going to ESP rose by over 50 per cent. The country has committed to increased allocations to the MOHFW budget by at least 10% annually, while efforts will be ongoing to increase the absorptive capacity through improved and more transparent procurement and financial management systems. The MOHFW will reallocate resources to the poorest districts, and design and implement a beneficiary identification system in order to target public subsidies in favour of the poor thus ensuring reduction in health inequalities. Furthermore, the MOHFW has already initiated demand-side financing pilots (e.g. vouchers for maternal health) as an alternative way of reaching the poor. The MOHFW also is moving towards more diversified service provision through greater public-private partnerships.

Important remarks and lessons were shared by the Delegates from France, IPPF, Mongolia, Tonga, UNAIDS, UNICEF, U.S., Pakistan, Malaysia, ESCAP, GAVI, UNFPA, Nepal, and Japan. The importance of donor coordination, the need to include NGOs in national health strategies, accountability, and the importance of sharing Asian experience was highlighted. The U.S. Delegate informed the group about new Maternal, Newborn and Child Health Partnership, which will be launched at the United Nations General Assembly in September. UNICEF shared its 10 principles for developing MDG-oriented health systems and policies. The Japanese delegate stressed the importance of ownership, country-specific approaches, and the importance of the complementarity of aid approaches.

Ways to secure resources and increase effectiveness

- Taking into account country-specific demographic and epidemiological trends is critical for developing both short and long-term financing strategies
- Securing adequate public and private resources in an equitable, efficient, and sustainable manner linked to results is critical for achieving the MDGs and preventing individuals from falling into poverty from health shocks
- Improving domestic resource mobilization is a critical concomitant of effective and equitable financing policies
- Using resources more effectively can result in both important health gains and improved equity
- Obtaining increased external grant funding through better alignment of country

and donor strategies and removing barriers to the effective use of external funds are necessary conditions for meeting the MDGs, particularly in low income countries
- Improving the predictability, longevity, and coordination of donor aid is essential for reducing transactions costs on countries, creating fiscal space, and assuring medium to long-term financial sustainability
- Placing economic growth at the heart of the overall development policy is essential to ensure sufficient and sustainable finance needed to realize health MDGs
- Peace and security are necessary conditions for sustainable efforts in health, development, and fiscal space. The imperative to preserve health infrastructure against wilful destruction in conflict situation was emphasized.
- Promoting and strengthening support for South-South Cooperation is an effective way of sharing good practices and know-how among developing countries faced with similar challenges and should be supported by donor countries.
- Building public and private partnerships among various stakeholders at the community, national, and international levels is important for mobilizing resources, effective service delivery, and increasing development impacts.

Session D: Promoting equity in access to quality health services

Many countries in the region are making good progress in achieving the health MDGs. However, regional averages mask a widening of health inequalities and increasing inequalities to access to quality health services. This session discussed key dimensions of equity in relation to the health MDGs and considered ways to close the disparities.

Among the main points raised at the session were the following:

Key dimensions of equity

- Important health inequities exist in the Asian region, as in other regions.
- There are many important sources of inequity in health: social disparity including gender; geographic, urban-rural, economic, ethnic, and others. The situation varies greatly among countries and regions.
- Even basic health services intended to reach the poor normally achieve higher coverage rates among the better off, thereby exacerbating disparities.
- Reaching the poor and excluded is not only a human rights imperative but also essential for reaching MDGs.

Ways to close disparities

- Protect the poor by integrating health dimensions in Poverty Reduction Strategies (PRS).
- Identifying and remaining vigilant to the existence of disparities in health service coverage constitutes an important starting point. For this purpose, there is for a need for collecting and analysing data on health that are disaggregated by economic status, gender, and other types of inequity.
- An approach based on the perspective of human security, which places the focus on individuals and emphasizes protection from threats and fear as well as empowerment of the people, is important in addressing disparity.
- Promotion of women's empowerment, gender equality and universal access to reproductive health services, in accordance with the Beijing Platform of Action and the International Conference on Population and Development (ICPD) Programme of Action, are important to address health disparities related to wealth and gender. In this context, it was suggested to add the target of universal access to reproductive health by 2015, in relation to MDG 5 to address women's health beyond mortality prevention – also recognizing its importance in combating HIV/AIDS and reducing child mortality, as well as in promoting gender equality and eradicating poverty.
- Many different techniques for orienting health services towards the poor have been found to work well in certain situations. Examples covered in the discussion include:
  - Focus on poor areas during the initial stages of a universal coverage programme. While blanket approaches can be effective, for the most marginalized, special intervention may sometimes be needed. One way of doing this is through

giving high priority to delivering services to districts with low levels of human development.

- While improving services including more service-oriented attitudes by health staff to everybody is important to reach the poor and marginalized, one cannot reach them just by waiting in health facilities for people to come to use the services. Outreach to bring services to people, empowerment of people to raise awareness of need to use services and of right to demand good services is as important.
- Support NGOs shown to work effectively with marginalized and low-income communities.
- Participatory project development has shown to work more effectively than a top-down approach addressing in equity.
- Provide subsidized health insurance to poor individuals identified through a means test, as in the Philippines. Philippines national health insurance programme, "PhilHealth", succeeded in extending coverage to 84% of the population, including self-employed, rotaries, migrant workers, through cross-subsidy between central government, local government and the relatively well off.
- Cambodia's Equity Fund that is currently under development aims, inter alia, to facilitate access of the poorest to priority public health services and to protect the poor from falling into deeper poverty due to catastrophic health events.
- Vietnam has established a health care fund for the poor that, since 2002, has provided free care for more than 14 million people, and covered 77% of Vietnam's poor people in a joint effort of the government and the society. Vietnam also has a health care network at grass-roots level through which national programmes to control such diseases as TB, leprosy, malaria, goitre have been successfully implemented.
- Monitoring access to essential health services including reproductive health services and health outcome based on appropriate indicators and under a multi-sectoral system such as a high, level steering committee is necessary for addressing health inequity.
- Changing attitudes needs person-to-person communication but also promotion of social dialogue by diverse groups. This social dialogue is needed for widespread attitude and behavioural changes that help individuals make decisions that were not part of their deep-rooted traditions.

Annex 5

"Health and Development" Initiative (HDI)

~ Japan's contribution in achieving the health related MDGs ~

June 2005
Government of Japan

1. Japan's basic position

(1) In the year 2000, the United Nations member states adopted the Millennium Declaration, in which development goals were incorporated, putting poverty reduction at the center of concerns. Those Development Goals, which later came to be known as Millennium Development Goals (MDGs) and established the time-bound targets to be achieved by 2015, are composed of eight goals, three of which explicitly refer to health. Achieving the health MDGs is recognized to be important in order to attain all the eight MDGs. However the progress toward achieving MDGs is lagging in many developing countries.

(2) The issues related to health services in developing countries are not simply medical problems but also serious inhibiting factors in the pursuit of development because health problems are not only threats to individual lives, "human security", but also have negative socioeconomic impacts on societies. For example, people's health conditions become worse with the problems caused by a fragile health system, such as a lack of access to health services, health education, safe drinking water and adequate sanitary facilities, as well as malnutrition, resulting in, at the national level, the shrinkage of labor force, increase in the cost of medical care, and loss of the educational opportunities among those affected by poor health and leading to poverty worsens. It is therefore extremely significant to achieve health MDGs to address poverty reduction.

(3) With the advancement of globalization, there has been a growing threat that infectious diseases such as HIV/AIDS, avian flue and Severe Acute Respiratory Syndrome (SARS) are spreading easily across country borders. Infectious diseases, which the "ODA Charter" and the "Mid-Term Policy on ODA" regards as one of the global issues, are a common threat to human beings. Japan has responsibility to take measures against infectious diseases for the protection of the people's health not only in Japan, but also throughout the world, in collaboration with the international community including the developing countries, other donor countries and international organizations.

(4) Through the Okinawa Infectious Disease Initiative (IDI) announced at the Kyushu - Okinawa G8 Summit in 2000, Japan has implemented assistance in health-related areas that considerably exceeds US$ 3 billion, the amount pledged in 2000 in the five years between FY2000 and FY2004. The initiative not only helped the international community acknowledge the importance of infectious disease control, but also paved the way for the establishment of the Global Fund to fight AIDS, Tuberculosis and Malaria, thus realizing the concept of a public-private partnership. Looking also to the past, in 1994 Japan announced the "Global Issue Initiative on Population and AIDS" in collaboration with the United States, and gave comprehensive support to actions against HIV/AIDS as well as family planning and population control. In 1997, Japan announced the "International Parasite Control Initiative (also known as Hashimoto Initiative)," and in 1998, Japan adopted the "TICAD Tokyo Action Plan", which included measures against various health problems in Africa such as infectious diseases.

(5) With the completion of IDI in March 2005 and the importance of MDG-related measures, and in view of the convening of the United Nations High Level Plenary Meeting on the Millennium Declaration, the Government of Japan launches this initiative, to continue and further enhance its active contribution in the health-related sector through ODA, with an emphasis on the achievement of MDGs by 2015.

2. Basic policies

Based on the following basic policies, Japan will support the self-help efforts of developing countries through its ODA in order to promote people's health in developing countries and thereby contribute to achieving the health MDGs.

(1) Emphasizing the "Human Security"[22] perspective

The international community has become interdependent to an unprecedented degree. Against this background, in order to address humanitarian crises resulting from the spread of infectious diseases including HIV/AIDS, it is necessary to provide assistance with the perspective of "human security", which places the focus on individual people, along with national perspectives. "Human security" focuses on individual people and aims at building societies in which everyone can live with dignity, by protecting and empowering individuals and communities that are exposed to threats. The perspective of "human security" is particularly important in health which is directly related to human lives. Based on this recognition, in order to address various health threats including malnutrition, a lack of safe water supplies and sanitary facilities, and health services, and the spread of infectious diseases, and enable individuals and local communities to protect themselves from ill health, Japan will support sustained capacity development in order for individuals to protect themselves from health problems by providing quality health services, prevention education and enlightenment. In case regions or socially disadvantaged people such as ethnic minorities without adequate access to health services due to regional, income or gender disparities, Japan will give consideration to enabling them to have access to such services.

(2) Cross-sectoral actions

Since the challenges existing in the field of health and the causes of problems are diverse and complex, it is important to implement cross-sectoral actions in order to effectively address those challenges and problems. To this end, in addition to dealing directly with individual health related challenges on a case-by-case basis, Japan will implement comprehensive assistance that cover the whole sector including strengthening health systems. Furthermore, taking into consideration its support for other sectors which relate closely to health, Japan will seek to provide the integral support that combines the various modalities of its assistance.

In the post-Second World War era, Japan drastically reduced the infant mortality rate and improved life expectancy through improving nutritional status, the promotion of the Mother-and-Child Health Handbook and health education in schools, improvement of water supply and sanitation systems, local health activities and institutional capacity building. Furthermore, concerning infectious diseases, Japan substantially reduced the number of tuberculosis patients and eradicated some parasitic diseases including malaria, schistosomiasis and filariasis. Utilizing its own experience and expertise that Japan has developed in improving people's health through such cross-sectoral actions, Japan is determined to extend effective cooperation in the health and medical field.

In concrete terms, establishing a basic infrastructure for health services and health systems thereby improving the quality of medical services are measures which will contribute to overcoming many challenges in the health field. By combining assistance directly related to health and assistance indirectly related to health, including the improvement of water supplies and sanitation, education and infrastructure (roads, communication networks, electric power systems and garbage dump systems), Japan will work for the achievement of MDGs. Furthermore, Japan will take into consideration gender perspectives in taking these actions.

(3) Collaboration and coordination with the international community

Collaboration with other donor countries and international organizations as well as other developing countries need to be strengthened in order to enhance the effectiveness of assistance. Japan will promote South-South cooperation[23] in which developing countries share their experiences and the measures that were effective, and utilize them fully to address their common concerns. Collaborating with other donor agencies, Japan will endeavor to provide assistance effectively in a unified and coherent manner by sharing strategies and goals. With regard to the approaches in which international organizations have comparative advantages,

[22] "Human Security" means focusing on individuals and building societies in which everyone can live with dignity, and protecting and empowering individuals and communities that are exposed to actual or potential threats. In concrete terms, it aims at protecting individuals from "fears," such as conflict, terrorism, crime, human-rights violation, displacement, disease epidemics, environmental destruction, economic crises and natural disasters, and "wants" such as poverty, hunger and lack of educational and health services, and empowering people so that they can make choices and take actions for improving the quality of their lives.

[23] South-south cooperation is an exchange of resources, experiences and know-how among developing countries and newly emerging donors. It enables a smooth transfer of technologies sustainable for a recipient country from a country with a similar background of economic development.

Japan will seek to contribute through financial cooperation, taking into due consideration synergies with Japan's bilateral aid. Cooperation with NGOs and civil societies pertaining to health will be strengthened with a view towards achieving MDGs.

(4) Formulation of assistance programs in accordance with various local needs in developing countries

It is necessary to formulate an aid strategy in the health field based on an accurate understanding of the health needs of each partner country. By understanding the priority needs of partner countries and then formulating an appropriate strategy in light of those priorities, Japan is determined to provide its assistance effectively and efficiently. When developing countries have their own development programs or strategies related to health, Japan will implement its assistance in a coordinated manner, taking into full consideration those strategies.

(5) Strengthening the research capacity on the ground and paying due respect to local conditions

In providing assistance, it is essential to fully understand local culture and traditions, and the social norms and practices toward illness. For instance, in a society where a certain type of diarrhea is considered an initiation in order for children to become adults, there might be difficulties in conducting appropriate diarrhea control in a timely and efficient manner. Japan will thus seek to extend its assistance, taking into due consideration those local culture, traditions and norms toward ill health. Utilizing its own experience and know-how not only in health and medical fields, but also in other fields, such as sociology and anthropology, Japan will seek to strengthen research capacity at the field level, in particular research activities for project implementation[24].

3. Concrete measures

(1) Assistance for strengthening institutional capacity development in the health sector

Japan will take the following measures in order to support strengthening the basic capacity for all health-related MDGs. Local health systems are the basis of the health sector in developing countries, and support for the construction of systems through the following measures promotes development. Moreover, in developing those health and medical systems, Japan will implement multi-dimensional assistance, which includes human resources development in particular for those involved in national and local health administration and improvement of facilities such as construction of core hospitals, attaching great importance to addressing capacity-building and the correction of disparities in local communities.

(a) Strengthening health systems : Japan will support the construction and strengthening of referral systems[25], improvement of infectious disease surveillance functions[26], construction of a medical care information management system, and development of an essential drug supply system. Japan will also provide its assistance for the improvement of a health and population statistics system, and for the development of monitoring and evaluation capacities.

(b) Capacity building for health workers: Japan will support the formulation of medium- and long-term programs on human resources development and also support capacity development for those involved in national and local health administrations, as well as the health workers including doctors and public health nurses.

(c) Development of health facilities and strengthening of their functions: Japan will support the development of health facilities and strengthening their functions through the construction of health centers, hospitals and other health-related facilities, and providing for medical equipment.

[24] One example of research activities for project implementation is "operational research", which is the research that gives an answer to what the problems are and thus what technologies or models are appropriate to find the solutions to those problems.
[25] The system which offers high quality service by information exchange and close communication among health centers, clinics and hospitals enabling to transfer patients smoothly to appropriate health facilities.
[26] Continuous observation and analysis on the distribution and spread of infectious diseases and related factors with sufficient accuracy and perfection, and thereby establish efficient counter measures.

(2) Assistance in areas that reinforce the health sector and cross-cutting actions

In order to achieve health MDGs, assistance solely in the health sector is insufficient. It is therefore important to make efforts to address various problems, combining support in the health sector with other sectors. As an example, safe water supplies prevent children from infectious diarrhea and thereby contributes to the improvement of children's health overall. The improvement of literacy and health education contributes to illness prevention by understanding and conveying basic knowledge about diseases. The construction and maintenance of roads contributes to improved access to local health services. From a gender perspective, it is important to pay proper attention to women because women are often placed in a weak position socially and have more difficulties than men accessing health services. Based on such recognition, Japan will take the following measures which contribute to the achievement of health MDGs.

(a) Promoting gender equality: Gender equality should be addressed across all measures taken in the health sector. Japan will provide assistance on reproductive health and rights[27], for addressing gender disparity in access to health services, and capacity development for women, in response to the particular needs of women's health.

(b) Assistance in the education sector: Japan will provide assistance for education focusing on sanitation and prevention such as against HIV/AIDS and parasitic diseases to address local health issues, at primary and secondary schools, non-formal schools for out-of-school children, school dropouts and street children, and literacy classes for adults. Moreover, support will be given to protect AIDS orphans from dropout and discrimination. Furthermore, Japan will support school meal programs and thereby improve the nutritional status of children.

(c) Assistance on water and sanitation: A safe water supply and access to adequate sanitary facilities greatly contribute to improving public health and prevents children from diarrhea, which is one of the major causes of infant death. Moreover, assistance for sanitary facilities such as the provision of safe water and installation of latrines is effective as a measure to control parasitic diseases. Japan will therefore support these activities in a comprehensive manner, for instance, combining the installation of water supply equipment and toilets, and health education at schools in implementing a project for school construction, or combining the appropriate development of safe water supplies and sanitary facilities, and health education in areas where the frequent epidemics of waterborne infection are recognized.

(d) Assistance for improving socio-economic infrastructure: Assistance for development of roads, telecommunication systems, electric power systems, and garbage dump systems are important so as to improve access to health services and to preserve quality health services. Japan will support infrastructure development to improve the quality of health services and medical care. Moreover, Japan will conduct surveys and studies to maximize the effect of cross-sectoral assistance, including consideration of the necessary factors to be considered for the improvement of health services in developing infrastructure such as roads.

(3) Actions toward achieving MDGs

In addition to the actions mentioned in (1) and (2) above, the initiative focuses on practical actions to achieve the health MDGs, namely Goals 4, 5 and 6, as follows:

Goal 4: Reduce child mortality
Target 5: Reduce under-five mortality rate by two thirds by 2015
Indicator 13: under-five mortality rate
Indicator 14: infant mortality rate
Indicator 15: proportion of 1 year-old children immunized against measles

Current situation: Approximately 11 million children die every year in the world. The majority are children living in developing countries and most of them die of diseases that are preventable and treatable with existing medical technology and care. It is reported that the indicators in sub-Saharan Africa are now at the worst levels and their infant mortality rate per 1000 births

[27] Reproductive health and rights are those related to sex and reproduction. Programme of Action adopted at the 1994 International Conference on Population and Development states that " reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so".

in most of the countries in the region is over 100. It is foreseen that the goal could be achieved in North Africa, Latin America, Caribbean and Southeast Asia. However there are enormous disparities within regions, between urban and rural areas, the rich and the poor, and gender disparity, even in those regions with positive perspectives. It is expected that at the current pace no more than a 42 % reduction (the target is two thirds=about 67% reduction) in child mortality can be achieved. ARI, diarrhoea, malaria, measles and HIV/AIDS are the major causes of the infant mortality. More than 60% of infants are suffering from malnutrition. Most child deaths are preventable if the appropriate interventions are made, such as nutritional treatment, and hygienic environment, immunisation, education and ensuring access to health services. It is also important in achieving improved child health to ensure children are protected against child abuse, sexual exploitation and child labour.

Measures: Japan will support the efforts made by developing countries including coping, for example, with diarrhoea by universal usage of ORS (Oral Rehydration Salt[28]) and ensuring access to safe water and adequate sanitary facilities, and as per ARI (Acute Respiratory Infections) by providing antibiotics. Concurrently Japan will also support developing countries in providing vitamin A and iodine to improve the nutritional status of the children. Against malaria, Japan will provide the insecticide-treated bed nets and treatment with effective anti-malarias. For measles, which is still a killer disease against children, Japan will extend its support for immunisation since measles is preventable by safe, effective and relatively cost-effective vaccination. At the same time, Japan will support the prevention interventions for improvement of the health status of infants by ensuring health check-ups and weighing children regularly. As the various factors are related to children's death, Japan will support developing countries in promoting the IMCI (Integrated management of Childhood Illness[29]), which many countries have adopted as the comprehensive approach to children's health and establishing antenatal care in local communities.

Goal 5: Improve maternal health
Indicator 16: Maternal mortality ratio
Indicator 17: Proportion of births attended by skilled health personnel

Current situation: 13% of deaths of women of reproductive age (15-49 years of age) occur in pregnancy or childbirth, and it is the third major cause of death followed by HIV/AIDS and injuries. Maternal mortality is often preventable with appropriate interventions. Although the impact of the death of women who play important roles to ensure family health is not measurable, it certainly seriously affects the children's health and family health status. The situation in sub-Saharan Africa and the South Asian region is especially serious. Since maternal mortality is related to not only economic factors (MMR is relatively high in rural areas and among the poor) but also the social factors (gender disparities in access to health services, and some traditional practices which influence women's health), the challenges to improve the situation are enormous. It is presumed that the goal will not be achieved except in the Middle East and North Africa. In order to achieve this goal, it is indispensable to ensure the universal access to reproductive health, greater skilled attendants at delivery, improved prenatal health check-ups, improved use of family planning, etc. At the same time, it is important to coordinate these interventions in an effective manner with those to achieve MDG Goal 2 (Achieve universal primary education) and Goal 3 (Promote gender equality and empower women).

Measures: In order to protect maternal health and reduce maternal mortality in pregnancy and childbirth, avoiding unwanted pregnancy, premature labor and appropriate spacing, Japan will support awareness raising and community education and distribution of contraceptive, especially focusing on adolescents. Japan will support training for health staffs to increase skilled attendants at delivery. By providing medical equipments, medicines, ambulances and supporting clinics and hospitals, Japan will ensure the safe delivery and improve emergency obstetric care[30]. In addition, Japan will provide assistance to improve access to health facilities by rehabilitating infrastructure such as roads. In addition, bearing in mind the importance of continuous care for maternal and children's health, Japan will endeavour to disseminate

[28] ORS contains a variety of salts (electrolytes) and sugar. The combination of electrolytes and sugar stimulates water and electrolyte absorption from the intestines. It therefore prevents or reverses dehydration.
[29] Because most child deaths occur at home, before reaching health facilities, improving children's health through the community are at the core of IMCI. This strategy has three main areas of focus: improving health worker skills, improving health systems and improving family and community practices.
[30] It is the emergency care to prevent pregnancy related mortality and morbidity. The emergency obstetric care is to focus on dealing with bleeding during pregnancy, pregnancy induced hypertension, pre-term labor, obstructed and prolonged labor, intrauterine death, anemia, and post-partum hemorrhage. For this emergency care to function efficiently, community education, quality antenatal care and transfer systems for the emergency patients are essential.

Mother-and-Child Health Handbooks and to increase prenatal health check-ups and thereby protect maternal health.

Goal 6: Combat HIV/AIDS, malaria and other diseases
Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS
Indicator 18: HIV prevalence among pregnant women aged 15-24 years
Indicator 19: Condom use rate of the contraceptive prevalence rate
Indicator 20: ratio of school attendance of orphans to school attendance of non-orphans aged 10-14.

Current situation: Estimates suggests that approximately 3 million people died of AIDS just in 2003, and more than 25 million people have died of AIDS since the inception of its pandemic. As of now, it is estimated that about 90% of the people living with HIV/AIDS are in developing countries. HIV/AIDS affects populations at productive ages, and thereby seriously affects the society and the economy. HIV/AIDS is one of the major causes of poverty.

With regard to areas or regions, Sub-Saharan Africa is most affected by HIV/AIDS, followed by the Caribbean, Eastern-Europe, Russia and newly independent countries from former Soviet Union where prevalence of HIV is increasing drastically. HIV/AIDS has been spreading among general population quite rapidly in Asia, especially in East and South Asia. Furthermore, particularly regarding women, there exist a number of social factors that make women more vulnerable to HIV infection. Actions need to take into account the gender perspective. Since, as of the end of 2003, there were about 15 million children who lost at least one parent to HIV/AIDS, actions must address the issue of AIDS orphans.

Measures: In order to reduce the risk of being infected with HIV/AIDS, prevention through awareness raising and education, condom use are important activities. With emphasis on adolescents, Japan will support human resource development in order to facilitate prevention activities and provide such supplies as condom. For effective prevention, various measures will be targeted to those at a high risk of HIV infection. In providing assistance to build a large-scale infrastructure, it is also important to include prevention interventions to those who are part of a migratory labor force, as well as to those living in the surrounding area, for instance, through prevention education or provision of condoms. In addition, Japan will provide support to control Sexually Transmitted Infections, which increase the risk of acquiring HIV, paying a close attention especially to the most vulnerable populations.

With regard to treatment and care for HIV/AIDS, Japan will promote Voluntary Counseling and Testing (VCT) through the supply of test kits, support to develop human resources for counseling, and providing health care facilities. Through its contribution to the related international orgnizations, Japan also will seek to help scale up anti-retrovirus therapy (ART), and to support treatment and care for opportunistic infections. At the same time, Japan will provide assistance for the prevention of mother-to-child transmission, and for the greater involvement of people living with HIV/AIDS (GIPA). Japan will address the issue of protection of AIDS orphans from social dropout and discrimination. Japan will also support the development of the health system in order to supply safe blood, and thereby reduce the risk of acquiring HIV. In order to make the aid more effective at the field level, Japan attaches importance to aid harmonization and alignment, emphasizing the importance of the principles of "Three Ones"[31] that UNAIDS advocates. Moreover, through utilizing the program funds approved by the Global Fund to Fight AIDS, Tuberculosis and Malaria, Japan will seek to develop human resources and support areas where Japan has a comparative advantage at the field level such as prevention.

Goal 6: Combat HIV/AIDS, malaria and other diseases
Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other diseases
Indicator 21: Prevalence and death rate associated with malaria
Indicator 22: Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures
Indicator 23: Prevalence and death rate associated with tuberculosis
Indicator 24: proportion of tuberculosis cases detected and cured under DOTS

[31] To achieve the most effective and efficient use of resources, and to ensure rapid action and result-based management, the USAIDS and other major donors advocate one agreed HIV/AIDS action framework; one national AIDS coordinating authority; and one agreed country-level monitoring and evaluation system.

(A) Malaria and tuberculosis

Current situation: Each year, there are 300 million people throughout the world who newly acquire malaria and 60 million who are newly infected with tuberculosis- about 1 million die of malaria and 2 million die of tuberculosis. With regard to malaria, 80% of deaths are found in children who live in Sub-Saharan Africa. As for tuberculosis, Asia and the Pacific account for approximately 57% of the patients and 55% of deaths due to tuberculosis. Tuberculosis is the common infectious disease in Asia and the Pacific, and those who suffer are adults who are at the center of the society and whose productivity is high.

Despite the fact that there exist effective measures to control or treat these diseases, a large number of people die from them. Furthermore, tuberculosis is closely related with HIV/AIDS and those infected with tuberculosis is increasing along with the spread of HIV/AIDS. The resulting decrease in the labor force, either directly or indirectly, and the increase in the cost to treat sick people is a serious cause of poverty for individuals as well as for government finance.

Measures: With regard to malaria, Japan will support prevention education, check-ups and treatment. In particular it will provide assistance to supply anti-malaria drugs and insecticide-treated bed nets, if possible long-lasting ones, which is considered a useful measure in the "Roll back malaria"[32] initiative endorsed by WHO, UNICEF and World Bank. Further, when constructing dams or irrigation facilities, Japan also will provide assistance to raise awareness for the prevention of malaria.

With regard to tuberculosis control, since it is known that the DOTS[33] strategy is quite effective, Japan will seek to supply anti-TB drugs and test kits, and provide assistance to develop human resources that are needed to promote the DOTS strategy.

(B) Other infectious diseases

(a) Polio

Current situation: The number of polio cases reported around the world decreased dramatically from 35,251 in 1988 to 1,919 in 2002. Although polio eradication was declared successful in North and South America, the Western Pacific regions and Europe, polio cases still remain, if smaller in number, in South Asia and sub-Suharan Africa.

Measures: Japan will continue to support polio eradication programs through the supply of polio vaccine, and technical cooperation on diagnosis, surveillance and production of vaccine.

(b) Parasitic diseases

Current situation: Major parasitic diseases in the developing countries are filariasis, schistosomiasis, duracunculiasis, onchocerciasis, and tripanosomiasis. Throughout the world, more than half the population is infected with those parasitic diseases, many of them in the developing countries.

Measures: In order to control parasitic diseases, it is effective to support prevention, treatment and education through schools and local communities. Providing assistance, including through South-South cooperation, Japan will support human resource development to control parasitic diseases including filariasis, schistosomiasis, dracunculiasis, onchocerciasis, and tripanosomiasis. In close collaboration with WHO/WPRO, Japan is seeking to eradicate filariasis in the Western Pacific region with the objective of achieving this by 2010. In addition, since construction of irrigation facilities may lead to prevalence of parasitic diseases, in connection with such assistance, Japan will provide assistance to raise awareness of prevention and countermeasures against parasitic diseases.

(c) Emerging diseases

Current situation: Infectious diseases such as SARS or avian flu are newly emerging threats to human beings and thus might result in severe damage to people's health. Besides, viruses

[32] The Roll Back Malaria (RBM) Global Partnership was launched in 1998 by the WHO, UNICEF, UNDP and the World Bank. RBM's goal is to halve the burden of malaria by 2010.
[33] Directly Observed Treatment, Short course; it is the treatment in which anti-tuberculosis drugs are given to the patients under directly observed conditions.

such as influenza mutates so rapidly that it might attain the potential ability to easily spread world-wide.

Measures: Cooperating with other donors and international organizations such as the WHO, Japan will support the establishment of the worldwide surveillance system for early detection, thereby contributing to taking countermeasures against epidemics at an early stage.

4. Strengthening the Japan's aid implementation capacity

Japan will further endeavor to strengthen its own capacity for development aid in order to put this initiative into operation. In concrete terms, Japan will develop human resources so as to provide health-related assistance. In formulating its aid strategies and implementing related projects, Japan will seek close collaboration among ministries concerned and the establishment of the networks among research institutions. Furthermore, Japan will strengthen collaboration between government and other stakeholders such as NGOs, universities and research institutes, and private enterprises so as to ensure implementation of its economic cooperation in a unified and coherent manner. Japan will also strengthen monitoring and evaluation systems in order to have effective feedback for more efficient and effective implementation.