United Nations E/2009/86

Economic and Social Council

Distr.: General
28 May 2009

Original: English

Substantive session for 2009
Geneva, 6-31 July 2009
Item 2 (b) of the provisional agenda*
High-level segment: annual ministerial review

Letter dated 19 May 2009 from the Permanent Representative of Japan to the United Nations addressed to the President of the Economic and Social Council

It is my honour to transmit to you herewith the national report of Japan, entitled "Implementing the internationally agreed goals and commitments in regard to global public health", for the annual ministerial review scheduled to be held during the high-level segment of the 2009 substantive session of the Economic and Social Council (see annex).

I would be grateful if you could kindly circulate the present letter and its annex as a document of the Economic and Social Council, under item 2 (b) of the provisional agenda.

(*Signed*) Yukio **Takasu**
Ambassador
Permanent Representative

* E/2009/100.

09-35381 (E) 290609

Annex to the letter dated 19 May 2009 from the Permanent Representative of Japan to the United Nations addressed to the President of the Economic and Social Council

National report of Japan

Implementing the internationally agreed goals and commitments in regard to global public health

A. Efforts by the Government of Japan to implement national development strategies and policies

1. Policy framework

(a) The Official Development Assistance Charter

1. Japan's official development assistance (ODA) is an integral part of its foreign policy. It supports capacity development and nation-building in developing countries, and also contributes to meeting global challenges. As stipulated in the ODA Charter revised in 2003 from the 1992 original version, the objectives of Japan's ODA are "to contribute to the peace and development of the international community, and thereby to help ensure Japan's own security and prosperity".

2. The basic polices that are pursued under the ODA Charter are: (a) supporting the self-help efforts of developing countries; (b) considering issues from the perspective of human security; (c) assuring fairness; (d) utilizing Japan's experience and expertise; and (e) pursuing collaboration with the international community and other stakeholders, including international organizations, other donor countries, non-governmental organizations (NGOs) and the private sector. The Charter also identifies the following issues as priorities: (a) poverty reduction; (b) sustainable growth; (c) addressing global issues; and (d) peacebuilding. The Charter's principles of ODA implementation stipulate that assistance may never be put to military use, and that it must promote the democratization of developing countries.

(b) Medium-Term Policy on Official Development Assistance, Country Assistance Plans and annual Priority Policy for International Cooperation

3. Under the ODA Charter, the Medium-Term Policy on Official Development Assistance, adopted in 2005, was formulated for the purpose of defining and elaborating Japan's basic policies on medium-term assistance, including what it provides in advancement of the Millennium Development Goals. The Medium-Term Policy is supplemented by Japan's Country Assistance Plans, which provide the basis for the assistance it gives each country, and sector-specific initiatives, which are field-by-field guidelines. Together, the plans and initiatives provide an additional framework for Japan's assistance, and to date, Japan has adopted 28 of the former and 8 of the latter, including in the health sector. In order to implement ODA in a more consistent, efficient and effective manner, each of the Country Assistance Plans sets out the timetable for the assistance that is to be provided over approximately the next five years, based on the target country's developmental needs and its current developmental plans. It also outlines the significance of Japan's assistance to that country, the direction cooperation should take in the

future, priority areas, major challenges and issues that should be considered in connection with the implementation of aid.

4. Furthermore a paper called "Priority Policy for International Cooperation" has been formulated every fiscal year since 2007. Supplementing the country assistance plans, it identifies those issues to which Japan attaches priority, so that it may respond swiftly to recent developments and issues in Japan's diplomacy. For fiscal year (FY) 2009, the following priorities were identified: (a) supporting Asian countries' efforts to strengthen their growth potential and expand domestic demand in response to the current financial and economic crisis; (b) supporting efforts for reconstruction in Afghanistan and economic stabilization in Pakistan in order to eradicate terrorism; (c) supporting measures to address climate change issues (promoting the "Cool Earth Partnership"); (d) steadily implementing commitments such as doubling Japan's ODA to Africa (TICAD IV) and contributing to realizing the Millennium Development Goals (G8 Hokkaido Toyako Summit); (e) promoting trade and investment to developing countries; and (f) further promoting collaboration with NGOs.

2. Basic structure and implementation

(a) Strategic function

5. Japan's international cooperation programme has undergone major reform and significant restructuring since 2006. Specifically, its strategic and policy planning functions have been strengthened and the new JICA was established.

6. With regard to the strengthening of strategic functions, the Overseas Economic Cooperation Council was established in April 2006 as the supreme strategic decision-making body. Chaired by the Prime Minister and composed of the Chief Cabinet Secretary, the Minister for Foreign Affairs, the Minister of Finance and the Minister of Economy, Trade and Industry, it engages in flexible and practical deliberations on important matters pertaining to overseas economic cooperation. Among the issues to which it has turned its attention are ODA policy; the extent and quality of ODA relating to Asia, Africa, China, Iraq, India and Afghanistan, resources, energy, the environment, support for legal systems and peacebuilding.

(b) Policy planning/formulation function

7. Regarding the policy planning and formulation function, the Ministry of Foreign Affairs plays a major role within the Government, serving to coordinate activities in the policy area. Within the Ministry itself, the International Cooperation Bureau, established in August 2006, is charged with comprehensive planning and drafting of policies relating to bilateral as well as multilateral development assistance. Within the Government, the Bureau also plays a central role in coordinating the work done by government agencies, so as to ensure that the ODA provided by each is designed and executed coherently and in line with strategic values and yields the maximum results. The International Cooperation Planning Headquarters, established under the Minister of Foreign Affairs, plans and formulates policies such as the "Priority Policies for International Cooperation" and also deliberates on important matters relating to international cooperation.

3. Establishment of New Japan International Cooperation Agency

8. In October 2008, former Japan International Cooperation Agency (JICA), which carried out technical cooperation and promoted the implementation of grant aid, merged with the Overseas Economic Cooperation within the former Japan Bank for International Cooperation (JBIC), which had been in charge of providing ODA loans, creating New JICA. In addition, a large part of the responsibility for implementing grant aid that had previously belonged to the Ministry of Foreign Affairs (MOFA) was transferred to New JICA, making it the world's largest bilateral development organization, with some US$ 10.3 billion in available financial resources. This enables New JICA to handle all three instruments of aid: technical cooperation, grant aid and ODA loans in an integrated fashion, thereby enabling it to maximize synergy effects. For example, previously, when a project was being formulated, separate development studies were conducted for different assistance instruments. Preparatory surveys, which are newly adopted survey studies applied uniformly to the three schemes, can conduct development studies without being tied to any of them and accelerate the project formulation process. New JICA regards surveys and research on international cooperation as among its key functions, and therefore established the JICA Research Institute. New JICA continues to conduct its long-established operations such as the dispatch of Japan Overseas Cooperation Volunteers and Senior Overseas Volunteers to assist in the social and economic enhancement of developing countries and Japan Disaster Relief Teams to provide emergency relief goods in the wake of major disasters. The inauguration of New JICA enhances the quality of Japan's ODA by promoting more efficient, effective and rapid implementation.

4. Aid volume

9. During the 1990s, Japan was the largest donor country in the world. Japan's ODA budget peaked in fiscal 1997, and since then, the scale of its assistance has declined more or less steadily. Among Organization for Economic Cooperation and Development-Development Assistance Committee (OECD-DAC) countries, Japan's net ODA disbursements in 2002 ranked second behind the United States; in 2008 they ranked fifth. Japan's net ODA disbursements in 2008 totalled US$ 9,362 million, compared with US$ 7,678 million in 2007, an increase of 8.2 per cent in real terms over 2007. Japan's gross ODA disbursements in 2008 totalled US$ 17,401 million, compared with US$ 13,566 million in 2007, representing an increase of 13.8 per cent in real terms. Japan's ODA/gross national income (GNI) ratio rose from 0.17 per cent to 0.18 per cent in this time.

10. A breakdown of ODA net disbursements in 2007 shows that bilateral ODA accounted for roughly 75.2 per cent of the total; the remainder went to ODA channelled through international organizations.

(a) Allocation by region

11. With regard to bilateral ODA by region, Japan traditionally has placed emphasis on Asia. In recent years, it has gradually shifted allocations from Asia to Africa and the Middle East. This is partly because many Asian countries have developed to the point where they no longer need Japan's ODA. Also, Japan has made commitments to Africa in forums such as the Tokyo International Conference on African Development (TICAD) and engaged in peacebuilding efforts in the

Middle East that have included reconstruction projects in Iraq and Afghanistan and also the Middle East peace process. In 2000, 54.8 per cent of Japan's net ODA disbursements went to Asia while 10.1 per cent went to Africa and 7.5 per cent to the Middle East. In 2007, Asia accounted for 28.3 per cent of the total, at US$ 1,634 million. Africa accounts for 29.4 per cent at US$ 1,701 million and the Middle East accounts for 16.4 per cent, at US$ 948 million. Latin America accounts for 3.9 per cent of the total, at US$ 226 million, Oceania for 1.2 per cent, at US$ 70 million, and Europe for 0.8 per cent, at US$ 48 million. Assistance covering multiple regions accounts for the rest, at about US$ 1,152 million.

(b) Allocation by method

12. A breakdown of bilateral ODA indicates that disbursements calculated as grant aid totalled US$ 3,414 million, amounting to 44.5 per cent of overall net ODA disbursements. Of this amount, debt relief accounted for 25.3 per cent, at US$ 1,941 million, grant aid through international organizations accounted for 5.1 per cent, at US$ 395 million, and funds provided by Japan for grant aid excluding other aforementioned categories accounted for 14 per cent, at US$ 1,078 million. Additionally, technical cooperation accounted for 33.5 per cent, at US$ 2,569 million, loan aid amounted to US$ 205 million, and loan aid excluding debt relief amounted to US$ 161 million.

(c) Aid effectiveness

13. Japan is firmly committed to the principles of the Paris Declaration and Accra Agenda for Action. Japan has formulated its own Action Plan for Implementing the Paris Declaration, and progress in implementing it is described in annual reports. In addition, the emergence of new donors makes it more important than ever for the donor community to coordinate their activities so as to maximize their effectiveness and collective impact on developing countries. To that end, Japan, together with other donors, organized workshops in Asia to exchange experiences on this subject with developing countries and providers of development assistance.

B. Efforts by the Government of Japan to implement the internationally agreed goals and commitments in regard to global public health

1. Basic principles of Japan's global health policy

(a) Basic principle

14. Health problems in developing countries are not only threats to individual lives or human security, but also have a negative socio-economic impact, and are therefore grave obstacles to development. For example, health conditions worsen when health systems are fragile, when there is a lack of access to health services and health education, when there is malnutrition, or a lack of safe drinking water and adequate sanitary facilities. At the national level, the result is a shrinking of the labour force, increases in the cost of medical care, and declining levels of education, all of which in turn contribute to rising rates of poverty. To reduce poverty, it is therefore extremely important to improve the health situation.

15. Moreover, with the progress of globalization, we need to address threats posed by infectious diseases such as HIV/AIDS, avian and emerging influenza, and severe acute respiratory syndrome (SARS) which spread easily across national borders. These are global issues which are common threats to humankind. Japan consequently has a responsibility to take measures against infectious disease in order to protect people throughout the world.

16. In 2000, the United Nations Millennium Declaration was drawn out, incorporating internationally agreed goals focusing on poverty reduction. Three out of eight Millennium Development Goals (MDGs) drawn out based on the Declaration are health-related, and Japan, in addition to pursuing several independent health initiatives, is committed to achieving these MDGs, as important goals to which we should contribute.

17. In realizing this basic view, Japan adheres to both a "comprehensive approach", which addresses measures to combat infectious diseases and strengthen health systems in a balanced manner, and a "participatory approach", which calls for the participation and cooperation of all stakeholders, including donor countries, international organizations, the private sector, academia and civil society. The importance of these two approaches was emphasized by Mr. Masahiko Koumura, Minister for Foreign Affairs, in his policy speech entitled "Global Health and Japan's Foreign Policy-From Okinawa to Toyako"[1] and was thoroughly reflected in the approaches presented at TICAD IV and the Group of Eight (G8) Hokkaido Toyako Summit.

(b) Human security

18. With the progress of globalization, threats that are endangering people such as internationalization of local or regional conflicts, the spread of infectious diseases, increases in poverty, outflows of refugees and the sudden occurrence of economic crises. We have more threats than a single State alone can fully address. It is in response to this situation that the concept of human security emerged. Complementing national security, human security focuses on primary focus on individuals, aims to fully realize their rich potential by providing protection and empowerment, and tries to achieve nation-building.

19. Human security constitutes one of the pillars of Japan's diplomacy, and we actively promote the concept in bilateral and multilateral diplomatic arenas. Through these efforts, the concept of human security is becoming increasingly prominent in the global agenda. For example, the 2005 World Summit Outcome addressed the concept of human security, and in May 2008 the United Nations General Assembly convened thematic debate on this subject. Furthermore, human security is being discussed under the frameworks of the G8, the Asia-Pacific Economic Cooperation (APEC), the Organization for Economic Cooperation and Development (OECD), the Organization for Security and Cooperation in Europe (OSCE). Moreover, we held workshops with regional organizations such as the European Union (EU) and the African Union (AU) for the purpose of disseminating the concept.

20. To realize the concept of human security in the field, Japan has been providing assistance in respect of this concept as our basic principle of ODA programme. In addition, Japan established the Human Security Trust Fund at the United Nations, and as of March 2009 it has donated 37.3 billion yen in total.

21. Thus, human security, which aims to protect and empower both individuals and communities, is an indispensable conceptual basis for achieving greater peace and development in the world, as well as for promoting further efforts in the area of health. The human security approach is vital in seeking ways of achieving MDGs 4, 5 and 6, especially in sub-Saharan Africa, where there is concern they may not in fact be achieved.

2. Initiatives of the Japanese Government

(a) Okinawa Infectious Diseases Initiative

22. In the 1970s, the majority view was that infectious diseases were close to being eradicated in developed countries. However, in the last two decades, new types of infectious diseases called emerging and re-emerging infectious diseases spread, such as HIV/AIDS, Ebola haemorrhagic fever, SARS, avian influenza, multi-drug resistant tuberculosis (MDR-TB), extensively, resistant tuberculosis (XDR-TB) and most recently, influenza A (H1N1). For those people living in developing countries who are hygienically and nutritionally vulnerable, the prevalence of infectious diseases is a threat directly linked to death. The measures that need to be taken in response are consistent with the concept of human security, on the basis of which people are to be protected from vast and grave threats to their existence, lives and dignity, and empowered so that they can address these issues themselves.

23. Against this background, the Japanese Government decided to renew and strengthen measures against infectious diseases. At the G8 Kyushu Okinawa Summit in July 2000, under the chairmanship of Japan, the issue of infectious diseases in developing countries was for the first time made one of the major items on the agenda. Japan took the opportunity to announce the Okinawa Infectious Diseases Initiative (IDI) for the implementation of comprehensive measures in this area, to which it said it would allocate US$ 3 billion over the five-year period FY 2000 to FY 2004.

24. The IDI was formulated under the leadership of the Ministry of Foreign Affairs, following a wide-ranging discussion with related ministries and agencies, NGOs, United Nations organizations, and experts. It mainly addresses the problem of infectious diseases, including disease-specific measures to be taken against HIV/AIDS, tuberculosis (TB), malaria, parasitic infections, and polio. However, the IDI goes beyond such steps to include measures to strengthen health systems, for example, through the provision of a safe water supply, enhancement of primary health care, reinforcement of laboratory functions, and the human resources development of community health workers. This is where the IDI differs from development assistance, which specifically focuses on measures to combat certain infectious and other diseases. Under the IDI, Japan provided approximately US$ 5.8 billion worth of assistance, vastly exceeding its initial pledge of US$ 3 billion.

25. These policy developments served to enhance international interest in taking measures against infectious diseases and prompted the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in 2002. For this reason, Japan is called “the founding father of the Global Fund”. It has contributed approximately US$ 1.04 billion to the GFATM to date.

(b) Health and Development Initiative

26. In 2002, the United Nations presented the MDGs as common development goals for the international community. The MDGs highlighted the challenges to be tackled and made it clear that they were interlinked. In response, Japan began to place strong priority on the need to shift from a disease-specific to a comprehensive approach that would include enhancing maternal, newborn and child health and strengthening the health systems that serve them in order to confront mounting health challenges. It also came to recognize that these challenges cannot be overcome only by addressing health issues.

27. In 2005, at the High-level Forum on Health MDGs in Asia and the Pacific, Japan announced what it called the "Health and Development Initiative (HDI)", which was to be a comprehensive approach, and it pledged US$ 5 billion in assistance over the five years from FY 2005 to FY 2009. In the formulation process, MOFA gathered a wide range of views from major stakeholders, including relevant governmental ministries and agencies, the Japan International Cooperation Agency and NGOs.

28. The HDI acknowledges that "the achievement of health MDGs is crucially important for that of all MDGs as three out of eight MDGs are directly related to health", and proposes that Japan carry out the following activities to help achieve health-related MDGs in developing countries.

(i) Emphasizing a human security perspective

29. Placing the focus on individuals, through provision of quality health services, Japan will support sustainable capacity development for individuals and local communities as a means of addressing their health problems.

(ii) Cross-sectoral approaches

30. In addition to direct support for efforts to address health-related issues, Japan will pursue a comprehensive approach, for example, by working to improve the health systems. Furthermore, Japan provides cross-sectoral support because progress in non-health sectors can often contribute to progress in the overall situation in the health sector.

(iii) Collaboration and coordination with international development partners

31. Japan will provide support with a view to enhancing South-South cooperation, in which developing countries share with their peers good practices — in this instance, practices they have devised to tackle problems in the health sector. Collaborating with other donor agencies, Japan will continue to provide development assistance in a unified and consistent manner by sharing strategies and goals with them.

(iv) Formulation of aid strategies in accordance with local needs of developing countries

32. Making certain that it first understands the priority needs of each developing country, Japan will formulate appropriate strategies and provide assistance effectively and efficiently. When developing countries have their own development programmes relating to health, Japan will implement its assistance taking such initiatives fully into account.

(v) Strengthening research capacities in the field and implementation of initiatives based on an understanding of the local context

33. It is essential to fully understand each country's cultures and traditions as well as its social customs and practices in health care when providing assistance. Japan will make assistance available in a manner duly respectful of each country's practices and traditions.

34. The goal of the HDI is to contribute to the achievement of health-related MDGs and in particular, the inclusion of human security perspective, which focuses on protecting and empowering children, women, and other vulnerable groups in society, and the perspective of strengthening health systems as an effective means to reducing infant and maternal mortality, and provide strong support for the achievement of MDGs. In addition, the impact of infectious diseases, particularly influenza A (H1N1), largely depends on the health service capacity in each country. Strengthening health systems is inevitable in responding to emerging and re-emerging infectious diseases, and constitutes a part of enhancing preparedness to pandemic influenza which might occur in the future. Moreover, the importance of a cross-sectoral approach, which includes assistance in the areas of gender, education and water and sanitation, has come to receive wide international support. Last year, it was confirmed by the G8 leaders at the Hokkaido Toyako Summit.

35. Under the HDI, Japan provides health-related assistance throughout the world, but particularly in Asia and Africa, utilizing diverse assistance schemes, including bilateral aid and contributions to international organizations as will be discussed later. Japan contributed approximately US$ 1.2 billion in FY 2005, US$ 1.9 billion in FY 2006 and US$ 1.4 billion in FY 2007. As of April 2009, its total contributions have considerably exceeded its initial pledge of US$ 5 billion.

(c) TICAD IV

36. The African continent is the region where complex issues of poverty, hunger, conflict and infectious disease have most intensely arisen, and in sub-Saharan Africa especially, if prevailing trends persist, the expectation is that none of the MDGs will be met by 2015, or that there will simply be no progress.[2]

37. Japan, whose basic view is that "there will be no stability and prosperity in the world in the 21st century unless the problems of Africa are resolved", has acknowledged the need to make contributions that are appropriate for a member of the international community to make and has taken action accordingly. After the end of the cold war, while working to rebuild its economy, it implemented economic and technical cooperation and investment in support of the growth of Asian countries. To share this experience with countries in Africa, Japan proposed the establishment of the Tokyo International Conference on African Development (TICAD).

38. TICAD is the world's largest-class policy forum on African development co-hosted by the Japanese Government, the United Nations and the World Bank (WB). Since the first TICAD held in Tokyo in 1993, it has been held once every five years, and there have also been regular ministerial conferences.

39. TICAD IV was held from 28 to 30 May 2008 in Yokohama, Japan, with more than 3,000 participants, including delegates from African countries, developing partner countries, Asian countries, international and regional organizations, private sectors and NGOs. In the preparation process, a sector-based "cluster approach" was

taken where relevant United Nations organizations and private foundations formed groups and jointly provided their inputs to the Japanese Government.[3] In addition, active dialogues with NGOs were held. As one outcome of the discussion, their significant inputs in the field of reproductive health were reflected in the outcome document.[4]

40. TICAD IV was held under the basic theme "Towards a Vibrant Africa: A Continent of Hope and Opportunity", and active discussions were conducted on the direction of African development, with the issue of health among the major subjects. In his keynote speech at the opening ceremony, the then Japanese Prime Minister, Mr. Yasuo Fukuda, pledged in his capacity as chairman to "train one hundred thousand people in Africa over the next five years as health workers", and to "contribute 560 million US dollars to the Global Fund to Fight AIDS, Tuberculosis and Malaria in the coming years, starting 2009, to support the fight against these three major infectious diseases".[5]

41. On the final day of the conference, the Yokohama Declaration on future initiatives and the direction of African development was adopted. It states that "in addition to tackling HIV/AIDS, tuberculosis, malaria, polio and other infectious diseases, the Participants acknowledged the significance of strengthening health systems to effectively deal with major health challenges including maternal, newborn, and child health", thus reconfirming the importance of a comprehensive approach to health.[6]

42. Based on the Yokohama Declaration, the conference presented the Yokohama Action Plan as a road map in support of African growth. In the area of health, the Action Plan identified three priority issues, namely, strengthening health systems, improving maternal, newborn and child health and addressing infectious diseases, and presented specific actions to be taken by the international community as part of the TICAD process.[7] Measures the Japanese Government and other implementing partners proposed to take are listed in the appendix. Besides those already mentioned, they include saving the lives of 400,000 children and improving reproductive health.[8]

43. The comprehensive approach presented at the TICAD IV contributes directly to the progress that can be made towards health-related MDGs, especially in sub-Saharan Africa, such as the targets "to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio" and "halt and reverse spread of tuberculosis," which "have seen no improvement or [are] deteriorating", and achieving other health-related MDGs, whose "target is not expected to be met by 2015".[9]

44. To improve transparency and accountability with regard to TICAD activities, TICAD IV formally launched the TICAD Follow-up Mechanism, composed of three tiers: the Secretariat, the Joint Monitoring Committee of the TICAD Process and TICAD follow-up meetings.[10]

45. In March 2009, the first TICAD Ministerial Follow-up Meeting was held in Botswana, and participants confirmed that they would steadily carry out the commitments they had made at TICAD IV as a responsibility they owed to Africa, where the consequences of the financial and economic crisis are grave. In addition, as a measure to directly address the crisis, commitments such as the prompt implementation of US$ 2 billion of grant and technical assistance, provision of

approximately US$ 300 million in food and humanitarian assistance to mitigate the impact on socially vulnerable people and disbursement of approximately US$ 200 million to the GFATM were announced.[11]

(d) Hokkaido Toyako Summit

46. The discussions and outcomes at TICAD IV in the field of health were taken up at the G8 Hokkaido Toyako Summit in July 2008, and the Japanese Government once again made health a major item on the agenda in the context of development and Africa. Prior to the summit in November 2007, the then Minister for Foreign Affairs, Mr. Masahiko Koumura, gave the policy speech "Global Health and Japan's Foreign Policy" and expressed Japan's intention to "develop a set of common frameworks for action shared by the international community", inviting the participation and cooperation of "all key stakeholders, including national Governments, international organizations, the business community, academia and civil society".[12] The discussions leading to the summit were based on this speech.

47. As Japan succeeded the role of chair in 2008, it established the G8 Health Experts' Meeting to elaborate on earlier discussions on health with a view to contributing to the discussion that G8 leaders would have at the summit. Three meetings, the first of the kind to be organized in the history of the summits, were held, in February, April and June, and at the first, an outreach session was held, with the participation of a group of major health-related international organizations called the Health Eight (H8)[13] and representatives of Norway and the AU. After a lively discussion, the G8 and outreach members arrived at a consensus on the present state of affairs with regard to global health and future challenges. For example, the AU pointed out the need for a strategy to retain and increase the number of health workers, given the serious lack of health resources in Africa.

48. Additionally, as chair of the Health Experts' Meeting, the Japanese Government exchanged views with major health-related NGOs from Japan and abroad on five separate occasions and obtained their views, based as they were on their experience in the field.

49. The discussions involving stakeholders in addition to the G8 were consolidated in a recommendation from the G8 Health Experts to the leaders of the G8 entitled "Toyako Framework for Action on Global Health"[14] and contributed to the leaders' discussion at the summit.

50. In parallel with the above developments, Challenges in Global Health and Japan's Contributions: Research and Dialogue Project was launched in September 2007 under the leadership of Prof. Keizo Takemi, a research fellow at the Harvard School of Public Health.[15] Its aim was to contribute to the discussions that were to take place at the summit through policy dialogues and research activities. Conducted as part of a public-private partnership involving prominent Japanese researchers, NGO representatives, participants from MOFA, the Ministry of Health, Labor and Welfare (MHLW) and the Ministry of Finance, they took a participatory approach to the subject. As a result, it was proposed to the G8 Health Experts that the G8 should pay more attention in their discussions to the strengthening of health systems.

51. At the Summit itself, held from 7 to 9 July, health issues were discussed under the agenda item "Development and Africa". In the Leaders Declaration, the G8 agreed to promote the comprehensive approach which mutually reinforce disease-

specific approach and health systems strengthening; to work towards increasing the health workforce with a view to attaining the World Health Organization (WHO) threshold of 2.3 health workers per 1,000 people, initially in partnership with the African countries; to improve maternal, newborn and child health and reproductive health with an emphasis on nutrition; and to provide 100 million long-lasting insecticide-treated nets by 2010 as a measure against malaria. It was also agreed to work towards the goal of providing at least a projected US$ 60 billion over five years to fight infectious diseases and strengthen health, as was agreed at the G8 Heiligendamm Summit the previous year, and to establish a follow-up mechanism to monitor the progress that was made towards meeting G8 commitments.[16] The G8 Health Experts Meeting is now under the chairmanship of Italy, and follow-up on these agreements is being implemented.

3. Efforts by the Government of Japan to implement the internationally agreed goals and commitments in regard to global public health

(a) Consensus-building mechanism

52. In this section, we will examine how consensus is being built in regard to achieving the MDGs and health commitments set out at TICAD IV and G8 Hokkaido Toyako Summit.

(i) National consensus-building mechanism

53. MOFA undertook structural reform in August 2006, creating the International Cooperation Bureau to strengthen its ODA planning/formulation function. Departments dealing with ODA, namely, the Economic Cooperation Bureau, which had principal responsibility for bilateral aid and a section of the Global Issues Department of the Minister's Secretariat responsible for multilateral aid merged to create the International Cooperation Bureau to improve the effectiveness of bilateral and multilateral economic cooperation activities.

54. The following year, the Health Task Force was set up within MOFA to further strengthen the above-mentioned collaborative framework. The task force meets whenever necessary, with the participation of a wide range of parties not only from relevant MOFA divisions but also from the MHLW and JICA — Japan's ODA implementation organization — according to the theme of the discussion.

55. To date, the task force has taken up and discussed agenda items such as strategies towards the TICAD IV and the G8 Hokkaido Toyako Summit, collaboration with international organizations, and aid strategies such as measures to combat tuberculosis and polio. Indeed, this report for the National Voluntary Presentations at the annual ministerial review of the United Nations Economic and Social Council has been drafted as a result of incorporating various comments raised at the Task Force Meeting. As part of the trend towards rationalization and improved efficiency of its ODA, MOFA, by implementing structural reform and launching the task force, has established an even stronger framework for multilateral and bilateral cooperation.

(ii) Consensus-building and consultation mechanism with national stakeholders

56. MOFA has always attached importance to the dialogue with NGOs. In 1994, the "Dialogue between MOFA/NGO on Global Issues Initiative on Population and AIDS/IDI" was established and regular consultations have taken place since that

time.[17] As of April 2009, 85 dialogues have been conducted, with the participation of 42 health-related NGOs. It has taken up a wide range of subjects, such as Japan's health assistance policy, collaboration with NGOs under the framework of the G8 Summit and TICAD and cooperation between NGOs and international organizations. There have also been presentations by NGOs on their activities.

57. Furthermore, as previously mentioned, MOFA is a member of the Challenges in Global Health and Japan's Contributions: Research and Dialogue Project based on a public-private, participatory approach, and in collaboration with various national stakeholders, delivers messages to shape international opinion on health.

(iii) Country-based ODA Task Force

58. The last sections provided an overview of Japan's consensus-building mechanism in the health sector. This section discusses the activities of the Country-based ODA Task Force and its relationship with headquarters.

59. The Country-based ODA Task Force was established in 2003 to strengthen Japan's framework for the formulation, selection and implementation of specific projects, while reinforcing Japan's ODA policymaking capacity in cooperation with local donor countries/organizations. As of this writing (April 2009), there are such task forces in 78 recipient countries, each composed mainly of members of the staff of the embassy of Japan and the local offices of aid implementing agencies such as JICA. The functions of the task force are: (a) surveying and analysing developmental needs; (b) formulating and analysing aid policies; (c) formulating and selecting potential assistance projects; (d) strengthening collaboration with the local aid community; (e) strengthening alliances with Japanese aid implementers in the recipient country; and (f) conducting a review of Japan's ODA. In some countries, there are meetings devoted to health attended by the persons in charge of health matters at the embassy of Japan and JICA, where practical working-level discussions are held.[18]

60. The Country-based ODA Task Force consistently submits reports and proposals on trends in local aid communities and the appropriateness and effectiveness of Japan's ODA, as well as the challenges it faces, to relevant divisions in MOFA and JICA. These feedbacks from the field are widely shared among members of the health task force in Japan, and are utilized in building a consensus.

61. By incorporating voices from the field of ODA in its health policies, Japan implements a multi-tiered, "all Japan" approach under the leadership of MOFA, in cooperation with all major stakeholders, including relevant MOFA divisions, the MHLW, JICA, the private sector, academic experts, NGOs and local aid implementers.

(b) Schemes to provide assistance on health

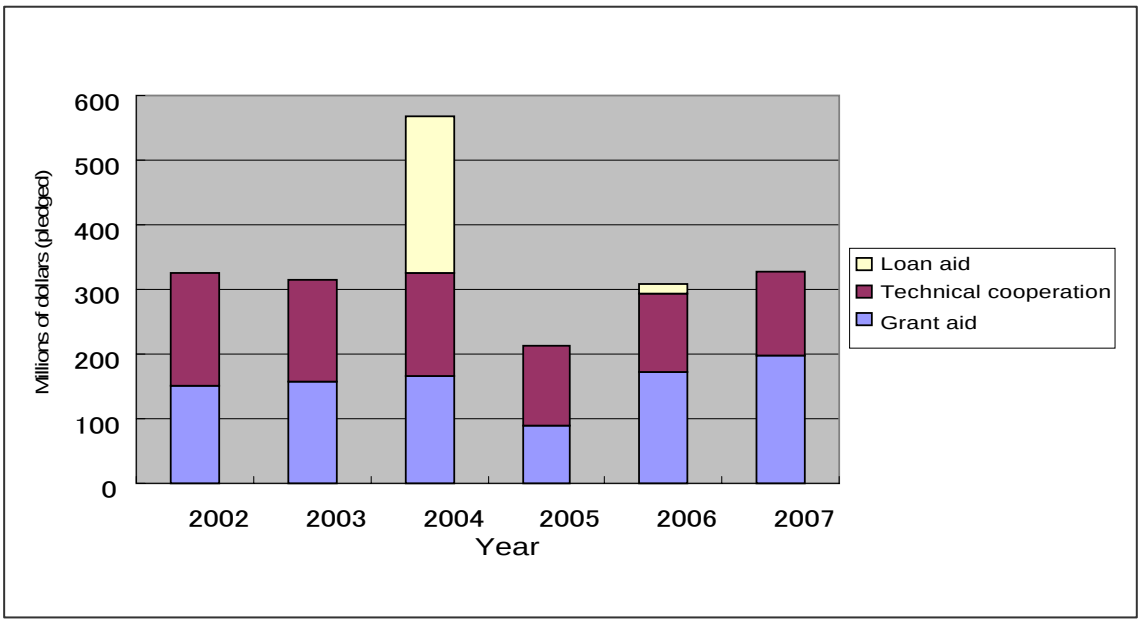
62. There are roughly four types of Japanese ODA schemes for all sectors, including health. They vary according to objective, recipient and amount and may take the form of grant aid, loan aid or technical cooperation, which is bilateral assistance, and contributions to international organizations, which is multilateral aid.

63. Grant aid is one type of economic cooperation which contributes to economic and social development in developing countries, and refers to assistance that is extended to developing countries for the procurement of necessary equipment and services, without imposing an obligation of repayment. It is not restricted to the health sector, but applies to issues including measures to combat terrorism and disaster prevention/rehabilitation, and is able to respond promptly and expeditiously to the needs of developing countries and the international community. There are several different types of grant aid in the health sector: Grant Aid for General Projects is extended to projects such as the construction/maintenance of hospitals and the provision of polio vaccine through UNICEF. Emergency Grant Aid is assistance provided as relief aid from a humanitarian perspective to victims of natural disasters and conflicts, refugees and displaced persons. Grant Assistance for Grassroots Human Security Projects provides funding for small-scale, grass-roots projects based on the principle of human security for projects such as the establishment of hospitals/clinics. Grant Assistance for Japanese NGO Projects is implemented by Japanese NGOs to provide, for example, hospital equipment or develop water supply systems in developing countries.

64. Cooperation can take the form of low-interest and long-term loans to developing countries. It is possible to promote national self-help efforts by adding loan aid to grant aid and imposing a repayment obligation. Although there are only a small number of loan aid projects in the health sector per se, projects in the field of water and sanitation which develop water supply and sewage systems and secure drinking water, which are indispensable in enabling people to lead healthy and sanitary lives, can provide complementary assistance to health.

65. Technical cooperation, utilizing Japan's technologies and knowledge or assisting in the development and improvement of technologies that are suited to individual countries, contributes to fostering the human resources a developing country will need to shoulder the responsibility of social and economic development, and in that way helps to improve technological standards or create/maintain systems and institutions. It is widely implemented in areas that relate to basic human needs, from health and medicine to industrial technology. Technical cooperation in the health sector may take several forms: providing training to health administrators and health-care professionals from developing countries either in Japan, the recipient country or a third country; dispatching to the recipient country Japanese experts, including policy advisers and medical practitioners; providing medical equipment needed for project development; implementation of project-type technical cooperation combining these elements; technical cooperation for development planning studies for the formulation of health sector development plans in developing countries and dispatching Japan Overseas Cooperation Volunteers (JOCV) and Senior Volunteers (SV) in support of grass-roots health activities.

Table 1
Japan's assistance for health by scheme (bilateral aid)



Source: Prepared by MOFA according to OECD-DAC statistics (2007).

66. In addition to the bilateral aid mentioned above, Japan implements multilateral aid by making contributions to international organizations. In recent years, global issues such as poverty, conflict, refugees, infectious disease and the environment are taking increasingly varied forms, and therefore can no longer be resolved through the efforts of a single country. Japan's multilateral aid in support of the activities of international organizations that possess both experience and knowledge in addressing global issues complements Japan's bilateral aid, and is an effective tool for international cooperation. It is from this perspective that Japan actively provides intellectual, personnel and financial contributions to international aid organizations. In the health sector, Japan makes contributions to organizations such as WHO, GFATM, UNICEF, United Nations Population Fund (UNFPA), United Nations Trust Fund for Human Security, International Planned Parenthood Federation (IPPF), World Bank, the United Nations Development Programme (UNDP), Asian Development Bank (ADB), World Organization for Animal Health (OIE), Joint United Nations Programme on HIV/AIDS (UNAIDS), African Development Bank (AfDB), United Nations Educational, Scientific and Cultural Organization (UNESCO), Inter-American Development Bank (IDB), Food and Agriculture Organization of the United Nations (FAO), United Nations World Food Programme (WFP) and United Nations Volunteers (UNV).

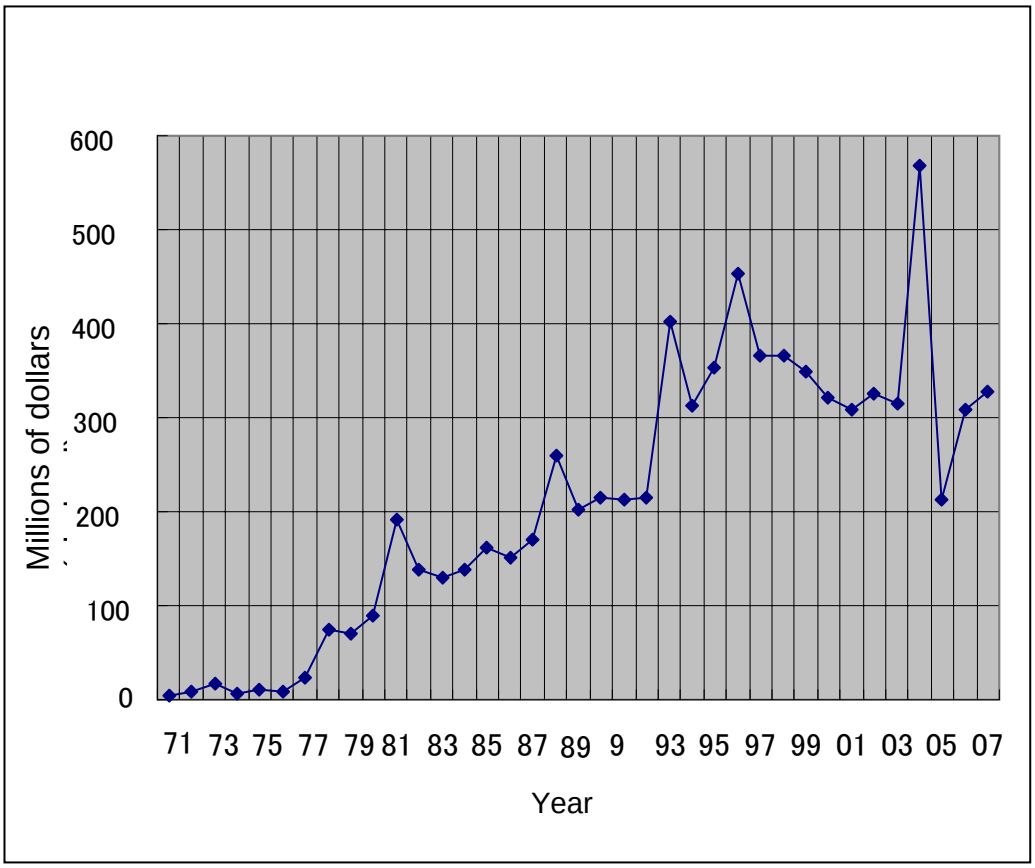
67. In this way, Japan provides health assistance through various schemes in accordance with the needs, level of development and financial situation of each developing country, and in a manner responsive to its conditions.

(c) Japan's achievements in the area of health assistance

(i) Trends in Japan's assistance in the area of health

68. As shown in table 2, Japan's bilateral aid in the area of health has increased steadily.[19] Following a gradual rise from US$ 3.33 million in 1971, when records began to be kept, to 1977, Japan's assistance increased approximately eightfold between 1977 (US$ 22.35 million) and 1981 (US$ 192.35 million). There was a sudden increase in 1988, but it then resumed its gradual upwards progress until 1993, when there was a twofold increase over the previous year. Thereafter it followed a fluctuating trend after it peaked in 1996, and it then increased to US$ 568.23 million in 2004. Although there was a temporary drop,[20] the rate of increase gradually recovered to the present level. For the sake of convenience, the above figures were based on DAC statistics, but in addition to the above-mentioned bilateral aid, Japan extends assistance for health in the form of contributions to international organizations such as GFATM.[21]

Table 2
Trends in the amount of Japan's assistance for health (bilateral aid)



Source: Prepared by MOFA according to OECD-DAC statistics (2007).

(ii) Comparison with other donors

69. As shown in table 3, a comparison of assistance (bilateral aid) in the area of health provided by major donors reveals that beginning in 2001, Japan has always been among the top 10.[22] The United States has retained the top position, and since President Bush announced the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003, pledging to spend US$ 15 billion over the next five years for emergency relief, the United States has outdistanced other countries in terms of total assistance provided (in 2008, PEPFAR was reauthorized to allocate US$ 48 billion over five years). The United Kingdom may fall short of the United States, but it has maintained a stable position, consistently ranking within fourth position. At its peak, Japan's assistance made it the second largest donor in 2004, but it fell to seventh place in 2005 and thereafter to sixth place. Japan nevertheless will continue to do its best to provide health assistance.

Table 3
Assistance for health, by major donor (bilateral aid)

Rank/ year	*2001*	*2002*	*2003*	*2004*	*2005*	*2006*	*2007*
1	USA 1 234.06	USA 1 964.17	USA 2 182.63	USA 2 569.83	USA 3 448.3	USA 4 189.59	USA 5 612.95
2	EC 349.31	UK 415.35	EC 490.47	Japan 568.23	EC 669.42	Netherlands 756.7	UK 1 014.7
3	Japan 308.53	EC 345.39	UK 459.81	EC 523.08	UK 587.84	UK 678.59	Canada 626.34
4	UK 190.7	Japan 326.38	Japan 314.35	UK 438.53	Canada 334.82	EC 580.17	EC 488.84
5	France 160.45	Netherlands 219.85	Germany 230.59	France 312.4	France 286.41	Germany 474.15	Germany 380.07
6	Norway 147.19	Germany 204.09	France 192.2	Canada 265.27	Netherlands 238.03	Japan 308.8	Japan 327.08
7	Netherlands 136.85	France 199.58	Canada 187.43	Netherlands 259.28	Japan 212.72	France 272.65	Sweden 275.41
8	Germany 122.47	Norway 123.4	Netherlands 157.92	Germany 244.63	Norway 199.56	Canada 250.18	Spain 250.57
9	Spain 90.96	Sweden 101.81	Norway 134.98	Sweden 166.41	Germany 198.08	Sweden 247.53	Norway 211.94
10	Canada 90.27	Canada 93.54	Sweden 116.2	Denmark 144.49	Spain 145.58	Norway 239.28	Australia 181.94

* Unit: millions of United States dollars (pledged).
Source: Prepared by MOFA according to OECD-DAC statistics.

(d) Characteristics and strengths of Japan's assistance for health

(i) Supporting the self-help efforts of developing countries

70. Self-help efforts refer to developing countries' taking responsibility for the future of their own countries and the efforts of their people to promote development. Japan's ODA, including health-related assistance, is founded on the idea that supporting the self-help efforts of developing countries is indispensable to realizing

sustainable economic growth. Moreover, Japan provides cooperation for implementing individual projects with the goal of ensuring sustainable development by the people of developing countries even after its assistance programme is concluded. This is a firm policy stemming from Japan's post-war rehabilitation and its subsequent experience providing support to other Asian countries. Since convening TICAD I in 1993, Japan has respected the self-help efforts of African countries and lent its support to maximizing those efforts in cooperation with other international partners.

71. Japan emphasizes human resource development, establishment of legal institutions and development of economic and social foundations (infrastructure) as important elements that support the self-help efforts of developing countries. Development of human resources, in particular, is essential for nation-building and economic development in developing countries, as is the establishment of legal institutions and the development of a sound economic and social foundation.

(ii) "Visible assistance" rooted in local communities

72. As just discussed, in providing ODA, including assistance for health, Japan considers cooperation for human resource development, establishment of legal institutions and development of economic and social foundations as vital to the self-help efforts of developing countries, as they form the basis of nation-building. With this in mind, Japan provides cooperation that helps a recipient country develop and enhance a comprehensive coping strategy, while respecting its autonomy, by transferring appropriate knowledge, technologies and expertise from person to person in the country or in Japan.

73. For example, under the technical cooperation scheme, Japan dispatches experts in a variety of fields to developing countries to provide assistance in implementing health-related technical cooperation projects (757 experts in the field of health in FY 2007).[23] Experts from institutions under the jurisdiction of the MHLW such as the National Institute of Public Health, the Infectious Disease Surveillance Center and the International Medical Center of Japan, the Civil Service, hospitals, university and research organizations, consulting firms and NGOs work day and night with their counterparts in addressing diverse health-related issues with a strong sense of vocation and a firm commitment. In some cases, Japan sends advisers to health ministries in developing countries who contribute to the efforts of the recipient organizations and institutions within the ministries by providing advice on improving health systems or planning/formulating new projects.

74. Younger generations of Japanese people take part in local cooperation activities in developing countries as JOCV and older persons as SV (a total of 316 volunteers for health in FY 2007).[24] At times, they travel into remote parts of a country where no other aid organization is present to work with local health authorities and communities to improve public health.

75. In addition to dispatching people to developing countries, Japan also invites individuals from developing countries to participate in training programmes in Japan. In FY 2007, Japan received 4,619 trainees from developing countries in the health sector.[25] As bearers of health care at the forefront of health administration and medical practice, these participants benefit from the experience and knowledge Japan's health systems can offer, which then helps them to expand their own health services.

76. Japanese NGOs working in the health sector are also important partners in Japan's health assistance. As of 2007, 28 organizations were utilizing government funding and carrying out thorough assistance at the grass-roots level.

77. In these ways, providing "visible assistance" can be considered one of the salient features of Japan's assistance for health as Japanese experts, volunteers and NGOs travel to remote areas of recipient countries, where they apply themselves to solving issues in close cooperation with local counterparts and residents.

(iii) Contribution to aid coordination

78. Japan is contributing to aid coordination that supports the effective achievement of common developmental goals such as the MDGs or the national health strategy, as well as reducing the burden of developing countries.

79. Global awareness about the importance of improving aid effectiveness has grown steadily in recent years, as witness the adoption of the Paris Declaration on Aid Effectiveness (Paris Declaration) in 2005. The declaration, to which Japan is a signatory, lays down five key principles for improving the quality of aid.[26] In September 2008, the Third High Level Forum on Aid Effectiveness was held in Ghana, for the purpose of conducting the midterm review of progress in the implementation of the declaration, and it produced the Accra Agenda for Action (AAA), which contains goals to be achieved by the year 2010.

80. At the field level, groups specializing in issues such as health and education have been created to implement assistance in the form of programmes in line with the developing strategies of the sector concerned, and many donor countries have participated in them. For instance, Japan joins in these programme-based approaches in the health sector in Kenya and Zambia, the education sector in Bangladesh and the agricultural sector in Tanzania.

81. Furthermore, since 2006 Japan has been assigning coordinators for economic cooperation in African countries where aid coordination is especially active.[27] The coordinators amass relevant information, exchange opinions and present views on Japan's development assistance to strengthen collaboration among foreign governments, aid implementing agencies and NGOs among others. For this reason, Japan is contributing actively to aid coordination, which is becoming increasingly mainstream.[28]

(iv) Utilizing Japan's experience and knowledge

82. Japan's aim in providing assistance is to apply its experience in economic/social development and economic cooperation for the benefit of developing countries and to share with them its innovative technologies, its knowledge, human resources and systems, in a manner responsive to their policies and needs for assistance.

83. Japan was closed off to the world for over 200 years, but with the emergence of the Meiji government in 1868, the country promoted rapid modernization and Westernization in all areas of society, including the industrial, administrative and education sectors. This was also done in the area of health, in which surveys were carried out, statistics collected, and laws and regulations concerning medical personnel established. At the same time, a centralized epidemic prevention system was established to combat acute infectious diseases such as cholera, dysentery and

typhoid fever, which spread throughout the country with the opening of the country following its long period of isolation.

84. As Japan readied itself for war during the 1920s and 1930s, there surfaced rising concerns about the need to establish countermeasures to tuberculosis, which was widespread in the country at the time, and to address the high infant mortality rate. The entire country was poverty-stricken. Many villages had no doctors, and even where they were available, many households could not afford to pay the doctor's fee. This situation led to the establishment of the Ministry of Health and Welfare, which supervised the health-care services from the central to the local, including local health centres throughout the country, and thus led to the enhancement of central to local health-care services. In villages, public health nurses began to play an active role in fighting tuberculosis, improving maternal and child health and formulating the so-called "community health approach".

85. After the war and the devastation it caused, Japan picked itself up and began rebuilding, with support from the United States and UNICEF and loan assistance from the WB, among other bodies. Under the leadership of the General Headquarters (GHQ), health-care services were re-established, and public health nurses, midwives and other female health professionals provided services, mainly at local health centres. At the same time, residents' associations and private organizations made efforts to address people's health needs, with the result that the situation with regard to tuberculosis and maternal and child health, which were immediate concerns at that time, improved greatly.

86. Beginning in the 1960s, social change gave rise to new health issues. For example, industrial development led to pollution and environmental problems and increased the incidence of occupational accidents. Changes in the way people lived increased the risk of heart disease, cancer and other lifestyle-related illnesses; and the aging of society raised concerns about the burden posed by medical expenses. In 1961, universal health insurance coverage was established.

87. In the 150 years that have passed since the establishment of the Meiji government, Japan, at times with the influence and support of other countries, has steadily accumulated experience in addressing the health-related challenges that many developing countries are now facing. These include finding ways to stop the spread of tuberculosis and other infectious diseases, lower infant mortality rates and maternal mortality ratios and establish strong health systems. Japan's experience has given shape to its community health approach, which, at a time when medical facilities and personnel were scarce at the local level, protected local residents' health through the concerted efforts of local health centres, midwives and residents. It also led it to issue the Maternal and Child Health Handbook (MCH Handbook) and implement measures based on it, and it provided the foundation for many of Japan's efforts to provide assistance to developing countries in the area of health. Clearly, Japan's assistance draws upon its experience, knowledge and systems. That experience is systematically described in a report and audio-visual teaching materials[29] it has issued, which developing countries may utilize as needed in accordance with their economic and social situation and with the health issues they are confronting.

(v) Steady implementation of initiatives

88. The steady implementation of a range of initiatives is another part of Japan's assistance for health. In 2000, it announced the Okinawa Infectious Diseases Initiative (IDI) at the G8 Kyushu Okinawa Summit, and pledged to implement US$ 3 billion in comprehensive measures against infectious diseases from FY 2000 to FY 2004. Ultimately, Japan provided approximately US$ 5.8 billion in assistance under the initiative, vastly exceeding its initial pledge of US$ 3 billion.

89. As mentioned earlier, Japan's inclusion of infectious diseases as a major agenda item for the first time in summit history and its subsequent announcement of the initiative against infectious diseases prompted the establishment of GFATM in 2002, and Japan has steadfastly fulfilled its commitment to the Fund. In June 2005, then Prime Minister Junichiro Koizumi pledged US$500 million to GFATM, and the disbursement took place between 2006 and 2008. At the TICAD IV conference held in May 2008, then Prime Minister Yasuo Fukuda emphasized the fact that Japan pledged US$ 560 million to GFATM starting 2009, and in March 2009 the Japanese Government disbursed approximately US$ 194 million as the first step of the multi-year commitment. As a consequence, Japan's disbursement to GFATM stands at US$ 1.04 billion as of April 2009.

90. Following the IDI, Japan announced the Health and Development Initiative at the High-level Forum on Health MDGs in Asia and the Pacific in 2005, and pledged US$ 5 billion in assistance over the five years from FY 2005 to FY 2009. To contribute to achieving the MDGs under this initiative, Japan provided support in the basic education and water/sanitation sectors, in addition to assistance for strengthening health systems, reducing infant mortality rates, improving maternal health and establishing measures to combat infectious diseases. It disbursed approximately US$ 1.2 billion in FY 2005, US$ 1.9 billion in FY 2006 and US$ 1.4 billion in FY 2007 (approximately US$ 4.5 billion in total). The initial pledge of US$ 5 billion over five years is about to be realized in just three years.

91. Japan's steady implementation of a range of initiatives to fulfil its responsibility to the international community can be said to be another salient characteristic of the assistance it provides.

(e) Case studies: best practices in Japan's assistance for health

(i) Maternal, newborn and child health (contributions for MDG4 and MDG5): Cooperation utilizing a comprehensive approach to the continuum of care for maternal, newborn and child health

92. From the perspective of human security, Japan has been expanding cooperation utilizing a comprehensive approach to the continuum of care for maternal, newborn and child health, often on the basis of the MCH Handbook. The MCH Handbook, which is one good example of assistance utilizing Japan's experience, has received great attention. It has now been introduced in countries as far from Japan as Palestine since its successful introduction and distribution among Asian countries such as Indonesia.[30] In addition to the number of copies of the handbook in circulation, achievement of the MDGs requires further qualitative improvements in maternal, newborn and child health services.

93. Based on this awareness, in 2004, Japan initiated a three-year technical cooperation project to improve maternal health care in rural areas in Morocco,[31]

where a remarkable regional difference in maternal mortality ratio was observed. Postgraduate training programmes to improve the practical skills, knowledge and awareness of health workers were established; capacity-building programmes were provided for health administrators, so that they could manage the project for maternal and child health care; and programmes utilizing information, education and communication (IEC) were strengthened, as were mobile clinic services for pregnant women. Also, childbirth classes, called "Tamago", meaning "egg" in Japanese, were established with the introduction of a health handbook for women,[32] which is similar to the MCH Handbook, in order to promote maternal, newborn and child health from a perspective of comprehensive health care.

94. As a result of the implementation of the project, changes have been brought about, including the establishment of a continuous education model for health workers involved in the care of pregnant women, improved motivation of nurses and midwives owing to the implementation of training based on the continuous education model and the realization of an appropriate reference, all of which ultimately resulted in an overall improvement in the quality of maternal health care.

95. Japan has implemented many other assistance programmes that have contributed to the same end, in particular through capacity-building and establishment of frameworks for cooperation among health administrators, local health service facilities, health workers and local organizations. These include the "Project for Improving Maternal and Child Health Services in Rural Areas in Cambodia" and the "Project for Improvement of Maternal, Newborn and Child Health Services in the Republic of Madagascar".

96. Since such regional maternal health service systems ultimately contribute to the general health of children, for example, through expanded vaccination programmes, the above projects are some of the best practices Japan has to offer in the area of maternal, newborn and child health.

(ii) Infectious disease control (contribution for MDG6): Tuberculosis Control through Directly Observed Treatment, Short Course in Cambodia

97. Tuberculosis is one of the leading causes of mortality in Cambodia, which has been classified as one of 22 high-burden tuberculosis countries. In 1994, the government of Cambodia strengthened the National Tuberculosis Control Program (NTP), in cooperation with WHO, with the result that the cure rate improved to a certain degree. However, due to rapid expansion of Directly Observed Treatment, Short Course (DOTS) services, the lack of skilled health workers engaged in controlling the disease and needs for training of human resources became apparent. The spread of HIV/AIDS was another reason for the increase in the number of tuberculosis patients.

98. In response, Japan implemented a five-year technical cooperation project to strengthen the capacity of the NTP and provided related training for health staff workers under the Tuberculosis Control Project Phase I, beginning in 1999. The coverage of DOTS services in 750 health centres nationwide reached almost 100 per cent. Frameworks for addressing tuberculosis/HIV co-infection, early diagnosis, treatment, and prevention were established or, where they already existed, expanded. These include a service called "afternoon clinics", which provides tuberculosis diagnosis for people living with HIV/AIDS, or a national External Quality Assurance Laboratory network to detect tuberculosis by means of a sputum

smear examination. Moreover, the project contributed to the formulation of five-year guidelines for a national tuberculosis programme, the creation of a sustainable drug logistics system, the strengthening of the technical and managerial capacity of the NTP staffs to conduct national prevalence survey and the expansion of DOTS, strengthening of the capacity of health administrators and laboratory technologist through training at the Research Institute of Tuberculosis/Japan Anti-Tuberculosis Association. Furthermore, as part of aid coordination, the World Food Programme, with support from the Government of Japan, provided food for approximately 33,000 tuberculosis patients who were receiving DOTS treatment each year, which was a strong incentive to them to receive the full tuberculosis treatment regime. Having achieved significant progress in DOTS expansion, the major focus of tuberculosis control efforts has shifted to strengthening health services under the NTP,[33] for example, through better quality management and increased attention to difficult-to-reach areas and groups. As a result, the Tuberculosis Control Project Phase II, also five years in duration, was commenced in 2004. Phase II applied a public-private mix of DOTS (PPM-DOTS) and community DOTS (C-DOTS), in order to provide the therapy to difficult-to-reach areas and groups. Guidelines for treatment beyond routine DOTS for tuberculosis/HIV co-infection and paediatric tuberculosis were also developed, and services have been provided in conformity with them. Moreover, effective IEC/advocacy activities were implemented to support the tuberculosis control programme, which aimed to promote change in the attitudes and behaviour of tuberculosis patients, their families and members of their communities.

99. The phase II project has achieved significant results and has had an impact on the Cambodian tuberculosis control programme. That is, it successfully attained the target with respect to tuberculosis, which was an 85 per cent cure rate and 70 per cent detection rate by FY 2006. This was attributed to several factors, including promotion of a cooperation scheme with private health workers and NGOs through implementation of PPM-DOTS, empowering community people through C-DOTS and establishing a scheme for coordination between tuberculosis/HIV activities and the NTP.

100. The above project in Cambodia, which incorporates the perspective of human security[34] and addressed tuberculosis issues by taking a comprehensive approach to them, is one of Japan's best practices in infectious disease control.

(iii) Private sector initiative: production of anti-malaria mosquito nets in Tanzania by Sumitomo Chemical Co., Ltd.

101. Malaria remains one of the most devastating diseases to afflict the world. An estimated 330-500 million people contract malaria every year — 90 per cent of them in Africa. In addition, the disease is estimated to cost Africa US$ 12 billion in lost gross domestic product (GDP). As the European Alliance against Malaria has noted, "the impact of malaria is not only felt in terms of the human suffering and death it causes, but also by the significant economic cost and burden".

102. Accordingly, Sumitomo Chemical developed the OLYSET® NET which is a mosquito net using special technology to impregnate the fibres with insecticide, thereby helping to control mosquitoes and prevent infection. The active ingredient is gradually released from the mosquito netting fibres to retain insecticidal efficacy for a minimum of five years, even after repeated washings. OLYSET® NET is the only

net fully approved by WHO as a Long-Lasting Insecticidal Net (LLINs). The nets have been widely distributed in some 40 African countries (especially in sub-Saharan Africa) and 20 South-east Asian countries through WHO, UNICEF and NGOs. Moreover, Sumitomo Chemical contributes to the achievement of MDGs by making donations of OLYSET® NET in cooperation with other organizations such as Millennium Promise[35] and UNICEF.

103. In September 2003, OLYSET® NET production technology was provided free of charge to the Tanzanian mosquito net manufacturer A to Z Textile Mills, Ltd., which is now operating an OLYSET® NET production plant. In February 2007, Sumitomo Chemical worked with the manufacturer to expand production, and with another local company set up a joint venture named Vector Health International, Ltd., to manufacture the OLYSET® NET. These initiatives helped to establish a sustainable self-help scheme in the local community by increasing supply capacity and reducing cost. As of the end of 2008, Tanzania's annual production capacity had increased to 38 million nets, and this expansion of production helped to create over 4,000 jobs in the local community, which in turn has contributed to enhancing the region's economy.

104. Sumitomo Chemical has decided to establish another production base in Nigeria as a response to the increasing demand for LLINs in Africa. Although plans have yet to be finalized, the company expects that annual production capacity will be 20 million nets and that more than 5,000 local jobs will be created.

105. This project is a pioneering effort and one of the best practices developed by a Japanese private company, as it directly links a core business to development assistance.

(iv) Asia Africa Knowledge Co-Creation Program (AAKCP): Total Quality Management (TQM) for Better Hospital Services: A Holistic Approach to Utilizing Existing Resources

106. Based on the importance of Asia-Africa cooperation, which was reaffirmed at TICADIII, JICA began the Asia Africa Knowledge Co-Creation Program (AAKCP) to promote South-South cooperation. "Total Quality Management (TQM) for better hospital services" is the second programme undertaken by AAKCP, which is now being implemented in 15 African countries.[36]

107. In Africa, it has often been pointed out that the management of the hospital service provision system has some problematic aspects. Due to a chronic shortage of medical resources, the challenge the system needed to tackle was finding a way to improve management of the system so that it would deliver the best possible hospital services. Because of the shortcomings and constraints on the system, the only one way to achieve a breakthrough was to improve management of hospitals and health policy planning in the day-to-day process. While Asian countries have long faced the same kinds of challenges, Sri Lanka, for example, has successfully overcome them by utilizing quality control management methods developed by Japanese manufacturing industry, such as 5S, CQI and TQM.[37]

108. Accordingly, under the AAKCP, three seminar/workshops and a pilot project were conducted with Asian resource persons both in Japan and Sri Lanka. Participating African health administrators and hospital managers were expected to devise practical schemes for ensuring the best possible hospital services that could

be introduced through the endogenous efforts of each country under existing conditions (fig. 1). The practical training provided, including visiting manufacturers such as Toyota Motors, was generally highly appreciated by the participants, and the programme is expected to foster a significant increase in human resources.

109. As South-South cooperation is one of the priority issues identified in Japan's Medium-term Policy on ODA, and as the focus of the AAKCP is improving daily management practices rather than requiring large financial investments, this programme is another of Japan's best practices, one suitable for African countries experiencing severe economic and financial conditions even beyond the current economic crisis.

Figure 1
Before and after AAKCP introduction

Source: JICA.

(v) Health Capital Investment Plan Support Project in Zambia

110. Under the health reforms initiated in 1992, the Government of Zambia attempted to reconstruct the entire health sector as an effective and efficient system. Together with this strategic plan, beginning in 2006, JICA implemented a two-year technical cooperation project designed to expand the information system that was created under the "Health Facility Census", the JICA overseas basic study in 2004, and helped in formulating a Health Capital Investment Plan (HCIP) to enable Zambia to provide efficient health care and medical services based on its National Health Strategic Plan (NHSP) (fig. 2).[38]

111. Accordingly, a health facility database has been developed covering 1,395 health facilities throughout the country below the primary level (particularly district hospitals, health centres, and health posts), and it has been integrated into the national health information management system (fig. 3). Also, a health facility atlas (fig. 4) was published and distributed to provincial and district health offices and other donors. In addition, health facility census feedback workshops were implemented for national, provincial and district health facilities.

112. In consequence, all the district health offices and hospitals have successfully prepared and submitted CIPs to the Ministry of Health (MOH) through provincial health offices after conducting a joint analysis of health facility and other relevant data. Moreover, since the health facility database includes not only information on health facilities and equipment but also human resource allocations and the

distribution of health services, it has also been utilized in connection with a national strategic plan to address the health worker brain drain, a project undertaken by the Global Alliance for Vaccines and Immunizations (GAVI) to strengthen health systems, a health information management system supported by the European Commission, as well as a performance assessment framework (PAF), an indicator for the National Development Plan of Zambia.

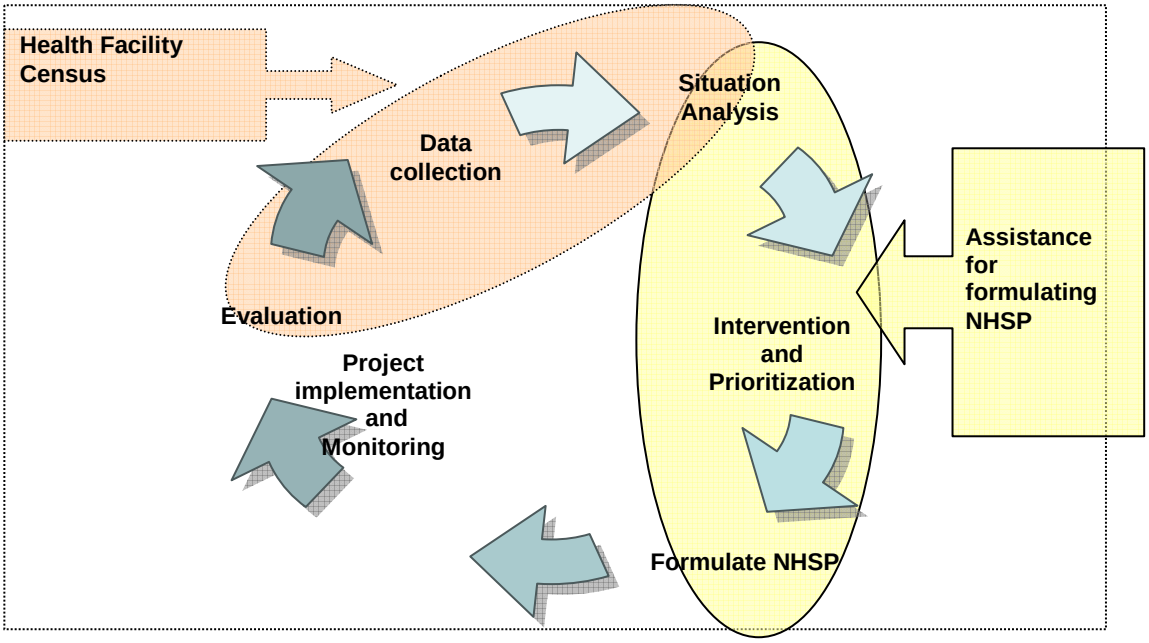
113. Based on the above, the project outputs can be summarized as follows: the availability of information on health facility status in the country has been improved; capacity at all levels of the public health system to use health facility data for HCIP has been improved; and integration of health sector investment with other national development plans at all levels has been strengthened; as has integration of HCIP with other sector development plans.

114. Based on the nationwide HCIP whose formulation the MOH completed in December 2008, it is expected that capital investment for improvement of health facilities and equipment will be supported with funds from the Zambian Government budget, a basket fund under the Sector-Wide Approach (SWAP) and/or direct funding from donors. Although Japan does not assist in such direct capital investment, it expects to launch a follow-up project in FY 2009, in order to enhance the efficiency of the management system for invested medical assets[39] within the framework of the HCIP.

115. The MOH estimates the budget for 2008 at approximately 750 million yen for the improvement of health facilities and equipments, out of a total investment in the health sector of approximately 5.6 billion yen, but the budget for the health sector is expected to increase since integration of HCIP with other sector development plans has strengthened.

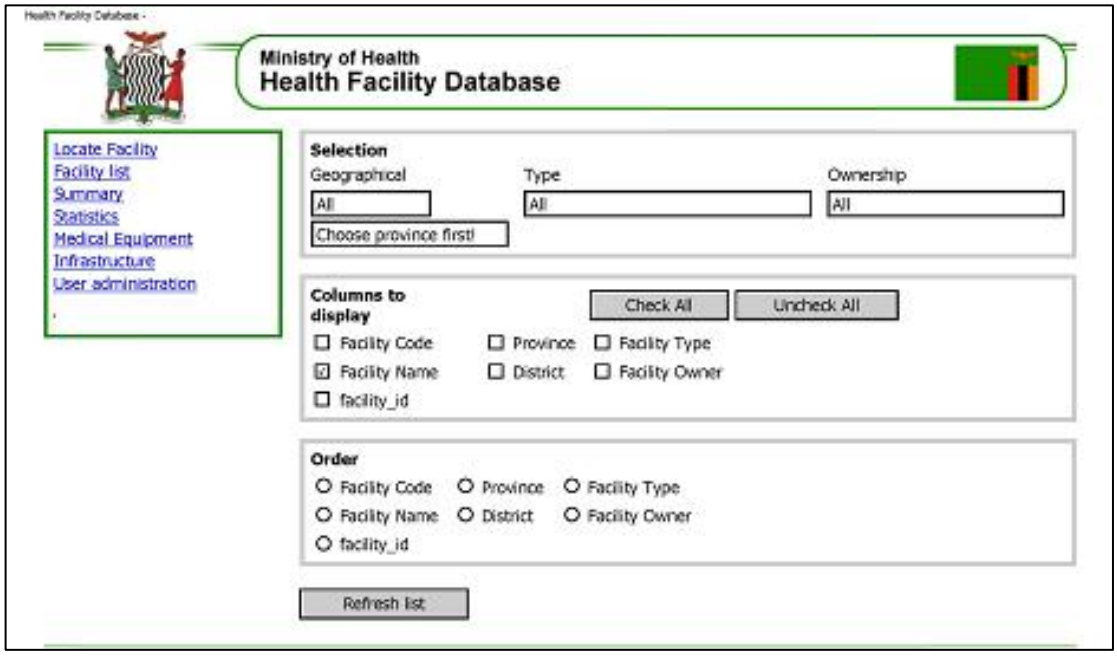
116. The above project is another of Japan's best practices and has showed that the project-type technical cooperation approach contributed to the development of the health sector at the national level by providing support for the NHSP, which in turn made it possible to utilize the Zambian Government budget, a basket fund under the SWAP and/or direct funding from various donors.

Figure 2
Framework for the "Health Facility Census" and HCIP Support Project



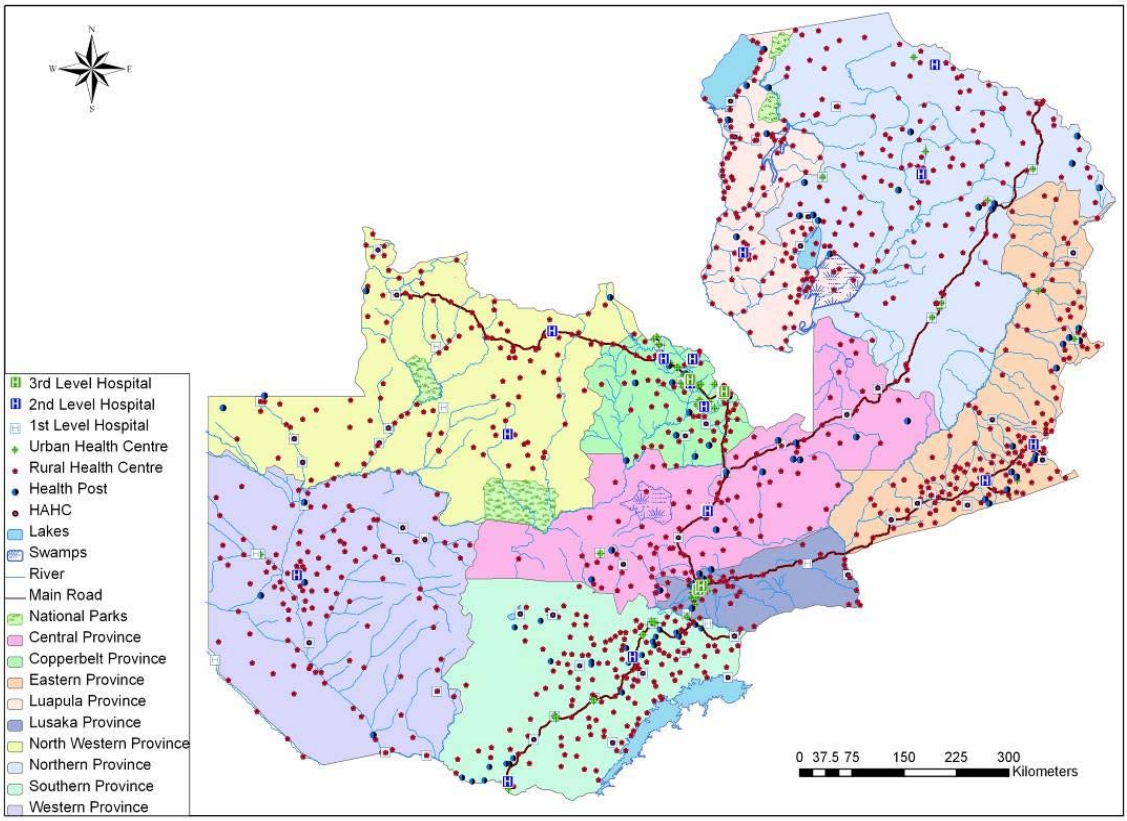
Source: JICA.

Figure 3
Front page of the health facility database



Source: JICA

Figure 4
Health facility atlas (mapping of health facilities nationwide)



Source: JICA

(vi) Assistance through the Human Security Fund (comprehensive assistance to adolescents through the United Nations)

117. In Bolivia, issues such as its high maternal mortality ratio and domestic and sexual violence are becoming serious social problems. In addition, the high incidence of teenage pregnancy is leading to an increased risk of HIV/AIDS. In the past, the policy towards adolescents was based on vocational training. Adolescents were not considered to be in great need of health care as they were thought to be the fittest segment of the population. Moreover, the Bolivian national development plan places high priority on reproductive health, although elements such as provision of education/information on contraception or developing independence and social inclusion targeting adolescents were not considered to be important.

118. To address this situation, UNICEF, UNFPA and WHO/Pan American Health Organization (PAHO) are jointly conducting a project entitled “Human Security for the Adolescent: Empowerment and Protection against Violence, Early Pregnancy, Maternal Mortality and HIV/AIDS”, which is sponsored by the Human Security Fund.

119. The three pillars of the project are: (a) health, (b) education and (c) social inclusion. To these ends, the project includes activities such as enhancement of

social and medical services and medical facilities in relation to HIV/AIDS; teenage pregnancy; maternal mortality; sexual and domestic violence and establishing networks to prevent them; and training of health workers. Furthermore, taking into account the fact that schools are becoming centres of sexual violence, the project provides education on health and sex, including information on HIV/AIDS; implements a curriculum on prevention of violence; improves teaching materials; and conducts awareness training that targets parents and communities. In addition, the project supports the creation and activities of peer groups so that adolescents themselves can address these issues, bringing their own insights to bear. Municipal systems in support of these peer groups are also being established in order to secure continuity of their activities.

120. The project addresses the health sector as well as other sectors such as education and social inclusion of adolescents in a comprehensive manner from the perspectives of both "protection" and "empowerment", based on sustainability and a long-term outlook.

121. United Nations organizations are implementing these activities in collaboration with local communities, including parents, NGOs and local authorities such as municipal government, thus embodying the participatory approach which is a significant element of human security. Moreover, in implementing the project, local JICA offices were consulted as early on as the planning stage, and joint monitoring was planned, thus taking into consideration the need for effective collaboration and assuring that each implementing organization would perform its own distinct role.

4. Future outlook

(a) G8 Summit follow-up

(i) Global action for health system strengthening

122. The Japanese Government made follow-up efforts to sustain the global momentum towards the improvement of health that had developed towards the G8 Hokkaido Toyako Summit. The Fourth G8 Health Experts' Meeting was convened in November 2008, and members agreed to continue working towards building a follow-up mechanism and implementing a regular review of G8 commitments, which was succeeded by Italy as this year's chair.

123. Follow-up activities led by the private sector are also taking place. Aware of the need to effect the strengthening of health systems on which Japan focused at the G8 Hokkaido Toyako Summit, both in the international arena as well as in the field, an international advisory committee and a task force on Global Action for Health System Strengthening[40] were set up under the leadership of Professor Keizo Takemi.[40] Comprising international opinion leaders in the field of health, the committee and task force aimed at making policy proposals to the G8 in three major areas relating to the strengthening of health systems, namely, the health workforce, health financing and health information.

124. In November 2008, the Working Group on Challenges in Global Health and Japan's Contributions, the Japan Center for International Exchange (JCIE), the MOFA, WB, WHO, and Bill & Melinda Gates Foundation jointly hosted the International Conference on Global Action for Health System Strengthening,[41] in Tokyo as a follow-up to the G8 summit. In addition to members of the international advisory committee and task force just mentioned, more than 150 scholars and

officials from development aid organizations such as the United Nations, NGOs, and government participated, engaging in thought-provoking discussions on issues relating to the health workforce, health financing, and health information. The input from participants was reflected in a report entitled "Global Action for Health System Strengthening-Policy Recommendations to the G8",[42] that was then delivered to the Japanese and Italian governments in January 2009, after which international conferences and seminars have been held by its authors in order to disseminate it widely. All stakeholders, including the task force members and government officials, are making concerted efforts to see that the proposals are acted upon.

(ii) Current situation regarding health systems strengthening

125. Although the international awareness on the importance of health systems strengthening is increasing, its definition, model, strategy and approach varies according to different agencies, and developing countries as well as the international community are still in discussion as to which are efficient and effective.

126. A resolution entitled "Primary Health Care, including Health System Strengthening" is due to be adopted at the sixty-second World Health Assembly to be held in May 2009 (as of 15 May 2009). This resolution is based on the draft resolution proposed by 39 countries including Japan at the 124th WHO Executive Board Session in January 2009 and aims at further specifying and promoting efforts of WHO and member states towards the issues of health systems strengthening including health financing, health workforce and health information/surveillance systems among others.

127. However, health systems strengthening cannot be achieved through the efforts of WHO and its member states alone. It is encouraging that H8 organizations such as the WB, GFATM and GAVI are all committed. Collaboration with all stakeholders is inevitable to bring about maximized results.

128. Health systems strengthening is mutually complementary with the concept of primary health care which places emphasis on the community perspective and aims for the universal access of basic health care services. The implementation of health systems strengthening should be realized through the national health plan, placing utmost priority on what is mostly needed in the communities/districts.

Box
Global Action for Health System Strengthening-Policy Recommendations to the G8

Policy Recommendations to the G8 Part 1: "Opportunities for Overcoming the Health Workforce Crisis"[43]

Human resources for health have been a long-standing concern in health planning and management, and there are currently monumental shortages of health workers around the world. But Professor Masamine Jimba, who heads the research team on health workforces, identifies other major challenges beyond the sheer number of health workers, including inadequate payment, motivation, training, and supervision, as well as poor working environments. Professor Jimba also identifies a massively unequal distribution of health workers, within and among countries and across specialties and skills. In response, his paper recommends four major actions by the G8 to address these problems:

1. Strengthen the capacity of countries to plan, implement and evaluate health workforce programmes so that they can more effectively use the existing health workforce and implement the G8 commitments.

1.1 Develop mechanisms for evaluating health workforce progress at the country level.

1.2 Identify ways to change macroeconomic policies to reduce constraints on expanding the health workforce.

1.3 Strengthen international networks of higher education institutions to provide access to health and medical education in areas with limited resources.

2. Address the demand-side causes of international health worker migration.

2.1 Clean their own houses by increasing the number of health workers in their own countries using their own resources.

2.2 Support the WHO code of practices to address migration issues.

2.3 Seek practical solutions that protect both the right of individuals to seek employment through migration and the right to health for all people.

3. Conduct an annual review of actions by G8 countries to improve the health workforce.

3.1 Assess what the G8 countries are doing, what has worked, and evidence to support this, using a standard set of common measures.

3.2 Use this review to evaluate how health systems are performing, to identify gaps in financing and information, to develop evidence-based best practices, and to increase knowledge on how to improve health system performance through strengthening of human resources, as well as to see how well G8 countries are carrying through on what they have pledged to do.

Policy Recommendations to the G8 Part 2: "Strengthening Health Financing in Partner Developing Countries"[44]

There are no fully accurate estimates of health financing in developing countries, but recent trends show that external and domestic sources of funding for health have been increasing. Yet in his paper on this topic, Dr. Ravindra P. Rannan-Eliya emphasizes that "more money has not necessarily meant better results". Some countries are able to achieve better health system performance with limited financial resources, while others that have made large investments in health have been less successful. This wide variation in country performance provides an opportunity for understanding the conditions under which some health systems work better with limited financing. There is a growing global consensus that public financing represents an important necessary condition, although the form of public financing (i.e., tax financing versus social health insurance) remains a point of debate.

Better. performance also depends on how the available funds are used and how health system coverage is expanded to hard-to-reach populations. Dr. Rannan-Eliya recommends three major actions by the G8 to address these challenges of financing for health systems in the developing world:

1. Complement efforts on increasing money for health with efforts to improve the value of health spending through support for better country-led health financing and systems policies.

2. Build on the existing consensus among technical experts with an explicit G8 commitment to prioritize support for country health financing policies that place public financing for health, in the form of tax financing and/or social health insurance, at the core of efforts to expand coverage for poor people and vulnerable groups in society.

3. Invest in the ability of developing country partners to make better financing policies. This will require increased investments in building national capacity for health systems policy assessment and in mechanisms to understand and share the lessons of best practice countries.

Policy Recommendations to the G8 Part 3: "Toward Collective Action in Health Information"[45]

The policy paper on health information, written by Professor Kenji Shibuya, identifies two major types of challenges in this area: technical and allocative inefficiencies. In the former, he explains that appropriate data do exist but are not used by policymakers or policy analysts, either because they do not have access to the information or because they do not have the capacity to analyze and use the data to answer questions about health system performance. Professor Shibuya describes the allocative inefficiency as uncoordinated data collection and compilation without well-defined measurement strategies. To correct these inefficiencies, he recommends three major actions by the G8:

1. Implement a G8 annual review to assess the G8's commitments to health systems and programmes.

1.1 Define a standard set of metrics and measurement strategies for monitoring and evaluating aid effectiveness, health programmes, and systems.

1.2 Plan and assess future health-related activities by the G8 and its partners using a common framework and metrics.

2. Establish a digital commons using a network of global and regional centres of excellence to improve access to — and the quality of — datasets and analyses at the country and global levels.

2.1 Promote the principles of open access and data-sharing in the public domain.

2.2 Develop a global databank for common indicators (starting with MDG targets, human resources, and resource tracking) and a data exchange and quality assurance mechanism.

2.3 Establish a Cochrane-type process for global health monitoring to generate empirical evidence for health policy.

3. Pool resources for health metrics at the global and country levels to create a Global Health Metrics Challenge.

3.1 Develop capacity and create an incentive structure for countries and data producers to collect, share, analyse and interpret better-quality data.

3.2 Make health funding contingent upon third-party evaluation that is compliant with agreed principles, including developing a standard measurement strategy, putting data in the public domain, strengthening local capacity and making appropriate use of information technologies.

3.3 In countries with incomplete or non-existent civil registration, prioritize development of civil registration systems.

3.4 Invest in a series of nationally representative household surveys for multiple diseases and risk factors.

5. Towards the realization of policy proposals

129. As can be exemplified in past and recent processes mounting to the health outcomes of the G8 Kyushu Okinawa Summit, TICAD IV and the G8 Hokkaido Toyako Summit, the Japanese government is in a unique and privileged position to create awareness, lead the way, and direct resources of all the related stakeholders including donor countries, developing countries, international organizations, private sector, academia and civil society towards a health issue. Japan will continue to take this remarkable participatory approach to contribute to the formulation of international discussion on health systems strengthening as well as to its materialization in the context of Japan's health assistance. By doing so, Japan will contribute to the achievement of the health-related MDGs. At the same time, Japan will make sure to demonstrate accountability in meeting its commitments.

Notes

[1] http://www.mofa.go.jp/policy/health_c/address0711.html.

[2] Statistics Division, Department of Economic and Social Affairs, United Nations (June 2008) *MDG Progress Chart 2008*.

[3] The health cluster provided the following inputs to the Yokohama Action Plan: (a) to promote continuum care for women and children across the span of pre-pregnancy, pregnancy, child birth and childhood via high-impact intervention such as provision of immunizations and micro-nutrients for children as actions to be taken in the next 5 years under the TICAD process, (b) to support the international efforts to achieve universal access to reproductive health services, and (c) to contribute to the international efforts to raise the proportion of birth attended by skilled birth attendant in Africa to 75 per cent in five years, as targeted by WHO.

[4] http://www.mofa.go.jp/region/Africa/ticad/ticad4/doc/action.pdf.

[5] http://www.mofa.go.jp/region/Africa/ticad/ticad4/pm/address.html.

[6] http://www.ticad.net/presskit-2008/YokohamaDeclaration-30May2008.pdf.
[7] http://www.mofa.go.jp/region/Africa/ticad/ticad4/doc/action.pdf.
[8] http://www.mofa.go.jp/region/Africa/ticad/ticad4/doc/appendix.pdf.
[9] Statistics Division, Department of Economic and Social Affairs, United Nations (June 2008) *MDG Progress Chart 2008*, June 2008.
[10] http://www.mofa.go.jp/region/Africa/ticad/ticad4/mechanism.html.
[11] http://www.mofa.go.jp/region/Africa/ticad/ticad4/speech0903.html.
[12] http://www.mofa.go.jp/policy/health_c/address0711.html.
[13] The Health Eight (H8) was informally established to improve health-related Millennium Development Goals through effective support. It refers to leaders of the eight global international health organizations: Bill and Melinda Gates Foundation; the Global Alliance for Vaccines and Immunization (GAVI); the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM); the United Nations Joint Programme on HIV/AIDS (UNAIDS); the United Nations Population Fund; the United Nations Children's Fund; the World Bank and the World Health Organization.
[14] http://www.mofa.go.jp/policy/economy/summit/2008/doc/pdf/0708_09_en.pdf.
[15] http://www.jcie.or.jp/thinknet/takemi_project/index.html#members. Professor Keizo Takemi was formerly a member of the House of Councillors and Senior Vice Minister of Health, Labour and Welfare, State Secretary for Foreign Affairs.
[16] http://www.mofa.go.jp/economy/summit/2008/doc/doc080714_en.html.
[17] The dialogues between the MOFA and NGOs have been held since 1994 as an open forum between the two parties to actively promote "Global Issues Initiative on Population and AIDS (GII)", which Japan announced in 1994.
[18] Third Party Evaluation 2008, The Ministry of Foreign Affairs of Japan, *Evaluation of Japan's ODA to the Health Sector*, 2009.
[19] The data is from OECD-DAC statistics since 1971, when health-related data started to be gathered. The statistics include population and reproductive health data.
[20] The difference of aid amount in 2004 and 2005 is due to the implementation of Exchange of Notes (E/N) for certain grant aid projects in 2004, and not due to an amendment in aid policy.
[21] Japan makes core supports and/or contributes to Japanese funds for the following international organizations: WHO; GFATM; UNICEF; UNFPA; United Nations Trust Fund for Human Security; IPPF; World Bank; UNDP; ADB; OIE; UNAIDS; AfDB; UNESCO; IDB; FAO; WFP; and UNV.
[22] Data taken from OECD-DAC statistics, including population and reproductive health. Japan contributes to international organizations, including to GFATM, in addition to bilateral aid.
[23] Ministry of Foreign Affairs of Japan, *Japan's Official Development Assistance White Paper 2008 — Japan's International Cooperation*, 2009.
[24] Ibid.
[25] Ibid.
[26] Five principles for aid effectiveness are as follows: (a) ownership; (b) alignment with partners' strategies; (c) harmonization; (d) managing for results; and (e) mutual accountability.
[27] Economic cooperation coordinators are staffed in the following African countries: Ethiopia, Ghana, Kenya, Madagascar, Mozambique, Senegal, the Sudan, Uganda and Zambia.
[28] The important principle of Japan's ODA is to support the self-help efforts of developing countries by extending cooperation for their human resource development, institution-building, including development of legal systems, and economic and social infrastructure building, which constitutes the basis for these countries' development. In carrying out the policy, Japan has given and continues to give priority to project-based support. This principle of placing project-based support at the basis of Japan's ODA will not change greatly for the time being as it creates a strong relationship between the donor and the recipient countries as well as from the viewpoint of accountability to the public. Nonetheless, as many countries seek budget support, Japan, if it is needed by the developing countries to implement effective aid in line with their national situations, provides budget support. So far, Japan provided budget support to Cambodia, Indonesia, the Lao People's Democratic Republic, the United Republic of Tanzania and Viet Nam.

[29] Institute for International Cooperation, Japan International Cooperation Agency, *Japan's Experience in Public Health and Medical System — Towards Improving Public Health and Medical Systems in Developing Countries*, *2004*, available from http://www.jica.go.jp/english/publications/reports/study/topical/health/index.html.

[30] Today, the MCH handbook is utilized not only by Japan but also by various donor countries and developing countries.

[31] Maternal mortality ratio in rural areas in Morocco: 227 (per 100,000 live births; 2005). This figure is 2-3 times higher than that in urban areas.

[32] The health handbook for women is distributed to women above 15 years of age or expectant mothers, and is utilized for health care and self-management in Morocco.

[33] National Center for Tuberculosis and Leprosy Control (CENAT), Provincial Health District (PHD), Operational District (OD), health centres, etc.

[34] Nine concepts of "Human Security" for the evaluation of tuberculosis control projects: (a) reaching those in need surely; (b) focusing on the most vulnerable people; (c) greater impact on early diagnosis and treatment of diseases and prevention of epidemic; (d) promotion for sustainability in management programmes; (e) countermeasure to health system vulnerability due to socio-economic conditions; (f) capacity-building of health service providers at all levels; (g) promotion and enablement of operational research and survey; (h) empowerment of people and service recipients in local community; (i) strengthening partnership and cooperation with various actors for a greater impact.

[35] Millennium Promise (MP) is a non-profit organization launched in the United States dedicated to achieve MDG1. Millennium Village project is its flagship initiative, in which MP currently works in 112 villages in rural African communities to promote an integrated approach to rural development by improving access to clean water, sanitation and other essential infrastructure, education, food production, basic health care, and environmental sustainability. MP also supports independent projects to address factors that contribute to extreme poverty, one of which focused on control of malaria. Within the project, OLYSET® NET nets are distributed as well as medical supplies are provided in the Millennium Villages.

[36] Group 1 (March 2007-November 2008): Kenya, Uganda, the United Republic of Tanzania, Malawi, Nigeria, Senegal, Madagascar, Eritrea; Group 2 (March 2009-November 2010): Morocco, Mali, Burkina Faso, Benin, Burundi, Congo, the Niger.

[37] 5S activities (sort, set, shine, standardize, sustain), CQI (continuous quality improvement), TQM (total quality management).

[38] A national plan to implement health capital investment: investment in health infrastructures, such as construction and restoration of health facilities, supply and replacement of medical equipments, and improvement of infrastructure, i.e., development of water, electricity, and communications.

[39] Medical assets refer to the investment choice which includes both medical equipment and health infrastructure, out of overall health investment.

[40] http://www.jcie.or.jp/thinknet/takemi_project/index.html#members.

[41] http://www.jcie.or.jp/thinknet/takemi_project/081104symposium.html.

[42] Task Force on Global Action for Health System Strengthening, *Global Action for Health System Strengthening — Policy Recommendations to the G8*, Japan Center for International Exchange, 2009.

[43] Masamine, Jimba, "Opportunities for Overcoming the Health Workforce Crisis", *Global Action for Health System Strengthening — Policy Recommendations to the G8*, Japan Center for International Exchange, 2009.

[44] Ravindra P. Rannan-Eliya, "Strengthening Health Financing in Partner Developing Countries", *Global Action for Health System Strengthening — Policy Recommendations to the G8*, Japan Center for International Exchange, 2009.

[45] Kenji Shibuya, "Towards Collective Action in Health Information", *Global Action for Health System Strengthening — Policy Recommendations to the G8*, Japan Center for International Exchange, 2009.