ECOSOC High-level Segment

Annual Ministerial Review: National Voluntary Presentations Of Bolivia, China, Jamaica, Japan, Mali, Sri Lanka, Sudan

Palais des Nation, 7-8 July 2009

Informal Summary

I. Introduction

Mr. Sha Zukang, Under-Secretary-General of UNDESA introduced the report of the Secretary-General on the theme of the Annual Ministerial Review (AMR) "Implementing the internationally agreed goals and commitments in regard to global public health". He stressed that development required an integrated and comprehensive approach, as goals in poverty eradication, alleviation of hunger, health, environment and global partnership were intertwined. This was especially critical now, as the world confronted food, energy and the climate crises, joined by the H1N1 pandemic. Overall, progress in the area of global public health was made, but visible gaps remained. The report highlighted six areas:

- The global financial and economic crisis was exacerbating gaps. There was a grave risk of reversing progress towards the Millennium Development Goals (MDGs). This would mean negative consequences not only for human well-being, development and economic growth, but also for peace and stability.

- In the area of health, progress had been made and there were success stories in the global response to HIV/AIDS, malaria and tuberculosis. There was less forward movement in the prevention, treatment and control of neglected tropical diseases and non-communicable diseases. The least progress has been made toward MDG5 on improving maternal mortality and newborn health. At the time of the Coordination Segment next year, there would be a report back to ECOSOC on the progress made in the follow-up to the 2009 High-level Segment of ECOSOC, especially in the area of maternal and women's health.

- The nexus between health and development was evident. The challenge was to ensure that policy making engaged all the relevant sectors and actors, and was accountable and oriented towards health equity.

- Aid to the health sector should be maintained, and aimed to achieve "more health for the money".

- To make the most of strong donor support and private sector engagement will require strengthening health systems – through better planning, investment and coordination of aid.

- Leaders have shown a strong commitment to the health-related MDGs, but this commitment and resolve has yet to be fully transformed into action. ECOSOC could spearhead the response needed to advance the global public health agenda.

During the national pillar of the AMR, seven countries made National Voluntary Presentations (NVP): **Jamaica, China, Japan, Bolivia, Mali, Sri Lanka** and **Sudan**, in the order of presentation. The following provides highlights of their presentations:

- Jamaica presented the case of middle-income, Small Island Developing State. Its major source of income is tourism and bauxite. In time of global recession like at present, the economy feels the impact severely. Yet, because of its middle-income status, it is hard to receive external support. Jamaica highlighted the progress made in the fight against HIV/AIDS. However, it underscored the issue of non-communicable diseases (NCDs) and proposed a special session of the UN General Assembly on NCDs and to include NCDs target in Goal 6 at the 2010 Summit.

- China pointed out that the major cause of poverty in the country was ill health and the Government had stepped up measures to improve health and nutrition. The health services and health technologies have been greatly enhanced. Recently, China made contributions to the global prevention and control of H1N1 through international exchanges and assistance by providing diagnostic services, training and personnel to countries in need, such as Mexico. China had in place a major health programme of 850 billion Yuan, as part of the stimulus package to the financial and economic crisis. As one of the remaining challenges, the disparity between rural and urban areas was highlighted. Over the next three years, China's priority would therefore be to increase coverage of health services in the rural area.

- Japan stated that it has been an active player in the field of global health. At the G8 Okinawa Summit in 2000, Japan took up the issue of infectious diseases and announced the Okinawa Infectious Diseases Initiative, which led to the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002. At the Fourth Tokyo International Conference on African Development and again at the G8 Hokkaido Summit last year, Japan emphasized the importance of a "comprehensive approach", which mutually reinforces the vertical, disease-specific approach and the horizontal, health systems strengthening approach. Japan noted that it invited all relevant stakeholders to participate in the formulation of the "Toyako Framework for Action". Two examples of their development cooperation projects were presented. One is on tuberculosis (TB) control in Cambodia, which employs a comprehensive approach based on health systems strengthening. Another is a health capital investment plan support in Zambia. Japan explained that it is currently following up on its commitments announced at TICAD IV by training 100,000 health and medical workers in Africa. Japan has disbursed approximately US$ 4.6 billion in total to the Health and Development Initiative. The initial pledge of US$ 5 billion over five years is

almost realized in just three years. In addition, Japan has disbursed, as of today, US$ 1.04 billion to the Global Fund.

- Bolivia emphasized that since 2006, it has implemented numerous socially inclusive policies. Because of the nationalization of the oil and natural resource companies, Government revenue has increased, which forms the bases of public investment and the social policies. A number of innovative policies have been introduced: bonds to increase school retention, pension scheme for retirees from bankrupt companies, programmes to alphabetize people, improvement of maternal and child health, and eye surgery to improve or restore eyesight. These showed already significant results. Bolivia identified the current financial and economic crisis as well as the need to accelerate the pace of progress as their two challenges in their efforts to achieve the MDGs.

- Mali presented the case of a least developed, landlocked, African country. It has identified progress in a number of areas, including poverty reduction and primary education. But they emphasized that progress is fragile. Within health-related MDGs, there is some tangible progress in halting HIV/AIDS and improving access to health services. However, maternal and child health remain a major concern of the country. Mali's NVP Friends praised the country's frank and pragmatic approach and assured their continued support to the effort of Mali towards achieving the MDGs.

- Sri Lanka presented the case of a country in a post-conflict context. After almost three decades of confronting terrorism, it had now put in place a supportive framework of social determinants for health. Sri Lanka had systematically invested funds to develop human and physical resources in the public health-care sector, and health-care services had been provided free of charge and within facilities located close to clients. Infant mortality had declined, placing Sri Lanka on track to achieve that MDG target in 2015, the maternal mortality rate was also likely to decline by 2015, thus also reaching the Goal target, and Sri Lanka was confident of completion of malaria eradication by 2015.

- Sudan presented the case of a developing country that had been afflicted by conflict, which, in turn, had dramatically diminished its opportunities for development. Poverty affected 50 to 60 per cent of the population in the North and more predominantly in the South of the country. Child mortality rates were alarming. Sudan therefore stressed that without peace there could be no health services, or development. Sudan had been committed $4.8 billion in aid, but had not received more than $30 million, disbursed by the various financial institutions, as part of the Highly Indebted Poor Countries initiative. In the area of health, there were only 1.5 health-care providers for every 1,000 people in Sudan. That affected the distribution of health services, which were markedly unequal. Particularly noteworthy was Sudan's basic nutrition plan, the nutrition emergency package, and the food fortification strategy.

II. National Voluntary Presentations

Jamaica

Jamaica showed mixed results in the achievement of the MDGs. Jamaica has achieved the goals for reduction in absolute poverty, reduction in hunger and universal access to primary education and is on track to achieve universal access to reproductive health, to halt and reverse the spread of HIV/AIDS, malaria and tuberculosis, and to achieve universal access to potable water and basic sanitation.

A major area of success is in addressing the HIV/AIDS pandemic. While there is room for improvement in tackling stigma and discrimination, significant inroads had been made in increasing access to anti-retroviral drugs, resulting in a significant reduction in mother-to-child transmission and deaths due to AIDS. As the prevalence of chronic non-communicable diseases (NCDs) presents new challenges to public health, Jamaica recommended that ECOSOC place before the UN General Assembly a new target relating to halving the incidence of chronic NCDs by 2015, and a new target pertaining to the prevalence of chronic NCDs by sex and age. Jamaica also recommended that more health-related development aid be made available to those countries that were heavily indebted, especially in light of the global recession.

Jamaica is developing a new primary health care strategy to meet challenges of sustainability, cost-effectiveness and quality. Strategies for renewal included (1) innovative health financing, (2) infrastructure upgrading, (3) improved information systems, better-trained leadership and managers, and (4) community empowerment. The National Health Fund is a Government agency that was established in 2003, making Jamaica the first country in the world to have an innovative health fund. It is financed through taxation of cigarettes, and the main focus is the provision of individual benefits, presently by way of pharmaceuticals.

The greatest long-term challenge in meeting the MDG targets is the debt burden, which was the fourth highest in the world, and makes it almost impossible to make significant headway in meeting development obstacles. Other challenges were the significant quality and equity issues in early childhood and primary education, including low rural attendance. While there is high levels of unemployment among women and low levels of representation, there is also underperformance by males at all levels of education, and thus both aspects of gender needs to be addressed. Jamaica is also far behind in reduction of child and maternal mortality. Shortage in midwifes has negatively impacted resources. While maternal deaths from direct causes were halved, deaths from indirect causes have increased. There is also slippage in achievement of significant improvement in the lives of slum dwellers.

More development aid is needed to prevent deterioration of many MDGs. Main policy interventions are: (1) the renewal of primary health care and in particular the upgrading of infrastructure, the re-engineering of human resources and improved

information systems; and (2) the abolition of user fees at public health facilities.

Brazil said that the World Bank had rightly recognized that many of those social indicators for Jamaica compared well with those in countries with higher income levels. Additional progress was needed in some areas, but the diagnosis and policy solutions presented in the report demonstrated that Jamaica was fully determined to tackle the challenges. The focus on public health was an understandable priority. In order to further reduce child mortality and improve maternal mortality rate, substantial additional human resources and financial resources were required. Overcoming the challenge regarding women's empowerment was crucial. Brazil welcomed Jamaica's initiatives to promote sustainable energy, including through expanded use of ethanol.

Canada underscored that sustaining Jamaica's efforts in the midst of the global financial and economic crisis would entail continued and concerted efforts, through close coordination with international development partners. The report reflected the seriousness with which Jamaica had embraced the MDGs as a framework for advancing Jamaica's human and social development, within which it had sought to insert the factors and indicators especially relevant to its own context and reality.

Namibia said Jamaica's presentation brought forth aspects that were common to most middle-income countries like Namibia. Jamaica had made great strides to achieve the MDGs. This progress was a result of commitments by the leadership, and the strategic and prudent deployment of scarce resources. However, Jamaica was still facing challenges, in particular with regard to child and maternal mortality, mainly due to lack of human and institutional capacities and financial resources. Gains could be reversed if the international community did not support the efforts of Jamaica. The impact of climate change and natural disasters had the potential to reverse achievements, just like the current financial and economic crisis. The international community was responsible to ensure that Jamaica remained on course to meet the internationally agreed development goals (IADGs) and MDGs, and should re-examine the situation of the middle-income countries, as it was inconceivable to fight poverty without increasing aid and resources provided to those countries.

Barbados said that Jamaica, as a middle-income country, did not qualify for financial aid. However, its efforts to achieve the MDGs showed the need for such support. The threat of the increasing frequency of natural disasters could worsen the situation of migration and the displacement vulnerable groups. Barbados underlined the importance of the upcoming Copenhagen conference to further address climate change. Barbados highlighted the need for additional funding to halt HIV/AIDS. ECOSOC should also identify the role of men to support females in programmes directed at women specifically. Given the present crisis, the middle-income countries were experiencing special challenges and should be given more attention, in particular at ECOSOC.

Jamaica, in response to comments and questions, said that violence in the country amounted to a significant amount of hospital time. Jamaica was addressing this issue in

two ways (1) it had increased the health budget and (2) it hoped that international organizations and countries would come to Jamaica's aid.

Brazil asked whether, in the absence of the World Bank and IMF in the conference room, it was possible to learn from Jamaica what response had been received from those institutions with regard to debt alleviation, debt-equity swaps, and financing for health care. It was important to consider what could be done in terms of the suggestions put forward by Jamaica, and perhaps to invite these institutions to comment on those later.

Jamaica said that the way that multilateral organizations were dealing with debt was a real concern. There was some assistance from the World Bank, especially for the HIV/AIDS programme. But it was not adequate and it was a matter of the ability to pay back the loan. Jamaica tried to pay back the debt, but its efforts were hindered when Jamaica's rating fell. The intervention of the international community had helped. Jamaica was now grappling with the issue of sustainability.

New Zealand noted that Jamaica had made progress in the field of education, but there were challenges in sustaining skilled labour in the public health sector. It questioned whether was Jamaica affected by the "brain drain", whereby skilled labourers left the country to pursue their professions in other countries. Furthermore, it asked what Jamaica was doing about trying to maintain skilled labour and its sustainability in the public health system.

Jamaica had been working on this with its partners, including Canada, to try to see how it could retain and recruit health workers into the system. It was not a short-term solution, and had an impact on the quality of service delivery. Jamaica needed to recognize that it was not competitive as far as salaries were concerned, and much of its migration was to North America, which had a need for health professionals. The World Health Organization (WHO) should work towards completing the Code of Practice in that regard. Many countries were suffering from the brain drain, and attaining the MDGs was predicated on retaining the health workforce. Jamaica is continuously training its health workforce, as the loss is tremendous. About one third of the trained medical workforce emigrated.

Barbados remarked that it was unfortunate that there was no representatives present from the World Bank and the IMF to discuss increased support from the international finance institutions for low-to-middle-income countries and asked the Chair if that request could be communicated to the representatives of the concerned institutions.

President of the Economic and Social Council, said that the question concerning the code of practice for health professionals had been discussed as part of the negotiations on the draft Ministerial Declaration. Also, regarding the issue of special challenges of middle-income countries, she again drew attention to the draft Ministerial Declaration, where that issue was mentioned.

China

China has made great achievements, in particular in eradicating hunger and poverty, combating malaria and tuberculosis and reducing maternal mortality. The percentage of poor has decreased from 10.2 per cent of the population in 2000 to 4.2 per cent in 2008, which means that China has met the poverty MDG already.

China conducted a study on the causes of poverty in the country, which showed that illness was a major factor. The Government has therefore taken measures to step up its response in health and nutrition. The health services and technologies have been greatly enhanced. Major diseases and endemic diseases have either been eradicated or brought under control. The under-five child mortality rate – 61 per thousand in 1991 – has decreased to 18.1 per thousand in 2007. China also made progress in reducing maternal mortality, which declined from 94.7 per 100,000 live births in 1990 to 34.7 per 100,000 live births in 2008. More needs to be done, however, to meet the MDG on maternal mortality.

In combating AIDS, malaria and other diseases, China has made good progress. Free treatment was provided for tuberculosis patients, with 100 per cent coverage. Since the severe acute respiratory syndrome (SARS) breakout in 2003, the Government has strengthened the public health system response mechanisms and emergency response networks. Joint actions and coordination at the international level have been greatly improved as well. With the outbreak of H1N1 flu, China has adopted effective measures to slow down the import, spread and prevalence of the disease nationwide, which has gained time to prepare for a more serious potential outbreak and to stockpile vaccines and drugs. 1,114 cases of H1N1 have been recorded and no critical cases or deaths reported. Furthermore, China has made a contribution to the global prevention and control of H1N1 through international exchanges and assistance by providing diagnostic services, training and personnel to countries in need. China believes that it is important to put people at centre stage, as their health is the basis to social and economic development.

China is confronting challenges. Five key tasks for 2008-2010 are (1) the improvement of grassroots medical and health service systems, (2) making primary public health services equally accessible for all, (3) expediting the construction of basic medical insurance systems, (4) establishing a national system of essential medicines, and (5) promoting reform pilot projects in public health. China is devoted to addressing the inequalities in income, social insurance, medical services and education and is actively involved in international cooperation to contribute to achieving the MDGs in the world.

Egypt observed that China had made noteworthy and remarkable progress in raising the standard of living and quality of life of its entire population over the past three decades, reducing the population living in absolute poverty from 250 million to 15 million. Within the context of the global financial and economic crisis, China had laudably decided to inject a massive 850 billion yuan in investments in its healthcare system, a bold move presenting a direct benefit to the Chinese public health system and an impressive stimulus package for the entire economy. The Chinese example highlights

the importance that traditional systems of medicine can have in enabling developing countries to diversify their medicine policy base as a cornerstone of their public health systems.

Pakistan said that China had presented a compelling case of how a clear political vision supported by nationally led, cooperatively framed and seriously implemented strategies, based on the principles of equity, social justice and equal opportunity. It could bring about a fundamental transformation in a society. The most striking aspect of China's endeavors was that it was people-driven, people-led and people-focused. China today is a trailblazer in the developing world in advancing the welfare and prosperity of its people. Pakistan asked how China had integrated traditional medicine into existing health plans built around contemporary health systems and how other countries could tap into that important health resource.

Malaysia recognized the scale of ensuring public health in China. The various programmes that had been identified in China's report and presentation could be models for other developing countries. The challenge faced by China to provide basic medical and health care, due to scale, is not only a matter of focusing on health policies, but also involves paying attention to other interrelated areas, such as poverty eradication, education, and hygiene. Given China's long and wide-ranging history and experience of traditional medicines and given it had equal status in the legal, academic and health-service spheres as that of Western medicine, how did China ensure that its traditional medicines were safe, of quality and effective, and how could that experience, including the traditional knowledge itself, be shared with other countries?

Russian Federation observed that China had achieved impressive success in the area of health care, in particular, in the reduction of maternal, child and infant mortality, and in combating the spread of infectious diseases, particularly in areas where formerly modern health care did not exist.

China, responding to a first round of questions, said that although China had made progress in the field of public heath, it still faced enormous challenges. In China, a major strategic decision had been made, which was to put people at the centre. Investment in the health sector is also an investment in economic development, as it contributes to increasing domestic consumption. A joint body of several government entities was set up to respond to the H1N1 case. Containment had to be combined with mitigation as two components. Since SARS incident, a reporting system had been set up, which now played a significant role. China had also decided to step up efforts to produce vaccines and was focusing on community-level measures. With the deepening of medical care reform, the monitoring system would be strengthened. Chinese traditional medicine was a major component of human medicine. About a quarter of patients in hospitals received treatment of traditional medicine and the figures were even higher in the rural areas. Regarding the concerns about the safety of traditional medicine, China said that control mechanisms were strengthened, for example through scientific research.

Cuba said that, from the beginning of the setting up of the Republic of China in 1949, the model upon which society had been built had been based on equity and social justice for all. Enormous progress had been made with regard to access to medical health services across the country and life expectancy increased from 35 to 73 years of age currently. What specific measures were included in that national health care reform strategy, and what impact would it have on access to medical health care services at the national level? China was an example of international cooperation in promoting the right to health and the right to the development of people.

Singapore praised the significant progress China had made towards the health-related MDGs, in particular with regard to the health of rural populations. What China has achieved would certainly have an important impact on all those in the region. China should further share its useful experience in assisting developing countries to move forward in accomplishing the MDGs.

Sri Lanka was interested in knowing more about China's experience using a health scheme.

Indonesia said that the emergency response network and the information release system noted in the report were welcomed, as prevention and control of diseases were common challenges faced by countries. Indonesia asked China for more information about institution-building and lessons learned.

Venezuela saw that the report revealed major developments in social development and health in China, with the human at the centre. In that regard, China was an example for the whole world, in particular for developing countries. What was the situation in the area of human resources for the health sector and training in both Western and traditional medicine?

IOM noted that China had mentioned a high number of migrants in the country and IOM wanted to know more about their access to healthcare services and whether there was a specific body in the Government dealing with that group.

China*,* in response to the second round of questions and comments, agreed that as a whole China had achieved considerable progress in the healthcare field. However, they still had a long way to go. Due to unbalanced development, there was a huge imbalance in life expectancy between the western and eastern provinces of China of as much as 10 years in most cases. The Government has been aiming to ensure basic health care for all. Health was the responsibility of both Governments and individuals. The health care system currently covers more than 90 per cent of farmers. Over one million medical and technical persons needed to be trained in order to ensure appropriate services in the countryside. One major challenge faced by China was how to encourage doctors to practice in the countryside and western and eastern provinces. There was currently a crisis in developing and extending traditional medicine because of the market situation. Three types of medical teams needed to be established in China (1) one team focused on traditional medicines, (2) second focused on Western medicine, and (3) third combining

both. However, in order to create that last team, a special policy would be necessary. Finally, in order for health services in China to be further developed, this responsibility should not rely solely on the Ministry of Health, but on all ministries.

Japan

Japan attached great importance to the issue of global health. In order to address global issues such as terrorism, infectious diseases, environmental degradation, poverty and conflict effectively, Japan had promulgated the concept of human security, aimed to protect the vital core of all human lives in ways that enhanced human freedom and fulfilment through protection and empowerment of both individuals and communities. Such a comprehensive approach was necessary, including a disease-specific approach involving all stakeholders.

Japan had learned good practice in achieving prominent health goals through strengthening national health systems, such as the Tuberculosis Control through Directly Observed Treatment project in Cambodia. Japan had steadily fulfilled its commitments to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and was firmly implementing comprehensive health assistance programmes tailored towards achieving the health-related MDGs.

However, progress in achieving the health-related MDGs worldwide was lagging behind. If the current trends persisted in sub-Saharan Africa, the prospect was that none of the health-related MDGs would be met. In the worst-case scenario, there would simply be no progress at all by 2015. Japan had thus committed itself to bringing this issue to the attention of the international community, raising it at international conferences. Japan was living up to its commitments, by training thousands of health workers in Africa and placing a special focus on health system development in its health partnerships with international organizations and bilateral partners.

All bodies, international organizations, the private sector and civil society, as well as others, should play their respective role in the field of health system strengthening. These efforts should be enforced through a participatory approach. As funding gaps should be filled, the financial crisis could be seen as a golden opportunity for the international community to distribute resources to their fullest potential and to those who need it most towards the achievement of the MDGs.

Cambodia said that it was honoured that the Tuberculosis Control Project had been implemented with significant success from 1999 to 2009. Tuberculosis was one of the leading causes of mortality in Cambodia. Japan’s support contributed to most of the achievements, including in data aggregation, formulation of evidence-based national programmes, development of networks for early diagnosis, treatment and prevention and capacity-building of health workers. Through those approaches, Cambodia’s case detection rate and cure rate of tuberculosis had been raised to the WHO standards. In view of the best experience and practices applied so far in Cambodia, did Japan intend to

maintain or increase the fund to assist poor countries in the area of combating infectious diseases at the global level?

Norway underscored that Norway and Japan were heavily engaged in promoting global health, and coordinated closely with one another within the framework of international conferences and meetings on global health strategies. Both Norway and Japan shared the view that there was an urgent need to collect data on which to base policies and results. Now was the time to ensure consolidated platforms for national health systems. No national health system could take the risk of being totally dependent on external support. Norway was at the forefront of promoting global health to achieve policies and systems to achieve security and a high level of health care. Japan had made human security a building block for its global health security. Norway asked what was Japan's approach or stance towards a coordinated health approach.

Zambia said the health support plan project in Zambia had been cited as an example of good practice, both in the report and in the statement made by Japan. Under the reforms instituted in 1992, Zambia had sought to reconstruct its health system into an efficient and comprehensive one. As a result of Japan's technical cooperation, all district health offices and hospitals had compiled data and prepared and submitted capital investment plans to the Ministry of Health, which allowed the Government and the donor community to invest capital appropriately. What was Japan's position towards general budget support?

Japan, in a first round of responses to questions, said that it had provided support to countries affected by tuberculosis, such as Afghanistan and it had provided targeted support to Pakistan, Myanmar, Bangladesh and Zambia. Japan would continue its commitments, both bilaterally and multilaterally in those projects. Japan noted that reinforcing the development of health systems to continue the fight against infectious diseases was crucial. The fight would not become effective unless there was a solid backing of a health system. The concept of human security was a leading principle, empowering the people on the ground, and was often transformed into a multisectoral approach, including the health sector, education, water and sanitation. Japan appreciated Norway's efforts to coordinate aid efforts and reiterated Japan's commitment to the Paris Declaration and aid effectiveness. Japan had always put an emphasis on project-based assistance. There were cases when budget support was needed but if budget support could work at all, the recipient country would have to have a stable management structure, transparency and accountability, as well as a transparent exit strategy to avoid aid dependency. Unfortunately, many developing countries were not able to provide those conditions.

The United Nations Population Fund (UNFPA) applauded the leadership that Japan had exercised and continued to provide in reaching the international health goals and in particular in improving maternal health, combating HIV/AIDS, malaria and other diseases, ensuring universal access to reproductive health and the goals set at the ICPD. Japan was specifically praised for giving priority to strengthening health systems with a special focus on maternal, newborn and reproductive health. It was critical that those

efforts be sustained. UNFPA noted with great interest the measures taken by Jamaica with regard to adolescent and reproductive health, and in the case of China, measures taken to address the gaps that still existed with respect to health care coverage in rural areas.

The Philippines said it had benefited from generous support from Japan to strengthen its health system, including the delivery of health and medical services; improvement and upgrading of many of its provincial hospitals; and further enhancement of public health facilities. The Philippines urged Japan to continue playing its leading role and sharing its best practices and expertise. It acknowledged the tremendous help given in trying to lift up the new members of the Association of Southeast Asian Nations, including Cambodia.

Japan, responding to this second series of comments and questions, said that coordination was needed at two levels to ensure human security: with sectors such as industry and NGOs; and with other components, such as education experts and sanitation experts. Human beings could not be happy with health alone, but health was needed. Investment was also needed. To lower the maternal mortality rate in Japan, the Government had given out handbooks as well as sufficient funds for the delivery of child and support for the employers whose employees would be off for maternity leave.

Bolivia

For Bolivia, achieving the MDGs required deep structural changes that had been included in the Constitution and the "Live Well" programme within the framework of the National Development Plan, with its four pillars: a dignified, sovereign, productive and democratic Bolivia to "Live Well". This covers decent work, decent housing, adequate food, education, transport, electricity, water, and sewage systems.

Health was key priority. The Government had begun to pay the mother-child voucher, "Juana Azurduy", an incentive for safe motherhood and integral development of children from birth to two years of age. The voucher would cover 74 per cent of households that had no access to social security. In 2006, 545 new public health establishments had been created. The rate of extreme poverty had fallen from 41.2 per cent in 1996 to 31.8 per cent in 2008. There had been a decline in chronic malnutrition during the period 2003 to 2008 by 5.3 percentage points, reaching 20.3 per cent. Infant mortality had been lowered to 50 deaths per 1,000 live births. Pregnant women attended by health personnel had increased from 43 per cent to 64 per cent between 1998 and 2008.

In the area of education, Juancito Pinto voucher programme is improving enrolment, retention rates, and the quality of education by providing incentives for children to be enrolled, attend and complete their primary school grades in public schools. With respect to illiteracy, the main action undertaken is the National "Yes, I can" Literacy Programme.

To improve nutrition, the multisectoral Zero Malnutrition Porgramme, focusing on children under five years of age and especially those under two years of age, gives priority to activities in the more vulnerable municipalities. The programme promotes the consumption of supplementary food for children aged 6 to 24 months, and the consumption of food fortified with micronutrients for pregnant women. The programme also encourages the immunization of children.

The external shocks in 2007 and 2008 had increased international food and energy prices and resulted in lower terms of trade for Bolivia's exports, which limited its capacity to progress towards the MDGs. Mechanisms need to be put in place and agreed upon to prevent smaller economies from falling into the abyss of the crisis. Unless there is a global covenant to combat asymmetries, all efforts to progress towards the MDGs will be in vain.

Cuba highlighted the need to increase official development assistance (ODA) and reform the international financial architecture with a new vision for the world and achievement of the MDGs. The very positive advances that had been recorded by Bolivia were a very clear example of what could be achieved by a country committed to alleviating the situation of the poorest. Bolivia should explain to the Council what specific areas within the country would benefit from international cooperation.

Brazil said that for Bolivia and Brazil the promotion of fundamental rights – such as the right to health, education, employment, development, housing and food – were all essential components of public policies. In the area of health, there was an important increase in medical attention, especially the special voucher programme for mothers and children had caused a drop for chronic malnutrition in children under two years of age and a fall in child mortality. However, there was still much to do. It would be interesting to know what Bolivia was able to receive from UNICEF and what the situation was in terms of combating HIV/AIDS and other diseases. Bolivia had also played a fundamental role in the establishment of the Union of South American Nations, with the goal to favor a more equitable development in South America.

Ecuador noted the progress made by Bolivia to build a just and equitable State. The Government of Bolivia was pushing forward projects aimed at creating an environment of participatory democracy, building a new, inclusive, national, dignified and sovereign State. Ecuador praised Bolivia's successful management of its foreign debt, distribution of land, especially to indigenous persons, and the increased coverage of services to rural areas.

Venezuela said the path followed by the Bolivian people to improve their quality of life had not been easy, but it was on the right path to the eradication of poverty. Venezuela was working to promote complementarily in policies in the region. The inclusion of the people allowed Bolivia to reach a new social and economic order in full harmony with nature and humanity. The work of Bolivia gave a clear picture of how it was recovering its natural resources, which now belonged to the people, and were administered by the State. Venezuela supported the proposal to discuss access to water as

a human right, which was as fundamental as the right to health, and could not be discussed as merchandise. The IMF and the World Bank should be restructured in order to serve the people.

Uruguay subscribed to the importance to the access to drinking water. Uruguay complimented Bolivia on its Juancito Pinto voucher programme against school drop out, as well as the Juana Azurduy voucher programme, which had led to a drop in maternal and infant mortality, as well as a drop in malnutrition. Uruguay asked what concrete results Bolivia had achieved so far through its programmes against malnutrition.

Nicaragua believed the NVP was an important mechanism to know what the national experiences were in other countries, as such exchange of best practices helped others address their challenges to meet the MDGs. Could Bolivia share more information about the experiences they faced in light of the global economic crisis, including whether the Government had made any changes as a result, and what those changes were?

Barbados complimented the Minister of Bolivia for his presentation, and the Government for its management of the fiscal accounts, which had led to a surplus, most of which was being used to assist in the implementation of programmes to achieve the MDGs. Those programmes were very impressive, and the national approach was an interesting model, with policies moving the very poorest out of poverty. It was hoped that Bolivia would receive support from the donor partners without conditionality to continue its progress.

Bolivia said that the MDGs, mainly on poverty, had to be seen in a comprehensive manner, not only the social point of view. Efforts to achieve the MDGs would be underpinned by various financial resources, which were now available thanks to the processes of recovery of national resources. It was important that topic of poverty should not be limited to image of poverty. This was not only a question of the poor people, but also of the rich.

Bolivia questioned the practices of the World Trade Organization and IMF. Cooperation with Cuba was valued high as this was in line with the joint pooled efforts, such as North-South and South-South trade. Such cooperation would be effective if supplemented by the restructuring of international institutions. Bolivia underlined the special need to protect small farmers. In the area of health, efforts should be concentrated on new medicines for neglected diseases, such as tuberculosis, financing, exchange of best practices, access to primary education, and conditions placed on trade. Bolivia was concerned about infant health and had undertaken measures to support breastfeeding.

Mali

In terms of human development, Mali was among the least developed countries. Between 1997 and 1999 a national study was conducted calling upon all Malians to describe their vision for Mali to be reached in 2025. That study provided a basis for the

creation of strategic frameworks to combat poverty, improve governance and participation and to develop human resources and basic infrastructure.

With regard to the MDGs, success had been achieved in many areas. Food security was ensured and malnutrition combated over the last decade through two programmes: “160 Communes Initiative”, aimed at addressing the needs of the most vulnerable communes in the country, and the “National Programme for Food Security”. With regard to ensuring primary education for all, the growth rate in 2008 had been 80 per cent as compared with 77.6 per cent for 2006-2007 in Mali. The girl-boy ratio had gone from 68 for every 100 students in 2004 to 81 in 2008. This was the result of increased funding for educational development programmes.

Considerable challenges remained. The insufficiency of training for instructors, resources and facilities was a major challenge. The maternal mortality rates remained high, as there are between 500-600 deaths for every 100,000 births. Similarly, the child mortality rate was also still high. There was a slight decrease in HIV/AIDS prevalence rates. The constraints facing the Government in that area were based on the slowness of the transfer of resources to communities, the insufficient sanitary plans in some areas, non-coverage by communities, the absence of community law on health and the lack of access in some of the regions in the north of the country, as well as the lack of qualified personnel at all levels.

Promoting equality between men and women, in particular by improving the level of literacy among women remained a concern. Mali had taken measures to give better access for women to microcredit and ensure equal access for women to Government, either by election or by appointment to public office. There was a funding gap of $5.7 billion to achieve the MDGs. The Government expected to contribute 14 per cent, with another 13 per cent made up by donors to various development programmes and projects. Mali urged international donors and partners to respect their commitments in ODA, in conformity with the Paris Declaration.

Canada underlined that progress achieved by Mali in health, education, management of drinking water and food security remained fragile. Donors should respect their commitments, in particular those related to the increase of ODA and the implementation of the Paris Declaration. The targets related to access to drinking water and the fight against HIV/AIDS were within reach and achievable. With additional concerted effort, those related to universal primary education and the fight against extreme poverty could also be met. Significant challenges remained in lowering infant and maternal mortality rates. Mali had put in place several initiatives worth underlining: on education, health and social development, and justice, and exerted significant efforts at reforming the public sector and improving and modernizing the management of public finances.

France intended to remain a strong partner of Mali in international development. There was a major gap in achieving the MDGs, which required the support of the international community. France wanted to support Mali in setting up social safety nets,

as well as health care insurance. There were regional disparities, as well as inequalities between men and women that should be dealt with. There was also progress in the fight against HIV/AIDS, which was impressive and needs support.

Luxembourg welcomed efforts taken by Mali and cooperating with it to implement a strategic framework for development, with basic health care chosen as the main area for cooperation. That bilateral cooperation aimed at improving health care conditions in the country, which should be geographically and financially accessible. Luxembourg supported projects carried out by UN agencies in conjunction with the Mali Government, for instance the UNFPA project against female circumcision.

Belgium had been building solid cooperation bonds with Mali, allowing a new indicator cooperation programme to be concluded between the two countries. Belgium also provided financing in support of social and economic development, including food security and decentralization. Mali was evolving towards becoming a country that respected human rights, and was concerned with the economic and social development of its population. Despite economic and financial difficulties, it was engaged in a process to eliminate poverty. The participation of Malian women in local development was also encouraged. The international community should honour its commitments to Mali, despite the current international financial environment. The Malian Government was conducting a successful fight against terrorism and drug trafficking in the North of the country, two scourges which constituted a hindrance to its development, and Mali deserved the active assistance of the international community.

Saint Lucia underlined that a good primary education provided a good basis for development. Saint Lucia was encouraged to hear the commitments from all the Friends of Mali that had made commitments towards supporting Mali to achieve the MDGs. St. Lucia underscored the importance of primary education and encouraged Mali to stay the course.

Algeria underscored the importance of having the voice of the brotherly African country in ECOSOC. Mali was a model country. Mali was able to demonstrate that a country did not need to be wealthy to be democratic, and that it did not need to be rich to promote human rights or remain a symbol of national unity. Mali was successful at ensuring national unity and security while it aimed at achieving the MDGs. Mali’s achievements were astounding, given the circumstances, given that external assistance was limited. Algeria called on the international community within the framework of trade policies to support the cultivation of Mali’s lands.

Mali, in responding to the questions and comments, thanked those countries that had supported Mali's proposals. The President had submitted the previous week to a similar exercise to the one in ECOSOC within the Africa Union, where there was a mechanism for evaluation of the situation of the State. That had been a very positive exercise for Mali, and the support of countries was also a great pleasure, encouraging it to continue to move forward. There were disparities between regions, but decentralization could help to genuinely reduce those through the transfer of skills and resources.

Sri Lanka

Sri Lanka underlined that the realization of MDGs required global partnerships. This year's discussions at ECOSOC would make a constructive contribution towards realizing the health-related MDGs.

Sri Lanka was early among developing countries to invest in human resources, gender equality and social development. A large share of public expenditure had been allocated over the years, even during almost three decades of confronting terrorism, to free education and health services, to the development of human and physical resources in the health-care sector, and to food subsidies and subsidized credit. Supported by high levels of literacy in society, there had also been growing awareness among the people about the benefits of good health. A large segment of the health-care system integrated indigenous systems of medicine, focusing on both preventive and curative care.

The impact of policies on health-care indicators had been impressive. Infant mortality had declined, placing Sri Lanka on track to achieve that MDG target in 2015. The health authorities were also confident of being able to achieve the maternal mortality target and complete malaria eradication by 2015.

A major challenge is to reach all social groups, and in that, many institutions other than those related to health care had to play a role in creating a supportive environment. The health-care system currently operated under many stresses as a result of the overall country situation in terms of macroeconomic, developmental, historical, social, political and legal conditions.

The principle lesson was that human development could be brought to high levels even at low levels of per capita income through systematic and well thought out interventions. This required, however, strong economic growth and an enabling global environment.

Bangladesh complimented Sri Lanka on its high and sustained literacy rate, which had a positive impact on its health care system. The hallmark of the Sri Lankan success in many issues was its resilience. The Sri Lankan health service infrastructure had shown an impressive capacity to withstand and surmount challenges, including the tsunami in 2004. Bangladesh wanted to know how Sri Lanka had incorporated its health strategy in its strategy for disaster reduction. Also, did Sri Lanka intend to establish any mechanism, such as health insurance systems, for pulling in private resources into health financing? Noting that Sri Lanka had achieved a 97.6 per cent skilled attendance at delivery, which had reduced maternal mortality, Bangladesh wanted to know how Sri Lanka had gone about ensuring that success rate.

Cuba said there was now a clear picture of the commitment and efforts made by Sri Lanka to achieve the MDGs and ensure a better level of social justice and equity in the country, despite challenges faced. It was essential to have political will, which Sri Lanka had, but also financial resources, through international cooperation and assistance.

Cuba asked Sri Lanka to elaborate on the assistance it had received, and if they could provide additional information on the challenges taken or faced in the climate of the post-conflict situation in the country.

India commended the fact that Sri Lanka had been one of the high-end performers in the efforts to achieve the IADGs, including the MDGs, as its achievements were unique, not only in the region, but also in comparison to many of the developed countries, despite its three-decade-long fight against terrorism as well as natural disasters. India asked what the trend of expenditure on public health care had been in Sri Lanka over the years? The Government should also explain how it met the challenge of providing health care for the displaced in the aftermath of the conflict. The scale of assistance being received for the health sector from the international community should also be elaborated.

China said that Sri Lanka had set a great example for other developing countries in formulating strategies for the health sector in line with its national priorities, which were to promote the health of women and children. Sri Lanka and China faced a number of similar problems, for example the ageing population. China hoped that Sri Lanka's health strategies would have further success and supported Sri Lanka in its efforts.

Venezuela recognized the efforts made by Sri Lanka to uphold economic and social rights, and in particular the right to development, which was an inalienable and universal right. Particularly noteworthy was the national health plan for 2007-2016. Venezuela asked Sri Lanka to explain how cooperation with the international community was carried out on the ground, in terms of humanitarian assistance and aid to overcome the devastating effects of the 30-year-long conflict.

Pakistan said Sri Lanka was one of the few developing countries that had made sustained investments in human and social programmes, which were now bearing fruit with almost universal primary education and increasing life expectancy. That all persons had access to a health-service outlet within a three-kilometer radius was important. What measures were being taken to bring the indigenous traditional Ayurvedic system into mainstream health-care, and to increase its standards? Also, how did the Government plan to balance competing health system demands in a context of an aging population?

Algeria said that the lessons learnt from Sri Lanka's experience had to be shared with other countries since enormous efforts towards the achievement of the MDGs had been attained during a long conflict. Sri Lanka had noted that the international assistance it enjoyed was limited, and Algeria wished for further clarification. Algeria also urged the international community to support the Sri Lankan authorities in their efforts and local communities, which had demonstrated their capacity to deal with the tsunami.

Maldives congratulated Sri Lanka for its success achieved so far in dealing with the devastating impacts of the tsunami, despite its long-term wartime history. It was now clear that there was a political will to promote rights in the country. Maldives asked Sri Lanka, how was the indigenous medicine system integrated into the mainstream health

care system, and how did the Government undertake to provide health care to all citizens in the country?

Morocco congratulated Sri Lanka for the efforts and achievements that placed them on the right path to achieve the MDGs, despite the difficulties. The achievements in terms of bringing down the rate of maternal mortality were particularly welcomed. Was there a form of participatory governance, and what was women's place in decision-making at the national and regional level?

The Philippines commended Sri Lanka on its impressive track record in delivering health services to all its citizens. Sri Lanka was asked to provide more information about the problem in the north and east of the country, where more resources, human and financial, were needed to get a broader picture about the support needed.

The moderator posed one final question. He noted that it was explained that "certain aspects of local culture has helped the authority to achieve high rate of success" in the presentation. He asked for the elaboration.

Sri Lanka, in response to questions and comments, said that NCDs were a major challenge for the future and caused the Government to develop a national policy, which focused more on prevention and health promotion. Funds had been allocated to support the policy, with support from WHO and the World Bank, among others.

There was a very good health structure in Sri Lanka, based on the six building block guidelines recommended by WHO, which had contributed to gains in maternal health. The report indicated that the maternal mortality rate was 3.7 per 1,000 live births. On issues related to the conflict, the Government had made plans to resettle the internally displaced persons in the country. However, assistance from development partners and international partners was still needed. Support was being received from the World Bank, WHO, UNICEF and others in the resettlement of internally displaced persons. With respect to indigenous medicines, there was a separate ministry for indigenous medicines, which helped to continue to develop traditional medicine systems in the country.

Sri Lanka said for financing of health-care services, there was a dual system of funding which prevailed in the country. Public sector expenditure accounted for 48 per cent, the private sector providing the rest. Within the 48 per cent, 5 per cent was external finance. Free education and health services started in 1930s after the introduction of some form of electoral system in the country. The culture that was referred to in the presentation alluded to the culture of good health practices, which had been promoted in Sri Lanka before western medicines were introduced into the country by the traditional system of medicine. Good health system was promoted by traditional leaders.

Sudan

Sudan was facing many great challenges which it had to meet at the same time. Sudan had sought to end the conflict in the country, as peace, security and stability were the foundation to achieve the health and development goals. The President had put an end to the war in the east of the country and in Darfur and tried to contain the effects of the conflict in the realm of health. As a result, there had been no health catastrophe in Darfur. Sudan's partners included the United Nations and the specialized agencies, which had made tremendous efforts to help the country to manage the post-conflict situation. Sudan had been promised $4.8 billion in aid, but had not received more than $30 million, disbursed by the various financial institutions, as part of the Highly Indebted Poor Countries initiative.

Challenges are the size of the country, bordering on nine other countries, with generally free movement across, which has implications on health and development. There is also massive population movement and displacement, mainly due to civil conflict and natural disasters. And a high illiteracy rate, mainly among women, and low population awareness on health issues. The low number of health-care providers is a concern, as there are only 1.5 care providers for every 1,000 people. There is also a high turnover, especially of doctors which affected the distribution of health services that are markedly unequal.

Other challenges are low school attendance with only 53.7 per cent of school age children attending primary school, with disparities among States. The ratio of girls to boys is 93 per cent. Only 4 per cent of the population has a comprehensive knowledge, as how to prevent HIV/AIDS. Only 55.1 per cent of the total population uses improved water sources or have access to them, and only 31.4 per cent have access to sanitary means of excreta waste disposal. The infant mortality rate is 80.7 out of 1,000 live births for the whole country. The maternal mortality ratio itself is one the highest in the world, 1,106.7 per 100,000 women of reproductive age on average.

China noted the gradual progress in Sudan. In terms of human resources development, Sudan still had certain challenges to face. Sudan should make full use of the economic growth to build basic health-care services. That would be vital to control chronic diseases and new infectious diseases. China asked for more data in terms of fiscal percentages, in terms of the GDP and the distribution of medical professional among the population. China urged the international community to strengthen its support to Sudan.

Algeria underscored that Sudan’s report presented important measures taken with regard to development, despite the challenges faced. A recent survey indicated that poverty affected 50 to 60 per cent of the population, in the North and more predominantly in the South. The child mortality rates were alarming. Noteworthy of the Government of Sudan’s efforts towards the MDGs was the proposed five-year plan for the period 2007-2011, which aimed to bring about unification and peace in Sudan, based on the fair distribution of wealth, peace and the rule of law. The promotion of equality between the sexes, women’s rights, lowering the child mortality rate, improvement in maternal mortality, the use of contraception, improvement in measures to combat HIV/AIDS, the

preservation of the environment and establishment of a global partnership for development were some of the challenges that remained.

Cuba noted a gender balance in Sudan's delegation. Progress over recent years bore witness to the political will of Sudan to make progress after the conflict situation. How could Sudan benefit from international cooperation on a larger scale, in particular with regard to gaining greater sources of financing?

Japan said that it had presented the concept of human security during its own voluntary national presentation. There was a United Nations Trust Fund for Human Security which supported a number of projects on the ground. There were also projects in Sudan, such as the safe motherhood programme. Japan wanted to know whether Sudan thought that project was suitable and should be extended.

The Philippines said Sudan's health strategy was directly in line with the objectives set out in the MDGs. Particularly noteworthy was Sudan's basic nutrition plan, the nutrition emergency package, and the food fortification strategy. While the Philippines noted measures taken to enhance the skills of medical staff and health care professionals, there was a need for many more. The Philippines urged Sudan to continue to cooperate with its partners for the full realization of the MDGs.

Brazil understood the difficulties in having a large territory, with populations living in hard-to-reach areas, and encouraged Sudan to expand access to maternal and child health services. More information should be given on what could be done to improve the situation with regard to international aid, as Sudan had noted that more cooperation on the health system was required.

Barbados congratulated Sudan on the achievements it had made in the attainment of the MDGs. ECOSOC should call for a more genuine partnership between the international community and Sudan to see if the international community could not give more needed support.

Saint Lucia congratulated the delegation of Sudan and associated itself with the statement made by Barbados. The presentation focused greatly on security, which had to be dealt with, but there should also be preventative efforts made in the area of nutrition and education, which would assist in the efforts made on security. Saint Lucia asked if Sudan could share some of the best practices it had experienced in developing its health-care system.

Kazakhstan also noted gender equality in the Sudanese delegation. Kazakhstan acknowledged that it was difficult to achieve all social needs in a country like Sudan, as it was always before the Security Council due to instability and the security situation. Kazakhstan supported the appeal made in the presentation to Member States to fulfill their commitments of financial support to development. Kazakhstan asked what kind of coordination efforts might be needed from the international community and from the United Nations bodies.

Sudan, in responding to questions and comments raised, said that most of the international support in health was directed at specific programmes, such as vaccines or tuberculosis. Sudan needed such targeted and coordinated support rather than vertical support from different donors. Regarding the distribution of health personnel in Sudan, Sudan had recently thought of task shifting. The distribution of doctors and other staff that was already working in health services was very unequal and Sudan was now thinking of including community workers into health services.

Sudan's presentation was based on the household survey of 2006, only one year after the long war. One year was not enough to make a big difference on the ground. There was also a very sharp variation in the sectors. Sudan was trying to come up with a balance in those areas. It was also now preparing for the household survey 2010 and had tried to come up with real indicators. Regarding human security, there was no consensus. In broader terms, Japan was one of the countries that had contributed largely to human development, which was more inclusive and would help Sudan to achieve more.