managed. The government was also revisiting incentive mechanisms of obstetric and pediatric services, as many physicians quit or avoid obstetric and pediatric services because of high physical burden. In addition, roles of private midwives were recognized again, considering them as comprehensive care providers, both physically and mentally, throughout pregnancy and childbirths.

There are very few serious public discussions about family planning, while fertility continues to decline. However, alternative choices of contraceptives and adequate counseling services in accordance with lifestyle of each woman are still very limited in Japan. Condoms are the most popular contraceptive method, while other methods were not widely used. Low-dose oral contraceptive pills and copper-coated IUD were not approved until 1999. The emergency contraception pill has not been approved yet, despite its effectiveness for preventing unwanted pregnancies.

There are no systematic adolescent sexual health education and services. However, there are increasing needs for reaching out young people. Abortions and sexually transmitted infections are increasing among under-twenty age group, while the overall number of abortion is decreasing.

3.5 Lessons from the Japanese experience

Maternal mortality declined dramatically in Japan during the last century. Fertility declined sharply as well. Key factors of the success of maternal health care and family planning were: (1) mobilization of capable female health professionals such as midwives and public health nurses; (2) involvement of local communities; (3) approaches pursuing individual concrete benefits; (4) complementary roles among various actors including the government, NGOs, health professionals, and communities; (5) commitment and ownership of the government; (6) relatively high education levels of women; and (7) improved life standards along with economic development.

(1) Female health professionals: Traditional midwives were licensed and integrated to the modern health system. Midwives assisted deliveries at home and cared throughout pregnancy and childbirth. Public health nurses were introduced following European and American examples. Then, they played unique roles in rural villages for visiting homes to provide with various services, and for facilitating community activities. The outreach activities of public health nurses were enabled because of their respectable social status, secured career and income, regular supervisions and supports, as well as high motivation of themselves. Midwives and public health nurses were trusted and knew personal lives of community people. Therefore, they could successfully provide with family planning services despite the cultural sensitivities.

(2) Community involvement: Before the rapid economic growth and urbanization, rural communities had mutual support mechanisms. Involving local community networks contributed to improve maternal health through disseminating knowledge and information of health, encouraging health check-ups, improving nutrition, and reducing labor burden of women. Community organizations were often initiated by the government, and facilitated by public health nurses and midwives. In turn, community organizations linked community people to the government. Women who had received guidance from public health nurses participated in community activities. Community organizations for maternal and child health were also mobilized for expanding family planning. Extensive education activities were conducted to deliver knowledge and information of family planning to the community.

(3) Benefit seeking approach: Promoting maternal health was linked to direct benefits such as free antenatal check-ups and supplementary food by the MCH handbook system. Every activity stressed the health and happiness of the individual women and children. Family planning was promoted as a part of maternal and child health, considering individual needs of women. Family planning, which was an issue of deep concern of local women, could contribute to reduce abortions and to mitigate health hazards caused by abortions.

(4) Complementary roles: The government developed policies, regulatory frameworks and infrastructures, while health professionals in both the public and private sectors and NGOs were active in implementation. The government sometimes took initiatives to formulate NGOs and community organizations for implementing various interventions. Professional institutions and academia provided specialized technical advice based on their researches and surveys. NGOs played major roles in promoting family planning, after the government shifted their priorities. NGOs purchased contraceptives in bulk at cheap prices and sold them to family planning workers at wholesale prices.

(5) Government commitment: Since early period of modernization, the government committed strongly to improve health of mothers and children, although this was motivated to achieve industrial and military development. An imperial initiative promoted community based maternal and child health activities. Reducing maternal and child mortalities and providing with preventive services were priority policy objectives during the post-War period. Rapid population growth immediately after the War made the government commit to promote family planning.

(6) High education level of women: Since women's literacy had been relatively high, written health information was easily spread. MCH handbooks had spaces for mothers to record by themselves.

(7) Economic and social development: Along with the economic development, quality of life of people improved remarkably. Environmental sanitation improved, thus infectious diseases decreased. Increasing income and developing technology enabled people to have nutritious food and to reduce burden of physical labor. Access to health services were secured, as health facilities increased and health financing and regulatory mechanisms were installed. Combination of these socio-economic changes contributed to improve maternal health remarkably.

Japanese experience also had negative aspects. Fertility decline and cost containment of health services are threatening sustainability of obstetric referral services. Weakened community networks and increased demands for high quality services caused overburden of hospitals and shortage of obstetric and pediatric specialists. Effective obstetric referral networks need to be re-organized urgently.

Regarding family planning, contraceptive prevalence rate failed to grow much beyond the 50 to 60 percent level. High quality services offering proper counseling and method mix to meet individual needs are in shortage. Adolescent sexual and reproductive health issues are left behind, although, abortions and sexual transmitted infections among young people are increasing. It is yet culturally and politically sensitive to reach out young people.

4 Health financing systems in Japan

4.1 Health insurance systems in Japan

Health financing systems among the industrialized countries can be categorized into three models: (A) tax based national health systems, as in the United Kingdom; (B) social insurance models, as in Germany; and (C) private insurance schemes supplemented by public safety nets, as in the United States. Japan applied a social insurance model, which in principle shares risks, costs and benefits among the participants. Basically, service provision, financial management, and beneficiaries are distinguished one another. A beneficiary pays premium to the insurer, and receives services from health service providers. The insurer evaluates the services provided, and then refunds the fee to the providers. The insurer is usually an independent private organization, which would be the subject of the various forms of government regulation.

Japanese health insurance system achieved universal coverage through a combination of two distinct elements: (a) workplace-based health insurance associations for employees; and (b) national health insurance designed for self-employees including farmers. Employee health insurance schemes

comprised of many individual workplace health insurance associations, and the government managed health insurance for small businesses. The national health insurance is funded by taxes and premiums, of which local municipalities act as insurers. The system is a unique combination of one very large insurer, the government, and a very large number of small insurers. The level of benefits varies according to the insurance plan. The amount of the premium is a fixed percentage of the income, although the premium rate differs among insurers. Employee health insurance associations also contribute to finance the health services for the elderly.

The Japanese system allows clients to access any service providers both in the public and private sectors. The government regulates the services covered by the insurance, their fees, premium rates and user co-payment, following discussions with representatives of health service providers, insurers, and beneficiaries. All insurance plans are regulated by the government to ensure that everyone has access to the same quality of service at the same price. The Japanese system can be regarded as a combination of a social insurance model and a tax-based national health system. The system has an aspect of social welfare, or income redistribution, rather than a social insurance.

The long term care insurance system covers nursing care services at home or in nursing facilities, and other recognized forms of care and support. Long-term care insurance is administered by the municipalities. All Japanese aged 40 and over have to pay the premium. Half of the benefits are funded by the premiums, while the government contributes the rest. Anyone aged 65 years or older can receive the services once they are recognized as being in need of nursing care or other support. Those between 40 and 65 years old can receive services only in case their conditions are associated with aging, such as Parkinson disease.

The health insurance system is complemented by welfare support for the poor and for the disabled and publicly funded medical services. Medical expenses incurred by households on welfare support are paid out of health support without any co-payment. Public funding for medical services comes in many different forms, defined by laws for veterans, tuberculosis control, mental health, narcotics control, and infectious disease control. Public funding is also provided for treatment of 45 listed specific illnesses and 10 listed chronic illnesses of children. Local administrations also provide funding for a range of medical expense plans.

4.2 Toward universal coverage of health insurance

Health insurance schemes started in Japan in early 1900s, when some governmental agencies and large private companies introduced mutual benefit associations. In addition, organizations resembling health insurance

cooperatives had existed as mutual-aid organizations in rural villages since late 1800s. Health Insurance Law was enacted in 1922 for building a national system, however, this scheme covered only employees of industries, but not covered farmers who were then majority of the population, and adequate medical treatment was not necessarily guaranteed.

The government introduced the National Health Insurance Law in 1938 to extend this system to cover those not formally employed, particularly farmers. In 1939, the Employees Health Insurance Law and Seamen's Health Insurance Law were enacted, further expanding the coverage of health insurance. In the end of 1943 during the wartime, the national health insurance system had already spread to 95 percent of municipalities throughout Japan.

The national health insurance system was near to collapse in the post-War economic and social deterioration. About one third of Japanese, mostly farmers and self-employees, were not covered by any health insurances. To rebuild the health insurance finances, the average monthly wage was revised, the premiums were increased, and the number of eligible people were expanded.

Following the recommendations by the social security system committee in 1956 a new National Health Insurance Law was enacted in 1958. With considerable public support, a nationwide compulsory participation mechanism was installed, and the universal health insurance coverage was achieved in 1961.

Since those covered by the national health insurance had to pay higher amount of co-payment than those covered by the employee health insurance, adjustments of the system had been continued up to 1980. Co-payment for the national health insurance was reduced and the deficit was covered by the government budget. This improved consultation rates, particularly among the elderly. The government also introduced the elderly medical fees payment system in 1973, allowing public funds to pay for medical costs of the elderly. User co-payment was introduced to employee health insurances in 1984.

4.3 Adjustment to the demographic and economic changes

Due to the rapid increase of the aged population, medical costs for the elderly increased dramatically. Health insurance and social security systems needed to be adjusted to meet the new demands caused by the demographic and economic changes. First, prevention, treatment and rehabilitation of illnesses were standardized. Then, Law for the Health and Medical Services for the Elderly was enacted in 1982, which made the elderly pay a part of co-payments.

Along with the population aging continued, prevalence of chronic illnesses increased and their treatment costs rose. However, health insurance income would not grow due to reduced income growth caused by slowing economic

growth and increasing irregular employment of young people.

In response to this structural deficit of health insurance systems, benefits, co-payments and premium rates were revised in 1997. Contribution to the health services for the elderly was reviewed in 1998, and health insurance for the elderly introduced 10 percent co-payment in 2001. In 2000, the Long-term Care Insurance Law was implemented to accommodate the needs of the rapidly aging society, and a part of the health care costs for the elderly were allocated as welfare services. In 2003, employee health insurance raised co-payment to 30 percent, comparable to the co-payment for national health insurance.

While the government tried to contain health care costs, repeated minor adjustments did not lead to an overall reform of the system built in the past century. Since theses adjustments were implemented within the context of economic structural reform, the government had not yet produced a coherent strategy to achieve maximum level of health and welfare services in the matured society. A drastic reform of the system is urgently required for securing financial sustainability and for maintaining quality of services.

4.4 Lessons learned from Japanese health financing systems

Japanese health insurance system achieved universal coverage, which enabled anyone to have access to the same quality of health services in anywhere at any time with affordable amount of co-payment. Although most insurance schemes in other countries could hardly include informal sector workers, the Japanese system successfully covered them through introducing national health insurance.

At first, an insurance system for government workers and employees of major corporations was created, as observed in many other countries. Meanwhile, local insurance schemes that could meet local needs and capacity were set up, based on a form of farming insurance managed by village-based cooperatives. Then, municipalities took over the roles of independent local insurers. Finally, the national health insurance system was introduced to cover everyone.

A key factor that enabled to achieve universal coverage was a strong political commitment. Not only the government but also politicians and the general public shared political consensus regarding the importance of equal access to health services. In addition, local municipalities and the government had stable administrative capabilities to manage public health insurance schemes.

Another key factor was that the whole system was established gradually with a step by step manner. It began with small-scale local insurance plans, gradually broadened the scope of eligibility, and reached universal coverage under the government control. It took over 20 years to build the current form of

health insurance system. Meanwhile, the overall economic growth enabled to generate sufficient taxes to extend the system and increased incomes made people enable to pay premiums. Although there were absolute shortage of health service providers immediately after the War, a network of health service providers, both in the public and private sectors, had been developed along with the economic development, and ensured availability of health services. In addition, the step by step approach allowed local municipalities to build their administrative capacities.

It was also important that the government regulate the whole system to ensure equal access and quality of services, which are not always guaranteed in developing countries. In case of cost escalation, the government put minor adjustment to contain costs, following discussions with representatives of health service providers, mainly physicians' syndicates, insurers and beneficiaries. This was a unique mechanism for regulating and balancing the whole system.

In principle, the Japanese system emphasized equality rather than efficiency. Thus, the system has more tax-based welfare feature than the original principle of insurance.

While the egalitarian approach achieved overall improvement of health status of the people, this system has little space for freedom to receive the highest quality of care beyond the benefit package for those who can afford. Low co-payment also brought moral hazards among the beneficiaries, such as overuse of hospital care and deterioration of referral mechanisms. The fixed fee for service may discourage the health service providers to improve quality of services.

5 Lessons for developing countries from Japanese experience

5. 1 Key factors of the success

Reviewing the histories of health policies and interventions as described above, several key factors that contributed to achieve remarkable improvement in health of all Japanese are identified. They are: (1) strong commitment and ownership of the government; (2) broad consensus on egalitarian approach; (3) devotion of motivated health professionals; (4) long term engagement to achieve objectives; and (5) involvement of communities and local municipalities. In addition, factors beyond the health sector contributed substantially to improve health of people. Those factors include: relatively high education attainment among people; improved life standards along with increased incomes; and development of life infrastructures, such as water and sanitation, roads, electricity, and telephone during overall economic development.

(1) Government commitment: Since late 19th century, the government was keen to bring new knowledge and technology, and determined to catch up the advanced countries. Spending a large portion of their own budget, the government invited foreign scholars, and sent officials and students to abroad. The foreigners were regarded as technical instructors to transfer knowledge and skills to Japanese counterparts, but not as simple service providers. The dispatched officials and students returned to Japan after several years and contributed to develop their specialties. Furthermore, there were strong leaderships, such as Nagayo in late 19th century, and Sams after the War. The government also committed to various public health programs including maternal and child health, infectious disease control, and universal coverage of health insurance.

(2) Egalitarian approach: Originating Buddhism charities and farmers cooperatives, and being enhanced by the concept of democracy, general public, as well as politicians and bureaucrats, shared broad consensus that equal access to health services should be guaranteed everyone. Thus, people accepted the concept of sharing risks, costs, and benefits, and supported the efforts to achieve universal coverage of health insurance. In line with this egalitarian principle, basic health services such as maternal and child health and immunization extended throughout the country including remote rural areas.

(3) Health professionals: Even in the feudal era, some devoted physicians were eager to learn new knowledge and skills from abroad. During the period of modernization, government technical officials, scholars, physicians and other health professionals worked very hard to import advanced medical sciences and to establish new health systems. Qualification mechanisms of physicians were in place and traditional midwives were also licensed and integrated into the new health system. Midwives were mobilized for not only maternal care but also for family planning. Public health nurses, as well as midwives, devoted to improve health of women and children in rural communities. They kept motivated even they were deployed to remote rural areas, as they enjoyed respectable social status, had secured income and career, and were supervised properly.

(4) Long term engagement: It took over 20 years to achieve universal coverage of health insurance, as the government gradually introduced various mechanisms. Even after the system was installed, modifications and amendments were continued to adjust demographic and social changes and to contain costs.

(5) Community involvement: When resources were scarce and health problems were abundant in rural areas, it was important to mobilize local communities. The government sometimes took lead to initiate and organize

community activities, such as maternal and child health activities. Community involvement was also useful to identify local needs and to implement proper interventions. Local municipalities were mostly responsible for implementing public health policies, including management of the national health insurance. Municipalities are closer to the people than the central government, therefore, they can intervene effectively according to local needs.

5.2 Experience of negative aspects

Although Japanese has achieved one of the best health status in the world, there were also experience of negative aspects which should be shared with developing countries.

When the health financing system was designed, population was young and economic growth was powerful. Since the situation changed much faster than expected, no suitable solutions have not yet found to sustain the health system, despite rapidly aging population and stagnated economic growth. Several developing countries such as Thailand and China are now facing the population aging problem, so they may learn lessons from Japanese experience.

Equality was so emphasized that efficiency was often left behind. This contributed a lot to improve overall health status. However, quite a few public funded services and hospitals could not be sustained when economic situation changed. While public regulations were important to ensure equality and quality, management skills of the private sector should have been introduced to improve efficiency.

During the period of rapid economic growth, industrial environment pollutions caused serious health problems among the local residents. It took very long time and required heavy financial burden for both the government and the industry to compensate victims and to clean the environment. This experience encouraged to develop environment regulation frameworks and environment protection technologies. Developing countries under rapid economic growth should not repeat the same mistakes and should install environment protection mechanisms urgently.

5.3 Japanese experience applicable to developing countries

Japanese experience in maternal and child health may be applicable to low income countries and poor areas in middle income countries. High maternal mortality and high prevalence of infectious diseases are still major issues in those countries. Their financial resources are scarce and management capacities are weak. Health service delivery systems are not yet established and qualified health professionals are in shortage. The situation is similar to

that of Japan before and immediately after the World War II.

In those days, community based approach in maternal and child health was effective. Existing female health professionals such as midwives and public health nurses were mobilized for the outreach services. The government sometimes took initiatives to organize communities, and the local health professionals facilitated community activities. Benefits of individual women and children were emphasized, as seen in the MCH handbook that provide with visible benefits such as food. These are the experience applicable to maternal and child health activities in developing countries.

Japanese experience indicates the importance of the commitment of the government. Although the government commitment in developing countries is often weak, countries such as Thailand and Vietnam committed firmly to improve basic health services. The government of these countries had relatively strong administrative capacities, and had achieved favorable results.

Technical assistance funded by the own government budget, or loan, may strengthen ownership and motivation of the country, as seen in Japan in Meiji era. It sometimes happens that technical assistance funded by donor grant would not achieve sustainable results as expected. It is not unusual that donor-funded technical experts provide with professional services directly, while there are no counterparts learning from them. In addition, professionals of developing countries often do not return the country after studying abroad.

The commitment and ownership of the country may be enhanced by sharing the burden. Technical assistance by own expense would be possible for the middle income countries with sufficient administrative capacities. For example, in 2007, Egyptian government contracted a British university for improving nursing education and paid for the technical assistance by their budget. The government initiated the process and kept motivation and commitment.

Although universal coverage of health insurance may not be always applicable to other countries, lower-middle income countries may learn from Japanese experience to develop health financing systems. Japanese system is a combination of social insurance and tax-base welfare, each aspect may be applicable to developing countries according to their social and economic situation. It is a difficult issue to include informal sector workers in the health financing system in developing countries, thus a publicly managed health insurance may be a useful option. Developing countries can also learn lessons from the procedures of licensing and regulation, as well as the efforts to contain costs.

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国　際　開　発　学　会
第　9　回　春　季　大　会
報　告　論　文　集

Proceedings of the 9th Spring Conference
The Japan Society for International Development

開催日　：　2008年6月7日（土）

June 7, 2008 (Sat.)

会場　　：　東京工業大学　大岡山キャンパス　西9号館

Tokyo Institute of Technology,
W9 building on O-okayama campus

実行委員会事務局

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Tokyo Institute of Technology

保健医療分野の国際イニシアティブとパートナーシップ

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キーワード：保健医療、国際イニシアティブ、パートナーシップ、垂直アプローチ、保健医療システム強化

1. はじめに

保健医療分野の開発協力では、予防接種拡大計画等、各種国際イニシアティブに沿った取組みがされており、ミレニアム開発目標にも、いくつかの保健医療分野目標が定められた。しかし、トピックが大きくて各国際機関の活動が重複したり、当初の意図が一般化してしまったりして、それらイニシアティブが効率的に実施されていないこともある。日本は、国際イニシアティブに対し、資金・技術両面では多大な貢献をしてきたが、国際社会で主要な立場を維持し、指導力を発揮し続けることは、一部の例外を除き多くなかった。

本研究の目的は、保健医療分野の各種国際イニシアティブの背景要因と形成の経緯、及び、国際機関・開発援助機関のパートナーシップについて、調査・分析することである。まず、保健医療分野の各種国際イニシアティブに関して、国際機関、政府・民間の開発援助機関の刊行物・ウエブサイトから、資料を収集して検討した。加えて、世界銀行、世界保健機関 (World Health Organization: WHO) 等の国際機関、世界エイズ結核マラリア対策基金 (The Global Fund to Fight AIDS, Tuberculosis and Malaria: GFATM)、Bill and Mellinda Gates 財団等の民間機関の関係者からも、情報を収集した。

2. 保健医療分野の国際イニシアティブ

本研究における国際イニシアティブとは、重要課題を解決するために、一定の目標を掲げ、同一あるいは共通性のある方法論により、多数の開発途上国あるいは世界各国を対象として国際的に実施する活動を指すこととする。多くの場合、国際機関や政治家等がリーダーシップを発揮し、わかりやすいキャッチフレーズを掲げて、世界的キャンペーンを展開する。目標達成の時期や活動期間を限定したり、一定の資金提供と連携したりすることも多い。

保健医療分野には、感染症対策、母子保健、プライマリヘルスケア等、多種多様な国際イニシアティブが存在する (表1)。その多くは、WHO等の国際機関や、米国等の主要ドナー国がリーダーシップをとって形成されており、日本が主導したイニシアティブもある。

3. 国際機関・開発援助機関のパートナーシップ

特定の機関・政府がリーダーシップをとって形成された国際イニシアティブであっても、実施に際しては、国際機関、政府機関、民間機関、研究機関等、多数の機関が参加した、複雑なパートナーシップの形をとることが多い。1990 年代後半頃からは、従来からの国際機関、政府、開発援助 NGO のみならず、財団や企業等の民間機関が加わってより幅広くなってきている。WHO のように主に技術的役割を果たす機関や、GFATM や Bill and Melinda Gates 財団のように主に資金を提供する役割を果たす機関等があるが、

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実際には、資金提供機関の発言力が大きいようである。

このようにパートナーシップが複雑化したのは、まず、保健医療分野で活動する機関が増加し、しかも多岐に渡っていることによる。WHO に加え、国連児童基金 (UNICEF)、国連人口基金 (UNFPA)等の国連機関も保健医療活動をしている。資金提供機関としては、世界銀行等の開発銀行、Bill and Melinda Gates 財団等の民間財団の存在が大きい。技術力のある実施機関として、国際 NGO や大学等の研究機関もあげられる。NGO や民間財団は、国連機関や国家と同列のパートナーとして認知されている。

多数の機関が同一分野に参入しているため、調整・協調の必要が生じる。また、各機関が本来の設立目的から役割を拡大しており、役割分担が不明確になり、機能が重複していることも否めない。加えて、技術能力はあるが資金のない機関、資金はあるが実施方法論の乏しい機関もあり、協力と相互補完が必要とされる。WHO のような国連機関は、もともと国家間の調整機関であるが、公・民合わせた多数機関の調整役となっている。このパートナーシップは、特定の目的に限られた緩やかな連携だが、国連エイズ合同計画 (UNAIDS)、GFATM のように、新しい機関が設立された場合もある。

4. 国際イニシアティブの動向と課題

国際イニシアティブは、特定の疾患あるいは課題に対する垂直アプローチをとることが多い。とくに政治主導の感染症関係のイニシアティブに、その傾向が見られる。単一の疾患·課題を取り上げることは、保健医療を専門としない政治家、民間企業、一般市民にとって理解しやすく支持を得やすい。実施方法論も比較的単純であり、投入の効果も評価し易い。

国際イニシアティブの推移を概観すると、1980 年代頃までは小児保健、1990 年代は HIV/AIDS、2000 年代半ばからは保健医療システム強化に重点が移っている。単一疾患·課題に資金を投入しても、保健医療システム整備が進まなければ効果が現れないことが、理解されてきたからである。近年では、単一疾患・課題を対象としたイニシアティブであっても、保健医療システム強化を平行して進めることを明言するようになっている。しかし、保健医療システムの定義が曖昧で、拡大解釈される傾向もある。加えて、保健医療システム強化が、英国はじめヨーロッパ諸国主導のイニシアティブであるという側面もある。

国際イニシアティブには、政治的な意味合いも強く、国連機関のトップや、米国等先進国の政権が交代した際に、新たなイニシアティブが開始されることは多い。G8 経済サミットや国連の会議等の場で、保健医療分野に関するコミットメントが表明されることも少なくない。政治的コミットメントがあるため、資金は確保され、実施能力も強化され、有効な活動となるという利点もある。

他方、多くの重要課題の中から、目立ちやすく効果の現れやすいものを選びがちなことから、優先度については課題を残す。また、世界的に展開する場合、必ずしも、現地の優先課題と一致しないこともある。さらに、政治的リーダーシップや資金提供期間が終了した後の持続可能性にも、疑問が残る。加えて、政治主導の場合、技術的専門家の意見が十分に反映されない可能性もある。

5. おわりに

日本の経験・理念に基づいて効果的に国際貢献を進めるには、日本発の国際イニシアティブを増加させるとともに、国際機関等の仕組みを検討して、国際社会の意思決定メカニズムを理解することが重要である。

謝辞

本研究は、「平成19-20年度厚生労働科学研究費補助金 (社会保障国際協力推進研究事業)『国際保健分野での知識マネジメントに関する研究』(主任研究者: 青山温子)」により実施した。

表1: 主な保健医療分野の国際イニシアティブ

時期	イニシアティブ	活動内容	背景·経緯	主な関係機関
特定の感染症撲滅				
1958 ～ 1980	Smallpox Eradication Initiative (天然痘根絶)	ワクチン接種、サーベイランスと封じ込めを世界的に実施。天然痘を根絶。	1958 年時 33 ヵ国で流行。1977 年ソマリアでの発生が最後。1980 年世界根絶宣言。	WHO
1988～	Polio Eradiation Initiative (ポリオ根絶)	2000 年までのポリオ根絶を目標とする計画。経口ワクチン定期接種・全国一斉投与、急性弛緩性麻痺サーベイランス。	1988年、125ヵ国で発症。1994年南北米、2000年西太平洋、2002年欧州で、根絶。南アジア・アフリカ11ヵ国に残る。	WHO、CDC、Rotary International、UNICEF、Gates 財団、世界銀行、UN 基金、先進国、企業。
2001～	Measles Initiative	アフリカ等での、予防接種と患児治療推進。	2004年までに死亡半減。2010年までに死亡を90% 減少。	米国赤十字、CDC、WHO、UNICEF、UN 基金
小児予防接種				
1974～	Expanded Programme on Immunization (EPI) (予防接種拡大計画)	BCG、DPT 、麻疹、ポリオ(後にB型肝炎等追加)のワクチンを小児に投与。女性の破傷風予防接種、小児のビタミンA投与も合わせて実施。	1974 年当時の予防接種率は5% 程度であったが、20年間で75%を超える水準に到達。	WHO、UNICEF
1990～	Children's Vaccine Initiative (CVI)	予防接種率の向上、新しいワクチン開発、ワクチンの品質管理、供給体制整備の推進。	サブサハラアフリカ諸国等では、1990年代に接種率低下し、50%以下となっていた。	WHO、UNICEF、UNDP、世界銀行、Rockefeller 財団
2000～	GAVI Alliance (Global Alliance for Vaccines and Immunization)	GAVI 基金を設置。定期予防接種の普及、B 型肝炎、Hib ワクチン等、新しいワクチンの導入を支援。	CVI を継続発展させるために、2000年に形成された公的機関と民間機関のパートナーシップ	UNICEF、WHO、世界銀行、Gates 財団、Rockefeller 財団、政府、国際製薬業界連盟、市民団体、研究機関等
マラリア・結核対策				
1998～	Roll Back Malaria (RBM)	患者の早期発見と治療、Insecticide Treated Net (ITN) の普及、妊娠中のマラリア予防等により、マラリア死亡を減少。	WHO 事務総長 Brundtland。1960 年代に根絶失敗。1990年代以降、アフリカ諸国、製薬·研究機関等が、活動再開。	WHO、UNICEF、UNDP、世界銀行、流行国、先進国、大学、研究機関、NGO、民間財団、製薬会社等。
2005 ～ 2010	U.S. President's Malaria Initiative (PMI)	ITN 供給、殺虫剤屋内散布、抗マラリア薬治療、妊婦のマラリア予防等の、予防・治療対策。	米国大統領 Bush。アフリカ重点国の死亡半減のため、5年間で12億ドル以上出資。	USAID、CDC
2000～	The Stop TB Partnership	1983 年以来の治療法 DOTS を拡大、薬剤確保、多剤耐性·HIV合併結核対策等。2005年までに診断率70%、治癒率85% 目標。	1998年、Stop TB Initiative 設立。2000年、流行20ヵ国アムステルダム宣言、Global Partnership to Stop TB 設立。	WHO 等の国連機関、各国政府、NGO、民間企業など、500 以上の機関
HIV/AIDS 対策				
2002～	3 by 5 Initiative	Treat 3 million by 2005。2005 年末までに患者300万人にARV供給する目標。ARV 供給体制整備、治療ガイドライン策定、人材養成、資金供給のアドボカシー。	WHO 事務総長 Lee。途上国では 5～600 万人に治療が必要だが、30万人しか治療していない。2005年6月末までに、約100万人に治療提供。	WHO、UNAIDS
2002～	Clinton Foundation HIV/AIDS Initiative (CHAI)	開発途上国での良質な ART へのアクセス向上の支援。薬剤のコスト低下や技術支援	前米国大統領 Clinton が、2001年財団設立、国内外での慈善事業と途上国のエイズ対策。	Clinton 財団
2003 ～ 2008	U.S. President's Emergency Plan for AIDS Relief (PEPFAR)	100億ドルを15重点国に供与。40 億ドルを他の国への供与と研究、10億ドルを GFATM 拠出。2010年までに、治療200万、予防700万、ケア1,000万人目標。	米国大統領 Bush が、2003年に発表、1国による最大規模のエイズ対策支援。5年間で150 億ドルのエイズ対策支援。	米国政府
小児保健				
1985 ～ 1994	Child Survival Initiative	予防接種、栄養、下痢症対策、小児急性呼吸器感染症の簡便な診断·治療等を実施。経口補水塩(ORS)普及、DPT 等接種率向上。	1960 年代から途上国の小児の健康改善活動。1985年、議会はChild Survival Initiative 採択、50億ドル以上の支援。	USAID

1994～	BASICS (Basic Support for Institutionalizing Child Survival)	マラリア、肺炎、下痢症、分娩時合併症、HIV/AIDS を予防できる既存の方法を、普及、拡大。	Child Survival に引き続き、途上国の新生児・小児の主要死因対策を普及・拡大。	USAID John Snow, Inc 等 6 団体が共同で受託
1996～	Integrated Management of Childhood Illness (IMCI)	下痢症、肺炎、麻疹、マラリア、栄養障害等小児疾患を包括的にケアする指針。現地状況に応じて改訂。予防接種、栄養指導等の予防的サービスも提供。	WHO と UNICEF が、1992 年以降開発してきた、小児疾患に対する包括的ケア指針。下痢症・ARI 対策等は、徐々に IMCI に移行。	WHO、UNICEF
母性保健				
1987～	Safe Motherhood Initiative (SMI)	妊産婦死亡・合併症を 2000 年までに半減する目標。家族計画、流産後ケア、妊婦健診、医師・助産師等による分娩介助、EOC、思春期保健等の対策・介入。	1987 年、ナイロビで開催された Safe Motherhood Conference において、開始。	Inter-Agency Group (IAG) for Safe Motherhood = WHO、世界銀行、UNFPA、UNICEF、UNDP、IPPF、Population Council
1994	ICPD Programme of Action カイロ行動計画	リプロダクティブヘルス/ライツの概念確立。2015 年までの目標は、サービスへのアクセス確保、乳幼児・妊産婦死亡率削減、女性のエンパワメント。	1994 年 9 月、International Conference on Population and Development (ICPD: カイロ国際人口開発会議) にて、179 ヵ国により採択。	UNFPA、各国政府、NGO
2005～	The Partnership for Maternal, Newborn and Child Health (MNCH)	母子の健康改善活動の協調・強化。国家計画策定支援、資金増加、実証された費用対効果の高い介入、進捗を評価してアカウンタビリティ確保。	ミレニアム開発目標 4・5、妊産婦と幼小児の健康改善を達成するため、2005 年 9 月に、母子保健関係の 3 パートナーシップ併合	80 ヵ国以上の政府、WHO、UNDP、UNFPA、UNICEF、世界銀行、IPPF、FIGO、USAID、CDC、Population Council 等 88 機関。
プライマリヘルスケア(PHC) 他				
1978	Declaration of Alma-Ata (アルマ・アタ宣言)	PHC の基本活動項目として、健康教育、環境衛生、母子保健、栄養、必須医薬品等。	1978 年、アルマ・アタでの国際会議で、Health for All by the Year 2000 (HFA) を宣言。	WHO、UNICEF
1987～	Bamako Initiative	医薬品回転資金システム (Drug Revolving Fund) の導入、コストの抑制、基本的保健医療サービスの質・アクセスの向上。	1987 年、マリのバマコでのアフリカ諸国保健大臣会議で採択。医療費負担・サービスの質改善。	UNICEF、WHO
2000～2015	Millennium Development Goals (MDGs) (ミレニアム開発目標)	保健医療分野の目標は、幼児死亡率削減、妊産婦の健康改善、HIV/AIDS、マラリア等の拡大防止、飢餓人口半減、安全な飲料水と基礎的な衛生施設、安価な必須医薬品の入手・利用確保。	2000 年 9 月国連サミットにて 189 ヵ国が、国連ミレニアム宣言採択、2015 年までに達成すべき国際開発目標がまとめられた。8 つの目標と、18 の量的ターゲット。	UNDP、国連機関、各国政府
日本が主導したイニシアティブ				
1998	国際寄生虫対策(橋本)イニシアティブ	日本は、アジア(タイ)とアフリカ(ケニア、ガーナ)に人材養成と研究開発の拠点をつくり、寄生虫対策の人材養成と情報交換等を向上させる。	1997 年 G8 サミットで、橋本首相が寄生虫対策を提唱。1998 年 G8 サミットにて、感染症及び寄生虫症に関する相互協力の強化を表明。	日本、G8、タイ
2000	沖縄感染症対策イニシアティブ	HIV/AIDS、結核、マラリア等の感染症対策と 2010 年までの数値目標表明。感染症対策沖縄国際会議で行動計画策定。日本は 5 年間で総額 30 億ドル拠出。	2000 年 G8 九州・沖縄サミットで採択。同年、感染症対策沖縄国際会議開催、各機関のパートナーシップ強化と具体的行動計画策定。	日本、G8
1999～	人間の安全保障 (Human security)	飢餓・疾病・抑圧等の脅威からの安全確保と保護を含めた包括的概念。感染症や環境問題等が健康を損なうことは脅威。人々の生存と尊厳を確保、脅威からの保護とエンパワメント。	1994 年、UNDP 人間開発報告書に掲載。1998 年、小渕首相の政策演説、1999 年、国連に人間の安全保障基金設立。2001 年、人間の安全保障委員会創設。2003 年、最終報告書。	日本、国連

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世界エイズ･結核･マラリア対策基金の5年評価
(経過報告1)

The 5 year evaluation of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Progress report 1)

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<要約> 世界エイズ･結核･マラリア対策基金(GFATM)は、2002年に設立されて以来、世界136ヵ国452事業に対し、総額約84億ドルを提供した。2007年より5年評価を開始、(1) GFATM組織の効果・効率、(2) 事業の実施とパートナーシップの状況、(3) 3感染症に対するインパクトという、3 領域に関する評価が、段階的に進められている。GFATMの5年評価を事例として紹介し、国際機関の評価の特色と課題について検討した。

<キーワード> 世界エイズ･結核･マラリア対策基金(GFATM)、技術評価委員会(TERG)、組織の効果・効率、パートナーシップ、インパクト

1．はじめに

世界エイズ・結核・マラリア対策基金(The Global Fund to Fight AIDS, Tuberculosis and Malaria: GFATM)の設立は、2000年のG8九州・沖縄サミットで、開発途上国の感染症対策が課題となったことを契機とする。2001年4月のアフリカ・エイズ・サミット、6月の国連エイズ特別総会等での議論を経て、7月のG8ジェノバ・サミットにて、感染症対策基金設立が合意された。その後、先進国(出資国)、途上国(受益国)、NGO、民間財団、国際機関等によるワーキンググループが準備を進め、2002年1月に財団として設立された。

GFATMからの資金提供は、受益国側が申請し、専門家による委員会が審査した後、理事会によって決定される。理事会は、出資国、受益国、NGO、感染者組織、民間財団、企業等の代表から構成されている。受益国保健省、国連機関、NGO等が資金を受け入れ、実施組織に資金を移転して事業が実施される。2007年までに、136ヵ国452事業に対して、総額約84億ドルの支援契約がなされた。

GFATMの5年評価は、2006年の理事会で、1,714万ドル(基金の0.6 %)を投じて実施することが承認され、米国のコンサルタント会社等からなるコンソーシアムが受注した。技術評価委員会(Technical Evaluation Reference Group: TERG)の監督下、(1) GFATMの組織の効果・効率、(2) 16ヵ国における事業実施とパートナーシップの状況、(3) 20ヵ国における3感染症に対するインパクトという、3評価領域(Study Area: SA)について、段階的に評価を実施する。

この報告では、GFATMの5年評価を、国際的な資金提供機関の評価の事例として紹介する。そして、国際機関の評価の特色、評価内容・規模の適正性等について検討する。

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