Approaches for Systematic Planning of Development Projects

〈Reproductive Health〉

December 2005

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Since FY2002, the Japan International Cooperation Agency (JICA) has referred to scheme types such as Project-Type Technical Cooperation, Individual Expert Team Dispatch, and Research Cooperation collectively as Technical Cooperation Projects. However, since there is a possibility of confusion with the original names of scheme types, this report also uses the current term Technical Cooperation Projects with reference to projects that started prior to FY2001 for consistency.

Similarly, collaborative projects with other entities such as NGOs have been collectively referred to as JICA Partnership Programs since FY2002, and this report, therefore, uses the term Partnership Program with reference to projects that started prior to FY2001 for consistency.

Published by: Institute for International Cooperation (IFIC)
Japan International Cooperation Agency (JICA)
10-5, Ichigaya Honmura-cho,
Shinjuku-ku, Tokyo 162-8433 Japan
FAX: +81-3-3269-2185
E-mail: iictae@jica.go.jp

Foreword

The Japan International Cooperation Agency (JICA) has been working toward the enhancement of its country-specific and issue-specific approaches by formulating JICA Country Programs, implementing Project Request Surveys, and drafting Thematic Guidelines. At present there are significant differences between countries in terms of progress levels or categorizations of development issues and cooperation programs. To improve further JICA Country Programs and deal with important development issues requires appropriate formulation of programs and projects based on a fundamental understanding of development issue and effective approaches toward them, while recognizing that situations and issues differ from country to country. JICA must clarify the priority areas for cooperation, based on both the actual conditions of each target country and a systematic approach for each development issue.

Therefore in FY2001 and FY2002 as a part of an effort to promote country-specific approaches by enhancing issue-specific approaches JICA conducted the study on "Approaches for Systematic Planning of Development Projects" in eight issues: Basic Education, HIV/AIDS, Rural Development, Promotion of Small and Medium Enterprises (SMEs), Poverty Reduction, Trade and Investment Promotion, Higher Education, and Information and Communication Technology. The study systematized these issues and specified the indicators to be used as references in planning, monitoring and evaluating JICA's activities. Furthermore, the study reviewed JICA's previous projects and summarized their trends, matters of concern and representative cases for each issue, based on Development Objectives Charts.

Due to a growing demand for systematization of other issues as well, a further study was carried out in FY2003. Three new development issues were taken up: Water Resources, Reproductive Health, Agricultural and Rural Development.

The findings of this study will be incorporated into the JICA Thematic Guidelines and further developed by the Agency Thematic Network.

In conducting the study and preparing this report, a task force was set up, chaired by Mr. Hiroshi Kato, JICA Director of Planning Group, Planning and Coordination Department, and comprising JICA staff of related departments, JICA Senior Advisors, Associate Specialists, and external consultants. A considerable number of JICA staff members, as well as external experts, further contributed by offering valuable comments on the draft report. I would like to take this opportunity to acknowledge the efforts and contribution of all of these individuals.

Finally, it is my sincere hope that this report will prove a worthwhile step in the enhancement of issue-specific approaches.

August 2004

Toru TAGUCHI
Director General,
Institute for International Cooperation
Japan International Cooperation Agency

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Outline of Study

1. Background and Purpose of the Study

This study comprises Phase 3 of the "Analysis/Evaluation Method for Country-specific/Issue-specific Approaches," a study implemented in years 2001 and 2002, to promote country-specific approaches through issue-specific approaches. Phases 1 and 2 systematically organized eight major development issues (basic education, anti-HIV/AIDS measures, promotion of small and medium enterprises (SMEs), rural development, reduction of poverty, promotion of trade and investment, higher education, and information and telecommunication technology) and reviewed JICA projects based on the Objectives Chart while also clarifying effective approaches. The results have been summarized in the report "Approaches for Systematic Planning of Development Projects."

Since there was strong demand for similar systematic organization for other subjects as well, it was decided that research and investigation be implemented for three issues, "water resources," "reproductive health" and "agricultural development and rural development" in 2003 upon adjustments with the related departments within JICA.

The results of this study have the following applications:

- Use as the basic material for preparing/revising the Developmental Objective Matrix for JICA Country Program implementation plans
- Use as the basic material for project formation investigation, case formation and program development
- Use as the basic material for program evaluation and country evaluation
- Use as material for explaining JICA's ideas on the issues in discussion among JICA executives, survey team, experts, etc. and the recipient country or other donors
- Storage in a field issue database to share the ideas and approaches on each issue within JICA

2. Report Constitution[1]

Chapter 1 Overview of the issue (circumstances of the issue, definition, international trends in assistance, trends in Japan's assistance)

Chapter 2 Approach to the issue (purpose of the issue, effective approach)
A systematic chart in which the approach is organized systematically is prepared to describe the approach to the issue or to review the JICA projects.

Chapter 3 JICA's cooperation policy (JICA's priorities and points to be noted, future issues to be examined)

Appendix 1. Main operations

Appendix 2. Approach by major donors

Appendix 3. Basic checklist (including major indicators)

[1] Based on the position of the study results to be applied in issue-specific guidelines, the report constitution conforms to the standard constitution of the issue-specific guidelines to be prepared in the future.

3. How to Look at the Development Objectives Chart

In this study, a Development Objectives Chart is prepared for each development issue as follows:

Example of Development Objectives Chart
(for Information and Telecommunication Technology for the previous fiscal year)

Development Objectives	Mid-term Objectives	Sub-targets of Mid-term Objectives	Example of Activities
1. Improvement of IT policy development capacities	1-1 Establishment of electrical communication policy	Introduction of competition principle	×Support for development of foreign currency introduction policy ×Support for policy for promotion of private investment ×Support for mitigation of market entrance regulation ○Support for formation of competitive markets

* Symbols of ◎, △, etc. in "Example of activities" indicate JICA's implementation status.
◎(Mostly implemented), ○(there are some cases of cooperation), △(there are cases of implementation as parts of project activities), and ×(little implementation)

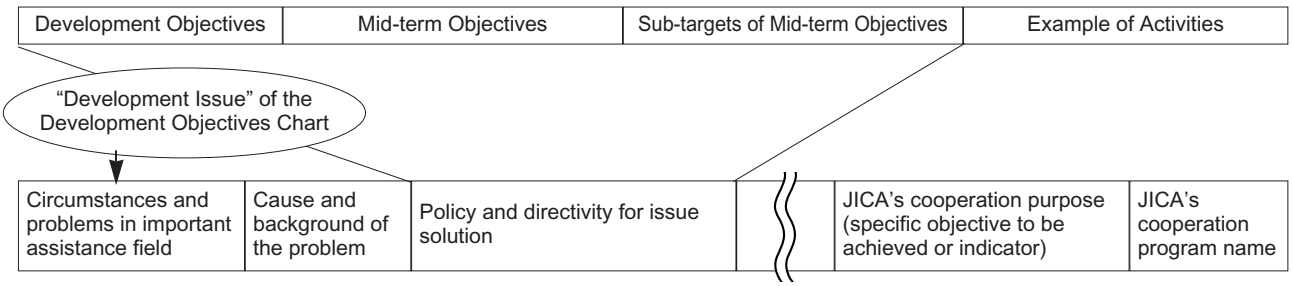
The above "Development Objective," "Mid-term Objectives" and "Sub-targets of the Mid-term Objectives" comprise a breakdown of each development issue.

The Development Objectives Chart incorporates the overall chart, which covers everything from the Development Objectives to the Example of Activities, and a chart that includes the example of activities for each Development Objective is incorporated in the corresponding section of this document.

The relationship between the Development Objectives Chart and JICA Country Program varies depending on the specific conditions of each country and sector. "Development Issues" in a Development Objectives Chart corresponds to the "Important Assistance Field" of a Development Objective Matrix in a JICA Country Program. "Development Objectives," "Mid-term Objectives" and "Sub-targets of Mid-term Objectives" in a Development Objectives Chart correspond to "Policy and Directivity for Issue Solution" of a Development Objective Matrix in a JICA Country Program (The target corresponding to the "Development Issue" in the Development Objective Matrix varies by country and sector).

Correspondence between Development Objectives Chart
and Development Objective Matrix in JICA Country Program

<Development Objectives Chart>



<Development Objective Matrix in JICA Country Program>

4. Task Force

The task force for this study was as follows. A draft was prepared by the group in charge for each issue, and the draft of each issue was examined in the study meeting. In addition, we received comments from offices abroad, experts and headquarter for the interim draft of the study. Based on the comments, the draft was updated for the final report.

Study Task Force

Chief	Director, Planning Group, Planning and Coordination Department	Hiroshi Kato
Knowledge site task	Project Planning Team, Planning Group, Planning and Coordination Department	Hironobu Murakami
Regional task	Team 2 Leader, Project Adjustment Group, Planning and Coordination Department	Naoyuki Kobayashi
	Management Team Leader, Regional Department II	Kenzo Iwakami
	Vice Director, Mexico Office	Atsushi Ueshima (until March 2004)
	Management Team Leader, Regional Department III	Naoki Kamijo (from April 2004)
	South and East Africa Team Leader, Regional Department IV	Koichi Kito
Water resources	Group 3 Leader (Water Resources/Disaster Prevention), Global Environment Department	Hajime Adachi
	Management Team Leader, Management Group, Institute for International Cooperation	Taisuke Watanabe
	Management Team Leader, Rural Development Department	Noriaki Nagatomo
	Poverty Reduction, Rice Paddy Area Team 1 Leader, Group 1, Rural Development Department	Takahiro Morita
	Southeast Asia Team 3, Group 2, Regional Department I	Shinichi Masuda
	Water and Hygiene Team, Operations Group 1, Grant Aid Management Department	Shigeyuki Matsumoto
	Water and Hygiene Team, Operations Group 1, Grant Aid Management Department	Junko Uno
	Issue/Activity Support Team, Project Management Group, Secretariat of Japan Overseas Cooperation Volunteers	Junko Mimaki
	Team 2, Group 3 (Water Resources/Disaster Prevention), Global Environment Department	Yutaka Fukase
	Team 2, Group 3 (Water Resources/Disaster Prevention), Global Environment Department	Hisakatsu Okuda
	Team 2, Group 3 (Water Resources/Disaster Prevention), Global Environment Department	Izumi Shoji
	General Adjustment Team, General Affairs Group, General Affairs Department	Kosuke Odawara
	Associate Specialist, Morogoro State Health Administration Reinforcement Project in Tanzania	Mari Tsuda
	“Water Resources” Support Unit, Field Issue Network	Akira Wada (from April 2004)
		Shiyuko Kamada (February 2004 – March 2004)
		Satoko Tsutsui (until January 2004)
	Technical Section Chief, Overseas Services Department, Nihon Suido Consultants Co., Ltd.	Takemasa Mamiya

Reproductive health	International Cooperation Expert, Institute for International Cooperation	Tokiko Sato
	Maternal and Child Health Team Leader, Group 4 (Health 2), Human Development Department	Yoshiharu Yoneyama
	Central and West Africa Team, Regional Department IV	Keiichi Takemoto
	Maternal and Child Health Team, Group 4 (Health 2), Human Development Department	Ritsuko Sakamoto
	Training/Learning Team, Domestic Group, Secretariat of Japan Overseas Cooperation Volunteers	Mai Okada
	Associate Specialist, Maternal and Child Health Team, Group 4 (Health 2), Human Development Department	Kyoko Takashima
	Associate Specialist, Phase 2 (dispatched to UNFPA Tokyo Office)	Kayako Sakisaka
	Associate Specialist, Maternal and Child Health Team, Group 4 (Health 2), Human Development Department	Shoko Sato
	“Health and Medical Care” Support Unit, Field Issue Network	Eiichi Shimizu (until March 2004)
	Non-Profit Organization HANDS	Tomoyo Wada
Agricultural development/rural development	Group 2 (Arviculture Area) Leader, Rural Development Department	Seiichi Yokoi
	Management Team Leader, Global Environment Department	Manabu Aiba
	International Cooperation Expert, Institute for International Cooperation	Shiro Akamatsu
	International Cooperation Expert, Institute for International Cooperation	Hikaru Niki
	Wide Area Investigator, Institute for International Cooperation	Hideo Ohsawa
	Dry Agriculture Area Team 2, Group 3, Rural Development Department	Hitoshi Fujiie
	Dry Agriculture Area Team 2, Group 3, Rural Development Department	Hiroaki Nakahori
	Associate Specialist, East Africa Team, Regional Department IV	Hiromi Isero
	“Agricultural Development/Rural Development” Support Unit, Field Issue Network	Tetsuo Dokiya (from April 2004)
		Masayo Tanimoto (from April 2004)
		Minako Igarashi (until March 2004)
		Miwa Hayashi (until February 2004)
	Agricultural Development Department, Nippon Koei Co., Ltd.	Hajime Kamo
Secretariat	Second Research and Development Division Chief (Colombia Office Manager at present), Institute for International Cooperation	Ryozo Hanya (until January 2004)
	Research and Development Group Leader, Institute for International Cooperation	Kyoko Kuwajima (from February 2004)
	Second Research and Development Division Assistant Chief (Evaluation and Planning Team Leader, Project Evaluation Group, Planning and Coordination Division at present), Institute for International Cooperation	Kazuaki Sato (until November 2003)
	Assistance Method Team Leader, Research and Development Group, Institute for International Cooperation	Naoko Ueda (from December 2003)
	Project Strategy Team, Research and Development Group, Institute for International Cooperation	Sota Sekine
	Researcher, Second Research and Development Division, Institute for International Cooperation	Ayano Inami (until March 2004)
	Researcher, Assistance Method Team, Research and Development Group, Institute for International Cooperation	Yasuko Doguchi (from April 2004)
	Researcher, Assistance Method Team, Research and Development Group, Institute for International Cooperation	Eriko Jibiki (from March 2005)

Development Objectives Chart for Reproductive Health (1)

Development Objectives	Mid-term Objectives	Sub-targets of Mid-term Objectives	Examples of Activities
1. Improvements of Major Reproductive Health Issues in Development	**1-1 Improvement of Maternal Health**	**Safe delivery**	◎Training of birth attendants ◎Distribution of basic obstetric equipment △Establishment of Emergency Obstetric Care systems △Humanized maternity care
		Promotion and quality improvement of care at delivery and prenatal/postnatal care	△Holding of mother's class (nutrition, care during pregnancy, vaccination, promotion of antenatal care, etc.) ◎Training of health workers ◎Establishment and improvement of maternal and child health center, obstetrics ward, etc. ◎Utilization of Maternal and Child Health Handbooks
		Improvement of maternal nutrition	△Distribution of iron supplements △Nutrition education (survey on available food, culture related to food, private vegetable garden)
		Safe motherhood, prevention of induced abortion and promotion of care	△Introduction of counseling and education before marriage and/or after delivery ◎Family planning service ○Health education related to safe motherhood (including birth spacing) △Understanding of induced abortion rate (survey) ◎Education and information dissemination on family planning
	1-2 Reduction of Infant Mortality/Morbidity	**Popularization and quality improvement in infant care**	◎Promotion of vaccination △Mother's class (nutrition, hygiene, diarrhea, ARI measures) △IMCI training △Recording of growth monitoring chart (training of mothers and health workers) ◎Utilization of Maternal and Child Health Handbooks ○Training of health workers △Establishment and improvement of emergency pediatrics system △Distribution of iodine supplement, popularization of iodine-fortified food products ×Distribution of vitamin A supplement
	1-3 Reduction of Unwanted Pregnancy	**Education and dissemination of family planning**	◎Promotion activities on family planning ○Education and dissemination on contraceptive methods ×Premarital check-up
		Promotion and quality improvement of family planning service and care	◎Human resource development for family planning service/care providers ◎Improvement of facility for providing family planning service/care ○Improvement of demographic statistics
		Improvement of access to contraceptive methods	○Provision of contraceptive methods △Strengthening social marketing of contraceptive methods ×Development and research on contraceptive methods
		Provision of information and service on adolescent reproductive health (ARH)	△Collection and analysis of existing statistical data related to sexual and reproductive health among adolescents as well as need assessment △Reproductive health education at schools (human resource development, learning material development) ×Improvement of laws and policies that prohibit provision of contraceptive information and services to young people △Provision of information in medical facilities and communities as well as establishment of health service ×Mass media campaign on information and services △Peer education/peer counseling ×Social marketing of contraceptive methods to adolescents
	1-4 Measures against Sexually Transmitted Infections (STI) including HIV/AIDS	**Prevention, treatment and care of STI**	○Substantiation and promotion of early diagnosis and proper treatment △Reinforcement of school health ○Strengthening of sex education for young people ○Education and promotion about symptoms, risk factors and prevention methods △Provision of condoms ○Provision of STI testing drugs and treatment drugs △Human resource development in workers to serve in STI testing/treatment ○Improvement of facilities to provide STI testing/treatment
		Prevention and control of HIV/AIDS	(For details, please see "Approaches for Systematic Planning of Development Projects (HIV/AIDS).") ○Dissemination of correct HIV/AIDS knowledge about HIV / AIDS ○Promotion of condom use △Establishment of diagnosis and treatment techniques for sexually transmitted infections △Promotion of VCT △Prevention of transmission through pregnancy, delivery or breast feeding ×Joint research and development support in the vaccine and related basic medical fields

Development Objectives Chart for Reproductive Health (2)

Development Objectives	Mid-term Objectives	Sub-targets of Mid-term Objectives	Examples of Activities
2. Improvement of Women-Specific Health Problems and Measures against Infertility	**2-1 Measures against Disorders and Risks to Health by the Life Stage**	**Treatment of malignant obstetric tumors, etc., reduction of health loss caused by cancer in reproductive organs (uterus, ovary, etc.) and breast cancer**	○Substantiation and promotion of early diagnosis and proper treatment ○Education and advocacy on symptoms, risk factors and prevention methods ○Human resource development and improvement of facilities for screening and service providers
		Improvement of lowered quality of life (QOL) by menopausal disorders, etc. due to aging	×Training on symptoms and risk factors for health workers ×Substantiation and promotion of early diagnosis and proper treatment ×Support to activities on further dissemination and understanding of knowledge on symptoms, factors, improvement methods, etc. targeting general residents
	2-2 Measures against Infertility		×Promotion of dissemination and understanding of proper knowledge and improvement of treatment methods sufficiently considering human rights
3. Gender Equality and Women's Empowerment	**3-1 Elimination of Unequal Opportunities between Men and Women**	**Improvement in girls' education**	△Provision of opportunities for literacy, elementary and vocational education △Women's capacity development in education and employment ×Development of non-discriminative education and training
		Improvement of women's access to health services	△Gender advocacy activities for health service providers △Advocacy for regional forces and opinion leaders ○Establishment of health services that are easily accessed with consideration of women's privacy ×Improvement of gender-disaggregated health statistics
		Motivation for health promotion by individuals	×Health education for women who have less access school education (plays, picture-story shows, songs, videos) △Provision of health services in combination with literacy education and informal education programs
	3-2 Reduction of Violence against Women and Sexual Violence	**Elimination of Female Genital Cutting (FGC)**	×Education and advocacy for girls, their families and regional forces on health risks of FGC ×Training and advocacy of human resources for health services
		- Establishment of social environment that opposes violence against women (violence in armed conflicts, domestic violence, rape, forced prostitution, etc.) - Substantiation of referral services after suffering violence (including services other than health services)	△Education and advocacy of women, men, regional forces and religious leaders about sexual violence △Human resource development and advocacy for health service providers ×Human resource development in referral service providers ×Improvement of facilities for providing referral services
	3-3 Promotion of Understanding and Participation by Men		△Development of contraceptive methods, information, counseling methods for men ×Peer counseling activities among men
	3-4 Promotion of Social Participation of Women and Improvement of their Economic Power		○Improvement of knowledge and self-esteem by gender training for health service providers and receivers △Provision of health services in combination with income increase programs for women △Gender training for men, regional forces, religious leaders, etc.
4. Establishment of System to Improve Reproductive Health	**4-1 Establishment of Political Commitment**	**Establishment of political framework**	×Development of national strategy △Development of activity plan
		Moderation of public finances for health care	×Budget increase
	4-2 Reinforcement of Administration Systems for Health	**Improvement in management capacity**	△Training of administrators ◎Training of local administrators △Reinforcement of coordination with related authorities or international organizations △Development of education plan and re-education plan for health service providers △Increase in research and investigation capabilities △Financial strengthening by introduction of user fee system, etc.
		Establishment of health information management system	◎Establishment of statistical systems △Development and improvement of health information management software △Implementation of training on operation instruction on PC, software and data analysis for personnel in charge of statistics method

Examples of Activities:
◎: JICA has considerable experience in reproductive health cooperation projects.
○: JICA has certain experience in reproductive health cooperation projects.
△: JICA has experience as a component of projects in reproductive health cooperation projects.
×: JICA has little experience in reproductive health cooperation projects.

Overview of Approach for Systematic Planning of Reproductive Health: Executive Summary

1. Overview of Reproductive Health

1-1 Present Situation of Reproductive Health and its Importance

The establishment of a reproductive health system not only provides a measure against the population problem, but also contributes to the improvement of individual health.

The circumstances that surround reproductive health in developing countries are serious compared to developed countries, as indicated by many indicators including high birth rate, Maternal Mortality Ratio and HIV/AIDS morbidity. One of the major causes for this is insufficient information on reproductive health and related services. It is therefore highly significant that Japan, which has rich experience and technology in this field, should cooperate in improving the reproductive health of the international society.

1-2 Definition of Reproductive Health

When "Reproductive Health" is translated into Japanese, it means "life-long health and rights on sex and reproduction for all people." More specifically, it indicates "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes." In addition, "Reproductive Rights" mean "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health." This report uses the term "Reproductive Health" including the meaning of "Reproductive Rights" instead of "Reproductive Health/Rights."

1-3 Trends in International Assistance

The most important conference in the history of reproductive health is the International Conference on Population and Development (so-called Cairo Conference), held in Cairo in 1994. In this conference, the ICPD Programme of Action was adopted upon agreement by 179 countries. It was recognized that the "achievement of reproductive health is a presumption for sustainable, human-centered development and stable population." Furthermore, in the Millennium Development Goals (MDGs) adopted in the fifty-fifth United Nations General Assembly in September 2000 (so-called the Millennium Assembly), four out of eight development objectives were directly related to reproductive health.

1-4 Trends in Japan's Assistance

Japan's initiatives related to reproductive health include the Japan-U.S. Common Agenda (common issues for cooperation with global prospects) proposed in July 1993 as a joint initiative for Japan and U.S., "Global Issues Initiative on Population and AIDS (GII)" announced with the purpose of providing proactive cooperation to developing countries in the fields of population and AIDS in February 1994, and the Okinawa Infectious Diseases Initiative (IDI) proposed in the Kyushu-Okinawa Summit in July 2000. A comprehensive approach that includes perspectives from reproductive health and gender was adopted in the "Global Issues Initiative on Population and AIDS (GII)" and approximately 5 billion US dollars were donated for the seven years from 1994 to 2000.

1-5 Trends in JICA's Assistance

Our technical cooperation in the field of reproductive health began in the "Family Planning Seminars (group training in Japan)" in 1967, and the first project-type technical cooperation, "Family Planning Project," started in Indonesia in 1969. Then, a project integrating family planning and maternal and child health was implemented in the 1980s, and diverse projects based on the reproductive health concept were implemented since 1994. As of 2003, nine different projects related to reproductive health are being implemented.

2. Approach for Systematic Planning of Reproductive Health

2-1 Purpose of Cooperation in Reproductive Health

While improvement in reproductive health itself is a right to be solidly addressed for each individual as the "improvement of health related to sex and reproduction," it also conforms to the concept of "human security." Moreover, it is a comprehensive challenge that can contribute to the achievement of several globally important objectives, which are also targeted in Millennium Development Goals. Therefore, the purpose of cooperation in the field of reproductive health is to improve the various serious problems in the world, mainly in the developing countries, through comprehensive involvements concerning "health related to sex and reproduction" and contribute to achievement of Millennium Development Goals and "human security."

2-2 Approach for Systematic Planning of Reproductive Health

Development Objective 1: Improvements of Major Reproductive Health Issues in Development

The major reproductive health issues which should contribute to the achievement of Millennium Development Goals directly and to be solved comprehensively with highest priority are summarized in "Improvement of Major Reproductive Health Issues in Development." This development objective includes four mid-term objectives: (1) improvement of maternal health, (2) reduction of infant mortality/morbidity, (3) reduction of unwanted pregnancy, and (4) measures against sexually-transmitted infections including HIV/AIDS. While these mid-term objectives are to be approached with the highest priority in developing countries and especially in less-developed countries, they are also objectives to be addressed comprehensively due to their deep interrelation.

A continuous maternal care system from pregnancy to post-delivery should be established in addition to training of birth attendants and the expansion of emergency obstetric care in order to improve maternal health. To reduce the number of unwanted pregnancies, promotion and quality improvement of family planning service/care as well as the improvement of access to contraceptive methods are required. Especially in the promotion of family planning service/care, it is desired that the reproductive health care for adolescents (adolescent reproductive health) be expanded including measures against HIV/AIDS.

Development Objective 2: Improvement of Women-Specific Health Problems and Measures against Infertility

While there are different issues depending on the age group and the stage of life-cycle when women-specific health problems are considered, the health of women had been discussed mainly within the scope of maternal and child health in the developing countries. However, reproductive health not only considers reproductive age group but also the improvement of health of men and women throughout their lives. It is not limited to health during reproductive age. Although there are few experiences of cooperation by JICA, it is a field in which assistance will be needed in the future in measures against women-specific diseases and health damage that suit each life stage as well as measures against infertility.

Development Objective 3: Gender Equality and Women's Empowerment

To address the issues of reproductive health, approach from the health field alone is not sufficient. Attention should be paid to the aspects of economic circumstances, education, employment, life and home environment, social/gender environment, traditional norms, etc. of the people. Women's social and cultural status is an especially important factor that affects their reproductive health. As "Promote gender equality and empower women" is also the third objective of the Millennium Development Goals, this objective itself should be promoted as a global issue in development assistance. At the same time, empowerment of women is an essential factor for achievement of reproductive health.

Some specific approaches include health education for women for whom the opportunity for education is limited, the elimination of unequal opportunities between men and women by providing training on gender considerations to health service providers, and measures against violence towards women and sexual violence including elimination of Female Genital Cutting (FGC). Furthermore, it is desired that the understanding and participation by men, social participation by women and improvement of economic power are also dealt with simultaneously.

Development Objective 4: Establishment of System to Improve Reproductive Health

In order to place the improvement of reproductive health as a priority issue of the country so that the activities of the above Development Objectives 1 to 3 are implemented smoothly and successively, it is important to establish a system for improving reproductive health. In particular, system and capacity development of existing health systems is important considering the sustainability of assistance projects. In order to proceed in system establishment, improvement of management capacity of the health administration including training of health administrators at central and regional levels and cooperation in the establishment of health information system are important in addition to assistance in the establishment of political commitment.

3. JICA's Cooperation Policy

3-1 Priorities and Points to Be Noted for JICA

(1) Basic Concept

1) Improvement of Reproductive Health

Improving reproductive health, as well as achieving universal primary education, contributes most to the achievement of Millennium Development Goals. At present, the ratio of the budget related to cooperation in reproductive health in the entire JICA budget is only slightly more than 1%. It is essential that the budget for reproductive health be expanded greatly from the present situation considering JICA's policy towards approaching the Millennium Development Goals more proactively.

2) Cooperation Related to Reproductive Health

Since a comprehensive approach is required, it is important to first organize the objectives and needs of the assisted country. Then, it is desirable to select the range of JICA involvement based on the approach of other donors and the comparative advantages of Japan.

(2) Issues JICA Should Prioritize

JICA should approach the following three important issues:

1) Improvement of Maternal Health

"Improvement of maternal health" with importance on the establishment of a continuous pregnancy-delivery care system is the field in which Japan can contribute most. Reduction of maternal mortality ratio is

an issue of which achievement is the greatest concern within the Millennium Development Goals, and it is desired that JICA take a leading role in solving this issue in effective cooperation with other international organizations and NGOs.

2) Promotion of Family Planning

Promotion of family planning is important not only for the solution of the population problem but also for achievement of universal primary education and poverty reduction, and cooperation with effective combination of advocacy activities and stable supply of contraceptives is necessary.

3) Adolescent Reproductive Health

In many developing countries, particularly African Countries, reproductive health care for adolescents is the most important issue. JICA should rapidly train specialists in this field while utilizing the resources of the assisted country or a third country to proactively address this issue.

Furthermore, future cooperation in reproductive health will place importance on Sub-Saharan Africa, the Middle-East and South Asia. Considering the seriousness of the issues in Africa, focus should be shifted from Southeast Asia to Africa.

(3) Points to Be Noted in Implementing Cooperation

1) While more and more donors shift importance to selective and concentrated involvement adopting a vertical approach by health concern, JICA should re-evaluate the effectiveness of a comprehensive approach targeted in reproductive health and present it to the international society.
2) A gender-disaggregated approach is inevitable. Situation analysis and specific action in relation to gender need to be incorporated in all projects.
3) Involvement in governmental policy as well as grass-root activities needs to be reinforced.
4) Grant aids cooperation and equipment provision are comparative advantages of Japanese ODA, and they should be utilized more strategically and effectively.
5) A sustainable approach with the establishment of a long-term strategy is required. In particular, concerning pilot projects in model areas, continuous follow-up to set a road map for national expansion is necessary.
6) Cultural consideration is required.

3-2 Future Examination Issues

1) What to use as indicators for outcomes in reproductive health requires discussion. It is especially difficult to obtain reliable data on the Maternal Mortality Ratio (MMR) and an indicator to replace it needs to be examined.
2) JICA needs to scientifically demonstrate the effectiveness of Japanese cooperation in reproductive health and take steps to gain international recognition in this approach.
3) Strategic coordination with sectors other than health such as basic education, rural development and infrastructure should be examined in the future.

Chapter 1 Overview of Reproductive Health

1-1 Present Situation of Reproductive Health and its Importance

The establishment of a reproductive health system provides not only a solution measure to the population problem, but also contributes to the improvement of individual health[1], and it is based on the definition of "health"[2] as provided by the World Health Organization (WHO) in its Constitution. However, the range of reproductive health is wide and the definition and interpretation of its concept remain varied.

Many people in the world have no chance to enjoy reproductive health due to various causes. Such causes include insufficient knowledge of human sexuality, inappropriate or low-quality information and service on reproductive health, the spread of high-risk sexual behavior, discriminative social customs, negative attitudes toward women and girls, and the limited empowerment of women and girls in relation to sex and reproduction, etc. Adolescents are in an especially vulnerable position. This is because there is little information available on reproductive health and few related services in many of the countries in the world.

While more than 500,000 women die of pregnancy- or delivery-related causes every year in the world, 99% of them are in developing countries[3]. More than 1/5 of the diseases in women of reproductive age are related to sex and reproduction[4]. The contraceptive prevalence rate is lower and the age of delivery is earlier for women in poorer groups, and the average total fertility rate for the whole of Africa is 5[5]. Approximately 130 million girls in the world experience Female Genital Cutting (FGC), and 2 million girls face its threat every year[6]. The number of people living with HIV/AIDS had reached approximately 40 million worldwide by the end of 2003, of which 28 million people live in Sub-Sahara Africa. Consequently, the average life expectancy of this area is decreasing drastically[7].

For better individual health including the solving of the population

[1] "Individual" here refers to not only any woman of reproductive age, but also any person including man, child, adolescent, elderly, handicapped and minority (ethnic minority, immigrant, refugee, homosexual, etc.).

[2] The WHO defined "health" in 1948 as follows: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

[3] UNFPA (2002) p.9

[4] *ibid.* p.33 According to this report, this value reaches 40% in Sub-Saharan Africa.

[5] *ibid.* p.72

[6] UNFPA (2003a) p.21

[7] UNAIDS (2003) According to this report, the total number of HIV carriers and AIDS patients was estimated to be 34 to 46 million worldwide and 25 to 28.2 million in Sub-Sahara Africa at the end of 2003.

problem, the cooperation of our country has great significance. Japan considers the improvement of maternal health, reduction of infant mortality/morbidity, reduction of unwanted pregnancy, and measures against sexually transmitted infections including HIV/AIDS as major cooperation issues in improving the reproductive health status of developing countries. In addition, in trying to improve reproductive health, improving health problems unique to women, gender equality and the empowerment of women are essential factors and thus they are examined in this report.

1-2 Definition of Reproductive Health

When "Reproductive Health" is translated into Japanese, it means "life-long health and rights for all people regarding sex and reproduction." However, this report uses the term "Reproductive Health" as it is in order to avoid different interpretations by translation. In addition, this report uses the term "Reproductive Health" instead of "Reproductive Health/Rights" to include the meaning of "Reproductive Rights." Though the term "sexual and reproductive health" was also suggested due to the focus on "health related to sex" ever since the International Conference on Population and Development held in 1994, it has been omitted considering that sexual health is included in reproductive health. The following sections summarize the definitions[8] of "Reproductive Health," "Reproductive Health Care" and "Reproductive Rights" used in this report.

(1) Reproductive Health

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Therefore, reproductive health means that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

It also includes access to information and services on safe, effective, affordable and acceptable contraceptive methods.

(2) Reproductive Health Care

In adherence to the above definition of reproductive health, "reproductive health care" is defined as "the entire set of methods, techniques and services that contribute to reproductive health and its well being through prevention and

[8] They are based on the definitions agreed in the Cairo International Conference on Population and Development Programme of Action (ICPD Programme of Action) in 1994 and are described in Chapter 7, 7.2 – 7.3 (Translation supervised by the Ministry of Foreign Affairs of Japan in 1996. Partially excerpted from the International Conference on Population and Development "Programme of Action": Cairo International Conference on Population and Development resolution document, published by Sekai No Ugoki Sha. See "References" for the original text of this programme). Interpretation of reproductive health and rights is still under discussion among Catholic nations, Islamic nations, developed nations, etc. That is, there is insistence that infertile women, girls, elderly, disabled, men, homosexuals, etc. cannot enjoy services on reproductive health and rights, and suggestion that they may lead to eugenics or abortion.

solution of various problems related to reproductive health." Reproductive health includes health related to sex for the purpose of individual sex and the enhancement of human relationships (sexual health), and is not simply limited to counseling and care related to reproduction and sexually transmitted infections.

(3) Reproductive Rights

Reproductive rights are basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

Box 1-1 Difference between Reproductive Health and Family Planning/Maternal and Child Health

Reproductive health differs from conventional family planning or maternal and child health in the following points:

(1) Reproductive health indicates life-long, wide ranging health not only limited to the health of women of reproductive age groups from 15 to 49. It also points out the importance of women being able to control their health from the perspective of the human life cycle instead of being careful only during the period when they have children.

(2) Reproductive health targets a comprehensive approach which encompasses family planning/maternal and child health and other health issues related to reproduction including sexually transmitted infections including HIV/AIDS that had been treated in isolation in conventional vertically separated administration systems.

(3) It is difficult to say whether conventional family planning programs have dealt appropriately with the needs, roles and responsibilities of men and special needs of adolescents. However, reproductive health activities require sufficient consideration of these problems. It also refers to the roles and responsibilities of men in other reproductive health fields (such as sexually transmitted infections including HIV/AIDS).

(4) Reproductive health calls for the rights of individuals and couples related to family planning and especially the rights to select the method of family planning. At present, many individuals and couples are not given any opportunity to choose the method of family planning or the opportunity is insufficient or inappropriate even when given. Reproductive health insists on the rights of individuals and couples to utilize family planning and select the family planning method that seems appropriate for each individual, and state the assurance to substantiate the health care and information which will enable such rights.

(5) Reproductive health points out that violence against women creates large health problems. In particular, rape, sexual abuse, human trafficking, forced prostitution, and harmful traditional customs including female genital cutting constitute violence against women which often occur within the framework of "sex and reproduction." In addition, it is also important to deal with violence that affects not only physical health, but also the mental health of women.

Source: Tokiko Sato (2002) (Partially modified)

Reproductive rights are part of human rights which are already acknowledged in domestic laws, international documents on human rights, and other related documents agreed in the United Nations. These rights are **basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.** In addition, it also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. The rights to use appropriate health care services so that women can enjoy safe pregnancy and delivery and couples can have the best opportunities to have healthy children are also included.

1-3 Trends in International Assistance

How was reproductive health established and developed? The following sections give an overview of the trends in major international assistance in the field of reproductive health (see Table 1-1).

(1) Before the 1990s

The basic concept of reproductive rights[9] originates in the "women's health" movement[10] which appeared during the latter half of the 1960's. Until the second World Population Conference (Belgrade Conference) in 1965, scientific conferences were held on the subject of demographics. The importance of the human rights of women was discussed in the first International Conference on Human Rights (Tehran Conference) in 1968, and "reproductive rights" were mentioned for the first time in a United Nations conference. This conference accepted that "parents have a basic right to determine freely and responsibly the number and spacing of their children and to have the information and means to do so." In the third World Population Conference in Bucharest in 1974 and the fourth International Conference on Population in 1984 (Mexico City Conference), the rights were declared as the rights of "all couples and individuals" instead of "parents."

Then, through the "United Nations Decade for Women" (1976-1985) that targeted improvements in women's status, and the third World Conference on Women (Nairobi Conference) in 1985, recognition that "women's rights are human rights" was spread throughout the world. As mentioned above, the basic concept of reproductive health has been received by international society through discussions in international conferences.

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[9] The background of the reproductive health concept is not clarified here because there are several different theories. Some say that it is a concept that the WHO started using in order to grasp people's health needs comprehensively, and others say that it was a concept proposed by Dr. Fathalla, who was the director of the Special Programme for Research, Development and Research Training for Human Reproduction in 1988.

[10] The "Women's health movement" started in the latter half of the 1960's to 1970's, and sex, contraception and abortion became the priority issues for women's movements, influencing the establishment and popularization of the reproductive health/rights concept.

The International Conference on Population and Development (ICPD/Cairo Conference) in 1994

(2) The 1990's and Onwards

In the International Conference on Population and Development (ICPD, hereafter referred to as the Cairo Conference) held in Cairo in 1994, the **ICPD Programme of Action (Twenty-Year Programme)**[11] was adopted. This programme of action was agreed by all 179 participating countries, and an international recognition that the "achievement of reproductive health is a presumption to sustainable, human-centered development and stable population was established." The Cairo Conference also adopted "enjoyment of

Table 1-1 Trends in Assistance Related to Reproductive Health

Year	International Trends (●indicates conferences mentioned in the ICPD Programme of Action.)	Japanese Trends
1950's – 1960's	'54: First World Population Conference (Rome) '64: Second World Population Conference (Belgrade) '67: Declaration on the Elimination of Discrimination against Women (adoption in the UN General Assembly) '68: First International Conference on Human Rights (Tehran)	'62: Establishment of Overseas Technology Cooperation Agency (OTCA) '63: Establishment of Japan Emigration Service (JEMIS) '65: Launching of Japan Overseas Cooperation Volunteers (JOCV) '67: Launching of International Family Planning Training Project '68: Establishment of Japanese Organization for International Cooperation in Family Planning (JOICFP)
1970's – 1980's	'74: Third World Population Conference (Bucharest) '75: First World Conference on Women (Mexico City) '80: Second World Conference on Women (Copenhagen) '81: Convention on the Elimination of all Forms of Discrimination against Women came into effect. '84: ●Fourth International Conference on Population (Mexico City) '85: ●Third World Conference on Women (Nairobi)	'74: Establishment of Japan International Cooperation Agency (JICA) '85: Ratification of Convention on the Elimination of all Forms of Discrimination against Women, promulgation of the Equal Employment Opportunity Law
1990	●World Summit for Children (New York)	
1992	●United Nations Conference on Environment and Development (Rio)[12] ●International Nutrition Conference ●World Conference on Human Rights	Announcement of Japan's Official Development Assistance Charter (ODA Charter)
1993		Japan-U.S. Common Agenda
1994	**●International Conference on Population and Development (Cairo)**	Announcement of Global Issues Initiative on Population and AIDS (GII) Promulgation of the Basic Law for a Gender-Equal Society
1995	**●Fourth World Conference on Women (Beijing)**	Announcement of Japanese Government WID Initiative
1996		Enactment of Mother's Body Protection Law
1999	**Special Session of United Nations General Assembly (ICPD + 5) (New York)**	Approval of low-dose pills
2000	**Agreement on Millennium Development Goals (MDGs)** **Special Session of United Nations General Assembly (Beijing + 5) (New York)**	Announcement on Okinawa Infectious Diseases Initiative (IDI)

Source: Japan International Cooperation Agency (2001a)

[11] The ICPD Programme of Action demands addressing of the following by year 2015: (1) universal access to reproductive health services including family planning and sexual health, (2) drastic reduction in infant mortality and maternal mortality, (3) wide range of measures to ensure equality between men and women and empowerment of women, (4) universal access to elementary education, (5) correction of the "gap between men and women" in education.

[12] The Rio Declaration included "participation by women is necessary for sustainable development in environmental and developmental issues."

reproductive health" as one of the reproductive rights. The introduction of the concept of reproductive health put an end to the idea of conventional policy of suppressing population increase that was based only on the macro-perspective of "population increase inhibits economic development."

Ever since the Cairo Conference in 1994, many UN organizations and countries started to reflect the concept of reproductive health in their existing family planning programs and to modify their policies. In addition, the approach to the population problem has shifted its emphasis to gender equality, women's empowerment (improvement of their status and capacity), and the promotion of reproductive health. In the 4th World Conference on Women (Beijing Conference) held in Beijing in 1995, reproductive rights were clearly stated as a part of women's human rights, and equal relationship, agreement and joint responsibility between men and women regarding sex and reproduction were widely recognized. Around this time, the concept further expanded with emphasis on roles in sexually transmitted infections, infertility and sex of boys, making it necessary to consider social factors in addition to maternal and child health and perinatology/perinatal medicine.

In 1999, five years since the Cairo Conference, a special session of the United Nations General Assembly on Population and Development called "ICPD+5" was held. The document adopted in ICPD+5 included a sentence that claimed that the objectives and policies related to population need to be appropriately reflected in international agreement (treaty) in the fields of environment, trade, etc.

Furthermore, the **Millennium Development Goals (MDGs)** were adopted in the 55th United Nations General Assembly in September 2000 (the Millennium Assembly) with the support of 149 heads of state including Japan. Four of the eight development goals[13] were directly related to reproductive health. Regarding cooperation with international organizations and countries in the field of reproductive health, achievement of these MDGs is an important guideline along with the ICPD Programme of Action.

1-4 Trends in Japan's Assistance

(1) Governmental Trends

The Japanese Government started technical cooperation through JICA from the latter half of the 1960's (see p.7 (2)), and started contributing to the International Planned Parenthood Federation (IPPF) in 1969 and the United Nations Population Fund (UNFPA) in 1971.

[13] The following four goals among the eight Millennium Development Goals are directly related to Reproductive Health: Goal 3: eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015; Goal 4: reduce by two thirds the mortality rate among children under five; Goal 5: reduce by three quarters the maternal mortality ratio; Goal 6: halt and begin to reverse the spread of HIV/AIDS, and halt and begin to reverse the incidence of malaria and other major diseases. For details on the Millennium Development Goals, see the UNDP Tokyo Office Homepage :http://www.undp.or.jp/mdg/index.html.

Japan-U.S. Common Agenda in 1993

The Japan-U.S. Common Agenda (common issues for cooperation with global prospects) was proposed in July 1993 as a joint initiative for Japan and the U.S. and as a part of the Japan-U.S. Framework. Talks on Bilateral Trade. Through this initiative, Japan has implemented more than seventy projects in eighteen different fields including "population," "HIV/AIDS," "child health," and "support for women in developing countries."

Global Issues Initiative on Population and HIV/AIDS (GII) in 1994

The Japanese Government announced the **"Global Issues Initiative on Population and HIV/AIDS (GII)"** in February 1994 with the aim of providing proactive cooperation to developing countries in the fields of population and HIV/AIDS. This initiative was to promote assistance to developing countries in the fields of "population and HIV/AIDS" with a prospective total ODA of 3 billion US dollars for the seven years from fiscal year 1994 to 2000. It adopted a "comprehensive approach" that included not only the conventional direct cooperation as in the "population problem," "family planning" and "maternal and child health," but also reproductive health and gender perspectives such as basic health care related to the health of women and children, primary education, women's literacy education and vocational training. Financial assistance amounted to about 5 billion US dollars for the total of seven years.

In 1996, the Japanese Government reformed the Eugenics Protection Law to Mother's Body Protection Law upon adoption of the ICPD Programme of Action. The first "White Paper on Gender Equality" (1997) states "the concept of reproductive health in the Cairo Conference is endorsed and today the importance of women's human rights is recognized. (Omission) General policies to support the health of all women throughout their lives shall be promoted from the standpoint of reproductive health."[14]

Okinawa Infectious Diseases Initiative (IDI) in 2000

The Japanese Government proposed the **Okinawa Infectious Diseases Initiative (IDI)** in the Kyushu-Okinawa Summit in July 2000. Its purpose was to reinforce cooperation in the fields of infectious disease measures, public hygiene, research network, basic education, water supply, etc. The government has expressed its intention to cooperate with developing countries with a total contribution of 3 billion US dollars in these fields. The Japanese Government plans to implement cooperation with a focus on support for adolescents, and the first specific measure was to provide 1 million US dollars to the "Trust Fund for HIV/AIDS" which was newly established by IPPF.

(2) Trends in JICA's Assistance

Japan's technical cooperation in the field of reproductive health began in the "Family Planning Seminars (group training in Japan)" in 1967. It was then followed by the first Project-Type Technical Cooperation[15], the "Indonesia Family Planning Project" (mainly on the development of audio-visual education software for the promotion of family planning and the provision of

[14] Prime Minister's Office (1997)

[15] Indicates the form of technical cooperation in which a period of cooperation of about 3–5 years is set to combine expert dispatch, counterpart training in Japan, equipment provision, etc. and implement from planning to evaluation consistently. Several forms were collectively named as "Technical Cooperation Projects" since fiscal year 2002.

contraceptives) which began in 1969. Regarding the Project-Type Technical Cooperation, many had been assisting in suppressing population increase in the assisted country through assistance such as family planning, demographic information and the promotion of population education until the mid-1980's. From the latter half of the 80's to the beginning of the 90's, cooperation in integration of family planning and maternal and child health became the mainstream.

Ever since the Cairo Conference in 1994 and adoption of GII, JICA has cooperated in the fields related to GII by providing over 2.4 billion US dollars and proactively formed and implemented various projects that incorporated reproductive health. Projects such as the "Viet Nam Reproductive Health" which aimed for the establishment of safe environment for delivery of women in rural areas started in 1997 and the "Jordan Family Planning WID" related to the improvement of women's status were implemented. Among the 38 technical cooperation projects in the field of health implemented by JICA in 2003, nine were related to reproductive health[16].

Commodity/equipment provision projects (Multi-Bi Cooperation) in cooperation with international organizations have increased since the Cairo Conference, including successive establishments of "Special Equipment Provision for Population and Family Planning" (in cooperation with UNFPA) in 1994, "Special Provision of Blood Testing Equipment for Measures against HIV/AIDS" (in cooperation with the United Nations Programme on HIV/AIDS (UNAIDS)), and "Special Equipment Provision for Maternal and Child Health" in cooperation with the United Nations Children's Fund (UNICEF).

[16] As organizations other than JICA, activities of the Japanese Organization for International Cooperation in Family Planning (JOICFP), which is a representative NGO in the field of reproductive health, is worth noting. This organization has promoted cooperation in family planning and maternal and child health since the 1970's based on Japan's post-war experience.

Chapter 2 Approach for Systematic Planning of Reproductive Health

2-1 Purpose of Cooperation in Reproductive Health

Reproductive health is the right of every individual, and it conforms to the concept of human security. It also contributes to the solution of macro-level developmental problems such as population and poverty issues.

According to the definition of reproductive health in Chapter 1, improvement in reproductive health requires improving life-long health related to sex and reproduction and achieving physical, mental and social well-being for all people. This requires protection of the minimum and essential rights of all men and women in not only developing countries but also developed countries. **It is also a challenge to recognize the freedom of each individual in relation to sexual and reproductive health and ensure the health and safety of every man and woman, which also conforms to the concept of human security.**

As well as being every individual's right, improvement in reproductive health contributes to **the solution of macro-level problems such as population issues and poverty issues, in other words, it contributes to national and global security.**

This chapter presents this issue in relation to more specific development goals in the context of development assistance to developing countries.

(1) Purpose of Cooperation in Reproductive Health Field in Development Assistance

While the most distinguished goals in development assistance are the Millennium Development Goals adopted by the United Nations General Assembly in September 2000, **the improvement of reproductive health contributes directly or indirectly to the achievement of most of the Millennium Development Goals.** Improving reproductive health status contributes directly to three goals in the field of health, namely "Goal 4: Reduce child mortality," "Goal 5: Improve maternal health," and "Goal 6: Combat HIV/AIDS, malaria and other diseases," and a close synergic effect is seen among "Goal 2: Achieve universal primary education" and "Goal 3: Promote gender equality and empower women." In addition, many experts have pointed out that family planning directly contributes to "Goal 1: Eradicate extreme poverty and hunger." and indirectly to "Goal 7: Ensure environmental sustainability" through the solution of the population problem. Figure 2-1 summarizes the cause-effect relationship between improvement in reproductive health status and the Millennium Development Goals based on the "State of World Population 2002."

In summary, **improvement in reproductive health status itself is a right to be addressed for each individual as the basis of the improvement of health related to sex and reproduction, and at the same time it also conforms to the concept of human security. Moreover, improvement in reproductive health contributes to the achievement of several globally important objectives that**

are also incorporated in Millennium Development Goals.

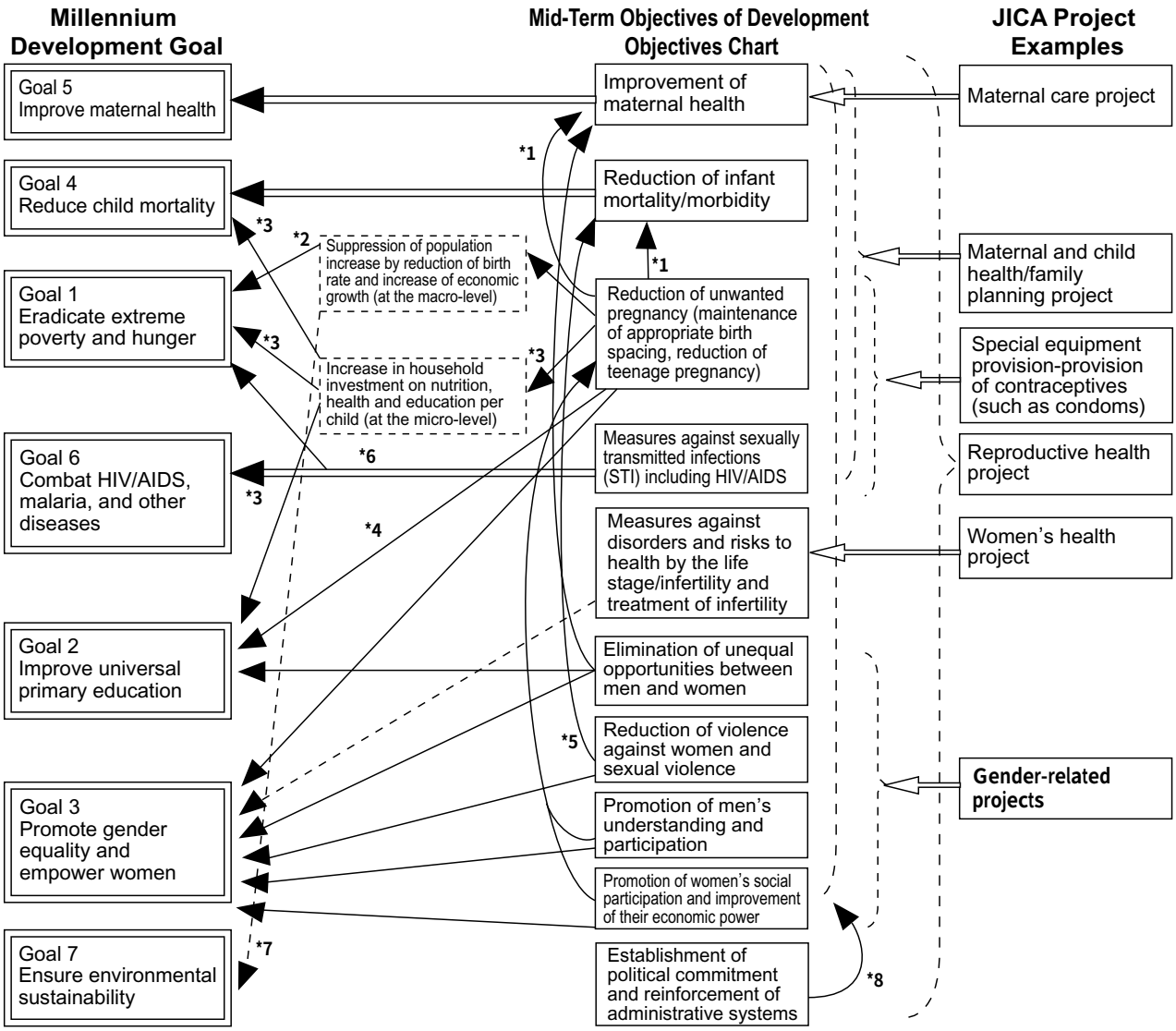
The current world situation of reproductive health and poverty is shown in Table 2-1. The purpose of cooperation in development assistance in the field of reproductive health is **to improve these global problems, which are especially serious in developing countries, and to contribute to achieving the Millennium Development Goals and ensuring human security by taking comprehensive approach toward sexual and reproductive health.**

Table 2-1 World Population, Reproductive Health and Poverty

Item	Estimated value
- World population	6,301,500,000
- Population living on two dollars or less per day	3.0 billion
- Population living on one dollar or less per day	1.2 billion
- Population of young people living on one dollar or less per day (15–24 years old)	228 million (one out of four)
- Maternal death (Frequency of maternal death one case per minute)	529 thousand every year
- Risk of death during pregnancy or delivery in life, one out of seventy-four (Risk in Sub-Saharan Africa, one out of sixteen)	
- Serious maternal morbidity	20 million every year
- Child birth among teenagers	14 million every year
- Unsafe induced abortion	20 million cases every year
- Couples whose family planning needs are not satisfied.	Total number 120 million or more
- Population suffering infertility	Total number 80 million
- Female Genital Cutting (FGC)	Total number 130 million
- Treatable sexually transmitted infections	Total number 333 million
- Number of people living with HIV/AIDS by 2003 (Of which number of people living with HIV/AIDS in Sub-Saharan Africa, 26.5 million)	Total number 40 million
- Number of young people living with HIV/AIDS (15–24 years old) (Of which ratio of those who know they are positive, 10% or less)	Total number 11.8 million
- Number of newly infected with HIV/AIDS in 2003 (Of which ratio of young people (15–24 years old), about half) (Frequency of new infection among youth, one person every fourteen seconds)	5 million a year
- Deaths due to HIV/AIDS in 2003	3 million a year
- Number of children who lose their parents from HIV/AIDS (Of which number of children in Sub-Saharan Africa, 11 million or more children)	Total number 13 million or more
- Number of infants of low weight at birth	25 million every year
- Perinatal deaths	7.6 million every year
- Preventable deaths of infants younger than five years old	11 million every year
- Number of infants younger than five years old with insufficient nutrition	one out of three
- Ratio of children without primary education	121 million
- Number of girls without primary education	65 million
- Number of illiterate women (15–24 years old)	96 million (1.7 times that of men)

Source: UNFPA (2003a), UNICEF (2004), etc.

Figure 2-1 Relationship between Improvement of Reproductive Health and Millennium Development Goals



*1: Infant mortality and maternal mortality can be improved by reducing the number of teenage pregnancy/child birth and maintaining an appropriate birth interval. For example, the risk of death in pregnancy aged 15–19 years is double that of twenty years or older. The reduction of unwanted pregnancy is also important to avoid induced abortion and protect maternal health.

*2: Reduction in the birth rate provides favorable opportunities for the population and accelerates social and economic development. Semi-advanced countries in East Asia have obtained one third of their annual economic growth rates through the favorable opportunities for the population. In addition, economic profits gained from a lower birth rate change the distribution of wealth and contribute to reduction of poverty. For example, a 4/1000 reduction in the net birth rate would lead to a 2.4% reduction in the number of people living in absolute poverty for the next ten years.

*3: Teenage pregnancy/child birth with short birth intervals will lead to a large family, which divides the assets of a poor family further and makes the family poorer. In addition, if there are a large number of children in a poor family, some of the children cannot receive education or have delays in the start of education or dropout. Reducing the number of unwanted pregnancies and teenage pregnancy/child birth and maintaining appropriate birth intervals lead to increased nutrition, health and education investment for each child.

*4: Unwanted teenage pregnancy/child birth often prevents women from continuing education or empowerment opportunities. In Sub-Saharan Africa, 8–25% of women dropout of education due to pregnancy. Furthermore, early marriage also prevents girls and women from continuing education.

*5: Correction of the gender gap in education, reduction of sexual violence, promotion of understanding by men, promotion of women's social participation and improvement of their economic power not only contribute to reducing the number of teenage pregnancy/child birth and unwanted pregnancies but also lead to the prevention of sexually transmitted infections such as HIV/AIDS. In addition, the probability of children dying younger than five years would be reduced by 5–10% if a woman received education for one more year.

*6: About half of new HIV positives are young people aged 10–24 years old. Thus it is important to provide education and information as well as contraceptives such as condoms to young people in order to prevent infection of HIV/AIDS. Furthermore, in some African Countries, nine out of ten young people in their teens who are sexually active know nothing about HIV/AIDS. The spread of HIV/AIDS puts heavy pressure on the national budget by increased medical expenses and therefore hampers economic development. It also increases the number of HIV/AIDS orphans and leads to increase in extreme poverty.

*7: An increase in the poor, rural population deteriorates the rural environment. If population increase is left unchecked, it may also lead to environmental deterioration, and food and water shortages. For example, it may be impossible to ensure the water necessary for life for 5 billion people in 2025 if the population increase and water consumption continues at the current level.

*8: System establishment related to reproductive health supports and reinforces all other efforts.

Source: Data and information issued by UNFPA (2003), UNICEF (2004), etc. are used as reference for footnotes.

Four Development Objectives for Reproductive Health:
(1) Improvements of Major Reproductive Health Issues in Development.
(2) Improvement of Women-Specific Health Problems and Measures against Infertility.
(3) Gender Equality and Women's Empowerment.
(4) Establishment of System to Improve Reproductive Health.

(2) Four Development Objectives in Reproductive Health

Cooperation in the field of reproductive health is to be implemented with the purpose of addressing many development objectives including the Millennium Development Goals while improving the sexual and reproductive health for all people. In particular, **measures against four health issues: improvement in maternal health, reduction of infant mortality/morbidity, reduction of unwanted pregnancy, and measures against sexually transmitted infections including HIV/AIDS are urgent matters to be dealt with in less-developed countries where development is especially slow, and these are directly connected to the achievement of the Millennium Development Goals.** Furthermore, since activities to address these issues are closely interrelated and a comprehensive approach is necessary, these issues should be integrated and organized as one Developmental Objective. Therefore, we organize these issues **comprehensively and with the highest priority in development** that directly contributes to the achievement of the Millennium Development Goals, as Development Objective 1 "Improvements of Major Reproductive Health Issues in Development," and examine effective approaches.

Improving reproductive health includes not only measures for mothers, children and adolescents, but also includes the objective of **improving women's health related to sex and reproduction throughout their lives.** While it is inevitable that priority is placed on the above issues, which are directly linked to the Millennium Development Goals in cooperation to less-developed countries, measures against women-specific health problems, should not be forgotten in cooperation to semi-advanced countries. The approach to such issues is organized as Development Objective 2 "Improvement of Women-Specific Health Problems and Measures against Infertility."

In addition, in many developing countries, addressing **social and cultural factors that inhibit the improvement in reproductive health** is also important along with the approaches in the above Development Objectives 1 and 2. Elimination of unequal opportunities between men and women, elimination of sexual violence towards women, etc. need to be implemented in concurrence with direct involvement in the health sector, and they are specified in the Millennium Development Goal 3. The approach to these issues is organized as Development Objective 3 "Gender Equality and Women's Empowerment."

In addition, **establishment of system to improve reproductive health** is necessary in order for the outcomes of the above Development Objectives to progress sustainably and independently, and this is organized as a different objective: Development Objective 4 "Establishment of System to Improve Reproductive Health."

In summary, this report sets out the following four Development Objectives:

(1) Improvements of Major Reproductive Health Issues in Development
(2) Improvement of Women-Specific Health Problems and Measures against Infertility

(3) Gender Equality and Women's Empowerment
(4) Establishment of System to Improve Reproductive Health

2-2 Approach for Systematic Planning of Reproductive Health

Development Objective 1
Improvements of Major Reproductive Health Issues in Development

Development Objective 1 Improvements of Major Reproductive Health Issues in Development

As described in 2-1 above, **measures against four issues; improvement of maternal health, reduction of infant mortality/morbidity, reduction of unwanted pregnancies, and measures against sexually transmitted infections including HIV/AIDS are urgent matters in developing countries and especially in less-developed countries.**

In development assistance, promotion of family planning has been considered a method for solving the issues of population and poverty. Although the approach to family planning has changed dramatically from "government's effort to control population growth" to "voluntary family planning in which individual autonomy is respected" ever since Cairo Conference, its importance as a measure for approaching the issues of population and poverty has not changed. Meanwhile, the promotion of family planning in reducing the number of unwanted pregnancies and lengthening the birth interval is also closely related to improving maternal and infant health (maternal and child health), and thus family planning and maternal and child health have been considered inseparable since the 1970's. The problem of sexually transmitted infections such as HIV/AIDS should also be considered as a reproductive health issue since there are emerging needs to address adolescents and to prevent mother to child transmission. That is, important issues of reproductive health that are common to less-developed countries such as family planning, maternal and child health, and measures against sexually transmitted infections are closely interrelated and a comprehensive approach is required to examine and solve them as a whole.

Based on the above concept, objectives of reproductive health to contribute directly to achieving the Millennium Development Goals and to be solved with highest priority in development are summarized in Development Objective 1 "Improvements of Major Reproductive Health Issues in Development," so that effective approaches can be examined.

Mid-Term Objective 1-1
Improvement of Maternal Health

Mid-Term Objective 1-1 Improvement of Maternal Health

More than 500,000 women in the world lose their lives every year due to causes originating from pregnancy or delivery, and 99% of them are in developing countries. It is calculated that one woman dies every minute due to pregnancy or delivery-related causes somewhere in developing countries.

To reduce maternal mortality, it is necessary that demonstrative examinations be repeated on site so that an effective approach can be established.

Although the **Safe Motherhood Initiative (SMI)**[17] began based on international consensus in 1987, little improvement has been made in terms of maternal mortality. Even in health statistics, there is a difference of nearly hundred-fold in the maternal mortality ratio between developed countries and developing countries while the difference in the infant mortality rate remains about ten- to thirty-fold.

Three fourths of maternal mortality are caused by hemorrhage, infection, obstructed or prolonged labor, and most of them are considered avoidable with the provision of appropriate health services including family planning. However, maternal mortality has not improved because there has been no consistent strategy and the scarce resources have not been streamlined into an effective approach[18]. A method that is clearly effective in the improvement of maternal health and reduction of mortality ratio has not been established yet, and it is still under much debate. **It is necessary that demonstrative examinations be repeated on site while obtaining international consensus so that an effective approach can be established.**

The fact that woman in pregnancy or at delivery is attended by a Skilled Birth Attendant and has access to Emergency Obstetric Care in case of complications, leads to the reduction of maternal mortality. This requires:
(1) Training of Skilled Birth Attendants (SBAs).
(2) Emergency Obstetric Care (EmOC).

(1) Safe Delivery

To reduce maternal mortality, **when a woman gives birth, she should be attended by a Skilled Birth Attendant (SBA) and have access to Emergency Obstetric Care (EmOC) in case there are complications.** As an approach for this, both the **training of birth attendants and the establishment of an Emergency Obstetric Care System** are important.

In **training birth attendants,** it is important to understand that there are primary prevention to avoid the occurrence of complications by safe and clean delivery and secondary prevention in case of emergency. In addition, the preparation of a support system that allows appropriate assignment of trained attendants as well as effective activities by the trained attendants is also an important factor.

While those subject to training include obstetricians, midwives, Traditional Birth Attendants (TBAs) and health workers, **the acceptance of TBAs as trainees depends on the donor.** While its effect is questioned by international organizations such as UNICEF, some insist that it would be effective if the training method is improved, as some NGOs implement it proactively. As a matter of fact, birth attendance by TBAs occupies a large portion of the deliveries in rural areas of developing countries. Thus, it is not always appropriate that their roles be rejected. Some approaches in the use of TBAs are worth considering when combined with the promotion of emergency measures in coordination with local health providers, etc.

Furthermore, international organizations such as WHO, UNICEF are stressing the importance of Emergency Obstetric Care (EmOC), and consider

[17] SafeMotherhood.Org (http://www.safemotherhood.org)
[18] Some suggest two causes: (1) no planning, implementation and evaluation of safe motherhood measures using an appropriate epidemiological method and (2) lack of comprehensive measures that include primary health care to high-level medical organizations.

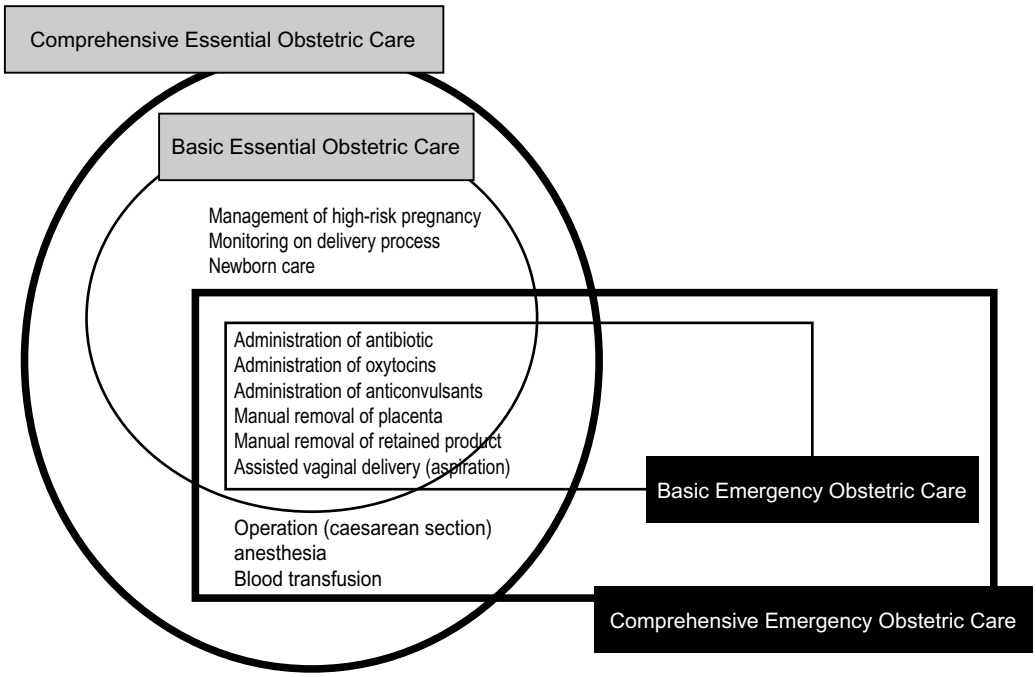
Box 2-1 Comparison among Approaches for Reduction of Maternal Mortality

The major causes of maternal mortality include atonic bleeding after delivery, pregnancy toxemias, hysterorrhexis, pueaperal infection due to unclean delivery treatment, and sepsis as a complication of illegal abortion. Direct approaches to reduce the frequency of these complications and mortality can be summarized as follows:

(1) Early finding of high risks and anomalies with promotion of antenatal care.
(2) Measures in case of emergency and prevention of infection by training of birth attendants.
(3) Reduction of high risks and unwanted pregnancy by promotion of family planning.
(4) Reduction of deaths from complications by establishment of Emergency Obstetric Care Systems.
(5) Approach to the social environment that surrounds women.

Of the above items, the most feasible in developing countries are (1) – (3) and (5) with relatively low economic burden on the government. On the other hand, the establishment of EmOC systems requires major expense in ensuring a safe blood transfusion and transport system in addition to the establishment of facility/equipment and human resource training, and is difficult for many developing countries to address these areas. There are also concerns about promotion of gap expansion and the medicalization of delivery. It is necessary to organize and analyze knowledge regarding the reduction of maternal mortality while also considering Japan's experience and accomplishment in support for developing countries so that scientific data can be accumulated.

Figure 2-2 Essential Obstetric Care (EOC) and Emergency Obstetric Care (EmOC)



the establishment of a consistent EmOC system that connects local residents, health centers and local hospitals with a focus on delivery due to their judgment that it is impossible to completely predict and prevent all major causes that lead to maternal mortality. They also insist that resources for assistance be provided with special focus on the establishment of EmOC facilities. In general, one comprehensive obstetric care facility and four basic obstetric care facilities are required for every 500,000 population. Establishment of EmOC facilities is an important approach for reducing the maternal mortality ratio.

However, some question the significance of proceeding with the strategy to concentrate resources on the Emergency Obstetric Care Systems of international organizations such as WHO and UNICEF in all less-developed countries. For many poor countries, it is often unrealistic to maintain the Emergency Obstetric Care facilities due to problems of costs and human resources even when the Emergency Obstetric Care facilities are established in rural areas with assistance funds, and some fear that it may expand the gaps when costs and human resources concentrate only on the Emergency Obstetric Care facilities. It is critical that Emergency Obstetric Care Systems be established with balance among primary to tertiary services within a package of comprehensive maternal care measures while also considering the budgetary situation of the assisted country.

It is necessary to make approaches for establishment of infrastructure such as roads that enable emergency transport and an enhanced social environment for women in addition to the establishment of Emergency Obstetric Care (EmOC) systems.

In addition, it is not easy for many women living in rural areas to solve the **problems of physical and social access to Emergency Obstetric Care facilities.** There are many difficulties in receiving health services, such as long distance to the health facility, lack of time, and low status within the family. Thus, it is also necessary to **make approaches for establishment of infrastructure such as roads that enable emergency transport and an enhanced social environment for women** (see Development Objective 3 “Gender Equality and Women’s Empowerment”).

In many countries, women in rural areas are shunned from health services by the health service providers’ arrogant attitudes, and thus, some recent projects include activity to promote **friendly services to women (client-friendly services).** On the other hand, there is **an approach in semi-advanced countries from the standpoint of re-evaluating Humanized Maternity Care that reviews overemphasis on the medical involvement in delivery and respects the natural power of humans.** This **Evidence-based Approach** has been scientifically verified by WHO and attracted much attention. In particular, it is important to consider this approach in planning cooperation in South and Central American Countries where the rates of Caesarean section are abnormally high and in the ex-Communist countries where the concept of service has not penetrated socially.

Box 2-2 Three Delays in Maternal Mortality

The three delays in relation to maternal mortality that UNFPA suggests are the following:

(1) Delay in finding of obstetric complications (including delay in self recognition) and delay in time from identification to the decision to go to hospital (home and community).

(2) Delay in arriving at an appropriate facility (transportation).

(3) Delay until appropriate care is given in the facility (high-quality care).

These three delays indicate that not only involvement in the health sector but also equality between genders, improvement in women's economic power, the establishment of infrastructure, etc. are required in the approach for reduction of maternal mortality.

Source: UNFPA (http://www.unfpa.org) (partially modified)

Box 2-3 Secret of Successful Training on Traditional Birth Attendants (TBAs)

Although international assistance organizations have long devoted great interest and budget to the training of TBAs, the "Joint Statement for Reducing Maternal Mortality" by UNFPA, UNICEF and WHO in 1999 clarified their view that it is difficult to reduce the maternal mortality ratio by projects that only focus on TBA training." Indeed, TBA can only become involved in normal delivery, and there is a limit to their skills. However, due to social, cultural and economic reasons, there are large populations who do not have access to delivery assistance services other than TBA especially in rural areas in many developing countries. Based on these facts, many governmental organizations of developing countries and NGOs still support TBAs. Such organizations recognize that so-called "dialog-type" training in which they start from the same viewpoint as TBAs and respect and share their traditional methods and world view related to delivery assistance is more effective, and they have moved away from the traditional teaching method of "teacher to student" —where medical specialists with educational background on European and American medicine teach uninformed TBAs 'correct' knowledge and skills— towards implementing a "dialog-type" training.

Box 2-4 Case of Support for Humanized Maternity Care

In many countries of the world, "safe delivery" has been overly valued and perinatal care came to put much emphasis on "delivery in a short time and not causing the death of mother" by means of overuse of Caesarean section, routine use of Oxytocin, artificial rupture of membranes, episiotomy and others. Though humanized maternity care should be provided for pregnant and nursing women, "safe, human and good delivery" has been difficult to afford in such medical environments. This phenomenon is especially common in Central and South American Countries, with the Inter-American Development Bank pointing out in its report that about 425 million dollars are used every year for over 850 thousand unnecessary operations in Latin America ("The IDB" No.5, Volume 5, October 2000 "Caesarean Section in Fashion" by the Inter-American Development Bank Office in Japan (2000)), warning that overuse of Caesarean section not only risks maternal health unnecessarily but further drains the already limited budget of the health sectors in developing countries. To improve this situation, JICA implemented a "family planning/maternal and child health project" to promote "humanized maternity care" in Brazil. Consequently, delivery with the attendance of the family, etc. was allowed, pregnant woman became free to choose her delivery position, and other physical environments related to delivery were generally improved and humanized. In addition, internal examination of pregnant women was done only when necessary, and instead listening to fetal heartbeats and good observation of uterine contraction were implemented more often. Many of the women who experienced such humanized maternity care came to recognize the merits of natural delivery, and demand of local care with heart instead of care in a large hospital at a distance was voiced as a consequence. Meanwhile, medical providers increased their sense of satisfaction as professionals and renewed their awareness of the value of family and community in implementing humanized care for pregnant and nursing women.

Establishment of continuous care for pregnant and nursing women is important in order to find anomalies at an early stage.

(2) Promotion and Quality Improvement of Care at Delivery and Prenatal and Postnatal Care

Unlike the strategies of WHO and UNICEF that try to concentrate assistance resources on Emergency Obstetric Care, Japan considers it possible to find certain levels of dangerous symptoms by preventive measures and devotes efforts in **consistent health management in each process during pregnancy, delivery and after delivery.** First, **improvement in the quality of health service providers and substantiation of facility and medical equipment are necessary in order to establish reliable health service facilities for patients.** Then, promotion activities for safe delivery should be implemented in **mother's class and through IEC activities** to inform pregnant women of the necessity for medical checkups as well as immunization. Moreover, the establishment of a **recording system on the mother and child health conditions using the Maternal and Child Health Handbook** is also an effective approach for finding anomalies in pregnancy and delivery.

Japan's maternal and child health measures after World War II:
(1)Antenatal care
(2)Maternal and Child Health Handbook
(3)Child raising group activities
(4)Maternal and child health promotion personnel, etc.

Antenatal care, the Maternal and Child Health Handbook, local activities with the participation of residents (child-raising group activities, maternal and child health promotion personnel) were the foundation of maternal and child health measures in Japan after World War II. Although it has not been scientifically proven that antenatal care and the use of the Maternal and Child Health Handbook are directly connected to the reduction in the number of maternal mortality, they provide an entry point for health education and health services including nursing and family planning with the pregnant and nursing women in local areas. It is important that these approaches, which are based on Japan's experience, should be positioned as one measure of comprehensive maternal care while adjusting them to the circumstances of the developing countries.

(3) Improvement of Nutritional Status of Pregnant and Nursing Women

While overall improvement of women's health by nutritional improvement is important in reducing the maternal mortality ratio, intervention starting from childhood is important in order to become a healthy mother.

Overall improvement of women's health by nutritional improvement also contributes to the reduction of mortality and morbidity related to pregnancy and delivery. Malnutrition and anemia cause various problems during pregnancy and delivery and account for increased maternal mortality. According to a recent report by UNICEF, 50,000 women die in delivery every year from anemia caused by iron-deficiency. To be healthy, pregnant and nursing women require not only improved nutrition including iron supplements but also appropriate intervention from early childhood for sufficient nutritional intake. In addition, ensuring a stable and continued supply system is an important factor in providing iron supplements.

(4) Safe Motherhood, Prevention of Induced Abortion and Promotion of Care

Prevention of induced abortion and maintenance of appropriate birth spacing with planned pregnancy/delivery is important for maternal protection.

In countries or areas where induced abortion (referred to as abortion hereafter) is illegal, abortion is implemented with risks, and the health of women is threatened by infections, pain, infertility, etc. with high mortality caused as a result. Maternal mortality due to unsafe abortion accounts for about 10 to 20% of all maternal mortality[19].

Delivery at young age and delivery with short intervals between births also increase the risk in delivery. For maternal protection, the **provision of high-quality family planning service and dissemination of knowledge on planned pregnancy and delivery** are necessary for all people so that the number of unwanted pregnancies and unsafe deliveries can be reduced. Before marriage and after delivery are good opportunities to give **counseling service** that encourage appropriate family planning methods and birth spacing in the future. **Counseling, education and provision of family planning service after abortion** is also expected to lead to the prevention of repeated abortion.

[19] UNFPA estimates that maternal death caused by unsafe abortion comprises 14% of all maternal deaths.

Box 2-5 Maternal and Child Health Handbook

Although only Holland, South Korea and Thailand use Maternal and Child Health Handbook at a national level, Japan's Maternal and Child Health Handbook is gaining greater attention as reproductive health becomes more widely recognized as a global issue.

The Maternal and Child Health Handbook has a significant impact on parents and parties related to health, and the following three characteristics are unique:

First, health records in pregnancy, delivery and on the child are all summarized in one book. Although this is a simple matter, it fosters parental recognition that care from pregnancy is important for the child to grow healthily. The handbook induces significant changes in people's awareness of pregnancy and delivery, considering the fact that historically, pregnant women have worked in heavy labor until immediately before delivery and pregnancy has not been considered a kind of illness.

Second, health education materials are included. Before 1960, limited information about child rearing was available with no magazines on child rearing published. In this context, the "Booklet for Child Rearing" which is distributed with the handbook by local authorities is highly valued.

Third, all the records and information are provided in the Maternal and Child Health Handbook so that it can be kept at hand of the parents and used in case they change the medical institute they are attending during pregnancy or child rearing. In addition, not only mothers but also fathers have access to the results of checkups. When seen from the standpoint that health data belong to the patient, the Maternal and Child Health Handbook can be considered printed material that assures a very modern right, which makes it surprising considering that its distribution started as early as 1948.

Source: JICA Institute for International Cooperation (2004)

<Approach by JICA>

While JICA has introduced the Maternal and Child Health Handbook to trainees from many countries in group training on maternal and child health in Japan, some of the trainees have tried to introduce the handbook in their own country upon their return. For example, the Maternal and Child Health Handbook has already been promoted in Thailand. This was prompted by the training in Japan and the maternal and child health project of JICA. In Indonesia, technical cooperation projects targeting the promotion of the Maternal and Child Health Handbook have been implemented, and introduction has already been made in 40% of the country (see Box A1-3). The promotion of the Maternal and Child Health Handbook has already had effects such as strengthening the custom of breast feeding and improvement of child health.

However, the cost of introducing the Maternal and Child Health Handbook requires thorough examination because less-developed countries may have insufficient funds, thus the assisted country and the government's financial capability to take the burden should be considered. Furthermore, when the handbook is introduced, its position in the maternal and child health administration should be clarified so that a system of effective promotion activities is developed. WHO is researching the effect of the introduction of the Maternal and Child Health Handbook in Indonesia in concurrence with IMCI (Integrated Management of Childhood Illness) and the potential introduction to other countries will be examined based on WHO's findings.

Box 2-6 Regional Resident Activities by Mothers (with Example of Child Raising Group Activities)

When it was discovered that the infant mortality rates were extremely high in rural agricultural fishing villages before World War II, whole residents of such villages participated in Child Raising Group Activities called "Aiikuhan". Specific activities included home visiting, cooperation in health consultations and group checkup, and cooperation in research. The child raising groups actually identified the problems by themselves and resolved them according to their needs , for example, the child raising group members who received lectures from health specialists disinfected the obstetric equipment to prevent puerperal fever, helped in household chores on the day of delivery, and opened a nursery during the busy farming season to change clothes and give baby food. In addition, the group invited external specialists and raised the awareness of the village residents. Visits from the Ministry of Health and Welfare, UNICEF, study inspections by trainees from other prefectures, etc. improved the confidence of residents and helped strengthen their organization.
Source: JICA Institute for International Cooperation (2004)

<Approach by JICA>

In the reproductive health project currently implemented in Viet Nam, child raising groups have been introduced in three communes in Nghe An Province. Other communes are also in the process of setting up child raising groups with reference to Japan's experience as part of their efforts to promote community health (see Box A1-1).

Additionally, there are women's regional activities like those of the child raising groups in many parts of Japan. Leaders of such activities are normally elderly, and they are hampered from participating fully in international cooperation because of the language barrier. It would be beneficial to connect and utilize such human resources with international cooperation efforts.

Mid-Term Objective 1-2
Reduction of Infant Mortality/Morbidity

Mid-Term Objective 1-2 Reduction of Infant Mortality/Morbidity

The Infant Mortality Rate (IMR) and the Under-Five Mortality Rate (U5MR) are important indicators in grasping the level of health service for infants. In developing countries, **Primary Health Care (PHC) services such as immunization and environmental hygiene are not generally established, and thus it is characteristic that morbidity and mortality caused by infection, malnutrition, diarrhea, etc. continue to occur frequently even after infancy** and the rate of infant mortality in U5MR is low. In such cases, it is recommended both in terms of efficiency and effectiveness to implement such support as: setting the reduction of U5MR as the immediate target, **establishment of PHC services,** disease prevention for mothers and regional residents, early finding of anomalies, health education activities on appropriate measures at home and **promotion of resident empowerment** in which residents protect their own health.

In developing countries, the reduction of U5MR should be set as an immediate target. Importance should be placed on supporting PHC service establishment and health education and promotion of resident empowerment.

Meanwhile, more precise care is required in **reducing IMR.** While the rate of low birth weight infants (less than 2,500g) is about 17% in the world,

Approaches for the "Reduction of Infant Mortality/Morbidity" become more efficient and effective by promoting comprehensive and continuous care.

many developing countries have rates over 20%. However, in developing countries where home delivery is mainstream, weight measurement is not taken at birth or there is no functioning referral system in many cases of anomalies. Therefore, it is important **to train health workers** including birth attendants and ensure the **establishment of infant emergency care system** including human resources, equipment and drugs.

The promotion of child health and development is more effective when it is initiated early. In particular, mother's health during pregnancy affects the health of the child[20]. Hence, approaches for the **"Reduction of Infant Mortality/Morbidity"** become more efficient and effective by considering **the "Mother-Baby Package"[21] developed by WHO and UNICEF or a comprehensive approach in which maternal and child health and family planning are combined. Mother's class and parent's class,** which recommend nutrition intake for the mother during pregnancy, immunization for tetanus, and reception of health check-up for pregnant women, provide care for the mother and child during the prenatal stage which is important for the healthy development of the child. As to post-delivery, it is important that a **continuous health support system be established for the mother and child by local health organization** to ensure that there is appropriate care such as promotion of breast feeding, immunizations, regular weight monitoring and measures in case of anomalies as well as early identification of anomalies.

[20] Elimination of malnutrition for child-bearing women reduces infant health problems by nearly one third (UNICEF, 2001). In addition, the health of the infant correlates with low birth weight, mother's age, sex at birth, birth interval, education level of the mother, etc.

[21] This program focuses on the health of the mother and the newborn in order to address the Safe Motherhood Initiatives, and is comprised of family planning; basic motherhood care; breastfeeding; prevention, early identification and management of complications; prevention of anemia during pregnancy; and sexually transmitted infections including HIV/AIDS, etc.

Box 2-7 Aiming to Harmonize Approaches by International Organizations (IMCI, IMPAC) and Japan's Experience in the Field of Maternal and Child Health

The purpose of **Integrated Management of Childhood Illness (IMCI)** initiated by WHO/UNICEF in 1995 is to reduce the number of infant mortalities caused by five major infant diseases, namely, acute respiratory infection (ARI), diarrhea, measles, malaria, and malnutrition. It aims to ensure that all health services provides diagnoses of pediatric disorders by following a flow chart. This management system was developed because sufficient results could not be achieved only with disorder-specific measures although prevention/treatment strategies have been developed for individual disorders of malaria, diarrhea, etc. since the 1980s. In fact, many children may carry one or more of the above five disorders, and comprehensive diagnosis/treatment at the primary health level is required. IMCI is comprised of the following three components:

(1) Improvement in the case management skills of health workers

(2) Improvement in the health systems at national and local levels

(3) Improvement in family and community care practices

Meanwhile, a strategy called **Integrated Management of Pregnancy and Childbirth (IMPAC) in which maternal care and early newborn care in a comprehensive management** along with IMCI was developed in 2000. IMPAC is comprised of the following two components:

(1) Complex obstetric care targeting health workers in obstetric wards

(2) Basic obstetric care targeting health workers at health centers and local paramedical workers involved in obstetrics

Such integration of "infant care programs" and "maternal care/early newborn care programs" originated since the World Development Report in 1993 from the concept of a minimum package focusing on the disease control in which effective results can be achieved for each input.

JICA incorporates IMCI as one of the activities in the "Health Service Reinforcement for Children Project" currently being implemented in Lao PDR. In addition, working in close cooperation with WHO, UNICEF, NGOs and other donors, JICA is in the process of planning the "Integrated Maternal and Child Health System" in the Philippines in which child care and antenatal care are integrated. Aiming to promote comprehensive and continuous care for mother and child, JICA is searching for a harmonized form of support in the maternal and child health field including IMCI, IMPAC and the Maternal and Child Health Handbook, which is one form of continuous care for mother and child based on Japan's experience.

Box 2-8 GOBI Program by UNICEF

UNICEF's GOBI Program (growth monitoring, oral rehydration salt (ORS), breast feeding and immunization) and its expanded version GOBI-FFF (with addition of food supplementation, female literacy, and family planning) are widely known as approaches for mother and child.

For example, using the easy-to-understand growth chart, it is possible to visually grasp the health of the child at weight measurement. ORS became widespread over the world because of its simplicity of dissolving one ORS package in one liter water, and it led to a reduction by half in the number of child mortality caused by diarrhea. On the other hand, it is impossible for the people who are not used to measuring body weight or one liter water to become self-reliant in the future unless they understand the significance of body weight measurement and the importance of dehydration measures in the case of diarrhea, and an approach that ensures the programs or systems brought in from outside to be truly accepted by the local community is important.

Mid-Term Objective 1-3
Reduction of Unwanted Pregnancy

Mid-Term Objective 1-3 Reduction of Unwanted Pregnancy

To postpone pregnancy until being mature enough for it, become pregnant in a planned fashion, allowing an appropriate birth interval and having a desired number of children are rights included in the concept of women's reproductive health. Reducing the risk of unwanted pregnancy leads to improvement in the situation in which abortion must be chosen and therefore, lowers the risk of maternal mortality. Hence, it is important that family planning is implemented with contraception so that women's health and welfare are ensured, the happiness of children is increased and women are allowed to determine by themselves the number of child births and when to have a child.

(1) Education and Information Provision on Family Planning

To prevent unwanted pregnancy, it is necessary to provide sufficient information in relation to family planning and enable users to adapt their behavior accordingly.

To prevent unwanted pregnancy, knowledge and information related to family planning must be provided through **IEC (information, education and communication) activities.** However, not all people change their behavior even when knowledge and information are provided. Use of the so-called **Behavioral Change Communication (BCC)**[22] through which the receiver is convinced and facilitates his/her will to change is becoming increasingly important. Men in particular tend to have little concern about family planning and make decisions without consulting their sexual partners (mainly their wives) even when they recognize the importance of family planning. Therefore, focus should be placed on a process in which understanding of family planning is promoted both for men and women so that they can both participate in making family planning decisions and implement family planning based upon consensual agreement.

[22] See Boxes 2-8 to 2-12.

(2) Promotion of Family Planning Service/Care and Improvement in Quality

When giving support to family planning, sufficient precaution is required before implementation since it is related to culture or custom based on different values, sexual taboos, etc. **Giving training on family planning counseling to service providers** enables them to consider the problems faced by the users of the service who may be trapped in their values, culture or customs, and it is possible to build a trust-based relationship and create good opportunities for finding appropriate solutions. Furthermore, there is an advantage to counseling service by service providers in respecting the will of the service user and broadening the range of selection for contraception. It is also important to make approach for systematized counseling service provision so that the service provision is sustainably maintained.

(3) Improvement in Access to Contraceptive Methods

Access to contraceptives should be improved for both men and women of all age regardless of whether they have a sexual partner. The number of married women who do not use any family planning method is estimated to be 120 million to 150 million in the world[23]. It is therefore necessary that a distribution system to facilitate sufficient contraceptives be established promptly.

Possible distribution methods include distribution through people's organizations by social marketing and distribution by health centers or public clinics. It is also necessary that sufficient consideration be given to the cost so that a price is set that can easily be paid by the users.

Furthermore, as there are different advantages and disadvantages to each contraception method, a method that suits the user's needs or situation must be provided. The user must have sufficient understanding of the characteristics of each method including the usage and adverse effects.

Meanwhile, **legal and social regulations that inhibit family planning services and the provision of information must be removed.** It is also necessary that the system barriers to inhibit the roles of men in family planning be eliminated. For example, current services may need to be contrived for men, such as **opening special clinics for men and providing services at work.**

In reproductive health activities for adolescents, the environment and needs of adolescents must be fully understood.

(4) Provision of Information/Service Related to Reproductive Health to Adolescents

In considering unwanted pregnancy, it must be recognized that **adolescents [24] have specific needs that are different from those of adults.** ICPD Programme of Action calls attention to the necessity of reproductive health for adolescents. In adolescence, they lack understanding of reproductive health while sexual behavior becomes active, and have a high risk of unwanted pregnancy and sexual

[23] UNFPA (1997) p.33

[24] See UNFPA (2003a), p.3. Adolescents include ages of 10 to 19 years old. In this UNFPA report, youth is classified as ages 15 to 24 years old and young people as 10 to 24 years old. This report also adopts the same age classification.

abuse as well as sexually transmitted infections including HIV/AIDS. Nevertheless, adolescents have limited access to reproductive health services such as family planning and the treatment of sexually transmitted infections because they are "young" or "unmarried." Based on such situation and needs of adolescents, it is important that their health and rights for decision-making be assured and that the risks of unwanted pregnancy and sexually transmitted infections including HIV/AIDS be reduced by providing appropriate education, information, service and care in relation to reproductive health.

Providing the same level of information/services to young people as those for married couples indicates public acknowledgement that unmarried young people are already sexually active, and there may be social resistance to this, although the degree of resistance may vary. This is a major difficulty in providing reproductive health/services to young people.

Box 2-9 Circumstances of Adolescent Reproductive Health

Although the crisis of the HIV virus is a major risk to young people in Sub-Saharan Africa, access to condoms is fairly limited. The staff of local NGOs in South Africa who promote HIV infection prevention activities complain that access to condoms is not easy for unmarried young people. According to one report on the situation in South Africa, the average age for starting sexual activity is from 14 to 15 years old. However, this NGO staff says "if a fifteen-year-old goes to a local clinic and asks for a condom in South Africa, the health worker will only scold 'Don't think about sex when you are still young and have not yet married! Shame on you for coming here and asking for condoms!' and chase him/her out." This issue is complex in that it is difficult to promote adolescent reproductive health activities without changing the awareness of society. However, this issue cannot be avoided in order to prevent HIV/AIDS infection from spreading further among young people in Sub-Saharan Africa.

Box 2-10 Behavioural Change Communication Method 1

Individual counseling by local volunteers contributes greatly to the field of reproductive health thorugh Behavioral Change Communication Method. Volunteers visit individual households in the area one by one. Normally, people who understand the village circumstances well and are respected by the local residents are selected as volunteers for the village. They are taught about reproductive health, communication skills, etiquette for visiting homes, etc. and start visiting households. To cite one recent example, Iran, which is a devout Islamic country, has been successful in reducing the birth rate by adopting this communication method as one of the project strategies. Although Iran's population growth rate was 3.2% and the total fertility rate was 5.4% in 1988, they decreased rapidly in 2001 to 1.3% and 2.0% respectively.

Box 2-11 Behavioural Change Communication Method 2

Combining mass communication and person-to-person communication is an effective Behavioral Change Communication Method in the field of reproductive health besides individual counseling by home visiting. **Participatory Entertainment-Education** is one such method, which has been gaining popularity in recent years. Workshops applying this method are based on interaction in which all the participating residents actively take part. In this method, facilitators play an important role in activating opinion exchanges among participants. Video dramas and short plays are shown at the beginning of the workshop to activate conversation among participants. These videos and plays include entertaining educational issues that later form the topics of discussions.

Box 2-12 Behavioural Change Communication Method 3

Peer education is one of the most general approaches for adolescent reproductive health[25]. Peer education refers to advocacy/education activities within a group that shares a similar social background, experience and sense of value. In many cases, a core member is appointed from the group as an advocacy leader and peer educator to conduct learning activities. An example of peer educator activities is an activity to visit young people in the same generation in the community and provide information related to reproductive health to mutually increase awareness and knowledge. The peer educator himself/herself can learn much from this activity too. In this fashion, peer education is expected to facilitate recognition of reproductive health problems, efforts for stable body and mind and ease access to services by sharing personal experiences with young people of the same generation.

Mid-Term Objective 1-4
Measures against Sexually Transmitted Infections including HIV/AIDS

Mid-Term Objective 1-4 Measures against Sexually Transmitted Infections including HIV/AIDS

Having sexually transmitted infections (STIs) increase the risks of HIV/AIDS infection and greatly affect women's pregnancy and delivery.

Sexually Transmitted Infections (STIs) are a major threat to health worldwide, **and they not only increase the risks of HIV/AIDS infection but also affect women's pregnancy and delivery drastically.** According to a report by UNFPA (1997), approximately 300 million cases of treatable sexually transmitted infections (chlamydia infection, gonococcus, syphilis, trichomonas infection, etc.) occur worldwide. The morbidity rate of women is five times as high as that of men, and about **two thirds of all cases of infertility are caused by complications due to sexually transmitted infections.** Furthermore, a report by UNAIDS estimates that there were about 40 million (34 million to 46 million) people living with HIV/AIDS (PLWHA) at the end of 2003, and 95% or more of them reside in developing countries. Having **sexually transmitted infections increase the risk of HIV infection** because the HIV virus easily

[25] UNFPA (2003a) p.33

enters the bloodstream if there is an ulcer in the sex organs.

Such measures against sexually transmitted infections including HIV/AIDS must be considered **from the aspects of prevention as well as care.** Specifically, they are as follows:

Measures include improving access to health services and information and incorporating measures against sexually transmitted infections in reproductive health services.

(1) For prevention of sexually transmitted infection, **promotion of safer sexual activities** for lowering the risk of infection such as expansion in the use and supply of condoms as well as **dissemination of correct knowledge on symptoms and risk factors** are important. HIV/AIDS infection of adolescents is a serious global problem, and addressing adolescent reproductive health in conjunction with the problem of HIV/AIDS is becoming increasingly important (see Mid-Term Objective 1-3 (4)).

In order to treat sexually transmitted infections, **support in drugs and facilities is essential in addition to providing appropriate diagnosis and treatment.** Specifically, the establishment of a screening system and high quality treatment with the use of appropriate drugs and human resources are necessary for substantiation/promotion of early diagnosis and appropriate treatment. It is also necessary to provide STI testing drugs and treatment drugs and improve the facilities (for details about prevention, treatment and care of HIV/AIDS, see JICA Institute for International Cooperation (2002)).

(2) Mother to Child Transmission (MTCT) is a particularly important aspect of reproductive health. In prevention of Mother to Child Transmission of HIV/AIDS, short-term administration of anti-HIV drugs such as Nevirapine is gaining attention. Infants can avoid being infected by the HIV virus contained in breast milk by avoiding breast feeding. However, some argue that the risk of infant mortality by other infectious diseases is reduced with breast feeding, which increases the immune strength of the infant, so there are many factors to consider.

Since reproductive health is greatly influenced by social, cultural and economic aspects, **consideration from not only health but also various perspectives and a comprehensive approach are important** for the issue of sexually transmitted infections including HIV/AIDS. Specifically, consideration of **access to health services and information** is particularly necessary, and it should be possible **to implement measures against sexually transmitted infections effectively by incorporating the measures in maternal and child health services and family planning services.**

Approach by JICA

JICA's cooperation in Development Objective 1 "Improvements of Major Reproductive Health Issues in Development" initiated from the "Family Planning Seminars (group training)" in 1967 and the "Family Planning Project" in Indonesia in 1969. **It began from the field of family planning** centered on the Mid-Term Objective 1-3 of Reduction of Unwanted Pregnancy. The main content of this project was to manufacture audiovisual software for training and

Transition in JICA's Approach
- 1960's: Centered on the field of family planning
- 1980's: Shift to maternal and child health and family planning
- 1990's: Comprehensive approaches including reproductive health, sexually transmitted infections including HIV/AIDS, and even empowerment of women in income generation, etc. and adolescent reproductive health become mainstream.

to provide contraceptives. Until the mid-80's, the core of JICA's cooperation was family planning to control the population increase through provision of contraceptives and audiovisual materials. Then, from the latter half of the 1980's in countries such as Indonesia, Thailand, Philippine and Mexico, projects with a concurrent approach for the **promotion of family planning (Mid-Term Objective 1-3 Reduction of Unwanted Pregnancy) and improvement in maternal and child health (Mid-Term Objective 1-1 Improvement of Maternal Health and 1-2 Reduction of Infant Mortality/Morbidity)** initiated, and **comprehensive projects centered on the concept of reproductive health** increased in number after the Cairo Conference in 1994. Meanwhile, as discussed in Mid-term Objective 1-4, **consideration from various perspectives and comprehensive approache** are also important **in order to tackle the problems of sexually transmitted infections including HIV/AIDS.** In the "Tunisia Reproductive Health Education Reinforcement Project" (see Box A1-5), cooperation is implemented with Mid-Term Objective 1-3 as the prime objective and aiming for comprehensive reproductive health improvement while also placing importance on the approach for Mid-Term Objective 1-4.

At present, projects are being implemented in the field of reproductive health in more than ten countries. **While many of these put emphasis on maternal and child health measures to deal with both "improvement of maternal health" and "reduction of infant mortality/morbidity" as the central issues, emphasis is also placed on factors such as family planning, measures against sexually transmitted infections and the improvement of women's status, depending on the needs and circumstances of the assisted country.** Although there are differences in objectives, degree of importance and cooperation startup methods depending on the needs of the assisted country, **recent major JICA projects take a comprehensive approach towards achieving several Mid-Term Objectives.**

When considering regional characteristics, projects in Asia mainly focus on improving maternal and child health and promoting family planning, and are being implemented in Cambodia, Viet Nam, Bangladesh, etc. Furthermore, JICA has implemented a project to improve maternal and child health through the introduction and promotion of the Maternal and Child Health Handbook in Indonesia, a project aiming to improve the management capability for Expanded Programme on Immunization (EPI) and suppress the number of cases of Iodine Deficiency Disorders (IDD) in Mongolia, and a project aiming to reinforce health services for children aged 15 years old or younger in Lao PDR.

On the other hand, cooperation has been implemented in the Middle-East and Africa with concurrent focus on improving women's status in society and measures against sexually transmitted infections. JICA has implemented a project targeting the creation of income for women and improvement of their status along with family planning in Jordan, and cooperation aimed at improving reproductive health status including measures against sexually transmitted infections among young people in Tunisia in the "Reproductive Health Education Reinforcement Project" previously described. This project aims for

comprehensive improvement of reproductive health of young people and supports the development of various audiovisual and printed materials as well as the human resource development to serve in consultation services so that correct knowledge is transmitted to young people and their behavior can be changed.

Many countries still require this kind of assistance, and it is expected that the number of JICA projects in this field will increase. While entry points and focus of the projects may vary to suit the unique circumstances in the assisted region/country and the activities of other donors, in essence, projects should be implemented comprehensively to improve the reproductive health related to mothers, children and adolescents, and the number of such projects is expected to increase in the future.

Many projects take the form of Technical Cooperation Projects in coordination with grant aids, Japan Overseas Cooperation Volunteers, etc. However, there are schemes implementing only equipment provision in cooperation with other international organizations, and JICA has implemented equipment provision (contraceptives, delivery assistance, etc.) at a cost of approximately 10 to 20 million yen to several countries every year.

Development Objective 1 Improvements of Major Reproductive Health Issues in Development

Mid-Term Objective 1-1 Improvement of Maternal Health			
Sub-targets of Mid-term Objectives	**Examples of Activities**	**Case No.**	**JICA's Schemes**
Safe delivery	◎Training of birth attendants ◎Distribution of basic obstetric equipment △Establishment of Emergency Obstetric Care systems △Humanized maternity care	33, 34, 36 28, 33, 34, 76 56, 61 36	• Training on maternal and child health medical providers • Distribution of basic medical equipment
Promotion and quality improvement of care at delivery and prenatal/postnatal care	△Holding of mother's class (nutrition, care during pregnancy, vaccination, promotion of antenatal care, etc.) ◎Training of health workers ◎Establishment and improvement of maternal and child health center, obstetrics ward, etc. ◎Utilization of Maternal and Child Health Handbooks	27, 28 14, 27, 28, 34 64, 76, 88, 92 20, 28, 34, 39	• Training on maternal and child health medical providers, reinforcement of training function • Promotion of Maternal and Child Health Handbook programs • Establishment of maternal and child health centers (grand aid)
Improvement of maternal nutrition	△Distribution of iron supplements △Nutrition education (survey on available food, culture related to food, private vegetable garden)	231, 254 14	
Safe motherhood, prevention of induced abortion and promotion of care	△Introduction of counseling and education before marriage and/or after delivery ◎Family planning services ○Health education related to safe motherhood (including birth spacing) △Understanding of induced abortion rate (survey) ◎Education and information dissemination on family planning	 2, 6, 7, 9, 13, 30 34 3, 8, 10, 12, 28	• Provision of information for better family planning services, reinforcement of resident organization functions, improvement in counseling capabilities • IEC activities related to family planning and maternal protection

Mid-Term Objective 1-2 Reduction of Infant Mortality/Morbidity			
Sub-targets of Mid-term Objectives	**Examples of Activities**	**Case No.**	**JICA's Schemes**
Popularization and quality improvement in infant care	◎Promotion of vaccination	23, 49, 74, 78	• Provision of vaccine and cold chain equipment (grant aid)
	△Mother's class (nutrition, hygiene, diarrhea, ARI measures)	28, 36, 42	
	△IMCI training	22	
	△Recording of growth monitoring chart (training of mothers and health workers)	28	
	◎Utilization of Maternal and Child Health Handbooks	20, 28, 34, 39	
	○Training of health workers	22, 28, 36	
	△Establishment and improvement of emergency pediatrics system	4, 22, 81	
	△Distribution of iodine supplement, popularization of iodine-fortified food products	23	
	×Distribution of vitamin A supplement		

Mid-Term Objective 1-3 Reduction of Unwanted Pregnancy			
Sub-targets of Mid-term Objectives	**Examples of Activities**	**Case No.**	**JICA's Schemes**
Education and dissemination of family planning	◎Promotion activities on family planning	3, 8, 10, 12, 28	
	○Education and dissemination on contraceptive methods	6, 11	
	×Premarital check-up		
Promotion and quality improvement of family planning service and care	◎Human resource development for family planning service/care providers	3, 8, 10, 12, 28	
	◎Improvement of facilities for providing family planning service/care	69, 177, 181	
	○Improvement of demographic statistics	29, 35	
Improvement of access to contraceptive methods	○Provision of contraceptive methods	70, 155, 185, 237	• Special equipment provision for population/family planning (in cooperation with UNFPA)
	△Strengthening social marketing of contraceptive methods		
	×Development and research on contraceptive methods		
Provision of information and service on adolescent reproductive health (ARH)	△Collection and analysis of existing statistical data related to sexual and reproductive health among adolescents as well as need assessment	12, 117	
	△Reproductive health education at schools (human resource development, learning material development)	110	
	×Improvement of laws and policies that prohibit provision of contraceptive information and services to young people		
	△Provision of information in the medical facilities and community as well as establishments of health service	36	
	×Mass media campaign on information and services		
	△Peer education/peer counseling	107, 108	
	×Social marketing of contraceptive methods to adolescents		

Mid-Term Objective 1-4 Measures against Sexually Transmitted Infections(STI) including HIV/AIDS			
Sub-targets of Mid-term Objectives	**Examples of Activities**	**Case No.**	**JICA's Schemes**
Prevention, treatment and care of STI	○Substantiation and promotion of early diagnosis and proper treatment △Reinforcement of school health ○Strengthening of sex education for young people ○Education and promotion about symptoms, risk factors and prevention methods △Provision of condoms ○Provision of STI testing drugs and treatment drugs △Human resource development in workers to serve in STI testing/treatment ○Improvement of facilities to provide STI testing/treatment	12, 32 110 12, 109, 110, 117 12 220, 237 144, 149, 161 5 77	• Dissemination of knowledge on STI by young people (Technical Cooperation Project) • Provision of STI-related drugs (special equipment, in cooperation with UNFPA) • Improvement in STI-related facilities (grant aid)
Prevention and control of HIV/AIDS	(For details, please see "Approaches for Systematic Planning of Development Projects (HIV/AIDS)") ○Dissemination of correct knowledge about HIV/AIDS ○Promotion of condom use △Establishment of diagnosis and treatment techniques for sexually transmitted infections △Promotion of VCT △Prevention of transmission through pregnancy, delivery or breast feeding ×Joint research and development support in the vaccine and related basic medical fields	12, 32, 108, 110 5 32 16	• Dissemination of knowledge about HIV/AIDS and promotion of preventive actions in young people and high risk groups (Technical Cooperation Project)

※For details about Case Numbers, please see the table in Appendix 1.

◎=JICA has considerable experience in Reproductive Health Cooperation Projects
○=JICA has some experience in Reproductive Health Cooperation Projects
△=JICA has experience as a component of projects in Reproductive Health Cooperation Projects
×=JICA has little experience in Reproductive Health Cooperation Projects

Development Objective 2
Improvement of Women-specific Health Problems and Measures against Infertility

Potential measures against women-specific disorders include (1) supporting women in gaining further knowledge/understanding of health risks so that they can prevent and take measures proactively, (2) promoting participation and understanding of men, and (3) consideration of women's rights, human rights and psychological anxiety. Of particular concern is the fact that graying of society[28] has the tendency to advance rapidly.

Development Objective 2 Improvement of Women-Specific Health Problems and Measures against Infertility

While there are different issues depending on the age group and the stage of life cycle (see Figure 2-3), the women-specific health problems have been discussed mainly within the scope of maternal and child health in developing countries. However, the concept of reproductive health not only includes women in the reproductive age group (20–44 years old)[26] but also the improvement of health of men and women throughout their lives. It is not limited to focus on health during the period in which delivery is possible. Therefore, reinforcement in approaches for **(1) supporting women to deepen the knowledge and understanding towards the danger to health caused by women-specific infections, disorders and malignant neoplasm and to proactively take part in prevention and measures, (2) putting emphasize on the view that not only women's, but also men's participation will bring improvement,** and (3) including women's average life-stage into perspective as a consideration towards environment surrounding women, **focusing on women's rights, human rights and psychological anxiety,** should be considered to improve women-specific health problems.

According to the research by the World Bank, cost effectiveness is high in

[26] Some classify as 15–49 years old (Sato (2002) p.104).

measures against disorders related to pregnancy and delivery from 15 to 44 years old[27]. On the other hand, support for measures against cervical cancer is cost effective from 45 to 59 years old – after the period capable of pregnancy and giving birth or after the period.

Effective approaches for women-specific disorders and health problems should take account of the following 3 items:

(1) Although cooperation towards health institutions, research institutions and health workers is necessary, **support in prevention is less expensive** than support in treatment, and should be recommended.

(2) **Support measures with high cost effectiveness should be selected** in treatment.

(3) Although women in developing countries are expected to marry/have children early and help in household chores, they should also be given sufficient opportunities to benefit from access to knowledge. Therefore, dissemination **of knowledge and publicity/advocacy activities for prevention measures held in places other than educational facilities** should be considered in addition to health education programs at schools.

Mid-Term Objective 2-1
Measures against Disorders and Risks to Health by Life Stage

Mid-Term Objective 2-1 Measures against Disorders and Risks to Health by Life Stage

In developing countries, the population at ages sixty years old and higher will exceed 20% from the present 8% by the year 2020. Ageing[28] usually accelerate in a short time[29] and health problems for senior citizen are becoming serious in developing countries[30]. According to the classification by the World Bank[31], ages 45 years old and higher are beyond the reproductive age. Heart disorder, tuberculosis, diabetes and arthritis are included as disorders often seen in this age group in developing countries[32].

Women-specific disorders include malignant neoplasm such as cancer in reproductive organs (uterus, ovary, etc.), breast cancer and obstetric disorders (uterine myoma, endometriosis, serous cystoma, prolapsus uteri, fistulas[33], mastitis, etc.). In addition, many cases of menopausal disorders and osteroporosis are seen in the latter half of reproductive age or after menopause. Discussion and approaches for understanding and treating these disorders are insufficient in the entire field of reproductive health. Even WHO and the World Bank have only started to reinforce their approaches for reproductive health in the latter half of reproductive age and in post-menopause in the latter half of the

[27] World Bank (1994)
[28] According to the definition by the United Nations, a region or country has "grayed" when the rate of population at ages 65 years old or higher exceeds 7% of the total population.
[29] JOICFP (2003)
[30] Reproductive Health Outlook (http://www.rho.org/html/older_overview.htm)
[31] World Bank (1994)
[32] *ibid.* p.16
[33] UNFPA has only held the first international conference on fistulas in 2003, and a future approach is expected

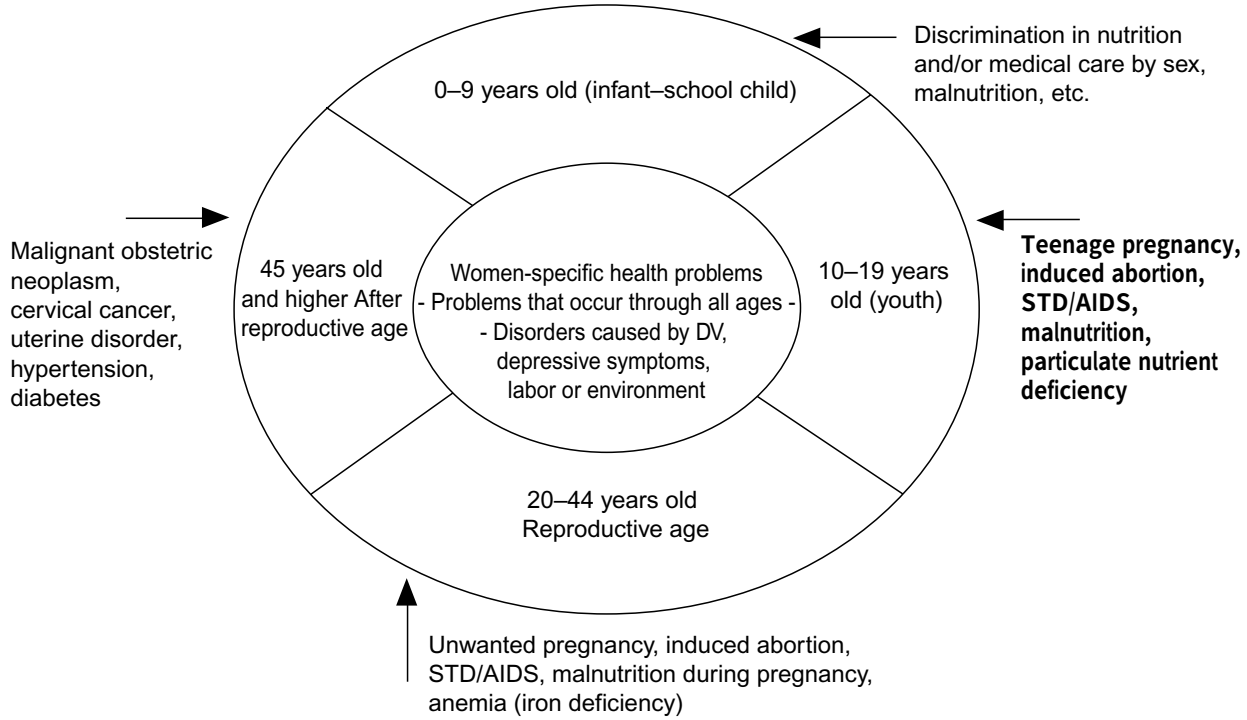
1990's[34]. Further discussion is required on ways to support the health of senior women[35].

Support for prevention/treatment of women-specific infections, disorders as well as malignant neoplasm such as cancer in reproductive organs (uterus, ovary, etc.) and breast cancer reduces the loss of health and ensures better Quality of Life (QOL) for affected women. Early diagnosis as well as development and promotion of appropriate treatment method are required in order to provide support in prevention and treatment. **It is important to implement research, education and advocacy activities on symptoms, risk factors, prevention methods, etc.** Health professionals are mainly expected to conducted activities towards research and education. Advocacy activities for general residents are expected to contribute to improving reproductive health. Potential prevention methods that are more familiar and inexpensive can be effectively provided by community health promoters, NGOs or residents themselves in addition to those provided by health professionals. While checkup for early identification is a highly cost effective method of prevention for cervical cancer, the implementation of checkup under circumstances in which access to appropriate treatment has not been ensured is ethically problematic. In promoting checkups, sufficient explanation should be given to the medical examinee with consideration given to avoiding any psychological or physical burden. Cooperation in adopting remedies that considers the human rights and the QOL of patients including sparing of reproductive organ functions should also be discussed as an aspect of support in treatment.

[34] WHO (http://www.who.int/reproductive-health)

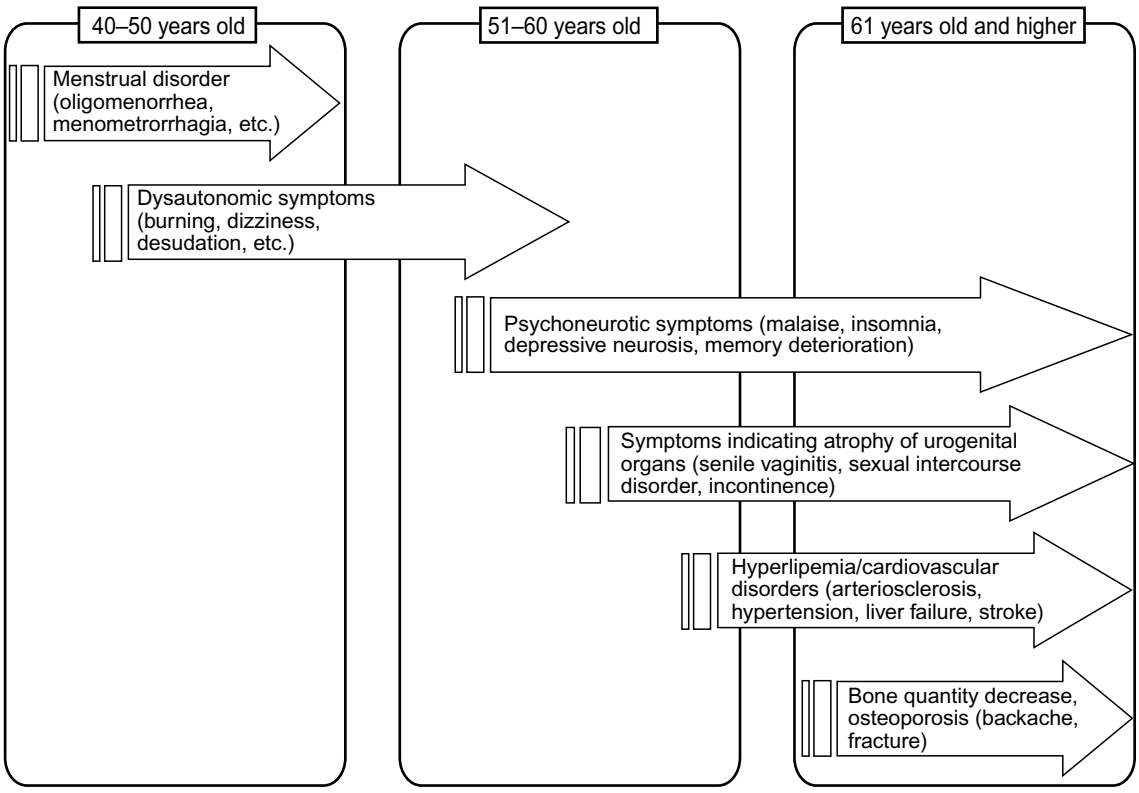
[35] Second World Assembly on Ageing, Madrid, 2002 (http://www.un.org/ageing), etc. discuss the current status and issues to be reinforced.

Figure 2-3 Major Health Problems by the Life Stage of Women



Source: Prepared based on World Bank (1994) p.86.

Figure 2-4 Women-Specific Disorders and Symptoms by Age



Source: Prepared by partially revising JOICFP (2003) p.31.

Health problems after reproductive age should be considered. Understanding of this issue should be promoted in order to eliminate prejudice in this area.

Approach by JICA

JICA implements the "Women's Health Project" (1999–2004) in the state of Veracruz in Mexico as part of a support on women-specific diseases, and cooperates in the improvement of the screening rate for cervical cancer and cell diagnosis systems. In this project, human resource development on treatment service providers and the improvement of treatment facilities were implemented in addition to the reinforcement of women-specific disorder screening (see Appendix 1. Box A1-6). JICA also has experience in providing equipment for fistulas as a special provision of medical equipment.

Boxes 2-13 and 2-14 introduce examples of cooperation in women-specific disorders that have been attempted by other donors.

Box 2-13 Approach to Health Problems in Middle-Aged and Elderly Women (Case of World Bank)

The World Bank classifies the ages 45–55 years old as the age bracket in which harm to health may occur due to menopause, and recognizes that information on the menopause should be disseminated. Although menopause settles within two years on average, it harms women's health, and WHO and the World Bank **positions improvement of women's QOL that is deteriorated by menopausal disorders as an issue that developing countries must face as an aspect of reproductive health improvement.**

The World Bank focuses on advocacy activities to prevent the health problems of middle-aged and elderly women. Specifically, calcium intake for preventing osteoporosis and arthritis, regular and moderate exercise, reduced alcohol intake and abandonment of smoking are recommended. Although such measures are helpful in developed countries in the sence that it is not cost-effective, measures centered on advocacy on the improvement of nutritional balance is considered more practical in developing countries. Thus potentially effective approaches for this issue are **(1) giving health workers opportunities to obtain knowledge about symptoms, risk factors, improvement methods and to study about early diagnosis and appropriate treatment methods, and (2) cooperation in disseminating knowledge about factors that harm health, and improvement methods for women during menopause so that the bias caused by insufficient knowledge can be reduced among community people.**

Especially in developing countries, the significance of health problems during menopause can be overlooked by women themselves because medical institutions may not consider it important to take account of women's menopausal health problems in addition to the emphasis on merit that anxiety towards unwanted pregnancy is removed by menopause. Projects that aim to support women-specific diseases have been implemented in some developing and semi-advanced countries (see Appendix 1. List of Cases Related to Reproductive Health), and some cases can be used as reference in Japan's international cooperation.

Box 2-14 Case of Approach to Fistulas (Ethiopian Fistulas Special Hospital Project)

In Ethiopia, many women suffer from fistulas due to young marriage and delivery as well as insufficient health services. Function recovery surgery for fistulas started in Addis Ababa in 1959, and the Addis Ababa Fistulas Hospital was established in 1975. Surgery is implemented free of charge by a team of five surgeons, and thirty cases are treated every week on average (it is supposed to cost 350 US dollars per patient). While it takes only 1–3 hours with spiral anesthesia, it requires in-hospital care for two weeks and sufficient care is required including mental care during the recovery period. In order to support financial difficulties, new clothing and travel expenses are supplied when the patient leaves the hospital. Instructions such as, avoid sexual intercourse for several months, and have delivery in hospitals if the patient is to deliver are also given to the patient upon leaving the hospital. Many patients treated in this hospital became nurses, hospital staff or regional supporters of fistulas treatment. Surgery on fistulas requires difficult techniques, and every year, trainings have been provided to about ten surgeons from developing countries. This hospital treats about 1,000 women every year, and the rate of successful surgery is 92%. It also implements advocacy activities on avoiding heavy labor during pregnancy, receiving appropriate medical services, raising the age of delivery, knowledge about hygiene for preventing sexually transmitted infections and knowledge about sexually transmitted infections.

Mid-Term Objective 2-2
Measures against Infertility

Infertility is also one of the reproductive health issues, and treatment with due consideration of human rights as well as advocacy activities to eliminate bias are desired in the activities against infertility.

Mid-Term Objective 2-2 Measures against Infertility

About 80 million people suffer from infertility worldwide, which indicates that one out of every ten couples face infertility problems[36]. While around 5% of total infertility problems are considered unresolvable by the present medical technology, there are many cases of infertility caused by sexually transmitted infections, infections such as tuberculosis, unsanitary abortion, intermarriage and Female Genital Cutting (FGC). WHO has recently mentioned Assisted Reproductive Technologies (ART[37]) in its approach for reproductive health and recognizes **that infertility and its treatment requires further discussion**[38]. In developing countries where ART cannot be adopted due to technical and financial reasons, polygamy may be used to have children. However, in cooperation related to infertility in the scope of reproductive health,

[36] WHO (http://www.who.int/reproductive-health/infertility/index.htm)

[37] UNFPA (1998) states as around fifty years old. It mentions that women without experience of delivery, who smoke or are in poverty may have menopausal disorders earlier.

[38] *ibid.* p.56. Since menopausal disorders are caused by decrease in estrogen, suggested measures include (1) hormone replacement therapy (HRT), (2) improvement in life habits (recommendation for exercise, improvement in nutrition, etc.), (3) drug treatment except hormone therapy mainly consisting of Chinese herbal medicines, and (4) counseling and psychotherapy. Among various symptoms due to female hormone (estrogen) decrease, osteoporosis, etc. have been proven to improve by estrogen supplementation. However, method (1) has not been completely established on when, how much, and which drug should be administered to replace estrogen since there are variations among individuals. Future improvement is expected in treatment methods that correspond to the individual circumstances of the patients.

health workers are expected to develop and improve the treatment methods with due consideration of human rights. Furthermore, **advocacy activities are essential in order to disseminate correct knowledge and eliminate bias.**

Based on cooperative experience in other countries, the following have been clarified[39]: (1) while the bias that the cause of infertility lies in the woman still prevails, it should be recognized widely that the problem may lie in the reproductive functions of man, (2) most causes of infertility can be clarified at low cost, (3) treatment proceeds effectively if the degree of education of the couple is high. JICA has no case of direct cooperation on this issue. Therefore, learning from approaches by other organizations will help in finding an effective approach[40].

Development Objective 2 Improvement of Women-Specific Health Problems and Measures against Infertility

Mid-Term Objective 2-1 Measures against Disorders and Risks to Health by Life Stage

Sub-targets of Mid-term Objectives	Examples of Activities	Case No.	JICA's Schemes
Treatment of malignant obstetric tumor, etc., reduction of health loss caused by cancer in reproductive organs (uterus, ovary, etc.) and breast cancer	○Substantiation and promotion of early diagnosis and proper treatment ○Education and advocacy about symptoms, risk factors and prevention methods ○Human resource development and improvement of facilities for screening and service providers	40	
Improvement of lowered quality of life (QOL) by menopausal disorders, etc. due to aging	×Training on symptoms and risk factors for health workers ×Substantiation and promotion of early diagnosis and proper treatment ×Support to activities on further dissemination and understanding of knowledge about symptoms, factors, improvement methods, etc. targeting general residents		

Mid-Term Objective 2-2 Measures against Infertility

Sub-targets of Mid-term Objectives	Examples of Activities	Case No.	JICA's Schemes
Infertility and measures against infertility	×Promotion of dissemination and understanding of proper knowledge and improvement of treatment methods sufficiently considering human rights		

※For details about Case Numbers, please see the table in Appendix 1.

◎＝JICA has considerable experience in Reproductive Health Cooperation Projects
○＝JICA has certain experience in Reproductive Health Cooperation Projects
△＝JICA has experience as a component of projects in Reproductive Health Cooperation Projects
×＝JICA has little experience in Reproductive Health Cooperation Projects

[39] See Figure 2-4.
[40] Reproductive Health Outlook (http://www.rho.org/html/older_overview.htm)

Development Objective 3
Gender Equality and Women's Empowerment

Development Objective 3 Gender Equality and Women's Empowerment

Approaches from healthcare outlined in Development Objectives 1 and 2 are insufficient to address the problems of reproductive health. Further attention should be paid to the aspects of economic circumstances, education, employment, life and home environment, social/gender environment and traditional norms of the people. Women's social and cultural status is an especially important factor that affects their reproductive health.

Promotion of gender equality and improvement of women's status are the third objective of the Millennium Development Goals, and it should be promoted as a global issue in development assistance. At the same time, empowerment of women is an essential factor for achieving reproductive health.

Mid-Term Objective 3-1 Elimination of Unequal Opportunities between Men and Women

The human rights approach, as characterized by the ICPD Programme of Action in 1994 presumes respect for reproductive rights as human rights of people (especially women). Reproductive rights refers to "basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so."

Education is especially important among these basic rights. Improvement in the opportunities for education increases the age of first marriage (age of first delivery) and the contraceptive practice, which directly decrease the birth rate. In addition, increase in knowledge about health, nutrition and hygiene through education reduces the mortality rate and indirectly leads to a lower birth rate.

Unequal opportunities for education between men and women in developing countries is serious (about 60% of the estimated 104 million children who cannot receive education are girls. Two thirds of the 880 million illiterate adults are women), and various approaches are required in order to address this issue. To increase the level of education for women, it is necessary that women are able to participate in both formal education and informal education such as literacy education and vocational training, and that existing education programs and facilities be corrected if they have gender bias so that non-discriminative education and training can be developed. It is equally important to consider how to support women with difficulty or inability to access health services and information about health under the existing reality of unequal opportunities for education and employment.

Potential approach methods include gender sensitivity training on health service providers and gender advocacy activities targeting regional forces and religious leaders so that access to health services can be promoted.

Potential methods of approach **include gender sensitivity training for health service providers and gender advocacy activities targeting religious leaders so that access to health services can be promoted.** Furthermore, to protect one's own reproductive health or to recognize and implement the right of **self decision about sex is important** even if women do not have the opportunity for education. **Advocacy activities and motivating for such purpose are** also

effective approaches for this Mid-Term Objective.

Approach by JICA

JICA's New Standard for Gender Equality/WID Statistics[41] (Gender Mainstreaming Unit) has three categories: "women-targeted project," "gender equality project," and "gender-integrated project." Approaches in the field of reproductive health are considered either women-targeted project or gender-integrated project.

Ever since JICA began to focus on gender at the beginning of 1990's, the necessity for WID consideration in projects has been gradually increasing, and gender perspective is now being incorporated more consciously in many reproductive health-related projects.

This Mid-Term Objective is more frequently approached compared to the other three Mid-Term Objectives. For example, "Population Education Promotion Project" in Kenya (1988–1993) which was implemented before the Cairo Conference had useful contrivances for improving women's access to health services by implementing advocacy activities using folk media (a method of communicating educational messages through locally oriented songs and dances) for women with a high rate of illiteracy as part of IEC activities aiming for the reform of the sense of values related to the desired family scale.

On the other hand, even after the Cairo Conference, some cases did not specially aim for improvement of the gap between men and women in the implementation process although they are reproductive health-related cases (example: "Indonesia Maternal and Child Health Project," "Mother and Child Health Project in Mongolia," "Ghana Maternal and Child Health Medical Service Improvement Project," etc. Strictly speaking, these are not gender-integrated projects).

It is difficult for any project to become gender-integrated unless the perspective of gender is incorporated from the project planning stage. In order to consider gender, it requires detailed observation and examination of the social and cultural background of women.

Mid-Term Objective 3-2
Reduction of Violence against Women and Sexual Violence

Mid-Term Objective 3-2 Reduction of Violence against Women and Sexual Violence

Reproductive health is a comprehensive concept that treats problems related to women's sex and reproduction throughout their lives, and it is not limited to just health problems but treats all types of violence originating from discrimination of women and sexual violence such as sexual harassment and

[41] The following three standards are defined in the JICA Thematic Guidelines on "Gender Mainstreaming/WID": (1) "Women-Targeted Project": A project that deals with the practical needs of women as the main beneficiaries and substantiation of women's strategic needs as the final objective, (2) "Gender Equality Project": A project whose main purpose is to promote gender equality and the empowerment of women, (3) "Gender-Integrated Project": A project in which contrivances/measures are taken for correction of gender gaps from the stages of implementation or planning although gender equality or empowerment of women is not specified as the priority objective or project objective.

domestic violence (violence from partner).

Violence based on gender including Female Genital Cutting (FGC), violence against women during armed conflict, Domestic Violence (DV), rape, forced prostitution, dowry death[42], honor kiling[43], and girl killing have adverse influence on women's health and social participation throughout their lives. Violence against women harms women's health and well-being by causing unwanted pregnancy, unapproved and dangerous abortion, forced infertility/forced contraception and sexually transmitted infections including HIV/AIDS.

Reducing the number of cases of violence against women and sexual violence requires establishment of a social environment that opposes violence against women and strengthens referral services for treating physical/mental harm caused by violence. Female Genital Cutting is considered a type of sexual violence.

Reduction in the number of cases of violence against women and sexual violence **requires establishment of a social environment that opposes violence against women and strengthening of referral services for treating the physical harm and mental care services when violence is suffered** as well as efforts to eliminate FGC. In particular, the traditional custom of FGC is an extremely harmful type of sexual violence to women and demand for its abolition has been growing as reflected in the ICPC Programme of Action. Some countries have taken measures to ban the custom.

Box 2-15 Female Genital Cutting (FGC)/Female Genital Mutilation (FGM)

In many societies in Africa and West Asia, Female Genital Cutting (FGC)/Female Genital Mutilation (FGM), which is often called circumcision for girls, is performed. Approximately 130 million girls and young women experience this dangerous and painful custom, and approximately 2 million girls undergo this dangerous cutting every year. FGC indicates cutting the clitoris or other external genitalia partially or entirely. This is based on the deep-rooted folk belief that the sexuality of girls must be controlled and that the virginity of girls must be protected until marriage.

Approach by JICA

Although JICA has few approaches for this Mid-Term Objective, there have been some projects over the past several years. As examples of the Technical Cooperation Project, the "Jordan Family Planning WID Project (see Appendix 1, Box A1-4 for details)" incorporated the subject of domestic violence against women in training of female personnel for home visits, and the "Honduras Seventh Health Region Reproductive Health Improvement Project" included the subject of sexual violence as a lecture given by a specialist in the field of counseling. In addition, the "Project for Strengthening of the Local System of Integral Health Care (SILAIS) of Granada" held workshops for

[42] Dowry death: A custom spread in twentieth century in traditional Indian society in which the husband or his family kills the bride because the dowry is too small or that the bride's family does not pay additional dowry. Some estimate that more than 5000 brides are killed each year.

[43] Honor killing: A custom seen in Arabic/Islamic Societies. It is based on the concept that it is a disgrace for the father or family if a woman has sexual intercourse with someone other than her husband and killing is permitted to save their honor. In some cases, a woman may be killed based on a rumor, regardless of whether sexual intercourse actually took place.

reducing violence and countermeasures in cooperation with local NGOs and police as part of adolescent reproductive health education.

In the scheme of the former Community Empowerment Program, the program under "Mexico Sexual Health Project for Street Children" provides psychological counseling through interviews in shelters to children who have suffered sexual violence.

Although there are no accurate statistics, JOCV has the most experience in this field. In Central and South America and Asia, activities are conducted in the fields of sexual harassment, DV and rape for adolescents, public health nurses, midwives and village development volunteer workers. What is common to these cases is that it was recognized that they are problems that cannot be neglected and thus staff activities began, although no activities related to gender and violence were requested at the beginning. This problem cannot be treated easily without building a relationship of trust between donors and beneficiaries based on thorough communication.

FGM/FGC is an extremely serious problem among various types of violence against women. Although the Japanese Government has experience in cooperation through the Japan WID Fund of UNDP in Egypt, JICA itself has no direct experience. This issue requires addressing based on a comprehensive understanding of the problem.

Mid-Term Objective 3-3
Promotion of Understanding and Participation by Men

Mid-Term Objective 3-3 Promotion of Understanding and Participation by Men

Even when women are given access to information and services related to reproductive health by overcoming unequal opportunities, decisions about sex and reproduction are often made by the male partner. As a result, the risks of unwanted pregnancy/delivery and sexually transmitted infections such as HIV/AIDS increase. Particularly in the case of HIV/AIDS, women are more apt to be infected biologically due to the structure of their reproductive organs, and have a greater risk of transmission because there are many cases of forced sexual intercourse or they cannot make their own decision to use condoms as contraceptives. Furthermore, in some developing countries, only female health workers are allowed to diagnose pregnancy and attend delivery due to cultural reasons, and thus women have limited opportunities to receive diagnosis due to the shortage in the number of female doctors and midwives. There are also many cases in which privacy or human rights of women are not guaranteed in health institutes.

For gender equality, which is a requirement for addressing reproductive health, **promotion of understanding and participation by men is essential.** The attitude and behavior of men is largely influenced by a fixed definition of masculinity (the stereotype that they must be vigorous and capable). Therefore, an approach is necessary to unwind such fixed gender concept and implement educational/advocacy activities on the roles and responsibilities of men in reproductive health. Discussion between men and women on the roles and

responsibilities in the household empowers the household and leads to a reduction in gender inequality. It is also necessary to provide similar advocacy activities for other family members, community leaders and health service providers. It is especially effective to give reproductive health training including family planning, gender training, peer counseling, etc. to single men and adolescent men who are sexually active.

Approach by JICA

The recognition that the promotion of understanding and participation by men is essential for achieving gender equality has been established since the Cairo Conference, and means of encouraging the understanding and participation of men are gradually being implemented. In the "Mexico Family Planning/Maternal and Child Health Project," a message to the father was incorporated on each page of the Maternal and Child Health Handbook (named "My Handbook"). In addition, the "Bangladesh Reproductive Health Human Resource Development Project" implemented parent's class in maternity hospitals. "Jordan Family Planning WID Project" took an approach to respect the traditions of local societies by holding IEC workshops that presented male residents with the same topics as women in their homes and Beduin in Arabic.

Mid-Term Objective 3-4
Promotion of Social Participation by Women and Improvement of their Economic Power

Mid-Term Objective 3-4 Promotion of Social Participation by Women and Improvement of their Economic Power

Women must be able to make their own decisions in relation to their sex and reproduction in order to ensure reproductive health throughout their lives, and it is necessary that the cultural and customary aspects in which men or other parties make decisions against the will of women be improved to enable an equal relationship between men and women based on mutual respect. "Gender Equality and Women's Empowerment" is an important goal of the ICPD Programme of Action. In order to promote women's empowerment, it is necessary to implement activities that raise women's awareness that they are entitled to self-esteem, be able to enjoy good mental and physical health and have their will respected in relation to sex and reproduction.

Empowerment of women requires:
(1)Integration of income generation activities and reproductive health.
(2)Gender training of health service providers.
(3)Advocacy and educational activities for men, regional forces and religious leaders, etc..

Realistic indicators of the empowerment of women based on self-esteem are their abilities to make their own decisions, equal social participation and improvement in economic power. Potential approaches include the **provision of health services with conscious combination of an income improvement program** with women as the receivers, **gender training by specifying only women as the health service providers** such as community health workers, and **advocacy and educational activities for men, regional forces and religious leaders.**

Approach by JICA

The first Technical Cooperation Project that specified this Mid-Term Objective as the central theme was the WID case, "Jordan Family Planning WID Project" (see Box A1-4). This project integrated reproductive health

improvement, advocacy activities to local residents and women's income creation activities (goat breeding, beekeeping, etc.). Gender training was incorporated in preliminary training of health service personnel (female) selected from regional residents, and when the personnel made individual home visits, she provided gender advocacy activities such as family planning and care for pregnant and nursing women besides health services. This not only improved gender awareness of female residents but also self-esteem of the health service personnel. Moreover, income generation activities assuming women as beneficiaries served as an entry point for incorporation of the community including men. Such improvement in women's economic power led to the higher status of women in households and strengthened their self-esteem. Furthermore, advocacy workshops given separately for male and female residents and activities to gain understanding by regional forces and religious leaders (regional development committees) were also effective as an approach that took account of regional characteristics. It is important to receive the advice and cooperation of local international organizations and consultants in activities related to gender, which are greatly influenced by cultural and religious factors.

This project has been implemented as a former Community Empowerment Program. It is a valuable case in analyzing the synergistic effect between women's empowerment and reproductive health, and behavioral changes in women and men, and further monitoring is required.

The "Bangladesh Reproductive Health Regional Expansion Project" (2001–March 2004) started as a former Partnership Program and follow-up cooperation is being implemented at present. This project was implemented in cooperation with a Japanese NGO (JOICFP) and a local NGO (Bangladesh Family Planning Association) aiming at raising the awareness of women in rural areas in order to protect their own health and the health of their families, and an integrated approach was applied combining various activities. It has many similarities to the above project in Jordan in organization of women, nurturing of home development volunteers, incorporation of local municipalities, provision of reproductive health services, and activities that lead to women's empowerment (literacy education, vocational training in sewing schools, income creation activities by dress-making, poultry farming, etc.). Such activities lead to increased capabilities of women in the household and greater opportunities for their participation outside the house.

Furthermore, the "Family Health and Empowerment of Women Project" (September 2003–August 2006) is being implemented in Pakistan as a former Community Empowerment Program. In this project, income generation for poor women in slum areas is supported through improvement in reproductive health services and technical training (sewing, handicrafts, etc.). In the challenge for raising awareness on empowerment, lectures on gender issues and measures to encourage women to discuss their own experiences are being expanded from the main implementing body, which are the representatives of the NGO regional centers, to the representatives of each community (female volunteer) and further to regional residents.

Development Objective 3 Gender Equality and Women's Empowerment

Mid-Term Objective 3-1 Elimination of Unequal Opportunities between Men and Women			
Sub-targets of Mid-term Objectives	**Examples of Activities**	**Case No.**	**JICA's Schemes**
Improvement in girls' education	△Provision of opportunities for literacy, elementary and vocational education △Women's capacity development in education and employment ×Development of non-discriminating education and training	7, 8, 118	
Improvement of women's access to health services	△Gender advocacy activities for health service providers △Advocacy for regional forces and opinion leaders ○Establishment of health services that are easily accessed with consideration of women's privacy ×Improvement of gender-disaggregated health statistics	8, 36, 34	
Motivation for health promotion by individuals	×Health education for women who have less access to school education (plays, picture-story show, songs, videos) △Provision of health services in combination with literacy education and informal education programs	2, 3	

Mid-Term Objective 3-2 Reduction of Violence against Women and Sexual Violence			
Sub-targets of Mid-term Objectives	**Examples of Activities**	**Case No.**	**JICA's Schemes**
Elimination of Female Genital Cutting (FGC)	×Education and advocacy for girls, their families and regional forces on health risks of FGC ×Training and advocacy of human resources for health services		
- Establishment of social environment that opposes violence against women (violence in armed conflicts, domestic violence, rape, forced prostitution, etc.) **- Substantiation of referral services after suffering violence (including services other than health services)**	△Education and advocacy of women, men, regional forces and religious leaders on sexual violence △Human resource development and advocacy for health service providers ×Human resource development in referral service providers ×Improvement of facilities for providing referral services	8, 41, 117	

Mid-Term Objective 3-3 Promotion of Understanding and Participation by Men			
Sub-targets of Mid-term Objectives	**Examples of Activities**	**Case No.**	**JICA's Schemes**
Promotion of men's understanding and participation	△Development of contraception methods, information, counseling method for men ×Peer counseling activities among men	8, 14, 39	

Mid-Term Objective 3-4 Promotion of Social Participation of Women and Improvement of their Economic Power			
Sub-targets of Mid-term Objectives	**Examples of Activities**	**Case No.**	**JICA's Schemes**
Promotion of social participation of women and improvement of their economic power	○Improvement of knowledge and self-esteem by gender training for health service providers and receivers △Provision of health services in combination with women's income increase programs for women △Gender training for men, regional forces, religious leaders, etc.	7, 8, 118	

※For details about Case Numbers, please see the table in Appendix 1.

◎＝JICA has considerable experience in Reproductive Health Cooperation Projects
○＝JICA has some experience in Reproductive Health Cooperation Projects
△＝JICA has experience as a component of projects in Reproductive Health Cooperation Projects
×＝JICA has little experience in Reproductive Health Cooperation Projects

Development Objective 4 Establishment of System to Improve Reproductive Health

In order to position improvement of reproductive health as an important national issue and to implement activities of the above Development Objectives 1 to 3 smoothly and successively, **"establishment of system to improve reproductive health"** is important. At present, some donors implement assistance in which they deal with the residents directly without involving the existing public health system, and JICA partially implements such assistance. However, such approach leaves concern about the possibilities for sustainability when the assistance fund ends, although direct and visible effect may be seen. Considering that assistance will end sooner or later, implementing system establishment and capacity development on existing health systems is important.

Mid-Term Objective 4-1
Establishment of Political Commitment

Mid-Term Objective 4-1 Establishment of Political Commitment

For reproductive health to be improved comprehensively, it is desirable that a budget, system, and human resource be established including law establishment. To do this, reinforcement of political will and political commitment is required. Developing a comprehensive political framework for the field of health as a country, preparing a national strategy that specifies the period for achievement, and mentioning in the strategy, the reinforcement of reproductive health including women's rights will be the driving force for improving reproductive health. Furthermore, political commitment for related fields including the establishment of a social infrastructure such as road transportation and waterworks/sewer system and expansion of opportunity for education is also essential for improving access to health services[44].

Reinforcement of Political Commitment
(1)Development of a comprehensive political framework.
(2)Preparation of a national strategy.
(3)Improvement of access to health services.
(4)Expansion of opportunity for education, etc..

One approach for strengthening political commitment is to implement advocacy including political suggestions, holding international conferences, high level meetings, training, implementation of study tours with the participation of policy-makers, publication of books and theses, and approach for various public relations and mass media comprehensively and successively[45].

In addition, an approach for budget expansion for the field of health, especially for the field of reproductive health is necessary since ensuring sound health finance and rightsizing of health finance are important factors for maintaining good quality health services.

As discussed above, possible methods for becoming involved in policy include assisting in developing the master plan for the entire health sector and giving political advice by sending health policy advisors whose counterparts are

[44] WHO/AFRO (http://www.whoafro.org/press/2003/pr20031024.html). The WHO report presents some successes in the area of reproductive health such as Mauritius where access to medical facilities was enabled from any area by expansion of the opportunities for education and infrastructure establishment, Seychelles where helicopters and airplanes were prepared for medical emergencies, and Cape Verde where basic medical care and basic education were made free as a result of strong political initiative.

[45] UNFPA (http://www.unfpa.org/supplies/essential/7a.htm)

high-level officials in the department of health. Furthermore, it is necessary that approach is made so that improvement of reproductive health is considered an important issue in the process of developing these national strategies and budget is distributed appropriately if assistance is to be given in creating a national development plan for the country's Poverty Reduction Strategy Paper (PRSP), mid-term financial plan, etc. Towards this end, assistance should be implemented not only for the policy of the department of health but also in advocacy activities for the political authorities by working in cooperation with advisors to the ministry of finance or competent authorities for economic policy and political assistance programs for macro-economic management.

Approach by JICA
(1)Assistance in the drawing of development plan.
(2)Health policy advisors.

Approach by JICA

Since the start of 1990's, **JICA has assisted the drawing of development plan in the field of health at national and local levels, using the development study scheme,** as assistance in the political framework development. In particular, the "Development Study in Reproductive Health in the State of Madhya Pradesh, India" (see Appendix 1 Box A1-8) is an example of assistance for development of the master plan for reproductive health improvement. In this cooperation, a development program (master plan) was prepared in the state of Madhya Pradesh in India by setting "women's health" as the highest priority issue. Development studies have also been implemented in Lao PDR, Uzbekistan and Sri Lanka for preparation of national development programs in the field of health.

JICA has dispatched health policy advisors to several countries, and political advice has been given by these specialists on the entire health policy including reproductive health.

The "Viet Nam Reproductive Health Project" is an example which reflected the activities of locally implemented projects on the policy of central government (see Box A1-1). Various systems developed through the project were incorporated in the 10-year national program on reproductive health which was instituted by the Vietnamese Government. This is a good example of how grassroots activities can be reflected in national program.

Mid-Term Objective 4-2
Reinforcement of Administrative Systems for Health

Mid-Term Objective 4-2 Reinforcement of Administration Systems for Health and Medicine

In order to improve and maintain reproductive health, it is necessary that **(1) improvement of managerial capabilities of the administrative body, (2) establishment of an information control system and (3) development of finance reinforcement systems in the health sector** be implemented from the standpoint of reproductive healthcare on both levels of national and local administration.

To improve the managerial capabilities of administrative bodies, training of administrators is essential so that national policy and an action plan for reproductive health are developed and implemented properly and efficiently

The following three items are necessary for reinforcing the administrative systems for health and medicine:
(1)Improvement of managerial capabilities of the administrative body.
(2)Establishment of an information. management system
(3)Development of finance reinforcement systems in the health sector.

under proper budget distribution while considering the international agreements and objectives, domestic circumstances, etc. Concurrently, **development of administrative capabilities of the local administrative bodies and local administrators** is also important due to the progress in decentralization in many developing countries. Greater attention is being paid to the quality of reproductive health care services in recent years and the role of local government is becoming more and more important in addition to that of the central government in providing higher quality services. Local governments must: (1) recognize reproductive health as an important issue and distribute budget for reproductive health with weight, (2) develop appropriate programs based upon accurate understanding of the circumstances and needs of the local residents, and (3) use the budget appropriately and effectively and implement programs with responsibility. An effective approach for this is to repeat **advocacy activities to local government leaders and train local administrators.**

Furthermore, it is important **to strengthen cooperation between the health department and not only the population/family planning department but also other sectors including social welfare and education** and promote reproductive healthcare. One possible method for this is to establish **an inter-ministry committee** and to support its functions. The committee should have its office in the ministry of health and include parties from each ministry related to reproductive health and even civil organizations such as NGOs and universities. It is also effective in terms of smooth implementation of projects to establish a working committee consisting of local government, ministry extensions, NGOs and support its functions when implementing local reproductive health care projects.

Assistance is also necessary for **"establishment of health information management systems"** for accurate understanding of reproductive health circumstances and the needs of local residents, **"installation and reinforcement of think tank organization"** and **"capacity development for research and evaluation"** for development, implementation and evaluation of appropriate administrative programs. Since health information management systems are not functioning in many developing countries, there are problems such as the insufficient collection of information, inability to analyze collected information, and inability to feed back, which makes it difficult to develop appropriate policies and programs based on the circumstances and needs of the country or region. Since Japan has accumulated knowledge in this field, cooperation can be expanded. Specifically, **(1) establishment of statistical systems, (2) development and improvement of health information management software including GIS, (3) training of statistics officer on use of computers, and (4) training on software use and data analysis method** are possible. However, it is important to check and organize the fundamental issue of **how and for what purpose these statistical skills will be used** before implementing such technical assistance.

On the other hand, an appropriate **approach for budget expansion** is

The establishment of health information management system is important in order to form policies and programs based on the situation and needs of respective country or region.

necessary as described in Mid-Term Objective 4-1 to reinforce finance for the promotion of reproductive health. A potential additional method for ensuring a budget other than tax revenue is to introduce **medical insurance or user fee system.** It is possible to introduce **a user fee system for the Maternal and Child Health Handbook, community insurance in drug supply,** etc. However, such introduction is not easy in regions with a high ratio of poor residents and so far, there has been little cooperation.

Approach by JICA

JICA has experience of cooperation in Honduras, Kenya, Bolivia, Malawi, etc. with purpose of improving "community health system."

A health information management system has been established in the development study scheme in Pakistan. In addition, assistance has been given in introduction of a health information management system in the Nghe An Province in the Viet Nam Reproductive Health Project. This system has been introduced in Nghe An Province with improvements by the project on the software for data aggregation and reporting developed by the Vietnamese Health Department in cooperation with UNFPA and WHO. With the approval of other donors and health ministry, they are currently preparing to introduce the system nationwide.

As to financial reinforcement, cases to be referred to include introduction of a user fee system for the Maternal and Child Health Handbook in Indonesia Maternal and Child Health Handbook Project and medical fee collection at the National Maternal and Child Health Center to enable stable finance in Maternal and Child Health Project in Cambodia.

Development Objective 4 Establishment of System to Improve Reproductive Health

Mid-Term Objective 4-1 Establishment of Political Commitment

Sub-targets of Mid-term Objectives	Examples of Activities	Case No.	JICA's Schemes
Establishment of political framework	×Development of national strategy △Development of activity plan	124	
Moderation of public finances for health care	× Budget increase		

Mid-Term Objective 4-2 Reinforcement of Administration Systems for Health

Sub-targets of Mid-term Objectives	Examples of Activities	Case No.	JICA's Schemes
Improvement in management capacity	△Training of administrators ◎Training of local administrators △Reinforcement of coordination with related authorities or international organizations △Development of education plan and re-education plan for health service providers △Increase in research and investigation capabilities △Financial strengthening by introduction of user fee system, etc.	16 16, 22, 28, 34 8, 14, 28, 34 1 25 16, 20	• Training of health and medical workers (improvement in managerial capabilities, reinforcement of training activities, improvement in treatment abilities) • Cooperation with local NGOs and international organizations
Establishment of health information management system	◎Establishment of statistical systems △Development and improvement of health information management software △Implementation of training on operation instruction on PC, software and data analysis for personnel in charge of statisticsmethod	29, 31, 34, 35 31, 35 29, 34, 35	• Establishment of health information control system

※For details about Case Numbers, please see the table in Appendix 1.

◎＝JICA has considerable experience in Reproductive Health Cooperation Projects
○＝JICA has some experience in Reproductive Health Cooperation Projects
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×＝JICA has little experience in Reproductive Health Cooperation Projects

Chapter 3 JICA's Cooperation Policy

3-1 Priorities and Points to Be Noted for JICA

(1) Basic Concept

1) Improving reproductive health is one of the most effective approaches for the achievement of Millennium Development Goals, and JICA should further extend cooperation in this field.

Improving reproductive health is one of the most effective approaches for achievement of Millennium Development Goals.

The ICPD Programme of Action (twenty-year plan) was adopted in the Cairo Conference in 1994 by 179 countries under the common recognition that "the achievement of reproductive health is essential for human-centred sustainable development and population stability." Although specific objectives were stipulated including the achievement of universal access to reproductive health by 2015, later adoption of the Millennium Development Goals (MDGs) in the United Nations General Assembly in September 2000 focused the world's interest on the achievement of these Millennium Development Goals.

However, the ICPD Programme of Action and the Millennium Development Goals share many objectives, and **many approaches for the improvement of reproductive health contribute to the achievement of the Millennium Development Goals** and thus, they should not be discussed separately. The improvement of reproductive health not only directly contributes to the goals of "improvement of maternal health," "reduction of infant mortality/morbidity," "reduction of sexually transmitted infections" and "promotion of gender equality," but also greatly contributes to the goals of "elimination of extreme poverty and starvation" and "universal achievement of primary education" (see Figure 2-1).

However, it is feared that many of the Millennium Development Goals may not be achieved by 2015. While donor agencies worldwide search desperately for the most effective approach for addressing the goals, **reproductive health and basic education** receive the most attention. If the world is to seriously work for the achievement of the Millennium Development Goals, it is necessary to reaffirm the significance of reproductive health and re-position it as a central issue in assistance.

The budget related to reproductive health in the JICA budget is only a little more than 1%. The budget should be expanded greatly in the future.

At present, only about 1% of the entire development assistance budget of the Japanese Government goes towards reproductive health, and **it barely exceeds 1% of the JICA budget.** Considering JICA's policy of approaching the Millennium Development Goals more proactively, it is essential that **the budget for reproductive health assistance be expanded greatly from the present.**

2) The basics for cooperation related to reproductive health is to adopt a comprehensive approach, and it is important to first organize the objectives and needs of the assisted country. The range of JICA involvement should be selected based on the trend of other donors' activities and the comparative advantage of Japan.

In cooperation in reproductive health it is necessary to first understand the objectives and needs of the assisted country and organize a comprehensive program frame.

As discussed in Chapters 1 and 2, reproductive health is a very comprehensive concept and its various activities and outcomes have a complex cause-and-effect relationship that cannot be organized in a simple chart (see Figure 2-1). In particular, **the relationship in countries where social and cultural consideration is essential such as less-developed countries and Islamic countries show that nearly all approaches in the "Development Objectives 1, 3 and 4" in the chart are required** and that the outcomes are interrelated and complementary in achieving the Millennium Development Goals. Thus it is not appropriate to limit the activities before starting the project and **it is essential that the overall reproductive health problem and needs of the assisted country be grasped appropriately** in cooperation with the assisted country and other donors **so that a comprehensive framework of assistance can be established.** In doing so, JICA should determine appropriate objectives to which it can contribute and then select what kind of cooperation should be provided.

In selecting the range of JICA involvement, various factors must be considered such as the degree of needs in the assisted country, existence of experience/resources in Japan, and the approaches of other donors. The following section (2) describes the issues on which JICA should focus.

(2) Issues JICA Should Prioritize

1) "Improvement of maternal health" with focus on the establishment of a consistent delivery care system is the field in which Japan can contribute most.

Issues JICA Should Prioritize:
(1) Improvement of maternal health
(2) Promotion of family planning
(3) Adolescent reproductive health
While (1) and (2) are fields in which JICA has rich experience, (3) is a new issue to be approached.

At present, one woman dies of a pregnancy- or delivery-related cause every minute. Many of these deaths can be avoided with appropriate treatment and Japanese technology and experience are very useful in assisting such treatment.

For improvement of maternal health, **it is important to establish a consistent delivery care system, covering from the pregnancy through to post-delivery periods.** JICA has implemented its original maternal and child health projects based on Japan's experience, such as grasping and registering the number and situation of pregnant/nursing women using the Maternal and Child Health Handbook, antenatal care, training of delivery attendants and expansion in emergency obstetric care, and providing support in relation to all processes of pregnancy and delivery. It is necessary that the experience and know-how accumulated in these projects are utilized fully and that focus be given to expansion of basic emergency obstetric care in local health facilities, training of delivery attendants who can work actively on PHC level, promotion of antenatal care, **while placing importance on rural areas where the delivery care**

In improvement of maternal health, importance should be placed on rural areas to promote the establishment of a continuous delivery care system.

system is under-developed.

Reduction in the maternal mortality ratio is the task considered to be most difficult in achievement among the Millennium Development Goals, and JICA should take a leading role in solving this issue in effective cooperation with other international organizations and NGOs.

Promotion of family planning is important for dissemination of basic education and reduction of poverty and both advocacy activities and a stable supply of contraceptives are necessary. It is important to note the relationship between family planning and reduction of poverty and expansion of opportunities for education not only on a macro-level of the demographic viewpoint but also on micro-levels (families/households).

2) Promotion of family planning is important for dissemination of basic education and the reduction of poverty, and cooperation with an effective combination of advocacy activities and a stable supply of contraceptives is necessary.

Reducing the birth rate by family planning induces economic growth and contributes to a reduction in poverty. For example, the control of population growth through family planning in East Asian and Central and South American semi-advanced countries is reported to have resulted in rapid economic growth. However, there is a risk that the introduction of this family planning theory may lead to a certain level of forced control of the population growth by governments, and women in poor villages are unlikely to be convinced by potential benefits of mere theories.

While JICA has discussed family planning from the demographic viewpoint and conducted surveys in the past, **it is important to note the relationship between family planning and the reduction of poverty and the expansion of opportunities for education, not only on a macro-level but also on the micro-level of individual families and households.** As shown in Figure 2-1, promoting the reduction of unwanted pregnancy and teenage pregnancy, and improvement of birth interval not only protects women's lives and health but also increases the opportunities for education for women and for their children and contributes to avoiding poverty of households.

In Japan, immediately after World War II, advocacy activities and a stable supply of contraceptives were promoted by public health nurse and livelihood extension worker, and the reduction of unwanted pregnancy and improvement of birth interval were rapidly advanced. As a consequence, investment in nutrition, health, and education per child increased in the household and led to significant economic growth on the macro-level. It is necessary in JICA's cooperation that such past experience be re-examined carefully so that it is utilized properly to suit the circumstances of developing countries. Although JICA has implemented the provision of contraceptives in medical equipment supply porogram, cooperation with UNFPA should be reinforced and Japan's experience and medical equipment supply should be combined so that family planning is promoted effectively.

Reproductive health care on adolescents is also important from the viewpoint of Millennium Development Goals and "human security." It is a new approach for JICA to deal with and there are needs to start taking actions in training experts immediately.

3) In many developing countries and African countries in particular, reproductive health care for adolescents is the most important issue. JICA should rapidly train experts in this field while also utilizing the resources of the assisted country or a third country to proactively address this issue.

Young people of 10 to 24 years old comprise 30% of the world's population, and they also comprise approximately half the number of newly HIV-infected people at present. In addition, most young people cannot receive reproductive health services due to the fact that adults do not wish to admit that they are sexually active, although in many countries, more and more teenagers become sexually active.

Therefore, it is necessary to target **young people in early adolescence** and give support for reproductive health care. Involvement with these adolescents is easier and more effective in deriving behavior changes by BCC (Behavioral Change Communication) compared to adults. Furthermore, it is **also life skill education for adolescent women to avoid various dangers and opportunity losses they may face in the future[46], and targeting and implementing these activities for women in poverty and/or situations of conflict who are in the weakest positions is an important approach that conforms to the concept of "human security."**

The fact that Japan has few resources in this field has hampered its cooperative efforts. However, the number of Japanese citizens who learn special knowledge of behavioral change in graduate schools and approach this issue in international organizations, Japan Overseas Cooperation Volunteers and NGOs have increased steadily. Such resources should be accessed and human resource training should be implemented in cooperation with domestic research institutes such as universities and NGOs to foster Japanese experts. It is also necessary to develop a network with NGOs/research institutes on site or in a third country with experience in this field and try to utilize their resources effectively and proactively.

Areas of cooperation in the future:
(1) Sub-Saharan Africa
(2) Middle East
(3) South Asia
Focus shall be shifted from Southeast Asia to Africa.

4) Future cooperation in reproductive health will place importance on Sub-Saharan Africa, Middle East and South Asia. Considering the seriousness of this issue in Africa, importance in terms of focus area should be shifted from Southeast Asia to Africa immediately.

The indicators related to reproductive health such as maternal mortality, infant mortality, and HIV/AIDS show the worst results in Sub-Saharan Africa. Considering the serious situation of HIV/AIDS, **implementation of adolescent reproductive health in Sub-Saharan Africa should be prioritized.** Moreover, improvement of maternal health in this area cannot be neglected considering the fact that one out of six-teen women die of a complication caused in relation to pregnancy or delivery.

Middle East have environments in which it is difficult for western

[46] By implementing an approach to provide proper information related to reproductive health care and induce behavioral changes of adolescent women, the following risks and opportunity losses should be avoided: (1) infestation of sexually transmitted infections including HIV/AIDS, (2) mortality/morbidity (including fistulas) caused by delivery or abortion, (3) infant mortality/morbidity at delivery, (4) poverty, starvation and malnutrition of the household caused by fertility, (5) loss of opportunity for education or empowerment by young pregnancy, and (6) loss of opportunity for education for the children due to fertility. However, sexual education including the prevention of non-consensual sexual intercourse and use of contraceptives and gender education should be given to adolescent men as well.

countries to assist in family planning due to confrontation between their cultures and the role of Japan in the field of reproductive health is receiving attention. Maternal mortality and birth rates are still high in many countries in South Asia, and the needs for maternal and child health as well as family planning is still high. In Afghanistan, one out of six women risks death in pregnancy, and urgent measures are required.

As to Southeast Asia, many projects have been implemented in the field of maternal and child health and family planning. JICA's project outcomes should be promoted and expanded nationwide and in more countries, and it is desired that the minimum level of assistance be continued while fomenting ownership and utilizing South-South Cooperation and local cooperation.

Furthermore, in Central and South America, there is a need for cooperation in "humanized maternity care" based on the excessively high rate of Caesarian section. New issues including "Development Objective 2: Improvement of Women-specific Health Problems and Measures against Infertility" should be challenged in some semi-advanced countries.

While an increasing number of donors have shifted importance to a disease-specific vertical approach, it is necessary that the effectiveness of a comprehensive approach targeted in reproductive health be re-evaluated.

(3) Points to Be Noted in Implementing Cooperation

1) While an increasing number of donors have shifted importance on vertical approach by disorder, it is necessary that JICA should re-evaluate the effectiveness of a comprehensive approach targeted in reproductive health and present it to the international society.

In recent JICA projects, measurable outcomes are demanded and some insist that selective and concentrated involvement by vertical approach is thus required. However, a vertical approach is not always optimal in fields related to reproductive health even on a project level. Although approach for issues in Development Objective 1 is most prioritized in many developing countries, it is necessary that problems sorted as Development Objective 3 "Gender Equality and Women's Empowerment" and Development Objective 4 "System Establishment for Improvement of Reproductive Health" are also approached at the same time for solution of these issues, and the scale of outcome appearance may be expanded in many cases (see following Sections 2) and 3)). Such approach may require additional involvement during project implementation or may work as an entry point[47] for implementing the project smoothly.

In recent years, the U.S. Government has placed importance on a disease-specific vertical approach, and downsized the assistance in reproductive health. It is necessary that Japan **should show the effectiveness of a comprehensive approach and proactively lead the approach in reproductive health.**

[47] In the Jordan "Family Planning/WID Project," women's income creation activities were used as an entry point that played an initiating role of starting reproductive health activities in community (see Box A1-4). In addition, an approach other than direct involvement in family planning or maternal and child health worked as an entry point for many reproductive health projects as in the introduction of "furnace" in the Kenya "Population Education Promotion Project" and measures against parasites in the Integrated Project by the Japanese Organization for International Cooperation in Family Planning (JOICFP).

In cooperation in reproductive health, the gender situation must be considered. Actions in relation to gender need to be included in activities of all projects.

2) In cooperation in reproductive health, consideration of gender is essential and situation analysis and specific actions in relation to gender need to be included in activities of all projects.

The overwhelmingly high morbidity of women in unwanted pregnancy and HIV infection is in many cases caused by non-consensual sexual intercourse. That is, social and cultural backgrounds centered on men lead to gender inequality even in sexual intercourse and obstruct the improvement of reproductive health. Furthermore, the low status of women in society may lead to insufficient establishment of emergency obstetric care in the case of abnormal delivery.

Opportunities for the education of women increase when the number of unwanted pregnancies is reduced, and conversely, an improvement can be seen when the number of unwanted young pregnancies is reduced and opportunities for the education of women is promoted. This means that improving reproductive health promotes the empowerment of women, and the empowerment of women reduces the gender inequality. Reproductive health and gender equality are two sides of the same coin in that they are essentially complementary. In cooperation in reproductive health, **it is important to ensure that the social inhibition factors caused by discrimination or gender inequality are analyzed. Concurrently, it is necessary to aim at specific improvements in the social environment surrounding women so that** not only women who are the beneficiaries but also **men can cooperate.**

Reflection on governmental policy (or harmony with policy) should be aimed clearly from the beginning of projects in reproductive health.

3) In cooperation in reproductive health, involvement in governmental policy as well as grass-root type activities need to be reinforced.

Action towards policy is important so as not to let project activities in model regions be concluded as model activities. However, in past JICA projects, the degree of involvement in policy depended on the abilities of the individual expert, and outcomes in the model region were not always well reflected in wider policy.

Involvement in national level policies should be positioned clearly as a part of the project activities from the beginning of the project. To do this, "reflection on policy" must be incorporated clearly as a project activity or outcome or as project objective[48] when developing the Project Design Matrix (PDM).

Furthermore, if the national strategy and implementation plan for reproductive health have already been established in the assisted country, the project design should be in harmony with such plans. For this purpose, certain involvement at the policymaking level needs to be maintained at all times. High-level involvement is important in demonstrating the effectiveness of JICA's

[48] Related parties should be encouraged to recognize the necessity for reflection on policies to clarify both "improvement of reproductive health indicators in the model region" and "reflection on policies" as objectives instead of limiting to one PDM project objective. Although it was conventionally considered that there should be only one PDM project objective, it is justified at present to set up two objectives in case of a project that implements a solution to a problem in a model region and a political approach based on the model activities concurrently.

cooperation and leading donor collaboration to the desired direction under the movements for Sector-Wide Approaches (SWAPs) and common basket arrangements, which have recently become popular in some countries.

It is necessary that a program approach is promoted further by incorporating technical cooperation, volunteer projects and monetary assistance strategically and effectively.

4) Cooperation with grant aid and medical equipment supply projects is a comparative advantage of Japanese ODA, and they should be utilized more strategically and effectively.

Many donors have a limited budget to be used for facility establishment and medical equipment supply. Thus it is a strength of JICA that grant aid and equipment provision schemes can be incorporated in implementing technical cooperation.

However, in the past, technical cooperation and grant aid were provided separately in many cases of Japanese ODA. In future, a **program approach should be promoted** by linking JICA's technical cooperation, volunteer projects, grant aids, medical equipment supply project, and Grant Aid for Grassroots strategically and effectively. It is especially effective when monetary assistance is utilized at the stage of horizontally expanding the outcomes of technical cooperation in the model region.

Furthermore, cooperation with and utilization of local NGOs and people's organizations are also essential in promoting community participation and expanding grass root projects, and project consigning and fund provision (Grant Aid for Grassroots, etc.) to such organization should be incorporated proactively in the entire program while monitoring its sustainability.

Continuous approach with development of long-term strategy is required in cooperation in reproductive health. JICA should participate proactively in the development of a long-term strategy for the entire program as well.

5) In cooperation in reproductive health, continuous approach based on development of a long-term strategy is required. In particular for pilot projects in model regions, continuous follow-up to set a road map for national expansion is necessary.

Many of the reproductive health activities induce behavioral changes beyond social and cultural barriers in poor women living in rural areas, and they cannot be addressed in a short term. Furthermore, in order to promote the model activities in one region to the national level, strategy must be considered in a long span of ten years or longer. Considering this point, it is not appropriate to limit the implication to the JICA project cooperation period (3–5 years) but an approach should be taken **to develop a roadmap for problem solving in the assisted country as a strategy for entire program and implement individual project under the long-term span of ten to twenty-year period.** JICA should participates as much as possible in the development of a long-term strategy while coordinating with the assisted country and other donors. In addition, it is desired that all monetary assistance and activities of other donors, etc. described in above 4) are incorporated in the program.

The conventional idea of evaluating only project level outcomes in a short-term when a five-year cooperation period ends and pulling out as soon as the project objective is achieved should be reconsidered. In particular, the idea that the assisted government should take charge of national promotion as to the

outcomes of JICA projects in model regions is not always appropriate except for in some countries that are sufficiently self-sustaining. Although one should be careful not to impair the ownership of the assisted government, JICA may need to continue its assistance until the outcomes gained in a model region can be applied to the national level and the base for a nation-wide promotion is prepared. Such ongoing assistance is important to have JICA projects properly demonstrate their expected effects.

Cultural consideration is required especially in cooperation in reproductive health. One method for avoiding cultural conflict is to utilize local experts for international organizations and local NGOs.

6) Cultural consideration is required especially in cooperation in reproductive health.

In cooperation in reproductive health, issues of family planning, abortion and gender are involved and there is a high possibility for religious and cultural conflicts. One method for avoiding such conflicts is to utilize the local experts from international organizations and local NGOs that already have established relationship of trust with the local people. Compared to the time in which family planning was at the fore, the environment has been prepared for reproductive health to be accepted more easily by many countries. However, it is necessary to continue to pay strict attention to cultural aspects on the activity levels including cooperation in the field of health.

3-2 Future Examination Issues

The following issues should be examined in the future in implementing cooperation in reproductive health:

Future examination issues:
(1) Examination of evaluation indicators.
(2) Demonstration and transmission of teffectiveness of JICA projects.
(3) Reinforcement of linkage with other sectors.

1) Determining appropriate indicators for outcomes in reproductive health requires further discussion. It is especially difficult to obtain reliable data on the Maternal Mortality Ratio (MMR) and an indicator to replace it needs to be developed.

In reproductive health projects, evaluation indicators are always an issue of discussion. It is said to be almost impossible to obtain accurate data on the Maternal Mortality Ratio (MMR) because many of the values in developing countries are estimated values although it is an indicator of the Millennium Development Goals (MDG). However, there has been no indicator suggested as a replacement for MMR, and no clear evaluation method has been developed for qualitative outcomes such as capacity development and awareness change.

In evaluating JICA projects, outcomes should be expressed in values as much as possible to fulfill the responsibility for explanation to external parties. It is necessary that JICA also continue to examine the evaluation indicators for future projects related to reproductive health with reference to the process indicators currently examined by the United Nations (see Appendix 3. Basic Checklist) while also paying attention to the results of discussions by international organizations.

2) JICA needs to demonstrate the effectiveness of Japanese cooperation in reproductive health scientifically and promote it internationally.

As shown in Chapter 2, in many cases, international consensus on an effective approach for maternal health has not been formed. In particular, several approaches based on Japan's experience are undervalued internationally. One reason for this is that JICA has neglected to positively review the effectiveness of the approaches it has taken and demonstrate it internationally .

The effects of various approaches that are at issue on a global scale such as the Maternal and Child Health Handbook, antenatal care, training of qualified midwives, substantiation of emergency obstetric care services, training of TBAs and humanized maternity care should be studied using Japan's experience and JICA projects as reference, and appeal the results in the forms of reports, theses and presentations to academic societies. It should work not merely as publicity and explanation of JICA projects but also **as Japan's "measurable international cooperation" as intellectual contribution for global improvement of reproductive health.** It is also important for Japan to develop a mechanism for effectively accumulating on-site experience in various parts of the world and share it.

3) Strategic cooperation with sectors other than health such as basic education, rural development and infrastructure should be examined in the future.

While the conventional reproductive health care projects have been self-conclusive in the field of health, strategic cooperation should be considered with sectors other than health including basic education, rural development and infrastructure establishment not to mention gender in the future.

It is also possible **to implement integrated projects on basic education and reproductive health** since education and health has been placed within the same jurisdiction of the Human Development Department by the organizational reform of JICA.

Furthermore, cooperation with the Japan Bank for International Cooperation (JBIC) should be considered in order to establish cooperation for road construction supported by loans and emergency obstetric care. Another idea is to utilize geographic information systems (GIS) to have total mapping of roads, schools, health centers, emergency obstetric care facilities, etc. to approach establishment when drawing a grand design for a new comprehensive regional development. Such multi-sectorial approach with a combination of hardware and software expansion including human resource development and system development should be considered.

Appendix 1 JICA's Main Operations (Reproductive Health)

As discussed in Chapter 2, cooperation in the field of reproductive health covers approaches for health-related to sex and reproduction in developing countries, and specific cooperation activities vary greatly as shown in the separate table (List of Projects Related to Reproductive Health).

The most frequent form of cooperation is **program cooperation with a technical cooperation project as the main project, in combination with grant aid and volunteer projects** mostly conducted in Asia and the Middle-East. This indicates that the combination of both software assistance (human resource development and system development) and hardware assistance (establishment of obstetric care facilities, provision of contraceptives, etc.) is required for solution of problems related to reproductive health.

Cooperation is implemented in two ways: **(1) a type in which a model region is selected where a regional-level model is established which then be expanded horizontally and reflected in policies, and (2) a type in which a hub hospital or training center is established and based on those facilities, human resource development is implemented.** Technical cooperation is rarely initiated based on development study (policy suggestion, master plan development etc.) as seen in other sectors. The only development study case specialized in reproductive health is the reproductive health assistance program study in India, but no projects have been implemented based on this development study and JICA cooperation has not crystallized yet. Thus the effectiveness of development study schemes is yet to be confirmed.

While needs for cooperation are high in Sub-Saharan Africa, there are few cases of program-type cooperation as shown above. Due to reasons such as small investment budget, there are only a few cases of consigning small-scale projects to local NGOs (former Community Empowerment Programs) except in Kenya and Ghana.

Below, JICA projects are classified into several groups by issue, and described in terms of difference in approach.

1-1 Regional Expansion Type: A model region is selected where a regional level model is established which then be expanded horizontally and reflected in policies (technical cooperation projects, monetary assistance, volunteer projects, etc.)

Many JICA projects including the "Philippines Family Planning/Maternal and Child Health Project" and "Viet Nam Reproductive Health Project" **take this form.**

In this type of project, a region with a population from several hundred thousands to a little over one million people is selected as a model region, and in Phase I, human resource development and system development are implemented at community level. In the following phase, the activity outcomes obtained in Phase I are proactively used as a model to expand the range of activities to a larger area and to reflect in policies. At this stage, **many cases cleverly combine various assistance schemes of Japan** such as grant aid, Grant Aid for Grassroots, Japan Overseas Cooperation Volunteers, cooperation with Japanese and local NGOs in addition to the technical cooperation project for horizontal expansion. There is a case such as the "Indonesia Maternal and Child Health Handbook Project" which implemented rapid promotion of the Maternal and Child Health Handbook by involving a wide range of donors including international financial institutions such as the World Bank and local NGOs at the stage of horizontal expansion.

In the "Viet Nam Reproductive Health Project," involvement in policy was successful by implementing an approach based on the outcomes of grass root activities in Nghe An Province so that they are reflected in the national 10-year plan for reproductive health. Furthermore, the "Philippines Family Planning/Maternal and Child Health Project" implemented development of a training module for national promotion based on the outcomes from the model region and including factors of the program implemented by international organizations. Assistance is planned to help the Philippine Government expand its activities to the national level when it is completed. In the "Tunisia Reproductive Health Education Reinforcement Project," an education program was implemented at the national level and two courses of third country training have been provided concurrently with targets being French-speaking African countries and Middle-East in Phase II.

In following such an approach, involvement in policies should be implemented at the same time, and every possible funding resource should be combined at the stage of planning horizontal expansion so that the activities in the model region do not end up only as a model. In addition, it is also necessary that the scale of input in the model region should not be too large considering expansion to other areas, and that the method for ensuring funding for horizontal expansion be discussed. Based on these viewpoints, several projects described in the following Boxes A1-1 to A1-6 should be referred to in future cooperation.

Box A1-1 Viet Nam: Reproductive Health Project (Phase I: 1997–2000, Phase II: 2000–2005)

In Nghe An Province located in the northern center of Viet Nam, a technical cooperation project is being implemented with the theme of "safe and clean delivery." This project originally developed from local community participation-type activities, which the Japanese Organization for International Cooperation in Family Planning (JOICFP) implemented. At the time of project start-up, the small national budget of the Vietnamese Government was prioritized for measures against infections and population policy, and there was little left for the field of maternal and child health. After Phase I (1997–2000), set up in eight districts (1.55 million people) among nine-teen districts of Nghe An Province, activities expanded to the entire Nghe An Province (2.95 million people) in Phase II.

Phase I consisted of three basic activities: (1) establishment of project organization, (2) package assistance, and (3) monitoring of the Commune Health Center (CHC). As establishment of the project organization, a project working committee was set up at each administrative unit of province, district and commune to establish the foundation for project promotion/maintenance. Package assistance was a form of cooperation by refresher training of CHC midwife staff, provision of equipment, materials and medical drugs, and facility improvement, and this resulted in high quality services at CHC. Confirming these activities through monitoring by the working committee lead to confirmation of outcomes of refresher training and improvement in the monitoring capability of the working committee. In Phase II, new approaches were followed including expansion of activities (approach for reduction in induced abortion, improvement in family planning services through reinforcement of counseling and implementation of RTI survey), capacity building for sustainability, reinforcement of regional organization activities in cooperation with women's unions, establishment of client-friendly services and establishment of Health Management Information System (HMIS) in addition to project expansion to the entire Nghe An Province including the mountainous regions.

The characteristics of these projects are as follows:

(1) Project ownership is promoted and an organization to utilize available resources organically is established by setting up a project working committee at each administrative unit of province, district (nineteen districts), and commune (469 communes).

(2) Cooperation was implemented in all communes with package of three components: refresher training of midwives, equipment provision to health center and facility improvement.

(3) Participation of community was promoted by incorporating health education activities centered on the existing women's union and activities of the Japanese child raising groups.

(4) Under the project strategy, a pilot district was set up for each activity field and each district accumulates experience in its priority activity field. District-level leaders were trained at the same time, so that the activities can be easily expanded from the model district to entire region.

(5) While placing importance on the improvement in reproductive health at the commune-level (input ratio: commune 67%, district 26% and province 7%), an approach not limited to Nghe An Province was made at the policy-level, including providing proposal for a ten-year national reproductive health strategy and hosting of seminars for thirty-one northern Vietnamese provinces to share their experiences.

(6) JICA schemes including cooperation with JOCV and medical equipment supply including commune-level facility improvement sourced by Grant Aid for Grassroots were utilized effectively.

(7) In cooperation with JOICFP, which has rich experience in grassroots activities, more effective cooperation has been enabled. Viet Nam Project Support Unit has been set up in JOICFP and supportive activities such as acceptance of counterpart training and expert dispatch have been consigned.

(8) Mid-term evaluation was consigned to the NGO, Population Council (PC) to which the baseline survey was also consigned. In addition to evaluation based on five items, the situation analysis method which PC uses was also adopted in the survey. Some consider that this is superior than the conventional evaluation study conducted by JICA in terms of quality and budget. While final evaluation is planned to be consigned to PC again, it is necessary that, in the future, effective utilization of local resources in combination with JICA's evaluation method be considered for improving the quality of evaluation.

Box A1-2 Philippines: Family Planning/Maternal and Child Health Project (Phase I: 1992–1997, Phase II: 1997–2002)

The Phase I outcomes from the Tarlac Province (900 thousand people), one of the Region III provinces (six provinces), were expanded to the entire Region III (6.9 million people) in Phase II. Although the initial project objective was to "improve reproductive health in the entire Region III through promotion of outcomes obtained in the maternal and child health project in Tarlac Province," it was later changed to "improve awareness for primary health care (PHC) including reproductive health in the pilot area of Region III through improvement in PHC and reproductive health." This is because, in the project implementation process, support for community participation and community organization were greatly emphasized, and the fact that approach to health activity took the comprehensive PHC approach not limited to reproductive health was reflected. The major activities are as follows:

(1) Integrated maternal and child health program: support for maternal and child health centers, health volunteer/health center staff training, and the promotion of maternal/infant health checkups.
(2) Reproductive health program: production and promotion of videos for adolescents, incorporation of men in family planning, and development of educational materials.
(3) Community organization activity assistance program: NGO union training, support for management of community-based drug revolving fund, puppet play activities, health video production and promotion, support for income improvement by dressmaking, and manufacture of simple toilets.

The characteristic features of this project are summarized as follows:

(4) The zone defense method, in which three experts were assigned to three regional offices respectively and took charge of two provinces each among the six provinces in Region III, was adopted for efficient activity control/instruction.
(5) Since community participation, which is important in PHC, is emphasized, a method of developing the most effective approach while implementing activities by trial and error based on the needs of the beneficiaries (demand-side approach) instead of an approach with a clearer objective setup was adopted. It was an excellent approach in terms of sustainability with activities created by the community itself.
(6) As a project to incorporate men's participation in family planning, male health volunteers called "male motivators" were trained. A proactive approach was adopted for men who rarely participate in educational activities in family planning/maternal and child health, where trained male staff approached the men in his community, and their participation in family planning and child-raising was promoted. An unexpected impact was seen in improvement in male participation in other health activities such as blood donation and hygiene improvement.
(7) In the process of horizontal expansion, JICA's schemes were utilized and cooperation with NGOs were conducted. In enhancing aid efficiency and effectiveness, improvement of health centers using grant aid or complementary and organic cooperation with Japan Overseas Cooperation Volunteers were effective. In addition, it is considered that cooperation with NGOs which are positioned as administrative bodies in the Philippines local municipality law, as well as development of NGO Union contribute to sustainable development.
(8) Effective cooperation was conducted with various organizations such as, technical exchange with JICA's projects in close countries (Indonesia Family Planning/Maternal and Child Health Project and Thailand Family Planning Project), study tours to observe population control project implemented by JOICFP and UNFPA in the Philippines, and cooperation of AMDA in counterpart training.

Box A1-3 Indonesia: Maternal and Child Health Handbook Project 1998–2003

Japan has implemented the "Family Planning/Maternal and Child Health Project" with Central Java as the model region for five years since 1989, and the Indonesian version of the Maternal and Child Health Handbook was developed and put to trial in this project. Based on the outcome that the Maternal and Child Health Handbook is effective as a health education material for mothers and children, this project began in 1998 to improve maternal and child health services with Maternal and Child Health Handbook activities as a component.

Ever since specifying Central Java (a population of 150 thousand) as the model region, the Indonesian Government also approached the promotion of the Maternal and Child Health Handbook as a national program, and it was expanded to a total population of 7.3 million over twenty-four states in three years. In 2001, the Indonesian Government distributed 1.4 million copies of the Maternal and Child Health Handbook, of which 850 thousand copies were provided from Japan and 300 thousand copies were provided from international organizations. In addition to promotion of the Maternal and Child Health Handbook, development of health education materials and maternal and child health training were also implemented. Cooperation between the project and JOCV was highly evaluated where JOCV cooperated in monitoring activities, or implemented activities utilizing the Maternal and Child Health Handbook in six states where no experts were dispatched.

Although more than fifty years have passed since Japan adopted the Maternal and Child Health Handbook, this project only used the Japanese Handbook as a model and did not use a translated-version. Taking the regional diversity into consideration, a national/local version was developed using the local language and illustrations. It was designed so that its significance can be understood and utilized if there is at least one family member who is literate even when the mother is illiterate.

One of the reasons for this rapid promotion of the Maternal and Child Health Handbook was that, during the decentralization process, a proactive approach was made towards the local government's policy and system establishment. As a result, some local governments assured their own budget to bear the printing costs, and systems to collect the fee from users were established in more than twenty cities including the introduction of a beneficiary cost bearing system in North Sulawesi. In addition, distribution over a wide range has been enabled as a result of focusing on the importance of cooperation with other organizations including bilateral aid organizations, international organizations, and NGOs. For example, the "Medical Equipment Supply for Population/Family Planning" scheme was adopted in 1996 under cooperation with UNFPA. Activities in Central Java were covered in combination with a regional health/nutrition project of the World Bank. In the latter half of the project, more than eight international aid organizations and NGOs participated in the Maternal and Child Health Handbook activities.

In this project, Japan learned much in the process of utilizing and applying its experience in developing countries. For example, upon receiving feedback from the questionnaire conducted in Indonesia, a survey was conducted for users of the Maternal and Child Health Handbook in Japan in fifty years.

Box A1-4 Jordan: Family Planning/WID (Phase I: 1997–2000, Phase II: 2000–2003)

Conventionally, reduction in population has been the main focus in the population problem, and it was considered that it could be solved through macro-type approaches such as government policy and campaign. However, in the International Conference on Population and Development conducted in Cairo in 1994, a new direction was presented, which insisted that population problem should be discussed in a more humane way taking into consideration the will and choice of each man and woman. Consequently, the two concepts of reproductive health and the empowerment of women were suggested, and these were successfully supported by the majority of the participant countries as working concepts for considering the population problem for the next twenty years. The Jordan Family Planning/WID Project described here was a challenge to put family planning into practice at the community level based on these two concepts.

The objective of the Jordan Family Planning/WID Project was to put family planning into practice to prevent more women from becoming pregnant against their will in the Hashemite Kingdom of Jordan. To address this objective, a so-called comprehensive approach was taken by integrating the concepts of the empowerment of women and reproductive health. The above two concepts are culturally and socially delicate themes in Arab Countries. However, by consciously integrating these concepts into a comprehensive approach, this project has been acclaimed as the leading project in the Kingdom to this day.

The project was implemented in Phase I (July 1997–June 2000) and Phase II (July 2000–June 2003) with the target group of married women of 15 to 49 years old and their spouses. In the first phase, South Ghour District of Kerak Province located in the southern region of the Hashemite Kingdom of Jordan was selected as the target region (population of a little over 30 thousand). In the second phase, the target area moved to the central city of Kerak Province and its proximity (population of approximately 170 thousand) except for South Ghour District. As for South Ghour District, it was positioned as the follow-up region, and activities continued although on a smaller scale.

The activities consisted of three pillars. The first pillar was the Information, Education and Communication (IEC) Program, which aimed to induce changes in awareness, attitude and behavior in target communities concerning gender focused on the empowerment of women, and family planning/reproductive health (reproductive health focused on family planning). The second pillar was assistance to maternal and child health centers through training of health staff working at those centers of Ministry of Health and the provision of medical equipment. The third pillar was small-scale income creation activities for women. As for the relationship among these elements, the first and second pillars established a foundation for inducing behavioral changes in community concerning gender and family planning/reproductive health, and the remaining pillar of income creation activities was an “activator” that pushed the IEC program forward. Therefore, the beneficiaries of the income creation activities were promoted to participate in the IEC program of this project with priority. This integrated measure is essential for a comprehensive approach.

In conclusion, what was the overall outcome of the comprehensive approach? The number of new male and female users of modern contraceptives, which was realistically measurable, was used as an indicator for measuring the outcome of this project. Consequently, the number of new users of modern contraceptives in South Ghour District, the target region for Phase I, increased steadily from July 1997 when the project started, while the number of new users of modern contraceptives in the entire Kerak Province has been dropping for the recent few years. The number also increased for the entire region involved in this project in Kerak Province including South Ghour District since July 2000. Since there is no project related to reproductive health in Kerak Province that was implemented simultaneously with this project, the increase in the number of new users of modern contraceptives is regarded as an outcome of the project activities.

Two new regional expansion-type activities started immediately after the above project completed based on its outcomes. One was a Grassroots Technical Cooperation (former Community Empowerment Program) implemented to succeed the project activities in the same target region of Kerak Province, and the other was a Third Country Training that aimed to advocate gender and reproductive health in Arab areas. Furthermore, it is currently at the stage of examining the “Kerak Model” based on the lessons and experience of the project so that it can be widely applied to other provinces in Jordan.

Box A1-5 Tunisia: Reproductive Health Education Promotion Project 1999–2004

In many Middle Eastern Islamic Countries, the promotion of family planning is slow, and the population growth rate is high. Among such countries, Tunisia is known to be the only country which succeeded in promoting family planning with the population increase rate (1.1%) that is below the world average of 1.2%.

Office of Nationale de la Famille et de la Population (ONFP) is an organization that has implemented family planning activities in Tunisia in close cooperation with the International Planned Parenthood Federation (IPPF). With this ONFP as the counterpart organization, JICA has implemented cooperation in the production of IEC materials (especially audiovisual materials) related to family planning for five years from 1993 ("Population Education Promotion Project").

During this period, the Programme of Action on reproductive health was adopted in the International Conference on Population and Development in 1994, and the government of Tunisia re-positioned the family planning project, not just as a measure against population increase, but also from a wider view point of reproductive health, and decided to reinforce activities related to women's health and adolescent's sexual health. Especially due to changes in awareness about sex in adolescents in large cities such as Tunis and Sfax, reproductive health measures for adolescents were considered an important issue.

With this background, the "Reproductive Health Education Reinforcement Project" began in 1999 as Phase II to promote reproductive health among adolescents. In this project, the reinforcement of ONFP organization is targeted through the reinforcement of IEC activities in relation to adolescent's sexual and reproductive health. That is, ONFP, which had been a family planning promotion organization targeting only married women, was to become an organization to deal with adolescent reproductive health problems targeting young men and women as well, and JICA was to assist in this process.

The major activities of this project included technical assistance providing printing machines and giving technical instructions, developing and producing educational materials, training for staff awareness increase, and training leaders. Two sets of audiovisual educational materials ("Amina" with the theme of unwanted pregnancy, and "Selim" with the theme of secondary sexual characteristics* and the sexuality of boys), sex education sheets with many illustrations, etc. were all popular, and have been distributed to national ONFP clinics. In addition, the first (official) adolescent consultation room in Tunisia named "Espace des Jeunes (space for the young)" was opened in the Bizerte branch (one hour from Tunis) in March 2004, and is expected to be a model facility for adolescent reproductive health service provision.

Moreover, in concurrence with this project, two courses of Third Country Training have been implemented in the field of reproductive health at the ONFP International Training Center as a South-South cooperation for French-speaking African and Middle East Countries. One of these two courses is to transfer techniques of producing audio-visual education materials, which is one of the outcomes of the previous project, and the other is training for IEC activities on reproductive health.

* Secondary sexual characteristics: The characteristics of men/women that appear due to difference in the effect of sex hormones during adolescence and later. It includes beginning of menstruation and breast development in girls and growing of beard and change in voice in boys.

Box A1-6 Mexico: Women's Health Project 1999–2004

This project has been implemented by JICA to improve the rate of uterine cancer examination and improve the cytological examination system in the State of Veracruz with the Agency of Uterine Cancer Prevention and Measures and Servicious de Salud de Veracruz (SESVER) in the Ministry of Health in Mexico as counterparts.

In Mexico, deaths by obstetric malignant neoplasm is a serious issue, and in particular, cervical cancer claimed the third highest number of lives of women of twenty-five years and older (1995). Hence, the Ministry of Health placed measures against cervical cancer as the most important issue in the field of reproductive health, and specified women's insufficient knowledge about cervical cancer and improvement of the unestablished cytological examination system (insufficient human resources and equipment), which is necessary for the early diagnosis of cervical cancer as urgent matters. In response to this situation, Japan decided to start a project to reduce women's deaths caused by cervical cancer, to increase the number of women receiving cervical cancer examination subjectively, to improve the quality of services in the cytological examination division, etc. using the state of Veracruz as the model region. To address these objectives, the project implemented assistance by conducting surveillance in relation to cervical cancer, community-level advocacy and education, training of health workers and improvement in cytological examination techniques.

The health education activities focused on cervical cancer, leading to an increase in the number of examination receivers, and improved quality of samples by staining instruction in cytological examination contributed to improvement in test accuracy and speed. Furthermore, training of cytological examination experts lead to capacity development in health workers. In addition, the project shortened the time to mail out the test results to three weeks after checkup, compared to previous three to six months which was partly due to the insufficient mailing system. As a result of these measures, the number of early diagnosis increased. The Mexican Government also reinforced their measures against cervical cancer by increasing the budget ten-fold in three years. It is expected that Veracruz will become the most advanced center of cytological examination.

Furthermore, for the plan after the completion of this project, the In-Country Training for health workers from the other six states in the south by gathering them in this state as well as Third Country Training in nearby countries are being considered so that the outcomes can be spread to other states and nearby countries.

1-2 Human Resources Development at Base Facilities: Hub hospitals are reinforced to implement human resource development (grant aid, technical cooperation project)

Bangladesh Human Resource Development in Reproductive Health (HRDRH) Project and Cambodia Maternal and Child Health Project take the approach of establishing the top referral hospital with initial capacity training and then implementing human resource development based in the hospital. In this approach, a hub hospital or training center is established with grant aid and technology transferred to the counterpart organization, and then locally active health workers are trained using the facility at the center. Such form is often taken in human resource development related to somewhat advanced medical technology such as midwife skills for emergency obstetric care.

Since this approach may increase the gap between central and peripheral health provision in which establishment of only the hub hospital proceeds and it

does not contribute to improving local health, **it is necessary that the approach be proceeded with extra care based on the local circumstances (primary health care (PCH) level).** In the Bangladesh Human Resource Development in Reproductive Health Project, we tried to contribute to improving the PHC level of maternal and child health by letting trainees survey the local circumstances and feed back to the training and reinforcing the cooperation with local expansion-type projects implemented in cooperation with NGO in concurrence.

In Phase I of Cambodia Maternal and Child Health Project, the counterpart organization, the National Maternal and Child Health Center was established as a top referral hospital and training center, and in Phase II, in addition to the further enhancement of the training center, proactive cooperation was conducted in activities to improve maternal and child health capabilities in local health centers and in involvement in health policies. Furthermore, this project provides technical advice in selecting mechanical equipment under medical equipment supply program for population and family planning and in monitoring, which are implemented by JICA in concurrence. The project also takes the leading role in new approaches for prevention of the mother to child transmission of HIV.

As shown in the above cases, it is desired that proactive expansion to the local area and involvement in management or policy related to utilization of other schemes should be implemented in concurrence in this type of cooperation instead of limiting the activities only to the top referral hospital or training center.

Box A1-7 Bangladesh: Bangladesh Human Resource Development in Reproductive Health (HRDRH)

This project began as a technical cooperation project in September 1999 in concurrence with the reform of the Maternal and Child Health Training Institute (MCHTI) by grant aid. Under the project objective of "fostering abilities to understand and implement the role of maternal and child health service providers through training based on the needs," activities in relation to startup of training department, function reinforcement as training organization, and establishment of training organization network were implemented during the former half of the project while focusing on reinforcement of the clinical functions of the training institute.

By the middle of the project, on the clinical aspect, provision of twenty-four-hour emergency obstetric care and newborn care were enabled and outcomes of technical transfer were apparent in the establishment of a clinical test department and an ultrasonic diagnosis department. In the training department, training on midwife skills and emergency obstetric care were given to Family Welfare Visitors (FWVs) as well as post-training monitoring.

However, post-training monitoring revealed insufficiency in the environment for FWV to assist facility delivery including shortage in budget, materials and equipment, insufficient facility and system and that the trainees who returned to their regions were not always allowed to utilize the skills they learned (some FWVs implemented home delivery assistance individually). Therefore, Sadar in Narshingdi District was set up as the model region in the latter half of the project to concurrently implement local approach to promote preparation of a list of pregnant and nursing women, a referral system, etc. for continued care of pregnant and nursing women following local survey so that the regions to which trainees return can benefit from the trainees experience. Although the trial has not advanced smoothly due to the health policy of Bangladesh itself being in transition, the awareness of FWVs is being changed gradually.

Meanwhile, it had been planned in Bangladesh that the status of MCHTI, which belonged to the Family Planning Department, would also be improved in the process of health sector reform called the Health Population Sector Program (HPSP) including integration of the health department and the family planning department. However, integration of these departments was not successful and status of MCHTI did not change as wished. Although the Bangladeshi Government is currently preparing the next five-year sector program, systems for health and family planning in rural regions may change depending on its movement, and the status of MCHTI and training subjects remain in a state of flux.

Based on the above circumstances, the succeeding case for the project implemented currently is discussed in direction for implementing more locally instead of limiting to MCHTI activities while also coordinating at the political level. Specifically, activities in the local-implementation type Partnership Program, which was implemented by JICA in cooperation with the Japanese Organization for International Cooperation in Family Planning (JOICFP), at the same time in Narshingdi District and Fenni District will be incorporated to shift importance to system establishment on a community, county (Thana) or district level. In addition, on the policy level, we plan to dispatch population and health advisor for involvement in sector programs and to approach facilitating the effect of the JICA project. In particular, expectations are high in the role of the advisor as to determining what position Japan/JICA will take in the Sector Wide Program Approach (SWAPs) and the common basket approach that are being proceeded in Bangladesh.

Moreover, issues related to linkage between grant aid and technical cooperation are also suggested in this project. While grant aid was given prior to technical cooperation project, some project experts have pointed out the problems of facility layout and medical equipment. Some also pointed out that small medical devices and equipment should be purchased to suit the purpose after the installation of the technical cooperation, and this should be a lesson learned to be utilized in the future.

1-3 Plan Development Type: A master plan or project plan is prepared, and technical cooperation is implemented based on the plan (development study, policy advisor, technical cooperation project)

Although JICA has many cases of development study and policy advisor dispatch related to the entire health sector, it has few cases of providing policy proposal or master plan limited to the field of reproductive health. The only case of master plan preparation in a development study on reproductive health was the case implemented in India, but implementation of the project or JICA involvement based on this survey remains to be examined, and the effectiveness of the approach also needs to be verified.

It is important to make a baseline survey and long-term strategy at an early stage in the field of reproductive health as well. Although whether as much input is necessary as that for the current development survey is still to be examined, the approach to be involved from such survey should be discussed for countries with long-term program implementation plans.

Furthermore, although there are several development survey cases targeting the ministry of health in relation to health sector master plan and health system reform, it is true that there are few cases of reproductive health projects implemented based on the surveys. It is surmised that this was because reproductive health requires a plan that is not limited to the health sector but covers several fields. However, it is necessary to examine how reproductive health can be incorporated when implementing a survey in the health sector.

Box A1-8 India: The Development Study on Reproductive Health in the State of Madhya Pradesh, India

While situation analysis on health, nutrition, hygiene, education and labor environment was implemented for women in Sagar Division of Madhya Pradesh State located in the northern region of India, the existing government program was reviewed to develop the district master plan. Madhya Pradesh State has the highest maternal mortality rate in India, and the central government prioritizes implementation of the Safe Motherhood Program in this state. It is a state in which women's health indicators and social development indicators are especially low. As a result of survey and analysis, the following four points were considered as possible causes of such low indicators:

- Problems and constrains in Reproductive and Child Health (RCH) service delivery systems, namely inadequate coverage (actual availability and access) of RCH services and poor quality of services
- Lack of awareness and knowledge of RCH and RCH services and behavior changes among general population
- Social and cultural factors which hinder RCH improvement
- Lack of management capability and health administrative office at district level and block level and PRIs

With overall goal as " to improve health status of all women and children through a Reproductive and Child Health (RCH) approach contributing to population stabilization in the target districts," five priority projects were developed and an action plan to expand from district to block and then to state was prepared as the master plan.

While suggestions from this development survey will be addressed by the Indian Government, JICA has been asked to provide a technical cooperation project centered on expert dispatch. Cooperation beginning with expert dispatch for addressing the suggestions of development survey is being considered for implementation in the future.

1-4 Small-scale Projects Utilizing NGOs (NGO consignment type project: former Partnership Program, former Community Empowerment Program)

While in Asia and the Middle-East many program cooperation cases are implemented by utilizing several schemes as in above 1-1 and 1-2, there are few cooperation cases in Sub-Sahara Africa because total amount of input to this region is limited although the need is high. It is also true that the number of technical cooperation projects is small due to difficulty in obtaining Japanese experts who can work in Sub-Sahara Africa.

Under such circumstances, several projects have been implemented utilizing local NGOs. An alternative method is to start from a small-scale project utilizing international NGOs or local NGOs that have been active at the site if it is difficult to obtain Japanese experts. JICA has experience in projects utilizing NGOs (former Partnership Programs) in countries such as Tanzania, Zimbabwe and Zambia.

Box A1-9 Zimbabwe: Adolescent Reproductive Health Care in Zambezi River Basin (Former Community Empowerment Program) 2000–2003

In Zimbabwe, the rate of HIV infection in the population of fifteen years old and above is thought to be 20% or higher. It has been recognized that the spread of HIV/AIDS is not just a problem of health but a problem that affects society and economy seriously, and it was one of the important fields of ZIMPREST (Zimbabwe Programme for Economical Social Transformation), which was the guideline for development policy in 1996–2000. Furthermore, in the review of interim plan for HIV/AIDS/STD measures (1994–98), multi-sectoral cooperation, an approach to education curriculum, IEC program, promotion of sexual behavior pattern changes, etc. were suggested as future issues. In the Binga and Kariba Districts of the Tonga Tribe, which is a minor tribe in the border region with Zambia, fishery is a major industry and there are frequent visits by external fishermen. This fact and insufficient education on infection have led to a high risk of HIV/AIDS.

Based on these circumstances, this project was implemented with the scheme of the former Community Empowerment Program in a form of supporting the international NGO "Save the Children Fund (UK)" which has long experience of cooperation in Binga and Kariba Districts. While aiming for awareness raising and changes in sexual behavior patterns by mutual advocacy activities of the young people themselves who are at risk of HIV infection in the project region, it intended to reinforce/improve the reproductive health care easily accessible for young people. It took a new approach to make it easier for young people to accept the education by mutual advocacy and education among them instead of the conventional lecture style of adults delivering lectures to young people. The project was regarded as highly significant in putting such approach into practice, and was adopted as a model project.

The activities of this project included three fields of (1) measures against malaria, (2) measures against HIV/AIDS and STIs, and (3) water supply, hygiene activities. Especially in measures against HIV/AIDS and STIs, peer education activities were implemented for young people with two pillars of in-school and out-of-school (for children who do not go to school) activities. In schools, health clubs were organized under the instruction of Health Master (teacher in charge of health) and aimed for behavioral changes by broadening children's knowledge about HIV/AIDS and STDs through plays, songs, and dances. Furthermore, out-of-school activities included organization of Out of School Youth Clubs centering on young people in their mid-teens and advocacy through play as well.

Support by the district office was discontinued due to political competition between the Government and the opposition party in Zimbabwe's presidential election in the middle of the project, and some restrictions were given to peer education activities, which stagnated in the latter half of the project period. Furthermore, there were delays in assistance by alternation of the personnel in charge of the NGO, and the final outcomes were disappointing due to such external conditions. However, it is a project that induced behavioral changes by peer education activities utilizing international NGOs that are well accepted at site, and the method can serve as a reference for future projects in other regions as well.

1-5 Equipment Provision Programs by Cooperation of International Organizations (medical equipment supply program)

JICA has projects in which equipment is provided in coordination with other international organizations. This medical equipment supply program is a scheme used only in the field of health, and it is implemented for measures against infectious diseases including anti-polio measures and immunization,

measures against HIV/AIDS, and population and family planning.

Equipment supply program for population and family planning has been in place in cooperation with UNFPA, and equipment is provided with the upper limit of 20 million yen in contraceptives and basic delivery assistance equipment. While many cases of this scheme entrust monitoring and, technical instruction to international organizations, it is considered that **further collaboration with technical cooperation projects should be conducted.** It is especially desired that cooperation as a program be advanced by organically coordinating this medical equipment supply program and technical cooperation project because there are limits to technical cooperation project in terms of horizontal expansion and successive follow-up.

Box A1-10 Cambodia 2001–2003 and Lao PDR 1995–2003 (except 1997–1999): Medical Equipment Supply Program for Population and Family Planning

In Cambodia and Lao PDR, medical equipment supply program for population and family planning has been implemented in cooperation with UNFPA, and a budget of approximately 15 million yen has been allocated for equipment purchase/transport fee for each country.

Equipment Supply Program started in Cambodia in 2001, and educational advocacy tools called "Maggie Aprons" and magnet-type education models as material for reproductive health publicity, basic delivery assistance equipment for health centers have been provided. In selecting the equipment, opinions from an existing technical cooperation project (Maternal and Child Health Project Phase II) were considered, and technical instructions and advice were also given as necessary for effective utilization of the equipment provided.

The equipment provision project in Lao PDR started in 1995, and oral contraceptive pills, delivery assistance equipment, small-scale surgery set have been distributed to county hospitals and health centers. For oral contraceptive pills, UNFPA has been giving local training on method of administration, which is being conducted together with drug provision by JICA.

The following list shows the major projects and forms of cooperation in the field of reproductive health. Existing cooperation projects (project-type technical cooperation, grant aids, Community Empowerment Programs, etc.) are classified with a description of characteristics of each, and past cases are summarized as a case list (Table "List of Projects Related to Reproductive Health"). For the order of countries, regional classification by UNFPA[1] has been referred to. Countries in each of the five regions of Sub-Sahara Africa, Arab countries, Asia and Pacific, Latin America and Caribbean, and Eastern Europe and former Soviet Union (transitional economies) are listed in alphabetical order.

[1] UNFPA (http://www.unfpa.org/worldwide/)

Annex Table: List of Projects Related to Reproductive Health

No.	Country	Case	Period	Form	Mid-term Objective	Characteristics
1. Project-Type Technical Cooperation (1960 – 2002)						
1	Ghana	Maternal and Child Health Service Improvement Plan	1997.06 – 2002.05	Project-Type Technical Cooperation	1-1 1-2	The training program for health workers in the country was reviewed and a refresher training system (in-service training) was developed/reinforced.
2	Kenya	Promotion of Population Education	1988.12 – 1993.12	Project-Type Technical Cooperation	1-3	IEC activities were reinforced and educational media were developed and produced in order to change the sense of desirable family size.
3		Promotion of Population Education Phase II	1993.12 – 1998.12	Project-Type Technical Cooperation	1-3	The objective was to disseminate information related to population through multimedia and promote life quality improvement and family planning. Integration of IEC activities in the model community and service delivery community activities and assistance for promotion of low-price hand-made education materials were implemented.
4	Tanzania	Maternal and Child Health	1994.12 – 2001.11	Project-Type Technical Cooperation	1-1 1-2	In order to lower the maternal morbidity rate and mortality rate, improvement in quality of pediatric department and capability of EPI disorder virological diagnosis in Muhimbili Medical Center (MMC) and reinforcement of maternal and child health activities in Tanga Region (model region) were assisted.
5	Zambia	Measures against HIV/AIDS and Tuberculosis	2001.03 – 2006.03	Project-Type Technical Cooperation	1-4	Improvement in testing techniques in the central test room for HIV/AIDS and tuberculosis surveillance. Survey on genetic characteristics and drug resistance of HIV/AIDS. Implementation of regular management meeting with HIV/AIDS and tuberculosis working group. Cooperation with Zambia Family Planning Association, which is a member of IPPF.
6	Egypt	Family Planning, Maternal and Child Health	1989.09 – 1994.03	Project-Type Technical Cooperation	1-1 1-2 1-3	Promotion and improvement of family planning in rural areas, technical improvement for antenatal care using checkup vehicle, and activities for publicity were implemented.
7	Jordan	Family Planning/WID (Phase I)	1997.07 – 2000.06	Project-Type Technical Cooperation	1-1 1-2 1-3 3-3 3-4	For promotion of family planning in South Ghour District, Kerak Province, improvement in women's status was attempted through reinforcement of community organization functions, maternal and child health services and income creation activities. A comprehensive family planning approach was taken including WID consideration, empowerment of women in rural villages, promotion of participation by men in family planning, and cooperation with local NGOs.
8		Family Planning/WID (Phase II)	2000.07 – 2003.06	Project-Type Technical Cooperation	1-3 3-4	Receiving the outcomes of Phase I, the target region was expanded to the entire Kerak Province and improvement in women's status was promoted through information provision by community assembly or home visiting, functional enhancement of community organizations, reinforcement of maternal and child health services, and income creation activities by goat rearing or bee-keeping.
9	Turkey	Promotion of Population Education	1988.11 – 1993.11	Project-Type Technical Cooperation	1-3	IEC activities for family planning promotion through radio and school education materials and cooperation related to IEC pilot center activities were implemented. It was developed to Third Country Training.
10		Promotion of Population Education Phase II	1993.11 – 1998.11	Project-Type Technical Cooperation	1-3	Based on the audio-visual education materials in Phase I, IEC activities, development of education material and training based on the local needs were implemented in Bursa and two regions in east Turkey.

No.	Country	Case	Period	Form	Mid-term Objective	Characteristics
11	Tunisia	Promotion of Population Education	1993.03 – 1999.03	Project-Type Technical Cooperation	1-3	IEC activities were reinforced to improve the rate of contraception. Major activities included baseline survey, provision of video devices and training for operation and control, production of educational materials.
12		Reproductive Health Education Reinforcement	1999.09 – 2004.09	Project-Type Technical Cooperation	1-3 1-4	While there is delay in family planning in rural areas, improvement in reproductive health for adolescents in cities is also an important issue. IEC activities were implemented with a focus on reproductive health education activities for young people.
13	Bangladesh	Family Planning	1976.03 – 1985.03	Project-Type Technical Cooperation	1-1 1-2 1-3	With DND Region (Dacca-Narayangaji Demura) near Dacca as the model region, family planning promotion activities were implemented in (1) advocacy activities for family planning, (2) education and training on field workers, and (3) maternal and child health activities.
14		Reproductive Health Human Resource Development	1999.09 – 2004.08	Project-Type Technical Cooperation	1-1 1-2	Reinforcement of clinical and training functions of the Maternal and Child Health Training Institute (MCHTI) constructed with grant aid in 2000. Human resource development of workers in maternal and child health. Cooperation with USAID and GTZ.
15	Cambodia	Maternal and Child Health	1995.04 – 2000.03	Project-Type Technical Cooperation	1-1 1-2	Grant aid for improvement in National Maternal and Child Health Center and education on health workers at the center (improvement in control and management capabilities, reinforcement of training activities, and improvement in diagnosis, treatment capabilities).
16		Maternal and Child Health (Phase II)	2000.04 – 2005.03	Project-Type Technical Cooperation	1-1 1-2	Approach for reinforcement of functions of the National Maternal and Child Health Center as top referral hospital and training center, and human resource training for maternal and child health service at local hospitals and health centers. Cooperation among the Ministry of Health, national hospitals, local hospitals and health centers was reinforced.
17	People's Republic of China	Family Planning	1982.11 – 1987.11	Project-Type Technical Cooperation	1-3	To support the Chinese Government, which targeted in suppressing the population to 1.2 billion or less by 2000 and achieve zero population increase rate, cooperation was implemented in IEC equipment provision for family planning promotion network and human resource development for improvement in the statistical evaluation technology level.
18	Indonesia	Family Planning	1969.01 – 1985.03	Project-Type Technical Cooperation	1-3	Cooperation in the production of audio-visual education software for family planning promotion activities (- '82). Then promotion and education activities, provision of contraceptives, light vehicles for promotion activities and audio-visual equipment were implemented centered in Jakarta using the developed software.
19		Family Planning/ Maternal and Child Health	1989.11 – 1992.11	Project-Type Technical Cooperation	1-1 1-2 1-3	Using central Java as the model region, cooperation was implemented with the objectives of promoting family planning and maternal and child health services for local residents and improving the referral system. Human resource development and promotion of educational materials were also implemented in relation to family planning.
20		Maternal and Child Health Handbook	1998.10 – 2003.09	Project-Type Technical Cooperation	1-1 1-2 1-3	Receiving the outcomes of the "Family Planning/Maternal and Child Health Project" in 1989–92, improvement in maternal and child health services were targeted through the introduction of a national version of the Maternal and Child Health Handbook Program. Utilizing Japan's experience in the Maternal and Child Health Handbook, cooperation was expanded and standardized.

No.	Country	Case	Period	Form	Mid-term Objective	Characteristics
21	South Korea	Maternal and Child Health	1984.08 – 1990.07	Project-Type Technical Cooperation	1-1 1-2	Technical cooperation was implemented for Soonchun Hyang University and South Korea Maternal and Child Health Center in the fields of NICU, perinatal control and reproductive medicine.
22	Lao PDR	Reinforcement of Health Service for Children	2002.11 – 2007.10	Project-Type Technical Cooperation	1-2 4-2	Human resource development in health and information exchange between center and rural areas were reinforced. Improvement in pediatric health service mainly targeting county health centers and county hospitals were implemented.
23	Mongolia	Health of the Mothers and Children	1997.10 – 2002.09	Project-Type Technical Cooperation	1-1 1-2	To improve maternal and child health in Mongolia, elimination of iodine deficiency disorder (IDD) and promotion of sustainable management of Expanded Programme of Immunization (EPI) were implemented.
24	Nepal	Population and Family Planning	1985.10 – 1991.10	Project-Type Technical Cooperation	1-1 1-2 1-3	In 2 model regions, reinforcement of family planning and maternal and child health projects was attempted and health post establishment, training of health workers, provision of drugs and health checkup devices, and IEC equipment were implemented.
25	Pakistan	Maternal and Child Health	1996.06 – 2001.06	Project-Type Technical Cooperation	1-1 1-2	Maternal and Child Health Center was constructed with grant aid in the premises of the Pakistan Medical Science Institute. Expansion of research and training function, human resource development, etc. were implemented to make it a training organization to give fundamental refresher training for improvement in safe motherhood.
26	Philippines	Family Planning	1974.07 – 1989.03	Project-Type Technical Cooperation	1-3	Advocacy and information dissemination on family planning were implemented in the model region.
27		Family Planning/ Maternal and Child Health	1992.04 – 1997.03	Project-Type Technical Cooperation	1-1 1-2 1-3	Cooperation was implemented in promoting local health activities through community participation, reinforcement of maternal and child health service delivery system and improvement in capabilities of health workers in the model region in the Region III, Tarlac Province. Field-level cooperation was conducted with local NGOs, USAID and JOICFP.
28		Family Planning/ Maternal and Child Health Phase II	1997.04 – 2002.03	Project-Type Technical Cooperation	1-1 1-2 1-3	Based on the outcomes of Phase I, target region was expanded to the entire Region III to improve capacities of health workers and municipal officials and family planning centered on maternal and child health activities by community participation. Cooperation with JOCV, grant aid and grant aid for grassroots, fostering and cooperation with local NGOs, WID, and an approach for men and young men were introduced.
29	Sri Lanka	Population Information	1987.11 – 1992.11	Project-Type Technical Cooperation	1-3	Preparation of a database for population and health as well as development of population statistics database for improving the demographic dynamics statistical system. Improvement in the precision of health statistics such as a population census.
30	Thailand	Family Planning	1974.07 – 1989.03	Project-Type Technical Cooperation	1-1 1-2 1-3	Nakhonsawan Province was used as the model region to implement family planning publicity for maternal and child health and education activities.
31		Family Planning/ Maternal and Child Health	1991.06 – 1996.05	Project-Type Technical Cooperation	1-1 1-2 1-3	To improve the level of health of community in northeast Thailand, human resource development, health information control system establishment, survey, etc. for family planning, maternal and child health activities and IEC activities were implemented.
32		AIDS Prevention Regional Care Network	1998.02 – 2003.01	Project-Type Technical Cooperation	1-4	Prevention of HIV/AIDS infection as well as preparation of a comprehensive model for provision of universal care for carriers were implemented. A methodology to utilize the experience in north Thailand, which is advanced in measures against HIV/AIDS compared to other areas of Thailand as well as other countries, was established.

No	Country	Case	Period	Form	Mid-term Objective	Characteristics
33	Viet Nam	Reproductive Health	1997.06 – 2000.05	Project-Type Technical Cooperation	1-1 1-3 4-2	Using Nghe An Province, where there are few midwives as a model region, human resource development of health administration staff related to maternal care, development and promotion of IEC education materials for the community, provision of sufficient drugs for village health centers, etc. were implemented.
34		Reproductive Health (Phase II)	2000.09 – 2005.08	Project-Type Technical Cooperation	1-1 1-3 4-1 4-2	Using Nghe An Province, where there are few midwives, as a model region, reinforcement of organizational functions of health administration related to maternal care and improvement in reproductive health in villages (provision of drugs, sufficient contraceptives, etc. to commune level) were implemented.
35	Argentina	Population Statistics	1995.09 – 2000.09	Project-Type Technical Cooperation	1-3	To enable formulation of a population policy, preparation of statistical data at central government and municipality levels, setting of census divisions with the use of GIS, and establishment of training system for statistic workers were supported.
36	Brazil	Family Planning/ Maternal and Child Health	1996.04 – 2001.03	Project-Type Technical Cooperation	1-1 1-2 1-3	Cooperation was given in medical assistance for newborns, control of diarrhea disorders, maternal care, family planning and reinforcement of health worker capabilities in Ceara State in northeast Brazil. Promotion of “humanized delivery (from caesarian section to natural delivery)” was targeted.
37	Columbia	Family Planning/ Maternal and Child Health	1985.11 – 1990.11	Project-Type Technical Cooperation	1-1 1-2 1-3	Promotion of family planning and maternal and child health activities for people in urban and surrounding areas as well as border areas. Equipment provision of family planning instructor kits, audio-visual devices, devices for diagnosis and treatment was implemented.
38	Mexico	Population Activity Promotion	1984.07 – 1988.09	Project-Type Technical Cooperation	1-3	A basic survey was conducted for population prediction and education and cooperation provided to establish an appropriate statistical method.
39		Family Planning/ Maternal and Child Health	1992.04 – 1998.03	Project-Type Technical Cooperation	1-1 1-2 1-3	Introduction of ultrasonic diagnosis techniques in antenatal care in the model area (Guerrero State and Veracruz State) and trial introduction of Mexican version of the Maternal and Child Health Handbook were implemented to contribute to improving maternal and child health services.
40		Women’s Health	1999.07 – 2004.05	Project-Type Technical Cooperation	2-1	In the state of Veracruz, an approach was pursued for improvement in health checkup through health education and quality of cytological examination department so that the number of early diagnosis of cervical cancer can be increased.
41	Honduras	Reproductive Health Improvement in 7th Health Region	2000.04 – 2005.03	Project-Type Technical Cooperation	1-1 1-4 2-1 3-2	In the model region (7th health region), reproductive health improvement is targeted through achievement of (1) control on infections, maternal diseases, (2) reduction in violence, and (3) prevention of non-infectious diseases of women at reproductive ages.
42	Peru	Family Planning/ Maternal and Child Health	1989.10 – 1994.10	Project-Type Technical Cooperation	1-1 1-2 1-3	Improvement in health and hygiene for infants and pregnant or nursing women and promotion of family planning were targeted through maternal and child health services in the model region (south region of Lima City). Technical instruction was also given to staff of maternal and child health service promotion .

No	Country	Case	Period	Form	Mid-term Objective	Characteristics
2. Grant Aids (1992 – 2002)						
43	Angola	Children's Welfare Grant Aid (Health Reinforcement Program)	2000	Grant Aid	1-2	The Ministry of Health has implemented the Expanded Programme of Immunization since 1979, and cold chain equipment, mosquito nets, etc. have been purchased for reduction in polio, measles or malaria morbidity and mortality.
44		Lucrecia Paim Obstetric Hospital Medical Equipment Supply Program	2000	Grant Aid	1-1	Procurement of diagnosis/ treatment equipment for Lucrecia Paim Obstetric Hospital was supported.
45	Central Africa	Maternal and Child Health Reinforcement/ Measures against Disorder Program (Children's Welfare Grant Aid)	2000	Grant Aid	1-1 1-2	Preparation of equipment for measures against malaria and tuberculosis, and preparation of medical equipment necessary for establishment of immunization system and establishment/ reinforcement of maternal and child health environment were supported.
46	Kenya	Children's Welfare Grant Aid (Expanded Programme of Immunization)	1999	Grant Aid	1-2	Procurement of vaccine, cold chain equipment, etc. was supported to reinforce a regular immunization system and ensure NID implementation.
47	Malawi	Expanded Programme of Immunization (Children's Welfare Grant Aid)	2001	Grant Aid	1-2	The infant immunization rate has tended to decrease in recent years, and support was given in preparation of cold chain equipment, vaccine distribution vehicles and vehicles for immunization activities.
48	Mali	Cold Chain Expansion Program for Maternal and Child Health, Polio Elimination, Vaccine Inoculation Expansion	2000	Grant Aid	1-1 1-2	With the background of a stagnating immunization rate, support was given in vaccine purchase and the preparation of transport vehicles and cold chain materials and equipment.
49	Senegal	Program of Maternal and Child Health Reinforcement and Measures against Malaria	2000	Grant Aid	1-1 1-2	The government of Senegal had been dealing with the establishment of an immunization system and a system for dealing with malaria, and cold chain equipment including refrigerators and vehicles as well as equipment for anti-malaria measures such as mosquito nets were provided. Technical instruction was given on equipment monitoring and the evaluation system.
50	Zambia	Children's Health Grant Aid (General Measures against Malaria)	1998	Grant Aid	1-2	Procurement of malaria infection prevention equipment (mosquito net, etc.), diagnosis and treatment equipment, and equipment for mosquito net transport and monitoring was supported in five districts where the pilot program against malaria had already been implemented.
51		Children's Welfare Grant Aid (Expanded Programme of Immunization)	2001	Grant Aid	1-2	For implementation of the "Immunization System Establishment Program," support was given in funding for procuring working vehicles, which are essential in order to update old cold chain equipment and maintenance activities.
52	Djibouti	Maternal and Child Health Reinforcement Program	2000	Grant Aid	1-1 1-2 2-1	Djibouti has high Under five Mortality Ratio. Thus immunization- related equipment, equipment related to maternal and child health activities, and obstetric equipment, etc. were purchased.
53	Palestine	Children's Health Grant Aid (Expanded Vaccine Inoculation Program)	1999	Grant Aid	1-2	Immunization was to be implemented for Palistinian Refugees in the west coast Gaza Strip, and burden on the government swelled. Based on the Expanded Vaccine Inoculation Program prioritized by the government as the most important issue, vaccine purchase was supported.
54		Children's Welfare Grant Aid (Second Expanded Vaccine Inoculation Program)	2000	Grant Aid	1-2	Immunization was to be implemented for Palestinian Refugees in the west coast Gaza Strip, and burden on the government swelled. Based on the Expanded Vaccine Inoculation Program prioritized by the government as most important issue, vaccine purchase was supported.

No.	Country	Case	Period	Form	Mid-term Objective	Characteristics
55	Yemen	Vaccine Storage System Establishment Program (Children's Health Grant Aid)	1998	Grant Aid	1-2	The government has prepared the National Program on Expanded Immunization and aims to eliminate infantile paralysis and improve children's health. Freezers and refrigerators were purchased for establishment of vaccine storage and inoculation facilities.
56		Local Hospital Maternal and Child Health and Medicine Equipment Supply Program	1999	Grant Aid	1-1 1-2	Establishment of primary medical facilities in a total of eight hospitals in local cities and preparation of medical equipment for training of health workers such as midwives.
57	Bangladesh	Program of Expanded Immunization for Newborn Tetanus and Measles (Children's Health Grant Aid)	1998	Grant Aid	1-2	Necessary funding was provided for tetanus vaccine and measles vaccine inoculation of pregnant women and infants residing in high risk regions and urban slum regions.
58		Maternal and Child Health Institute Improvement Program (National Bond B)	1998	Grant Aid	1-1 1-2	Since there were obstructions in birth attendance, clinical internship, and maternal and child health services, support was given for improvement/ construction of the corresponding training institute and equipment purchase.
59		Maternal and Child Health Institute Improvement Program (Term 2/3)	1999	Grant Aid	1-1 1-2	Since there were obstructions in birth attendance, clinical internship, and maternal and child health services, support was given for improvement/ construction of the corresponding training institute and equipment purchase.
60		Maternal and Child Health Institute Improvement Program (National Bond Term 3/3)	2000	Grant Aid	1-1 1-2	Since there were obstructions in birth attendance, clinical internship, and maternal and child health services, support was given for improvement/ construction of the corresponding training institute and equipment purchase.
61		Emergency Obstetric Care Service Reinforcement Program	2001	Grant Aid	1-1 1-2	In Bangladesh, the rates of maternal mortality and morbidity are relatively high compared to other neighboring countries. Support was given for the purchase of medical equipment in order to improve emergency obstetric services through the establishment of district health centers.
62	Bhutan	Maternal and Child Health/Basic Medical Equipment Preparation Program	2000	Grant Aid	1-1 1-2	Support was given for preparation of equipment related to reinforcement of maternal and child health system at national hospitals, local hospitals, district hospitals and local health centers (fundamental medical equipment, repair equipment, education materials, etc.)
63	Cambodia	Maternal and Child Health Center Construction Program	1995	Grant Aid	1-1 1-2	Procurement and preparation of the related equipment in the relocation and construction of a new hospital because more than thirty years had passed since the construction of the National Maternal and Child Health Center which had poor hospital functions.
64		Maternal and Child Health Service Improvement Program	1998	Grant Aid	1-1 1-2	Procurement and preparation of the related equipment in the relocation and construction of a new hospital because more than thirty years had passed since the construction of the National Maternal and Child Health Center which had poor hospital functions.
65	People's Republic of China	Nanjing Maternal and Child Health Medical Equipment Preparation Program	1996	Grant Aid	1-1 1-2	The government developed the plan for construction of Jiangsu Province Health Center for Women and Children, and began establishing a health service for women and children. The medical equipment necessary for these medical facilities and services were prepared.
66		Tuberculosis Suppression Program in Poor Regions (Children's Welfare Grant Aid)	2000	Grant Aid	1-2	The government used DOTS in cooperation with WHO for the purpose of tuberculosis suppression, and support was given in purchase of medical equipment (microscopes) and antitubercular agents.

No.	Country	Case	Period	Form	Mid-term Objective	Characteristics
67	People's Republic of China	Chongqing Maternal and Child Health Medical Equipment Improvement Program	2001	Grant Aid	1-1 1-2	To improve the general maternal and child health in Chongqing City, equipment (electronic microscope for children, newborn monitors, etc.) necessary for substantiating diagnosis and educational functions that suit the level of each medical facility (Chongqing Medical College Children's Hospital, Chongqing City Hospital for Women and Children, and thirty-two region and county hospitals for women and children) were provided.
68	India	Sir JJ Hospital and Cama and Albless Maternal and Child Hospital Medical Equipment Preparation Program	1998	Grant Aid	1-1 1-2	To substantiate the tertiary medicine in Maharashtra State, which is located in west India, medical equipment was prepared at Sir JJ Hospital and Cama and Albless Maternal and Child Hospital.
69	Indonesia	Family Planning Promotion Activity Reinforcement Program	1992	Grant Aid	1-3	Vehicles were purchased for rural villages where loudspeaker vans are not distributed so that direct family planning publicity and promotion activities can be implemented for local community.
70		Family Planning Program	2000	Grant Aid	1-3	Free distribution of oral contraceptives to couples who could not afford to implement family planning unaided due to the effect of the economic crisis.
71	Lao PDR	Program for Measures against Malaria (Children's Health Grant Aid)	1998	Grant Aid	1-2	Based on the program for measures against malaria targeting three provinces and seventeen districts where no other organization provided support, aid was given for the purchase of mosquito nets, simple diagnosis sets, anti-malarial drugs, test drugs, audio-visual materials for advocacy, etc.
72	Pakistan	Maternal and Child Health Center Construction Program (Term 1/2)	1996	Grant Aid	1-1 1-2	In order to improve medical services to mothers and children, education and training were given to female health workers. To implement the program, support was given for construction of maternal and child health center and purchase of medical equipment.
73		Maternal and Child Health Center Construction Program (Term 2/2)	1997	Grant Aid	1-1 1-2	In order to improve medical services to mothers and children, education and training were given to female health workers. To implement the program, support was given for construction of maternal and child health center and purchase of medical equipment.
74		Program of Expanded Newborn Immunization on Tetanus (Term 2/3)	1999	Grant Aid	1-2	Pakistan had an especially high frequency of newborn tetanus, and vaccines, syringes, cold chain equipment, etc. were purchased for newborn tetanus immunization in areas with specially high frequencies.
75	Papua New Guinea	Maternal and Child Health Service Reinforcement Program	1999	Grant Aid	1-1 1-2	The existing cold chain equipment was aging, and equipment preparation including cold chain equipment was provided to 222 domestic medical facilities.
76	Philippines	Local Health Facility Improvement/ Equipment Preparation Program	1999	Grant Aid	1-1 1-2	As a part of health service improvement in the entire 3rd administrative region, outdated maternal and child health center, local health centers, and village health centers were improved and necessary materials were provided in order to reinforce improvement/ promotion of family planning and maternal and child health.
77	Viet Nam	AIDS Prevention Program	2000	Grant Aid	1-3	In order to reduce the number of HIV/AIDS carriers, which was increasing in Viet Nam, support was given in reinforcing blood testing and blood screening system as well as advocacy activities, provision of blood collection vehicles, audio-visual education materials, condoms, etc. especially in Ho Chi Minh City and its proximity where the rate of carriers was high.

No.	Country	Case	Period	Form	Mid-term Objective	Characteristics
78	Viet Nam	Measles Elimination Campaign (Children's Welfare Grant Aid)	2000	Grant Aid	1-2	The government introduced the system of two measles inoculations in regular immunization in stages from 2004. To implement this, materials and equipment including vaccine, syringes, incinerators, etc. were provided for the northern areas.
79		Measles Suppression Program	2001	Grant Aid	1-2	Measles vaccine, needles, safety boxes, simple incinerators, etc. that were necessary for implementation of general measles immunization campaign were provided for the northern twenty-six districts.
80		Measles Suppression Program	2002	Grant Aid	1-2	Measles vaccine, needles, etc. necessary for implementation of a general measles immunization campaign were provided for the southern areas.
81	Bolivia	La Paz Maternal and Child Health Hospital Medical Equipment Supply Program (Detailed Designing)	1998	Grant Aid	1-1 1-2	The pediatrics department and obstetric department of an existing hospital were integrated, and procurement of medical equipment in the new special hospital for maternal and child health with expanded scale was supported.
82		La Paz Maternal and Child Health Hospital Medical Equipment Supply Program (National Bond Term 1/3)	1999	Grant Aid	1-1 1-2	The pediatrics department and obstetric department of an existing hospital were integrated, and procurement of medical equipment in the new special hospital for maternal and child health with expanded scale was supported.
83		La Paz Maternal and Child Health Hospital Medical Equipment Supply Program (National Bond Term 2/3)	2000	Grant Aid	1-1 1-3	The pediatrics department and obstetric department of an existing hospital were integrated, and procurement of medical equipment in the new special hospital for maternal and child health with expanded scale was supported.
84		La Paz Maternal and Child Health Hospital Medical Equipment Supply Program (National Bond Term 3/3)	2001	Grant Aid	1-1 1-4	The pediatrics department and obstetric department of an existing hospital were integrated, and procurement of medical equipment in the new special hospital for maternal and child health with expanded scale was supported.
85		Cochabamba Maternal and Child Medicine System Reinforcement Program	2001	Grant Aid	1-1 1-5	In order to reinforce the maternal and child health system in Cochabamba City, "Cochabamba Maternal and Child Medicine System Reinforcement Program" was developed including reconstruction of the German Urquidi Hospital and reconstruction and new constructions of three health centers, and funding for implementation of this program was supported.
86	El Salvador	Program of Measures against Infant Diseases	1999	Grant Aid	1-2	Due to the damage caused by hurricane Mitch in 1998, food insufficiency and the number of infant deaths increased. Procurement of essential drugs including antibacterial at the primary medical facilities over the country was supported.
87	Haiti	Children's Health Grant Aid	1997	Grant Aid	1-2	To improve children's health status, which showed high infant mortality rate, drugs (vaccine, etc.) and medical equipment (cold chain equipment) were provided.
88		Second Children's Health Maintenance Program	1999	Grant Aid	1-2	To improve the rate of vaccine inoculation for infections, which was a major cause of child death, procurement of vaccines, syringes, cold chain equipment, etc. was supported.
89	Honduras	Program of Measures against Children's Diseases	1999	Grant Aid	1-2	To deal with deteriorated medical and nutritional conditions of children due to damage caused by hurricane Mitch, procurement of essential drugs, solar refrigerators, etc. was supported at thirteen hospitals and 510 clinics in nine departments.

No.	Country	Case	Period	Form	Mid-term Objective	Characteristics
90	Nicaragua	Children's Health Reinforcement Program (Children's Health Grant Aid)	1999	Grant Aid	1-2	The infant mortality rate increased as a result of life infrastructure destruction by hurricanes, and support was given in purchase of basic drugs, vaccines, etc.
91		Second Children's Health Reinforcement Program	2000	Grant Aid	1-2	The infant mortality rate increased as a result of life infrastructure destruction by hurricanes, and support was given in purchase of basic drugs, vaccines, etc.
92	Paraguay	Asuncion University Hospital Japan-Paraguay Friendship Maternal and Child Center Establishment Program (Detailed Designing)	1999	Grant Aid	1-1 1-2	The government specifies reinforcement of maternal and child health services as a priority issue. Support was given in construction of a maternal and child center integrating pediatric, obstetric and gynecologic departments and procurement of basic medical equipment.
93		Asuncion University Hospital Japan-Paraguay Friendship Maternal and Child Center Establishment Program (National Bond A)	1997	Grant Aid	1-1 1-2	Asuncion University Hospital plays an extremely important role in the medical services of the country, and a maternal and child health center integrating pediatric, obstetric and gynecologic departments was constructed and medical equipment to be used in this center was purchased.
94		Asuncion University Hospital Japan-Paraguay Friendship Maternal and Child Center Establishment Program (Term 1/2)	1998	Grant Aid	1-1 1-2	Asuncion University Hospital plays an extremely important role in the medical services of the country, and a maternal and child health center integrating pediatric, obstetric and gynecologic departments was constructed and medical equipment to be used in this center was purchased.
95		Asuncion University Hospital Japan-Paraguay Friendship Maternal and Child Center Establishment Program (Term 2/2)	1999	Grant Aid	1-1 1-2	Asuncion University Hospital plays an extremely important role in the medical services of the country, and a maternal and child health center integrating pediatric, obstetric and gynecologic departments was constructed and medical equipment to be used in this center was purchased.
96	Azerbaijan	Maternal and Child Hospital Medical Equipment Supply Program	1998	Grant Aid	1-1 1-2 2-2	Provision of medical equipment necessary for improving the conditions in the second Pediatric Hospital and fiftth Obstetric Hospital which are major public medical facilities in the maternal and child health in the capital city, Baku.
97	Albania	Tirana University Hospital Pediatrics Ward Medical Equipment Supply Program	2000	Grant Aid	1-2	The aim is to update and expand the medical equipment at the Mother Theresa Pediatric Hospital of Tirana University, which leads to proper and prompt diagnosis and treatment for diseases that could not be treated previously.
98	Armenia	Maternal and Child Hospital Medical Equipment Supply Program	2000	Grant Aid	1-1 1-2	Provision of basic maternal and child health equipment in the capital and local maternal and child health facilities.
99	Kirgiz	Emergency Medicine Improvement Program	1998	Grant Aid	2-1	Equipment provision for improving the emergency medical services at the emergency center in Bishkek and five other hospitals.
100		Obstetric Hospital Medical Equipment Improvement Program	1999	Grant Aid	2-1	"Obstetric Hospital Medical Equipment Improvement Program" was developed in order to improve the level of maternal and child health in the capital city, Bishkek and three local provinces, and funding for the purchase of medical equipment, etc. required for implementing this program was assisted.
101		Obstetric Hospital Medical Equipment Supply Program	2002	Grant Aid	2-1	"Obstetric Hospital Medical Equipment Improvement Program" was developed in order to improve the level of maternal and child health in the capital city, Bishkek and three local provinces, and funding for the purchase of medical equipment, etc. required for implementing this program was assisted.

No.	Country	Case	Period	Form	Mid-term Objective	Characteristics
102	Moldova	Maternal and Child Hospital Medical Equipment Supply Program	1998	Grant Aid	1-1 1-2	Assistance was given to the first Hospital (former Maternal and Child Center) and second Hospital (former National Pediatric Hospital) in the capital city, Kishinyov.
103	Ukraine	Okhmadet Pediatric Hospital Medical Equipment Supply Program	2000	Grant Aid	1-2	The mortality rate for newborn babies younger than one year old had increased dramatically, and various types of medical equipment were provided at the Okhmadet Special Pediatric Hospital.
104	Uzbekistan	Maternal and Child Hospital Medical Equipment Supply Program in Central Region	1997	Grant Aid	1-1 1-2	Since much of the medical equipment used was from the former Soviet Union and had deteriorated, medical equipment supply was implemented for obstetric and pediatric wards of the core hospitals in five provinces.
105		Pediatric Vaccine Supply Program	2000	Grant Aid	1-2	The vaccine procurement level was falling due to the reduction in support at the time of the disintegration of the Soviet Union. Vaccine and cold chain equipment were purchased in order to reinforce the supply system.
3. Community Empowerment Program/Partnership Program (1997 – 2004)						
106	Ghana	General Program for Family Planning, Nutrition Improvement and Parasite Prevention	1998.03 – 2001.03	Community Empowerment Program	1-1 1-2	It aims for reduction in infant and maternal mortality rates and improvement in health status for local community in the target region of the project.
107	Tanzania	Reproductive Health and Lesson for Young People in Dar es Salaam	1999	Community Empowerment Program	1-3 1-4	Improvement in health conditions, reduction in unwanted pregnancy, prevention of sexually transmitted infections and reduction in rate of infection through advocacy and promotion for young people such as peer counseling.
108	Zambia	HIV High Risk Group Advocacy Activities	2000.02 – 2003.01	Community Empowerment Program	1-4	In order to reduce the spreading HIV/AIDS infection rate, advocacy activities for the target group, condom distribution, and human resource development for peer educators and field staff were implemented in three border regions targeting high risk groups including truck drivers and workers in the sex industry.
109	Zimbabwe	Reproductive Health for Young People	1999	Community Empowerment Program	1-4	Planning and implementation of advocacy activities regarding safe sexual intercourse among young people were promoted in order to reduce STI and HIV infection rate.
110		Reproductive Health Care for Young People in Zambezi River Basin	2000.03 – 2003.02	Community Empowerment Program	1-4	In order to raise awareness and change sexual behavior patterns among adolescents, advocacy activities were conducted by adolescents themselves who are at risk of HIV/AIDS infection. Also, so that the reproductive health/care accessible for young people can be reinforced/ improved, advocacy activities and human resource development were implemented by adolescents' and women's groups.
111	Bangladesh	Family Planning with Local Community Participation	1998.03 – 2001.03	Community Empowerment Program	4-2	Activities related to family planning and maternal and child health involving local community. Construction of training center, community advocacy activities, and training of volunteers.
112		Family Planning with Local Community Participation Phase II	2001.12 – 2004.12	Community Empowerment Program	4-2	As continuation and reinforcement of Phase I activities, training of government health personnel and promotion of local activities by trained women are implemented in this program.
113	Cambodia	Reproductive Health for Women	1998.12 – 2001.03	Community Empowerment Program	3-4	The aim is to reinforce the cooperative relationship among NGOs, Ministry of Women's Affairs, and JICA experts and focus on women's health and promotion for employment so that multilateral measures to eliminate poverty can be suggested.

No.	Country	Case	Period	Form	Mid-term Objective	Characteristics
114	Myanmar	Meiktila Maternal and Child Health Project	1999.01 – 2001.03	Community Empowerment Program	1-1 1-2	Improvement in maternal and child health and reduction in maternal and infant mortality rates by expansion of primary health care and medical facilities in the Meiktila District.
115	Philippines	NGO Assistance Project on AIDS/Sexually Transmitted Infections/ Maternal Health Measures	1998.12 – 1999.03	Community Empowerment Program	1-1 1-2 1-4	Coordination/assistance activities centered on reinforcement of public and NGO clinic functions including referral system development and a preventive education program.
116		Comprehensive Reproductive Health Promotion	1999.02 – 1999.03	Community Empowerment Program	1-3 4-2	Reinforcement of NGOs, IEC activities, network formation and adjustment with governmental organizations related to reproductive health.
117	Mexico	Sexual Health Project for Street Children	2000.12 – 2003.12	Community Empowerment Program	1-2 1-3	Situation analysis and provision of advice on sex to street children. Lead them to take integrated care/treatment if necessary.
118	Bangladesh	Reproductive Health Local Implementation Project	2001.03 – 2004.03	Partnership Program	1-1 1-2 1-3 3-4	Targeting Narshingdi District and Fenni District, the women's multi-purpose centers were repaired for village women to address capacity building and improvement of status. In addition, basic package of reproductive health was provided to improve the health of village women,.
119	Myanmar	Primary Health Care for Mothers and Children	2002.07 – 2005.03	Partnership Program	1-1 1-2	In the districts of Meiktila, Nyaung U and Pakkoku located at the center of Myanmar, a composite local development project has been implemented including improvement in local medical organizations in pediatrics, establishment of emergency patient transport system, and activities related to ensuring safe drinking water.
120	Thailand	AIDS Prevention and Care through Community Organizations in North Thailand	1998.11 – 2001.03	Community Empowerment Program	1-4	Targeting seventy villages in four provinces centered around the northern Phayao Province where the number of People Living with HIV/AIDS (PLWHA) carriers is large, community level activities in care for PLWHA were implemented in cooperation with the "AIDS Prevention/Local Care Network" Project to develop the maternal and child health system on HIV/AIDS.
4. Development Study (1995 – 2004)						
121	Kenya	Study for Local Health and Medical System Reinforcement Program	1997.09 – 1998.11	Development Study	4-2	Specifying Western Kenya as the major target region, a basic strategy as well as the priority program were developed in order to reinforce the regional health and medical system.
122		Study for Transfusion Blood Supply Program	2001.09 – 2001.12	Development Study	1-4	Targeting the whole of Kenya, the condition of blood donation, screening and blood transfusion was analyzed at more than 250 major medical organizations. Basic data was prepared for future measures against infections and policy development.
123	Malawi	Study for Primary Health Care Reinforcement Program	1998.06 – 2000.01	Development Study	1-1 1-2 4-2	In this country where the infant mortality rate and maternal mortality rate are high, the master plan was developed in order to improve access to health services through primary health care.
124	India	Study for Reproductive Health Assistance Program	2000.11 – 2002.03	Development Study	1-1	In India where the population problem is serious, the condition of women's health, nutrition, hygiene, education, labor environment, etc. were analyzed and the existing governmental program was reviewed to develop the master plan for a target region where the maternal mortality rate is high so that the health services can be improved.
125	Lao PDR	Study for Health/ Medical Service Improvement Program	2001.04 – 2002.08	Development Study	4-1	Lao PDR has high rates of infections including malaria, respiratory diseases and diarrhea, and chronic malnutrition has been reported. In order to improve this situation, the master plan was developed in relation to national health services.

No.	Country	Case	Period	Form	Mid-term Objective	Characteristics
126	Sri Lanka	Health/ Medical System Improvement Program	2002.03 – 2003.08	Development Study	4-1	Due to financial difficulty and an undeveloped referral system in the medical sector, it is impossible to meet the changes in regional gaps and disease structures. In this study, the master plan for national health system reform was developed.
127	Bolivia	Beni Province Regional Health and Medical System Reinforcement Program	2001.04 – 2002.03	Development Study	1-1 1-2 4-2	Infant and maternal mortality rates by infection exceed the national average in Beni District, and reinforcement of the functions of existing medical organizations and development of referral system are major issues. This study was implemented in order to develop the master plan for reinforcement of local health and medical systems in Beni District.
128	Honduras	Study for Program for Overall Improvement in National Health and Medicine	1995.01 – 1996.07	Development Study	4-2	This study has the target completion years of 2000 and 2010, and the master health plan and model master program in which several strategies and plans were integrated were developed.
129	Uzbekistan	Study for Health and Medical System Improvement Program	2002.10 – 2003.12	Development Study	4-1	Development of health system conforming to the flow of the market economy after independence is an issue to be addressed. While maintaining consistency with the progress in the "National Program on Health Reform" of this country, study has been implemented mainly on reinforcement of financial sources for health, improvement in medical resource distribution and improvement in local public health.
5. Training Programs (1998 – 2004)						
130	Indonesia	The Role of Media in Family Planning	1998 – 2002	Third Country Training	4-2	Trainees from Asia, Pacific and African countries are (1) given the opportunity to improve their knowledge about the role of the media in family planning and reproductive health programs, and (2) learn basic skills of desktop publishing and desktop presentation.
131	Thailand	Population/ Reproductive Health	1999 - 2003	Third Country Training	4-1 4-2	Based on the request of the Population and Society Research Institute, Mahidol University in Thailand, the aim is to learn about population and reproductive health in neighboring and African countries, research skills and competency to utilize the skills in the programs/policies of their own country in the corresponding field.
132		Measures against Infections	2002 - 2004	Third Country Training	4-2	Public health employees of Cambodia and Myanmar improve their knowledge and competency about malaria and HIV/AIDS, and skills to implement surveillance in border areas.
133	Tunisia	Audio-visual Communication in the Field of Reproductive Health	2000 - 2004	Third Country Training	1-3	Training is given to advocacy personnel and instructors related to population and family planning in Arabian and African countries to improve the capacity of IEC programs.
134	Turkey	Communication with Audio-visual Materials in Maternal and Child Health	1998 - 2002	Third Country Training	1-1 1-2 1-3	Education and publicity activity skills for maternal and child health and family planning are learned to improve the general health knowledge in the target country.
135	Mexico	Reproductive Health	1999 - 2003	Third Country Training	1-1 1-2 1-3	In order to expand the outcomes of the Technical Cooperation Project "Family Planning/Maternal and Child Health" implemented in Mexico to other Central and South American countries and Caribbean countries, the development of reproductive health program and action plan to promote activities has been implemented.
136	Worldwide	Adolescent Reproductive Health Seminar	1999 - 2003	Group Training	1-3	In order to reinforce human resource development in the field of adolescent reproductive health, development of program proposal, network formation, development of educational materials and promotion of use were implemented.

No.	Country	Case	Period	Form	Mid-term Objective	Characteristics
137	Worldwide	Reproductive Health Leader Seminar: Reinforcement of Region-Rooted NGO Capabilities	2001 – 2003	Group Training	4-1 4-2	Based on Japan's experience in community participation after the war as well as the experience of JOICFP, a sustainable reproductive health activity approach rooted in the community and exchanges of experience among trainees are used to develop the plan.
138		Measures to Improve Maternal and Child Health Indicators II	2001 – 2005	Group Training	1-1 1-2	Skills necessary for reviewing the management of infant mortality rate improvement policy of each country, analytical skills on factors that inhibit IMR and MMR improvement, and skills related to general maternal and child health are achieved.

No.	Country	Period	Form	Mid-term Objective	Major Equipment Name
6. Special Equipment Provision (1997 – 2002)					
139	Cape Verde	2001	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Incubators, ultrasound diagnosis devices, vehicles, etc.
140		2002	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Incubators, newborn treatment tables, emergency resuscitation kits, etc.
141	Ethiopia	1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Drugs, delivery assistance devices, RPR kits, etc.
142		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Amoxycillin, cloxacillin, ampicillin, etc.
143	Ghana	1997	Medical Equipment for AIDS Measures/Blood Testing	1-4	Micro plate readers, micro plate cleaners, AIDS testing reagents
144		2002	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV-1 nucleic acid multiplication quantitative precise test kits, etc.
145	Kenya	1997	Medical Equipment for AIDS Measures/Blood Testing	1-4	PCR reagents, HIV antigen, UV sample shooting devices, etc.
146		1998	Medical Equipment for AIDS Measures/Blood Testing	1-4	Virus load analyzers, low-pressure chromatograph, spectrophotometers, etc.
147		1998	Medical Equipment for AIDS Measures/Blood Testing	1-4	Drugs (zidovudine), PCR reagents, pipette tips, etc.
148		2002	Medical Equipment for AIDS Measures/Blood Testing	1-4	Desktop micro centrifuge, constant-temperature bath, etc.
149	Lesotho	2002	Medical Equipment for AIDS Measures/Blood Testing	1-4	AIDS testing kits, at-home care kits, etc.
150	Malawi	2001	Medical Equipment for AIDS Measures/Blood Testing	1-4	Blood packs, refrigerators, micro pipettes, etc.
151		2002	Medical Equipment for AIDS Measures/Blood Testing	1-4	Hepatitis testing kits, etc.
152	Morocco	1998	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Closed incubators for premature infants, aspirators, ultrasound fetus detectors, etc.
153		1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Ultrasound fetus detectors, hemoglobin measuring instruments, delivery table, etc.
154	Nigeria	2001	Medical Equipment for AIDS Measures/Blood Testing	1-4	Deep freezers, power generators, etc.
155	Senegal	2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-3	Contraceptives, equipment for health post, TVs, VCRs, radio-cassette players, etc.
156		1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	UNICEF maternal and child health kits, equipment for health centers, equipment for health post, medical equipment for obstetric department, contraceptives, IEC equipment
157		2000	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	A set of equipment for medical post, a set of medical equipment for medical center, maternal and child health kit

No.	Country	Period	Form	Mid-term Objective	Major Equipment Name
158	Senegal	2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	A set of equipment for health post, contraceptives, etc.
159		2002	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Sphygmomanometer, stethoscopes, diagnostic chair for obstetrics, delivery table, etc.
160	South African Republic	2001	Medical Equipment for AIDS Measures/Blood Testing	1-4	Vehicles, computers, liquid crystal projectors, etc.
161	Tanzania	1997	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV testing kits, research equipment, information processing equipment
162		1998	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Delivery tables, sterilizers, antibacterial substances, insecticides, working clothes, etc.
163		1998	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV testing kits, micro plate cleaners, ELISA readers, etc.
164		1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Delivery table, sterilizer, antibacterial substances, simple pregnancy test kits, working clothes, etc.
165		1999	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Radio sets, delivery tables, etc.
166		1999	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV testing kits, syphilis testing kits, etc.
167		2000	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV antibody test reagents, syphilis test reagents, etc.
168		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Diagnosis beds, sterilizers, etc.
169		2001	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Airways for adults, airways for newborns, nose aspirators, a set of transceivers, solar batteries, delivery tables, etc.
170		2001	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV antibody reagents, HIV speed diagnosis kits, blood collection tubes, blood collection needles, etc.
171		2002	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Radio sets, transceivers, etc.
172		2002	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV antibody reagents, etc.
173	Zambia	2000	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Drugs for treatment of sexually transmitted infections, diagnosis devices before delivery, equipment for care during delivery, etc.
174		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	IEC materials (fliers, booklets, brochures, maternity books, etc.)
175		2001	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV speed diagnosis kits, HIV-1 P24 measurement kits, etc.
176		2002	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV simple speed testing kits, etc.
177	Egypt	2000	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Equipment for producing educational videos for population education (editor, VTR related equipment, etc.)
178		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Ultrasound diagnosis equipment
179	Turkey	1998	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	OHPs, human body models
180		1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Ultrasound diagnosis equipment, overhead projectors, human body models

No.	Country	Period	Form	Mid-term Objective	Major Equipment Name
181	Turkey	2000	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	OHP, screens/stands/lamps for OHP, VCRs, projection-type TVs, PCs, etc.
182		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Materials for education on family planning, computers, OHPs, etc.
183	Bangladesh	1998	Population and Family Planning Medical Equipment (front line)	1-1 – 3	Medical equipment for midwives, maternal and child health kits for visitation by public health nurses, etc.
184	Cambodia	1999	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2, 1-4	Drugs (antibacterial substances), oral rehydration salt, HIV testing equipment, vehicles, HIV testing kits, etc.
185		2000	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Penicillin-type antibacterial substances
186		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Low-dose oral contraceptives, paracetamol, mebendazole, etc.
187		2001	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Cloxacillin, folic acid, mebendazole, etc.
188		2001	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV antibody testing kits, microscopes, centrifuge, etc.
189		2002	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Magnell kits, desktop high pressure vapor sterilizers, etc.
190		2002	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Mebendazole tablets, oral liquid-supplementation salt, etc.
191	People's Republic of China	2001	Medical Equipment (AIDS Measures)	1-4	Fluorescence microscopes, ultra pure water generation systems, etc.
192	Cook Islands	1998	Medical Equipment (Obstetric Equipment)	1-1	Ultrasound diagnosis device, liquid nitrogen tanks, ultra cool refrigerators, etc.
193	India	1998	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Sets of delivery assistance devices
194		1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	DAI (delivery) kit
195	Indonesia	1998	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Maternal and Child Health Handbooks, breast feeding promotion guidebooks, etc.
196		1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Maternal and Child Health Handbooks, newborn care guidebooks, breast feeding promotion guidebooks, etc.
197		1999	After-Care Equipment (Basic Technology for Raw Vaccine Manufacture)	1-2	Receiving substation facilities, polio test analyzers, freeze-drying freezers, etc.
198		2000	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Maternal and Child Health Handbooks, maternal and child health guidebooks for local health volunteers, etc.
199		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Maternal and Child Health Handbooks, maternal and child health guidebooks for local health volunteers, etc.
200		2002	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Maternal and Child Health Handbooks, guidebooks for mother and child health handbook, etc.
201	Lao PDR	1998	Population and Family Planning Medical Equipment (front line)	1-1 – 3	Incubators, obstetric diagnosis equipment, fetal heartbeat stethoscopes/Doppler, etc.
202		1999	Population and Family Planning Medical Equipment (front line)	1-1 – 3	Devices of patient diagnosis and testing, emergency treatment tools, sets of maternal and child health equipment, etc.
203		1999	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Maternal and child health kits, incubators, microbuses, trucks, sterilizers, reagents (for blood cell measurement, lipid, electrolyte testing), etc.

No.	Country	Period	Form	Mid-term Objective	Major Equipment Name
204	Lao PDR	2000	Population and Family Planning Medical Equipment (front line)	1-1 – 3	Patient diagnosis and treatment equipment, test devices, consumables for clinical tests, etc.
205		2001	Population and Family Planning Medical Equipment (front line)	1-1 – 3	Patient diagnosis and treatment equipment, general test reagents, linen products, etc.
206		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Urine testing kits, delivery tables, autoclaves, etc.
207		2001	Medical Equipment for AIDS Measures/Blood Testing	1-4	Freezers, centrifuges, shakers, etc.
208		2002	Population and Family Planning Medical Equipment (front line)	1-1 – 3	Stretchers, beds, mattresses, wheelchairs, etc.
209		2002	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Gel for ultrasound diagnosis equipment, etc.
210	Malaysia	2002	Medical Equipment for AIDS Measures/Blood Testing	1-1, 1-2	AIDS testing kits, etc.
211	Myanmar	1999	Medical Equipment for Health Measures for Mothers and Children	1-4	Drugs (zidovudine), PCR reagents, pipette tips, etc.
212		2000	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Mosquito nets, malaria treatment drugs, blood testing drugs, etc.
213		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Drugs, midwife kits, delivery assistance kits, low dose oral contraceptives, paracetamol, mebenzazole, etc.
214		2001	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV antibody test reagents, syringes, blood collection tubes, etc.
215		2002	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Oral contraceptives, treatment drugs for infections of reproductive organs, Rankine-type distillation system, reagents for food colorant testing, etc.
216		2002	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Chloroquine tablets, mefloquine tablets, simple malaria testing kits, etc.
217		2002	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV/AIDS testing measures, AD syringe, HIV virus speed testing kits, etc.
218	Pakistan	1997	Medical Equipment for AIDS Measures/Blood Testing	1-4	ELISA reader, micro plate cleaning systems, HIV/PA testing kits, etc.
219		1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-2	Infant scales
220		2000	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-3	Condoms, oral contraceptives
221	Philippines	1997	Medical Equipment (AIDS Measures)	1-4	HIV testing kits, HIV testing equipment, antibacterial substances, vehicles, etc.
222		1998	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV testing equipment, antibacterial substances, vehicles, HIV testing kits, etc.
223		1999	Population and Family Planning Medical Equipment (front line)	1-1 – 3	Equipment for checkup and delivery assistance, basic drugs, autoclaves, scales, microscopes, syringes, etc.
224		1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Microscopes, diagnosis table, delivery kits for midwives, sterilizers
225		2000	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Diagnosis tables, uterine tool insertion kits, health volunteer kits
226		2001	Population and Family Planning Medical Equipment (front line)	1-1 – 3	Basic drugs, test reagents, diagnosis and treatment devices
227		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Microscopes, medical wagons, kerosene sterilizers, etc.
228		2001	Medical Equipment for AIDS Measures/Blood Testing	1-4	Equipment for testing, recording and aggregation, test reagents, etc.

No.	Country	Period	Form	Mid-term Objective	Major Equipment Name
229	The Philippines	2002	Population and Family Planning Medical Equipment (front line)	1-1 – 3	Diagnosis and treatment devices, health instruction equipment, etc.
230	Sri Lanka	1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Contraceptives, iron tablets, vitamin C, etc.
231		2000	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Iron tablets, intrauterine contraceptives, folic acid, ascorbic acid, condoms
232		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Contraceptives (condoms), pelvis models, copy machines, iron tablets, folic acid, etc.
233		2001	Medical Equipment for AIDS Measures/Blood Testing	1-4	Automatic apheresis systems, apheresis kits, etc.
234		2002	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Copy machines, contraceptives (condoms), etc.
235	Thailand	2002	Medical Equipment for AIDS Measures/Blood Testing	1-1 – 3	Ultra cool freezers, liquid nitrogen freezer sets, blood testing equipment, etc.
236	Viet Nam	1998	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-4	Magnell kits, educational materials
237		1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-3	Condoms, Magnell kits, educational materials
238		2000	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-3	Condoms
239		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Contraceptives, insertion/removal kits, wagons for round of visits, sterilizers, etc.
240	Brazil	1997	Medical Equipment for AIDS Measures/Blood Testing	1-4	Testing equipment, test reagents
241	Mexico	1998	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3 2-1	Diagnosis kits, surgery devices, color TVs, OHPs, video software, etc.
242		1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)		Equipment for cervical cancer diagnosis, TBA kits, audio-visual education materials, etc.
243		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Portable medical packages (package + medical devices), OHPs, ultrasound diagnosis systems, sphygmomanometers, obstetric devices, doxycycline, etc.
244		2001	Medical Equipment for AIDS Measures/Blood Testing	1-4	HIV/AIDS testing kits, safety cabinets, thermal cyclers, centrifuges, etc.
245		2002	Medical Equipment for AIDS Measures/Blood Testing	1-4	Thermal cyclers, etc.
246	Panama	2002	Medical Equipment for AIDS Measures/Blood Testing	1-4	Refrigerators for blood pack storage, etc.
247	Peru	1997	Medical Equipment (Family Planning/ Maternal and Child Health)	1-1 – 3	Resuscitator, lighting for surgery, portable Doppler for fetus, audio-visual materials
248		1999	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Diagnosis kits, surgery devices, color TVs, OHPs, video software, etc.
249		2000	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Equipment related to checkup/delivery, equipment related to education and planning
250		2001	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Fetal Doppler phonocardiographs, resuscitators for adults, pulse oximeters, etc.
251		2002	Population and Family Planning Medical Equipment (Cooperation with UNFPA)	1-1 – 3	Fetal Doppler phonocardiographs, pulse oximeters, etc.

No.	Country	Period	Form	Mid-term Objective	Major Equipment Name
252	Kazakhstan	2001	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Electric refrigerators, emergency medical sets, aspiration pumps, etc.
253		2002	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Paracetamol liquid, benzylpenicillin benzathine injection agent
254	Uzbekistan	2001	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Iron tablets
255		2002	Medical Equipment for Health Measures for Mothers and Children	1-1, 1-2	Ion salt tablets, ferrous sulfate liquid, etc.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
1. Japan Overseas Cooperation Volunteers (JOCV) (1960 – 2002)						
256	Botswana	2000.04 – 2002.04	Village development volunteer	JOCV	3-4	Consultant activities were provided on general management in cooperative societies where they consistently implement production through the distribution of tapestries and table cloths, etc. by processing wool. This cooperative society was an organization of village women, and it supported the village through one of the few industries that brought cash income to the village.
257	Burkina Faso	2002.12 – 2004.12	Midwife	JOCV	1-1 1-2 4-2	In clinics which are the end public health organizations in an area fifty km southwest of the capital, antenatal care, instruction on maternal and child health, and advocacy activities in family planning, etc. were implemented in cooperation with midwives at the dispatch destination clinics, village development promotion volunteers, medical volunteers at other areas of the same province.
258		2003.04 – 2005.04	Midwife	JOCV	1-1 1-2 1-3	IIn an area located 340km northwest of the capital, basic hygiene education, antenatal care, instruction on maternal and child health, advocacy activities in family planning, etc. were implemented by visiting the dispatch destination health centers and neighboring villages in cooperation with the counterpart.
259		22002.12 – 2004.12	Village development volunteer	JOCV	1-1 1-2	In clinics which are the end public health organizations, improvement in immunization rate, instruction on maternal and child health and advocacy activities aiming for improvement in basic knowledge for preventing diseases were implemented in cooperation with the midwife volunteers dispatched in the same city and nurse volunteers in other areas of the same province.
260	Côte d'Ivoire	1998.07 – 2001.07	Midwife	JOCV	1-1 1-2	In a small village near Tiassale City where the provincial government is located, health services (antenatal care, vaccine inoculation, delivery assistance, etc.) at midwifery homes were implemented as well as health and nutrition instruction on local residents.
261		1998.12 – 2000.09	Midwife	JOCV	1-1 1-2 1-3	The main activities were antenatal care, infant nutrition instruction, and obstetric medical services such as delivery assistance at the midwifery home within the village hospital. Advocacy activities in health and hygiene in the local community were also implemented including sex education in local elementary and middle schools.
262		1999.04 – 2001.03	Midwife	JOCV	1-1	In addition to antenatal care (blood pressure, weight measurement, etc.), vaccine inoculation and instruction on baby food to mothers at the midwifery home in hospital, hygiene education was implemented for communities in cooperation with local public health nurse in the village.
263		1999.07 – 2001.07	Midwife	JOCV	1-1 1-2	Activities centered on obstetric medical services (delivery assistance, antenatal care, health checkup on infants, vaccine inoculation, etc.) at the midwifery home in hospital (with twenty beds).

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
264	Côte d'Ivoire	2000.04 – 2002.04	Midwife	JOCV	1-1 1-2	At the maternal and child protection center in medical office, maternity care up to eight months pregnancy, hygiene education, health checkup and immunization on newborns, maternal and child health control for about two years since delivery were implemented. In addition, neighboring villages were visited regularly with the local staff to implement immunization and education on health and hygiene.
265		2000.04 – 2002.04	Midwife	JOCV	1-1 1-2	Based on the obstetric services (antenatal care, delivery assistance, etc.) at the midwifery home located next to the local clinic (with electricity but no waterworks), vaccine inoculation visiting, public hygiene instruction were implemented for local communities and school children in cooperation with public health nurse volunteers dispatched at the same clinic and local staff.
266		2002.04 – 2003.04	Midwife	JOCV	1-1 1-2	Using the midwifery home in rural village as the beachhead, instruction to receive antenatal care, infant weight measurement, nutrition instruction, immunization, etc. were implemented for residents in the neighboring villages who could not visit the midwifery home. Antenatal care, infant immunization assistance, etc. were also implemented as necessary.
267		2002.07 – 2003.04	Activities for young people	JOCV	1-3 3-1	Working at the headquarters for the NGO, which implemented steady activities in various fields including measures against HIV/AIDS, and literacy education for young people. Planning on activities for young people was assisted in thirteen domestic regions with the staff.
268		2002.07 – 2003.04	Village development volunteer	JOCV	3-4	Advocacy on school lunch management and organization on local residents with special focus on women, and food production for school lunch began by the voluntary effort of the community. Using this community activity as an opportunity, promotion of community development activities centered on elementary schools by the voluntary efforts of the local community was assisted.
269		2002.07 – 2005.07	Village development volunteer	JOCV	3-4	Advocacy on school lunch management and organization on local communities with special focus on women, and food production for school lunch began by the voluntary effort of the community. Using this community activity as an opportunity, promotion of community development activities centered on elementary schools by the voluntary efforts of the local community was assisted.
270	Djibouti	2003.07 – 2005.07	Activities for young people	JOCV	3-1	Activity plan was developed and implemented for improvement in women's life with the volunteer as leader.
271	Ghana	1999.04 – 2001.04	Midwife	JOCV	1-1 1-2 1-3	Dispatch destination organization was an NGO in Ghana, whose main activity was promotion of family planning by operating clinics in five villages. The volunteer lived with the village residents and implemented promotion on maternal and child health and family planning at the grassroots level.
272	Kenya	2001.04 – 2003.04	Village development volunteer	JOCV	3-4	The volunteer was dispatched to the provincial branch of agricultural department, and was involved in management instruction on local farmers and women's groups in cooperation with the branch employees. Advice was given to the target group on new business and cash acquisition measures.
273		2001.07 – 2003.07	Village development volunteer	JOCV	3-4	The volunteer was dispatched to the women's group (NGO) with the main activities of oyster farming in order to improve the quality of life and activate the community, and assisted in improving organization management as well as search and implementation of new activities.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
274	Kenya	1999.07 – 2001.07	Public health nurse	JOCV	1-1 3-1	Daily diagnosis and treatment activities in clinics. In addition to starting, planning and management of antenatal care, etc., advice and instruction were given on daily activities by local women's groups.
275		2001.04 – 2003.04	Public health nurse	JOCV	1-1 1-2 1-4	The volunteer assisted management of in-hospital care and visiting treatment clinic as MCH coordinator. Antenatal care, health checkup on infants, immunization, and instruction and training on HIV prevention education groups were assisted.
276	Madagascar	2002.12 – 2004.12	Midwife	JOCV	1-2 4-2	While implementing delivery assistance, regular health checkup, vaccine inoculation, etc., volunteer gave technical instruction to nurse aides (to around ten people for two years), and new midwives. The volunteer also accompanied the local midwives to give visiting nutrition instruction for premature babies in neighboring villages.
277	Malawi	1998.12 – 2000.12	Village development volunteer	JOCV	3-4	The volunteer assisted in improving the quality of life of residents in an organization under the jurisdiction of an agricultural development agency that works to improve agriculture, instruction and promotion for farmers, improving the quality of life, etc. Although instruction is given from the aspects of nutrition, cooking, home economics, child rearing, etc., promotion of firewood ovens was a particular focus.
278	Niger	1998.07 – 2000.07	Activities for young people	JOCV	3-1	There are demands for cultural activities for local community and activities for women in the "house for youth" which is the place of youth activities. Women's group was formed and various events including cooking schools and handicraft schools were planned and implemented.
279		1998.12 – 2000.12	Village development volunteer	JOCV	3-4	The volunteer visited each village and cooperated with the residents for agriculture promotion. Cash income methods for improving the quality of life were established and advocacy activities for women were implemented.
280		1999.07 – 2001.07	Village development volunteer	JOCV	3-4	The volunteer gave instruction on management of facilities throughout the city by instructing social workers on activity methods and supported protection of the socially weak and improvement in life environment. Activity centered on visiting instructions in women's schools with the social worker.
281		1999.07 – 2001.07	Village development volunteer	JOCV	3-1	The volunteer promoted improved ovens and women's groups and implemented health and hygiene as well as activities for improving the quality of life.
282	Senegal	1999.04 – 2001.04	Midwife	JOCV	1-1	In villages in the area covered by Kolda Medical Center, the volunteer worked on activities for improving the quality of local life and health centered on management of village clinic, visiting antenatal care, etc.
283		2003.12 – 2005.12	Midwife	JOCV	1-1 1-2 4-2	To support maternal and child health issue, the volunteer gave on-the-job instructions on unqualified midwives by visiting clinics in the county and implemented vaccine inoculation, infant weight measurement, and advocacy activities in health issues by visiting villages with the staff. Composite support was also implemented for the area in cooperation with other volunteers in the same area.
284		1999.12 – 2001.12	Activities for young people	JOCV	3-1	An organization that implemented various activities aiming for improvement in the social status of women by eliminating poverty and reinforcing economic power. The volunteer especially supported lyric drama production and playing at the social education center targeting girls, video production, planning and management of open-air schools, etc.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
285	Senegal	2000.04 – 2002.04	Activities for young people	JOCV	3-1	For healthy growth of young people (especially girls), the volunteer cooperated in planning, management and implementation of various events and facilities. The volunteer also supported the development of an instruction textbook for group leaders, advocacy for improvement in women's status through participation in camps, etc.
286		2002.04 – 2004.04	Activities for young people	JOCV	3-1	Activities for children and women (observation tours to hospitals, etc., activities to clean public spaces, group activities, etc.) were implemented. Planning and management of events to promote social education of children and improvement in women's status were implemented.
287		1999.12 – 2001.12	Village development volunteer	JOCV	3-1 3-4	Cooperating with the women's group in the county, the volunteer worked in planning and management of small projects for group activation and supported village development. Specifically, agriculture and literacy education, and hygiene education activities were implemented.
288		2000.04 – 2002.04	Village development volunteer	JOCV	3-4	Targeting women's groups and youth groups in the county, the volunteer planned, promoted and adjusted the programs in order to improve the quality of life and improve women's status.
289		2001.12 – 2003.12	Village development volunteer	JOCV	3-1 3-4	This area is a fishing port, and the volunteer cooperated in improving the quality of life for local residents through planning and proposing cash income measures using the fishery resources, organization and activation of community groups, etc. The volunteer also supported clarifying local problems such as the problem of unemployed youth and women's literacy education and devised measures.
290		2001.12 – 2003.12	Village development volunteer	JOCV	3-1 3-4	Many women's groups in this county had agricultural and literacy education activities and there are leaders to these groups. However, the connection among these groups was weak, and organization itself was unstable. The volunteer supported activities to collect these group activities and give objectives to lead to rural village development.
291		2003.04 – 2005.04	Village development volunteer	JOCV	3-4	The volunteer instructed on vegetable cultivation and supported the organization of women's groups to ensure their sustainability. Promotion activities in tree planting, health and hygiene, provision of skills and ideas for increasing incomes (dress making, dyeing, loaning, etc.), promotion of sports for young people, etc. were also implemented.
292		2003.04 – 2005.04	Village development volunteer	JOCV	3-4	The volunteer grasped the problems in community life and supported improvement in the quality of life. Specifically, the volunteer supported activation of women's groups, provision of skills and ideas for cash income, dissemination of basic health and hygiene knowledge, and reduction in daily labor for women.
293		2003.07 – 2005.07	Village development volunteer	JOCV	1-1 1-2 3-4	The volunteer discussed with the dispatched organization and determined the activity location from the village communities and villages in the county to plan and implement activities such as: (1) support for women's groups (management, activity assistance, bookkeeping, etc.), (2) health control for pregnant women and children, hygiene instruction (general advocacy activities), (3) other activities to contribute to improvement in the quality of life of local community.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
294	Senegal	2003.12 – 2005.12	Village development volunteer	JOCV	3-4	In cooperation with the technical instructors of the dispatch destination and representatives of women's groups, targeting the women's groups in the community or village, the volunteer implemented improvement and activation of existing activities including small scale vegetable cultivation, processing fishery products, food processing, soap making, etc. and new planning and product commercialization to increase cash incomes.
295		2000.04 – 2002.04	Public health nurse	JOCV	1-1 1-2	Hygiene improvement and substantiation of health services for the county residents were supported. The volunteer implemented vaccine inoculation, malaria prevention activities for reduction in infant mortality, and maternal and child health activities through antenatal care. Improvement in the quality of village life was also supported in cooperation with the vegetable/village development promotion volunteers dispatched in the same region.
296		2000.07 – 2002.07	Public health nurse	JOCV	1-1 1-2 3-4	The volunteer cooperated in improving the health and hygiene situation for village residents in the county. Specifically, vaccine inoculation on infants and pregnant women, malaria prevention promotion, and various health checkups were implemented. Ensuring safe water and improvement in the quality of women's life were also implemented in cooperation with village development promotion volunteers.
297		2002.04 – 2004.04	Public health nurse	JOCV	1-1 1-2	The volunteer visited two clinics in the community and neighboring villages to implement basic hygiene education, maternal and child health, infection prevention promotion activities aiming for improvement in local health.
298		2002.07 – 2004.07	Public health nurse	JOCV	1-1 1-2	The volunteer visited the villages in the county upon discussion with the dispatched organization to grasp the health conditions based on vaccine inoculation, antenatal care and infant weight measurement and implemented health instruction such as nutrition improvement. Health education for the community on prevention of malaria and parasites was also implemented in cooperation with the local health post.
299		2002.12 – 2004.12	Public health nurse	JOCV	1-1 1-2	The volunteer visited the villages in the county upon discussion with the dispatched organization to grasp the health conditions based on vaccine inoculation, antenatal care and infant weight measurement and implemented health instruction such as nutrition improvement. Health education for the community on prevention of endemic disease (malaria, parasites, etc.) was also implemented in cooperation with the local clinics.
300	Tanzania	2000.07 – 2003.03	Activities for young people	JOCV	1-3 3-1	In cooperation with forty peer counselors belonging to the youth center, the volunteer implemented plays, group discussions, and visiting instructions including distribution of contraceptives for the poor residents in the city of Dar es Salaam for reproductive health advocacy and promotion.
301		1999.07 – 2001.07	Village development volunteer	JOCV	3-4	The volunteer assisted activation and organization of 66 local women's groups in order to increase cash incomes and the quality of life at the Local Development Department of Mbeya City in the southwest.
302		2000.07 – 2002.09	Village development volunteer	JOCV	3-4	Aiming for local development and improvement in the quality of life in villages in thirty regions in the city of Dodoma, the volunteer supported activities for cash income by the existing women or youth development groups and provided advice/instruction for management, etc.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
303	Tanzania	2000.07 – 2000.11	Village development volunteer	JOCV	3-4	In order to improve the quality of life and promote local development in rural villages in the province, the volunteer provided visiting instruction and education on women at home with the employees. Targeting increase in cash income, advice and instruction were also given on starting vegetable gardens or home business, etc.
304		2002.07 – 2004.07	Village development volunteer	JOCV	3-1 3-4	The volunteer studied and planned the directionality of village-activating business promotion with the women and youth groups in the area and implemented support for realization as well as wide range of activities including environmental education.
305	Zambia	1998.12 – 2000.12	Village development volunteer	JOCV	3-4	260 farming families live in a 200 ha irrigation land constructed by the Mongu Region Rural Development Program. Since women's groups were low in social status and had little power, the volunteer supported them so that the opinions of women could be reflected in union management in cooperation with other rice cultivation, vegetable and agricultural construction volunteers.
306		2001.04 – 2003.04	Village development volunteer	JOCV	3-4	As a member of the group dispatch volunteers for the Mongu Region Rural Development Program, the volunteer organized the existing women's groups and implemented advocacy activities to promote activation of female members of the farmer groups and promote activities of women's committees centering on the project site.
307	Zimbabwe	2001.07 – 2003.07	Village development volunteer	JOCV	1-4 3-1	The provincial health agency was established next to a provincial general hospital with approximately 140 beds. The volunteer assisted in planning and adjustment of round of visits care services and planning and implementation of health education on measures against diseases such as malaria, cholera and HIV/AIDS.
308		2003.12 – 2005.12	Village development volunteer	JOCV	1-4	An organization to implement advocacy activities for HIV/AIDS prevention on women working in the sex industry. The volunteer implemented assistance to women's groups that were separated by region (book-keeping, organization management, profitable production activities).
309	Egypt	1999.12 – 2001.12	Public health nurse	JOCV	1-1 1-2	The volunteer assisted in health education, maternal and child health instructions, public health instructions, etc. in villages to be established among local community. The volunteer understood the customs of Islamic culture and, as an initial stage, became accepted by the local residents, then implemented home-visits.
310	Jordan	2000.12 – 2003.04	Midwife	JOCV	1-1 1-2 1-3	In the administrative organization on health which supervised one national general hospital, twelve local health centers and thirty branch clinics, the volunteer visited the region in charge and implemented antenatal care and health checkup on infants, instruction on family planning, immunization, etc. to support improvement in maternal and child health in villages.
311		2001.12 – 2003.12	Midwife	JOCV	1-1 1-2 1-3	In centers where immunization, dental treatment, maternal and child health, family planning, etc. are implemented in addition to normal diagnosis in proximity of the capital, the volunteer cooperated in awareness promotion in relation to health, hygiene and health education through antenatal care, nursing instruction, etc.
312		22001.07 – 2003.07	Public health nurse	JOCV	1-1 1-2 1-3	The volunteer participated in planning and management of lectures on general daily life for the local community and implemented feedback on health education based on study, analysis and evaluation of health problems for local community.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
313	Morocco	1999.07 – 2001.07	Midwife	JOCV	1-1 1-2	<Regional activity type> The dispatch destination clinic watched over the health of approximately 40,000 people in the surrounding area with only 6 health staff. Pregnant women in the region never received diagnosis until delivery which was performed according to a traditional method. Visiting health instructions were provided centering on pregnant women and infants in the village.
314		2000.04 – 2002.04	Midwife	JOCV	1-1 1-2 3-1	<Regional activity type> The clinic watched over the health of approximately 15,000 people in the surrounding area, and about 40% of the pregnant women in the region never received diagnosis until delivery which was performed according to a traditional method. Visiting health instructions were provided centering on pregnant women and infants in the village.
315		2001.07 – 2003.07	Midwife	JOCV	1-1	<Regional visiting type> The clinic was located at the center of the village in the mountainous region with population of 20,000, and was constructed by community participation. Patients usually travel to the clinic on mules, donkeys or on foot. Since it is mountainous region, most of the pregnant women cannot receive antenatal care at the clinic and they have delivery alone or with a TBA in the village. The volunteer visited the village and provided antenatal care.
316		2002.04 – 2003.04	Midwife	JOCV	1-1 1-2	The dispatch destination clinic watched over the health of approximately 17,000 people in the surrounding area, and many of the pregnant women in the region never received diagnosis until delivery, which was performed with TBAs in attendance. It was considered that visiting health instructions were necessary centering on pregnant women and infants in the village, and thus visiting activities were implemented.
317	Bangladesh	1998.12 – 1999.06	Midwife	JOCV	1-3	It was a local NGO with forty-year history that implemented activities to disseminate the correct concept of family planning through training such as hygiene education. The volunteer cooperated with the staff to provide visiting instruction on rural regions and skill improvement training on TBAs.
318		1999.07 – 2000.03	Midwife	JOCV	1-1 1-2 1-3	The volunteer instructed the family planning instructors and village midwives working in the region of maternal and child health program implementation on health control on pregnant women, safe delivery and appropriate contraception by visiting the villages.
319		1999.07 – 2001.07	Midwife	JOCV	3-1	This association was an NGO that aimed for promotion of independence of women in poor communities and implemented various trainings, health services and advocacy activities in health and hygiene education. The volunteer supported the doctors in the headquarter clinic and implemented instructions in order to improve staff awareness and skills.
320		2002.04 – 2004.04	Midwife	JOCV	1-1 1-2	Allo Shikha was a local NGO belonging to the NGO agency. The volunteer provided visiting instructions on maternal and child health in the village 200km away from the capital and surrounding villages along with health workers.
321		2002.04 – 2004.07	Midwife	JOCV	1-1 1-2	The dispatched organization was an NGO in a rural region 230km away from the capital, and the volunteer provided visiting instructions with doctors and local employees as well as activities for promotion of antenatal care involving TBAs. The volunteer also gave advice for improvement in midwife knowledge and skills of doctors and nurses as a hospital staff.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
322	Bangladesh	2000.12 – 2002.12	Village development volunteer	JOCV	3-4	The volunteer cooperated in trainings on cultivation, fowl rearing, dress making, etc. for promotion of self-employment for young men and women which were implemented by the dispatch organization. Cooperation was mainly given in motivation of female residents.
323		1998.12 – 2001.08	Public health nurse	JOCV	1-3	Targeting a local NGO with forty-year history, the volunteer implemented activities to disseminate correct concept of family planning through hygiene education and various trainings. The volunteer implemented training program development, assistance in health checkup at the clinic, visiting instruction and health study in rural regions.
324		2001.07 – 2003.07	Public health nurse	JOCV	1-3	Targeting an NGO that implemented activities for forty-six years in order to introduce and disseminate concept of family planning in this country, the volunteer implemented health and hygiene education by making visits to villages and assisted in dissemination of knowledge about maternal and child health.
325		2001.07 – 2004.02	Public health nurse	JOCV	1-1 1-2 3-1	The volunteer was dispatched to a project which was subject to JICA Community Empowerment Program and cooperated in review of training program for local health promotion personnel who contributes to maternal health, health education and nutrition improvement in villages as well as improvement in knowledge and skills. The volunteer also visited the villages and instructed women in rural villages directly.
326		2003.07 – 2005.07	Public health nurse	JOCV	1-1 1-2	The volunteer belonged to the NGO that implemented JICA Partnership Program in a village 190km away from the capital and worked as a public health nurse. The volunteer provided instruction on maternal and child health, health and hygiene education, etc. on women in rural villages.
327	People's Republic of China	2002.07 – 2004.07	Midwife	JOCV	4-2	The dispatched special hospital centered on obstetrics and pediatrics, and aimed for higher levels of obstetric nurses and midwives by introducing "chiropractic nursing" centered on patients. The volunteer supported improvement in obstetric nursing process in cooperation with senior nursing officer and chief nurses through introduction of Japanese technology and suggestions in practice.
328	Indonesia	1999.12 – 2001.12	Midwife	JOCV	1-1 4-2	In the obstetric ward of a hospital that played the central role in the Bali Island (with 777 beds, 335 doctors and 788 nurses), the volunteer supported improvement in nursing services centering on awareness change in the concept of hygiene.
329		2001.07 – 2003.07	Midwife	JOCV	1-1 1-2	<Regional visiting type> Based on the "Maternal and Child Health Handbook National Program" which started in 1998, the volunteer implemented establishment of the Maternal and Child Health Handbook and promotion activities among local community. Utilizing the experience in Japan, the volunteer also gave instruction/advice to local staff on use of the Maternal and Child Health Handbook and supported improvement in maternal and child health services.
330		2001.07 – 2003.07	Midwife	JOCV	1-1 4-2	The volunteer implemented instruction on midwives in the obstetric ward of the dispatched hospital with 293 beds, 46 doctors, 296 nurses and 94 other workers including clerks. Since the infant mortality rate was high, instruction was given in order to improve the quality of health services in the obstetric ward in correct delivery, hygiene concept, newborn control, etc.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
331	Indonesia	2002.04 – 2003.03	Midwife	JOCV	1-1 1-2	While promotion of the Maternal and Child Health Handbook was underway in JICA projects, its promotion started since 1998 in this province. The volunteer instructed on effective use of the handbook.
332		2002.12 – 2004.12	Midwife	JOCV	1-1 1-2	<Regional activity type> Based on the “Maternal and Child Health Handbook National Program” which started in 1998, the volunteer implemented establishment of the Maternal and Child Health Handbook and promotion activities among local community. Utilizing the experience in Japan, the volunteer also gave instruction/advice to local staff on use of the Maternal and Child Health Handbook and supported improvement in maternal and child health services.
333	Lao PDR	1998.07 – 2000.07	Midwife	JOCV	1-1 1-2 1-3	The volunteer instructed on measures in antenatal care, delivery attendance and abnormal delivery in the obstetric wards and maternal and child health wards of provincial hospitals. Advice was also given on family planning, maternal and child health education and immunization expansion program.
334		1999.04 – 2001.04	Midwife	JOCV	1-1 1-2 1-3	In this center which implemented maternal and child health and public health activities in the province, the volunteer implemented activity planning, monitoring of maternal and child health departments and work evaluation in cooperation with the staff. The volunteer also implemented antenatal care, family planning and immunization by visiting the surrounding areas of the center.
335		1999.04 – 2001.04	Midwife	JOCV	1-1 1-2 1-3	The dispatch destination was a district hospital located in urban areas, and it has three clinics and provides medical services to residents of thirty-seven villages. The volunteer implemented practical instruction in maternal and child health field such as antenatal care, delivery attendance, family planning and immunization, plan development for maternal and child health education, etc. in cooperation with employees.
336		1999.12 – 2001.12	Midwife	JOCV	1-1 1-2	The volunteer implemented antenatal care, immunization, maternal and child health education in cooperation with the hospital staff in the outskirts of the capital. The volunteer also implemented instruction on medical skills of delivery attendance, etc.
337		1999.12 – 2001.12	Midwife	JOCV	1-1 4-2	In addition to providing antenatal care and technical instruction to midwives on delivery attendance, the volunteer conducted development and implementation of planned health education in cooperation with the hospital employees, linking together patient and clinic and/or clinic and district hospital.
338		2001.04 – 2003.04	Midwife	JOCV	1-1 1-2	The dispatched hospital was established in 1980 with 20 beds, 20 departments and 97 staff including 10 doctors. The hospital was at a remote location with inconvenient traffic system, and the volunteer implemented instruction in relation to delivery, antenatal care and instruction on infant nutrition so that patients are properly supervized and cared for.
339		2002.12 – 2004.12	Midwife	JOCV	1-1 1-2	The volunteer implemented technical instruction on general nursing skills, antenatal care, health instruction and delivery attendance in a hospital of a county located eight km away from the capital with population of 80,000. Since the dispatched hospital was a beachhead for PHC, hygiene education on health workers and visiting immunization, etc. were also implemented.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
340	Lao PDR	2001.04 – 2003.04	Public health nurse	JOCV	1-1 1-2	The dispatch hospital was one of the nine district hospitals in Vientiane Municipality, and supervised seven clinics. The volunteer supported technical improvement so that the work of primary health care department (vaccine inoculation, hygiene education, dengue/malaria survey, antenatal care, etc.) can be implemented more effectively.
341		2001.04 – 2003.04	Public health nurse	JOCV	1-1 1-2	The dispatch hospital was one of the nine district hospitals in Vientiane Municipality, and supervised seven clinics. The volunteer supported technical improvement so that the work of primary health care department (vaccine inoculation, hygiene education, dengue/malaria survey, antenatal care, etc.) can be implemented more effectively.
342	Nepal	1998.07 – 2000.12	Midwife	JOCV	1-1 1-2 1-3	The volunteer visited the field with the staff of the dispatch destination branch with eleven clinics/consultation rooms and implemented antenatal care, infant health checkup, diagnosis of the sick and drug prescription, family planning publicity, hormone injection for contraception, study groups for parasite prevention and maternal and child health, sex education on adolescent women, etc.
343		2000.04 – 2002.04	Midwife」	JOCV	1-1 1-3 4-2	The volunteer provided delivery attendance at the "Family Health Center" constructed with Grant Aid for Grassroots and visited fifteen field sites in the district three times per week to implement antenatal care, family planning instruction, etc. The volunteer also implemented management/control of the center and developed and implemented staff training and instruction.
344		2000.04 – 2002.04	Midwife	JOCV	1-1 1-2 1-3	Among the twenty-two field offices in the district, the volunteer visited five closest to the branch one a day and implemented family planning publicity/instruction, maternal and child health checkup, general health checkup, antenatal care and infant health checkup, prescription of contraceptives, etc. Health education, reproductive health and field worker training were also implemented.
345		2000.07 – 2002.07	Midwife	JOCV	1-1 1-2 1-3	The volunteer implemented family planning instruction, antenatal care and infant health checkup, instruction on contraception and prescription of contraceptives, hormone injection, etc. in a clinic within the branch in cooperation with the staff. The volunteer also implemented study groups on maternal and child health, family planning, etc., field visiting instructions, reproductive health and sex education in turn.
346		2000.12 – 2003.03	Midwife	JOCV	1-1 1-2 1-3	With field clinic visiting as the main activity, the volunteer implemented family planning instruction, antenatal care and infant health checkup, contraceptive instruction and prescription of contraceptives, hormone injection, etc. The volunteer also supported public advocacy to local residents, technical assistance to health staff, improvement in problems in the branch, etc.
347		2000.12 – 2002.12	Midwife	JOCV	1-1 1-2 1-3	The volunteer visited field clinic and implemented family planning instruction, antenatal care and infant health checkup, general diagnosis and treatment to support improvement in local maternal and child health. The volunteer also implemented assistance to improvement in branch management and control, and assistance in management and control and delivery services once the new center was constructed.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
348	Nepal	2002.12 – 2004.11	Midwife	JOCV	1-1 1-2 1-3	The volunteer implemented family planning instructions, antenatal care and infant health checkup, prescription of contraceptives, etc. with the staff at the clinic in branch in a town which was a famous tourist spot with Chitwan National Park located at a distance of six hours southwest of the capital by bus. Regular visiting instruction to field clinics was also implemented in turn.
349		2003.04 – 2005.04	Midwife	JOCV	1-1 1-2 1-3	Among the twenty-two field offices in the district, the volunteer visited the four closest to the branch at a rate of one a day and implemented family planning publicity/ instruction, maternal and child health checkup, general health checkup, antenatal care, prescription of contraceptives, etc. Health education, reproductive health and field worker training were also implemented.
350		2002.04 – 2004.04	Village development volunteer	JOCV	3-1 3-4	In order to improve social and economical status of women, the volunteer supported activation of women organizations with funding assistance by UNICEF. Study group planning and proposal on use of small-scale financing, literacy lessons, etc. were also supported.
351		2002.12 – 2004.11	Village development volunteer	JOCV	1-1 1-2 1-3	The volunteer assisted in family planning, maternal and child health, antenatal care, infant health checkup, prescription of contraceptives, etc. Field publicity activities and study groups were especially implemented with focus in cooperation with the staff.
352		2003.04 – 2005.04	Village development volunteer	JOCV	1-1 1-2 1-3	This branch promoted family planning and maternal and child health in Kaski District in Western Nepal. The volunteer succeeded the rural community development activities undertaken by the previous volunteer and implemented advocacy activities in family planning to the community.
353		2003.07 – 2005.07	Village development volunteer	JOCV	3-1 3-4	The dispatch destination implemented activities to promote empowerment of women. The volunteer cooperated with other staff to reinforce cooperation with other related organizations delaing in health, education, livestock, and agriculture and implemented planning of an organized program that suited the needs of women.
354		2001.04 – 2003.04	Public health nurse	JOCV	1-3	The volunteer visited the field clinics and mainly worked in promotion and publicity of family planning to local residents. Technical assistance to health staff, and assistance in the smooth management of clinics were also implemented.
355		22001.07 – 2003.07	Public health nurse	JOCV	1-1 1-2	The volunteer assisted in the management of six visiting clinics in the city and development of local health program centered on resident education on maternal and child health, prevention of infections such as tuberculosis, and public health.
356	Marshall	1999.07 – 2001.07	Midwife	JOCV	1-1	The volunteer cooperated in improving midwife and nursing skills of the health staff while also working in the obstetric ward of the national general hospital which covered the entire country.
357		2000.12 – 2002.12	Midwife	JOCV	1-3	The volunteer implemented development of a lecture curriculum for youth/community (young pregnancy, contraceptives, nutrition improvement, etc.) and cooperated in lecture groups held in remote islands.
358		2001.07 – 2003.07	Midwife	JOCV	1-1 1-2 4-2	The volunteer cooperated in improving midwife and nursing skills of the staff while working in the obstetric ward (delivery, newborn room, sickrooms).
359	Micronesia	1998.07 – 2001.07	Midwife	JOCV	1-1 1-2 1-3	The main activities were visiting instructions at hospitals, villages and remote islands centered on maternal and child health and family planning. Instruction was given to pregnant women and nursing mothers on family planning, preventive health, newborn nursing, etc. that suited the community.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
360	Pakistan	1999.04 – 2002.01	Village development volunteer	JOCV	3-1 3-4	In the rural development project implemented by women development/social welfare/special education department, the volunteer planned and implemented activities for improvement in the quality of life in villages in cooperation with the residents. Specific activities were determined upon discussion with the personnel in charge of project and village residents so that resident participation is promoted and activities suit the level of the village.
361		1999.12 – 2001.12	Public health nurse	JOCV	1-3	The population department established the Family Welfare Center and had been implementing activities to promote understanding and participation in family planning by local residents. The volunteer implemented instruction on family planning, maternal and child health, population education, advocacy activities and training on staff so that family planning is recognized by the community.
362		2001.04 – 2002.07	Public health nurse	JOCV	1-3	The volunteer mainly implemented advocacy activities in family planning to the local residents at the clinics.
363	Philippines	2002.04 – 2004.04	Midwife	JOCV	1-1 1-2	In the rural development project implemented by women development/social welfare/special education department, the volunteer planned and implemented activities for improvement in the quality of life in villages in cooperation with the residents. Specific activities were determined upon discussion with the personnel in charge of project and village residents so that resident participation is promoted and activities suit the level of the village.
364		2001.07 – 2003.07	Village development volunteer	JOCV	3-4	Through providing advices for an NGO that supports women, the volunteer assisted the market surveys for planning vocational training for women that led to increased incomes. The volunteer also promoted small-amount financing and small-scale business startup assistance project for residents (women).
365		1999.07 – 2001.07	Public health nurse	JOCV	1-1 1-2 1-3	The volunteer implemented diagnosis and treatment in villages and towns with midwives and nurses as well as midwife instruction at the dispatched health center. Advice at the health center, instruction and advice for village residents in various seminars (nutrition, family planning, maternal and child health, infections, etc.) were implemented as well.
366		1999.12 – 2001.12	Public health nurse	JOCV	1-1 1-2 1-3	<Visiting Instruction Type> The dispatch destination implemented antenatal care, family planning, infection control, and statistic control, and the volunteer cooperated with midwives and nurses to give advice and instruction in diagnosis and treatment in villages and towns as well as in various seminars (nutrition, maternal and child health, family planning, etc.).
367	Solomon	1999.04 – 2000.12	Midwife	JOCV	1-3	In a hospital that was the only hospital in the province and is considered an important medical beachhead, the volunteer implemented technical transfer to the local nurses through actual work of midwife. In addition to general work related to delivery, health education on women in the surrounding areas was promoted through mothers' class, etc.
368		1999.07 – 1999.11	Midwife	JOCV	1-1 1-3 3-1	The volunteer implemented technical transfer to the local nurses through midwife work in a local medical beachhead hospital with eight obstetric beds. Health education on women in the surrounding areas was promoted through mothers' class, etc.
369		1999.12 – 2000.10	Midwife	JOCV	1-1	The volunteer implemented technical transfer to the local nurses through midwife work in a hospital which is the only medical beachhead in the province with total bed number of twenty-one Health education on women in the surrounding areas was promoted through mothers' class, etc.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
370	Sri Lanka	2001.07 – 2003.07	Midwife	JOCV	1-1	There was a high frequency of abnormal delivery due to troubles during pregnancy or delivery, and the rate of disabled babies was high. The volunteer assisted in raising awareness for safe delivery by the mothers and improvement in technical problems for health workers by centering on technical instruction at the dispatched hospital and preventive activities at local health center.
371		2000.01 – 2002.02	Village development volunteer	JOCV	3-4	The volunteer cooperated in reinforcing women's groups and small-scale financing, etc. in increasing incomes, improving the quality of life, kindergarten management assistance, and a health promotion activity program targeting the residents of low-income areas and especially women. It was also implemented in concurrence to examine the cooperative system in terms of health in kindergartens.
372		2001.04 – 2003.04	Village development volunteer	JOCV	3-4	The volunteer cooperated in a project to improve the quality of life targeting the resident organizations in low-income areas and especially women. The volunteer was involved in small-scale financing project, waste treatment project improvement, environmental education promotion project, etc. promoted by the city and assisted in proposal, planning, adjustment and promotion of various programs.
373		1999.07 – 2001.07	Public health nurse	JOCV	1-2 1-3	The volunteer implemented infant care, school health assistance, hygiene statistics, family planning and health and hygiene education in low-income areas and local clinics.
374	Thailand	2002.07 – 2004.07	Activities for young people	JOCV	3-1	The volunteer planned and implemented various activities in career training facility targeting poor women of 13–35 years old who did not have opportunity to receive higher education so that the women can have mental and physical health in life.
375		1999.07 – 2001.07	Village development volunteer	JOCV	3-1 3-4	As a member of a model village development team for supporting the independence of mountainous tribes, the volunteer implemented training cooperative organization centered on women from the viewpoint of increasing incomes, fostering of home industries such as handicraft, and planned and implemented various lectures on general home economics such as child raising, education, and family budget.
376		1999.07 – 2001.12	Village development volunteer	JOCV	3-4	Targeting women's groups in frontier rural villages in the northeast, the volunteer searched for possibilities of home industry such as agricultural product processing and handicraft production as income sources other than farming and was involved in evaluation/planning/ adjustment/implementation from its organization development to market development.
377		1999.12 – 2001.12	Village development volunteer	JOCV	3-4	Targeting women's groups in rural villages in the north, the volunteer searched for various activities for organization activation and possibilities of home industry such as agricultural product processing and handicraft production as income sources other than farming and was involved in evaluation/planning/ adjustment/implementation from its organization development to manufacture and sales.
378		2000.04 – 2002.04	Village development volunteer	JOCV	3-4	Targeting women in mountainous tribal villages in the north, the volunteer assisted planning to implementation of various projects related to improvement in the quality of life/social development. The volunteer also searched for various activities for organization activation and possibilities of handicraft production as home industry for increasing incomes and was involved in evaluation/planning/ adjustment/implementation from its organization development to manufacture and sales.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
379	Sri Lanka	2000.04 – 2002.01	Village development volunteer	JOCV	3-4	For women's groups in villages in the northeast, the volunteer searched for possibilities of home industry such as agricultural product processing and handicraft production as income sources other than farming and was involved in evaluation/planning/ adjustment/implementation from its organization development to market development.
380		2003.04 – 2005.04	Village development volunteer	JOCV	3-4	For women's groups in the northeast villages, the volunteer assisted in evaluation/planning/ adjustment/implementation from product development to market development in order to foster an organization that implements home industry such as fabric production, handicraft, agricultural product processing that will be income sources other than farming.
381	Vanuatu	2000.07 – 2002.07	Public health nurse	JOCV	1-1 1-2 1-3	<Remote island regional activity type> The volunteer implemented activities using the major hospital on an island 225km away from the capital as the beachhead. Health instruction and education in hospital and visiting instruction at local health centers were also implemented. The activities varied greatly from maternal and child health to school health, nutrition instruction and family planning.
382		2000.12 – 2002.12	Public health nurse	JOCV	1-1 1-2	Local public health activities in the provincial health centers. The volunteer implemented visiting activities in the province in cooperation with the maternal and child health staff. The field was not limited to maternal and child health but centered on health education and health consultation related to local public health. The volunteer was also involved in developing a visiting program and data processing.
383	Solomon	2001.04 – 2003.04	Public health nurse	JOCV	1-1 1-2	The volunteer visited three major islands with seven local public health activity staff at the provincial health center and participated in maternal and child health education at the adjacent hospital. In visiting, activity centered on health consultation and health education at village clinics. The volunteer also assisted in developing a visiting program and data processing.
384		2003.07 – 2005.07	Public health nurse	JOCV	1-1 1-2 1-3	The volunteer mainly took charge of maternal and child health (MCH) at the health center which was the beachhead for province. Activities for school health, individual hygiene, family planning, sex education and nutrition were implemented. In concurrence, the volunteer cooperated with other volunteers with the same job who are dispatched in the same area to study specific health education and implement activities for national promotion.
385	Viet Nam	2000.12 – 2002.12	Midwife	JOCV	1-1 1-2	The dispatch destination hospital was the largest hospital in Hue City with an in-hospital care facility of seventy beds, and had three deliveries/day on average. Cooperation was requested for improvement in nursing levels of the obstetric staff. The volunteer implemented activities for the series of nursing process from pre-delivery to delivery and leaving the hospital in cooperation with the midwife leader.
386		2001.04 – 2003.04	Midwife	JOCV	1-1 1-2	The volunteer implemented maternal nursing before and after delivery and delivery attendance along with the staff of the dispatch destination center, and also implemented instruction to village health centers, introduction and instruction on skills/experience in monthly midwife training courses in cooperation with the visiting teams of the center.
387		2002.12 – 2004.12	Midwife	JOCV	1-1 1-2	The volunteer cooperated in maternal care before and after delivery or after surgery, delivery attendance, visiting instruction on village health centers, introduction of skills/experience by attending monthly clinic midwife meeting, etc. at the health centers targeted by JICA Reproductive Health Project.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
388	Viet Nam	2002.12 – 2004.12	Midwife	JOCV	1-1	The volunteer cooperated in maternal care before and after delivery or after surgery, delivery attendance, visiting instruction on village health centers, introduction of skills/experience by attending monthly clinic midwife meeting, etc. The obstetric ward had sixteen beds (four rooms, one delivery room, one family planning room).
389		2003.04 – 2005.04	Midwife	JOCV	1-1 1-2	The volunteer cooperated in maternal care before and after delivery or after surgery, newborn and infant care, child-raising group activities, etc. at the health centers targeted by JICA Reproductive Health Project.
390		2003.04 – 2005.04	Midwife	JOCV	1-1	The volunteer cooperated in maternal care before and after delivery or after surgery, delivery attendance, visiting instruction on village health centers, etc. at the health centers targeted by JICA Reproductive Health Project.
391		2003.07 – 2005.07	Midwife	JOCV	1-1	Improvement in obstetric nursing skills was expected, and the volunteer worked as an assistant to obstetric ward chief. Cooperation was implemented in the series of activities related to maternal care from pre-delivery to delivery and leaving.
392		2003.07 – 2005.07	Village development volunteer	JOCV	1-4 3-4	In order to solve the health/social issues such as HIV/AIDS and gambling which were increasing in concurrence to development of tourist attraction in the historic city of Hue, the volunteer planned and implemented advocacy and publicity activities in cooperation with members of women's union, etc. Cooperation was also implemented in developing efficient cooperation with general public organizations and administration.
393	Belize	2003.07 – 2005.07	Activities for young people	JOCV	1-3 3-1	The volunteer reinforced the programs for young people at an NGO that promoted family planning and primary health care. In cooperation with the personnel in charge of youth department in this NGO, the volunteer assisted in planning, adjustment, educational material development and implementation of various projects for young people in the community.
394	Bolivia	1999.04 – 2001.04	Midwife	JOCV	1-2	The volunteer used the hospital in the village as the beachhead and worked in primary and secondary health service centering on delivery attendance in cooperation with the staff who make round of visits to three other villages to give diagnosis and treatment.
395		1999.07 – 2001.07	Midwife	JOCV	1-1 1-3	The volunteer worked for the obstetric ward of the dispatch destination to improve the nursing and other processes while in nursing practice with the other Bolivian assistant nurses. Lectures on family planning were also given to local residents.
396		2001.07 – 2003.07	Midwife	JOCV	4-2	The volunteer aimed for improvement in the quality of the dispatched hospital through opinion exchanges with Auni-Pucarani Hospital employees. Awareness-raising in health for community was also implemented through local visiting instructions.
397		2003.07 – 2005.07	Midwife	JOCV	4-2	This country works for establishment of primary level health facilities in the capital for the purpose of substantiating the local health network that conform to the local culture. The volunteer assisted improvement by extracting the issues related to all of health service through hospital activities and visiting instructions on nearby health centers.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
398	Chile	1998.07 – 2000.12	Village development volunteer	JOCV	3-1 3-4	The volunteer belonged to the Women's Issue Group of the Local Promotion Department of the city which worked to raise the awareness of problems of women in rural villages and those without career skills, and implemented problem analysis as well as cooperation in developing programs for improving the quality of life and increasing incomes.
399	Dominican Republic	2000.07 – 2002.07	Village development volunteer	JOCV	3-4	The volunteer assisted in sales and agriculture system improvement in cooperation with experts and other volunteer of the same job to aim for activation of female society in villages dotted in the jurisdiction area for a JICA project, agricultural development program for mountainous and slope areas centering on pepper.
400		2002.07 – 2004.07	Village development volunteer	JOCV	3-4	The volunteer implemented activities in the areas where a JICA project, "Agricultural Development Program for Mountainous and Slope Areas" has been implemented. Women's groups were reinforced to search for activities that lead to improvement in the quality of life and to promote them in ten villages.
401		2000.07 – 2002.07	Public health nurse	JOCV	1-1 1-2	The volunteer conducted activities in maternal and child health, gave advice on health and hygiene to housewife volunteers, and cooperated in raising awareness on local health and hygiene through immunization, home visiting, etc. at a clinic run by the NGO organization which implemented wide range of social development activities in the low-income areas.
402	Ecuador	1999.04 – 2001.04	Midwife	JOCV	1-1 1-2 1-3	The volunteer implemented activities in assistance in diagnosis and treatment in out-patient section of the obstetric ward, maternity instruction, promotion of family planning, etc.
403		2001.07 – 2003.07	Midwife	JOCV	1-1	The volunteer assisted in diagnosis and treatment as well as maternal instruction in out-patient section of the obstetric ward of a clinic run by the city targeting low-income residents.
404		2000.07 – 2001.06	Activities for young people	JOCV	1-3 1-4	The volunteer worked at the youth department of the city government and ,through youth activities, assisted the measures against unwanted pregnancy, sexual diseases, alcoholism, etc. which are the juvenile delinquency problems in the city. The volunteer cooperated with the local coordinator to develop and implement activity plans.
405		2002.12 – 2004.12	Village development volunteer	JOCV	3-4	The volunteer belonged to the on-campus agriculture promotion center which provided guidance to local farmers and visited parts of the area to give instructions on methods for improvement in the quality of life mainly by agricultural skills for residents mostly consisting of women's groups. Instructions on processing skills for jam, etc. and cooking with consideration on nutrition were also given.
406		1999.07 – 2001.07	Public health nurse	JOCV	3-1	The free clinic run by social welfare corporate was used as the beachhead for activities. Regular lectures were held for local residents in relation to hygiene, and dissemination of hygiene concept and environmental protection awareness was assisted. The volunteer also worked as an obstetric nurse to support the volunteer doctors.
407	El Salvador	2000.04 – 2002.04	Midwife	JOCV	1-1 1-2 4-2	Receiving the health policy of the government to aim for improvement in infant mortality rate which was implemented from fiscal year 1998, the volunteer implemented instruction on pregnancy, delivery, puerperal, and newborn care services for nurse employees at health centers and implemented birth attendance advice to TBAs in the jurisdiction.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
408	Guatemala	2000.07 – 2002.07	Village development volunteer	JOCV	3-1	In cooperation with an NGO, the volunteer visited different villages and implemented various lectures for women. By providing lectures on improvement of livelihood skills, the time constraints were reduced, awareness change was induced and a situation in which women were given opportunities for receiving education was created.
409		2000.12 – 2002.12	Village development volunteer	JOCV	3-3 3-4	The volunteer implemented visiting health care and instruction on health and hygiene in areas with many indigenous people where infant and maternal mortalities were high. The volunteer participated in forming a project that suited the residents' needs and cooperated to raise awareness on community development.
410		2002.04 – 2004.05	Village development volunteer	JOCV	1-3 3-4	The volunteer implemented small-scale projects on developing kitchen gardens in order to improve nutiritional status and increase incomes, family planning and sex education in cooperation with the village leaders, etc. in a mountainous village in a coffee plantation.
411		2002.12 – 2004-12	Village development volunteer	JOCV	1-3	The volunteer implemented projects for women to receive cash income, lectures for women's groups in villages for nutrition improvement, etc. Adjustment for inviting lecturers from various governmental organizations was also assisted.
412		2003.12 – 2005.12	Village development volunteer	JOCV	1-3 3-1	At a clinic (NGO) located in a poor area of the country, the volunteer visited villages with local staff and the nurse volunteer to be dispatched to the clinic and implemented local health activities including hygiene instruction, nutrition instruction, disease prevention and family planning promotion.
413		1999.07 – 2001.07	Public health nurse	JOCV	1-1 1-2 1-3 1-4	In a local clinic of Guatemala Family Planning Association, the volunteer implemented emergency treatment in obstetrics (pregnancy, vaginal infection by delivery), sexually transmitted infections (AIDS, syphilis, gonorrhea), pediatrics (diarrhea, respiratory infections). The volunteer also implemented sex education on knowledge about health and disease prevention, educational instructions in terms of hygiene.
414		2000.12 – 2002.12	Public health nurse	JOCV	1-1 1-2 1-3	In cooperation with doctors and nurses, the volunteer cooperated in instruction on preventive health and hygiene, and family planning. The volunteer also participated in the nutrition improvement team comprised of doctors, nurses, etc. to visit villages and cooperated in providing instruction to local midwives and health promotion personnel.
415		2000.12 – 2002.12	Public health nurse	JOCV	1-1 1-2	The dispatch destination was a local NGO organized in an area with many indigenous people where infant and maternal mortalities were high. The volunteer visited neighboring villages and cooperated in implementing various lectures on health and hygiene for women and children. The volunteer also assisted in study to make lectures more suitable for local needs and preparation of educational materials.
416		2003.04 – 2005.04	Public health nurse	JOCV	1-1 1-2	The volunteer worked in the health department of an international NGO whose purpose was to protect the environment and to disseminate knowledge about maternal health among village residents, midwives, etc. so that they could put the knowledge into practice.
417		2003.04 – 2005.04	Public health nurse	JOCV	1-1 1-2	In order to reduce infant and maternal mortality rates in areas that suffered from the civil war, the volunteer implemented health and hygiene education for mothers at elementary schools. Cooperation was also given to lecture follow-up, home visiting for evaluating the improved ovens provided in WID-related equipment provision, training of advocacy personnel, etc.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
418	Honduras	2000.07 – 2002.07	Midwife	JOCV	1-3 2-1	The main activities included family planning instruction and uterine cancer examination at the out-patient section of the obstetric ward of a local hospital in the area that had a population of 160,000. The volunteer also provided instruction to practical nurses and assistant nurses.
419		2003.07 – 2005.07	Midwife	JOCV	1-1 1-2	The volunteer belonged to a hospital (secondary health facility) in a local city about 90km away from the capital, and instructed practical nurses on basic knowledge and skills about prevention of infection for safe delivery, maternal and child control after delivery, etc. Cooperation was also given in reinforcing the core hospital in local public health system.
420		2000.07 – 2002.07	Public health nurse	JOCV	1-1 1-2	At the health office of a region located in eastern part of the country where development was the slowest, the volunteer implemented visiting instruction for local practical nurses and residents on measures against infections (diarrhea, malaria, etc.), maternal education, nutrition improvement, etc. Cooperation was also given in practical nurse training programs.
421	Jamaica	2000.04 – 2002.04	Public health nurse	JOCV	1-1 1-2 1-3	The volunteer worked full time at the health center of Cascade Village (village with no doctor) located in the Blue Mountains and instructed local residents on health and hygiene while also implementing management and control of the health center. Elementary medicine such as treatment of cuts, maternal and child health, instruction on family planning, and health checkup were also implemented.
422	Mexico	1999.07 – 2001.07	Midwife	JOCV	1-1	Nurses and local instructors who can give proper instruction on pre-delivery control were trained. The volunteer gave visiting instructions in the target area and gave instruction on public health as well.
423		1999.12 – 2001.12	Midwife	JOCV	1-1	The volunteer worked at a health center and implemented training for nurses and assistant nurses on nursing, delivery and care after delivery in lectures and OJT in cooperation with the chief nurse. Hygiene education and nutrition instruction were also implemented for out-patients.
424		2002.04 – 2004.04	Midwife	JOCV	1-1 1-2 1-3	The dispatch destination was an NGO pediatric hospital opened in order to provide health services to poor people including indigenous people. Many indigenous people had young pregnancy and delivery as well as premature delivery and relied on traditional religion. The volunteer implemented regular visiting instructions to local villages aiming for reinforcement of health education, maternal and child health, etc.
425		2002.04 – 2004.04	Midwife	JOCV	1-1 1-2 1-3	MEXFAM (NGO) provided medical and educational services on reinforcement of maternal and child health, family planning, etc. to poor remote country villages and urban poor regions. The dispatch destination clinic assisted reinforcement of maternal and child health services, reduction in infant mortality rate, family planning, etc.
426		2001.12 – 2004.06	Public health nurse	JOCV	1-3	At MEXFAM (NGO), which was the dispatch destination, the volunteer provided health and educational services in relation to family planning and sex education mainly in poor remote country villages with indigenous people and urban poor regions. Visiting activities were implemented.
427	Nicaragua	1998.12 – 2000.12	Midwife	JOCV	1-1 1-2 1-3	The volunteer was assigned to the maternal and child health department and implemented health and hygiene instruction, birth attendance instruction to midwives, family planning and maternity instructions in cooperation with the counterpart. Education and instruction were given by visiting various areas.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
428	Nicaragua	1999.07 – 2001.07	Midwife	JOCV	1-1 1-2	The volunteer participated in maternal and child health projects on perinatal death, antenatal care, etc. and implemented visiting instructions on uneducated midwives.
429		2000.12 – 2002.12	Midwife	JOCV	1-1 1-2	The health centre that supervised ten regions in Rivas Province targeted reduction in maternal and infant mortality rates, and assisted improvement in maternal and child health services. The volunteer visited each substation health center and implemented reinforcement of knowledge and skills of nurses and TBAs as well as health instruction to local residents.
430		2003.07 – 2005.07	Midwife	JOCV	1-1 1-2	Centering on the health center constructed by Japanese grant aid, the volunteer participated in local maternal and child health activities and gave necessary advice while also working as manpower. Lifestyle guidance on obstetrics, health consultation at local health agency and visiting instructions were also provided.
431		1999.07 – 2000.10	Village development volunteer	JOCV	3-4	In cooperation with the local extension workers, the volunteer studied the situation of 16 groups near the capital, in suburbs or in proximity of several local cities and cooperated in forming general social development programs that suited the situation of each region. Implementation of projects for women.
432	Panama	2003.12 – 2005.12	Midwife	JOCV	1-1 2-1	In the target villages for “Panama Canal Basin Protection Program,” the volunteer implemented maternal health promotion and improvement in knowledge about disease prevention in cooperation with the health committee. The volunteer also assisted in promoting regular health checkup reception and advocacy and promotion of measures for early identification of obstetric diseases.
433		2003.07 – 2005.07	Public health nurse	JOCV	1-1 1-2	In cooperation with the health committee organized by local residents and clinic staff, the volunteer implemented activities to contribute to improving maternal and child health services with high resident needs (especially by infants and women) for residents of villages located on slopes in upstream of Panama Canal where slash-and-burn agriculture was widespread.
434	Paraguay	1999.04 – 2001.04	Midwife	JOCV	1-1 1-2	Concepcion Province, which is located in the northern region of the country, has many indigenous villages, and has various problems of health and hygiene such as a high infant mortality rate due to poverty and a low level of knowledge about hygiene. The volunteer assisted in implementing perinatal care in hospitals and a maternal and child health program in the region.
435		1999.07 – 2002.01	Midwife	JOCV	1-1 1-2	The provincial hospital treated hundred deliveries per month on average with sixty beds and fifty nursing staff. The volunteer cooperated in improving perinatal care in the obstetric ward as well as implementation of maternal and child health program for out-patient and the region. Cooperation was also given in planning and implementing training program for maternal and child health staff.
436		2000.04 – 2002.04	Midwife	JOCV	1-1 3-1	It was a public hospital with seventy-five beds, twenty-eight doctors and fifty-three nurse employees. The volunteer cooperated in instruction on pregnant women and nursing mothers, nurses and students while also working in the daily procedure of the obstetric ward. Cooperation was also given in planning and implementation of mothers’ class, etc. for out-patient and the region.

No.	Country	Dispatch Period	Job	Form	Mid-term Objective	Characteristics
437	Paraguay	2000.04 – 2002.04	Midwife	JOCV	1-1 1-2	The volunteer worked for the obstetric ward of the only hospital in the province with NICU facility. The volunteer contributed to improving nursing quality while giving instructions to assistant nurses on NICU control, instruction on incubators and breathers, and care for premature babies in cooperation with the counterpart.
438		2000.07 – 2002.07	Midwife	JOCV	1-1 1-2	The volunteer used the medical vehicle and visited the areas without clinics (including indigenous villages) along with the staff of dispatch destination to implement antenatal care, immunization and maternal and child health education.
439		2001.04 – 2003.04	Midwife	JOCV	1-1 1-2	Many of the residents in regions supervised by the center were poor farmers and had problems of young pregnancy and delivery, perinatal death, premature delivery, etc. Aiming for improvement and reinforcement of maternal and child health, the volunteer cooperated in antenatal care, hygiene education on in-patient pregnant women, etc.
440		2002.04 – 2003.07	Midwife	JOCV	1-1	Aiming for improvement in quality of antenatal care and maternal instruction in the obstetric ward of a central organization for health in Paraguari Department (sixty beds, twenty-five doctors, five nurses and five midwives), the volunteer cooperated in reducing unnecessary medical involvement in delivery and implementation of delivery attendance and care incorporating the idea of natural delivery in cooperation with the staff.
441		2003.12 – 2005.12	Midwife	JOCV	1-3	Using several clinics of the dispatched institute in rural regions as footholds, the volunteer formed groups and implemented sex education for local youths. Young pregnancy in poor groups was a serious problem in this country, and continued sex education was supported.
442		2000.07 – 2002.07	Public health nurse	JOCV	1-1 1-2 1-3	The dispatch region had many indigenous villages (South American Indians), which had many poor groups due to geographical reasons as well as serious health and hygiene problems. The volunteer implemented nutrition improvement, improvement in hygiene environment, prevention and care for diseases, and education for improving the quality of life such as family planning for the local residents.
443		2000.07 – 2002.07	Public health nurse	JOCV	1-1 1-2 3-1	The region supervised by the dispatch health center was located at the national border and had large gaps in wealth. Aiming for improvement in resident health, the volunteer cooperated with the local employees to give visiting instructions. Cooperation was given in improving maternal and child health measures and establishment of educational method for dissemination of basic knowledge for prevention of diseases such as diarrhea, parasites, etc.
444	Uzbekistan	2000.07 – 2003.01	Midwife	JOCV	1-1 2-1	The dispatch destination institute implemented population statistics and health survey and had an obstetric ward. It had 110 beds for the obstetric department and 90 beds for the gynecology department with 133 nurses and 70 midwives. The volunteer shared experience and information from Japan and assisted in dissemination of knowledge and skills while working in daily procedures.
445		2003.04 – 2005.04	Midwife	JOCV	1-1	The volunteer worked for the medium obstetric hospital and provided operation improvement instructions while working in the hospital ward. Although irregularly, the volunteer also visited clinics in the Samarkand Province to instruct midwives and nurses on delivery attendance.
446		2003.04 – 2005.04	Midwife	JOCV	1-1	In the most advanced obstetric hospital in Uzbekistan, the volunteer implemented instructions on midwife skills, newborn care, etc. while working with midwives and nurses. There were ten deliveries per day on average and about twenty at most.

Appendix 2 Basic Checklist (Reproductive Health)

The basic check items on the next page are the major indicators used to understand the current situation or issues of reproductive health problems. Various reports published from United Nations Organizations are used as the main materials to refer to these data. To precisely understand the current situation of reproductive health, there are many other health indicators and economic and social factors to be grasped before starting international cooperation. This section presents only the important items that are considered necessary in implementing assistance. More detailed investigation items that suit the target country, region and organization are required in implementing individual cases. In some cases, the statistical agency or health department of the national government may publicize them on websites.

To make analysis by comparing the data by the year or country, definition of indicators, fiscal year, the range covered and data collection method must be noted. Compared to countries in which the birth/death registration system is fully established such as Japan, the reliability of health statistics in many developing countries are fairly low. The health and hygiene statistics that are published conventionally are usually based on hospital surveys. However, many people live in rural areas without health facilities or services and thus the statistical values reported are likely to be smaller than the actual values.

Basic check items 4 to 10 are “Process Indicators Related to Maternal Care Services”[2] defined by UNICEF, WHO and UNFPA in 1997. The long-standing problem of the precise measurement of the maternal mortality ratio (MMR) indicator in developing countries being extremely difficult and unrealistic lies behind such definition of indicators. However, there are limits to these process indicators in that the data source is extremely limited, and they are not yet ready to be obtained or published by UN organizations. Under the current situation, countries may have data individually or some data may be available for specific countries or regions as scientific reports.

[2] UNICEF, WHO and UNFPA (1997)

Basic Checklist (Reproductive Health)

	Check Item/Indicator	Unit	Calculation Method	Remarks
(Items Related to Reproductive Health)				
1	Underweight Children under Age Five	%		Low-weight children with standard deviation of -2 or smaller from the median value for the reference group with appropriate weights for the ages.
2	Total Fertility Rate: TFR	Number	Calculated by summing the birth rate by age for women of 15–49 years old at reproductive age.	Can be considered as the average value for the number of children delivered by a woman in her lifetime.
3	Births per 1,000 Women Aged 15-19	Number		Indicator to measure the situation of teenage pregnancy
4	Amount of Basic EmOC Services Available			Number of facilities that can meet basic EmOC care. It is considered desirable that at least 4 basic EmOC care facilities exist for each population of 500,000.
5	Amount of Comprehensive EmOC Available			Medical facility equipped to provide Cesarean section and blood transfusion. It is considered desirable that at least one comprehensive EmOC care facility exists for each population of 500,000.
6	Geographical Distribution of EmOC Facilities	%		Distribution of EmOC facilities. It is considered desirable that basic and comprehensive EmOC care facilities exist at 100% sub-national levels.
7	Proportion of All Births in EmOC Facilities	%	The rate of births in facilities where EmOC care is available	The minimum of 15% is considered desirable. It is based on the assumption by WHO that “the rate of maternal complications is approximately 15%.”
8	Met Need for EmOC Services	%	The rate of mothers with complications delivering at facilities where EmOC care is available	It is considered desirable that 100% mothers with complications deliver at medical facilities.
9	Cesarean Section as a Percentage of All Births	%	The rate of Cesarean sections of all births	WHO defines the “natural rate of Cesarean section” as 5% at minimum and 15% at maximum, and warns that countries in which the rates of Cesarean sections are substantially higher than these “not only implement unnecessary medical involvement in perinatal care and cause adverse effect on the mind and health of pregnant women but also deteriorate the health finances of the country.” This indicator is especially high in Central and South American Countries.
10	Case Fatality Rate	%	The rate of mothers with complications who were diagnosed at medical facilities and died in medical facilities	1% at maximum is considered desirable. At present, the indicator is “the rate of mothers with complications who were diagnosed at medical facilities and died in medical facilities,” since whether the mother died of pregnancy complication or not can only be judged in medical facilities.
11	Maternal Mortality Ratio: MMR	Number	Maternal deaths/number of live births×100,000	Indicates the rate of maternal deaths (sum of deaths by direct and indirect obstetric causes) for 100,000 live births.
12	Pregnancy-related Death Ratio			Used when considering total deaths during pregnancy, delivery and nursing, and is considered identical to maternal deaths.
13	Perinatal Mortality Rate		Number of infant deaths + number of early neonatal deaths/number of births×1,000	The rate of stillbirths after twenty-eight weeks of pregnancy and early newborn deaths less than 1 week against 1,000 births in one year.
14	% of Births Attended by Trained Health Personnel	%		The rate of deliveries attended by properly-skilled health personnel or witness-doctors (special doctors and other doctors) and/or personnel with midwife skills capable of diagnosis/treatment of obstetric complications in addition to normal delivery.
15	Early Neonatal Mortality Rate		Number of early neonatal deaths/number of births×1,000	Defining deaths of infants less than seven days old (168 hours) as early neonatal deaths, it is expressed as the ratio of the number of deaths less than 7 days old (early neonatal deaths) against 1,000 births for one year.
16	Neonatal Mortality Rate		Number of newborn deaths within 28 days/number of births×1,000	Defining deaths of infants less than twenty-eight days old as newborn deaths, it is expressed as the ratio of the number of deaths less than twenty-eight days old (newborn deaths) against 1,000 births for one year.

	Check Item/Indicator	Unit	Calculation Method	Remarks
(Items Related to Reproductive Health)				
17	Infant Mortality Rate		Number of infant deaths within 1 year/ number of births×1,000	Defining deaths of infants less than one year old as infant deaths, it is expressed as the ratio of the number of deaths less than one year old against 1,000 births for one year.
18	Under 5 Mortality Rate		Number under 5 deaths/number of births ×1,000	Defining deaths of infants less than five years old as under five deaths, it is expressed as the ratio of the number of deaths less than five years old against 1,000 births for one year.
19	Contraceptive Prevalence/Modern Methods	%	Population using contraceptive methods/number of people surveyed	The rate of married, women at reproductive age (15-49 years old) or their husbands who use modern contraceptive methods. The modern contraceptive methods include sterilization of man or woman, IUD, pills, injections, hormone implantation, condoms, and barrier method for women. The ages of population subjected to survey are unified to 15-49 years old.
20	One-Year-Old Fully Immunized against Measles	%		Measles immunization is recommended at less than one year old and this is the rate of immunization.
21	Antenatal Care Coverage	%		Rate of women 15-49 years old receiving diagnosis by medical expert (doctor, nurse, midwife) at least once during pregnancy.
22	Estimated Number of People Living with HIV/AIDS. Adults and Children 0-49	Number	Average value between high order estimated value and low order estimated value for the investigated region (country)	Number of people infected with HIV/AIDS including adults and children 0-49 years old.
23	Estimated Number of People Living with HIV/AIDS. Children 0-14	Number		Number of people infected with HIV/AIDS in children 0-14 years old.
24	Estimated Number of People Living with HIV/AIDS. 15-49	Number		Number of people infected with HIV/AIDS in people 15-49 years old.
25	HIV/AIDS Prevalence Rate, 15-49	Number		Number of people infected with HIV/AIDS in people 15-49 years old. Number of HIV/AIDS carriers divided by the total population.
26	HIV Prevalence Rate, M/F, 15-24	%		Difference in infection rate between genders reflects that women are more apt to be infected with HIV/AIDS due to physical and social reasons. It is also affected by the age gap between the sexual partners.
(General Health)				
27	Life Expectancy at Birth	Age		Average life expectancy at birth (zero years old). Biologically, women have longer life expectancy than men. However, women have shorter life expectancy in some developing countries (such as Nepal) indicating that social and health conditions for women are extremely severe.
28	Population with Sustainable Access to an Improved Water Source	Age		The rate of population using one of the following water supply facilities for drinking water: Piping to homes, public waterworks, pump-type bored well, wells with protective fences or covers, springs with protective fences or covers, and rain water.
29	Population with Sustainable Access to Affordable Essential Drugs			The rate of population who can continuously obtain at least twenty types of the most important drugs at affordable prices at public or private medical facilities or drugstores within 1 hour from their homes.
30	Health Expenditures/ Public	% of GDP	Budget for health and medicine field/total budget for government	Caution is required in comparing countries since investment value will vary under situations where departments or sectors vary.
31	% of Population Using Adequate Sanitation Facilities			The rate of population using adequate sanitation facilities including toilets connected to sewage or sewer tank system, flush toilet, simple toilets and improved toilets with ventilation.
32	Health Related Worker	Number		Doctors, nurses, midwives, pharmacists, medical technologists, etc.
33	Training System of Health Related Worker			Methods for working in various positions, education systems for qualification, educational attainment, etc.

	Check Item/Indicator	Unit	Calculation Method	Remarks
(Basic Statistics)				
34	Crude Birth Rate	Number		Ratio of number of births per population of 1,000 for a certain year. Annual number of births divided by the mid-year population for the same year.
35	Population Growth Rate	%		Average annual rate of population increase for each country
36	Total Population	Number		Current population scale in each country
37	Projected Population	Number		Future population scale in each country
38	% of Population Urbanized	%		Ratio of urban population among total population of each country
39	Adult Literacy Rate	%	Number of literate adults at 15 years and older/adult population of 15 years and older	The rate of people at fifteen years or older who can read and write short and simple sentences related to daily life with understanding.
40	Gross Enrollment Rate in Primary Education	%	Number of children enrolled at elementary schools/ population at elementary school age	There are two types of enrollment rates: Gross and Net. While gross enrollment rate is the ratio of enrolled students against the number of students at enrollment ages, the net enrollment rate is the ratio of enrolled students at enrollment ages against number of students at enrollment ages. Gross enrollment rate shows the whole number of students without correction, and thus includes students at higher ages due to late-enrollment, dropout, returning, or repeating.
41	Net Enrollment Rate in Primary Education	%	Number of children enrolled at elementary schools at elementary school age/population at elementary school age	

Source: Masataka Koda, et al. (2001) “WIBA Modern Terms for Health, Medicine and Welfare (2001 Version)”
Seiichi Matsumoto, et al. (1992) “New Maternal and Child Health Glossary” 1992
UNDP (2002) “Human Development Report 2002”
UNFPA (2003) “State of World Population 2003”
UNICEF (2003) “The State of the World’s Children 2003”

Table of Comparison by Country Using Basic Checklist

Check Item/Indicator		Unit	Viet Nam	Tunisia	Tanzania	Honduras	Japan	Source
(Items Related to Reproductive Health)								
1	Underweight Children under Age Five	Number/1,000 (Year 2001)	38	27	165	38	5	2,4
2	Total Fertility Rate: TFR	Number	2.3	2.2	5.2	3.9	1.4	4
3	Births per 1,000 Women Aged 15-19	Number	21	7	120	103	4	3
4	Amount of Basic EmOC Available	Reference value 4 facilities /500,000	N/A	N/A	N/A	N/A	N/A	
5	Amount of Comprehensive EmOC Available	Reference value 1 facility/500,000	N/A	N/A	N/A	N/A	N/A	
6	Geographical Distribution of EmOC Facilities		N/A	N/A	N/A	N/A	N/A	
7	Proportion of All Births in EmOC Facilities	Reference value 15%	6.6	N/A	14.1	N/A	N/A	
8	Met Need for EMOC Services	Reference value 100%	6.9	N/A	14.6	N/A	N/A	
9	Cesarean Section as a Percentage of All Births	Reference value 5-15%	10.6	N/A	3.0	N/A	N/A	
10	Case Fatality Rate	Reference value 1% or less	1.0	N/A	3.6	N/A	N/A	
11	Maternal Mortality Ratio: MMR	Number/100,000 live births (Year 2001)	125	68	1,408	108	9	3
12	Pregnancy-related Death		N/A	N/A	N/A	N/A	N/A	
13	Perinatal Mortality Rate	Number/1,000 Delivery	N/A	N/A	N/A	N/A	5.5	
14	% of Births Attended by Trained Health Personnel	% (Year 2001)	70	90	36	54	100	2,3,4
15	Early Neonatal Mortality Rate		N/A	N/A	N/A	N/A	N/A	
16	Neonatal Mortality Rate		N/A	N/A	N/A	N/A	1.8	
17	Infant Mortality Rate	Number/1,000 live births (Year 2001)	30	21	104	31	3	2,4
18	Under 5 Mortality Rate	Number/1,000 live births (Year 2001)	38	27	165	38	5	4
19	Contraceptive Prevalence/Modern Methods	% (15-49 years old) (after 1995)	56	51	17	41	53	3
20	One-Year-Old Fully Immunized against Measles	% (Year 2001)	97	92	83	95	96	2,4
21	Antenatal Care Coverage	% (Years 1995-2000)	68	79	49	84	—	4
22	Estimated Number of People Living with HIV/AIDS, Adults and Children, 0-49	Number (Year 2001)	130,000	N/A	1,500,000	57,000	12,000	1,4
23	Estimated Number of People Living with HIV/AIDS, Children, 0-14	Number (Year 2001)	2,500	N/A	170,000	3,000	110	1,2,4
24	Estimated Number of People Living with HIV/AIDS, 15-49	Number (Year 2001)	130,000	N/A	1,300,000	54,000	12,000	1
25	HIV/AIDS Prevalence Rate, 15-49	% (Year 2001)	0.3	N/A	7.8	1.6	<0.1	1,2,4
26	HIV Prevalence Rate in Young People, M/F, 15-24	% (by gender) (Year 2001)	0.38／0.20	N/A	4.25／9.67	1.44／1.80	0.02／0.04	1*

	Check Item/Indicator	Unit	Viet Nam	Tunisia	Tanzania	Honduras	Japan	Source
(General Health)								
27	Life Expectancy at Birth	Age (men/women) (Year 2002)	66.9／71.6	70.8／74.9	42.5／44.1	66.5／71.4	77.9／85.1	3
28	Population with Sustainable Access to an Improved Water Source	% (2000)	77	80	68	88	N/A	2,4
29	Population with Sustainable Access to Affordable Essential Drugs	% (1999)	80-94	50-79	50-79	0-49	95-100	2
30	Health Expenditures/ Public	% of GDP (Years 1998-2001)	1.3	2.2**	2.8	6.0	2.6	3,5
30	Health Expenditures/ Public	% of GDP (Years 1998-2001)	1.3	2.2**	2.8	6.0	2.6	3,5
31	% of Population Using Adequate Sanitation Facilities	% (Year 2000)	47	84	90	75	N/A	2,4
32	Physicians	Number/100,000 (Years 1990-2002)	52	70	4	83	197	2
33	Training Systems of Health Related Worker		N/A	N/A	N/A	N/A	N/A	
(Basic Statistics)								
34	**Crude Birth Rate**	**Number/100,000 (Year 2001)**	**20**	**18**	**39**	**31**	**9**	4
35	Population Annual Growth Rate	% (Years 2000-2005)	1.3	1.1	1.9	2.3	0.1	3
36	Total Population	Million (Year 2050)	81.4	9.8	37.0	6.9	127.7	3
37	Projected Population	Million (Year 2050)	117.7	12.9	69.1	12.6	109.7	3
38	% of Population Urbanized	% (Year 2001)	25	66	33	54	79	3
39	Adult Literacy Rate	% at 15 years or older (by gender) (Year 2000)	96／91	81／60	84／67	78／85	N/A	4
40	Gross Enrollment Rate in Primary Education	% (by gender) (Years 1995-1999)	110／107	121／115	63／63	96／98	101／101	4
41	Net Enrollment Rate in Primary Education		95／94	99／97	46／48	85／86	100／100	4

Source: 1. UNAIDS (2002)
2. UNDP (2003)
3. UNFPA (2003)
4. UNICEF (2003)
5. World Bank (2003)

* While UNAIDS give high order and low order estimate values, this table presents high order estimate values.

** UNFPA (2002) “State of World Population 2002” was used as reference.

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Terms and Abbreviations

Terminology/Abbreviation	Summary
Terminology Related to Reproductive Health	
abortion	Death of the fetus before delivery. Although it mainly indicates induced abortion, it may also include miscarriage.
Acute Respiratory Infections (ARI)	General term for respiratory diseases including upper respiratory infections and pneumonia. It is the second most frequent cause of children's death after diarrhea.
Adolescent Reproductive Health	Includes the issues related to reproductive health and various activities for awareness-raising targeting adolescents (normally 10–19 years old). Due to the background of an increasing number of sexually transmitted infections and young pregnancies caused by lack of knowledge or lack of a sense of self worth, advanced country donors and international organizations have come to deal with this issue proactively. Although it is centered on advocacy activities, the peer education method, which utilizes communication among the members of the same generation, has been adopted as an effective method in recent years.
advocacy	Indicates various activities for promoting awareness of the beneficiaries as a part of advocacy and education activities. Publicity activities, seminars, training courses, influential organizations and persuasion activities to VIPs (lobbying) are included.
AIDS	Acquired immunodeficiency syndrome
antenatal care/prenatal care postnatal care	Care including maternal health checkup before delivery, recovery after delivery, breast feeding and nursing instructions and mental support. It is essential for safe delivery as well as reduction of maternal and infant deaths.
Assisted Reproductive Technology (ART)	Medical technology for solving infertility. Artificial insemination, etc. are also included.
atonic bleeding	Mainly indicates postpartum haemorrhage and intrapartum bleeding, which are the major causes of maternal deaths.
Behaviour Change Communication (BCC)	BCC is the advocacy method focusing on behavioral changes in the receivers compared to Information, Education and Communication (IEC) focused on the method of input.
birth spacing	It is normally considered that the negative effect on the mother is serious if the interval from one delivery to the next is less than twenty-four months, and birth spacing is recommended from the perspective of maternal protection. It is also pointed out that prolificacy may affect the raising and health of children due to economic reasons.
child abuse	General term for child abuse of all kinds including violence against children, forced labor, meal limitation, leaving and neglect.
Commercial Sex Worker (CSW)	While they had been named the factors of STI spread, they have recently gained attention as promoters of contraception and the prevention of STIs. Although there are many discussions on how to eliminate CSW, for many developing countries being a CSW is a means of earning a living and thus is difficult to eliminate. Therefore, CSW is often incorporated in a plan as a target group of a program. However, the CSW industry remains as the hotbed for trafficking of girls, child abuse and drug addiction.
complications of pregnancy and childbirth	Mainly includes pregnancy toxemia, anemia, edema, increased blood pressure, diabetes and adrenal diseases.
Contraceptive Prevalence Rate (Modern Methods)	The rate of married women at reproductive age (15–49 years old) or their husbands using modern contraceptives. Modern contraceptives include sterilization of the man or woman, IUD, pills, injections, hormone implantation, condoms, and barrier method for women.
demographic transition	Change of population structure in concurrence with increase in economic level due to development. The usual trend is from many births and deaths to many births and few deaths and then to few births and deaths.
Emergency Contraception (EC)	Contraceptive method after sexual intercourse for preventing pregnancy due to emergency reasons such as rape.

Terminology/Abbreviation	Summary
Emergency Obstetric Care (EmOC)	An approach suggested based on the concern that safe motherhood approaches by WHO and UNICEF have been inconsistent. Indicates the comprehensive obstetric system at emergency to reduce deaths of mothers and children at delivery and ensure safe delivery. Specifically, it refers to the condition in which in-hospital facility, blood transfusion and drugs, facility in which surgery is possible, emergency transport equipment/vehicle, attendance by medical technicians with special skills, etc. are established.
essential drugs	Based on the list of essential drugs prepared for the first time by WHO in 1997, which has been revised more than ten times since then. As selection requirements, drugs that satisfy the needs of the majority, disease structure for the country, situation of health facilities, financial situation, etc. are used as reference, and drugs with effectiveness and safety data, excellent potency compared to other drugs of the same type, and being single drugs as much as possible are conditions for selection.
Female Genital Cutting (FGC)/ Female Genital Mutilation (FGM)	A traditional custom to cut all or a part of the female reproductive organ using razors, etc. It occurs in Sub-Sahara Africa, the Middle East, and parts of Asia, and there are 130 million women at present who have undergone FGC and 2 million more cases occur each year. Urinary tract infection, dysmenorrheal, pelvis infection that leads to infertility, difficulty in delivery, etc. are caused by FGC. Movements for FGC elimination have become more active recently in terms of human rights protection for women. Although it has conventionally been referred to as FGM, the more neutral expression of FGC is used nowadays since “mutilation” includes the negative sense of value that the reproductive organ is “destroyed.” Some women’s groups and human rights activists who oppose this custom may intentionally use the term FGM. The term “female genital circumcision (FGC)” is rarely used in order to distinguish this custom from circumcision for boys.
fistulas	Formally called Obstetric Fistulas. A disease that causes vaginal or uterine damage due to sexually transmitted infections, unsanitary delivery, abortion, prolificity, etc. and is found largely in developing countries. Although function can be recovered by surgery, not enough measures are taken for the improvement of treatment techniques. It leads to discrimination or divorce in many cases due to odor by incontinence and exulceration. Female genital cutting (FGC) is also a cause.
Gender and Development (GAD)	GAD is the concept for implementing sustainable development by improving the mutual relationship between men and women in society during the development process. The concept of GAD has been evolved out of the fact that the conventional projects focusing only on women does not always contribute to the improvement of women’s disadvantageous status, and such development does not directly lead to women’s benefits and nor to social development.
gender bias	Gender-related biases that exist in all aspects of society. There are clear or implied differentiation and asymmetrical treatment of men and women on various levels including social structure, behaviors of people and awareness.
HIV	Human immunodeficiency virus
Hormone Replacement Therapy (HRT)	A treatment method for various disorders included in the menopause, which is caused by imbalance in hormones in the latter half of the reproductive age.
humanized maternity care	It is an approach that respects the natural power of humans and re-evaluates humanized maternity care that reviews overemphasis on medical involvement in delivery which causes the extremely high rate of Cesarean section in semi-advanced countries such as Central and South America.
ICPD Programme of Action	Programme of Action agreed in International Conference on Population and Development in 1994. It mentioned reproductive health and rights in relation to the population issues, and is characterized by shifting from macro-perspective approaches to micro-level or individual-level approaches.
Infant Mortality Rate (IMR)	Death of infants younger than one year old is defined as infant death. The infant mortality rate is the expression of the ratio of the number of deaths younger than one (number of infant deaths) in a year compared to 1,000 births in a year.
infertility	The issue specified by WHO as one of the many issues of reproductive health. Unsanitary delivery, induced abortion, sexually transmitted disease and women-specific diseases lead to infertility and problems that cause infertility, and medical technology for reproduction assistance whose methods and implementation is controversial in advanced and semi-advanced countries is also focused on as an issue.
Integrated Management of Childhood Illness (IMCI)	A strategy developed mainly by WHO/UNICEF in order to improve prevention/care/treatment of the five major preventable diseases (pneumonia, diarrhea, measles, malaria and malnutrition) and reduce the number of deaths in infants younger than five. IMCI comprises of the following three components: (1) improvement of case management capabilities for health workers, (2) improvement of the health system, and (3) improvement of child care at home and in the community.

Terminology/Abbreviation	Summary
Integrated Management of Pregnancy and Childbirth (IMPAC)	A strategy developed mainly by WHO to control maternal and early newborn care comprehensively. It comprises of obstetric care in hospital wards and local basic obstetric care.
Knowledge, Attitude, Practice (KAP)	Epidemiological factors used mainly for clarifying the related factors of disease or death, and for taking measures against them. Specific indicators are set for each area of knowledge, attitude and practice as the KAP investigation.
Maternal Mortality Ratio (MMR)	Maternal death is defined as the death of women during pregnancy or within forty-two days after the end of pregnancy with pregnancy or delivery related causes. The maternal mortality ratio expresses the ratio of maternal deaths against 100,000 births.
MCH	Maternal and child health
menopause	General term for various complaints seen during the later half of reproductive ages and the menopause (45–50 years old). While different symptoms are seen by the individual including mental instability, headache, cold sweat and dizziness, they usually recede within two years. For the health and reproductive health of women during and after menopause, a sufficient approach has not been adopted even in the field of international cooperation.
midwife	Although qualification, capacity, and activity range may vary by country, the role of health technicians who support the improvement of women's health across a wide range including safe motherhood, infant nursing instruction, and family planning in addition to delivery attendance is considered to be important in international cooperation. While the qualification also covers the qualification as nurse in Japan, it may only qualify as midwife or the qualification itself may not exist in many countries.
Millennium Development Goals (MDGs)	Millennium Development Goals are the common development objectives to be addressed by 2015, which were adopted in the United Nations Assembly in September 2000 with the support of 149 countries. The framework comprises of eight goals—eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability; and develop a global partnership for development—with 18 numerical targets and 48 indicators
morbidity	Diseases, affection by diseases and morbidity.
Mother to Child Transmission (MTCT)	Infection from the mother to the fetus. It has become a problem in recent years in HIV/AIDS, etc. Although many mother to child transmissions are through the placenta, it may be transmitted through breast milk or the birth canal in some cases.
peer education	Education and advocacy method in which the advocacy leader to be the core of the same generation or group is appointed and trained, etc. and then the leader transmits the method to the members of the target group. Since the experience to be shared is on the same level among the members of the same generation even on sensitive issues, it has the characteristic advantage of promoting common understanding. It is considered especially effective in sex education.
pregnancy toxemia	Although it is a complication of pregnancy, it can be prevented or improved by antenatal care, weight control, nutrition instruction, etc. Symptoms of edema, blood pressure increase, etc. are seen and it may lead to the death of the mother and child if serious.
Primary Health Care (PHC)	Mainly indicates the eight basic activities that are proposed in the Alma Ata Declaration in 1978, which clarified that health is a right for everyone to be enjoyed. These are the eight inexpensive, minimum required activities for the health of all residents even in poor regions: Health education, ensuring safe water, promotion of maternal and child health including immunization, measures against endemic diseases, supply of essential drugs, utilization of community health workers, measures against general diseases, and nutrition improvement.
pro-choice/pro-life	Discussion that started with the human rights of the fetus and how life is defined, which is a fundamental issue mainly in the U.S. in the course of discussing whether family planning, especially induced abortion is right or wrong. Many countries still forbid induced abortion partly due to Catholic dogma.
referral system	The patient introduction/transfer system in which simple treatment is given at clinics and the patient is transferred to a community hospital in case of serious disorders for which more advanced medical care is considered necessary or diseases that require emergency measures.

Terminology/Abbreviation	Summary
reproductive health	Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Therefore, reproductive health means that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. It also includes access to information and services on safe, effective, affordable and acceptable contraceptive methods.
reproductive rights	Reproductive rights are part of human rights which are already acknowledged in domestic laws, international documents on human rights, and other related documents agreed in the United Nations. These rights are basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. In addition, it also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. The rights to use appropriate health care services so that women can enjoy safe pregnancy and delivery and couples can have the best opportunities to have healthy children are also included.
Safe Motherhood Initiatives (SMI)	A comprehensive measure for safe motherhood that began under international consensus in 1987. Includes the establishment of emergency obstetric care (EmOC), promotion of antenatal care, TBA training, supply of micro-nutrients, promotion of education for women, etc.
Sexually Transmitted Infections (STI)	General term for diseases whose infection expands through sexual behavior. In addition to gonorrhea, syphilis and chancroid, which were the major sexual diseases, chlamydia and mycoplasma infections have recently increased in Japan. Infection of HIV/AIDS by transfusion of blood products in addition to infection by sexual behavior is also a serious problem
Total Fertility Rate (TRF)	Sum of birth rate by age of women from 15 to 49 years old. It can be considered the average value for the number of children delivered by a woman in her lifetime.
Traditional Birth Attendant (TBA)	Birth attendants who specialize in delivery attendance in countries or areas where there are no or few midwives, etc. Since they are not medical technicians and are not provided with any opportunity for special training, they have insufficient medical knowledge. They are often illiterate and depend on voodooism or traditional medicine. It is seen as a problem that TBAs cannot manage when anomalies occur in the health of the mother during delivery. On the other hand, the attendance skills of TBAs for normal delivery are highly evaluated as humanized maternity care that respects the natural power of humans, and many TBAs are respected by their communities. Some countries or regions may provide the opportunity for TBAs to learn medical knowledge.
Under five Mortality Ratio (U5MR)	The number of deaths of children under five years old are defined as under five deaths. The under five mortality rate expresses the ratio of deaths under five years old in a year against 1,000 births in a year.
Unmet Needs for Family Planning	Indicates that individual desires in relation to pregnancy and delivery such as the number of children desired and birth spacing are not satisfied for some reason.
Women in Development	Refers to development assistance by recognizing that women are not only receivers but also implementers of development so that the participation of women in development projects is assured. It is based on the concept that women play an important role in economy and society, and that the participation of women in development is extremely important in ensuring the effect of development assistance.
Terminology Related to Development Aid	
Basic Human Needs (BHN)	The concept of providing assistance to people in low-income groups with daily needs. Refers to the basic needs of humans including minimum necessary goods for living such as food, shelter and clothes, safe drinking water, sanitary facility, health and education.
capacity building/capacity development	Improving the capacity for implementing and managing organization/institution building. It refers to the establishment of self-sustaining abilities consisting predominantly of implementation.
Community-Based Organization (CBO)	An organization established to solve a specific purpose with general residents as the members. In the context of international cooperation, it is used to mean “an organization composed and operated by the local residents themselves” in comparison to various outsiders from outside the community.
Comprehensive Development Framework (CDF)	A more comprehensive concept of development in developing countries, which was announced by the World Bank in January 1999. The basic principles are: (1) ownership of the developing country, (2) partnership, (3) decision making process with participation, (4) result orientation, and (5) long-term vision, and not only macro-economic but also structural, social and human aspects are considered.

Terminology/Abbreviation	Summary
DAC Guideline on Poverty Reduction	Developed by OECD/DAC in April 2001. DAC Poverty Reduction Network (POVNET) examined the "Guideline on Poverty Reduction" for addressing the objectives of New Development Strategy and was approved by a high-level meeting in April 2001.
DAC (Development Assistance Committee)'s New Development Strategy	The appellation for a long-term DAC development strategy for the twenty-first century, "Shaping the Twenty-first Century; The Contribution of Development Co-operation," adopted at a high-level meeting in 1996. The three main characteristics of the strategy are: (1) emphasis on ownership and partnership; (2) pursuit for comprehensive approach and individual approach; and (3) setting of specific development goals (such as halving the proportion of the population in extreme poverty in the world by 2015). The strategy increases the expenditure ratio for social infrastructure and seeks to rationalize and decentralize implementing institutions in recipient countries.
Global Issues Initiative (GII) on Population and AIDS	An initiative announced by the Japanese Government in February 1994. Stipulates that it will provide 3 billion American dollars for aid to developing countries in the field of "population/AIDS" in the seven years from 1994 to 2000.
governance	Indicates the state of operation and management capabilities in the context of "governing." It may include the aspects of government functions as to whether the government is effectively and efficiently functioning for a certain purpose (political/administrative mechanism) or the meaning of the democratic political system or democratic system.
high-risk group	People highly prone to suffering specific problems. In the HIV/AIDS problem, commercial sex workers (CSWs), truck drivers, etc. are included in the "high risk group prone to HIV/AIDS infection."
Human Development Index (HDI)	An index developed with focus on various aspects of human development by United Nations Development Programme (UNDP) in issuing the "Human Development Report."
income poverty	"Poverty" grasped by setting up the poverty line that indicates the minimum necessary level of various types of asset consumption for living (or substantial income level to address it) and defining the individuals or households that do not reach the poverty line as "poor groups." Since it is easy to make econometric analysis or statistical treatment on income, it is frequently used as a measure of poverty.
informal sector/informal economy	The field of economic activities by people who work in minor and miscellaneous jobs whose economic activities are not formally recorded.
International Conference on Financing for Development	Held in Monterey, Mexico in March 2002 with the theme of "development fund for poverty reduction". United Nations, International Monetary Fund (IMF), World Bank, and World Trade Organization (WTO) co-hosted the conference and representatives from governments, businesses and resident communities also participated.
Japan's Official Development Assistance Charter	A charter established by the government of Japan in 1992, in order to garner broader support for Japan's ODA through better understanding both at home and abroad and to implement it more effectively and efficiently. Japan attaches central importance to the support for the self-help efforts of developing countries towards economic improvement based on the idea that assistance was part of Japan's foreign strategy in the post-Cold War period.
Least Developed Countries (LDC)	One of the classifications of developing countries by the United Nations on the basis of income level, and indicates the most underdeveloped countries among developing countries. There were forty-eight countries considered to be Least Developed Countries as of January 2000.
literacy	Being able to read, write and calculate as necessary in daily life.
Medium-Term Policy on ODA	A systematic and specific five-year guideline on Japan's ODA since 1999, aiming for effective and efficient implementation of assistance.
microfinance/microcredit	Small-scale financing implemented in order to mitigate poverty of poor groups or low-income groups.
nonformal education	Education other than formal education at schools, such as religious education, social community education, adult education, and literacy education.
Non-Governmental Organization (NGO)	Also called Non-Profit Organization. Indicates organizations that implement activities for the benefit of others who are publicly or socially weak at the non-governmental and non-profit position. In Japan, NGO often means a non-governmental, non-profit, resident-led organization that deals with various international issues, and NPO often means an organization that mainly deals with domestic or community issues such as welfare.
Non-Profit Organization	Non-Profit Organization (see NGO).

Terminology/Abbreviation	Summary
Official Development Assistance (ODA)	Comprises the center of government-based economic cooperation by advanced countries, etc. that are implemented as cooperation for economic or social development, improvement of welfare of residents and social stability in developing countries.
Okinawa Infectious Diseases Initiative (IDI)	Japan proposed international measures against parasites in the 1998 Birmingham Summit on the global spread of infections, and the Japanese Government urged that advanced countries should reinforce approaches against infections in the 2000 Kyushu/Okinawa Summit as "Okinawa Infectious Diseases Initiative."
Participatory Poverty Assessment (PPA)	A method of poverty measurement that is gaining attention as the multilateral features of poverty are recognized. An approach to try to understand what kind of conditions the poor group itself consider as poverty, how it deals with the problems and what are the true needs by excluding inductions and biases of external evaluators as much as possible.
poverty line	A reference for measuring the situation in which the minimum life level cannot be achieved.
poverty profile	Description of poverty index, poverty conditions and measures, aid situation, etc. for the corresponding country. It has been prepared for twenty-nine countries at present.
Poverty Reduction Strategy Paper (PRSP)	Strategy document proposed and adopted in World Bank and IMF general assembly in 1999 to cope with the debt release problem of HIPCs (Heavily Indebted Poor Countries). It is intended that the funds generated by the debt release measure of this strategy will be used appropriately for development and poverty reduction.
safety net	Protective measures for the socially weak in development aids. Food distribution, employment assurance system, etc. are included.
school mapping	Analysis of the gap between needs and education service level by not only expressing the spatial positions of schools (on the map) but also investigating the attributes of the schools (number of students and teachers, rate of dropouts, rate of qualified teachers, etc.).
social capital	Consideration of invisible matters or structures considered useful resources for growth and development such as confidence, principles and network as "capital" that can be measured and accumulated in a similar fashion to economic capital.
social marketing	Marketing in order to expand public benefit such as health promotion, environmental protection and accident prevention. In developing countries, it is applied in condom promotion activities as HIV/AIDS prevention measures, etc. mainly in the field of health.
Sector Program (SP)	A sectoral or sub-sectoral program coordinated by development assistance participants including donors under ownership of the recipient country.
Sector Wide Approaches (SWAPs)	Approaches to develop and provide assistance according to a plan created by the recipient government with bilateral and multilateral donors on a sector basis such as in the education and health sectors. Implemented mainly in African countries.
United Nations Millennium Summit	Held in concurrence to the United Nations Millennium Assembly in New York in September 2000, and the Millennium Development Goals (MDGs) were adopted based on the international development objectives agreed by then.
World Summit for Social Development (WSSD)	Held in Copenhagen in 1995. Declared to pursue social development centered on humans and halve the absolute poverty in the world.
World Summit on Sustainable Development	Also called the Johannesburg Summit. It was held in Johannesburg, South Africa in August 2002 with the goal of addressing "sustainable development" in the ten years following the Global Summit (Rio de Janeiro), which dealt with "environment and development" comprehensively for the first time.
JICA Aid Scheme Terminology	
Bilateral Aid	A type of ODA aid implemented between two countries: developed country and a developing country. Advantages include: (1) mobile and minute assistance, (2) large contribution to increased friendship with the recipient country by directly impressing the policy/results of assistance by the assisting country.
Community Empowerment Program	Provision of assistance through local NGOs for maternal and child health care, social welfare for the aged, people with disabilities, children, and other poverty reduction programs. Only countries where a JICA overseas office is located are eligible. Implemented in 1997. Projects implemented in cooperation with NGOs such as Partnership Programs and Community Empowerment Programs have been integrated as Partnership Programs in fiscal year 2002.
Grant Aid for Grassroots	A scheme by the Ministry of Foreign Affairs of Japan and Japanese embassies at the request of local authorities in developing countries. It aims to support relatively small projects that cannot be dealt with adequately by ordinary grant aid.

Terminology/Abbreviation	Summary
human security	The concept of reinforcing approaches with importance on safety centered on “human” which was proposed in the “Human Development Report” by UNDP in 1994. Security of individual, society and community to be released from the threats of starvation, diseases, etc. and have no repression by difference in ethnicity, principles, etc. which does not replace the security of the country. UNDP divides it into seven concepts of food, health, environment, individual, community, politics and economics.
In-country Training	Training conducted in recipient countries to spread the effects of Japanese technical cooperation. Conceptually, Japan is the “first country,” the recipient of Japanese technology is the “second country,” and a neighboring country is the “third country.”
Japan Overseas Cooperation Volunteers (JOCV)	A volunteer system established in 1965 that dispatches volunteers aged between 20 and 39 years old to developing countries. Approximately 23,000 volunteers have been dispatched to seventy-six developing countries.
Master Plan Study (M/P)	A study to draw up a comprehensive development plan on a country or specific region or a long-term plan on a specific sector.
Multilateral Aid	Refers to ODA assistance in which cooperation is given to the development of developing countries though funding provision to international organizations. It is possible to utilize the advanced special knowledge, rich experience and global assistance network of the various international organizations and assure political neutrality. Thus cooperation in refugee assistance, global environment problems, etc. which are difficult to support with bilateral aid, and effective assistance is possible even when there is lack of information/knowledge on the target region or assistance method.
Overseas Development Survey	Small-scale studies to formulate a basic development plan, analysis of relevant basic data, and/or a supplementary study on official statistics. Implementation initiated by overseas offices using local consultants. Renamed in fiscal year 2002 as “Overseas Basic Survey.”
Partnership Program	A scheme where by JICA requests Japanese NGOs, local governments and universities with experience in international cooperation to respond to the various regional-level needs of developing countries and provide detailed development assistance to communities. Projects implemented in cooperation with NGOs such as Partnership Programs and Community Empowerment Programs have been integrated as Partnership Programs in fiscal year 2002.
Partnership Program	A JICA project in which it assists cooperation activities for local residents of developing countries through organizations including Japanese NGOs, universities, local governments and public corporations with intent for international cooperation as a type of ODA. Special focus is placed on “technical cooperation” involving people, projects/ target areas with urgency such as reconstruction support, and provision of opportunity to promote understanding and participation in international cooperation in Japanese citizens.
Project Formulation Study	A study conducted when connection to other donors, effect of cooperation, effect on the environment or society, development sustainability, etc. are unclear in the development program or cooperation field of the recipient country when cooperation is to be implemented. Collection of lacking information, discussion with local study commission, recipient government, related organizations, assistance in preparing request document, etc. are also included.
Project-Type Technical Cooperation	A technical cooperation scheme planned, implemented and evaluated within a three-five year cooperation period. The scheme includes the dispatch of Japanese experts, acceptance of counterparts as trainees, and provision of equipment. It was integrated with other forms in fiscal year 2002 as a Technical Cooperation Project.
South-South Cooperation	Mutual promotion of economic development between developing countries through local economic cooperation, etc. Although the idea that the development of developing countries must depend on assistance from advanced countries had been conventionally mainstream, the diversification of developing countries deepened and the importance of mutual cooperation among developing countries was recognized.
Technical Cooperation Projects	A cooperation scheme with logical organization of the relationship between the results and input/activities with a purpose of addressing a certain outcome by a certain date, and expert dispatch, trainee acceptance, equipment provision, etc. are combined to suit the purpose.
Third Country Expert	One of the JICA expert dispatch projects in which human resources of other developing countries are dispatched as technical cooperation experts to the developing country to be assisted as part of South-South cooperation. Due to similarity in environments, technical level, culture, language, etc., technical transfer can be made more efficiently.
Third-Country Training	A training course inviting participants from developing countries to relatively-advanced neighboring developing countries, utilizing local human resources trained under Japanese technical cooperation. Conceptually, Japan is the “first country,” the recipient of Japanese technology is the “second country,” and a neighboring country is the “third country.”

Abbreviation	Formal Designation	Summary
International Organizations/Donor Agencies		
ADB	Asian Development Bank	An international bank that provides loans on a semi-commercial basis in order to promote development in developing countries in the Asian region. Established in 1966.
CDC	Centers for Disease Control and Prevention	American federal organization for information collection, research and measures in order to ensure the health and safety of people in the U.S. as well as the world. The headquarters is located in Atlanta, USA.
CIDA	Canadian International Development Agency	A governmental organization of Canada which deals with development aid functions and processes.
DfID	Department for International Development	While the Overseas Development Administration (ODA) had operated the development aid policy monistically from planning to implementation in Britain, ODA was upgraded to Department for International Development (DfID) with an in-Cabinet minister in concurrence to transition in administration in 1997.
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	A fund established as a measure to prevent the spread of infections on a global scale. It has a mechanism to execute the budget when many organizations such as NGOs submit requests and it undergoes examination within the fund. Although Japan is a major contributing country, only part of the funding necessary for the elimination of diseases such as HIV/AIDS is met.
GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit	A German corporation with full capital investment by the government, which was established in 1975 by merger of BfE and GAWI.
IPPF	International Planned Parenthood Federation	The world's largest international NGO in the field of reproductive health. The importance of family planning was pointed out as a recurrence of disputes caused by the poverty problem combined with the population explosion. It was established in 1952 to promote family planning. The headquarters is located in London. Governments of various countries fund its activities.
JBIC	Japan Bank for International Cooperation	An international bank established in 1999 by union of Export-Import Bank of Japan and Overseas Economic Cooperation Fund.
JICA	Japan International Cooperation Agency	A Japanese organization which is in charge of the implementation of ODA technical cooperation projects and grant aid cooperation promotion.
OECD	Organization for Economic Cooperation and Development	Established in 1961 by reorganizing OEEC (Organization for European Economic Co-operation) founded in 1948 for reconstruction of European economy. The goals of this organization are economic growth, assistance to developing countries, and multilateral expansion of free trade. There are thirty member countries at present.
UNAIDS	Joint United Nations Programme on HIV/AIDS	An international organization (headquarters in Geneva) established in 1996 for measures against HIV/AIDS, which is one of the new infectious diseases. It is an organization with joint investment by ten international organizations: UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and World Bank. Its major role is to develop policy, develop and cooperate in technology and implement research instead of grant assistance, and prevention of HIV/AIDS, adjustment of treatment, and assistance are given in each target region or country by assigning a program advisor in fifty countries in the world.
UNFPA	United Nations Population Fund	Established in 1967 as the United Nations Trust Fund for Population Activities. Its abbreviation remains the same although it was renamed to its current name in 1969. The headquarters is located in New York, USA. An organization for technical cooperation in relation to population.

Abbreviation	Formal Designation	Summary
UNICEF	United Nations Children's Fund	Established as United Nations International Children's Emergency Fund in 1946 as an emergency measure to help children who were victims of the Second World War. Its abbreviation remains the same although it was renamed to the current name in 1953. The headquarters is located in New York, USA. It started during the 1950's to give general assistance to children through nutrition improvement, supply of drinking water, maternal and child welfare, education, etc. as well as emergency assistance in case of natural disaster, etc. mainly in the field of health in developing countries.
UNU	United Nations University	University charter was adopted in the United Nations General Assembly in 1973 and the headquarters was established in Tokyo in September 1975. This university is an international community of scholars and scientists by the network sharing autonomy within the frame of United Nations and connecting universities and research institutes in the world.
USAID	The United States Agency for International Development	USAID was established as a unified and integrated organization for non-military assistance which was a part of the Department of State by succeeding the functions of the conventional aid organizations, International Cooperation Agency (ICA), Development Loan Fund (DLF), Food Program for Peace and the task of local currency loaning by Export-Import Bank of the United States (EXIM) under the administrative order that conformed to the Foreign Assistance Act in 1961.
WHO	World Health Organization	Established based on the Constitution of the World Health Organization in 1948 in order to suppress global diseases, improve health and nutrition and promote analysis and research through international cooperation. The headquarters is located in Geneva, Switzerland.
WB	World Bank	Generally indicates both the International Bank of Reconstruction and Development (IBRD) and the International Development Association (IDA). Collection of International Finance Corporation (IFIC), Multi-national Investment Guarantee Agency (MIGA), and International Centre for Settlement of Investment Disputes (ISCID) in addition to these two is called the world bank group.

Source: Dobun Shoin *"New Glossary for Maternal and Child Health,"* Kokusai Kaihatsu Journal *"Glossary for International Cooperation,"* UNFPA *"State of World Population,"* JICA annual reports and other reports, etc. were used as reference in preparation.

For information on domestic and international NGOs active in the field of international health, see the following web site:
eFASID (web links in the field of health and medicine): http://www.efasid.org/J/weblink/healthsector/healthtop.htm