

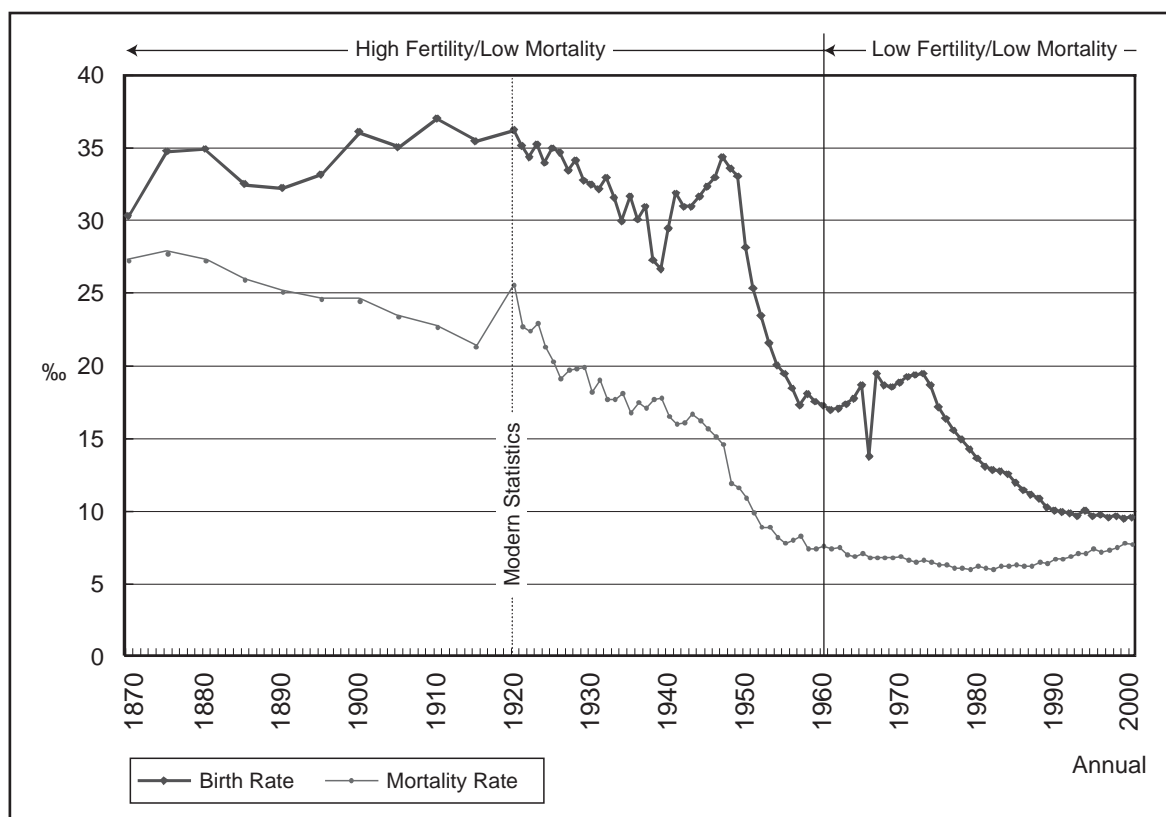
## Chapter 2 Japan's Demographic Experience

### 2-1 Japan's demographic transition

#### 2-1-1 Japan's demographic transition process

Japan currently enjoys the lowest infant mortality rates and the longest life expectancy in the world. A rough breakdown of Japan's demographic transition shows three periods: a period of high fertility and high mortality rates (up to 1870), a period of high fertility rates but low mortality rates (1870–1960), and a period of low fertility and low mortality rates (1960–present). Until around 1870 (the beginning of the Meiji Era), fertility and mortality rates were both significantly higher. Then the mortality rate started to decline, and Japan entered a period of high fertility and low mortality. From around 1920, the fertility rate also started to decline slowly and the sharp decline after WWII ushered in the demographic transition. Currently, Japan is in a period of low fertility and low mortality and both have settled at low levels. Japan's demographic transition has taken nearly the same path as Western countries, but the speed of the transition has set Japan apart (see Figure 2-1).

**Figure 2-1 Japan's Demographic Transition**



Source: 1870-1920 – Yoichi Okazaki (1995), 1920-1997 – “Population Survey Report,” Statistics and Information Department, Cabinet Secretariat, Ministry of Health and Welfare.

### **2-1-2 Causes of the decline in mortality rates**

The cause of decline in mortality rates from the beginning of the Meiji Era (1870s) to just before WWII is not as fully analyzed as is that for the decline experienced by Western countries in the 18<sup>th</sup> and 19<sup>th</sup> centuries. However, all of the following three factors worked together: the achievement and dissemination of modern medicine and public health under the direction of the government, improvements in the quality of life and nutritional levels through economic growth, and the increased prevalence of concepts of sanitation through the extension of compulsory education.

Mortality rates declined sharply during the post-war “baby bust” period. Reduced mortality resulted from an increase in the use of antibiotics and DDT following the war, which sharply reduced the number of infectious diseases such as pneumonia, gastroenteritis, and tuberculosis. As a result, average life expectancy increased and had reached 65 for men and 70 for women by 1960, almost catching up with the minimum level in developed Western countries.

### **2-1-3 Causes of the decline in fertility rates**

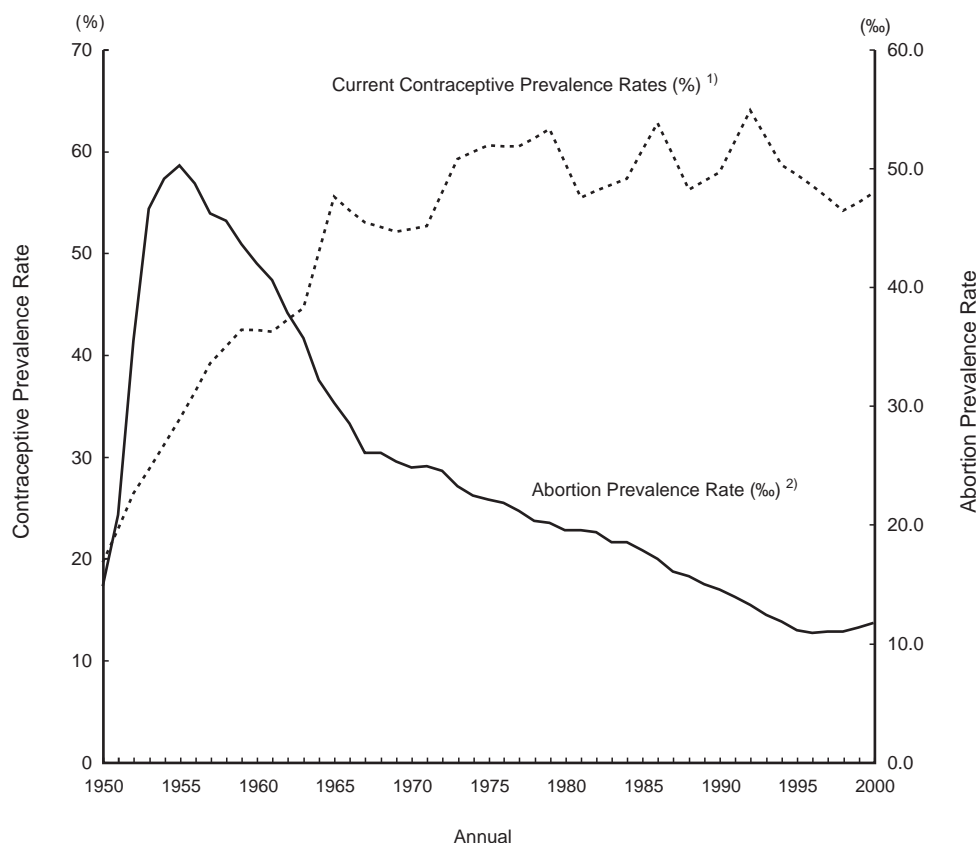
During the three years after WWII from 1947 to 1949, a baby boom occurred in which the annual number of births exceeded 2.7 million. It peaked in 1949, however, and the fertility rate declined suddenly, and was called a “baby bust.” This is the period in which Japan is said to have achieved its “demographic transition,”

A number of factors are thought to have contributed to the rapid decline in fertility after 1949, with one of the first being the Eugenic Protection Law, established in 1948 and later revised three times. This law sanctioned relatively easy access to induced abortions, resulting temporarily in the general use of induced abortion as the main method of fertility control for married couples. Following this, however, due to the popularization of family planning through both the public and private sectors, contraception replaced induced abortion as the primary method of fertility control (see Figure 2-2, p.20).

### **2-1-4 Demographic bonus and the aging population**

The sharp decline in the fertility rate after the war generated a “demographic bonus” as described by Ogawa in Box 1-1, Chapter 1. Japan achieved its rapid economic growth by effectively utilizing the demographic bonus during the period of 40 years following 1950. However, the other side of the demographic transition was the start of the aging of Japan's population. The sharp decline in fertility in Japan predetermined its subsequent experience of a rapid aging of the population. The burden of support on the productive population is increasing due to this aging, but has yet to be discussed as a major challenge in the area of population issues.

**Figure 2-2 Induced abortions and Contraceptive Prevalence Rates**



Note: 1) A survey was conducted targeting married women under the age of 50. The Current Contraceptive Prevalence Rate is a figure indicating the ratio of women using contraceptives at the time of the survey to the total number responding to the survey.

2) The Abortion Prevalence Rate is the number of abortions for every 1,000 women between the ages of 15 and 49 (according to Maternal Protection Statistics).

Data: Mainichi Shimbun Population Problems Research Council “The Population and Society of Postwar Japan Based on Half a Century of Family Planning” (2000). “Maternal Protection Statistics” (2002) Statistics and Information Department, Cabinet Secretariat, Ministry of Health, Labor and Welfare.

Source: National Institute of Population and Social Security Research, Ministry of Health, Labor and Welfare.

## 2-2 Contributions to the post-war demographic transition

Following the war, a vigorous democratization policy was implemented in Japan under the direction of the Allied Forces General Headquarters (GHQ). As a result, a range of reforms were introduced to administrative organizations and local communities. The Japanese government did not come up with a clear population policy for fertility control even during the period in which the population was growing rapidly following the war. Japan was able to achieve its demographic transition as a result of multiple and varied reasons, such as reform of the health administration, family planning guidance by public health nurses and midwives, family planning movements undertaken by private organizations or companies, and movements to improve the quality of life in rural areas.

### 2-2-1 Government-led family planning policy

In the three years from 1947 to 1949, Japan experienced an unprecedented baby boom. Few people at the time, however, had accurate knowledge about contraception and it was difficult to obtain contraceptives. As a result there were many unwanted pregnancies, necessitating a dramatic increase in illegal “unsafe abortions”. These illegal abortions performed under very poor conditions resulted in death or subsequent complications for many women. In September 1948, the Eugenic Protection Law was enacted through the efforts of the members of the Diet to protect mothers from this type of situation. In the following year (1949), the law was partially revised and the wording “for economic reasons” was added to the existing “physical reasons” and this resulted in the more widespread use of abortion. As a result, reported abortions jumped markedly and reached 1.17 million in 1955 (Figure 2-2).

Then the government implemented a system called the Family Planning Workers system, in which midwives, public health nurses, and nurses were retrained and specialized groups were given training to enable them to provide technical guidance on family planning. Family Planning Workers visited every family on foot and were dedicated to real grassroots education and dissemination activities about maternal and child health and family planning. For practicing midwives in particular, the creation of a system that compensates them financially for providing counseling and instruction made sustainable family planning implementation and guidance possible. The role subsequently played by the Family Planning Workers in the dissemination of family planning concepts was very important.

After the war came an era in which the slogan changed from “give birth and multiply” to “planned childbirth,” but the new idea and methods were not readily accepted among citizens. It was under these circumstances that researchers at the National Institute of Public Health were actively sent out to every region in the country to provide guidance on planned childbirth and family planning. The researchers obtained valuable information and knowledge about such things as which types of contraceptive methods are suitable for Japan and the level to which abortion can be reduced through the guidance provided in the three Model Villages for Planned Childbirth during a seven year period from 1950, which set an important direction for the dissemination of family planning concepts in Japan. The approach of the three model villages served to increase understanding of the nature of family planning and why it is important. The key to the success of the process was that it first educated whole villages and gained the understanding and cooperation of the people surrounding the women who actually wanted to practice family planning, including the mothers- and fathers-in law. In this way, it became clear that to achieve behavioral changes in individual citizens it is important to remove the restrictions of the surrounding environment that hinder such changes. While the same issue is a major concern in today's donor societies that support efforts in the reproductive health field, it is noteworthy that a systematized model had already been established in post-war Japan. The women of the model villages actively participated in and highly evaluated the guidance, and the guidance bore fruit as changes in contraceptive methods and a reduction in induced abortions.

### **Box 2-1 Maternity and Child Health Handbook**

The Maternity and Child Health Handbook is a record of the health of a mother and child that a mother can carry with her. Its predecessor, the Maternal Handbook, got its start in July 1942, shortly following Japan's involvement in World War II.

According to a survey on the estimated 2 million pregnancies nationwide conducted by the Japan Society of Obstetrics and Gynecology, there were 280,000 miscarriages or stillbirths, 60,000 abortions, and another 60,000 premature births. Dr. Mitsuo Segi (later professor emeritus of Tohoku University, now deceased), an employee of the Maternal and Child Health Division of the Ministry of Health and Welfare recommended and implemented a system to prevent this type of situation, in which pregnant women were required to send in pregnancy notifications, receive instruction, be instructed in how to get health check-ups at least three times during their pregnancy, and receive distributions of food supplies. Dr. Segi got the idea of implementing such a program in Japan through his experience as an exchange student at Germany's University of Hamburg where he observed a system in which a health record was carried by pregnant women.

In the handbook system at the time, pregnant women notified their town or village, received a handbook, underwent health check-ups from an obstetric doctor or midwife three times before delivery, and recorded entries describing the condition of the pregnancy such as "date of examination or guidance," "number of months pregnant," "notes (remarks about examinations, checkups)," and "notes about delivery," as well as the progress at the time of delivery and anything unusual that occurred, and the handbook became a reference for the next pregnancy. At the time, most deliveries occurred at home with the assistance of midwives, and the descriptions, however simple, that were noted by veteran midwives about blood pressure or the position of the baby provided valuable data for subsequent pregnancies.

The objective behind the introduction of the handbook system was partly the government's aim to "ensure that women have strong children," which had been an idea that arose during the war. Even during periods of wartime food shortages, pregnant women who had the handbooks received special allocations of maternity sanitary napkins, gauze, soap, and eggs.

The maternity handbooks continued even after the war and with name changes to Mother and Child Handbooks in 1947, and Maternity and Child Health Handbook in 1965, the contents of the handbooks were also expanded, and they have become educational materials for teaching about maternal and child health.

### **2-2-2 Expansion of the health administration**

The health administration in Japan was reformed as part of the democratization policy of the GHQ. They reformed the central and regional health administration systems, established the Preventative Vaccine Law as a measure against infectious diseases, reorganized state hospitals and sanitariums, and worked to develop medical facilities and improve the quality of healthcare professionals. It is particularly noteworthy that the health centers established during the war became the basic institutions for public health in rural areas through expansion of the network and enhancement of operations.

Measures for maternal and child health were also revamped and taken from the new perspective of pregnant women and infants. A Maternal and Child Health Division was newly established in the Ministry of Health and Welfare, and a Child Welfare Law was enacted, strengthening the foundation for maternal and child health. More specifically, a system was developed with health centers at its core, which: a) provided healthcare advice to pregnant mothers and guardians of infants concerning pregnancy, childbirth, and parenting, b) conducted infant health examinations, c) provided financial assistance to those in need so that they could receive healthcare advice, d) issued pregnancy notifications and maternity and child health handbooks (formerly called maternity handbooks) (see Box 2-1), and e) created measures for admittance to childbirth facilities for pregnant women who could not

**Box 2-2 “Love Box”**

The Family Planning Workers system retrained certified midwives, public health nurses, and nurses as Family Planning Workers and popularized family planning in every area of Japan. An organization of workers called the “Wakakusa-kai” (or “Young Grace Association”) was organized at the Mikkabi Health Center north of Hamana Lake in Shizuoka Prefecture. The association targeted not only housewives, but also their husbands and mothers-in-law, those who were in control of the family finances. Housewives were frustrated with a situation in which they felt no amount of guidance would help if they were not able to actually go out and buy the necessary products. This led to the creation of Mother-in-Law guidance. At the time, mother-in-law held the purse strings of the household, and housewives were not given money to use freely, but rather had to go and get money from their mother-in-law each time they went shopping.

New messages were sent out, such as “It is difficult to care for a lot of grandchildren. There is a way for daughters-in-law to have children when they want, and not to have them when they don’t. That is to give them some spending money.” By repeating these types of messages in their conversations, mothers-in-law eventually came to understand, and some housewives went to buy condoms at the village drugstore with their spending money. However, many were too shy to buy condoms. Therefore, it invented a small wooden box called a “Love Box” filled with condoms, sanitary goods, and a price list, which was passed from house to house. Housewives would put money in the box for the desired items, and after five or six houses, the box would be returned to the Wakakusa-kai office. The system was well received, and the idea spread throughout the country.

**Box 2-3 Drug Home Delivery System to the home in medically underserved areas**

A drug home delivery system was begun in the Edo Period (1603–1867). In this system, household medicines were delivered to homes in towns and villages that had no doctor or medical system for use in an emergency, which contributed to the improvement of the health of Japanese people.

The medicines were such things as: anthelmintics (medicine to remove roundworms), medicine for stomach or abdominal pain, cold remedies, medicines for before and after childbirth, medicine for menstrual problems, medicines for temper control, and headache medicines. Historically, successive generations of feudal lords encouraged the production of medicines, and a pharmacy in Toyama that produced many household medicines was particularly famous was called the household medicine distributors of Etchu Toyama.

The pharmacist would carry a wicker trunk on his back that was wrapped in a black cloth and was filled with medicines, and would make visits to every household once or twice a year. He would open their medicine chests and collect payment for the items that had been used, in this “use first, pay later” system. This form of trade could exist due to the relationship of trust between the customers and sellers, and is rarely found anywhere in the world. Pioneers who lived in the frontier areas and poor farmers, who had little cash on hand, were very grateful for the system. Medicines that had passed their expiration dates were removed, and replenished with the necessary items.

It is said that some vendors would make inquiries about the health of family members, such as “How do you feel?” “Have you lost weight?” “Are you eating regularly?” and would make adjustments in the types of medicines they left based on their answers. In this way, they were not only medicine vendors, but also served in the role of healthcare advisors.

It may seem that these vendors were just peddlers, but in fact they have come to gain the position of Home Delivery Drug Suppliers under the current Pharmaceutical Affairs Law.

have their children in hospital for financial reasons. They also held, as part of the measures for maternal and child health, parenting classes, baby contests, and nationwide maternal and child health conventions. The result of these efforts was a steady decline in the infant mortality rate.

**(1) Activities of public health nurses**

The main activities of the village public health nurse at the time were to establish and support organization of health volunteers made up of women “health volunteers” to provide stool tests and measures to eradicate parasites, to conduct medical checkups for infants and pregnant women, and to

**Box 2-4 Number of Births Halved in Model Areas in One Year**

The New Life Movement at the Kawasaki Steel Corporation not only brought about family planning results through the guidance provided, but also created an atmosphere of mutual friendship and cooperation among the families of employees working at the same plants. When unions were on strike and picketing, the Family Planning Workers were the only ones greeted with a smile at company housing, and these scenes indicate the effectiveness of the movement. The actual results observed in the model areas one year later were as follows ([Promotion of New Life Movement in Companies, Asia Family Planning Association], January 1959): the contraceptive prevalence rate jumped from 40.7% before guidance to 70.8% after guidance. This rate surpassed that of the 50% prevalence rate of the educated class in urban areas, and matched the rates of Western countries.

Prior to guidance, condoms were the overwhelming contraceptive method used, at over 50%, but as a result of individual guidance, the ratio of women who proactively used contraceptive jelly or diaphragms increased markedly. The effect of this on fertility control was tremendous, with a 47% drop in the number of births and a sharp 79% drop in the number of abortions.

According to the reports of other companies, a broad range of activities such as nutrition classes, cooking lessons, and workshops on how to keep household expense books, as well as activities to encourage savings were conducted. This movement was clearly good for the company too, because in reducing the number of births through family planning the company could reduce the dependants allowances and childbirth expenses that it had to pay and could also cut down on medical benefits through reducing the number of abortions.

hold family planning workshops for married couples that were known as the “Oshidori-kai (Mandarin duck club).” These activities were all conducted with the agreement and cooperation of all residents, and their main feature was the involvement of men and local decision-makers.

(2) Activities of midwives

In 1950, most childbirth occurred in the home with the assistance of practicing midwives, and it was not uncommon for two generations of mothers and children to be delivered by the same practicing midwife. Residents therefore had a great amount of confidence and trust in midwives and it was in this climate of trusting the advice of the midwife that family planning made its way into the lives of married couples.

At the time, the most widely used method of contraception was the condom, and with the approval of condom sales by Family Planning Workers (public health nurses and practicing midwives) at the time of counseling, not only were the incentives for Family Planning Workers increased, but a sense of ownership among residents was also established.

**2-2-3 Activities of non-profit organizations**

Following the war, at least 20 non-profit family planning organizations were established creating a situation of rivalry. In 1954, the Family Planning Federation of Japan was founded as an organization to govern those organizations, and in the following year the Fifth Annual World Convention of the International Planned Parenthood Federation was brought to Tokyo. This had a major impact on Japanese public opinion concerning family planning.

In the same year, the Japan Family Planning Association was founded, and efforts were made to

reduce the number of induced abortions by providing information and selling contraceptives, to develop and spread educational materials, and to train family planning workers in related areas. The same organization established a Family Planning Study Group that comprised government personnel, experts (scholars), and concerned private organizations that met at a regularly scheduled monthly meeting, and was charged with the important role of determining the process of family planning in Japan.

In 1933, the Imperial Gift Foundation Aiiiku-kai, established under the Imperial Fund, set up "Aiiiku-han," or community-based volunteer organizations, in every village, in which local women participated to decrease the infant mortality rate in farming and fishing villages, and worked to educate women through hands-on activities and through dissemination of the concept of mothering. It also partnered with the Maternal and Child Health Program of the Ministry of Health and Welfare following the war, and contributed to the strengthening of local organizations related to mother and child health.

The Mainichi Shimbun formed a study group to look at population issues in 1949, and conducts a survey on family planning-related knowledge, attitudes, and practice (called the KAP survey) biennially, producing valuable statistical materials and data.

#### **2-2-4 Family planning movement in private companies**

Alongside family planning projects conducted by the government, the New Life Movement flourished at a variety of private companies under the guidance and support of non-profit organizations centered on the Foundation - Institute for Research on Population Problems starting in 1952. The main objective was the dissemination of family planning and in order to achieve that objective, the following aims were set: to stabilize household finances, promote health, emphasize children's education, and develop educated and culturally enriched lives. Family planning guidance was easily provided by companies to employees as a group, and as a result it spread quickly with the addition of those involved in shipbuilding, coal, electricity, the chemical industry, paper manufacturers, the national railway, private rail companies, Nippon Telegraph and Telephone Corporation (NTT), transportation companies, the police, and firefighters, and at its peak it involved the participation of 55 companies or groups and 1.24 million individuals (see Box 2-4).

The previously described Model Villages for Planned Childbirth that were established by the National Institute of Public Health became a catalyst, and interest in family planning guidance for companies and employees grew. An ob-gyn doctor at the hospital attached to Joban Coal Mine in Fukushima Prefecture enlisted the cooperation of the National Institute of Public Health, and started providing guidance to those living in company housing (716 households, 3,632 people) with the goals of creating happy lives for the employees and their families, and saving women from the harmful effects of abortion. Of the women who received guidance, 94% decided to use birth control, which shows how interested the women were. As a result, improvements in contraceptive methods and a reduction in the number of pregnancies were observed.



### **2-2-5 Post-war movements to improve rural livelihoods**

The policy of Rural Democratization carried out under the powerful leadership of the GHQ brought to light the need for women to participate in decision-making that had up to that time been suppressed. It took up a problem-solving technique for farmers (today's PRA: Participatory Rural Appraisal) in which women themselves made decisions, and contributed greatly to women's empowerment and an improvement in the quality of life in rural areas. The central players were the women themselves, called Livelihood Improvement Extension Advisors. The initial stage of the Livelihood Improvement Extension Advisors was started in 1949, with American-style training in Tokyo, and education about the American-style dissemination system, the Participatory Social Development Technique. The program had no top-down objectives whatsoever. All of the Livelihood Improvement Extension Advisors were sent out into the field where farmers themselves were expected to recognize their own problems and the Advisors served as facilitators to help find solutions to their problems. Implementation of the needs-based PRA technique led to multi-sectoral development, such as nutritional improvements, family planning, and maternal and child health under the direction of the Ministry of Health and Welfare, social education, and the new life movement under the direction of the Ministry of Education, as well as the promotion of environmental health by local governments.

Livelihood Improvement Extension Advisors partnered with influential people and existing groups in the local areas, and were able to expand the program throughout the region. They also attended cooking classes and nutritional lectures held in neighboring towns which led to various opportunities for training. The notable point here is that the Workers were required to share the results of their activities with the other members. Through the training and activities of these women, women became empowered and their behavior changed.

Another feature of the Livelihood Improvement Movement was that it encouraged participants to save money made through their efforts and think of creative ways to use local resources. An improved cooking stove was one of the most successful projects that utilized inexpensive materials and was taken on by many farming village groups. It is said that the improved cooking stove became the catalyst (entry point) for farmers to become even more proactively involved in the Livelihood Improvement Movement (see Box 2-5).

### **2-2-6 Summary**

The demographic transition that occurred in post-war Japan was achieved through a variety of activities carried out all across the country, from cities to rural areas, by central ministries, communities, private organizations, and companies. Consequently, contraceptive prevalence rates rose considerably from 19.5% in 1950 to 53.0% in 1967.

Considering Japan's post-war experience in the context of today's development strategies, it can be seen that the capacity building achieved by administrative organizations along with the vigorous

policy of democratization by the GHQ was tremendous. In other words, a thoroughly democratic bottom-up approach was effectively implemented under the top-down leadership of the administration. Ultimately, it was the residents themselves who accomplished the achievements using their local resources without reliance on outside knowledge, manpower, funding or external support. In addition, by choosing the problem-solving technique for farmers (PRA) that was based on the needs of the citizens themselves, the approach became a multi-sectoral one covering areas such as industry (agriculture), sanitation, health, education, and leisure. In this type of activity development process, a sense of ownership and sustainability were fostered among area residents. With the appointment and training of women leaders and the participation of all women, the participatory approach was very effective, and proved that women's empowerment is a valid development strategy.

**Box 2-5 Livelihood Improvement Movement –Experiences of the Okanaru community, Nomura-village, Ehime Prefecture**

The community of Okanaru in Nomura-village, Ehime Prefecture is surrounded by steep mountains and has no good water wells. Residents used to have to go down the hill to the valley and bring their drinking water back up to the community every day, spending 8,000 hours annually on drawing water. This job fell on the shoulders of the women. Combined with this fact, the dark, smelly kitchens and the summers with their swarms of mosquitoes resulted in talk among neighboring villages that Okanaru was not a place families should let their daughters go when they got married. In 1947, five young men returning home from the war organized a group called the Matsuba-kai with their new wives, and held discussions about their situation. They decided that the community of Okanaru could not be left as it was, and that in order for every resident to lead a satisfying life, improvements in agriculture and livelihood were needed. They formed a Culture Promotion Society with the participation of everyone in the community. The Culture Promotion Society assumed a life expectancy of 80 years (at the time the average life expectancy was about 60 years) and developed a community restoration plan for the coming 30 years. Their plan was similar to the comprehensive regional plans of today. The plan was divided into three 10-year periods, and the residents worked first of all to secure drinking water during the first decade. It started with a simple trial water supply system made out of bamboo pipes built by the community youths. The group used this success to receive a subsidy from the village government to lay down a simple water supply system. Everything was carried out in the spirit of doing things through their own efforts and learning from each other in livelihood and youth classes. The Rural Improvement Extension workers and Livelihood Improvement Extension Workers took on the job of providing technical and moral support.

**The improved cooking stove**

The young people of the Okanaru community decided to make bread using the milk of the many local goats and flour, and went to the Livelihood Improvement Extension Workers for help. The youths were soon sent an instruction guide used by the prefecture's agriculture extension specialists, and they built a test cooking stove for bread in the corner of a shed all by themselves, and started baking bread. The women of the Matsuba-kai heard of this and asked the youths to build cooking stoves in their homes, since not only the bread was delicious, but the cooking stoves were also smokeless and soot-free. However, in the beginning the husbands were not especially interested in the idea of their wives using the cooking stove for every day cooking (under the eaves of the house with no ventilation and filled with soot). The Livelihood Improvement Extension Workers were approached for advice, and in turn made a list of functional problems of the original cooking stove and gathered scientific arguments that improvements in the cooking stove would lead to a decrease in the cost of firewood, shorten of the number of days for gathering wood, and reduce the amount of time required for cooking. They also estimated the time wives would save in the kitchen, and calculated how much of the saved time could be used for farm work. These figures were all announced at a study meeting for "economical living." The most convincing point for the mothers- and fathers-in-law was the data showing that the number of days for gathering wood would be cut in half, and that those days could be used for farm work. The Livelihood Improvement Extension Workers were especially good at convincing people who were opposed to an idea by showing them the scientific evidence for their arguments. The Okanaru cooking stove, originally developed in the community of Okanaru, was produced for half the price by tradesmen, and with added research and improvements, was installed in nearly every

household. After that, the inconvenient points of the kitchen were improved one after another, by moving the cooking stove from under the eaves of the house to inside the main building, adding windows to the kitchens to make them brighter, making cement sinks, putting in countertops, and wiring electric lights. The improved cooking stove came out of a spirit of service and turned houses in the community into ones that more highly valued the livelihood of the family members, and is reported to have brought about major changes in the status of the women who used to be working in dark and unsanitary conditions.

**Box 2-6 JOICFP Integration Project (IP) – Integration of Health and Family Planning in Developing Countries**

**Ryoichi Suzuki, JOICFP**

• **Activities of JOICFP**

The Japanese Organization for International Cooperation in Family Planning (JOICFP) was founded in 1968 in order to utilize Japan's post-war family planning movement experiences for international cooperation in population, family planning, and maternal and child health in developing countries. At the time the organization was founded, its most important role was implementing financial assistance given by the Japanese government to IPPF. In 1971, the Japanese government started making contributions of a million dollars to UNFPA (1.5 million U.S. dollars when added to those half million dollars to IPPF), and JOICFP has played a coordinating role between both organizations and the Japanese government ever since. At the same time, JOICFP is carrying out its own assistance to population and family planning areas in developing countries, using Japan's experiences, including those of the Japan Family Planning Association (JFPA).

• **Integration Project (IP)**

In the 1970s, Mr. Chojiro Kunii of JOICFP (then Executive Director of JOICFP, Founding Chairperson of JFPA), opposed to the top-down measures for promoting family planning that were being used at the time in Asia, took an approach of promoting human-centered family planning, and initiated an integration project (IP) in 1974 for the integration of the community-based family planning, nutrition, and parasite control, and was proactively involved with cooperation projects for developing countries throughout his life. IP is currently implemented in eight Asian countries (China, Bangladesh, the Philippines, Nepal, Laos, Vietnam, Myanmar and Cambodia), two countries in Latin America and the Caribbean (Mexico and Guatemala), and three countries in Africa (Ghana, Tanzania and Zambia). The features of IP include: 1) parasites as the entry point 2) valuing women's empowerment, 3) local government ownership and strengthening partnerships, and 4) versatile development that meets the needs of a country or region.

• **IP in China**

JOICFP's IP in China could be a model for the reproductive health/rights (RH/R) approach. IP in China introduced by JOICFP now combines three factors: family planning and economic development of the village people, Quality of Life (QOL) improvement through the efforts of residents, and building a healthy and happy family. It is a comprehensive approach to "build up happy families." JOICFP has conducted activities that have targeted 42 counties (cities) of 31 provinces (autonomous regions, special cities) throughout the country with the financial assistance of IPPF since 1983. Marked improvements in reproductive health have been acknowledged through partnering with local governments, keeping an eye on needs and results, receiving a welcome from many residents of project areas, incorporating incentives for improvement in living conditions and livelihood, and working toward comprehensive village renovation. Projects include: training for dissemination to each level (administration, village committees, and from principals to teachers of primary schools), health education about parasite control in school health, family health services through children and outreach, setting up of water facilities to secure needs-based safe drinking water, dissemination of sanitary toilets (developing and popularizing electric lights and cook stoves that utilize methane gas from toilets as bio-gas), and supporting women's groups to raise livestock and take on reforestation to improve their livelihoods. As a result, the status of women has been improved and the activities have brought about a desire to be self-reliant.