4.1 A question on the current trend toward across-the-board financial support

Across-the-board financial support may provide partner countries with opportunities to execute development programs according to their development plans. However, such support would also involve some difficulties. One major issue would be sustainability. In many partner countries, budgets allocated for health and medical care are seriously limited. Such financial support may provide a short-term remedy. But there is a possibility that sharing a burden through financial support on a wide scale would also promote long-term dependency, and in the worst scenario, it could ultimately annihilate the power of partner countries. Financial support for the salary of government staff and other recurrent costs, especially, could pose a threat to the overall health system from the viewpoint of sustainability.

Therefore, JICA presently provides financial support for specific works in a limited time frame to ensure that the partner country will gradually increase its financial capability to sustain the work through their own efforts, and maintains its principle of developing the capacity of partner countries through a bilateral cooperation mechanism as described in Chapter 2.

4.2 Formulation of strategies through closer consultations

To better respond to the demand of partner countries, it may become increasingly important for JICA to set out clear cooperation strategies in close consultation with the partner countries on a regular basis. Such strategies should support the national development policy to respond to the ownership and needs of partner countries. These strategies can provide relatively long term development projections for partner countries, donor communities as well as JICA, and will facilitate programmatic approaches that will have more impact on sectoral development. And long term development projections will also make it possible to avoid providing assistance on an ad-hoc basis, which may produce only limited results within a limited scope. In conjunction with these strategies, JICA will continue to explore possibilities to improve its methodologies and modalities in development assistance.

4.3 Utilization of local expertise

In the field of community health and primary health care, there are usually indigenous knowledge and experience in the partner countries, and in many cases they already accommodate social and cultural sensitivities. At the same time, there are also cases where expatriate intervention can facilitate the process of development
by making use of their expertise and experience. There is a potential that a mixture of local expertise and Japanese experience would create a significant change in improving health status. In fact, JICA utilizes local resources in such cases as much as possible. And the future perspective is that there would be more dependency on local expertise. However, careful attention should be paid so that utilization of local resources will not cause local labor market distortions.

JICA provides various forms of technical cooperation in the health sector, responding to the needs of partner countries whose health status and health administrative structures may vary greatly.

It recognizes, as its focus, the capacity-building of government organizations, and has helped to develop the potential capacity of partner countries in terms of human resources, institutions, health-related systems to efficiently run national programmes, and, furthermore, national level guidelines and strategies.

Capacity-building is no easy task. Mere theories and knowledge are not sufficient for real changes to take place. Knowledge based on field practice will become a base to build capacity that will have a greater impact on the overall health system, thus contributing to capacity development. JICA has taken this factor seriously into its operations, and placed emphasis on the capacity-building on the middle-level management where actual field practice takes place.

Examples of the technical cooperation of JICA are shown below in the order of "health care on the ground level," "infectious disease control," and "health system development." These examples are just one aspect of our wide-ranging development work, but will hopefully provide readers with an entry point to understand how JICA has tried to help develop the capacity of partner countries in health.

5.1 Health care on the ground level

JICA has assisted in upgrading health care services for people in need, going deep down to the grass-roots level. One important factor is to develop a mechanism carefully tuned to the social and economic conditions peculiar to local communities. The technical cooperation of JICA covers various areas in primary and secondary health care, and its achievements on the grass-roots level are expected to serve as a model that can be replicated to a wider community in close collaboration with government bodies situated in a higher hierarchy. The cases shown here are our efforts in the field of reproductive, and maternal and child health.
**Case 1**

Vietnam


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**Outline**

The project is aimed at strengthening the reproductive health services in Nghe An province, so that safe and clean deliveries can be ensured in poverty-stricken villages.

Nghe An province is located 300 km to the south of Hanoi. The population of the province is 2.9 million, of which 90% live in agricultural rural areas. The beneficiaries are women of reproductive age, estimated to number over 710,000. There are around 41,000 births a year. The project provides 466 Commune Health Centers with a package of training for midwives, and provision of equipment and basic medical facilities. It strengthens the District Health Center and the Maternal and Child Health Center, in terms of managerial and monitoring capacity.

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**Outcomes**

The project, which covers the whole province, having the third largest population in Vietnam, has a national-level impact as a model for strengthening reproductive health services. In three years, the project created an environment in which approximately 27,000 pregnant women every year can have safe and clean deliveries. By August 2005, almost all of the pregnant women in the province will have received equal-quality services. The system developed through the project activities has become the basis of the 10-Year National Strategy on Reproductive Health Care. The government intends to apply the system to other provinces, on their own initiative.

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**Features**

**Participation of various stakeholders**

The project has set up steering committees comprising representatives from government, the health sector, and the Women’s Union, which has a strong network on the grassroots level: 1 on the provincial level, 19 on the district level, and 466 on the commune level. Each committee held a workshop, through which awareness of the importance of reproductive health was raised. The district level steering committee meets on a regular basis to monitor and evaluate the progress of the project. Through collaboration with the Women’s Union, the villagers’ support for the project was strengthened. Active participation of stakeholders on various levels has led to a high level of commitment and ownership regarding the promotion of reproductive health services. This has become a model in Vietnam and is expected to be replicated on their initiative to other provinces.
In 1993, JICA started to provide the Government of Indonesia with technical and financial support for the development and dissemination of the Maternal and Child Health (MCH) handbook. The handbook was developed, referring to the experience of Japan, where the MCH handbook has been utilized over 50 years. However, it was modified to respond to local needs. It was pilot-tested in a municipality of Central Java province, where there is a population of 150,000, and found effective, later to be integrated into the development policy of Indonesia as a national programme.

The current project is aimed at upgrading the quality of maternal and child health services through MCH handbooks. It develops teaching materials on health education for training courses for health service providers. It conducts training courses on the use of MCH handbooks as well.

The project has rapidly expanded its coverage areas. It initially started with West Sumatra and North Sulawesi provinces, the population of which is over 7.3 million in total. In three years, it was expanded to 24 provinces, covering 159 cities and districts throughout Indonesia.

### Features

**Integration into the existing mechanisms**

The Government of Indonesia took an initiative in developing and disseminating MCH handbooks to the whole country and requested technical and financial support from JICA. JICA promptly responded to their initiative, and helped develop the MCH handbooks based on the 50-year experience of Japan in this field. These handbooks were carefully developed to respond to the country’s regionally specific conditions, and were published in different local languages and pictures, which may be why the handbooks were well received by many provinces.

It was relatively easy to extend the handbooks to the grass-roots level since in its initial stage the project was placed as an integral part of the existing mechanism of health service infrastructures that have reached end-users residing in local areas. Prior to the dissemination of MCH handbooks, the project had strengthened the capacity of health institutions through training for health service providers and health volunteers so that the handbooks would be used effectively.
Concerted efforts by the government and other donor agencies

The usage of the MCH handbook has been rapidly expanded to many provinces of Indonesia. The decentralization process of the country would be one factor that has prompted its expansion. Local governments have begun to allocate their own budget for the printing of the handbooks in addition to the budgets prepared by the central government. Over 20 cities and districts have already introduced a system of collecting fees from users in non-poverty populations.

In 2001, the Government of Indonesia disseminated over 1.4 million handbooks, of which JICA supported the printing of 850,000. International organizations provided significant support for the printing of over 300,000 handbooks in the same year. UNICEF, the Asian Development Bank and the World Bank are the main contributors. Such international efforts made by development partners have also quickened the process of expanding the handbook to different parts of Indonesia.

Training for health service providers

Case 3
A Challenge in the urban slams: the power of people in the Lusaka case
Zambia

Lusaka District Primary Health Care (1997-2007)

Outline

According to the Health Reform, which began in the early part of 1990s, the most important policy issue was to strengthen the primary health care system. Through the process of decentralizing medical services, District Health Management Teams (DHMTs) are expected to provide medical care on the district level. However, DHMTs must be strengthened in terms of human resources and their financial base.

The project was initiated in 1997, to strengthen the capacity of the Lusaka District Health Management Team (LDHMT) to raise the health status of people in Lusaka, where urban slams pose a serious health threat to people in poverty. It promotes primary health care services in George Compound, a pilot area, through Growth Monitoring and Promotion (GMP) for children under five years old, in cooperation with Community-based Organizations (CBOs) and activities for creating an environment of safe water and sanitation. Other activities include improving the technical level of health care and laboratory staff, through training and the provision of equipment, and promoting school health at eight primary schools.
Building on the achievement made through the first phase (1997-2002), the project is currently in the second phase (2002-2007) to cover the other 5 compounds and to further strengthen the collaborative health works between communities and the government that supports the activities of local volunteers, thus increasing the level of sustainability by the hand of Zambian people.

Outcomes

The primary aim of the project is focused on capacity-building through human resources development on different levels. It has so far trained 260 Health Center staff members, 150 Community Health Workers (CHWs), 100 Nutrition Promoters (NPs), and 48 George Environmental Health Committee (GEHC) members.

Grants for the construction of sanitary facilities, such as latrines, fee-paying public toilets, and showers, were also provided in conjunction with the technical cooperation. The mortality rate from cholera in Georgia declined from 70/10,000 in 1994 to 1/10,000 in 2000.

GMP is now being implemented on a monthly basis at 19 points. As a result, the ratio of low-weight children under five years old decreased, from 23% in 1999 to 15% in 2000. The rate of fully immunized children under a year old increased, from 15% to 61%, and the measles cases of children under five years old declined, from 8.5/1,000 to 1.8/1,000.

As for school health, health checks and de-worming were done for 15,000 students at 8 pilot schools. Health care staff for school health, and health staff at schools, worked together to promote health. The PTAs began to bear the costs for de-worming.

Features

Community participation to make a drastic change

The project emphasizes community participation to increase the accessibility of the community to health services. Local community representatives were trained as community volunteers to work closely with health specialists in a community. They implement GMP and provide health education, counseling on nutrition, and vitamin A. To upgrade sanitary conditions, Participatory Hygiene and Sanitation Transformation (PHAST) was gradually installed and has enabled the community to prioritize sanitary work through participatory learning action modules. JICA experts promoted the participation of community stakeholders and facilitated processes to increase community participation, providing technical advice when necessary.
Training on microscopic smear examinations

JICA began its assistance for a public health project focused on TB control, as its major project component, during 1992 - 1997. The project produced the National Tuberculosis Control Programme (NTP) Guideline, and set up a reference laboratory in Cebu to upgrade the quality of sputum smear examinations.

From 1997 - 2002, technical cooperation was provided as its second phase to expand the implementation of the Directly Observed Treatment with Short Course Chemotherapy (DOTS), within the framework of NTP and establish a National Tuberculosis Reference Laboratory. This was also to support the Stop TB Initiative of the World Health Organization (WHO) to expand DOTS implementation in various countries, considering tuberculosis as a global issue that needs to be tackled through international support.

The Department of Health set 2010 as the target year to halve the mortality and morbidity caused by tuberculosis. JICA has decided to continue to support NTP through: (1) networking laboratories among the National Tuberculosis Reference Laboratory, regional and provincial laboratories and microscopy centers; (2) assisting with monitoring and supervision activities of the regions and provinces; and (3) conducting operational researches, in order to upgrade and ensure the quality of DOTS implementation.

During 1997 - 2002, the project has expanded the implementation of DOTS to nine provinces, covering a population of 13 million, which compose approximately 17% of the total population.
In the target areas, the project achieved, in two years, an 85% cure rate, which is the target by WHO, and 90% for three sputum collection rates.

The project supported revision of the NTP Guideline and produced the Manual of Procedures, which is being used nationwide.

Based on the experience at the Cebu Reference Laboratory, the project established a quality control system for sputum smear examinations, which enables provinces to achieve good results: lower than 5% for the false positive rate, and lower than 2% for the false negative rate.

The Philippines is among the 22 high-risk countries for TB, as designated by the WHO. The Department of Health places TB control as one of the highest priority programmes, and makes the utmost effort to secure budgets for operational costs of the project, facilities necessary for sputum examinations, and its staff.

The project primarily conducted training to build the training capacity of the technical staff, who are supposed to disseminate requisite knowledge and skills to field health workers. These factors are important to ensure the quality of DOTS implementation and have contributed to technical and financial sustainability.

Sustainability

Fighting TB in the context of complex health situations

Cambodia is also one of the WHO’s 22 designated high-risk countries for TB. The estimated TB incidence in the country is the second highest among those 22 countries and is the highest in the region. On top of that, HIV/AIDS began to spread rapidly in the 1990s. Since most of the People Living with HIV/AIDS (PLWH) in Cambodia are infected with TB, TB among PLWH has an epidemiological impact on the overall TB control, and the area is gaining an increasing need for technical support.

The project aims at strengthening the National Tuberculosis Programme (NTP) of Cambodia through institutional and human resources development at the National Tuberculosis Center (CENAT), expansion of quality DOTS implementation across the country and support for surveys/surveillances on TB prevalence, TB drug resistance and TB-HIV/AIDS co-infections.
Outcomes

Before the project started, there had been only 5 hospitals that provided services for TB patients for the population of 1 million in Phnom Penh. This had aggravated circumstances for the people, especially those in poverty, to gain access to proper health services. With support from JICA, the Phnom Penh Municipality organized the "STOP TB Collaboration Committee," and rapidly expanded DOTS implementation in 2001. Currently, over 20 hospitals and health centers implement DOTS in Phnom Penh.

In its initial stage, the project warned that TB-HIV/AIDS co-infection would become a major health problem. Indeed, it is said that more than half of the PLWH in the country have already been infected with TB. The project has been providing training for laboratory technicians on safety procedures for examinations and HIV testing, and has conducted national HIV sero-prevalence surveillance among TB patients as well as TB screening services to PLWH, HIV Voluntary Counseling and Testing (VCT) for TB patients.

Technical Cooperation situated in the holistic sectoral development

The Health Sector Reform (HSR) has been undertaken in Cambodia since the late 1990s. JICA has been working closely with the HSR core group to have the tuberculosis programme integrated into the overall health care service structures as envisaged by HSR. The strategy of the project to make DOTS services available for the poor and those in remote areas was adopted as the national policy of tuberculosis control in 2001, and is being expanded under the new health service system.

Partnerships with various organizations to fight the complex health situations

The project has been collaborating and coordinating with various development partners to increase the effort to fight TB. It worked with WHO to support the STOP TB Initiative. It collaborated with the World Food Programme (WFP) to nourish TB patients, which is key to sustaining a high treatment success rate in the country. To further expand the DOTS implementation, the project frequently organizes workshops for NGOs on community DOTS. Furthermore, the project has facilitated the process of partner coordination through its support for a series of partner meetings with Cambodia’s Ministry of Health. As a result, the Inter-agency Coordination Committee was officially launched in April 2001, and is expected to create concerted efforts to fight TB.
In the Mekong region, school-aged children have a high rate of worm infections: in some areas, 90% of school students have one or more worms at any given time. Parasites are prevalent in some tropical areas and travel beyond borders between countries. There is an urgent need to develop a capacity for setting up a national policy and training human resources to tackle this regional issue.

The Asian Centre of International Parasite Control (ACIPAC) was established in 2000 in the Faculty of Tropical Medicine at Mahidol University, Thailand. The project is aimed at building the capacity for parasite control on a regional level, and it conducts regional training courses for parasite control personnel in Thailand, Cambodia, Laos, Myanmar, and Vietnam. As a follow-up, a pilot project on school-based health promotion is expected to start in each country. The project promotes South-South Cooperation among these five countries.

In the past two years, parasite control committees on the national level were established in Cambodia and Laos, respectively, and they are being set up in the other countries as well, to strengthen parasite control measures based on their own national policies.

The ACIPAC international training has enabled the formation of a human network in parasite control. The curriculum was prepared through a workshop in which personnel of the Ministries of Health and Education of each country participated.

As a result, the prevalence of parasite infections drastically declined to almost nil. JICA experts provided technical knowledge and experience on a school health-based approach for malaria and soil-transmitted helminthiases control, which has been widely accepted by the partner countries.
South-South Cooperation for tackling the regional issue

The project selected two model areas in which a parasite control project based on school health is implemented in Thailand. These areas are also used as fields for practical training for participants of the international training courses from the region. In many aspects, the conditions are much more similar to those of the five countries than those of Japan. The international training also contributes to building a human network as a base for tackling a regional health problem.

5.3 Health system development

Here, the definition of "the health system development" is broad. It contains the development of health-related information, a data base and regulations in the case of Ghana, the development of guidelines and health systems for "humanized maternity care" in Brazil, the development of health-service structures as in the case of Vietnam, and the development of an educational system in the case of El Salvador. All the cases show that JICA experts played a supporting role and that participatory processes were introduced to develop health systems tuned to the circumstances specific to partner countries.

Case 7
A First in Africa: development of an in-service training system

Health In-Service Training (HIST) (1997-2002)

Outline

The Health In-Service Training (HIST) provides opportunities for health workers to catch up with rapidly changing medical skills and knowledge. Ghana’s Ministry of Health (MOH) has set a high priority on the HIST to secure the provision of quality health care for the people in Ghana. However, HISTs urgently needed to be standardized, well-coordinated and properly recorded since the lack of these conditions had failed to produce HIST’s expected optimum output despite the significant amount of investment made by various organizations in this area. The Health In-Service Training Project was initiated in June 1997 to effectively and efficiently make use of various training programmes.

The project was targeted at developing four major HIST system components:

1) to set a HIST framework through the development of the HIST Official Course Classification;
2) to develop the HIST Information System to have all HIST-related data systematically recorded;
5.3 Health system development

The Government of Ghana recognized the need to set up an in-service training system, in order to provide quality health and medical care for its people. The government expressed its importance in the First Five-Year Plan: 1997-2001, and formulated the In-service Training Policy in 1997. The project supported the initiative of the government.

Support for the ownership of Ghana

The Government of Ghana recognized the need to set up an in-service training system, in order to provide quality health and medical care for its people. The government expressed its importance in the First Five-Year Plan: 1997-2001, and formulated the In-service Training Policy in 1997. The project supported the initiative of the government.

Participatory approach to develop the HIST system

Indigenous knowledge was in place in Ghana. The government knew what kind of system was necessary and had its policy. However, it lacked technical skills and financial resources to conceptualize and implement it. The HIST system was materialized through a participatory approach, involving most of the HIST-related officials in Ghana. It was worked out through collaboration between the Ghana stakeholders and JICA experts. The project concretized the system by facilitating such participatory processes, involving various stakeholders at different levels, and building the capacity of relevant authorities.

Outcomes

The HIST Course Official Classification was established and has contributed to classifying all HISTs conducted in Ghana into standardized categories. This provides a basic structure of the HIST Information System and Logbooks. The classification sets a target of developing curricula and textbooks of HIST courses in Ghana. The HIST Information System has already been introduced in three pilot regions and has provided crucial information needed to plan and review HIST activities in these regions. The HIST Logbook was already developed, and its distribution is on-going for all health workers in Ghana. The logbook will be used not only for tracking individuals’ HIST records but also for appraising the skills of health workers through HIST credit points. Regular HIST monitoring is conducted routinely through the HIST monitoring sheets developed by the project.

Features

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To create a patient-friendly health environment, health facilities introduced measures to make patients feel relaxed and comfortable and to protect their privacy. The LDR system, which enables pregnant women to stay on the same bed through the processes of labor, delivery and recovery, was developed. A behavioral change was observed among women who had experienced humanized maternity care in preferring natural deliveries to Caesarean sections. 363 assistant nurses who serve pregnant women were trained in skills based on the concept of humanization.

In response, JICA started technical cooperation in 1996. The project’s aim was to upgrade the quality of maternal and child health care services in the North-East of the country by revitalizing the concept of “humanized maternity care” because the conditions surrounding pregnant women were not generally favorable at that time. The focus was placed on creating a patient-friendly environment through the development of health personnel and improvement in health facilities based on the concept of human-centered care.

The road to success was rocky in its initial stage. There were varied opinions about instilling a different concept, partly built on the experience of Japan, to the existing mechanisms in Brazil. However, through continued dialogues and close collaboration between the Government of Brazil and JICA, a friendly health environment for mothers and children was realized to be widely replicated in Brazil.

Outcomes

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Features

Continued dialog to find the real problem

One significant factor which led to a success of the technical cooperation would be continued dialogue between the Brazilian government and JICA. Of the five-year project, the first year was entirely spent on a joint research conducted through cooperation between Brazilian specialists and JICA.
experts. This research made it possible to pinpoint specific problems surrounding health care services for pregnant women, and became a base to develop various training programmes to introduce humanized maternity care.

**One project's nationwide impact**

Many of the measures for quality maternal and child health care services developed through the technical cooperation have become national guidelines. The LDR system was decided by the Government of Brazil as its national standard in 1997. The government built 40 centers to promote natural deliveries and to train maternity nurses in 1999. The Government of Brazil started on its own initiative a "humanization programme" to support human-centered care in its health and medical system in 2000, and selected model hospitals to promote humanized maternity care. In the same year, an international conference was organized in Ceara, Brazil, to produce the Ceara Declaration that promotes humanized health care on an international level. About 2,000 people from 25 countries exchanged views and the concept of humanization was widely shared and accepted.

**Tertiary medical service for community health**

*Back Mai Hospital (2000-2005)*

**Outline**

The Back Mai Hospital has contributed to providing medical care for Vietnamese people, as a central hospital in the northern part of the country, since its establishment in 1911. It has 1,400 beds and covers 31 provinces as a tertiary hospital. In addition to its diagnosis and treatment role, it has also played important roles as a teaching hospital as well as a center for technical advice and guidance for medical service providers posted in rural areas. The hospital sees poverty-stricken patients free of charge.

The technical cooperation focuses on three areas: (1) enhancement of managerial and technical knowledge and skills needed for a tertiary level hospital, (2) strengthening its role to provide technical support in the context of community health, and (3) improving its function as a teaching hospital. The project envisions the hospital in a regional health service structure for the northern part of the country, and takes the approach of helping to develop a total health care system, extending the outreach of the hospital to regional peripheral levels.
Outcomes

Upgrading the efficiency and technical level of the hospital is an important factor for a hospital of this level. To enhance its efficiency, technical cooperation has been concentrated on planning, financial management, information management, management and maintenance of medical equipment, and others. As a result, the salary of the staff increased by 22% and the rate for uncollected medical fees declined by 24%. The rate of internal infections decreased from 9.6% in 1999 to 6.5% in 2001. As a result of enhancing the technical level, the number of biochemistry tests dramatically increased, from 419,695 in 1999 to 871,534 in 2001. The number of outpatients expanded, from 224,357 in 1999 to 295,663 in 2001. The number of X-ray diagnoses increased, from 59,523 in 1999 to 89,130 in 2001. As to its role in the context of community health, the hospital has conducted technical Training of Trainers for provincial hospitals. Materials for IEC were also developed, to upgrade the diagnosis level of local medical facilities.

Features

Sharing experience and knowledge

Perhaps, technical cooperation on the tertiary level would be an area where a partner country could make the most of technical knowledge and skills from expatriate experts. Overall, hospital management and treatments usually require a relatively high level of skills and experience to sustain the standard required for a tertiary hospital. In addition, a "total care system," or coordinated work of treatment and care was introduced to strengthen the care service function for patients.

Responding to the ownership and needs of the Vietnamese government

The Ministry of Health has made a policy to extend technical support from the tertiary hospitals to local peripheral level health providers in the public sector. In line with the initiative of the government, the project has supported the effort of the Back Mai Hospital in strengthening its function of the DOHA or the Direction Office of Health Care Activities at Provincial and Lower Levels. The hospital organizes training for health personnel fielded in provinces, and its medical doctors regularly visit peripheral hospitals to give technical advice and guidance.
The project intended to involve different levels of stakeholders, to ensure upgrading of comprehensive quality education. The technical cooperation was led by the Ministry of Health and members of nurse schools. The ministry increased its staff at the central level, from two to nine, to strengthen nurse education on the policy level. Six schools developed curricula through technical cooperation, which were fed back to the policy level and have become the national standard. They reformed or constructed training facilities on their own initiative. Furthermore, nurse instructors and nurses began to organize meetings on their own initiative, to improve their technical skills.

Outcomes

The educational curricula developed by the project were approved by the Ministry of Health and have become the national standard. The curricula enabled all nurse schools in the country to sustain a sufficient technical standard.

Various training courses were conducted to build capacity for planning, monitoring, and evaluation in nurse education, as well as to develop educational materials. As a result, eight technical committees set up by the project have developed guidelines and models on their own initiative.

Features

Participation, the power of people

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