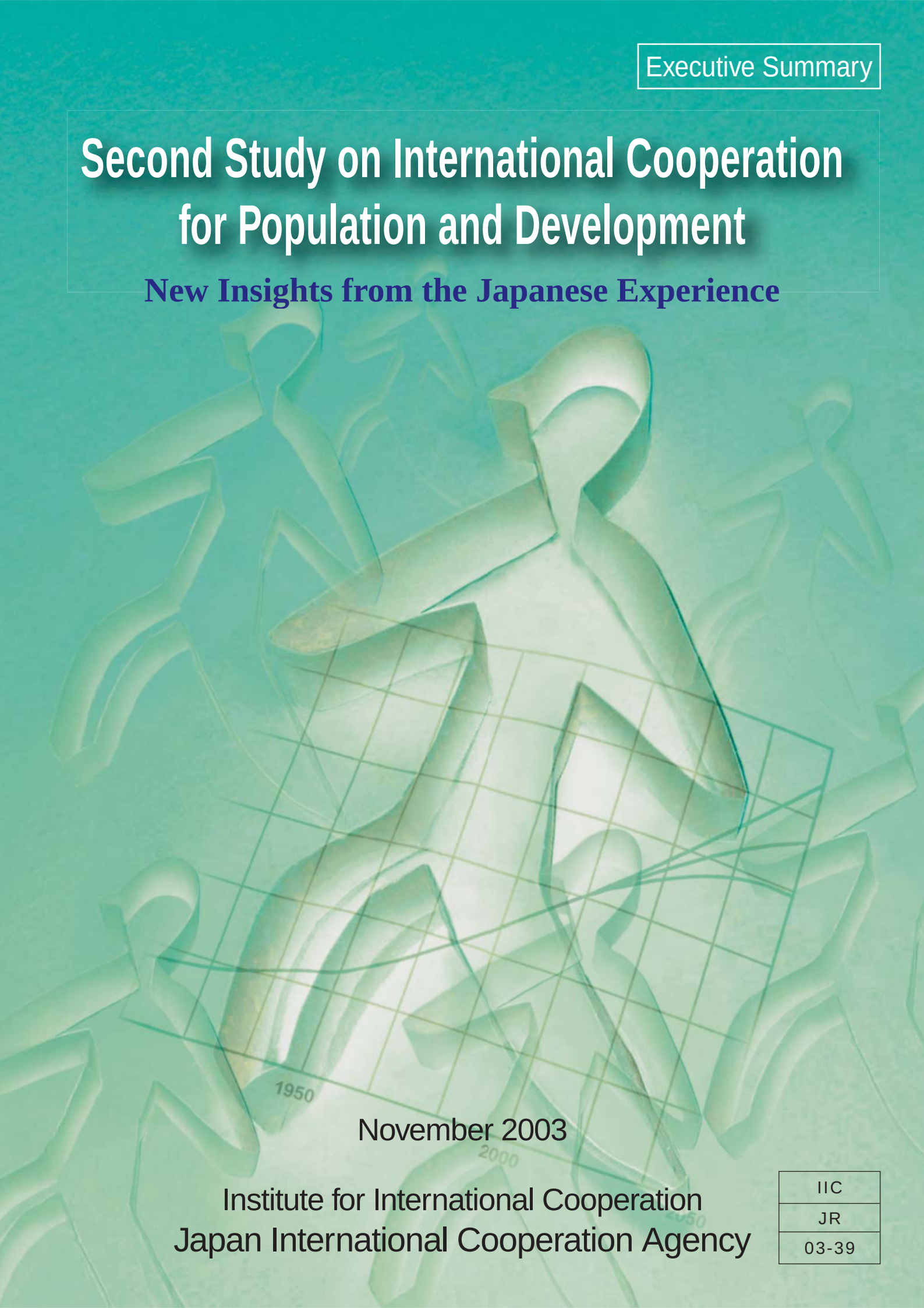
Executive Summary

Second Study on International Cooperation for Population and Development

New Insights from the Japanese Experience



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This report is a summary of the views of the study group (Chairperson: Dr. Makoto Atoh, Director-General of the National Institute of Population and Social Security Research) and does not necessarily reflect the official views of the Japan International Cooperation Agency.

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Foreword

The population of the world was approximately 2.5 billion in 1950 and has now surpassed 6 billion. The 2002 United Nations population forecast estimates that the world population will reach 8.9 billion people in 2050. In an effort to work toward the stabilization of this kind of drastic population growth, the United Nations (UN) has held global international conferences on population issues once every decade to the present. The concepts of Reproductive health/rights (RH/R) appeared for the first time at the 1994 International Conference on Population and Development (ICPD) in Cairo. The introduction of these concepts resulted in a shift in the focus of population policy from the macro level (country level) to the micro level (individual level), and vastly changed the approach taken on population issues.

Japan's contributions to solving population issues in developing countries have been through technical assistance on a bilateral basis as well as through contributions to international organizations. Since 1994, Japan has provided more than 3 billion dollars of assistance to population and AIDS programs based on the Global Issues Initiative (GII). In 1992, the Japan International Cooperation Agency (JICA) organized a Study Group on Development Assistance for Population and Development, and has made recommendations regarding assistance in the field of population.

Despite these efforts, however, population issues are still a major challenge for humankind, especially for people in developing countries, and are directly related to the environment, to our food supply, and to development. These issues continue to become increasingly complex and serious. In the light of this situation, JICA organized a Second Study Group on Development Assistance for Population and Development in August 2001 to formulate a new direction for assistance based on the major changes in the trends seen at the Cairo Conference and other recent population conferences.

This study group comprised nine committee members and advisors with Dr. Makoto Atoh (Director General of the National Institute of Population and Social Security Research) as its chairperson, along with a taskforce of six members, and held a total of 13 study meetings. It also enlisted the cooperation of 28 experts from both within and outside of Japan to participate in the study meetings and preparatory meetings as well as to write reports. The present report is a summary of the fruits of all these efforts, and we hope it will be useful not only for government agencies in order to guide their future cooperation in the field of population, but also for all related agencies and organizations.

I am exceedingly grateful for the efforts of Chairperson Dr. Makoto Atoh and all of the committee members, advisors, and members of the taskforce, and would like to express my deep appreciation to all those who participated in the discussions of this study group.

January 2003

Takao Kawakami, President
Japan International Cooperation Agency

Preface by the Chairperson

This report is a compilation of the results of the study conducted from August 2001 through October 2002 by the Second Study Group on Development Assistance for Population and Development organized by JICA.

The First Study Group on Development Assistance for Population and Development was organized in 1992 and its final reports were published in the same year. Ten years have already passed since then, and during that time there have been major changes in the status of the world's population as well as in international population assistance strategies. This study group aimed to accurately assess the new trends of the 1990s while taking the results of the First Study Group into consideration, and to reconsider the future population development assistance strategies that are expected to be taken by the government and by JICA.

Some of the new trends in the world's population that arose in the 1990s are: (1) an overall decline in fertility rates and population growth rates, but the emergence of Sub-Saharan Africa and South and West Asia as hotspots for population issues, (2) the shortened life expectancy in a number of countries due to HIV/AIDS, particularly in Sub-Saharan Africa, (3) a decline in the birthrate and a lack of improvement in life expectancy in Eastern European countries following the collapse of the Soviet Union, and (4) the beginning of the aging of the population in some developing countries following a transition in fertility trends.

The most striking new trend in international population assistance strategy was the reproductive health/rights (RH/R) approach that was developed at the Cairo Conference.

This new approach, characterized by the Program of Action of this conference, is a population strategy that indirectly promotes a demographic transition through efforts aimed at achieving reproductive health, including family planning, and is based on a foundation of respect for people's (especially women's) human rights and reproductive rights. It is a powerful antithesis to the population strategy agreed upon at the 1974 Bucharest conference, which asserted the need to popularize family planning in order to achieve population control for the promotion of economic development (World Population Plan of Action). The adoption of the new approach has been called a paradigm shift to a human rights approach.

The reproductive health/rights (RH/R) approach started to take hold internationally through the activities of the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF). However, there is still considerable disagreement regarding the development of a population strategy. This study group has made recommendations that are based on continuing observation of the actual conditions in developing countries and in the field of assistance. With an accurate awareness of the significance of population issues – the macro-level phenomenon of population dynamics and the effects it has on economy, society, and environment – the group is committed to the value of the reproductive health/rights (RH/R) approach in solving population issues through concrete measures, in particular with regard to the popularization of family planning. A catch

phrase to describe the recommendations would be “Think globally, and act respecting individuals.”

The initial plan of the study group was to bring to light Japan’s historical experience in population development and examine whether they could be utilized in Japan’s population development assistance strategies. The group conducted interviews to obtain information concerning Japan’s fertility transition, improved maternal and child health, family planning dissemination, livelihood improvement activities, and the activities of NGO’s immediately following World War II, and has derived several useful recommendations based on the information obtained from these interviews. Needless to say, since Japan achieved its demographic transition without any organized national programs or international cooperation in population or family planning, it may be difficult for developing countries in the world today to utilize Japan’s experiences as their model. Nevertheless, if we look back at Japan’s experience, we find that the new approach in today’s population activities and population assistance was in fact utilized previously in Japan under a different name. For example, there were many instances of the use of a community-based approach (CBA) and partnerships between the government and NGOs. There are also other programs from Japan’s own experience that, to a considerable extent, can be utilized in today’s population assistance activities, such as the utilization of maternity and child handbooks, the retraining of traditional midwives to promote family planning, and the integrated approach used by Japan’s international NGOs.

We endeavored to explore the possibility of highlighting Japan’s originality and ingenuity in its population assistance activities, so that, while being based on international population strategy trends, they would not be simply emulating them. It is imperative that we do not stop at the recommendations of this report, but continue learning valuable lessons from the population assistance activities of JICA and Japanese NGOs, and continue to make efforts to turn the lessons learned into programs that can be easily understood by everyone.

The recommendations of this report are diverse, but focus on reproductive health activities including family planning, and suggest a “shift from a sector-wide approach to a multi-sectoral approach.” Until now, international cooperation in this field was handled by JICA as a part of health cooperation activities within the single sector of medical cooperation. It is true that it is difficult to cooperate in areas of the health field without including medical or healthcare specialists since this field is related to human reproduction, such as sexuality, contraception, abortion, childbirth, and pre- and post-natal care. However, as seen from Japan’s own historical experience as well as the experience of Japanese NGOs, and in fact, as is also seen in the Program of Action from the Cairo Conference, the diffusion of family planning goes beyond the field of healthcare. Rather, it is very deeply involved with women’s education, influence, and decision-making along with the economic power behind it, and is also closely tied to efforts to improve the living conditions (village development, public health standards, etc.) of the whole community. JICA, being aware of this fact, is already carrying out experimental projects for the dissemination of family planning concepts in combination with several developmental elements, but this type of comprehensive approach should become the mainstream in future.

This study group comprised nine committee members, advisors, and a JICA taskforce, as well as secretarial staff. Active discussions were conducted on a nearly monthly basis through meetings, attended throughout by the Director of the Institute for International Cooperation, the former vice president of JICA, and various outside experts. The committee members were international population researchers, experienced persons from international population assistance organizations and international NGOs, current leaders of Japanese international population assistance NGOs, those in charge who are active at the front lines of JICA's population cooperation, and an ex-journalist specializing in the population field. They represent a wide variety of perspectives and were, therefore, able to study the problem from different angles, including theory and practice in assistance for population development, macro-level and micro-level perspectives, domestic and international perspectives, and program implementation as well as education and public relations activities.

The field of population and development is different from the fields in which JICA typically provides assistance. As the theme of population and development itself is very broad, the nine committee members along with many domestic and overseas experts spent the first few months of the study conducting interviews and gathering information in each specific field. They also made use of the study reports of visiting researchers and had the opportunity to go to the field and observe assistance programs in population and family planning in Bangladesh and Thailand. These interviews, visiting researcher reports, and observations have been utilized in various aspects of this report. Furthermore, in formulating recommendations, we asked a few outside experts to contribute to the report in areas that could not be sufficiently covered by the members of the study group. I would like to take this opportunity to thank all of the domestic and overseas experts, visiting researchers, and those working on the Bangladesh and Thailand projects who willingly took time out of their busy schedules to work with this study group.

I hope that this report will contribute to the efforts of all of those working diligently in planning and implementing assistance activities in the field of population and development in Japan. It is my wish that a qualitative improvement in Japan's assistance activities will contribute, even in some small way, to improvement in the welfare of each and every citizen of the developing countries.

January 2003

Second Study on Development Assistance for Population and Development
Makoto Atoh, Chairperson

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Acronyms and Initials

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AusAID	Australian Agency for International Development
BCC	Behavior Change Communication
BHN	Basic Human Needs
CBA	Community Based Approach
CDF	Comprehensive Development Framework
CHC	Commune Health Center
CIDA	Canadian International Development Agency
CPR	Contraceptive Prevalence Rate
DAC	Development Assistance Committee (OECD)
DHS	Demographic and Health Survey
EPI	Expanded Programme on Immunization
ESCAP	Economic and Social Commission for Asia and the Pacific (ECOSOC)
EU	European Union
FGM	Female Genital Mutilation
FPAB	Family Planning Association of Bangladesh
GHQ	Allied Forces General Headquarters
GII	Global Issues Initiative on Population and AIDS
GTZ	German Agency for Technical Cooperation
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
HPSP	Health and Population Sector Program
ICOMP	International Council on the Management of Population Programmes
ICPD	International Conference on Population and Development
IDA	International Development Association
IDE-JETRO	Institute of Developing Economies, Japan External Trade Organization
IDGs	International Development Goals
IDI	Okinawa Infectious Diseases Initiative

IDU	Injecting Drug Users
IEC	Information, Education and Communication
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IP	Integration Project
IPPF	International Planned Parenthood Federation
IUD	Intra-Uterus Contraceptive Device
IUSSP	International Union for the Scientific Study of Population
JFPA	Japan Family Planning Association
JICA	Japan International Cooperation Agency
JOCV	Japan Overseas Cooperation Volunteers
JOICFP	Japanese Organization for International Cooperation in Family Planning
JSDF	Japan Social Development Fund
LANA	Learning and Action Network on AIDS
LCG	local consulting group
LLDCs	Least among Less Developed Countries
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MOFA	Ministry of Foreign Affairs
MSM	Men who have sex with other men
NDHS	National Demographic and Health Survey
NGO	Non Governmental Organization
NIEs	Newly Industrializing Economies
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
OISCA	Organization for Industrial, Spiritual and Cultural Advancement
OPEC	Organization of Petroleum Exporting Countries
OTCA	Overseas Technical Cooperation Agency
PHC	Primary Health Care

PHRD	Population and Human Resources Development Fund
PRA	Participatory Rural Appraisal
PRSP	Poverty Reduction Strategy Paper
PRSTF	Poverty Reduction Strategy Trust Fund
PTC	Project-Type Technical Cooperation
QOL	Quality of Life
RH/R	Reproductive Health/Right(s)
SIAP	United Nations Statistical Institute for Asia and the Pacific
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAPs	Sector Wide Approaches
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TICAD	Tokyo International Conference on African Development
UN	United Nations
UNAIDS	The Joint United Nations Development Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WID	Women in Development

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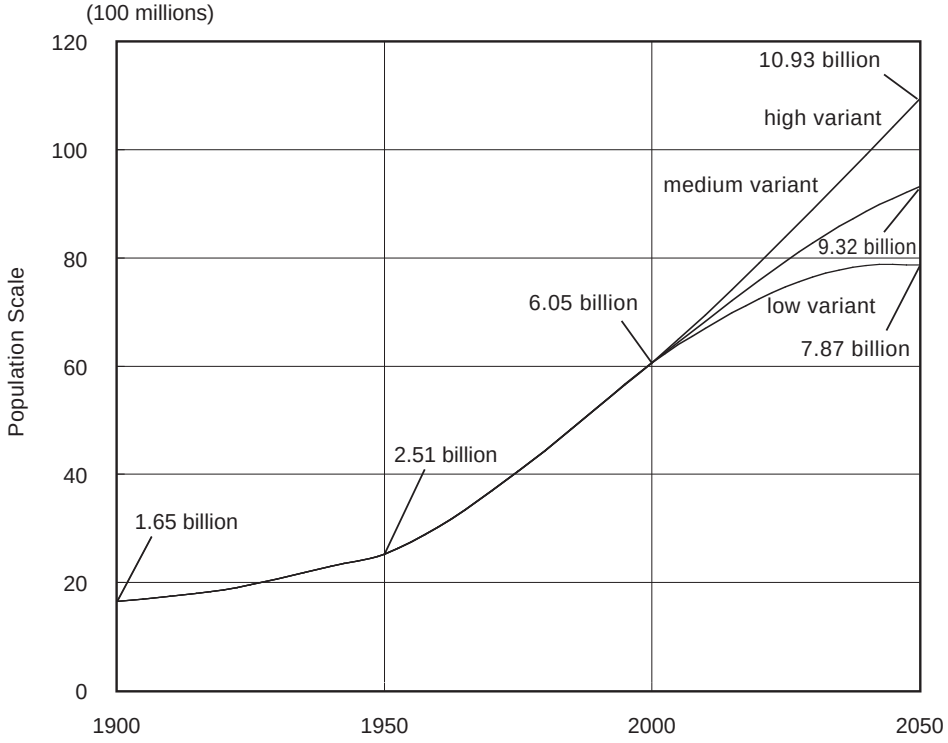
Chapter 1 Population Issues in the Twenty-First Century (Overview)

1-1 Global population trends: hotspots of population issues

1-1-1 Global population trends – the direction of the population explosion

Although the twentieth century may be characterized as having been a period of scientific and technological advancement and economic growth, in terms of population it will surely go down in the history of humankind as the century of an explosive increase in the population. With the beginning of the demographic transition in developed regions around the middle of the eighteenth century, population growth rates started to rise, and the world's population of 950 million in 1800 grew to 1.65 billion in 1900. In the first half of the 1900s, the average annual population growth rate for the world increased to about 1%, and in 1950 the population increased to 2.51 billion. In the latter half of the twentieth century the world's population continued to increase at a rate that was nothing short of "explosive." The average annual population growth rate for the world jumped to 1.79% in the period from 1950 to 1955, and continued to increase until it reached the unprecedented rate of 2.04% in the period from 1965 to 1970. World population growth rates started to decline after 1970 (due to a decline in the population growth rate in China, a country representing one-fifth the world's population), but the global population rose above 5 billion in 1987 to reach 6 billion by 1999 (see Figure 1-1).

Figure 1-1 Estimated and Projected Population of the World



Source: United Nations (2001a)

In the 1990s, world population growth rates declined unexpectedly (the 1995-2000 annual rate was 1.35%). UN world population projections in 1990 estimated that the world's population would reach 10 billion by 2050, but subsequent revisions to the 2050 world population estimates were made every two years, and in 1998 the figure was revised to 8.9 billion. However, growth rates in the World Population Prospects for 2000 were revised upward somewhat, to a world population of 9.3 billion by 2050. The results of the recent forecast are a kind of warning to those who are overly optimistic. Although world population growth rates are clearly on a declining trend, the population base used in those annual calculations is still growing. Therefore, it is thought that the scale of annual population growth reached an annual average of 79 million from 1995-2000, and will continue at the 70 million level until around 2025. The global population explosion is still continuing.

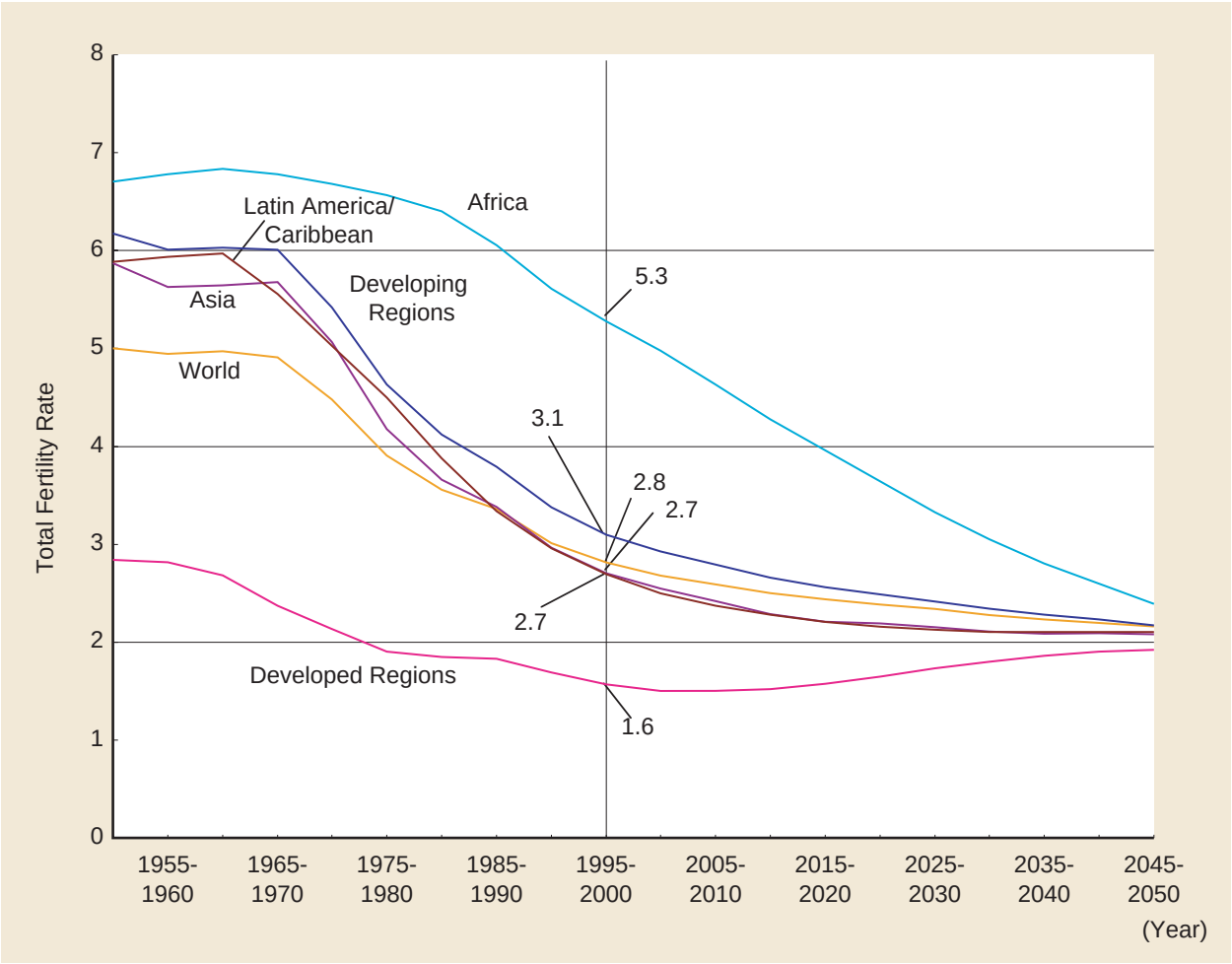
1-1-2 Population trends in developing countries : a focus on Sub-Saharan Africa and South and West Asia

The principal reason for the recent unexpected decline in world population growth rates is the rapid and overall decline in fertility rates in developing regions. However, the discrepancies in the fertility rates (in this document measured by the total fertility rate (TFR)) among developing regions are growing. Fertility rates in Asia and Latin America declined steadily after 1970 with both reaching 2.7 in 1995–2000 (see Figure 1-2). Both regions are viewed as being in the last stage of an overall fertility transition. Regional disparities within Asia, however, are large, as East Asia, including China have already completed their fertility transition (TFR=1.8), and Southeast Asia is nearing the last stages (TFR=2.8), in contrast to South and West Asia, which are still in the intermediate stage (TFR=3.6 and 3.9 respectively). Meanwhile, while Africa overall is in the early stage of its fertility transition (TFR=5.3), Middle, East, and West Africa still have high fertility rates, exceeding 6.0 (TFR in Sub-Saharan Africa is 5.8) in contrast to North and South Africa, which are already in the intermediate stage of their transition. The hotspots for world population from the perspective of high fertility rates and population growth are primarily Africa, particularly Sub-Saharan Africa, and secondarily South and West Asia.

Africa, in particular the Sub-Saharan region (47 countries), is still in the early stage of its fertility transition, and continuing high fertility rates make it a breeding ground for poverty. The Republic of South Africa is the most serious target area in terms of population problems, not only from a reproductive health perspective considering that the AIDS epidemic affects one in nine people in this country, but also from a development perspective considering the insufficiently productive labor force.

The transition process experienced by East and Southeast Asia has not yet occurred in South Asia, including India and Pakistan. In particular, India, which will overtake China by the year 2050 as the world's most populous country, will become a population hotspot, where further efforts should be made to eradicate poverty, raise educational levels, implement social and economic reform, and so forth.

Figure 1-2 Total Fertility Rate for the Major Regions of the World – Trends and Prospects



Source: United Nations (2001a)

1-2 The earth at 10 billion – population growth and sustainable development

1-2-1 Population increases, economic development, and sustainable development

The unprecedented rapid population growth after WWII in developing regions gave rise to academic and policy interest in the relationship between population growth and economic development. Orthodox economists argued that if population growth from high fertility rates continues, resources are consumed in supporting the increasing child population, and economic development is held back because of setbacks in savings and investment. An interest in the environment was added to this line of argument in the early 1970s. In 1972 the Club of Rome's The Limits to Growth report suggested that if population and economic growth continued at the levels of the 1960s, the world would face a catastrophe brought about by the depletion of resources and environmental degradation. The orthodox argument was seen as almost axiomatic. However, it was observed to be a fact during the 1960s and 1970s that population growth rates and economic growth rates did not necessarily have a negative correlation in developing regions, and a revisionist theory emerged. This theory emphasized the

positive aspects of population growth, such as the fact that population growth itself spurs technological advancement and raises the standard of living, and that human beings are the "ultimate resource." It argued that while population growth may be a minus in the short-term, it is a plus for economic development in the long-term.

Disagreement about the relationship between population growth and economic growth still remains among economists. In the Asian NIEs that achieved the fastest economic growth among developing regions as well as in several ASEAN countries, a decline in fertility rates resulted in capital deepening (an increase in the capital-labor ratio) bringing about increased savings and capital formation, and this in turn led to economic growth (OGAWA, see Box 1-1).

1-2-2 Population growth and the supply of renewable resources

The most basic resources needed to support human life are water and food. The question is whether there will be a sufficient supply of these two resources in our twenty-first century world, particularly in developing regions, in which explosive population growth and economic advancement continue.

(1) Population and water

The water supply situation was defined by Swedish hydrologist Malin Falkenmark as three different states: 1) adequate water, 2) water stress, and 3) water scarcity[1]. According to her definition, the world as a whole is now in an adequate water state and will still be in 50 years. However, looking at the situation by region, North Africa and major portions of West Africa are in a water scarcity state, South and Central Asia are already in a water stress state, and future population growth, urbanization, food production increases along with advances in industrialization will result in a worsening of the water scarcity state. It is possible that such a water scarcity state could restrict economic development. The world's most populous countries, India and China, are currently in an adequate water state, but it is thought that before long India will be in a state of water stress, and China will approach the water stress state in 50 years. In these countries, efficiency in the utilization of water must be improved through measures such as the construction of dams and canals, changes to ensure that agriculture and industry are more water efficient, and policy efforts to prevent the contamination of water, which reduces its quality.

(2) Population and food

Since the world population began increasing rapidly, many have started to be concerned about the

[1] A country with 1,700 tons (m^3) or more renewable fresh water available on an annual per capita basis has *sufficient water*, those with as much as 1,000 tons or more but less than 1,700 tons are in a state of *water stress*, and those with less than 1,000 tons are in a state of *water scarcity*.

question: “Just how many people can the earth support?” We have seen a variety of forecasts concerning population and food. Taking the world as a whole, if the current acreage used for cultivating grain (approx. 700 million hectares) yielded the equivalent amount per unit area as in Western Europe, it would be possible to support a population of 10 billion with yields that exceed the current per capita grain supply. Therefore, at least in theory, it is possible to provide for a world population that may reach 10 billion in the latter half of the twenty-first century. The problem with food is the same as water – a regional one. Per capita food production growth rates in Sub-Saharan Africa and South Asia are sluggish, and, at present, 30% of the population in Sub-Saharan Africa and over 20% of that in South Asia are suffering from malnutrition. Most countries in these regions are dealing with a great number of factors that restrict food production, problems such as difficulty increasing the cultivable land area, diminishing family farm area resulting from population growth, shrinking of the area of farmland due to soil depletion, the aforementioned water scarcity, water contamination and ineffective irrigation methods, and wastage in the storage and shipping of food. These countries are in need of measures to increase food production such as: land reform under a stable government, overseas assistance, effective management of water and farm/crop lands, and improvements in irrigation methods and in crop quality.

(3) Population and the environment

The world is experiencing a range of environmental problems such as acid rain, tropical forest destruction, decreasing biodiversity, desertification, contamination of the oceans, and destruction of the ozone layer, but the biggest problem from the standpoint of its ever-widening effects and intractability is global warming. While all of the effects of global warming are certainly not yet understood, it is at least considered that there is a connection to the warming of the seas and the melting of glaciers, which is causing sea levels to rise (0.88m in 100 years), resulting in the submersion of towns and villages in island nations and in coastal areas, a decline in agricultural and fishing yields from temperate climates to tropical climates, the frequent occurrence of unusual weather (severe storms, floods, droughts, and heat waves), the spread of infectious diseases, adverse impacts on tropical rainforests, desertification, and decreasing biodiversity. Since there is a close relationship between global warming and consumption of the energy that supports the overall economic activity of modern society, it will take a considerable amount of time until truly effective measures are taken internationally.

(4) Can we avoid catastrophe for humankind?

Taking into consideration food and water alone, it may be possible to support the nearly 10 billion people projected to be living in this world at the end of the twenty-first century. However, as seen in the Limits to Growth model, if the proper measures to combat global environmental degradation, in

particular to combat global warming, are not taken, the results could be catastrophic for humankind and modern civilization. To avoid such a scenario, it is necessary to develop, and apply on a wide scale, energy-saving technologies, to develop and utilize effective alternative energy sources in place of fossil fuels, and create and implement immediately an international agreement on the reduction of greenhouse gases with every country on board. Developing countries need to be cognizant of the fact that striving for quick completion of the demographic transition and the resulting population stabilization will not only facilitate economic development in their own country, secure for them a stable water and food supply, and promote social development, but will also contribute to solving global environmental problems in the long run.

1-3 Paradigm shift to the human rights approach: the Cairo Conference's Program of Action

1-3-1 From the Bucharest conference to the Mexico conference

The first intergovernmental conference on population, the World Population Conference, was held in Bucharest, Romania in 1974. A conflict ensued between western developed countries headed by the United States and the many developing and socialist countries. The Western countries called for government-led restrictions on population growth through family planning programs based on the idea that the population explosion in developing countries was holding back their economic development, while developing and socialist countries insisted that development itself was the best contraceptive and that what was important was not population control but economic development. The World Population Plan of Action was adopted as a result of compromises on both sides, and, although it incorporated the assertion of those who gave priority to development, the substance of the plan turned out to be one recommending more population control measures on the part of governments.

Ten years later, the International Conference on Population held in Mexico City (1984) adopted a recommendation for the further implementation of the World Population Plan of Action. The report included many recommendations concerning family planning programs, making it the first intergovernmental meeting in which family planning was internationally recognized.

The population policy strategies discussed at these two conferences assumed that rapid population growth generates constraints on resources and hampers economic growth, and therefore, in order to promote economic growth, it is necessary to restrict population growth and that government-led large-scale family planning programs are an effective means of achieving this purpose.

1-3-2 Significance of the Cairo Conference's Program of Action – shift in population strategies

The 1994 Cairo Conference adopted a new 20-year Program of Action to replace the World Population Plan of Action. The IPCD Program of Action set itself apart from previous population

strategies by including 1) the use of the new concept of "reproductive health/rights (RH/R)," 2) emphasis on the importance of gender equality and women's empowerment, and 3) the incorporation of numerical and fund-raising targets, and is referred to as a paradigm shift to population policies that are based on a human rights approach.

The concept of reproductive rights was generated as part of the WHO Special Program that has continued since 1972 in an effort to gain a comprehensive understanding of health needs as they relate to the human reproductive process. Some of the aspects of the issue that come under the category of reproductive health are: (1) fertility regulation, (2) sterility, (3) sexual health, (4) safe motherhood, and (5) infant survival, growth, and development. More specifically, it includes family planning (contraception), the efficacy and safety of birth control methods, the development of new birth control methods, unwanted pregnancy, general abortion issues, problems arising from illegal abortion, measures for secondary sterility, treatment for sterility, female genital mutilation (FGM), sexually transmitted diseases (STDs), in particular HIV/AIDS, maternal death, and maternal and child health.

Reproductive rights is a concept whose inception arose in the feminist movement of the 1970s, without any linkage to the fields of medicine or health, and it expanded internationally through the 1985 UN International Women's Conference. The basis of this concept is that women have the right to decide whether or not to have children, and if so, when and how many to have. It means that women must be provided with the necessary information, education, and high quality service concerning the means with which to exercise such rights. It also asserts that male-female sexual relations should be based on the principles of equality, mutual respect, and responsibility, and includes a woman's right not to be forced into having sex.

As reproductive health/rights (RH/R) is now a central concept in the Cairo Program of Action, population policy has undergone a major shift, from a macro level (country level) to a micro level (individual level) viewpoint, and the subject of population policy itself has changed from governments to the individual, in particular to women. Specifically, family planning is not a means of achieving government population growth control objectives, but is rather a means by which people (especially women) can make decisions about pregnancy and childbirth. Family planning had previously been equated with birth control for married couples, but has now taken a broader view including issues concerning young unmarried people (adolescents) such as sex, pregnancy, childbirth, and birth control. It now emphasizes a tolerant stance toward abortion, including the recommendation that abortion be treated as a women's health issue. In addition to the fulfillment of reproductive rights, the Cairo Program of Action cited the principle that "advancing gender equality is the cornerstone of the solution to population issues" and at the same time set the achievement of gender equality and equity, as well as the empowerment of women, as important objectives of the Program of Action. Achievement of this type of gender equality, respect for women's reproductive rights, and achievement of reproductive health are all interdependent.

1-3-3 Assessment of the Cairo Program of Action

A variety of assessments have been made since the Cairo Conference concerning the paradigm shift towards the human rights approach to international population strategy in the Program of Action (Yanagishita, see Box 1-3). However, there is no doubt that adoption of the concept of reproductive health/rights (RH/R) as the central theme of the Program of Action rectified many aspects of government-led family planning programs that had previously gone beyond what is appropriate (such as the implementation of programs that prioritized program objectives over women's needs and ones that emphasized the number of recipients of family planning while ignoring the quality of service).

It is obvious, however, that it is desirable for many developing countries to increase the prevalence of family planning, accelerate the fertility transition (and demographic transition), and stabilize the population as fast as possible in relation to the development of their economies, poverty reduction, the promotion of education, and conservation of the environment and natural resources. While the Cairo Program of Action does not ignore these points, it is undeniable that overall the message in these areas has been watered down compared to previous documents.

1-3-4 Reproductive health/rights: trends and challenges

This section provides an overview of the conditions and challenges in developing countries, looking at the main elements of reproductive health/rights: family planning, and other elements.

(1) Expanding family planning and its challenges

First of all, in looking at the current state of family planning, it became clear from the results of the Demographic and Health Survey (DHS) conducted from the late 1980s that there is still a high level of unmet needs, as defined by the percentage of women who do not desire pregnancy but are who not using contraception despite the rapid increase in its use in developing regions in recent years. The central focus of family planning programs in developing countries today is the measurement of unmet needs and the provision of services to fulfill those needs. There has been criticism regarding the unmet needs approach saying that too much attention has been paid to increasing contraceptive prevalence while the viewpoints of the users (particularly women) has been ignored. Recommendations on this issue have been made recently in which cases of side effects and ineffective contraceptive methods used by men or women would be included in the definition of unmet needs. Some people have pointed out that for an increase in contraceptive prevalence, the most important aspect is not easy access to family planning services (supply side), but rather a reduction in the desired number of children (demand side). However, the implementation of family planning programs does increase people's knowledge about birth control, which more people perceive plays a critical role in the demographic transition.

(2) Other important elements

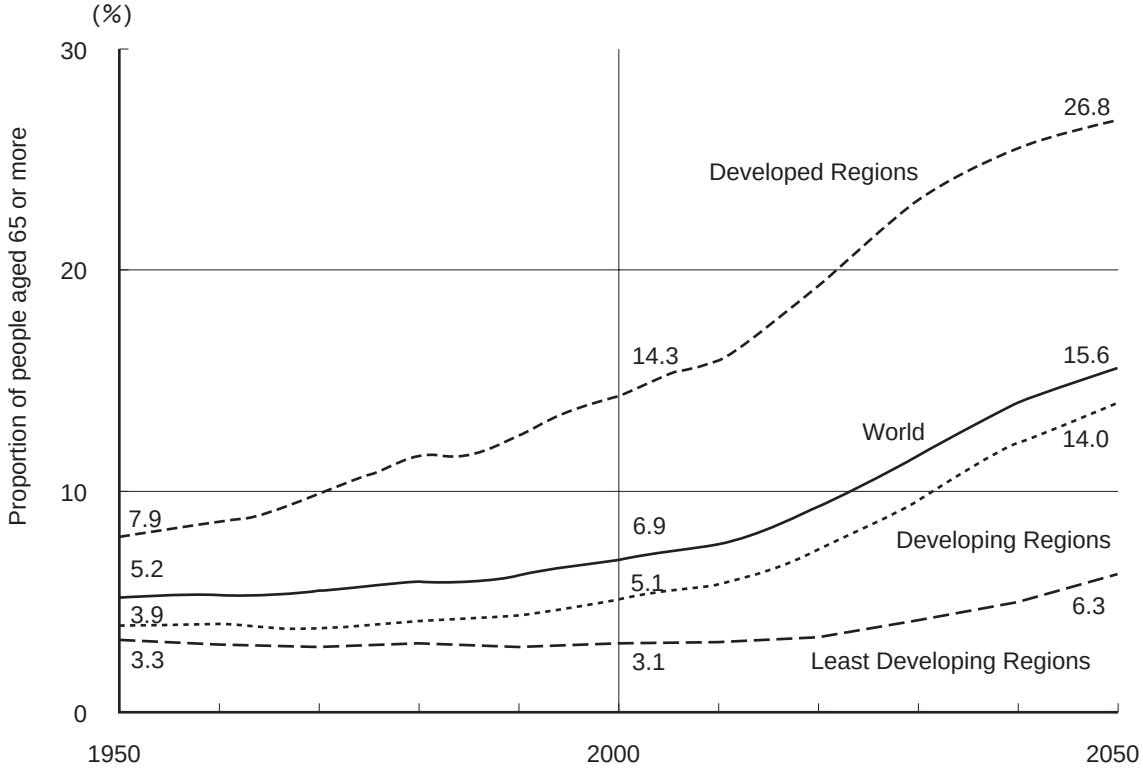
In looking at elements other than family planning (maternal health, abortion, reproductive health for adolescents, sexually transmitted diseases (STDs), gender discrimination, and sexual violence), there is an urgent need to improve maternal health from the standpoint that of the nearly 600,000 maternal deaths every year throughout the world, most occurring in developing countries. Abortion is also a serious problem and it is estimated that 90% of the annual 20 million unsafe abortions are performed in developing countries. Furthermore, meeting the reproductive health needs of adolescents, and at the same time raising the mother's age at first pregnancy and birth, will bring about a decline in fertility in developing regions that have high fertility rates. Each year, there are approximately 300 million cases of treatable STDs (gonorrhea, syphilis, and chlamydia) in the world, with the great majority occurring in developing countries. Sexually transmitted disease rates are five times higher for women than for men, with STDs being the cause of two-thirds of the cases of sterility, which is also a major issue. Finally, with respect to gender discrimination and sexual violence, female genital mutilation (FGM) has recently become the focus of attention as a form of sexual violence and a blatantly damaging traditional custom. Even now, two million are at risk of suffering from FGM every year. Recently there has been an increasing trend among women's movements to demand its abolition, and the elimination of FGM was also specifically included in the Cairo Conference Program of Action.

1-4 Global aging

1-4-1 Aging in the developed and developing world

The level of aging of the world's population (the proportion of the population that is 65 years old or over) was only 5.2% in the middle of the twentieth century and remained at the same level thereafter. However, the proportion started to increase around the mid-1980s and rose to 6.9% in 2000 (see Figure 1-3). According to UN projections, the aging of the world's population will accelerate as we enter the twenty-first century and the proportion of the aged population will increase to 16.4% by the middle of the century, just surpassing today's average aging levels in the developed regions. The proportion of the aged population in the developed world has risen from 7.9% in 1950 to 14.3% in 2000, and will continue to increase markedly, so that by the middle of the twenty-first century, it will surpass 25%. The proportion of the aged population in the developing world slowly grew from 3.9% in 1950 to 5.1% in 2000, and population aging is now finally starting to occur in developing countries. However, aging in such countries has continued to increase in the twenty-first century, and it is estimated to reach 14% by the year 2050, a level much like that of the current developed regions.

Figure 1-3 Population Aging of the Developed and Developing Regions of the World



Source: United Nations (2001a)

Looking more closely at the global aging situation, it is clear that there are major differences in the level of aging in the three regions of the developed world: Europe, North America, and Oceania. The proportion of people aged 65 or over in Europe is the highest, with a current level of 14.7% and an expected increase to 29.2% in the next 50 years. In contrast, the proportion in Oceania is currently 9.9%, with an increase that will slow to 18.0% in 2050. North America stands somewhere in between. Meanwhile, Asia and Latin America exhibit aging trends that will slightly exceed the average in developing regions and that are expected to come close to the levels in Oceania by 2050. However, the proportion of the aged population in Africa will continue at the 3% level until 2020 and finally reach 6.9% in 2050.

1-4-2 Aging issues in the developing world

The main societal issue brought on by the graying of the population is how the increasing number of elderly will be supported, an issue faced by both developed and developing countries.

(1) Rate of aging

As a result of the fact that it took European countries at least 50 years to complete their fertility transition, the rate at which aging progressed in those countries was also gradual. Due to the fact that

Japan achieved its fertility transition mainly over a period of less than ten years following WWII, Japan inevitably faces having the highest rate of aging among all the developed countries. Similarly, in addition to Japan, the speed of the recent demographic transition in other East and Southeast Asian countries (Korea, Hong Kong, Taiwan, China, Singapore, and Thailand) has been much faster than that of the European countries, and for this reason they are also expected to experience an aging process that will occur at a much faster rate than the European countries. There is a good possibility that many developing countries that have yet to complete their fertility transition will in the end experience aging at a much faster rate than that of the European countries.

It goes without saying that the more gradual the rate of aging, the more time that can be devoted to preparing to deal with it (creating social systems to support and care for the elderly), while the faster the aging process, the more difficult it is to cope with it.

(2) Economic development and the increasing graying of the population

Many developing countries will experience a 20–30 year period in which there is a relatively high proportion of young workers and a relatively light burden on them to support children and the elderly following a rapid fertility transition. This demographic condition is referred to as the "demographic bonus" and is a result of the fertility transition. If countries utilize this window of opportunity to further their economic development, just as Japan did during its high economic growth period, they will be able to adopt aging policies under an adequately developed economy. However, if they fail to do so, they will have to deal with the dual policy challenge of ensuring economic development and meeting the needs of an aging population.

(3) The effectiveness and limitations of extended families

The traditional family system of non-Western countries, including Japan, is the extended family. It is a common practice for elderly in these countries to spend their senior years living with and being dependent on their son's or daughter's family. However, as economic development continues to progress, young people are moving from the villages to the cities, the parental generation remaining in the villages forms a nuclear family household, and the children, now in the cities, form their own nuclear family household. When the parent's generation grows old, the family alone is no longer able to function sufficiently in the support and care of the elderly. In Japan as well, until the 1970s it was said that "the family is a latent asset in the country's welfare budget," and the family was expected to take responsibility for the support and care of the elderly. However, in the 1980s it became clearer that support and care of the elderly could not be sufficiently provided for by the family alone, and this grew into a strong call for the development and strengthening of a public system for the support and care of the elderly. It will also become necessary in developing countries to develop public systems for the support and care of the elderly – social welfare systems –concurrent with advancement of

economic development, urbanization, and aging.

1-5 HIV/AIDS

1-5-1 Population and HIV/AIDS

HIV/AIDS is a major concern, not just from the perspective of reproductive health in valuing individual health and human rights, but also from a development standpoint in terms of its role in diminishing the labor force. This is a result of the fact that most people living with AIDS are in their reproductive years (15–49 years of age), and since most of the infected die after the onset of AIDS following a long incubation period, the decrease in the reproductive population greatly distorts the demographic pyramid. It is predicted that countries in which one-third to one-quarter of the population of productive age (15–64 years of age) is HIV positive will see dramatic reductions in this age group in the near future. Such a dramatic reduction in the population of productive age will have a significant impact on society by taking a toll not only on the country's economy, but also on household finances.

Meanwhile, the illness or death of the family's main wage earners will mean that children and the elderly will have to provide care and livelihood support for the AIDS victims. Consequently, the number of children who miss out on opportunities for education and the numbers of children and the elderly who engage in dangerous work for low wages will increase. When parents die of AIDS, children are left behind as AIDS orphans, and the effects on society, such as increased child labor and street children, are severe. There are already an estimated 14 million AIDS orphans worldwide.

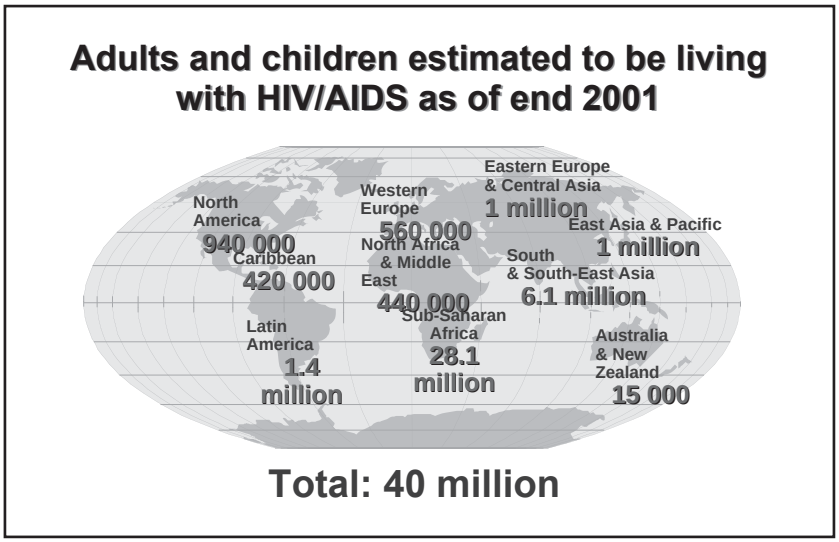
1-5-2 World HIV/AIDS epidemic

According to 2001 year-end estimates, there were thought to be 40 million HIV cases worldwide (Figure 1-4). That year, estimates showed that 5 million people became newly infected worldwide, and the cumulative death toll to have been 30 million. Also, some 95% of all HIV cases are concentrated in developing countries.

The most serious situation is in Sub-Saharan Africa where more than 70% of the HIV victims in the world live. For 12 countries in this region, more than one in ten adults aged 15 to 49 was HIV positive at the end of 2001, and in some of these countries one in three or one in four adults is living with the disease. In these Sub-Saharan African countries, it is a generalized epidemic[2] in which most of the infections are through heterosexual activity. As a result, these countries are characterized by the fact that there are more infected women than men, and there is a sharply increasing number of babies

[2] Country-specific HIV/AIDS estimates compiled by teams led by the Joint United Nations Programme on HIV/AIDS (UNAIDS) classify the HIV epidemic into two different types: concentrated epidemics and generalized epidemics. A concentrated epidemic is one in which an HIV prevalence of 5% or more is observed within high risk behavior groups such as injecting drug users (IDU) and men who have sex with other men (MSM), but a less than 1% HIV prevalence in the general population. The generalized epidemic stage is one in which an HIV prevalence of 1% or more is observed in the general population and prevalence in high risk behavior groups is already high.

Figure 1-4 2001 Year-end HIV/AIDS Totals



Source: UNAIDS (2001)

who die of AIDS due to mother-to-child transmission as well as AIDS orphans whose parents have died of AIDS. In many countries in this region, it is thought that the peak period of mother-to-child transmission has already passed, but even now mother-to-child transmission levels remain high. Countries in this region are experiencing dramatic changes in terms of deaths, the crude death rate, and average life expectancy.

There is still a strongly-rooted prejudice against HIV/AIDS among some people. If countries and communities do not overcome discrimination and difficulty and work together to direct their efforts into the prevention of HIV and the care of those who are infected, the number of infected people will continue to increase and the future may be very bleak. AIDS is a major issue on which developing and developed countries must work together to find a solution.

1-6 International migration and increasing urbanization

1-6-1 International migration

Estimates[3] of the UN Population Division indicate that the total foreign-born population worldwide has increased markedly since 1965. That number grew rapidly from a worldwide figure of 75 million in 1965, to 84 million in 1975, and 105 million in 1985, and reached 120 million in 1990. It is estimated that at the beginning of this century approximately 150 million people will be living in countries other than their country of birth.

International migration is actively occurring throughout the world. The main regions of the world that are experiencing a population influx are concentrated in the developed regions such as Europe,

[3] International migration is an area in which the development of statistics is lagging far behind and is therefore difficult to accurately assess. However, the foreign-born population (stock) of a country has been used as an indicator with which to understand the scale of migration.

North America and Oceania, and out-migration is occurring in developing regions such as Asia, Africa, and South America.

If the various reasons for and types of international migration are analyzed, it is found that there are those who migrate of their own free will, such as permanent settlers (permanent or semi-permanent), migrant workers, and illegal migrants. At the same time, there are refugees who had to move, but for whom the destination is not clear. The term "refugee" applies to people who are outside their country of nationality due to the fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinions.

International migration is an inevitable consequence of globalization. The question for a country of how many and what kinds of people to allow in involves a complicated entanglement of national sovereignty and individual rights, and does not have an easy answer. It is first necessary to clearly assess the actual international migration situation and then discuss the possible impacts and issues that may arise on the part of the sending and receiving countries. As aging progresses and fertility rates decline in Europe, countries will be faced with a need to accept a certain number of immigrants in order to maintain economic activities. In the near future, Japan will also be faced with this kind of situation. Under such circumstances, mutual cooperation between Japan and its neighboring developing countries may be needed for Japan's acceptance of foreign workers to care for the elderly.

1-6-2 Urbanization

(1) Increasing urbanization

The world's population more than doubled from 2.5 billion in 1950 to 6.1 billion in 2000 (with an average annual growth rate of 1.8%). During the same period, the population of cities nearly quadrupled from 750 million to 2.7 billion (with an average annual growth rate of 2.6%). Consequently, the rate of urbanization (the ratio of the population living in cities to the total population) rose from 30% in 1950 to 44% in 2000. Nearly half of the world's population currently live in cities.

According to recent UN population projections, global urbanization will progress even more in the period from 2000 to 2030. During this period, annual growth rates for the world's population are estimated to be 1.0%, but the population living in cities will grow at a rate of more than double this. During the period from 2000 to 2030, the urban population of developing countries is estimated to grow at a rate of 2.4% annually. Conversely, the rural population of developed countries will dwindle at an average annual rate of 1.1%. As a result, the rate of urbanization worldwide that was 30% in 1950 will double to 60% in 2030.

However, when considering the problems accompanying the future urbanization of developing countries, it is important to take into account not only the average annual growth rates of the urban population, but also the increase in the absolute population. During the period of 1950 to 1975, when

the urban population growth rates of developing countries peaked at 4%, the population increased by 500 million people. Even though the growth rate of this population during the 30 years period from 2000 to 2030 may drop to 2.4%, the population will still grow by 2 billion people. It is estimated that during this period of time the world's population will grow by 2.2 billion people. That fact is that most of this population growth will be in urban areas of developing countries.

(2) Challenges of and measures for dealing with urbanization

The principal factor in the urbanization of developing countries is not necessarily the influx of population from rural to urban areas as is generally thought, but is the natural growth in cities themselves with the exception of Asia in the 1980s. This trend is particularly strong in countries with low rates of economic development. For this reason, policies are required that have an impact on natural population growth in cities.

In addition, the primary social problem accompanying urbanization that occurs with economic growth is an increase in the poorest segment of the population in cities. It is safe to say that in the near future many people living in poverty will be concentrated in cities. The future increases in those living with HIV in cities is another matter of concern. In major cities in developing countries, the long-standing situation in which mortality rates are lower in cities than rural areas is starting to reverse.

Policies that have attempted to restrict urbanization up to this point have failed across the board, and countries are now becoming more and more aware of the importance of the role played by major cities in their economy, society, and culture. As a result, urbanization policies are starting to become more comprehensive policies that target urban issues. In other words, the direction is to start creating more desirable policies, such as ones that will assist newcomers to cities in adjusting to them.

Box 1-1 Japan's population trends and economic development

Naohiro Ogawa, Nihon University

The demographic transition theory is one of the lessons we have learned historically from the experiences of developed countries. It is a theory in which economic development brings about a shift from high to low birth and death rates. This view based on the demographic transition theory regarding Japan's post-war economic development has been common among Japanese economists. However, what I would like to emphasize is the fact that it is the decline in birth rates that induced economic growth, not the other way around. In other words, as a result of Japan's birth rate being halved in the 10 years from 1947 to 1957, families had more economic resources available for household savings, which in turn served to revive Japan's devastated economy through public investment. Then, at the beginning of the 1960s the baby boom generation entered the workforce in large numbers, contributing to the miraculous economic growth performance.

The economic gain induced by such a fertility reduction is referred to as a "demographic bonus." A demographic bonus is created from a combination of two factors: 1) a process in which a fast fertility decline results in reduced household consumption, consequently leading to increased family savings and public investment, and 2) despite the decline in fertility, the productive population continues to increase for some time. For developing countries, the utilization of this "demographic bonus" is an extremely important factor in placing them on a sustained economic growth path.

The regions in East and Southeast Asia that effectively utilized their demographic bonuses experienced rapid economic growth in the latter half of the twentieth century. Salient examples of successful cases in these regions include Japan, South Korea, Singapore, Thailand, Taiwan, and Indonesia. They did so through a process that involved a complex web of factors such as health, human capital investment, advancement of women in the workforce and society, equalization of income distribution, and family planning programs. In particular, in recent research by demographic economists, equalization of income distribution in Asia – which is equalized to a much greater extent than other developing regions – is being treated as a major factor for facilitating economic growth as it promotes the dissemination of compulsory education and primary health and brings about the augmentation of human capital.

Currently, Indonesia is approaching the phase in which it can enjoy the demographic bonus, Thailand and Taiwan are nearing the peak of theirs, and Japan is at the end of its window of opportunity. For those countries entering the demographic bonus phase, it is essential that they approach it knowing that the window of opportunity is relatively short, and they should endeavor to effectively turn the fruits of that bonus toward economic development.

Box 1-2 Reproductive health/rights (RH/R) and population

Machiko Yanagishita, Josai International University

Reproductive health/rights (RH/R) is an important concept for women's health and human rights that started appearing in places like UN documents from the 1960s. Reproductive health is not simply limited to maternal health, but is about health in sexuality and parenting throughout one's lifetime, and includes adolescent health, the prevention and care of STD's including HIV/AIDS, measures against unsafe abortions, and menopause. Reproductive rights are about the basic right of a woman to decide freely and responsibly how many children to have and when to have them, and the right of access to knowledge and services about safe and effective contraceptive methods that meet a woman's individual needs. It goes on, however, to include the elimination of discriminatory social practices and violence that are detrimental to women's reproductive and sexual health.

One of the reasons that this concept began to emerge in the population development field was the international movement for women's rights. Reproductive rights have become defined through the Declaration on the Elimination of Discrimination against Women (1969), the UN Decade for Women (1975-1985) that was aimed at the advancement of women, and the women's health movement as part of the feminism of the 1970s, and then the increased awareness of violence and traditional customs as human rights violations in the early 1990s. The enjoyment of reproductive health (including sexual health) was adopted as a new part of reproductive rights at the Cairo Conference in 1994.

Another part of the process of change has been the shift in the development field from economic development to human development. The economic development theory that poverty would disappear as a result of economic growth has failed, and there is now a call to value social development and citizen participation. It has been documented that investment in the general population, in particular in health, education and gender equity and equality is the key to achieving the stabilization of population growth and sustainable development. There is an increasing awareness that in addressing population issues in developing countries, what is needed is not population control from a macro-level standpoint, but a gender perspective that considers the low status of women in developing countries and recognizes that it is essential to support women's autonomy and empowerment.

Under these movements, there has been increased awareness of the importance of reproductive health/rights (RH/R) in addressing population issues, but there has been much debate following the Cairo Conference about the shift in approach toward population development assistance. There are a range of criticisms of the significance of reproductive health/rights (RH/R) and women's empowerment approaches such as: will this micro-level level approach really be a timely solution to the imminent population issues that exist on a global scale; is macro-level population control not necessary after all; are Western feminist groups having too much influence on international population policies; since women's underlying issues of health and rights are a part of the problem of poverty so should we not first solve this problem; will this not dilute the program efforts thus far to increase contraceptive prevalence rates by diverting a the limited amount of funds from financially-strapped donor countries to a broad range of reproductive health services; and will the new approach be difficult not only from a practical methodology standpoint, but also from the standpoint of program evaluation? While the reproductive health/rights approach is drawing plenty of debate, the perspective itself represents a historically necessary direction that has brought the needs, rights, and health of women, to the center of population development issues.

Box 1-3 Population, family, and economy in the Middle East

Junko Fujita, Sagami Women's University

It is a fact that we are undoubtedly facing the risk of a population explosion. While it is absolutely imperative for us to develop population policies to avoid such an explosion, measures to attain this purpose should not be standardized as they have been in the past. The Islamic world is centered on the "umma" (community) system, and national systems have a back-seat existence at best. This is intrinsically different from the Western society, in which the country is the cornerstone of a society, and communities are secondary.

An area that shows this difference clearly is the traditional economy. Trade is conducted through negotiation in the traditional markets of the Islamic world, and is not based on the one price law like the fixed price economy of capitalistic markets. That is because the economy strongly favors variety over uniformity. Also, with respect to "people," "commodities," and "money" which are the mediums of economic activity, the individuality of people is always superior in Islamic systems and is never threatened by commodities or money that can be converted equivalently as in the case of capitalism.

For Muslims, individuals and families are the foundation of social life, and natural needs are never disregarded because of other criteria or standards. In other words, differences in individuals, and the family life based on them, are the foundation of their lives, and any discussion of population policy that does not take this fundamental fact into consideration will not be accepted systemically into the Islamic Middle East.

In solving population issues, we must respect the basis of people's perceptions rather than trying to introduce new ways of thinking from the outside or the product of other societies' livelihoods. In the Islamic world, where the differences between people and commodities are valued, the theory that restricting the number of children born is necessary in order to solve the world's poverty and social hardships will be hard for people to accept. One of the region's main characteristics is that people have a stronger tendency to marginalize national directives, and will instead make judgments and decisions based on individual and family concerns. The basic unit in Islamic society is the family, and it is important to view the culture with the awareness that an individual remains a part of the family unit from birth until death.

Even in the Islamic Middle East, however, various countries have begun to implement their own strategies to adapt to the world around them. For example, criminal law in Egypt prohibits abortion, and the women who break the law, as well as those who assist them, will be punished. However, there is a provision allowing abortions when the woman's health is at risk. In Tunisia and Turkey, however, early abortions are unconditionally permitted just at the request of the pregnant woman. Abortion for women who have had five or more children became allowed in Tunisia in 1965, and provisions were made to allow unconditional abortions within the first three months of pregnancy in 1973. Turkey approved abortion within the first 10 weeks of pregnancy in 1983. These examples show clearly that there are technically major differences. Each of these countries are practicing Islam based on their own social, political, historical and religious traditions, and in light of these differences, we must come to a deeper understanding of the special circumstances of the region. In order to do so, it is essential that we understand the nature and function of Islamic law, as well as gain a comprehensive understanding of the main themes of the special characteristics of the cultural and social traditions that have been built up based on it.

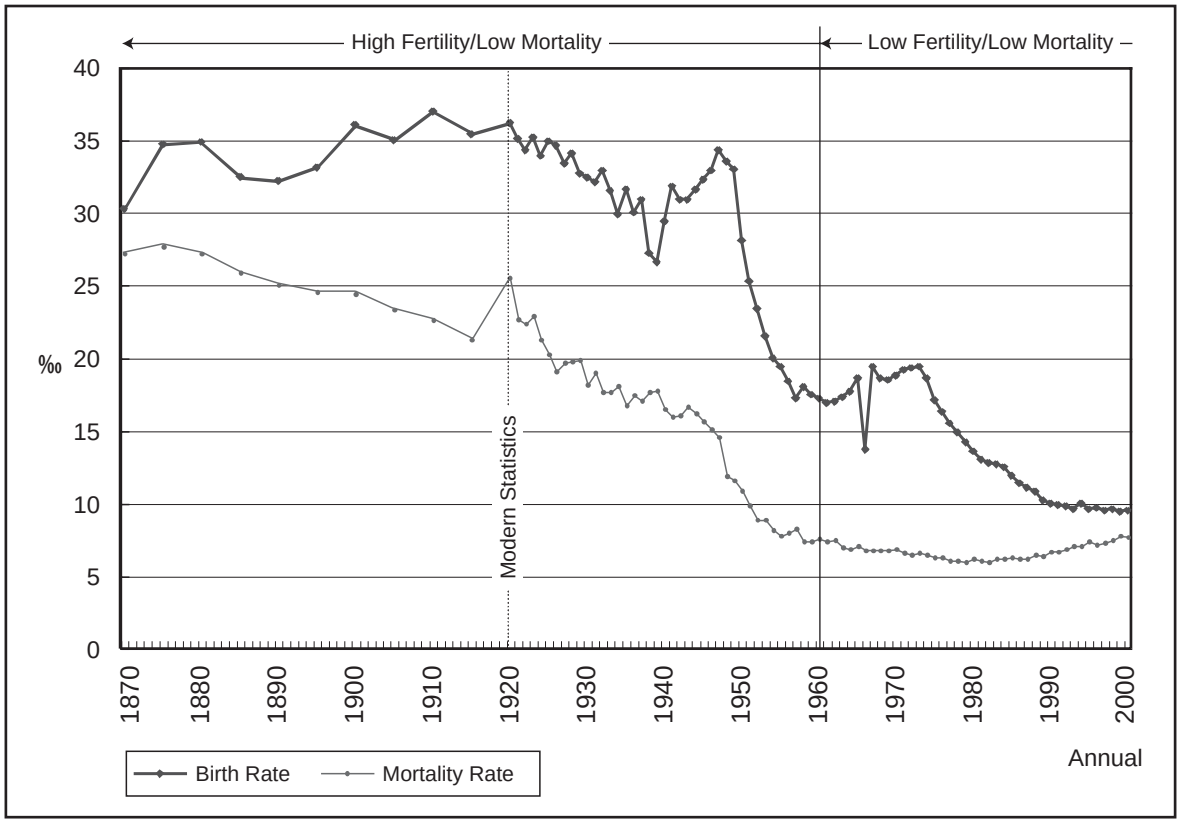
Chapter 2 Japan's Demographic Experience

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 18th and 19th 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

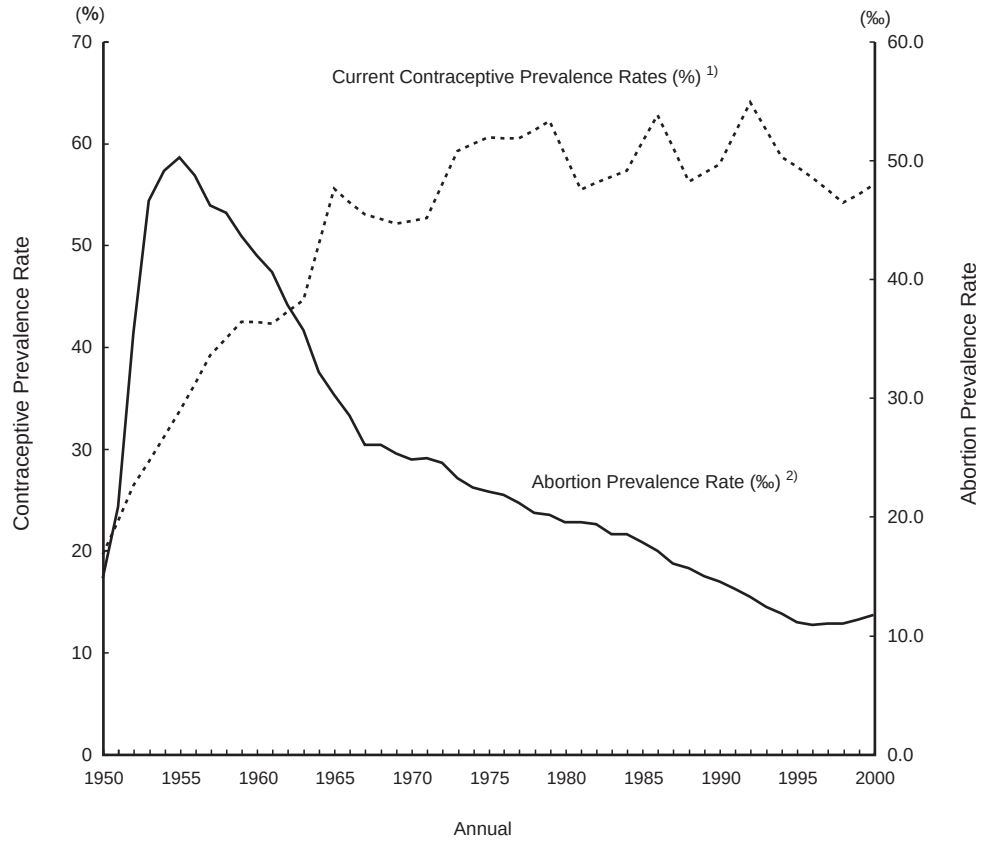
During the three years after WWII from 1947 to 1949, a baby boom occurred in which the annual number of births exceeded 2.7 million. It peaked in 1949, however, and the fertility rate declined suddenly, and was called a "baby bust." This is the period in which Japan is said to have achieved its "demographic 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 Aiiku-kai, established under the Imperial Fund, set up "Aiiku-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.

Chapter 3 Trends in International Population and Development and Japan's Cooperation

3-1 Review of international and Japan's development assistance trends in the field of population and development

3-1-1 Prior to the 1980s

The United Nations was established in 1945 at the end of WWII, and the United Nations Population Commission was established the following year, in 1946. The United Nations Population Commission gathered demographic statistics from countries and exchanged views on population issues. Japan joined the UN in 1956 and two years prior to that, in 1954, began its technical cooperation through ODA. However, until around 1960, there was no climate for open discussion about population policy in the international community.

In contrast, the family planning movement was becoming very active in the private sector from the perspective of protecting individual rights, especially those of women. In 1952, the IPPF was formed in Bombay as a pioneer among international NGOs for family planning through a global network. IPPF has been the driving force of the family planning movement in developing countries to the present. In line with this movement, the Family Planning Federation of Japan got its start in 1954, and it has been active as the core part of Japan's family planning movement up to the present day.

In the same year (1954), the first World Population Conference, a meeting of experts, was held in Rome and was hosted by the UN with cooperation from the International Union for the Scientific Study of Population (IUSSP).

The period from the 1960s to the 1970s was called the United Nations Development Decade, and witnessed a worldwide push for development. Meanwhile, in 1960, the world's population reached 3 billion, and in the latter half of the 1960s the population growth rate in developing countries hit an unprecedented high of 2.4%.

It was under these circumstances that another conference of experts, the World Population Conference, was held in Belgrade in 1965. It was around this time that the international community began to debate population policy, and with the successes that had been made in family planning in countries such as Taiwan and Korea, the discussion opened up from the theory of demographic transition that accompanies socioeconomic development to a discussion about the possibility of lowering birth rates through policy. In 1967, the United Nations Trust Fund for Population was established (later reorganized as UNFPA in 1969).

In 1972, the Club of Rome's report called The Limits to Growth was published, shocking the world with the prediction that continued population growth would deplete resources, destroy the environment, and result in food shortages, leading humankind into catastrophe. In 1974, the World Population Conference was held in Bucharest, and a conflict ensued between the western industrialized

nations and developing nations. While the industrialized nations called for restrictions on population growth, the developing nations asserted that development was more important than population control. Based on this debate, the World Population Plan of Action, adopted at the conference, recommended the furtherance of government-led population control policies.

Japan's ODA continued on the track of expansion in the 1970s, backed by the country's trade surplus. The substance of its assistance also expanded, from having been concentrated mainly on the development of economic infrastructure to including Basic Human Needs (BHN) and human resources development. The targeted regions were also broadened beyond the previous focus on Asia to include the Middle East, Africa, Latin America, and Oceania. In accordance with these circumstances, the Overseas Technical Cooperation Agency (OTCA) and Japan Emigration Service (JEMIS) merged to form the Japan International Cooperation Agency (JICA) in August 1974.

Japanese government cooperation in the field of population and family planning began with contributions to UNFPA in 1971. From the latter half of the 1970s, JICA's technical cooperation in the field of population and family planning also evolved from an assistance to population control policy to a more integrated approach centered on maternal and child health.

In 1984, the International Conference on Population was held in Mexico City. In contrast with the previous conference held in Bucharest, a consensus was reached between all countries, including developing countries, on the importance of stabilizing the world's population in the future. The conference also focused its attention on newly recognized population issues such as rapid urbanization, international migration, and the aging of populations, and at the same time, emphasized the importance of improving women's status and expanding their roles and gathering and researching basic statistics. In 1989, the International Forum on Population in the Twenty-First Century was held in Amsterdam, and it acknowledged the importance of women's roles in development, a fresh awareness of and new technology in family planning, refugees and international migration, as well as the new population issue of HIV/AIDS.

In Japan, the Ministry of Foreign Affairs began to publish the development of a Country-specific Assistance Policy for each targeted country (later Country-specific Assistance Plan) in 1989 and JICA began to publish a Country-specific Program Implementation Basic Policy (later Country-specific Program Implementation Plan) in order to point the way for a new country-specific assistance direction in ODA. Meanwhile, in considering how to diversify assistance schemes, new channels were formed to support partnerships with recipient country NGOs, such as Grant Assistance for Grassroots Projects. In the field of Population and Healthcare, Japan's contributions to UNFPA made it the top donor from 1986 to 1999. And, when it became clear that Japan had insufficient personnel in the medical cooperation field, one which is directly related to the field of population, efforts were made to develop human resources for international cooperation in that field, including the establishment of a Department for International Medical Cooperation at the National Hospital and Medical Center.

3-1-2 After the 1990s

Since the emphasis on economic growth in their assistance during the late 1980s and early 1990s had not yielded the desired results, the international donor community changed the direction of its efforts toward "emphasizing the individual," with poverty reduction as the central theme. In 1990 the World Bank World featured poverty in its Development Report and in 1992 the Earth Summit in Rio de Janeiro addressed the need for a breakthrough in poverty to be incorporated into the balance of protecting the global environment. Under such a global climate, in September 1994 the International Conference on Population and Development (ICPD) was held in Cairo and reproductive health/rights became pivotal concepts. As a result, the focus of population policy underwent a major shift, from a macro-level (national) to a micro-level (individual) perspective, and the actors in population policy shifted from governments to individuals, in particular, to women.

In 1999, the International Conference on Population and Development + 5 (ICPD+5) held in New York set new objective indicators that included halving the 1990 illiteracy rates for women and girls and raising the number of deliveries assisted by trained professionals to 80%, both by the year 2005.

Meanwhile, at the 1996 Development Assistance Committee (DAC) High Level Meeting, "Shaping the 21st Century: The Contribution of Development Co-operation" (DAC New Development Strategy) was adopted, and with this, donor countries and international organizations including the U.S. Agency for International Development (USAID), the Canadian International Development Agency (CIDA), and the United Nations Development Programme (UNDP) made the transition to a results-based framework. In 1999, the World Bank proposed a Comprehensive Development Framework (CDF) that would go beyond the previous approach of implementing one individual project or program after another. In September of the same year, the World Bank/International Monetary Fund (IMF) Annual Meetings made compulsory the adoption of the Heavily Indebted Poor Countries Initiative (HIPC Initiative) and the use of the Poverty Reduction Strategy Paper (PRSP) as a reference for decision-making of the International Development Association (IDA) on loans, taking the course of strengthening the ownership of recipient governments and harmonization between aid agencies.

Japan surpassed the U.S. in 1989 (calendar year) to become the world's largest donor nation and held the top donor spot for ODA until 2000 (with the exception of 1990). In the Population and Healthcare field as well, Japan held the top ranking from 1986 to 1999 for contributions to UNFPA. In addition, in the 1990s, Japan's ODA policy entered a new phase. In June 1992 the Japanese government made a Cabinet Decision on the Official Development Assistance (ODA) Charter (commonly known as the ODA Charter), and announced its basic philosophy and principles for assistance. Then, in 1993, the governments of Japan and the United States hammered out a U.S.-Japan Common Agenda (The U.S.-Japan Common Agenda for Cooperation in Global Perspective), with both countries agreeing to cooperate in the two fields of population and AIDS, among a variety of issues. In February of the following year (1994), the Japanese government announced the Global Issues Initiative on Population and AIDS: GII. The GII is Japan's first announcement of an international cooperation

strategy for a specific field to the international community. In addition, with the international trend of results-oriented cooperation and increasing efforts to reform Japan's ODA, JICA also has started to put efforts into creating a more effective and efficient system of formulation, implementation and evaluation of projects. As part of these efforts, JICA established Regional Departments in January 2000 to strengthen the country-specific and region-specific approach. Following that, an integrated survey of requests for aid by important sectors and issues was started, and the system continues to evolve into one that is country-specific and sector-specific. JICA also continues to strengthen its evaluation system, with the aim of facilitating more effective and efficient assistance.

3-1-3 Trends in JICA's cooperation in the field of population

Japan's cooperation efforts in the field of population began with the 1967 Family Planning Seminar (Group Training Program). Then, in 1969, OTCA began its first Technical Cooperation Project, the Indonesia Family Planning Project. Through the 1970s there were few technical cooperation projects in the field of population, and these were all in Asia. In the 1980s, however, the total number of projects and target regions were expanded, with five projects in Asia, three in the Middle East and Africa, and three in Latin America.

Until the mid-1980s, the substance of technical cooperation projects had been mainly family planning, population information, and population education to support population issues in recipient countries, with a focus on the provision of audio-visual materials and equipment for the creation of such educational materials. From the latter half of the 1980s to the beginning of the 1990s, however, projects that integrated family planning and maternal and child health became the mainstream.

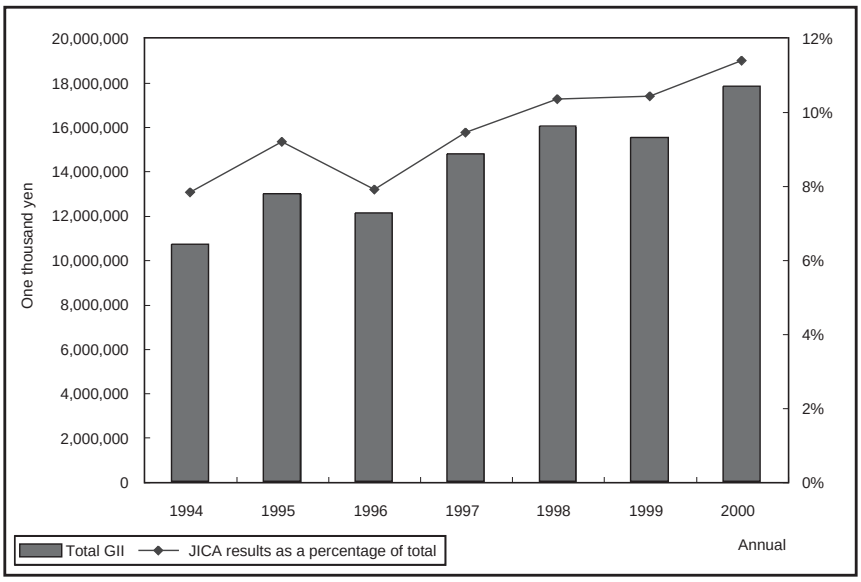
In 1991, a Study Group on Development Assistance for Population and Development was organized that examined future assistance strategies for JICA in the field of population. With the 1993 announcement of the U.S.-Japan Common Agenda and announcement of the GII in 1994, JICA also moved in the direction of emphasizing a comprehensive approach toward the fields of population and AIDS. Furthermore, as a result of the discussion from the 1994 Cairo Conference, the number of projects that incorporate the concepts of reproductive health/rights (RH/R) in cooperation in the fields of population and family planning has increased. Some examples include: the "Jordan Project for Family Planning and Women in Development (WID)" that incorporated support for family planning and income generation for women, JOICFP's "Vietnam Reproductive Health Project" that utilized Japan's post-war experience, and the "Strengthening of Reproductive Health Education in Tunisia" that aimed to educate adolescents about reproductive health (see Box 3-1).

JICA strengthened its stance toward emphasizing a comprehensive approach after the GII and started to combine different types of cooperation. JICA expanded its "multi-bi cooperation" (a type of bilateral grants to provide equipment and materials through international agency's technical support), and accelerated aid harmonization with the USAID.

A look at the history of JICA's budget for the field of population by reviewing the budget for the

Medical Cooperation Division (which represents a large proportion of assistance in the population field), shows that the budget has increased nearly seven-fold, from approximately 1.3 billion yen in 1974, the year JICA was established, to approximately 9.1 billion yen in 2000.

Figure 3-1 Trend in the GII Track Record



Source: Created from JICA's Global Issues Division records.

3-2 JICA's efforts for GII

3-2-1 Outline of the GII

The Japanese government announced the GII in February 1994, and declared a target amount of a total of 3 billion US dollars of ODA over a 7-year period by FY2000 for the promotion of assistance (including both grant aid and loan aid) in the field of population and AIDS. GII aimed to cut across sectors and take a comprehensive approach that included the three fields of: 1) Direct Cooperation for Population (family planning, maternal and child health, demographic statistics, etc.), 2) Indirect Cooperation for Population (primary healthcare, primary education, vocational training for women, etc.), and 3) HIV/AIDS. The strategic approach also identified 12 priority countries (the Philippines, Indonesia, India, Pakistan, Bangladesh, Thailand, Kenya, Ghana, Tanzania, Senegal, Egypt, and Mexico). Project formulation in all of these fields has been active, and as of FY2000, 18 Project Formulation Study Teams have been dispatched.

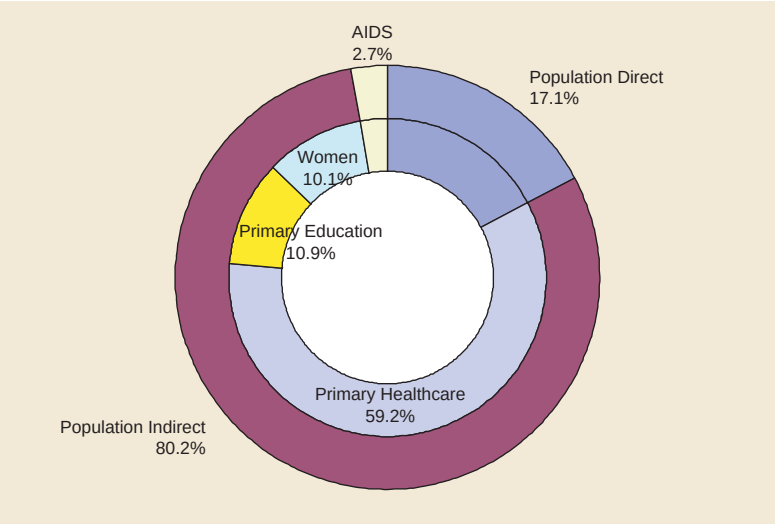
3-2-2 GII's Track Record

JICA is also actively working toward the achievement of the GII targets, with a cooperative track record of 100 billion yen toward GII-related fields from FY1994 to FY2000 (Figure 3-1). The

breakdown of 17% to Direct Cooperation for Population, 80% to Indirect Cooperation for Population, and 3% to HIV/AIDS shows that contributions to Indirect Cooperation for Population are comparatively high. A large proportion of the total, nearly 60%, is represented by primary healthcare (Figure 3-2).

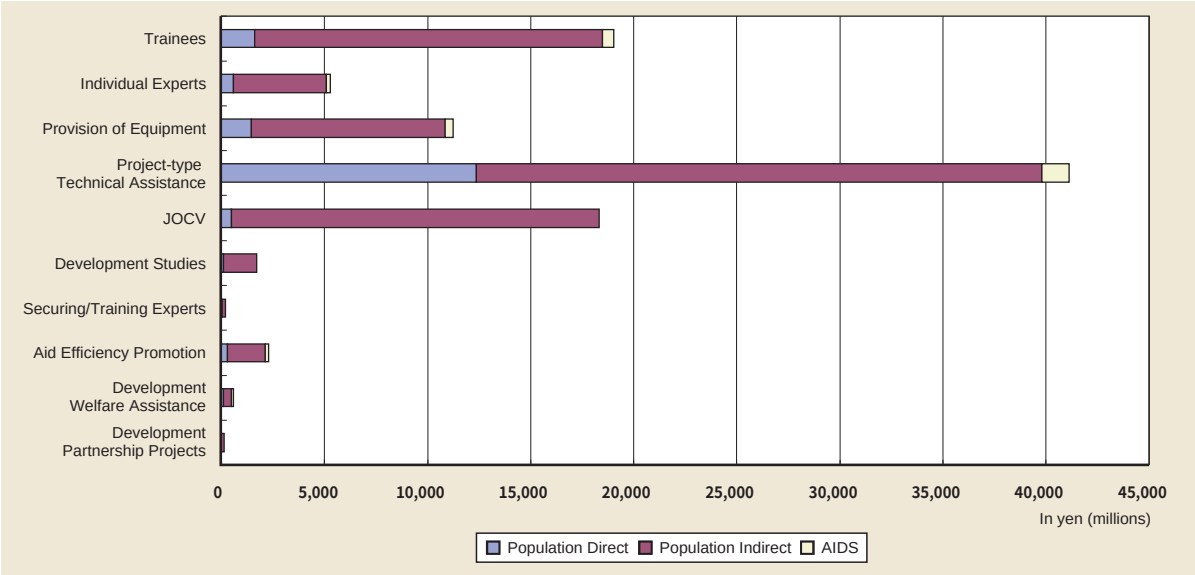
Looking at types of assistance, 42% of overall aid was in Project-Type Technical Cooperation (hereinafter PTC) (Figure 3-3). Much of the assistance in Direct Cooperation for Population was in PTC assistance.

Figure 3-2 GII Achievements by Field



Source: Created from JICA's Global Issues Division records.

Figure 3-3 GII Track Record by Type of Assistance (in yen)



Source: Created from JICA's Global Issues Division records.

In addition to these, increased attention has been given to the role of the Japan Overseas Cooperation Volunteers (JOCV) organization in being able to meet the diverse community-based needs following the GII and the Cairo Conference. JOCV groups have been developed and one group-type JOCV project named "Family Planning and Maternal and Child Health Front Line Plan," integrating Direct Cooperation for Population, women's empowerment, and maternal and child health, has been carried out to the Philippines, Laos, Bangladesh, and Tanzania.

Since the needs of developing countries continue to diversify, JICA established the Community Empowerment Program in FY1997, the JICA Partnership Program in FY1999, and the Small Scale Development Partner Program in FY2000 in order to enlist the cooperation of civil society, including Japanese NGOs, in order to respond to these needs on a small scale. In FY2002, JICA integrated these three programs into the Grassroots Technical Cooperation Program and is strengthening its partnerships with NGOs and local governments.

At the same time, Japan has called attention to the importance of South-South Cooperation in the international community. Some primary examples of JICA's assistance in South-South Cooperation are: Third-Country Training, in which it supports training implemented by developing countries, and Third-Country Expert Dispatch, in which experts from one developing country are dispatched to another developing country. In terms of Direct Cooperation for Population, Third-Country Group Training including reproductive health (Thailand, Mexico), IEC (Indonesia, Tunisia, Turkey), and AIDS diagnosis (Philippines, Kenya) have been implemented. Regarding Third-Country Experts, experts from Thailand have been sent to the JICA Maternal and Child Health Project in Cambodia in the field of HIV/AIDS counseling, and to neighboring countries in the field of public health. In addition, a variety of international conferences have been sponsored for the promotion of South-South Cooperation.

3-2-3 GII Achievements

Two important points, aside from strengthening the presence of the Japanese ODA strategy, have been identified as positive outcomes of GII. The first is the creation of a comprehensive approach under the broad theme of Population and AIDS, in contrast to the previous method of programs by type of cooperation. The second point is the extensive involvement of NGOs as partners in implementing ODA. In addition to the Ministry of Foreign Affairs' start in building full-scale partnerships with the private sector, a network among NGOs has been widened and strengthened (NGOs are participating in activities not only in the field of Population and Health, but also in fields such as agricultural development, urban issues, the environment, and women's issues). As of March 2002, 41 private organizations have joined the network. These activities also contribute to capacity building among Japanese NGOs working in international cooperation.

3-2-4 From GII to IDI

Japan declared its commitment to the “Okinawa Infectious Diseases Initiative (IDI)” at the Kyushu-Okinawa G8 Summit of July 2000. It was formed with a focus on: 1) strengthening ownership in developing countries, 2) human resource development, 3) partnerships with organizations in civil society, donor countries, and international organizations, 4) support for South-South Cooperation, 5) promotion of research activities, and 6) promotion of public health at the regional level. It set numerical targets to be achieved by the year 2010 with respect to HIV/AIDS, tuberculosis, and malaria. In order to achieve these objectives, it was agreed to establish “new and innovative partnerships” among all of those involved in creating measures to deal with infectious diseases, including the governments of the G8, developing countries, international organizations, and all segments of the civil society, including NGOs and private enterprises. In this initiative, a pledge was made for a target for cooperation totaling 3 billion US dollars over a five-year period.

Box 3-1 Major examples of Project-Type Technical Cooperation (PTC)

Jordan Family Planning and Women in Development (WID) Project
(July 1997-June 2000, July 2000-June 2003)
-Women's Empowerment-

The rate of population growth in Jordan is high and in the current situation of economic stagnation, rapid population growth is becoming a significant hindrance to economic recovery. The Jordanian government considers the population issue a serious national challenge and has requested technical assistance to NGOs that are promoting comprehensive family planning programs that cover healthcare, women's issues, and the field of education. In this project, we support the enhancement of the comprehensive family planning implementation system in model areas with continued consideration to WID and aim for the empowerment of rural women and further participation in family planning by men.

Phase 2 of the project that began in July 2000 aims to carry out a more comprehensive project by expanding target areas for the project, and carrying out project activities through the Jordanian NGOs and the government (the Ministry of Health and the National Population Commission). It focuses on educational activities concerning family planning, enhancement of maternal and child health, and activities to generate income for women.

Vietnam Reproductive Health Project
(May 2000-August 2005)
-Reduction of Maternal Mortality Rates-

The Program of Action adopted by ICPD emphasized partnerships with NGOs in order to promote the efficiency of projects in each country. This project is also being carried out through the utilization of the advantages of both JICA and JOICFP, a Japan-based international NGO with a good track record in family planning. The seeds that JOICFP has sown through its unique formula, the Integrated Project (IP) (in which using parasite eradication as an entry point has led to family planning through maternal and child health and nutritional improvements) have been nurtured as JICA projects, and, with that, advancements are being made in creating an environment in which "safe and sanitary childbirth" can occur, gaining the involvement of the community in poor rural areas of Vietnam.

The direct objective of the project is to make it possible to give birth safely in a Commune Health Center (CHC) in the village. To do that, the project is improving CHC facilities, and trained midwives, physician assistants and staff who have not been sufficiently trained because of the war,. Dispatching experts from Japan and conducting training in Japan are carried out to improve birthing technology and to train midwives.

Project characteristics are: 1) community participation, 2) promotion of primary health care that is rooted in the region, not of high level technology, 3) maximizing the utilization of existing personnel and resources, and 4) expanding into other areas and creating sustainable services.

Tunisia Strengthening Reproductive Health Education Project
(September 1999-September 2004)
-Adolescent Reproductive Health-

Tunisia has earned a good reputation in terms of population and family planning in the Islamic world, and has already achieved the reproductive health targets set at the Cairo Conference. Given that, Tunisia is now taking a broader reproductive health viewpoint in population policy and strengthening its activities regarding women's health and adolescent and youth sexuality. In addition, the dissemination of family planning concepts is lagging behind in rural areas. STDs are a major issue for young people in urban areas where the population is mostly concentrated. Given this context, this project is being carried out to strengthen education activities targeting young people concerning reproductive health.

Chapter 4 Field Survey Report (Bangladesh and Thailand)

4-1 Outline of the field surveys

This chapter will examine the field surveys of Bangladesh and Thailand as case studies to learn about current population issues and the status of assistance in developing countries, and will attempt to provide some useful recommendations on Japan's assistance in the field of population. The studies were conducted in Bangladesh from March 29 through April 5, 2002, and in Thailand from April 5 through April 9, 2002. The study team comprised committee members of this study group: Hirofumi Ando, Professor, College of International Relations, Nihon University as the Team Leader; two Committee Members, one Task Force Leader and two Members of the Secretariat.

4-2 Major findings from the Bangladesh field survey

Bangladesh is one of the countries that are classified as Least among Less Developed Countries (LLDCs). However, because of its government's proactive work in population and family planning, the contraceptive prevalence rate is nearly 54%, and the number of children born in a woman's lifetime (TFR) is 3.3, putting Bangladesh at a notable level among developing countries. However, since around 1993 or 1994, improvement in those indicators slowed for seven or eight years. The direct causes of that slowdown include inaccurate or insufficient statistics on contraceptive prevalence rates, and an increase in the shift from the use of reliable methods of family planning to unreliable methods. Indirect causes include the bureaucratic nature of the two divisions of the Ministry of Health and Family Welfare that are in charge of reproductive health, the decline in fiscal expenditures for the social sector, and a scaling down and cuts in population assistance from the United States.

The Bangladesh government is putting efforts into promoting reproductive health as its national policy, and, in order to realize its goals, it has been taking a comprehensive sector-wide approach, the Health and Population Sector Program (HPSP). HPSP has integrated over 130 projects by various donors in 1997 into one program with the objective of a reduction in TFR, the infant mortality rate, maternal death rates, etc., and has been implementing this program as a five-year plan that started in 1998.

Donors cooperate with the government through the following three local consulting groups (LCG): 1) the Common Fund[4] (World Bank Consortium), 2) others (Japan, ADB, U.S., Islamic Development Bank, OPEC, France, Denmark, etc.), and 3) UN Organizations. As sector-wide aid harmonization gets underway, some people expressed their concern at the decline in the presence of Japan's ODA resulting from institutional limitations on the implementation of new assistance methods, including direct budget support.

[4] A shared account in which each donor country or agency can contribute a portion of development assistance aid to specified sectors.

Japan is the largest bilateral assistance donor country for Bangladesh, and has carried out a wide variety of assistance programs through various types of assistance, including in the field of health and population. At present, Japan is extending a range of development assistance through PTC, Grassroots Technical Cooperation Projects (the Community-empowerment Program and JICA Partnership Program were combined in FY2002), Japan Overseas Cooperation Volunteers (JOCV), and Grassroots Grant Aid. These types of individual activities aim to serve as organic links in the field.

JICA envisions changing individual projects in the future to make them into programs from the planning stages (to make them "packaged"), in order to improve the comparative advantage of Japan's cooperation while further increasing our effectiveness, and to increase our presence.

In Bangladesh, administrative services are not sufficiently able to reach the end users. The existence of NGOs as a bridge connecting the very end administrative units (unions) with local residents is extremely important. A very important key to success will be the extent to which we can form strategic partnerships with the NGO, the Family Planning Association of Bangladesh (FPAB), which has a very central role.

Box 4-1 Capacity Building for the Sustainable Reproductive Health Care Project (CBSRHC), Phase II

Terms of cooperation: December 10, 2001, through December 9, 2004
Implementing agency: Family Planning Association of Bangladesh (FPAB)
Outline of cooperation: The integration of health services and family planning in Bangladesh is lagging behind, and the provision of packaged services at the regional level is not sufficient. Based on these circumstances, this project was a Community Empowerment Program that aimed to reduce maternal and infant mortality rates through the promotion of activities in community-participatory preventative health, and through grassroots community health promoter training for providers of comprehensive local health services.[5]
Phase I accomplished 1) facilitating of resident self-initiated activities related to maintaining citizen's health and 2) implementation of activities for educating health and family planning volunteers. And, in Phase II, it is 3) cultivating government health personnel for a community clinic and 4) supporting the promotion of status-building for community health promoters (women).

[5] A type of cooperation in which JICA entrusts the implementation of the project to a local NGO in a developing country.

Box 4-2 Community-Operated Reproductive Health Project (CORHP)

Terms of cooperation: March 2001 through March 2004

Implementing agencies: Bangladesh: Ministry of Health and Family Welfare, Family Planning Association of Bangladesh (FPAB)
Japan: JOICFP

Outline of cooperation: While the family planning program in Bangladesh has been evaluated as being on a successful path, many challenges still remain with respect to improvement in women's status and the establishment of the right to self determination for women in family planning, particularly in rural areas. This project is a JICA Partnership Program that aims to improve the reproductive health of the whole rural society through assistance from JOICFP to FPAB.[6]
Specifically, the project aims to 1) provide packaged basic services for reproductive health at multi-purpose women's training centers, 2) enlist the participation of rural women in social and economic activities, and 3) build the capacity of FPAB and develop human resources. These are all to improve reproductive health conditions and women's status through community-participatory activities in the Narshingdi District and the Feni District. It includes a wide range of activities, such as improving Multi-purpose Women's Training Center facilities, creating educational materials, literacy education and income-generating activities for women and leadership training in community reproductive health.

4-3 Major findings from the Thailand field survey

Thailand is sometimes called an "AIDS Forerunner Country." The first AIDS case in Thailand was confirmed in 1984.

In the early stages, most of those infected with HIV/AIDS were in high risk groups, such as homosexuals and commercial sex workers, but recently there has been a shift to infections among married and unmarried couples and mother-to-child transmission. Correspondingly, Thailand's AIDS policy has undergone a transition from an approach that targeted homosexuals and others in high risk groups in the first phase (1984-1990) and commercial sex workers and their male customers in the second phase (1990-1996), to a comprehensive approach that targets the socially vulnerable and communities in the third phase.

JICA began to extend the first Project-Type Technical Cooperation in 1998, called the Prevention of AIDS/Regional Care Network Program, which targeted the Phayao province, the one hardest hit by HIV/AIDS. This project takes a micro-level perspective (local, individual), and utilizes traditional cooperative volunteer organizations in the region (youth groups, women's groups, and elderly groups) with the aim of promoting resident-led activities for the prevention of HIV/AIDS. The project also builds a patient network and encourages peer counseling. All of these are efforts to build a local support system for those living with the disease. A study by the team found difficulties possibly arising from women's lack of economic autonomy, including wives wishing to hide the fact that they are infected, wives who have lost their husbands to AIDS remarrying repeatedly, and wives not being able to stand up to their husbands who dislike using condoms. Therefore, measures toward AIDS should not

[6] A type of cooperation in which JICA entrusts the implementation of a project to groups such as Japanese NGOs, local governments, and / or universities that are familiar with and experienced in the local situation.

Box 4-3 Project for Model Development of Comprehensive HIV/AIDS Prevention and Care

Terms of cooperation: February 2, 1998, through January 31, 2003

Implementing agencies: Ministry of Health (Bangkok, Phayao Province, and 9 provinces in extension areas)

Outline of cooperation: AIDS measures have been proactively taken in Thailand since 1991; however, the AIDS prevalence rate in Thailand is already over 1%. What is needed is not only measures such as have been taken until now, that focus on prevention of infection, but also the implementation of comprehensive measures that include the creation of a care system that would make it possible for society and those living with AIDS to coexist. Given these circumstances, this project is a Project-Type Technical Cooperation (PTC) Project that expands upon the achievements of the AIDS Prevention Project, cooperation implemented by Japan over a three year period from 1993, with the aim of building a variety of networks that can make possible cross-sectoral and ongoing comprehensive measures at the district level.

The objectives of this project are to expand the process model of the Learning and Action Network on AIDS (LANA), a keyword in HIV/AIDS prevention and care measures, which has been mainly implemented in Phayao province, to other provinces through 1) the development of human resources for solving HIV/AIDS-related issues, 2) the establishment of a care system for infected persons, patients and their families, approaching this as a measure for maternal and child health, and 3) the promotion of community activities and responses to HIV/AIDS.

be merely medical services, but should be a comprehensive approach including creating jobs and improving educational opportunities for women.

4-4 Considerations

Challenges and recommendations for JICA's assistance based on the field surveys are summarized as follows:

- Assistance should be synchronized with the long-term strategies of the recipient countries, such as their national plans.
- It is suggested that synergistic effects be promoted through aid harmonization with other bilateral donors, international agencies, and international NGOs.
- Linkages between JICA's assistance in health and population should be strengthened.
- Policy dialogue for the improvement of administrative structures for the reproductive health policies of recipient countries should be enhanced.
- Health and population statistics should be developed and the capacity to monitor related development programs should be strengthened.
- The importance of family planning in achieving reproductive health should be reaffirmed (family planning plays an important role both in improving women's health and in empowerment).
- Strategies should be developed to erase the misunderstanding that the lack of change in fertility behavior among women is due to their low level of knowledge about family planning and little incentive to adopt it (It is necessary to change the environment and improve the quality of service providers).
- For effective reproductive health and HIV/AIDS measures, comprehensive approaches such as the creation of jobs and the expansion of educational opportunities for women are necessary.

- Key factors are the involvement of local citizen organizations and partnerships with experienced NGOs.
- All assistance projects should be carried out keeping in mind the goal of sustainability after the completions of assistance.

Chapter 5 Population Strategies for the Twenty-First Century (Recommendations)

Think globally, but take an individual approach

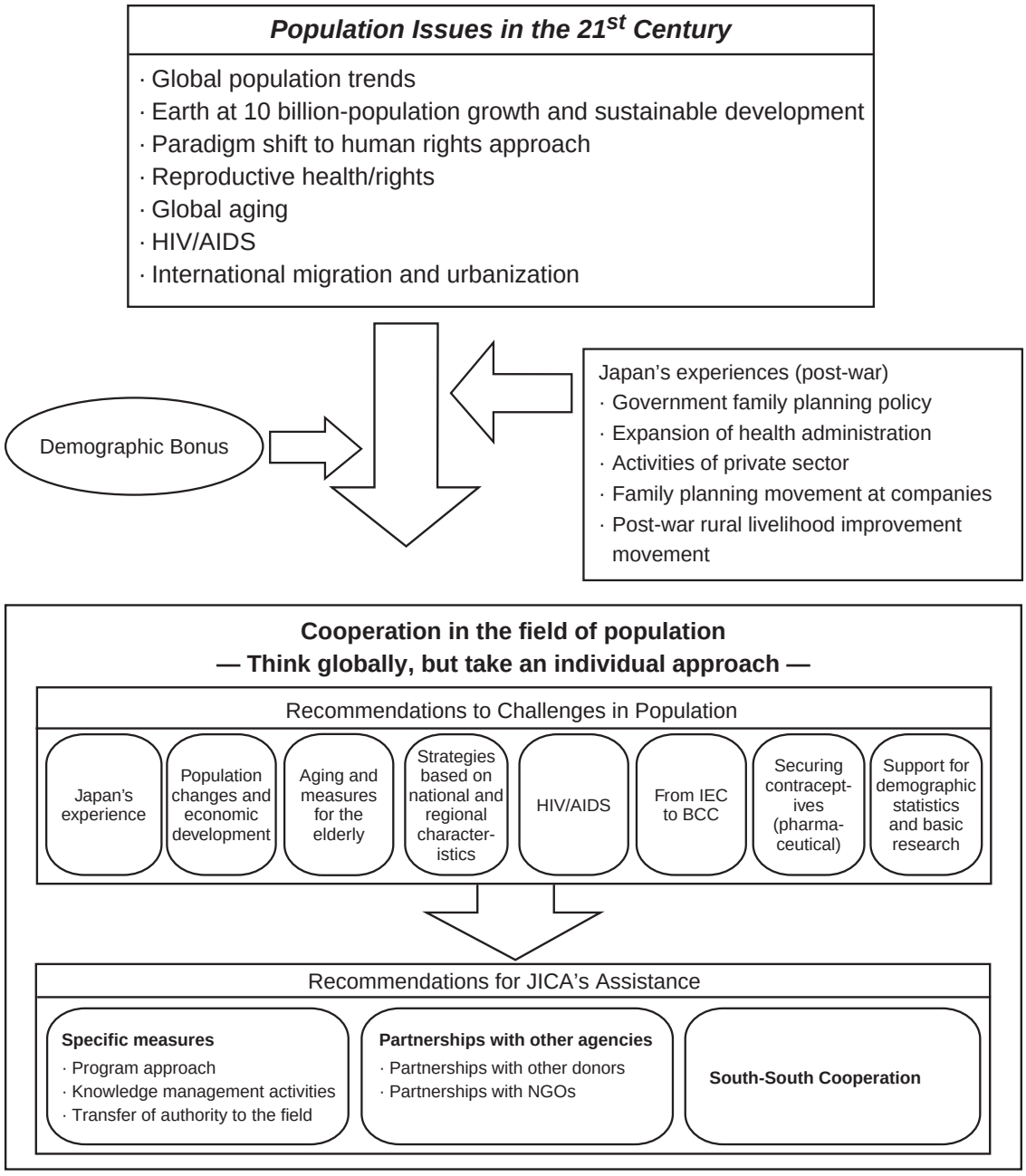
Although world population growth has leveled off somewhat in the twenty-first century, population problems still exist as the denominator in the equation of population and sustainable development since the population growth rate remains high. While it may be possible with the current technology to provide sufficient resources in total, in particular food and water, to support a world population that is estimated to become nearly 10 billion by the year 2050, there are great disparities among regions and countries. A major challenge will be how to distribute the necessary resources to the regions and countries in need. It is also necessary to start thinking about the AIDS issue from a macro-level perspective as a problem that exists on a global scale.

The micro-level approach of population assistance that is represented by the reproductive health approach is revolutionary in terms of having shifted the target of assistance from governments to individuals, in particular to women, after the 1994 Cairo Conference. However, the impact that demographic changes can have on the economy or environment at the macro-level have tended to be played down. If it is considered that Japan's post-war maternal and child health activities led to economic development by generating an economic gain through a rapid fertility reduction, called a "demographic bonus", and if this relationship is generalized to cooperation in the reproductive health field, it can be expected that the demographic changes generated by a micro-level approach can also contribute to macro-level development under certain conditions. Those who are actually working on development issues should not just work toward the objective of achieving health and happiness for individuals through a micro-level approach, but should also have a vision that links their work with the issues that determine the long-term success or failure of sustainable development in developing countries – and share that vision with the recipient country.

Considering all of this, the Study Group recommends the strategy of "Think globally, but take an individual approach" when considering the population challenges of the world in the twenty-first century, and once again emphasizes the importance of taking on the challenges on a macro-level while dealing with them through a micro-level approach. With this in mind, recommendations have been formulated first as "Recommendations for Population Issues," that examine a broad range of issues regarding Japanese cooperation for developing countries. The Study Group has then provided recommendations for a more effective and efficient system to carry out the assistance, under "Recommendations for JICA's assistance." The overall framework of the recommendations in this report and the relationship between each are illustrated in Figure 5-1.

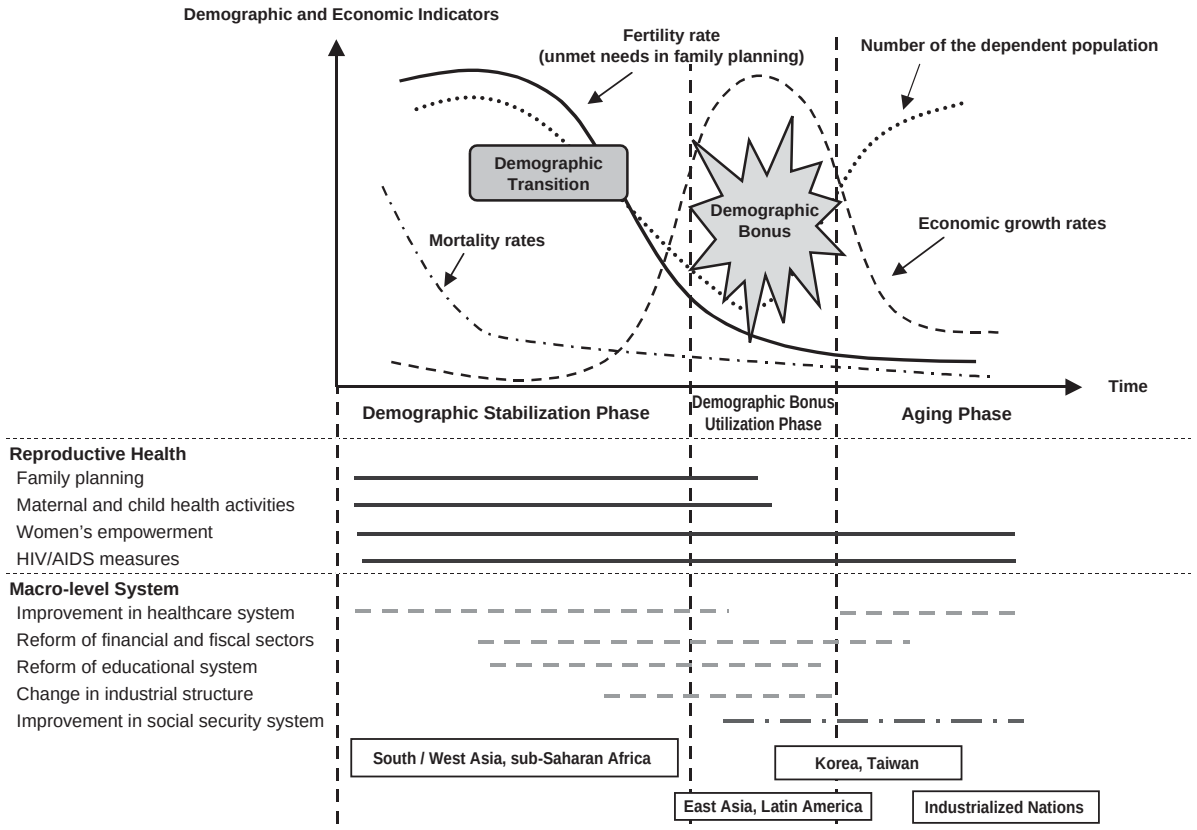
Using Japan's experience as a reference, the Study Group has built a model in Figure 5-2 of the means to effectively and efficiently carry out Japanese cooperation, called "Recommendations for JICA's micro-level approach and its macro-level impacts" as applied to the forty to fifty years of

Figure 5-1 Orientation of Recommendations



development process in the developing countries, considering their different stages of development. This model is different from that of western industrialized nations, in that it depicts explicitly and schematically the path taken by East Asian countries, including post-war Japan, of rapid fertility declines and the resulting impacts on development, along with the subsequent advent of an aging society. This shows that for many developing countries, if population policies succeed during the Demographic Stabilization Phase and fertility rates are reduced, and if there is an appropriate menu of policies and assistance available, then it will be possible to put countries on the track to a future "Demographic Bonus Utilization Phase" and then an "Aging Phase." At present, assistance in South Asia and sub-Saharan Africa is mainly focused on reproductive health, and these regions need to

Figure 5-2 Three Phases of Population and Sustainable Development (drawing upon Japan's experience)



Source: Created by Akihisa Tanaka based on committee discussions. (2002)

consider micro-level activities in their long-term strategies, as seen in this model. Additionally, East Asian countries and some Southeast Asian countries whose economies are now starting to take off need to reserve the gains of the demographic bonus to prepare social security systems for the coming "population aging phase."

When carrying out effective cooperation in the reproductive health field, Japan's experiences can serve as a useful reference for many developing countries that are in the Demographic Stabilization Phase. The recommendations in this chapter are made with a view to utilizing the essence of Japan's experience to assist developing countries. In addition to cooperation in the health care field, which is regarded as a conventional measure of population assistance, the Study Group also emphasized the need for a multi-sectoral approach that includes other areas such as social and agricultural development as well as the need to include a wide variety of players as actors in these activities, such as the central governments, local governments, rural communities, NGOs, and the private sector.

At the same time, the Study Group recommends that JICA utilize and promote more strategically and proactively the ongoing internal reform, which will make a comprehensive approach possible. This would include, for example, the adoption of a program approach that can flexibly combine a variety of schemes for specific issues and the introduction of programs to further promote partnerships with NGOs.

5-1 Recommendations for population issues

The Study Group has proposed the following nine recommendations for "Thinking globally, but taking an individual approach."

5-1-1 Utilizing Japan's experiences in reproductive health cooperation

Japan achieved its fertility transition while in poverty after WWII through maternal and child health programs, lifestyle improvement movements, and the activities of NGOs. Even aside from the uniqueness of Japan in already having developed the potential foundation for this transition, such as widespread basic education, social and human resources, and organizational competency prior to World War II, Japan's experience can be of use when providing assistance to developing countries.

The post-war approach in Japan can be roughly divided into two categories: a top-down government-led approach and a bottom-up civic approach. In the government-led approach, as part of its thorough democratization policy, a top-down chain of command was established from the central Ministry of Health and Welfare to the prefectures, cities, towns, and villages. At the same time, the system was further decentralized and the rural health administration was strengthened. In addition, public health centers were established and services were diversified in order to strengthen services to those rural areas that had few medical institutions. With these public health centers as a base, maternal and child health services were developed and public health nurses and independent midwife practitioners played an important role. The completion of a healthcare service network that stretched from the top to the grassroots level was the first essential step of the process.

The most important factor in relation to the public health nurses and independent midwife practitioners who played a key part in providing services is that these women were able to build strong relationships of trust with the citizens and that their services were provided based on the actual needs of citizens and were not forced on them. These practioners elicited the autonomy of citizens, improved maternal and child health, and made great contributions to the dissemination of family planning concepts. The community activities of these women involved and made use of the influence of local leaders, such as village leaders and leaders of women's groups, who were in direct contact with the local area. They made autonomous development possible by drawing on all of the existing resources and knowledge in the local area and not depending on external funding or technical support. Another important point in Japan's experience was the division of labor among the three players – the government, the academic community, and the private sector (NGOs and independent midwife practitioners) – who formed a system of cooperation.

The activities that were actually carried out in the local areas where rural development was taking place in post-war Japan were largely characterized by their promotion of behavioral change in poor people, in particular, in women who had not had any real decision-making authority. Some examples of specific caveats that are thought to be instrumental in behavioral change in the rural areas of

developing countries included: starting with easily visible results (so that people could see that activities were for their own benefit); using a group approach; responding to constraints that surrounded individuals; building a relationship of trust between service providers and recipients; and providing monitoring and support on an ongoing basis.

5-1-2 New challenges in demographic changes and economic development

As for the timing involved in demographic changes and economic development, this section emphasizes the importance of reviewing the impact of the fertility transition on the macro-level economy and the environment, and of taking into consideration the three phases of population and development in recipient countries, as discussed earlier. Very little analysis has been conducted on Japan's utilization of its demographic bonus until now, but, at the very least, it is possible to say that, as a result of the rapid fertility transition, consumption at the household level decreased, savings increased, and the increased savings, for example postal account savings, flowed into the Trust Fund Bureau of the Ministry of Finance, resulting in fiscal investments and loans, eventually linking to an increase in exports through increased production.

The demographic bonus is also closely related to such factors as savings and investment, labor force, health and education, women's status, income distribution, and family planning policy. In order to utilize the demographic bonus and turn it into economic development, it is necessary to draw up a development plan that integrates all of these components.

Additionally, the question of how to effectively utilize the demographic bonus, which is the economic gain that is obtained over a very limited span of time and then to prepare a system for a subsequent aging society will be a serious challenge for developing countries in the future. In this respect, Japan's experience may most likely prove to be of use to them.

5-1-3 Striking a balance between macro-level and micro-level perspectives

Through placing emphasis on individual needs and human rights, the reproductive health approach adopted at the 1994 International Conference on Population and Development in Cairo (ICPD) raised awareness of the importance of independence and responsibility among individuals. Accordingly, in solving population issues, rather than the previous approach of bureaucratic family planning that was widely adopted and was unifunctional what is needed is a more comprehensive social development program that includes improvements in the status of women and more widespread education.

It cannot be denied, however, that the shift in direction toward reproductive health has brought about confusion in a variety of ways in its actual operation in many countries. In particular, since reproductive health itself was a new concept, a lack of understanding of the definition and substance of the concept, albeit temporary, resulted in the loss of a certain sense of direction in family planning activities. In addition, prior to the ICPD, many, if not most, developing countries were carrying out

family planning through hierarchical and highly specialized or unifunctional administrative structures, but the reproductive health approach calls for cross-organizational efforts, and more than a few countries fell behind in making the transition. One of the major challenges in implementing reproductive health programs that include family planning is how best to balance specialization and the integration of functions.

Prior to the Cairo Conference, many developing countries had established such administrative structures as national family planning committees that were independent of health ministries These committees specialized in population and family planning issues and had strong mandates both politically and financially. However, since the Cairo Conference, these functions have been transferred to the ministries of health, and this has, as a result, not infrequently brought about a decline in political commitment to population and family planning activities as well as setbacks in financial support. Consequently, appeals to the donor community have also waned.

In addition, there is also a problem of the prevalence of a tendency to overemphasize the issue of reproductive health services and rights. More concretely, it can be argued that the interest and support of those who are outside the health sector is being lost, in particular among many population experts and economists. It is necessary to draw attention to the fact that the shift to the reproductive health approach should not disregard macro-level issues.

The bottom line is that population and family planning must continue to be centered on reproductive health from now on. However, a good balance between macro- and micro-perspectives is essential in extending overall population activities.

5-1-4 Aging of the population and supporting the elderly

The proportion of the aged (over the age of 65) in developing countries was 5.1 per cent in 2000, and has just started increasing. However, as the proportion of the aged in developing regions continues to increase in the first half of the twenty-first century, and it is estimated that by the year 2050 it will reach 14 per cent, a level much like that of the current developed regions, The aging of the population will be a major issue in the future for developing countries as well. In developing countries like those in East Asia that have rapidly completed their fertility transitions, equally rapid aging is expected, and because Japan is the first country to have experienced this kind of population aging, its experience may be useful in helping solve aging-related issues in developing countries.

Specifically, with respect to the aging of the population and the need for measures to deal with this in developing countries, the first step is to compile a record of the Japanese experience, including its failures, and to disseminate this information. Then, for developing countries that are still in the Demographic Bonus Utilization Phase or the Population Stabilizing Phase, it is important to emphasize the fact that the Aging Phase will arrive and efforts to build a foundation for that phase should start now. Also, regarding increases in average life expectancy, the idea of “health-condition–specific life expectancy,” in which there is a division between the healthy years and the unhealthy years, has

received attention. Assistance in research and human resources could be devoted to developing countries in this area.

The period of trial and error experienced by the Japanese in the past can be of some use in such fields as creating meaningful lives for the elderly, on gender issues, and working in partnership with NGOs. It is necessary to work together with developing countries to come up with their own solutions.

5-1-5 The formulation of strategies based on national and regional characteristics

For JICA's future assistance in the field of population and sustainable development, it is necessary to focus on and prioritize our efforts toward developing countries that are in the greatest need, and this requires the formulation of a strategy that addresses the seriousness of population problems in these countries.

One model that can be used in selecting countries is the methodology used by UNFPA to determine the priority countries for support. Using this methodology, the priority countries are determined based on the combination of a total of eight objectives from the ICPD Program of Action, including the three reproductive health access-related indicators, two indicators regarding mortality rate reduction, two indicators regarding primary education, and the annual GNP per capita as the economic indicator. The country that is the farthest from achieving all eight objectives is given the highest priority in receiving assistance.

Furthermore, the method used by UNFPA since 1994 can be used as a basic reference in determining priority fields for assistance. Population activities are broadly divided into three areas: Reproductive Health, Advocacy, and Population and Development. Two-thirds of the total assistance is given to Reproductive Health, and the remainder is divided between the other two areas. While it is necessary to continue to place importance on the Reproductive Health field, sufficient assistance for the other two fields must also be assured. In particular, more resources are needed for gathering and analyzing basic demographic data (including national censuses), and for studying changes in population dynamics and their socioeconomic impacts, or reproductive health and its economic effects, all of which are in the field of Population and Development. Additionally, by strengthening such organizations as regional and international population institutes as well as universities, research centers and training centers in developing countries, it is possible to contribute to human resources development in developing countries.

5-1-6 HIV/AIDS

The main priority with regard to HIV/AIDS is prevention, and the dissemination of Voluntary Counseling and Testing (VCT), which facilitates the earliest possible detection of HIV infections, is vital. Additionally, with regard to care using the anti-retrovirus medications that can delay the onset of AIDS, the global challenge is to establish an effective system for their procurement, supply and

administration, so that medications can be provided to even those living with the disease in developing countries.

In addition to this type of HIV/AIDS prevention and care, it is also important to provide support to those living with AIDS in sub-Saharan Africa and other countries where more than 10 per cent of adults are infected with HIV. In these countries, it is critical that the approach is community-based with popular participation. Also, as Japan is not at a comparative advantage technically with regard to HIV/AIDS and has only limited expertise, it would be desirable to establish a domestic base for the systematic and organized accumulation of technical knowledge and to secure and train personnel. Furthermore, strengthening the partnership and exchange of information among the three central points of Japan's medical cooperation in Sub-Saharan Africa – the Noguchi Memorial Medical Research Institute (Ghana), the Kenya Medical Research Institute (Kenya), and the Zambia University Teaching Hospital (Zambia) – will facilitate the incorporation of measures for a broader geographic area, and will result in strategic Third-Country Training and South-South Cooperation.

With HIV/AIDS, it is necessary to adopt the idea of "damage reduction" and make syringes and condoms readily available regardless of the rights and wrongs of drug use or prostitution. In addition, among current HIV/AIDS measures there is no method that can produce perfect results in every situation. Therefore, since measures must be created that suit the actual conditions of communities and individuals, as well as the stage of infection, one effective way to do so will be planning, monitoring, and evaluating through a participatory approach. This participatory approach will raise awareness of the parties concerned in the country in question and will encourage people to make efforts to help themselves, which will then lead to the development of self-reliance.

5-1-7 From IEC to BCC

From the information and data in part from the Bangladesh and Thai field surveys, the Study Group found that the information, education and communication (IEC) activities tend to blame the victims. This is based on the misunderstanding that the reason the low family planning prevalence rates are not increasing is that there is little improvement in the level of knowledge of mothers and women. This misunderstanding is due to the failure of the service providers to understand that these mothers and women are already motivated to accept family planning, but cannot obtain access to decent services. Blaming mothers and women is really victimizing the victims, who are helpless without adequate services. Thus, the Study Group stresses the necessity of moving from Information, Education, and Communication (IEC) to Behavior Change Communication (BCC) in the reproductive health field. Specifically, in order to change women's behavior (for example, using contraceptives) it requires an approach that will change the awareness and behavior of not only the women, but also of those around them, especially the service providers; that will increase access to necessary and appropriate contraceptive devices in order to turn awareness into expected behavior (contraception); and that will create a system which can facilitate continuous support to women and the monitoring of

their situation and can continually deal with problems (obstacles).

In addition, since assistance in population is an extremely delicate area due to the fact that it intrudes on the lives of people, it is essential to have strong trusting relationships between the service recipients and providers, and therefore the attitudes and awareness of the service providers at the field level must be improved.

5-1-8 Securing access to contraceptives (pharmaceutical)

In order to realize the objectives in the area of reproductive health and rights, it is necessary that people in need are appropriately provided with reproductive health commodities, such as contraceptives (pharmaceutical) and devices, as well as testing agents and nutritional supplements for pregnant women. In particular, with respect to essential contraceptives (pharmaceutical) and condoms for the prevention of HIV/AIDS, a major problem is a lack of funding to meet the future requirements. In order to achieve the assurance of contraceptive supplies, Japan should continue to proactively look into the possibility and direction of expanding its cooperation.

For promoting cooperation in securing supplies of contraceptives, the Study Group makes the following recommendations: 1) It is essential to continue attending relevant international conferences to monitor the global trends in contraceptive demand and supply, and participate in donor meetings on logistics at the national level to secure supplies of contraceptives (pharmaceutical). 2) In order to ensure contraceptive supply security, it is important to support the strengthening of logistics for the needs forecasts and the control/distribution of contraceptives. In addition, partnerships with the private sector are also important, and it is therefore important to divide the roles among public and private entities and ensure appropriate price setting, quality assurance, strengthening of partnerships between related entities and improvement in coordination capacity where necessary. 3) With respect to contraceptive methods and means for family planning that are used in developing countries, but have not yet received approval for use in Japan, Japan must consider developing a policy on how to conduct cooperation with respect to such types of contraception. However, as there are few people in Japan with expertise and technology in this field, human resource development must also be considered along with the utilization of Third-Country Experts.

As contraceptive (pharmaceutical) use is expected to grow in the future, basic research is needed to study appropriate methods for the disposal of used syringes and condoms, along with the effects of pharmaceutical contraceptives as endocrine disruptors.

5-1-9 Support for demographic statistics and basic research

A fundamental requirement is for every country to comprehend the state and trends in the population, for which the development of demographic statistics is indispensable. Classified broadly, demographic statistics fall into two categories: “static statistics” that include the size, composition, and

spatial distribution of the population at a certain point in time and “dynamic statistics” that include the causes of change in population dynamics such as fertility, mortality, and migration. Population censuses are the main type of static statistics. Dynamic statistics of population, under ordinary circumstances, can be developed from registrations or notifications of births and deaths. However, in countries that do not have systems to collect such data, often times estimates of national or regional fertility rates and all types of mortality rates (including infant mortality rates) are made based on population censuses and sample surveys. Because population censuses are central to the development of a country’s statistics system, the United Nations has made continued efforts to facilitate population censuses in all countries since the 1950s. Given all this, in order to further develop demographic statistics through conducting population censuses and sample surveys, more proactive promotion of technical assistance to developing countries is necessary.

In the meantime, technical assistance for statistics is already being carried out under an international framework, which must also be taken into consideration. For example, at the UN, and elsewhere, there is a growing awareness of new important issues such as the application of appropriate new technology to census activities; improvement of census management; the integrated use of data from administrative records based on censuses, sample surveys, and records; and the generation of statistics on gender, children and youth, and the elderly. This must be kept in mind when engaging in cooperation. It will also be useful to support projects that are conducting international comparative surveys on developing countries such as the World Fertility Survey and the Demographic and Health Survey that have been advocated by international organizations. Japan could also advocate and promote regional comparative surveys related to such issues as population, health, and family planning in Asia. In addition, the development of human resources is also important, and more trainees should be sponsored at the United Nations Statistical Institute for Asia and the Pacific (SIAP), hosted by the Japanese government.

There are not enough statistics available on developing countries in particular and there are a number of problems, such as accuracy, with the statistics that do exist. It therefore requires some creative manipulation of incomplete data in order to construct useful indicators. Also due to the substantial differences that exist in the culture, history, society, and economic background of various countries, it is necessary to support basic research reflecting each of these factors. Furthermore, in order to deal with such global challenges as aging and international migration, it will prove useful to support international population research groups (e.g. the International Union for the Scientific Study of Population (IUSSP)), and research on broader issues including the implementation of multilateral regional comparative studies.

5-2 Recommendations for JICA's assistance

5-2-1 Recommendations for Japan's National Policy

Clarification of an integrated Japanese policy

There is no explicit policy on the part of the Japanese government for an integrated approach toward population. Because each government ministry implements its own projects, redundancy exists among government ministries and aid executing agencies, it is difficult to know whether projects are being carried out effectively or efficiently. First of all, the Japanese government must develop an integrated policy for its population assistance to developing countries, and then must explicitly formulate assistance strategies and objectives for population issues as a part of its medium- and long-term development assistance program.

5-2-2 Suggestions and specific strategies for JICA's cooperation in the field of population

The issue of population is a cross-cutting issue, involving all fields such as health and medicine (family planning), economics, education, gender, poverty, and community development. For this reason, when Japan formulates a development strategy for population, it is necessary for Japanese population experts and development experts to cooperate in examining measures that transcend bureaucratic barriers. One example of good practice is the GII (Global Issues Initiative concerning population and HIV/AIDS), implemented from 1994 to 2000. The most significant achievement of the GII is that it officially adopted for the first time the concept of a comprehensive program approach for Japanese ODA, with respect to the cross-cutting issue of population. It is hoped that further cooperation will be made to encourage the trend towards a comprehensive program approach promoted by the GII Suggestions and Specific Strategies for JICA's Cooperation in the Field of Population.

(1) Challenges in and recommendations for JICA's population projects

JICA has implemented its cooperation by the type of assistance or "scheme" to date, but rarely have schemes been linked together in an organized way to be more efficient and produce greater results. Currently, JICA is designing "Country-Specific Project Implementation Plans" based on the Country-Specific Assistance Plan designed by the Ministry of Foreign Affairs (MOFA), and making efforts to efficiently link the projects that are carried out by different departments. In addition, the Regional Department has taken that same Plan and is actively promoting the Program Approach in which schemes and sectors are combined flexibly. Also, as for the budget, from FY2002 the Project-Type Technical Cooperation Project Fund will no longer be used, but instead will be integrated into the Overseas Technical Cooperation Project Fund resulting in improvements such as reducing the barriers between schemes. In the future it is necessary to continue introducing innovative measures of

this type and to raise the awareness of the JICA staff. At the same time it is important to increase the knowledge and understanding of the Program Approach by the concerned agencies, parties, and recipient countries so as to relate it to concrete results.

In order to carry out effective assistance in the field of population and development, a cross-sector perspective is important, and it is necessary to comprehend poverty, AIDS, and nutritional improvement in rural development in an integrated manner when formulating projects. In supporting the formulation of this type of plan, it is necessary to establish support committees with members from various backgrounds. It will also be valuable for JICA to accumulate the knowledge of and experiences in population assistance that have until now been kept by departments or individuals and store them as part of knowledge management in the framework of the "population field."

Furthermore, since population assistance is a field that brings about social changes and behavior modification in individuals, it is necessary to have a perspective that is rooted in local needs and to effectively harmonize and collaborate with the assistance activities of international agencies, other donors, and NGOs. This requires a field-led framework for formulating and implementing projects, and the strengthening of coordination in Tokyo (among government ministries, and among JICA project departments, etc.) while continuing to further delegate authority to the field.

(2) Specific Strategies for Dealing with Issues

1) Formulation of a long-term design

Since population assistance is a field that requires social reform and behavior modification, it takes a long time to see outcomes and it is difficult to achieve an outcome by single individual projects. Firstly, it is necessary to develop a JICA population program, and then create a long-term comprehensive design for each country or region. A network for the "Population and Healthcare" field and issues was officially introduced in JICA in 2002, but in light of the fact that population affects various sectors, the possibility of establishing an independent field and issue network for population should be explored, which would include personnel with expertise in the areas of development economics, agriculture, environment, education, and city planning.

2) Expansion of the Program Approach

Along with its organizational reform, JICA has officially adopted the Program Approach, and has started linking existing schemes from FY2002. It would be desirable to take advantage of this opportunity to further strengthen and increase coordination among departments, as well as to look into coordination among the Research Division, Japan Overseas Cooperation Volunteers (JOCV), and Grant Aid Cooperation, and undertake a comprehensive examination of coordination between the headquarters and the field level and the feasibility of adopting a global and multi-sectoral approach.

3) Cultivating human resources and building a human network

One of the greatest challenges Japan faces in actually carrying out cooperation in the field of population and development is a shortage of human resources. The recommendations specifically from the perspective of developing human resources in the population and development field and for building a human network are as follows: 1) Clarify the stumbling blocks in the system related to Expert Dispatch and expand the scope of recruitment for Expert and JOCV assignment. 2) Build a system that will facilitate the dispatch of Third Country Experts, Domestic NGO Experts, and Experts from International Agencies to JICA projects. 3) In particular, with respect to partnerships with NGOs, utilize grassroots technical cooperation projects, and proactively support the expansion of NGOs into overseas development work. 4) Look into specific training on population issues for staff who are interested in global hotspots for population issues or staff who are already specialized in such areas. 5) With respect to the planning and implementation of cooperation, create training opportunities for people who are involved in this work (JICA staff, experts, etc.) so that they can gain a sufficient understanding of Japan's experience and can use it effectively in their cooperation activities. 6) Encourage even more effective utilization of training programs to develop personnel who can take a comprehensive approach to population issues in developing countries. 7) Support the development of population experts in developing countries. 8) Aim for the effective utilization of JOCV volunteers who have returned home, and establish for them a long-term overseas training program specifically for the population and development field. 9) Construct a network of human resources in the field of population in Japan. 10) formulate a human resources development plan for JICA staff. 11) Utilize a public recruiting system to identify experts.

4) Domestic assistance system

To strengthen the domestic support system, the Study Group recommends the creation of population and development field-specific assistance committees. We recommend enlisting a wide range of experts, not only from demography, and the health and medical fields, but also from the fields of gender, poverty reduction, and social/rural/community development. We also recommend the establishment of a regular meeting between Japanese NGOs in the field of population and research agencies, along with the expansion of a knowledge management system and the widespread provision of such a system outside of JICA.

5) Overseas support system

To strengthen the overseas support system, the Study Group recommends the formation of a comprehensive system. This system should include the deployment of "Expert Teams" who will play a field-specific policy advisory role in overseas offices; the dispatch of coordinators (project formulation

advisors, etc.) who will promote partnerships between those in the population field and those in other fields, an increase in staff who have knowledge of the field of population and development in the countries and regions that are identified as the hotspots of population, and the promotion of partnerships with local NGOs, universities, and agencies.

6) Coordination with projects supported by funds contributed by Japan to international organizations

The Japanese government is making voluntary contributions in large amounts to each of the international organizations in the field of population, and JICA projects should promote cooperation with the programs implemented by such international organizations. Examples would be cooperation between JICA projects and funds contributed to under the World Bank, such as PHRD (Population and Human Resources Development Fund), JSDF (Japan Social Development Fund), and PRSTF (Poverty Reduction Strategy Trust Fund), funds for building human resources (including the South-South Cooperation Fund), and WID fund contributed to under the UNDP, as well as voluntary contributions to UNFPA.

5-2-3 Partnerships with other agencies

(1) Partnerships and coordination with other donors

Aid harmonization between donors at the field level in developing countries, particularly in the areas of health and population, is progressing rapidly. One of the reasons for this is the advancement of the implementation of country-specific and sector-specific strategies, represented by the formulation of Millennium Development Goals (MDGs), Poverty Reduction Strategy Papers (PRSPs), and the Sector Wide Approach (SWAP). This is an area to which JICA must also give due consideration and make adjustments, and in which its contributions will be essential.

In the past, much of the sub-sector based cooperation that has been implemented by many donors, including Japan, has now been integrated into the SWAP and is being carried out through this approach. In carrying out its cross-sectoral cooperation, JICA must proactively participate in dialogues with donors that focus on the developing country itself, and provide assistance that is consistent with the overall health population plan. To do so, it must acquire knowledge not only of the specialties of each field, but also concerning development in order to formulate country-specific plans. Additionally, from FY2001, it was approved that MOFA can invest in the common fund under the “Sector Grant” framework of the Grant Assistance Program. Through the future utilization of this type of funding, Japanese assistance can contribute even more effectively to development in the field of health and population in developing countries.

(2) Partnerships with the government and civil society

If the "take an individual approach" is used in cooperation in the areas of population and reproductive health, partnerships with NGOs will be indispensable from the perspective of Japan's postwar experience and field surveys. In addition to partnerships between domestic and field NGOs, partnerships and information-sharing with well-known international NGOs will be useful, and we are looking forward to the creation of such a system.

5-2-4 South-South Cooperation

In order to undertake effective assistance with limited resources to support the wide range of needs in the area of population, it is also important to utilize South-South cooperation. It is essential to give consideration to the social environment, such as the culture, tradition, religion, customs, and language when cooperating in the field of population, and an effective approach to this will be to conduct cooperation between developing countries that have similar social environments. In particular, with regard to certain cultural and religious groups, it will be helpful to enlist South-South cooperation for countries whose religions are restrictive toward contraception and women's reproductive rights.

Specific examples of this type of cooperation could include: "HIV/AIDS Prevention and Adolescent Sex Education" fields in which Japan itself has little experience, "Regional Cooperation Through IT" in which we can respond even more effectively through broader regional alliances, "Joint Research on Population Measures and Economic Development" related to issues that are common to various regions such as aging, urbanization, and international migration, and "Asia/Africa Cooperation" to share the Asian population development experience with Africa.

References

Asahi Shimbun (May 3, 2002 Morning edition) *Ajia e no hasshin NGO ni kitai* [Expectations of NGOs Dispatched to Asia].

Haupt, Arthur & Kane, Thomas (Japanese version compiled by Shigemi Kono) (1998) Population Handbook, Ohtake Foundation.

Ashino, Yuriko & Toda, Kiyoshi (1996) *Jinko kiki no yukue* [Future of a Population Crisis], Iwanami Shoten Publishers.

Atoh, Makoto (1994) "The global significance of the Cairo Conference: the new Program of Action of the International Conference on Population and Development" *Jinko Mondai Kenkyu [Journal of Population Problems]*, Vol.50, No.3, pp.1-17, Tokyo, Japan.

Atoh, Makoto (1999a) "*ICPD + 5; Kairo kodo keikaku; gonenme no hyoka* [ICPD + 5; The Cairo Program of Action: Evaluation of its Fifth Year]," *Journal of Population Problems*, 55-3.

Atoh, Makoto (1999b) "Water Resources as a Limiting Condition on World Population," in Constraints on Development-Focusing on China and India, Tokyo, The Asian Population and Development Association.

Atoh, Makoto (2000) "Chapter 7 - Japanese Demographic Transition" in Contemporary Demography—Basic Knowledge about Aging Societies with Below-Replacement Fertility, Tokyo, Nihon-Hyohronsha.

Atoh, Makoto (2000) *Gendai Jinkougaku: Shoushi Koureishakai no Kisochishiki* [Contemporary Demography—Basic Knowledge about Aging Societies with Below-Replacement Fertility], Tokyo, Nihon-Hyohronsha.

Araki, Mitsuya (2001) "*Hanseiki ni oyobu ODA no rekishi kara nani wo manabebaii no ka oubei no karimono de wa nai Nihon dokuji no rinen wo moto* [What Should We Learn from our Experience with a Half-century of ODA: Developing an Independent Japanese Vision, not Borrowing from Europe and the US]," *International Development Journal* No.35, pp.6-7, International Development Journal Co., Ltd.

Ikegami, Kiyoko and Takahashi, Keiko (2002) The Second Study Group on Development Assistance for Population and Development (7th study meeting). Lecture notes and handouts.

Japan Aging Research Center (2002) "*Dai nikai koreika ni kansuru sekai kaigi ni sankashite* [Participating in the Second International Conference on Aging]," *Aging*, Summer issue, Japan Aging Research Center.

Okazaki, Youichi (1995) *Gendai Nihon Jinkoron* [On the Population of Present-Day Japan] (Revised Edition), Kokon Shoin.

Okazaki, Youichi (2002) "*Senzen no Jinko Seisaku* [Prewar Population Policy]," *Encyclopedia of Population*, Baifukan Co., Ltd.

Okazaki, Youichi et al. (1984) "*Kokuren kokusai jinko kaigi no gaikyo* [Overview of the United

Nations International Population Conference],” *Journal of Population Problems*, 172.

Ogawa, Naohiro (1980) *Shussei yokusei no keizaiteki gein* [Economic Gains from Controlling the Birthrate],” Keizai Shushi, Vol.50, 1980, pp.35-60.

Ogawa, Naohiro (2002) *Hon Kenkyukai Hokokusho* [The Report of the Second Study Group on Development Assistance for Population and Development]

Ozaki, Michio and Hashiguchi, Michiyo (1999) United Nations Population Development Special General Assembly Report.

Ministry of Foreign Affairs (ed. and trans.) (1996) *Kokusai jinko kaihatsu kaigi ‘kodo keikaku’ – Kairo kokusai jinko kaihatsu kaigi (9/5-13/1994) Saitaku bunsho* [Population and Development: Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994].

Ministry of Foreign Affairs, Japan and the Japan International Cooperation Agency (2000) *Official Development Assistance Annual Report 1999*.

Ministry of Foreign Affairs, Japan and the Japan International Cooperation Agency (2001) *Official Development Assistance Vol.1 and 2*. APIC: Association for Promotion of International Cooperation.

Kawashima, Hiroyuki et al. (2001) “*21seiki ni okeru sekai no shokuryo seisan* [Global food production in the 21st Century],” Institute for Studies of the Global Environment of Sophia University, *Chikyu kankyo to kagaku gijutsu II* [Global Environment and Scientific Technology II], Sophia University Press.

Kitamura, Kunio (1999) “*Teiyoryo piru tte donna hininyaku nano?* [What Kind of Contraceptive is the Low-dosage Birth-control Pill?],” *Egao* [Smile], Sept. 1999, Health Insurance Association for METI related agencies.

Kubo, Hidefumi (1997) *Nihon no kazoku keikakushi – Meiji / Taisho / Showa* [History of Family Planning in Japan; Meiji, Taisho, and Showa], Japan Family Planning Association, Inc.

Kuroda, Toshio (1974) “*Kokuren sekai jinko kaigi hokoku – konran kara dakyo, soshite ninshiki e* [United Nations Global Population Conference Report: From Chaos to Compromise, Then to Recognition],” *Journal of Population Problems*, 132.

Kono, Shigemi (1997) “*Feminizumu wa chikyu o sukuu ka: Kairo puroguramu saiko* [Does Feminism Save the Earth? Reassessment of the Cairo Program],” *Jinkogaku Kenkyu (The Journal of Population Studies)*, No.20, pp.37-46.

UNFPA (1995) *The State of World Population 1995*, New York.

UNFPA (2000) *The State of World Population 2000*: Gender Equality and the Glass Ceiling: Time for Reform, New York.

UNFPA (2001) United Nations Population Fund, *The State of World Population 2001*, New York.

Kobayakawa, Takatoshi (JICA (Japan International Cooperation Agency), ed.) (1998) *Kokusai hoken iryo kyoryoku nyumon* [Introduction to International Health Cooperation], Japan International Cooperation Publishing Co., Ltd.

Komatsu, Ryuichi (2000) "*HIV/AIDS ga jinko ni ataeru eikyo* [Effects of HIV/AIDS on Population]," *Jinkogaku Kenkyu (The Journal of Population Studies)*, (27) 52-56.

Komatsu, Ryuichi (2001) "Behavioral Studies and AIDS Prevention in Asia: the Case of Thailand," The Journal of AIDS Research, 3 (1).

Ministry of Health and Welfare (1988) *Koseisho goju nenshi (kijutsuhen)* [50-Year History of the Ministry of Health and Welfare (Descriptive section)], Kouseimondai Kenkyukai Foundation.

Kon, Yasuo (2000) "*Wagakuni no kazoku keikaku undo no ayumi* [The Path of Japan's Family Planning Movement]," *Kazoku keikaku binran 2000 – Shoshi korei shakai to ripuro herusu* [Family Planning 2000 Manual - Decreasing Children, Aging Society and Reproductive Health], Japan Family Planning Association, Inc. 15-23.

Kon, Yasuo (2002) *Dai ni kai jinko to kaihatsu bunyabetsu enjo kenkyukai (dai 10 kai kenkyukai) koenroku* [Study Group on Development Assistance for Population and Development (10th study group) lecture notes].

Kusano, Atsushi (1997) *ODA no tadashi mikata* [The Correct Way of Looking at ODA], Chikuma Shobo Publishing Co., Ltd.

Japan International Cooperation Agency (1992) Study on Development Assistance for Population and Development, Japan International Cooperation Agency.

Japan International Cooperation Agency (2001a) JICA Annual Report 2001, Japan International Cooperation Agency.

Japan International Cooperation Agency (2001b) JICA Annual Evaluation Report 2001, Japan International Cooperation Agency.

Japan International Cooperation Agency (2002) Handouts for JICA Evaluation Seminar on the "JICA-USAID Collaboration Review."

Japan International Cooperation Agency Medical Cooperation Department (2001) *Hoken iryo bunya gijutsu kyoryoku purojekuto gaiyohyo (OTCA jidai – 7/1/2001)* [Medical Technology Cooperation Project, Overview (the OTCA era to July 1, 2001).

Japan International Cooperation Agency Medical Cooperation Department, *Kaigai iryo kyoryoku iinkai kaigi jiroku dai 1 kai – dai 33 kai* [Proceedings of the Overseas Medical Cooperation Committee Meetings 1 – 33].

Japan International Cooperation Agency Institute for International Cooperation (2001) Rethinking Poverty Reduction: PRSP and JICA, Japan International Cooperation Agency.

Japan International Cooperation Agency Institute for International Cooperation (2002) Approaches for the Systematic Planning of Development Projects: Anti-HIV/AIDS Measures, Japan International Cooperation Agency.

International Medical Center of Japan (2001) "*Kokusai hoken iryo kyoryoku handobukku* [International Health Cooperation Handbook]," The International Development Journal Co., Ltd.

International Development Center of Japan (Commissioned by the Ministry of Foreign Affairs) (2002) Evaluation Study on the Global Issues Initiative on Population and AIDS (GII).

Sagaza, Haruo (2000) "*Jinko koreika to shakai hendo* [Population Aging and Societal Changes]" in Yoshikuni Ishi et al., ed. *Ajia no jinko mondai* [Population Problems in Asia], Tokyo, Taimeido

Sagaza, Haruo (2001) The Second Study Group on Development Assistance for Population and Development (4th study meeting). Lecture notes and handouts.

Sagaza, Haruo (2002) The Second Study on Development Assistance for Population and Development. Proceedings from the 4th meeting.

Health and Welfare Statistics Association (2002) in *Kokumin eisei no doko* [Activities in National Health] 2002 Vol.49 No.9), Health and Welfare Statistics Association.

Satoh, Ryuzaburo (2000) "*Ripurodakutibu herusu/raitsu to gendai shakai* [Reproductive Health and Rights and Modern Society]" in Atoh and Hayase, (eds.) *Jenda to Jinko Mondai* [Gender and Population Problems], Tokyo, Taimeido.

Sato, Hiroshi (2002) Lecture notes from "*The Livelihood Improvement Movement (LIM) in Postwar rural Japan: a Successful Experience of Multi-sector Social Development*," presented at a symposium on agricultural development in postwar Japan and in developing countries (April 24, 2002).

GII Roundtable NGO Group (2001) *GII kokunai koho kyanpein hokokusho* [Report on the Domestic Publicity Campaign for GII].

Japanese Organization for International Cooperation in Family Planning, Inc. (1998) "Chance and Challenge – *Atarashi JOICFP wo mezashite* [Working towards a new JOICFP]—30 Years 1968-1998."

Japanese Organization for International Cooperation in Family Planning, Inc. (2000) *Heisei 11 nendo gaimusho kaigai gijutsu kyoryoku suishin dantai hojokin ni yoru jinko, kazoku keikaku moderu purojekuto suishin jigyo – chugoku purojekuto hyoka chosa hokokusho – hainansho konhaishi to shanshisho dariken purojekuto* [Evaluation Report on Population and Family Planning Model Projects in Qionghai City of Hainan Province and Dali County of Shaanxi Province in China undertaken through a Ministry of Foreign Affairs FY1999 Technical Cooperation Promotion Group Subsidy], Japanese Organization for International Cooperation in Family Planning, Inc.

Japanese Organization for International Cooperation in Family Planning, Inc. (2000) *Heisei 11 nendo gaimusho kaigai gijutsu kyoryoku suishin dantai hojokin ni yoru jinko, kazoku keikaku moderu purojekuto suishin jigyo – chugoku purojekuto hyoka chosa hokokusho* [Evaluation Report on Projects in China - Population and Family Planning Model Project Undertaken through a Ministry of Foreign Affairs FY1999 Technical Cooperation Promotion Group Subsidy], Japanese Organization for International Cooperation in Family Planning, Inc.

Japanese Organization for International Cooperation in Family Planning, Inc. (2002) *Jinko kazoku keikaku ripurodakutibu herusu bunya kokusai kyoryoku jigyo chugoku IP hyoka ronbun hokokushu* [International Cooperation Activities in Population, Family Planning and Reproductive Health – Report of Evaluation and Research on China's IP], Japanese Organization for International Cooperation in Family Planning, Inc.

Japanese Organization for International Cooperation in Family Planning, Inc. (2002) *Jinko kazoku keikaku ripurodakutibu herusu bunya kokusai kyoryoku jigyo chugoku IP hyoka ronbunshu – boshi hoken kiseichu yobo nado no kenko kyoiku hoken sabisu katsudo ni yoru kazoku keikaku ripurodakutibu herusu no integureshon purojekuto 18 nen no keiken* [International Cooperation Activities in Population, Family Planning and Reproductive Health – Report of Evaluation and Research on China's IP – Integrated project (IP) for Reproductive Health through Maternal and Child Health, Health Education regarding Parasites, and Health Care Activities –Experience over 18 years].

Suzuki, Ryoichi (1994) "*Sekai ni hirogaru JOICFP no IP* [JOICFP's IPs Throughout the World]" in *Kazoku keikaku binran 1994* [Family Planning Manual 1994], Japan Family Planning Association, INC. 217-226.

Suzuki, Ryoichi (2002) "*Jinko ripurodakutibu herusu kokusai kyoryoku wo kangaeru* [Thinking about International Cooperation in Population and Reproductive Health]" in *Jinkogaku Kenkyu (The Journal of Population Problems)*, Vol.30, 2002, 5, 76-81.

T.G. Outlaw, et al. (1998) *Mizu wo itsumademo: jinko to saiseikanona mizu kyokyu no shorai – kaitei data* [Sustaining Water, Easing Scarcity: A Second Update (Revised Data for the Population Action International Report, Sustaining Water: Population and the Future of Renewable Water Supplies)], Population Action International.

Meadows, Donella H., et al. The Limits to Growth: A Report for the Club of Rome's Project on the Predicament of Mankind. New York: Universe Books, *1972*, (translation supervised by Saburo Okita (1972), Diamond Co., Ltd.).

Meadows, Donella H., et al. (Takaharu Matsuhashi, et al. trans.) (1992) Beyond the Limits, Diamond Co., Ltd.

JICA website, Global Issues, What we do.

Population Association of Japan (ed.) (2002) *Encyclopedia of Population*, Baifukan Co., Ltd.

Nishiuchi, Masahiko (2001) *Rensai 6 Nihon no ripuro herusu / raitsu no akebono – Kubo Hidefumi, Muramatsu Minoru ni kiku, Ugokidashita sanji seigen* [Part 6 of Japan's Reproductive Health and Rights Interview with Hidefumi Kubo and Minoru Muramatsu - Birth Control Now Underway], Japanese Organization for International Cooperation in Family Planning, Inc.

Nishiuchi, Masahiko (2001) *Rensai 7 Nihon no ripuro herusu / raitsu no akebono – Kubo Hidefumi, Muramatsu Minoru ni kiku, Moderu mura de shido hajimaru* [Part 7 of Japan's Reproductive Health and Rights Interview with Hidefumi Kubo and Minoru Muramatsu – Counseling Starting in Model Villages], Japanese Organization for International Cooperation in Family Planning, Inc.

Nishiuchi, Masahiko (2001) *Rensai 8 nihon no ripuro herusu / raitsu no akebono – Kubo Hidefumi, Muramatsu Minoru ni kiku Seifu ga jutai chosetsu shido ni noridasu* [Part 8 of Japan's Reproductive Health and Rights Interview with Hidefumi Kubo and Minoru Muramatsu – Government Launching of Birth Control Counseling]. Japanese Organization for International Cooperation in Family Planning, Inc.

Nishigata, Noriko (2002) Lecture materials from *Seikatsu kaizen katsudo no jissen keiken: "kangaeru nomin" no ikusei kara shuraku no infura seibi made* [Practical Experiences of the Livelihood Improvement Movement: from the Training of "Thoughtful Farmers" to the Construction and Improvement of the Infrastructure of Villages], presented at a symposium on rural developments in postwar Japan and in developing countries (April 24, 2002).

Nishikawa, Jun (2001) "The Theoretical Framework of Social Development," in Jun Nishikawa (ed.) *Shakai kaihatsu – keizai kaihatsu kara ningen chushingata hatten e* [Social Development – From Economic Development to Human-centered Development]. Iwanami Shoten, Publishers.

Norway, Ministry of Foreign Affairs (Japan International Cooperation Agency Planning Department, Evaluation and Management Section, trans.) (1996) *Kaihatsu enjo no hyoka – hyoka no tame no handobukku* [Evaluation Handbook for the Evaluation of Developmental Aid]. Japan International Cooperation Agency.

Hasegawa, Toshihiko (2001) The Second Study Group on Development Assistance for Population and Development (3rd study meeting). Lecture notes and handouts.

Hyodo, Chika (2000) "*Kokusai jinko kaigi kodo keikaku to shishunki ripurodakutibu herusu/raitsu* [International Population Conference Action Plan and Early Adolescent Reproductive Health and Rights]" in Hara and Nomura (eds.) Health and Gender. Akashi Shoten Co., Ltd.

FY2000 Japan International Cooperation Agency Member Research Report (2001) *Jinko mondai ni taisuru soron to kadai (zenpen) – soron, shusseiritsu to ripurodakutibu herusu/raitsu, shiboritsu to HIV/AIDS* [Overview and Challenges of Population Problems (part one) – Overview, Birth Rates and Reproductive Rights and Health, Mortality Rates and HIV/AIDS].

FY2000 Japan International Cooperation Agency Member Research Report (2001) *Jinko mondai ni kansuru soron to kadai (kohen) – Jinko koreika, kokusai jinko ido, toshika / kokunai jinko ido* [Overview and Challenges of Population Problems (part two) – Aging of the Population, International Population Migration, Urbanization and Domestic Population Migration].

FY2001 Japan International Cooperation Agency Member Research Report (2002) *Chuto isuramu sekai no jinko, kazoku, keizai – takakuteki shiza donyu no kokoromi* [Population, Family and Economics in the Middle Eastern Islamic World – Attempts to Introduce Multilateral Viewpoints].

Boland, Reed (1997) *Sei to seishoku ni kansuru kenri – ripurodakutibu raitsu no suishin* [Promoting Reproductive Rights: Sex and Reproductive Rights] (Katsura Fusano, trans.). Akashi Shoten Co., Ltd.]

Makabe, Sayoko (2002) *Hinin no subete ga wakaru hon* [Understanding Everything about Birth Control]. Kodansha Ltd.

Muramatsu, Minoru (2002) *Sengo no kajo jinko to sanji seigen* [Postwar Overpopulation and Birth Control]. *Encyclopedia of Population*. Baifukan Co., Ltd.

Muramatsu, Yasuko (1996) "*Enpawamento ni mukete* [Towards Empowerment]," in Yasuko Muramatsu and Yasuko Muramatsu eds. *Enpawamento no joseigaku* [Women's Studies of Empowerment].

Yukihako Publishing Co., Ltd.

Mizuta and Hashiguchi (committee members) (2001) The Second Study Group on Development Assistance for Population and Development (3rd study meeting). Lecture notes and handouts.

Meguro, Yoriko (1986) *Onna yakuwari – sei shihai no bunseki* [Women's Role – Analyzing Sexual Control]. Kakiuchi Shuppan.

Yanagishita, Machiko (2001) "*Jinko mondai to jenda* [Population Problem and Gender]," in Makoto Satoh (ed.) *Shakai kaihatsu ron – nanboku kyosei no paradaimu* [Social Development Theory – Paradigm of North-South Co-existence]. Yushindo.

Jansson-Yanagisawa, Yumiko (1997) "*Karada to sei, watashi wo ikiru* [The Body and Sex, Living my Life]" in Reproductive Health and Rights. Kokudosha.

Yomiuri Shimbun (May 21, 2002, Morning ed.) *Tojokoku demo mondai shinkoku/chakujitsu ni susumu taisaku sakutei* [Worsening Problems even in Developing Countries – Progressing on Designing Countermeasures].

Ripurodakutibu ho to seisaku sentahen [Reproductive Law and Policy Center] (ed.) (1997) *Ripurodakutibu raitsu – sekai no ho to seisaku* [Reproductive Rights – Laws and Policies Around the World] Katsura Fusano (trans.). Akashi Shoten Co., Ltd.

Wagatsuma, Takashi (2002) Reproductive Health. Nankodo Co., Ltd.

Watanabe, Machiko (2000a) "Urbanization and Labor Migration in Asia" in Yoshikuni Ishi & Yasuko Hayase (eds.) Population Problems in Asia. Tokyo, Taimeido.

Watanabe, Machiko (2000b) *Toshika / keizai kaihatsu to jinko ido – Ajia wo rei to shite* [Urbanization, Economic Development and Population Migration – Asia's Example]. IDE World Trend, Vol.58 No.7.

Ahlburg, Dennis A. (1998) "Julian Simon and the Population Growth Debate," Population and Development Review, 24-2.

Alan Guttmacher Institute (AGI) (1998) Into a New World: Young Women's Sexual and Reproductive Lives, AGI.

Alan Guttmacher Institute (AGI) (1999) Sharing Responsibility: Women, Society and Abortion Worldwide, The Alan Guttmacher Institute, New York.

Andreev, E. (1999) "The Dynamics of Mortality in the Russian Federation," in United Nations, Health and Mortality Issues of Global Concern, Proceedings of the Symposium on Health and Mortality (Brussels, 19-22 November 1997), United Nations.

Ashford, S. Lori (2001) "New Population Policies: Advancing Women's Health and Rights," *Population Bulletin* Vol.56, No.1.

Bangladesh Demographic and Health Survey 1999-2000.

Becker, Charles, M. and Andrew R. Morrison (1999) "Urbanization in Transforming Economies." in Paul Cheshire and Edwin S. Mills (eds.) Handbook of Regional and Urban Economics, Vol.3. Applied Urban Economics, New York: Oxford University Press, pp.1673-1790.

Bobak, Martin. (1999) “Health and Mortality Trends in Countries with Economies in Transition,” in United Nations, Health and Mortality Issues of Global Concern, Proceedings of the Symposium on Health and Mortality (Brussels, 19-22 November 1997), United Nations.

Bongaarts, John (1992) “Population Growth and Global Warming,” Population and Development Review, 18-2.

Bongaarts, John (1997) “The role of family planning programmes in contemporary fertility transitions” in G.W. Jones et al. (eds.) The continuing demographic transition, Clarendon Press, Oxford.

Boserup, Ester (1965) The Conditions of Agricultural Growth: The Economics of Agrarian Change under Population Pressure, Aldine.

Brown, Lester R., et al. (1998) Chinese Water Shortage Could Shake World Food Security, Worldwatch Institute.

Brundland, G. H. (1987) Our Common Future, World Commission on Environment and Development, Oxford University Press.

Brockerhoff, Martin (1998) “Migration and the Fertility Transition in African Cities.” in Bilsborrow, Richard (ed) Migration, Urbanization, and Development: New Directions and Issues. New York: United Nations Population Fund and Kluwer Academic Publishers, pp.357-390.

Brockerhoff, Martin (1999) “Urban Growth in Developing Countries: A Review of Projections and Prediction,” Population and Development Review 25 (4): 757-778.

Brockerhoff, Martin (2000) “An Urbanizing World.” Population Bulletin 55 (3). Washington, DC: Population Reference Bureau.

Brockerhoff, Martin, and Ellen Brennan (1998) “The Poverty of Cities in Developing Regions.” Population and Development Review 24 (1): 75-114.

Cleland, J. G. and Wilson, C. (1987) “Demand Theories of Fertility Transition: An Iconoclastic View,” Population Studies, 41-1.

Coale, Ansley et al., 1958. Population Growth and Economic Development in Low Income Countries: A Case Study of India's Prospects, Princeton University Press.

Cohen, J. (1995) How Many People Can the Earth Support? W.W. Norton.

Conly, S.R. and S. de Silva (1998). Paying Their Fair Share? : Donor Countries and International Population Assistance, Population Action International.

Chen, Nancy, Paolo Valente, and Hania Zlotnik (1998) “What Do We Know About Recent Trends in Urbanization?” in Bilsborrow, Richard (ed) Migration, Urbanization, and Development: New Directions and Issues. New York: United Nations Population Fund and Kluwer Academic Publishers, pp.59-88.

Coale, A.J., and E.M. Hoover (1958) *Population Growth and Economic Development in Low-Income Countries. Princeton*: Princeton University Press.

Crimmins, Eileen M., Mark D. Hayward, and Yasuhiko Saito (1994) “Changing Mortality and Morbidity Rates and the Health Status of Life Expectancy of the Older Population,” *Demography*, 31:159-175.

Des Jalais, D.C., Marmor M., Paone D., et al. (1996) "HIV incidence among injecting drug users in New York City syringe-exchange programmes," Lancet, 348 (9033) : 987-91.

Dixon-Mueller, Ruth (1993) Population policy and women's rights: transforming reproductive choice, Westport, Connecticut: Praeger.

Dixon-Mueller, Ruth and Germain (1992) "Stalking the Elusive 'Unmet Need' for Family Planning," Studies in Family Planning, 23-5.

Ehlich, Paul R., et al. (1971) "Impact of Population Growth," Science, 171.

Ehlich, Paul R. 1990. The Population Explosion, Simon and Schuster.

Ellen Grant (1985) Haruhiko Imanishi (ed. and trans.) (1992) The Bitter Pill. Medicus Shuppan, Publisher.

Enke, S. (1966) "The economic aspects of slowing population growth," *Economic Journal* 76: 44-56.

Falkenmark, Malin (1991), Rapid Population Growth and Water Scarcity: The Predicament of Tomorrow's Africa, K. Davis et al., (eds.), Resources, Environment and Population: Present Knowledge, Future Options, Oxford U.P.

Falkenmark, Malin et al. (1992) Population and Water Resources: A Delicate Balance, Population Bulletin, Population Reference Bureau.

FAO (1999) The State of Food Insecurity in the World, FAO.

Findley, Sally E. (1993) "The Third World City: Development Policy and Issues" in Kasarda J.D. and Parnell, A.M. (eds.) Third World Cities: Problems, Policies, and Prospects. Newbury Park: Sage, pp.1-31.

Flemming, D.T. and Wasserheit J.N. (1999) From epidemiological synergy to public health policy and practice, Sexually Transmitted Infection, 75 (1) : 3-17.

Gelbard, Alene, Carl Haub, and Mary M. Kent (1999) "World Population Beyond Six Billion." Population Bulletin, 54 (1).

Guay L.A, Musoke P., Fleming T., et al. (1999) "Intrapartum and neonatal Single-dose Nevirapine compared with Zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda, Lancet," 354 (9181) : 795-802.

Harris, John R., and Michael P. Todaro (1970) "Migration, Unemployment and Development: A Two-Sector Analysis." American Economic Review 60: 126-142.

Harris, J.R., and Michael P. Todaro (1970) "Migration, unemployment, and development: a two sector model," American Economic Review, No.60.

Hartmann, Betsy (1995) Reproductive Rights and Wrongs (revised edition), Boston: South End Press.

Hasegawa T. (2001) "Challenging Inequities in Health from Ethics to Action," Oxford University Press.

ICMOP Newsletter on Management of Population Programmes Vol.XXVI No.3. 2001 International Council on Management of Population Programmes.

Im-em W. (1999) Mortality trends and levels to verify the AIDS Epidemic in Thailand, Institute for Population and Social Research, Mahidol University; Nakhon Pathom, Thailand.

International Organization for Migration (IOM) (2000), World Migration Report 2000. Geneva.

IPCC (2001) Summary for Policymakers: Climate Change 2001: Impacts, Adaptation and Vulnerability, IPCC.

Jain, Anrudh; Judith Bruce (1993) "Implications of reproductive health for objectives and efficacy of family planning programs," Programs Division Working Paper, No.8, 1993, New York: Population Council.

Jain, Anrudh, et al. (1992) "Setting Standards of Quality in Family Planning Programs," Studies in Family Planning, 23-6.

Johnson, S.P. (1994) World Population—Turning the Tide: Three Decades of Progress, Cambridge: Graham and Trotman.

Jones, G.W. (1988) "Consequences of rapid fertility decline for old age security," presented at the IUSSP Seminar on Fertility Transition in Asia: Diversity and Change, Bangkok.

Kasarda, John, D. and Allan M. Parnell (ed) (1993) Third World Cities: Problems, Policies, and Prospects. Newbury Park: Sage.

Kelley, A.C. (1988) "Economic consequences of population change in the Third World," Journal of Economic Literature 26: 1685-1728.

Khauna, J. et al. (eds.) (1992) Reproductive Health—a Key to a Brighter Future, Biennial Report 1990-1991: Special 20th Anniversary Issue, WHO.

Knodel, J. and van de Walle, E. (1979) "Lessons from the Past: Policy Implications of Historical Fertility Studies," Population and Development Review, 5-2.

Knodel, John and Gavin W. Jones (1996) "Post-Cairo Population Policy: Does Promoting Girl's Schooling Miss the Mark?" *Population and Development Review* 22 (4).

Lamb, Vicki L. (1999) "Active life expectancy of the elderly in selected Asian countries," NUPRI Research Paper Series No.69. Tokyo, Japan: Nihon University Population Research Institute.

Lee, R.D., A. Mason, and T. Miller (2001) "Saving, wealth, and the demographic transition in East Asia." In A. Mason ed., *Population Change and Economic Development in East Asia: Challenges Met, Opportunities Seized*, pp.155-184. Stanford: Stanford University Press.

Lewis, W. Arthur (1954) "Economic Development with Unlimited Supplies of Labor," Manchester School of Economic and Social Studies 22: 139-91.

Mason, A., ed. (2001) *Population Change and Economic Development in East Asia: Challenges Met, Opportunities Seized*. Stanford: Stanford University Press.

Mason, A., N. Ogawa, and T. Fukui (2001) "Aging, intergenerational transfers, and saving in Japan," presented at the NUPRI/IUSSP Seminar on Population Aging in the Industrialized Countries: Challenges and Responses, Tokyo.

Massey, Douglas S. (1996) "The Age of Extremes: Concentrated Affluence and Poverty in the Twenty-First Century," Demography 33 (4): 395-412.

Mazur, L. A. (ed.) (1994) Beyond Numbers, Island Press.

McDonald (1981) "Influence of Maternal Education on Infant and Child Mortality: Levels and

Causes," International Population Conference: Manila, IUSSP. Vol.2.

McNicoll, Geoffrey (1995) "On Population Growth and Revisionism," Population and Development Review, 21-2.

Moser, Caroline (1992) *Gender Planning and Development*, London & New York: Routledge.

Nelson K et al. (1996) "Changes in sexual behaviour and a decline in HIV infection among young men in Thailand." New England Journal of Medicine, 335: 297-303.

OECD (1999) Trends in International Migration. Annual Report 1999 Edition.

Ogawa, N., and D. Suits (1982) "Lessons on population and economic change from the Japanese Meiji experience," *The Developing Economies* 20: 196-219.

Ogawa, N., G. Jones, and J. Williamson, eds. (1993) *Human Resources in Development along the Asia-Pacific Rim*. Singapore: Oxford University Press.

Oppong, Christine (1983) "Women's Roles, Opportunity Costs, and Fertility," Bulatao, A.B. et al. (ed.), Determinants of Fertility in Developing Countries, Vol.1, Academic Press.

Palloni, Alberto, 2001. "Living Arrangements of Older Persons," United Nations Population Division, United Nations Technical Meeting on Population Aging and Living Arrangements of Older Persons: Critical Issues and Policy Responses, New York, 8-10 February, 2000.

Peter Bromwich & Tony Parson Contraception. Atsushi Kawagoe (ed. and trans.) (1995) *Hinin kakumei* [Contraception Revolution]. Kamawanu Shobo.

Pitchett, L.H. (1994) "Desired Fertility and the Impact of Population Policies," Population and Development Review. 20-1.

Presser, B. Harriet (2000) "Demography, Feminism, and the Science-Policy Nexus," in *Women's Empowerment and Demographic Processes: Moving Beyond Cairo* by H. Presser and G. Sen, New York: Oxford University Press.

Preston, Samuel H. (1979) "Urban Growth in Developing Countries: A Demographic Reappraisal," Population and Development Review, 5 (2) : 195-215.

Preston, Samuel (1994) Population and the Environment, IUSSP, Distinguished Lecture Series on Population and Development.

Romer, P.M. (1986) "Increasing returns and long-run growth," *Journal of Political Economy* 94: 1002-1037.

Schiff, Maurice (1996) "Trade policy and international migration: substitutes or complements?" In Development Strategy, Employment and Migration: Insights from Models, J. Edward Taylor, ed., Paris, OECD.

Schwartläder, et al. (1999) "Country-specific estimates and models of HIV and AIDS: methods and Limitations," AIDS, 13-17, pp.2445-2458.

Sen, Gita and Srilatha Batliwala (2000) "Empowering women for reproductive rights," in *Women's Empowerment and Demographic Processes: Moving Beyond Cairo* by H. Presser and G. Sen, New York: Oxford University Press.

Simon, J.L. (1959) "The value of avoided births in underdeveloped countries," *Population Studies* 23:

61-68.

Simon, Julian (1981) The Ultimate Resource, Princeton University Press.

Sjaastad, Larry A. (1962) "The costs and returns of human migration," Journal of Political Economy, No.705.

Stalker, Peter (1994) The Work of Strangers: A Survey of International Labor Migration, Geneva, ILO.

Stark, Oded, and David E. Bloom (1985) "The New Economics of Labor Migration." American Economic Review, 75 (2): 191-106.

Suits, D., and A. Mason (1978) "Measuring the gains to population control results from an econometric model," presented at the annual meeting of the Population Association of America, Atlanta, Georgia.

Suzan Wysock and Ann J.Davis, Handbook for Nurse Practitioners, Masako Horiguchi (ed. and trans.) (2000) *Josei no kenko wo mamoru tame no rinsho katsudo* [Clinical practices for women's health]. *Sei to kenko wo kangaeru josei senmonka no kai* [Organization for women specialists regarding sex and health].

UN (2000) World population prospects: The 1998 Revision, Volume III: Analytical report, United Nations, New York.

UN and UNAIDS (1999) "The demographic impact of HIV/AIDS, Report on the technical meeting," New York, 10 November 1998, UN Population Division.

UNAIDS (1998) Relationships of HIV and STD declines in Thailand to Behavioral Change: A Synthesis of Existing Studies, UNAIDS.

UNAIDS (2000a) Report on the Global HIV/AIDS Epidemic; June 2000, UNAIDS.

UNAIDS (2000b) Voluntary Counselling and Testing (VCT), UNAIDS Technical update.

UNAIDS (2002) Report on the Global HIV/AIDS Epidemic: 2002, UNAIDS.

UNAIDS and WHO (1997) Report on the Global HIV/AIDS Epidemic: December 1997, UNAIDS and WHO.

UNAIDS and WHO (1998a) AIDS Epidemic Update: December 1998, UNAIDS and WHO.

UNAIDS and WHO (1998b) Report on the Global HIV/AIDS Epidemic: June 1998, UNAIDS and WHO.

UNAIDS and WHO (1999) AIDS Epidemic Update: December 1999, UNAIDS and WHO.

UNAIDS and WHO (2000) AIDS Epidemic Update: December 2000, UNAIDS and WHO.

UNFPA (1993a) Population Growth and Economic Development, UNFPA.

UNFPA (1993b) Report of the Executive Director reviewing the Fund's experience in implementing the priority country system. DP/1993/33.

UNFPA (1995) The State of World Population 1995-Decisions for Development: Empowerment and Reproductive Health, UNFPA.

UNFPA (1996) A Revised Approach for the Allocation of UNFPA Resources to Country Programmes, Report of the Executive Director. DP/FPA/1996/15, 5 February 1996.

UNFPA (1997) The State of World Population 1997-Reproductive Health and Reproductive Rights,

UNFPA.

UNFPA (1998) The State of World Population 1998—The New Generations, UNFPA.

UNFPA (2001) The State of World Population 2001—Population and Environmental Change, UNFPA.

UNFPA Donor Support for Contraceptives and Logistics (2000).

UNFPA Reproductive Health Essentials (2002).

United Nations (1956) The Aging of Population and Its Economic and Social Implications.

United Nations (1980) Patterns of Urban and Rural Population Growth. New York: United Nations.

United Nations (1994) AIDS and the Demography of Africa. New York: United Nations.

United Nations (1994) Population and Development: Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September. Ministry of Foreign Affairs (ed. and trans.) (1996) *Kokusai jinko kaihatsu kaigi 'kodo keikaku'* — [The International Conference on Population and Development Programme of Action]. Sekai no Ugoki Sha.

United Nations (1995) "Population and Development: Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994. ST/ESA/SER.A/149, New York: United Nations.

United Nations (1998) World Population Monitoring 1997: International Migration and Development, New York.

United Nations (1998) World Population Prospects: The 1998 Revision, New York.

United Nations (1998) World Population Monitoring, 1996: Selected Aspects of Reproductive Rights and Reproductive Health, United Nations, New York.

United Nations (1998) Department of Economic and Social Affairs. National Population Policies. ST/ESA./SER.A/171.

United Nations (1999-a) The World at Six Billion, New York, United Nations.

United Nations (1999-b) Long-Range World Population Projections: Based on the 1998 Revision, New York.

United Nations (1999-c) Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development, 21st Special Session of the General Assembly, June 30 - July 2, 1999.

United Nations (1999) *World Abortion Policies* 1999, ST/ESA/SERA/178, New York: United Nations (http://www.un.org/esa/population/publications/abt/fabt.htm).

United Nations (1999) World population prospects: The 1998 Revision. New York: United Nations

United Nations (2000) The World's Women 2000: Trends and Statistics.

United Nations (2000a) Population Division Department of Economic and Social Affairs. World Urbanization Prospects: The 1999 Revision Data Tables and Highlights.

United Nations (2000b) Department of Economic and Social Affairs. Urban and Rural Areas 1999, ST/ESA/SER.A/185.

United Nations (2001) The World Population Prospects: The 2000 Revision, Highlight, New York: United Nations ESA/P/WP 165.

United Nations (2001a) World Population Prospects: 2000 Revision, Vol.1, New York, United Nations.

United Nations (2001b) World Population Monitoring 2001: Population, Environment and Development.

United Nations (2001c) HIV/AIDS: Population Impact and Policies, 2001.

United Nations (2002) World Urbanization Prospects: The 2001 Revision.

United Nations (2002) World Population on Aging 1950-2050.

United Nations (2002) International Plan of Action on Aging.

United Nations (forthcoming) Levels and Trends in International Migration in Asia.

United Nations High Commissioner for Refugees (UNHCR) (2000) Refugees and Others of Concern to UNHCR, 1999 Statistical Overview.

United Nations Secretariat (1988) "Global Trends and Prospects of Aging Population Structure," United Nations, Economic and Social Implications of Population Aging.

United Nations Population Fund (1996) The State of World Population 1996, Changing Places: Population Development and Urban Future. New York: United Nations.

US Bureau of Census (2000) International Database.

Van de Kaa, Dirk J. (1987) "The Second Demographic Transition," Population Bulletin, 42-1.

Van de Kaa (1999) "Europe and its Population: The Long View," in European Population Conference, European Population: Unity in Diversity, Dordecht, Kluwer Academic Publishers, pp.1-50.

WHO (2000) "The World Health Report 2000: Health Systems: Improving Performance" (online version, http://www.who.int).

World Bank (2000) Entering the 21st Century World Development Report 1999/2000, Washington D.C.: World Bank.

World Commission Urban 21 (2000) World Report on the Urban Future 21 published in conjunction with the Global Conference on the Urban Future (Bonn: Federal Ministry for Transport, Building and Housing, Federal Republic of Germany, 2000). Accessed on line at: www.urban21.de/english/

World Resources Institute (1994) World Resources 1994-5, Oxford University Press.

Williamson, J.G. (1993) "Human capital deepening, inequality, and demographic events along the Asia-Pacific rim." In N. Ogawa, G. Jones, and J. Williamson, eds., *Human Resources in Development along the Asia-Pacific Rim*, pp.129-58. Singapore: Oxford University Press.

Zaidan, G. (1968) *The Foregone Benefits and Costs of a Prevented Birth: Conceptual Problems and an Application to the U.A.R.* International Bank for Reconstruction and Development, Economics Department Working Paper No. 11.

Zeng, Yi et al. (2001) "Extremely Rapid Aging and the Living Arrangements of Older Persons," United Nations Population Division, United Nations Technical Meeting in Population Aging and Living Arrangements of Older Persons: Critical Issues and Policy Responses, New York, 8-10 February, 2000.