Third Party Evaluation 2008
The Ministry of Foreign Affairs of Japan

Evaluation of Japan's ODA in the Health Sector

-Summary-

March 2009

Preface

This report is a summary of the “Evaluation of Japan's ODA in the Health Sector” undertaken by the External Advisory Meeting on ODA Evaluation requested by the International Cooperation Bureau of the Ministry of Foreign Affairs of Japan (MOFA).

Since its commencement in 1954, Japan’s Official Development Assistance (ODA) has contributed to the stability and development of developing countries, and solutions of international issues which vary with the times, as well as to the security and prosperity of Japan. Recently, there have been increased domestic and international calls for more effective and efficient implementation of ODA. The MOFA, as a coordinating ministry for ODA, has been conducting ODA evaluation mainly at the policy level with two main objectives: to support implementation and management of ODA; and to ensure its accountability.

This report is a summary of a comprehensive evaluation of Japan’s ODA in the health sector, in regards to its validity, effectiveness, and appropriateness. The evaluation was carried out in fiscal 2008, which marked the halfway point until the deadline set to achieve the Millennium Development Goals (MDGs), created following the United Nations Millennium Declaration in 2000. Further, 2008 was a year of significant international movements in development assistance, including in the health sector, as in May the Fourth Tokyo International Conference on African Development (TICAD IV), and then in July the G8 Hokkaido Toyako Summit, were held. Japan was responsible for holding each of these meetings, and it positioned the health sector as one of the main issues for discussion at the G8 summit. As a result, it is considered that expectations have been raised both domestically and internationally for Japan to play an even greater leadership role for those international efforts in the health sector intended to promote the achievement of MDGs.

In order to maintain the significant momentum created in 2008, this evaluation study was implemented with the objective of obtaining lessons from recent efforts and providing recommendations that will contribute to determining the direction that Japan’s ODA policy should take in the near future. This evaluation study also aims at providing recommendations that will contribute to implement more effective and efficient ODA in the health sector while maximizing the strengths and advantages of Japan’s ODA.

The External Advisory Meeting on ODA Evaluation was formed as an informal advisory body of the Director-General of the International Cooperation Bureau of the MOFA to improve objectivity in ODA evaluation. The Advisory Meeting is commissioned to design and conduct evaluations of ODA and feed back the results and recommendations of each evaluation to the International Cooperation Bureau of the MOFA so that they could be reflected in the actual implementation of ODA for improvement. Prof. Hiroko Hashimoto, a member of the meeting, was in charge of this evaluation.

Prof. Etsuko Kita, the president of the Japanese Red Cross Kyushu International College of Nursing, being an advisor to the study, made enormous contribution to this report.

Likewise, the MOFA, the Japan International Cooperation Agency (JICA) including former Japan Bank for International Cooperation (JBIC), and the ODA Taskforces also made invaluable contribution. We would like to take this opportunity to express our sincere gratitude to all those who were involved in this study. The ODA Evaluation Division of the International Cooperation Bureau of the MOFA was in charge of coordination of all the involving associates. All other supportive works including information collection, analysis and report preparation were provided by Mizuho Information & Research Institute, Inc., under the commission of the MOFA

Finally, we wish to add that the opinions expressed in this report do not reflect views or positions of the Government of Japan or any other institution.

March 2009

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Evaluation of Japan's ODA in the Health Sector

1. Theme: Japan's ODA in the Health Sector

2. Case Study County: Republic of Senegal

3. Evaluators:

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Hiroko Hashimoto, Professor, Jumonji University
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4. Period of Evaluation Survey:
July 2008 to March 2009

At a Counseling Center for Adolescent

At the Thies State Hospital

Outline of Evaluation

1. Evaluation Results

(1) Validity of the policies

The Japan's latest official development assistance (ODA) policy of the health sector, "Health and Development Initiative (HDI)" announced in 2005, is consistent with the MDGs (Millennium Development Goals), which are high-level international policies, and has subsequently served as the foundation upon which Japan has shown leadership in building higher level international policies. Furthermore, it has been confirmed that the themes taken up in the HDI have a high degree of accordance with the development plans of the governments of aid recipient countries.

(2) Appropriateness of processes

In terms of appropriateness of processes, following 5 points have been recognized: (i) In comparison to past Initiatives, with respect to the degree of recognition, it is hard to say that the HDI has been successful; (ii) the degree of satisfaction with respect to the expertise and role being played by the advisors that are being dispatched to the Ministry of Health has been high both on the Japan side and the side of the aid recipient countries; (iii) Japan's ODA activities in the health sector have been evaluated by the governments of aid recipient countries as being superior to those of other donor nations with respect to planning based on long-term prospects, and support; (iv) in activities funded by the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), there are Japanese official aid development parties active in both formal and informal capacities in aid recipient countries. Taking into account current trend of the GFATM, there is a concern that the work burden on location will rise in the future to deal with GFATM

activities; and (v) in the HDI, there are traces of the opinions of several actors such as aid organizations, NGO that have been incorporated, and the HDI has been formulated through a process having a high degree of transparency.

2. Main Recommendations

For decision making for ODA policy of the health sector

(1) Strengthening the approaches that contribute to the achievement of the MDGs

In combination with the carrying out the formulation of the next initiative (new ODA policy of the health sector), a fixed scale of investment for the five-year period starting in 2010 should be decided upon, and assistance bound for Sub-Saharan Africa, a region which continues to be behind with respect to the state of progress towards reaching the MDGs, should continue to be bolstered.

(2) Needs for action plan and financial commitment to ensure the feasibility of ODA policy

It is important that the next Initiatives for ODA in the health sector follow the basic principles and agenda of the HDI with an emphasis on priority subjects, with a formulation of an action plan and announcement of a total contribution to the health sector in the following years, so as to secure the practicability of carrying out the stated agenda.

(3) Strengthening the decision-making processes of ODA policy of the health sector

In formulating the next Initiative for ODA in the health sector, from the stage before drawing up a draft, the opinions of a variety of concerned parties, including experts, citizens groups and the like should be heard, which will make the policy formulation process having even higher degree of transparency.

(4) Strengthening the communication and public relations for ODA policies of the health sector

There is a need to boost the level of understanding of the basic principles and agenda of ODA policies of the health sector (initiatives) with respect to actors related to Japan's ODA in the health sector, and to further strengthen the linkage between policy and actual aid activities.

For Implementation of Japan's ODA in the health sector

(5) Strengthening assistance processes to establish the foundations of the health system in aid recipient countries

With regards to grant aid, it is necessary that the effects of the introduction of medical equipments and the sustainability of those effects are carefully deliberated, and in the event that standard criteria are not met, a decision of a grant aid should be put off as ever. Furthermore, efforts must be made to secure the support system of the aid recipient countries so as to further enhance the sustainability of the effects of ODA activities.

(6) Improving the presence of Japan's ODA through promoting the JICA program

To the extent possible, JICA program which is a strategic framework to support the achievement of mid- and long-term development goals should be promoted so that the presence of Japan's ODA will increase among a number of donors in the health sector.

(7) Strengthening the structure of the provision of Japan's ODA in the health sector in aid recipient countries

For Japan's strategic aid recipient countries in regards to the health sector, from this point onward, experts should be actively dispatched to the Ministry of Health of respective aid recipient countries as an advisor, ideally to the Secretariat level, in order to enhance Japan's structure for providing ODA in the health sector.

(8) Cooperation and collaboration with the GFATM activities

Taking into account the trends of GFATM, it is necessary to determine where there are possibilities for coordination and collaboration between Japanese bilateral cooperation (ODA) and the local activities of GFATM, and to establish appropriate plans and implement measures with urgency.

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Chapter One: Outline of the Evaluation Study

1-1 Backgrounds and Objectives

Following the announcement of the United Nations Millennium Declaration in 2000 and the adoption of the Millennium Development Goals (MGDs) the following year, 2008 marks the midway point until the deadline for the achievement of these goals in 2015.

However, some countries have made slow progress toward achieving the improvements needed to reach some of the MDGs, the development goals held in common by the international community. This is particularly the case for health-related MDGs (goal numbers 4, 5, and 6)[1], and it looks unlikely that several countries will achieve these goals in time by the deadline. In order to promote achievement of targets by the 2015 deadline, Japan must also further strengthen and promote its efforts in the health sector toward improving its results in MDG-related indices.

Further, 2008 saw a number of significant movements relating to development assistance including the health sector occurring in the international community. In May, the Fourth Tokyo International Conference on African Development (TICAD IV), and then in June, the G8 Hokkaido Toyako Summit, were convened. One of the goals of these events was to once again cultivate a shared awareness and sense of purpose among development partners and aid recipient countries for the measures intended to achieve MDGs relating to assistance in the health sector.

These events raised expectations among the international community regarding the increased leadership role Japan would play in the area of international cooperation in the health sector, particularly following the G8 Hokkaido Toyako Summit in which Japan positioned the health sector as one of the key issues for discussion.

In order to maintain momentum created by these events in 2008, it is necessary to reconsider Japan's ODA policies of the health sector and try to determine how to effectively implement assistance. In other words, we recognized that we must consider what Japan needs to do in order to achieve MDGs by the 2015 deadline.

Simultaneously, 2008 marked the final stage in Japan's ODA reform process and was also a part of the period when a new ODA structure was established in Japan. In 2006, the International Cooperation Bureau was created as the organization having overall jurisdiction for ODA within the Ministry of Foreign Affairs, which is responsible for policy making. Then in October 2008, the partial integration of assistance-implementing agencies Japan International Cooperation Agency (JICA) and Japan Bank for International Cooperation (JBIC) was completed. The new JICA organization created from this integration is responsible for the uniform implementation of three assistance schemes – technical cooperation, loan aid, and grant aid – and become one of the world's largest assistance agencies. Through this reorganization, in actual terms the Japanese ODA policymaking function and the assistance implementation function were consolidated within the International Cooperation Bureau in the MOFA, and within JICA.

Beneath this new ODA structure, it was intended that Japan's future ODA activities and policies in the health sector would be organically integrated with multilateral and bilateral ODA to further increase the efficiency and effectiveness of the assistance

[1] MDG 4： reducing the infant mortality rate; MDG5：improving the health of pregnant and nursing women、MDG 6： preventing the spread of HIV/AIDS, malaria, and other diseases

activities Japan conducts. Further, the new system sought to strengthen assistance for developing countries that was intended to bolster and accelerate their own initiatives toward reaching MDGs.

In advance of these efforts, the objectives of this evaluation were to obtain lessons from past efforts and to provide recommendations that can be used to help determine the future direction of Japanese ODA policy of the health sector. An overall evaluation of the validity, effectiveness, and appropriateness of Japan's ODA in the health sector was examined in consideration of international situation. In addition, this evaluation also aims to help understand how Japan can continue to carry out efficient and effective assistance that maximize the strengths and the advantages it possesses.

1-2 Targets of Evaluation

1-2-1 Overall Evaluation

Fundamentally, the main objects for evaluation for this study were Japan's ODA activities in the health sector that were implemented after the 2000 United Nations Millennium Declaration and that were intended to achieve the MDGs, the goals created to address those development issues shared by the international community.

Specifically, the following items were considered as the targets of evaluation.

- Evaluation of policy：Health and Development Initiative (HDI) announced in 2005

  This initiative was evaluated for consistency with ODA general principles, ODA interim policies, and the frameworks of domestic and international high-level policies, such as MDGs. In addition, the nature of the assistance and assistance processes carried out in the health sector under the auspices of the initiative was also evaluated.

- Evaluation of ODA investment performance：

  Evaluation of ODA investment performance was conducted in terms of: ODA investment in the health sector between 2000 and 2007 (including designated donations to international organizations and grant aid implemented via international institutions); cross-sectoral activities intended to supplement assistance intended for the health sector; and donations to various types of Japanese funds established at international organizations, such as those to reduce poverty, were evaluated.

  The investment performance targets of evaluation were limited to the health sector, and include the following items as designated by the OECD-DAC categorization of assistance sectors.

  - I.2. Health (I.2.a. Health, General and I.2.b., including Basic Health)
  - I.3. Population Pol./Progr. & Reproductive Health

- Evaluation of ODA activities：

  Assistance activities launched after 2000 that were intended for the health sector (technical cooperation, grant aid, and loan aid) were evaluated.

In principle, the evaluation team determined if each grant aid project or loan aid project should be categorized as assistance intended for the health sector and therefore a target

of evaluation, based on the name and the summary of that measure. Also, those technical cooperation activities that were included in the “health sector” section in the “Activities according to assistance sector” on the JICA website were categorized as targets of evaluation.

1-2-2 Case Study

A case study was selected from the international health sector in recent years, with particular priority to candidate countries from the Sub Sahara region of Africa, and an evaluation study of the Republic of Senegal (Senegal) was conducted.

Senegal is a vitally important country in order to achieve peace and stability in West Africa. In addition, Japan has considered it to be an important state from the perspective of its diplomacy in Africa. It occupies a crucial position both within the region and within the African Union (AU). Moreover, it is a leading country in New Partnership for Africa's Development (NEPAD). However, there are significant disparities within Senegal between urban and rural areas and it faces a number of development problems, such as population increase and desertification.

Senegal has received ODA to assist its efforts to address these problems. ODA for Senegal has enormous significance from the perspective of realizing two of the ODA’s major goals; “the reduction of poverty” and “sustainable growth.”[2] In November 2007, Japan formulated the first stage of a country assistance program (CAP) for Senegal, establishing the following 2 medium-term goals within this program: 1. “improving the quality of life of the poorest section of the population in regional villages”; and 2. “creating foundations for sustainable economic growth.”

The health sector was identified as a key sector and subsequently, sub-goals within the medium-term goals were established. Japan has launched a range of assistance schemes in Senegal in the health sector. These include technical cooperation projects, general grant aid, grant assistance for grass-roots projects, and the dispatch of technical advisors to the Minister's Secretariat level in the Senegal Ministry of Health (dispatch of experts).

In these ways, Japan has maintained a fixed level of commitment to assistance to countries in the French-speaking region of Africa and contributed assistance to the health sector. Through this evaluation of the Senegal case study, we believe that we can obtain lessons on the best ways for Japan to carry out assistance in Sub Saharan Africa, and in particular, carry out assistance to countries in the French-speaking region of West Africa.

[2] From the “ODA data book” and “The first stage of an Assistance Program for Senegal”

1-3 Evaluation Framework

In accordance with “ODA Evaluation Guidelines, Version 4” for policy level evaluations implemented by the MOFA, the framework for this evaluation was based on three perspectives of the “validity of the policies” “the effectiveness of the results,” and “the appropriateness of the processes.”

Information collected from the MOFA and data published by international institutions were used for the evaluation, and in addition, data were collected from literature research, hearing investigations, and questionnaires. For the case study, in addition to a literature research the evaluation was based on the results of sector investigation hearings and Senegal local government policy materials and related documents.

1-3-1 Validity of the Policies

For the evaluation of the validity of the policies, we looked at whether the latest Japan’s ODA policy of the health sector, Health and Development Initiative (HDI), was consistent with domestic and international upper-level polices in the health sector. Further, we evaluated whether the priority fields in the health sector identified in CAP were consistent with the national development plans of aid recipient countries.

Verification was carried out based on the following evaluation items.

1. Consistency with international, high-level frameworks

To evaluate the consistency of the ODA policies with international, high-level frameworks, we primarily used a literature research to verify consistency with MDGs, which are recognized as common challenges for international community in the health sector, and with HDI.

2. Consistency with Japanese, high-level frameworks

To evaluate the consistency of the ODA policies with Japanese, high-level frameworks, we primarily used a literature research to verify consistency with ODA general principles, ODA interim polices, and HDI.

3. Consistency with recipient country development polices and needs in the health sector

To evaluate consistency with the key health-sector issues in the aid recipient country and with Japan’s priority assistance issues for each country, we used the results of surveys answered by several Japanese Embassies and JICA offices in aid recipient countries.

1-3-2 Effectiveness of the Results

The “effectiveness of the results,“ was verified by evaluating the effectiveness of Japan’s ODA policy of the health sector based on HDI, and the activities implemented as part of Japan’s ODA in the health sector. The following evaluation items were used for verification.

1. Input effectiveness (results from provision of ODA)

To carry out an evaluation of the effectiveness of ODA input on the HDI announced in 2005, secondary data was used and a range of factors such as: the percentage of ODA in the health sector from Japan's total ODA expenditure; and changes in the number of health-sector ODA activities for each kind of scheme; were verified.

In addition, to evaluate the effects of donations to international institutions, the ODA Evaluation Guidelines, Version 4 states that, "contributions and donations to the regular budget of international institutions are not targets of evaluation, and evaluation shall be restricted to contributions for which Japan clearly specified the use and which were used for that purpose." Consequently, Japan's total donation amount was used as a reference value, and with regards to WHO (World Health Organization), UNFPA (United Nations Population Fund), and UNICEF (United Nations Children's Fund), changes in performance for both designated donations and grant aid projects for each institution to which contributions were made were evaluated. However, because Japan did not specify the use for its donations to GFATM, the evaluation focused on the total amount of donations to GFATM.

Elsewhere, in related sectors that complement assistance for the health sector, in particular for the evaluation of cross-sectoral activities intended to reduce poverty toward the achievement of MDGs, changes in the amount of donations and also use of the donations contributed to the new funds established in 2000, the JSDF (Japan Social Development Fund)[3] and the JFPR (Japan Fund for Poverty Reduction)[4] were verified.

Also, the input evaluation included a rough comparison with the results of the contributions made by other donors. Specifically for the case study, the percentage of Japan's ODA donations among the total amount contributed by all donors in the health sector in Senegal was verified.

2. Outcome effectiveness (MDG-based indices)

For the evaluation of the outcome of the HDI announced in 2005 and the outcome of the health-sector ODA implemented by Japan under the auspices of HDI, the changes and conditions for each region for health-related MDG indices was verified using secondary data.

When conducting an outcome evaluation, strictly speaking, it is preferable if the results that can be precisely identified as the outcome of Japan's contributions became the targets of outcome evaluation. However, there is a variety of external factors other than the impact by Japan's ODA contributions in the health-sector outcomes such as the contributions by the recipient country government, other donors, the private sector, and NGOs. Therefore, it is difficult to isolate and evaluate the outcomes solely obtained from Japan ODA.

In consideration of this point, the outcome evaluation for this evaluation study was carried out with improvements to health-related MDGs, the development assistance targets held in common by international community, as the criteria for the evaluation.

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[3] The Japan Social Development Fund was created in June 200 with a10 billion yen (about 95 million US$) contribution by the Japanese government. It is managed by the World Bank.

[4] The Japan Fund for Poverty Reduction was created to support policies to reduce poverty within developing member countries of the ADB (Asian Development Bank), which was adversely affected by the financial crisis that occurred in these emerging-market countries. It was established within ADB in May 2005 by a contribution from the Japanese government.

1-3-3 Appropriateness of Processes

An evaluation was conducted to determine whether the processes for activity planning, implementation, evaluation and monitoring, and the decision-making process for Japan's ODA policies of the health sector, were appropriately carried out. Verification was conducted based on the following evaluation items.

1. Appropriateness of processes toward achieving consistency with ODA policies and ODA activities

Targeting Japanese Embassies and JICA offices that are directly involved in creating ODA activities and, evaluations were carried out to ascertain whether: 1) the contents of HDI policy – which constitutes Japan's ODA policy of the health sector – were widely understood; and whether 2) the ODA activities, including such areas as the planning, implementation, and monitoring of activities, were implemented with sufficient reference to HDI policy. Verification was carried out based on the results of surveys answered by Japanese embassies and JICA offices.

2. Appropriateness of processes toward achieving cooperation among Japan assistance-related parties and ODA implementation

Evaluation was conducted to determine whether: 1) meetings were held that enabled information exchange among actors related to Japan's ODA including health-sector experts at the ODA task forces and the like in aid recipient countries in the ODA implementation process; and whether 2) the deployment of Japan's health-sector experts and other expert staff are appropriate in aid recipient countries where the health sector has been a prioritized sector for Japan' ODA. Verification was carried out based on the results of surveys answered by Japanese embassies and JICA offices.

3. Appropriateness of processes for policy consultation, coordination and ODA implementation with recipient country governments

The evaluation was carried out to determine: 1) if there were appropriate and sufficient consultations and coordination with the representative of the aid recipient country governments from the ministry with jurisdiction over the health sector and other responsible persons (relating to both assistance as a whole and individual activities in the health sector) in terms of participants and frequencies of the meetings; whether 2) Japan's ODA policies such as HDI and CAP were communicated and explained appropriately to the recipient country governments; and 3) the appropriateness of Japan's ODA activity planning, implementation, evaluation, and monitoring of the health sector. The verification was carried out based on the results of surveys answered by Japanese Embassies, JICA offices, and the Ministry of Health of aid recipient countries.

4. Appropriateness of processes for policy consultations and coordination with other donors including international organizations

An evaluation was carried out to determine: 1) whether Japan, appropriately consults with other donors, including international organizations, when it makes health-sector ODA contributions; and 2) if there is a functioning framework of procedures for consultation and coordination with other donors, (e.g. Government-Donor Coordination Committees to promote the achievement of the recipient country's development goals

such as MDGs). The verification was carried out based on the results of surveys answered by Japanese Embassies, JICA offices, and the Ministry of Health of aid recipient countries.

Moreover, the relationship with GFATM Country Coordination Mechanism (CCM) in aid recipient countries was evaluated in terms of participation of Japan's assistance-related personnel in CCM and coordination with local activities funded by GFATM; this part of evaluation was conducted based on the results of a survey that JICA has independently conducted. GFATM, which has invested heavily in activities to counter three major infectious diseases (i.e. HIV/AIDS, tuberculosis, and malaria) administers the CCM in aid recipient countries, supervises the creation, coordination, and implementation process of aid activities.

5. Appropriateness of processes for decision making on Japan’s ODA policy of the health sector

Finally, the appropriateness of decision-making processes for Japan's ODA policy of the health sector, which is HDI, was evaluated. Primarily, the methods of consulting with civil society in draft-formulating processes were evaluated based on the results of interviews and survey obtained from NGOs.

The main objectives of this evaluation part were to obtain lessons and provide recommendations to the MOFA and NGO discussion meetings on GII/IDI[5], which serves as a discussion forum for opinion exchange regarding the aid for the health sector, and to the decision-making process of the next initiative as Japan’s new ODA policy of the health sector.

[5] Originally, these discussions meetings were created to actively promote GII (Global Issues Initiative on Population and AIDS), which was announced by Japan in 1994. The meetings began in the same year as a discussion forum for the Ministry of Foreign Affairs and NGOs. The following year, based on the announcement of the IDI (Okinawa Infectious Disease Initiative) in 2000, infectious diseases were added to the agenda for the discussion meetings. As of November 2008, 42 NGO that are concerned with Japan’s ODA policy of the health sector, such as GII and IDI , participate in the meetings. The meeting is held once every two months to promote collaboration and information exchange between the Ministry of Foreign Affairs and NGOs with the goal of carrying out effective support activities in the health sector.

1-4 Evaluation Methodology

The methods and the targets of each study are described in this part. The following methods were used to conduct this evaluation study: a case study (oversea research), domestic research in Japan, questionnaire surveys in aid recipient countries (surveys answered by Japanese Embassy, JICA offices, and Ministry of Health of the recipient country governments), a questionnaire survey answered by Japanese NGOs, and literature research. Also, a variety of secondary data were collected and analyzed for the evaluation.

1-4-1 Case Study

This evaluation study entailed a field research in Senegal in October 2008. Interviews were held at the Japanese Embassy, JICA offices, the Ministry of Health, and also other institutions and personnel related to Japan's ODA activities in Senegal.

1-4-2 Domestic Research

For the domestic research interviews were conducted for the relevant personnel from the MOFA and related government departments, JICA, NGOs, the International Medical Center of Japan, and for the personnel related to the case study.

1-4-3 Questionnaire surveys

1. Surveys targeting Japanese Embassies, JICA offices, and the Ministry of Health

For questionnaire surveys for Japanese Embassies and JICA offices in Japan's major aid recipient countries, questionnaires made by the evaluation team were distributed and collected via ODA Evaluation Division, International Cooperation Bureau, MOFA.

The questionnaire survey for the Ministry of Health was distributed via ODA Evaluation Division to a relevant person in charge of Japan's ODA in the health sector of aid recipient countries according to certain criteria. The evaluation team then collected the completed questionnaires by email or fax directly from the Ministry of Health.

Based on the results of Japan's ODA contributions to the health sector from 2000 onwards, the country to be investigated in each survey was determined as follows:

- Survey for Japanese Embassies
  -include: 79 countries where Japan's ODA contributions to the health sector were made via grant aid or loan aid[6], or JICA activities since 2000

- Survey for JICA offices
  -include: 78 countries among countries where Japanese Embassy questionnaires

[6] It refers to "grant aid (general grant aid projects, and others)" within the Ministry of Foreign Affairs ODA homepage "data classified by countries and regions data" and "ODA activity search" sections. However, ODA-graduated countries were excluded.

were conducted, excluding Cote d'Ivoire.[7]

- Survey for the Ministry of Health

  -include: 41 countries of the above-mentioned countries, 2 or more activities contributing to the health sector have been carried out since 2000, regardless of type of scheme and where JICA offices have been established (excluding Senegal as being a target country of the case study).

2. Survey targeting NGO

A mail questionnaire survey targeting the 42 NGO groups in Japan, which participated in the MOFA / NGO discussion meetings concerning GII / IDI, was carried out. The evaluation team distributed the questionnaires by post and collected the completed questionnaires from each organization by email or mail.

3. Responses for each survey

The number of countries that responded to the survey and the response rate are shown below:

Japanese Embassy：	56 countries out of 79	(70.9%)
JICA offices:	55 countries out of 78	（70.5%）
Ministry of Health:	19 countries out of 41	（51.2%）
NGO：	14 groups out of 42	（33.3%）

For expediency, this evaluation study was carried out based on the data obtained from country responses, but it was not a complete country survey and therefore it is not necessarily the case that the data will accurately reflect the questionnaire target or a complete picture of Japan's ODA in the health sector. It should be noted that this is one of the limitations of the evaluation study.

[7] At the time of survey, JICA staff had already been pulled out of Cote d'Ivoire.

Chapter Two: Evaluation Results and Recommendations

2-1 Overview of Evaluation Results

2-1-1 Validity of the Policies

1. Validity of ODA policies of the health sector

The “Health and Development Initiative (HDI)” announced in 2005 represents a consolidation of current Japanese strategies and activities for ODA policies of the health sector and is highly consistent with MDGs, which served as common development goals in the international community.

Moreover, it is proved that the international high-level policy documents for development aid including aid for the health sector following the creation of HDI were based on the content of HDI: the “Yokohama Declaration” and the “Yokohama Action Plan” declared in TICAD IV; and the “Toyako Framework for Action on Global Health”, which include a report compiled by the G8 Health Experts Group and proposed to G8 leaders at the G8 Hokkaido Toyako Summit.

Accordingly, it is ascertained that HDI was formulated to have enough consistency with other international high-level policies. Subsequently, HDI became the foundation for the formulation of other international high-level policies in which Japan has taken a leading role. The validity of HDI as policy was highly evaluated based on a consideration of these points.

2. The validity of ODA policies of the health sector in consideration of the policies of aid recipient countries

When viewing Japan's ODA policy on a per country basis, such as CAP, there is a high level of consistency between the priority issues that the recipient country demands in the health sector and Japan's priority fields in the health sector for most countries.

In addition, the majority of the recipient country's health ministries apparently hold the opinion that Japan's assistance policies sufficiently consider their own policies and priorities. This is considered to be one of the characteristics of Japan’s ODA in the health sector.

With regard to the fields of "maternal/ reproductive health," "human resources development,” and "overall healthcare system," there is a high degree of consent between the priorities of Japan and recipient side. Therefore, one can say that Japan is successful in meeting the needs of the aid recipient countries particularly in these fields.

In the fields of "HIV/AIDS,” ”tuberculosis,", "malaria," "child health," and "Medical facilities,” there are instances where only the recipient side considers them as priority. On the other hand, there are instances where only Japan views as priority, such as "Human resource Development," "other infectious diseases," and "medicines and medical equipment."

Based on these findings, we can see that Japan has been carrying out its assistance activities with an emphasis on HDI themes, while the aid for countermeasures to three major infectious diseases (HIV/AIDS, tuberculosis, and malaria), in which the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) has been making large-scale

contributions, are not so much prioritized in terms of bilateral ODA. As Japan has been also making significant contributions to GFATM, it has demonstrated that Japan's ODA for countermeasures to three major infectious diseases tend to be provided multilaterally via GFATM, but not bilaterally as much. If we evaluate Japan's ODA both in terms of bilateral ODA and multilateral ODA implemented via international institutions, we can conclude that Japan's ODA policies of the health sector possess high levels of validity.

2-1-2 Effectiveness of the Results

1. Effectiveness of the results from an evaluation of input (bilateral)

Due to the decrease in Japan's overall ODA budget, the ranking of Japan's bilateral ODA programs among donors in the health sector has been falling steadily throughout 2005 and 2006, and Japan has not been able to regain the position it held in 2004 and earlier yet. In particular, it is desirable to strengthen the level of ODA bound for Africa.

Looking at the changes in the amount of contributions according to region and the nature of the ODA activities implemented, there are high levels of consistency with the direction described in HDI and other initiatives. In particular, Japan should be highly commended for pushing forward activities that prioritize "human security," the basic philosophy on which HDI is based, and even on Japan's ODA implementation sites, there is a sense of progress.

When viewed according to scheme, it is considered that not only technical cooperation and grant aid, but also loan aid are utilized to some extent when the situation requires.

2. Effectiveness of the results from an evaluation of input (multilateral)

Year after year, GFATM has successfully been able to collect substantial funds from many donors and has been making steady progress towards achievement of the targets. It is of great significance that Japan has played a leading role in establishing GFATM. Further, within Japan's multilateral development assistance contributions, its contributions to GFATM have been increasing and Japan has been successfully demonstrating a high commitment for GFATM as a mother of this initiative.

Moreover, Japan has continually contributed considerable amount to emergency assistance through agencies such as WHO, UNFPA, and UNICEF, and to health-sector-related cross-sectoral assistance through the World Bank and ADB. Associating with the comparative advantage of the international organizations, it is considered that Japan is able to carry out appropriate development assistance through multilateral development assistance. This enables it to contribute to regions where it is difficult to contribute solely through bilateral development assistance and to initiate timely responses to various situations. Further, Japan positively engaged in multilateral development assistance in cross-sectoral assistance in the area of social development, such as the reduction of poverty, which deeply relates to aid for the health sector.

One of the basic initiatives defined by HDI is "assistance to health -related sectors to supplement health-sector assistance and cross-sectoral activities," and it is found that the validity of these activities is high, particularly when viewed from the perspective of collaborations with international institutions.

3. Effectiveness of results from an evaluation of outcome (based on MDGs indices)

It can be said that, overall, health-related MDG indices have been improving, though it is impossible to directly link the results of Japan's assistance initiatives to improvements in MDG indices.

However, geographically, compared to other regions, it is noticeable that Sub Saharan Africa is lagging behind in improvements to health-related MDG indices, and the situation there remains severe. Since 2005, Japan has increased the proportion of its total assistance intended for Africa. Based on the conditions in this area, Japan needs to continue to strengthen its assistance for this region in the future.

2-1-3 Appropriateness of the Processes

1. Appropriateness of the processes aiming for consistency between Japan's ODA policies of the health sector and its ODA activities

It cannot be said that the level of understanding of basic principles and agenda of HDI is particularly high at JICA offices located in aid recipient countries. It may be due to the fact that, as the agencies responsible for actually implementing the assistance, staffs at JICA offices may have few opportunities to refer to high-level initiative-type policies. It is thought that there is a room for improvement that the Japanese Embassies should make efforts to deepen the understanding of current ODA policy of the health sector among Japan's ODA related staffs working in recipient countries through the activities of the ODA task forces and other groups.

Alternatively, the levels of reference to CAP have been high, regardless of whether they are Japanese Embassies or JICA offices. Considering this situation, it is extremely important to secure consistency between policies and individual ODA activities, because Japan's ODA policy of the health sector is sufficiently reflected in CAP for each aid recipient country.

On this point, HDI has been highly regarded among assistance-related groups in the health sector for being both comprehensive and substantial. However, compared to "Okinawa Infectious Disease Initiative (IDI)" announced at the Kyushu Okinawa Summit in 2000, successes in increasing public awareness and understanding is difficult to achieve, as was pointed out in several interviews.

Based on this situation, it is necessary not only to strengthen public relations but also to strengthen the penetration of the basic principles and agenda of Japan's ODA policies of the health sector through activities to increase the awareness of initiatives among personnel related to Japan's ODA in the health sector.

2. Appropriateness of the processes to promote collaboration between Japan’s assistance-related parties and to ensure the effective implementation of ODA

For the aid recipient countries where the health sector is prioritized in Japanese ODA policies such as CAP, it is possible to strengthen the structure of assistance in the health sector by dispatching as many experts as feasible to the Ministry of Health in the recipient countries as advisors.

Both Japan and the recipient countries have highly evaluated expertise and roles played by the Japanese advisors previously dispatched to Ministry of Health or the related institutions. In addition, the majority of Japan’s Embassies and Ministry of Health regard those advisors possess expertise and play the roles indispensable for an advisor for the Ministry of Health.

Japanese Embassies that have previously dispatched advisors have identified the most important role that these advisors play as “providing advice on the overall development of the recipient country's health sector." In those Japanese Embassies that have not previously dispatched advisors, the majority have requested to dispatch the advisors up to a Minister's Secretariat level within the Ministry of Health. This suggests a latent need on the Japanese side for the dispatch of personnel to a Minister's Secretariat level, being able to provide comprehensive advice on the construction of a health system. Similarly, the role mostly requested by the Ministry of Health for the advisors was also to provide advice on the overall development of the health sector in the recipient countries.

Based on this situation, in the future and to the greatest possible extent advisors should be dispatched to the Minister's Secretariat level within the Ministry of Health in those countries where the health sector is prioritized according to the Japanese ODA policies.

It is considered that associated with implementation of individual ODA activities in the health sector, Japan’s provision of advice on overall development in the health sector via an advisor for the ministries having jurisdiction over the health sector in the aid recipient country this creates is one means of constructing a system for the effective implementation of ODA in the health sector.

3. Appropriateness of the processes for policy consultations, coordination, and implementation of the ODA activities with the aid recipient country governments

The results of the questionnaire survey confirmed that a sufficient level of consultation and coordination is taking place among the recipient country governments (Ministry of Health), Japanese Embassies, and JICA offices. However, some countries expressed a hope for greater opportunities for consultation and coordination with personnel from Japanese Embassies.

As a result of the questionnaire survey for the Ministry of Health, it has been found that the aid recipient country governments have frequently evaluated Japan's health-sector assistance processes as being superior to those of other donors in terms of "elaborateness in follow-up activities," "consistency," "elaborateness in planning," and "speed of planning."

From these four perspectives, it can be said that recipient countries consider Japan's planning capabilities based on the long-term views and support to be superior to those of other donors. This is considered a reflection of one of the characteristics of Japan’s ODA in the health sector, a respect for ownership of aid recipient countries.

However, there are few countries that evaluated Japan positively in elements such as “flexibility in implementation” and “speed of procedure,” while some countries regard Japan as

inferior to other donors in these elements. Japan's elaborateness in planning could also lead to a lack of flexibility in implementation in some situations.

In addition, due to conditions inherent to Japan, such as a fiscal year that differs from the aid recipient countries, the results of the evaluation suggest that aid recipient countries feel Japanese procedures as being somewhat time consuming. These comments need to be considered and should be utilized in measures for improvement of the ODA implementation process, such as increasing the discretionary powers of staff on location when ODA activities are being implemented.

The consultation process with the Ministry of Health is frequently used to clarify the distribution of duties between the recipient country side and the Japanese side for the assistance to address a development issue. However, measurements of if the benefits of assistance are sustainable or not do not always take place in the consultation process, and there are only a few countries that have concrete self-checking frameworks on the Japanese side.

In particular, for donations such as medical equipment and related, in addition to confirming the appropriateness of the medical equipment through established checking procedures, such as providing expert advice while the checks are carried out, Japan should also encourage the recipient countries' own efforts to secure the sustainability of its assistance structure and strive to increase the sustainability of the results of assistance.

4. Appropriateness of the processes for policy consultations and assistance coordination with other donors including international organizations

Japan has secured sufficient opportunities to hold meetings to consult and coordinate with other donors, including international institutions, in 70 to 80% of recipient countries. Within this percentage, it maintains a high frequency of opportunities for it to explain its ODA policies mainly regarding CAP. However, as new donor organizations have come to the forefront, such as GFATM, the existing donor coordination committee or mechanisms may be insufficient to coordinate assistance at the actual implementation sites. At the implementation sites, there have been formal and informal interactions with GFATM activities including participation in "Country Coordination Mechanism (CCM)" by Japan's assistance-related personnel and intentional coordination at the assistance-implementation stage to avoid duplication with Japanese assistance.

There are various kinds of staff working at the implementation sites who respond to CCM and activities funded by GFATM, such as staffs at Japanese Embassies and JICA offices, (including regular staffs, planning survey staffs, and Japanese volunteers called JOCV). These responses include such areas as: formulating proposals needed for applications for GFATM; collecting information relating to GFATM activities; and coordinating with GFATM activities at the implementation stage. However, there are some cases which require high levels of expertise and coordination in the health sector, such as formulating proposals. Thus, it is concerned that the burden placed on staff at the location is going to increase in carrying out these responses. In the future, Japan will also be required to positively contribute to the high levels of coordination with GFATM activities and also to skillfully link Japan's bilateral ODA in the health sector with GFATM activities.

Regarding relations with GFATM at actual implementation sites, response policies need to be quickly defined not only by JICA but also by MOFA, including the deployment of personnel. In other words, an organizational response policy needs to be created.

5. Appropriateness of the processes decision-making of Japan’s ODA policies of the health sector

The decision making process of HDI, which determines Japan’s ODA policy of the health sector, can be highly evaluated for achieving decision making through appropriate processes, at least for its dealings with assistance-related organizations and NGOs. Further, through this evaluation study, it has been confirmed that formulating the next initiative for ODA in the health sector is extremely important to demonstrate to both Japan’ s domestic and international audiences how in the future Japan will act based on the achievements at the TICAD IV and the G8 Hokkaido Toyako Summit.

It is important that the next Initiatives for ODA in the health sector follow the basic principles and agenda of the HDI with an emphasis on priority fields, setting numeric targets, reviewing the action plans and announcing actual financial commitments. Moreover, the experience of public-private partnerships emphasized at the preparation phases for TICAD IV and the G8 Hokkaido Toyako Summit should be utilized in policy decision making processes to achieve even greater transparency in the process of formulation. Also, at the initiative draft preparation stage it would be preferable to hear a range of opinions on Japan’s health-sector assistance methods, from relevant government bodies, assistance agencies, experts, and NGOs.

2-1-4 Summary of the Case Study

With regard to the “validity of the policies,” Japan’s ODA in the health sector in Senegal has been confirmed as being consistent with international high-level policies (MDGs and TICAD III President’s Summary), Japan’s high-level policy of the health sector (HDI), and development plans and targets of the Senegal government.

Regarding “effectiveness of the results”, the results of input in recent years accompanied with the decline in the total ODA budget have not been encouraging. On the other hand, the output and outcomes are considered to be demonstrating a certain level of effectiveness. Also, when the "Program to Strengthen the Tambacounda State Health System” that began in 2007 becomes full-fledged, it is hoped that input can also be restored up to the levels achieved in the 1990s.

For "appropriateness of the processes," improvements in a range of aspects have been observed, particularly for strengthening of activities to promote the recipient country's independent efforts since 2000. Also, the "elaborateness in planning" and "ability to forecast planning" aspects of Japan's assistance have been highly evaluated by counterparts of the Ministry of Health in Senegal. This kind of commendation by the aid recipient country government reconfirms strength of Japan’s ODA in the health sector after the success of implementation even if some intractable uncertainty had been seen at the planning stage.

In addition, the decision-making process of the "Program to Strengthen the Tambacounda State Health System” was highly evaluated among Japan’s ODA actors, the Ministry of Health, other donors, and international institutions for the achievement of significantly appropriate and pinpoint levels of consultation and coordination.

The results of this program cannot be evaluated at the present time, but it will be necessary to verify and evaluate the “effectiveness of the results” sometime around 2015.

2–2 Recommendations

Followings are recommendations guided by the overall evaluation. Each recommendation was arranged after the examination of the contents of the overall evaluation entirely.

～For decision making for ODA policy of the health sector ～

Recommendation 1: Strengthening approaches that contribute to the achievement of the MDGs

The amount of Japan's bilateral ODA in the health sector fell substantially in 2005, accompanying decrease in the total ODA budget. Subsequently, the amount increased up until 2007, but in terms of its ranking with other donors it has not been able to return to the position prior to 2004

Improvements in health-related MDG indices have lagged behind other MDGs, and it is necessary that Japan, which has been taking an international leadership role in health-sector assistance, further increases and maintains the relative amount of its contributions for bilateral ODA in the health sector to promote the achievement of MDGs by the 2015.

With this in mind and in conjunction with the formulation of the next policy initiative in 2010, it would be effective for Japan to announce contribution in the form of a certain level of funds for the health sector as a part of a 5-year plan until the deadline for the achievement of MDGs.

Comparing overall health-related MDG indices in developing countries before 2000 and after 2005, all of the indices for countries with improvement exceeded those countries with worsened indices. However, with regard to improvements at a regional basis, there have been geographical discrepancies in the progress made. In particular, compared to other regions of Africa, Sub Saharan Africa is noticeably lagging behind in improvements made for all indices, and the situation there remains very severe. Accordingly, it is considered that the needs of ODA in the health sector in Sub Saharan Africa are high compared to those of other regions.

In May 2008, together with the World Bank and other organizations, Japan held TICAD IV and once again helped create a policy for strengthening assistance to Africa, including the health sector. Further, in July of the same year Japan assumed the presidency of the G8 and convened the G8 Hokkaido Toyako Summit," positioning "development and Africa" as one of the discussion themes, which reconfirmed the importance to Japan of health-sector development.

Looking back, on a time line and per region basis, we can see that the percentage spent on the African region rose from 2005 to 2007 which is to close the gap between Asian regions. This shift should be welcomed from the perspectives of the considerable needs in development of the African region and the shift is consistent with the international trends. In the future, Japan should continue to strengthen its ODA in the health sector particular for African region.

Recommendation 2: Needs for an action plan and financial commitments to ensure the feasibility of ODA policy

Japan's health-sector initiatives have been continuously created a series of continuous measures spanning for 15 years, with GII in 1994, IDI in 2000, and HDI in 2005. Since the creation of GII, a fixed level of contributions has been declared while passages of health-sector initiatives were created. Moreover, although each initiative continued on a five year basis, they were not considered as transitory policy documents but have been largely recognized as policies that reflected the general direction of health-sector

assistance of Japan’s ODA in that time period.

Compared to the results of other sectors, there are reasons to think that health-sector initiatives have been relatively successful. Further, it should be noted that the contents of each of these initiatives preceded similar international measures. For example, the content of HDI, which reflects Japan's strategies and approaches to ODA policy in the health sector, was reflected in international policy documents that were later created such as: the “Yokohama Declaration” and “Yokohama Action Plan”, both created at TICAD IV in May 2008; and the "Toyako Framework for Action on Global Health," declared at the G8 Hokkaido Toyako Summit in July of the same year.

Regardless of the fact that Japan was the presiding country at TICAD IV and G8 Hokkaido Toyako summits, the adoption of these international initiatives indicates the basic principles underpinning Japan's policies and the key agenda of these policies has been highly evaluated and positively taken up by international community. This point has considerable significance from the perspective of Japan "earning the trust of international community by fulfilling responsibilities commensurate to its country power."[8]

Based on this situation, there is no need for Japan’s ODA policy of the health sector to differ significantly from current policy, HDI. The significance that HDI has when initiatives are being created is enormous when we consider HDI’s international reputation at the moment as described above, which resulted in value for Japan’s diplomatic efforts. Further initiatives such as HDI become the foundation for CAP health-sector assistance, and as they are frequently referred by many Japanese ODA actors in the health sector, we think that HDI should be further elaborated to create the next initiative by 2010, five years after previous decision marked on HDI.

Health-sector assistance, which directly serves peoples’ lives and health, should be in essence by multifaceted and carried out by many sectors. It is therefore natural course that HDI is a truly comprehensive assistance policy. However, because it is at the point of the halfway period for the deadline of MDGs, more tangible results are required. On the other hands, it is important for Japan to make more “selection and concentration” in all assistance sectors due to the deteriorating conditions of Japan’s finance and economies.

Accordingly, while the next Japan’s ODA initiative in the health sector should continue to be based on HDI basic principles and agenda, it is crucial that setting of an agenda for specific fields need to be prioritized and strengthened, and the specific part of the action plans should be enhanced. It is also important that a framework for implementation including a declaration of financial commitments should be strengthened.

Recommendation 3: Strengthening the decision-making processes of ODA policy of the health sector

When HDI initiatives actually implemented, the Ministry of Foreign Affairs (MOFA) utilizes NGO proposal documents submitted in the MOFA and NGO discussion meetings (GII/IDI). Further, in addition to explain HDI draft document to Japan International Cooperation Agency (JICA) and related ministries to obtain feedback, the MOFA also explained to NGOs to provide an opportunity for opinion exchange at the meeting. The final draft is settled after receiving the approval of a specialist committee comprised of representatives of relevant ministries.

There are some examples of the opinions of NGOs, in addition to the feedback from JICA and related ministries, in the final paper of HDI. The “appropriateness of processes”

[8] Revision of Japan’s Official Development Assistance Charter

would be highly evaluated for the fact that decision making processes based on the incorporated opinions from a wide variety of actors in health-sector assistance.

As the next stage, when creating a new initiative for the next period, it should also look into the way of achieving higher levels of transparency at the draft document decision-making stage. To achieve this, it is recommended to organize task forces for decision making on initiatives while the MOFA, the Ministry of Health, Labour and Welfare, the International Medical Center of Japan, JICA, healthcare experts, and NGOs all participate. There should be in-depth discussion with all those actors about the direction and scope of the next Japan's ODA policy in the health sector.

The existing discussion meetings between the MOFA and NGOs on GII/IDI represent opportunities to exchange information on health-sector assistance. These meetings are extremely important to promote partnerships with the private sector. Further, as a result of the questionnaire survey, these meetings are not only meaningful for the Ministry, but also for those NGO's active in the field of the health sector and should continue to be held from now on.

Recommendation 4: Strengthening communication and public relations for ODA policies of the health sector

In 2005 at the Asia Pacific High Level Forum on health-related MDGs, Japan announced and presented HDI together with a good-practice paper named "contributions made to achieve health related MDGs in the Asia Pacific region" which contains a review of Japan's ODA in the health sector in the Asian region.

Among Japan's ODA related actors in the health sector, HDI and its contents have been highly evaluated as being both comprehensive and substantial. However, compared to IDI announced at the 2000 Kyushu Okinawa Summit, it has proven difficult to successfully increase levels of general awareness and understanding about it, based on the results of hearings and questionnaire surveys.

Furthermore, based on the results of Japanese Embassies and JICA questionnaire surveys, it is vital to enhance understanding of Japan's high-level ODA policies of the health sector among staffs of Japanese Embassies and JICA offices in the countries where assistance is being carried out, and to increase more awareness of these policies while going about their daily duties.

Regarding this point, there is a need to strengthen public relation activities for audiences, to promote greater understanding of HDI's basic principles and agenda, and to further strengthen the connection between policy and the assistance activities actually being carried out

The results of the Ministry of Health questionnaire survey suggests that international assistance policies announced by Japan at international conferences and summits have not sufficiently been communicated to health ministry officials in some countries. These international conferences and summits are frequently attended by higher-level members of the MOFA and other ministries who may not fully aware of health-sector ODA and activities at the actual implementation sites. As a result, it is desirable if Japan makes further efforts to communicate with officials in the Ministry of Health to deepen their understanding of the contents of international conferences such as TICAD IV and G8 Summit on the issues of development assistance at a local level.

～For Implementation of Japan's ODA in the health sector ～

Recommendation 5: Strengthening assistance processes to establish the foundations of the health system in aid recipient countries

To maintain the foundations needed for health systems in developing countries, it is essential to enhance the function of medical facilities through provisions of medical equipments and their necessary repairs of medical facilities. Prior to the provision, it should be evaluated in advance to assess the equipment needs in the region. Also, the following criteria should be verified whether: 1) staff are in place who are trained, or are able to use the equipment; 2) the necessary consumable goods are procurable within the recipient country; 3) operating capabilities are appropriate (electricity and necessary materials), 4) a system for maintenance is prepared, 5) repairs and procurement of replacement parts are available, 6) the necessary financial resources to enable each of the above to be continuously maintained. Also, the provision must be made based on the social and environmental conditions of each region, such as weather, operating infrastructure (including frequency of power cuts, stability of voltage, purity of raw materials, etc.) and manufacturing and distributing system of consumable goods and parts.

For grant aid, the final decision on whether: the equipment distributed is appropriate to the conditions of the recipient country; and whether the benefits of the contributed equipment is appropriate for the amount donated; should be made properly and in cautious manner. Therefore, decisions on whether the equipment is necessary and can be used sustainably should be made based on objective evaluations conducted by doctors, technicians, other experts, and where necessary, including clinical laboratory technicians. The persons carrying out the evaluation must be knowledgeable about development assistance and the environment where the equipment will be used will be like.

Japan should continue to appropriately investigate the benefits of contributed medical equipment, sustainability of these benefits, and assistance structure established by the aid recipient country for grant aid based on the decision making process explained above. If certain criteria are not practiced properly, it is necessary to change a decision on the distributions.

As was seen in the case study examples, it is also substantial to encourage the recipient country's own efforts to sustainably maintaining its assistance structure. Japan should repeatedly consult with the recipient country governments to ensure that they can steadily maintain an assistance structure and that the benefits of assistance are sustainable.

Recommendation 6: Improving the presence of Japan's ODA through promoting the JICA program

Since fiscal 2007, in Senegal, the case study country for this evaluation study, a "JICA program" has been implemented, which consists of grant aid projects, a technical cooperation projects, and JOCV activities. The program is called "Program to Strengthen the Tambacounda State Health System," which targets to strengthen the overall health system and accessibility to healthcare service in the state of Tambacounda. This JICA program has been highly evaluated by the Ministry of Health in Senegal for being developed in accordance with their own development program and strategies. What is remarkable of this program is that the high level of awareness about the program was achieved, not only in the Ministry of Health, but also among other donors.

The launch of this program has dramatically changed the perceptions of the Ministry of

Health about Japan's ODA in the health sector in Senegal. Previously, the Ministry of Health in Senegal tended to perceive as: "Japan provides a range of assistance in response to our requests, but ultimately we are not sure in what the Japan have most contributed."

For most aid recipient countries, in health-sector assistance, Japan should attempt to shift toward increased scheme coordination in order for JICA programs to be implemented as more strategic assistance in 'specific' regions and in 'specific' fields. This will deepen the counterpart's understanding of the basic principles of Japan's assistance and the direction of assistance policy, which will ultimately increase presence of Japan's ODA among aid recipient countries.

Also, contributions of medical equipment through grant aid should be coordinated with assistant projects of other schemes as much as feasible. It is possible to carry out "soft" assistance as one component of such programs accompanying "hard" assistance. (i.e. contributions of medial equipments, such as the training of personnel to operate and maintain those equipments through technical cooperation.). In this way, synergy benefits from both types of schemes can be realized.

Recommendation 7: Strengthening the structure of the provision of Japan's ODA in the health sector in aid recipient countries

To strengthen the health systems of developing countries, it is necessary to undertake comprehensive assistance for development policies of central governments which are responsible for the health sector. To carry out this kind of assistance, Japan can participate in the policy decision-making processes within the ministry by dispatching Japanese experts as advisors within the country's Ministry of Health.

From the results of the survey[9], we can see that the dispatch of advisors who posse appropriate expertise to the Minister's Secretariat level of the health ministries and /or related departments, has the following advantages:

1) It becomes possible to make inter-department coordination within the health ministry when Japan implements individual ODA activities;
2) It becomes easier to grasp trends in health ministry policy making and their assistance needs;
3) It becomes easier for Japan to communicate its assistance policies and strategies;
4) It becomes possible to provide advice to the health ministry at the rank of Director-General of bureau or above;

Through these benefits, we anticipate that the dispatch of advisors to health ministries will increase the effectiveness of implementation of Japan's ODA in the health sector. The benefits can be expected particularly from dispatches to the Minister's Secretariat level, as they will facilitate coordination among the multiple departments involved at Japan's ODA activities. In fact, the results of case studies confirm these points.

Based on the points mentioned above, Japan should continue to positively dispatch advisors to the Ministry of Health, in particular at the Minister's Secretariat level, for the aid recipient countries where the health sector is prioritized in Japan's ODA policy. In this wise, Japan should actively participate in health-sector development policies in recipient country and investigate how to create systems to smooth implementation of Japan's health-sector

[9] From the "Expert Operations Secretariat Report (September 3, 2007) by the former technical consultant to the Minister's Secretariat, Health and Preventive Care Ministry, Republic of Senegal, and the results of the questionnaire survey for the Ministry of Health in several aid recipient countries.

assistance.

However, for Japan's experts to function as advisors within the health ministries, it is essential that not only they must have appropriate levels of expertise and experience, but also they have the necessary communication skills with language capability. A major problem must be addressed on how to continuously recruit the human resources with the high-level skills required in Japan.

Recommendation 8: Cooperation and collaboration with GFATM activities

GFATM was created out of the opportunity generated by the 2000 G8 Kyushu Okinawa Summit and Okinawa Infectious Disease Initiative (IDI). Year after year, GFATM has successfully collected large contributions from many donors and has made steady progress toward achieving its targets.

Japan played a leading role in the creation of this fund, served as one of the presiding countries, and has continuously contributed to a series of organizational reforms and evaluations, and should be praised for these efforts.

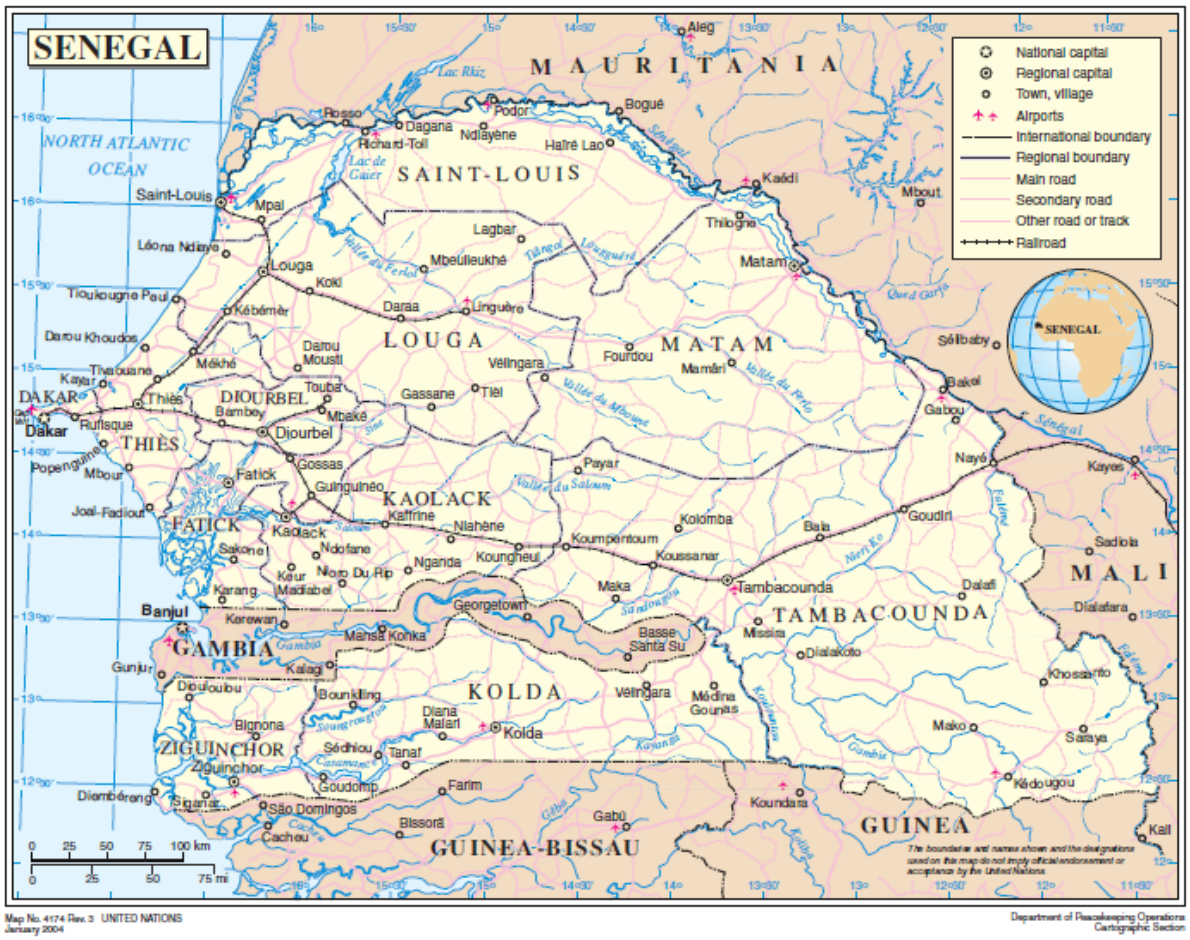
Conversely, despite the fact that GFATM has become an extremely large donor in fighting the three major infectious diseases of AIDS, tuberculosis, and malaria, there are no means of tracking how the donated funds are used. Thus, one demerit is that it is difficult to directly assess in what portion Japan's donations to GFATM has contributed to the fight against the three major infectious diseases.

Consequently, Japan should actively work at the local level to interlink the assistance it provides with the activities funded by GFATM, through the positive participation in CCM, or by conducting small scale projects for infectious-disease countermeasures that are coordinated with the activities funded by GFATM.

However, the current situation is that existing Japan's assistance actors at implementation sites (Japanese Embassies' staff, JICA office staff, JICA experts, JOCV) both formally and informally be concerned with GFATM, for example participating in the CCM, joining proposal writing, and coordinating with activities funded by GFATM. In the future, from the standpoint of advancing cooperation and collaboration with GFATM at a local level, we believe it is necessary to investigate the deployment of expert personnel responsible for conducting appropriate responses to GFATM related work on location.

Based on the current trend of GFATM, not only JICA but also the MOFA should quickly determine how Japan should formally deal with GFATM at local level. Specifically, they should implement appropriate measures with urgency and determine policy with regards to how Japan participates, cooperates, and collaborates with GFATM activities in all Japan's aid recipient countries.

MAP OF REPUBLIC of SENEGAL



Source: United Nations, Map No.4174, Rev. 3. January 2004.