2．ミニッツ（PDM、TSI、プロジェクト・ドキュメント添付）

MINUTE OF MEETINGS BETWEEN JAPANESE PROJECT DESIGN TEAM AND AUTHORITIES CONCERNED OF THE GOVERNMENT OF THE LAO PEOPLE'S DEMOCRATIC REPUBLIC ON JAPANESE TECHNICAL COOPERATION FOR THE PROJECT FOR STRENGTHENING HEALTH SERVICES FOR CHILDREN

The Japanese Project Design Team (hereinafter referred to as "the Team") organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Dr. Yasuo Chiba, visited the Lao People's Democratic Republic (hereinafter referred to as "the Lao PDR") from August 28, 2002 to September 5, 2002 for the purpose of working out the details of the technical cooperation program concerning the Project for Strengthening Health Services for Children in the Lao PDR (hereinafter referred to as "the Project").

During its stay in the Lao PDR, the Team exchanged views and had a series of discussions with the Lao authorities concerned with respect to desirable measures to be taken by both Governments for the successful implementation of the Project.

As a result of the discussions, the Team and the Lao authorities concerned agreed upon the matters referred to in the document attached hereto. This Document is related to the Record of Discussions on the Project for Strengthening Health Services for Children, signed on the same date.

Vientiane, September 4, 2002

Dr. Yasuo Chiba	Mrs. Chanthanom Manodham
Leader	Director of Cabinet
Japanese Project Design Team	Ministry of Health
Japan International Cooperation Agency	Lao People's Democratic Republic
Japan	

THE ATTACHED DOCUMENT

I. PROJECT DESIGN MATRIX

The Project Design Matrix was elaborated through discussion by the Team and the Laos authorities concerned. Both sides agreed to recognize PDM as the important tool for project management, and the basis of monitoring and evaluation of the Project. The PDM will be utilized by both sides throughout the implementation of the project. The PDM is shown in Annex I.

The PDM will be subject to change within the framework of the Record of Discussions when necessity arises in the course of implementation of the Project by mutual consent.

II. TENTATIVE SCHEDULE OF IMPLEMENTATION

The Tentative Schedule of Implementation (hereinafter referred to as "TSI") has been formulated according to the Record of Discussions, on condition that the necessary budget will be allocated for the implementation of the Project by both sides. The schedule is subject to change within the scope of the Record of Discussions when necessity arises in the course of implementation of the Project. The TSI is shown in Annex II.

III. PROJECT DOCUMENT

Both sides jointly have prepared the Project Document for the rationalization of the plan and justification of the project implementation. The Project Document is subject to change within the scope of the Record of Discussions when necessity arises in the course of implementation of the Project. The Project Document is attached in Annex III.

IV. PROJECT OFFICE

Both sides agreed that the project office will be located in the building of the Ministry of Health, at least two rooms, the space which was previously used by the JICA Development Study Team on the Improvement of Rural Health Service.

ANNEX I PDM

ANNEX II TSI

ANNEX III PROJECT DOCUMENT

Project Name: MOH - JICA project for Strengthening of Health Services for Children in the Lao P.D.R.
Duration: 2002 – 2007 **Target Area:** Oudomxay, Vientiane Provinces **Target Group:** Children (≦15 years old)

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal Health standard of children is improved in the Lao P.D.R.	- Mortality rate of major child diseases	- MOH	- The national health policy continually remains unchanged on child health
Project Purpose The central and local health services for children are strengthened with participation of various levels of stakeholders	- Number of District Health Office and District Hospital satisfying with a minimum standard - Number of under 15 population's access to health services - Mortality rate of major child diseases (diarrhoea, malaria and pneumonia) in model provinces	- MOH - HC	- The EPI activities are continually implemented - Unexpected serious epidemic outbreak does not occur
Outputs 1. Capacity building to provide better health services for children 2. Present functions on vertical (Central – Locals) health systems for children are strengthened in MOH 3. Present functions on horizontal health systems for children are strengthened in the model provinces 4. Preventive and care activities against such major child diseases as diarrhoea, malaria and pneumonia are intensified in the model provinces 5. Health education is improved 6. The central and local capacity to establish supportive relationships and coordinate with such partners as national authorities, bilateral donor agencies, and international organizations is promoted	1-1. Number of activities based on participatory approaches 1-2. Number of feed back activities (monitoring and evaluation) 2-1. Prevailing a minimum standard 2-2. Number of supervise visiting 2-3. Number of standardized reports 2-4. Number of training 2-5. Number of trained persons 2-6. Number of communication (number of people exchanges, number of use of communication devices) 2-7. Number of activities and programs at health center supported by district hospital 3-1. Number of coordinated training 3-2. Number of meetings organized by multi-centers 4-1. Number of training 4-2. Number of preventive and care activities in the model provinces 4-3. Rate of appropriate use of formats 5-1. Number of school involved 5-2. Number of school student involved 5-3. Number of campaigns 6-1. Number of cooperative activities	- MOH - MOE - Provincial Health Offices - Health Centers - Women's Union - Youth Union - M/M of specific meetings - Records of specific campaigns - Records of educational programs	- Public cooperation does not decrease - Trained health staff continue working for the health services - Improved systems continue working for child health in MOH

(Note: In nature of the project cycle management, the PDM can be modified in accordance with the project progress by participatory process)

Activities	Inputs		
1-1. To develop a system (problem identification, analysis, planning, implementation, monitoring, and evaluation) at central and local levels for providing better health services for children through a participatory approach. 2-1. Assist to formulate a minimum standard on child health services at central and local level 2-2. Improve the existing central-local interactive communication systems 2-3. Improve the existing health data and the processing systems 2-4. Implement training programs on child health services 2-5. Improve the existing health information dissemination activities 3-1. Create coordinating functions among the existing vertical health services (MCH, IEC, Malaria etc.) 4-1. Strengthen health services to be required at each level in accordance with minimum standard for children 4-2. Implement training programs for health staff of district level 5-1. Build a close relationship between MOH – MOE for school health activities 5-2. Implement school health activities at elementary schools in cooperation with the ACIPAC (Asian Center of International Parasite Control) project 6-1. Cooperate with Women's and Youth Unions 6-2. Build cooperative relationship with international agencies such as WHO, ADB, and World Bank	**1. Lao side** (The central and local levels) 1-1. Personnel - Project Manager - Project Coordinator - Specific Health Staff (MOH and provincials) - Others 1-2. Facilities - Office room - Furniture for new office - Others 1-3. Local cost - Project implementation - Project management - Specific budget - Others	**2. Japan Side** 2-1. Personnel 1) Long term experts: - Chief Advisor - Project Coordinator - Community Health Advisor - Others 2) Short term experts: - as required 2-2. Equipment - Specific equipment to be required by the implementation of the project	- The Women's Union dose not oppose the cooperative relation - The Youth Union dose not oppose the cooperative relation - Community does not oppose the participation - The international agencies do not oppose the cooperative relation **Pre-Conditions** - National health policy supports the project - The MOH master plan policy strategy toward 2005 supports the project - MOE and the local educational authorities do not oppose the project

(Note: In nature of the project cycle management, the PDM can be modified in accordance with the project progress by participatory process)

TENTATIVE SCHEDULE OF IMPLEMENTATION

	Input/year	2002.11 - 2003.10	2003.11 - 2004.10	2004.11 - 2005.10	2005.11 - 2006.10	2006.11 - 2007.10
	year	First	Second	Third	Fourth	Fifth (final year)
		03.4	04.4	05.4	06.4	06.4
1	Dispatch of Japanese Experts					
1)	Long term experts					
	①Chief Advisor					
	②Coordinator					
	③Community Health					
	④Mother and Child Health					
	⑤School Health					
2)	Short term experts					
	①IEC					
	②Epidemiology					
	③Communication Devices					
	④Health Administration					
	⑤Equipment					
	⑥Nutrition					
	⑦Infectiou Diseases					
2	Lao personnel training in Japan					
	①Health Administration					
	②Mother and Child Health					
	③IEC					
3	Equipment supply					
4	Dispatch of Japanese study team					
				Mid-term Evaluation		Project Evaluation
5	Laos-Japanese Joint Committee	◇	◇	◇	◇	◇

Note: This schedule is formulated tentatively on the assumption that necessary budget will be acquired by both side.

This schedule is subject to change within the scope of the "Record of Discssions" if the necessity arises during the course of the Project Implementation

Project Document
of the Project for
Strengthening Health Services for Children
in Lao P.D.R

Project Document of the Project for Strengthening Health Services for Children in Lao P.D.R

Contents

1 Introduction
2 Basic Information on Laos
 2-1 Socio-economic context
 2-2 Present conditions of the Health Sector
 2-3 Host country strategy
 2-4 Prior or on-going assistance
3 Problems to be addressed: the current situation
 3-1 Institutional framework for the health sector
 3-2 Problems to be addressed
4.Project Strategy
 4-1 Project strategy
 4-2 Implementation structure
 4-3 Coordination arrangements
 4-4 Sustainability
 4-5 Special Consideration
5.Project Design
 5-1 Overall goal
 5-2 Project Purpose, Outputs and Activities
 5-3 Inputs
 5-4 Pre-conditions, Important Assumptions and Analysis of Risk
6. Project Justification
 6-1 ODA Project as Public Service
 6-2 Accuracy of Technology
 6-3 Reasons for assistance from JICA
 6-4 Expected effects of the Project
 6-5 Overall Project Justification

1 Introduction

1-1 Background of technical cooperation request

The condition of health service in Laos is low in comparison with those of Neighboring countries. To improve this situation, the Japan International Cooperation Agency(herein after referred to as "JICA") implemented two technical cooperation projects; Primary Health Care Project (1992-1998) and Pediatric Infectious Disease Project (1998-2001).

Those two projects succeeded in eliminating polio. As a result, infant mortality rate decreased from 128 to 75, maternal mortality rate from 656 to 530, during the period 1989 - 1999.

By the year of 2020, the Government of Laos aims to reduce under 1 infant mortality rate to 20, under 5 mortality rate to 30, and improve national health conditions, building on previous efforts. To achieve this goal, Laos has requested JICA for a technical cooperation in child health improvement through strengthening the central and local health services in Laos.

1-2 Objective of the Project Document (this report)

This Project Document was prepared to achieve the following objectives.

1 Information sharing

Information concerning the project is summarized in this document to share with everyone concerned the same understanding on current problems, strategies, and Project objectives.

2 Analysis on the Project's strategy

The document provides strategies to maximize the impact and sustainability, and includes basic information collected at the preparation stage which have became the base to set up the strategies. The document also can be used as a reference for stakeholders.

3 Establishment of indicators for achievements

Necessary baseline information contained in the document can be used to facilitate focused discussion on indicators to objectively evaluate achievements to be produced by the project.

4 Analysis on the Project's justification

The impact expected of the Project is summarized in the document and provides justifiable reasons for executing the project.

5 Publication of information on the Project

The document will be a reference to be used for presenting the project to donors and other relevant organizations.

The document is subject to revisions to be made jointly by the Laos and Japanese sides, to increase the level of achievements expected of the project. The first draft of the document was prepared based on the results of the preparatory study conducted from February through April of 2002.

2 Basic information in Laos

2-1 Socio-economic context

2-1-1 Population, ethnicity and culture

Laos has an estimated population of about 5 million according to the data in 1998. It is comprised of numerous ethnic groups, which go over 60 groups. Each group possesses a unique traditional culture, lifestyle, and economic activities rooted on local socio-economic conditions. The official language is Phasa Lao, and about 95 percent of population are Buddhists. Its culture has been historically influenced by India, Thailand, China and France. Now the government takes a policy on building national culture, and promoting cross-culture activities with such foreign countries as Thailand.

2-1-2 Politics

The Lao People's Democratic Republic was established in 1975, which is a socialist country with only one political party, Lao People's Revolutionary Party (LPRP). The present President is Khamtay SIPHANDONE, the leader of the LPRP. In 1986, Laos launched a "New Economic Mechanism", which encourages market mechanisms. Following this, new laws were enacted to promote and guide foreign investment. The National Assembly adopted the new Constitution to support for a commercially oriented legal framework in 1991. The 5th Socio-economic Development Plan and the socio-economic development strategy for 2010 to 2020 were approved by the National Assembly in 1996. The priority areas of the strategy up to 2010 is to establish a hab function in the transport sector, to develop basic industries, and human resources. The long-term vision is to achieve balanced development between the urban and rural regions and between the agriculture, forestry sectors and other sectors by 2020.

2-1-3 Economy

The main economic sector in Laos is agriculture, which produces 52 percent of GDP in 2000. GDP per capita is US$338 in 1997. The average annual economic

growth rate for Laos from 1996 to 2000 was 6.2 percent. Although the country did not achieve the targeted 8 to 8.5 percent growth rate announced at the 6th Lao People's Revolutionary Party (LPRP) meeting in 1996, the transition to a market economy has continued to make a progress. Corresponding its transition from a Socialist to a free market economy and its affiliation with ASEAN and AFTA, the Lao government is to swiftly establish an economic infrastructure. Consequently, its expectations on donor cooperation to help develop its socio-economic sector are high.

2-1-4 Relations with neighboring countries

Laos was accepted by ASEAN in 1997, and participates in the Mekong Committee of the Mekong River Basin Development Plan. Laos intends to maintain and develop its friendship with neighboring countries. Thailand, which shares a similar language and culture and whose investments comprise nearly one-half of all investments in Laos, is important for Laos. Vietnam also has extremely strong relationship as well as a similar socio-economic system.

2-2 Present conditions of the Health Sector

To represent health status in Laos, several indicators, such as life expectancy, infant mortality rate, under-5 mortality rate and maternal mortality rate, are shown in the Table 2-1. There is some gradual improvement in the indicators from 1960 to 2000. Among South-East Asian countries, however, the health status of Laos remains low and similar to those of Cambodia and Myanmar.

Health Indicators of Laos

Year	Life Expectancy (years)	Infant Mortality Rate (/1,000 live births)	Under-5 Mortality Rate (/1,000 live births)	Maternal Mortality Rate (/100,000 live births)	Source
1960	40.4	155	-	-	UNDP, 1995
1970	-	145	218	-	UNDP, 2001
1985	-	118	139	-	UNFPA, 1992
1994	51.7	93	134	650	UNDP, 1997
2000	59	82.2	106.9	530	SPC and NSC, 2001

Table 2-1

The leading causes of morbidity and mortality are described in the Table 2-2. It shows that malaria, pneumonia, and diarrhoea are the top 3 diseases contributing to high mortality in this country. In fact, children are liable to have these diseases.

Leading Causes of Morbidity and Mortality, 1999

Morbidity (/100,000 population)		Mortality (/100,000 population)	
Malaria	1761.60	Malaria	13.71
Pneumonia	676.12	Pneumonia	4.69
Influenza	636.88	Diarrhoea	2.71
Diarrhoea	523.28	Meningitis	1.55
Dengue haemorrhagic fever	178.53	Haemorrhagic fever	0.52

Source: WHO, Country Health Information Profiles, 1999

Table 2-2

As for medical services, there are 2 central hospitals, 6 specialized centers, 5 regional hospitals, 13 provincial hospitals, 126 district hospitals and 566 health centers in Laos. In addition, there are 230 private clinics and 1990 private pharmacies. The total number of health personnel is about 12,000, of which those posted to the central, provincial and district health service institutes are about 16 %, 33 %, and 50 %, respectively.

About some 40 % of the people live in rural areas where health service are not accessible within one day. Ethnic minorities living in remote areas should be given due consideration in extending health services in this country. As the health indicators reveal, good heath services have not yet covered the whole country.

Many projects in the health sector were and have been executed. According to the Foreign Aid Report 1999-2000, at least 40 projects concerning health services were supported by donor countries, international agencies, and NGOs. Generally speaking, most of the projects have been carried out to achieve their goals in a particular period. Many projects had to stop their activities due to the lack of budget. Furthermore, these projects are not equally distributed all over the country. Some provinces/districts do not receive any foreign aid in health while some others do. The difficulties in sustainability and imbalanced allocation of donor assistance are issues that need to be tackled.

Based on these experiences, the MOH has developed a health strategy to 2020 that gives priority on the equity of healthcare services.

2-3 Host country strategy

The Health Strategy to 2020, which was produced by Ministry of Health in July

2001, sets the general goal of health development as follows:

"To free the healthcare services in Lao PDR from the state of underdevelopment and to ensure full healthcare services coverage, justice and equity in order to increase the quality of life of all Lao ethnic groups."

It emphasizes the next four basic concepts to guide future health development efforts;

1) equity of health services,
2) early integration of healthcare services,
3) demand-based healthcare services,
4) self-reliant healthcare services.

Six directions for health development is also set to follow in accordance with those four basic concepts;

1) To strengthen the capability of health staff in terms of attitudes, ethics and technical skills in order to ensure high quality services
2) To improve community-based health promotion and disease prevention
3) To improve and expand hospital services at all levels and in remote areas
4) To promote the utilization of traditional medicine by integrating modern and traditional care
5) To promote scientific and research activities for health development
6) To ensure effective health management, including administration, finance and health insurance systems.

2-4 Prior or on-going assistance

In Laos, contributions from donor counties have occupied a large portion of the budget for health. In 1998, 24.4% of total cost of the health sectors was from bilateral and multilateral cooperation, and 6.1% was from NGOs. Main international organizations which provide support to Laos are following;

●World Bank:

It worked with the Ministry of Health in the Health System Reform and Malaria Control Project from 1995 through 2001. It contained four components: primary health care, malaria control, health education, and project management.

●Asian Development Bank:

It provided assistance for the Primary Health Care project until 2000 in Xiengkhuang and Oudomxay provinces. It built 70 health centers, provided essential drugs, and trained health workers on district level. This project is now entering phase 2. The goal of phase 2 is to improve access to primary health care in northern region and to strengthen institutional ability of primary health care until 2006.

●World Health Organization:

WHO provides a wide range of technical and financial support to the activities of the Ministry of Health. It mainly cooperates on the level of policy-making, but also works in Malaria control, Tuberculosis control, mother and child health, health education, and medical information system.

●UNDP

Until 1997, UNDP had provided assistance for the projects for training of health staff in North provinces, supporting drug revolving funds, and reconstructing provincial and district hospitals. Recently, UNDP supports the project for preventing expansion of HIV/AIDS in Savannakhet province.

●Japan

Japan implemented two technical cooperation projects through JICA; Primary Health Care Project (1992-1998) and Pediatric Infectious Disease Project (1998-2001). A technical cooperation project for the Improvement of Sethathirath Hospital, which was constructed with Japanese grant aid in 2001, is being executed.

●Australia

Its' cooperation concentrates on the field of primary health care in rural areas, and most activities are carried out by NGOs. There is Laos-Australia health and social development program, which is aimed at improving the quality of life and health in Phongsali and Huaphanh provinces.

●France

Its' cooperation concentrates on the field of training of doctors, medical technologists, and hospital managers. As a main project, France provides technical supports to the Mahosot Hospital, especially in the field of emergency care and anesthesiology. It also supports a training program for doctors and nurses in Savannakhet provincial hospital.

●Sweden

SIDA implements projects in the field of Mother and Child Health, and developing a clean water supply system. It also provides drugs through local health posts, and assists the Laos government in settling up its National Drug Policy.

Thus, there are many kinds of projects assisted or executed by various donors. To create greater impact, cooperation and communication among different donors would become increasingly important. Laos is anticipated to play a pivotal role to coordinate development work by these donors.

3 Problems to be addressed, the current situation

3.1 Institutional framework for the health sector

This chapter reviews the institutional framework and human resources development in the health sector of Laos. It may be useful for the project to consider how to assist the targeted institutions and people during the project activities.

The Ministry of Health (MOH)

Present structure of MOH (Figure 3-1)

A. Central level

(1) Departments of the MOH

The Cabinet Office is headed by the Chief of Cabinet and two Deputies. It has 5 divisions: 1) Research & Development, 2) External Relations, 3) Health Regulation, 4) Primary Health Care and 5) Administration. This office is responsible for facilitating and coordinating external aid to the health sector, and provides general administrative support to the ministry.

The Department of Hygiene and Disease Prevention consists of 5 divisions: 1) Hygiene and Prevention, 2) Health Promotion, 3) Environment, 4) Mother and Child, and 5) Administration. It has direct responsibility for 6 centers: 1) Mother and Child Health Center, 2) Center of Malaria Parasitology and Entomology, 3) Center of Laboratory and Epidemiology, 4) National Committee for HIV/AIDS Control, 5) Centre of Information and Education for Health, and 6) Center of Environmental Sanitation and Water Supply. In addition, the department is managing 3 national programmes: Healthy Cities, Vitamin A Promotion, Iodine deficiency disease.

The Curative Department is responsible for general hospitals and private clinics throughout the country. The central hospitals in Vientiane are directly under this department, while the provincial hospitals are managed by provincial heath offices, and district hospitals and health centers by district health offices. Major hospitals have their own local management structures and they are relatively autonomous at present, as they can raise a certain amount of revenue independently through cost recovery schemes.

The Department of Planning and Finance is responsible for policy and planning, including the formation of overall health policies, long-term strategies, annual and five-year development plans, and foe liaison with the Committee of Planning and Cooperation. The department is also responsible for the management of national public health budgets, collecting and reporting health statistics, creating health insurance

schemes and monitoring the construction of all health facilities.

The Department of Food and Drugs: The main roles of the department are to formulate decrees, regulations, technical standards and basic management methods and inspection and quality control of food and drugs.

The Department of Personnel and Organization comprises 5 divisions: 1) Education and Refresher Staff Training, 2) Health Personnel and Organization, 3) Staff Welfare, 4) Party Bureau and 5) Administration. The department is responsible for health staff allocation, health staff training institutions including the National Institute of Public Health, Francophone Institute of Tropical Medicine (IFMT), and the College of Health Technology and other low-level training schools.

Department of Inspection is responsible for the inspection of health sector activities in respect both to budget audit and to the quality of work, and it woks closely with the MOH Party Committee and the Board of Minister.

(2)Centers affiliated to the MOH

Mother and Child Health Center

The Mother and Child Health Center, established in 1989, is responsible for formulating maternal and child health policies and programs, and coordinating the nationwide provision of maternal and child health services. This includes the prioritizing of interventions, monitoring of progress towards targets and coordination of international donors and NGO activities. The center conducts important specialized programs to deal with the major causes of morbidity and mortality of mothers and children, such as save motherhood, control of diarrhoeal disease, acute respiratory infections, birth spacing, immunization, breast-feeding promotion, reproductive health, and the integrated management of childhood illness. In particular, Expanded Program on Immunization (EPI) under this center eradicated Polio with the assistance of Japan, WHO, UNICEF, and AusAID in 2000.

Center of Malariology, Parasitology and Entomology (CMPE)

The main duties and responsibilities of CMPE are to ensure the reduction of morbidity and mortality due to malaria both by controlling the vectors through impregnating bed nets or other methods and by offering early diagnosis and treatment. Its other duties are to modify standard treatment protocols, to promote adequate supplies of chemicals at reasonable prices and to supervise, follow-up and evaluate implementing programmes.

Laboratory and Epidemiological Center

The center is responsible for strengthening the epidemiological system, assessing the needs of peripheral laboratories, and making plans for developing and strengthening the eapability of central, regional and provincial laboratories. The center also conducts cross-sectional studies on potential outbreaks of infectious diseases.

National Committee for Control of HIV/AIDS (NCCA)

The NCCA was established in November 1998 to be responsible for planning, co-ordination of resource allocation, management and administration for the national HIV/AIDS plan. It is also responsible for preparing the national strategy for STD prevention and control including preparing a training curriculum on syndrome case management, which is to be included as part of the country's primary health care training.

Center of Information and Education for Health

The center has a number of duties, in spite of its limited capacity and resources:

- To promote health issue for the MOH
- To coordinate and cooperate with multi–sector institutions, both local and international, for health promotion and disease prevention
- To develop health education materials and support all health programs of the MOH
- To improve health education for health staff at health facilities of all levels
- To monitor and evaluate health education and information activities

The Environmental Sanitation & Water Supply Center

The Environmental Sanitation & Water Supply Center was set up in 1982 to administer the National Water Supply and Environmental Health Program, but also has responsibility for establishing and promoting water supply for all rural people and environmental health promotion in urban and rural areas. Other responsibilities are to promote and establish clean and standardized latrine systems for rural and urban people, to promote school hygiene and to manage solid and water waste disposal in rural areas, schools and hospitals, and to promote "the 3 hygiene (eat clean, keep the house clean, wear clean cloths)" through community participation.

Medical product Supply Center (MPSC)

The main duties of MPSC are to develop policies on medical product supply for the MOH and to formulate plans for the procurement of drugs and medical equipment.

Food and Drug Analysis Center (FDAC)

The FDAC is responsible for research and analysis under the guidance of the Food and Drug Department.

Traditional Medicine Research Center

The center is responsible for traditional medicine research, including compiling and inventory of medicinal plants, partly for preparation of herbariums.

(3) National Institute of Public Health (NIOPH)

The NIOPH is a technical organization of the MOH, and is the central focal point for promotion, support, consultation, advertising, coordinating and implementing health research activities, health policies and health legislation. It conducts in-country training of health staff in their relevant technical areas at different levels, and also co-operates with foreign organizations. It co-ordinates directly with the Department of Organization and Personnel and the Francophne Institute of Tropical Medicine. It also plays a coordinating role for the Council of Medical Sciences Office.

(4) College of Health Technology and Nursing Schools

The College of Health Technology and auxiliary nursing schools have the following duties:

- To develop and reform their existing curricula in line with the socioeconomic situation of Laos
- To increase the knowledge, skills and experiences of staff in health and other subjects by providing appropriate training to prescribed national standards
- To provide teaching equipment of sufficient quality and in sufficient quantities for both classroom and field practice in order to enable effective teaching and learning outcomes for all students at all levels

(5) Central Hospitals

There are 9 central hospitals in Vientiane Municipality, namely Mahosot Hospital, Friendship Hospital, Sethathirath Hospital, Mother and Child Hospital, Traditional Medicine Research Center, Rehabilitation Center, Ophthalmology Center, Dermatology Center and Tuberculosis Control Center. These hospitals have two main duties: treatment and health promotion/prevention. The MOH also plans to upgrade the central hospitals to become teaching hospitals and the third level referral facilities for the whole country.

(6) Pharmaceutical Factory No.3

The factory produces medicine both for the MOH and commercially in order to be financially autonomous.

B. Provincial Level (Figure 3-2)

The provincial health offices have administrative and technical responsibility for health services within their provinces, including provincial hospitals, the network of Primary Health Care facilities, the implementation of vertical programs, and the regulation and inspection of private sector facilities. The organization and resources of health services vary significantly among the provinces. The provincial hospital provides second referral services including emergency care and surgery. Because of its size, catchment population and functions, the provincial health system equates to WHO's definition of a "district health system". Due to the basic level of services and training capacity at provincial level, the government plans to strengthen the three regional centers in order to provide advanced training and specialist referral care.

The provincial health offices have the following duties:

- Translating regulations, laws, agreements, directives and plans from MOH into operational plans appropriate to local conditions, and monitoring their implementation
- Collecting information on the health status of the population, promoting environmental preservation, collecting comprehensive information and statistics for health development, establishing projects and seeking funding assistance, monitoring and supervising the use of both domestic and foreign-aided funds
- Keeping records of comprehensive health works for the districts under their responsibility, and making periodic reports to MOH and provincial governors
- Selecting, assigning and supervising government staff within the province, and implementing governmental staff policies
- Assisting, monitoring and inspecting the implementation of health care services provided by both state and private sectors at village/community levels
- Promoting disease prevention activities, health examination and treatment and health rehabilitation for ethnic minorities in certain provinces
- Overseeing and administering the operation of their own provincial health department
- Coordination and liaison with both state and private organizations to seek assistance

and cooperation for health promotion activities

The ministerial regulation on the establishment and operations of Provincial Health Offices lays down guidelines for staffing levels. There should be 2 or 3 staff comprising the Provincial Health Office directorate, 12 to 16 administrative staff, and 4 to 6 technical staff, while staffing of the various technical sections will depend on the amount and duration of work assigned. For provincial hospitals, staffs are allocated on a ratio of 1-1.2 staff per bed.

C. District Level (Figure 3-3)

District Health Office has the following duties:

• To investigate and collect information on the health status of the population disease and the operational conditions of health care services in the district

• To report to higher authorities, and prepare plans for each period

• To improve links between distinct and village levels to ensure that effective health care can be achieved by focusing on disease prevention

• To oversee the training and education of governmental staff in accordance with governmental staff regulations

• To implement and promote health care services for people through projects and activities, and to raise awareness and understanding of health care among governmental staff and the population at large

• To provide health care service and treatment at the first and second referral levels

• To expand the provision of traditional herbal treatment

• To oversee and monitor the use of drugs, medical equipment, finances, and other governmental property

• To coordinate with both public and private sector health actors to ensure that all service providers are operating in accordance with laws and regulations

• To establish relationship and cooperate with state, mass, and private organizations

The district health offices are responsible for the co-ordination of health service within districts. The district hospital in Laos is comparable to a Health Center in many other countries, providing outpatient and basic inpatient care with 10-15 beds, mother and child services, outreach services, and logistic support and supervision of service in the district.

The ministerial regulation on the establishment and operations of District Health Offices

provides for the following staffing levels: 1 director (responsible for the administration section, and for the district hospital), and 1 vice- director (responsible for health promotion, hygiene, and the disease prevention unit), and 4 to 6 administrative staff, and 12 to 15 staff for the Health Promotion, Hygiene, and Disease Prevention Unit. Since inpatient services are provided by a provincial hospital, the districts in the vicinity of provincial town only has outpatient unit and there should be 8-12 staff. For District Hospitals in rural areas, a staff ratio of 0.8-1 per bed is envisaged.

3.1.2 Health human resources and training system for them

1. Classification of government health personnel

Health personnel are categorized into 3 levels according to their educational level, namely first, second, and third level. First-level personnel, who are medical doctors, pharmacists, or dentists, have completed 5-7 years of study after senior high school at the Faculty of Medical Science, National University of Laos (Formerly, the University of Health Science). Second-level personnel, according to the current training system for health staff, include registered nurses/midwives, assistant pharmacists, physiotherapists, laboratory assistants, and hygienists. They have completed 3 years' study after senior high school at the College of Health Technology located in Vientiane municipality. Auxiliary nurses, who constitute third-level personnel, study two years or less in nursing schools in the provinces.

The educational background of third-level staff varies much more widely. Until 1994, each province had an auxiliary nurse school and the length of the training varied from 3 to 24 months. Students' general educational background also differs. While some have completed or at least started junior or senior high school, others have not even completed primary school. Some also received short-term nursing training in the army during the period of the revolution. In addition, it has been found that at local level health facilities such as district hospitals and health centers, there are staffs who have learnt to practice herbal medicine from monks or traditional healers. They are usually regarded as pharmacy technicians, like those who have been working in laboratories but are under-qualified. All are categorized as third-level staff on the basis that they have received not more than 2 years' formal training.

2. Health staff training system

At present, there are three providers of pre-service training for health workers in the

country: the Faculty of Medical Science in the National University of Laos, the College of Health Technology and the Auxiliary Nursing Schools. According to the Ministry of Education, the Faculty of Medical Science is classified as tertiary education (= high-level: sansung), the College of Health Technology as upper secondary technical education (= middle-level: sankang), and the Auxiliary Nursing Schools as upper secondary vocational education (= low-level: santon). Thus the qualifications from the health training institutions are graded one level lower than other technical/vocational schools. However, it is generally recognized that more years of training are required for workers in the health sector than for general vocational and technical training.

(1) Faculty of Medical Science, Department of Medicine

Yearly intake of students is 100 to 120 at the Department of Medicine. The course of the Department of Medicine lasts seven years. Students must study at the Faculty of Foundation Studies for two years. They study Preclinical Sciences in the 3rd and 4th years through lectures and practical training Clinical Sciences are taught from 5th to 7th years. Textbooks in French and English are available in the library, although not in sufficient quantities. Foreign language acquisition is regarded as important and so is included in all five years of the professional course. However, few students are able to read textbooks written in foreign languages. Many students use textbooks translated into Laos, most of which are outdated. In typical year, 82 students graduate from the Department of Medicine. Of these, almost half become government health staff, including 10 going to the MOH. Others find jobs with international organizations. The remainder find jobs outside the health sector.

(2) Postgraduate Education

Until 1997, there was no postgraduate medical education in Laos. Professional postgraduate education was then only available abroad in countries such as Thailand, France and Russia. At present, there is a "Pediatric Residency Program", which is the country first Residency Program. The program is supported by Health Frontiers, an American NGO. The program started in 1997 and accepted medical doctors with three or more years' clinical experience. The 5 or 6 doctors accepted onto the course receive training at Khon Kaen University in Thailand and Case Western Reserve University in Ohio, in addition to the training at the Department of Medicine in Vientiane. The objectives of the Pediatric Residency Program are:

• To educate pediatricians who can contribute to the development of child health in Laos

• To improve the people' quality of life and health status, and to improve average life expectancy, especially in rural areas

• To upgrade the knowledge and skills of graduates of the Department of Medicine

The program also contributes to clinical research, the development of clinical practice for medical students, foreign language training, and the development of information technology. The Department of Medicine understands the importance of postgraduate education, and is trying to establish other postgraduate resident programs such as internal medicine, obstetrics and gynecology, and ophthalmology next year in co-operation with NGOs.

3.General In-service Training

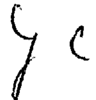
Serving health staff do have opportunities to receive training to upgrade their qualifications. Between 70 to 90 staff receive upgrade training either in or out of the country every year. Generally speaking, staff under 36 years old are entitled to apply for Bachelor or diploma courses which equate to middle- or high- level education within Laos. As for postgraduate level, generally staff aged between 37 and 45 can apply for Master courses; staff of any age can be considered for Ph.D. courses if the educational institute accepts their application.

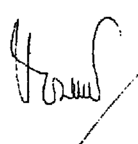
Within the country, the Faculty of Medical Science and the College of Health Technology accept serving health staffs who intend to upgrade their qualifications from middle- to high- level or from low- to middle-level. Under the present system, they start from the first year of the relevant course, so that they have to study for the same period as secondary school graduates. MOH is considering shortening the training period as required for upgrading in-service staff. The College of Health Technology has already developed a 2-year curriculum for its nursing/midwifery, laboratory assistants' and physiotherapy courses.

Low-level staffs who have not completed upper secondary school are not eligible for upgrade training. They can only receive short-term training.

(1) School of Public Health

The School of Public Health is a section of the National Institute of Public Health (NIOPH). Its major roles are: 1) to develop and run various continuing training courses for health staff, 2) to investigate postgraduate training needs, 3) to develop and implement postgraduate training courses, 4) to provide technical support such as curriculum development and teaching to all health staff training schools in the country,





and 5) to carry out quality evaluation surveys of health staff. There are two permanent staff (director and deputy director) in the school. Teachers for the training courses are second from MOH, affiliated institutes/centers and other sections of NIOPH.

Training courses conducted in the past and planned for the future are summarized below.

① Master in Public Health: run between 1997 and 2000 with the support of the French government. Fifteen students (14 medical doctors and 1 pharmacist) were taken from Provincial Health Offices and MOH. The course was divided into 15 semesters and was taught in French. With all lectures coming from France for 2-3 weeks of each semester, the course took 2 years to complete. The course comprised pedagogy of health education, bioscience, epidemiology, health management, and health education and promotion. The course will be repeated, beginning in November 2001.

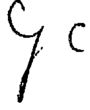
② Health administration course: a 3-month course jointly funded be ADB and MOH. It was run about 6 times between 1995 and 2000 with 30 participants each time. The main participants were directions and deputy directors of Provincial Health Offices and Provincial Hospitals. The school wants to run the course again in the 2001/02 fiscal year, but the necessary funding has not yet been secured.

③ Health project management course: one-moth course for health staff responsible for the management of projects (such as EPI and PHC) at provincial and district level. The course has been conducted 3 times so far and each course has had 30 participants.

④ Health education pedagogy course: one-month training of trainers at province level. The course covered curriculum development, topic selection, lecturing, and attitude towards trainees. The course was run twice before 1999.

⑤ Short-term training courses on demand: the school also offers 2-3 week training courses when needs arise. The school has, for instance, run courses on health education, health promotion, and administration and management.

⑥ Master in Public Health (taught in English): the school plans to run a similar course to the one in French, but this is still at the planning stage, and sponsors have not yet been identified. Lecturers would be brought from Thailand and the course



would last 10 months, potentially starting in 2002 with 15-20 students.

⑦ Bachelor in Public Health and Health Administration: still under consideration by MOH. If approved, the course would provide for 30 students to follow a 2-year professional course at the School of Public Health after having studied for 3 years in the Faculty of Foundation Studies at the National University of Laos.

The school's major difficulty is that it has to depend almost totally on outside funding for its activities. Therefore, the training capacity of the school is not sustainable at present.

(2) Francophone Institute of Tropical Medicine (IFMT)

IFMT has been running 2-year postgraduate courses for graduates of the Faculty of Medical Sciences since 1999. It is supervised by the Agency for Fransophone Universities (AUF) --- an NGO based in Quebec. The objective of AUF are as follows:

- To establish a postgraduate program in tropical medicine
- To conduct high quality research on critical health problems in Asia
- To study strategies for the development of public health services in Asia
- To collaborate with other countries and donors

The 20 trainees accepted each year must pass an examination in French. AUF also conducts other health-related activities in Lao PDR. For example, in August 2001, a health forum entitled Functions of medical directors in the clinical field at district hospitals was held.

4. Other training opportunities

There are other kinds of training opportunities. Some form components of certain projects or programs, while others are initiated by MOH with financial support from donors or NGOs.

The following are a few examples:

- Training of trainers in the MCH program (funded by UNFPA)
- Postgraduate courses in surgery at Mahosot Hospital (funded by CCL)
- Training courses for provincial hospital staff at Mahosot Hospital
- Training courses for doctors from district hospitals at Sethathirath Hospital (part of JICA's technical cooperation)
- Intensive training courses in pediatrics and obstetrics for auxiliary nurses at the College of Health Technology (part of GTZ project at Bolikhamxay)

Ministry of Education (MOE)

The MOE is headed by a minister and two vice ministers with 9 departments, National Research Institute Committee of Inspection, National University of Laos and Cabinet (Figure 3-4). The structure of the education system in this country is shown in the Figure 3-5.

3.2 Problems to be addressed:

3.2.1 A core problem and its causes

The core problem of the project is "existing health service with poor quality". The causes of the core problem would be addressed from three points;

i) Personnel

ii) Central MOH

iii) Local MOH

3.2.2 Present Problems

i) Personnel

In 2000, there were 11,432 health personnel in the country. Of these, 16.4 % (1876 personnel) were working at the central level. Provincial level staff account for 33.8% (3861) of the total and district level staff for 49.7% (5679). About 66% of all low- level staff in the country work at district level. For middle level staff, 21% work at central, 38% at provincial, and 40% at district level. For post-graduate and high-level staff, 40% work at the central level with 38% work at provincial and only 22% at district level.

Finding qualified personnel to work in remote health centers is the most difficult issue in deployment. Although Director of the District Health Office has full control over the deployment and rotation of health staff in district, these powers are limited in practice due to a number of constrains:

• Staff salaries are insufficient to maintain livelihoods and in any case are often paid late. This means that staffs at district level are often engaged in secondary occupations such as agriculture or private medical practices in order to support their families, which would be compromised if they were redeployed.

• Few staffs are willing to be posted to remote area due to difficult living conditions poor transportation links and a lack of social services.

• Few health staffs are from ethnic minority groups. Cultural and linguistic differences mean they are reluctant to be posted to remote ethnic minority areas.

As a result, local health facilities tend to be staffed by younger and less experienced female nurses, with the result that staff shortages and inadequate levels of service are common problems at district and village levels.

ii) Central MOH

Health sector funding relies heavily on foreign sources such as 35% of the total, while the government contribution is about 10%. Central MOH needs funding to implement health projects but budget allocation has some limitation. Therefore, each department and center in the MOH is likely to be keen to obtain budget. Once a project has been funded, it is impossible to share the fund with the other projects. The MOH has a well-organized structure shown in the figure 3.1. However, there is no horizontal coordinating unit that makes some relationship among different departments and centers.

According to the preparatory study, central MOH identified several issues as follows;

- Through out the country, the inaccessibility of the health service is still high
- In some areas, although the availability of health services exists, their qualities are still low.
- Planning capacity of district health service is still limited
- Degree of decentralization to the district health system is still unclear
- The interface between the basic health services and concerned community is still weak and unable to motivate their continuous participation to improve their own health

iii) Local MOH

Local health organizational structure was shown in the figure 3-3. Local staffs in these health facilities have to manage health projects with difficulties. The preparatory study team revealed many problems at each local level as follows;

at Provincial Health Offices{X=Xiengkuang, O=Oudomxay, K=Khammuane, S=Sekong, V=Vientiane}

- difficulties of remote health service (X, O)
- lacking in health education for minor ethnic groups (X)
- lacking in equipment for health education program (X)
- not enough staff (O,K) space(S) transportation (O,K) equipment (O,S) educational materials (K) and budget (O,K,S)
- training for data analysis(O)

•training for capacity building(S)
•health education is not enough to people (K)
•bad communication between staff and people (K)
•some districts are not well developed (V)
•training to be a specialist is necessary (V)

at District Health Offices
•transportation (X,O)
•management of public health (X)
•staff's knowledge (X)
•not enough staff (X,O,S), budget (O,K), equipment (O,K,S)
•Budget is coming late (O)
•building is old (K)

at Health Center
•people's poor understanding about health (X,O,K)
•staff training (X,O)
•lacking in equipment (X,O,S,V)
•not enough budget (X,O), drug(X,O,S,V), staff(O,V)
•family planning and delivery (O)
•transportation (O,K)
•People do not want to come. (O)

4. Project Strategy

4.1 Project Strategy

This section focuses on explaining the means and objectives that were addressed in the analysis of the objective tree.

4.1.1 Basic Project Strategy

The Project is aimed at improving child health through capacity building of administrative institutions to do strategic planning and reengineer the local (district) health system . It is not a project to transfer pediatric technologies, nor one to build facilities. In other words, the Project is to improve child health through the development of a sustainable health system . This is the basic strategy of the Project. To realize this, the Project will take a multi-sectional approach (**Figure4-1**). Basically the Project will strengthen capacity building of planning and implementation of preventive/care services for children through training and system development.

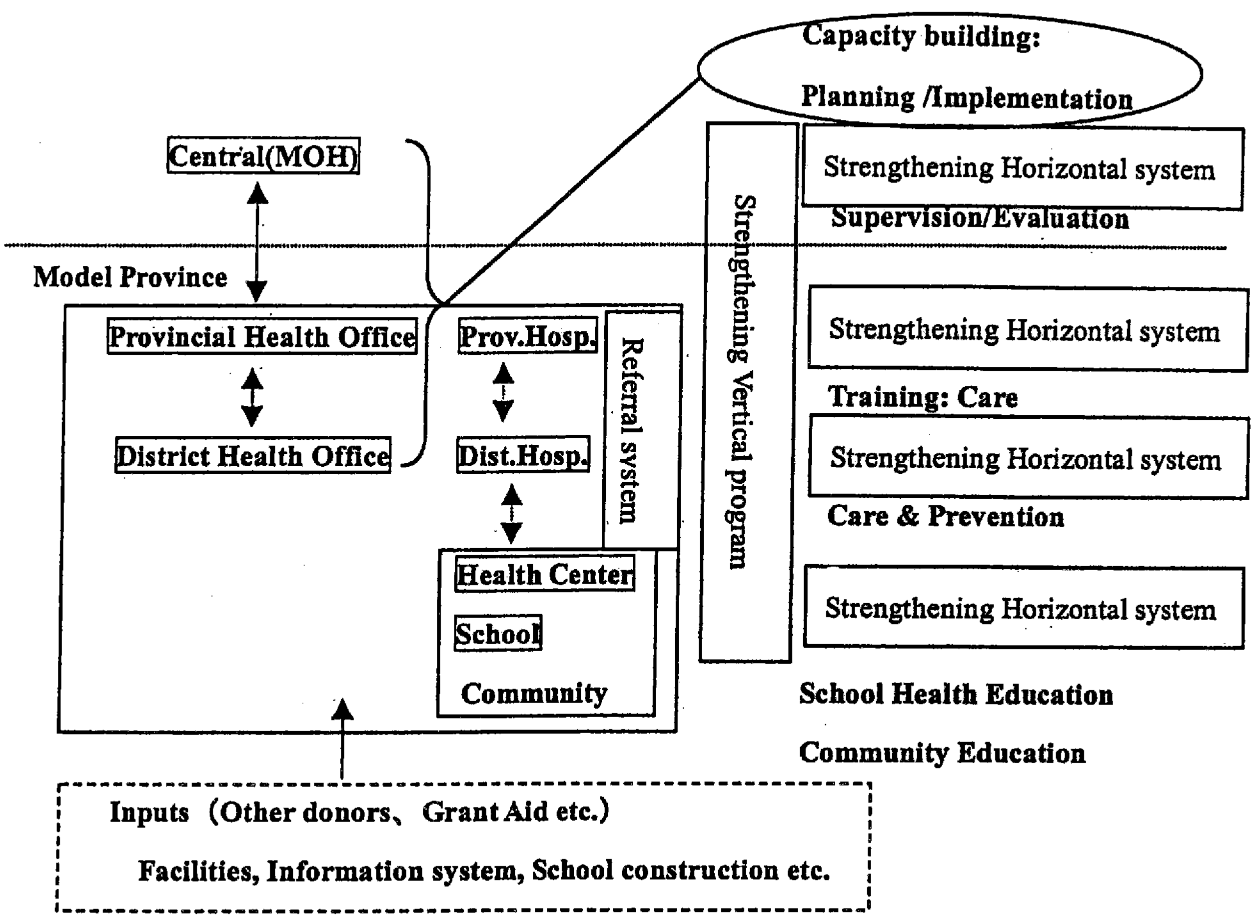


Figure 4-1 Concept of the Project

The reason why such strategy is needed is that the main problem of the health sector in Laos is the weakness in sustainability: Several projects executed in the past did not continue or expand although they were individually excellent.

Acquiring sustainability is not only by means of financial matters like income generation, but a consciousness revolution (change of mind). This issue is also widely recognized by the Lao side. And it plays an important role in achieving the project purpose effectively with low cost. So the Project sets sustainability as its central strategy.

4.1.2 Adjustment of the Project Objective

It was agreed at the PCM workshop that the problems described in the objective tree were too wide-ranging to discuss. The framework of the Project is formed by

recognizing a core problem, referring to the results of the preparatory study and the official proposal from the Lao side. Prioritization in sub-sector and region was necessary. Consequently, the following were chosen as the framework of the project:

- The first priority is given to health service improvement for children.
- Target population is children under 15 years old.
- As the model areas, Oudomxay and Vientiane provinces are selected.
- Xiengkhouang and Khammouane provinces are selected as areas to perform limited activities such as school health in collaboration with ACIPAC and Malaria control assisted through Japanese Grant Aid program respectively (**Figure 4-2**).

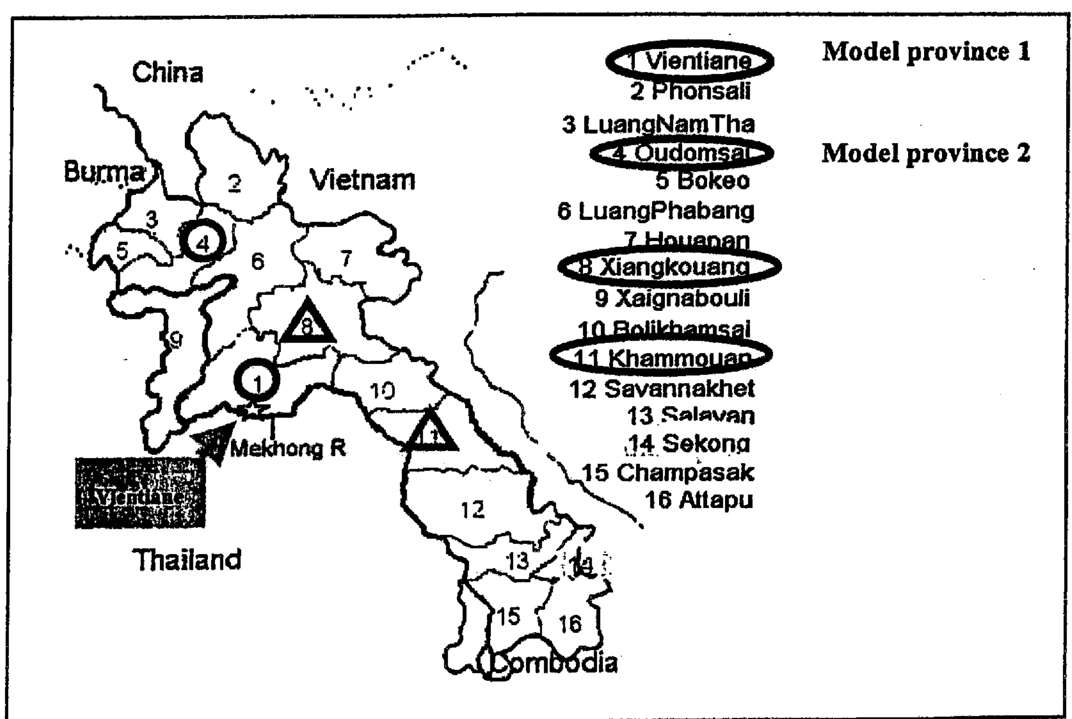


Figure 4-2 Site map of the Project related areas

The population of two model provinces is estimated about 600,000 (2000) (**Table 1**). As the ratio of under 15 years old is 44.1%(1999), the target population is about 250,000.

Table 1 Estimated average mid-year population by provinces

	1980	1990	2000
Xiengkuang	144	181	229
Oudomxay	167	283	240
Khammuane	299	245	311
Sekong	-	57	73
Vientiane	573	305	327
Total (Whole country)	3,199	4,140	5,218

(Source : National Statistics Center)

The following table shows why these provinces and activities were selected. The criteria for the selection are the location of other assistances provided by JICA, security and basic facilities such as electricity and communication systems, etc. (**Table 2**).

Table 2 Selection Criteria of the model provinces

	JOCV	Grant Aid	ACIPAC	Transportation (From Vientiane city)	Electricity	Security
Xiengkuang	OO	O	O	45 minutes by airplane	4 hours (6 p.m.- 10 p.m.)	● (partially)
Oudomxay	OO	O		1 hour by airplane	24 hours	
Khammuane	O	O		6 hours by car	24 hours	
Sekong				1 hour by airplane and 5 hours by car	24 hours	
Vientiane		OO		1 hour by car	24 hours	

4.1.3 Discussion on the Project Purpose: The central and local health services for children are strengthened with participation of various levels of stakeholders

Based on the analysis in the previous chapter, it is obvious that the project must focus on strengthening the central and local health services for children.

In order to achieve this objective, efforts of all persons involved, in other words, active participation of all stakeholders are indispensable. Problems could exist in individuals capacity, mutual relationships among individuals, in organizations and

inter-organizations between the central and local level. The first step is to figure out what problems are and then analyze them. The project intends also to develop capacity building to identify problems and reach solutions based on a participatory approach. Improvement in the central and local health services for children is measured by the increased number of utilization of health facilities, i.e., increased access to health services. To increase access, the minimum requirements such as increasing number of health centers with proper infrastructures, sufficient personnel, and allocation of sufficient national and local budget for child health services will be needed. In Laos, such budget allocation decided by the central government based on the health data from the local level. Therefore, introduction of a participatory approach is significant to better respond to the local situations, and would ultimately contribute to sustainability.

4.1.4 Discussion on the Direct Means (Outputs) to achieve the Project Purpose

In the Project Design Matrix, the direct means for achieving the project objective is regarded as project outcomes. There are six outcomes. The order of these outcomes does not coincide with the structure of objective trees. Since outcome (1)/Capacity building to provide better health services for children will become a base for all other outcomes, it is placed on top of all outcomes. This outcome is a top priority as it will facilitate participation of all actors related to this project.

(1) Capacity building to provide better health services for children

Capacity building includes both technical and managerial aspects.

The major outcome of this project is to improve the capacity of MOH and provincial/district level health offices, especially in terms of identifying problems and finding solutions through a participatory approach.

In concrete terms, the project intends to develop a process-oriented system in which problem finding/solving, planning, implementation, supervision and monitoring/evaluation of each preventive and curative health program will be strengthened. The system should be built in clinical and preventive activities.

The system will be strengthened through active participation of various stakeholders. Without this process, the system introduced by the Project will not sustain. Therefore, it is inevitable although this outcome will take a long time to hold and the evaluation will be more easy in this part.

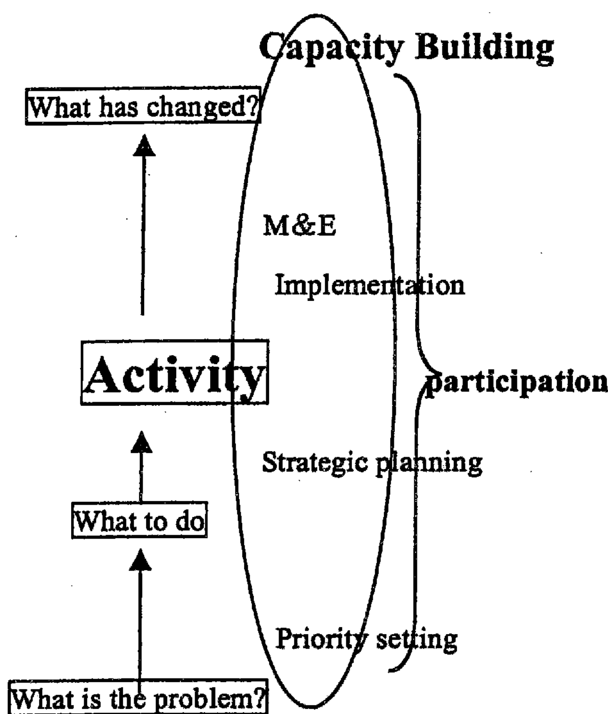
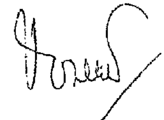


Figure 4-3 Capacity building and Participation

(2) Present functions on vertical (Central —Locals) health systems for children are strengthened in MOH

An important aspect of a vertical system is a functional linkage between the central and local levels. It includes a communication system and health information system, etc. **(Figure4-4)**

The data obtained through a vertical system will be analyzed and used for decision-making. This decision will be translated into implementation with consensus between the central and local levels, which is necessary to build a sustainable system.



Activities will be planned in soft and hard aspects. The former is introducing or reactivating a communication-coordination joint committee and standardizing health information forms etc., and the latter is installing such equipment as radio-communication system and improving basic infrastructures.

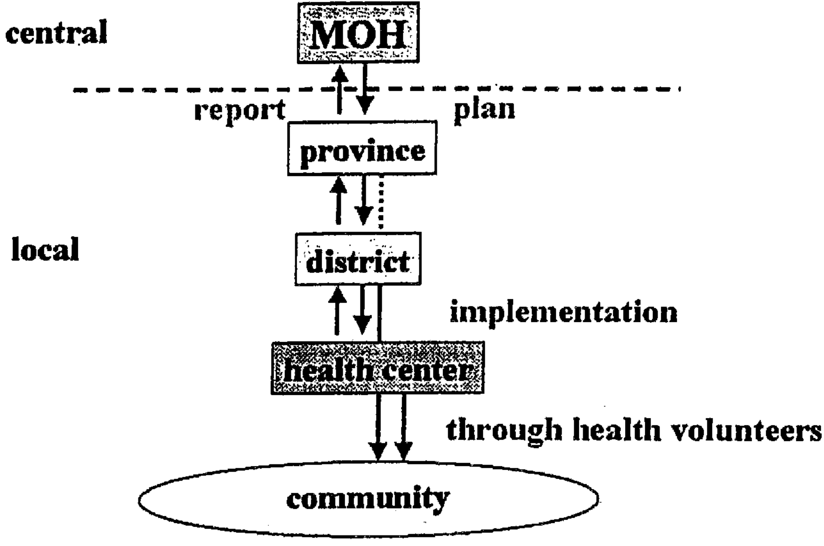


Figure 4-4 Strengthening Vertical System

(3) Present functions of horizontal health systems for children are strengthened in the model provinces

The horizontal system means a linkage among several sections within MOH or local health offices. Its function is to coordinate several vertical health services (for example, Malaria, MCH etc.)(**Figure 4-5**). A trans-sectional coordinating committee will be useful to hold a joint training course in view of achieving higher efficiency and improving quality of services.

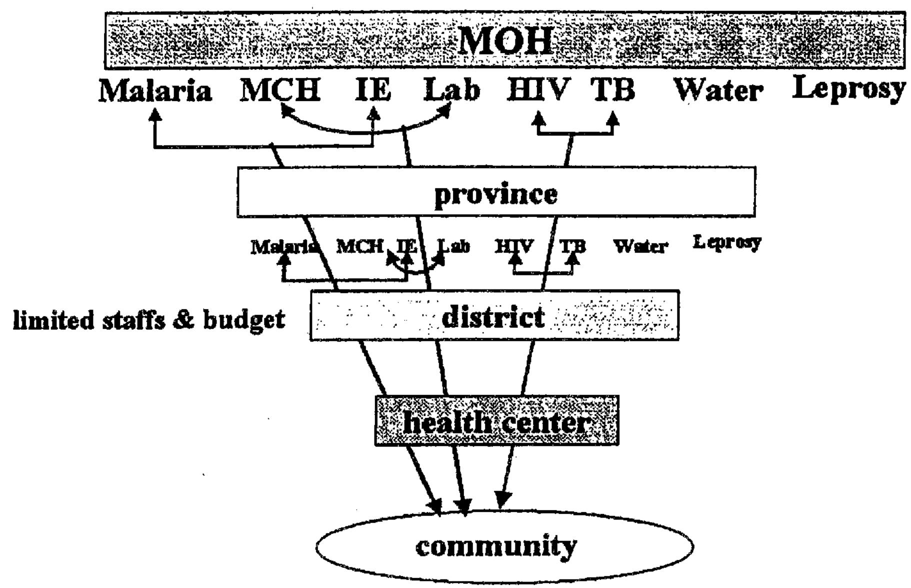


Figure4- 5 Strengthening Horizontal Systems

(4) Preventive and care activities against such major child diseases as diarrhea, malaria, and pneumonia are intensified in the model provinces

The capacity building of care at hospitals and health posts is as important as the managerial aspect. Following approaches for both care and prevention in child health are indispensable,: development and/or evaluation of national standards for prevention and care for such major child diseases as diarrhea, malaria, and pneumonia.

(5) Health education is improved

Health education is one of the most effective measures for prevention. This can be achieved through school health education and community health education.

A school health education program has already started in the Xiengkhouang province

in 2002 with support from ACIPAC. The Project will collaborate its activity. Moreover, elementary schools planned to be constructed with assistance from the Japanese grant aid program would be utilized as a place for school health education. Community health education will be provided at health centers and transmitted from students to their parents.

(6) The central and local capacity to establish supportive relationships and coordinate with such partners as national authorities, bilateral donor agencies, and international organizations is promoted

In the Xiengkhouang province collaboration is anticipated with ACIPAC in executing a school-based pilot project. A malaria control program in the Khammouane province has been considered definitive concrete activities at present. Moreover, many other activities on different levels can be included in the Project.

Figure 4-6 shows coordination among other modalities of JICA technical cooperation. The Project is anticipated to play its role of a major health sector cooperation program of JICA, from which future cooperation will be extended. On the central level, collaboration with the JICA health adviser to MOH will be important.

Category						
Sector	Health					
Field (1)		Public Health		(Clinical)	Research	
Field (2)		PHC		MCH	Ped	Obstetrics
(C/P)		Health office	Community	Health [illegible]	Hospitals	
AREA	National	Model Provinces (Oudomxay, Vientiane)			Sub-model Provinces (Xiengkhouang, Khammouane)	

☐ Project

■ Cooperation with Health advisor of MOH

▨ Cooperation with Grant aid program

Cooperation with JOCV

Cooperation with ACIPAC

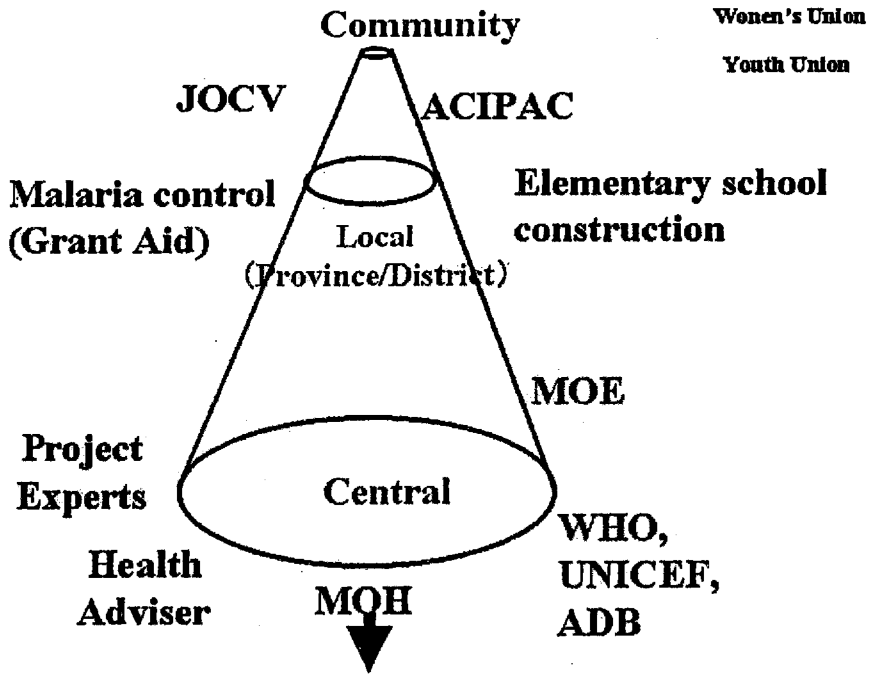
Figure4-6 Mutually supportive relationships with other JICA cooperation schemes

The project promotes collaboration with local organizations such as women s union and youth union, and international organizations such as WHO, ADB, and World Bank, etc. to create greater impact on the over all health services for children.

Figure 4-7 shows an overall image of the Project. For the early phase of the Project, activities will be limited to the central level. Gradually, activities will begin on the local level.

Activities conducted below the provincial level will be decided through workshops at local levels after starting the Project.

At early stage :



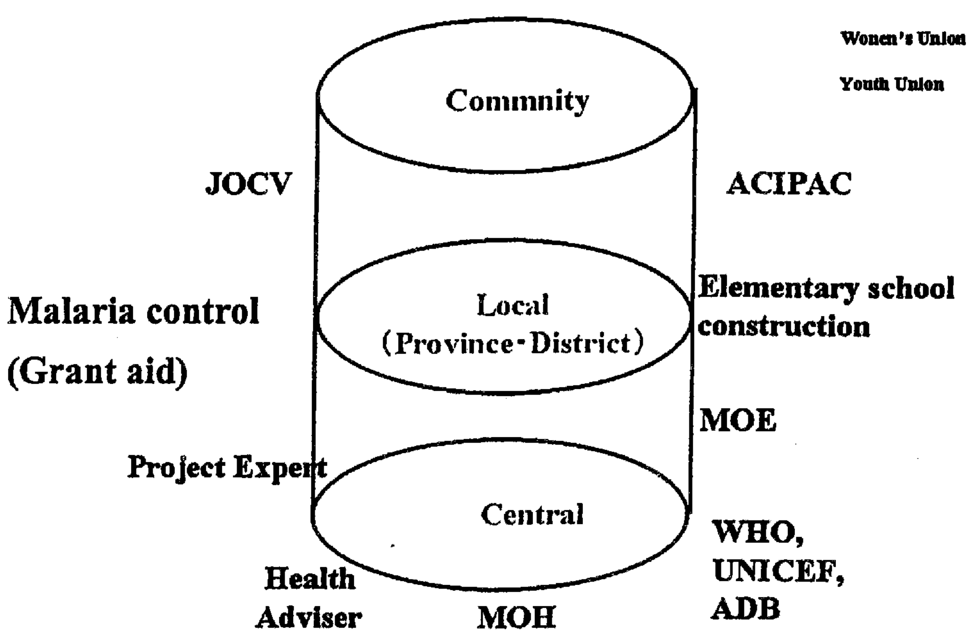


Figure 4-7 Project Image

4.2 Implementation Structure

4.2.1 Capacity of the Counterpart Organization

(1) Budget Allocation

MOH will be responsible for allocating budgets incurred by the Lao government.

The budget of MOH in the fiscal year 2001 is shown below (**Table 3**).

Table 3 Budget of MOH

year	(kip)
1998	4,504,610,000
1999	8,670,720,000
2000	11,648,620,000

Although the total budget for MOH is increasing year by year, it is still very limited (3.2% of GDP, 11.5US$ per capita; 1997/1998). The government health expenditure is only 9% of the total government expenditure. Major part of this spending goes to the purchase of drugs. 35.2% of health expenditure depends on foreign aid.

In such circumstances, one of the outcomes of the Project is to review its activities to increase and allocate budget.

(2) Institutional Arrangements

1. Central level

As shown before, the Project will be responsible by various departments of MOH. The main implementation body will be the Department of Hygiene and Prevention. The Department of Curative Medicine, the Department of Planning and Prevention, and the Department of Human Resources will also participate. Therefore, it is necessary to establish an institutional arrangement in the Cabinet to coordinate project activities under the responsibility of different department.

The MOE is also part of the implementation body in terms of school health education.

2. Local level

The Provincial Health Office is the implementation body on the local level. Permission and support from the Governor will be necessary. After starting the Project, each activity will be decided in detail.

As the superior decision mechanism, the joint coordinating committee will be organized and institutions mentioned above will be the main members of the committee.

(3) Organization Management

As part of the capacity building of MOH, there are issues concerning the financial management. Therefore, the management capacity building is included in the activities of the Project. Regular reporting and transparency of the administration is at least necessary.

(4) Counterpart Allocation

The counterparts for each activity may be appointed from MOH and other organizations (**Table 4**). It is necessary for MOH to appoint the following counterparts before the implementation of the project:

Apart from the individual counterparts, it is desirable to nominate the counterpart who works exclusively for this Project.

Although the counterparts for the local level activities should be insured too, they will

be decided in detail after starting the Project.

Table 4 Counterpart Allocation (Central and Provincial level)

Outcomes	Activities	Expected C/P (Section of planning and JICA staff should arrange all of activities)
1. Capacity building to provide better health services for children	1-1. To develop a system (problem identification, analysis, planning, implementation, monitoring, and evaluation) on central and local levels in view of providing better health services for children through a participatory approach	All related sections (Central、Provincial) Especially Dept. of Hygiene and Disease Prevention
2. Present functions on vertical (Central — Locals) health systems for children are strengthened in MOH	2-1. Assist to formulate a minimum standard on child health services at each level	Dept. of Hygiene and Disease Prevention, The Curative Dept.
	2-2. Improve the existing central-local interactive communication systems	All related sections (Central、Provincial) Especially Dept. of Hygiene and Disease Prevention, The Dept. of Planning and Finance
	2-3. Improve the existing health data and the processing systems	All related sections (Central、Provincial) Especially Dept. of Hygiene and Disease Prevention, The Dept. of Planning and Finance
	2-4. Implement training programs on child health services	Dept. of Hygiene and Disease Prevention, The Curative Dept.
	2-5. Improve the existing health information dissemination activities	All related sections (Central、Provincial) Especially Dept. of Hygiene and Disease Prevention
3. Present functions on horizontal health systems for children are strengthened in the model provinces	3-1. Create coordinating functions among the existing vertical health services (MCH, IEC, Malaria etc.)	Dept. of Hygiene and Disease Prevention、The Curative Dept. Center of Malariology
4. Preventive and care activities against such major child. diseases as diarrhea, malaria and pneumonia are intensified in the model provinces	4-1. Strengthen health services to be required at each level in accordance with the minimum standard for child health	Dept. of Hygiene and Disease Prevention, The Curative Dept. Dept. of Personnel & Organization
	4-2. Implement training programs for health staff of district level	Dept. of Hygiene and Disease Prevention

5. Health education is improved	5-1. Build a close relationship between MOH —MOE for school health activities	Dept. of Hygiene and Disease Prevention, Dept. of Personnel & Organization MOE
	5-2. Implement school health activities at elementary schools in cooperation with the ACIPAC (Asian Centre of International Parasite Control) project	Dept. of Hygiene and Disease Prevention, Dept. of Personnel & Organization Center of Malariology MOE
6. The central and local capacity to establish supportive relationships and coordinate with such partners as national authorities, bilateral donor agencies, and international organizations is promoted	6-1. Cooperate with Women s and Youth Unions	All related sections (Central、Provincial) Especially Dept. of Hygiene and Disease Prevention
	6-2 Build cooperative relationship with international agencies such as WHO, ADB, and the Wold Bank	All related sections (Central、Provincial) Especially Dept. of Hygiene and Disease Prevention, The Dept. of Planning and Finance

(5) Past Achievements

In Laos, JICA has provided assistance for the health sector in collaboration with MOH as a counterpart for a long time. Two public health projects were implemented to strengthen PHC and EPI (**Table 5**).

Table 5 Technical Cooperation Project

Primary Health Care Project	1992-1998
Pediatric Infectious Disease Prevention Project	1998-2001

Besides, there have been other continued assistance such as grant aid, dispatches of Junior Overseas Cooperative Volunteers (JOCV), and Senior Volunteers etc.

Moreover, at present, a hospital development project is being executed in the Vientiane City, A Health Master Plan is also being prepared with assistance from JICA.

4.2.2 Project Implementation Structure

The Joint Coordinating Committee will be established. It will be comprised of the Ministry of Health (MOH), Ministry of Education (MOE) and the JICA Laos office. In

future, the provincial governments and provincial health offices will participate in it. The Director of the Cabinet of the Ministry of Health will be the Project Supervisor, and the Director of the Dept. of Hygiene and Disease Prevention will be the Project Director. And also the Project Manager will be responsible for the managerial, technical and implementing aspects of the Project and the Project Coordinator will be assigned as the project counterpart personnel.

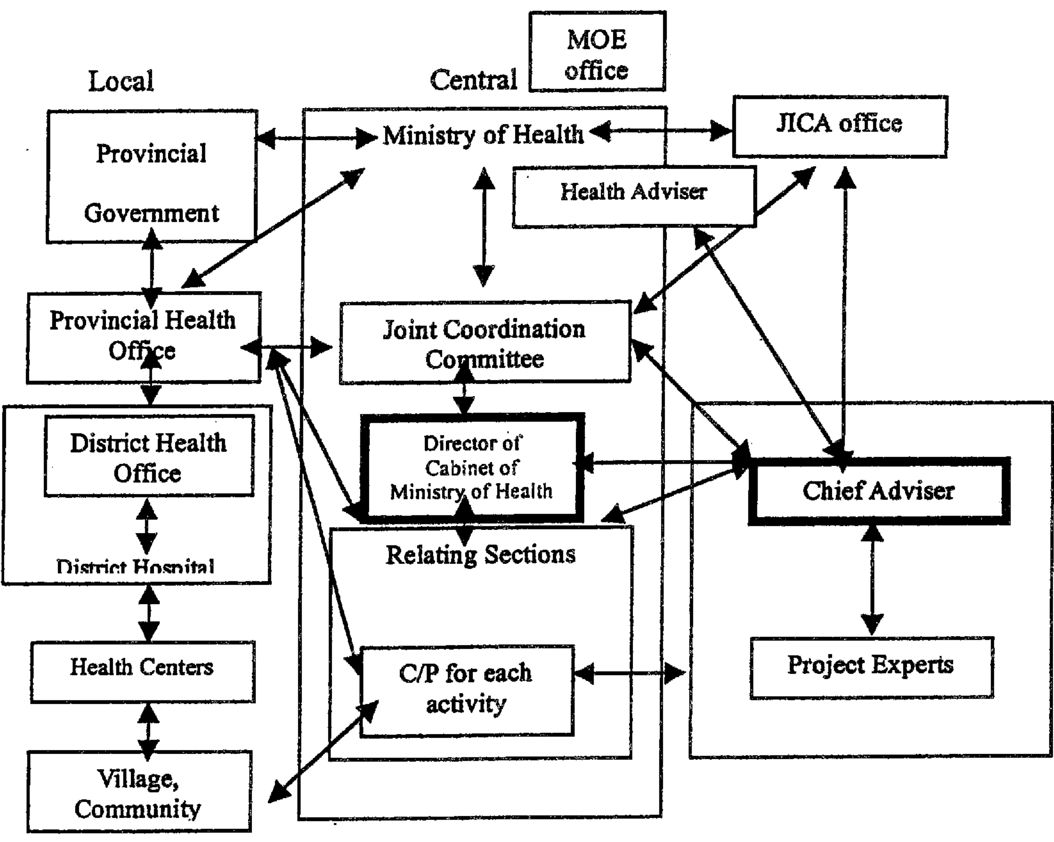


Figure 4-8 Project Implementation Structure

4.3 Coordination Arrangements

As shown in Chapter 4.1.4(6), **The central and local capacity to establish supportive relationships and coordinate with such partners as national authorities, bilateral donor agencies, and international organizations is promoted .** It is imperative for the Project to coordinate and cooperate with other JICA modalities, WHO, ADB, and World Bank, etc. Also cooperation with Youth Union and Women s Union is considered.

- Areas that will need coordination with other JICA modalities;

1. Capacity building to provide better health services for children
2. Present functions on vertical (Central —Locals) health systems for children are strengthened in MOH
3. Present functions on horizontal health systems for children are strengthened in the model provinces
4. Preventive and care activities against such major child diseases as diarrhea, malaria and pneumonia are intensified in the model provinces
5. Health education

- Areas where strong collaboration with the international organization such as WHO, ADB and the World Bank is anticipated;

2. Present functions on vertical (Central —Locals) health systems for children are strengthened in MOH

4. Preventive and care activities against such major child diseases as diarrhea, malaria and pneumonia are intensified in the model provinces

- Areas that will need strong collaboration with the national organizations such as Youth Union and Women s Union;

4. Preventive and care activities against such major child diseases as diarrhea, malaria and pneumonia are intensified in the model provinces

6. Health education

YC

Output 4: Preventive and care activities against such major child diseases as diarrhea, malaria and pneumonia are intensified in the model provinces

The project :
- Strengthen health services to be required at each level in accordance with the standard
- Implement training programs for HC staff as well as health volunteers
- Investigate patient s records at HC

Other JICA scheme :
- Malaria control program (Grant Aid)
- Senior Volunteer
- Individual Experts
- ACIPAC program

WHO :
- Standard
- EPI, IMCI, Parasitic Disease Control

ADB :
- PHC

Youth Union and Women s Union :
- Health Volunteer?

Output 5:

Health education is improved

The project :
- Build a close relationship between MOH — MOE for school health activities
- Implement school health activities at elementary schools in cooperation with the ACIPAC

Other JICA Scheme :
- ACIPAC
- Grant Aid (construction of elementary schools)

WHO :
- School Health

Youth Union and Women s Union :
- Health Education

Figure 4-9 Mutually supportive relationships with other JICA cooperation schemes

4.4 Sustainability

4.4.1 Institutionalization

During the implementation of the project, the following activities are to be introduced and strengthened. In order to institutionalize these activities continuously after the termination of the project, it is necessary to consider them at the beginning of the project.

Table 6 Institutionalization

Activities required to institutionalize	Factors to be considered to institutionalize
1-1. To develop a system (problem Identification, analysis, planning, implementation, monitoring, and evaluation) on central and local levels in view of providing better health services for children through a participatory approach	Selection, local adoption and implementation of Participatory Approach
2-1. Assist to formulate a minimum standard on child health services at each level	Elaboration of the standards of child health services
2-2. Improve the existing central-local interactive communication systems	Establishment of health information committee Appointment of responsible person
2-3. Improve the existing health data and the processing systems	Uniformalization of health information forms
2-4. Implement training programs on child health services	Planning and implementation of training
3-1. Create coordinating functions among the existing vertical health services (Malaria, MCH, IEC, etc.)	Establishment of coordination committee
4-1. Strengthen health services to be required at each level in accordance with the minimum standard for child health	Elaboration of the standards of child health services
4-2. Implement training programs for health staff of district level	Planning and implementation of training
5-1. Build a close relationship between MOH—MOE for school health activities	Establishment of Inter-ministry coordination committee
5-2. Implement school health activities at elementary schools in cooperation with the ACIPAC (Asian Centre of International Parasite Control) project	Coordination with Center of Malariology
6-1. Cooperate with Women s and Youth Unions	Coordination of contents of cooperation activities

4.4.2 Overall Review of Sustainability

The next table was summarized with regard to the following six factors to ensure the sustainability of the project: policy framework and priority of the country, institution, leadership, community participation, financial and economic situation, possibilities of

budget allocation, technical factors (appropriate technologies), social and cultural factors, and environmental factors.

Table 7 sustainability of the project

Factors	a	b	c	d	E	Remarks
① Political scope and priority	○					Health is the national top priority.
② Institution, leadership and community participation		○				Institutional Strengthening of MOH needs to be carried out on a basis of the plan at early phase of the Project.
③ Financial and economic situation and possibilities of budget allocation			○			The budget for training and accreditation needs to be allocated.
④ Technical factors (appropriate technologies)		○				Most technologies are identified as appropriate ones and need to be applied. Appropriate problem-oriented approach should be developed.
⑤ Social and cultural factors	○					There are no negative factors influencing the society and culture.
⑥ Environmental factors	○					There is no negative factor influencing the environment.

a: There are enough conditions to ensure sustainability.

b: There are a few destabilizing factors, but still a high probability for sustainability.

c: Neither applies in both cases.

d: There are lots of destabilizing factors and a low probability for sustainability.

e: There is little possibility of sustainability.

Figure 4-10 shows the Project formation based on the Sustainability.

Factors for sustainability | *Levels*

Voluntary

Consciousness change

Ownership

Participation

Social Mobilization

Solidarity

Incentive Motivation Advocating

Empowerment

Sustainability

Capacity Building

Institutionization

Budget

Personnel Income Generation

DRF, User s charge etc.

Commitment (Central Government)

Compulsory)

Individual

Social

Community

NGO

Community organization

Health Center

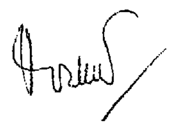
Hospital

Administration body

(Local : Province、District

Central : MOH)

Figure 4-10 Project formation based on the Sustainability



4.5 Special Consideration

Regarding the objectives, outputs and activities of the project, it is essential to consider the following issues.

(1) Consideration for equity

Although the Project will start from the central level (MOH), the final beneficiaries are the people. This project focuses on marginalized people in poverty, remote areas and ethnic groups.

Monitoring and evaluation of the Project is necessary to direct its activities for the target beneficiaries.

(2) Coordination among donors

One of the outcomes of the Project is **The central and local capacity to establish supportive relationships and coordinate with such partners as national authorities, bilateral donor agencies, and international organizations is promoted** . For better coordination the project may organize coordinating meetings when necessary.

5. Project Design

5.1 Overall Goal

It is defined that an overall goal of a project is effects as well as positive impacts on the development resulting from the achievement of the project purpose.

The overall goal of the project is identified that "*Health standard of children is improved in Laos.*".

This overall goal implies that if the project is successfully achieved and implemented in the model provinces and the vertical and horizontal child health systems are strengthened, similar activities on child health would continually be carried out in other provinces of Laos. Consequently, health standard of children in Laos will be improved.

For measuring the achievement of the overall goal, items of objectively verifiable indicators are established as follows:

- Mortality rate of major child diseases

5.2 Project Purpose, Outputs and Activities

5.2.1 Project Purpose

"The project purpose" is defined that a purpose which is expected to be achieved by the end of a project.

(1) Problems and the Core Problems

For establishing the project purpose of this project, at the first setout, the PCM workshop clarified several problems on child health services as follows:

a. Prevention aspects

- a-1. Poor communication, cooperation, information and evaluation on health services between the central and local levels
- a-2. Poor managerial capacity in health sector
- a-3. Poor health education at school for children
- a-4. Poor health knowledge among local population
- a-5. Lack of coordination with and within external donors

b. Care aspects

- b-1. Standard on child health care is not prepared
- b-2. Not enough health providers are available for child health care
- b-3. Quality of health staff is poor
- b-4. Poor equipment and technology on health are available at every level

b-5. No access of all children and mothers to health service in remote areas

In accordance with the problems analysis process, "*Existing health service (on child health)*[*1] *with poor quality (is provided)*[*2]" has been selected as the core problem.

(2) Approaches

In order to improve these problems, as shown in Table 5-1, six approaches have been eventually employed by evaluating several approaches identified in the objectives analysis process and by partially combining some of them.

Table 5-1 The Approaches

Approaches	Characteristic
1. Capacity building approach within MOH	A comprehensive and primary approach can contribute to fully perform other approaches
2. Vertical health service improvement approach	A systematic approach to improve the existing public health services
3. Horizontal health service strengthening approach	A systematic approach to improve the existing public health services
4. Child health standard preparation approach	A care approach to support preparation of a national child health standard
5. Health education improvement approach	A preventive approach to improve present health education systems and activities
6. Cooperation with internal and external entities approach	A coordination approach to build a sound cooperative relation with domestic entities and external donor agencies

The conceptual structure of each approach can be described as shown in Figure 5-1.

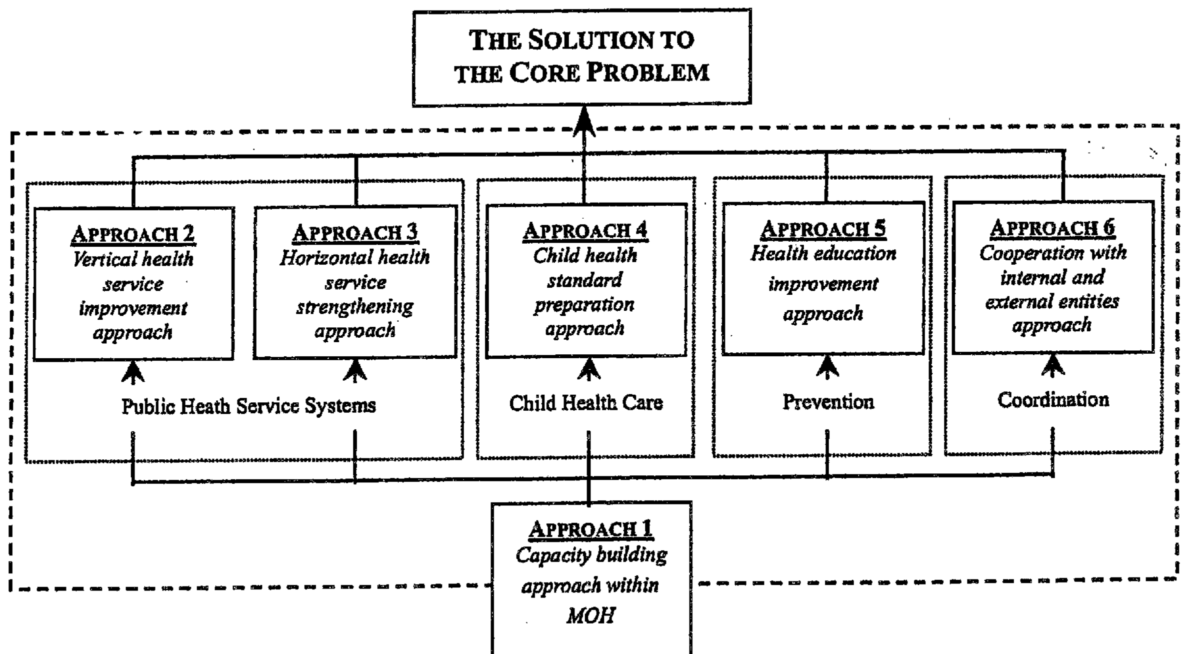


Figure 5-1 The Conceptual Structure of the Approaches

*Note *1,2: Phrases in parentheses were herein added for bringing about a better understanding of the core problem.*

(3) Project Purpose

Accordingly, by adopting these approaches as well as by considering suitable model provinces to be selected for improving the problems, "*The central and local health services for children are strengthened with participation of various levels of stakeholders*" is decided as the "Project Purpose".

For measuring the achievement of the project purpose, items of objectively verifiable indicators are set out as follows:

- Number of District Health Office and District Hospital that meet a minimum standard
- Number of under 15 population's access to health services
- Mortality rate of major child diseases (diarrhoea, malaria and pneumonia) in model provinces

5.2.2 Outputs

"The outputs" are goals that have to be reached for achieving the project purpose. The outputs to be attained are identified as follows. The conceptual structure of the outputs can be illustrated as shown in Figure 5-2.

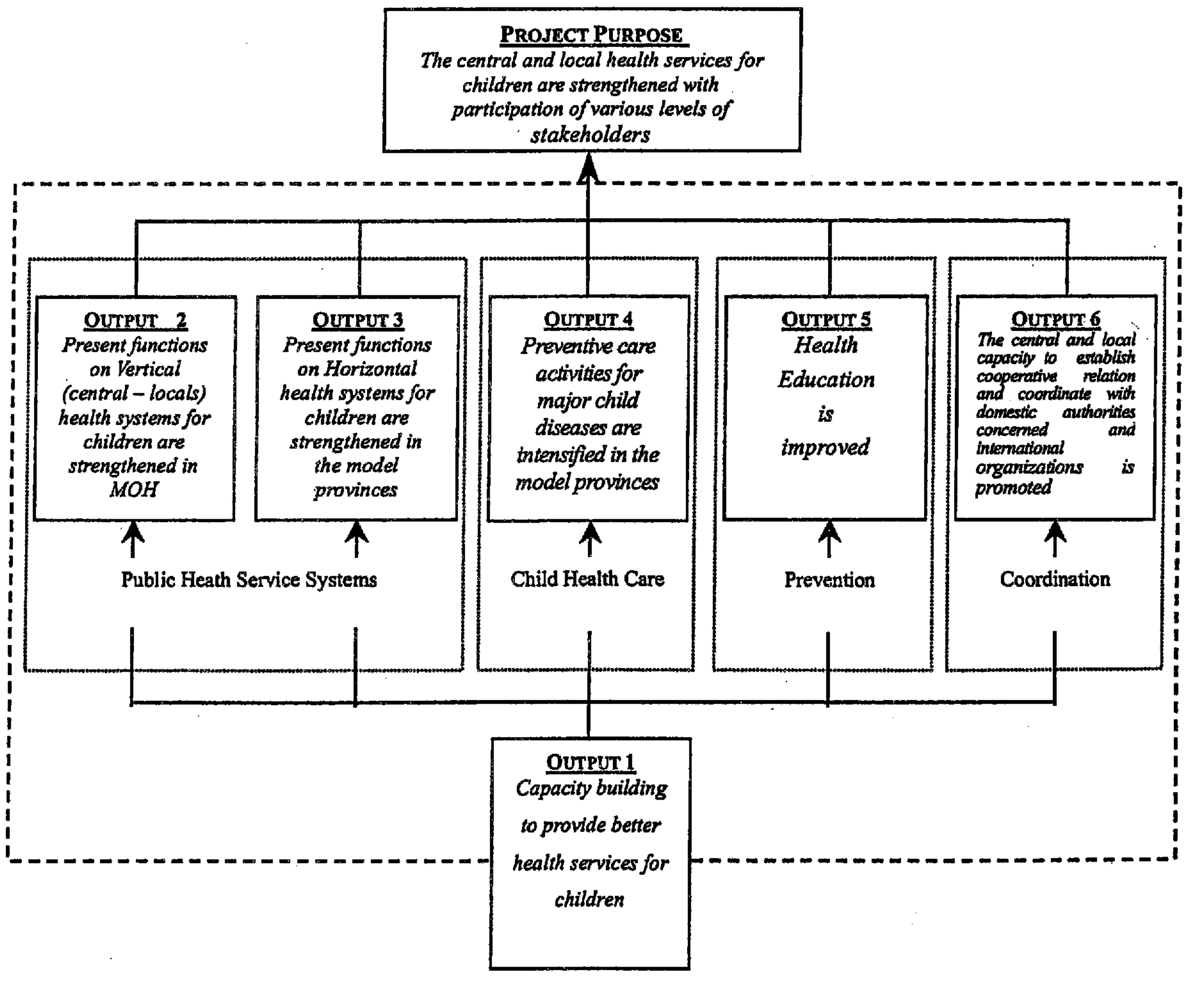


Figure 5-2 The conceptual Structure of the Outputs

Output 1. Capacity building to provide better health services for children

A system to plan, implement, monitor and evaluate health services for children is developed on the central and local levels through active participation of various stakeholders

For measuring the achievement of the output 1, items of objectively verifiable indicators are established as follows:

- Number of activities based on participatory approaches
- Number of feed back activities (monitoring and evaluation)

Output 2. Present functions on vertical (Central – Locals) health systems for children are strengthened in MOH

Vertical child health systems will be strengthened through such activities as the establishment of a minimum child health standard; improvement in the present health data collection and processing procedures; and execution of training programs for health staff.

For measuring the achievement of the output 2, items of objectively verifiable indicators are established as follows:

- Prevailing a minimum child health standard
- Number of supervision visits
- Number of standardized reports
- Number of training
- Number of trained persons
- Number of communication
- Number of activities and programs at health center supported by district hospital

Output 3. Present functions on horizontal health systems for children are strengthened in the model provinces.

Coordination among the present child health programs including EPI, MCH, IEC and so on is strengthened in the model provinces to adjust appropriately to the local health service conditions, especially in the view of using limited resources on health services for children.

For measuring the achievement of the output 3, items of objectively verifiable indicators are established as follows:

- Number of coordinated training
- Number of meetings organized by multi-centers

Output 4. Preventive and care activities against such major child diseases as diarrhoea, malaria and pneumonia are intensified in the model provinces

To decrease cases of major child diseases, including diarrhoea, malaria, pneumonia and so on, appropriate preventative and care activities are implemented at local hospitals and health centers by applying a minimum standard on child health, and by implementing training programs suitable for relevant health personnel including health volunteers.

For measuring the achievement of the output 4, items of objectively verifiable indicators are established as follows:

- Number of training
- Number of activities (ex. mosquito nets)
- Rate of appropriate use of formats

Output 5. Health education is improved

Health education at primary schools and advocacy on child health on the community level are effective preventive measures. The existing health education system is improved by building a close relationship between MOE and MOH on school health, and implementing related activities in cooperation with the ACIPAC project.

For measuring the achievement of the output 5, items of objectively verifiable indicators are established as follows:

- Number of school involved
- Number of school student involved
- Number of campaigns

Output 6. The central and local capacity to establish supportive relationships and coordinate with such partners as national authorities, bilateral donor agencies, and international organizations is promoted

A coordinating capacity of MOH, including its local functions is improved to perform reasonable health services for children by building supportive relationship with internal authorities and external agencies including bilateral donor agencies and international organizations in the field of health and sanitation.

For measuring the achievement of the output 6, items of objectively verifiable indicators are established as follows:

- Number of cooperative activities

5.2.3 Activities

"The activities" are actions intended to fully achieve the Outputs. The activities are consequentially identified as the means to accomplish the outputs. The following shows activities to be implemented to achieve each output of this project.

1. **Activities for the Output 1:** ***Capacity building to provide better health services for children.***

1-1. To develop a system (problem identification, analysis, planning, implementation, monitoring, and evaluation) on central and local levels in view of providing better health services for children through a participatory approach.

2. **Activities for the Output 2:** ***Present functions on vertical (Central – Locals) child health systems are strengthened in MOH***

2-1. Assist to formulate a minimum standard on child health services at each level
2-2. Improve the existing central-local interactive communication systems
2-3. Improve the existing health data and the processing systems
2-4. Implement training programs on child health services
2-5. Improve the existing health information dissemination activities

3. **Activities for the Output 3:** ***Present functions on horizontal child health systems are strengthened in the model provinces***

3-1. Create coordinating functions among the existing vertical health services (e.g. MCH, IEC Malaria, etc.)

4. **Activities for the Output 4:** ***Preventive and care activities against such major child diseases as diarrhoea, malaria and pneumonia, are intensified in the model provinces***

4-1. Strengthen health services to be required at each level in accordance with the minimums standard for child health
4-2. Implement training programs for health staff of district level

5. **Activities for the Output 5:** ***Health education is improved***

5-1. Build a close relationship between MOH – MOE for school health activities
5-2. Implement school health activities at elementary schools in cooperation with the ACIPAC (Asian Center of International Parasite Control) project

6. **Activities for the Output 6:** *The central and local capacity to establish supportive relationships and coordinate with such partners as national authorities, bilateral donor agencies, and international organizations is promoted*

6-1. Cooperate with Women's and Youth Unions
6-2. Build cooperative relationship with international agencies such as WHO, ADB, and the World Bank.

5.3 Inputs

"Inputs" stand for personnel, budgets and equipment and so on necessary for the implementation of a project. The following shows the outline of the "Inputs" supposed to be needed for the project. The full listing of the Inputs will be prepared in accordance with the progress of the project preparation.

a. Lao side (The central and local levels)

a-1. Personnel

- Project Manager
- Project Coordinator
- Specific Health Staff (MOH and provincials)
- Others

a-2. Facilities

- Office room
- Furniture for new office
- Others

a-3. Local cost

- Routine health services
- Project management
- Specific budget
- Others

b. Japanese Side

b-1. Personnel

1) Long term experts:

- Chief Advisor
- Project Coordinator
- Community Health Advisor
- Nursing
- Others

2) Short term experts:

- as required

b-2. Equipment

- Specific equipment to be required in the implementation of the project

5.4 Pre-Conditions, Important Assumptions and Analysis of Risk

5.4.1 Pre-Conditions

"Pre-Conditions are defined as important and necessary conditions that must be satisfied before a project commences.

This project will be implemented in line with the development policy of the Lao Government and in the context of MOH policy on health. In addition, a strong cooperative relationship with MOE and local educational authorities is necessary to implement school health activities. Therefore, the project is in line with the National health policy, The MOH master plan policy strategy toward 2005, and MOE and the local educational authorities do not oppose the project

5.4.2 Important Assumptions

"Important Assumptions" are defined as conditions necessary for the accomplishment of a project which are existing outside the control of the project and cannot be controlled by the project.

In identifying the Important Assumptions for this project, the following perspectives were examined in accordance with the project characteristics:

a. Budgets	: National budgets related to health as well as child health services
b. Policies	: National policy and MOH policy on Health
c. Environment	: Natural disaster like floods may lead to epidemic out breaks
d. Cooperation	: Cooperative relationship with other internal and external entities
e. Staffing	: Skilled employees and trained staff on health services
f. Socio-culture	: Community participation and collaboration
g. Other Projects	: Other projects related to child health and health education

According to the examination, the Important Assumptions were summarized as follows:

(1) Important Assumptions for the Overall Goal

It is important that the EPI activities will be continually implemented, because the activities have an extremely close relationship with child health improvement activities. As well, an unexpected serious epidemic outbreak cased by a natural disaster like a flood will not occur, since such an outbreak may increase child mortality and mobility. Thus, the important assumptions for the overall goal are identified as follows:

- The EPI activities are continually implemented
- An unexpected serious epidemic outbreak does not occur

(2) Important Assumptions for the Project Purpose

In order to achieve the project purpose, it is primarily required that the full accomplishment of the outputs. That is to say, strengthened staff capacity and skills are properly fixed as well as the improved existing systems on child health are well functioned at the central and the local levels. Furthermore, since the project targets

children of model provinces, a sustainable participation and cooperation of the communities and population is extremely necessary for carrying out child health activities of the project at the community level. Thus, the important assumptions for the project purpose are identified as follows:

- Public cooperation does not decrease
- Trained health staff continue working for the health services
- Improved systems continue working for child health in MOH

(3) Important Assumptions for the Outputs

The project deal with not only MOH capacity and systems on child health but also enhancing ability to build cooperative relationship with external entities of the domestic, by- and multi- donors. As for activities on school health, access to community and the building of cooperative relations with population for child health, especially, Women's Union and Youth Union of the Lao have strong channels with community. Thus, the important assumptions for the outputs are identified as follows:

- The Women's Union dose not oppose the cooperative relation
- The Youth Union dose not oppose the cooperative relation
- Community does not oppose the participation
- The international agencies do not oppose the cooperative relation

5.4.3 Risk Analysis

(1) Risk of Important Assumptions of the Overall Goal

In order to attain the overall goal, the project purpose has to have a positive impact upon other provinces. This could possibly be assured by maintaining the national annual budgets for child health and related activities, since the characteristic of this project is capacity strengthening oriented to the existing health systems.

As for the EPI activity, it depends largely on national policy and programs on health as well as donors' assistance. However, it seems that it will not be a serious constraint so long as the current condition remains.

Serious epidemic outbreaks are also assumed not to be likely to happen considering the past history and health record.

(2) Risk of Important Assumptions of the Project Objective

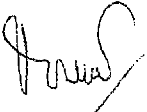
The assumptions of the trained health staff and the improved health systems continue working and functioning for the health services depend highly upon the Lao political and administration situation. Especially, resulting from a change of the government as well as the government administrative structures may largely change the staff in MOH, local health offices and hospitals, and health centers. Therefore, it is expected that such a change of government have a negative impact upon the project implementation and daily work of MOH. However, so far as the political and the administration of the Lao are concerned, the present government is stable. Therefore, it seems that they will

not be a serious constraint so long as the current political and administrative condition remains.

As for the public cooperation, currently a minor anti-government and rebel movement has been reported and identified in some limited remote areas. Except for these limited areas, most of the provinces of the Lao are relatively safe condition at present. Therefore, it seems that they will not be a serious constraint so long as the current condition remains.

(3) Risk of Important Assumptions of the Outputs

The domestic administrative relations between MOH and Unions of Women and Youth have been already built up in the field of school health. As well, the diplomatic relations between the Lao government and external donor agencies have also been built up and implemented a lot of projects in the field of health. Therefore, it seems that these assumptions will not be a serious constraint so long as the current condition remains.



6. Project Justification

6.1 ODA Project as Public Service

The project purpose is to strength the central and local health services children with efforts of all persons involved. Accordingly, public benefits and equity of the project can be discussed as follows.

(1) Public Benefits

The project aims at strengthening the existing public health services for children as well as heightening capacity of the health personnel. Therefore, the public benefits are sufficiently guaranteed.

(2) Equity of the Project

The target groups of the project are as follows:

- All children under 15 year-old live in model provinces as the primary target utilizing pubic health facilities and schools, and
- Inevitably their parents and the community may be involved in related activities of the project as the secondary and tertiary targets in terms of health education, and the expected participation and cooperation.

Since this is the case, equity of the project is guaranteed.

In addition, the project purpose is confined within the model provinces. Yet know-how and technique of participatory approach and human resource development to achieve the strengthening of the self-improvement capacity and the vertical and horizontal child health systems in the model provinces can be adapted to other provinces in accordance with their circumstances. Thus, there is less risk of over-investment in the model provinces.

6.2 Accuracy of Technology

Most of the activities, which are proposed in this project, aim at the strengthening of the existing health services and systems for children. That is, the main focus of the activities is to learn know how for spontaneously finding and analyzing problems and issues of the existing activities and systems, planning and implementing the most suitable alternative solutions, and monitoring and evaluating such activities and services without special medical devices and facilities.

On the one hand, it is identified that there are several activities by which specific technique (expertise and experience) is required for the implementation as shown in Table 6-1. These activities are marked with a check-symbol (√) in the table.

As a matter of course, the implementation of such activities will not be so simple. It is evaluated that, however, they are considered feasible.

Table 6.1 Activities requiring Special Technique

Technique	Activities
√	1-1. To develop a system (problem identification, analysis, planning, implementation, monitoring, and evaluation) on central and local levels in view of providing better health services for children through a participatory approach.
√	2-1. Assist to formulate a minimum standard on child health services at each level
	2-2. Improve the existing central-local interactive communication systems
√	2-3. Improve the existing health data and the processing systems
	2-4. Implement training programs on child health services
	2-5. Improve the existing health information dissemination activities
	3-1. Create coordinating functions among the existing vertical health services (MCH, IEC, Malaria etc.)
√	4-1. Strengthen health services required at each level in accordance with the minimum standard for child health
	4-2. Implement training programs for health staff of district lebel
	5-1. Build a close relationship between MOH – MOE for school health activities
	5-2. Implement school health activities at elementary schools in cooperation with the ACIPAC (Asian Centre of International Parasite Control) project
	6-1. Cooperate with Women's and Youth Unions
	6-2. Build cooperative relationship with international agencies such as WHO, ADB, and the World Bank.

6.3 Reasons for assistance from JICA

Laos is one of the countries of which status on health and sanitation is least developed in the world. In order to deal with the status, several health projects were/have been recently implemented by assistance from Japan through the JICA schemes as follows.

a. Project Type Technical Cooperation

- 1992-1998: Primary Health Care Project
- 1998-2001: Pediatric Infectious Disease Project

By these projects, eradication of polio infection has been achieved as well as infant mortality rate and maternal mortality rate have been reduced from 128 to 75, and from 656 to 500 respectively between 1989 and 1999.

b. Development Study

- 2001-2002: The Study on the Improvement of Health and Medical Service in the Lao P.D.R.

At present, this study is being conducted to prepare a master plan on health and medical service in Laos in the target year of 2020.

c. Grant Aid (MOFA)

- 1998-2001: Construction of the new *Sethatirath* hospital
- 2001-2005: Project on supporting the second five-year national plan of malaria control

As for malaria, the Lao has prepared the second five-year national plan of malaria control (2001-2006). As a strategy of the plan, the government points out a comprehensive approach including distribution of insecticide coating mosquito nets, health education, preemptive diagnosis and care, and so on. The project on malaria has been lunched by Japan to support the approach and to contribute to reduce the health impact of malaria as well as parasite diseases of the school children by procuring necessary equipment, distributing appropriately and monitoring the utilization of these.

As just noted above, Japan has considerably made contribution to improve the health status of Laos. It is understandable that, therefore, further expectations for Japan's assistance in the field of health development are very high due to these positive outcomes of previous and on-going related projects.

In addition, there have been a lot of bi- and multi-donor projects in the field of health development in Laos so far. However, the JICA preparatory study team has confirmed several opinions on the health projects by the donors, which were pointed out and perceived by the Lao side. The following show the critical opinions among them:

- Donor driven: Most of the projects are planned and operated by donors with less participation of the Lao side.
- Less coordination: There have been less coordination among activities of donors in the implementation of health projects.

The key issues are "ownership", "transparency", "partnership" and "efficiency" in official development assistance (ODA) projects. To deal with these issues, participatory approach and more flexible responses are need. A few partnership projects have recently tried to:

- JICA Pediatric Infectious Disease Project (1998-2001) :

  The main aim of the pediatric infectious disease project was to eradicate polio infection. The project was implemented in cooperation and coordination with other donor agencies of WHO, UNICEF and AusAid. As mentioned above this project on polio was implemented through technical cooperation by JICA.

- ADB Primary Health Project (phase 1: 1995-2000, phase 2: 2000-2006)
- WB (IDA) Health System Reform and Malaria Control Project (2000-2002):

  These two projects had been coordinated in a certain period by the Project Coordination Unit (PCU) of MOH to cover their respective activities to all provinces of the Lao.

These partnership projects exemplified above will serve as a useful reference for implementing the (new) project.

As a result, the technical cooperation of JICA has a great advantage for implementing the project.

6.4 Expected effects of the Project

(1) Effects on the Development Policy Framework

- Positive participation of all personnel involved in child health system at each level in the model provinces, is expected to improve the quality of health services and to be replicated to other provinces.
- Policies on child health may be improved and utilized as models. (In order for a model to be built, it will be necessary to introduce the experiences to other provinces by the end of the Project's.)

(2) Effects on the Institutional Framework

The capacity of MOH, including local health offices, hospitals and health centers, is expected to be built. The following impacts are expected.

- Strengthening of the vertical and horizontal child health systems (regular meetings, interactive information exchanges and coordination functions are expected to be implemented by the project)
- Organizing of the joint coordinating committee for promoting the project within MOH to coordinate various activities related to child health, which are being implemented by the departments, centers and institutions as well as activities on school health by MOE. (institutionalization of some extent is expected to be completed at the early stage of the project)
- A positive cooperative activities on heath education with the Women's Union and Youth Union. (Cooperative relations are expected to be built by the project)
- A positive community participation on child health (Public cooperation is expected to promote health education at the community level by the implementation of school health activities in cooperation with the ACIPAC)

(3) Effects on the society and culture

The primary targets of the project are children under 15 years old in the model provinces. Inevitably their parents and the community will be involved in related activities of the project as the secondary and tertiary targets in terms of health education, and the expected participation and cooperation. Therefore, low-income communities, which have no other choice but to rely on public health service, will actually be the project targets.

The total population of child and the population are estimated to be approximately 250000 and 600000 respectively, of which majority are persons who can only use the public health services. As a result, the following items are considered to be most important in the social and cultural impact and recognized as overall goals of the project.

- Quality improvement of current public health services, in particular health centers, and the support of education on child health to the children and the parents, that is,

the communities (increasing in health knowledge among the population and promoting of community participation approach in the communities are expected, which may lead further health improvement of not only children but the population).
- Through making comprehensive child health services responding to their health issues at the community level, this project will have more easily adapted or extended to other provinces.

(4) Effects from the Technical Standpoint

Although direct training for all staff involved throughout the project can not be realized, it will be necessary to create a training plan to strengthen the capacity for providing better health services that includes the establishing of an adequate target number for staff to be trained once the project has commenced.

- There will be technical impact if the extent of training for staff of MOH and the model provinces is accurately planned.
- It is expected that MOH-led training courses will be revitalized in areas outside the model provinces. This expectation is based on the experience of continued training promoted by the project.

(5) Economic benefit

Economic impacts or returns are expected as child mortality and morbidity rates decrease resulting from improvements in several areas as follows:

- Increased life income
- Increase in school attendance ratio of children resulting from prevention and early recovery
- The decrease in medical expenditures resulting from prevention and early recovery
- Time savings both of children and the parents resulting from reliable medical services and improvement of access
- Time and financial savings from the improvement of medical facilities/institutions functions.

The EIRR (Economic Internal Rate of Return) cannot be calculated here, nor the return estimated, within the time frame of the short-term study (reliability is not guaranteed even if it is estimated or calculated). The economic impact depends on the decrease in the child mortality and mobility usage based on sound public health services, which is the overall goal of the project. In the event that the results are achieved, a large economic impact will be expected.

6.5 Overall project justification

The relevance of the project was reviewed based on 5 DAC (Development Assistance Committee) of OECD criteria utilizing the preliminary study project checklist (see below). Each item on the checklist will be reviewed when the Project has started. If necessary, the plan will be redesigned in order to achieve a realistic and effective project.

C-1. ***Effectiveness:*** Project purposes should be clarified in order to see improvements in indicators. It is possible to attain project purposes if Japan has advantage in technologies related to health and an appropriate number of specialists/expertise are recruited.

C-2. ***Impact:*** Positive political, organizational, social and cultural impacts are expected.

C-3. ***Efficiency:*** The cost-effectiveness depends on an increase in users of public health services. Cost-efficiency will be constantly monitored, as well as evaluated at mid-term and at the end of the project.

C-4. ***Relevancy:*** This project is appropriately justifiable since some of the personnel trained during the previous projects can be recruited for this project. In addition, participatory planning and a review of monitoring and evaluation plans will be done in order to obtain the highest level of the benefit.

C-5. ***Sustainability:*** The financial capacity of the MOH is relatively low. It is necessary to improve the management and problem-solving capabilities of MOH in order to obtain higher self-sustainability.

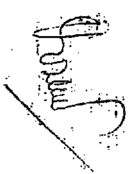
In conclusion, it can be appraised that the project would withstand the 5 DAC evaluation criteria.

Checklist: Preliminary Study

Criteria	Specific evaluation items	Examination within preparatory short-term study	Note
C-1. Effectiveness	1) Is the plan logical?	• The relations between the project-design items are clear.	The plan was prepared by the PCM method
	2) Is the objective clear and relevant to the set indicators?	• The overall goal and the project purpose have been clearly developed as discussed in chapter 5. • The items of the indicators, that is "what will be measured", have been exclusively enumerated here. During the project design discussions and processes, it is extremely necessary to consider and set up desired values and benchmarks for each indicator.	
	3) Does Japan have a technical advantage?	• Japan has several experiences in the field of health and medical assistance projects in the Lao. • In addition, Japan has conducted a lot of assistance projects in the field of the industrial management in many developing countries thus far. These experiences and know-how on the management skills can adapt to the health programs and projects.	
C-2. Impact	1) How extend of social and economic impacts are expected?	• The performance measure (target figures) shall be set up based on an agreement with C/P team. • Policy, institutional and social-cultural impacts are expected as discussed in chapter 6	
	2) Do the project objectives and needs of the recipient country match?	• The objective of the project contributes to the realization of policies on health.	
	3) Is the project environmentally sensitive and will there be no negative impact?	• It is predicted that there will be no negative impact.	
	4) Is there a high possibility or important assumptions being realized so that the project results link to the project objective and the project goal?	• There is few risk on important assumptions as discussed in Chapter 5 • There is little possibility that the health administration budget itself will be cut. • There is a high possibility that the EPI activities will continue. • It is impossible to predict natural disasters or sudden national and provincial economic slumps.	
	5) Are risks being considered that may prevent achievement of the project goal and objectives?	• The project is designed so that the system operation will continue despite staff changes. • Problem-solving capacity building is integrated within the project so that it can correspond to problems that arise. • Organizational strengthening is included in the project so that the organization can respond to changing situations.	
	6) Is there a strategic implication for Japanese ODA?	• This project aims at building self-improvement capacity and participatory approach, which is suitable for a self-help concept of Japanese ODA	

Checklist: Preliminary Study

Criteria	Specific evaluation items	Examination within preparatory short-term study	Note
C-3. Efficiency	1) Is an adequate amount and quality of equipment and personnel input planned for the project outputs?	• The project assists the self-support development of the Lao side by mainly providing experts and other inputs as needed. • The experts and inputs will be prepared where necessary.	
	2) Does the expected project impact measure up to the quantity and quality of project inputs such as equipment and human resources? Are the EIRR and FIRR expected to reach a certain level?	• The importance and extent of the predicted impact is justified against the above-mentioned inputs. • Judgment will be made on efficiency based upon the increase of public health facility users, and the decrease in the number of child mortality and mobility rate instead of calculating the EIRR.	
C-4. Relevance	1) Is the project appropriate for public ODA funds?	• Equity and public benefits are guaranteed. (See chapter 6.1)	
	2) Has the plan been formulated in a participatory manner?	• As the first step, this initial plan was formulated in a participatory manner with the participation of central representatives. • The initial plan will be subjected to modify at each step as required for suit circumstances in accordance with the progress of the project with the participation of relevant representatives at the provincial and community levels.	
	3) Has an adequate management system been put into place?	• As mentioned in chapter 4, there are many problems in the central management system of MOH, but the improvement of management itself is a project objective.	
	4) Has the plan been created and a monitoring and evaluation system established?	• Currently the only indicator noted is "what will be measured." It is unclear "when it will be achieved" and "to what extent." There will be a need to decide on the benchmarks for measuring achievement at an early stage in the project.	
C-5. Sustainability	1) Does the implementing organization have the basic institutional and financial capacity at the start of the project?	• Staff salaries for basic personnel are guaranteed by the government budget. • Budgets for the health services have grown drastically from FY 2001 but are still inadequate. Measures to maximize effects within the limited budget are included within the activity of problem-solving methods. • Fund raising capacity required for the necessary facility and equipment strengthening is inadequate. Therefore, budget for project's infrastructure support shall be included within the project's activity. • The fund raising capacity required to strengthen training is too small. In order to moderate the problem, problem-solving methods will be introduced, effective and efficient training will be implemented and other activities will be included in the project.	In order to mitigate the lack of training funds, it might be worth examining project activities, or including a system that would disseminate the training that some staff has undergone.



The Summary of the PCM Workshop

1. Purpose

The purposes of the PCM workshop were as follows:

- To identify existing problems on coordination of public health services on child health (excluding polio) at all levels from MOH to local health functions.
- To discuss necessary approaches to be taken in an envisioned new project.
- To clarify the perspective and direction of the new project

2. Explanatory Meeting on the PCM Workshop

(1)Schedule and Program

An explanatory meeting on the PCM Workshop was held on 27th March 2002 at a conference room of MOH as shown in Table 1.

Table 1 PCM Workshop Explanatory Meeting

Time	Contents	In charge
8:30 - 8:40	Opening Address	MOH
8:40 - 9:00	Framework for the new project	Dr. Sugiura, JICA Study Team
9:00 - 10:00	Procedures of PCM Workshop	Mr. Igarashi, JICA Study Team
10:00 - 11:30	Stakeholders Analysis	All Participants

(2)Participants and Language

- ***Participants*** : Approximately 20 officials of MOH (see the Participants List 1).
- ***Language*** : English (as circumstances demand, Lao – English interpretation was done)

(3)Stakeholders Analysis

Due to the following reasons, Stakeholders Analysis as the first step of the PCM workshop was carried out on the same day.

- To exercise all participants in the most basic and principal procedure of the workshop as the participants write their own opinions on paper cards and they post each card on a board to give a visual presence to each opinion.
- To get the participants' hands in the PCM workshop through the exercise
- It was necessary to start earlier the stakeholders analysis due to the time constraint of two days, which had been in advance reserved for the workshop.

In addition, the stakeholders analysis here aimed at,

- briefly discussing and identifying the framework and direction of the new project
- dealing with various targets from the central level to the community level
- including related entities in Lao and international organization concerned

Therefore, the stakeholders analysis was carried out not by preparing a "matrix table" with which detailed information on the possible stakeholders are able to be expressed, but by illustrating a "relation diagram" with which relationships among the possible stakeholders are able to be expressed.

The "relation diagram" as a result of the stakeholders analysis is as shown in Annex 1 and is summarized as follows.

- A vertical line from MOH as the center of public health service to the local health services including children
- A horizontal line within MOH as well as within the local public health service authorities
- A line connects with other official entities concerned such as MOE, MOF, MOI, Women's Union, Youth Union and so on
- A line connects with international organizations

The following shows noteworthy information identified in the stakeholder.

- The Women's Union and the Youth Union are entities that have a similar authority to the Ministry level in Lao.
- It is required that, therefore, the new project shall build sound cooperative relationships with these unions in terms of activities on health education and community participation

3. PCM Workshop

(1)Program

The two-day PCM workshop was held in 4th and 5th April 2002 at a conference room in MOH as shown in Table 2.

Table 2 PCM Workshop Program

Day/Time		Program	Person in-charge
Day 1 (4/4)	8:30 - 8:40	Introduction and Greetings	• MOH • Dr. Miyoshi, Team Leader, JICA Study Team
	8:40 - 9:00	Framework of the new project	• Dr. Sugiura, JICA Study Team
	9:00 - 9:30	Review of the Stakeholders Analysis	• Mr. Igarashi, JICA Study Team
	9:30 - 9:45	Break	
	9:45.- 11:30	Problems Analysis	• Mr. Igarashi, JICA Study Team
	11:30 - 13:30	Lunch	
	13:30 - 15:00	Problems Analysis	• Mr. Igarashi, JICA Study Team
	15:00 - 15:10	Break	
	15:10 - 16:00	Objectives Analysis	• Mr. Igarashi, JICA Study Team
Day 2 (4/5)	8:30 - 10:00	Objectives Analysis	• Mr. Igarashi, JICA Study Team
	10:00 - 10:15	Break	
	10:15 - 11:30	Project Selection	• Mr. Igarashi, JICA Study Team
	11:30 - 13:30	Lunch	
	13:30 - 15:45	PDM	• Mr. Igarashi, JICA Study Team
	15:45 - 16:00	Closing Address	• MOH • Dr. Miyoshi, Team Leader, JICA Study Team

(2)Participants and Language

- ***Participants*** : Approximately 40 officials of MOH, MOE, JOCV, WHO/WPRO including several observers (see the Participants List 2).
- ***Language*** : English (as circumstances demand, Lao – English interpretation was done)

3. Results of the PCM Workshop

(1)Problems Analysis

1) Core Problem

The Core Problem was identified as "Existing health service with poor quality".

2) Problem Tree

The problem tree was described as shown in Annex 2.

(2)Objectives Analysis

1) Core Objective

The Core Objective was identified as "Existing health service are improved with good quality"

2) Objectives Tree

The objectives tree was described as shown in Annex 3.

(3)Project Selection

Approaches to be selected were decided out of the objectives tree as follows:

- Capacity building approach within MOH
- Vertical health service improvement approach
- Horizontal health service strengthening approach
- Child health standard preparation approach
- Health education improvement approach
- Cooperation with internal and external entities approach

For the selection of each approach, the following points were fully considered.

- Improvement of present health services in Lao
- Child health service focused project
- Strengthening other cooperative schemes
- No disease oriented project
- No equipment oriented project

- Social factor
- Effectiveness
- Other factors

(4)PDM formulation

A PDM was developed in accordance with each approach discussed above. The PDM shows Annex 4. As for the preparation of the PDM, the expression and terms presented on the objectives tree were properly transcribed having consensus of the participants.

ສາທາລະນະລັດປະຊາທິປະໄຕປະຊາຊົນລາວ

ສັນຕິພາບ ເອກະລາດ ປະຊາທິປະໄຕ ເອກະພາບ ວັດທະນະຖາວອນ

ກະຊວງສາທາລະນະສຸກ

ກົມອະນາໄມ-ກົມພະຍາດ

ບັນຊີລາຍຊື່ຜູ້ທີ່ເຂົ້າຮ່ວມກອງປະຊຸມ Preparation and Explannation

ວັນທີ 27 Mach(3) 2002

No ລ/ດ	Name ຊື່ແລະນາມສະກຸນ	Organization ມາຈາກພາກສ່ວນ	Responsible ຕຳແໜ່ງ	Signature ລາຍເຊັນ	Telephone
1	Khanthong Dr [illegible]	MCHC [illegible]	[illegible]	[signature]	21-4038
2	Dr Amousone	EPI		[signature]	312352.
3	Dr. Tayphasavanh	DHP	Deputy	[signature]	214010
4	Dr. Khatthanaphone	DHP		[signature]	-"-
5	BounPanh	D.H.P.	Head Division	[signature]	-"-
6	Dr phasouk	H&P Dept	officer	[signature]	214010
7	Dr. sothi	TB Center	head divi.	[signature]	214041
8	Dr. Nouanta	Water Supply	Director	[signature]	520903
9	Dr. Soumountha	CIEH	Technical officer	[signature]	214034.
10	Dr. Manisone	MCHcentre	SMH	[signature]	21.4038
11	Dr. Phouvieng	Secrétariat	project manager Deputy	[signature]	214005
12	Dr thongkam	ODI	[illegible]	[signature]	518766.
13	Dr Bounkham	DCM	Head Division	[signature]	214011
14	Dr Somphone	DHP		[signature]	214010
15	Dr Latsamy	DHP	MCH	[signature]	214010
16	Dr Somchanh	Dept. of personnel	Head Division	[signature]	21222.
17	Dr Sithat INSISIENGMAY	CLE	Director	[signature]	312351

ລ/ດ	ຊື່ແລະນາມສະກຸນ	ມາຈາກພາກສ່ວນ	ຕໍາແໜ່ງ	ລາຍເຊັນ	Telephone
18	ດຣ ພັນນະສິນ	ສູນ ວັນນະໂລກ	ຫົວໜ້າ		
19	Dr Phannasinh	Director	Tuberculosis Centre		
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					

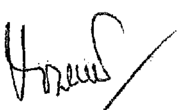
ວຽງຈັນ ;ວັນທີ....../....../........

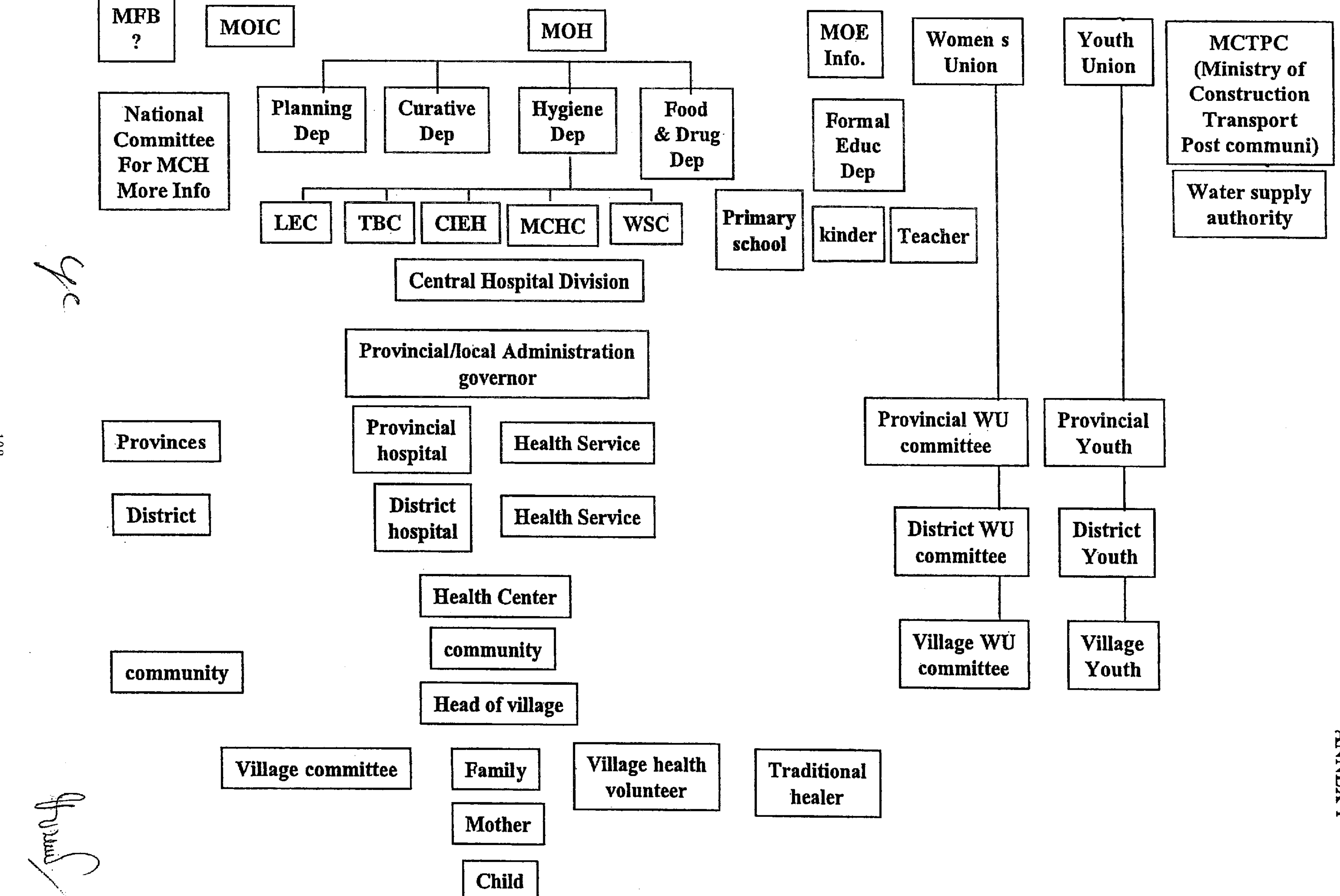
List of Participants of the PCM Workshop on the Japanese Technical Cooperation for Child Health Improvement Project in the Lao PDR (April 4 & 5, 2002)

	NAME	TITLE	ORGANIZATION		TEL.
1.	Dr. Somphone SOULAPHY,	Staff	DHP	MOH	214010
2.	Dr. Khanthong SYHALATH,	Head of MCH Division,	MCHC	MOH	214037
3.	Dr. Thanome,	Staff	MCHC	MOH	214038
4.	Dr. Anousone,	Staff	EPI	MOH	312352
5.	Dr. Kongkeo,	Staff	NCCA	MOH	315500
6.	Dr. Soumountha,	Staff	CIEH	MOH	214039
7.	Dr. Ketkeo,	Staff	CIEH	MOH	214039
8.	Dr. Somsy,	Head of DP Division	DHP	MOH	214010
9.	Dr. Phosikeo BOUNTHONG	Staff	DHP	MOH	214010
10.	Dr. Latsamy THAMMAVONG	Staff	DHP	MOH	214010
11.	Mr. Sithat OUTHAITHANY,	Staff	DHP	MOE	020-510406
12.	Dr. Bounnaloth,	Staff	DHP	MOH	214010
13.	Dr. Phonepraseuth,	Staff	DHP	MOH	214010
14.	Dr. Kotsaythoune,	Staff	DPB	MOH	217850
15.	Dr. Phouthone SOUTHALACK	Deputy Director	NCCA	MOH	315500
16.	Dr. Bounfeuang PHOMMALAYSITH	Secretary to Minister		MOH	253010
17.	Dr. Saykhek CHAREUNSOUK,	Head of Division,	LCP	MOH	312355
18.	Dr. Soukpadith PHOLSENA,	Staff	NEW	MOH	413310
19.	Dr. Sawady KINGKEO	Head of Division,	CMPE	MOH	252880
20.	Dr. Phasouk,	Staff	DHP	MOH	214010
21.	Dr. Somchanh,	Head of Division	DOP	MOH	212221
22.	Dr. Khatthanaphone,	Staff	DHP	MOH	214010
23.	Dr. Khampheng,	Staff	CLE	MOH	312351
24.	Dr. Somthana,	Director	EPI	MOH	350027
25.	Dr. Phannasinh,	Director	TBC	MOH	214041
26.	Dr. Bounleua,	Deputy Director	MCH	MOH	214038
27.	Dr. Soth,	Staff	TBC	MOH	214041
28.	Dr. Amlian,	Staff	EPI	MOH	312352

Participant Lists (4

Name	Position	Dept.	Org.	Tel.
29. Dr. Sanya,	Staff	EPI	MOH	312352
30. Dr. Song LAOPANY	Deputy Director	CMPE	MOH	219111
31. Dr. Vonthalom	Staff	CMPE	MOH	214040
32. Mrs. Phengdy	Staff	DOC	MOH	214011
33. Ms. Hiroko FUJII	JICA/JOCV			020-615572
34. Dr. Oukham.	Sethathirat Hospital			351160
35. Mr. OTSUKI	JICA/SHIP			020-515306
36. Dr. Chiaki MIYOSHI	JICA Team Leader			
37. Dr. Yasuo SUGIURA	Member			
38. Mr. Norihiko IKEDA	Member			
39. Mr. Kenji IGARASHI	Member			
40. Dr. Hiroko TANAKA,	Technical Staff		WHO	





ANNEX 1

ANNEX 2

Supporting Agencies concerned

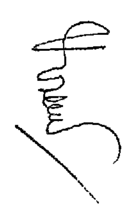
WHO

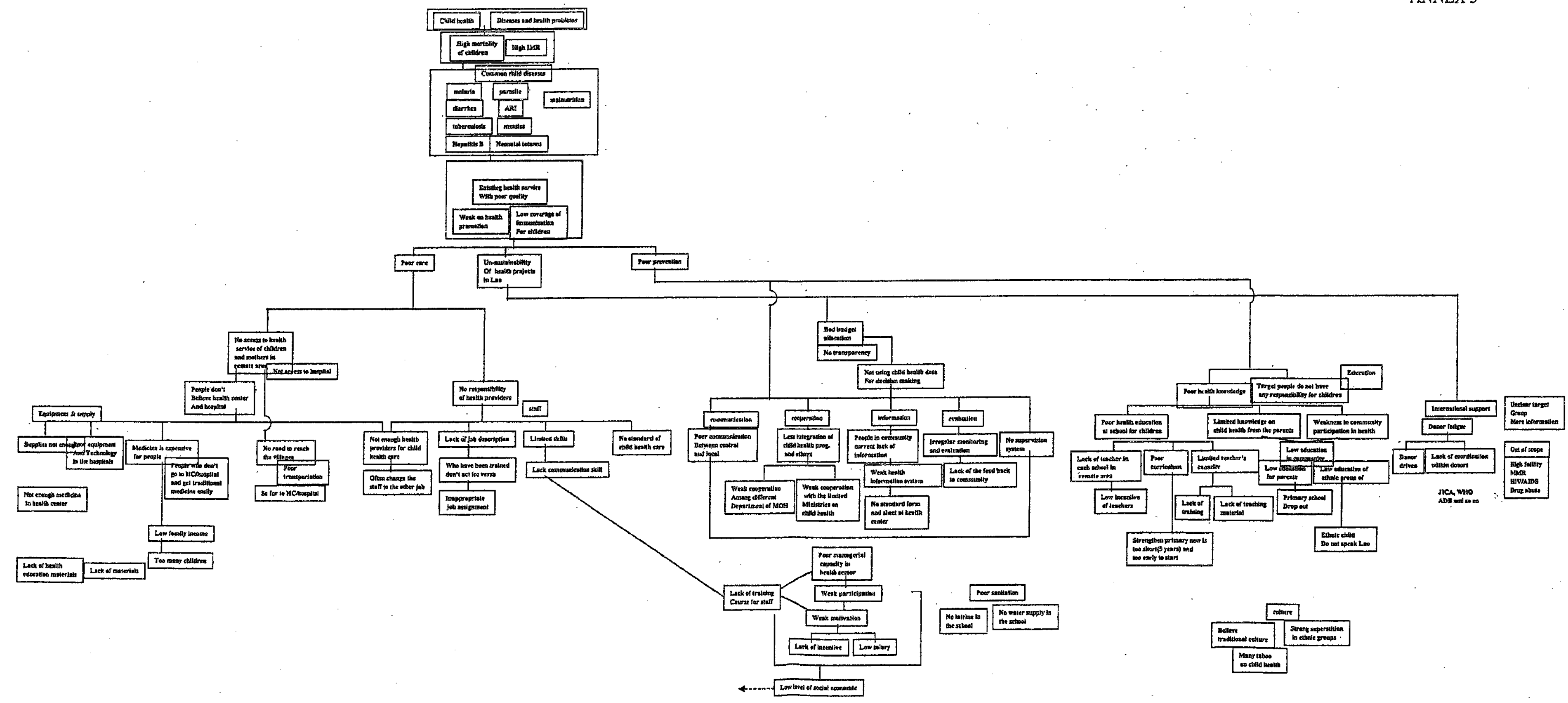
UNICEF

JICA

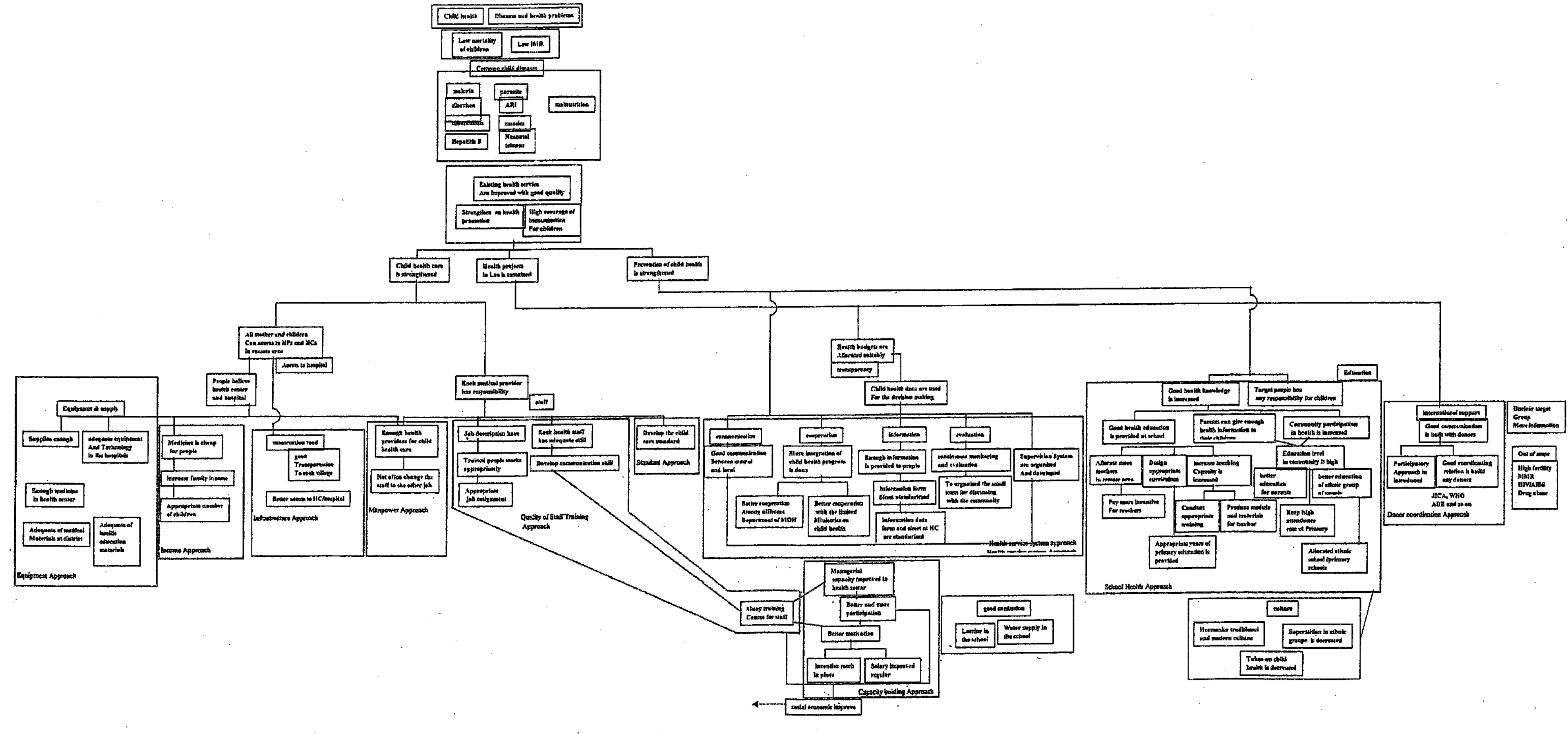
NGOs

Save the Children UK | **World Vision** | **Aus Aid** | **CLL** | **MSF** | **EED** | **Care International**





Problems Tree



Objectives Tree