Table 2 List of Trainings Completed Targeting Sub-divisional Supervisors

Training Course	Training Objectives/Contents	Training Period	Partici-pation rate[1)]	Satisfaction rate[2)]
In-service Training (1)	To gain knowledge and skills to plan and implement in-service training at the Sub-divisions.	2005 AUG 3 days	69%	Very High: 57%
				Fairly High: 43%
Health Planning	Situation analysis on the existing information management practices. Introduction of the data analysis formats.	2005 SEP 1.5 days	83%	Very High: n.a.
				Fairly High: n.a.
Information Management	To understand the role of supervisors in information management, understand the indicators utilized in CMRs, to understand needs assessment and planning.	2005 NOV 2 days	76%	Very High: 38 %
				Fairly High: 57 %
In-service Training (2)	Refresher training on in-service training. Review of past year's achievements and lessons learned. Development of 2007 Training Plan, etc.	2006 SEPT 3 days	88 %	Very High: 24%
				Fairly High: 71%

Note: 1)Participation rate was calculated based on the number of participants among the 25 Supervisors invited per session, except for the session on Health Planning where there were more invitees and the session for the In-service Training(2) where there 26 participants were invited. 2) Since no standard method was applied to measure the satisfaction rate of respective courses, different means were used to calculate the satisfaction rate. The Team arbitrarily chose one, several or all questions included in the questionnaire from each trainings relating to the participants' satisfaction, and calculated the average % of participants who answered either very high satisfaction or fairly high satisfaction.
Source: Project Office, November 2006.

The Project encouraged a Task Force to be established in each of the Sub-divisions, which would be responsible for all management, implementation, and monitoring of in-service training programs. The supervisors identified the respective persons that should be included during one of the training conducted in August 2005. At the time of the evaluation however, regardless of the fact that in-service training programs are now being implemented according to its training plan in all Sub-divisions, these Task Forces have yet to be fully established as an institution. Through the interviews conducted during the mid-term evaluation, it was noted that the supervisors recognizes that having such Task Force in place would enhance the effectiveness of the training programs. In reality nevertheless, that except for Suva, the supervisors are doing whatever they can among themselves whenever they are available to organize the trainings; and that most discussions either take place during regular staff meetings or on ad hoc basis when the need arises. Again, with the exception of Suva, supervisors cited difficulties in garnering support from staff who have not received training with the Project, such as the hospital based nurses or doctors[8]/health practitioners. The absence of a Divisional Training Policy which would formalize such Task Force in each Sub-division may act as another disincentive to institutionalize the Task Force. Under such conditions, the Sub-divisional supervisors should be much acknowledged for their high personal commitment for carrying out the in-service training program for 2006. Plans for in-service training were first formulated in 2005 for the fiscal year 2006. The supervisors are now conducting training needs analysis, and are finalizing their training plans for 2007. No annual reports on prioritized issues for training have been received by the Project to date.

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[8] The Project has invited Sub-divisional Medical Officers (SDMO) to the trainings, nevertheless it was reported that having SDMO leave their posts at the same time with SDHS would be very difficult. In Suva, the SDMO's responsibilities are more managerial than clinical, therefore she has more flexibility with regards to her participation.

2.5 Achievement of Output 3

Output 3:	Objectively Verifiable Indicators
In-service training for community health nurses functions in each sub-division.	1. Sub-divisional business plans announcing implementation of in-service training. 2. Number of implemented in-service training and number / participation rate of trainees. 3. Number of visits to nursing stations by supervisors. 4. Number and timing of monitorings. 5. Kinds and volume of materials developed and distributed for in-service training.

Output 3 has been achieved to a reasonable degree. If more efforts are directed towards the strengthening of the monitoring mechanisms and other institutional aspects of the in-service training programs, there is good prospect of its full achievement by end of Project.

FY 2006 was the first year in which all of the five Sub-divisions introduced the in-service training program targeting the community health nurses. To date, only Rewa Sub-division completed all of their scheduled in-service trainings for 2006, and it is most likely that both Suva and Serua/Namosi Sub-divisions will be able to complete by the end of the year. All of these in-service trainings have been organized under the initiative of the Sub-divisional supervisors, and the costs have been covered based on their resource mobilization efforts[9]. This signifies the supervisors' high commitment in carrying out their in-service trainings as well as their resourcefulness. Furthermore, as seen below in Table 3, the participation rate of the community health nurses was reasonably high. During the Team's interviews with some of the community health nurses, most of the nurses confirmed that the in-service trainings were very useful to carry out their day-to-day responsibilities. Other information regarding the training programs, such as the number of trainings planned versus implemented and the number of reports submitted is summarized in below Table 3.

Table 3 Number of In-service Training Planned and Implemented in the five Sub-divisions in 2006

Sub-division	No. of Trainings planned	No. of Trainings implemented	Participation Rate[1)]	No. of reports submitted
Suva	11	9	73%[2)]	5
Rewa	7	7	56%	7
Tailevu	11	7	90%	3
Naitasiri	4	3	97%	2
Serua/Namosi	3	2	70%	1

Note: 1) The participation rate is the average of participation rate for each of the In-service Training implemented per Sub-division. The number of nurses and Task Force members that should have participated for each of the sub-division was calculated as follows: Suva 68, Rewa 42, Tailev 14, Naitasiri 17, Serua/Namosi, 20. 2) The average participation rate for Suva does not include the figures for two trainings in which the attendance record was not taken.

Source: Project Office, November 2006.

[9] The Sub-divisions acquired budget for their In-service Training programs based on proposals submitted to the Divisional Office. Mainly Suva and Rewa funded their trainings through this channels. For other Sub-divisions they relied on other resources. Tailevu and Naitasiri utilized external resources already allocated to their Sub-division to cover for their trainings costs. For Serua/Namosi, they reported no costs for trainings, which usually consists of the cost of refreshments, since the participants themselves managed on their own.

Despite the relatively successful implementation record, the supervisors have expressed their concern to the Team during the interviews and evaluation workshop regarding their lack of means to ensure the relevancy and effectiveness of these trainings. Many of the supervisors recognized the need to assess the impact of the in-service training program vis-à-vis the performance of the community health nurses. However since there is an absence of any standard in which to measure the performance of the community health nurses[10], the supervisors are experiencing difficulties in identifying a set of criteria to monitor and compare before and after the implementation of the trainings. If the impact assessments of the trainings are at all not feasible in the short term, one of the possible ways to observe and follow up on the in-service trainings is through the Supervisors' regular monitoring of the activities of the community health nurses. Here also, the Supervisors are challenged from various aspects such as unavailability of transport, staff shortage, and lack of sufficient time to conduct any systematic monitoring[11]. The Sub-divisional Health Sisters are obligated to visit each health center and nursing station under her responsibility at least on a quarterly basis, however it has been reported that the number is much lower, although the exact data was not made available to the Team.

Furthermore, with the current in-service training programs, the institutional aspects remain weak. As mentioned in section 2.4, Sub-divisional Task Force need to be formed officially and their activities need to be included into the Annual Sub-divisional Business Plan, as it have not been so far. There is also very limited coordination and linkages with the existing rules and procedures related to trainings in which the Divisional Training Committee is responsible for overseeing. All these issues need to be addressed in order to integrate the current in-service training programs into the greater national health services for further sustainability.

The Project, so far with regards to Output 3, opted for a minimalist approach so as to encourage the initiative and ownership of the in-service training programs by the Sub-divisions. It has not developed any new training manuals, but supported in provision of existing materials on three different topics targeting three Sub-divisions. While regular monitoring of in-service trainings has been conducted, very little intervention has been initiated targeting the Sub-divisions outside the context of trainings. In order to support the Supervisors to systematically plan, implement and especially monitor the in-service training programs, there is much scope for the Project to expand its assistance at the Sub-divisional level to increase its impact at that level.

2.6 Achievement of Output 4

Output 4:	**Objectively Verifiable Indicators**
Project model of in-service training is presented to other divisions/countries.	1. Number of published progress report. 2. Number of presentations at conference. 3. Number of seminars/workshops and number of participants.

Output 4 focuses on the dissemination of the experiences and some of the tools implemented in the Project, therefore much of its activities, such as publication of progress reports and organization of dissemination seminars/workshops, are expected to take place in the latter half of the implementation period. Nevertheless, the Project has taken advantage of various national and international forums and made a total of five

[10] This lack of standards is being addressed by the Project under Output 1.

[11] From the Questionnaire survey for the Mid-term evaluation.

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presentations on it's activities and progress to date.

Although not included in the original PDM, the Project began issuing a monthly newsletter, *Smart Nurse,* since July 2006. So far five issues have been published and approximately 250 copies per issue are distributed to major stakeholders and relevant organizations of the Project: all health centers and nursing stations within the Central Division, health centers in Eastern, Northern and Western Divisions, MoH Headquarters, donor agencies and other partner organizations.

3. ISSUES CONCERNING PROJECT IMPLEMENTATION PROCESS

The following are some of the issues regarding the Project implementation process, which have had considerable effect on the Project achievements to date.

3.1 Project Design and the Level of Inputs

The Project was designed so that a significant portion of the technical inputs by the Japanese side were provided through the dispatch of short-term experts, to complement the programmatic activities lead by one long-term expert stationed in Fiji. It was noted that such project design presented challenges in the project management. In view of the process-oriented nature of this Project, continuous and systematic monitoring as well as follow up of Project activities were crucial. The Project also entailed consultations with a wide range of stakeholders at the policy, Divisional and Sub-divisional levels for the implementation of any given activity, to encourage the participation and ownership of the Fiji side. On the other hand, this translated into heavy coordination and advocacy efforts demanded from the long-term expert, resulting in the over-concentration of programmatic responsibilities as well as workload on her part.

3.2 Project Monitoring

Project monitoring has been conducted regularly by the Project Regular Meeting which consists mainly of the Divisional Counterparts, senior level Supervisors of Suva Sub-division, and the Japanese experts. Much of the planning and decision-making of the Project activities took place either through this forum or through a variety of working groups set up jointly by the Fiji and Japanese sides. Such arrangements contributed to the perception shared among main Counterparts that they either participated very much or to a fair extent in the decision-making processes regarding the Project strategy or activities[12]. On the other hand, it was reported that arrangement of such forums were mainly lead by the Japanese side.

3.3 Interpretation of the Project's Implementation Strategy

The Team discovered that the Counterparts are well versed in the Project's plans[13]. Nevertheless, the Team also recognized that, while there appears to be a common understanding of the Project's implementation strategy at the activities' level, some discrepancies exist among the key stakeholders in the interpretation of the Project Purpose and the core strategy to achieve it. This resulted in expansion of activities that encompass simultaneously the policy, Divisional and Sub-divisional levels; spreading thin the Project's

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[12] Results from the Questionnaire Survey targeting Counterparts. Out of the 5 respondents, 3(60%) stated that she feels she took part very highly, and that 2 answered that they took part to a fair extent.

[13] Similarly, to the question of whether they are familiar with the Project's plan in the form of PDM or Plan of Operations, all five replied that they were very much familiar with the plans.

resources and lowering its efficiency.

3.4 Linkages with MoH Headquarters

With regard to the policy level stakeholders at the MoH headquarters, the Project's current linkages and channels remain limited. This matter has affected the progress of activities related to Output 1, and in the near future, poses as a risk when some of the other Project achievements would require institutionalization and integration into the national health system. The MoH, in partnership with the Fiji Health Sector Improvement Program supported by AusAID, is undertaking new policy-level initiatives in the area of information management systems (e.g. development of the new CMR) and workforce assessments, which may have significant implications on the Project.

4. EVALUATION RESULTS BY THE FIVE EVALUATION CRITERIA

4.1 Relevance

The Project's relevance remains high vis-à-vis the national policies of Fiji, needs of the target group, and the official development policies of Japan.

In MoH's Strategic Plan for 2005-2008, "development and retention of a valued and committed and skilled workforce to enhance the delivery of quality health services" is one of the five Strategic Goals for the Ministry, signifying the very high priority it has placed on human resource development. Also the Strategic Plan highlights increasing training opportunities for health professionals as one of the main focus in attaining the strategic goal[14], in view of growing emigration of health professionals in the recent years. In this context, the Project continues to be very much in line with Fiji's national policy priorities.

In addition, the Project's objectives and its approach effectively address the needs of the target group (Sub-divisional Supervisors and community health nurses). During the evaluation, many of the Supervisors and community health nurses interviewed by the Team acknowledged that the Project has been the first opportunity in which they are able to systematically and comprehensively obtain the necessary skills and knowledge to enhance their day-to-day responsibilities. These frontline service providers are in the position in which they have to match the needs of the communities with the vertical programs initiated at the national level; thus the enhancement of their management skills would be more critical than, for example clinical nurses who work in hospitals. On the other hand, with regards to the needs of the society as whole, the enhanced quality of community health services would be highly beneficial especially in a country like Fiji where more and more the burden of disease is shifting towards non-communicable diseases.

Finally, according to the JICA's latest Country Assistance Strategy (Draft, 2006), Health has been underscored as one of the highest priority areas for the country program to Fiji. This is in line with the Japanese Government's ODA policy to Fiji, which was based on the discussions held in 2002 with the Government of Fiji, highlighted six areas for bilateral assistance including Health. In this light, the Project's objectives are also consistent with the Japanese ODA policy to Fiji.

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[14] Ministry of Health Strategic Plan 2005-2008, p.4.

4.2 Effectiveness

Project Purpose:	Objectively Verifiable Indicators
Management skills and competence of community health nurses are reinforced through in-service training in Central Division.	1. Annual accomplishment report at each zone/ district and sub-division is published. 2. Number of community group activity is increased in Central Division

The effectiveness of the Project is relatively high. The Project has shown good progress so far towards achieving its Project Purpose, and already some changes in performance of community health nurses are being reported.

In the questionnaire survey conducted during the evaluation, the Sub-divisional Supervisors were asked if they have observed any changes in the level of performance among the community health nurses since the start of the Project in April 2005. Among 15 respondents, 3 (20%) answered that have seen significant changes, and 11 (73.3%) answered that they have seen to a fair extent. Some of the changes highlighted in the questionnaire and the interviews were as follows: enhanced accuracy and timeliness of the submission of the Consolidated Monthly Returns (CMR), higher initiative as in increased number of proposals for community activities, and overall better understanding of the kind of community health services that they are supposed to provide.

The community health nurses interviewed by the Team also acknowledged that mainly in the area of data collection and reporting, they are gradually changing how they are reporting, through the CMRs, although many insist that they need to receive feedback from their supervisors to validate whatever they are doing new would appropriate or not. This confirms again that in order to induce behavior change at that level and achieve the Project Purpose, some kind of a feedback mechanism or monitoring needs to be conducted by the Supervisors to complement the trainings.

With reference to the objectively verifiable indicators identified to measure the level of achievement for the Project Purpose, the Team could not obtain data for Indicator 1, the number of annual accomplishment report in the sub-divisions or medical areas. Also with Indicator 2, the definition of "community group activities" remains uncertain and the number of proposals have not been systematically recorded at the Sub-divisional level. Due to some uncertainties in the data source[15] it is recommended to drop Indicator 1 and be replaced with another indicator to measure the achievement of the Project Purpose.

4.3 Efficiency

The level of efficiency of the Project was adequate at the time of the evaluation, but would require improvements in the latter half of the Project.

The Project's efficiency regarding its utilization of inputs has been mixed. For example, concerning the Project budget, through encouraging cost-sharing with the Fiji side, the Project has managed to increase its efficiency vis-à-vis the current achievement level of its Outputs. However with the provision of equipment, due to some security concerns, the equipment procured for FY2006 have yet to be distributed and thus utilized by the Counterparts. Similarly the dispatch of the short-term experts has not taken place as

[15] Annual Accomplishment Reports hardly exist as a reporting system either the community health nurses or Sub-divisions. No fixed format exists, and there is ambiguity concerning the contents of the report.

scheduled; only four of the initially planned seven experts were dispatched which had significant ramifications on the Project's plans for that year. On the other hand, some of the Project's major achievements, such as the information management tools (CMR Data Entry Standard, Data Analysis Format, Handbook) or the Supervisors' Training, were attained through considerable technical inputs by these short-term experts.

Participatory and consultative approach adopted by the Project may not have been efficient since it is both labor-intensive and time-consuming. Nevertheless, such approach is expected to contribute to the various achievements of the Project as it is essential in strengthening partnerships with the stakeholders on the Fiji side.

Due to the unexpected influence from some of the external factors (refer to section 2.3), the achievement level of Output 1 (Role and function of community health nurses are redefined) especially concerning the Competencies Standard remains limited; and this underachievement of Output 1 had implications on the achievement levels of Output 2 (Supervisors' knowledge for in-service training is reinforced) and 3 (In-service training for community health nurses functions in each sub-division). With the limited time remaining in the implementation period, the Project would need to review its inputs, priority activities and implementation strategy in order to guarantee the production of all four Outputs by the end of the Project. Especially with regards to the implementation strategy, the Project team should consider adopting a more flexible approach to increase its efficiency. The Project should be open to revise its PDM and scale down and consolidate some of the activities, if and when its activities are hampered by some of the external factors.

4.4 Impact

Overall Goal:	**Objectively Verifiable Indicators**
Quality of community health services by community health nurses is improved in Central Division.	1. Score of Performance Management System for Community health nurses is improved in Central Division 2. Patient satisfaction for community health service is improved in Central Division.

At the time of the evaluation, the data for the indicators to measure the prospect of the Project's achievement level of the Overall Goal was not available[16]. Both indicators need to be reviewed, especially with regards to the Patient satisfaction since no baseline survey was conducted to measure the impact of the Project.

To assess the current prospect of the achievement of the Overall Goal, the Team, through the questionnaire survey, requested the Supervisors to rate what would be the most critical in improving the community health services by the community health nurses in the Central Division. The respondents were requested to provide a five point grading for each of the following eight factors: "increase in the number of community health nurses", "improve the technical effectiveness of the community health nurses", "increase the quantity and quality of health information from the nursing centers", "clarify role and responsibilities of community health nurses", "improve physical facilities and equipment", "enhance monitoring and evaluation systems", "increase operation budget of community health centers", and "increase compensation

[16] Performance Management System has been put on hold since 2005, and no patient satisfaction survey has been conducted.

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for community health nurses." Among the eight factors, the most number of respondents (93.3%) rated the "increase operation budget of community health centers" as the most critical in improving the community health services, while a significant number of respondents (80% respectively) also rated most critical the "improve physical facilities and equipment" and "enhance monitoring and evaluation systems". Likewise, a good portion of the respondents (78.6%) also rated most critical "increase the technical effectiveness of community health nurses through training". From the survey, it may be concluded that the Project's Purpose of enhancing the management skills and competencies of the community health nurses would be a very critical factor in achieving the Overall Goal, nevertheless other external conditions would also be met, such as sufficient budget, physical facilities and equipment, and better monitoring and evaluation systems.

Prospects for other positive impacts aside from the achievement of the Overall Goal are good, if the Project managed to successfully institutionalize its achievements such as the Competencies Standard, CMR Entry Standards, Handbook within the project implementation period. These tools were developed based on the real on-the-ground needs of the community health nurses, and once endorsed at the national level, it is assumed that there would be enough demand from the nurses in other Divisions to be mainstreamed in other parts of the country.

Some of the positive impacts that already are emerging from the Project were reported as follows:

- The Director of Public Health at MoH Headquarters, in the interview with the Team, acknowledged that the Project's CMR Entry Standards had contributed much to the development of the new CMR format within their ongoing exercise to devise a new health information system.
- Through the various in-service trainings targeting the Supervisors, communication channels were strengthened between teams from different Sub-divisions.
- Many of the Sub-divisions acknowledged that increased teamwork within the Sub-division through the planning and organization of the in-service training programmes.

No negative impacts of the Project may be expected from the Project, and none has been reported so far.

4.5 Sustainability

The Project has made a good effort in which to enhance its sustainability from the beginning of the Project. However more activities are required to ensure that all of its achievements will be sustained after the Project completion due to the following reasons.

From the policy aspect, the MoH's commitment to prioritizing human resource development within the health system appears solid, as it has just approved the National Training Policy and Procedures. This policy has not been widely distributed yet, and its implication on the Divisional Training Committee or the Project's activities remains uncertain.

The Project's sustainability may be strengthened if stronger functional linkages are developed between the Divisional and the Sub-divisional level. To date, aside from the In-service Training Coordinator who was assigned to the Project, none of the Divisional staff has been involved in the monitoring of the Sub-divisional in-service training programs. This position of the Training Coordinator is not an official position within the CentEast Health Service structure, and there is concern that with the end of the Project, it will lose this function.

From the financial aspect, the Divisional Training Committee would be the main forum with the mandate to standardize and facilitate Divisional and Sub-divisional training programs. For the first time in 2006, the Divisional Training Committee received specific budget allocation for training worth F$15,000, and this

was where a substantial part of the Sub-divisional in-service training programs was funded on demand basis. However it was reported that this budget was not sufficient to cover all of the proposed trainings, and other funds such as those from the special programs (e.g. Health Promotion fund) had to be utilized to supplement the training budget. The Chairperson of the Divisional Training Committee expressed that the Division would most likely to receive the same level of training budget for 2007, but does not expect any significant increase in the short run[17].

Technically, the sustainability of the Project effects remains relatively high at the Sub-divisional level. The Sub-divisions are already implementing their in-service training programs mostly on their own initiative by inviting external resource persons when necessary to act as trainers. Supervisors are fairly well informed of other processes required to enhance the quality of training programs, such a systematic training needs assessment exercise or monitoring and evaluation of trainings, although they still need further guidance on how to specifically introduce these tools into their respective context. Moreover, demand from the community health nurses themselves may continue to drive the sustainability of these activities.

On the other hand, the sustainability of the in-service training program targeting the Supervisors at the Divisional level remains weak. It has been mainly the Japanese Experts who have been organizing and providing the Supervisors' Trainings, and there appears to very little handing over of these activities to the CentEast Health Service. One of the reasons is again, an absence of appropriate focal point for such activities, except for the Training Coordinator aforementioned, in which the Project could transfer appropriate knowledge and skills to. This matter should be addressed by both Fiji and Japanese sides to enhance the sustainability of the Project.

5. CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The Team confirmed that some of the delays in the activities had limited the level of achievement of Output 1. On the other hand, the Project has shown good progress so far in the production of Output 2 and Output 3. With regards to Output 4, the activities are expected to scale up in the latter half of the Project as planned.

The Project's relevance and effectiveness is reasonably high, and it also has good potential to have a significant impact on the community level health services in the long run. However, its efficiency needs to be enhanced further in order to ensure that the Project Purpose is achieved by the end of the implementation period, and that the sustainability of its effects is secured.

While it is observed that the Project has made a number of positive impacts in improving the capacity of community health nurses at the Project sites, more efforts are needed by both sides to further improve as follows:

- The Project needs to review its inputs, priority activities and implementation strategy in order to guarantee the production of all four Outputs by the end of the Project. In this context, the Team concluded that the existing PDM should be revised.
- Greater support from the CentEast Health Service, and the MoH Headquarters would be necessary to address some of the issue of institutionalization of Project achievements. For this, the Team formulated

[17] Based on interview with Dr. Sala Saketa, General Manager of Community Health and Chairperson of the Divisional Training Committee. 7 November 2006.

some recommendations to specify the next steps.

5.2 Recommendations

In order to achieve the Project purpose within the remaining period, it is essential that both Fiji and Japan sides re-assure the importance of ownership and partnership. While it is observed that the Project has made a number of positive impacts in improving the capacity of community health nurses at the Project sites, more efforts are needed by both sides to further improve. It is recommended that the following steps are taken in the later half of the project.

5.2.1 Recommendations to Fiji Side

(1) To establish a sustainable management system of In-service Training:

In order to sustain in-service training for community health nurses in Sub-divisional level after the Project completion, it is vital to develop a functional management system for in-service training at CentEast Health Service.

1) To develop procedure guideline of Sub-divisional in-service training by Divisional Training Committee

2) To establish permanent position of In-service Training Coordinator who will liaise between CentEast Health Services and the Sub-divisional In-service Training Task Force

(2)To ensure succession planning for Counter-parts:

In order to minimize the negative impact of staff turnover, succession planning needs to be in place.

(3)To authorize the Project's achievements by the government:

In order to ensure the effects of the Project to make greater impact in improving the capacity of community health nurses, the Project's achievements need to be replicated by the authorities. Particularly, Competencies Standard needs to be tested in the field as soon as possible, therefore prompt discussion and approval for piloting is necessary.

(4)To share information on new CMR system:

The Project activities have focused considerably on information management and developed various tools to assist community health nurses consolidates and analyzes health-related data on CMR. Since the utility of these tools depends on the health information system adopted by MOH, it is requested to keep the Project up-to-date on the latest development.

(5)To advocate and disseminate the Project's achievements to other Divisions:

Although the Project itself targets the Central Division, the initial expectation was that if its achievements are effective, it should be actively replicated in other Divisions. Therefore it is recommended MOH and CentEast Health Service actively share the achievements to date and any future best practices with other Divisions.

(6) To ensure the financial sustainability of the Supervisors' Training and In-service Training

In order to strengthen the sustainability of the Project, the Team would like to recommend that sufficient financial resources are made available annually for the implementation of the Supervisors' Training and In-service Training.

(7) To follow up on the revision of Position Description for Community Health Nurses

It is recommended that the MoH follow up on the revision of the Position Description for Community Health Nurses as a parallel activity to the Project.

5.2.2 Recommendations to Japanese Side

In order to achieve the Project's purpose in the remaining implementation period, the Japanese side needs to review the inputs, priority activities and implementation strategy. This should include reviewing the delineation of responsibilities among the experts and priorities of their activities. In addition, appropriate input of Japanese experts according to the plan need to be considered to accomplish the Project purpose.

5.2.3 Changes in the PDM

Based on the results of the evaluation exercise and consultation with stakeholders, PDM version 2 was drafted. Major changes from the PDM version 1 are highlighted below.

PDM version 1	PDM version 2
Indicators of the Overall Goal: 1. Score of Performance Management System for Community health nurses is improved in Central Division. 2. Patient satisfaction for community health service is improved in Central Division.	**Indicators of the Overall Goal:** 1. Score of Performance Management System for Community health nurses is improved in Central Division.
Indicators of the Project Purpose: 1. Annual accomplishment report at each zone/ district and sub-division is published. 2. Number of community group activity is increased in Central Division.	**Indicators of the Project Purpose:** 1. Level of managerial competency of Community Health Nurses 2. Annual accomplishment report at each zone/ district and sub-division is published. 3. Number of project proposal by Community Health Nurses
Output 1: Role and function of community health nurses are redefined. **Indicators:** 1. The Position Description with defined roles and functions of supervisors. 2. The Position Description with defined roles and	**Output 1:** Standard of competencies and function of community health nurses are established. Indicators: **Indicators:** The following documents are authorized by MOH by the end of Nov. 2007: 1. Competency Standard

functions of community health nurses. 3. Implementation of evaluation of community health nurses with the Competency Requirement Standard. 4. Degree of utilization of the handbook in practice.	2. Standardized recording formats and recording handbook
Output 2: Supervisors' knowledge for in-service training is reinforced. **Indicators:** 1. Number and timing of task force meetings implemented. 2. Satisfaction rate of supervisors of Trainers' Training. 3. Participation rate of supervisors in Trainers Training. 4. Annual reports on prioritized issues and in-service training plan in each sub-division (to CentEast Divisional Health Services).	**Output 2:** Supervisors' knowledge on management of in-service training is improved. **Indicators:** 1. Number of supervisors training conducted with approval by Divisional training committee 2. Evaluation of supervisors training by the participants 3. Degree of understanding by the participants 4. Number of participants attending supervisors training 5. Annual SD IST training plan (submitted to Divisional Training Committee) 6. SD IST program of information management/planning
Output3: In-service training for community health nurses functions in each sub-division. **Indicators:** 1. Sub-divisional business plans announcing implementation of in-service training. 2. Number of implemented in-service training and number / participation rate of trainees. 3. Number of visits to nursing stations by supervisors. 4. Number and timing of monitorings. 5. Kinds and volume of materials developed and distributed for in-service training.	**Output3:** In-service training for community health nurses functions in each sub-division. **Indicators:** 1. Sub-divisional business plans announcing implementation of in-service training. 2. Number of SD in-service training and number / participation rate of trainees. 3. Number of support by division for SD in-service training. 4. Number of SD IST reports by SD supervisors. 5. Number of SD IST task force meeting. 6. Kinds and volume of materials developed and distributed for in-service training.
Output 4: Project model of in-service training is presented to other divisions/countries. **Indicators:** 1. Number of published progress report. 2. Number of presentations at conference. 3. Number of seminars/workshops and number of participants.	**Output 4:** Achievements of the project are presented to other divisions/countries. **Indicators:** 1. Number of report to MOH (JCC, NEC etc). 2. No. presentation at meetings. 3. Number of seminars/workshops and number of participants (within and out of target area). 4. No. distribution of news letters

Activities 1-1 Review and revise the Position Description (PD) for community health nurses, health sisters, senior health sisters and sub-divisional health sisters.	Deleted
Added activities	2-1 Develop annual training plan regarding in-service training for SD supervisors. 3-1 Develop procedure guideline of SD IST by Divisional Training Committee. 4-1 Regularly report achievements of SD IST to MOH.