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MINUTES OF MEETINGS
BETWEEN THE JAPANESE FINAL EVALUATION STUDY TEAM
AND
THE AUTHORITIES CONCERNED OF THE GOVERNMENT
OF THE SOCIALIST REPUBLIC OF VIETNAM
ON THE JAPANESE TECHNICAL COOPERATION
FOR
THE REPRODUCTIVE HEALTH PROJECT IN NGHE AN PROVINCE PHASE II

The Japanese Final Evaluation Study Team (hereinafter referred to as "the Team"), organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Prof. Hirofumi ANDO, visited the Socialist Republic of Vietnam from June 8 to 24, 2005. The purpose of the Team was to confirm the achievements made during the five year's cooperation period, and to make the final evaluation for the Reproductive Health Project in Nghe An Province Phase II (hereinafter referred to as "the Project")

During its stay, both the Team and authorities concerned of the Socialist Republic of Vietnam (hereinafter referred to as "both sides") had a series of discussions and exchanged views on the Project. Both sides jointly monitored the activities and evaluated the achievements.

As a result of the discussions, both sides agreed upon the matters referred to in the document attached hereto.

Vinh City, June 22, 2005

Prof. Hirofumi Ando, PhD
Leader
The Final Evaluation Study Team
Japan International Cooperation Agency
Japan

Mr. Hoang Ky
Vice Chairperson
People's Committee of Nghe An Province
Socialist Republic of Vietnam

Dr. Tran Trong Hai
Director General
International Cooperation Department
Ministry of Health
Socialist Republic of Vietnam

Mr. Ho Minh Chien
Director General
Labor, Culture and Social Affairs
Department
Ministry of Planning and Investment
Socialist Republic of Vietnam

THE ATTACHED DOCUMENT

The Joint Evaluation Team and the People's Committee of Nghe An Province carried out the joint final evaluation based on the five criteria (relevance, effectiveness, efficiency, impact and sustainability) and compiled their findings and observations as described in the Joint Evaluation Report. The summary of the Report is presented in this document. The both sides confirmed the following matters according to the result of the Joint Evaluation Report.

I. EVALUATION BY FIVE CRITERIA

1. Relevance

Relevance of the Project is very high. The Overall Goal and the Project Purpose are coherent with the Vietnamese policy, including *the National Strategy on Reproductive Health Care (2001~2010),* and the Japanese Assistance to Vietnam. It is also designed to meet the reproductive health care needs of the Nghe An people. The Project's approach to focus commune and grassroots levels, and to involve political and social organizations has secured its responsiveness to the needs of the beneficiaries and furthered its coherence with the local agenda. Nevertheless, due to the limited geographical access to some mountainous areas, the Project focused intensive activities under some components to limited intervention areas .

2. Effectiveness

Effectiveness of the Project was very high, but with varied extent of results in mountainous and plain areas. In general, reproductive health care services have become more convenient and accessible to clients than in five years ago, and clients are satisfied with the services. The effectiveness of the Japanese contribution in terms of facilities upgrade and equipment/logistics provision; technical assistance; and human resource development to the reproductive health program in Nghe An Province was very high. The fundamental factors of the achievement are the "readiness" or "package" approach, which is composed of technical assistance by Japanese Experts; re-training of service providers at the commune level; facility improvement; and, equipment/logistics provision, as well as the high competency of the provincial MCH/FP Center that can promote quality reproductive health care.

3. Efficiency

The efficiency of the Project is very high, as the Inputs to the Project are considered appropriate in terms of their quality, quantity, and mostly timing. Competency levels, areas of expertise and the number of Japanese Experts are considered to be appropriate. There have been occasional delays or inadequacies in timing of the visits by some Short-term Experts, the assignment of Counterpart Personnel, some of the equipment, and disbursement of the local costs incurred by Vietnamese side. This, however, did not adversely affect obtainment of results, and most of the Inputs had been rationally utilized to produce Outputs efficiently.

4. Impact

The Project interventions appeared to have contributed to the improvement of the reproductive health of women in Nghe An Province. It is reflected in the reduction of maternal mortality rate, obstetrics complications, infant mortality rate, and number of abortions including menstrual regulations, as well as the increased contraceptive prevalence rate. Key components of the Project, such as the facility improvement, equipment/logistics provision, re-training of service providers, facilitated the increase of awareness and knowledge which brought about the significant behavior change of not only the service providers but also that of the clients. The Project has demonstrated a very good example of organizing reproductive health programs for other provinces. Experiences of the Project have also contributed to the formulation of *the National Strategy on Reproductive Health Care (2001~2010).*

5. Sustainability

Overall sustainability of the Project is quite high: Much institutional competency has been developed over the five years particularly at the MCH/FP Center with the solid technical expertise among most of the staff and, more importantly, with motivation to develop further to pursuit their own mission to serve the beneficiaries better. Strong sense of ownership, especially at grass-root level has also been generated to sustain the Project activities. High-level commitment among the local political and social leaders is secured for continuing the Project's Steering Committees in the future and for working in the area of reproductive health. Hence, it is likely to promote allocation of financial resources to essential activities relating to reproductive health to sustain not only the results produced by the Project, but also to further related efforts.

II. CONCLUSION

Overall performance of the Project is excellent: Considering the very difficult geographical and economic conditions and limited resources, the achievement level of six Project Outputs, namely, safe and hygienic delivery, monitoring, abortion reduction, reproductive tract infections (RTI) treatment, IEC activities and Health Management Information System (HMIS) improvement, is highly commendable.

The Project generated extraordinary political commitment and support from all the sectors in Nghe An, to sustain the expanded reproductive health activities. It has also been demonstrated as a useful model for other provinces for the improvement of reproductive health. It has also facilitated participation of various social organizations and individuals especially at the grass-root level, to provide better reproductive health services to women particularly in Nghe An Province. The Joint Evaluation Team observes that the JICA Reproductive Health Project in Nghe An is a highly effective model not only for improved reproductive health services but also for social and economic development of Vietnam. The administrative systems and practices adopted by the Project, drawn

from the Counterpart training in Japan and from working with Japanese Short-term and Long-term Experts, contributed to improvement of the management of the MCH/FP Center but also served as a useful model for other departments of Nghe An Province as well as the other MCH/FP Centers in Vietnam. This Project has accomplished much more than its original objectives of the Project design within the set duration. The team firmly believes that the experiences gained through the Project be further utilized for the reproductive health program in Nghe An Province as well as in Vietnam.

The Joint Evaluation Team finds that one critical challenge for the reproductive health program in Nghe An, is to make further efforts to bring to the mountainous areas the benefits Project was able to provide for other parts of the Province.

The Joint Evaluation Team reaffirms that reproductive health includes a number of inter-dependent components. Therefore, it is necessary to integrate such components as pre-natal care, contraception, and RTI treatment, to produce desired results of protecting women's health; one of which is the reduction of incidence of abortions. Further integration of the different Outputs through the Project has produced better results under the strong political commitment of Nghe An Province.

In order to share experiences of Nghe An Province with other Provinces, the Joint Evaluation Team supports "Project for capacity building for dissemination of community-based reproductive health promotion" and reaffirms the usefulness of the Reproductive Health Care Center for further improvement of reproductive health of Vietnamese people. The Joint Evaluation Team is also convinced that the Center can serve to facilitate the south-south cooperation between Vietnam and its neighboring countries, especially in terms of human resource development in reproductive health.

The Joint Evaluation Team also acknowledges with appreciation the genuine and strong mutual trust between Vietnamese and Japanese nurtured by the Project as one of the most important impacts.

III. RECOMMENDATIONS AND LESSONS LEARNED

Acknowledging highly successful implementation of the Project, which produced significant results; the Joint Evaluation Team suggests the following recommendations for further progress to be made by the reproductive health programs in Nghe An Province in particular, and Vietnam in general.

1. Recommendations

1.1 Recommendations for the Project

1.1.1 Safe and hygienic delivery

(a) The District Steering Committees (DSC) and Commune Steering Committees (CSC) need to ensure that all deliveries at Commune Health Centers (CHCs) are safe and hygienic by effective deployment of trained health staff and that necessary facilities and equipment be properly maintained.

(b) The DSCs and CSCs need to provide continuous financial and technical support to trained health staff (hamlet health workers and midwives) especially in terms of supportive monitoring and re-training in order to ensure that all home deliveries are safe and hygienic, particularly in mountainous and remote areas.

(c) With the leadership and technical advises of the MCH/FP Center, DSCs and CSCs should provide necessary support for the health staff so that they can make at least the second home visits to improve post-natal care.

(d) DSCs and CSCs, through Women Union and other social organizations, should encourage more male participation for women's reproductive health.

(e) In the future, Nghe An Provincial Health Service should assign CHCs to provide reproductive health services in accordance with the Decision No. 385 issued by the Ministry of Health.

1.1.2 Monitoring

(a) The MCH/FP Center needs to continue training on monitoring objectives and skills to provide appropriate feedback.

(b) DSCs and CSCs should ensure better participation of concerned monitoring members.

(c) DSCs and CSCs need to ensure sufficient financial and technical support to monitoring activities.

(d) DSCs should consider use of monthly and quarterly meetings to supplement monitoring activities.

(e) The MCH/FP Center needs to utilize to a greater extent the HMIS data and its analysis to support monitoring activities.

1.1.3 Reduction of abortions

(a) PSC, DSCs, CSCs, and other concerned social organizations need to reconfirm the close linkage between contraceptive acceptance and abortion reduction for the promotion of women's reproductive health.

(b) The MCH/FP Center need to upgrade the re-training contents so that the health staff provide the clients with counseling on FP/abortion for all the reproductive health care services, including pre-natal, post-natal and RTI services.

(c) Health staff and FP collaborators should emphasize in counseling the benefits of modern contraceptives to avoid unexpected pregnancy rather than overly focusing on abortion risks.

(d) PSC, DSCs, CSCs and other concerned social organizations may pay further attention to adolescent and youth reproductive health issues and develop an appropriate program for them.

1.1.4 RTI detection and treatment

(a) The MCH/FP Center need to maintain provision of quality RTI services by the Center and

DHCs with technical advises by other health institutions, such as the Provincial and Tu Du Hospitals.

(b) PSC, DSCs and CSCs need to strengthen health education on prevention of RTIs

1.1.5 IEC activities

(a) The Women Union (WU) and other social organizations need to continue emphasizing the information contents focusing on where and when quality reproductive health services including family planning are available, and how to obtain such services.

(b) In mountainous areas, DSCs, CSCs and other social organizations should make use of local and traditional events to provide RH education and services for residents.

(c) The MCH/FP Center in collaboration with the Provincial WU and Provincial Committee for Population, Family and Children (PCPFC), is encouraged to continue supporting the training of commune- and hamlet-level workers including the CHC staff, the WU members, the FP collaborators and the hamlet health workers to improve their IEC activities on reproductive health.

(d) The MCH/FP Center also needs to review and improve the content of IEC activities to further protect women's reproductive health.

1.1.6 HMIS management

(a) The MCH/FP Center under the supervision of the Provincial Health Service and in collaboration with DHCs needs to organize additional training for both district and commune levels to ensure the quality of HMIS data (Overall health statistical reporting software and MCH/FP statistical reporting software).

(b) The MCH/FP Center should establish closer linkage between HMIS and monitoring of the reproductive health care services especially at CHC level. For example, the MCH/FP Center and DHCs can provide analysis of data to CHCs to strengthen RH services.

1.2 Recommendations for sharing experiences with other Provinces

(a) In view of the substantial results attained by the Project in Nghe An Province, the Joint Evaluation Team reaffirms the observation made by the Mid-term Evaluation Mission (August 29, 2003) that it is useful to establish the Reproductive Health Care Center as a national model to sustain the activities of the Project after its completion and to disseminate the experiences of the Project to other provinces as well.

(b) For the upcoming three-year technical assistance project, concerned implementing organizations are recommended to ensure its smooth and effective execution.

(c) The concerned government offices are recommended to expedite application of the MCH/FP statistical reporting software.

(d) PSC needs to establish an institutional memory for future reference by compiling and storing

the key training manuals and IEC materials in a user-friendly format.

2. Lessons Learned

(a) The strong sense of ownership of the Project among the Counterparts from the inception of the Project has contributed to Project's sustainability and further development.

(b) Setting up an effective managerial structure in the form of the Steering Committees at Provincial, District and Commune levels with the involvement of key organizations enabled effective translation of political commitment into action.

(c) Objective external monitoring adopted by the Project has assured relevance of Project interventions and thus secured substantial results. The third-party assessments conducted by the Population Council provided reliable and practical information for reprogramming of the Project activities. The Project also integrated monitoring activities and continuous reviews within the Project, and conducted four operational studies, all of which facilitated better programming.

(d) Better coordinated IEC and reproductive health service tended to have produced more desired behavior changes.

(e) Investment of a "critical mass" of Experts, which means minimum size of human resources required, at the most appropriate timing, contributed to the significant outcomes of the Project.

(f) A need-based, well-organized, collective Counterpart training program in Japan contributed not only to the effective transfer of knowledge and skills, but also to its translation into action upon return to Vietnam. It has also contributed to the formation of teamwork among participants.

(g) "Readiness" or "package" approach, where three essential components including equipment/logistics provision, facility upgrade and re-training of health staff, is effective. The facility upgrade combined with improvement of technical skill of the service providers is very effective in attracting clients to receive reproductive health services, as it provides the sense of security/confidence with the services among clients as well as that of service providers and promotes institutional delivery at CHC level. This approach was enhanced by an effective collaboration between the technical cooperation project and the grant assistant for grass-root project.

JOINT EVALUATION REPORT
ON
THE JAPANESE TECHNICAL COOPERATION
FOR
THE REPRODUCTIVE HEALTH PROJECT IN NGHE AN PROVINCE
PHASE II
IN THE SOCIALIST REPUBLIC OF VIETNAM

JAPAN INTERNATIONAL COOPERATION AGENCY
JAPAN

AND

NGHE AN PROVINCE PEOPLE'S COMMITTEE
THE SOCIALIST REPUBLIC OF VIETNAM

JUNE, 2005

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LIST OF DIAGRAMS

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ABBREVIATIONS

ANC	Ante-Natal Care
BCC	Behavior Change Communication
CPFC	Committee for Population, Family and Children
CHC	Commune Health Center
C/Ps	Counterparts
CPR	Contraceptive Prevalence Rate
CSC	Commune Steering Committee
DHC	District Health Center
DSC	District Steering Committee
FP	Family Planning
GAGRP	Grant Assistance for Grassroots Projects
GO-NGO	Governmental and Non-governmental Organizations
HBMR	Home-based Maternal Record
HHW	Hamlet Health Worker
HMIS	Health Management Information System
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IUD	Intra-Uterus Device
JBIC	Japan Bank for International Cooperation
JETRO	Japan External Trade Organization
JICA	Japan International Cooperation Agency
JPY	Japanese Yen
MCH/FP	Maternal and Child Health / Family Planning
MM	man-month
M/M	Minutes of Meetings
MOH	Ministry of Health
MMR	Maternal Mortality Rate
MR	Menstrual Regulation
MT	Mountainous
ODA	Official Development Assistance
OVI	Objectively Verifiable Indicator
PCPFC	Provincial Committee for Population, Family and Children
PCM	Project Cycle Management
PDM	Project Design Matrix
PHS	Provincial Health Service
PNC	Post-Natal Care
PSC	Provincial Steering Committee
RD(R/D)	Record of Discussions
RH	Reproductive Health
RTI	Reproductive Tract Infection
TFR	Total Fertility Rate
TT (T/T)	Tetanus Toxoid cf. TT2 (=second shot of TT)
VND	Vietnam Đong

I. INTRODUCTION

1. Evaluation Team

The Japanese Final Evaluation Team (hereinafter referred to as "Japanese Team"), organized by Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Prof. Hirofumi ANDO, visited the Socialist Republic of Vietnam from June 8 to June 24, 2005 for the purpose of the joint Final Evaluation with the Vietnamese Evaluation Team (hereinafter referred to as "the Vietnamese Team") on Japanese technical cooperation to the Reproductive Health Project in Nghe An Province Phase II (hereinafter referred to as "the Project"), which is scheduled to terminate of August 31, 2005, according to the Record of Discussions (hereinafter referred to as "R/D") signed on July 14, 2000.

Both Teams jointly examined and discussed together the relevance, effectiveness, efficiency, impact and sustainability and future perspective of the Project in accordance with the Project Cycle Management (hereinafter referred to as "the PCM") method.

Through careful examinations and discussions, both Teams summarized their findings and observations as described in this document.

2. Members of the Joint Evaluation Team

[The Japanese Evaluation Team]

Prof. Hirofumi ANDO (Leader)	Professor Advanced Research Institute for the Sciences and Humanities, Nihon University
Mr. Ryoichi SUZUKI (Project Management)	Deputy Executive Director Japanese Organization for International Cooperation in Family Planning (JOICFP)
Dr. Tomoko SAOTOME (Reproductive Health)	Chief Doctor Department of Obstetrics and Gynecology, Fureai Yokohama Hospital
Mr. Kenta SASAKI (Evaluation Planning)	Staff Human Development Department, Japan International Cooperation Agency
Ms. Yoko OGAWA (Evaluation Analysis)	Specialist in International Health Social Development Department, Global Link Management, inc.
Ms. Ran NAGAI (Interpreter)	Training Coordinator Japan International Cooperation Center

[The Vietnamese Evaluation Team]

Dr. Cao Xuan Nghiem (Leader)	Vice Director Provincial Health Service, Nghe An Province
Dr. Nguyen Ba Tan (Project Management)	Director MCH/FP Center, Nghe An Province
Dr. Le Thi Hoai Chung (Reproductive Health)	Vice Director MCH/FP Center, Nghe An Province
Dr. Le Thi Quynh Nga (Evaluation Analysis)	Mailman School of Public Health Columbia University

II. EVALUATION PROCESS

1. Evaluation Method

Both Teams agreed to use the Project Design Matrix (PDM), which was revised upon the mid-term evaluation in August 2003 as the basis of evaluation. Based on the PDM, achievement of the narrative summary and process of the Project were reviewed. Then the both sides assessed the Project based on the following five criteria:

1) Relevance	Relevance of the Project plan is reviewed in terms of the validity of the Project purpose and the overall goal in connection with the development policy of the Government of Vietnam and needs of the beneficiaries, as well as the logicality of the plan.
2) Effectiveness	Effectiveness is assessed by evaluating to what extent the Project has achieved its purpose and clarifying the relationships between purpose and outputs.
3) Efficiency	Efficiency of the Project implementation is analyzed with emphasis on the relationships between outputs and inputs in terms of timing, quality, and quantity.
4) Impact	Impact of the Project is assessed by measuring either positive or negative influences made by the Project, which are not originally expected in the Project plan.
5) Sustainability	Sustainability of the Project is assessed in organizational, technical and financial aspects in terms of the extent to which the achievements of the Project are sustained or expanded after the Project is completed.

2. Information for Evaluation

In order to review past performance, the following materials were used:

1) Documents signed by both sides prior to and/or in the course of the project implementation, including Record of Discussions (R/D), Minutes of Meetings (M/M), Project Design Matrix (PDM) and others.
2) Reports, data and statistics prepared by the Project.
3) Ministry of Health (MOH) and MCH/FP Center documents related to the Project.
4) Baseline Survey, Mid-term Assessment and Final Assessment by the Population Council.
5) Results of series of interviews, field observations and workshops.

III. BACHGROUND AND GENERAL REVIEW OF THE PROJECT

1. Background of the Project

Vietnam has established a relatively effective health service system, and health indicators concerning Maternal and Child Health (MCH) have been moderate level relative to other developing countries. However, due to the Vietnam War, human resource development of health staff was hampered, and the consequent lack of well-trained health staff has been causing a serious problem, especially in rural areas.

Since 1995, the Vietnamese government had promoted nationwide family planning with some success. However, the maternal health situation had not improved since the 1980s and awareness of maternal health among the population was still low.

Under this condition, the Vietnamese government requested the Japanese government for technical cooperation project for improvement of Reproductive Health in Nghe An Province as a model case. The Japanese government and the Vietnamese government agreed to have a technical cooperation project of "Reproductive Health Project in Nghe An Province (Phase I)", and signed on the R/D in April 1997.

"The Reproductive Health Project in Nghe An Province (Phase I)" commenced in June 1997 with a three-year cooperation period with the aim of improving women's reproductive health in Nghe An Province. Phase I was conducted in 8 target districts out of the 19 districts of the Province and the main objective was to enable the safe and hygienic delivery in Commune Health Centers (CHCs). The project improved midwifery skill of CHC staff and upgraded CHC facility and equipment.

After this first project, aiming for further progress, "The Reproductive Health Project in Nghe An Province Phase II" began in September 2000, expanding the target areas to cover all 19 districts of Nghe An Province.

2. General Review of the Project

The 5-year Project started on September 1, 2000 and has been directed by the project steering committees, which have been composed of 4 agencies/sectors, such as People's

Committee, Health Sector, Women's Union and Committee for Population, Family and Children at provincial, district and commune level. The project purpose is to improve the reproductive health service in Nghe An Province.

The original PDM of the Project was jointly formulated by Japanese and Vietnamese in the workshop in April 2000, and the Master Plan of R/D was signed on July 14, 2000 by both sides. After that, the Project was implemented based on the first PDM. At the Project Consultation Studies in August 2001 and in August 2002 and at the Mid-term evaluation on August 2003, the PDM was revised. The revision of the PDM from the Mid-term evaluation is the final PDM and the basis for this Final Evaluation.

3. PDM for Final Evaluation (PDM revised in 2003 at the time of Mid-term Evaluation)

Target Group	Women of reproductive age (15-49) (Total: 752,741 [2004])
Target Areas	Nghe An Province (19 Districts and 469 Communes) 16,487 km^2
Overall Goal	Reproductive health of women in reproductive age is improved in Nghe An Province.
Project Purpose	Reproductive health service in Nghe An Province is improved.
Outputs	0. Steering Committees at all levels are established and function regularly and continuously for further integration of Reproductive Health (RH) and Family Planning (FP) services.
	1. Safe and hygienic delivery is promoted at commune level. 1-1. Prenatal care at commune level is improved. 1-2. Delivery care at commune level is improved. 1-3. Postnatal care at commune level is improved. 1-4. Essential medical equipment is utilized to all Commune Health Centers (CHCs). 1-5. Hygienic facilities such as delivery room, latrine, well and shower room of CHCs are improved. 1-6. Integration of RH and FP is promoted and improved at all levels.
	2. Monitoring capacity of MCH/FP Center and selected District Health Centers (DHCs) is improved.
	3. Number of abortions including Menstrual Regulations (MRs) conducted at MCH/FP Center and selected districts is reduced.
	4. Capacity for Reproductive Tract Infection (RTI) detection and the development of prevention strategy is improved at MCH/FP Center.
	5. Quality of IEC & Motivation activities of MCH/FP Center and the selected districts, women's union and DHCs in particular, for RH promotion aiming at behavioral change of service providers, women as well as men is improved.

	6-1. The system of recording, summarizing and reporting health information is upgraded. 6-2. Hardware related to Health Management Information System (HMIS) is improved. 6-3. Capability of HMIS personnel is upgraded. 6-4. HMIS activities are assessed regularly. 6-5. HMIS data is adequately utilized.

IV. RESULTS OF EVALUATION

1. Achievements

Accomplishment of the Project was measured in terms of inputs, activities, outputs and project purpose, all of which were assessed using the R/D and the PDM as the framework.

1.1 Inputs

Actual Inputs made by the Project at the time of the Final Evaluation are described in reference to the contents agreed in PDM and/or the R/D.

Analysis of the distribution pattern of the financial Inputs at Commune-, District- and Provincial-level Outputs confirms the Project's community focus, with 71% of total costs[1] expended to commune and grassroots level activities, 19% to district level, and 10% to Provincial level (See Diagram 1-1). As for the distribution of the amount per each Output, Output 1, "Safe motherhood component" received the most at 58%, followed by 14% for IEC component, 12% for Steering Committee meetings, and 3~4% each for the rest of Outputs (See Diagram 1-2).

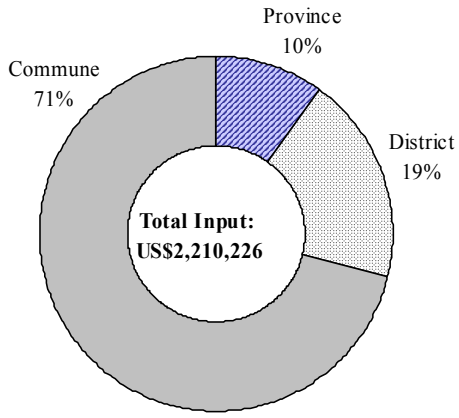


Diagram 1-1: Inputs by Administrative Levels

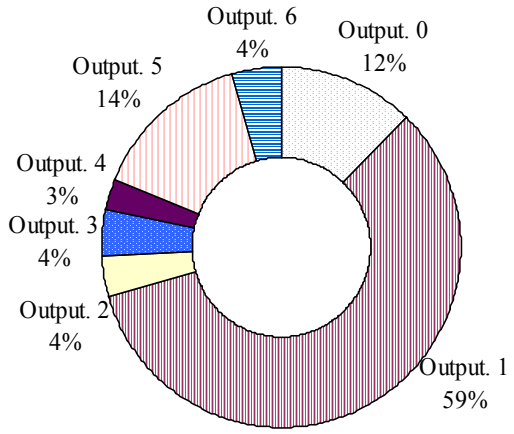


Diagram 1-2: Distribution of Inputs per Outputs

The total cost does not include US$163,814 funded by the Japanese Grant Assistance for Grassroots Projects for upgrading the CHC facilities.

1.1.1 Japanese Side

a) Experts

Long-term Experts: A total of nine (9) Long-term Experts in five (5) areas of expertise, totaling 259 MM, have been allocated. They are the Team Leader, Administrative Coordinator, experts in fields of Midwifery, Community Health, and Health Management Information System (HMIS) - Demography. These areas correspond to those specified in the R/D.

[1] Calculation was made by the Project Office based on the distribution of activities per Outputs. Some inputs were counted twice or more under different Outputs, making the gross total of US$2,210,000 (excluding C/P Training and costs for Japanese Experts).

Short-term Experts: A total of twenty-three (23) short-term experts in forty-eight (48) visits, totaling 24 MM, have been dispatched and planned at the time of the Final Evaluation. This includes one (1) expert who is being planned for dispatch for 0.2 month in July 2005, after the Final Evaluation period. Average duration per visit was 0.5 MM, with intended tendency of the same Experts making multiple visits averaging 2.1 times per person with the maximum being five (5) times. They performed their functions in a variety of fields ranging from Midwifery Education, Public Health, Obstetrics-Gynecology, Laboratory, Project Management, Information Education and Communication (IEC), and RH-related surveys, covering approximately twenty (20) areas, in line with R/D.

The list of experts is shown in **ANNEX Ⅲ**.

b) Provision of equipment

Equipment worth US$ 1,162,765 (JPY124,415,855)[2] in total had been provided at the time of the Final Evaluation. The list of equipment is shown in **ANNEX Ⅳ**.

c) Training for Counterparts

A total of forty (40) persons have been trained under the C/P training scheme in the fields of Reproductive Health, more than twice as many as planned (13~16 persons) stipulated in R/D. This is made possible by the additional resources that were allocated from the country-focused group training scheme. Institutions which provided the Counterpart training included JOICFP, Japanese Red Cross Katsushika Maternity Hospital, Fukushima Red Cross Hospital; Prefectures of Kagoshima, Gunma, and Yamanashi, etc. in Japan. Most of those institutions were Project-related, such as organizations of the Long-term/Short-term Experts. Additional four (4) persons are now being trained at several institutions listed above.

The focus and duration of each training program has been a two/three-week reproductive health management, but also included a nine-month midwifery-training course at a maternity hospital. When the training of the four persons is completed in Japan, this will make a total of fifty-one (51) months worth of training in duration, averaging 1.2 months per person.

One thing to note is that the trainees included four (4) persons from the central level and another four (4) from different Provinces, for the purpose of sharing the experiences in Nghe An Province. Out of thirty-six (36) trained counterparts in Nghe An Province, twenty-five percent (25%) have left the post: four (4) left for other organizations; another four (4) have retired; and one on a long-term leave for promotional training.

Additionally, the Project funded eight (8) Counterparts (4 from MCH/FP Centers and 4 from DHCs), one (1) Interpreter and one (1) JICA Expert to take part in a technical exchange program in Thailand for 6 days (March18~23, 2002) in order to gain experience through exchanges with foreign professionals working in the same field.

The list of the above training provided is shown in **ANNEX Ⅴ. and ANNEX Ⅵ.**

[2] Calculation is made with the exchange rate at 1US$=107JPY (the same rate applies within this Report)

d) Operational Costs

A total of US$1,564,651 (JPY167,417,657) was expended for Project activities at the time of the Final Evaluation from the Japanese side, of which US$401,886 (JPY43,001,802) was allotted for local training, project activities, baseline and assessment surveys and the rest US$1,162,765 for equipment provision. The expended amount is within the range as agreed in R/D (JPY 40~60 million for local training, and JPY120~150 million for equipment provision).

A table/chart of the local operational costs over five years is shown in **ANNEX Ⅶ.**

e) Mobilization of Non-Project Resources

The Project has also mobilized non-Project resources to fill in what could not be covered by the Project funds. These included:

US$163,814 from Grant Assistance for Grassroots Projects by the Japanese Embassy for facility upgrading in CHCs;

US$11,119 from the Technical Assistance Follow-up Fund by the JICA Vietnam Office for the repair/replacement of non-functioning/outdated equipment provided during the Phase I Project; and,

Additional resources (US$50,897) from the GO-NGO Collaboration Fund by the JICA headquarters for two (2) operational studies conducted to guide more effective implementation of Project activities.

1.1.2 Vietnamese Side

a) Assignment of Counterparts

Total of thirty-six (36) persons have been allocated as the Counterpart personnel by the Vietnamese side. In addition, the Project also involved District Steering Committee members of all nineteen (19) districts, as well as four-hundred sixty-nine (469) Commune Steering Committees working closely with the Project.

The list of Counterparts together with the duration of assignment is shown in **ANNEX Ⅷ**.

b) Buildings and facilities

Sufficient room for the Project Experts and training facilities for Project implementation have been provided for by the Vietnamese, as per agreement in R/D.

c) Cost-sharing expenses

The Vietnamese side financially contributed to the Project's activities through their budget, since 2002, as agreed in R/D. The amount totaling VND431,148,000 (US$27,859)[3] was utilized for 1) CHC staff retraining; 2) provincial and district steering committee meetings; 3) monitoring on model activities and experience sharing workshops; 4) renovation of conference room; 5) follow-up of supplied equipment, 6) administrative and operating cost, and, 7) maintenance of the provided equipment. However, the proportion of Vietnamese

[3] Calculation was made with the exchange rate at 1US$=15,476VND.

contribution to the JICA contribution was 1.8%, short of the target of 3% stipulated in R/D.

A table/chart of financial contribution from the Vietnamese side over the past three years is shown in **ANNEX Ⅸ**.

1.2 Activities

As per the PDM revised at the time of the Mid-term Evaluation, Activity items required under seven (7) Outputs totaled eighty-five (85) in number. They were reported by the Project as mostly completed as per plan, details of which are given in a matrix (**ANNEX Ⅹ**). The Project modified, omitted and supplemented Activities to adjust to local demands and circumstances as they were encountered during implementation, as well as in response to findings through continuous monitoring activities and operational studies that were incorporated into the Project Design Matrix (PDM). All in all, changes made were appropriate, as they were determined under the principle of achieving Project's objectives.

1.3 Outputs

The extent to which each Output has been achieved is described below.

Output 0: Steering Committees at all levels are established and function regularly and continuously for further integration of RH and FP services.

Objectively Verifiable Indicators (OVIs) for Output 0:

(a) Participation rate of 1) DSC quarterly meeting, 2) CSC annual meeting, and 3) attendance at the monitoring visits

(b) Staffing of District and Commune Steering Committee from 4 organizations (People's Committee, Women's Union, Health Centers and PCPFC) are continuously fulfilled and function for the integration of RH and FP.

Output 0 has been fully achieved, as the RH Steering Committees were established in 2000 at the commune, district and provincial levels in all 19 districts and 466 communes (later 469 due to reorganization). The Provincial Steering Committee (PSC) performed the role of Project's secretariat, and most of the members in each level have been participating in regular review meetings, with representation from four (4) organizations, to share experiences. In all the districts that conduct CHC level monitoring activities, members of the CSC, especially from the Commune People's Committee and the Commune Women's Union often took part in the exercise to share tasks and responsibilities. Furthermore, the willingness among the DSC and CSC members to maintain the function of the Steering Committees for the improvement of reproductive health of women even after the Project completion was observed in all locations that the Japanese Evaluation Team has visited.

The Joint Committee was also established at the central level to hold overall responsibility for the project implementation. It consists of the central leaders of the People's Committee, the Women's Union, the JICA Vietnam Office joined by the Provincial Health Service, the MCH/FP Center and the Japanese Experts based in Nghe An Province. The RH Department (former MCH/FP Department) of the Ministry of Health, as an advisor, and the Japanese Embassy, as an observer, also take part in the Joint Committee. Provincial level Steering Committee was established at the MCH/FP Center.

Participation rate of DSC in quarterly meetings over five years held with support by the Project are given in Diagram 1-3 with a breakdown into four organizations. Since 2002, Committee for Population, Family and Children (CPFC) has been represented in the Steering Committees at all levels. Overall participation rate has been good with above 75% throughout five years[4], in part due to the administrative reminder from the Provincial People's Committee to its District body not to leave their duty station for frequent meetings in Vinh City.

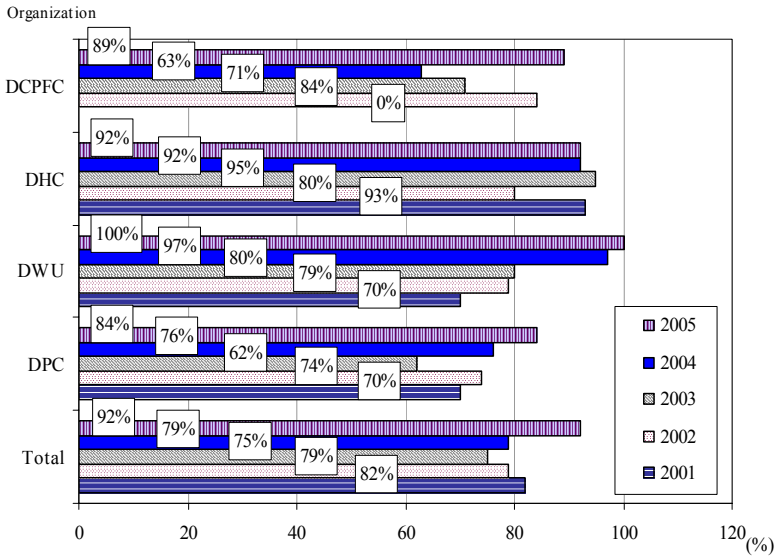


Diagram 1-3: DSC Participation Rate and Representation (2001~05)

Participation of the Commune Steering Committees in the annual district-level meetings / workshops has also been good with above 80% participation rate throughout five years (See Diagram 1-4).

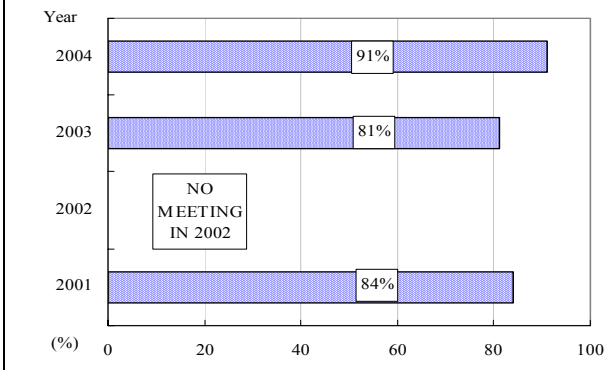


Diagram 1-4: CSC Participation Rate in 19 Districts (2000~04)

Information obtained through the Final Assessment Survey by the Population Council and interviews conducted by the Joint Evaluation Team suggests that this achievement is attributed to the high level of commitment and dedication from the political and social leaders at different levels. Such commitment / dedication has been evolved through 1) collaborative working experiences

[4] The Committee for Population, Family and Children

and mutual trust between Vietnamese and Japanese sides carried on from the Phase I Project; 2) coherence of the Project's objectives and contents in accordance with the National Strategy on RH Care (2001~2010) of the government; 3) Project's weighed investment (12% of activity costs) into involving key stakeholders; 4) systematic and frequent feedback mechanism of visible results among key stakeholders that further encouraged their involvement; and, 5) Project's persistent focus on grass-roots level that helped clarifying specific roles of the provincial, district and commune level organizations.

Output 1: Safe and hygienic delivery is promoted at commune level.

Major OVIs for Output 1:

(a) Percentage of deliveries at CHCs in non-mountainous area will be 95% and percentage of deliveries attended by trained health worker (CHC staff/trained hamlet health worker) in mountainous area will reach 60%

(b) Number of deliveries attended by trained health personnel at hamlet level

(c) Average number of pre-natal check-ups in non-mountainous districts (9 out of 19 districts) is at least 4 times

(d) Number of pregnant women received T/T remains as high as 95% in non-mountainous area and as 70% in mountainous area

(e) Number of cases of early detection of high-risk pregnancies referred to DHCs

(f) Partograph is applied more than 90% of the deliveries at CHCs in selected districts and 80% in non-mountainous area districts.

(g) Percentage of CHC has hygienic facilities

Output 1 is mostly achieved, as safe and hygienic delivery has been well promoted at commune level. Deliveries attended by trained health personnel have increased, and the average number of pre-natal check-ups increased in the Province, both in mountainous and plains areas. More efforts and attention are required for the services in mountainous areas, and for post-natal care.

The following are indicators that show such changes over time.

Prenatal Care: The proportion of the CHCs organizing Home-Based Maternal Record (HBMR) was 83.9% in non-mountainous area and 83.1% in mountainous area in 2001, and increased to 95.3% and 94.2 % in 2004 respectively according to the Project record. The Final Assessment report by the Population Council indicates that HBMR is available at the all the randomly selected CHCs for the assessment, and all the interviewed pregnant women had the HBMR. At 92 % at mountainous and 97% of non-mountainous CHCs HBMR was sufficiently and correctly recorded. HBMR is recognized as a useful record for both pregnancy management for the health facility and the mothers themselves to know their condition. MOH encourages applying HBMR nation-widely. In the project area, 100% of CHCs have the HBMR management box.

According to the MCH/FP Statistical reports, number of prenatal check-ups increased from 3.0 times per pregnant women in 1999 to 3.3 times in 2004 in non-mountainous areas, and from 2.2 times (1999) to 2.8 times (2004) in mountainous areas (See Diagram 1-5). At the same time, data from the survey covered all CHCs shows that the total number of visits to CHCs also increased significantly from 1999 to 2003 (See Diagram 1-6). The proportion of pregnant women who received TT2 also increased from 95.1% in 2000 to 97.2% in 2004 in non-mountainous areas, and from 73.8% (2001) to 89.1% (2004) in mountainous area. These figures exceeded the national benchmark of 95% in plains and 85% in mountainous areas for 2010.

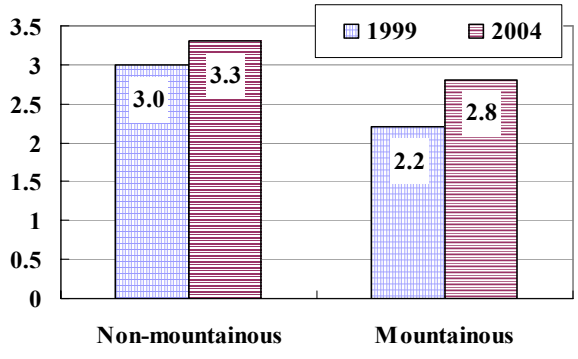


Diagram 1-5: Average No. of prenatal check-ups per Pregnant Woman in Nghe An Province

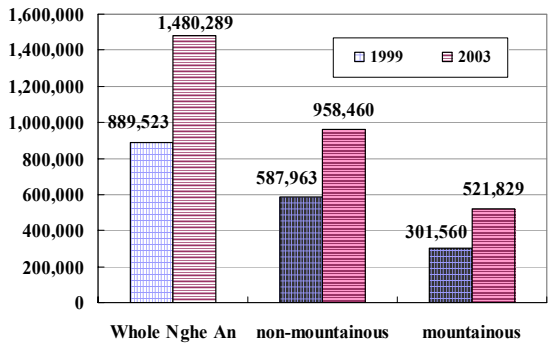


Diagram 1-6: Total Number of visits to CHCs in Nghe An Province (1999 : 2003 comparison)

The average first gestational age for the fist prenatal check-up has shown dramatic improvement: From 29 weeks in 2001 at the time of Baseline Survey to 15.6 weeks according to the 2005 Final Assessment result by the Population Council. Difference is observed between mountainous and plains areas, 14.6 weeks and 16.9 weeks respectively.

As for prenatal guidance and counseling, 8 main topics were selected for the Baseline Survey and the 2005 Final Assessment. Seven out of 8 topics related to prenatal care show improvement, indicating that the counseling has improved since 2001. The number of prenatal visits shows some decline, possibly due to the fact that people are more willing to come for the check-ups.

The above changes indicate the condition of the prenatal care at commune level has been improved.

Delivery Service: In general, conditions at the CHCs have improved, which benefited those women who chose to deliver at CHCs. The benefits brought about regarding delivery services was more qualitative improvement rather than quantitative expansion, as the number and proportion of deliveries at CHCs did not significantly change between 1999 and 2004 (See Diagram 1-7 and Diagram 1-8)[5]. In non-mountainous areas, deliveries took place at health institutions increased from 94% in 2000 to nearly 97% in 2004, 65% of

[5] Nevertheless, the number of visits to CHCs (for any reasons) has shown significant increase, perhaps due to cleaner and more equipped facilities, and partially reflecting increased number of prenatal visits (See Diagram 1-6).

which was at the CHC level. In mountainous districts, institutional delivery increased more sharply from 61% in 2000 to 72.5% of delivery conducted at health institutions, and 41% at CHCs (40% in 2000). The rate of delivery at CHCs has not changed, but the total number of deliveries at the institutions has been increased. The rate of home delivery decreased from 39% in 2000 to 27.5% in 2004. It has been difficult to collect data on the proportion of deliveries at hamlet level that have been attended by the trained health workers. However, nearly 2,300 hamlet health workers received a refresher course organized by DHCs in 10 mountainous districts. Therefore, it is probable those hamlet health workers in their respective hamlets are providing services in their improved capacity.

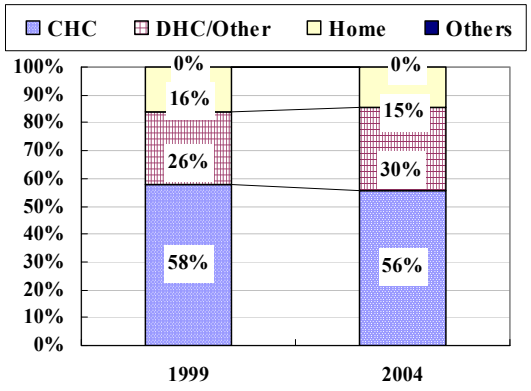


Diagram 1-7 : Proportion of Place of Delivery in Nghe An Province (1999 : 2004 Comparison)

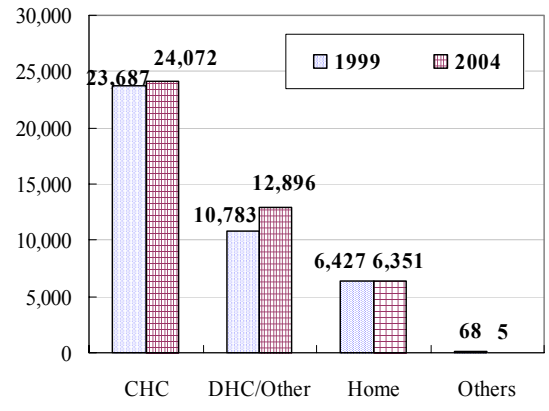


Diagram 1-8: Place of Delivery (No. of cases) in Nghe An Province (1999 : 2004 Comparison)

The overall percentages of health staff at CHCs using the Partograph in 2001 are 60.3% in 2001 and 98% in 2005, although procedures of records on the Partograph at the CHCs need to be improved. All the CHCs have re-trained staff in midwifery services and the basic medical equipment, and 80% of CHCs have already conducted the activities to construct hygienic facilities.

Postnatal care: The percentage of mothers and newborns having received at least one home visit by health workers increased from 66.4% in 2000 to 85.4% in 2004. The percentage of mothers and newborns having received at least two home visits did not show much difference from 44.2% in 2000 to 42.5% in 2004. While the first home visits have shown significant increase, more attention should be paid to the second home visits. This indicates that the health service providers have a tendency to focus on the care immediately after the delivery. Traditional customs, limited time and resources of the midwives also contribute to the limited result. Compared with the prenatal care service, the postnatal care still needs much more improvement in terms of services and re-training of CHC staff.

CHC Facilities: The remaining 20% CHCs are now working on the toilet construction supported by the Grant Assistance for Grassroots Projects (GAGRP). The provision of the essential medical equipment to all the CHC was completed at the early stage of the Project Phase II. The essential equipments at CHC are generally well utilized and their conditions are checked at the time of delivery. Some equipment requires stable and sufficient supply

of electricity, which is not available in some communes[6].

Throughout Phase I, with the support by GAGRP, 244 CHCs renovated the delivery room, dug wells, and constructed toilet and shower facilities. During the Phase II, the Japanese Embassy approved the GAGRP proposals to support 116 CHCs in 2001 and 88 CHCs in 2004 respectively with the construction of toilet and/or shower facility. In Phase II, the Project focused on toilet and shower facilities for pregnant women as the Vietnamese government through the World Bank funds also renovated/constructed CHCs. Once this GAGRP activity is completed, all the remaining CHCs will be covered with renovation activities.

RH/FP Integration: The Final Assessment report by the Population Council indicates that the availability of the contraceptives at health facility is sufficient. The coordination among health staff and FP collaborators at commune level has improved. The CPFC members of project steering committee have been involved in the project activities at all levels and well collaborated with the other concerned agencies. The integration of the RH and FP has been well promoted.

Additional indicators are shown in the **ANNEX Ⅺ.**

Output 2 : Monitoring capacity of MCH/FP Center and selected District Health Centers (DHCs) is improved.

OVIs for Output 2:

(a) Monitoring are conducted utilizing standardized check list according to plan

(b) 90% of DHCs and CHCs receive monitoring visit by the upper level annually

(c) Number of staff trained on monitoring according to the monitoring standard set by MCH/FP Center.

Output 2 is mostly achieved, as the monitoring capacity of the MCH/FP Center and DHCs in general has been much improved, and has contributed to the improvement of the reproductive health care services. Especially at the MCH/FP Center, supportive monitoring has become the regular activities of the Center. The concept of supportive monitoring has been well understood by the people involved, not only the health staff, but the representatives of people's committee, Women's Union, and the Committee for Population, Family and Children. The CHC staff also understands the objective of the monitoring is to improve their services rather than to assign blame.

Geographical conditions of the remote CHCs make it difficult for upper level personnel to visit these CHCs often enough. Some receive only one visit a year. The long-term experts provided guidance in analyzing the information and data obtained through monitoring and HMIS, and in reflecting the findings to the planning of the refresher courses for the CHC staff at the DHC. Further guidance and continuous training on monitoring by the MCH/FP

[6] Proportion of CHCs with permanent electricity is 100% in plains areas and 93% in mountainous areas. Availability of electricity is the issue.

Center to DHCs is encouraged.

The number of CHC monitoring visit made by MCH/FP Center and JICA experts has become over 170 CHCs in Phase II. An average of 4~5 CHCs are visited monthly with the purpose of providing on the job training for the monitoring implementers as well as the monitoring of the CHC activities. In recent years, the monitoring has been fully conducted by the counterpart without intervention by the experts. All the CHCs have received monitoring visits by DHC monitoring team since 2000 every year. 90% of DHCs have received monitoring from the upper level in 2004 and 80% in 2001.

The number of staff trained on monitoring methods in accordance with the monitoring standard set by MCH/FP Center are: in 2002, 35 DHC staff, 3 MCH/FP Center staff; in 2003, 33 DHC staff, 13 MCH/FP Center staff; and in 2004, 77 DHC staff, 12 MCH/FP Center staff; for a cumulative total of 145 DHC staff and 28 MCH/FP Center staff.

While the monitoring activities have become regular activities where various technical guidance is provided, some issues identified during the monitoring activities have remained unsolved, most of which are facility/equipment maintenance and repair that require additional resources at commune or district levels.

Output 3 : Number of abortions including MRs conducted at MCH/FP center and selected districts is reduced.

OVIs for Output 3:

(a) Number of abortions and MRs conducted in Nghe An Province (reduced) by 700 cases or more per year

(b) Percentage of women of post abortion and MR at MCH/FP Center and the selected districts accepted modern contraceptive method will be 75%

(c) Percentage of repeated abortion and MR conducted at MCH/FP Center and the selected districts reduced by 5% per year

(d) Number of modern contraceptive users by methods increases 2% per year

Output 3 has been mostly achieved; the number of abortion cases as well as the abortion ratio in Nghe An Province has been reduced. However, the percentage of women of post-abortion and menstrual regulation (MR) has not decreased significantly, requiring betterment in the quality of counseling for abortion clients.

The abortion rate in Nghe An Province was 27.9 per 100 live births in 2000 and declined to 21.6 per 100 live births in 2004, which is lower than the national benchmark (target) 25 per 100 live births for 2010. Nghe An Province achieved the national target for 2010 already in 2005. Furthermore, Nghe An Province has achieved substantial decrease in abortion cases.

The percentage of repeated abortion is: 12.2% in 2003 and 13.6% of total abortion including MR cases in 2004 at the MCH/FP Center, 20.2% and 11.6% in Yen Thanh, 11.1% and 7.6% in Nghia Dan, 15.3% and 9.5% in Thanh Chuong, and 7.6% and 6.2% in

other districts respectively. The percentage of repeated abortion has decreased in all cases except MCH/FP Center. It may be possible that the MCH/FP Center have wider service coverage, including those women from outside of Nghe An Province seeking for the better services, leading to the increased figure at the MCH/FP Center. This issue should be carefully examined.

The percentage of women of post-abortion and MR who accepted modern contraceptive methods were 33.3% in 2003 and 75.7% in 2004 at the MCH/FP Center, which is a significant increase. This is an indication of the improvement of counseling at the MCH/FP Center. In Yen Thanh District, 41.1% in 2003 and 48.8% in 2004, showing some increase. On the other hand, the corresponding figures were 26.3% in 2003 and 13.3% in 2004 in Nghia Dan District, and 56.4% and 53％ in Thanh Chuong, that shows the decrease. More efforts must still be made in promoting utilization of modern contraceptive methods by improving the quality of counseling, particularly in DHCs.

The CPR in Nghe An Province is higher than national average. The CPR of modern methods in Nghe An was 77.9% in 2001 and 79.1% respectively in 2004. The national CPR of modern contraceptive method was 61.1% in 2001 and 64.6% in 2004. About half of the modern contraceptive accepters are IUD users, followed by contraceptive pills and condom. The number of injectable users is gradually increasing.

The activities that gave emphasis on the community leaders and men have been conducted. At the workshops for the 469 CSCs of 19 districts, the themes of abortion reduction and contraceptive methods were dealt with. At the advocacy seminar held in August 2004, provincial leaders of various organizations, such as the communist party, Fatherland Front, Farmer's Union, Youth Union, Culture and Information Department, Women's Union and health sector were invited together with DSC members. The various RH issues were covered including abortion reduction in order to improve the RH knowledge among Nghe An leaders. At the mass media seminar organized in September 2004, the journalists and TV correspondents were invited to increase their awareness on abortion issues among the participants. The reaction of the participants was quite positive, and male involvement activities are likely to be carried on by the social organizations.

There are some indications that the number of adolescents and youth getting abortion services are on increase. Statistical data on abortion including MR is solely based on cases recorded in public health institutions, and does not include cases at the private practitioners. More attention should be paid to issues relating to adolescent pregnancies and abortion in the future.

Additional indicators are shown in the **ANNEX Ⅺ.**

Output 4 : Capacity for RTI detection and the development of prevention strategy is improved at MCH/FP Center

OVIs for Output 4:

(a) Situation of RTI in Nghe An province become known.

(b) Strategy for prevention of RTI is developed.

(c) Proper treatment method for RTI is identified.

Through the reproductive tract infections (RTI) survey conducted with the involvement of the MCH/FP Center staff, situation of RTI in Nghe An Province has become known to concerned organizations, and a strategy for prevention of RTI has been developed in four (4) districts with the leadership of MCH/FP Center. Furthermore, a proper treatment method for RTI treatment has been identified, and the treatment services are provided to more RTI patients in three DHCs and MCH/FP Center. Thus, Output 4 is achieved.

The RTI survey conducted in the 10 communes in 4 districts covering 505 pregnant women has provided important findings and lessons that can be applied to the whole of Nghe An and also to Vietnam. Based on this learning, the training on RTI diagnosis for gynecologists and laboratory technicians of the 19 DHCs was conducted. This has improved the RTI examination and treatment services at the DHC. As indicated in the Final Assessment report by the Population Council, the percentage of the DHCs that can conduct proper laboratory test (87%) significantly increased in comparison to 2001 Baseline Survey (53%), indicating significant improvement in the provision of laboratory test for RTI diagnosis in the district level. A seminar to disseminate the survey findings was organized inviting the relevant organizations in Hanoi. The survey report was widely distributed and the findings were acknowledged as being very useful.

The treatment for RTI is available, and the appropriate application of the treatment according to the correct diagnosis based on the laboratory examination is one of the key findings. The technical level of laboratory section of the MCH/FP Center has improved and more patients start coming for the RTI services at the Center.

Strategies for prevention of RTI for each of the four districts surveyed have been formulated based on the analysis of the RTI survey outcomes. The follow-up of the strategy is one of the activities for the MCH/FP Center and the respective DHCs to continue.

Future integration and collaboration with other services within an institution (e.g. Prenatal care counseling, FP counseling, etc.) as well as with other health institutions require closer consideration.

Additional indicators are shown in the **ANNEX XI.**

Output 5 : Quality of IEC and motivation activities of MCH/FP Center and the selected districts, women's union and DHCs in particular, for RH promotion aiming at behavioral change of service providers, women as well as men is improved.

OVIs for Output 5:

(a) The classes for RH education organized at MCH/FP Center twice/week and in the selected districts twice/month

(b) There are average of at least 10 participants at the health education at MCH/FP Center and 20 participants at the selected districts

(c) Number of pregnant women in Aiiku-han selected communes visit to CHC earlier for the first prenatal check-up before 12 weeks

(d) At least 4 visits to CHCs for prenatal check ups in Aiiku-han selected communes.

(e) Number of the visits to CHCs for prenatal check ups.

(f) The coverage of topics of prenatal guidance and counseling

Through technical and managerial training and technical assistance on IEC activities provided by the Project, quality of IEC and motivation activities has been significantly improved at the MCH/FP Center as well as in all the districts and commune levels. The IEC channels and forms have diversified from one-way communication through the loud-speaker to ones involving small dramas, interactive learning using Maggie Aprons, and contests. Target audience has also been expanded, from married women to youths/adolescents and men. The number of visits for prenatal services by pregnant women has improved, and the timing of the first visits became much earlier.

At MCH/FP Center, the number of health education including parents classes organized regularly has increased steadily, from 21 classes in 2000 to 166 classes in 2004. The total number of participants was 349 in 2000 and increased to 4,351 persons in 2004. The average number of participants per class became over 20 persons since 2002. The MCH/FP Center staff also conducts health education sessions outside of the Center. Pamphlets developed during the C/P training by the participants have been distributed to the clients in order to improve the quality of the IEC activities.

There is a high diversification of IEC channels and forms, including small dramas, contests, videos, radio broadcasts, cassettes, and developing small village libraries. These materials are assessed to be relevant, easy to understand and attractive by the local people. The collaboration between health sector and the Women's Union has been much improved. In particular, the MCH/FP Center staff always joins and support the IEC sessions organized by the Women's Union with their expertise. The IEC materials that the project provided, such as Maggie Apron and pregnancy simulator, have been effectively utilized as a result of the technical training on IEC, and in collaboration among Women's Union, CHC staff, and other relevant agencies. The RH information has also been disseminated among male leaders from the Communist Party, Fatherland Front, Farmer's Union, Youth Union, Culture and Information Department at the commune level, and male participation was encouraged and expanded the support population.

As for the timing of the first prenatal check-up in "Aiiku-han" model commune, it was not as early as the average gestational age of 15.6 weeks (Nhan Tanh commune 18.8 weeks, Hop Thanh commune 21.2 weeks, Nam Thanh commune 19.4 weeks). Although all are earlier than in 2001 as assessed by the Baseline Survey (29 weeks), there remains a need for more improvement. The Provincial Women's Union has expanded "Aiiku-han" activities to three additional communes, making the total of six, and has a plan to further expand the activity in 2005~2006.

While acknowledging the improvement in communication skills and increase in confidence of advocacy workers, contents of the information/messages should be continuously and carefully reviewed and improved to ensure responsiveness to changing health status and to improve women's reproductive health and rights. Broader approach to IEC activities utilizing some of the medical interventions such as prenatal and postnatal care should be promoted to a greater extent to disseminate information on RTIs, abortion and family planning.

Output 6-1 : The system of recording summarizing and reporting health information is upgraded
Output 6-2 : Hardware related to HMIS is improved.
Output 6-3 : Capability of HMIS personnel is upgraded.
Output 6-4 : HMIS activities are assessed regularly.
Output 6-5: HMIS data is adequately utilized.

Main OVIs for Output 6:

(a) All DHCs, MCH/FP Center and PHS use computer to prepare statistical report
(b) Three (3) DHCs and MCH/FP Center use the new hospital-based HMIS
(c) 80% of CHCs use standardized record books and report forms
(d) Computer skills and knowledge of PHS staff increased
(e) Six (6) out of 19 DHCs manage the new HMIS properly
(f) MCH/FP Center manages the new HMIS properly
(g) Six (6) out of 19 DHCs are monitored
(h) Six (6) DHCs and MCH/FP Center prepare reports on data analysis
(i) Six (6) DHCs feed back information to their CHCs

Output 6 is mostly achieved, with the system of recording, summarizing and reporting health information has been computerized and upgraded, and significant improvement is made in the capability of HMIS personnel in all the districts.

Project had made a significant accomplishment in improving the competency of HMIS staff at the Provincial and District levels to the extent that all of them are conversant in computerized reporting, as well as in advising lower levels for data recording, summarizing and reporting. The district staff has now been acting as trainers of the CHC staff on the use of the new recording format.

However, the feedback mechanism from the upper level staff to the DHCs and to Communes largely remained corrections of erratic or erroneous data entries. One of the factors attributed to as the low quality of data is the complex and numerous data that the CHC staff has to compile and the lack of appreciation among the CHC staff of the importance of data collection.

Analysis of statistical data and utilization of such analyses to provide useful feedback to improve service deliveries through the monitoring visits are challenges to be continuously tackled in the future. Furthermore, the urgent need to attend to data management and recording at the commune level has been identified through the Final Assessment by the Population Council, as they are the primary data collection units for the Overall health statistical report as well the MCH/FP statistical software and affect the quality of information of the whole province. Indicators that support the achievements mentioned above are given in the following.

Improvement in HMIS software system: The MCH/FP Statistical Reporting Software that JICA expert developed based on the existing paper-based reporting formats and compatible with the Overall Statistical Reporting Software, has been adopted by all 19 DHCs and MCH/FP Center. The RH Department of the Ministry of Health recognized the usefulness of the MCH/FP software, and has a plan to apply the MCH/FP statistical reporting software in all the provinces in Vietnam. The operation of the Hospital-based software at the three DHCs has also started.

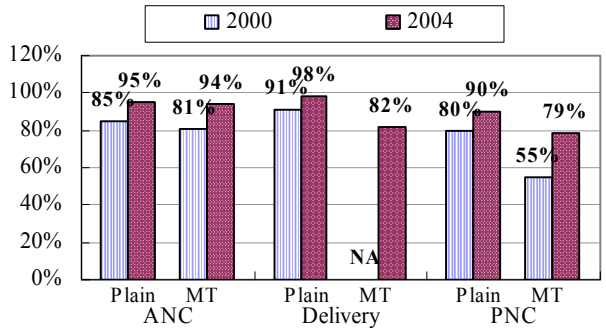
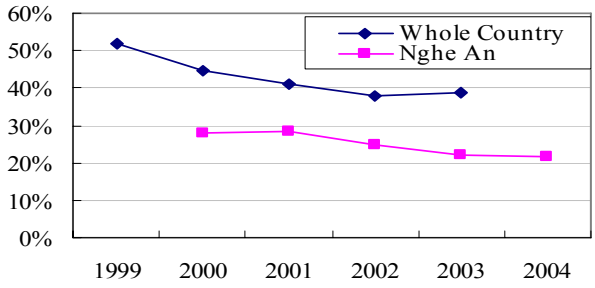
Improvement in the Hardware related to HMIS: The computer with necessary accessories and/or server computer have been provided to the PHS, MCH/FP Center and 19 DHCs based on the HMIS activities conducted at each institution and utilized properly. The setting up of the server system completed for the 3 DHCs, which will enhance feedbacks between the province and districts.

Capability of HMIS staff: The skill and knowledge of the two staff members at PHS have been improving and the on-the-job training is continuously provided. The staff in charge of statistics at 19 DHCs is now able to pay attention to the data quality. The capacity of the officer at the MCH/FP Center in charge of statistics has also increased through relevant training. The DHCs staff, after attending TOT workshop, independently organized training for the CHC staff on how to fill the new recording format. A total of 1,027 CHC staff participated in the training classes.

Utilization of HMIS data: The utilization of data that are useful for other project activities has started. The number of the selected DHC staff in charge of statistics who can check the data against errors is also increasing. The DHC staff's awareness towards the data quality is increasing. The computer with necessary accessories and/or server computer have been provided to the PHS, MCH/FP Center and 19 DHCs based on the HMIS activities conducted at each institution and utilized properly.

1.4 Project Purpose

Project Purpose: Reproductive health service in Nghe An Province is improved.

Verifiable Indicators	Results (as of June 2005)
(a) Quality prenatal care services are provided to 80% of pregnant women in plains area and 40% in mountainous area.	 **Diagram 1-9: Women receiving Quality ANC, Delivery & PNC in Nghe An Province (2000/2005)[7]**
(b) Quality delivery care services are provided to 80% of pregnant women in plains area and 40% in mountainous area.	
(c) Quality postnatal care services are provided to 80% of pregnant women in plains area and 30% in mountainous area.	
(d) 80% of CHCs in plains area and 30% in mountainous area are certified by Provincial Health Services and MCH/FP Center along with National Strategy on RH.	The number of CHCs certified to have cleared the high standards set by the National Strategy on Reproductive Health Care is only 40 out of 469 (8.5%).
(e) 80% of CHC provide client friendly RH service (trained personnel, quality facility/ equipment and stable supply)	**Facility (2005)** / **MT areas** / **Plains areas** CHCs w/ safe delivery rooms / 76% / 94% **Equipment** / **2001** / **2005** CHC w/ clean delivery kits / 25% / 49% CHC w/ iron tablets / 47% / 65%
(f) Rate of induced abortion including MR: 24%	 **Diagram 1-10: Abortion Ratio in Nghe An Province**

Source: Final Assessment, Population Council, June 2005; Data Table Prepared by the RH Project Office, June 2005

The reproductive health services in Nghe An Province have improved significantly, through Project's interventions to human resource development, upgrading of physical structure of CHCs and equipment provision for prenatal and delivery services.

[7] Quality of Prenatal Care: % of pregnant women receiving more than 3-time ANC services (RH Project, June 2005); Quality Delivery Service: % of assisted delivery by trained personnel (Population Council, June 2005) Quality of Postnatal Care: % of mothers and children received at least one post natal visit (RH Project, June 2005)

Improvements were visible and tangible in both plains and mountainous areas, although the level of achievement is still limited in mountainous areas. Some areas, such as the maintenance of facility/equipment/supplies, require further progress. Indicators that support such betterment are described below.

Quality Prenatal Service: The percentage of the CHCs that had adopted and utilized HBMR was 95.3% in non-mountainous areas and 94.2 % in mountainous areas in 2004. The HBMR is available at practically all the CHCs, and all pregnant women are provided with them. The HBMR was sufficiently and correctly recorded at 92 % of CHCs at mountainous and 97% of non-mountainous CHCs (Population Council, 2001:2005). Furthermore, the average number of pre-natal check ups among pregnant women increased from 3.0 times in 1999 to 3.3 in 2004 in non-mountainous areas, and from 2.2 times to 2.8 times in mountainous areas (MCH/FP Statistical Report).

Quality Delivery care services: Nearly 97% of deliveries in non-mountainous area took place at health institution in 2004, and in mountainous area, 72.5%. These levels are clearly improved over 2001. Percentage of deliveries assisted by trained personnel increased from 91% (2001) to 98% (2005) in plains areas, but remained 82% in mountainous areas in 2005. Utilization of the Partograph has greatly increased, with the utilization rate among health staff at CHC being 60.3% in 2001, and 98% in 2005.

Quality Post-natal care services: Percentage of mother and newborn received at least one home visit by health workers increased from 66.4% in 2000 to 85.4% in 2004.

Client Friendly Services at CHCs: The provision of trained personnel, quality facility and equipment and stable supply of CHCs relating to RH services has improved at the commune level. For communes in 10 mountainous districts where delivery at health facilities are not practicable, hamlet health workers (HHWs) have been trained in safe delivery. The population per obstetrical (midwifery) staff at CHC per population in 1999 was 10,340 in whole Nghe An, 13,097 in non-mountainous area, 7,564 in mountainous area. In 2003, it was 6,289 in the whole Nghe An, 7,494 in non-mountainous area, and 5,022 in mountainous area. The percentage of CHCs with a separate delivery room is higher in 2005 than in 2001 (86% compared with 59%). The percentage of CHCs with delivery rooms that met infection prevention and safety standards is also higher than 2001 figures, although there is still a significant difference between CHCs in mountainous areas (76%) from those in the plains areas (94%). Furthermore, the percentage of CHCs with clean delivery kits and iron tablets increased significantly (49% with clean delivery kits and 65% provide iron tablets for pregnant women, in comparison with 25% and 47% respectively in 2001).

At the same time, the average number of visits to CHC per person was 0.3 times a year in 1999 in both mountainous and non-mountainous areas, but increased to 0.5 times a year in 2003 for both areas, indicating that the services at CHC have been uplifted, hence more clients visited the CHCs.

Reduction of Abortion rate: The abortion ratio in Nghe An Province showed decline over

five years, from 27.9% in 2000 to 21.6% in 2004, which is lower than the national benchmark (target) 25% for 2010 (See Diagram 1-10). However, the figure does not include abortion cases conducted in private sector.

Areas that require further progress include bringing up the quality of services in mountainous and poverty-stricken areas and maintaining current standards through continuation of supportive monitoring.

Additional indicators are shown in the **ANNEX XI.**

1.5 Overall Goal

Overall Goal: Reproductive health of women in reproductive age is improved in Nghe An Province.

OVIs for Overall Goal:	Results (as of June 2005)					
	Target	2000	2001	2002	2003	2004
(a) Total Fertility Rate	2.0	2.8	2.8	2.6	2.4	2.6
(b) Maternal Mortality Ratio	70	42.9	19.2	23.8	25.0	11.6
(c) Infant Mortality Rate	25	9.3	9.0	8.7	7.2	n/a
(d) Peri-natal Mortality Rate	18	10.9	9.6	9.5	9.2	10.6
(e) Low Birth Rate (below 2500g)	6%	5.2%	4.2%	5.2%	3.2%	4.9%
(f) Modern CPR	70%	67.6%	71.9%	73.1%	80.6%	80.8%
(g) Provincial RH work plan		n/a	n/a	n/a	n/a	n/a

The Joint Evaluation Team has reviewed the current achievement level of the Overall Goal in terms of the OVIs and has confirmed overall improvement and accomplishment of the target level in the indicators, except the Total Fertility Rate (TFR) and the Peri-natal Mortality Rate.

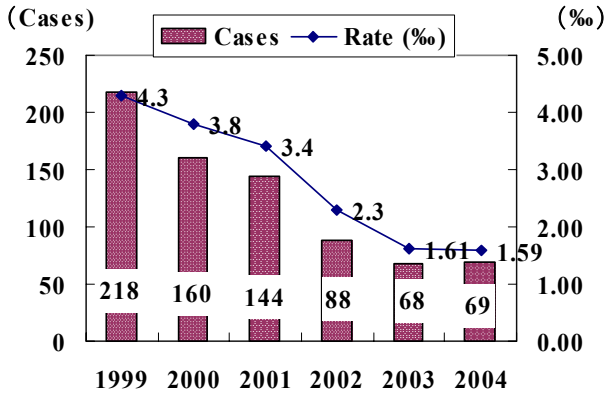


Diagram 1-11: Obstetrics Complications in Nghe An Province (1999-2005)

Furthermore, the number and the rate of obstetrics complications in Nghe An Province has shown steady and significant decrease over the last five years, indicating the improved quality of prenatal and delivery services (See Diagram 1-11). The Project interventions have contributed to the improvement in these OVIs. It should also be noted that the target of these OVIs had been set at the level lower than what had already been achieved in 2000.

General decrease is observed for maternal mortality rate (MMR), infant mortality rate

(IMR), and Peri-natal Mortality Rate, although a one-time increase was observed in MMR in 2003 and Peri-natal Mortality Rate went up again in 2004. Although the figure reported as MMR are often considered to be unreliable, the number of cases reported directly from the commune level shows clear decline of the maternal and infant death cases in Nghe An Province. For the proportion of babies born below the weight of 2,500g, the trend is the rate has decreased drastically in 2003 from 5.2 to 3.2 but increased slightly again to 4.9 in 2004.

Despite the increase in modern contraceptive prevalence rate (CPR), the TFR has increased in 2004. This is also observed for the national level, and may be explained by various interpretations of the Ordinance on Population (enforced from May 1, 2003), which might have led the people to believe that the government had de-regulated the policy of encouraging small number of children. This contradictory trend of indicators, namely, CPRs, the number of abortions including MRs and TFR, need to be further monitored and studied for possible policy and program implications.

For additional diagrams and tables of other indicators, please see Annex Ⅺ.

The above data and the present condition of Nghe An Province show that the RH of women in RH age in Nghe An Province will have prospect to keep improving further. Moreover, the Counterpart agencies in Nghe An Province have strong commitment and express their will to continue the RH promotion utilizing the experiences and learning gained through the Project.

2. Implementation Process of the Project

Despite the multiple responsibilities that the Counterparts had to cope with and the language barriers, Vietnamese and Japanese sides were able to collaborate closely and effectively, and almost all activities were carried out on schedule. Increased program management capacity, the sense of ownership of the Counterparts (C/Ps) as well as mutual trust that have evolved during the implementation of Phase I has been solidified in this Phase, and helped overcome the difficulties encountered during implementation. The Project has benefited from the start from the high level of ownership by the Vietnamese side, which had been further fostered by the Japanese Experts who had been a driving force for the undertaking. With the increasing understanding among the leaders that the Vietnamese side would have to take over the undertaking at the completion of JICA's supports to this Phase, it seems that the moving force of the Project implementation has gradually shifted from Japanese Experts towards the Project Steering Committee and other core stakeholders, particularly the MCH/FP Center.

One of the contributing factors to the high level of ownership and shared managerial responsibilities is the fact that the establishment of the Steering Committee, a local management structure with participation of the concerned organizations, was embedded in the project design, and the Project has made purposeful and sufficient provisions, in terms of Inputs and Activities, to strengthen this component.

The Project team, both Japanese and Vietnamese sides, understood and shared the Project objectives as stipulated in PDM, and the Project activities have been carried out in accordance with the implementation plan formulated from the PDM. The implementation plan of the Project was reviewed regularly, and the PDM was revised three times: twice at the time of Project Consultation Missions (August 2001; August 2002) and once at the time of the Mid-term Evaluation Mission (August 2003). These modifications were mostly appropriate as they reflected changes and/or unforeseen priorities and for furthered clarity and specification. However, the Project management did note 1) difficulty in interpreting and following the PDM itself, which evolved into a rather complex and detailed structure over time, and 2) strenuousness in collecting all the OVIs enlisted in Outputs level (7 for Overall Goal, 6 for Project Purpose, and 49 for all 7 Outputs).

3. Evaluation by Five Criteria

3.1 Relevance

Relevance of the Project is very high. The Overall Goal and the Project Purpose are coherent with the Vietnamese policy, including *the National Strategy on Reproductive Health Care (2001~2010),* and the Japanese Country Assistance Program to Vietnam. It is also designed to meet the reproductive health care needs of the Nghe An people. The Project's approach to focus on the commune and grassroots levels and to involve political and social organizations has secured its responsiveness to the needs of the beneficiaries and furthered its coherence with the local agenda. Nevertheless, due to the limited geographical access to some mountainous areas, the Project focused intensive activities under some components to limited intervention areas.

3.1.1 Consistency with Vietnamese government's policy

The Overall Goal and the Project Purpose are in line with the Vietnamese health policies and strategies, some of which are enlisted below:

(a) Strategy for Protection and Care of the People's Health 2001-2010

(b) National Strategy for Reproductive Health Care in the 2000-2010 period

(c) National Standards and Guidelines for Reproductive Health Care Services (2003)

(d) National Plan on Safe Motherhood in Vietnam 2003-2010 in implementation of National Strategy on Reproductive Health Care

(e) National Population Strategy 2001-2010

(f) Strategy on Behavior Change Communication in Population, Reproductive Health and Family Planning for 2001-2005

(g) Ordinance on Population (enforced from May 1, 2003)

The project also reaffirms Vietnam's commitment to the international agreements, such as:

(a) The United Nations Millennium Development Goal, and,

(b) The Plan of Action: International Conference on Population and Development (ICPD).

3.1.2 Consistency with Japanese Country Assistance Program to Vietnam

The Project is in line with the Country Assistance Program to Vietnam, which places importance on reproductive health and on the strengthening of primary health care. The Country Assistance Program to Vietnam adopted in April 2004[8] established three pillars of assistance areas: 1) promotion of growth; 2) improvement of living and social conditions; and, 3) institutional improvement. Assistance to the health sector is under the second pillar, "improvement of living and social conditions," in which reproductive health was highlighted as focused sub-sector for assistance.

3.1.3 Consistency with the needs of target groups

Project has been very responsive to the needs of the target groups, both women in reproductive age and the health staff. At the inception to the Phase I, health-related indicators in Nghe An Province were mostly below the national average, and service provision system were rather weak: majority of the midwives at CHCs had less educational and practical background; many CHC facilities were deteriorated; and few equipment was available. The quality of service at the CHC levels were very low, and the rate of home delivery was very high, with 40%~80% in plains areas and almost 100% in mountainous and poverty-stricken areas[9]. To address such issues, the Project provided much needed material and technical supports to the communes and grass-roots levels.

The Project's intention to involve key political and administrative organizations at provincial and below levels as well as at central level for advocacy purposes, and to establish a mechanism to obtain continuous feedback from the beneficiaries through social organizations have contributed to increase relevance of the Project interventions.

As for the appropriateness of selection of the target areas, Project's approach to cover the whole province and at the same time to select intensive intervention areas for some pilot components can be considered pragmatic, although it left out some Districts from benefits of the MR/abortion reduction[10], RTI prevention[11] and some part of HMIS activities[12].

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[8] Country specific assistance strategy was reviewed, revised and adopted in April 2004 by all the three Japanese ODA representations, namely, the Japanese Embassy in Vietnam, the JBIC Vietnam Office, the JICA Vietnam Office joined by the JETRO Vietnam Office. In the past, four apparatus used to produce their own assistance strategy/plan in reference to the ones produced by the Embassy.

[9] "Report from the Field Prepared by the RH Project Office in Nghe An," June 2005

[10] Project Activities relating to the reduction of MR/Abortion were incorporated into three (3) DHCs (Nghia Dan, Yen Thanh and Thanh Chuong) and MCH/FP Center.

[11] RTI prevention activities were piloted in 10 communes in three districts (Cua Lo, Nghi Loc and Nam Dan).

[12] All 19 districts have benefited from provision of equipment, comprehensive computer training, introduction of the Overall Health Statistical Reporting Software and the MCH/FP Statistical Reporting Software. Training on data analysis has targeted only six (6) districts, as it required not only the computer proficiency but also a certain level of statistical background.

3.2 Effectiveness

Effectiveness of the Project was very high, but with varied extent of results in mountainous and plains areas.

3.2.1 Achievement of Project Purpose

In general, reproductive health care services have become more convenient and accessible to clients than five years ago, and clients are satisfied with the services. The effectiveness of the Japanese contribution in terms of facilities upgrade and equipment/logistics provision; technical assistance; and human resource development to the reproductive health program in Nghe An Province was very high. The fundamental factors of the achievement are the "readiness" or "package" approach, which is composed of technical assistance by Japanese Experts; re-training of health staff at the commune level; facility improvement; and, equipment/logistics provision, as well as the high competency of the provincial MCH/FP Center that can promote quality reproductive health care.

Challenges remain in developing ways to further improve the access to quality services by the residents in remote and mountainous areas.

3.2.2 Contribution of Project Outputs to the Project Purpose

The Project design suggests that the seven Outputs are to compliment each other, especially the IEC component (Output 5) and HMIS component (Output 6) being supporting services for the improvement of service delivery (Output 1, 2, 3 and 4). Monitoring component (Output 2) is also to support service delivery under other Outputs.

Outputs contributed to the achievement of the Project Purpose to varying extents. Establishment of the coordinating mechanism (Output 0) underpins the whole interventions, and has been instrumental in bringing up and maintaining the RH agendas high in both medical and social institutions. Output 1 has been the core component of the Project, and thus its high level of achievement greatly contributed to the quality service provisions and improvement of access. The monitoring component (Output 2) has contributed to ensuring the continuity of the good results in Output 1, through regular technical supports and troubleshooting to CHC levels. Activities under abortion and RTI prevention/reduction (Outputs 3 and 4) led to the formulation of strategies and thus greatly raised the awareness of the issues among Steering Committee members and those reached by IEC interventions. Nevertheless, a link between abortion and RTI prevention/reduction activities to the promotion of safe and hygienic delivery services seemed not to be at the desired level. On the other hand, IEC activities are considered to have boosted other Outputs relating to service delivery. Not only did it disseminate correct and motivational information enabling people to protect their own reproductive health, but it also enhanced the interest and support of the community (including health personnel) for high quality reproductive health service. Finally, the extent to which the strengthened data recording and reporting system (Output 6) has assisted quality monitoring and planning to better suit the given situation needs further improvement.

3.2.3 Analysis of the promoting and inhibiting factors

(a) Promoting factors

The following are identified as promoting factors:

(a) The experience of Phase I had built confidence and strong sense of ownership amongst the Vietnamese counterparts;

(b) Political commitment of Vietnamese Counterparts has been very high since the inception of the Project;

(c) Existence of highly effective coordinating mechanism that mobilized concerned organizations at provincial, district and commune levels;

(d) Existence of strong community networks, such as the Women's Union, allowed systematic dissemination of skills and knowledge directly to the target population;

(e) Several personnel from one organization participated in the Counterpart training, hence creating a shared vision within the organization. Such supportive environment facilitated them to adopt their newly acquire skills/knowledge in their work;

(f) Strong teamwork and mutual respect among the Vietnamese Counterparts and the Japanese Experts has contributed significantly to the successful implementation of the Project; and,

(g) Diligence of Nghe An people in general, and those involved in the Project in particular, who showed strong interest in adopting new ideas in their own context, and who favors systematic and specific methods in operations.

(b) Inhibiting factors

The following are identified as inhibiting factors:

(a) Physical accessibility to health facilities in mountainous and remote areas;

(b) Cultural and religious beliefs that counteract the promotion of the reproductive health;

(c) Limited basic knowledge on health among people, especially those living in remote areas; and,

(d) Limited financial resources.

3.3 Efficiency

The efficiency of the Project is very high, as the Inputs to the Project are considered appropriate in terms of their quality, quantity, and mostly timing. Competency levels, areas of expertise and the number of Japanese Experts are considered to be appropriate. There have been occasional delays or inadequacies in timing of the visits by some Short-term Experts, the assignment of Counterpart Personnel, some of the equipment, and disbursement of the local costs incurred by Vietnamese side. This, however, did not adversely affect obtainment of results, and most of the Inputs had been rationally utilized to produce Outputs efficiently.

Factors that increased the level of efficiency include: 1) involvement and mobilization of relevant stakeholders at commune, district and provincial levels which enabled coordination; 2) the "package approach[13]" that facilitated the "readiness" of a health facility to provide services; 3) monitoring of CHCs that promoted the maximum utilization of Inputs; and, 4) Project's principle of local procurement in Nghe An or national procurement in Vietnam. Furthermore, the Project's community-focused approach, i.e. investing bulk of its resources (71%) in the commune and grass-roots levels, definitely reinforced the efficiency to convey the benefits created by the project to the ultimate beneficiary.

On the other hand, factors that reduced the efficiency include: 1) difficulties in access in mountainous communes; and, 2) transferring of well-motivated and skilled Counterparts to other departments/organizations.

Accounts on individual component are given below.

3.3.1 Dispatch of experts

In terms of cost effectiveness, the perceived good performance of Project's Long-term Experts offsets relatively high costs of placing the Long-term Experts. They not only provided their technical expertise, but also made contributions towards assuring efficiency through: 1) timely and on-site responses to given conditions, 2) selection of the most appropriate Inputs based on first-hand knowledge; 3) facilitation of the preparation and follow-up activities for the Counterpart training and for the visits by the Short-term Experts; and, 4) developing mutual trusts with the Counterparts. Furthermore, their devotion to RH issues and diligence, demonstrated to those who work closely with them, seems to have furthered the motivation level of Counterparts, and brought about a significant change in working behavior of the Project-related organizations. They were also instrumental in linking the concerned central and the provincial organizations, and transmitting the good practices in Nghe An Province not only to the central government but also to other provinces as well.

Dispatching of the same Short-term Experts seems to have contributed not only to the smooth transfer of technical knowledge/skills to their Counterparts but also to building

[13] "Package approach" refers to the comprehensive provision of 1) facility upgrade, 2) re-training of health staff, and 3) equipment/logistics provision at CHC level.

mutual trust between Experts and Counterparts.

3.3.2 C/P training in Japan

The contents of the C/P training in Japan are considered to be relevant, practical and useful. The Project has made conscious efforts so that those who attended Counterpart training shared their knowledge and experiences with their colleagues and subsequently applied the knowledge and skills gained through the training to their work. According to the interviews with the Counterparts, the training in Japan is excellent not only to gain specific skills/knowledge, but also stimulate/enhance the motivation level of the participants by exposing them to a real-life model that stimulates their perspectives.

The language barrier inhibited the Project from sending the Counterparts to existing international courses operated by JICA, and forced to organize a customized Vietnamese-speaking course for Counterparts as a group. This arrangement, however, worked to their advantage in that the group members assisted one another while learning abroad and worked as a group in drafting reports and formulating action plans. This facilitated collaboration among them and cultivated stronger team spirit.

3.3.3 Provision of Equipment

The amount and quality of equipment provided through the Project was appropriate. The equipments for essential obstetric care were based on "specific demands," carefully examined through a small survey. It is also in line with the standard equipment list recommended by the Ministry of Health.

3.3.4 Operational cost

The Project's operational cost was efficiently utilized to carry out the implementation of all activities.

3.3.5 Mobilization of non-Project resources

JICA's technical assistance covered provision of basic RH equipment to all the CHCs in Nghe An Province, but did not finance the renovation of the toilet facilities and the delivery room. In order to fill this gap, the Project has mobilized the GAGRP fund, which financed facility upgrading of 116 CHCs in 2001 as well as 88 CHCs in 2004. Thus the RH Project has covered all the 469 CHCs combined with the ones covered in the Phase I Project. This has significantly increased "readiness" of providing quality services at CHCs.

3.3.6 Land, buildings and facilities at the Project sites

Required facilities were provided appropriately and in timely manner.

3.3.7 Allocation of Counterparts

Out of 26 Counterparts who were originally assigned, 8 have left the Project for retirement, higher education or assignment to another post. However, their successors were assigned without much delay, minimizing the loss from this attrition.

3.3.8 Administrative and experimental expenses and activities

The Vietnamese side has shown great commitment to the Project, but it has yet to be fully

substantiated in terms of the financial contribution to the Project. The amount contributed was 1.8% of the Japanese contribution, less than the target of 3%.

3.4 Impact

The Project interventions appeared to have contributed to the improvement of the reproductive health of women in Nghe An Province. This is reflected in the reduction of maternal mortality rate, obstetrics complications, infant mortality rate, and number of abortions including menstrual regulations, as well as the increased contraceptive prevalence rate. Key components of the Project, such as the facility improvement, equipment/logistics provision and re-training of health service providers, facilitated an increase of awareness and knowledge which brought about significant behavior change not only by service providers but also clients. The Project has demonstrated a very good example of organizing reproductive health programs for other provinces. Experiences of the Project have also contributed to the formulation of *the National Strategy on Reproductive Health Care (2001~2010).*

In addition, the Project made the following contributions:

(a) The MCH/FP Center invested its own resources in the upgrading of the facility to improve client friendliness, such as setting up shades/benches at the waiting areas, allocating spacious areas for counseling, and improving transparency of their operations through notice boards;

(b) Through the involvement of the key organizations for social mobilization activities concerning the reproductive health issues, momentum is created where those involved recognized how the "socialization" of health issues can be substantiated. The Women's Union played a key role;

(c) The usefulness of the HMIS software (MCH/FP software) developed in Nghe An by the Project Expert has been recognized by the RH Department in the Central Ministry of Health. It is planned to be replicated in other Provinces by the Department;

(d) Status of the laboratory section has increased through engagement in RTI surveys in districts and in treatment service at the MCH/FP Center; and,

(e) Through continuous working contacts with Japanese Experts, some Counterparts observed that a change in the ways of working was brought to the participating organizations.

No major negative impacts were observed. Some staff relocation had to be done for HMIS staff that may have given some ill feelings to those relocated and those who had to persuade them.

Factors that have promoted the impact include: 1) political commitment of the leaders that had been sensitized and continuously involved in PSC, DSC and CSC activities; 2) Project's effort to voice the Nghe An experiences to the central Ministry and donor meetings; and, 3) relevance of the approaches/contents of the Project

Factors that have limited the impact of the Project include: 1) local residents' limited educational level, 2) ingrained traditional beliefs such as son preference and 3) certain religious values that contradict the promotion of family planning and securing the rights to abortion.

3.5 Sustainability

Overall sustainability of the Project is quite high. Much institutional competency has been developed over the five years particularly at the MCH/FP Center with solid technical expertise among most of the staff and, more importantly, with motivation to develop further to pursuit their own mission to serve the beneficiaries better. A strong sense of ownership, especially at the grass-roots level, has also been generated to sustain the Project activities. A high-level commitment among the local political and social leaders is secured for continuing the Project's Steering Committees in the future and for working in the area of reproductive health. Hence, it is likely to promote allocation of financial resources to essential activities relating to reproductive health to sustain not only the results produced by the Project, but also to further related efforts.

3.5.1 Institutional Aspects

The Project management system established by the inter-sectoral partnership among the four organizations (the People's Committee, the Provincial Health Services (including MCH/FP Center), the Women's Union, and the Committee on Population, Family and Children) has proven to be effective. The Joint Committee and the Steering Committees have truly been the driving force of the Project and excised their capacity as decision-making bodies. The heads of each organization acknowledges the benefit of such partnership as being effective and instrumental in reaching whom they needed to reach and have shown the intention to continue working as a team in the future.

3.5.2 Technical Aspects

Capacity to sustain and further develop institutional competency is very high, which is partially attributable to the Project's focus on training activities. Notably, the level and depth of utilization and the capacity to transfer skills/knowledge have been very high, because of the willingness of Counterparts to adopt new ideas and methods. HMIS staff requires further technical improvement for the maintenance of aggregation software.

MCH/FP Center staffs, as well as district monitoring teams, have recognized the importance of continuous capacity building through organizing refresher training as well as supportive monitoring activities.

Factors that have contributed to furthering sustainability include:

(a) Involvement of key political and social organizations that internalized the RH agenda upon receipt of the related information;

(b) "Cycle management", a mechanism for continuous improvement through regular supportive monitoring, ensures application of learned skills and techniques as well as sustains the level

of technical skills of medical professionals;

(c) Gradual capacity development of MCH/FP Center;

(d) Pragmatic approach to improve the existing institutional arrangement to deliver better RH services; and,

(e) Dedication and commitment of local leaders and the MCH/FP Center staff.

Factors that limited the level of sustainability include: difficulties in securing budget to finance training and monitoring activities and the challenge of changing the attitudes of more health professionals to be motivated and action-oriented.

3.5.3 Financial Aspects

Although financial resources are limited, it is confirmed that promotion of activities leading to RH improvement is considered as one of the priority issues in Nghe An and in Vietnam in general. Therefore, it is likely that adequate financial resources would be mobilized in order to continue the activities.

V. CONCLUSION

The overall performance of the Project is excellent. Considering the very difficult geographical and economic conditions and limited resources, the achievement level of six Project Outputs, namely, safe and hygienic delivery, monitoring, abortion reduction, reproductive tract infections (RTI) treatment, IEC activities and Health Management Information System (HMIS) improvement, is highly commendable.

The Project generated extraordinary political commitment and support to sustain the expanded reproductive health activities from all the sectors in Nghe An. It has also demonstrated a useful model for other provinces for the improvement of reproductive health. It facilitated participation of various social organizations and individuals, especially at the grass-roots level, to provide better reproductive health services to women particularly in Nghe An Province. The Joint Evaluation Team observes that the JICA Reproductive Health Project in Nghe An is a highly effective model not only for improved reproductive health services but also for the social and economic development of Vietnam. The administrative systems and practices adopted by the Project, drawn from the Counterpart training in Japan and from working with Japanese Short-term and Long-term Experts, contributed to the improvement of the management of the MCH/FP Center but also served as a useful model for other departments of Nghe An Province as well as the other MCH/FP Centers in Vietnam. This Project has accomplished much more than the original objectives of the Project design within the set duration. The Joint Evaluation Team firmly believes that the experiences gained through the Project should be further utilized for the reproductive health program in Nghe An Province as well as in Vietnam.

The Joint Evaluation Team finds that one critical challenge for the reproductive health program in Nghe An is to make further efforts to bring to the mountainous areas the benefits the Project was able to provide for other parts of the Province.

The Joint Evaluation Team reaffirms that reproductive health includes a number of inter-dependent components. Therefore, it is necessary to integrate such components as pre-natal care, contraception, and RTI treatment, to produce desired results of protecting women's health, one of which is the reduction of incidence of abortions. Further integration of the different Outputs through the Project has produced better results under the strong political commitment of Nghe An Province.

In order to share the experiences of Nghe An Province with other Provinces, the Joint Evaluation Team supports the "Project for capacity building for dissemination of community-based reproductive health promotion" and reaffirms the usefulness of the Reproductive Health Care Canter for further improvement of reproductive health of Vietnamese people. The Joint Evaluation Team is also convinced that the Center can serve to facilitate the south-south cooperation between Vietnam and its neighboring countries, especially in terms of human resource development in reproductive health.

The Joint Evaluation Team also acknowledges with appreciation the genuine and strong mutual trust between Vietnamese and Japanese nurtured by the Project as one of the most important impacts.

VI. RECOMMENDATIONS AND LESSONS LEARNED

1. Recommendations

Acknowledging highly successful implementation of the Project, which produced significant results; the Joint Evaluation Team suggests the following recommendations for further progress to be made by the reproductive health programs in Nghe An Province in particular, and Vietnam in general.

1.1 Recommendations for the Project

1.1.1 Safe and hygienic delivery

(a) The District Steering Committees (DSC) and Commune Steering Committees (CSC) need to ensure that all deliveries at Commune Health Centers (CHCs) are safe and hygienic, by effective deployment of trained health staff, and that necessary facilities and equipment be properly maintained.

(b) The DSCs and CSCs need to provide continuous financial and technical support to trained health staff (hamlet health workers and midwives) especially in terms of supportive monitoring and re-training in order to ensure that all home deliveries are safe and hygienic, particularly in mountainous and remote areas.

(c) With the leadership and technical advice of the MCH/FP Center, DSCs and CSCs should provide necessary support for health staff so that they can make at least the second home visit to improve post-natal care.

(d) DSCs and CSCs, through Women Union and other social organizations, should encourage more male participation for women's reproductive health.

(e) In the future, Nghe An Provincial Health Service should assign CHCs to provide reproductive health services in accordance with the Decision No. 385 issued by the Ministry of Health.

1.1.2 Monitoring

(a) The MCH/FP Center needs to continue training on monitoring objectives and skills to provide appropriate feedback.

(b) DSCs and CSCs should ensure better participation of concerned monitoring team members.

(c) DSCs and CSCs need to ensure sufficient financial and technical support to monitoring activities.

(d) DSCs should consider use of monthly and quarterly meetings to supplement monitoring activities.

(e) The MCH/FP Center needs to utilize to a greater extent the HMIS data and its analysis to support monitoring activities.

1.1.3 Reduction of abortions

(a) PSC, DSCs, CSCs, and other concerned social organizations need to reconfirm the close linkage between contraceptive acceptance and abortion reduction for the promotion of women's reproductive health.

(b) The MCH/FP Center need to upgrade the re-training contents so that the health staff provide the clients with counseling on FP/abortion in all the reproductive health care services, including pre-natal, post-natal and RTI services.

(c) Health staff and FP collaborators should emphasize in counseling the benefits of modern contraceptives to avoid unexpected or unwanted pregnancy rather than overly focusing on abortion risks.

(d) PSC, DSCs, CSCs and other concerned social organizations may pay further attention to adolescent and youth reproductive health issues and develop an appropriate program for them.

1.1.4 RTI detection and treatment

(a) The MCH/FP Center needs to maintain provision of quality RTI services by the Center and DHCs with technical advice by other health institutions, such as the Provincial and Tu Du Hospitals.

(b) PSC, DSCs and CSCs need to strengthen health education on the prevention of RTIs.

1.1.5 IEC activities

(a) The Women Union (WU) and other social organizations need to continue emphasizing information on where and when quality reproductive health services, including family planning, are available, and how to obtain such services.

(b) In mountainous areas, DSCs, CSCs and other social organizations should make use of local and traditional events to provide RH education and services for residents.

(c) The MCH/FP Center in collaboration with the Provincial WU and Provincial Committee for Population, Family and Children (PCPFC), is encouraged to continue supporting the training of commune- and hamlet-level workers including the CHC staff, the WU members, the FP collaborators and the hamlet health workers to improve their IEC activities on reproductive health.

(d) The MCH/FP Center also needs to review and improve the content of IEC activities to further protect women's reproductive health.

1.1.6 HMIS management

(a) The MCH/FP Center under the guidance of the Provincial Health Service and DHCs needs to organize additional training for both district and commune levels to ensure

the quality of HMIS data (Overall health statistical reporting software and MCH/FP statistical reporting software).

(b) The MCH/FP Center should establish a closer link between HMIS and monitoring of the reproductive health care services, especially at the CHC level. For example, the MCH/FP Center and DHCs can provide analysis of data to CHCs to strengthen RH services.

1.2 Recommendations for sharing experiences with other Provinces

(a) In view of the substantial results attained by the Project in Nghe An Province, the Joint Evaluation Team reaffirms the observation made by the Mid-term Evaluation Mission (August 29, 2003) that it is useful to establish the Reproductive Health Care Center as a national model to sustain the activities of the Project after its completion and to disseminate the experiences of the Project to other provinces as well.

(b) For the upcoming three-year technical assistance project, concerned implementing organizations are recommended to ensure its smooth and effective execution.

(c) The concerned government offices are recommended to expedite application of the MCH/FP statistical reporting software.

(d) PSC needs to establish an institutional memory for future reference by compiling and storing the key training manuals and IEC materials in a user-friendly format.

2. Lessons learned

The Joint Evaluation Team observed the following lessons that could be referred to by other similar projects in the future.

(a) ***The strong sense of ownership*** of the Project among the Counterparts from the inception of the Project has contributed to Project's sustainability and further development.

(b) ***Setting up an effective managerial structure*** in the form of the Steering Committees at Provincial, District and Commune levels with the involvement of key organizations enabled effective translation of political commitment into action.

(c) ***Objective external monitoring*** adopted by the Project has assured the relevance of Project interventions and thus secured substantial results. The third-party assessments conducted by the Population Council provided reliable and practical information for reprogramming of the Project activities. The Project also integrated monitoring activities and continuous reviews within the Project, and conducted four operational studies, all of which facilitated better programming.

(d) ***Better coordinated IEC and reproductive health service*** tended to have produced more desired behavior changes.

(e) ***Investment of a "critical mass" of Experts***, i.e. a sufficient amount of human resources, at the most appropriate timing, contributed to the significant outcomes of the Project.

(f) ***A need-based, well-organized, collective Counterpart training program in Japan*** contributed not only to the effective transfer of knowledge and skills, but also to its translation into action upon return to Vietnam. It has also contributed to the formation of teamwork among participants.

(g) ***"Readiness" or "package" approach***, where three essential components including equipment/logistics provision, facility upgrade and re-training of health staff, is effective. The facility upgrade combined with improvement of technical skill of the health service providers is very effective in attracting clients to receive reproductive health services, as it provides the sense of security/confidence with the services among clients as well as that of service providers and promotes institutional delivery at CHC level. This approach was enhanced by an effective collaboration between the technical cooperation project and the grant assistant for grass-roots project.

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Project Design Matrix (PDM) Revised in 2003 at the time of Mid-term Evaluation

Project title: JICA Reproductive Health Project (Phase II)
Area : Nghe An Province (all 19 district), Vietnam
Target Group : Women in Reproductive Age (WRA) in Nghe An Provinc
Duration: Sept. 2000～Aug. 2005

Narrative Summary	Objectively Verifiable Indicator	Means of Verification	Important Assumptions
OVERALL GOAL Reproductive health of women in reproductive age is improved in Nghe An Province	Total Fertility Rate : 2.0 Maternal Mortality : 70/100,000 Infant Mortality Rate : 25/1000 Peri-natal Mortality Rate : 18/1000 Low Birth Rate (below 2500gm) : 6% Modern Contraceptive Prevelance Rate : 70% Rate of induced abortion including vacuum aspirations that used to be called menstrual regulations (MRs): 20% Provincial RH workplan formulated		
PROJECT PURPOSE **Reproductive health service in Nghe An Province is improved**	Quality prenatal care services are provided to 80% of pregnant women in plain area and 40% in mountainous area	Base line survey data and evaluation survey	*National Pop/FP program conducted in Vietnam continues as planned.
	Quality delivery care services are provided to 80% of pregnant women in plain area and 40% in mountainous area	Base line survey data and evaluation survey	
	Quality postnatal care services are provided to 80% og pregrant women in plain area and 30% in mountainous area	Base line survey data and evaluation survey	* Infertility situation is not worsen.
	80% of CHCs in plain area and 30% in moutainous area are certified by Provincial Health Service and MCH/FP Centre along with National strategy on Reproductive Health.	Base line survey data and evaluation survey, A ranking as the result of the annual inter-commune evaluation	* Adolescents' sexual behaviour will not activated than now.
	80% of CHC provide client friendly RH service (trained personnel, quality facility /equipment and stable suplied of CHC)	Base line survey data and evaluation survey	
	Induced abortion including MRs reduced by 20%		

Narrative Summary	Objectively Verifiable Indicator	Means of Verification	Important Assumptions
OUTPUTS			
0. Steering Committees (SC) at all levels are established and are functioned regularly and continuously for further integration of RH and FP services.	0.Participation rate of 1) DSC quarterly meeting, 2) CSC annual meeting, and 3) attendance at the monitoring visits	Meeting records	
	0. Staffing of District and Commune Steering Committee from 4 organizations (People's Committee, Women's Union, Health Centers and PCPFC) are continuously fulfilled and functioned for integrtion of RH and FP.	Regular reporting from SCs	
1. Safe and hygienic delivery is promoted at commune level.	1.Percentage of CHCs that organize HBMR will increase from 70% to 80% in plain area and 33% to 40% in mountainous area.	Base line survey data and evaluation survey, Report from selected DHCs	
	1. Percentage of deliveries at CHC in non-mountainous ara will be 95% and percentage of deliveries attended by trained health worker (CHC staff/trained hamlet health worker) in mountainous area will reach 60%	Base line survey data and evaluation survey, Report from selected DHCs	
	1. Number of deliveries attended by trained health personnel at hamlet level	Base line survey data and evaluation survey, Report from selected DHCs	
	1. At least 90% of health personnel trained pass the post-test.	CHC re-training course report	
	1. 80% of delivery kits and equipment at CHC are utilized, kept hygienic, and maitained properly	Base line survey data and evaluation survey, Monitoring report	
1-1 Prenatal care at commune level is improved.	1-1. Average number of pre-natal check-ups in non-mountainous districts (9 out of 19 districts) is at least 4 times	Base line survey data and evaluation survey, Report from DHC, Monitoring report	
	1-1. Number of trained CHC staff in charge of prenatal care in mountainous area	Base line survey data and evaluation survey, Report from DHC, Monitoring report	
	1-1. Number of pregnant women received T/T remains as high as 95% in non-mountainous area	Base line survey data and evaluation survey, Report from DHC, Monitoring report	
	1-1. Number of pregnant women received T/T reached as high as 70% in mountainous area	Base line survey data and evaluation survey, Report from DHC, Monitoring report	
	1-1. Number of cases of early detection of high-risk pregnancies referred to DHCs	Base line survey data and evaluation survey, Report from DHC, Monitoring report	
	1-1. The mean gestational age for the first prenatal check-up in non-mountainous area	Base line survey data and evaluation survey, Report from DHC, Monitoring report	
	1-1. The coverage of topics of prenatal guidance and counseling	Base line survey data and evaluation survey, Report from DHC, Monitoring report	

Narrative Summary	Objectively Verifiable Indicator	Means of Verification	Important Assumptions
1-2 Delivery Care at commune level is improved.	1-2. Partograph is applied more than 90% of the deliveries at CHCs in selected districts and 80% in non-mountainous area districts.	Base line survey data and evaluation survey, Report from selected DHCs	
	1-2. 90% of CHC has fulfilled the three conditions, i.e. 1) re-trained staff, 2) delivery equipment, 3) hygienic facility	Base line survey data and evaluation survey, Report from selected DHCs	
	1-2. 80% in plain area and 50% in mountainous area of trained health workers actually attend the delivery at hamlet.	Monitoring report, Training record, Base line survey data and evaluation survey	
1-3 Postnatal care at commune level is improved.	1-3. 40% of mother and newborn receive home visit by health workers with home visit kit	Base line survey data and evaluation survey, Monitoring report	
1-4 Essential medical equipment is utilized to all CHCs.	1-4 80% of CHCs utilize and maintain the medical equipment and facilities appropriately according to the creiteria set by PSC.	Base line survey data and evaluation survey, Monitoring report	
1-5 Hygienic facilities such as delivery room, latrine, well and shower room of CHCs are improved	1-5. Percentage of CHC has hygienic facilities	Base line survey data and evaluation survey, Monitoring report	
1-6 Integration of RH and FP is promoted and improved at all levels.	1-6. There is no stock-out of contraceptive methods in order to ensure the continuous and timely supply at all levels.		
2. Monitoring capacity of MCH/FP Centre and selected DHCs is improved.	2. Monitoring are conducted utilizing standardized check list according to plan	Report from selected Districts and MCH/FP Center	
	2. 90% of DHCs and CHCs receive monitoring visit by the upper level annually	Base line survey data and evaluation survey, Monitoring report	
	2. Number of staff trained on monitoring according to the monitoring standard set by MCH/FP Center.	Base line survey data and evaluation survey, Report from selected Districts and MCH/FP Center	
3. Number of abortion including MRs conducted at MCH/FP center and selected districts is reduced.	3. Number of abortions and MRs conducted in Nghe An Proivince by 700 cases or more per year	Report form MCH/FP Center and selected districts	*National Pop/FP program conducted in Vietnam continues as planned.
	3. Percentage of women of post abortion and MR at MCH/FP Center and the selected districts accepted modern contraceptive method will be 75%		
	3. Percentage of repeated abortion and MR conducted at MCH/FP Center and the selected districts reduced by 5% per year	Report form MCH/FP Center and selected districts	
	3. Number of modern contraceptive users by methods increases 2% per year	Report form PCPFC, MCH/FP Center	

Narrative Summary	Objectively Verifiable Indicator	Means of Verification	Important Assumptions
4. Capacity for RTI detection and the development of prevention strategy is improved at MCH/FP Centre	4. Situation of RTI in Nghe An province become known. 4. Strategy for prevention of RTI is developed. 4. Proper treatment method for RTI is identified.	RTI Survey report Availability of strategy Availability of proposal	
5. Quality of IEC&Motivation activities of MCH/FP Centre and the selected districts, women's union and DHCs in particular, for RH promotion aiming at behavioral change of service providers, women as well as men is improved.	5. The classes for RH education organized at MCH/FP Center twice/week and in the selected districts tiwce/month 5. There are average of at least 10 participants at the health education at MCH/FP Center and 20 participants at the selected districts 5. Number of pregnant women in Aiiku-han selected communes visit to CHC earlier for the first prenatal check-up before 12 weeks 5. At least 4 visits to CHCs for prenatal check ups in Aiiku-han selected communes. 5. Number of the visits to CHCs for prenatal check ups. 5. The coverage of topics of prenatal guidance and counseling	Report from selected Districts and MCH/FP Center Report from selected Districts and MCH/FP Center Report from selected Districts and MCH/FP Center Monitoring report Report from Women's Union Base line survey data and evaluation survey , Monitoring report Base line survey data and evaluation survey , Monitoring report Base line survey data and evaluation survey,Monitoring report	
6.1 The system of recording, summarizing and reporting health information is upgraded.	6.1 All DHCs, MCH/FP Center and PHS use computer to prepare statistical report 6.1 Three DHCs and MCH/FP Center use the new hospital-based HMIS 6.1 80% of CHCs use standardized record books and report forms	Monitroing and reports from DHC Monitroing and reports from MCH/FP Center and DHC Monitroing and reports from DHC	*National program on HMIS is developed as planned. * There will be no major change in HMIS program * There will be not major error in HIMS soft ware
6.2 Hardware related to HMIS is improved	6.2 PHS is equiped with adequate computers for HMIS training 6.2 At least 6 of 19 DHCs are quiped with adequate compters for HMIS 6.2 MCH/FP Center is equiped with adequate compters for HMIS	Monitroing and reports from PHS Monitroing and reports from DHC Monitroing and reports from MCH/FP Center	
6.3 Capability of HMIS personnel if upgraded	6.3 Comupter skills and knowledge of PHS staff increased 6.3 6 of 19 DHCs manage the new HMIS properly 6.3 MCH/FP Center manages the new HMIS properly	Create a check list and analysis of HMIS database and monitroing Create a check list and analysis of HMIS database and monitroing Create a check list and analysis of HMIS database and monitroing	
6.4 HMIS activities are assessed regularly	6.4 6 out of 19 DHCs are monitored	Report from DHC, MCH/FP Center, and PHS	
6.5 HMIS data is adequately utilized	6.5 6 DHCs and MCH/FP Center prepre reports on data analysis 6.5 6 DHCs feed back information to their CHCs	Monitoring reports Analysical report, feedback reports	

Narrative Summary	Objectively Verifiable Indicator	Means of Verification	Important Assumptions
ACTIVITIES	**INPUTS**		
For Output 0	VIETNAM:	JAPAN	
0.1 Review and define the function and responsibilities of SCs at all levels	1 Human Resource	1 Human Resource	
0.2 Review SC members in the experienced districts (8 districts)	JC, PSC, DSCs, CSCs and women's union members	1.1 Long-term experts	
0.3 Establish SC at district and commune levels in new project area (11 districts)	2 Building and facilities	Team Leader Administrative Coordinator,	
0.4 Conduct orientation of the Project to SC members of new project area	Renovation and expansion of JICA RH Project Office	Midwife Public Health Nurse	
0.5 Conduct exchange of experience among experienced districts and new districts	3 Budget	Demographer and others	
0.6 Conduct regular meeting of DSC and PSC (quarterly)	Counterpart budget for Administration	1.2 Short-term experts MCH/FP administration	
For Output 1	Middle level manpower training	RH Survey	
1.1 Retrain midwives and assistant doctor of ob/gyn	Monitoring and others	IEC	
1.2 Train hamlet health worker/TBA of mountainous districts on hygienic delivery and quality RH/FP services		Midwife Public Health Nurse	
1.3 Provide medical book for CHCs & DHCs	Expected counterpart budget of Vietnamese side is at least 3% of JICA budget with gradual increase in proportion to financial commitment	Community-based MCH promotion	
1.4 Provide all commune with IEC means and materials		Project Management	
1.5 WU carry out IEC activities on hygienic and safe delivery		Others	
1.6 Conduct preventive activities for better understanding of implications of abortion including MRs at all levels		2. Equipment	
		3. Training	
For Output 1-1		3.1 Counterpart Training in Japan 3.2 Local Training	
1.1.1 Provide pregnancy check-up means			
1.1.2 Promote pregnant women 2 tetanus vaccination		Estimated budget for 5 years	
1.1.3 Provide pregnant women with guidance & counselling services		Equipments: J.Yen 120~150 million	
1.1.4 Train women's union members to have good IEC skills to promote pregnancy check-up, utilization of HBMR, and RH/FP services		Local Training and others: J.Yen 40~60 million	
1.1.5 Train midwives at district and commune level to have good skill of using Maggie Apron		Counterpart training in Japan: 13~16 persons	
1.1.6 Provide CHC with enough Maggie apron			
1.1.7 Implement Aiiku-han model to manage pregnancy at hamlet level		The budget mentioned above is subject to change	
1.1.8 Organise RH/FP promotion classes in the selected CHCs, DHCs and MCH/FP Centre			
1.1.9 Increase the usage of pregnancy management box			
1.1.10 Make use of HBMR in all areas of Nghe An			
1.1.11 Have correct monthly data for pregnant women			
1.1.12 Refer high risk pregnant women to the upper level as soon as possible			

Narrative Summary	Objectively Verifiable Indicator	Means of Verification	Important Assumptions
For Output 1-2 1.2.1 Strengthen the capacity of MCH/FP Centre on delivery assistance skill 1.2.2 complete procedure (process) of infection control 1.2.3 Promote delivery at CHCs 1.2.4 Train on usage of partograph 1.2.5 Use partograph for deliveries at health facilities **For Output 1-3** 1.3.1 Develop manual for post-natal care 1.3.2 Train midwife or ass. doc. Ob/Pd on post-natal care 1.3.3 Train WU on post-natal care promotion 1.3.4 Provide home visiting kit for midwives and ass. doc. Ob/Pd 1.3.5 Conduct standardised post-natal care to post-delivery women within 42 days **For Output 1-4** 1.4.1 Review the existing equipment at CHCs 1.4.2 Categorise the function of CHC (mountainous, plain or city type) 1.4.3 Prepare a list of equipment 1.4.4 Provide medical equipment for CHCs according to the categories 1.4.5 Train CHC staff on usage and maintenance of the equipment **For Output 1-5** 1.5.1 Upgrade health facilities in CHCs (delivery room, shower room, latrine and well) 1.5.2 Train CHC staff on maintenance of the facilities 1.5.3 Conduct IEC/BCC training **For Output 2** 2.1 Formulate monitoring team at MCH/FP Centre and DHCs 2.2 Conduct training for monitoring teams 2.3 Develop monitoring check list 2.4 Provide means of transportation to MCH/FP Centre and DHCs			

Narrative Summary	Objectively Verifiable Indicator	Means of Verification	Important Assumptions
2.5 Develop monitoring plan at MCH/FP Centre and DHCs 2.6 Conduct monitoring according to plan 2.7 Submit the summary of monitoring findings to the Project office **For Output 3** 3.1 Access the current situation of abortion including MRs 3.2 Develop strategy to reduce of abortion including MRs 3.3 Train health staff of MCH/FP Center and DHCs on counseling skill in order to reduce abortion including MRs and to increase modern contraceptive practice instead. 3.4 Train WU of P/D/C to have good IEC skill 3.5 Provide enough IEC means 3.6 Provide good quality of post abortion counselling 3.7 Monitor activities of preventing abortion including MRs 3.8 Continue abortion including MRs survey at MCH/FP Centre and the selected DHCs 3.9 Conduct evaluation survey on abortion including MRs in Province **For Output 4** 4.1 Identify counterpart for RTI survey 4.2 Set up research team 4.3 Conduct feasibility study on the RTI survey in project area 4.4 Formulate RTI survey plan 4.5 Strengthen laboratory examination capacity at MCH/FP Centre and the selected DHCs 4.6 Train ob/gyn doctors and other health personnel for diagnosis skill of RTI 4.7 Provide necessary equipment for RTI survey 4.8 Conduct RTI survey 4.9 Formulate strategy for RTI prevention			

Narrative Summary	Objectively Verifiable Indicator	Means of Verification	Important Assumptions
For Output 5 5.1 Provincial, district and commune SCs develop their own IEC plan 5.2 IEC means are supplied 5.3 Sufficient IEC materials are supplied to district and commune WU 5.4 P/D/C SCs cooperates with other organizations in IEC promotion 5.5 Provide training and information to press & broadcast station at all levels on RH 5.6 Promote "Aiiku-han" (community-based MCH promotion system) activities in the selected districts and communes 5.7 P/D/C SC open RH counselling rooms/offices in their own area 5.8 Conduct TOT for DHC & MCH/FP Center staff in order to organize reproductive health education classes, including parents class, breastfeeding class, breast massage class, adolescents health class, counseling class for better understanding of implications of abortion including MRs, and menopause class 5.9 Develop manuals, guidelines and textbooks for reproductive health education classes **For Output 6** 6.1.1 Provincial HMIS SC is organized and functioned regularly 61.2 Conduct workshops on proper recording, summarizing and reporting at commune and district levels. 6.2 Provide equipment used for the new HMIS 6.3.1 Prepare training materials on HMIS 6.3.2 Conduct training on report preparation using computer for selected DHCs and MCH/FP Center 6.3.3 Conduct training on hospital-based HMIS for the selected DHCs and MCH/FP Center 6.3.4 Implement on-the-job training for HMIS personnel at PHS 6.4 Monitor HMIS actcivities 6.5 Conduct training on statistical analysis and data utilization			

RECORD OF DISCUSSIONS
BETWEEN THE JAPANESE IMPLEMENTATION STUDY TEAM
AND
THE AUTHORITIES CONCERNED OF THE GOVERNMENT OF
THE SOCIALIST REPUBLIC OF VIET NAM
ON JAPANESE TECHNICAL COOPERATION
FOR
THE REPRODUCTIVE HEALTH PROJECT IN NGHE AN PROVINCE (PHASE II)

The Japanese Implementation Study Team (hereinafter referred to as "the Team") organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Prof. Hirofumi ANDO, visited the Socialist Republic of Viet Nam from July 9, 2000 to July 16, 2000 for the purpose of working out the details of the technical cooperation program concerning the Reproductive Health Project in Nghe An Province (Phase II).

During its stay in the Socialist Republic of Viet Nam, the Team exchanged views and had a series of discussions with the Vietnamese authorities concerned, with respect to the desirable measures to be taken by both Governments for the successful implementation of the above-mentioned Project.

As a result of the discussions and in accordance with the provisions of the Agreement on Technical Cooperation between the Government of Japan and the Government of the Socialist Republic of Viet Nam, signed in Hanoi on October 20, 1998 (hereinafter referred to as "the Agreement"), the Team and the Vietnamese authorities concerned agreed to recommend to their respective Governments the matters referred to in the document attached hereto.

Hanoi, July 14, 2000

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ATTACHED DOCUMENT

I. COOPERATION BETWEEN BOTH GOVERNMENTS

1. The Government of the Socialist Republic of Viet Nam will implement the Reproductive Health Project in Nghe An Province (Phase II) (hereinafter referred to as "the Project") in cooperation with the Government of Japan.

2. The Project will be implemented in accordance with the Master Plan which is given in Annex I.

II. MEASURES TO BE TAKEN BY THE GOVERNMENT OF JAPAN

In accordance with the laws and regulations in force in Japan and the provisions of Article III of the Agreement, the Government of Japan will take, at its own expense, the following measures through JICA according to the normal procedures under the Technical Cooperation Scheme of Japan.

1. DISPATCH OF JAPANESE EXPERTS

The Government of Japan will provide the services of the Japanese experts listed in Annex II.

2. PROVISION OF MACHINERY AND EQUIPMENT

The Government of Japan will provide such machinery, equipment and other materials (hereinafter referred to as "the Equipment") necessary for the implementation of the Project as listed in Annex III. The provisions of Article VIII of the Agreement will be applied to the Equipment.

3. TRAINING OF VIETNAMESE PERSONNEL IN JAPAN

The Government of Japan will receive Vietnamese personnel connected with the Project for technical training in Japan.

4. SPECIAL MEASURES FOR TRAINING OF MIDDLE-LEVEL PERSONNEL

The Government of Japan will supplement a portion of the following local expenditures necessary for the training programs for middle-level personnel conducted in The Socialist Republic of Viet Nam:

(1) Travel allowances for the training participants between their places of assignment and the site of the training.
(2) Production costs for teaching materials.
(3) Travel costs of the training participants for their field trips.
(4) Costs for procurement of supplies and equipment necessary for the training program.
(5) Travel allowances for the local instructors of the training programs accompanying the trainees on their field trips.
(6) Remuneration for the instructors invited from institutions other than those directly connected with the Project.

Japanese funding for the above-mentioned expenses will be reduced annually.
The reductions in Japanese funding will be compensated by additional Vietnamese funding.

III. MEASURES TO BE TAKEN BY THE GOVERNMENT OF THE SOCIALIST REPUBLIC OF VIET NAM

1. The Government of the Socialist Republic of Viet Nam will take necessary measures to ensure that the self-reliant operation of the Project will be sustained during and after the period of Japanese technical cooperation, through the full and active involvement in the Project by all related authorities, beneficiary groups and institutions.

2. The Government of the Socialist Republic of Viet Nam will ensure that the technologies and knowledge acquired by the Vietnamese nationals as a result of Japanese technical cooperation will contribute to the economic and social development of the Socialist Republic of Viet Nam.

3. In accordance with the provisions of Article VI of the Agreement, the Government of the Socialist Republic of Viet Nam will grant in the Socialist Republic of Viet Nam privileges, exemptions and benefits to the Japanese experts referred to in II-1 above and their families.

4. In accordance with the provisions of Articles VI and VIII of the Agreement, the Government of the Socialist Republic of Viet Nam will take measures necessary to receive and use the Equipment provided through JICA under II-2 above and equipment, machinery and materials carried in by the Japanese experts referred to in II-1 above.

5. The Government of the Socialist Republic of Viet Nam will take necessary measures to ensure that the knowledge and experience acquired by the Vietnamese personnel from technical training in Japan will be utilized effectively in the implementation of the Project.

6. In accordance with the provisions of Article V of the Agreement, the Government of the Socialist Republic of Viet Nam will provide the services of the Vietnamese counterpart personnel and administrative personnel listed in Annex IV.

7. In accordance with the provisions of the Article V of the Agreement, the Government of the Socialist Republic of Viet Nam will provide the buildings and facilities listed in Annex V.

8. In accordance with the laws and regulations in force in the Socialist Republic of Viet Nam, the Government of the Socialist Republic of Viet Nam will take necessary measures to supply or replace at its own expense machinery, equipment, instruments, vehicles, tools, spare parts and any other materials necessary for the implementation of the Project other than the Equipment provided through JICA under II-2 above.

9. In accordance with the laws and regulations in force in the Socialist Republic of Viet Nam, the Government of the Socialist Republic of Viet Nam will take necessary measures to meet the running expenses necessary for the implementation of the Project.

IV. ADMINISTRATION OF THE PROJECT

1. The Vice Chairperson of the Nghe An People's Committee, as the Project Director, will bear overall responsibility for the administration and implementation of the Project.

2. The Deputy Director of Health Service of Nghe An Province, as the Project Manager, will be responsible for the managerial and technical matters of the Project.

3. The Japanese Chief Advisor will provide necessary recommendations and advice to the Project Director and the Project Manager on any matters pertaining to the implementation of the Project.

4. The Japanese experts will give necessary technical guidance and advice to the Project Director and the Project Manager on any matters pertaining to the implementation of the Project.

5. For the effective and successful implementation of technical cooperation for the Project, a Joint Coordinating Committee will be established whose functions and composition are described in Annex VI.

V. JOINT EVALUATION

Evaluation of the Project will be conducted jointly by the two Governments through JICA and the Socialist Republic of Viet Nam authorities concerned, (at the middle and) during the last six months of the cooperation term in order to examine the level of achievement.

VI. CLAIMS AGAINST JAPANESE EXPERTS

In accordance with the provisions of Article VII of the Agreement, the Government of the Socialist Republic of Viet Nam undertakes to bear claims, if any arise, against the Japanese experts engaged in technical cooperation for the Project resulting from, occurring in the course of, or otherwise connected with the discharge of their official functions in the Socialist Republic of Viet Nam, except for those arising from the willful misconduct or gross negligence of the Japanese experts.

VII. MUTUAL CONSULTATION

There will be mutual consultation between the two Governments on any major issues arising from, or in connection with, this Attached Document.

VIII. MEASURES TO PROMOTE UNDERSTANDING AND SUPPORT FOR THE PROJECT

For the purposes of promoting the support for the Project among the people of the Socialist Republic of Viet Nam, the Government of the Socialist Republic of Viet Nam will take appropriate measures to make the Project widely known to the people of the Socialist Republic of Viet Nam.

IX. TERM OF COOPERATION

The duration of technical cooperation for the Project under this Attached Document will be five years from September 1, 2000.

ANNEX I. MASTER PLAN

I. Objective of the Project

1. Overall Goal
Reproductive Health of Women of Reproductive Age in Nghe An Province is improved.

2. Purpose
Reproductive Health Service is improved in Nghe An Province.

II. Main Output and Activities of the Project

1. Output of the Project

Steering Committees*[1] at all levels will be established in order to achieve output (1)-(4).

(1) Management and guidance / counseling capacity of the MCH / FP Center and DHC is improved.
(2) Safe and hygienic delivery is promoted at the commune level.
(3) Guidance and counseling skills of MCH / FP Center staff are improved to reduce the number of abortions.
(4) Capacity for reducing RTI is improved at the MCH / FP Center and selected districts*[2].

Note: 1. For the effective implementation of the Project, Steering Committees of the Project will be formulated at the provincial, district and commune levels. The function and responsibility of the Committee are to promote and support Project activities, to coordinate the efforts made by respective organizations to maximize the impact of the Project, and to mobilize available resources in the community.
The Steering Committees at the district and commune levels are composed of representatives of People's Committee, DHC or CHC, Women's Union. The members of the Steering Committee at provincial level will be senior staff members of the MCH/FP Center, including the director and two vice directors.
2. Selected districts: Several districts of Nghe An Province will be selected to provide new components of the Project as model districts
3. Project area: 17 districts, one town and one city of Nghe An Province
(total 19: whole area of Nghe An Province)
4. Experienced areas: The Project will be implemented in 8 districts that carried out the former Project from June 1997 to May 2000
5. New project areas: The Project will be implemented in 9 districts, one town and one city

2. Activities of the Project

For Output 1-(1):

(1) To review the capacity of MCH / FP Center staff
(2) To reassign roles and responsibility
(3) To conduct self-assessment of training needs on management and guidance skills at MCH/FP Center
(4) To formulate plan of management and guidance skills training
(5) To formulate monitoring team at DHC
(6) To conduct training for monitoring and guidance skill
(7) To provide means of transportation to the MCH/FP Center

(8) To conduct monitoring and guidance activities according to the plan
(9) To establish data and report filing system at the MCH/FP Center

For Output 1-(2):
(1) To review utilization and effectiveness of equipment supplied
(2) To prepare list of equipment
(3) To formulate a plan of equipment supply
(4) To carry out retraining of midwives and obstetrics and gynecology assistant doctors who attend delivery (10 courses)
(5) To upgrade equipment at CHC and obstetrics and gynecology dept. at DHC
(6) To upgrade facilities of CHC such as delivery rooms, FP service/counseling rooms, shower rooms and toilets
(7) To conduct training on IEC for Women's Union members
(8) To provide IEC materials to commune-level Women's Union
(9) To promote IEC on safe hygienic delivery (by the Women's Union)
(10) To promote "Aiiku-Han"(community-based MCH promotion system) activities in selected districts and communes
(11) To conduct regular monitoring of CHC by DHC monitoring team
(12) To conduct TOT on education plan and teaching plan for DHC

For Output 1-(3):
(1) To conduct assessment on the abortion situation in the selected area and the MCH / FP Center
(2) To develop guidance and counseling strategies
(3) To develop and produce necessary materials for guidance and counseling
(4) To conduct training on guidance and counseling for MCH/FP Center staff and selected districts (DHCs)
(5) To conduct regular supply of necessary contraceptives

For Output 1-(4):
(1) To identify counterpart for RTI survey
(2) To conduct a feasibility study on the RTI survey in project area
(3) To formulate task force for RTI survey
(4) To formulate RTI survey plan
(5) To conduct RTI survey
(6) To formulate strategy for RTI prevention
(7) To develop and produce necessary materials for counseling and guidance
(8) To conduct training on counseling and guidance for prevention of RTI

ANNEX II. LIST OF JAPANESE EXPERTS

1. Long-term experts
(1) Chief Advisor
(2) Project Management and Coordination
(3) Midwifery Education
(4) Public Health Nurse
(5) Others mutually agreed upon as necessary

2. Short-term experts
(1) Midwifery Education
(2) Information, Education and Communication (IEC)

(3) Medical Doctor in Obstetrics and Gynecology
(4) MCH / FP Administration
(5) Reproductive Health Survey
(6) Health Information Management
(7) Community-based MCH Promotion Activities
(8) Health Service and Management
(9) Others mutually agreed upon as necessary

ANNEX III. LIST OF MACHINERY AND EQUIPMENT

1. Equipment for training activities
2. Equipment for capacity building of the MCH / FP Center in Nghe An Province
3. Equipment for Clinical Medicine
4. Vehicles and spare parts necessary for the implementation of the Project
5. Other equipment mutually agreed upon as necessary

ANNEX IV. LIST OF VIETNAMESE COUNTERPARTS AND ADMINISTRATIVE PERSONNEL

1. Project Director
2. Project Manager
3. Other Technical Counterparts
4. Other support staff including administrative staff and secretaries, mutually agreed upon as necessary

ANNEX V. LIST OF BUILDINGS AND FACILITIES

1. Sufficient space for the implementation of the Project
2. Offices and other necessary facilities for the Japanese experts
3. Facilities such as electricity, gas and water, sewage systems, telephones and furniture necessary for the activities of the Project
4. Other facilities mutually agreed upon as necessary

ANNEX VI. JOINT COORDINATING COMMITTEE

1. Functions

The Joint Coordinating Committee will meet at least once a year and whenever the necessity arises, and work:

(1) To review and authorize the annual work plan of the Project in line with the Tentative Schedule of Implementation formulated in accordance with the framework of the Record of Discussions
(2) To monitor the progress of the Project
(3) To evaluate the activities of the Project
(4) To discuss other major issues relevant to the Project

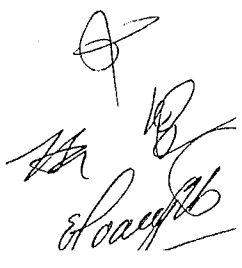
2. Composition

(1) Chairperson: Vice Chairperson, People's Committee of Nghe An Province
(2) Members:

Vietnamese side:
Department of Health Service, Nghe An Province
MCH / FP Center, Nghe An Province
Women's Union, Nghe An Province

Japanese side:
Chief Advisor
Expert on Project Management and Coordination
Experts
Resident Representative of the JICA Viet Nam Office
Other personnel concerned with the Project to be dispatched by JICA

Note: 1. Official(s) of the Embassy of Japan may attend the Joint Coordinating Committee as observer(s).
2. Representative(s) of MCH / FP Department of Ministry of Health will attend the Joint Coordinating Committee as advisor(s).



TENTATIVE SCHEDULE OF IMPLEMENTATION
OF
THE REPRODUCTIVE HEALTH PROJECT
IN NGHE AN PROVINCE (PHASE II)

The Japanese Implementation Study Team (hereinafter referred to as "the Team") and the Vietnamese authorities concerned have jointly formulated the Tentative Schedule of Implementation of the Project with its Project Design Matrix (hereinafter referred to as "PDM") annexed hereto.

This has been formulated in connection with the attached document of the Record of Discussions signed between the Team and the Vietnamese authorities concerned for the Project on the conditions that the necessary budget will be allocated for the implementation of the Project by both sides, and that the schedule and 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.

Hanoi, July 14, 2000

Prof. Hirofumi Ando, Ph. D.
Leader
Implementation Study Team
Japan International Cooperation Agency
Japan

Mr. Hoang Ky
Vice Chairman
People's Committee of Nghe An Province
The Socialist Republic of Viet Nam

Dr. Duong Duc Ung
General Director
Department of Foreign Economic Relations
Ministry of Planning and Investment
The Socialist Republic of Viet Nam

Trinh Bang Hop, M.D.
Director
Department of International Cooperation
Ministry of Health
The Socialist Republic of Viet Nam

Tentative Schedule of Implementation

Activities	Target	Schedule																				Responsible person in Project Team	Input	Remarks
		2000				2001				2002				2003				2004				2005			
		I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV			
0. Steering Committee at all levels will be established in order to achieve output 1.-4.																												
0-1. Review and define the function and responsibilities of Steering Committee at all levels																												
0-2. Review Steering Committee members in the experienced areas (8 districts)																												
0-3. Establish Steering committees at district and commune levels in new project area																												
0-4. Conduct orientation of the Project to Steering Committee members of new project area																												
0-5. Conduct exchange of experience among experienced districts and new districts																												
0-6. Conduct regular meeting of commune steering committees and district steering committees (monthly)																												
0-7. Conduct regular meeting of district steering committees and provincial steering committees (monthly, bi-monthly, quarterly)																												
1. Activities related to output: Management and guidance / counseling capacity of MCH / FP Center and DHC is established																												
1-1. Review the capacity of MCH / FP Center staff																												
1-2. Reassign roles and responsibility																												
1-3. Conduct self assessment of training needs on management and guidance skill at MCH / FP center																												
1-4. Formulate Plan of management and guidance skill training																												
1-5. Formulate Monitoring team at DHC																												
1-6. Conduct training for monitoring and guidance skill																												
1-7. Provide means of transportation to MCH/FP Center																												
1-8. Conduct monitoring and guidance activities according to the planned																												
1-9. Establish data and report filing system at MCH / FP center																												
2. Activities related to output: Safe and hygienic delivery is promoted at the commune level																												
2-1. Review utilization and effectiveness of equipment supplied																												
2-2. Prepare a list of equipment																												
2-3. Formulate a plan of equipment supply																												

Tentative Schedule of Implementation

Activities	Target	Schedule																				Responsible person in Project Team	Input	Remarks
		2000				2001				2002				2003				2004				2005			
		I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV			
2-4. Carry out retraining of midwives and obgyn assistant doctors who attend delivery (10 courses)							—	—			—	—			—	—												
2-5. Upgrade the equipment at CHC and obgyn dept. at DHC					—	—	—	—	—	—	—	—	—	—	—	—	—	—										
2-6. Upgrade facilities of CHC such as delivery room, FP service/counseling room, shower room and toilet					—	—	—	—	—	—	—	—	—	—	—	—	—	—										
2-7. Conduct training on IEC for Women's Union members					—	—	—	—	—	—	—	—	—	—	—	—	—	—										
2-8. Provide IEC materials to commune level women's union					—	—	—	—	—	—	—	—	—	—	—	—	—	—										
2-9. Promote IEC on safe hygienic delivery (by Women's Union)					—	—	—	—	—	—	—	—	—	—	—	—	—	—										
2-10. Promote "Aiiku-han" (community-based MCH promotion system) activities in selected districts and communes					—	—	—	—	—	—	—	—	—	—	—	—	—	—										
2-11.Conduct regular monitoring to CHC by DHC monitoring team					—	—	—	—	—	—	—	—	—	—	—	—	—	—										
2-12. Conduct TOT on education plan and teaching plan for DHC					—				—				—															
3. Activities related to output: Guidance and counseling skill of MCH/FP Center staff is improved to reduce the number of abortion																												
3-1. Conduct assessment on abortion situation in the selected area and MCH/FP Center					—	—	—	—	—	—																		
3-2. Develop guidance and counseling strategies										—	—																	
3-3. Develop and produce necessary materials for guidance and counseling											—	—	—	—	—	—	—											
3-4. Conduct training on guidance and counseling for MCH/FP Center staff and selected districts (DHCs)													—				—				—							
3-5. Conduct regular supply of necessary contraceptives					—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—						
4.Capacity for reducing RTI is improved at MCH/FP Center and selected districts																												
4-1. Identify counterpart for RTI survey					—	—																						
4-2. Feasibility study on the RTI survey in project area						—	—	—																				
4-3. Formulate task force for RTI survey										—																		
4-4. Formulate RTI survey plan										—	—																	
4-5. Conduct RTI survey											—	—	—	—	—	—	—											
4-6. Formulate strategy for RTI prevention																			—	—								
4-7. Develop and produce necessary materials for counseling and guidance																				—	—							
4-8. Conduct training on counseling and guidance for prevention of RTI																					—							

Tentative Schedule of Implementation

Activities	Target	Schedule																				Responsible person in Project Team	Input	Remarks
		2000				2001				2002				2003				2004				2005			
		I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV			
Inputs by Japanese side																												
Ⅰ. Dispatch of Long Term Experts																												
1. Chief Advisor																												
2. Expert on Management and Coordination																												
4. Expert on Midwifery Education																												
5.Public Health Nurse																												
6. Others mutually agreed upon as necessary																												
Ⅱ. Dispatch of Short Term Experts																												
1. Expert on Midwifery Education																												
2. Expert on Information, Education and Communication (IEC)																												
3. Expert on Obstetrics and Gynecology																												
4. Expert on MCH / FP Administration																												
5. Expert on Reproductive Health Survey																												
6. Expert on Health Information Management																												
7. Expert on Community-based MCH Promotion Activities																												
8 Expert on Health Service and Management																												
9. Others mutually agreed upon as necessary																												
Ⅲ. Counterpart Training in Japan																												
1. MCH / FP Administration																												
2. Midwifery Education																												
3. Public Health Nurse																												
4. Others mutually agreed upon as necessary																												
Ⅳ. JICA Study Team																												
1. Management Consultation Team																												
2. Advisory Team																												
3. Evaluation Team																												
V.Inputs by Vietnamese side																												
1. Assignment of Counterpart Personnel																												
2. Provision of Land, Building and Facilities for the Project																												
3. Cost of Unity such as Electricity and Water																												
VI.Annual Report																												

Project Design Matrix (PDM)

Reproductive Health Project in Nghe An Province Phase II

(September 2000 – August 2005)

Narrative Summary	Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal: Reproductive Health of Women in Reproductive Age in Nghe An Province is improved	1. Maternal mortality reduced 2. No. of abortion reduced 3. No. of women who suffered from RTI reduced	Data from Provincial Health Office, Statistics Office and PCPFP	High commitment by local authorities, health sector and mass organization will be continued Economic condition will not be worsened
Project Purpose: Reproductive Health Service is improved in Nghe An Province	1. Range of RH services is broadened 2. Certain no. of CHCs are certified as standard RH service center by Provincial Health Service and MCH/FP Center	Reports from MCH/FP Center and DHCs	Utilization rate of public health facilities is not worsened RTI prevention activities will be carried out according to the developed plan
Output: 0. Steering Committees at all levels will be established in order to achieve object 1.-4.	0.1 Staffing of Steering Committees at all levels is continuously fulfilled 0.2 Meetings of Steering Committee at all levels are organized regularly 0.3 Staffing of Steering Committees at all levels is continuously fulfilled	Reports from SCs	Agricultural production is not reduced
1. Management and guidance/counseling capacity of MCH/FP Center and DHCs is improved	1.1 Standard check-list for monitoring of CHC developed 1.2 No. of staff trained on monitoring according to the standard set by Provincial Health Service and MCH/FP Center 1.3 Monitoring is conducted as planned 1.4 Standard for RH services is set by the Provincial Health and MCH/FP Center 1.5 Parents class is applied and organized regularly at DHCs	Reports from MCH/FP Center and DHCs	Unexpected serious natural disaster will not hit the project area Nutrition Status of pregnant women will not be worsened
2. Safe and hygienic delivery is promoted at the commune level	2.1 No. of home deliveries are decreased 2.2 At least 90% of Health Personnel trained pass the post test 2.3 Percentage of utilization of partograph at CHCs is increased 2.4 Average no. of prenatal check-ups among women delivered becomes over 3 times 2.5 There are less maternal death cases due to lack of timely referral at CHC and at home 2.6 All CHC (467) in Nghe An Province have improved 4 facilities (delivery room, latrine, well and shower room) to secure safe hygienic delivery 2.7 Safe and hygienic environment secured for more than 90 % of deliveries in the rural areas of Nghe An Province 2.8 All CHCs(467) of Nghe An Province are able to provide all essential items of pregnancy check-up	Reports from DHCc and CHCs	
3. Guidance and counseling skill of MCH/FP Center staff is improved to reduce the number of abortion	3.1 Counseling manual is developed 3.2 No. of qualified staff in counseling/guidance is increased 3.3 Qualified counseling system is established at MCH/FP Center 3.4 No. of repeated case of abortion is decreased	Report from MCH/FP Center	
4. Capacity for reducing RTI is improved at MCH/FP Center and selected districts	4.1 Survey report is prepared 4.2 Strategy for reduction and prevention of RTI is developed	Report from MCH/FP Center	

Activities: 0.1 Review and define the function and responsibilities of Steering Committee at all levels 0.2 Review Steering Committee members in the experienced (8 districts) 0.3 Establish Steering Committees at district and commune levels in new project area 0.4 Conduct orientation of the Project to Steering Committee members of new project area 0.5 Conduct exchange of experience among experienced districts and new districts 0.6 Conduct regular meeting of commune steering committees and district steering committees (monthly) 0.7 Conduct regular meeting of district steering committees and provincial steering committees (monthly, bi-monthly, quarterly) 1.1 Review the capacity of MCH/FP Center staff 1.2 Reassign roles and responsibility 1.3 Conduct self assessment of training needs on management and guidance skill at MCH/FP Center is carried out 1.4 Formulate Plan of management and guidance skill training 1.5 Formulate Monitoring team at DHC 1.6 Conduct training for monitoring and guidance skill 1.7 Provide means of transportation to MCH/FP Center y 1.9 Establish data and report filing system at MCH/FP Center 2.1 Review utilization and effectiveness of equipment supplied 2.2 Prepare a list of equipment 2.3 Formulate a plan of equipment supply 2.4 Carry out retraining of midwives and obgyn assistant doctors who attend delivery (10 courses) 2.5 Upgrade the equipment at CHC and obgyn dept. at DHC 2.6 Upgrade facilities of CHC such as delivery room, FP service/counseling room, shower room and toilet 2.7 Conduct training on IEC for Women's Union members 2.8 Provide IEC materials to commune level women's union 2.9 Promote IEC on safe hygienic delivery (by Women's Union) 2.10 Promote "Aiiku-Han" (community-based MCH promotion system) activities in selected districts and communes 2.11 Conduct regular monitoring to CHC by DHC monitoring team 2.12 Conduct TOT on education plan and teaching plan for DHC 3.1 Conduct assessment on abortion situation in the selected and MCH/FP Center 3.2 Develop guidance and counseling strategies ar 3.3 Develop and produce necessary materials for guidance and counseling	Inputs: Vietnam (Nghe An Province) 1. Building and facilities Renovation and expansion of JICA RH term Project Office 2. Essential drugs and contraceptives 3. Other local cost Cost for administration, monitoring and other	Japan 1. Experts 1.1 Long Team Leader Coordinator Midwife Public Health Nurse 1.2 Short MCH/FP administration Center Management RH survey, IEC Community participation and MCH promotion, etc/ 2. Equipment 3. Traini Counterpart training in Japan Local training	Salary for health workers will not be decreased

3.4 Conduct training on guidance and counseling for MCH/FP Center staff and selected districts (DHCs) 3.5 Conduct regular supply of necessary contraceptives 4.1 Identify counterpart for RTI survey 4.2 Feasibility study on the RTI survey in project area is carried out 4.3 Formulate task force for RTI survey 4.4 Formulate RTI survey plan 4.5 Conduct RTI survey 4.6 Formulate strategy for RTI prevention 4.7 Develop and produce necessary materials for counseling and guidance 4.8 Conduct training on counseling and guidance for prevention of RTI		**Pre-condition** New districts of Nghe An Province do not oppose to carry out RH Projct Phase II

Note:

1. For the effective implementation of the Project, Steering Committee of the Project will be formulated at Provincial, District and Commune levels. The function and responsibility of the Committee are to promote and support of the Project activities, coordinate the efforts to be made by respective organizations to maximize the impact of the Project and mobilization of available resources in the community. The Steering Committees at district and commune levels are composed of representatives of People's Committee, DHC or CHC, Women's Union. The members of the Steering Committee at provincial level are senior staff of MCH/FP Center including director and two vice directors.The Steering Committees at district and commune levels are composed of representatives of People's Committee, DHC or CHC, Women's Union. The members of the Steering Committee at provincial level are senior staff of MCH/FP Center including director and two vice directors.
2. Selected districts Several districts of the Nghe An Province will be selected to provide new componenets of the Project as model districts
3. Project area : 17 districts, one town and one city of Nghe An Province (total 19: whole area of Nghe An Province)
4. Experienced areas: 8 districts that carried out the former Project from June 1997 to May 2000 and the Project will be implemented
5. New project areas: 9 districts, one town and one city that the Project will be newly implemented

List of Japanese Experts

JICA RH Project (Phase II)
Duration: September 1, 2000 - August 31, 2005

Long Term Experts

No.	Name	Designation	Period	Duration (months)	Re.
1	Ms.Sumie ISHII	Team Leader	Sep.7,2000 - Apr.15,2002	19.3 Month(s)	
2	Ms.Mayumi KATSUBE	Team Leader	Mar.26,2002 - Aug.31,2005	41.1 Month(s)	
3	Mr.Shinya IWAYANAGI	Administrative Co-ordinator	Sep.1,2000 - Jul.16,2002	22.5 Month(s)	
4	Mr.Kenji YAMAZAKI	Administrative Co-ordinator	Jun.25,2002 - Aug.31,2005	38.2 Month(s)	
5	Ms.Kazuyo WATANABE	Midwifery	Sep.1,2000 - Aug.31,2003	36.0 Month(s)	
6	Ms.Miyuki OIKAWA	Community Health	Apr.10,2001 - Apr.9,2003	24.0 Month(s)	
7	Mr.Tomomichi YAMADA	Health Management Info. System (HMIS)	Sep.2,2002 - Aug.31,2005	35.9 Month(s)	
8	Ms.Tamami Minamishima	Community Health	Mar.27,2003 - Mar.26,2005	24.0 Month(s)	
9	Ms.Sawako TAKEDA	Midwifery	Feb.23,2004 - Aug.31,2005	18.2 Month(s)	
	LONG TERM EXPERTS TOTAL (in Months)			**259.1 Month(s)**	
	LONG TERM EXPERTS AVERAGE DURATION (in Months)			**28.8 Month(s)**	

Short Term Experts

No.	Name	Designation	Period	Duration (months)	Re.
FY 2000/2001					
1	Ms.Yasuko AOKI	Midwifery Education	Oct.1,2000 - Oct.13,2000	0.4 Month(s)	
2	Dr.Shoko NAGAYA	MCH/FP Administration	Nov.13,2000 - Dec.6,2000	0.8 Month(s)	
3	Ms.Miyuki OIKAWA	Public Health	Dec.19,2000 - Jan.7,2000	0.6 Month(s)	
4	Dr.Sadao HORIGUCHI	OBGYN	Dec.27,2000 - Jan.7,2001	0.3 Month(s)	
5	Mr.Tomomichi YAMADA	HMIS	Mar.25,2001 - Apr.21, 2001	0.9 Month(s)	
6	Ms.Lisa ASAMURA	IEC	Mar.31,2001 - Apr.8,2001	0.3 Month(s)	
FY 2001/2002					
7	Mr. Nobuhiro KADOI	RH- related survey	Apr.8,2001 - Apr.21,2001	0.4 Month(s)	
8	Ms.Keiko ASATO	Project Management (PCM)	Jul.1,2001 - Jul.21,2001	0.7 Month(s)	
9	Ms.Atsuko SUGIYAMA	Midwifery Education	Jul.21,2001 - Aug.11,2001	0.7 Month(s)	
10	Dr. Akira OKAMOTO	MCH & Comm. Participation	Aug.5,2001 - Aug.23,2001	0.6 Month(s)	
11	Ms.Mayumi KATSUBE	Project Management	Sep.9,2001 - Sep.29,2001	0.7 Month(s)	
12	Dr. Shoko NAGAYA	MCH/FP Administration	Nov.25,2001 - Dec.8,2001	0.4 Month(s)	
13	Dr. Akira OKAMOTO	Community Health	Dec.29,2001 - Jan.5,2002	0.2 Month(s)	
14	Mr.Tomomichi YAMADA	HMIS	Jan.7,2002 - Feb.1,2002	0.8 Month(s)	
15	Dr.Sadao HORIGUCHI	OBGYN	Jan.13,2002 - Jan.24,2002	0.4 Month(s)	
16	Ms.Emiko WATANABE	Public Health Service & Center Mgmt	Jan.13,2002 - Jan.22,2002	0.3 Month(s)	
17	Mr. Nobuhiro KADOI	RH- related survey & action planning	Feb.25,2002 - Mar.19,2002	0.8 Month(s)	
18	Dr.Aya GOTOH	RH- related survey (RTI)	Mar.4,2002 - Mar.29,2002	0.8 Month(s)	
19	Ms.Lisa ASAMURA	IEC	Mar.22,2002 - Apr.2,2002	0.3 Month(s)	
FY 2002/2003					
20	Ms.Atsuko SUGIYAMA	Midwifery Education	Jul.5,2002 - Jul.21,2002	0.5 Month(s)	
21	Dr.Aya GOTOH	RTI Survey Training	Nov.27,2002 - Dec.29,2002	1.1 Month(s)	
22	Ms.Yuko ABE	Laboratory	Nov.27,2002 - Dec.29,2002	1.1 Month(s)	
23	Ms.Kayoko HIGASHI	Community Health	Dec.15,2002 - Dec.23,2002	0.3 Month(s)	
24	Dr.Sadao HORIGUCHI	Post natal care mgmt.	Jan.5,2003 - Jan.15,2003	0.3 Month(s)	
25	Ms.Emiko WATANABE	MCH & Comm. Participation	Jan.12,2003 - Jan.21,2003	0.3 Month(s)	

(continued)

Short Term Experts

No.	Name	Designation	period	Duration (months)	Re.
26	Dr.Masato TAKEUCHI	Health Service & Center Mgmt.	Jan.12,2003 - Jan.21,2003	0.3 Month(s)	
27	Dr.Shoko NAGAYA	MCH/FP Administration	Mar.4,2003 - Mar.17,2003	0.4 Month(s)	
28	Ms.Lisa ASAMURA	IEC	Mar.8,2003 - Mar.17,2003	0.3 Month(s)	
FY 2003/2004					
29	Dr.Aya GOTOH	RTI Survey	Apr.12,2003 - Apr.26,2003	0.5 Month(s)	
30	Ms.Yuko ABE	Laboratory	Apr.12,2003 - Apr.26,2003	0.5 Month(s)	
31	Dr.Masato TAKEUCHI	Health Service & Center Mgmt.	Jul.4,2003 - Jul.15,2003	0.4 Month(s)	
32	Dr.Aya GOTOH	RTI Survey	Jul.19,2003 - Aug.12,2003	0.8 Month(s)	
33	Ms.Atsuko SUGIYAMA	Midwifery Eduction	Jul.21,2003 - Aug.9,2003	0.6 Month(s)	
34	Mr.Minato NAKAZAWA	Health Mgmt. Info. System	Aug.5,2003 - Aug.16,2003	0.4 Month(s)	
35	Ms.Yoshiko TAKAHASHI	PCM Methods	Nov.22,2003 - Dec.11,2003	0.6 Month(s)	
36	Ms.Lisa ASAMURA	IEC	Mar.6,2004 - Mar.15,2004	0.3 Month(s)	
37	Ms.Sumie ISHII	Project Management	Mar.3,2004 - Mar.15,2004	0.4 Month(s)	
FY 2004/2005					
38	Dr.Aya GOTOH	RTI Survey	Apr.17,2004 - Apr.30,2004	0.4 Month(s)	
39	Dr.Masato TAKEUCHI	Health Service & Center Mgmt.	Jun.12,2004 - Jun.19,2004	0.2 Month(s)	
40	Ms.Yuko ABE	Laboratory	Jun.26,2004 - Jul.9,2004	0.4 Month(s)	
41	Mr.Nobuhiro KADOI	Epidemiological survey & abortion reduction	Jul.16,2004 - Jul.26,2004	0.3 Month(s)	
42	Ms.Akiko OOMORI	Midwifery Eduction/Nursing Care Mgmt.	Jul.31,2004 - Aug.9,2004	0.3 Month(s)	
43	Mr.Minato NAKAZAWA	HMIS	Aug.4,2004 - Aug.14,2004	0.3 Month(s)	
44	Ms.Lisa ASAMURA	IEC	Dec.14,2004 - Dec.23,2004	0.3 Month(s)	
45	Ms.Kyoko NISHIKIORI	Community Participation & Health Admin.	Aug.31,2004 - Sep.14,2004	0.5 Month(s)	
46	Ms.Tomoko SAOTOME	Obstetrics & Gynaecology	Sep.18,2004 - Sep.25,2004	0.2 Month(s)	
47	Ms.Sumie ISHII	Project Management	Mar.27,2005 - Apr.5,2005	0.3 Month(s)	
FY 2005/2006					
48	Ms. Keiko HAMANO	Project Management	May.9,2005 - Jun.7,2005	0.9 Month(s)	
49	Ms.Sumie ISHII (planned)	Participatory dissemination approach for the community-based project	Jul.9,2005 - Jul.16,2005	0.2 Month(s)	
Short Term Experts: Total Duration in M/M				**23.8 Month(s)**	
Short Term Experts: Total Number of Experts				**23 Persons**	
Short Term Experts: Total Number of Visits				**49 Visits**	
Short Term Experts: Average Duration per Visit				0.5 Month(s)	
Short Term Experts: Average Number of Visits by the same Expert				2.1 Times	
Short Term Experts: Range ~ Number of Visits per Expert				1~5 Times	

As of June,2005

List of Equipment Provided

JICA Reproductive Health Project (Phase II)
Duration: September 1, 2000 ∽ August 31, 2005

Items	$	Total/year
CHC Equipment for CHCs and DHCs	$110,757	
Public Addressing System TOA for 11 DHCs	$9,133	
Motorcycle with Helmets 5 sets for Provincial Level	$29,980	
Overhear Projector & Screens for 11 DHCs	$6,212	
Richo Copier for MCH/FP Center	$3,170	
Toyota Landcruiser 2 units (for MCH/FP Center 1, for Japanese Experts Monitoring 1)	$50,600	$209,852
Air Conditioner for DHCs	$21,777	
OB/GYN Equipment, Infant Warmer, Colposcolpe, Doppler	$82,590	
CHC Equipment 75items	$102,861	
Furniture and Medical Equipment 125 sets	$222,761	
Autoclave, Sterilizer Oven, Oxygen Concentrator, Oxyeng Flowmeter, Operation Instrument,	$63,978	$493,967
Home Visit Kit 506 CHCs & DHCs	$76,811	
Maggie Apron 19 DHCs	$24,420	
Wall Clock 222 CHCs	$1,665	
Medical Books 11DHCs	$18,026	
Bookshelf 233CHCs	$2,796	
Computer/Printer for Model DHCs	$28,489	
Colposcope for OBGYN Dept.,Provincial Hospital	$2,280	
CHC Basic Equipment for flood-affected 3 CHCs, N.D.	$1,415	$155,901
CHC Equipment for 3 CHCs	$6,007	
Microscope 19 DHCs	$15,713	
Water Pump 253 CHCs	$14,591	
Electricity Generator 19 DHCs	$14,488	
Boat Engine for T.D.DHCs	$1,402	
River Boat T.D.DHCs	$679	
White Board for HMIS Information 469 CHCs	$18,997	
Pregnancy Simulator 19 DHCs	$15,105	
Ultrasound Diagnostic Machine SHIMADZU for MCH/FP	$23,425	
Desktop Server P/C, UPS	$13,500	
Laptop P/C DELL MCH/FP Center	$1,970	
Sanyo Video Projector for MCH/FP Center	$7,800	
HMIS Terminal P/C, UPS, Modem, Printer for DHCs	$11,385	
307 Telephone Sets and Cables for CHCs	$14,033	$159,095
IUD Insertion Kit DHCs19, MCH/FP Center 4, CHCs469	$7,076	
OB/GYN Medical Equipment DHC19, MCH/FP Center1	$14,930	
Home Visit Kit for 3 New CHCs	$455	
Step (Stair to Delivery Table) CHCs34 in Nghi Loc	$984	
Server P/C & Network Peripherals for 3DHCs	$6,750	
UPS, Modem, Peripherals	$2,727	
Desktop Terminal P/C, UPS, Printer for 10 DHCs	$6,800	
Public Addressing System for 469 Commune Women Unions	$52,211	
Reproductive Health Educational References for 7000 Destinations of Provincial, Distric, Commune and Town Women Union (56,000sets)	$52,017	$143,950
FY2000∽FY2004	**Grand Total:**	**$1,162,765**

In VND(@15476):	**17,994,943,712**
In JPY(@107):	**124,415,804**

List of Counterpart Trainees

JICA Reproductive Health Project (Phase II)
Duration: September 1, 2000 ∽ August 31, 2005

No.	Name	Period	Duration	Training Field	Training Course	Institution	Post at the time of Training	Present Post
1	Dr. Nguyen Ba Tan	June 18, 2000 - July 19, 2000	1.0 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Fukushima Red Cross Hospital; Kagoshima; Gunma; Kagoshima.	Vice-director, MCH/FP Centre	Director, MCH/FP Centre
2	Dr. Bui Dinh Long	June 18, 2000 - July 19, 2000	1.0 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Fukushima Red Cross Hospital; Kagoshima; Gunma; Kagoshima.	Vice-director, MCH/FP Centre	Vice-director, MCH/FP Centre (training leave since Oct. 2003)
3	Mr. Hoang Ky	Feb. 20, 2002 - Mar. 12, 2002	0.7 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Yamanashi	Vice-chairperson, Nghe An Provincial People's Committee; Chairperson of Joint Committee for the Project	No Transfer
4	Dr. Nguyen Duy Khe	Feb. 20, 2002 - Mar. 22, 2002	1.1 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Yamanashi; Kagoshima.	Vice-director, MCH/FP Department, Ministry of Health	No Transfer
5	Dr. Tran Quang Phong	Feb. 20, 2002 - Mar. 22, 2002	1.1 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Kagoshima; Yamanashi; etc.	Head, Planning Division, MCH/FP Centre, Nghe An	No Transfer
6	Dr. Tran Ngoc Hanh	Feb. 20, 2002 - Mar. 22, 2002	1.1 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Yamanashi; Gunma	Vice-Director, Yen Thanh District Health Center	No Transfer
7	Ms. Pham Thi Hoai	Feb. 20, 2002 - Mar. 22, 2002	1.1 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Yamanashi; Gunma	Nghe An Provincial Women's Union	No Transfer
8	Ms. Nguyen Thi Hoa	July 2002 - Mar. 2003	9.0 Month(s)	Reproductive Health	Maternity care; MCH/FP Administration	Japanese Red Cross Katsushika Maternity Hospital	Administrative midwife, MCH/FP Centre	No Transfer
9	Dr. Cao Phi Nga	Feb. 11, 2003 - Mar. 15, 2003	1.1 Month(s)	Reproductive Health	MCH/FP Administration	Japanese Red Cross Katsushika Maternity Hospital; Yamanashi; Kagoshima	PSC Member; Planning Division, MCH/FP Centre	Left MCH/FP (Jan. 2004)
10	Dr. Dao Trong Dung	Feb. 11, 2003 - Mar. 15, 2003	1.1 Month(s)	Reproductive Health	MCH/FP Administration	Japanese Red Cross Katsushika Maternity Hospital; Yamanashi; Kagoshima	Chief, Planning Division, Nghe An Health Service	No Transfer
11	Ms. Nguyen Thi Lien	Feb. 11, 2003 - Mar. 15, 2003	1.1 Month(s)	Reproductive Health	MCH/FP Administration	Japanese Red Cross Katsushika Maternity Hospital; Yamanashi; Kagoshima	PSC Member; Chairperson, Nghe An Women's Union	No Transfer
12	Dr. Nguyen Xuan Hong	Feb. 11, 2003 - Mar. 15, 2003	1.1 Month(s)	Reproductive Health	MCH/FP Administration	Japanese Red Cross Katsushika Maternity Hospital; Yamanashi; Kagoshima	Health and Medical Expert, Secretary to Vice-Chairperson of Nghe An People's Committee	No Transfer

No	Name	Period	Duration	Training Field	Training Course	Institution	Post at the time of Training	Present Post
13	Dr. Hoang Quoc Kieu	Jun. 03, 2003 - Jul. 19, 2003	1.5 Month(s)	Reproductive Health	Midwifery education; hospital management	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Director, Obstetrics Department、MCH/FP centre	(No Information)
14	Dr. Hoang Thi Thu	Jun. 03, 2003 - Jul. 19, 2003	1.5 Month(s)	Reproductive Health	Midwifery education; hospital management	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Doctor, Obstetrics, MCH/FP centre	(No Information)
15	Ms. Nguyen Thi Thuy Anh	Jun. 03, 2003 - Jul. 19, 2003	1.5 Month(s)	Reproductive Health	Midwifery education; hospital management	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Nursing, Second in Charge (PNC), MCH/FP centre	No Transfer
16	Ms. Pham Thi Hai	Jun. 03, 2003 - Jul. 19, 2003	1.5 Month(s)	Reproductive Health	Midwifery education; hospital management	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Plannning Division, MCH/FP centre	No Transfer
17	Dr. Nguyen Thi Phuc	Jan. 27, 2004 - Feb, 22, 2004	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Gunma	President, Provincial Committee for Population, Family and Children（FP連携協力）	Joint Committee member; Director, Provincial Health Service
18	Mr. Pham Xuan Hoi	Jan. 27, 2004 - Feb, 22, 2004	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Gunma	Joint Committee member; President, Provincial Committee for Population, Family and Children（FP連携協力）	No Transfer
19	Dr. Nguyen Danh Linh	Jan. 27, 2004 - Feb, 22, 2004	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Gunma	Head of Obstetric Dept and Vice-Director of Nghe An Provincial Hospital	No Transfer
20	Mr. Duong Van Lam	Jan. 27, 2004 - Feb, 22, 2004	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Gunma	Provincial Sterring Committee member; MCH/FP centre, Procurement and Personnel	No Transfer
21	Dr. Dang Manh Binh	Jan. 27, 2004 - Feb, 22, 2004	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Gunma	Director, Hung Yen District Health Service; Hung Yen District Steering Committee member	No Transfer
22	Ms. Tran Kim Nguyen	Jan. 27, 2004 - Feb, 22, 2004	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Gunma	Bureau of Labor, Society and Culture, Ministry of Planning & Investment	(No Information)
23	Dr. Nghiem Thi Xuan Hanh	Jan. 27, 2004 - Feb, 22, 2004	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Gunma	In charge of UNFPA RH Project, Ministry of Health	(No Information)
24	Mr. Truong Quoc Chien	Jan. 27, 2004 - Feb, 22, 2004	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Gunma	Provincial Health Service, Hoa Binh Province	(No Information)

No.	Name	Period	Duration	Training Field	Training Course	Institution	Post at the time of Training	Present Post
25	Dr. Nguyen Quang Vinh	Jan 12, 2004 - Feb. 8, 2004	0.9 Month(s)	Reproductive Health	Reproductive Health	JOICFP, Fukushima Univ., Tohoku Univ.	Tu Du Hospital, Ho-Chi-Ming City	Medical and Pharmacy University Hospital, HCMC
26	Dr. Pham Nghiem Minh	Jan 12, 2004 - Feb. 8, 2004	0.9 Month(s)	Reproductive Health	Reproductive Health	JOICFP, Fukushima Univ., Tohoku Univ.	Tu Du Hospital, Ho-Chi-Ming City	No Transfer
27	Dr. Bui Thi Chau	Jun. 21, 2004 - Jul. 16, 2004	0.8 Month(s)	Reproductive Health	Reproductive Health	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Doctor, Obstetrics, MCH/FP Centre	No Transfer
28	Dr. Tran Phong	Jun. 21, 2004 - Jul. 16, 2004	0.8 Month(s)	Reproductive Health	Reproductive Health	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Doctor, Obstetrics, QL disctict Health Centre; District Steering Committee member	No Transfer
29	Dr. Nguyen Thanh Thuy	Jun. 21, 2004 - Jul. 16, 2004	0.8 Month(s)	Reproductive Health	Reproductive Health	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Doctor, Obstetrics, MCH/FP Centre	Secondment to CHC, Tan Ky (Sept. 2004)
30	Ms. Doan Thi Thuc Anh	Jun. 21, 2004 - Jul. 16, 2004	0.8 Month(s)	Reproductive Health	Reproductive Health	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Assistant Doctor, Obstetrics, MCH/FP Centre	No Transfer
31	Mr. Tran Van Khoit	Jan. 11, 2005 - Feb. 6, 2005	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Ministry of Planning and Investment	(No Information)
32	Ms. Nguyen Thi Le	Jan. 11, 2005 - Feb. 6, 2005	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Ministry of Health	(No Information)
33	Mr. Tran Van Sinh	Jan. 11, 2005 - Feb. 6, 2005	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Bac Giang Provincial Health Service	(No Information)
34	Ms. Lam Thi Thu	Jan. 11, 2005 - Feb. 6, 2005	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	MCH/FP Centre, An Giang Province	(No Information)
35	Mr. Doan Huu Duc	Jan. 11, 2005 - Feb. 6, 2005	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	An Giang Provincial Hospital	(No Information)
36	Dr. Cao Xuan Nghiem	Jan. 11, 2005 - Feb. 6, 2005	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Deputy Director, Nghe An Provincial Health Service (MCH/FP)	No Transfer

No.	Name	Period	Duration	Training Field	Training Course	Institution	Post at the time of Training	Present Post
37	Ms. Le Thi Tam	Jan. 11, 2005 - Feb. 6, 2005	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Vice Chairperson, Women's Union, Nghe An	No Transfer
38	Dr. Le Thi Hoai Chung	Jan. 11, 2005 - Feb. 6, 2005	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Provincial Steering Committee member; Deputy Director, MCH/FP Centre	No Transfer
39	Dr. Nguyen Ngoc Khanh	Jan. 11, 2005 - Feb. 6, 2005	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Doctor, Obstetrics, MCH/FP Centre	No Transfer
40	Ms. Le Thi Har	Jan. 11, 2005 - Feb. 6, 2005	0.8 Month(s)	Reproductive Health	MCH/FP Administration	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Assistant Doctor, Obstetrics, MCH/FP Centre	No Transfer
41	Dr. Vo Thi Vinh	June 21, 2005 - July 24, 2005	1.1 Month(s)	Reproductive Health	Midwifery education	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Doctor, Obstetrics, Dien Chau District Health Centre; District Steering Committee member	No Transfer
42	Ms. Pham Thi Thu Hien	June 21, 2005 - July 24, 2005	1.1 Month(s)	Reproductive Health	Midwifery education	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Assistant Doctor, Obstetrics, MCH/FP Centre	No Transfer
43	Ms. Duong Thi Bich Hanh	June 21, 2005 - July 24, 2005	1.1 Month(s)	Reproductive Health	Midwifery education	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Midwife, MCH/FP Centre	No Transfer
44	Ms. Nguyen Thi Tuyet	June 21, 2005 - July 24, 2005	1.1 Month(s)	Reproductive Health	Midwifery education	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima	Assistant Doctor, Obstetrics, MCH/FP Centre	No Transfer
								As of Jun 6,2005
	TOTAL DURATION		**51.2 Month(s)**					
	AVERAGE DURATION per Trainee		**1.2 Month(s)**					

Exchange Programs and Missions

JICA Reproductive Health Project (Phase II)
Duration: September 1, 2000 ∽ August 31, 2005

∗ Technical Exchange Program in Thailand (Period: March 18 - 23, 2002)

1. Shinya Iwayanagi	JICA Expert
2. Nguyen Ba Tan	MCH/FP Center
3. Bui Dinh Long	MCH/FP Center
4. Dinh Thi Cung	MCH/FP Center
5. Duong Van Lam	MCH/FP Center
6. Tran Ba Khanh	DHC Nghi Loc District
7. Le Dinh Van	DHC Nghia Dan District
8. Le Thi Hang	DHC Anh Son District
9. Vu Ngoc	DHC Quynh Luu District
10. Le Thi Quynh Nga	Interpreter

∗ Technical Exchange Program: Myanmar Team visiting Nghe An Province (Period: May 3 – 7, 2005)

1. Dr. (Ms.) Theingi Myint	Assistant Director (Maternal and Child Health), Department of Health, Ministry of Health
2. Dr. (Ms.) Khin San Oo	Team Leader, School Health, Shan State (North), Kyaukme Township
3. Dr. (Ms.) Nwe Nwe Win	Township Medical Officer, Shan State (North), Naungcho Township
4. Ms. Nan Su Su Htay	Township Health Nurse, Shan State (North), Kyaukme Township
5. Ms. Khin Ohn Mynt	Township Health Nurse, Shan State (North), Naungcho Township
6. Ms. Nwe Nwe Khin	Deputy Director (Nursing), Department of Medical Sciences, Ministry of Health
7. Ms. Ryoko Nishida	Director, International Program, JOICFP, Japan

Note: This Program has been funded from the Myanmar Project.

∗ JICA 1st Consultation Mission (Period: August 19 - 25, 2001)

1.Prof. Hirofumi Ando	Professor, International Department, Nihon University
2.Mr. Ryoichi Suzuki	Assistant Executive Director, JOICFP
3.Mr. Naoyuki Kobayashi	Staff, First Medical Cooperation Department, JICA
4.Ms. Ran Nagai	Interpreter, JICE

∗ JICA 2nd Consultation Mission (Period: August 19 - 25, 2002)

1.Prof. Hirofumi Ando	Professor, International Department, Nihon University
2.Mr. Ryoichi Suzuki	Assistant Executive Director, JOICFP
3.Ms. Tomoko Masumori	Director, Nursing Department, Katsushika Red Cross Maternity Hospital
4.Ms. Kiyoka Takeuchi	Staff, First Medical Cooperation Department, JICA
5.Ms. Ran Nagai	Interpreter, JICE

∗ JICA Mid-Term Evaluation Mission (Period: August 21 - September 2, 2003)

1.Prof. Hirofumi Ando	Professor, International Department, Nihon University
2.Mr. Ryoichi Suzuki	Assistant Executive Director, JOICFP
3.Ms. Ryoko Kondo? Kato?	Head Nurse, NICU Unit, Katsushika Red Cross Maternity Hospital
4.Ms. Kyoko Takashima	Staff, First Medical Cooperation Department, JICA
5.Ms. Ran Nagai	Interpreter, JICE

∗ JICA Final Evaluation Mission (Period: June 12 - 24, 2005)

1.Prof. Hirofumi Ando	Professor, International Department, Nihon University
2.Mr. Ryoichi Suzuki	Assistant Executive Director, JOICFP
3.Ms.Tomoko Saotome	Ob-gyn. Doctor, Yokohama Fureai Hospital
4.Mr. Kenta Sasaki	Staff, RH Team, Human Development Department, JICA
5.Ms. Yoko Ogawa	Consultant, Global Link Management, Inc.
6.Ms. Ran Nagai	Interpreter, JICE

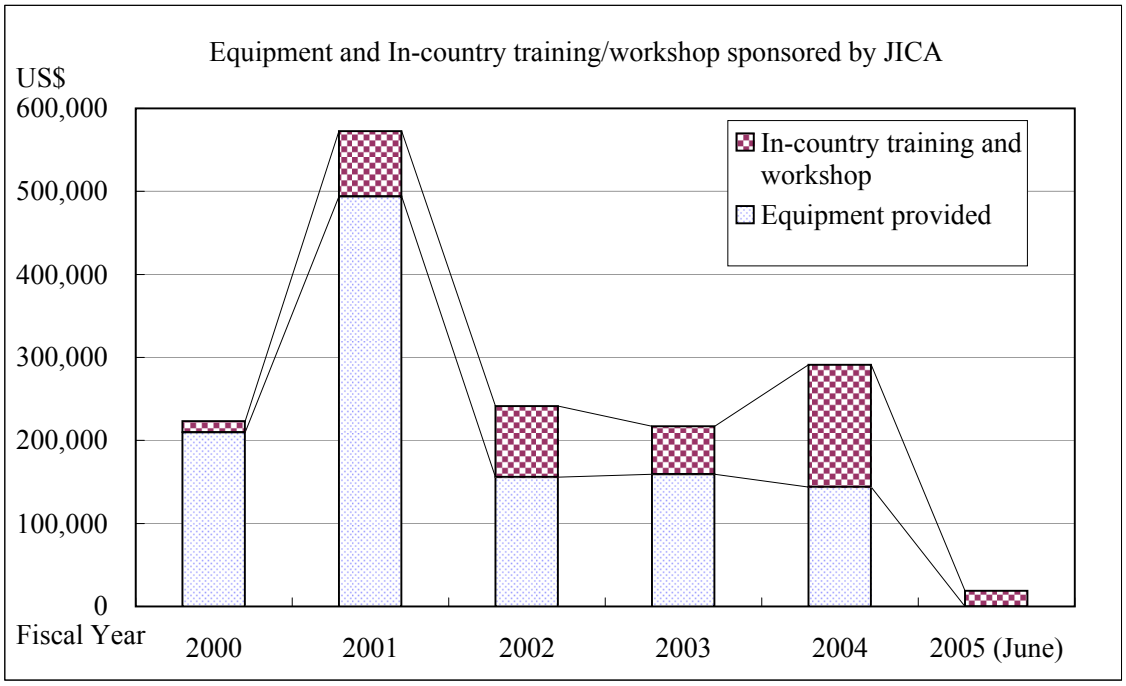
Equipment/In-country training and workshop sponsored by the JICA Project (US$)

JICA Reproductive Health Project (Phase II)
Duration: September 1, 2000 ~ August 31, 2005

(Unit: US Dollar)

FY	2000	2001	2002	2003	2004	2005 (June)	Total
Equipment provided	209,852.00	493,967.00	155,901.00	159,095.00	143,950.00		**1,162,765.00**
In-country training and workshop	13,317.00	78,820.00	85,451.00	57,950.19	147,283.44	19,064.00	**401,885.63**
Total	**223,169.00**	**572,787.00**	**241,352.00**	**217,045.19**	**291,233.44**	**19,064.00**	**1,564,650.63**

Notes: The Project has also mobilized non-Project resources: 1) US$163,814 for facility upgrading in CHCs from the Japanese Embassy through the Grassroots Grant Aid; 2) Follow-up funds for the equipment maintenance provided during the Phase I Project (US$11,119) from JICA VietNam Office; and, GO-NGO Collaboration funds for two operational studies from the JICA headquarters.



Assignment of the Counterparts

Technical Area	Name	Staffing						C/P Training		Organization/Position
		FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	Year	Training institution	
		4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1			
Project management	Mr. Hoan Ky	→	→	→	→	→	→	2001	JOICEP; Yamanashi, etc.	Vice-chairperson, Nghe An Provincial People's Committee; Chairperson of Joint Committee for the Project
	Dr. Pham Ung	→	→	→	→	Retired Aug. 2003		1998	JOICEP; Kagoshima, etc.	Director, Nghe An Provincial Health Service
	Dr. Tran Thi Thien	→	→	→	→	Retired Mar. 2004		1997	JOICEP; Kagoshima, etc.	Joint Committee member; Deputy Director, Nghe An Provincial Health Service
	Dr. Nguyen Thi Phuc			Joined in Training (FP Fund)	Director, Provincial Health Service since Aug. 2003 →	→	→	2003	JOICEP; Japanese Red Cross Katsushika Maternity Hospital (Jan.-Feb.2004 Course for Vietnamese Trainees)	Joint Committee member; Director, Nghe An Provincial Health Service（since Aug. 2003）
	Mr. Pham Xuan Hoi				*Chair,* Provincial Committee for Population, Family and Children since Aug. 2003 →	→	→	2003	JOICEP; Japanese Red Cross Katsushika Maternity Hospital (Jan.-Feb.2004 Course for Vietnamese Trainees)	Joint Committee member; Chair, Provincial Committee for Population, Family and Children (FP Fund）
	Ms. Nguyen Thi Minh Chau		Retired Dec. 2001					1999	JOICEP; Gunma, etc.	Joint Committee member; President, Women's Union（Retired Dec. 2001）
	Ms. Nguyen Thi Lien			President, Women's Union since Jan.2002 →	→	→	→	2002	JOICEP; Yamanashi, etc.	Joint Committee member; President, Women's Union （Since Jan. 2002）
	Dr. Do Thi Mui			Retired Dec. 2002				1999	JOICEP; Fukushima Red Cross Hospital; Kagoshima, etc.	Joint Committee member; Chair, Nghe An Provincial Steering Committee; Director, MCH/FP Centre (Retired Dec.2002)
	Dr. Nguyen Ba Tan				Director, since Jan. 2003 →	→	→	2000	JOICEP; Fukushima Red Cross Hospital; Kagoshima, etc.	Joint Committee member; Chair, Nghe An Provincial Steering Committee; Director, MCH/FP Centre (Since Jan. 2003)
	Dr. Bui Dinh Long	→	→	→	Training leave for Promotion Oct. 2003- Sept. 2005			2000	JOICEP; Fukushima Red Cross Hospital; Kagoshima, etc.	Member of Nghe An Provincial People's Committee; Vice-director, MCH/FP Centre (training leave since Oct.2003)

Technical Area	Name	Staffing						C/P Training		Organization/Position
		FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	Year	Training institution	
		4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1			
	Dr. Le Thi Hoai Chung				Deputy Director since May 2003 →			2004	JOICEP; Japanese Red Cross Katsushika Maternity Hospital (Jan.-Feb.2004 Course for Vietnamese Trainees)	Member of Nghe An Provincial Steering Committee; Deputy Director, MCH/FP Centre
	Dr. Tran Quang Phong	→	→	→	→	→	→	2001	JOICEP; Yamanashi; Kagoshima, etc.	Member of Nghe An Provincial Steering Committee; Head, Planning Division, MCH/FP Center, Nghe An
	Dr. Cao Phi Nga	- - - - - - - - -		Maternity leave Apr.-Sept. 2002	Short-term Assignment at Nursing College →	Left MCH/FP Jan. 2004		2002	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima, etc.	Member of Nghe An Provincial Steering Committee; Planning Division, MCH/FP Centre
	Mr. Duong Van Lam	→	→	→	→	→	→	2003	JOICEP; Japanese Red Cross Katsushika Maternity Hospital (Jan.-Feb.2004 Course for Vietnamese Trainees)	Member of Nghe An Provincial People's Committee; MCH/FP Centre Procurement and Perssonel
	19 District Steering Committee									Each district
	District People's Committee →	→	→	→	→	→	→			Chair or Vice-chair, District People's Committee (1)
	District Health Centre	→	→	→	→	→	→			President, District Women's Union (1)
	District Women's Union	→	→	→	→	→	→			District Health Centre (2)
	District Committee for Population, Family and Children	→	→	→	→	→	→			District Committee for Population, Family and Children (1), 95 members in total
	469 Commune Health Centre									Each commune
	Commune People's Committee	→	→	→	→	→	→			Chair or Vice-chair, Commune People's committee (1)
	Commune Health Centre	→	→	→	→	→	→			President, Commune Women's Union (1)
	Commune Women's Union	→	→	→	→	→	→			Commune Health Centre (1)
	Commune Population, Family and Children	→	→	→	→	→	→			Commune Committee for Population, Family and Children (1), 1,876 members in Total

Technical Area	Name	Staffing						C/P Training		Organization/Position
		FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	Year	Training institution	
		4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1			
MCH management	Dr. Nguyen Dinh Loan	→	→	→	→	→	→	1998	JOICEP; Kagoshima, etc.	Director, MCH/FP Department, Ministry of Health
	Dr. Nguyen Duy Keh		→	→	→	→	→	2001	JOICEP; Kagoshima, etc.	Vice-director, MCH/FP Department, Ministry of Health
	Dr. Pham Ung	→	→	→	→	Retired Aug. 2003		1998	(As above)	Director, Nghe An Provincial Health Service
	Dr. Cao Xuan Nghiem					→	→	2004	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima, etc. (Jan.-Feb.2005 Course for Vietnamese Trainees)	Deputy Director, Nghe An Provincial Health Service（MCH/FP Focal Point）
	Dr. Do Thi Mui	→	→	Retired Dec. 2002				1999	(As above)	Joint Committee member; Chair, Nghe An Provincial Steering Committee; Director, MCH/FP Centre (Retired Dec.2002)
	Dr. Nguyen Ba Tan	→	→	→	Director since Jan. 2003	→	→	2000	(As above)	Joint Committee member; Chair, Nghe An Provincial Steering Committee; Director, MCH/FP Centre (Since Jan. 2003)
	Dr. Bui Dinh Long	→	→	→	Training leave for Promotion Oct. 2003- Sept. 2005			2000	(As above)	Member of Nghe An People's Committee; Vice-director, MCH/FP Centre (training leave since Oct.2003)
	Dr. Le Thi Hoai Chung				Deputy Director since May 2003	→	→	2004	(As above)	Member of Nghe An Provincial Steering Committee; Deputy Director, MCH/FP Centre

Technical Area	Name	Staffing						C/P Training		Organization/Position
		FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	Year	Training institution	
		4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1			
Midwifery education	Dr. Bui Dinh Long				Meical Training leave Oct. 2003- Sept. 2005			2000	(As above)	Member of Nghe An Provincial People's Committee; Vice-director, MCH/FP Centre (training leave since Oct.2003)
	Ms. Nguyen Thi Hoa	→	→	→	→	→	→	2002	JOICEP; Japanese Red Cross Katsushika Maternity Hospital, etc.	MCH/FP Centre , Nursing, second in Charge (PNC)
	Ms. Nguyen Thi Thuy Anh	→	→	→	→	→	→	2002	JOICEP; Japanese Red Cross Katsushika Maternity Hospital, etc.	MCH/FP Centre, Nursing, second in Charge (PNC)
	Ms. Pham Thi Hai	→	→	→	→	→	→	2002	JOICEP; Japanese Red Cross Katsushika Maternity Hospital,	Planning Division, MCH/FP Centre
	Dr. Le Thi Hoai Chung				Deputy Director since May 2003 →			2004	(As above)	Member of Nghe An Provincial Steering Committee; Deputy Director, MCH/FP Centre
	Dr. Dang Manh Binh	→	→	→	→	→	→	2003	JOICEP; Japanese Red Cross Katsushika Maternity Hospital, etc. (Jan.-Feb.2004 Course for Vietnamese Trainees)	Director, Hung Yen Health Centre; Hung Yen District Steering Committee member
	Dr. Tran Phong	→	→	→	→	→	→	2004	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima, etc.	Doctor, Obstetrics, QL District Health Centre; District Steering Committee member
	Ms. Le Thi Ha	→	→	→	→	→	→	2004	JOICEP; Japanese Red Cross Katsushika Maternity Hospital, Kagoshima, etc. (Jan.-Feb.2005 Course for Vietnamese Trainees)	Assistant Doctor, Obstetrics, MCH/FP Centre
	Ms. Nguyen Thi Thuc Anh	→	→	→	→	→	→	2004	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima, etc.	Assistant Doctor, Obstetrics, MCH/FP Centre
	Dr. Vo Thi Vinh	- - -	- - -	- - -	- - -	- - -	planned - - - →	2005	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kyoto, etc.	Doctor, Obstetrics, Dien Chau District; District Steering Committee member

Technical Area	Name	Staffing						C/P Training		Organization/Position
		FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	Year	Training institution	
		4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1			
	Ms. Duong Thi Bich Hanh						planned	2005	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kyoto, etc.	Midwife, MCH/FP Centre
	Ms. Nguyen Thi Tuyet						planned	2005	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kyoto, etc.	Assistant Doctor, Obstetrics, MCH/FP Centre
	Ms. Pham Thi Thu Hien						planned	2005	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kyoto, etc.	Assistant Doctor, Obstetrics, MCH/FP Centre
Obstetrics	Dr. Nguyen Ba Tan				Director, Jan. 2003			2000	(As above)	Joint Committee member; Chair, Nghe An Provincial Steering Committee; Director, MCH/FP Centre (Since Jan. 2003)
	Dr. Hoan Quac Kieu							2002	(As above)	Director, Obstetrics Department, MCH/FP Centre
	Dr. Hoang Thi Tuu							2002	JOICEP; Japanese Red Cross Katsushika Maternity Hospital, etc.	Doctor, Obstetrics, MCH/FP Centre
	Ms. Nguyen Thi Hoa							2002	(As above)	MCH/FP Centre, Nursing, second in Charge (PNC)
	Dr. Le Thi Hoai Chung				Deputy Director since May 2003			2004	(As above)	Member of Nghe An Provincial Steering Committee; Deputy Director, MCH/FP Centre
	Dr. Dang Manh Binh							2003	(As above)	Head, Hung Yen Health Centre; Hung Yen District Steering Committee member
	Dr. Bui Thi Chau							2004	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima, etc.	Doctor, Obstetrics, MCH/FP Centre
	Dr. Tran Phong							2004	(As above)	Doctor, Obstetrics, QL District Health Centre; District Steering Committee member

Technical Area	Name	Staffing						C/P Training		Organization/Position
		FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	Year	Training institution	
		4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1			
	Dr. Nguyen Thanh Thuy	←	←	←	←	Secondment to CHC, Tan Ky since Sept. 2004		2004	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima, etc.	Doctor, Obstetrics, MCH/FP Centre
	Dr. Nguyen Ngoc Khanh	←	←	←	←	←	→	2004	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima, etc. (Jan.-Feb.2005 Course for Vietnamese Trainees)	Doctor, Obstetrics, MCH/FP Centre
Health Education	Dr. Do Thi Mui	←	←	Retired Dec. 2002				1999	(As above)	Joint Committee member; Chair, Nghe An Provincial Steering Committee; Director, MCH/FP Centre (Retired Dec.2002)
	Ms. Nguyen Thi Hoa	←	←	←	←	←	→	2002	(As above)	MCH/FP Centre, Nursing, second in Charge (PNC)
	Dr. Bui Thi Chau	←	←	←	←	←	→	2004	(As above)	Doctor, Obstetrics, MCH/FP Centre
	Ms. Nguyen Thi Thuc Anh	←	←	←	←	←	→	2004	(As above)	Doctor, Obstetrics, MCH/FP Centre
	Dr. Vo Thi Vinh	- - -	- - -	- - -	- - -	- - -	planned →	2005	(As above)	Doctor, Obstetrics, Dien Chau District; District Steering Committee member
	Ms. Duong Thi Bich Hanh	- - -	- - -	- - -	- - -	- - -	planned →	2005	(As above)	Midwife, MCH/FP Centre
	Ms. Nguyen Thi Tuyet	- - -	- - -	- - -	- - -	- - -	planned →	2005	(As above)	Assistant Doctor, Obstetrics, MCH/FP Centre
	Ms. Pham Thi Thu Hien	- - -	- - -	- - -	- - -	- - -	planned →	2005	(As above)	Assistant Doctor, Obstetrics, MCH/FP Centre

Technical Area	Name	Staffing						C/P Training		Organization/Position
		FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	Year	Training institution	
		4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1	4 7 10 1			
Health Statistics	Dr. Dao Trong Dung		→	→	→	→	→	2002	JOICEP; Kagoshima, etc.	Head, Planning division, Nghe An Provincial Health Service
	Dr. Tran Quang Phong	→	→	→	→	→	→	2001	(As above)	Provincial Steering Committee member; Head, Planning Division, MCH/FP Centre
	Dr. Cao Phi Nga	→	→	Maternity leave Apr.-Sept. 2002	Short-term Assignment at Nursing College	Left MCH/FP Jan. 2004		2002	(As above)	Provincial Steering Committee member; Plannning Division, MCH/FP Centre
Community Participation	Ms. Nguyen Thi Minh Chau	→	Retired Dec. 2001					1999	(As above)	Joint Committee member; President, Women's Union（Retired Dec. 2001）
	Ms. Nguyen Thi Lien			President, Women's Union since Jan.2002	→	→	→	2002	(As above)	Joint Committee member; President, Women's Union（Since Jan. 2002）
	Ms. Pham Hoai Thi	→	→	→	→	→	→	2001	JOICEP; Gunma, etc.	Nghe An Province Women's Union, Permanent Member
	Dr. Tran Hanh Ngoc	→	→	→	→	→	→	2001	JOICEP; Gunma, etc.	Deputy Director, Yen Thanh District Health Centre; District Steering Committee member
	Ms. Le Thi Tam				→	→	→	2004	JOICEP; Japanese Red Cross Katsushika Maternity Hospital; Kagoshima, etc. (Jan.-Feb.2005 Course for Vietnamese Trainees)	Vice President, Nghe An Province Women's Union
———	Already attended counterpart training in Japan									
- - - - - - - - - -	Expected to attend conterpart training in Japan									

Vietnamese Contribution to Project Activities (VND)

JICA Reproductive Health Project (Phase II)
Duration: September 1, 2000 ~ August 31, 2005

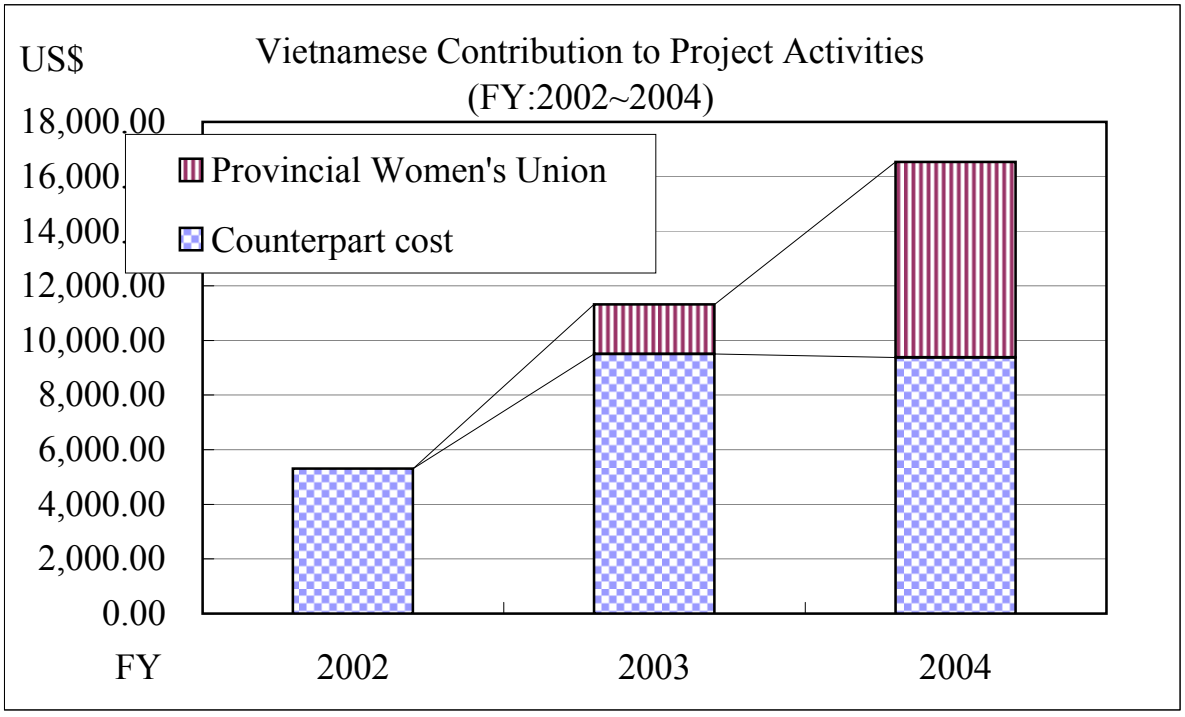
FY	2002	2003	2004	2005	TOTAL
Counterpart cost	82,066,020	147,000,000	145,000,000	n/a	**292,000,000**
Provincial Women's Union*	0	28,248,000	110,900,000	n/a	**139,148,000**
TOTAL	**82,066,020**	**175,248,000**	**255,900,000**	**n/a**	**431,148,000**

* PWU's contribution is not included in "counterpart cost"
** only 2002-2004 data were available.

Vietnamese counterpart cost (in US Dollar Equivalent)***

FY	2002	2003	2004	2005	TOTAL
Counterpart cost	5,302.79	9,498.58	9,369.35	n/a	**18,867.92**
Provincial Women's Union	0.00	1,825.28	7,165.93	n/a	**8,991.21**
TOTAL	**5,302.79**	**11,323.86**	**16,535.28**	**n/a**	**27,859.14**

*** Exchange rage: 1US$=15,476VND



Note: The Women Union has had contribution to the Project activities from there own resources since 2000. However, 2000~2002 figures were not available.

Table of Activities and Achievements April 2004 - April 2005

Achievement Level of Activities				
Plan of Activities **PDM activities**	**Expected outcome**	**Progress**	**Reasons for Delay or Difficulties**	**Future Plan**
For Output 0 : Steering Committees (SC) at all levels are established and are functioned regularly and continuously				
0.1 Review and define the function and responsibilities of SCs at all levels	The function and responsibilities of SCs at all levels are reviewed and defined	Each of the four member agencies, i.e. People's Committee, health sector, Women's Union, and Committee for Population, Family and Children plays its own role and responsibility in harmonious way for the good collaboration.	–	Check regularly by the Vietnamese counterparts
0.2 Review SC members in the experienced districts (8 districts)	SC members in the experienced districts (8 districts) reviewed	After the general election in April 2004, there has been the change in members of the steering committee, and the new membership has been confirmed. The no. of female vice chairpersons of PC has been increased.	–	Check regularly by the Vietnamese counterparts
0.3 Establish SC at district and commune levels in new project area (11 districts)	SC at district and commune levels in new project area (11 districts) established	After the general election in April 2004, there has been the change in members of the steering committee, and the new membership has been confirmed. The no. of female vice chairpersons of PC has been increased.	–	Check regularly by the Vietnamese counterparts
0.4 Conduct orientation of the Project to SC members of new project area	Orientation of the Project to SC members of new project area conducted	The workshops for strengthening collaboration were organized with the participation of the all members of 469 commune steering committee held in each district. The topic handled at the workshop were; review of the project activities, pregnancy care, abortion reduction, family planning, health of pregnant women.	Due to the general election organized in April, the implementation of the activities was delayed for about two months, however, it did not affect the overall progress, as the workshops for CSC members completed within the second quarter.	In 2005, the CSC workshops are planned to be organized in July - August for summing up the project outcomes and achievements in order to complete the project.
0.5 Conduct exchange of experience among experienced districts and new districts	Exchange of experience among experienced districts and new districts conducted	Experiences exchanged when there is opportunity such as DSC meetings. The differences in the progress among districts are found individual basis rather than the difference in terms of Phase I and Phase II coverage.	–	Implemented with the initiative of the Vietnamese counterparts.

0.6 Conduct regular meeting of DSC and PSC (quarterly)	Continue conducting regular meeting of DSC and PSC (quarterly)	The regular meetings were organized in July and December in 2004. In July, the main objective was to review and approve the 2003 activities and to approve the 2004 work plan.. In December, the plan of mid-term assessment in March 2005 was explained and each member was requested to collaborate with the research team. Due to the other activities that invited the DSC members, it was found not practical to organize quarterly DSC meetings, which is usually planned for 4 time. DSC members gathered for the seminars held in August and September 2004. In 2005 fiscal year, the first DSC members gathered together in May in order to review the 2004 activity report and 2005 work plan.	When seminars are organized by the short-term experts for the DSC members, it becomes difficult for DSC members to gather 4 times a year for the regular meeting. All the members hold important positions at the district level, thus it could be not so easy for them to come to Vinh City frequently. Provincial PC has given instruction to the district PC officials not to come to Vinh too often. Although the meetings related to the RH Project are not affected by this instruction according to the Provincial PC, some consideration needs to be given for the convenience for DSC members.	In 2005, DSC meetings are planned in June during the visit of JICA Evaluation Mission, and in August for the completion of the project.
For Output 1: Safe and hygienic delivery is promoted at commune level.				
1.1 Retrain midwives and assistant doctor of ob/gyn	At least one midwives and/or assistant doctor of ob/gyn each from 466 CHC will have been trained	During Phase II, 13 courses were organized and a total of 310 staffs participated. The all CHCs are covered by the first 10 courses. The CHC coverage rate then was 97.6%. In the additional 3 courses organized in 2003 and 2004, the trainees were invited from CHCs of which midwives are transferred or retired.	–	In 2005, two more courses are planned to be organized.
1.2 Train hamlet health worker/TBA of mountainous districts on hygienic delivery	Necessary and possible training provided to grass root level health workers based on the finding of survey.	The CHC staffs from mountainous areas are trained how to guide hamlet health workers on the pregnancy and delivery care. DSC staffs received TOT Training on the HHW refresher course. Based on the TOT, DHC formulated plans for HHW refresher course and organized the course during the period of December 2004 - January 2005. Some of the good refresher courses have been observed. For example, in Tan Ky, the hand made IEC materials were utilized and teaching method suitable for HHW was adopted in	Due to the general election, the timing of the refresher courses were delayed. The quality of the course plan submitted by DHCs varied, therefore, the processes of the review, feedback, and re-submission took time.	Continue follow-up by DHC and MCH/FP Center.
1.3 Provide medical book for CHCs & DHCs	Medical book for CHCs & DHCs provided	Provided in May 2002.	To develop habit to learn using the medical text book with one's initiative seems to be not easy. Some staffs claim that they are too busy to study. How to develop the individual motivation for the continuous learning is the issue.	Continuous efforts in guiding the CHC staffs to organize group learning will be necessary. MCH/FP Center and DHC should continue follow-up and monitoring.

1.4 Provide all commune with IEC means and materials	All commune with IEC means and materials will have been provided	The main IEC materials provided to Women's Union for their activities: 1) three kinds of pamphlets, text books on RH issues for hamlet Women's Union members 2) two kinds of posters on pregnancy care and HBMR utilization for commune level Women's Union 3) Maggie Apron for district women's union, all CHCs, and 19 DHCs 4) Pregnancy simulator for the 19 district Women's Union 5) Maggie Apron teaching guide for commune and hamlet level Women's Union 6) RH issues scenario collection for commune and hamlet level Women's Union 7) Amplifier for 469 commune Women's Union 8) TOA amplifier for 19 Women's Union	_	Continuously promote the effective utilization of materials and equipment
1.5 WU carry out IEC activities on hygienic and safe delivery	IEC activities on hygienic and safe delivery will have been carried out by WU	Through the IEC workshops for the commune and hamlet level members of Women's Union conducted in Oct.-Nov. 2002 and Jan. and March 2003, about 6,300 members were reached and the motivation and awareness towards their role in conducting the IEC activities were enhanced. RH contest on RH knowledge was conducted. CSC members from WU joined in the CSC workshops for strengthening of collaboration among agencies. The Aiiku-han activities have been under promotion. The technical workshop on the utilization of Maggie Apron were conducted for the district WU in March, June and July 2003 so that the WU is able to organize the dissemination workshop in collaboration with CHCs. After this TOT, district Women's Union organized training for the commune Women's Union. During the monitoring visit for the CHC activities, the comune levle Women's Union members receive guidance on the health education sessions. In 2003, it is reported that 832 health sessions were organized in 430 communes, and the accumulated no. of participants were about 43,000.	_	Continue encouraging commune level to plan health sessions based on the needs of the locality and conduct the activities in collaboration with CHC staffs and Women's Union.

1.6Conduct preventing activities for better understanding of implications of abortion including MR at all levels	Preventing activities for better understanding of implications of abortion including MR at all levels conducted.	The IEC workshops for dissemination of RH knowledge were organized in each districts by the Women's Union in collaboration with the healht sector. The topics were prevention of induced abortion = pervention of unwanted pregnancy = promotion of family planning, adolescents' RH. About a total of 3,000 representatrives of commune Communist Party, Fatherland Front, Farmers' Union, Culture and Information Department of People's Commitee, Youth Union, CHC staff (mountainous area), about 6,300 commune and hamlet level Women's Union members, a total of 9,300 people participated. It is expected that those leader will contribute to disseminate the kowledge and information. The same messages were disseminated at the CSC workshops. The Advocacy semianr invited the provincial and district level leaders of various organizeations, mass media seminar, workshop of abortion data analysis, guidance by the obgyn doctors were conducted. There are commune Women's Union members that organize health session with Maggie Apron for the reduction of aborion.	In general, the awareness among staff of the Committee for Population, Family and Children, especially among male staff is not very high. People are very much committed to limit the no. of children and the social pressure is quite strong at all levels. On the other hand, after the Population Ordinance was issued, National CPFC has a concern that the couples who intend to have the third child is increasing. The Nghe An PCPFC held a big campaign on FP promotion in 2004. The awareness among ordinary people is not strong enough to promote FP in order to avoid abortion. As one of the steps towards the reduction of the risk of abortion, Vietnam MOH tries to encourage earlier vacuum aspiration instead of D & C. In Nghe An Province, the awareness has been gradually increased among the male leader who participated in the workshops.	The message to promote the correct utilization of modern contraceptive methods will be disseminated by the initiative of PSC and DSC.
For Output 1-1 : Prenatal care at commune level is improved.				
1.1.1 Provide pregnancy check-up means	Pregnancy check-up means provided	Provided as a part of the basic equipment.	_	Regular monitoring by DHC initiative
1.1.2 Promote pregnant women 2 tetanus vaccination	Pregnant women 2 tetanus vaccination promoted and high level of vaccination rate maintained	The coverage of TT in Nghe An is high and it reached to nearly 94% in 2004. CHC retraining handles TT vaccination. RHC guideline were mass printed and provided to all 469 CHCs.	It is necessary to develop attitude to raise questions to the upper level and solve them and to take initiative to collect useful and new information on medical and health issues, which is completely lacking among the local health sector, including MCH/FP Center and DHC.	Regular monitoring by DHC initiative.
1.1.3 Provide pregnant women with guidance & counseling services	Pregnant women are provided with guidance & counseling services	The quality of parents class at the MCH/FP Center has been improved, e.g. distributing handouts to the clients. The parents classes are one of the topic of the CHC staffs retraining. The guidance is continuing during the monitoring refresher courses.	There is room to improve the basic communication skill among health with clients, i.e. whether heath workers can or they are willing to have a sympathetic attitude towards clients. Some health workers claim there is not enough time for them to spend more time for clients. It is also pointed out that there is no technical fee for counseling service thus counseling does not increase the income of the health workers.	Continuous follow-up through the monitoring and refresher courses.

1.1.4 Train women's union members to have good IEC skills to promote pregnancy check-up and utilization of HBMR	Women's union members have good IEC skills to promote pregnancy check-up and utilization of HBMR	A workshop on formulation of health plan was organized for the representatives of the local government and Women's Union from 6 communes in Yen Thanh District, including 3 Aiiku-han model communes. Representatives of the local government leaned their support is inevitable for the community health improvement, and how to collaborate with the community people. The key members of Women's Union at all levels have been reached with the skill training on utilization of IEC materials and the RH education sessions are conducted for the commune people.	_	Continue Aiiku-han model activities. Women's Union in collaboration with CHC staffs and Youth Union will continues identify needs of the communes, formulate education plan, and conduct health education utilizing IEC materials based on the plan.
1.1.5 Train midwives at district and commune level to have good skill of using Maggie Apron	Train midwives at district and commune level to have good skill of using Maggie Apron	Conducted training on utilization of Maggie Apron for the CHC staffs during the re-training course. In addition, the CHC staffs are invited when the commune level training on Maggie Apron utilization was organized in each district in collaboration with the Women's Union.	Generally speaking, the members of the commune Women's Union are more skillful in utilizing Maggie Apron than the CHC staffs. The Maggie Apron were provided to the CHCs, however, the materials are not well utilized by the CHC staffs, as it appears that CHC staffs cannot give priority to the health education among their work. Currently, the practical and effective way to promote health education session at the commune level is to organize the sessions with the initiative of the Women's Union involving CHC.	Women's Union in collaboration with other agencies, especially CHC and Youth Union will continues identify needs of the communes, formulate education plan, and conduct health education utilizing IEC materials based on the plan.
1.1.6 Provide CHC with enough Maggie apron	All CHC will be provided with enough Maggie apron	Supply of Maggie Apron to all CHC completed in May 2003. In order to promote active utilization of the material, 19 district Women's Union were also provided with Maggie Apron, and conducted skill training on utilization of the material. The know-how of utilization of the materials has been disseminated to the commune level, then the health sessions have been on-going in collaboration with CHC.	_	Women's Union in collaboration with other agencies, especially CHC and Youth Union will continues identify needs of the communes, formulate education plan, and conduct health education utilizing IEC materials based on the plan.
1.1.7 Implement Aiiku-han model to manage pregnancy at hamlet level	Aiiku-han model to manage pregnancy at hamlet level implemented	Monthly meetings among Aiiku-han members held regularly in 2004. It has been decided and agreed that the coordinating body that used to be health sector will be shifted to the Provincial Women's Union. This will make the support and supervision of the commune and hamlet level activities easier as the Aiiku-han members are the Women's Union members. The health sector continue providing support as before.	_	The provincial Women's Union plans to expand the Aiiku-han activities to the other communes in Yen Thanh in 2005, and to the other district in 2006.

1.1.8 Organize RH promotion classes in the selected CHCs, DHCs and MCH/FP Centre	RH promotion classes in the selected CHCs, DHCs and MCH/FP Centre will have been organized	The quality of the parents classes at MCH/FP Center has been improved and regularly organized with the stable no. of participants.	The follow-up of the health sessions of DHC has been thorough.	To encourage MCH/FP Center to create opportunity for DHC to observe the parents classes at MCH/FP Center.
1.1.9 Increase the usage of pregnancy management box	The usage of pregnancy management box will have been increased.	Almost all CHCs have prepare the pregnancy management box. Through the refresher courses at DHC and the model activities, the utilization has been guided.	_	MCH/FP Center and DHCs will ensure the provision and effective management box in all CHCs
1.1.10 Make use of HBMR in all areas of Nghe An	HBMR will have been utilized in all areas of Nghe An	HBMR has been distributed to all CHCs and utilized as the record for the prenatal check-ups at most of the CHCs.	The guidance is necessary so that HBMR is not only for the pregnancy care record but used as a useful referenct at the delivery.	The effective and proper utilization should start at MCH/FP Center so that the proper guidance can be
1.1.11 Have correct monthly data for pregnant women	Monthly data for pregnant women will have been collected	As a part of HMIS promotion, the training on how to fill the recording format for CHC staffs conducted with the initiative of DHCs. It was the first time for CHC staffs to receive this kind of training and considered to be useful.	As for the issue of accuracy of the data, MCH/FP Center, DHC, and PHS need to guide them continuously with patience.	The continuous follow-up and guidance by DHC need to be continued to improve the quality of raw data and reporting situation.
1.1.12 Refer high risk pregnant women to the upper level as soon as possible	High risk pregnant women will have been referred to the upper level as soon as possible	CHC staffs are trained on the risk cases during the CHC retraining and refresher courses organized by DHC.	It is difficult to assess the appropriateness of the referral cases.	Regular monitoring and refresher courses by DHC initiative on utilization of Partograph
For Output 1-2: Delivery Care at commune level is improved.				
1.2.1 Strengthen the capacity of MCH/FP Centre on delivery assistance skill	Capacity of MCH/FP Centre on delivery assistance skill will have been strengthened	Since 2002 every year, midwives, assistant doctors, and doctors of MCH/FP Center have been sent to the counterpart training on midwifery training. The long term expert on midwifery provide advices on the services through the daily observation sessions. Workshops on the client friendly services are conducted for the MCH/FP Center staff from all the divisions. Internal training has been organized weekly. The improvement of the MCH/FP Center facilities are regularly on-going.	Together with the attitude for the clients, the skill for delivery care should be guided, as the traditional methods are not likely client friendly. However, for many of the health workers, it does not seem to be easy to change the way for the delivery care that has been learnt at the school and practiced for a long time.	It is necessary to establish the system to review the services regularly and develop the mind among health staffs not to self conceited.
1.2.2 complete procedure (process) of infection control	Procedure (process) of infection control will be conducted completely	The workshop on the infection control by the short-term expert was conducted for the MCH/FP Center staff. Poster for hand washing was produced and distributed to DHCs and CHCs. In 2005, MCH/FP Center started the monitoring visit to check the infection control situation at DHC and CHC.	Generally speaking, health workers feel the infection control is not sufficiently practiced. It has been reported that the sterilization of medical supply is not frequent enough. Some explained that the CHC receives few clients therefore the frequent sterilization is not economical.	DHCs are expected to provide appropriate guidance to CHCs through monitoring and refresher courses. It is expected that the effective guidance will be conducted based on the outcomes of the infection monitoring by MCH/FP Center.

1.2.3 Promote delivery at CHCs	Delivery at CHCs will have been promoted	All the 466 CHC have been equipped with necessary equipment for safe and hygienic delivery. 97.6% of CHC staffs have gone through the re-training course. CHCs hygienic facilities are completed except 5 districts. The DHCs are encouraged to follow-up the knowledge and skill level of CHC staff through refresher courses and regular monthly meetings. Through WU members and CSC members, the information on the improvement of CHC situation is being disseminated. The CHC delivery rate in 2004 increased comparing with the data in 2003.	In mountainous area, some CHC facilities are located physically too far away from some community people and tremendously inconvenient. Some custom and practices, religious barriers are regarded to be difficult to overcome. It is suspected that some people do not find the merit to delivery at CHC by overcoming the geographical and other barriers. On the other hand, the report says that the rate of the delivery attended by the health workers (including the attended cases by the hamlet health workers at home) is over 90%.	There are areas in the mountainous districts where the home delivery rate is 100% , and people have to depend on the hamlet health workers. Continue encourage to promote the training of hamlet health workers through the strengthening of the collaboration with CHC and DHC.
1.2.4 Train on usage of partograph	CHC staffs will have been trained on usage of partograph	The utilization of partograph are thought and encouraged at CHC re-training course. Some DHCs that frequently provide necessary training for CHC staffs and improved the performance.	The level of CHC staffs after the re-training is still differs from person to person. Unless the continuous follow-ups are conducted in accordance with the individual needs, they are not able to utilize partograph correctly. The frequent change in format by the central level makes it difficult for grass-root practice difficult.	Regular monitoring and refresher courses on utilization of partograph by DHC initiative.
1.2.5 Use partograph for deliveries at health facilities	Partograph for deliveries at health facilities will be utilized	According to the sample survey by the mid-term assessment, about 40% of CHC are using partograph while it was not known the CHC when the project started.	The format of the partograph is continuously changed at the national level. It is difficult at the CHC level to follow the frequent change of format. The change seems to take place almost annually. If one understand the partograph as well as one can teach, it may not be so difficult to adapt the new form, however, at the commune level, it create uncertainty and discourage the utilization.	The Provincial Health Service is expected to feedback what happened in the commune level to the central level.
For Output 1-3: Postnatal care at commune level is improved.				
1.3.1 Develop manual for post-natal care	Manual for post-natal care will be developed	The post natal care guideline in the National Standard for RHC Guidelines has been utilized. The copies of the RHC guidelines were mass printed and distributed to all CHCs.	–	Encourage PHS and MCH/FP Center to disseminate the guideline.
1.3.2 Train midwife or ass. doc. Ob/Pd on post-natal care	Midwife or ass. doc. Ob/Pd will be trained on post-natal care	As a part of CHC staff re-training, the subject has been covered. The training for MCH/FP Center and DHC staff was conducted in Jan. 2003. The internal training at MCH/FP Center covers the subject, and there is a plan to produce leaflet on post-natal care.	The importance of the post natal care has been understood while the service at the CHC level is yet to be improved. For the provision of training, DHCs mention the time and financial as constraints.	Encourage DHC continuously to utilize the opportunity of refresher courses and monthly meeting to guide the CHC staffs. The PHS and MCH/FP Center will be encouraged to follow up the activities.

1.3.3 Train WU on post-natal care promotion	WU trained on post-natal care promotion	_	The topic covered by the health sessions organized by the Women's Union covered mainly pregnancy care and prevention of abortion, and the post natal care has been covered sufficiently yet.	MCH/FP Center is expected to organize the health sessions covering the post-natal care in collaboration with Women's Union. Aiilku-han activities will cover the post natal care aspect.
1.3.4 Provide home visiting kit for midwives and ass. doc. Ob/Pd	Home visit kit for midwives and ass. doc. Ob/Pd will be provided	The home visit kits have been distributed to the CHCs. DHCs are advised to covered the subject of post natal care in the refresher course.	_	The effective utilization of home visit kit will be promoted through the refresher courses and monitoring.
1.3.5 Conduct standardized post-natal care to post-delivery women within 42 days	Standardized post-natal care to post-delivery women within 42 days will be conducted	As a part of CHC staff re-training, the subject has been covered. Follow-up is conducted by MCH/FP Center and DHC. The rate of CHCs that conduct at least home visit after the delivery was 42% in 2003, and increased to 85% in 2004. As for the rate of CHCs that conduct post delivery home visits more than twice is 42% in 2004.	The different between the care immediately after the delivery and post-delivery should be well understood.	The follow-up by MCH/FP Center and PHS guidance will be promoted.
For Output 1-4: Essential medical equipment is utilized to all CHCs.				
1.4.1 Review the existing equipment at CHCs	The existing equipment at CHCs reviewed	At the initial stage of the Phase II, the information on the situation of the equipment at CHC and availability of electricity, etc. was collected through the respective DHCs. Based on the information, the list of appropriate equipment was considered. The condition and utilization of the equipments are checked at the time of monitoring activities.	When the other agencies, such as other government agencies, NGOs etc, provide with equipment, it is not easy to grasp the whole situation at the provincial level. The equipment of CHC are registered as the property of the People's Committee, therefore, once registered, it becomes almost impossible in practice to transfer the equipment even in the case of duplication. .	_
1.4.2 Categorize the function of CHC (mountainous, plain or city type)	The function of CHC (mountainous, plain or city type) categorized	The principal roles and functions of CHCs that are categorized according to the geographical areas have been generally understood,	_	PHS is expected to provide proper guidance to CHCs for the promotion of their function required according to their locality.
1.4.3 Prepare a list of equipment	List of equipment prepared	Based on the information on CHCs, such as availability of electricity obtained from respective DHCs, the CHC were categorized into groups. The different equipment lists were prepared according to the groups.	The list of basic equipment for CHC identified by MOH includes the equipments that cannot be necessarily utilized by CHC staffs due to their insufficient knowledge and skill.	_

1.4.4 Provide medical equipment for CHCs according to the categories	Medical equipment for CHCs according to the categories provided	In Phase II, in the first two years a total of 222 CHCs received the basic equipment sets. In Phase I, 244 CHCs received the equipment, that make a total 466. Later, 3 communes have been officially administered and they have been also provided the equipment. 100% of CHCs have been covered with the supply of equipment.	The reports submitted by DHC have not necessarily reflected the real situation. Within the current system, It is not easy for the health sector to obtain information on equipment that are supplied by the other sectors.	Three Additional sets of the basic medical equipment will be provided to the newly administered communes in 2003.
1.4.5 Train CHC staff on usage and maintenance of the equipment	CHC staff on usage and maintenance of the equipment trained	The project's direct intervention is to provide training session on the utilization and maintenance of equipment under the one-month re-training. A equipment maintenance workshop was organized for DHC with the technical support by the JICA Vietnam Office expert, a short-term expert of Bach Mai Hospital Project and the expert of Bach Mai Hospital in order to review the current problems.	Some necessary equipment cannot be utilized by CHC staffs due to their insufficient knowledge and skill. It takes time to train CHC staff to be able to utilize the equipment properly, and it is necessary to follow up frequently. However, this situation is not understood well among parties concerned. The reporting system of troubled equipment does not exist or not well functioned. DHCs are not necessarily knowledgeable of the CHC equipment condition, nor their own equipment. At the district level, there is no agency with acceptable capacity for the maintenance. MCH/FP Center and DHC are not capable enough to guide the lower level in equipment management.	It is hoped that some kind of system will be established for the appropriate maintenance of equipment with possible technical assistance from Bach Mai Hospital, for example.
For Output 1-5: Four facilities of CHCs (delivery room, latrine, well and shower room) are improved				
1.5.1 Upgrade health facilities in CHCs (delivery room, shower room, latrine and well)	Health facilities in CHCs such as delivery room, shower room, latrine and well, upgraded	2001 GAGRP activities for 116 CHC completed. The 88 CHCs of five mountainous districts receive 2004 support and the contraction in some communes started.	There are CHC where toilet facility is not utilized. The reasons are: water is not available in some months of the year, toilet is stuck as the clients do not know haw to use toilet, etc.	MCH/FP Center should be responsible for the supervising the implementation of the activities. Water is essential for CHC not only for toilet and for the overall services. PHS, MCH/FP Center and DHC shall strengthen guidance for the commune to secure the water sources. CHC will be guided it is possible to use toilet by keeping water in the container and not necessarily use as a flash toilet.
1.5.2 Train CHC staff on maintenance of the facilities	CHC staff trained on maintenance of the facilities	As a part of CHC staff re-training, this subject was covered.	_	Follow-up though the regular monitoring by DHC initiative
1.5.3 Conduct IEC/BCC training	IEC/BCC training conducted	—	—	The guidance to be continued through monitoring by MCH/FP Center and DHC.
For Output 2: Monitoring capacity of MCH/FP Centre and selected DHCs is improved				

2.1 Formulate monitoring team at MCH/FP Centre and DHCs	Monitoring team at MCH/FP Centre and DHCs formulated	Activities focused on the model districts are on-going. The monitoring workshop was conducted for all 19 DHCs. Currently selected as monitoring districts are;Tan Ky, Quy Hop, Dien Chau, Quynh Luu, Hung Nguyen。	_	Activities will continue.
2.2 Conduct training for monitoring teams	Training for monitoring teams conducted	Monitoring refresher courses were conducted every year in order to up-date and refresh the monitoring methods among the persons in charge. The monitoring check-list have been improved as necessary. In 2003, the refresher courses were conducted for 11 DHCs, and covered the planning, implementation and practice by visiting CHCs. In 2004, all 19 DHCs participated in the refresher courses. An accumulated no. of total no. of participants are 145 DHC staffs, and 28 MCH/FP Center staffs.	The general election also affected the schedule of the monitoring refresher course making it delayed for some months.	Continue monitoring with the initiative of MCH/FP Center and DHC.
2.3 Develop monitoring check list	Monitoring check list developed	Standard monitoring list has been completed. The improvement is being made constantly and as necessary	_	Continue using monitoring list
2.4 Provide means of transportation to MCH/FP Centre and DHCs	Means of transportation to MCH/FP Centre and DHCs provided	Completed	_	
2.5 Develop monitoring plan at MCH/FP Centre and DHCs	Monitoring plan at MCH/FP Centre and DHCs developed	It has become regular activities in the selected model districts	_	Follow-up activities will continue.
2.6 Conduct monitoring according to plan	Monitoring according to plan conducted	On-going in the selected districts	_	Follow-up activities will continue.
2.7 Submit the summary of monitoring findings to the Project office	Summary of monitoring findings to the Project office submitted	Followed by the annual activities assessment meeting organized by the MCH/FP Center. The long-term expert provided guidance how to review the data of monitoring outcome and analyze, ant reflect the outcome in the refresher course.	_	Continue conducting annual assessment.
For Output 3: Number of abortion conducted at MCH/FP centre and selected districts is reduced.				
3.1 Assess the current situation of abortion	The current situation of abortion assessed	With the technical assistance by the short-term expert, the workshop on data analysis was conducted. Conducted with the support by a short-term expert. Data input is being continued.	_	Continue the data input and training on data analysis to be given as a part of HMIS promotion.

3.2 Develop strategy to reduce of abortion	Strategy to reduce of abortion developed	Committee of Population, Family and Children conducted FH campaign in collaboration with health sector and other relevant agencies.	It has been pointed out that national program for abortion reduction has not been formulated therefore no fund is allocated.	The follow-up from MCH/FP Center will be strengthened. In collaboration with PCPFC that is the responsible agency for FP service provision at the grass-root level will be strengthened.
3.3 Train health staff of MCH/FP Centre and DHCs on counseling skill	Health staff of MCH/FP Centre and DHCs trained on counseling skill	A workshop on post abortion counseling was conducted for the MCH/FP Center staff and model DHCs. The operation plan formulated. As the client friendly services are promoted, the quality of counseling is also being improved.	While the lack of counseling skill has been indicated as a problem, the lack of sympathy towards the clients among the health workers can be the immediate problem. The motivation of the health workers remains low as there is no income merit for counseling provider compare to the medical service that can earn technical fee.	Encourage PHS and MCH/FP Center to increase awareness. Conduct follow-up by the long- and short- term experts and possibility of training by the national trainers will be considered. It is expected that the abortion will be considered as national issue.
3.4 Train WU of P/D/C to have good IEC skill	WU of P/D/C trained to have good IEC skill	A total of 9,300 leaders of various commune leaders and hamlet/commune Women's Union members participated in the RH knowledge dissemination IEC workshops. The topics covered were risk and prevention of abortion, modern contraceptive methods, and adolescent RH. Training on effective utilization of Maggie Apron was conducted, and RH contest on material utilization was organized for the dissemination and encouragement among implementers. In April 2005, the seminar on experience sharing of IEC promotion was organized inviting representatives from 11 Provinces and the activities by Women's Union in collaboration with the health sector under the RH Project was highly	_	Continuous implementation of the IEC activities in collaboration between health sector and Women' s Union will be expected.
3.5 Provide enough IEC means	IEC means provided	The19 DWU and 469 commune WU are provided amplifier for the further promotion of IEC activities.	_	Continue the effective utilization of IEC materials and equipment.
3.6 Provide good quality of post abortion counseling	Good quality of post abortion counseling provided	The staffs of MCH/FP Center gradually become capable to take the view point of clients and improve the counseling. Promotion of client friendly services are on-going .	The creation of motivation of the health workers are the key to improve the counseling methods. The lack of the skill is not the main reason but used as an excuse in some cases. Many of the health workers already have basic skill. Attitude training needs to be given while health worker are students of medical school.	Continue improvement of client friendly attitude at MCH/FP Center and become model for other health institutions.

3.7 Monitor activities of preventing abortion	Activities of preventing abortion monitored	Organized CSC collaboration workshop and worked on PC to take up abortion reduction as the agenda. CPFC members were also approached. A advocacy seminar for the provincial and district leaders of various organizations, such as Communist Party, Fatherland Front, Farmer's Union, Culture and Information Department of People's Committee, Youth Union and Women's Union, and media seminar for journalists and TV correspondents. Committee for Population, Family and Children organized campaign on contraceptive promotion. In Nghe An Province, the awareness among men towards risk of abortion is increasing.	Men's awareness is still quite low. The awareness among CPFFC members also need to be created and increased. One reason for this is the lack of RH knowledge among men. National government (MOH) encourages the earlier abortion with vacuum aspiration to reduce the risk as one of the steps towards reduction of abortion.	Continuous approach is necessary. Increasing knowledge and change in attitude among leaders are as important as that of women.
3.8 Continue abortion survey at MCH/FP Centre and the selected DHCs	Abortion survey at MCH/FP Centre and the selected DHCs continued	Conducted with the support by a short-term expert in the model districts.	–	Training on data soft ware will be conducted.
3.9 Conduct evaluation survey on abortion in Province	Evaluation survey on abortion in Province conducted	The report submitted by the DHC is followed.	–	Annual assessment will continue.
For Output 4: Capacity for RTI detection and the development of prevention strategy is improved at MCH/FP Centre				
4.1 Identify counterpart for RTI survey	Counterpart for RTI survey identified	Decided to conduct RTI survey with the support by short-term experts, doctors of Tu Du Hospital, and implemented by MCH/FP Center as the focal point and in collaboration with Center for Preventive Medicine, Provincial Hospital, etc.	–	–
4.2 Set up research team	Research team is set up	The details were discussed in March 2002 and research team has been set up.	–	–
4.3 Conduct feasibility study on the RTI survey in project area	Feasibility study on the RTI survey in project area conducted	Conducted in March 2002 .	–	–
4.4 Formulate RTI survey plan	RTI survey plan formulated	The details were discussed in March 2002and plan for the following activities were formulated.	–	–
4.5 Strengthen laboratory examination capacity at MCH/FP Centre and the selected DHCs	Strengthening laboratory examination capacity at MCH/FP Centre and the selected DHCs will be conducted	At MCH/FP Center, preparatory training on research methods, lab technique, and diagnosis was conducted for the staff of MCH/FP Center, Nghia Dan DHC, Preventive Medicine Center, Provincial Hospital, Dermatology Center. The MCH/FP Center's lab received guidance by a doctor of Tu Du Hospital for the continuous sampling and technical follow-up.	–	Continued follow-up of technical aspect will be considered.
4.6 Train ob/gyn doctors and other health personnel for diagnosis skill of RTI	4.6 Train ob/gyn doctors and other health personnel for diagnosis skill of RTI	Preparatory training was conducted in Dec. 2002. Skill training on RTI diagnosis with colposcope conducted	–	

4.7 Provide necessary equipment for RTI survey	4.7 Provide necessary equipment for RTI survey	Selected and supplied based on the advise given by experts from Tu Du Hospital.	_	Continuous and effective utilization will be promoted.
4.8 Conduct RTI survey	4.8 Conduct RTI survey	Conducted in July - August 2003. It become the practical training for the study team and the level of lab department at MCH/FP Center improved. The status of the lab department in the MCH/FP Center also improved.	_	_
4.9 Formulate strategy for RTI prevention	4.9 Formulate strategy for RTI prevention	Formulated based on the RTI study outcome. The outcomes were presented to the concerned agencies at the seminar organized in Hanoi. The report was printed and distributed to the concerned agencies.	The close follow-up of the action plan has not been done yet.	The preventive strategy and action plans should be followed.
For Output 5: Quality of IEC&M activities of MCH/FP Centre and the selected districts, women's union and DHCs in particular, for RH promotion is improved.				
5.1 Provincial, district and commune SCs develop their own IEC plan	Own IEC plan developed by provincial, district and commune SCs	MCH/FP Center has annual plan for the IEC activities at the Center. Women' Union has its own activity plan. Women's Union in collaboration with Youth Union also have their own IEC plans. The planning of effective IEC activities was conducted for the Women's Union members as a part of skill training on utilization of IEC materials. The workshop on health plan formulation was also organized for the local government and community-based organization (Women's Union) from 6 communes including Aiiku-han model communes.	Women's Union and health sector collaborate regularly. The member agencies of project steering committees also have their own agency plan for IEC and campaign activities. The collaboration are strong especially for the FP campaign, but there is room to promote RH field.	More involvement and collaboration among agencies in organizing IEC sessions, e.g. Maggie Apron session, are expected to promote further.
5.2 IEC means are supplied	IEC means are supplied	Provided amplifier, pregnancy simulator, Maggie Apron, to the district WU, RH text, teaching note of Maggie Apron, scenario books for hamlets and commune WU, amplifier for commune WU. For DHC, amplifiers and Maggie Apron for all CHCs.	_	Continue effective utilization of materials and equipment.

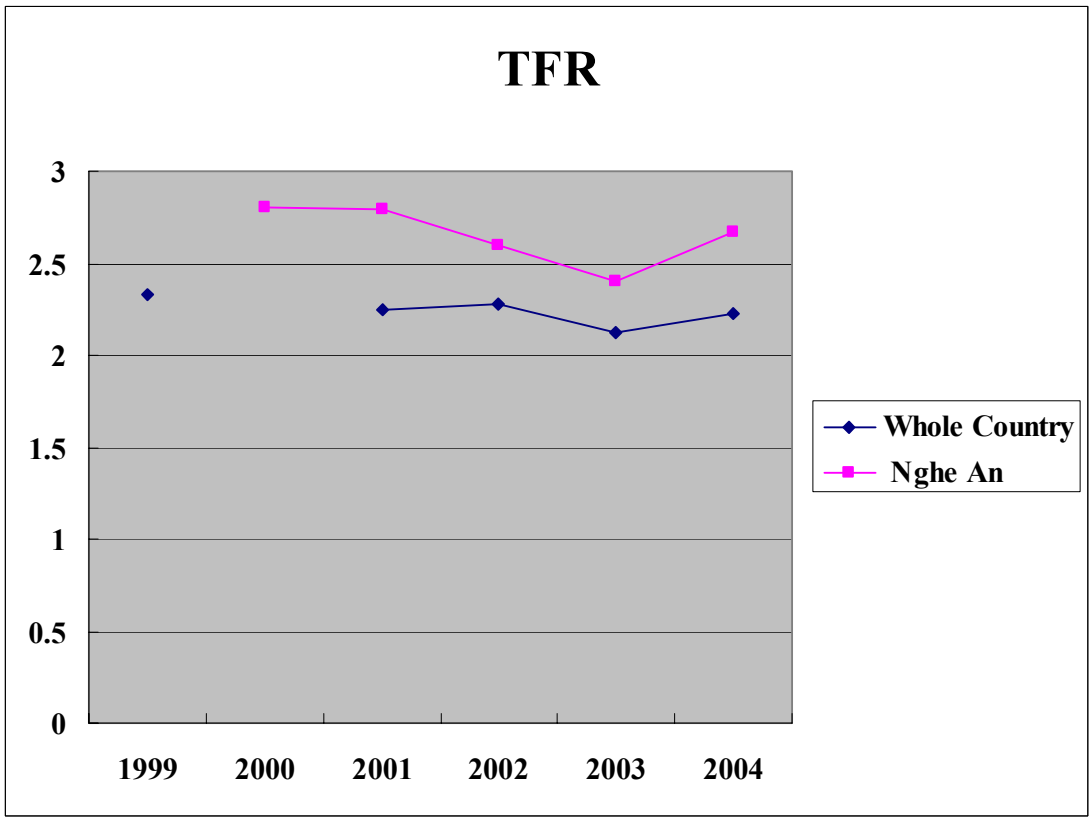
5.3 Sufficient IEC materials are supplied to district and commune WU	Sufficient IEC materials are supplied to district and commune WU	The main IEC materials provided to Women's Union for their activities: 1) three kinds of pamphlets, text books on RH issues for hamlet Women's Union members 2) two kinds of posters on pregnancy care and HBMR utilization for commune level Women's Union 3) Maggie Apron for district women's union, all CHCs, and 19 DHCs 4) Pregnancy simulator for the 19 district Women's Union 5) Maggie Apron teaching guide for commune and hamlet level Women's Union 6) RH issues scenario collection for commune and hamlet level Women's Union 7) Amplifier for 469 commune Women's Union 8) TOA amplifier for 19 Women's Union	Generally speaking, there is a tendency that IEC implementers claim the lack of materials, however, as long as the Women's Union concerns, the Project has made the best efforts to provide IEC materials to the hamlet levels.	Continue effective utilization of materials and equipment.
5.4 P/D/C SCs cooperates with other organizations in IEC promotion	P/D/C SCs cooperates with other organizations in IEC promotion	RH contests on utilization of IEC materials were organized by the Women's Union. The other concerned agencies were also involved. Through the contest, the skill for IEC at the commune level is quite good. The grass-root level IEC activities are conducted in good collaboration with relevant agencies.	_	Continue collaboration and cooperation among relevant agencies. Especially, the IEC sessions organized by Women's Union and health sector together should be continued.
5.5 Provide training and information to press & broadcast station at all levels on RH	Training and information provided to press & broadcast station at all levels on RH	In conducting IEC workshops, and CSC collaboration workshop, with the initiative by each DHC, the cultural and information department and district media have collaborated. Mass media seminar was also organized for journalists and TV correspondents.	_	Plan to provide information on RH to the cultural and information department at each level.
5.6 Promote "Aiiku-han" (community-based MCH promotion system) activities in the selected districts and communes	"Aiiku-han" (community-based MCH promotion system) activities promoted in the selected districts and communes	Activities ahs been on-going. Provincial WU is positive in expanding the activities to the other areas. The coordinating body has been shifted from health sector to the Women's Union considering the key player of the activities are the grass-root members of Women's Union. The health sector will continue providing support as key agency.	_	WU is expected to disseminate the experiences widely as well as continuation of activities.
5.7 P/D/C SC open RH counseling rooms/offices in their own area	RH counseling rooms/offices opened in P/D/C SC with their area	According to the MOH guidance, the setting up of the counseling room has been advised.	The awareness towards the needs of counseling space or room is still low. The concept of privacy is no existent. In reality, the standard building of CHC is small and not designed to allocate the independent counseling room. Some of the financially better off commune are expanding space, but still few. This aspect may have a lower priority at the moment.	PHS and MCH/FP Center will follow-up.

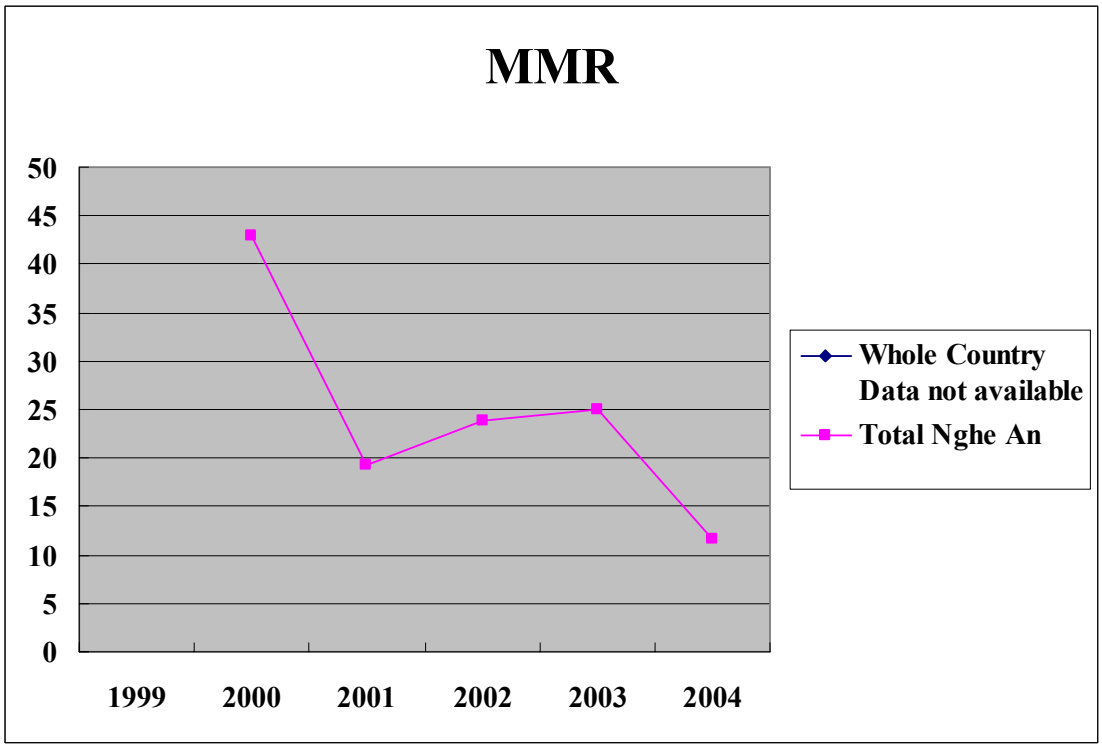
5.8 Conduct TOT for DHC & MCH/FP centre staff in order to organize health education classes	TOT conducted for DHC & MCH/FP centre staff in order to organize health education classes	The quality of parents classes at MCH/FP Center has been improved covering various subjects.	The situation of health education session at DHC has not been well known. The follow-up is not sufficiently done. The annual assessment meeting is the occasion to review the activities.	Follow-up of the implementation level. The collaboration with WU can be considered in order to strengthen health education.
5.9 Develop manuals, guidelines and textbooks for health education classes	Manuals, guidelines and textbooks for health education classes developed	Produced Aiiku-han handbook. MCH/FP Center started to distribute the leaflet on pregnancy care made during the C/P training. Produced scenario book which are effectively utilized at the grass-root level.	_	Promotion of the utilization of the existing materials. The wider distribution and broader utilization of Aiiku-han handbook can be considered. DHC can be encouraged to distribute materials such as the leaflet on pregnancy care.
For Output 6: Quality of HMIS (Health Management of Information Systems) at Provincial Health Service, MCH/FP Centre and the selected districts is improved				
6.1.1 Provincial HMIS SC is organized and functioned regularly.	Provincial HMIS SC is established and functioned regularly.	Nghe An HMIS steering Committee was established and meeting was organized.	_	
6.1.2 Conduct HMIS dissemination workshop for DHCs and hospitals	HMIS dissemination workshop for 6 model DHCs and MCH/FP Center	TOT training for the persons in charge of statistics from 19 DHC and MCH/FP Center on the recording format for the CHC. After the TOT, each DHC organized the training for CHC staffs.	—	—
6.2 Provide equipment used for the new HMIS	Equipment used for the new HMIS is provided.	Five sets of computer for training to the PHS and 2 sets to the MCH/FP Center were provided, and all 19DHC were also provided a set of computer for reporting. The server computer will be provided to PHS and 5 DHC and MCH/FP Center for the hospital based HMIS soft ware.	Nam Dan DHC was one of the 6 DHCs that were planned to apply the hospital based HMIS, however, the staff trained to become the network manager left the DHC for the study Therefore, it become not possible to introduce the system in the Nam Dan DHC.	—
6.3.1 Prepare training materials on HMIS	Training materials on HMIS are prepared.	The manuals for the computer training and tally software have been prepared. Tally software for RH data have developed. The Vietnamese version of Epi Info (analytical soft ware) was prepared, and manual has been developed. Nghe An map has been created (shapfile) so that the map can be used for data analysis.	_	Additional materials and manuals will be prepared. Formulate the soft ware for MCH/FP data for national use upon the request of RH Department of MOH together with the manual.
6.3.2 Conduct training on report preparation using computer fro selected DHCs and MCH/FP Center	Training on report preparation using computer fro selected DHCs and MCH/FP Center conducted	Training on computer operation and management for statistical report and utilization of HMIS soft ware for the 19 DHC and MCH/FP Center staffs. The training on data check was also conducted.	Data check and guidance for the CHC at DHC and MCH/FP Center is not yet sufficient.	Summing up training on computer operation will be conducted towards the completion of the Project.

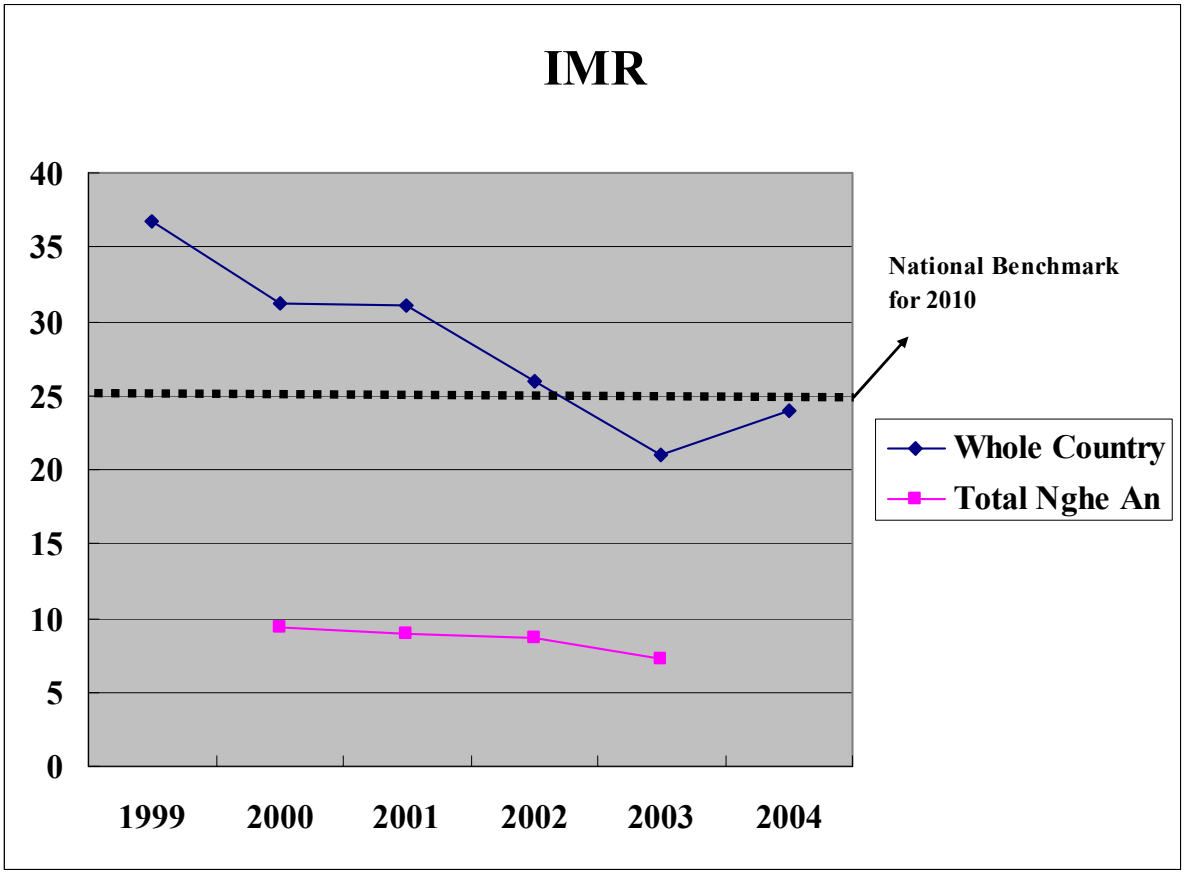
6.3.3 Conduct training on hospital-based HMIS for the selected DHCs and MCH/FP Center	Training on hospital-based HMIS for the selected DHCs and MCH/FP Center conducted	Training on hospital based HMIS conducted for the 5 model DHCs and MCH/FP Center, Pediatrics Hospital, and leprosy hospital.		Conduct follow up activities for the 2 DHCs that just finished the hospital based HMIS training.
6.3.4 Implement on the job training for HMIS personnel at PHS	On the job training for HMIS personnel at PHS is conducted.	Training continued for the two staffs in charge of information system at the PHS.。		Continue on the job training.
6.4 Monitor HMIS activities	HMIS activities are monitored and evaluated.	Conducted monitoring of situation of computer management and level of utilization of software, and conducted trouble shooting for the 19 DHCs.		Continue the activities.
6.5 Conduct training on statistical analysis and data utilization	Training on statistical analysis and data utilization is conducted.	Conducted workshop on abortion data analysis for the 5 DHC and MCH/FP Center. The training on the MCH/FP data utilization and analysis of abortion data for 4 DHCs and MCH/FP Center was also conducted. For those training, Vietnamese version of EpiIno was utilized.	The knowledge and experiences of persons in charge of statistics on data analysis is not enough.	Continue the training on data analysis and utilization.

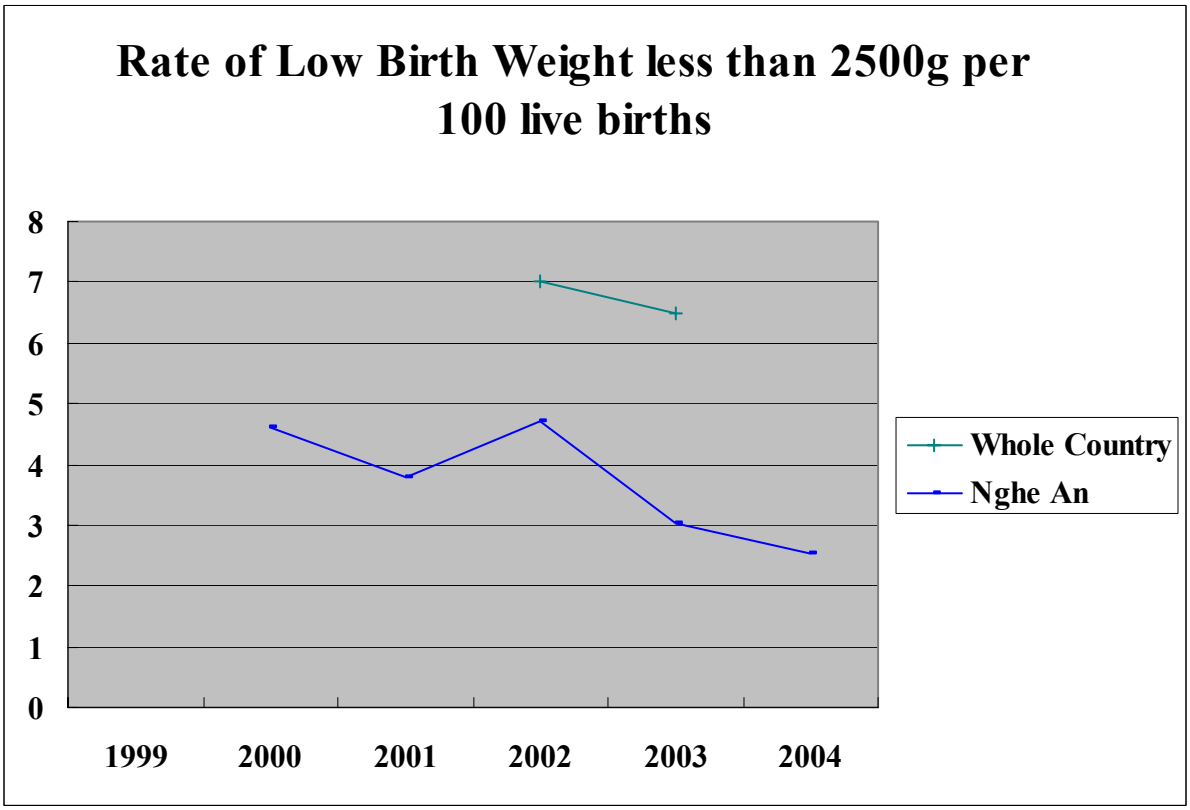
Additional Reproductive Health Indicators

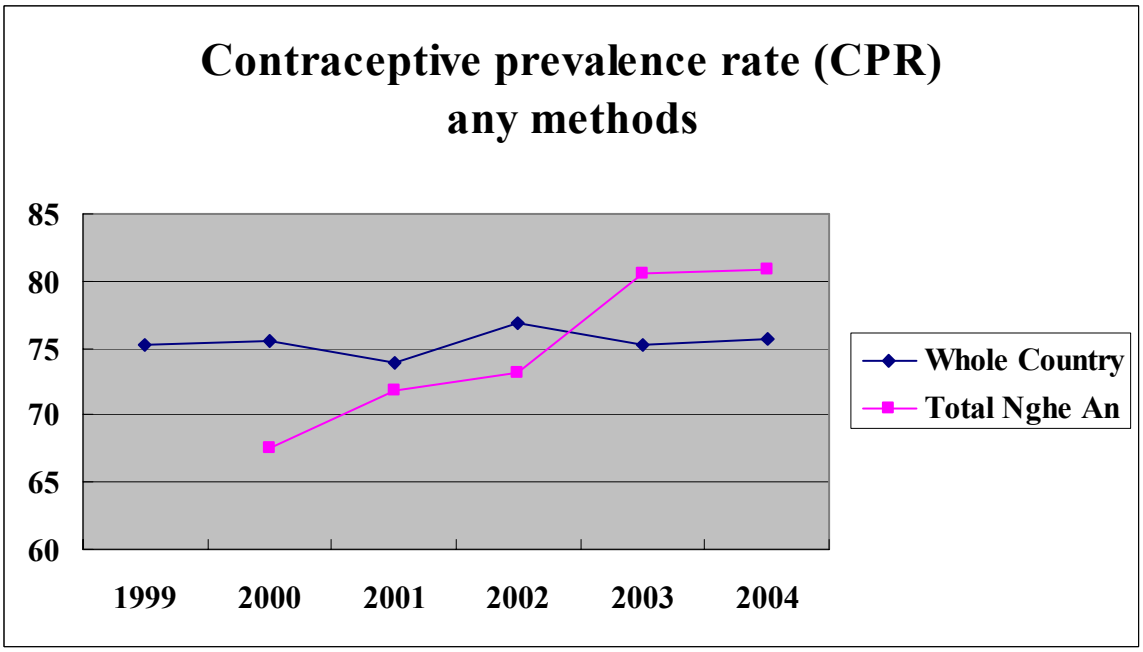
1. Indicators: Overall Goal Level

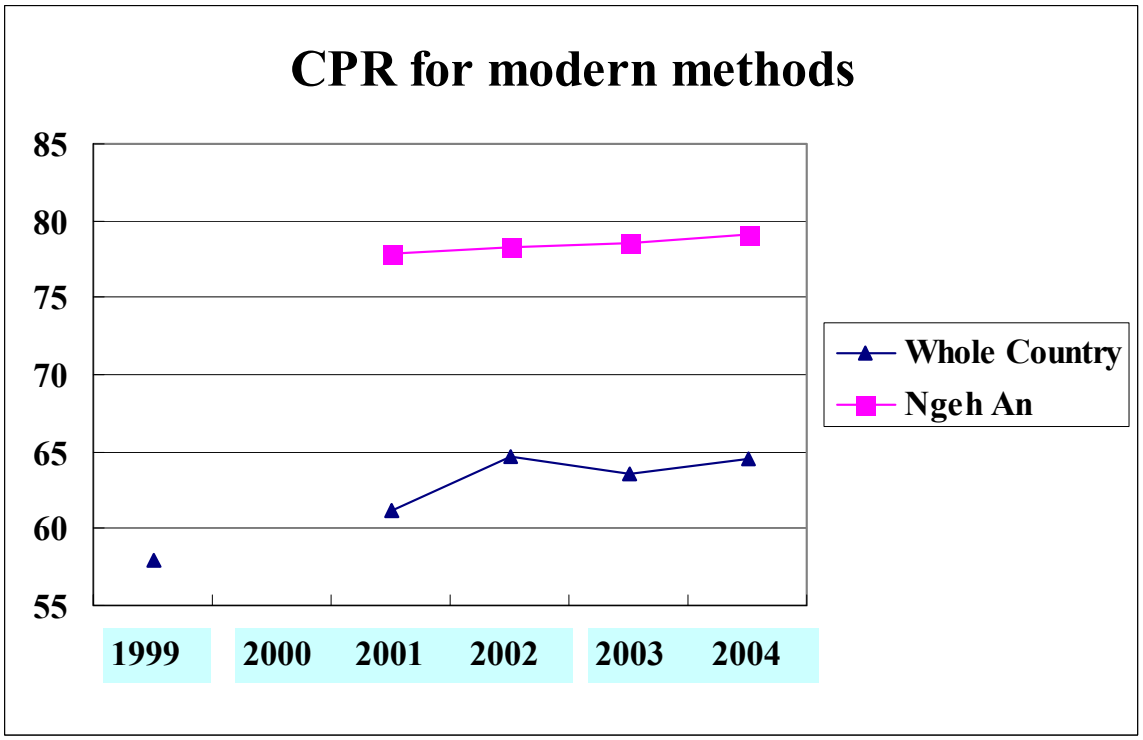





IMR
40
35
30
25
20
15
10
5
0
1999
2000
2001
2002
2003
2004
National Benchmark for 2010
Whole Country
Total Nghe An

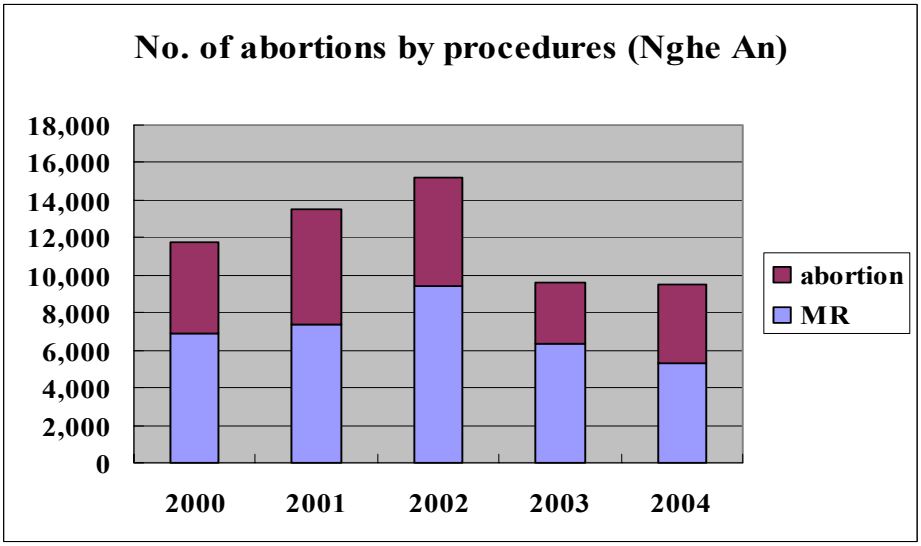

Rate of Low Birth Weight less than 2500g per 100 live births
8
7
6
5
4
3
2
1
0
1999
2000
2001
2002
2003
2004
Whole Country
Nghe An

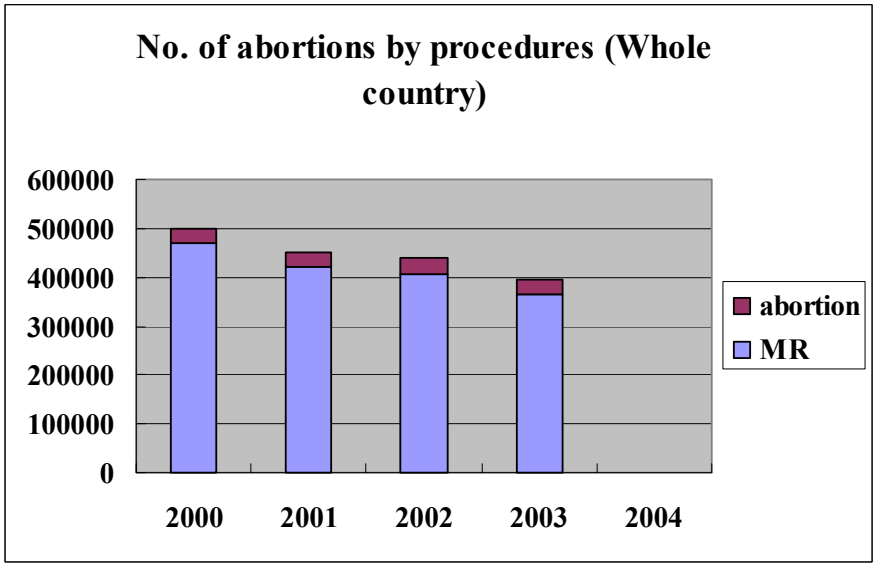

Contraceptive prevalence rate (CPR)
any methods
85
80
75
70
65
60
1999
2000
2001
2002
2003
2004
Whole Country
Total Nghe An

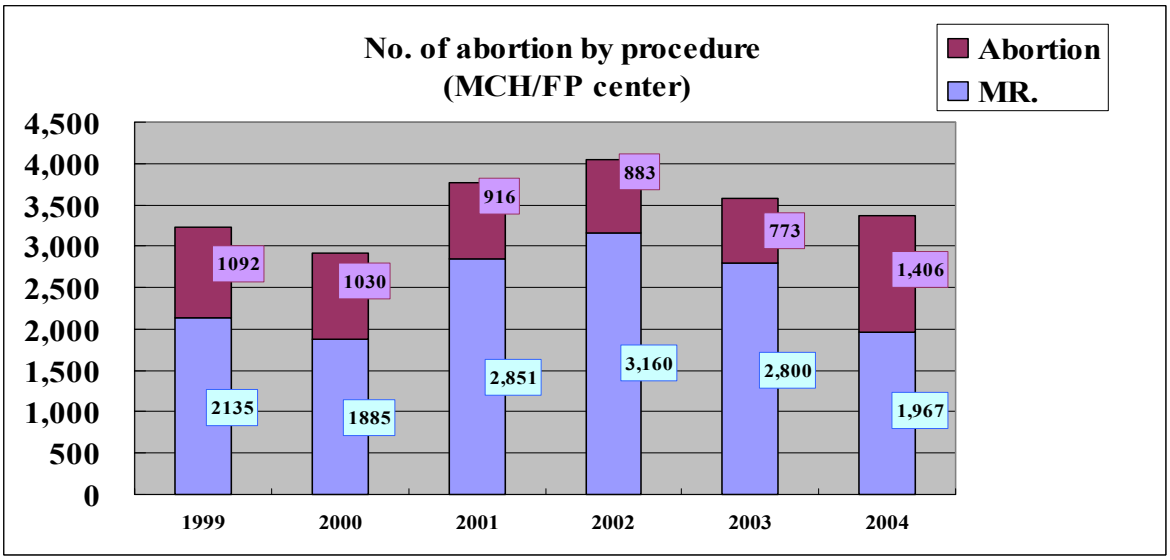

CPR for modern methods
85
80
75
70
65
60
55
1999
2000
2001
2002
2003
2004
Whole Country
Ngeh An

2. Indicators: Project Purpose and Outputs Levels

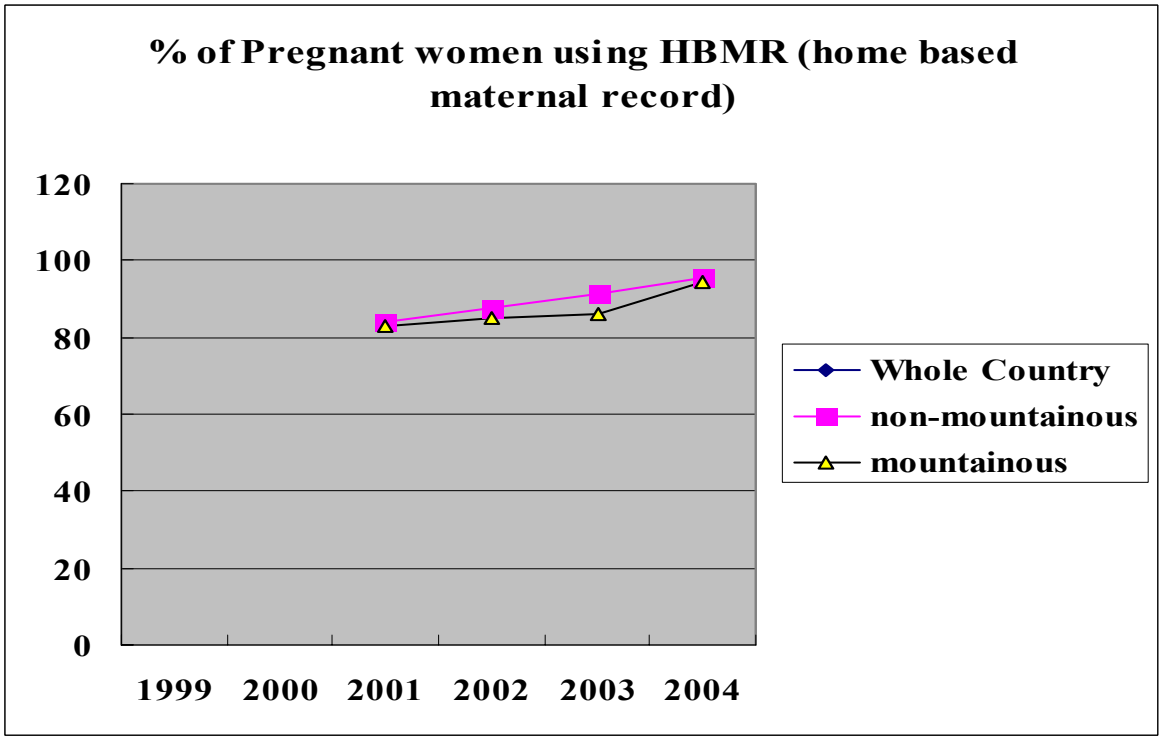
Abortions



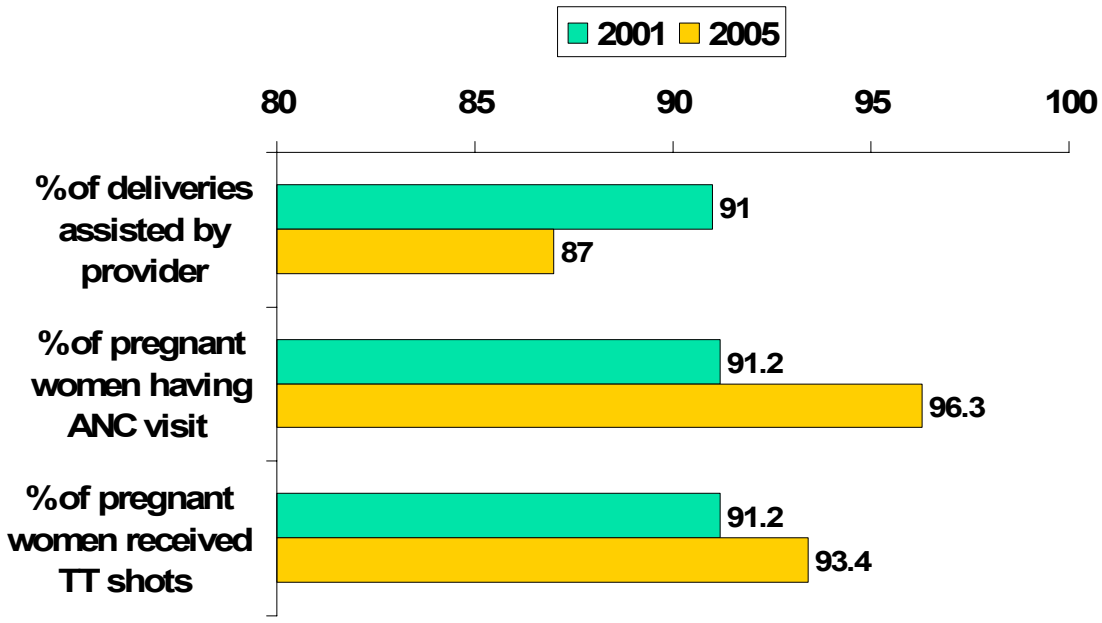


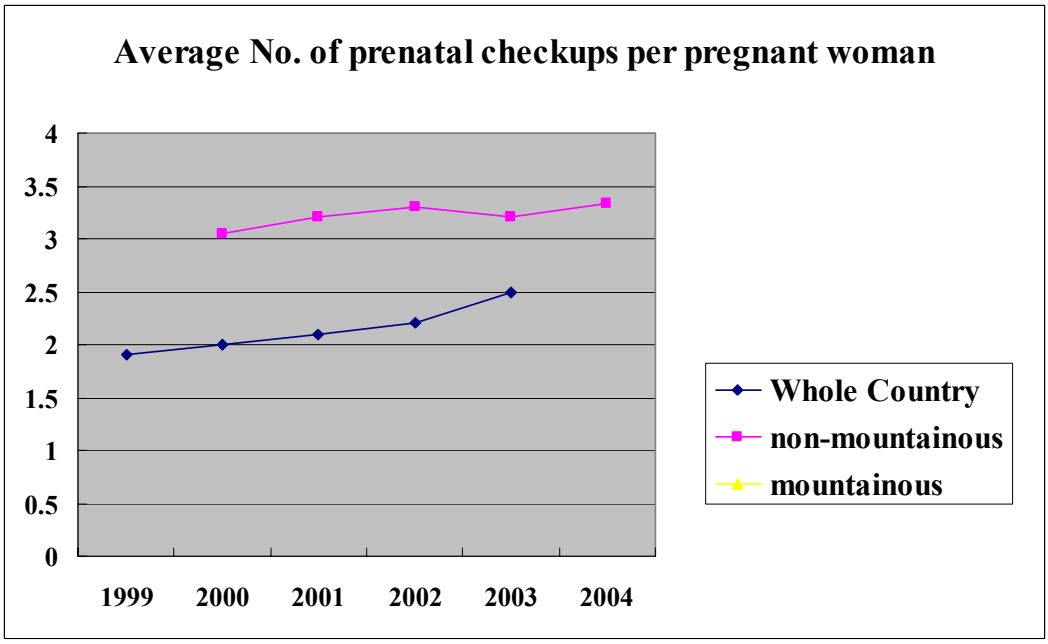


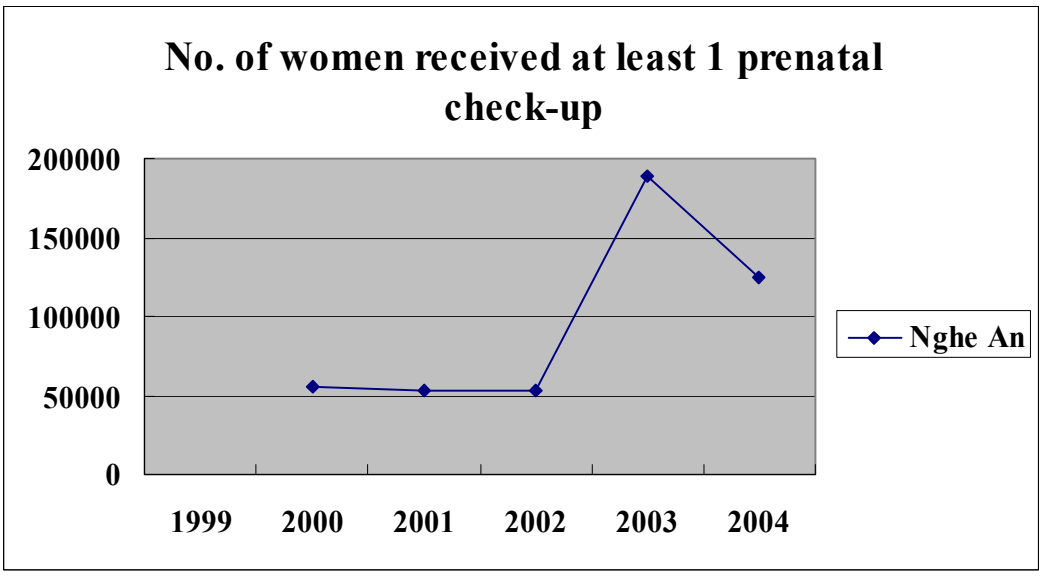
Indicators relating to ANC (prenatal care)



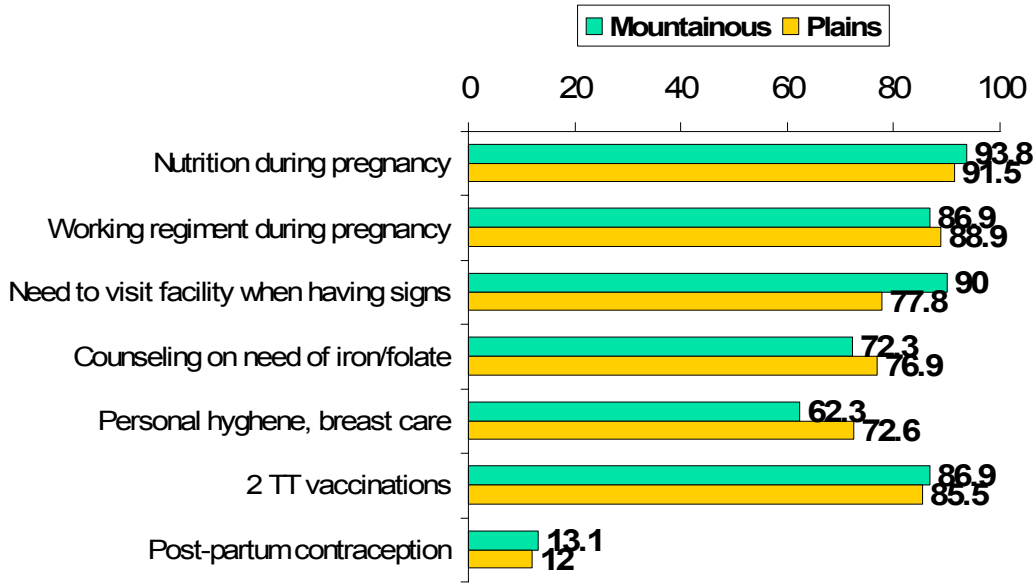
ANC care and delivery care at commune level




Average No. of prenatal checkups per pregnant woman
4
3.5
3
2.5
2
1.5
1
0.5
0
1999
2000
2001
2002
2003
2004
Whole Country
non-mountainous
mountainous

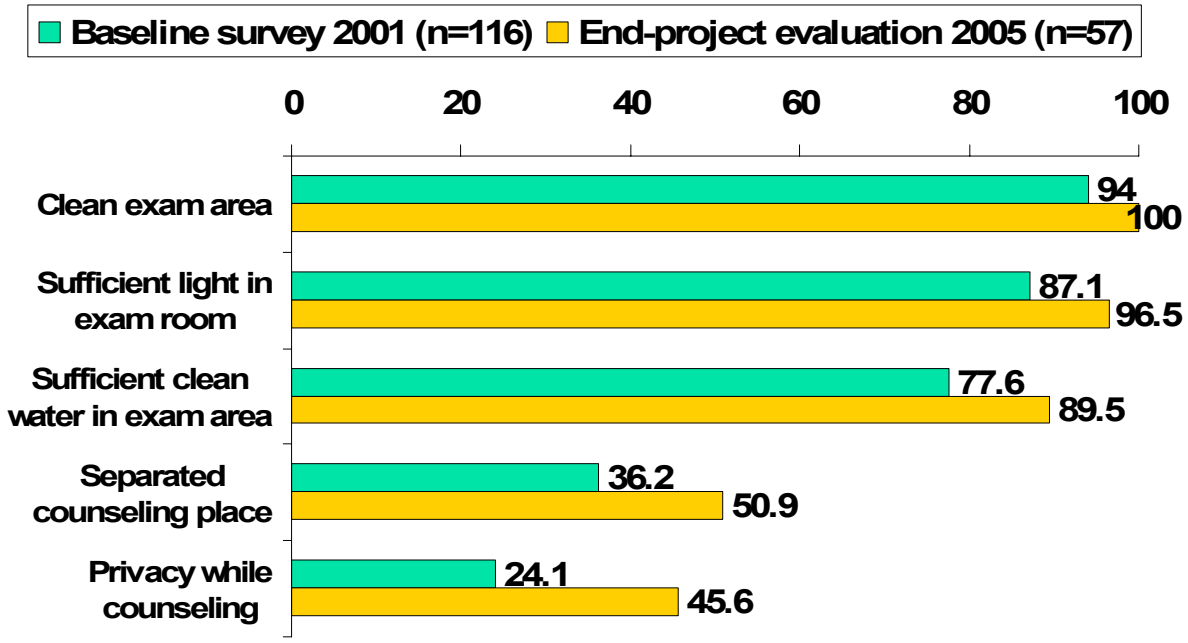

No. of women received at least 1 prenatal check-up
200000
150000
100000
50000
0
1999
2000
2001
2002
2003
2004
Nghe An

% of Prenatal clients received counseling on relevant issues

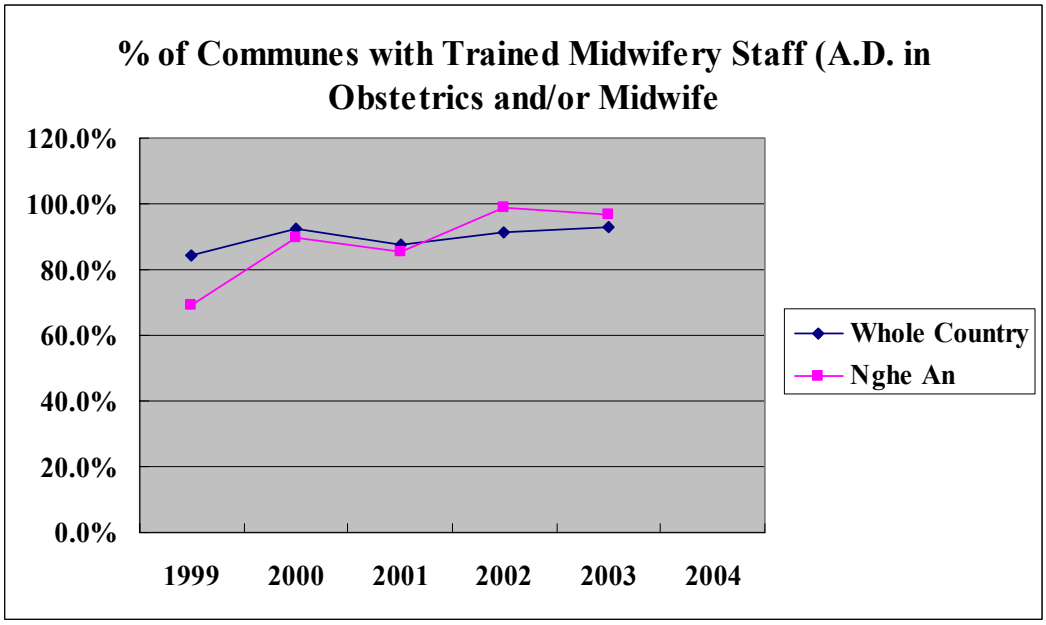


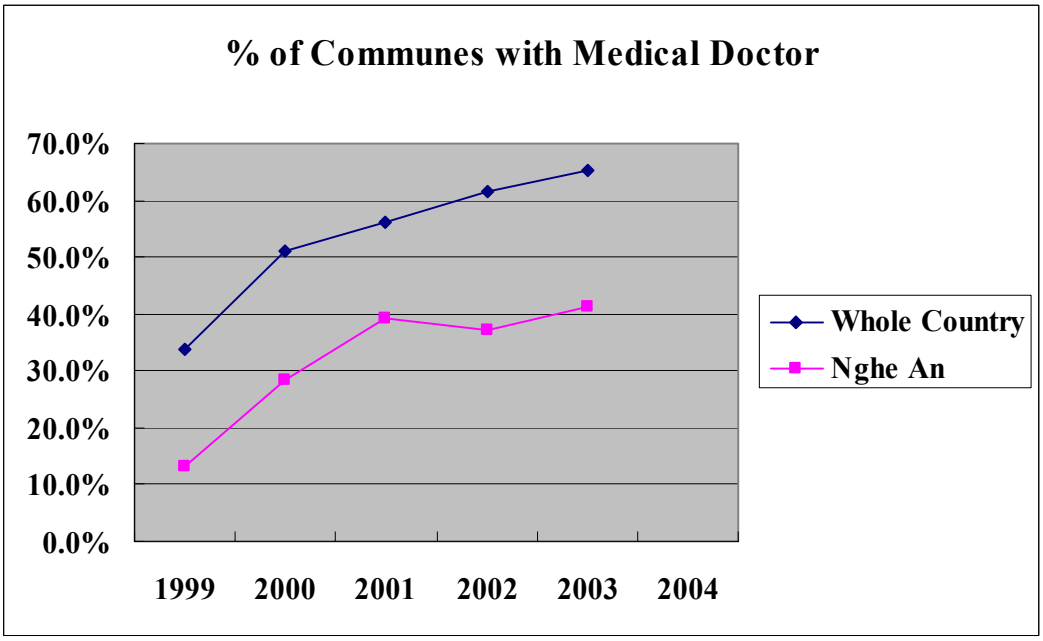
CHCs having utilities/commodities for clients

% of CHC having appropriate examination room

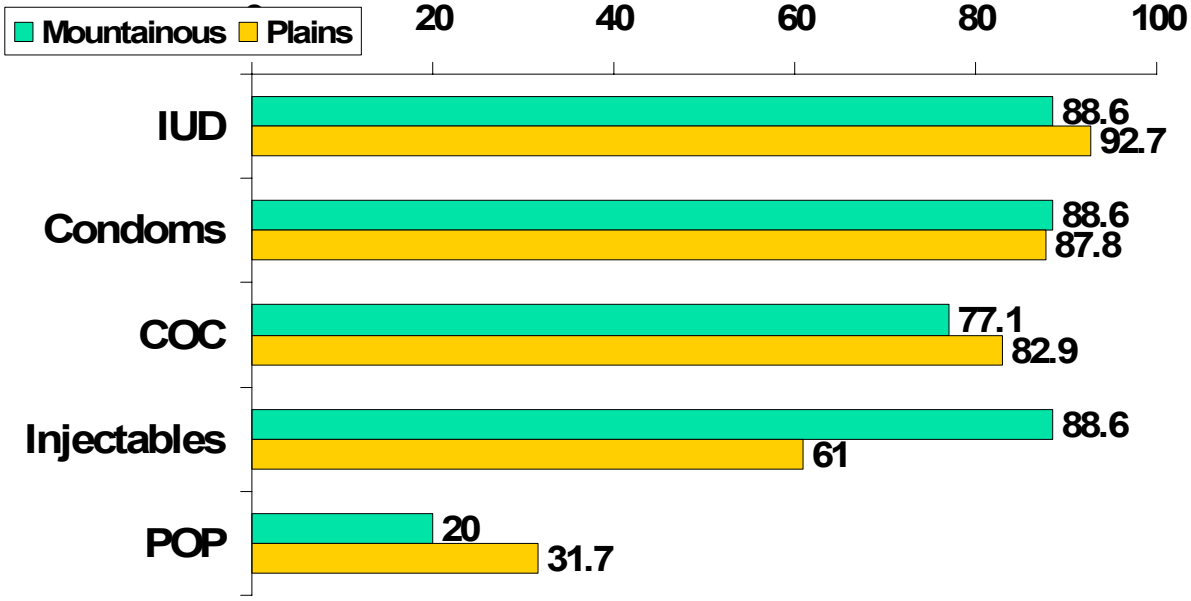


Medical staff allocation at CHC level

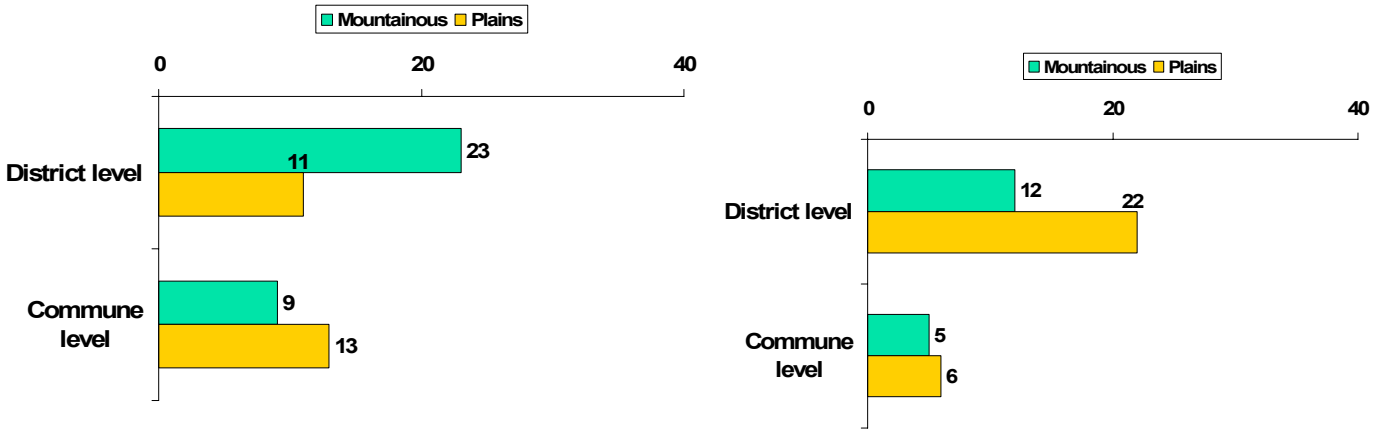




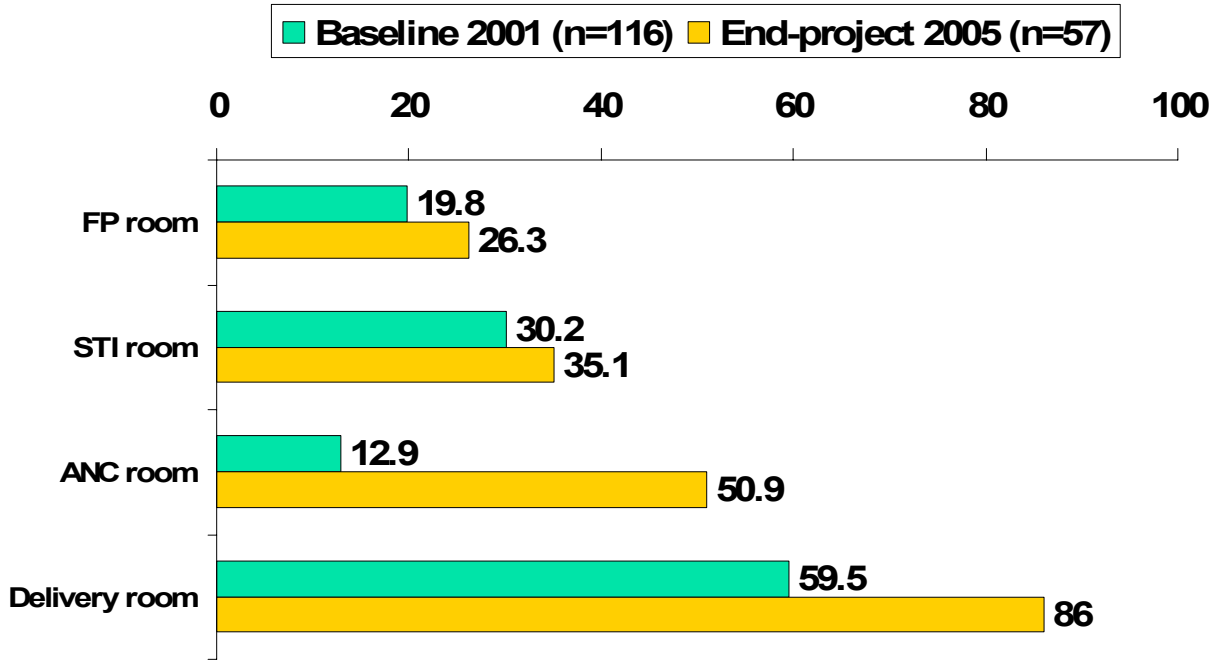
Contraceptive methods available at health facilities



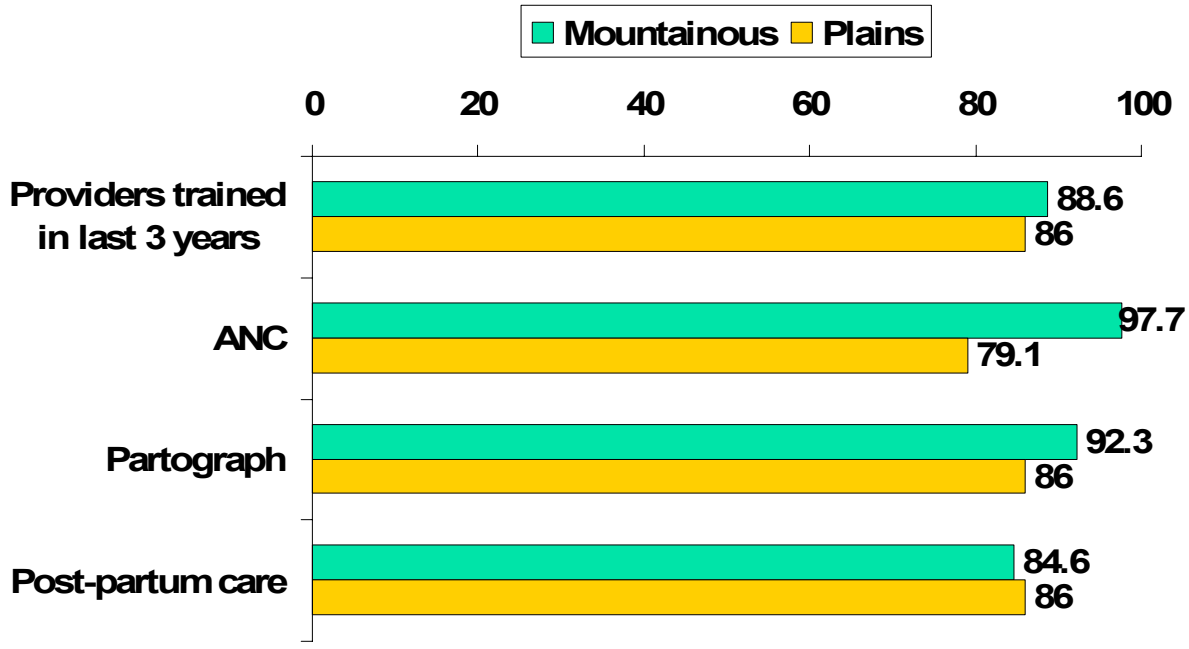
Integration of FP counseling to ANC service, and to RTI service



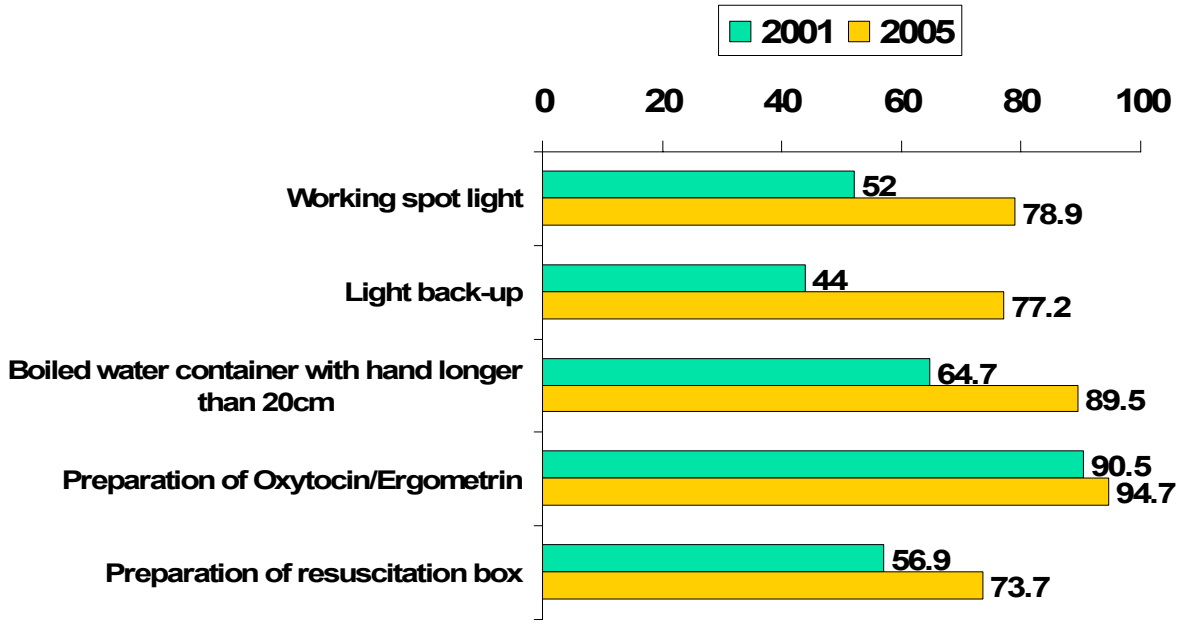
% of CHC have separated function rooms

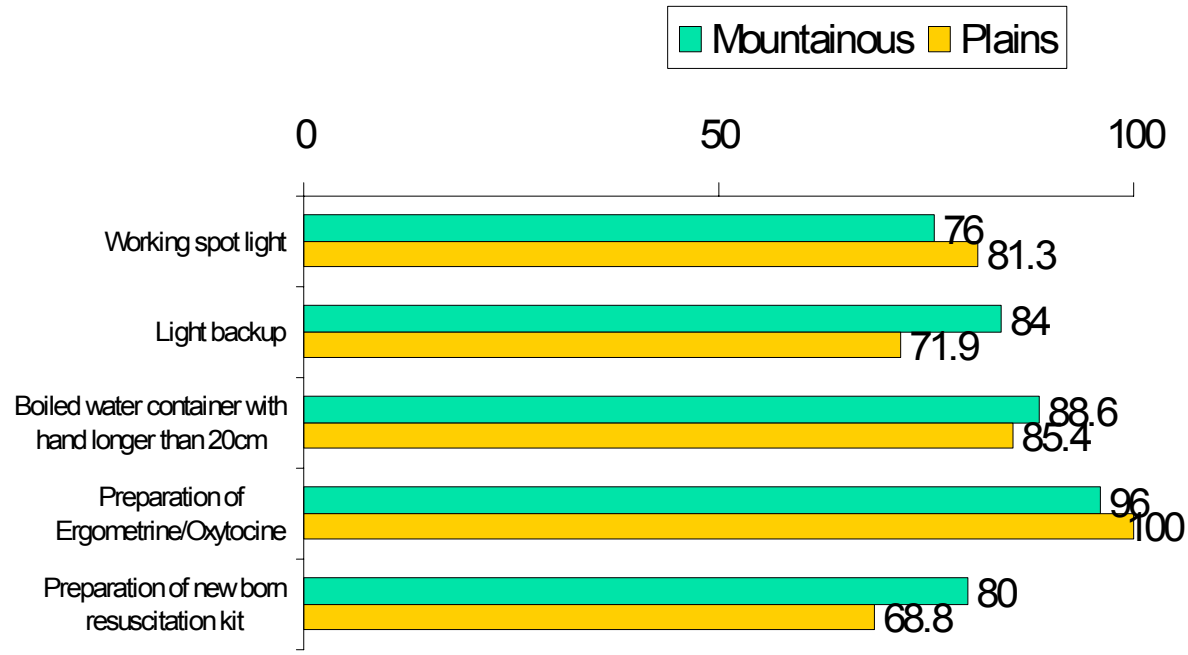


% of providers trained in prenatal care during last three years

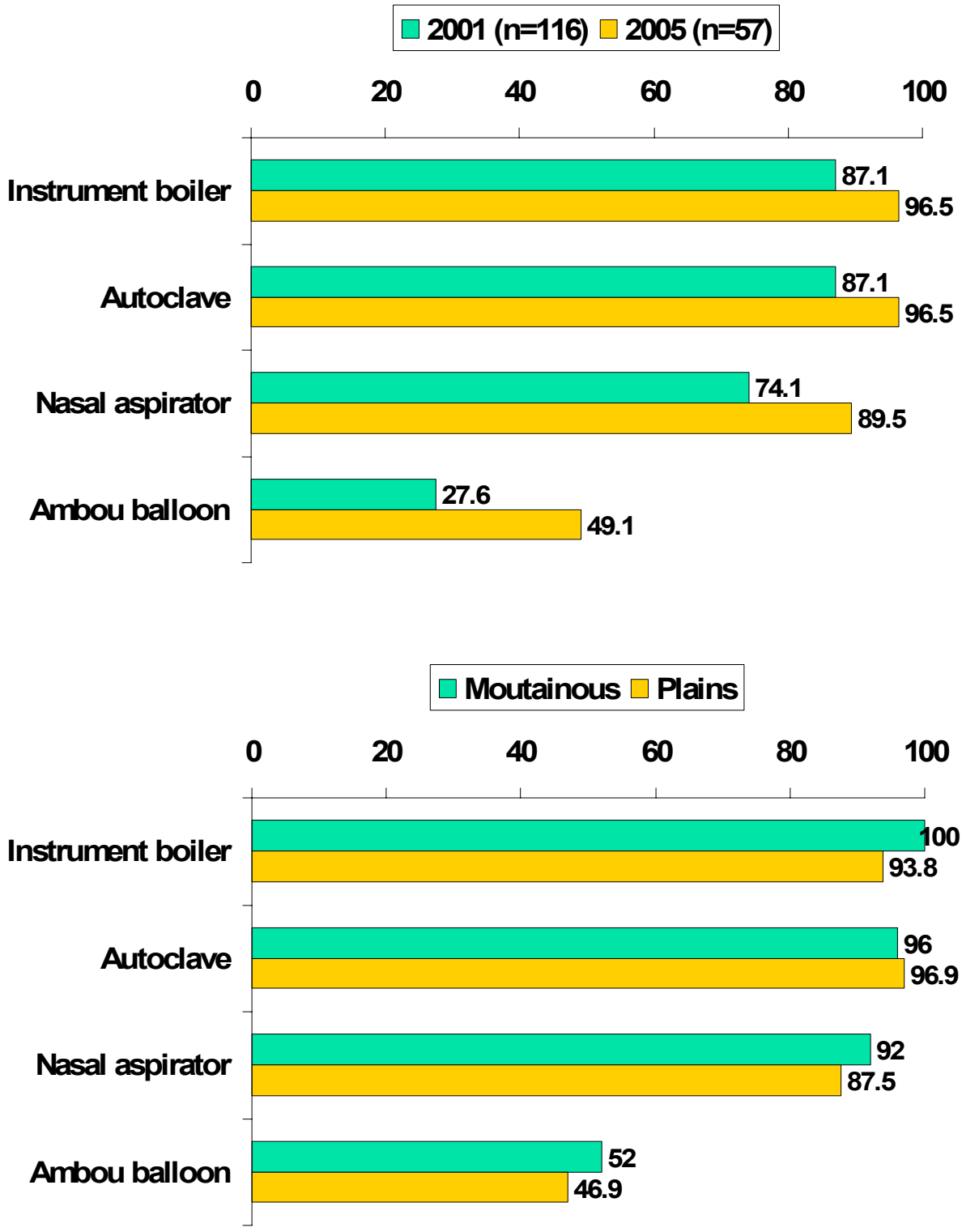


% of CHC have appropriate delivery room that meets with criteria of hygienic and clean delivery

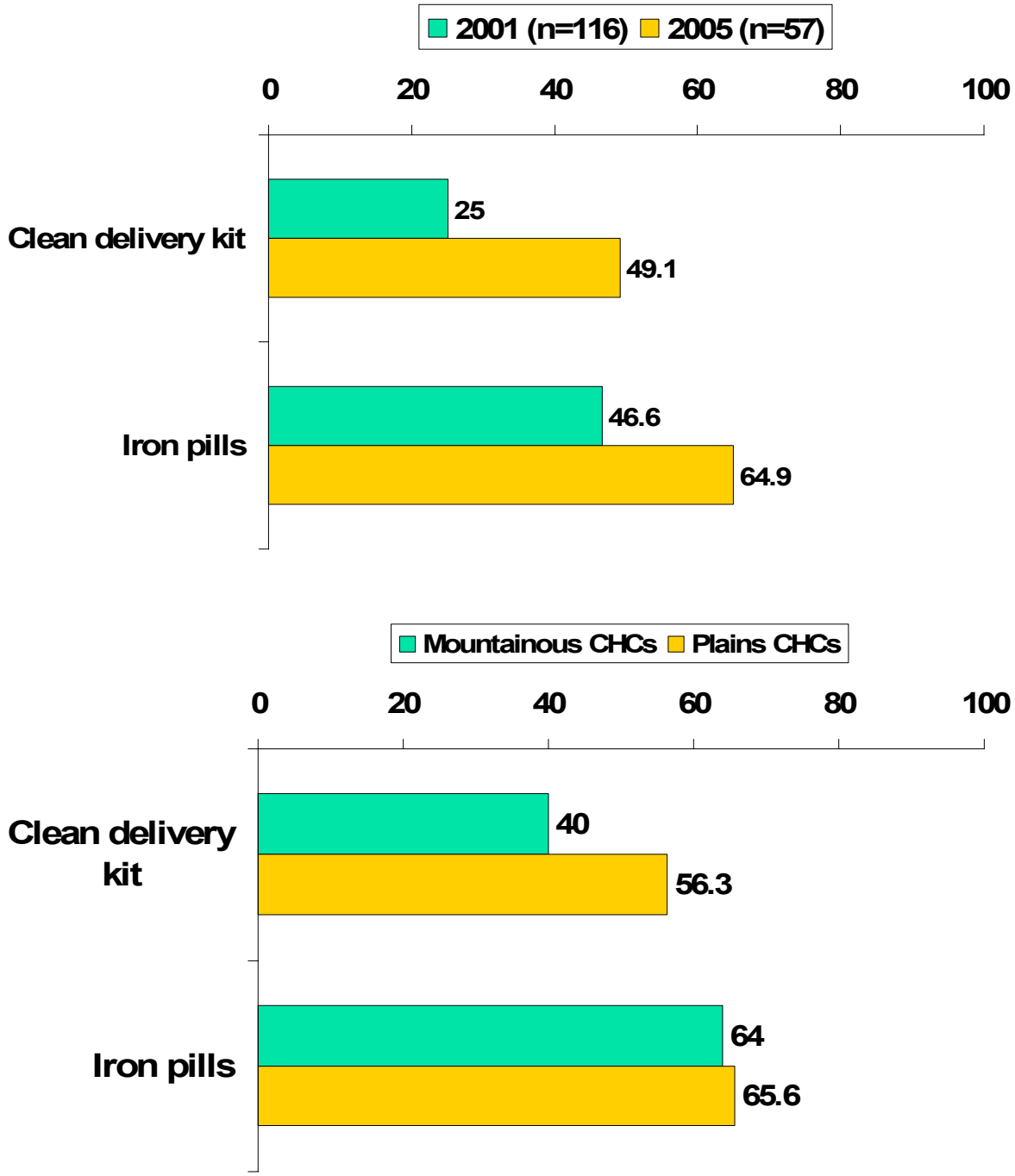




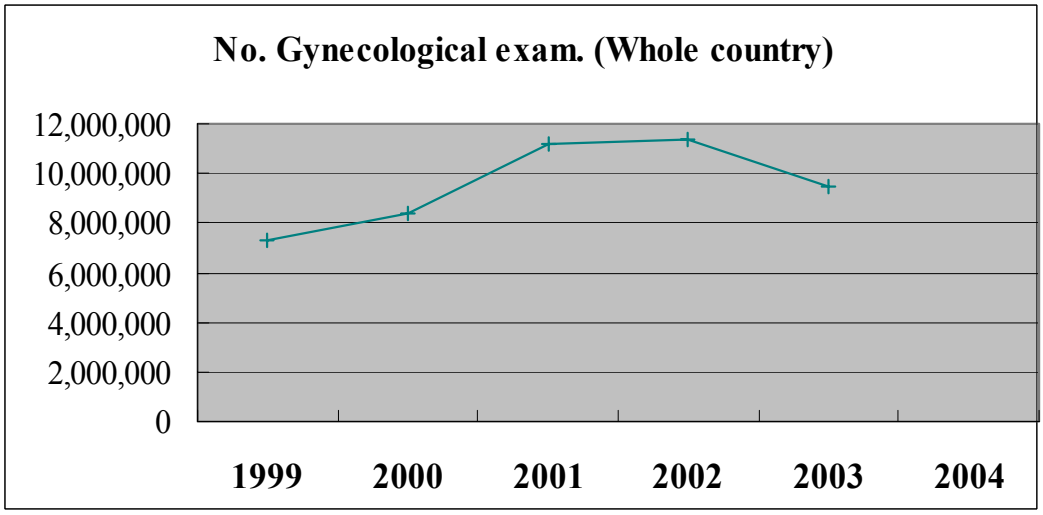
% of CHC having essential equipments for safe delivery

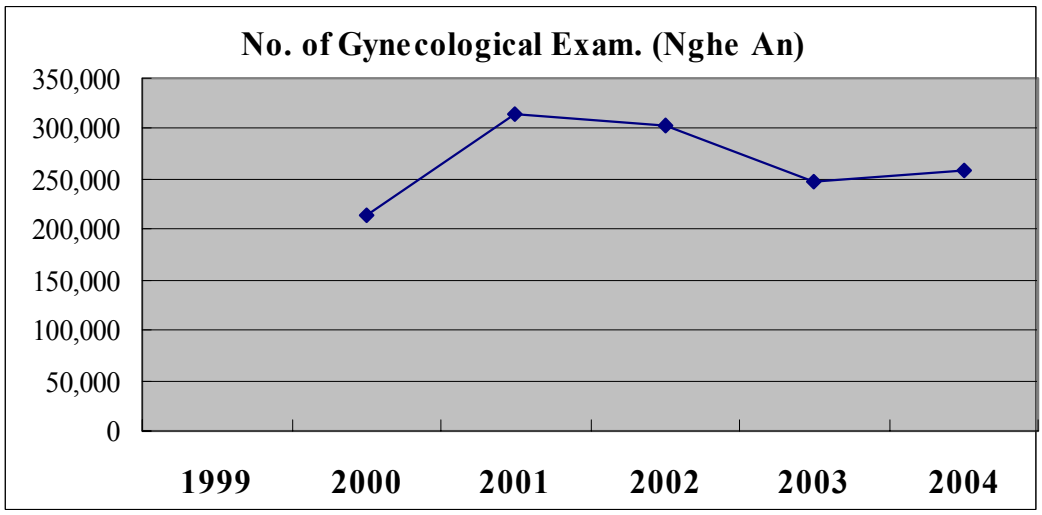


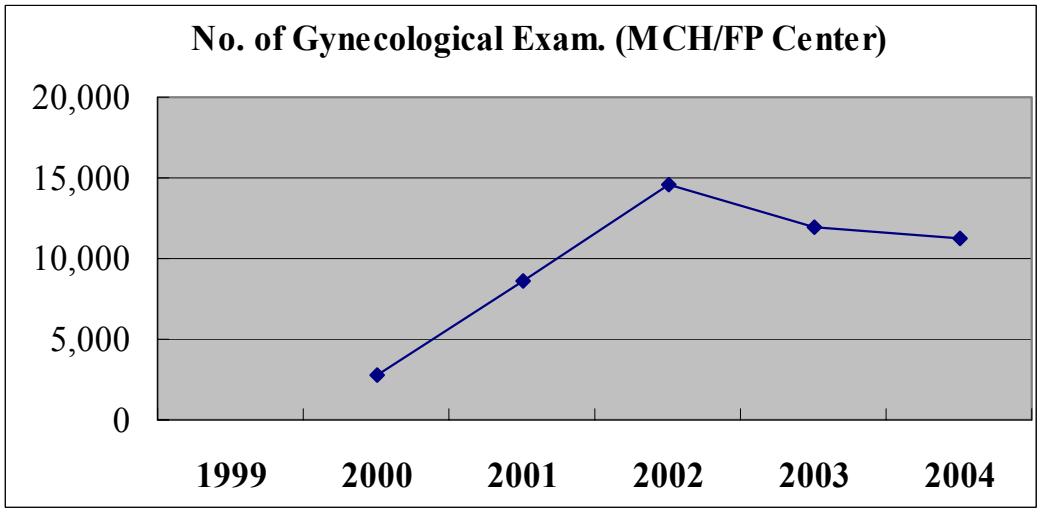
Supply and logistics: % of CHCs has supplies available



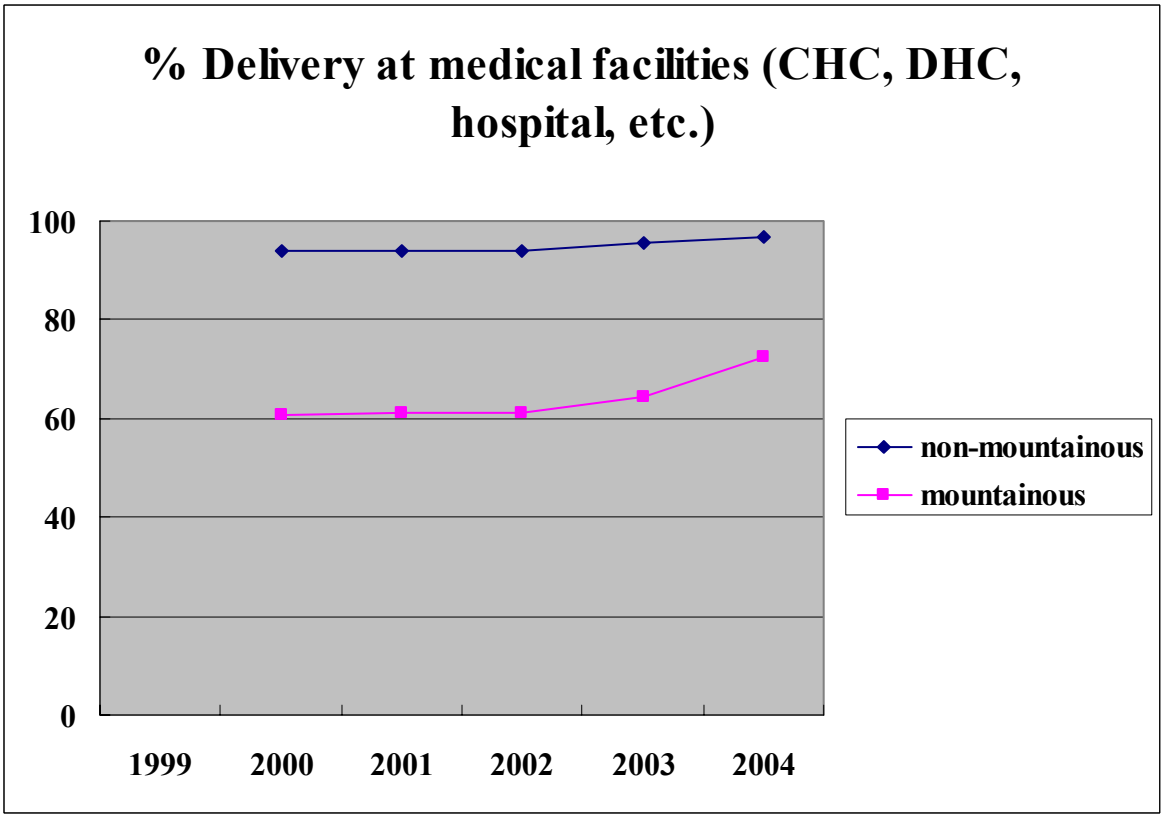
Number of Gynecological Examination (including RTIs)

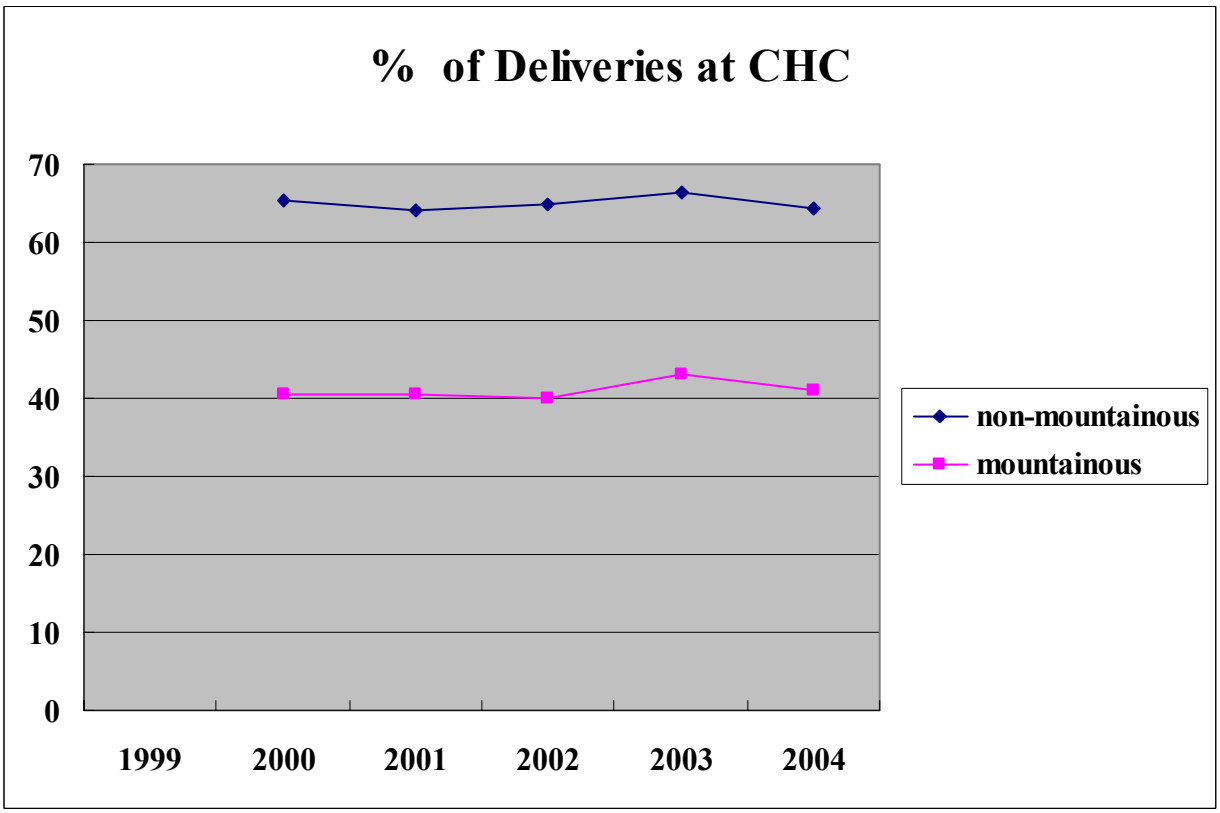




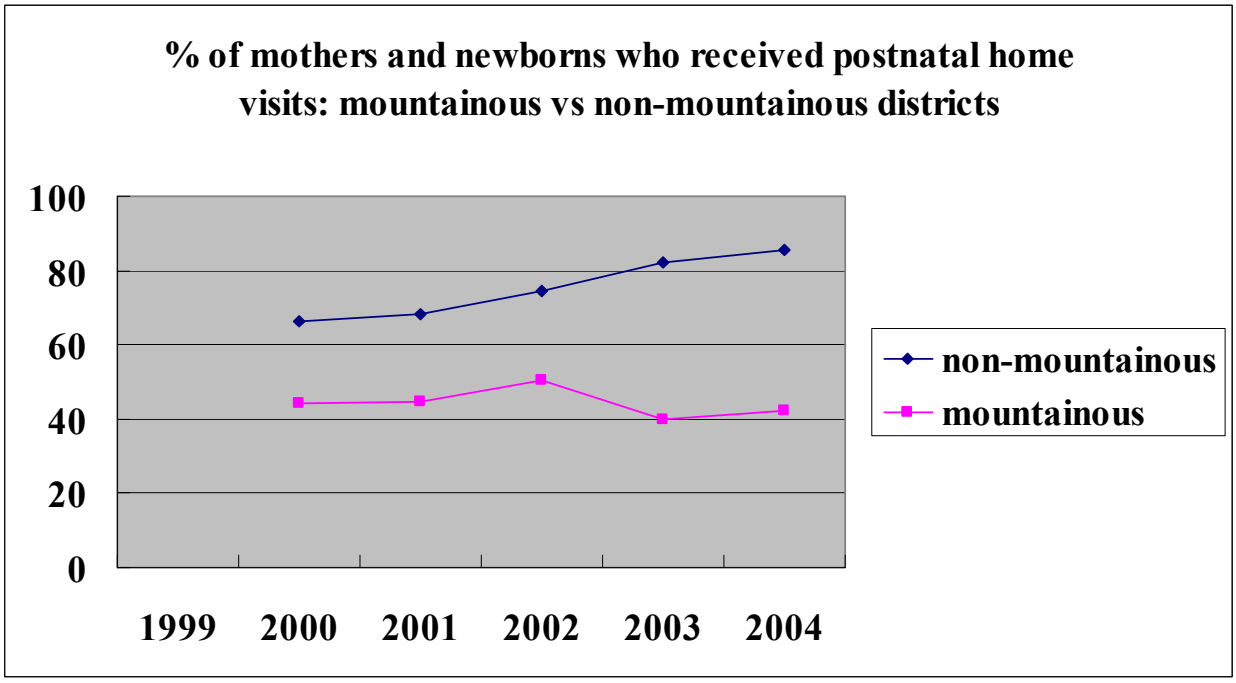


Place of Delivery





Post-natal Care



[Source of Data]

HYS: Health Statistical Yearbook, MOH, 1999-2003. (HSY2004 is not available yet.)

PDM Indicator matrix: This is the data PSC had prepared for the Final Evaluation according to the indicators set by PDM

MCH/FP data matrix: This is the data accumulated district data using the regular MCH/FP data-reporting format (The 2003 and 2004 data were processed by computer using electrical data from DHCs.)

MCH/FP Center client data 1999-2004: This is the data monitored by MCH/FP Center for their use.

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Baseline/Final Assessments: Population Council, 2001 and 2005