FINAL REPORT

FOR

THE PROJECT FOR STRENGTHENING FOR HEALTH SERVICES FOR CHILDREN (KIDSMILE)

(1 November 2002 o 31 October 2007)

KIDSMILE PROJECT
JAPAN INTERNATIONAL COOPERATION AGENCY

MINISTRY OF PUBLIC HEALTH
THE LAO PEOPLE'S DEMOCRATIC REPUBLIC

31 October 2007

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Reference

- Project Document of the Project for Strengthening Health Services for Children in Lao P.D.R. (September, 2002)
- Minutes of meeting between Japanese Project Consultation Team and the Ministry of Health of Lao P.D.R. on the Project for Strengthening Health Services for Children (November 27, 2003)
- Reports of long-term and short-term experts dispatched to the Project
- The Mid-Term Joint Evaluation Report on the Project for Strengthening Health Services for Children (KIDSMILE) (July 25, 2005)
- Joint Terminal Evaluation Report on the Project for Strengthening Health Services for Children (KIDSMILE) in the Lao People's Democratic Republic (June 12, 2007)

CONTENTS

ABBRIVIATIONS

ACIPAC	Asian Centre of International Parasite Control
ADB	Asian Development Bank
ARI	Acute Respiratory Infections
BTC	Belgian Technical Cooperation
CIEH	Center for Information and Education for Health
C/P	Counterpart Personnel
DOC	Department of Curative Medicine
DHP	Department of Hygiene and Prevention
DHO	District Health Office
DOP	Department of Organization and Personnel
FDD	Food and Drug Department
FFC	Face to Face Communication
EPI	Expanded Program on Immunization
HC	Health Center
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
JCC	Joint Coordinating Committee
JICA	Japan International Cooperation Agency
KAP	Knowledge, Attitude, Practice
LUX	Lux-Development S.A.
MCHC	Maternal and Child Health Center
MOE	Ministry of Education
MOH	Ministry of Health
MR	Minimum Requirements
ODY	Oudomxay Province
PDM	Project Design Matrix
PHO	Provincial Health Office
SSPP	Small Scale Pilot Project
TCIS	Training Course Information System
TIS	Training Information System
TOR	Terms of Reference
TOT	Training of Trainers
TPIS	Trained Personnel Information System
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VP	Vientiane Province
VVC	Voice to Voice Communication
WB	World Bank
WHO	World Health Organization
XKH	Xiengkhouang Province

I. BACKGROUND AND BASIC INFORMATION ON THE PROJECT

1. Title of the Project:

Project for Strengthening for Health Services for Children

2. Duration:

1 November 2002 – 31 October 2007 (5 years)

3. Implementing Agencies:

Department of Hygiene and Prevention of Ministry of Health,
Oudomxay Provincial Health Office, Vientiane Provincial Health Office

4. Supporting Agencies on Japanese Side:

1) International Medical Center of Japan (IMCJ), Tokyo, Japan
2) National Center for Child Health and Development
3) Japan International Cooperation Center (JICE) Okinawa branch office

5. Project Sites:

1) Ministry of Health, Vientiane City
2) Oudomxay Province
3) Vientiane Province

6. Background:

Lao PDR is one of the countries in Asia with very low health and hygiene indicators. It faces issues of human resource development, administrative capacity development, quality service delivery, etc. Country's health services are sustained mainly by the donors' supports. As a JICA support, Primary Health Care Project (PHC project) was implemented from 1992 to 1998 followed by Pediatric Infectious Disease Prevention Project (PIDP) towards eradication of polio for 1998-2001. However, the sustainability was not high not only because of budget constrains but also the mechanism of resource mobilization. The preliminary study mission of the Project conducted further research on this point and identified the necessity of strengthening the health system at the district level.

In such a context, the Government of Lao PDR requested the Government of Japan to provide technical cooperation to the Project. In response to the request, the Government of Japan, through JICA, dispatched a study team to discuss, based on the result of the above mentioned study mission, and agree with the Lao authorities on the framework of the project implementation. In September 2002, Record of Discussions (R/D), which is the official document describing the content of the Project, was signed and a five-year project for "Strengthening for Health Services for Children" was launched on 1 November 2002.

7. Objectives:

The original objectives and output of the Project stated in the R/D and reviewed by the Project team using the PCM approach upon recommendations made by the mid-term evaluation team can be phrased as follows:

Overall Goal:

1. The health standard of children is improved in target provinces.
2. Practical systems established by Project are utilized beyond the central level and the target provinces.

Project Purpose: Management system for child health services is strengthened among the MOH and target provinces with various levels' participation.

Output:

1. Training Information System is established at the target provinces and at the central level.
2. The Network System is strengthened at the target provinces and at the central level.
3. Minimum Requirements (MR)[1] and Integrated Management of Childhood Illness (IMCI) are established at the target provinces and at the central level.
4. Capacity of Information, Education and Communication is improved at the target provinces and at the central level.
5. Activity Cycle of planning, implementation, monitoring, evaluation and feedback are carried out at the target provinces and the central level.

[1] MR (Minimum Requirements) is a management tool to improve quality of health services. Please refer the contents of "Output 3".

II. EXECUTIVE SUMMARY

R/D of the KIDSMILE Project was signed in 2002. The Project began its PDM-based activities in 2003 starting with PDM-1 that was later revised into PDM-2. The overall goal of the Project was: Strengthen Child's Health Service at District Level in Two Provinces of Oudomxay and Vientiane.

The Project activities were implemented in all districts of the provinces. Activity plans were made jointly by provinces and the central level with a goal to achieve the following five outputs:

Output 1: Training Information System (TIS)

Output 2: The Network System

Output 3: Child Health

Output 4: Information, Education, Communication (IEC)

Output 5: Activity Cycle Management

1. Organisation

The Project office is under the supervision of the Cabinet and the Department of Hygiene and Prevention (DHP) plays a role of the Project coordinator. The central level Lao counterparts are Department of Personnel and Organization (DOP), Food and Drug (FDD), Curative and Medicine (DOC), Planning and Budgeting (DPB) and centers concerned such as Center for Information and Education for Health (CIEH), Mother and Child Health Center (MCHC). At the provincial level, Oudomxay and Vientiane Provincial Health Offices (PHO) worked as counterparts.

2. Implementation

The Project monitored progress of activities by conducting regular meetings every two weeks in the first two years and once a month in the remaining three years at the central level. Regular meetings at the provincial level were also conducted once a month. In these meetings, reports on implementing activities were discussed and activity plans for next month were approved. In addition, Intensive Discussions were organized every three months (total number of Intensive Discussions was fourteen). As for the Joint Coordinating Committee (JCC) Meetings, they were held every six months (total number was nine). The mid term evaluation was carried out almost in the middle of the Project period and the terminal evaluation - half a year before the termination of the Project.

3. Activity Implementation

At the central level, almost all sections in the departments concerned were assigned to implement activities. DOP was responsible for Output 1 regarding Training Course Information System (TCIS) and Trained Personnel Information System (TPIS) (this system kept records of staff who received training courses at the central, provincial and district levels by establishing database to monitor achievement and store data on training courses). CIEH implemented activities of IEC and MCH took responsibility of conducting the IMCI training. FDD monitored the rational use of drugs, DOC formulated 10 MRs, DHP implemented and monitored activities of FFC, VVC and child health service. DHP also

made summaries of activities. At the provincial level, PHOs carried out such activities as TIS, FFC, etc. They also showed initiatives to support such activities at district and some health center levels as clinical IMCI, MR, IEC campaign, and so on.

Implementation of project activities resulted in the following achievements:

1. Staff developed a concept of working in a team with a coordination of the departments in the MOH. This was a starting point of integrated activity that had never been seen in other projects.

2. For human resource development, trainings were organized regularly and staff from the central to local areas also received training courses. The staff were active in making plans and attempting to monitor activity implementation, found lessons learned from implementing activities, and the outstanding achievement was that the staff at the district level learned how to make plans. At the central level, the CIEH staff received training and there was an expert working with them, which was why the staff had more experiences in producing IEC materials.

3. Relation between the Project Experts and the Government Staff

   Relations between the Project experts and the government staff were based on good coordination and regular discussions. The Project staff showed good attitude providing assistance and explaining the Lao counterparts how to solve problems. The Project staff wanted the Lao counterparts to take ownership of implementing activities so that they would be strengthened and self-sufficient in the future.

4. Things to be continued after termination of the Project

   (1) Staff's capability of making implementation plan

   (2) TIS activities that will be continued by DOP and two target provinces

   (3) 10 MRs which will be continued by DOC and two target provinces

5. The knowledge staff acquired during training, study tours, meetings was applied in their responsible routine work, especially examples of Good Practice collected in places where the project was implemented.

When looking at KIDSMILE Project activities over the last five years, a conclusion can be drawn that achieved its goals. These achievements were confirmed by the KAP (Knowledge, Attitude, Practice) survey as well as the Dissatisfaction survey.

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III. OVERVIEW OF THE ACHIEVEMENTS OF THE PROJECT

The purpose of the Project

The purpose of KIDSMILE Project was to strengthen **management** systems for child health services among the Ministry of Health and target provinces with various levels' participation.

"**Management**" is a rather general word, however, in KIDSMILE Project, its meaning was defined as "getting things done, through learning from experiences, and utilizing it for next similar activity as feedback".

To monitor whether this purpose was achieved (although it is difficult to evaluate the improvement of "management") we set the following three indicators:

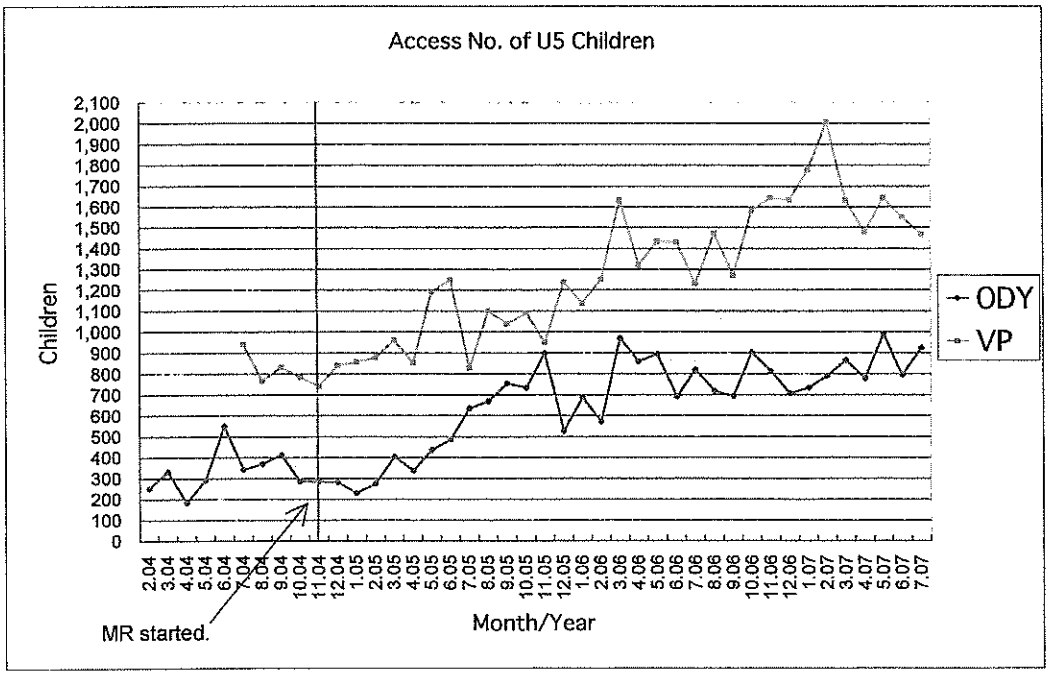
Indicator 1: Access of children under five years old to health services at the provincial and district health facilities is increased.

Indicator 2: Dissatisfaction rate of health services users at the provincial and district health facilities is decreased.

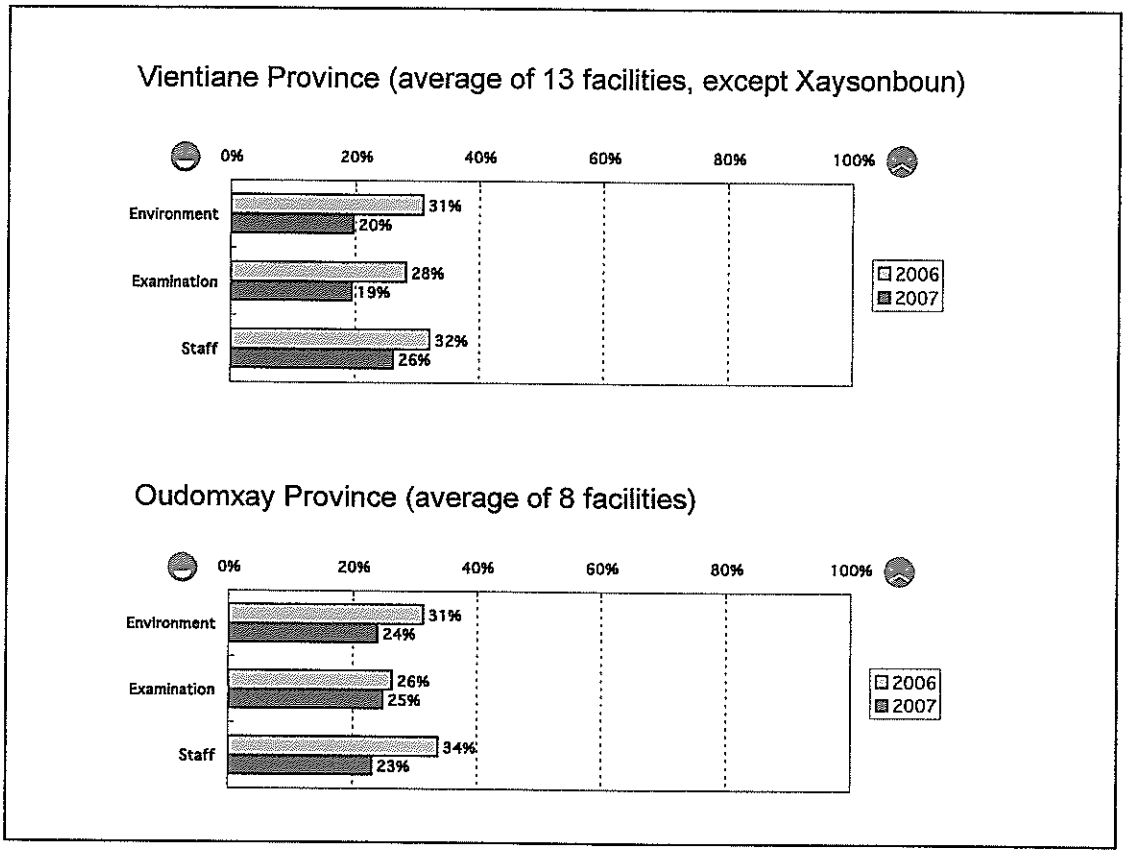
Indicator 3: MR is institutionalized at the district, provincial and central level.

By the end of the Project, the purpose was, in large extent, achieved. The main achievements can be summarized as follows:

1) The share of the population under five years old who received the health services at the provincial and district hospitals had been increasing steadily. It can be said that the Project, together with other factors, contributed to the increase of the number of service users.



2) Dissatisfaction rate of health services users at the provincial and district health facilities decreased.



3) MR is currently functioning well in two target provinces under clear demarcation between district, provincial and central levels, together with other systems such as FFC (Face to Face Communication) and DHO (District Health Office) meetings. However, there is still some room for improvement.

Five main Outputs of the Project

To realize the Project purpose, KIDSMILE had five main "Outputs", 1) TIS, 2) Network System such as VVC (Voice to Voice Communication) and FFC, 3) MR and clinical IMCI, 4) IEC, and 5) Activity Cycle.

"Output 5 (Activity Cycle)" was not really an activity implementation but a kind of conceptual method of **management**. To remember about its importance, we always treated "Output 5" as one independent component of Outputs.

The Project members regularly monitored all activities and indicators of each Output. The results of monitoring lead us to the conclusion that the objectives of the five Outputs had been, in large part, achieved.

However, at the time of the terminal evaluation in June 2007, we still had some tasks to accomplish before we could declare that the purpose of KIDSMILE was achieved. The terminal evaluation team recommended that the Project should implement necessary

actions before the termination of the Project, especially on TIS (Output 1) and MR (Output 3).

The importance of KIDSMILE process

Strengthening the management has a fundamental importance for all general activities. When we evaluate the achievement of this goal, we take into consideration not only the improvement of quantitative indicators but also the process and attitude change.

The reports on KIDSMILE activities (the report on MR evaluation, the report on qualitative impact evaluation of clinical IMCI, the workshop on Group Capacity Development, and the "Lessons learned workshop"), show that initiatives and motivations of the staff involved in KIDSMILE increased.

Especially, at the district level, after the introduction of MR, the staff began to recognize their responsibilities and work as one team in the hospital. They started to hold regular information-sharing meetings, keep records as evidence of activities and have discussions on accomplishment of the tasks included in the monitoring sheet. Closer relationships with various involved organizations, both vertical and horizontal, were also observed. These improvements are essential parts of the health service management, although their importance cannot be quantified.

We believe, even after the Project, management capacity of the health staff will be used by them as a basic skill in their day-to-day work.

Toward the final goal: for improvement of child health

The final goal of KIDSMILE is to improve the health standard of children in the target provinces.

To achieve this goal, especially in the second half of the Project period, we focused on child health activities such as clinical IMCI and IEC campaign events on Child Day, although we tried to strengthen whole management system.

KIDSMILE approach to strengthening the management system was very basic. Such a fundamental skill as office management (e.g. holding regular meetings, maintaining useful documentation, etc) is technically easy to start but actually not so easy to continue as a routine.

The Project wanted to lay the groundwork for sustainable child health service in Laos because we already knew that any nice health program or strategy could not be sustained without the basis of steady and stable health system of this country.

In all activities of KIDSMILE, we wanted the health staff at various levels to realize what they can do by themselves to improve the quality of health services under the current situation. We recognize there are many limitations of this fundamental approach aiming at improving the health condition of every child in Lao PDR. However, we believe that this initial step can be a strong basis for better health of all children in the future.

III. OUTPUTS OF THE PROJECT

Output 1

Training Information System is established at target provinces and at central level.

1. Outline

In May 2003, KIDSMILE analyzed and explored various systems for developing human resources with regard to MOH staff. From research findings it was clear that management staff within the MOH needed a training information system. The Director of DOP and her staff showed a great willingness and eagerness to build the system. It was then immediately approved by a vice minister of MOH. After approval, a technical team was organized and, thus, TIS was established.

TIS consists of two parts: the "Training Course Information System" (TCIS) and the "Training Personnel Information System" (TPIS). At present, TCIS is used mainly by DOP and TPIS is used by the Provincial Health Offices in two target provinces. Naturally, we think it is ideal to link both systems together in the future. TCIS is a database of Training (category, period, name of organizing department, name of supporting donor, expenses, etc), and TPIS is a database of training received by individual health staff (below the provincial level). Both systems are updated yearly and an annual report is made based on information recorded in each database.

2. Achievement of indicators

In PDM-2, Output 1 has four indicators as follows:

1-1. Annual report of monitoring TIS at target provinces and at the central level is made by DOP.

1-2. Collected TCIS is analyzed at the central level and distributed to related organizations annually.

1-3. Collected TPIS data is analyzed annually at target provinces and a summary is made of the data.

1-4. Training Evaluation Report is included in TCIS Annual Report by the end of the Project.

1-1. Annual report of monitoring TIS

DOP in MOH referred its activity on TCIS and TPIS in the annual report of DOP.

1-2. TCIS analysis and distribution by DOP

In May 2005, DOP summarized the first TCIS report (November 2003 to December 2004, 191 courses), and distributed it to around 20 related organizations, donors and NGOs in the dissemination meeting on May 30th, 2005.

In 2006, DOP summarized again the second TCIS report (September 2004 to November 2005) and distributed it in the meeting for "Documentation flow in MOH" organized by the Cabinet on December 16th, 2006.

1-3. TPIS analysis at target provinces

After set up of TPIS, both PHOs continued to collect data and input them into the database.

Oudomxay PHO summarized the all input data of TPIS (n=424), the first TPIS report was published (December 2003 to September 2005) in March 2006 and the second report (October 2005 to September 2006) in October 2007.

Vientiane PHO summarized the data of TPIS (n=633) and the first TPIS report was published (November 2003 to September 2004) in November 2005. The second summary report (October 2003 to September 2005) with the all new input data of TPIS (n=629) was published in September 2006 and disseminated in December 2006. Vientiane PHO published the third summary report (October 2005 to September 2006) in October, 2007.

1-4. Training Evaluation Report is included in TCIS Annual Report by the end of the Project.

TCIS annual report and the training evaluation report was made in October 2007.

3. Progress and problems of activities

TIS was established smoothly in 2003, because of strong leadership of DOP. Nowadays, we can get training information of various kinds of categories, levels, donors, costs, personnel data, and so on, which had been unclear until such data were analyzed by TIS database. Such data is vital to know in order to understand the situation in respect of training needs for health staff from the year 2003 to 2006.

However, the Training Information System needs continued effort in order for it to be sustainable in the future. When the project is terminated, the DOP, the main department concerned with TIS will continue the work and are very enthusiastic to do so. Here are some of the reasons as follows;

1) The results of data could not be utilized or fed back for similar training courses, or in human resources management, in addition Vientiane PHO had some cases when TPIS was utilized for training planning. This meant that the initial objective of using TIS for further training plans could not be reached.

In 2004, Dr. Sugiura, the first Chief Advisor had said that the major objective of TIS was not only to establish the database on training, but also to know the real situation upon implementation of all training courses approved by the Ministry of Public Health, to evaluate their qualities, and to plan better training according to the results of analysis. He also expressed that one practical objective of TIS was to at least to grasp the details of training on child health, and reflect the results on the training of KIDSMILE activities to improve their qualities year by year. However, we could not reach both goals. And such results affected the PHOs' future plan how to manage their TPIS with the direction of MOH.

Practically, in both PHOs, what all the responsible staff on TPIS can do is to collect data from DHOs and health centers once a year and input them into the database. Therefore, even though the PHOs wish to use their TPIS data to select applicants to next training courses, the data is already too old and out-of-date.

The terminal evaluation team recommended that the Project should reconfirm the significance and direction of TIS after the termination of the Project. The team also mentioned that TIS would function only if sector-wide coordination worked well. With that recommendation, the Project has supported the coordination of related departments in the Ministry.

2) Since June 2006, central TCIS had been halted, because the necessary documentation flow in MOH was changed and DOP was not able to get the TCIS form.

In December 2006, DOP discussed with the cabinet to share training information and how to circulate documents on training, and TCIS was restarted in January 2007, with collaboration between DOP and the Cabinet. From this experience, the Project understood, as the terminal evaluation team commented, TIS could function with the efforts not only by DOP, but also by sector-wide coordination.

3) In May 2005, after summarizing the first TCIS report, DOP decided to design an evaluation system for each training program in TCIS, because under the original system, TCIS collected only planned information, not the results of the training. The new evaluation system would enable MOH to allocate the training budget more effectively, and to improve the quality of training.

DOP started a new TCIS evaluation system in January 2006; however, many training organizers did not submit the evaluation form to DOP. We assumed that due to a lack of communication between parties there was a misunderstanding of why they had to submit new evaluation forms.

After the re-information with an official letter by vice-minister, DOP pushed to get more forms from training organizers. In October 2007, DOP made first TCIS evaluation summary with 17 data.

4) The TIS database, made by FileMaker-Pro, has been maintained by KIDSMILE staff. When and if the database faces some problems in the future, DOP will need to seek technical assistance from outside.

In addition, the responsible staff in PHOs shall still some need technical assistance for data management and analysis, though staff capabilities on TIS have improved.

Output 2

The Network System is strengthened at target provinces and at the central level.

1. Outline

One of fundamental aims of KIDSMILE is to promote better vertical and horizontal coordination of health administration at central, provincial, and district level, as well as among departments at each level, through VVC, Voice to Voice Communication, i.e. radio, and communication between the Provincial Health Office (PHO) and the District Health Office (DHO).

We also aim to promote increased FFC, Face to Face Communication, which will in turn lead to better management by PHO of the District Health Offices.

Both VVC and FFC use the existing systems. This is the primarily work of PHOs, yet they have not, in the past, been able to put these activities into practice due to poor facilities and the lack of a travel budget for official trips. KIDSMILE has supported the rebuilding and maintenance of this work and, importantly, the DHO now reports to the PHO about additional basic health information, this includes the number of children under five with access to district health services, the state of vaccination management and the outbreak of any infectious diseases, this information is processed through VVC at a fixed-time everyday. The PHOs are also in charge with supervising the activities of DHO every three months through FFC. These meetings are also an opportunity to address any reports completed through VVC over the previous three months.

We have continuously tried to improve the quality of both VVC and FFC activities and to adjust their implementation style so that they may continue after termination of KIDSMILE in October 2007.

2. Achievement of indicators

In PDM-2, Output 2 has three indicators as follows;

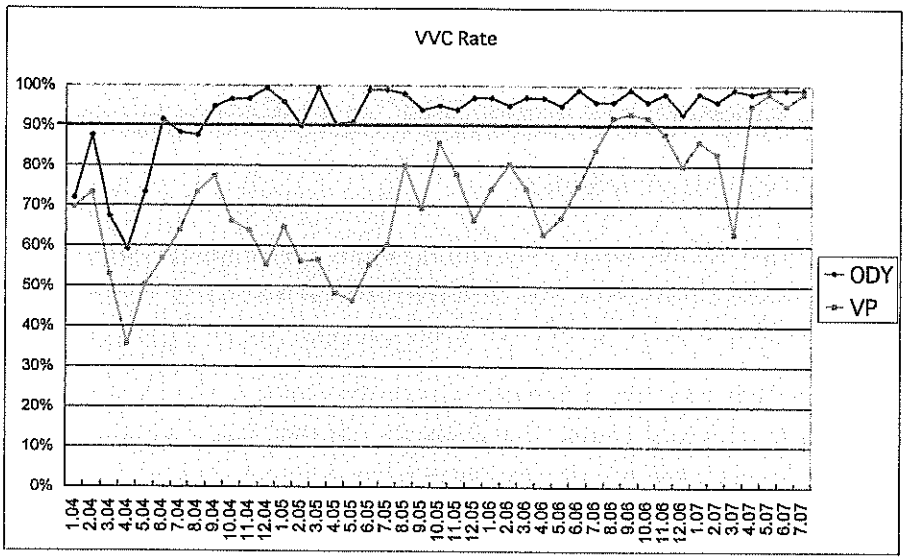
2-1. Voice to Voice Communication (VVC) is conducted and recorded 90% of the time expect when unavoidable factors interfere with the communication.

2-2. Face to Face Communication (FFC) is conducted at least four times per year.

2-3. Meetings are held regularly at target provinces and at central level (at least once a month).

2-1. VVC

In both model provinces, the average of daily communications ratio is almost more than 90%. In Oudomxay, performance of VVC including its recording is continuously more than 90%. Vientiane province improved its ratio with strong leadership of PHO, and achieved 90% in August 2006, although occasionally this ratio dropped below 90%. Please refer to the trend of VVC ratio in the chart below.



In both provinces, telephony has been maintained by using "Maintenance Manual for Telephony by PHO", summarized by KIDSMILE in 2004. In Oudomxay, PHO trained the supervisory staff of DHO and health centers on telephony maintenance and data-form in 2005 and 2006. In Vientiane Province,

There were some cases of the outbreak of infectious diseases and other emergencies which were shared between PHO and the DHO through VVC.

2-2. FFC

Since 2004, Oudomxay PHO had conducted FFC 16 times and Vientiane PHO had conducted FFC 13 times by the end of the Project. FCC have almost quadrupled in each province. The table below shows the implemented FFC per year.

Year	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007
ODY	FFC1 – 2	FFC3 – 7	FFC8 – 10	FFC11 – 13	FFC14 – 16
VP		FFC1 – 2	FFC3 – 5	FFC6 – 9	FFC10 – 13

Through FFC, PHO supervises health services of DHO, by checking six components specified by MOH, MR activities including clinical IMCI, and performance of their original plans.

The results of FFC were reported in the regular meetings at each PHO, and submitted to DHP. PHOs also shared the results of FFC with all DHO staff in the wrap-up DHO meeting after every FFC, for feedback.

2-3. Monthly regular meeting at each project site

Both PHOs held regular meetings almost once a month, amongst each section in PHO. They also held regular meetings among DHOs to feed back the results of FFC. They initiated a process to improve the quality of discussion of meetings, for example, the chairpersons are now rotated by every department, in turn.

Central staff had regular meetings almost once a month, though some departments were not able to attend meetings due to tight work schedules. Moreover, it seemed to be difficult for central staff to have a strong motivation to attend meetings, just to listen to activity reports of other departments.

3. Progress and problems of activities

In the all workshops of terminal evaluation, many participants pointed out that both vertical linkage among various levels (MOH-PHO-DHO-health center-community) and horizontal coordination at same level have strengthened through KIDSMILE activities.

As for vertical coordination, the linkage from provincial level to districts level became a stronger link than in previous times. For example, an FFC team can solve problems more quickly at district levels, than previously because it now includes several professional staff from each department. In addition, during the project period, a vertical network has now expanded to health center level. In both provinces, it became the responsibility of the DHO to organize DHO-health center meetings twice a year in Oudomxay, and every three months in the Vientiane province. FFC from DHO to health centers also began in the Vientiane province in 2006.

Also, with better horizontal coordination, health staff at each level seem to have more confidence to express their opinions on how to improve their health service.

In addition, with closer vertical and horizontal integration, the quality of discussions in meetings has been improved. At the beginning, not every participant knew the contents of KIDSMILE Project, because we welcomed anybody from various relevant departments to attend discussions. However, in the latter part of the Project, we had deeper discussions, going step by step with regular monitoring of the main activities. This was achieved by holding monthly meetings and having Intensive Discussions. As a result, participants gained confidence to avoid "superficial speech", and to express their own opinions in their own words.

Specifically, the Intensive Discussions among different departments of MOH deepened their understandings of KIDSMILE, mainly because deputy directors from almost all departments attended discussions, shared information, and discussed openly. Such discussions contributed to the achievement of the project objectives.

At provincial level, the role of meetings or workshops has been changed. Previously, meetings were top-down instructions and one-way information. Now, however, participants can share and exchange their personal opinions since these changes, and are now included in the decision making process, because of positive changes in their ways of thinking. To keep such a format in the future, a improved attitude of upper level management is required for better supervision and feedback.

Out of the activities of Output 2, FFC and wrap-up DHO meetings became one of essential components of the MR system. These activities are recognized as a part of MR by health staff, according to the "Report on MR Evaluation" by Dr. Akashi in 2006. After the termination of the Project, this fact should be considered when MOH expand MR into other provinces.

Through KIDSMILE Project activities, we can say that the network system (which means both vertical and horizontal relationships) has been strengthened. We have high expectations of effective utilization of the network for health administration to spread throughout Laos in the future.

Output 3

MR and IMCI are established at target provinces and at central level.

1. Outline

Major activities of Output 3 are MR (Minimum Requirements) and IMCI (Integrated Management of Childhood Illness).

The project conducted a baseline survey in Oudomxay Province at the beginning of the project period in May 2003 from the survey it was found that the district hospitals did not provide enough health services even in consideration of their situations. On the other hand, it was found through the workshop that health staff of district hospitals wanted to diagnose and treat children more accurately. Therefore, the project set up 10 minimum health services for children at district level and named it "minimum requirement (MR)". Clinical IMCI was also included. However, the project adopted only clinical IMCI of the three components of IMCI, thus, hereinafter, "IMCI" means clinical IMCI.

The table below shows 10 Items of Minimum Requirement.

MR1	The hospital is accessible to all patients 24 hours a day.
MR2	The hospital welcomes all patients with warmth and hospitality.
MR3	The hospital has all the essential drugs.
MR4	The hospital classifies and treats four major childhood illnesses.
MR5	The hospital carries out blood tests to identify Malaria.
MR6	The hospital has a patient referral system.
MR7	The hospital keeps records of all patients daily.
MR8	The hospital gives routine vaccination and maintains a good quality cold chain.
MR9	The hospital gives every child a "well-baby check-up" and monitors their growth.
MR10	The hospital monitors and evaluates all child health activities regularly.

* For all 10 items of MR, the hospital should have enough function of health education.

MR was originally formulated as a kind of standard of district level health services for children however, the concept of MR changed from being a standard into being a

management tool when MR was introduced to the target facilities. The project emphasized that it was important for the health staff to improve their health services irrespective of the constraints they faced in their daily work. In view of the constraints, it was decided that to set up the same standards for every hospital was inappropriate The project tried to improve health services through improving management by MR, therefore, MR was defined as a management tool. In MR, the hospitals themselves plan activities for respective 10 items of MR and they implement the activities according to the plan. They make records whenever they implement the activities and they then monitor their activities with the records by themselves. These procedures are the essence of MR.

MR was introduced to the all district hospitals of the target provinces in October 2004 and it has been implemented and involved many people both at the horizontal and vertical levels. At district level, a person in charge of MR was assigned to each facility and all the staff of the facility were involved because MR involved various sections' work and some activities were related to all staff's work. At provincial level, a person in charge of MR was assigned and many sections' staff were involved because MR activities were parts of respective sections' vertical programs and they needed to supervise the activities. MR activities were supervised from both management and from the technical aspects of the PHO. At the central level, Department of Curative Medicine (DOC) was responsible for MR.

Activities to support MR implementation in facilities were vital for effective MR implementation, and those activities and MR implementation in facilities composed the "MR system". Regular supervision by upper levels, especially PHO, was the key to effective MR implementation. PHO supervised MR activities through FFC. PHO also organized DHO meeting after every FFC to share information among PHO and the facilities. These activities were carried out as part of Output 2 of the Project. The results of MR implementation were reported from the facilities to PHO and from PHO to DOC.

Moreover, MR workshops were organized at the end of every fiscal year to evaluate MR implementation within the past year and to make next year's MR activity plan collectively amongst the facilities, PHO and DOC. All these activities composed the MR system and MR implementation in the facilities were working in this MR system.

IMCI was included as one of MR items, which was "The hospital classifies and treats four major childhood illness." To implement activities of this MR item in the facilities, the project introduced IMCI to all the facilities which participated in MR by holding IMCI clinical trainings. The facilities implemented IMCI as activities of MR after the training.

The project also implemented activities to sustain IMCI implementation in the facilities. The main actors of these activities were the central IMCI technical working group and the MCH section of PHO. Firstly, the project trained trainers of IMCI at provincial and district level by holding Training of Trainers (TOT) so that PHO could hold IMCI clinical trainings by themselves to train a sufficient number of health staff in the facilities. Secondly, the project conducted supervision of IMCI regularly. The project gave training

for follow-up visits to provincial and district staff. PHO supervised the facilities IMCI activities through FFC. Moreover, the central IMCI technical working group and PHO conducted IMCI follow-up visit which method was originally established by WHO.

2. Achievement of indicators

2-1. MR

The project has established the structure of MR implementation in the facilities as bellow.

Concept of MR was defined and 10 items of MR was finalized in July 2004. The method of implementing MR, namely planning, implementation of activities, monitoring/evaluation and supervision, was formulated by September 2004. This includes formulation of self-evaluation sheet (Indicator 3-1) and definition of "district objectives based on MR" (related to Indicator 3-2). "District objectives based on MR" was defined as "how much the facility implemented activities which they planned' and was calculated by scoring implementation status of activities.

In the facilities, they recognized MR activities as their original routine work but they thought that MR systematized their way of working and it was useful for them. They implemented the activities planned by themselves and they achieved more than 80% of implementation status (Indicator 3-2).

Evaluation of the effect of MR was conducted from October 2006 to February 2007 by Dr. Akashi, who was a short term expert of the Project, and it was found that MR improved facilities' management. Especially, the evaluation report emphasized that the decision-making process changed after introduction of MR and staff became involved in decision-making process, consequently, they came to work as a team.

Beyond Output 3, MR was closely related to other activities of the project, especially FFC and DHO meeting of Output 2. As mentioned in the outline, MR implementation in the facilities and MR related activities composed "MR system". MR evaluation report mentioned that PHO was involved in MR system, consequently, MR positively influenced PHO's management and the provincial health system.

MR was recognized as a very useful tool to improve health services at the central level and the DOC is planning to extend the MR programme nationwide.

2-2. IMCI

The project has established the structure of IMCI implementation from the central to the facility level as below.

The project gave IMCI clinical training to 192 health staff, consequently, more than 60% of the staff who had opportunities to examine sick children were trained in almost all the target facilities. The central level staff trained provincial and district staff in the first training of the project in 2003, however, after conducting TOT for provincial and district staff, the trainers shifted from the central level to provincial level year by year. Since 2005, PHOs of the both target provinces came to be able to conduct IMCI clinical training by themselves. The number of the health staff who received any kinds of IMCI training

(clinical, TOT, follow-up, refresher) was 247 totally (Indicator 3-3).

The facilities were making continuous efforts to sustain IMCI implementation by integrating it into MR. As a result, they came to apply IMCI to more sick children (Indicator 3-4). On the other hand, PHO and the central IMCI technical working group established the supporting system for IMCI implementation in the facilities. It was an important promoting factor for the facilities to implement IMCI. Firstly, PHO solved the problem that lack of IMCI recording form. In Vientiane Province, PHO formulated much cheaper recording book instead of costly recording form and the facilities made the recording book by themselves. In Oudomxay Province, PHO secured government budget to provide IMCI recording forms. Secondly, PHO and the central IMCI technical working group established a supervising system as mentioned in the outline. Moreover, the central IMCI technical working group revised IMCI follow-up visit form in 2006 and contents of follow-up visit were standardized. According to the results of supervision with standardized follow-up visit form, it was confirmed that the facilities were implementing IMCI correctly at certain level.

Impact evaluation of IMCI was conducted from February to April 2007 by Dr.Noda, who was a short term expert of the Project. The evaluation report stated that IMCI was useful for the health staff to improve the quality of health services for children and caretakers and health staff's skill to examine sick children was improved (Indicator 3-5).

2-3. Indicators of Output 3

<table>
<tr><td>Indicators of Output 3</td><td colspan="4">Results</td></tr>
<tr><td>3-1. Self Evaluation sheet for MR is formulated by September 2004.</td><td colspan="4">Self evaluation sheet for MR was formulated by September 2004.</td></tr>
<tr><td rowspan="3">3-2. 80 % of all District's objectives based on MR is achieved.</td><td></td><td>2004-2005</td><td>2005-2006</td><td>2006-2007</td></tr>
<tr><td>VP</td><td>83%</td><td>87%</td><td></td></tr>
<tr><td>ODY</td><td>75%</td><td>88%</td><td></td></tr>
<tr><td>3-3. More than 150 members of staff at target provinces are trained for IMCI.</td><td colspan="4">In total 259 health staff received IMCI training (any or all of clinical, TOT, follow-up and refresher).</td></tr>
</table>

(continued to the next page)

Indicators of Output 3	Results				
3-4. The Implementation rate of IMCI is improved. * This indicator is calculated using No. of U5 illness children reported by VVC, but, some districts' VVC data differ from No. of U5 illness children recorded at OPD & ER. As the result, VP shows the rate calculated using the data at OPD & ER in order to be precise.	VP	Oct 05-Mar 06	Apr 06-Sep 07	Oct 06-Mar 07	Apr 07-June 07
		64%	58%	107% *(93%)	91% *(98.7%)
	ODY	Oct 05-Mar 06	Apr 06-Nov 06	Dec 06-Feb 07	Mar 07-July 07
		72%	79%	81%	86%
3-5. Clinical skill of staff trained for IMCI is improved.	Impact evaluation of IMCI conducted from February to April 2007 confirmed that health staff's skill to examine sick children was improved.				

3. Progress and problems of activities

3-1. MR

3-1-1. Facilities which implemented MR

MR was introduced to all the district hospitals in target provinces in October 2004. Soon after that, Oudomxay Provincial Hospital participated. In Vientiane Province, due to change of administrative boundary, two big health centers participated in October 2005 and a new district hospital joined in October 2006. At the time of the project end, totally 22 facilities are implementing MR.

3-1-2. Difficulty to understand MR concept

MR was introduced in October 2004 but it took a long time to gain a satisfactory understanding of MR concept. MR was introduced as "minimum health services at district level health services". However, it was also explained that "MR is not a standard but a guideline for minimum health services" and each facility should do what they could do under their present situation toward each MR item. As a result, "minimum" of "minimum requirement" had a double meaning such as "minimum health service" and "doing what they could do under their present situation", and this caused much confusion. For provincial and district level, at first, it was very difficult for them to make an appropriate MR activity plan due to a difficulty in understanding the MR concept. However, they did come to understand what was MR through implementing MR and their MR activities improved year by year. On the other hand, different activities of respective facilities caused confusion at the central. Therefore, the concept of MR was reconfirmed amongst the people concerned with MR and subsequently redefined as "a management tool to improve quality of health services under the present situation" in 2006. This concept was shared with the individuals concerned with MR, but it is necessary to be shared more widely, especially within MOH.

3-1-3. Setting of expected outcomes and indicators of respective MR items

The project emphasized that it was important to do what the facilities could do under their present situation, and then implementation status was monitored as MR monitoring in order not to compare different results due to different situations. As a result, the facilities tended to aim at 100% implementation of activities without considering results of activity implementation. In some MR items, a discrepancy arose between activity implementation status and results of activity implementation such as high implementation status but little improvement of services. For example, implementation status of MR 4 activities was almost 100% but utilization rate of IMCI method for sick children was still low (50-60%). Therefore, to reconfirm the real objectives of respective MR items, expected outcomes and indicators of respective MR items were set up in 2006. PHO selected only a few indicators to monitor because it was difficult for the facilities to start monitoring all the indicators together. After starting to monitor the indicators, the facilities came to consider the results of activity implementation gradually.

3-1-4. Introduction of reporting system

There was no reporting system of MR before 2006. MR was monitored through FFC and PHO sent a report of the KIDSMILE project's activities to Department of Hygiene and Prevention (DHP). However, this is a special system only for the project and will disappear after the Project ends. Therefore, the Project formulated the reporting forms of MR (DHO-PHO, PHO-DOC) and introduced it in 2006. This system has been working well between DHO and PHO, however, it has not been working well between PHO and DOC so far,

3-1-5. Change of procedure of MR implementation

The procedure for MR implementation has changed every year to improve MR. Especially the planning procedure was complex and the project tried to make it simpler and easier. The project changed many points on the procedure and formulated the final one for the 3rd year's MR implementation in 2006. It was not necessarily easy for PHO and DHO staff to understand the new procedure every year, however staff did manage to follow them. The final procedure was summarized as "Handbook of MR implementation" in 2007.

3-1-6. MR system

"MR" means MR activity implementation in the facility in the narrow sense. However, MR has developed relating other activities of the project such as FFC and DHO meeting. Relationship among MR and its related activities was clarified by the evaluation of effect of MR conducted from 2006 to 2007. The evaluation report said that MR and its related activities composed "MR system" and MR was working effectively in this MR system, and not working alone. This idea was shared with the people concerned with MR in the last MR workshop of the project in 2007.

3-1-7. Institutionalization of MR

MR in the facilities was established through implementing the activities. However, it

cannot be said that "MR is institutionalized at district, provincial and central level" completely (Indicator of project purpose 2). The concept of MR has not been understood widely as well as the concept of the whole mechanism of MR (MR system). In addition, DOC was expected to manage the data of MR implementation and to conduct supervisory visits as necessary, but it was completed partially but there is still room for improvement. Toward MR extension nationwide, these matters are challenges to be overcome..

3-1-8. Change of administrative structure of MR implementation in Oudomxay Province after the project termination

Oudomxay PHO will change their administrative structure of MR implementation after the project ends. PHO has been managing MR implementation during the project period, but PHO will delegate authority to manage MR implementation to Provincial Hospitals according to their policy that Provincial Hospital manages the district hospitals in the province. However, Provincial Hospitals have limited experience in supervising MR activities in the district hospitals, moreover, Provincial Hospital itself is implementing MR but their performance of MR is rather lower than that of the district hospitals. This change will be a big challenge for Oudmxay Province to continue MR implementation after the project ends.

3-2. IMCI

At the end of the project a structure of IMCI implementation in the facilities and the supporting system for IMCI implementation in the facilities by upper levels was established. Therefore, it is expected that IMCI implementation in the target provinces will be sustained although they may not continue some activities which need a minimum budget such as follow-up visit.

Output 4

Capacity of Information, Education, and Communication is improved at target provinces and central level.

1. Outline

Through the activities of IEC, KIDSMILE aims to strengthen the function of CIEH (Center for Information and Education for Health) so that CIEH will be able to play the role of "Media planner" [2] and provide appropriate teaching materials alongside technical guidance to the target provinces in response to their requests.

The project recognizes the strength of campaigns as tools for disseminating information. One example of a campaign is a special event held on Child Day (June 1st, or thereabouts), every year. There have been three campaigns associated with Child Day conducted so far; The School Health Campaign 2005, whose theme was the "Three hygiene"[3], The Child Health Campaign 2005; theme, "Let's go to the hospital, for vaccination and child health check-up", and The Child Health Campaign 2006 that carried same theme as 2005.

Campaigns take careful planning stretching over a few months, activities include creating teaching materials; campaign songs, dramas, dances, posters and pamphlets, campaign characters named "SMILE man" and Virus man, audiovisual such as VCD and cassette tapes. Before this special event, all staff parade around the location, and manage all the events, there is a master of ceremony, a facilitator for asking quiz questions, a logistic manager, etc. "KAP" (Knowledge, Attitude, and Practice) survey is conducted before and after the campaign to measure its effectiveness and to provide feedback for evaluation during the next campaign.

2. Achievement of indicators

In PDM-2, Output 4 has three indicators as follows;

4-1. Scores in Evaluation sheet of Media planner are increased at CIEH.

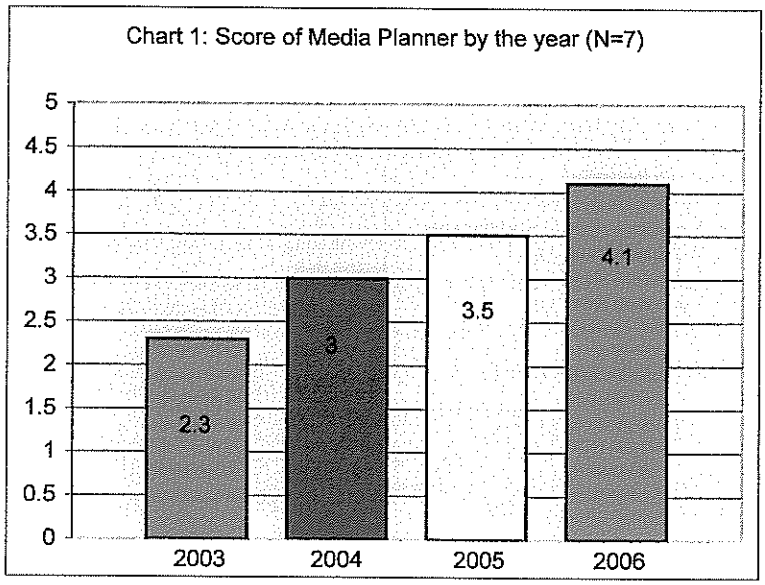
4-2. Target provinces and CIEH cooperate and implement more than five activities annually.

4-3. Knowledge, Attitude, and Practice of participants in campaign activities are improved.

[2] "Media planner" publishes information and provides technical assistance for making teaching materials and producing health education materials, according to clients' needs. They also evaluate the impact of their activities and products.
[3] School Health was one of main activities of the Project until 2005. The details are found at Output 4's activity 4-3 of the Summary of Activities for each Output in the Chapter III Activities of the Project.

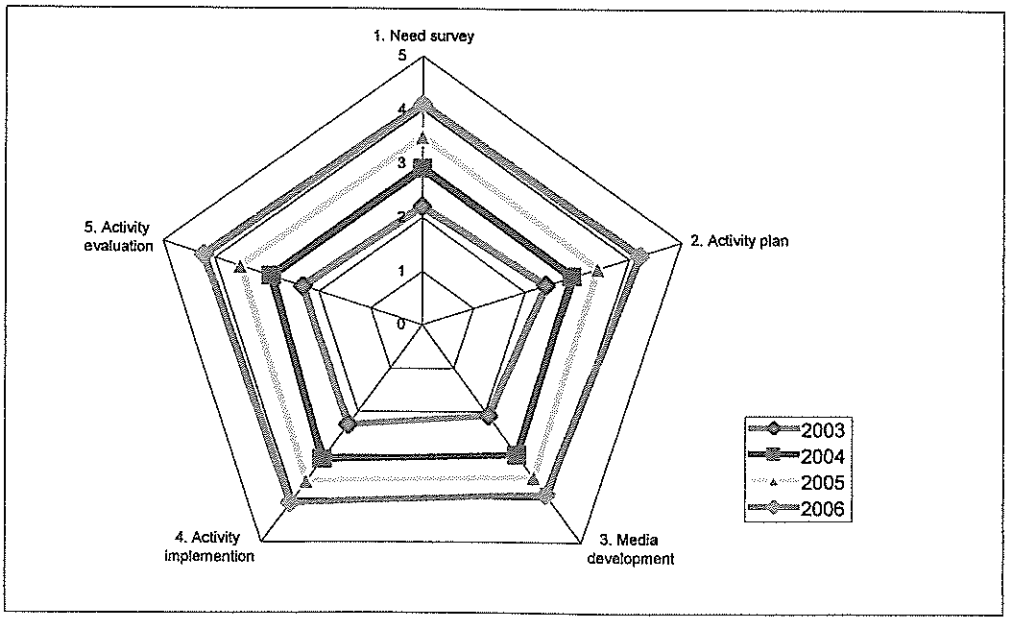
4-1. Scores in Evaluation sheet of Media planner are increased at CIEH.

According to Media planner evaluation for CIEH, the average of score has been increased from 2.3 in 2003 to 4.1 in 2006, out of 5 grades, as it is shown in the chart below.



In the Media Planner evaluation, five skills which are necessary for media planner are evaluated, for example: a "needs" survey, skill of activities planning, skill of media development, skill of activities implementation and skill of activities evaluation. The chart below shows a steady rise in skills year by year.

Chart 2: Score of Media Planner each skill by the year (N=7)



4-2. Target provinces and CIEH cooperate and implement more than five activities annually.

The number of activities that are implemented by the cooperation of target provinces and CIEH is more than five annually. In Oudomxay eight (8) IEC activities for 2005-2006 Lao Fiscal Year (LFY) and seven (7) for 2006-2007 LFY were carried out. In Vientiane six (6) activities for both 2005-2006 LFY and 2006-2007 LFY were implemented. The tables below show the details of activities in both provinces.

List of IEC Activities implemented by two Provinces with CIEH (from 10/2005 - 09/2006)

No.	Oudomxay Province		Vientiane Province	
1	12/05	Training on Health Education on Child Health Check Up Promotion for Teachers of pre schools	11/05	Impact Survey of Child Health Campaign 2005
2	12/05	IEC Skill Training, conducted in CIEH	12/05	IEC Skill Training, conducted in CIEH
3	12/05	Model Event of Child Health Campaign 2005	02/06	Evaluation of Child Health Campaign 2005 and Strategy Plan Meeting for Child Health Campaign 2006
4	01/06	Impact Survey of Child Health Campaign 2005	04/06	Pre-KAP Survey for Child Health Campaign 2006
5	03/05	Evaluation of Child Health Campaign 2005 and Strategy Plan Meeting for Child Health Campaign 2006	05/06	IEC Skill Training for Child Health Campaign 2006
6	05/06	Pre-KAP Survey for Child Health Campaign 2006	05.06	Monitoring Events of Child Health Campaign 2006
7	05/06	IEC Skill Training for Child Health Campaign 2006		
8	05/06	Monitoring Events of Child Health Campaign 2006		

List of IEC Activities implemented by two Provinces with CIEH (from 10/2006 - 09/2007)

No.	Oudomxay Province		Vientiane Province	
1	12/06	Model Event of Child Health Campaign 2006	10/06	Post-KAP Survey for Child Health Campaign 2006
2	01/07	Post-KAP Survey for Child Health Campaign 2006	12/06	Evaluation of Child Health Campaign 2005 and Strategy Plan Meeting for Child Health Campaign 2006
3	03/07	Evaluation of Child Health Campaign 2006 and Strategy Plan Meeting for Child Health Campaign 2007	02/07	IEC Skill Training, conducted in CIEH and Model Event for Child Health Campaign 2007
4	05/07	IEC Skill Training, conducted in CIEH	02/07	Pre-KAP Survey for Child Health Campaign 2007
5	05/07	Pre-KAP Survey for Child Health Campaign 2007	03/07	Monitoring Events of Child Health Campaign 2007
6	06/07	Monitoring Events of Child Health Campaign 2007	07/07	Post-KAP Survey for Child Health Campaign 2007
7	07/07	Post-KAP Survey for Child Health Campaign 2007		

4-3. Knowledge, Attitude, and Practice of participants in campaign activities are improved.

KAP surveys for Child health campaigns were conducted twice in 2006 and 2007 (in 2005, we had only Pre-survey). In 2006, a pre-KAP survey was done in April-May in both target provinces, and Post-KAP survey was done in November in Vientiane province, and in February 2007 in Oudomxay. In 2007, Pre-KAP survey was conducted in May in Oudomxay, and a Post-KAP survey was completed in February in Vientiane province, and

in July in Oudomxay. CIEH summarized the final report annually, and its capability on how to analyze data, increased every year.

According to the results of KAP survey, some improvement in Knowledge, Attitude, and Practice of participants has been observed. For example, from the result of survey in 2006 (n=108 in Oudomxay, n=172 in Vientiane province), caretakers knowledge in vaccination and breastfeeding has been increased in both target provinces. In addition, the behavior of care takers have changed positively and now take their children to hospitals for vaccination and child health check-up in the Vientiane province. In Oudomxay province, in the pre and post survey of 2006, the percentage of caretakers who took their children to facilities had not changed, however, total coverage of immunization for their children has increased.

3. Progress and problems of activities

Output 4 is one of the successful activities that clearly shows the progress of the organizational capacity development. CIEH have improved capability including both technical and management capacities, as one IEC professional organization. The reasons for these success are;

(1) IEC activities, especially, strengthening of campaigns is very practical and understandable for relevant stakeholders..

(2) IEC staff could see for themselves their progress and improvement (capacity development) by visible score increases in "Media planner evaluation sheet". At provincial level, the staff also succeeded to monitor their improvement by using a similar evaluation sheet.

Currently, at provincial level there is a capability to conduct IEC activities by themselves without too much assistance from the CIEH. As for Oudomxay, district level can manage campaigns including logistics as a result of the skills gained in activities such as organixing campaigns.

In November 2005, CIEH staff held "IEC technical skill training" for IEC staff of both PHOs. With their experiences of counterpart training courses held in Japan, CIEH staff transfer their lessons learned to provincial staff, as trainers. Some staff are now using the techniques for their daily work in each province. For example, IEC technical staff in Oudomxay improved the quality of their "PHO news", regular billboard newspaper. Originally, "PHO news" was handwritten articles reporting PHO activities in 2004. After the staff gained new skills training in CIEH, the "PHO news" was written on computer attaching some pictures, including contents of health education not only for PHO but also for the provincial hospitals and the PHC School. Moreover, the IEC staff is now utilizing their knowledge and are making regular radio broadcasts of "PHO news".

In the latter period of the Project, IEC activities had considerable synergy effect with Output 3 (Child health) related activities. It greatly contributed in informing the associated organizations and villagers of the importance of child health services, although we could not cover such a large population by other activities. In addition, IEC activities were very useful in introducing what the KIDSMILE Project aimed for, an awareness and public interest in the KIDSMILE project activities

However during the Project period, IEC activities needed the largest inputs including budget, equipment, and continued assistance by Japanese experts. And such an approach included some aspects which was over and above KIDSMILE original principle, that of "utilization of the existing resources". We have not yet evaluated the balance between such substantial inputs and the projects resulting outputs. It is not easy for PHO and districts to continue IEC campaign in the same mode as KIDSMILE has done so in the past. There needs to decisions made on how to manage PHOs, the districts, and CIEH and to utilize their experiences of campaigning and improvements made in IEC capacities, with their existing resources.

Fortunately, according to the terminal evaluation report, CIEH is receiving orders for provision of training and development of IEC materials (poster, brochure, VCD, commercial messages on TV or radio, and magazines, etc), because of its improved performance. At the provincial and district level, to hold campaign events, they received assistance from related organizations, such as primary schools, governors' offices, the Lao Women's' Union. We hope, in the future, such improved knowledge and skills, and established collaboration system will be utilized for all IEC activities at district, provincial, and central level.

In Oudomxay, even before KIDSMILE, PHO and some DHO would organize a child day's event, if they could find funding donors or a budget for the event. However, at that time, they organized the event by themselves only, without any technical collaboration with other partners. It was very difficult to hold such events regularly for DHO, because they had insufficient skills in human and financial resource management. When the Project finishes, it will be necessary for DHO to continue to get technical support from CIEH, to cooperate closely with local organizations (district governor office, army hospital, schools, Information and Cultural department, etc), and to request local sponsors such as companies or shops. Local government office and community people understand that such events are very important and so will continue to support to assist in organization of the events.

Output 5

Activity Cycle of planning, implementation, monitoring, evaluation and feedback are carried out at target provinces and central level.

1. Outline

The Activity Cycle follows the flow of implementation of decisions and actions i.e. "Plan - Do - Monitor - Evaluate - Feedback". The Activity Cycle has become an integral part of the KIDSMILE project. Its process is highly respected and relied upon, due to the lack of experience of health personnel.

KIDSMILE promote a core learning of the cycle so that every action can be given a purpose and a direction. We would like to encourage health personnel to recognize the singular importance of the Activity Cycle.

Each department is to make an annual plan and a proposal for activities related to the project. They must clarify their budget including cost breakdown and the way they intend to monitor, evaluate and provide feedback in a clear and concise manner on the proposal. They are also to submit a report at the end of the activity and provide feedback.

Implementation of the annual plan is monitored by all participants at regular meetings and Intensive Discussion. These are important opportunities for all relevant persons to come together to discuss intensively the project and the results are shared openly with the aim of continuously improving performance.

2. Achievement of indicators

In PDM-2, Output 5 has four indicators as follows:
5-1. 80% of activities in annual plan is implemented.
5-2. Proposal form in designed and distributed by May 2004.
5-3. 100% of activity report based on Proposal form is submitted.
5-4. Number of Good Practice is increased.

5-1. 80% of activities in annual plan is implemented.

Implementation status of all activities in annual plan is almost 80% (in 2005-2006, 75% at central level, 74% in Oudomxay and 84% in Vientiane province, and in 2006-2007, 77% at central level, 94% in Oucomxay and also 94% in Vientiane province).

5-2. Proposal form in designed and distributed by May 2004.

In 2004, the contents of proposal form were considered by DHP and Japanese experts. After using of draft form, that design was revised, and approved at the regular meeting at central level in January 2005.

Then, all KIDSMILE activities were implemented based on each proposal following this form.

5-3. 100% of activity report based on Proposal form is submitted.

The percentage of submission of activity report following the Proposal form is nearly 100% (94% (47 reports against 50 proposals) at central level, 97% (104 reports against 107 proposals) in Oudomxay, and 95% (144 reports against 152 proposals) in Vientiane province).

5-4. Number of Good Practice[4] is increased.

"Good Practice" can be represented by two "Activity Cycles" where the completion of one turn of the cycle flows into the beginning of the next cycle.

In 2006, seven cases were acknowledged as "Good Practice", followed by additional three cases. In the 10th Intensive Discussion, held in May 2007, more six new cases were approved, therefore, now, the total number of "Good Practice" is 16.

3. Progress and problems of activities

Output 5 is not a practical activity but a basic and general concept for good management. However, because it is stipulated on PDM as one "Output", despite the difference from Output 1-4, we could share and recognize the importance of "Activity Cycle".

The concept of Activity Cycle is a basis of various kinds of work. With strong awareness of that concept, many relevant personal feel they could have more responsibilities or be included in more teamwork than previously. We can state that Output 5 contributes to strengthening organizational capacity from the view of Capacity Development, although only four indicators cannot show such results.

The "Workshop on Group Capacity Development", held in January to February in 2007, was useful for members of KIDSMILE at various levels (district, province, and central) to all understand the meaning of Output 5; to learn through experiences, and to use that review for subsequent activities.

It took long time to understand the concept of Output 5, and there were many difficulties to put the Activity Cycle in place. For example, some staff could not complete the proposal form, because the form was not always appropriate for some activities.

To avoid confusion, before we begin a conceptual system such as Activity Cycle, we need to make clear the meaning of the concept, including definitions of all common words (i.e. objective, expected outcome, monitoring, evaluation, feedback, etc). This does make the process longer but avoids confusion later on.

In addition, even after there was a satisfactory understanding of the concept, it was not

[4] The definition of "Good Practice" is "model example which we could reflect former experience on identical or similar activities as feedback."

easy to use such a concept for real activities to improve health service quality in daily work. There is a big gap between concept and practice; although we can say recognition of the gap itself is one necessary step to strengthen health management.

Great effort was put into following the proper style of our Proposal form; however, we could not check whether the quality of contents had been improving or not improving.

One reason why the Project could not follow the contents in Proposal form was that the form pattern didn't reflect what we wanted to know. There was no item which requested the writers to describe "Lesson learned" of previous similar activities. This made it difficult to review whether the Activity Cycle had been really completed or not.

As a result, among all 17 cases approved as "Good Practice", there are no examples which we identify improvements with reference to both proposal and report.

Moreover, to evaluate the improvement of quality of each activity precisely, the evaluators need to fully understand its technical content. However, KIDSMILE activities embrace various technical areas (i.e MR includes several vertical/technical components, such as drug management, malaria, child health, vaccination, etc), so we could not evaluate all areas from a technical perspective.

List of Products

The followings are the outcomes of achievements in the last five years. As for item with *, you can see the copy in ANNEX 1.

1. **Training Courses** (IMCI related training programs were originally developed by WHO and UNICEF, therefore, those are not included herewith.)
   - Phony Maintenance Training
   - Well Baby Check Up Training
   - Campaign Management Training

2. **Manuals, Forms and Summary Reports**

2.1. Output 1

1) TIS database (TCIS, TPIS)

2) TCIS Form (with evaluation parts) *

3) TCIS Manual

4) TPIS Form *

5) TCIS and TPIS Summary Reports (9 books)
   - Data Collection and Study of TCIS at Central level (Nov. 2003 to Dec. 2004)
   - Data Collection and Study of TCIS at Central level (Sept. 2004 to Nov. 2005)
   - Data Collection and Study of TCIS at Central level (Jan. 2006 to Oct. 2007)

- Training Personal Information System Analysis in Vientiane Province (Nov. 2003 to Sept. 2004)
- Training Personal Information System Analysis in Vientiane Province (Oct. 2003 to Sept. 2005)
- Training Personal Information System Analysis in Vientiane Province (Oct. 2005 to Sept. 2006)
- Data Collection and Analysis of TCIS in Oudomxay Province (Dec. 2003 to Sept. 2005)
- Data Collection and Analysis of TPIS in Oudomxay Province (Dec. 2003 to Sept. 2005)
- Data Collection and Analysis of TPIS in Oudomxay Province (Oct. 2005 to Sept. 2006)

2.2.Output 2

1) Installation Manual for Phony
2) Maintenance Manual for Phony
3) Evaluation Manual for Phnoy
4) Map of Radio Network for MOH of Lao PDR
5) VVC Daily Report Form *
6) FFC Form (Provincial Level and District Level) *

2.3. Output 3

1) MR Handbook
2) MR Monitoring Sheet
3) MR Report Form *
4) MR Annual Report (3 books)
   - MR Report of Activity 2004-2005 and Report of Activity Plan 2005-2006
   - MR Report of Activity 2005-2006 and Report of Activity Plan 2006-2007
   - MR Report of Activity 2006-2007 and Report of Activity Plan 2007-2008
5) Well Baby Check Up Manual
6) IMCI Follow Up Check List *
7) IMCI Recording book (Vientiane)
8) IMCI Implementation Area Map *
9) Home Visit Form (Oudomxay) *

2.4. Output 4

1) CIEH material database
2) CIEH Information Card *

3) CIEH material list booklet

4) Media Planner Evaluation Sheet *

5) Campaign and KAP Survey Report (5 books)

- Project Evaluation: School Health Campaign on 3 Cleans Promotion in Vientiane and Oudomxay Provinces (January to December 2004)
- KAP on 3 Cleans Improvement among Teachers and Students at the Primary Schools in Vientiane and Oudomxay Provinces (June to October 2004)
- Child Health Campaign 2005 and KAP Survey Results in Vientiane and Oudomxay Provinces (January 2005 to January 2006)
- Child Health Campaign 2006 and KAP Survey Results in Vientiane and Oudomxay Provinces (January to December 2006)
- Child Health Campaign 2007 and KAP Survey Results in Vientiane and Oudomxay Provinces (January to August 2007)

2.5. Output 5

1) Proposal Form *

2) PDM-2 Project Monitoring Sheet * (ANNEX 2)

3) PDM-1 Project Monitoring Sheet * (ANNEX 3)

4) Annual Plan Monitoring Sheet * (ANNEX 4)

5) Good Practice Manual

6) Manual for making proposal (Vientiane)

3. Educational and Information Material

1) MR Brochure (printed by JICA Laos Office's Budget) *

2) VCD: Malaria Diagnosis with microscope (by JICA Net Budget)

3) DVD: Undertaking the Country's Capacity Development – KIDSMILE's Efforts in Laos (by JICA Net Budget)

4) PHO Monthly Newsletter (Oudomxay) *

5) CIEH Information Leaflet *

6) CIEH Information VCD

7) School Health and Child Health Campaign Goods (see ANNEX 5 for details)

8) KIDSMILE Project Logo Sticker (5 sizes) *

4. Others

1) School Health Policy (developed with technical assistance by our short term expert and printed by JICA Laos Office, WHO and UNESCO)

2) Report of the survey of mothers' perception for the district hospitals

3) Report on MR Evaluation (February 2007)

4) Report on Qualitative Impact Evaluation of IMCI in KIDSMILE Project (April 2007)

5) Report of Dissatisfaction Survey (2 books)

- Report on Dissatisfaction Survey for Health Facilities (June 2006)
- Report on Dissatisfaction Survey for Health Facilities (June 2007)

6) Annual MR Pennants (for 2005, 2006 and 2007)

V. ACTIVITIES OF THE PROJECT

1. Summary of Activities for each Output

Activities consisting of the following twenty (20) areas are shown in PDM-2 (LogFrame). The completed activities are summarised as follows:

Activities	Results
OUTPUT 1: Training Information System is established at target provinces and at central level.	
1-1. DOP monitor the progress of TIS at target provinces and at central level.	After the establishment of TPIS at target provinces, DOP monitors and supports TPIS implementation by the visits to each province according to the annual plan (once or twice a year). Regarding TCIS, DOP had training course again for provincial staff in February 2006.
1-2. DOP set up and implement TCIS.	After set up of TCIS, DOP continues to collect data and input them into the database. In Sept. 2006, DOP finalized the 2nd annual summary report (Sept. 2004 - Nov. 2005) and distributed it on 16 Dec. 2006. Although TCIS had been halted because of changing the necessary documentation flow in MOH, TCIS was restarted in Jan. 2007 with collaboration between DOP and the Cabinet.
1-3. PHO set up and implement TPIS and TCIS at target provinces.	After set up of TPIS, both PHO continuously collect data and input them into the database. The details on publishing TPIS summary report of both provinces are found at Output 1 in the Chapter III Outputs of the Project. Oudomxay PHO summarized the data of TCIS (n=165) and published the 1st summary report in Nov. 2006. PHO had the first TPIS/TCIS report meeting on 1 Dec. 2006 and the second meeting on 4 Oct. 2007.
1-4. DOP add evaluation system into TCIS.	To get more exact data, DOP modified the design of database of TCIS by addition of evaluation system. They held the introduction meeting on new evaluation system for related organizations on 15 Dec. 2005, and began to collect reports. However, few training organizers followed it. In Dec. 2006, DOP staff visited some organizations and had interview on the reason why they could not submit reports, and found that the new system needed more publicity. In May 2007, DOP staff informed related organizations again on the procedure of evaluation system. On 22 Oct. 2007, DOP staff reported the first TCIS evaluation summary with 17 data in the TIS meeting.

OUTPUT 2: The Network System is strengthened at target provinces and at central level.	
2-1. Establish VVC including analysis and feedback in target provinces.	Both PHOs established dairy VVC system. They maintain telephony by themselves using "Maintenance Manual for Telephony by PHO". Both target provinces keep dairy VVC ratio more than 90% now. Vientiane province improved its ratio with strong leadership of PHO and achieved 90% in Aug. 2006. On the other hand, the quality of data collection through VVC was not sufficiently pursued.
2-2. Establish FFC including analysis and feedback in target provinces.	Since 2004, Oudomxay PHO had 16 times and Vientiane PHO had 13 times* of FFC. (*In Vientiane province, from 8th FFC, PHO started to visit half of all districts per one FFC. It means that the total number of visits which each DHO received FFC became half.) The results of FFC were reported in the regular meetings at each PHO, and submitted to DHP. PHO also shared the results of FFC with all DHO staff in the wrap-up DHO meeting after FFC, for feedback. Both target provinces wish to continue FFC even after KIDSMILE Project. Both PHOs are considering how they can sustain FFC in adequate style, and how they can get necessary budget. The standard method on how and what MOH should monitor the results and supervise PHO is not yet confirmed.
2-3. Hold regular meetings.	Both PHOs held regular meetings almost once a month, among each section in PHO. They also held regular meeting among DHOs to provide feedback on the result of FFC. They made some device to improve the quality of discussion of meetings, for example, the chairpersons are now rotated by every department, in turn. Central staff almost had regular meetings almost once a month, though some departments were not able to attend it because of their tight schedule. Moreover, it seemed to be difficult for the central staff to have a strong motivation to attend all the time and just listen to activity reports of other departments. In regular meeting at central level, the DHP staff, who appointed as in charge of target provinces, report the current situations of each province, according to each provincial regular meeting report. Since Dec. 2003, Intensive Discussion has been organized 10 times. Each department and PHO rotates the role of the coordinator, in turn.
OUTPUT 3: MR and IMCI are established at target provinces and at central level.	
3-1. Establish MR based on each level of district hospital.	After baseline survey and participatory workshop to decide 10 items MR, every district hospital in target provinces introduced MR in Oct. 2004.

OUTPUT 3: MR and IMCI are established at target provinces and at central level.	
3-2. Implement MR activities which are confirmed.	Every district (and Oudomxay provincial hospital) implement MR activities according to the annual plan that they made by themselves. Activity implementation status is monitored by themselves and by PHOs' FFC. The average of activity implementation rates of Lao fiscal year 2005 was more than 80% in both model provinces. All the facilities report the results of self-monitoring to PHOs and MOH. The standard method on how MOH monitor the results and supervise PHO is not yet confirmed.
3-3. Provide necessary technical guidance to implement MR at districts.	Since 2003, necessary guidance related with MR has been provided at district and provincial levels. -Malaria training for Laboratory -Guidance for making essential drug list and its monitoring -Baby check-up training -Clinical IMCI training and its evaluation -Child Health Management Training targeted district staff in Khon Khaen and Chiang Mai Universities in Thailand (2004, 2005, and 2006).
3-4. Collect indicator data for evaluation of MR.	MR activity implementation status is self-monitored by each facility and supervised by PHOs through FFC and DHO meetings. In the MR annual workshop, the results are shared among all levels every year. Indicators to monitor Expected Outcome of each MR item and reporting system from DHO to PHO and MOH were introduced in Oct 2006. However, this system has not worked well so far. Methods for MOH to manage the whole MR system is not yet clearly established.
OUTPUT 4: Capacity of Information, Education and Communication is improved at target provinces and at central level.	
4-1. Capacity of CIEH as Media Planner is developed.	In 2004, CIEH introduced campaign methodology in target provinces. CIEH held "School Health Campaign 2004", and "Child Health Campaign 2005,2006, and 2007". In the campaign period, with both PHOs, CIEH held special events at districts in collaboration with related organizations, produced IEC materials (song, drama, poster, brochure, etc), conducted Pre and Post KAP (Knowledge, Attitude, and Practice) survey, monitored the effectiveness of events with PHOs, reported the results in regular meetings, and summarized the final reports. CIEH developed "Media Planner Evaluation Sheet" in 2006, and started to evaluate the progress of IEC capacity of main staff.

OUTPUT 4: Capacity of Information, Education and Communication is improved at target provinces and at central level.	
4-2. Target provinces establish a management system for IEC activities in collaboration with CIEH.	Both target PHOs conducted campaigns and some IEC activities with necessary guidance by CIEH. Relevant staff (IEC, MCH, etc.) in PHOs monitored IEC activities of districts with the support of CIEH. Both target PHOs made self evaluation sheet on IEC activities, with support of CIEH, and started to evaluate themselves. That evaluation sheet concerned the capacity of main staff for campaign activities in 2005 and 2006. We could see the increase of total score, every year.
4-3. Support SSPP and pilot activities relation to school health.	SSPP had been supported in Xiengkhouang, Vientiane provinces by the end of ACIPAC Project, March 2005. In Oudomxay province, school health activities had been entrusted to JADDO, from July 2003 to Feb. 2004. After these period, in both target provinces, some school health activities (de-worming activities, health education training for teachers, construction of latrine at model schools, etc.) have been conducted with initiatives of themselves. In 2004, School Health Task Forces were set up at central, provincial, and district levels. At central level, the workshop on drafting "National Health Promoting School Policy" was held in Nov. 2004, and the policy and its guidelines were made in March 2005. That policy and guideline were printed and distributed with support of WHO, UNESCO, and JICA. At the same time, the task force teams conducted the baseline survey for the guidelines on Health Promoting School, in Vientiane municiparity, Oudomxay province, and Vientiane province. Since Aug. 2005, all school health activities in KIDSMILE Project have been integrated into JICA's new schemes (school health advisor and Japan Overseas Cooperation Volunteer).
OUTPUT 5: Activity Cycle of planning, implementation, monitoring, evaluation and feedback are carried out at target provinces and central level.	
5-1. Make annual action plan.	In 2004, the form of annual activity plan was designed by DHP and Japanese experts, and revised by relevant persons. With the form of annual activity plan, each PHO and MOH summarize the plans prepared by each section. Both PHOs and each department of MOH (including CIEH, and IMCI working group) submit the summaries of plan to DHP, DHP examines the contexts of all plans at provincial and central levels, and approves them. Both PHOs and each department request activity budgets based on their annual activity plan. Each annual activity plan is regularly monitored in regular meetings at provincial and central level. And the results of monitoring are shared among all participants in Intensive Discussions.

OUTPUT 5: Activity Cycle of planning, implementation, monitoring, evaluation and feedback are carried out at target provinces and central level.	
5-2. Design a proposal form.	In 2004, the contents of proposal form were considered by DHP and Japanese experts. After using of draft form, that design was revised, and approved at the regular meeting at central level in Jan. 2005. Now, all KIDSMILE activities are implemented based on each proposal following this form.
5-3. Promote activity cycle comprised of planning, implementation, monitoring, evaluation, and feedback based on the proposal form.	In all proposal, every planner should describe how to monitor or evaluate the achievement to the objectives and expected outcome. The contents of proposal are discussed and revised between the planners and the Project before implementation. After each activity implementation, the report should be submitted to each department and KIDSMILE.
5-4. Establish the method of management collaboration with the Department of Planning and Budget, MOH.	Regarding 10% cost share at central level, in May 2006, DHP requested the recurrent budget of the Lao government to DPB, and DPB began to provide it to each department since Dec. 2006. Both PHOs request the budget for 10% cost share to governors' offices every year. To collect the good examples of completion of activity cycle, "Good Practice" was set as one of new indicators in PDM-2, and started to collect it from each project site. In the 8th Intensive Discussion we have shared some examples of "Good Practice". To make the concept of "Good Practice" more understandable, in Dec. 2006, we made "the first summary report of Good Practice". That summary includes the guideline for conducting activity cycle. In the following 9th and 10th Intensive Discussions, we also shared several case of "Good Practice". In Vientiane province, the guidelines for proposal form was made in 2005, for district staff.
5-5. Conduct the training on health statistics.	In Dec. 2003, "Workshop on health service management and health information" was held by statistic dept. of DPB with support of KIDSMILE.
5-6. Conduct the workshop for group capacity development.	In January and February 2007, the "Workshop for group capacity development" was held with the general objective 'to learn through experiences the characteristics of human interactions for improving capacity of our group'. This activity was a response to strong suggestions from some Counterperts, who had attended the counterpart training in Japan, especially Prof. Sommon, Director of DOC and Dr. Phouthone, Deputy Director of DOP, MOH. In total, 98 participants took part in three workshops lasting three and a half days each. The first one was conducted in Luangprabang for 35 staff from both PHOs and DHOs, the second also in Luangprabang for 33 health staff of the same level and the third one in Thalat for 30 participants mainly from MOH.

2. Other Activities

Apart from activities stated in PDM-2, there were some specific activities of respective target provinces as follows.

2-1. Oudomxay Province

Activities	Results
OUTPUT 2: The Network System is strengthened at target provinces and at central level	
1. DHO and HC meeting	As mentioned in the previous chapter, Oudomxay PHO introduced a regular meeting between DHO and its health centers at every district in October 2006. In the meeting, staff of DHO and health centers reviewed activities, shared experiences and tried to make next year's plan, while PHO staff supervised the entire meeting. After the meeting, PHO had time to review the meeting with DHO staff and provided feedback to DHO for better meeting management. The second round of this activity was held in August, 2007.
OUTPUT 3: MR and IMCI are established at target provinces and at central level	
1. Conducting Refresher training of clinical training	Oudomxay PHO conducted refresher training of clinical training in addition to clinical training in 2006 and 2007, because PHO found that it was difficult for some trainees to use IMCI correctly just after receiving training one time only.
2. Introduction of IMCI to health centers	Oudomxay PHO gave IMCI clinical training to all staff of all the health centers in the province by ADB's support. Then, follow-up visit was conducted for some health centers by KIDSMILE's support.
3. Home visit for postnatal care and newborns in Oudmxay Province	In Oudmxay, Provincial Hospital started home visit for postnatal care (PNC) and newborns in December 2005. Two staff of MCH center in Oudomxay Province, who attended counterpart training in Japan in 2004 and Child health management training in Chiang Mai in 2004, planned this activity applying their experience of the training. These MCH center staff carried out this activity in collaboration with staff of obstetrics and gynecology section of Provincial Hospital. They made their own checklist of home visit and visited puerperal women who lived in Zone 0 and delivered in Provincial Hospital within six weeks after delivery according to the records of the hospital. Home visit team consisted of two health staff. One was staff of MCH center and the other was staff of obstetrics and gynecology section of Provincial Hospital. They examined a mother and her baby and conducted health education for her and her family members such as her husband, grandparents and relatives. An appointment to visit Provincial Hospital was made when necessary. They had visited 355 families for this 22 months since December 2005 until September 2007.

2-1. Oudomxay Province (continued)

OUTPUT 4: Capacity of Information, Education and Communication is improved at target provinces and at central level	
1. PHO Radio News and Newsletter	IEC section of Oudomxay Province prepares some news related to PHO and Health and ask Radio station to broadcast them regularly. News is anything related to PHO activities. In addition, information on seasonal disease as well as some health promotion issues are broadcasted three times a day. The tasks of IEC section is to prepare news texts regularly and updates information for health promotion in the province. This is very useful activity in a province like Oudomxay where some areas are still lack of electricity and radio is a great device for people to get important and useful information. On the other hand, news related PHO and Health is printed in a newsletter format and displayed on information board of PHO, Provincial Hospital and PHC school so that staff can also share updated information.

2-2. Vientiane Province

Activities	Results
OUTPUT 2: The Network System is strengthened at target provinces and at central level	
1. FFC from DHO to HC, and 2. DHO and HC meeting	As mentioned in the previous chapter, Vientiane PHO also introduced a DHO and HC meeting in 2007. However, this meeting had a linkage with FFC from DHO level to health center level and was held after the FFC, which is like DHO meeting after FFC from PHO to districts. A team of DHO staff quarterly visited all health centers in the district for the purpose of monitoring activities at health centers and providing necessary advice to health center staff so that they could improve their working system. The first FFC from a DHO to health centers was implemented in August 2006. In the first quarter of 2006-2007 LFY some other DHOs followed. After this supervisory visit, some DHOs organized a meeting between DHO and all health centers to report the results of FFC and discuss and make a plan together for next activity implementation. Both activities were carried out with initiative of DHOs without supervision of PHO in principle.
OUTPUT 3: MR and IMCI are established at target provinces and at central level	
1. Formulation of IMCI recording book	Vientiane PHO formulated IMCI recording book and introduced it to the facilities instead of IMCI recording form in January 2006 because using recording book was much less costly than using the recording form. At the beginning of using the recording book, some confusion arose. However, by repeated supervision through FFC, the facilities came to implement IMCI with the recording book correctly.

2-2. Vientiane Province (continued)

OUTPUT 3: MR and IMCI are established at target provinces and at central level 3	
1. Formulation of IMCI recording book	Vientiane PHO designed 5 days IMCI clinical training instead of 11 days one. Originally this course was designed for the health center staff of Belgium Technical Cooperation (BTC)'s project site. Vientiane PHO utilized this course for the health staff of KIDSMILE Project's target facilities in 2006 and 2007. About the contents of the training, all essential lectures were remained but many practices were omitted. After the 5 days course, the Project followed performance of the trainees and it was not so different from the performance of 11 days course trainees.
2. Shortening of the duration of IMCI clinical training from 11 days to 5 days	Vientiane PHO introduced IMCI to all the health centers in the province by KIDSMILE's support. Follow-up visit was also conducted for some of health centers.
3. Introduction of IMCI to health centers	In order to improve management skill to make feasible plan and implement the activity within limited resources, DHO carried out two kinds of activities regarding MR with US$250 per DHO per year. One was village meeting in "Zone Zero" (the area without a mobile vaccination) as MR8. DHO held quarterly meeting with village authority committee at Zone 0 for the purpose of reporting immunization situation in the area and discussing and making a plan for implementation. Through this regular meeting, DHO tried to establish good collaboration with village authorities and promote community's participation for increasing EPI coverage.
4. Independent District level activities regarding MR with small budget	The other was quarterly Health Promotion Day as MR9 activity. DHO organized a health promotion day at the district hospital in order to promote well baby check-up and vaccination. Although Campaign Event was once a year special event for DHO, this activity is recognized as a part of routine health education and as a good occasion to utilize IEC technical skill they acquired through Child Health Campaign.

3. Activities/Plan of Operation

The uniqueness of KIDSMILE Project was its approach of respecting flexible design process and willingness to modify project components. In other words, this Project had no real five-year "Plan of Operation" which is usually prepared at the beginning of a JICA project. Instead, the Project introduced a monitoring sheet based on activities of PDM and used it until PDM-1 was revised. Therefore, PDM-1 Monitoring Sheet (ANNEX 3) is hereby shown as an alternative to "Plan of Operation" for the period between Nov. 2002 and Sept. 2005.

On the other hand, since 2004 both central and provincial levels have made annual activity

plans for a year starting in October (Lao Fiscal Year). When PDM-1 was revised after the midterm evaluation, we decided to regularly monitor annual plans at each site for the purpose of measuring one of Output 5 indicators, i.e. 80% of activities in annual plan is implemented. In this connection, in November 2005 we started using Annual Plan Monitoring Sheet that was based on the format of annual plan itself. ANNEX 4 contains monitoring sheets of two years for each PHO and the central level, which can be alternative to "Plan of Operation" for the period between Oct. 2005 and Sept. 2007.

VI. FACTORS CONTRIBUTING TO THE SUCCESSFUL IMPLEMENTATION OF THE PROJECT AND LESSONS LEARNED

1. Factors contributing to the successful implementation of the Project

According to the joint terminal evaluation, the following six points were recognized as contributing factors:.

1) Interaction of all outputs: All outputs are closely related to each other and produce synergy effect towards the project purpose.

2) Cost sharing and utilization of existing resources: Because of cost sharing and utilization of existing resources principle, counterpart personnel tried to not only reduce cost but also make things go well in systematic manner in their daily duties.

3) Intensive Discussion: This promoted good communication that is the basis of all the outputs towards realization of the project purpose.

4) Allocation of Japanese a long-term expert at provincial level: Working closely with Japanese long-term expert at provincial level produced substantial influence on better working style. Allocation to provincial level promoted even informal and frank communication that contributed considerably.

5) Training followed by practice: The quite appropriate contents of training were closely followed by practice/application.

6) Formulation of bases of management: The basic management skills such as human relationship, collaboration, teamwork and coordination, absorbed through the training and practice, served as engine of functional management system such as MR and FFC, etc.

Among six points, 2) and 3) were principles of the Project. The final evaluation report describes how these principles were put into life in the following way:

(1) Utilization of existing resources: The improvements that counterpart personnel have been practicing are conducted/practiced as a part of their duty. Consequently, those routine activities/practices can be continued after the termination of the Project. This is exactly what the principle of utilization of existing resources expected.

The followings are some examples of existing resources to be utilized.

1) Facility: Phony (More than 150 phony sets were already installed at the start of the KIDSMILE project) 【existing equipment】 = phony was utilized and VVC was started.

2) Mechanism: The document flow of TCIS (Originally, the documents for training implementation were circulated to be approved by the minister) 【existing mechanism】 =document flow was utilized and TIS was started.

3) Human resources: IMCI clinical training facilitator (They were already trained and prepared by WHO) 【existing human resources】 = trained personnel on clinical IMCI by WHO were utilized.

(2) Cost sharing: Because of cost sharing principle, Lao side tried to reduce the costs. Consequently, such efforts to cut down costs resulted in better resources utilization (less resources were wasted) and contributed to higher efficiency. Because of cost sharing, counterpart personnel became to feel a higher sense of ownership of the activities.

(3) "Intensive discussing": The intensive discussions for the information sharing were originally started with a relatively small number of participants. However, as time went by, the number of participants increased and the content of discussions evolved according to the project stage. Brainstorming for project design was the main topic of intensive discussions in their early stage, then monitoring became the main topic in the later phase of the project implementation. Discussions among different departments of MOH deepened their understanding of KIDSMILE since many deputy directors of various departments of MOH participated in them. In other words, intensive discussions organized by KIDSMILE contributed to strengthening the horizontal linkage among departments of MOH in addition to the vertical linkage down the MOH-PHO-DHO line. They promoted better coordination resulting from stronger linkage among various organizations.

The terminal evaluation report stated that there was no major inhibiting factor hampering the achievement of the project purpose. However, one of the principles of the Project had rather controversial aspect. That principle, Flexible Design Process, was introduced with the purpose to let the Lao side take initiative to carry out Project activities so that they feel ownership of the Project. As it is discussed in the next section, the principle was also recognized as one of lessons learned by the evaluation team. There is no doubt that the Lao side ultimately understood that the essence of KIDSMILE was to think and find what to do rather than follow instruction from outside. This can be considered a positive side of the principle.

However, it is also true that, at the beginning, counterpart personnel found it difficult to understand what KIDSMILE Project was due to the unfixed project design. Some even commented that too much time was wasted before they realized what KIDSMILE sought. This could be seen as a negative side of the flexible design process. We, the Japanese side, believe that this principle seems to have worked well only because of high tolerance level of Lao people.

2. What we learned through five-year activities of the Project

One of the objectives of the terminal evaluation was to share experiences and lessons learned (positive/negative) to be applied to other important health issues and activities. As a result, the joint terminal evaluation team recognized the following six lessons learned from the Project.

1) Developing capacities in management system at central and provincial levels contributes to the improvement in service provision of child health.
2) Esteeming of initiatives of counterpart personnel fosters a sense of motivation, commitment and responsibility.

3) "Flexible" process in designing and modifying project components provides opportunities to encourage capacity development.

4) Practice of "activity cycle" changes minds and attitudes of health administrators and service providers.

5) Providing opportunities of interactive communication intensifies commitments from various actors towards improving child health.

6) MR is an innovative device to improve quality of service delivery in child health.

We, the Project implementers, both Lao and Japanese side, accepted the above mentioned lessons, however, not a small number of people commented that the expressions of these lessons were too sophisticated and it was difficult to understand how they could be applied to real situations. Therefore, after the terminal evaluation, we decided to summarize using our own words what we learned through the Project at each site and share it in the final Intensive Discussion.

At the provincial level, the Project conducted small workshops for finding lessons learned on the occasion of DHP meetings which were held in early July 2007 in Oudomxay and in early August 2007 in Vientiane Province. In the workshops, DHO and PHO staff answered the questionnaire at first, shared each other's experiences and opinions written in the questionnaire as a group work, and then each group presented its summary. Later on, VP PHO selected seven lessons learned from the summaries. Oudomxay PHO together with the Japanese expert identified two items at the district level and five items at the provincial level.

At the central level the Project distributed the questionnaire to key C/Ps to gather their experiences and opinions. After collecting replies the Japanese experts categorized all of them and picked up several lessons out of them as a first draft. This first draft was presented in a regular meeting where the task force members were selected to discuss and prepare a final draft of what was learned at the central level. The task force meetings were held twice and prepared the summary of lessons.

In the final Intensive Discussion, which was organized on Sept. 13 and 14, 2007, each site presented their draft summary and got feedback from other participants. After that, a group of Oudomxay PHO, a group of Vientiane PHO and two groups of the central level shared comments and opinions from others within each group and again elaborated their writings reflecting the feedback they received. Then, each result was shared through presentations.

In addition, since the Japanese experts also found several lessons learned, they got a chance to present them in the Intensive Discussion and modify some parts.

The followings are what each project site as well as Japanese experts learned through five-year activities of the Project (we did not edit summaries made by each site out of respect for the unique writing style).

2-1. Oudomxay Province

1. Meeting with Sections Concerned

Explanation: Monthly meeting, quarterly meeting which attended sections concerned, provincial level, district level and zone level is important because it enables the staff to exchange lessons, provincial level can know evaluate activity implementation over the past time and PHO can know weak points at each level at the same time participants in the meeting can find way of solving problems in next time. Monthly meeting and quarterly meeting are routine work at each level.

2. Coordination between Provincial and District Levels

- Coordination is important for implementing activities at each level in order to reach achievement.
- Coordination is a way of relation with sections concerned such as vertical line and horizontal line.

(1) Vertical Line: - Provincial level coordinates with central level
- District level coordinates with PHO

(2) Horizontal Line: PHO coordinates with Provincial Governor Office, Mother and Child Health Committee at district level, village local authority and other sections concerned.

3. Health Staff at Provincial and District Level Can Implement and Monitor MR and IMCI Activities by themselves

1) Monitor whether the staff keep IMCI records, supervise them at that time and check number of IMCI forms each month.

2) There is a person in charge of MR in general and a person in charge of each activity and they put a mark on completely implemented activity in the activity plan.

3) Activity is monitored every day, every week and every month.

4) Director of DHO monitors MR activities

5) Meeting with MR related sections

6) Organize monthly meeting, quarterly meeting

7) Submit report together with MR indicator to PHO on 1-4th of each month

8) Provide IMCI form every month

4. Home Visit (Zone 0)

- When a child was born 4-6 weeks, MCH staff of provincial hospital have to visit and check mother's health as follows:

(1) Check bleeding inside

(2) Check mother's breast

(3) Check uterus and vagina

(4) Check mother's diet

(5) Family planning

(6) Check mother's cleanness

(7) Check mother's work, do not do heavy work

(8) Monitor child's health (Take baby to see doctor when he/she gets sick)

(9) Take a child to receive vaccination as appointed, give vitamin A and Folic to mother

- Check Child's Health:

(1) Monitor child's growth

(2) Check umbilical cord

(3) Check child sucking and child should be breast fed exclusively from the birth to six month

- All mentioned above is to solve health problem of mother and child on time in order to reduce infant mortality rate and maternal mortality rate.

5. FFC Implementation

- Health prevention and health promotion at district level
- Treatment and health rehabilitation
- Food and drug
- Human resource development
- Administrative management
- In order to implement the activities which have not been done well and give feedback to performers at district level to know what activities that were not achieved and let them know good points and weak points and give supervision at once.
- Find the way of problem solution between provincial level and district level.
- After monitoring FFC team reports the results of monitoring

6. Health Information Flowing System

- It is important and necessary in order to get number of health service users.
- To know the situation of health activity implementation.
- It is good for disease surveillance.
- It is convenient to make plan and find a way of solving problems.

- Reporting information is important in health sectors, therefore, information should be reported regularly and continuously. The following points should be reported:
  (1) Number of patients coming to hospital in each day
  (2) Situation of disease surveillance
  (3) Urgent need

7. Provincial Staff can do minor repair:

- Staff received training on repair and he has basis of electronic knowledge and there are many equipment in health sectors.
- There are enough tools for repairing phony set.
- Result of meeting among central, provincial and district levels.
- Dissemination on achievement of activity implementation
- Make activity plan.
- There is report of result of activities and lessons learned.

8. Reporting Information

- It is important and necessary to collect number of health service users.
- Know the situation of health activity implementation
- It is good for disease surveillance.
- It is convenient to make plan and find way of solving problem on time.
- Reporting information is important in health sectors, so information should be reported regularly and continuously, the following points should be reported:
  (1) Number of patients coming to hospital in each day
  (2) Situation of disease surveillance
  (3) Urgent need

9. Transfer Method of Monitoring to Staff at Each Level (Provincial Level and District Level)

Explanation: Monitoring is important for staff at each level in order that they can do self monitoring, however, staff should have knowledge and capability of self monitoring. Monitoring activity should be done regularly as staff's routine work, this is to improve quality of health service. For example, staff can monitor MR activities and IMCI by themselves.

10. Coordination with Other Sections Concerned

Explanation: To achieve activity implementation, coordination with other sections both vertical line and horizontal line is needed, in order to allocate responsibility to other sections concerned in province to understand and give financial support. For example, establish coordination committee at provincial and district levels.

2-2. Vientiane Province

1. Delegate Activity Management to Other Sections so that They Can Share Responsibility and Become Successful

Allocation of activity management from the central level to the local level makes each section share responsibility and enables it to follow project activity cycle according to real situation in each area. It means that the local area takes ownership of making plan, implementing activities, self monitoring and self evaluation. For example, the implementation of 10 MRs in hospitals is a good example of a of team work, each section takes responsibility of implementing activities.

2. Supervision after training

Example: IMCI is very important for child health service in current situation. IMCI is a new system which has never been implemented before. Its implementation was difficult because health staff, even those who had received an IMCI training, were not familiar with procedures of examination, keeping records and so on. Through implementation of supervision and giving feedback frequently, IMCI was improved and is now implemented systematically and became routine work at district and health centre levels.

3. Having Coordination with Various Sections is Important to Get Activities Done Well

Coordination along vertical or horizontal lines creates better environment for successful implementation of activities, cooperation among various sections can stimulate team work, through sharing responsibilities many activities can be implemented at the same time. Cooperation with local authorities is important to implement health activities. It can help local areas to take ownership, contribute cost sharing to activity implementation.

4. Regular Communication Can Help in Monitoring Activities and Solve Problems on Time

- VVC is important for routine work, it can be used for disease surveillance. Daily communication can help to solve problems on time.
- FFC: Provincial level supervises district level and the district level supervises health centre. This strengthens administrative management and health service, supervision is a kind of evaluation of the progress of activity implementation.
- Regular meetings enable each section to know the status of activity implementation in the province. In the meetings participants can share ideas, exchange experiences, solve problems together, give feedback. Sections take responsibility of organizing meetings, set time and agenda so that participants can prepare to participate.

2-3. Central level

1. Cost sharing as the contribution from the government towards implementation of project activities

Lao government paid good attention to its contribution towards implementation of project activities. Cost sharing from government included cash and in kind as well as community's contribution. Contribution of cost sharing is useful and very important for sustainability of the project in the future. Sometimes contribution of cost sharing was not done well because Lao Fiscal Year starts on September of each year while Japanese Fiscal Year starts in April of the next year, which means that Lao Fiscal Year starts before Japanese Fiscal Year. In addition, if the budget was not used in the year, unused funds should be returned.

2. Make guidelines for supervision of MR and FFC activities (it will be better if the concerned departments at the central level discussed the guidelines and released them before introducing new activities such as MR or FFC.)

Supportive "Supervision" is an important task of the central staff for improvement of activities at local health facilities. Before a team is sent on a supervisory field trip, a kind of guidelines or checklist should be prepared, especially for new activities such as MR or FFC. "Supervision" for such activities means not only observation of the situation and listening to the report from local staff. Effective supervision should include checking, monitoring or evaluation, and immediate feedback to implementers based on the supervisors' records and delivered by supervisors themselves. Standard guidelines should be used every time, which can help to maintain good quality of the supervision and let supervisors compare the results of the supervision, even if different staff attend it. If we could develop such guidelines before introduction of new activities, it would be less difficult for the personnel concerned to arrange field trip, even without Japanese experts.

3. Conducting regular meetings is useful to promote cross-departmental collaboration.

KIDSMILE Project holds regular monthly meetings, which are kinds of lessons learnt meetings. Monthly meeting is a method of working in team, making decision by participants from various departments. Regular meeting gives the staff from departments and centers a chance to meet each other, share ideas and look for solution of problems. It is also a good opportunity for the staff to get to know each other better. Even if they did not know each other, the staff, through repeating experiences of sharing information and discussing various issues they can get acquainted. Then, when they need another department's cooperation, it is easier for them to contact the staff they know and ask for their help. (The same personnel in charge should be delegated to attend the meeting.)

4. Staff's following certain principles and plan can effectively increase their sense of responsibility.

Working by following principles depends on goal of project or program, as well as office and department. Working by following principles is important and the principles consist

of team work or group work. Departments concerned will follow the principles and believe in them.

Principles consist of:

- Time management
- Team work, participation from others
- Coordination among various levels
- Working by following principles requires a clear plan. Having such a clear plan the staff can assign roles and responsibilities, staff have responsibility when they have a plan (assignment of responsibility, making decision).

Then the staff should implement monitoring activities and evaluation continuously. When we implemented activities in KDISMILE Project, prepared some principles and made a plan. Those principles and the plan helped the staff to understand what their task was and what they should do to achieve it. When the staff knew well what they were expected to do they tried to fulfill the expectation. In this way, staff's sense of responsibility was developed.

5. *Procedures of organizing a meeting, reporting and monitoring systems with participation of various departments have deepened a sense of teamwork in MOH and were helpful to solve problems together.*

Every time, before organizing a meeting, we had to contact or discuss closely with many relevant organizations to arrange suitable date and time so that the meeting has as many participants from various departments/centers as possible. This procedure promoted an approach of taking each participant's convenience into consideration and treating all members as one group.

After each activity, implementers submitted reports as well as made presentations in the regular meeting. Through this reporting system, participants were informed as equally as the implementers and shared others' experiences, which could help us feel that we belonged to the same group. On the other hand, when the staff from various departments went for monitoring activities, we found that the teamwork could solve problems. Even if one person found it difficult to solve a problem because he/she was not familiar with that field, other people from different departments were able to find a solution because they had different experiences and knowledge. Exchanging opinions within the group could also lead to finding a better solution.

6. *Keeping record of activity implementation always produces the evidence and is useful for planning next activity.*

Record of the previous activity implementation can be used as a reference for planning next activity because the record contains the good points and difficulties encountered during the implementation of the activity. Based on those evidence we can find ways of improving similar activities in next activity plan. We can also use the information in the

record to give feedback to the implementing sections. Without keeping record of the activity implementation it would be difficult for supervisors to check and monitor because they did not know the previous situation of implementation if they were not the same persons who attend previous supervision.

7. *It is very important that a meeting date is fixed early enough, the purpose and agenda are informed in advance to the participants, the necessary documents are prepared and sent to them for reading in advance, and then the meeting is managed well so that the organizer can be sure to get the expected outcomes.*

   How much of the expected outcomes of a meeting we could achieve depends on how well the preparation of the meeting was done.

   Organizing a meeting does not mean only managing the meeting on that day. If the meeting date is fixed early enough and the purpose and agenda are informed in advance to the participants, it becomes easier for participants to make a plan and for organizers to have sufficient time for necessary preparations. It will be effective if participants read documents in advance and they will participate the meeting actively.

8. *Experiences from Johari Windows were useful for improving our daily work.*

   The "Johari Window" is a symbol of "group capacity development training" in KIDSMILE Project. In this training course, participants learned through experiences characteristics of human interactions for improving group capacity.

   After such experiences, many participants became to respect other staffs' opinions, to try to get mutual understandings with equity among staff, to learn from those who had more experiences, and to work as a team with giving feedback to other staff. They also learned adequate planning to implement good activities, working by following plan, the way of self-evaluation, and the importance of keeping records. This experiential learning could be used by each individual in daily work.

   By the end of the Project, a total 115 staff members learned the "Johari Window" in KIDSMILE. One of the participants, Prof. Sommon, Director of Curative Department, introduced new working review system based on "Johari Window" in his department. He started weekly regular meetings to share information among staff based on review sheets. All staff came to know what other staff were doing and what was happening in DOC.

   Our learning points are:

   1. Working by following plan, regulation and staff's sense of responsibility increased
   2. Know the way of getting lessons learned from other, more experienced staff
   3. Have mutual understanding and equality among the staff
   4. Respect staff in MOH and outside
   5. Know the way of doing self-evaluation

6. Know how to make good plan to implement activities
7. Keeping record whenever activities are carried out, assign responsibilities to the staff
8. Directors of departments should guide the staff to work by following "Johari Window".

2-4. Japanese Experts

1. The proposal form should include an item of lessons learned from the previous activity so that we can effectively identify through the proposal form whether Activity Cycle is applied for the next activity or not.

The proposal and report forms were introduced to KIDSMILE as the tools to check whether Activity Cycle was really carried out in the project activities. The routine use of these forms is useful for smooth implementation of all activities. However, even though every staff member devoted all his/her energy to following the required style of the proposal form very strictly, the readers could not check from the form whether the quality of the activity contents was improved. The main reason of this problem is that the formats of the forms do not correlate with each other. Also, these forms do not have space for information expected by the reader, namely, the lessons learned from the previous activities. That is, in the existing proposal and report forms, there is no column where the staff could describe their "lessons learned" of the previous similar activities. It made it difficult for all of us to review whether Activity Cycle had been really completed.

2. It is necessary for the staff concerned to share the definition of terminology used in day-to-day activities of the Project.

The approach of KIDSMILE was rather conceptual. In such a project, for daily project activities, we often use some words which have broad and general meaning; i.e. "management", "supervision", "activity cycle", "good practice", etc. To avoid a situation when not everyone has the same understandings of a word (everyone tends to have a different image in each mind by using same one expression!), it is very important for all the people concerned to confirm the common definition of it, when we begin to use that word. Although it may take some time to share clear definition of each word at the beginning, such work can greatly help us proceed in one direction in the Project, with same understanding.

VII. INPUTS OF THE PROJECT

1. Dispatch of Japanese Mission Teams

Before the KIDSMILE Project started, two mission teams from Japan visited the Lao PDR with the task to work out the details of the project. During the five-year implementation period of the Project, we received three mission teams. The last mission was organized by the Japanese and Lao sides for literally joint terminal evaluation based on a lesson learned from the mid-term evaluation. The details of each mission are as follows:

Mission Title	Period	Purpose and Result
Preparatory Study Mission	25/02 – 9/04, 2002	To conduct the study regarding the Lao government's request for the Project. ☞ Defined PDM-0.
Project Design Mission	28/08 – 5/09, 2002	To work out the details of the Project. ☞ Elaborated PDM-0.
Management Consultation Mission	10/11 – 29/11, 2003	To review the past achievement during the first year, to discuss on current problem and to give some consultation about future direction of the Project. ☞ Modified PDM-0 and developed PDM-1.
Mid-term Evaluation Mission	29/06 – 24/07, 2005	To carry out the mid-term evaluation and discuss the future directions of the Project. ☞ Revised PDM-1 and developed PDM-2.
Final Evaluation Mission	7/05 – 12/06, 2007	To carry out the final evaluation and clarify the achievement and lessons learned of the Project. ☞ Concluded the Project was mostly achieved.

2. Dispatch of Japanese Experts

The list of experts is shown in ANNEX 6.

A total of eight (8) Long-term Experts in four (4) areas of expertise had been assigned by the end of the Project. The areas of expertise include Chief Advisory, Project Coordination, Community Health and Child Health.

Twenty Short-term Experts in 15 areas of expertise had been dispatched by the end of the Project. In total, they made 37 visits. The fields of expertise included the following 15 areas:

Communication Devices, IEC (Management), IEC (Material Production), Child Health, Planning for Human Resources Development, TIS, GIS Information Management, Health Information Management, School Health, Community Health, Infectious Diseases, Health Service Management, MR Evaluation, IMCI Training Evaluation and Organizational Capacity Development.

All 12 planned fields of expertise as stipulated in the Record of Discussions (R/D of 4 September 2004) were covered, and additional three (3) fields, i.e. MR Evaluation, IMCI Training Evaluation and Organizational Capacity Development, were added.

3. Overseas Training for Counterparts

The list of overseas training for counterparts is shown in ANNEX 7.

By the end of the Project a total of 40 persons were trained in Japan under the Counterpart (C/P) training scheme, whereas two (2) more Counterparts also participated in Asian Maternal and Child Health Workshop in Japan through non-Project resources arranged by the Project.

The areas of training include the following:

Health Management (1 person), Health Service Management (20), Health Administration (5), Human Resource Development Group Training (2), Theory and Practice on Public Enlightenment Using Multimedia (1), Community Health (2), Child Health Service (3), IEC Method (4), IEC Management (2).

On the other hand, a total of 88 persons received the training for Child Health Care Management at the Faculty of Medicine of Chiang Mai University and the Faculty of Nursing of Khon Kaen University, whereas two (2) more Counterparts participated in the training on Management Information System for Health Organization in Khon Kaen University.

4. Equipment provided by JICA

Total amount of Equipment donated by JICA through Annual Plan of the Project is shown in the following table:

Breakdown per year

Year/Currency	Cost in Yen	Cost in US$
Equipment for JFY 2002	¥15,743,630	US$127,366.00
Equipment for JFY 2003	¥12,360,884	US$ 113,822.36
Equipment for JFY 2004	¥4,642,940	US$ 42,151.43
Equipment for JFY 2005	¥2,012,795	US$ 18,749.83
Equipment for JFY 2006	¥4,425,637	US$ 38,152.00
Total	**¥39,185,886**	**US$ 340,214.62**

The following table shows the total equipment cost breakdown per project site:

Installed Place	Project Central Office	MOH	ODY	VP	XKH	Total
US$	75,524	85,554	77,689	73,445	4,515	316,727

Although Xiengkhouang (XKH) was not our target province, we provided some equipment to them. It was because XKH housed the Small Scale Pilot Project (SSPP) supported by JICA ACIPAC (Asian Centre of International Parasite Control) Project. KIDSMILE Project collaborated with the ACIPAC in the first half of the project period to carry out school health activities.

The following table is the cost breakdown of equipment provided to MOH:

Installed Place	DHP	DOC	DOP	EPI	MCH	MCHC	CIEH	Total
US$	15,191	5,704	4,407	6,442	3,806	6,249	43,755	85,554

The list of equipment provided to each department/center of MOH, Oudomxay and Vientiane Provinces is shown in ANNEX 8.

5. Local Expenditure of the Project

A table below shows annual Operational Cost (actual expenditure) from the Japanese side. A total of US$ 923,821 was expended by the Japanese side on local operational costs by the end of the Project. That amount includes some local training activities, such as basic computer skills development and English skills improvement. The training courses for Child Health Care Management at two Thai universities were also covered under this Operational budget.

Year	2002	2003	2004	2005	2006	2007	Total
US$	38,318	169,934	204,319	185,473.	213,544	112,233	923,821

ANNEX 9 shows tables of local expenditures in each Lao Fiscal Year by output and by site. The details of local expenditures on some main activities for each Lao Fiscal Year can be found in ANNEX 10.

The cost sharing for operational expenses by the Lao side is shown in ANNEX 11. The data collecting period is divided into two: the first is from the start of cost sharing to June 2005, just before mid-term evaluation, while the second starts after mid-term evaluation and continues till the end of the Project. Through both periods both PHOs succeeded to share 10% of the operational cost constantly. As for the central level, it was very difficult for each department except the affiliated centers such as CIEH and MCHC (and Mother and Child Health Hospital) to prepare the necessary budget. However, after the mid-term evaluation, the Project Coordinator of MOH and the Japanese side discussed with the Department of Planning and Budgeting and clarified the way to request the budget for cost sharing in MOH. As a result, the central level also succeeded to implement 10% cost sharing by cash in LFY 2006-2007, though it put heavy burden on the person in charge of the activity as well as the Japanese side because it took a long time before the budget was released.

VIII. HISTORY OF THE PROJECT DESIGN MATRIX (PDM)

1. PDM-0 (November 2002 - November 2003)

During the preliminary study before the beginning of the Project, a two-day PCM workshop was held on 4-5 April 2002, with around 40 participants from MOH, MOE, and Japanese team. The objectives of the workshop were 1) to identify existing problems on coordination of public health services on child health, 2) to discuss necessary approaches, and 3) to clarify the perspective and direction of the new project.

In this PCM workshop, the core objective of the new project was identified as "Existing health service are improved with good quality" and the following approaches were selected:

1) Capacity building approach
2) Both vertical and horizontal health service improvement approach
3) Child health standard preparation approach
4) Health education improvement approach
5) Cooperation with internal and external entities approach

For the selection of each approach, the following points were considered: (1) improvement of present health services in Lao, (2) child health service focused project, (3) strengthening other cooperative schemes, (4) no disease-oriented project, (5) no equipment-oriented project, (6) social factor, and (7) effectiveness.

Based on the results of this workshop, PDM-0 (Annex 12) was developed, and agreed with relevant persons in the minutes, on September 4 in 2002.

In PDM-0, the Overall Goal was "Health standard of children is improved in the Lao P.D.R." And the Project Purpose was "The central and local health services for children are strengthened with participation of various levels of stakeholders."

There were six Outputs in PCM-0, based on the above selected approaches as follows:

Output 1:	Capacity building to provide better health services for children
Output 2:	Present functions on vertical (central-locals) health systems for children are strengthened in MOH.
Output 3:	Present functions on horizontal health systems for children are strengthened in the model provinces.
Output 4:	Preventive and care activities against such major child diseases as diarrhea, malaria and pneumonia are intensified in the model provinces.
Output 5:	Health education is improved.
Output 6:	The central and local capacity to establish supportive relationships and coordinate with such partners as national authorities, bilateral donor agencies, and international organizations is promoted.

Even though the Project had PDM-0 from the beginning, KIDSMILE did not set a fixed or concrete target of the project outcomes at the outset of the Project. The Project respected flexible design process and was willing to modify project components. This was one strong characteristics of the Project, especially by the midterm evaluation in 2005

2. PDM-1 (November 2003 – December 2005)

When the Japanese project consultation team visited the Project in November 2003, both Lao and Japanese sides agreed to modify the PDM-0 because they thought the activities that had been specified as the Project had progressed. As a result of discussions concerned with the review of the activities, the PDM-1 was developed to strengthen monitoring activity of the Project.

In PDM-1 (Annex 12), the Overall Goal was changed; two Overall Goals were set. Firstly, the geographical target was reduced to two provinces. And another Overall Goal: "Practical systems established by the Project are utilized beyond the central level and target provinces" was added.

The Project Purpose of PDM-1 was the same as of PDM-0.

Regarding Outputs,

1) The systems expressed as "vertical" and "horizontal" in Output 2 and 3 in PDM-0 were clarified more practically as "human resource development system" and "health network system" in Output 1 and 2 in PDM-1, according to the actual activities of the Project.

2) Expression of Output 3 in PDM-1 followed the widely accepted definition of clinical IMCI.

3) Output 4 in PDM-1 showed a Project approach covering IEC.

4) Output 5 in PDM-1 stressed the importance of completion of the "Activity Cycle", consisting of planning, implementation, monitoring, evaluation, and feedback.

In PDM-1, there were five Outputs, based on the points as follows:

Output 1:	Capacity building in management systems of human resource development is improved in target provinces and at the central level.
Output 2:	The health network system is strengthened in target provinces and at the central level.
Output 3:	Treatment for and prevention against major childhood diseases such as diarrhea, malaria, and ARI are intensified in target provinces.
Output 4:	Information, education, and communication for child health services is improved in target provinces.
Output 5:	Health service management thorough planning, implementation, monitoring, evaluation and feedback are improved at target provinces and at the central level.

According to the changes in the Outputs between the two PDMs, both Indicators and Activities were largely revised.

3. PDM-2 (December 2005 – October 2007)

In July 2005, the mid-term evaluation was carried out in accordance with the PDM-1. Both Lao and Japanese sides reviewed all achievements of the activities and outputs of the Project. As a result of the discussions, both sides agreed to revise PDM again to share the future directions clearer in the remaining period of the Project.

In PDM-2 (Annex 12), the Overall Goal remains the same as in PDM-1.

The Project Purpose was changed, to share the concept that the Project continued to put priority on the improvement of the management system for child health services with all parties concerned. The new Project Purpose was phrased as "management system for child health services is strengthened among the MOH and target provinces with various levels' participation." We thought the new Project Purpose should be extracted from the former two and a half years of activities so that it could show more precisely KIDSMILE concept which the people concerned had respected from the beginning. In order to clarify the target level of the Project Purpose, the indicators to measure the achievement of the Project Purpose were revised.

The target beneficiary was also changed from "children under 15 years old" to "children under five years old", because the Project would focus on more vulnerable generation.

As for five Outputs, the total contents were not changed from PDM-1 to PDM-2, however, the expressions were modified in order to make them easier to understand and have them better explain what the Project should do practically.

Outputs in PDM-2 are as follows:

Output 1:	Training Information System is established at target provinces and at the central level.
Output 2:	The Network System is strengthened at target provinces and at the central level.
Output 3:	MR and IMCI are established at target provinces and at the central level.
Output 4:	Capacity of Information, Education, and Communication is improved at target provinces and at the central level.
Output 5:	Activity Cycle of planning, implementation, monitoring, evaluation and feedback are carried out at target provinces and at the central level.

With the recommendations by the midterm evaluation team, the rest of the items (Objectively verifiable indicators of each Output, Means of verification, important assumptions, Pre-conditions, and Activities) were completely revised within four months.

In August 2005, at each project site, "PDM revision task force" was established and had several discussions to make drafts of PDM-2. Based on this work, in 7th Intensive Discussion on 26-28 October 2005, all the persons concerned from each cite shared and exchanged their ideas and opinions and confirmed the final PDM-2. It was approved finally in the 6th JCC on 13 December 2005.

After the confirmation of PDM-2, with the PDM-2 and annual activity plans, the Project started regular monitoring of all project activities. All results, issues, schedules, etc have been reviewed and discussed jointly in regular meetings and Intensive Discussions. In the latter period of the Project, PDM-2 played a very important role for all members of the Project to share KIDSMILE concept and progress.

IX. RECORD OF THE JOINT COORDINATION COMMITTEE MEETINGS

A total of nine JCC meetings were held and each meeting's agenda and participants are shown in ANNEX 13. The frequency was twice a year, which is more than average of other JICA project. It was because the Project had three sites which made communication or understanding among them complicate. It was necessary to monitor each site activities and achievements and try to coordinate Project operation smoothly.