The JICA Reproductive Health Project in Nghệ An Province

A Case Study

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The case study explores how the Mother and Child Health Care and Family Planning Center of Nghệ An province (MCH/FP center) mobilizes the Official Development Assistance fund for functional enhancement, for institution building. The study includes three parts. The first part introduces Vietnam, Nghệ An province and the project. The second part analyzes some factors to show the effectiveness of Official Development Assistance in institution building. The third part provides the conclusion of the case study.

Abbreviations:

CHC Commune Health Center

CHC Commune Health Center

IEC Information, education, and communication

JICA Japanese International Cooperation Agency

JOICFP Japan Organization for International Cooperation in Family Planning

MCH/FP Mother and Child Health and Family Planning Center

RH Reproductive health

I. GENERAL INTRODUCTION OF VIETNAM, NGHỆ AN PROVINCE AND THE PROJECT

1. General introduction of Vietnam

Vietnam locates in the Southeast Asia with a population of over 80 million. After the war, baby booming, as well as many other economic and social matters raises the problem of reproductive health. The Ministry of Health is the agency in charge of enhancing reproductive health of the people. Let us see main reproductive health indicators: Total population is over 80 million; life expectancy 66.9 for male and 71.6 for female; maternal mortality ratio (per 100,000 live births) 95; infant mortality ratio (per 1,000 lives birth) 34; total fertility rate (1995-2000) 2.25; contraceptive prevalence rate (modern methods) 56; birth per 1,000 women aged 15-19 is 20; HIV prevalence rate (15-49) is 0.24 [1]. These figures show the low level of the medical sector, meaning much to do with the reproductive health problem.

2. Introduction of Nghệ An province

Nghệ An province locates in the north of Vietnam, about 300 km from Hà Nội with the capital of Vinh City. The area of the province is 16,487 km2; the population is about 3 million; the number of households is about 600,000. It is mainly agricultural province with 17 districts combining 466 communes. Main agricultural products are rice, potato, peanuts, oranges, etc. Nghệ An is a poor province with the annual GDP per capita of U$264 USD (in 1999), ranking the 43rd all over the country. There are 41 ethnic minorities, comprising of 460,000 people (16% of the population) [2].

Nghệ An provincial health service is the agency, which is in charge of the management of all health facilities and services in the province. There are 6 provincial hospitals, 20 district hospitals, and 466 commune health centers. In general, Nghệ An is a poor province with low-level indicators of health.

3. Introduction of the project

The Reproductive Health Project is the first Japan's GO-NGO partnership project in Vietnam, handled by JOICFP – a Japan-based international NGO on population and RH and JICA from 1997 to 2000. The project purpose is to improve the reproductive health status of women in reproductive age with special focus on commune women in Nghệ An province. The Project consists of 244 (among 264) communes of 8 (among 19 districts of Nghệ An province). Budget for the project is US$400,690 in 1997, US$982,800 in 1998, and US$430,790 in 1999 [3]. The stakeholders of the project are Japan International Cooperation Agency (JICA), the Vietnamese Government (Ministry of Health), Japanese Organization for International Cooperation in Family Planning (JOICFP), Provincial Health Service, MCH/FP Center, district health centers, and commune health centers. The project purpose is to improve the RH services for women. The project covered 244 communes of 8 districts out of total 19 districts in Nghệ An Province with nearly 3 million beneficiaries - the women, living in this province [4]. Through this RH project, MCH/FP center conducted many reform activities to improve reproductive health care services of the center. Main parts for reform divide into three groups: reform at the province's MCH/FP center, reform at district health centers, and reform at commune health centers. The first one includes institution building of the MCH/FP center with emphasis on retraining, management, monitoring and normal delivery through provision of equipment and technical cooperation of Japanese experts. The second one includes capacity building of mobile team of district health centers for follow-up training and monitoring CHC staff through provision of equipment and training. The third includes retraining of CHC staff, supply of medical equipment, and supply of materials including cement, iron bar and titles for the renovation of hygienic facilities of CHCs. Achievements of those reforms may be summarized as follow: CHC services are improved, including: training of 252 CHC staff, supply of basic medical equipment for 244 CHCs, renovation of CHC facilities of 202 CHCs; The management capacity at the MCH/FP center is also promoted; the monitoring and follow up system for CHC activities is established at provincial MCH/FP and district health centers; collaboration among the health sector, people committee and women union at provincial, district, and commune level is strengthened; IEC activities by women union are promoted; utilization of HBMR and pantograph is introduced and promoted [5]. Some of these activities are evaluated more in depth in the following paragraphs to see the effectiveness of the institutional reform.

II. ANALYSIS OF EFFECTIVENESS OF FINANCING, EQUIPMENT, FACILITIES, AND TRAINING SCHEME

1. Financial matter

The impulses and motivation for the institution reform come first from outside forces, particularly, some million USD investment from the Vietnamese Government (the Ministry of Finance, the Ministry of Planning and Investment, the Ministry of Health) by allocating grant from Japanese Government to the medical sector, particularly, to this Nghệ An province. Like other projects in health and education sector, the province does not have to worry about the payment. They have sources to invest in the social welfare development, which benefits the whole community. Different from JBIC loan project,

cost-effect analysis is not the focus, instead of that; analysis on effectiveness in financing structure, financing allocation and financing sustainability is conducted. Equipment facilitation and commune health center facilitation, which are included in this finance, are also analyzed in the next parts to examine the effectiveness of the ODA project.

Budget for the project is US$400,690 in 1997, US$982,800 in 1998, and US$430,790 in 1999. The size of financing is rather big. [6]

Regarding decentralization, the project was especially successful. The Project's total input (except for Japanese experts, counterpart training in Japan) was estimated at US$1,814,289. Of this number, the input for provincial level was US$441,967 (22.7%); for district level US$334,206 (18.4%); and for commune level US$1,068,116 (58.9%). Visually, lower level receives more money than higher level, meaning good policy for decentralization. Higher decentralization level means higher sustainability because the basic investment in the root of the market brings the basic living power to the market.

Let us take a closer look at decomposition of financing at every level. The project highlighted equipment facilitation and training. This was the right policy, which is made on the basis of local needs - enhancing local participation and ownership. Let's see the project allocation to provincial level, district, and commune level [7].

As we can see, structural and management reforms were the first priority at provincial level while equipment was the first priority at district and commune levels. Other groups of district and commune levels, such as facilities, IEC, training, mobile team receive relatively equal allocation. Actually, depending on the actual local needs the allocation of inputs was set in order of priority.

General structure of input said the same thing. From the Japanese side, three main parts of input were experts, equipment and training. Expert part includes three long-term experts each year: Chief advisor, coordinator, and nurse/ midwife and some short-term experts (RH, health service management, IEC, etc). Equipment part includes equipment and facilities listed in the equipment list worth US$500,000 – US$800,000 for three years. Training part includes counterpart training in Japan (7-9 people for 3 years) and local training worth US$130,000 – 140,000 for 3 years. Input from the Vietnamese side worth about US$326,137 for the construction of new quarter at the MCH/FP center includes training room, JICA RH office, maternity ward, laboratory, X-ray room, etc, monitoring and meeting, supply of essential drugs and contraceptives, CHC staff training, and CHC renovation [8]. According to the director of MCH/FP, the cost of this work exceeded the estimated cost. Both sides made great efforts to bear the extra cost to ensure the quality of the committed work. Particularly, health facilities were upgraded according to project standards and facilities received community contribution at least 30% of the cost. This evidence of success shows high level of local participation and ownership. In general, the structure of financing is good, expressing local need, decentralization, participation and ownership – those are all-important features of institution.

2. Equipment analysis:

First, let us compare the picture of health facilities before the project and after the project. The situation of equipment at commune health centers was really bad, as the survey, which had been conducted by the project staffs in 8 districts in 1996, shows: "There is no instrument cabinet; sterilization of equipment is not well done; the staff do not handle autoclave well; the record on medical equipment is not prepared; the staff do not utilized Maggie apron well; the pamphlet is not utilized; etc" [9]. These descriptions are repeated in most of the visited commune health centers.

During these three years, a great number of equipment was supplied by the project. The three main recipients are provincial MCH/FP center, district health centers and commune health centers. Equipment facilitation shows good features. Within scope of capacity building, the important technologies were transferred, both in equipment and skills. Maybe the most important part of every international cooperation project is the technology transfer – supply of medical equipment and transfer of techniques and skills. First, equipment need was surveyed and equipment plan was formulated. During 3 years, equipment was supplied. Manual for usage and maintenance was formulated and training on utilization and maintenance carried out.

We had opportunity to meet the directors of district hospitals again in August 2004 in the workshop for calling efforts to reduce abortion, which was the item of the JICA project following this project since 2000. We showed this list and ask if these materials were in good condition and good utility. They answered that JICA equipment and materials were well used and maintained. They said, "It looks like a hospital now" (personal communication, August 2004). The books are kept in the library for everybody to read. Particularly they continue to purchase and utilize most of the items from the same makers, for example, gloves of Vietnam rubber, cotton and white uniform from Nghệ An garment company. However, there is one difficult point of foreign made equipment. Several years after purchase, the guarantee period finishes. It is difficult to replace broken parts of equipment because there is no representative office of the maker in Nghệ An province. The interviewee said he had to go to Hà Nội and search complicatedly on Internet to find out how to purchase parts for the infant warmer (Nakamura made). In case of scrub station, it is quite comfortable because it is made by X-130 enterprise – a Vietnamese company. The maintenance resource and spare parts are easily available. The autoclave (Medda 9801-NH), which is made by Viettronics – a Vietnamese manufacturer, is also an easy thing to purchase, maintain and repair. In general, survey results show good purchase, usage and maintenance of equipment, which really

Provincial level	District level	Commune level
PU: US$268,666 (67%)	Equipment: US$229,971 (69%)	Equipment: US$545,520 (51%)
Equipment: US$103,914 (25%)	IEC: US$56,029 (17%)	Facilities: US$196,043(8%)
Training: US$34,094 (8%)	PU and training: US$31,166(10%)	IEC: US$205,685 (19%)
IEC: US$1,293 (1%)	Mobile team: US$17,040 (5%)	Training: US$102,304 (10%)
		PU: US$18,564 (2%)

helps the health staffs work better, bringing higher quality of the health services.

3. Renovation of commune health centers:

The best way is to absorb the appearance and content of commune health centers in 1996 and in 2004 to see the difference, which is actually done by the author. The participation of the author as a project interpreter brings many opportunities to absorb and evaluate the real context. This makes a very good advantage in efforts for saturated analyses. During 1995, 1996 the provincial MCH/FP center conducted a survey to check the real situation of commune health centers (CHC). We visited 17 CHCs in Diễn Châu district, 19 CHCs in Yên Thành district, 18 CHCs in Nghi Lộc district, 18 CHCs in Nam Đàn district, 17 CHCs in Đô Lương district, 21 CHCs in Thanh Chương district, 16 CHCs in Nghĩa Đàn district, and 14 CHCs in Con Cuông district. We set up criteria for evaluation including hygiene, facility and delivery room, family planning room and other rooms, equipment, pregnancy management, staff management, planning, recording, knowledge and skill of midwife. Situation of CHCs before the project may be described as follow:

Regarding hygiene, in different districts, CHCs have dirty surrounding environment; no shower room; no place specified for garbage; no toilet, no well or no lid for the well; or have dirty toilet, shower room, and spider nets, leakage on the floor; they do not separate medical and regular waste; have no shower room; and no place specified for urinating.

Regarding facility/ delivery room/ FP room and other rooms, in different districts, ergometria is not prepared; the boiled soap is not kept in a closed box; the instructions on obstetric emergencies are not prepared, the delivery rooms are also utilized for FP services; the number of CHCs, which do not prepare the instructions on obstetric emergencies is big; the number of CHCs, the equipment of which for aiding of hypoxia newborn is not prepared as a separate kit is big, CHCs have no separate kit of equipment utilized for aiding of hypoxia newborn; they have no instruction on obstetric emergencies, etc.

When we meet some CHC staff in 2004, they show us pictures of their facilities before the project began and after the project finished. One may be able to feel the difference. In 1998, facilities were assessed and upgrading plan was conducted. During four years, CHC facilities, particularly, delivery room, FP service and counseling room, water source, bathroom, toilets, were upgraded. They say up to present, monitoring and evaluation were conducted. All of items for reform, such as hygiene, facility and delivery room, family planning room and other rooms, equipment, pregnancy management, staff management, planning, recording, knowledge and skill of midwife are conducted and maintained well. Particularly, separate shower rooms and toilets are built; wells and lids for the well are built; mosquitoes, spider nets, leakage on the floor are cleared; ergo meter is supplied; the instructions on obstetric emergencies are pasted on the wall; the delivery rooms and room for FP services are separately equipped; the equipment for aiding of hypoxia newborn is prepared. A CHC staff said, *"During the training course we had opportunity to visit a CHC in Nghi Long commune, Nghi Lộc district. There are only three staffs in the CHC while the population of the commune is 76,000. The salary is low but they work hard. They see CHC as their home. Thanks to JICA project, CHC is upgraded. All the rooms are clean and tightly, neatly arranged. We also visited Nghi Trung CHC and Kim Liên CHC and see the same pictures."* (Vi Hoài Thanh, interview sheet, 2000)

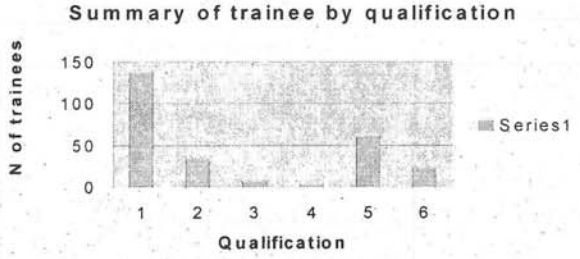
Both observation and interview show that the facilitation of commune health centers have been conducted successfully, bringing higher quality of reproductive health services at these hamlets, where women are able to enjoy better reproductive health care and a better quality of population may be gained.

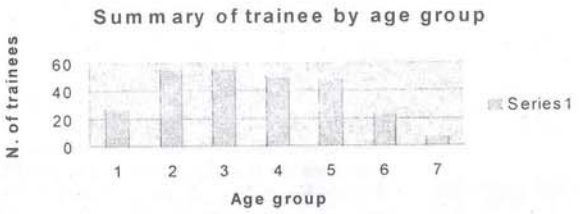
4. Analysis of the training scheme:

It is sure that the major portion of the ODA investment - training of health personnel is successful. It goes in line with the purpose of the project - for improving, reinforcing the structural capacity and managerial capability of health staff working in health institutions of Nghệ An province. Thank to the JICA project, the institutional capability of Vietnamese staffs is enhanced considerably, not only the professional knowledge and skill but also ability to do statistics, analysis and research work. At the beginning of the project, need assessment on training was conducted and training plan for health personnel was formulated. During 3 years, teaching materials were produced and training courses for health personnel was conducted. Monitoring, supervision, and follow up of trained personnel were conducted and evaluation and reporting were carried out regularly. According to the director of MCH/FP center, training courses are well prepared. To serve training courses, besides professional equipment and materials, office equipment such as computer, scanner, photocopier, printer, television, video, slide projector, overhead projector, screen, microphone, camera, etc are purchased and made. As observed in the classroom of the center, all of these equipment and materials are well kept in cabinets. A Japanese expert made a joke that he was sure the equipment was well and regularly utilized because there was no layer of dust on these cabinets. The success of the training scheme is best seen in the training result summary [10]. It is the best evidence of the success of the Reproductive Health Project, which is implemented in a province with many ethnic minorities, which really narrows the gap in living standard among many nationals residing in a common S-shaped country, which receives the great contribution of hearted people: Doctor Võ Thuỳ Phương, Doctor Đỗ Thị Mùi, Doctor Nguyễn Bá Tân, Doctor Cao Phi Nga, Chief Consultant Ms. Ishii, Ms. Mayumi, Midwife Kazuyo, etc, where I spent meaningful days of my life working for the difficult purpose: to protect and promote reproductive health of women in Nghệ An province. Let us look at the summary:

1: Primary midwife; 2: Secondary midwife; 3: Primary nurse; 4: Secondary nurse; 5: Ob/gen assistance Doctor; 6: Gen. assistant Doctor

As we can see, the stratum of trainees with qualification, who are primary midwifes is the biggest, which means that health staffs at the lowest level – commune level benefits the most from the project. This is a good evidence to show how ODA money helps to build the system – the network of the province effectively.





1: 20-24; 2: 25-29; 3: 30-34; 4: 35-39; 5: 40-44; 6: 45-49; 7: 50-54

As we can see, young people (25-34 years old) are the main training targets of the province, which means another good evidence of how ODA investment helps to build up the structure of the health institution.

The success of the training courses also can be confirmed in the book "Workshop Diary of 263 trainees", in which 263 midwives write about their impression and comment on the midwife training workshop, conducted by the project in the Mother and Child Health/ Family Planning Center, Nghệ An province. These survey results are quoted to reconfirm how the ODA fund really helps to create a change in acknowledgement and action of health staffs. The form of survey is rather simple consisting of date, time, name, working place (district, commune), study content, group name, self-evaluation and comment. All trainees are able to express their own ideas and comments that are useful for project implementation, particularly, for the formation of future projects in the same field. Many trainees give comments on how to allocate and utilize limited source of state fund and project fund, and how to mobilize fund from various sources to facilitate commune health stations, to improve specification skill of health workers to serve big number of women of their commune. Particularly, some comments of interviewees are quoted to show the institutional development of health staffs, particularly, midwifes, as follow:"

During the days we study in class; in the evenings we discuss with friends from other commune health centers and find many interesting things. Before we did many wrong things but we thought we did correctly with the professional criteria. Some say it is lucky that there happen no trouble with them. From now on, maybe there will not happen such kinds of complications as uterus hall due to the bad skill of Doctors or pregnancy after inserting IUD."(Ms. Vũ Thị Mai)"

I will apply what I learn here in my commune health center. Please, try your best. Do not forget Ms. Kazuyo's words. Please, make efforts in your life" (Ms. Nguyễn Thuý Mai, Nghĩa Quang commune, Nghĩa Đàn district)."

I have found many mistakes in theory as well as in practice. I wish such kind of training course will be opened more often in other places, so that more health staffs have opportunities to communicate with colleagues and get improved"(Ms. Hoàng Thị Kính)."

We have found that we have much weakness in knowledge and skill. I want to express my sincere thank to Ms. Kazuyo, Doctor Mùi, Doctor Mười, Doctor Hồng, Doctor Tuyết, etc. We can serve women in our commune better from now. We try to have a 4S delivery room" (Trương Thị Chức)"

I feel so sad to be far from Ms. Kazuyo and my friends. I write a poem to express my feeling""

I am from Thành An commune-a mountainous commune. We do not have delivery room yet. I have learnt many things from this project. We wish to have these courses every year." (Nguyễn Thị Xuân)"

I want to especially thank Midwife Kazuyo – a special Japanese girl who contributes much of her life and intelligence to Nghệ An province, in particular, and to Vietnam, in general. Thank the parents of Kazuyo, too, because they gave birth to an excellent Vietnamese girl – Kazuyo" (Nguyễn Thị Ba).

In general, ODA investment really brings a change to the appearance and content of the commune health centers. Thanks to the infrastructure investment in hardware, institutional development in software finds it opportunities to be enlarged.

III. CONCLUSION AND IMPLICATION OF THE CASE STUDY

During the final workshop, the director of the PCP/FP reported that the purpose of the project was achieved, which was the result of various reforms in the related institutions, which was shown by the following indicators [11]:

1. The average number of prenatal examination per pregnant women in the project area was increased to 3 or more.
2. 95% of pregnant women received prenatal examination.
3. The number of deliveries done in CHCs increased to 85%.
4. The number of women receiving gynecological examination and treatment increases by 2.5% annually.
5. The number of deliveries was reduced by 2% annually
6. The number of pregnant women receiving T/T2 increases by 2% annually.
7. The number of abortion including MR was reduced by 6% annually.
8. The modern contraceptive prevalence rate rose by 3% annually.

This figure can say much more than any description, which brings the power to convince people on the success of the ODA project. These figures had shown the success of not only the medical sector, but also other related organizations, such as the Women Union, Farmer Union, and other political and social organizations. These were the best indicators of the improvement of reproductive health of women in Nghệ An province. The study really shows the effectiveness of Official Development Assistance in functional enhancement, capacity strengthening, institution building in the Mother and Child Health Care and Family Planning Center, Nghệ An province, Vietnam.■

Notes:

[1] UNFPA. 2002. The State of World Population 2001; UNAIDS. 2001. Epidemiological Fact Sheets on HIV/AIDS and STI (2000 update); JOICFP homepage

[2] JICA (1999)

[3] JICA (2000)

[4] JICA (1999)

[5], [6], [7], [8] JICA (2000)

[9] JICA (1996)

[10] JICA (2000)

[11] The data is calculated by the end of the project within the project area and the figures are also estimated on the basis of provincial statistics.

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