Draft Design and Monitoring Framework

Project Number: 42143-01
April 2009

LAO: Developing Model Healthy Villages in Northern Lao PDR

A design and monitoring framework is an active document, progressively updated and revised as necessary, particularly following any changes in project design and implementation. In accordance with ADB's public communications policy (2005), it is disclosed before appraisal of the project or program. This draft framework may change during processing of the project or program, and the revised version will be disclosed as an appendix to the report and recommendation of the President.

Asian Development Bank

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
Impact Improved health status of the rural population in Xieng Khouang and Houaphanh provinces.	By 2015: Infant mortality rate in target provinces reduced to 80 per 1,000 live births. Maternal mortality ratio in target provinces reduced to 250 per 100,000 live births.	National statistics and census data Reports from ADB and development partners	**Assumption** • Government continues to give priority to primary health care in remote areas **Risks** • Economic or political instability or environmental disasters • Major epidemics and disease outbreaks
Outcome Target villages have achieved model healthy village status.	By 2013: At least 80% of families in target villages have access to safe water Average sanitation coverage in target villages is at least 80%, with a minimum of 50% At least 90% of households in target villages use impregnated bednets. At least 80% of women in target villages have access to pre- and antenatal care, and at least 50% of births are attended by a trained birth attendant. At least 80% of the target population is fully immunized. 100% of target villages have family planning and nutrition sessions available on a quarterly basis 100% of target villages have access to essential drugs, either through village drug kits or a health center.	Baseline[1] and follow-up project surveys Quarterly and annual project progress reports Final project evaluation Updated Project Implementation Manual and Field Guide	**Assumptions** • Public responds to improved primary health care delivery with stronger demand • Social barriers of health services, in particular for ethnic groups, can be overcome **Risk** • Health and hygiene awareness do not result in behavior change
Outputs 1. Strengthened	By 2013: 100 target villages have	Baseline and follow-up project	**Assumptions** • Provincial and district agencies

[1] Baseline data in each village will be collected as part of project start-up, and will be used for planning purposes and to assess achievement of outcome and outputs.

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Village Capacity for Participatory Planning and Management of Model Healthy Villages.	effective village health committees with at least 50% representation of women and ethnic groups 100 target villages have 2 trained and equipped village health volunteers, at least one of which is a woman. 100 target villages have developed village health plans, with at least 30% representation of women and ethnic groups. Community awareness of relations between health, hygiene and sanitation has increased by at least 50% Participation of women and minority ethnic groups in village planning has increased by at least 50%	surveys Quarterly and annual progress reports Project training records disaggregated by sex and by ethnic group Final project evaluation	are committed to community development • Behavioral change communication is effective
2. Improved village infrastructure for primary health care delivery.	By 2013: 100 villages have implemented village health initiatives, with appropriate provisions for O&M and cost-recovery At least 30% of jobs created for O&M of small-scale investments in each subproject are given to qualified women	Baseline and follow-up project surveys Quarterly and annual progress reports Project progress and project completion reports Final project evaluation	**Assumption** • Villages and districts provide continuous and sustained operation and maintenance of infrastructure.
3. Strengthened capacity of districts and health centers to support model healthy villages.	Model healthy village guidelines and health education materials are developed and distributed by 2011. 10 multi-disciplinary district teams, with at least 30% women representation, are established and operational by 2011. 10 districts have prepared district operational plans of action for supporting model healthy villages by 2011. 10 districts have implemented	Quarterly and annual progress reports Project progress and project completion reports Final project evaluation	**Assumption** • Capacity of districts and district teams are maintained **Risk** • Retention and turnover of staff

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	small-scale investments, with appropriate provisions for O&M and cost-recovery by 2012. A system for logistics management and retraining of staff is developed by 2011.		
4. Project Management and Implementation support.	Project management is established and staff is trained and operating with adequate resources by 2010. Consultants are recruited and operational by 2010. Project Implementation Manual and Field Guide are developed by 2010. Detailed annual work plans and personnel schedules are developed. A harmonized approach for scale-up nation-wide, including updated Project Implementation Manual and Field Guide, has been developed by 2013.	Project progress and project completion reports Detailed work schedule and budget plans Project management meeting minutes Quarterly and annual progress reports Audit reports Review missions	**Assumption** • National, provincial and district agencies allocate adequate staff and resources for project operating entities
Activities with Milestones **1. Strengthened Village Capacity for Participatory Planning and Management of Model Healthy Villages** 1.1 Undertake community mobilization, participatory workshops, meetings and inform stakeholders (Q2/2010 to Q2/2012) 1.2 Reinforce and train VHC members in each village throughout the project implementation (Q2 2010 to Q2/2012). 1.3 List of simple tasks for VHCs developed (Q2/2010). 1.4 Train VHVs and traditional birth attendants throughout project implementation (Q2 2010 to Q2/2012). 1.5 Support VHCs to serve as peer educators in community training on family planning, disease control, nutrition, clean environment, support for vulnerable groups, and other aspects of model healthy village (Q3/2010 to Q2/2012). 1.6 Support VHVs and VHCs to undertake information and health needs assessment and raise community awareness on health, sanitation and links with water use throughout project implementation (Q3/2010 to Q1/2012). 1.7 Development of village health plans (Q3/ 2010 to Q3/2011). 1.8 Undertake regular community-based monitoring and final evaluation of activities (Q2/2010 to Q3 2012). 1.9 Undertake knowledge exchanges and tours (Q3/2010 to Q3/2012). **2. Improved village infrastructure for primary health care delivery.** 2.1 Prepare sub-project proposals, subproject designs and tender documents progressively throughout project implementation (Q3/2010 to Q4/2011).			**Inputs** Total: $3.34 million • JFPR $3.0 million Civil Works: $760,000 Equipment and Supplies: $428,000 Training and Workshops: $861,973 Consulting Services: $510,400 Grant Management: $166,900 Contingencies: $272,727 • Government $0.19 million • Communities $0.15 million

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2.2 Plans between the district and individual villages for O&M prior to commencing physical works in each village (Q4/2010 to Q4/2011). 2.3 Improve household and village environments through small-scale health initiatives during project implementation (Q4/2010 to Q2/2012). 2.4 Build and strengthen the capacities of VHCs to undertake O&M of project facilities and services (Q3/2010 to Q2/2012). **3. Strengthened Capacity of Districts and Health Centers to Support Model Healthy Villages** 3.1 Introduce project to district staff, district health center staff and other stakeholders (Q4/2009). 3.2 Establish and train multi-disciplinary District Teams (Q1/ 2010 to Q3/ 2010). 3.3 Training of district teams and other district staff in planning and management of model healthy villages (Q1/2010 to Q1/2012). 3.4 Procurement of equipment and supplies (Q4/2009 to Q2/2010) 3.5 Develop DHPs (Q4 2010/Q3 2011). 3.6 Implement DHPs through district funds (Q4/2010 to Q1/2012). 3.7 Build and strengthen the capacities of district teams to undertake O&M of project facilities and services (Q4/2010 to Q1/2012). 3.8 Monitor and supervise village activities and DHPs (Q1/2010 to Q3/2012). **4. Project Management and Implementation Support** 4.1 Identify and train national and provincial project staff prior to project start (Q4 2009). 4.2 Mobilize international and national consulting services (Q4/2009). 4.3 Develop field guide and project implementation manual for the implementation of Project activities (Q4/2009 to Q1/ 2010). 4.4 Develop annual work plans for the Project (Q4/2009). 4.5 Establish and train PHCCU and district teams prior to project start (Q4/ 2009 to Q1 2010). 4.6 Provide project orientation to stakeholders and provide technical and management support to PHCCU throughout project implementation (Q1/2010 to Q3/2012). 4.7 Undertake regular monitoring of project activities (Q1/2010 to Q3/2012). 4.8 Undertake evaluation study (Q3/2012). 4.9 Produce updated operation manual and field guide with revised approach and strategy for further replication and up-scaling (Q3/2012).			

DHP = district health plan, JFPR = Japan Fund for Poverty Reduction, O&M = operations and maintenance, PHCCU = primary health care coordination unit, Q = quarter, VHC = village health committee, VHV = village health volunteer.