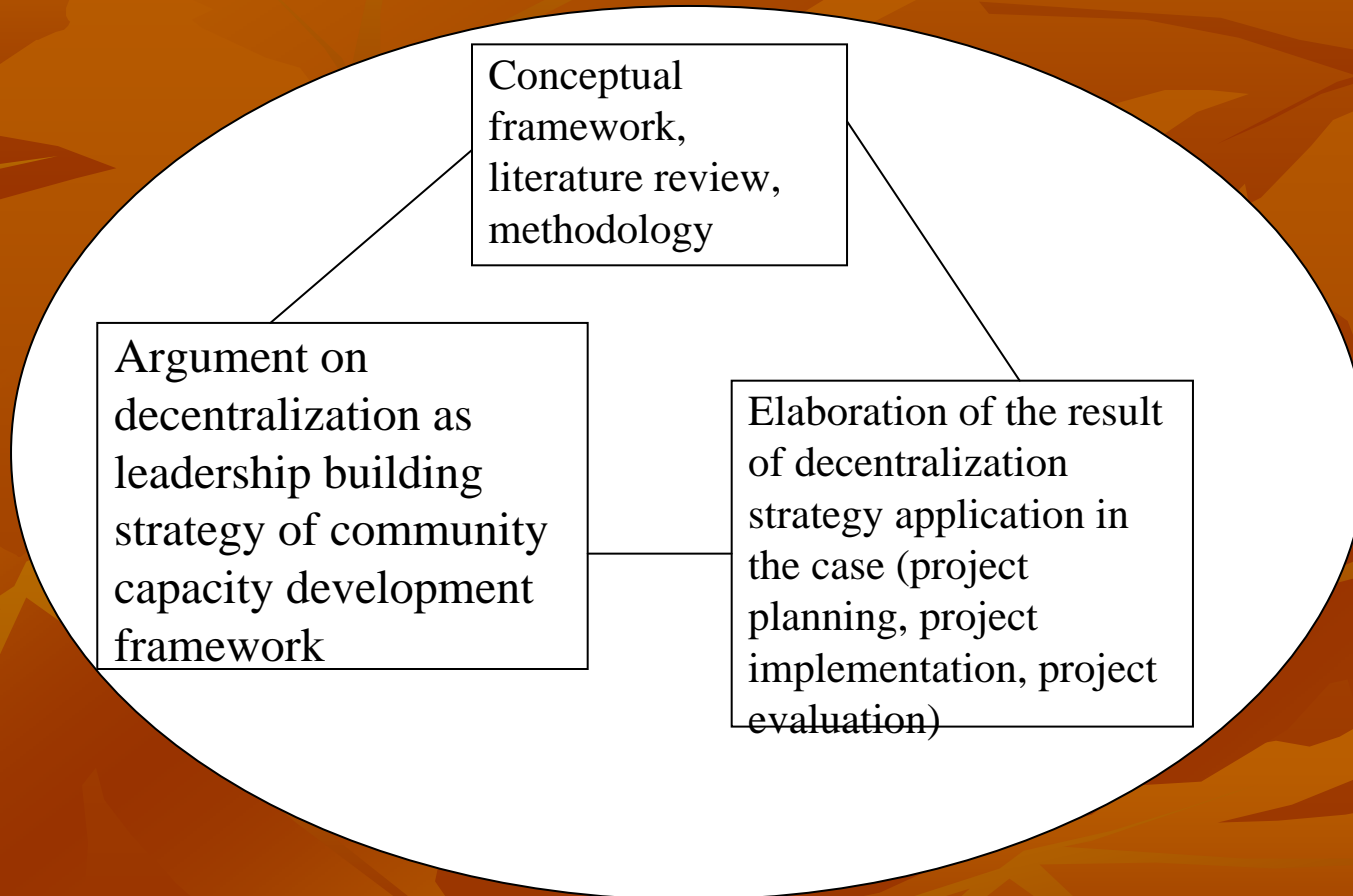


**Which strategy is better for a community
capacity development project:
Centralization or decentralization?**

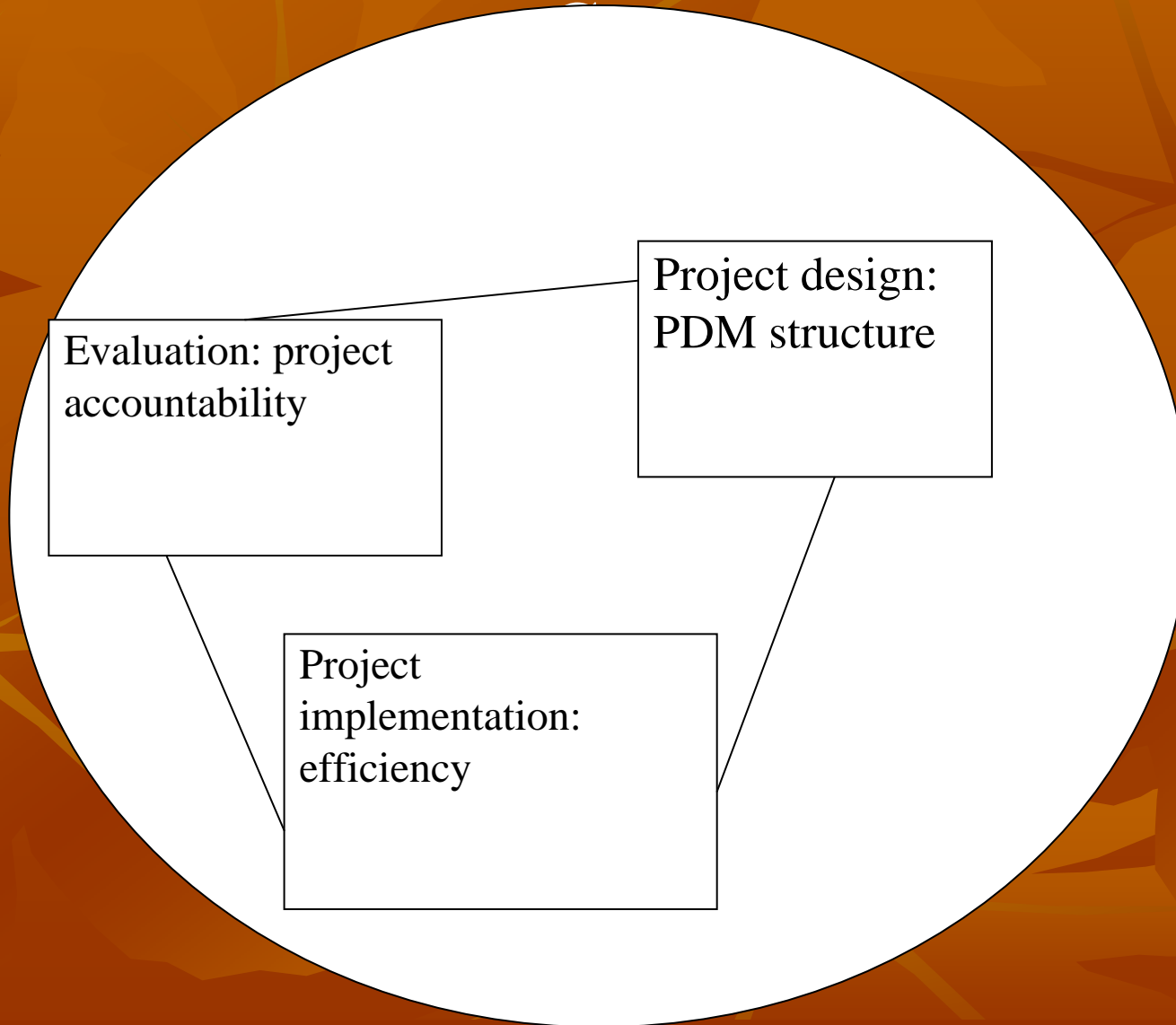
Pham Thi Thu Huong
Ritsumeikan Asia Pacific University

**Research problem:
decentralization result of the
JICA reproductive health project
in Nghe An province**

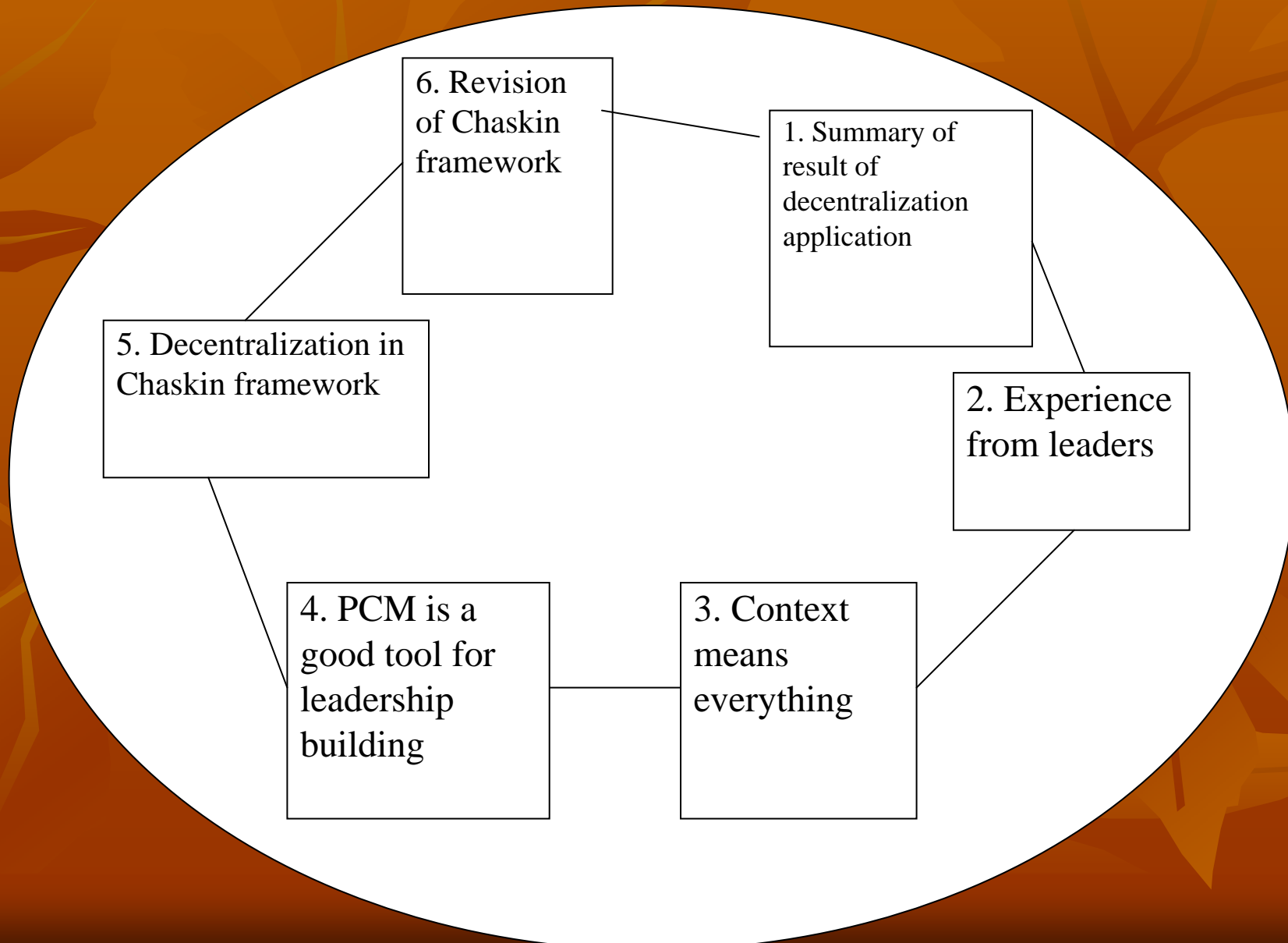
Research framework



Case



Case implication



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Research purpose, research questions, and research assumption

Purpose:

We aim to deduct the result of decentralization strategy application, which we name learning by doing, meaning exploring how the project managers learn by doing, how they clarify the disadvantages of project and apply new innovations in project design, project implementation, and project evaluation to fit with the local context, particularly, how the central organization transfers project investment to other local organizations and what are the results of that. Having experience from the case, we want to refine the concept of leadership building strategy of Chaskin framework by putting more weight on decentralization tool.

Question: how do they find out the disadvantage in monopolizing the project and transform the project to lower level and what are the results? How does the experience from the case say about the decentralization strategy of Chaskin framework?

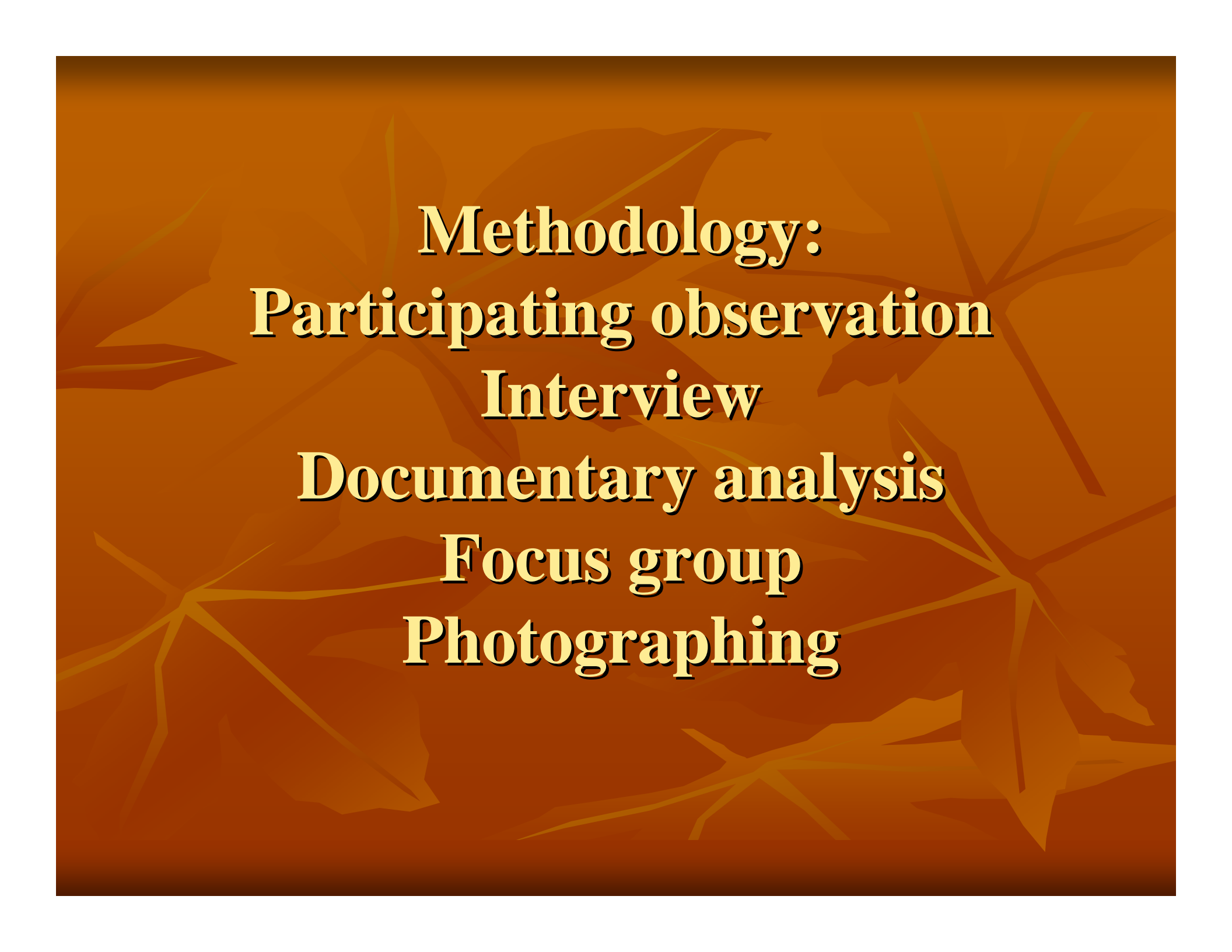
Our proposed implication is sevenfold: the case is a good experience for project leadership building; experience from leaders shows that leadership building is the process of decentralization in our case; context means everything; PCM is a good tool for project leadership building; decentralizing is more important than centralizing in an ODA project; refining Chaskin framework for community capacity building by focusing on decentralization strategy; theory helps me think about data and data helps me think about theory; and executive summary.

Literature review

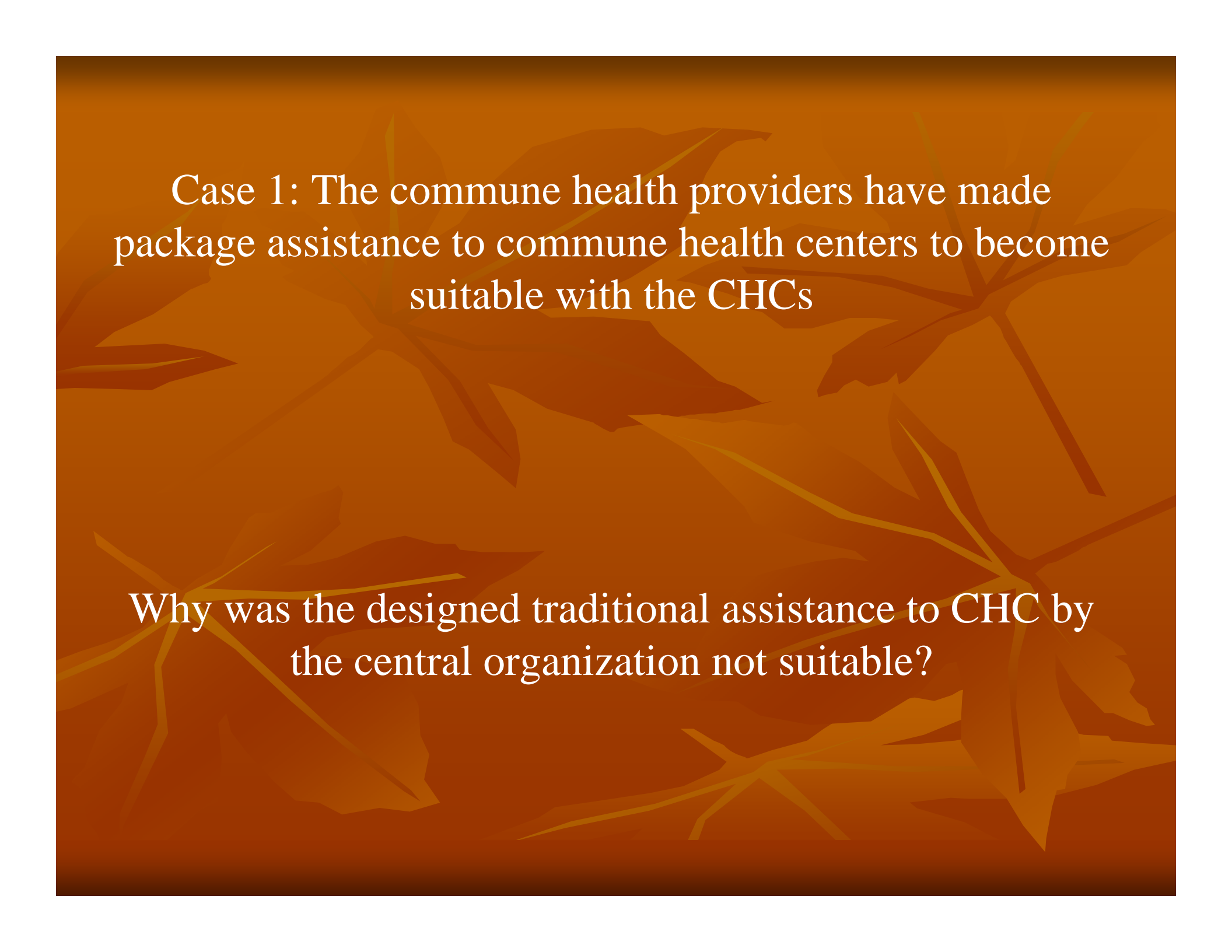
The research questions of the chapter include the two sets of questions, practical ones and theoretical ones:

Regarding the practical aspect, we propose some questions: What is already known about leadership in community health development projects in Vietnam? How does your research fit with project reports of the health sector of Vietnam? What to criticize about the argument on leadership building in the project evaluation reports? What is the new contribution of the research to ODA practitioners?

Regarding theoretical aspect, we propose some questions: What do we already know about the topic of community capacity building? What to criticize about what is already known about the community capacity building framework of Chaskin? How does your research fit with what have done before by Chaskin? What is new contribution of your research to the community capacity building framework of Chaskin?

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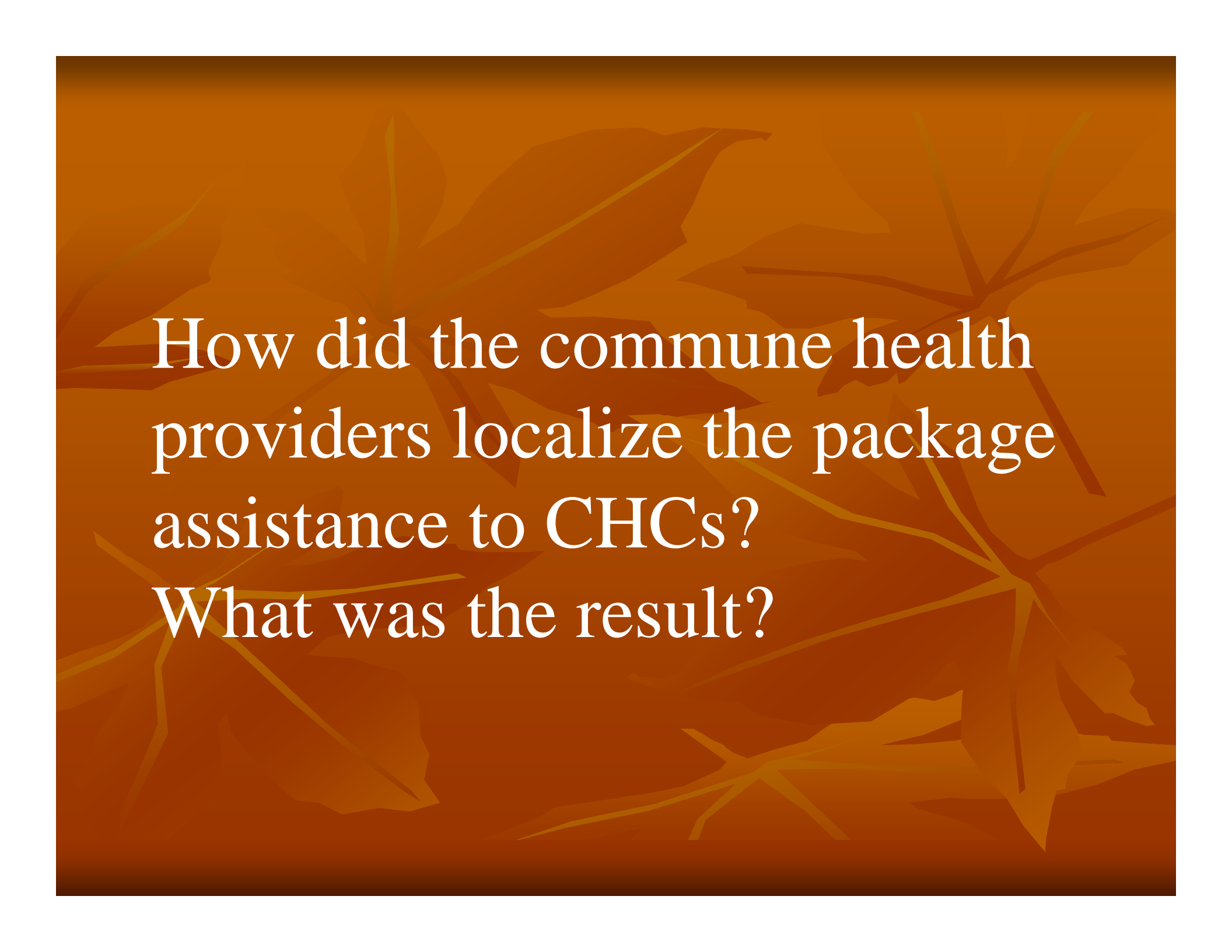
Methodology:
Participating observation
Interview
Documentary analysis
Focus group
Photographing



Case 1: The commune health providers have made package assistance to commune health centers to become suitable with the CHCs

Why was the designed traditional assistance to CHC by the central organization not suitable?

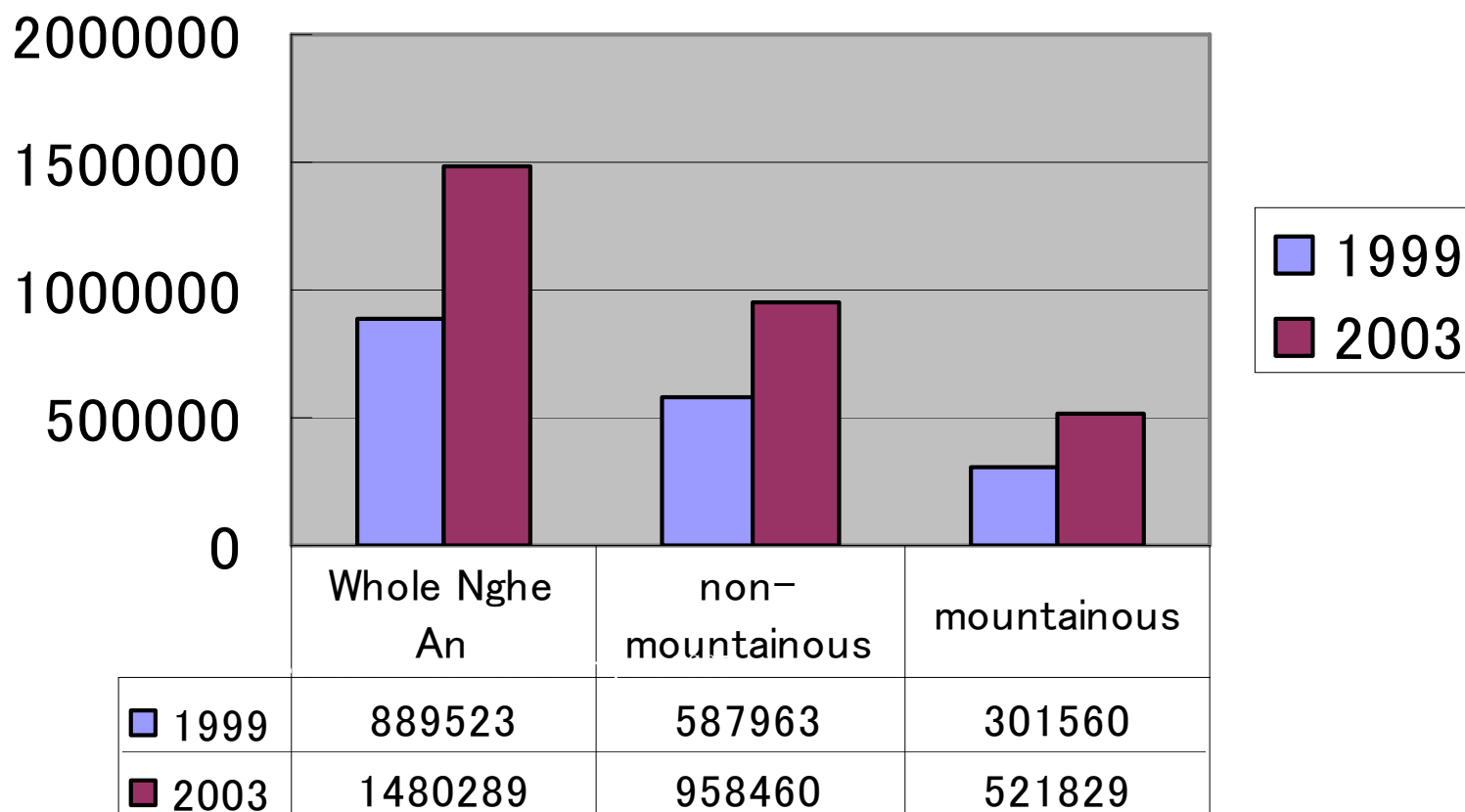
The project was conducted from 1996 to 2006 and was divided into the two stages: phase 1 (1996-2000) and phase 2 (2000-2005). During phase 1, they arranged the three items: CHC upgrade, CHC equipment, CHC training separately. Entering phase 2, they have found that it is not suitable any more to make the three separate jobs for the same CHC. If the combination were made, there would be the economization of cost such as transportation fee, staff salary, meeting fee, etc and most important was that the focus investment to CHC was assumed to result in the better performance of CHC.

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How did the commune health providers localize the package assistance to CHCs?
What was the result?

Observation: CHC facilities, particularly, delivery room, FP service and counseling room, water source, bathroom, toilets, have been upgraded at the same time with equipment facilitation and training. Not only facility (delivery room, family planning room and other rooms, equipment, door, windows, toilets, etc), but also pregnancy management, staff management, planning, recording, knowledge and skill of midwife have been upgraded. Particularly, separate shower room, toilet were built; well and lid for the well were built; mosquitoes, spider nets, leakage on the floor were cleared; ergo meter was supplied; the instructions on obstetric emergencies was pasted on the wall; the delivery rooms and room for FP services were separately equipped; the equipment for aiding of hypoxia newborn was prepared.

Total number of visits to CHCs in Nghe An province (1999–2003 comparison)



We were able to see the good impact of the package assistance, which cannot be observed if a block of hospital were built in Vinh City. Centralization investment in the form of this rapid package assistance to CHC was a successful expression of decentralization strategy application of Doctor Tan in our evaluation because the grassroot health providers could conduct the activity better than the MCH/FP center's staffs by applying the package assistance.

Case 2: The commune women union members have found that the designed ordering IEC activity at hamlet level was not suitable with the local rural community and changed to apply aiiku han model in Nghe An province

Why is the designed model of hamlet coordinator not suitable?

The designed way of communication for health care, including reproductive health care, at hamlet level was the one-way ordering design. The hamlet volunteer had no knowledge and no tool for health care communication. The only thing we could see was the death rate, birth rate. In urban areas the volunteers were often the retired doctors, who voluntarily help the community in health care. This one cannot be seen in rural areas.

Observation: Aiiku han volunteer cared about health and family such as counseling on raising children, medicine usage, nutrition, family planning, etc. This model was applied experimentally in three communes, after that, all Yen Thanh district, and all over the province by 2005. New Aiiku-han forms were translated and fix with our traditional forms, which recorded not only health and family problems, but also economic, agricultural production, financial, security, education problems. The head of groups of hamlet households were trained by these Aiikuhhan activities, too. The women union has managed to organize IEC workshops in 19 districts and 469 communes. Every hamlet has a bookshelf, a speaker, a micro. We evaluated that IEC was a really publicized after 2000 campaigns with nutrition - reproductive health contests, IEC campaigns, etc.

Women union showed their role in Aiiiku han as shown in the summary of sections they organize from March 2002 to December 2004:

Table 10: IEC sections, organized by women union, made by the author

Level	Section number	Participant number	Men
Province	5	97	
District	154	20850	2345
Commune	1260	44000	9000

Source: report of expert Chau

The Joint evaluation report showed that the number of parenting classes in hamlets increased year by year. In 2000, 21 classes were organized with 349 participants and in 2004, the number increased to 166 with 4351 participants.

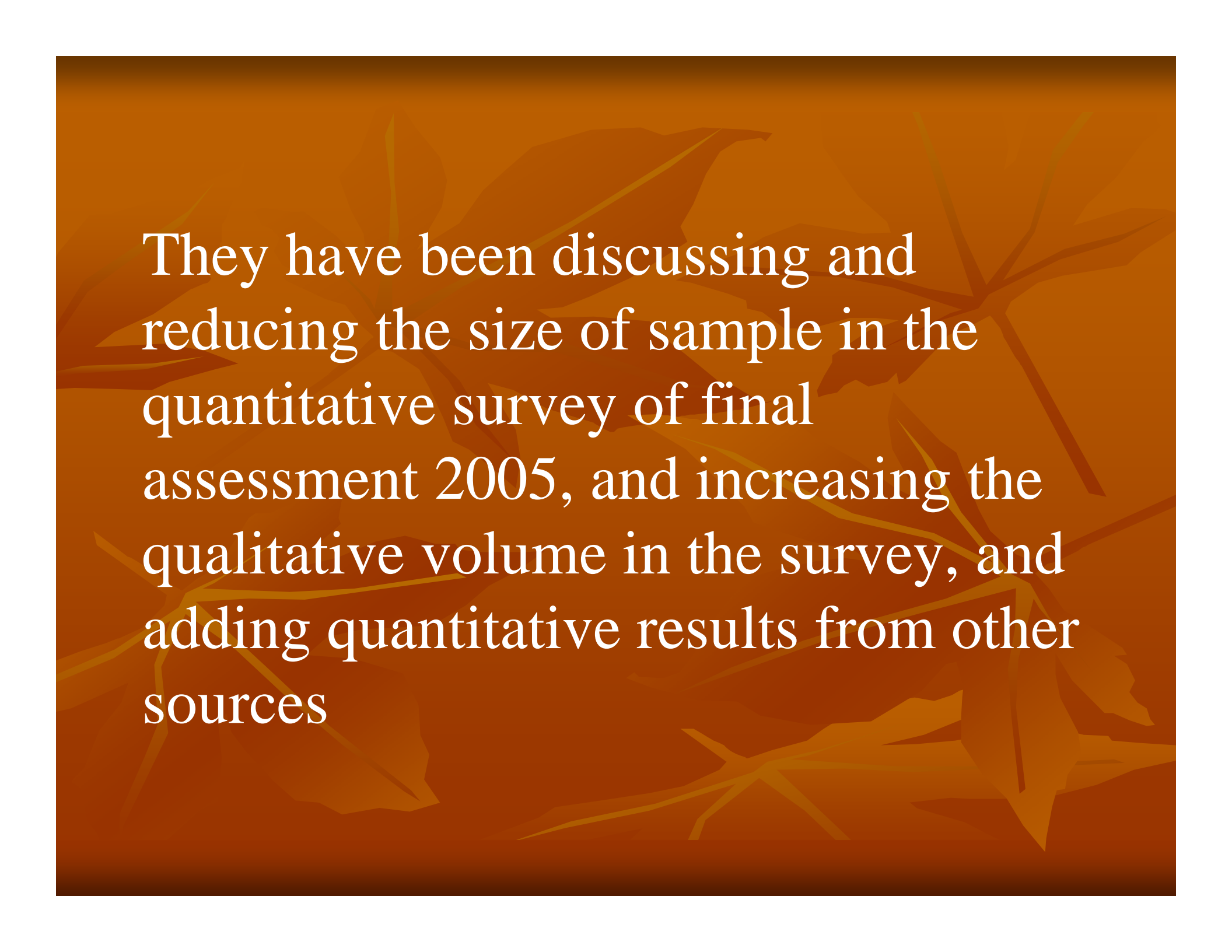
Women union successfully organized reproductive health and nutrition contest in 2002.

Women union successfully organized effective utilization of IEC materials for reproductive health promotion contest in 2004.

Case 3: commune population council members
changed the survey design

Why was the design by the MCH/FP Center not
suitable?

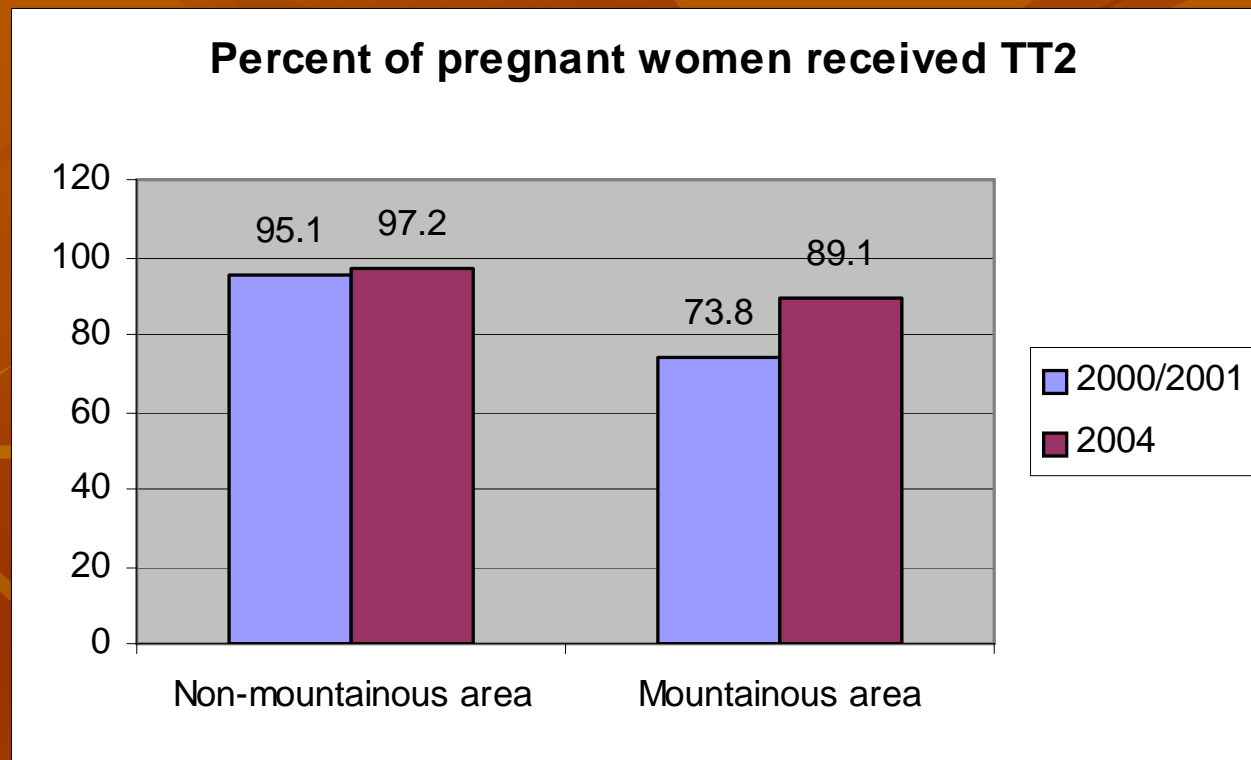
It is because the grouping was made by phase 1
and phase 2, which did not show the improvement
of indicators

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They have been discussing and reducing the size of sample in the quantitative survey of final assessment 2005, and increasing the qualitative volume in the survey, and adding quantitative results from other sources

137 communes to 77 communes

Chart 25: Percent of pregnant women received TT2



Source: Form Final assessment

Much qualitative data is added. In addition to increasing qualitative data, the population council added quantitative data from other sources, particularly, from provincial health service. They were % of pregnant women using home based maternal record, average number of prenatal checkups per pregnant woman, number of women received at least one prenatal check up, % of communes with trained midwife staff

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Case implication

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Context is the reason for decentralization in project planning

Context is the reason for decentralization in project implementation

Context is the reason for decentralization in project evaluation



Project cycle management is the solution
for decentralization in project planning

Project cycle management is the solution
for decentralization in project
implementation

Project cycle management is the solution
for decentralization in project evaluation

From learning by doing to on job training
to deccentralization

Refining Chaskin framework for
community capacity building by putting
more weight on decentralization strategy
for leadership building in community
capacity development projects

Empiricality is the new concept we add to
Chaskin framework