3．Project Design Matrix

The Project Design Matrix (PDM)

Project Title: Strengthening Reproductive Health Project in Syria
Project Duration: 3years
Project Area: Manbej Health District, Aleppo Governorate (Manbej, Al-Khafse and Maskane Health Centres as the project base)
Target Group: Marriaged and Unmarriaged Men and Women in Rural Areas

Date:September, 2005

Narrative Summary (プロジェクトの要約)	【Inputs/投入】	Objectively verifiable Indicators (指標) * When available, for Manbej District. ** For MOH Health Service Delivery Points Only (private clinics not included).	Means of Verification (指標データの入手手段)	Important Assumptions (外部条件)
【Overall Goal/上位目標】 Improve the Maternal and Child Health (MCH) & Reproductive Health (RH) status in Manbej district, Aleppo Region.	Japanese Government: 1.Experts (technical, management and coordination) 2.Training of project management staff in reproductive health in Japan 3.Provision of 1) basic equipment to the selected health centres (HCs) and 2) part of office equipment for the project team 4.Activity costs	1. Reduced # of recorded maternal deaths. 2. Increased Modern Contraceptive Prevalence Rate. 3. Reduced Infant Mortality Rate.	Baseline Survey Final Evaluation HIS/Aleppo PHC Directorate Project Progress Reports	Ministry of Health continues to support Reproductive Health as a policy priority, and continues to allocate at least the current level of human and financial resources.
【Project purpose/プロジェクト目標】 Increase utilization of quality and satisfactory MCH&RH services in Manbej, Aleppo.	Syrian Government: 1.Government staff as project staff 2.Office space, facilities, basic furniture and equipment 3.Administrative and operational costs for the project 4.Land, buildings and other facilities necessary for the implementation of the project 5. Repair of damages in health centres in the target areas and establishment of the maternity ward in key HCs in Manbej. 6. Maintain and try to increase the number of health personnel in key health centres (Manbej, Maskane and Al Khafse) in Manbej. 7. Give recognition for HCs which have fulfilled the requiremer	1.Increased % of pregnant women who received 1+ ANC visit 2.Increased % of births attended by skilled health personnel, including HC/Health Post(HP) staff and trained community health workers. 3. Increased # of referrals from the community to HC/HP. 4. Increased # of mothers who receive 1+ Post-natal Care visit. 5. Increased % of newborns immunized with BCT.	Baseline Survey Final Evaluation HIS/Aleppo PHC Directorate Project Progress Reports	Ministry of Health continues to support Reproductive Health as a policy priority, and continues to allocate at least the current level of human and financial resources.
【Outputs/成果】	【Activities／活動】			
1.Improve the quality of MCH&RH services in the project areas.	1-1 Assess the training needs of health service providers. 1-2 Establish the performance standard on MCH&RH for health service providers at HC/HP level. 1-3 Train and re-train health service providers (doctors, nurses,midwives, etc.), according to the set performance standard on MCH&RH, for strengthening the quality of services at HCs&HPs. 1-4 Strengthen supportive supervision throug the existing Monitoring Teams, to monitor and follow-up with the health service providers who were trained and re-trained. 1-5 Review and implement a minimum package of MCH&RH services (including family planning, referral activities, detection of cancer, respectful service provision, and adolescent-friendly health services) at HCs/HPs. 1-6 Ensure and encourage the quality of MCH&RH services provided at HCs through giving recognition to the HCs which 1-7 Provides basic medical equipment for Health Centers and Health Posts. 1-8 Repair major damages in major HCs and establish delivery space as necessary.	1-1 Increased % of cliants of MCH&RH services (including ANC and family planning) who are satisfied with the services. 1-2 Equipment provided to HCs/HPs, properly installed, utilized and maintained. 1-3 70% of hospitals/HC/HP receive monitoring visit by a Monitoring Team. 1-4 80% of health personnel meet the performance standad on MCH&RH set by the project(monitored both through daily monitoring and supportive supervision). 1-5 Increased # of HCs/HPs that fulfil the standard set by the MCH&RH minimum package, and obtain recognition from Aleppo Governor's Office.	Baseline Survey Final Evaluation HIS/Aleppo PHC Directorate Project Progress Reports	Population Department of National Planning Commission ensures a sufficient and timely contraceptive supply.

2.Raise awareness, and promote RH behavioral changes among community members in the project areas.	2-1 Conduct meetings for community/religious leaders, to brief on the project and obtain their support. 2-2 Establish Community-based Working Groups (CWG) and their workplans, in cooperation with the Health Education section in Aleppo, in order for the community members (including community and religious leaders, Women's Union, Youth Union and other stakeholders) to discuss and promote RH issues. 2-3 Select Community Health Volunteers (CHVs, including Health Educators, TBAs and young people) through CWGs. 2-4 Train CHVs through HCs to promote RH messages and contraceptives. 2-5 Conduct seminars, workshops, debate sessions and home visits to increase knowledge and awareness among women, men and adolescents in the community. 2-6 Conduct supportive supervision for CHVs through health service providers in HCs. 2-7 Revise Behavioural Change Communication (BCC) materials for target groups, based on the findings of a Knowledge, Attitude and Practice (KAP) survey (See the activity 4-1). 2-8 Conduct mass media campaigns with the messages on MCH&RH issues.	2-1 Increased % of the population who are aware of MCH&RH activities and messages conducted/distributed by the project, in the catchment area of the 3 HCs identified as the project base. 2-2 Increased # of women, men and young people in the catchment areas of the 3 HCs who have correct knowledge on: - Major MCH&RH issues. - When and where to obtain what services for major MCH&RH problems. 2-3 CWG meetings held every month, and attended by community leaders, HC heads and Health Director of Manbej. 2-5 The classes for MCH&RH education organized at HC/HP on a regular basis. 2-6 There are average of at least 10 participants at the health education class at HCs/HPs. 2-7 Increased # of pregnant women who visit HC/HP for the first prenatal check-up before 12 weeks.	Baseline Survey KAP survey Project Progress Reports Final Evaluation	
3.Advocate on the project activities and MCH&RH issues at the central level.	3-1 Document the project processes and lessons learnt on a half-yearly basis. 3-2 Disseminate the documentation of the project through media and workshops, targeting the general population and political leaders. 3-3 Mobilize the media, and advocate on MCH&RH issues at the national level, to create enabling social environment and incrase support for MCH&RH. 3-4 Organize workshops on MCH&RH issues, to target religious leaders and other influencial individuals.	3-1 Incrased # of the project mentioned in the newspaper, radio, TV and public speech. 3-2 Workshops for religious leaders and other influencial individuals held and constantly attended.	Project Progress Reports	
4. Strengthen monitoring and evaluation of project activities in the project areas.	4-1 Conduct necessary survey, including a baseline survey, final evaluation, feasibility studies of micro-credit/literacy activities, and KAP survey. 4-2 Review and revise, as necessary, the existing HIS form and data collection/analysis/utilization procedure. 4-3 Train HC/HP staff on the HIS format, data collection/analysis/utilization procedure and other necessary skills, in order to strengthen monitoring capacity. 4-4 Collect data through HIS to monitor MCH&RH situations in Manbej, and utilize it effectively to enhance project	4-1 Data against the PDM indicators collected, reported and reflected on project management on a half-yearly basis. 4-2 Manbej District Health/Aleppo PHC Directorate feed back monitoring information of Manbej to HC/HP on a regular basis. 4-3 80% of HCs/HPs utilize the standardized record books and report formats.	Baseline Survey Final Evaluation HIS/Aleppo PHC Directorate Project Progress Reports	
5. Empower community members, particularly women, through non-health activities, in order to enhance MCH&RH situations.	5-1 Conduct assessment of micro-credit and literacy activities, in order to determine project activities. 5-2 Conduct non-health activities to empower community members, according to the findings of the assessment.	5-1 Assessment done and suitable empowerment activities identified. 5-2 Proper empowerment activities identified, planned, and implemented in a timely manner.	Project Progress Reports	

4. Plan of Operations (Draft)

Strengthening Reproductive Health Project in Syria

Japanese fiscal year: April - March.

Schedule: months 9, 10, 11, 12, 1, 2, 3 | 2006: 4, 5, 6, 7, 8, 9, 10, 11, 12, 1, 2, 3 | 2007: 4, 5, 6, 7, 8, 9, 10, 11, 12, 1, 2, 3 | 2008: 4, 5, 6, 7, 8, 9, 10, 11, 12, 1, 2, 3

Expert	Field
Reproductive Health (Chief Advisor)	1 Reproductive Health (Chief Advisor) (Pink Japan)
Project Coordination/Micro Finance	2 Project Coordination/ Community Development
BCC/Advocacy	3 Behavioral Change Communication/Advocacy
HMIS	4 Health Management Information System

Experts	1	2	3	4	Activity
	X	X			Set up the project office in Manbej (procure office equipment and vehicle)
	X				Conduct RH training in Japan for major MOH officers (manager

Experts	1	2	3	4	Activity
					Output 1
Output 1	X				1-1 Assess the training needs of health service providers.
Output 1	X				1-2 Establish the performance standard on MCH&RH for health service providers at HC/HP level.
Output 1	X				1-3 Train and re-train health service providers (doctors, nurses, midwives, etc.), according to the set performance standard on MCH&RH, for strengthening the quality of services at HCs&HPs.
Output 1	X			X	1-4 Strengthen supportive supervision throug the existing Monitoring Teams, to monitor and follow-up with the health service providers who were trained and re-trained.
Output 1	X	X			1-5 Review and implement a minimum package of MCH&RH services (including family planning, referral activities, detection of cancer, respectful service provision, and adolescent-friendly health services) at HCs/HPs.
Output 1		X			1-6 Ensure and encourage the quality of MCH&RH services provided at HCs through giving recognition to the HCs which fulfilled the minimum package's requirements.
Output 1	X	X			1-7 Provides basic medical equipment for Health Centers and Health Posts.
Output 1		X			1-8 Repair major damages in major HCs and establish delivery space as necessary.
					Output 2
Output 2	X	X	X		2-1 Conduct meetings for community/religious leaders, to brief on the project and obtain their support.
Output 2		X	X		2-2 Establish Community-based Working Groups (CWG) and their workplans, in cooperation with the Health Education section in Aleppo, in order for the community members (including community and religious leaders, Women's Union, Youth Union and other stakeholders) to discuss and promote RH issues.
Output 2			X		2-3 Select Community Health Volunteers (CHVs, including Health Educators, TBAs and young people) through CWGs.
Output 2		X	X		2-4 Train CHVs through HCs to promote RH messages and contraceptives.
Output 2			X		2-5 Conduct seminars, workshops, debate sessions and home visits to increase knowledge and awareness among women, men and adolescents in the community (Monitoring).
Output 2			X		2-6 Conduct supportive supervision for CHVs through health service providers in HCs.
Output 2		X	X		2-7 Revise Behavioural Change Communication (BCC) materials for target groups, based on the findings of a Knowledge, Attitude and Practice (KAP) survey (See the activity 4-1).
Output 2		X	X		2-8 Conduct mass media campaigns with the messages on MCH&RH issues.
					Output 3
Output 3	X	X			3-1 Document the project processes and lessons learnt on a half-yearly basis.
Output 3		X	X		3-2 Disseminate the documentation of the project through media and workshops, targeting the general population and political leaders.
Output 3			X		3-3 Mobilize the media, and advocate on MCH&RH issues at the national level, to create enabling social environment and incrase support for MCH&RH.
Output 3	X		X		3-4 Organize workshops on MCH&RH issues, to target religious leaders and other influencial individuals.
					Output 4
Output 4	X	X			4-1 Conduct necessary survey, including a baseline survey, final evaluation, feasibility studies of micro-credit/literacy activities, and KAP survey. (for details see 4-1-1…6)
Output 4	X				4-1-1 Establish a framework of the baseline survey
Output 4	X	X			4-1-2 Monitor the progress and quality of the baseline survey
Output 4	X				4-1-3 Establish a framework of the KAP survey
Output 4	X	X			4-1-4 Monitor the progress and quality of the KAP survey
Output 4	X				4-1-5 Establish a framework of the final evaluation
Output 4	X	X			4-1-6 Monitor the progress and quality of the final evaluation
Output 4				X	4-2 Review and revise, as necessary, the existing HIS form and data collection/analysis/utilization procedure.
Output 4				X	4-3 Train HC/HP staff on the HIS format, data collection/analysis/utilization procedure and other necessary skills, in order to strengthen monitoring capacity.
Output 4				X	4-4 Collect data through HIS to monitor MCH&RH situations in Manbej, and utilize it effectively to enhance project management (Monitoring).
					Output 5
Output 5		X			5-1 Conduct assessment of micro-credit and literacy activities, in order to determine project activities (see 4-1)
Output 5		X			5-2 Conduct non-health activities to empower community members, according to the findings of the assessment.

５．PCM Workshop 参加者リスト

#	氏　名	所属先	備　考	
1	Dr. Wadah Al Houssein	PHC Manager	Aleppo	M
2	Dr. (Mrs.) Laqa'a Hallaq	Director of Reproductive Health Section Aleppo	Aleppo	F
3	Dr. Ahmad Sheikh Ahmad	Director of Manbej District Health Center	Manbeji	M
4	Dr. Ahmad Al Aboud	Director of Abo Kalkal Health Center	Manbeji	M
5	Dr. Imad Mohmand Nour El Dein	Director of Al Osajili Health Center	Manbeji	M
6	Midwife Aziza Kurat Ahmad	Abo Kalkal Health Center	Manbeji	F
7	Midwife Samar Hasson	Al Farat Health Center	Manbeji	F
8	Midwife Refaat Othman	Al Mabdom Health Center	Manbeji	F
9	Midwife Soumeiti Sheikh Dahdo	A Trainer for the Traditional Bath Attendance	Aleppo	F
10	Midwife Mervat Sawas	Leader of Trainers Team of TBA	Aleppo	F
11	Abdalah Mustafa Al Shami	Al Awqaf Ministry "Religion"	Aleppo	M
12	Suha Tabara	Senior Leader of Althoura Youth Department	Aleppo	F
13	Mohamad Abdel Rahnan	Althoura Youth Department	Manbej	M
14	Mary Iskander Adam	Senior Leader of Women Federation	Aleppo	F
15	Manar Al Batoucha	Women Federation	Manbej	F
16	Ayeda Jamous	Local Coordinator of Aleppo, SFPA	Aleppo	F
17	May Abi Salama	Senior Leader of Agriculture Instructor, Ministry of Agriculture	Aleppo	F
18	Amina Al Issa	Agriculture Instructor, Ministry of Agriculture	Manbej	F
19	Hala Haki	Midwives Laborer Union	Aleppo	F
20	Doha Al Monjaed	Midwives Laborer Union	Manbej	F

補足：２月３日に受領したアラビア語の出席者リストをもとに翻訳。
Manbej と Manbeji は同じマンベジ郡を指すと思われる。
F: 女性、M:男性

名称	Manbej Health Center	Abo Kalkal Health Center	Al Khafse Health Center	Maskane Health Center
所長	Dr. Ahmad Sheikh Ahmad	Dr. Ahmad Abord	Dr. Mahmound Al Abd	Dr. Samar Al Abdallah
施設	施設は約 70 年前に建設され、その後、建て増しを繰り返してきたとのこと。１階平屋建て。	１階平屋建て。	１階平屋建て。	１階平屋建て。
ベッド数	無し	無し	無し	無し
診療曜日・時間	日曜日～木曜日は AM8 時～PM3:30。金曜日と土曜日は休診。	日曜日～木曜日は AM8 時～PM3:30。金曜日と土曜日は休診。	日曜日～木曜日は AM8 時～PM3:30。金曜日と土曜日は休診。	日曜日～木曜日は AM8 時～PM3:30。金曜日と土曜日は休診。
医療従事者数	25 名。(内訳は医師 3 名、歯科医 4 名、看護師 2 名、看護助士 11 名、助産師 2 名他)	8 名。(内訳は医師 2 名、歯科医 2 名、看護師 1 名、助産師 2 名他)	9 名。(内訳は医師 1 名、看護師 0 名、助産師 5 名、助産助士 2 名他)	15 名。(内訳は医師 1 名、歯科医 2 名、看護師 4 名、助産師 2 名、助産助士 1 名、事務員 2 名、運転手名 1 他)
医療サービス、外来患者数、産前ケア、産後ケア等	外来患者数は約 27,000 人／月。 対象人口は約 150,000 人である。 産前ケアは同センターで行われている。Pregnancy Room が同センターにあり、妊産婦の体重測定、血圧測定等を行っている。 自然分娩センターは、アレッポにあるがマンベジにはない。自然分娩の多くは自宅分娩である。 産後ケアは同センターで行われていない。 リファラルシステムはほとんど機能していない。妊産婦に異常があれば、直接、マンベジの公立病院へ行く。同センターの医師が妊産婦の異常を発見した場合、レターを書いて、マンベジの公立病院に患者を紹介することは、たまにあるが記録がない。 毎月木曜日に各ヘルスセンターの所長が同センターに集まり、会議を開いている。各ヘルスセンターの	外来患者数は約 30 人／1 日。ただし、毎週月曜日は予防接種のため、約 70～80／1 日の外来患者がある。 対象人口は 9,047 名である。 産前ケアは同センターで行われている。妊産婦の異常をチェックしている。異常があれば、妊産婦は病院へ行く。家族計画も行っている。 同センターは健康教育が弱い。母親の授乳が不十分なため、ミルクを使用している。その調合等について、医師が指導している。 産後ケアは同センターで行われていない。 リファラルシステムは 4 件／月ほどある。同センターの医師が妊産婦の異常を発見した場合、レターを書いて、マンベジの公立病院に妊産婦を紹介しているが、記録がない。 保健情報システムとして、乳幼児の予防接種ファイル、リプロダクティブヘルス関連の検診ファイル、家	外来患者数は約 200 人／日である。 対象人口約 15,000 名である。 妊産婦検診は 101 人、家族計画 86 件、Pap Smear 検診 5 件 (2005 年 1 月の実績) 同センターには伝統的出産介助者(TBA)はいない。 産前ケアは同センターで行われている。 リファラルシステムは弱い。同センターの医師等が妊産婦の異常を発見した場合、レターを書いて、マンベジの公立病院、あるいはアレッポの病院に妊産婦を紹介している。件数は多くはない。記録もない。助産師は、時々、妊産婦の異常が分からないことがある。 同センターの助産師は勤務時間後に、プライベートで自宅分娩を有料で助けている。その金額は 1 回 3～4 時間で 1,000 シリアポンド(約 2,000 円)である。	外来患者数は約 200 人／月である。 乳幼児の予防接種に約 1,500 人が来る。(2004 年 1 月の実績) 対象人口は約 130,000 名である。 リファラルシステムは活発ではない。同センターの医師等が妊産婦の異常を発見した場合、医師がレターを書いて、マンベジの公立病院に妊産婦を紹介することがある。件数は多くはない。記録もない。同地域からマンベジの公立病院は遠い。 家族計画は 110 件／月の実績がある。 同センターの助産師は 8 時間勤務の 2 交代制をとっている。 検査機材が必要である。 妊産婦のプライバシーを守る部屋がない。 保健情報システムとして、乳幼児の予防接種ファイル、リプロダクティブヘルス関連の検診ファイル、家族計画登録者ファイル等がある。

	問題点、要求されたサービスのレベルに達していない場合の原因追究、STD 等の病気について話し合う。2 ヶ月に 1 回くらい、Supervision を行っている。各ヘルスセンターのサービス不足等があれば、同センターの Dr. Ahmad Sheikh Ahmad が出向いて原因追究する。アレッポ保健局の Dr. (Mrs.) Liqa'a Hallaq と Dr. Ahmad Sheikh Ahmad は、約 3 ヶ月に 1 回の割合いで Supervision にマンベジに出かけ、リプロダクティブヘルスに関する問題を話し合っている。 保健情報システムとして、乳幼児の予防接種ファイル、リプロダクティブヘルス関連の検診ファイル、家族計画登録者ファイル等がある。	族計画登録者ファイル等がある。妊産婦のプライバーを守る部屋がないことが問題。とくに Pap Smear 検診時。	保健情報システムとして、乳幼児の予防接種ファイル、リプロダクティブヘルス関連の検診ファイル、家族計画登録者ファイル等がある。	
主な既存機材	乾熱滅菌器、体重計 (ゼロ点調整ができないが、体重は測定可能)、血圧計、婦人科検診台、聴診器、車輌(所長の専用車)、冷蔵庫他。いずれも稼動する。	乾熱滅菌器(2 台)、体重計(ヘルスメータ型)、新生児用体重計、血圧計、婦人科検診台、歯科ユニット、冷蔵庫、聴診器他。いずれも稼動する。	乾熱滅菌器、婦人科検診台、身長・体重計、冷蔵庫他。	車(所長専用車)、乾熱滅菌器、身長・体重計、婦人科検診台 2 台(うち 1 台は老朽化)、冷蔵庫(老朽化、10 年以上使用)ほか。
医薬品の供給	3 ヶ月ごとにアレッポ保健局から医薬品が供給される。 在庫している医薬品の数量は足りている。金属製ラックに医薬品は置き、接種用医薬品は冷蔵庫に保管。ただし、患者の疾病に合わせた医薬品は、通常、アレッポの保健局から供給されるものに無いことが多いため、医師がその都度、レターを作成して、アレッポの保健局に要求している。入手に数週から数ヶ月、あ	3 ヶ月ごとにアレッポ保健局から医薬品が供給される。在庫している医薬品の数量は足りている。金属製ラックに医薬品は置き、接種用医薬品は冷蔵庫に保管。	3 ヶ月ごとにアレッポ保健局から医薬品が供給される。在庫している医薬品の数量は足りている。金属製ラックに医薬品は置き、接種用医薬品は冷蔵庫に保管。	3 ヶ月ごとにアレッポ保健局から医薬品が供給される。在庫している医薬品の数量は足りている。金属製ラックに医薬品は置き、接種用医薬品は冷蔵庫に保管。

	るいは、まったく入手できないことがある。			
道路状況	アレッポからマンベジ郡までは、幹線道路が通じており、約 90km 離れている。車で約 1 時間。片側 2 車線の高速道路である。マンベジ郡は一般道路が整備され、舗装道路である。	Manbej Health Center から同センターは南東側に位置し、車で約 20 分かかり、その間は一般道路で舗装されている。	Abo Kalkal Health Center から同センターは、さらに南下し、車で約 40 分。その間は一般道路で舗装されている。	Al Khafse Health Center から同センターは、さらに南下し、車で約 40 分。その間は一般道路で舗装されている。
問題点	建物が老朽化しており、雨漏りをする個所がある。 医療従事者が不足している。医師 4 名(小児科、婦人科)、看護師 6 名、助産師 6 名が必要である。 医療従事者が移動するための車輌がないため、診療活動等に不便である。 現状では、たとえば医師が外出する場合、タクシーやバスを利用している。保有している車輌 1 台は所長が主に使用している。 医師はマンベジ郡に在住ではなく、6 ヶ月ごとに移動する仕組みとなっており、患者にとっては不都合である。説明によると、医師は 6 ヶ月間、Health Center に勤務すると、病院・クリニックに戻るとのこと。 時間外の患者は、医療費の無料な公立病院か、あるいは有料のクリニックへ行く。交通手段はバス、タクシー、自家用者等を利用する。 緊急時は、110 に電話をかけて救急車の到着を待つ。救急車は１台のみ配備され、約 20 分～30 分、1 時	住民の同センターへの利用日に偏りがある。ある日は同センターが患者であふれ、ある日は患者が少ない。このため、予防接種に使用する薬剤の無駄が発生する。たとえば、一つの瓶の薬剤は 10 数人が使えるとすると、予防接種に来る人が少ない場合は、その薬剤は廃棄せざるを得ない。開封した薬剤は、同日に使いきる必要があるためである。 住民の住居が同地域に散在しているため、同センターへの交通手段が車輌(タクシー、バス等)に依存せざるを得ないため、不便である。 多産である。10 数人の子供を産むことも、珍しくはないとのこと。農業地帯であり、労働力を確保するために人手が必要とのこと。農業の機械化が進んでいないため、多産の問題がある。 妊産婦の検診用に超音波診断装置やラボ機材(血球計数装置、ヘモグロビンメーター等)が欲しい。 超音波診断装置の維持管理は、同センターに維持管理の技術者はいないため、製造業者の技術者をアレ	所長の話しでは、小学校の予防接種が大きな問題である。マンベジ郡では、教育省のスタッフの人数不足により、保健局が教育省にかわり、小学校の予防接種を行っている。 同センターには移動する車輌がないため、この問題を解決できていない。 説明では、保健局と教育省とは協力して、マンベジでは小学校の予防接種ができるとのこと。 機材が不足している。婦人科用として、ドップラー装置、超音波診断装置、婦人科検診台、診察ランプ等がほしい。 アレッポの保健局から、すべての種類の医薬品が供給されるわけではないので、患者の治療に必要な医薬品が不足している。患者の治療に必要な医薬品を、レターを作成して、アレッポの保健局に要求するも、入手できないことが多い。	施設が古い。 機材が不足している。超音波診断装置、ドップラー装置、コンピューター、滅菌器、婦人科検診用器具類、診察ランプ、救急検査室用ラボ機材がほしい。 所長の話しでは、超音波診断装置を使用することはできる。維持管理については、同センターに維持管理の技術者はいない。アレッポ等の製造業者の技術者を呼んで、維持管理を考えている。予算についは、アレッポの保健局で予算化は可能である。救急検査室用ラボ機材は、臨床検査技師が同センターにはいない。 Dr. (Mrs.) Liqa'a Hallaq の説明では、アレッポの Institute of Health を卒業した学生を、同センターに派遣して、検査業務をすることは可能である。 交通事故が多いため救急車がほしい。ガソリン車よりディーゼル車が燃費を比べた場合、有利である。現状では、ガソリンは約 22 シリアポンド(約 44 円)／１L、軽油は約 7.5 シリアポンド(約 15 円)／１L

	間かけて到着する。時により、救急車が来ない場合もある。	ッポ等から呼んで維持管理する。 維持管理に係る費用は、アレッポ保健局で予算化は可能との。ラボ機材を扱える臨床検査技師も、同センターにはいないため、アレッポ保健局で新たに雇用する等の手段が必要で、これも可能とのこと。		と、ガソリンに比べて約 3 分の 1 の価格である。 TBA(Traditional Birth Attendance)について、1997 年のデータによると、アレッポに約 1,640 名がいる。TBA の問題は、お産に関する知識が不足しているため、所長の話しでは、TBA は危険とみている。

Achievements of Reproductive health section in 2004

Aleppo Directorate of Health

The following information are translated from documents received from Directorate of health in Aleppo –Reproductive health section and provided by Dr. Liqaa Hallaq the head of the section.

2004.12.

Achievements of Reproductive health section in 2004

Aleppo Directorate of Health

Due to the fact that Reproductive Health programs are main part of Primary Health Care Program, all of the main principles must concentrate on :

1- The necessity of making health care accessibly for all.
2- Training the staff working in the reproductive health field.
3- Securing effective referral system.
4- Securing supportive, supervising and effective system.
5- Securing equipment, medicine, drugs and necessary logistics.
6- Using necessary techniques efficiently.
7- Necessity of the participation of local communities.

According to the above-mentioned facts the achievements in 2004 could be classified as follows:

I- In the field of training:

Staff were trained on different reproductive health programs. The training courses were approved by the central administration and is listed in the following table:

Course Name	No. of participants	Participation feature	Training period	Date
Reproductive Health	20	Midwives	5	Apr.04,2004
Reproductive Health	20	Midwives	5	Oct.30,2004
Loop Installation	10	Midwives	28	May.09,2004
Loop Installation	10	Midwives	28	Aug.22,2004
Smear	20	Midwives	3	Jul.27,2004

Under continuous training in the reproductive health, many training courses were conducted in several fields:

A- In the field of Information System:

District	Place	Date	Midwives	Gynecologists
First district	Khaled Bin Al Waleed Center	Jun.09,2004	6	7
Second District	Azzabdieh	Jun.13,2004	7	4
Third District	Al Firdos	Jun.15,2004	8	8
Fourth district	Al Malek Addaher	Jun.17,2004	5	7
I'zaz	E'zaz	Jun.21,2004	16	0
E'freen	E'freen	Jun.23,2004	19	0
AL Bab	AL Bab	Jun.27,2004	15	0
Jarablos-Ein Al Arab- Manbej	Manbej	Jun.29,2004	32	0
Assfira	Assfira	Jul.04,2004	11	0
Sam'aan (East)- Sama'an (West)	Bab Annairab	Jul.06,2004	28	0

B- In the logistic field: Store keepers of health districts were trained on how to estimate the health district's needs of reproductive health tools and equipment.

* The following staff were trained in the city center:

Name of the course	Participants No.	Position	Place of work
Cervix- scopy	2	Doctors	Comprehensive clinics center
Reading and coloring cervix smear	1	Laboratorian	======
Activating courses on reading and coloring cervix smear	3	Laboratorian	Khaled Bin Al Waleed Center

The following table clarifies the distribution and actual number of Midwives in health districts that provide reproductive health service in the centers:

District	Population	Total Centers	Women in Reproductive Age	Pregnant	Family planning	Gynecologists	Total Midwives	RH Midwives	%
First	530901	6	121842	18369	45764	7	24	11	46 %
Second	468442	7	107507	16208	40380	4	35	19	54 %
Third	489262	8	112286	16928	42174	8	33	15	45 %
Fourth	593361	5	136176	20530	51148	7	28	15	53 %
E'freen	213900	16	49090	7401	18438	0	27	22	81 %
E'zaz	245945	19	56444	8510	21200	1	33	27	82 %
Al Bab	277713	15	63735	9609	23939	0	32	26	81%
Manbej	351795	17	80737	12172	30325	0	30	17	56.6 %
Jarablos	58872	5	13511	2037	5075	0	7	6	85 %
Ein Al Arab	212343	10	48733	7347	18304	1	16	9	56 %
Sama'an East	148158	11	34002	5126	12771	0	37	15	40 %
Sama'an (West)	153170	13	35153	5300	13203	0	30	10	33 %
Total	177222	15	40672	6132	15277	0	36	16	44 %
	3921083	146	899899	135669	337997	32	368	208	56 %

The following table shows years when the staff training on RH program started and its rate out of the total staff until 2004 and according to kind of training:

Year / course	1997	1998	1999	2000	2001	2002	2003	2004	Total	%of the total Midwives 368	% of the RH staff (Midwives) 208
RH	19	18	44	80	20	40	40	40	301	81.70%	144%
Loop Installation	7	20	0	0	30	10	30	20	117	31.70%	56%
Smear	0	0	26	40	35	20	40	20	181	49%	%

II- in the field of enhancing Reproductive Health programs:

1) Family planning

This service is offered at all of the health centers which reached at the end of 2004 /146/ centers. All of the contraceptives are available as the central administration is supporting the centers regularly after studying the supplying situation quarterly.

Married un pregnant women in Aleppo at the end of 2004 were 8.61% of the total population (3921083). Number of un pregnant married women was (337997) ladies. At the end of Oct.2004, 104354 ladies visited the health centers to receive Family Planning measures (30.87%) and the total number of new registered ladies was 27657 ladies.

The following table shows the activities of family Planning in the health centers in the last three years:

Year	2002	2003	2004
Targeted Ladies for Family Planning	348105	37898	337605
Number of ladies benefited of FP	84782	97350	104354
Number of new ladies	25727	32296	27808
Coverage rate	24.36	29.65	30.87

(2004 data is until end of October)

The rate of family planning methods demands by the new beneficiaries was:

Method	Simple Bills	Complex Bills	Condoms	Loops	Foam tablets	Muscular Injection
Total No. of new ladies						
Demand of method	29%	33.9%	7.05%	24.50%	3.93%	4.14%

According to the Strategy of promoting the usage of loops, the following table shows the rates of loops usage in the previous years:

Year	2001	2002	2003	2004
Number of Beneficiaries	4754	5172	6355	6161
Newly registered with Family Planning	21904	25727	32296	27808
Demand on Loops installation	21.7%	20%	19.6	22%

(2004 data is until end of October)

2) Pregnant care:

A- This service is characterized by the fact that ladies are visiting private sector's clinics to receive pregnant care service as necessary equipment are available (Echo-Doubler..) And some times the lady may receive other treatment such as regular laboratory tests and others.

B- Beneficiaries are still not completely satisfied with the offered services due to several reasons:

* un availability of appropriate clinics.
* unavailability of Air-conditioning or heating systems.
* Laboratory tests are not available in the same center.

* Referral centers are not available in rural areas because staff and equipment are not available .

Natural Birth centers are not available in rural areas where clean and safe delivery can be obtained . Such centers can contribute in reducing the pressure on Government hospital and al Basel University Hospital .

* Shortage in Midwives number as only 56% of the total staff are working the field of reproductive health. In Rural Areas only /148/ midwives are serving /120/health centers. In addition most of the staff are not from local inhabitants and this usually leads to un observance of working hours that causes an obstacle in front of the execution of health care programs in general and reproductive health programs in particular.

Also pregnant number exceeded the data of previous years and the following table clarifies this fact:

Year	2001	2002	2003	2004
Rate of Women in reproductive age (out of total number of population)	22.9%	22.94%	22.94%	22.94%
Rate of pregnant women	3.4 %	2.72%	2.72%	3.47%
Rate of Married non pregnant	0	9.36%	9.36%	8.61%
Rate of Married women	0	12.08%	12.08%	12.08%

Targeted ladies in comparison with last years:

Year	2001	2002	2003	2004
Rate of pregnant (out of total population)	3.4%	2.72%	2.72%	3.47%
Targeted by Pregnant care programs	128489	101159	110134	136062

Coverage rate was:

Year	2001	2002	2003	2004
Visitors	23736	47471	35346	28231
New pregnant	9790	7197	13413	11665
Pregnant care coverage rate	7.62%	7.11%	12.7%	8.60%

The average of pregnant visits at the end of October 2004 was /2.4%/ , high risk pregnancy 16.32%. Practically no changes on the rate of coverage of pregnant care occurred in the last years.

III- in the field of early examining of feminine cancers:

A- Early inspection of cervical cancer:

Number of centers that offer the service of cervix smear till the end of October 2004 were /124/ centers . It shows that /25 / centers were increased and distributed in rural and urban areas.

The following table shows places where this service is offered till the end of 2004:

Area	Total number of centers in the area	Centers that offer smears	Remaining centers	Rate of centers that offer this service	Rate of centers that do not offer this service
First Area	6	5	1	83.3 %	16.6 %
Second Area	8	8	0	100 %	0
Third Area	8	7	1	87.5 %	12.5 %
Fourth area	5	5	0	100 %	0
Total urban	27	25	2	92 %	7 %
E'fren	16	12	4	75 %	25 %
E'zaz	19	13	6	68.4 %	31.5 %
Al Bab	15	15	0	100 %	0 %
Manbej	17	17	0	100 %	0 %
Jarablos	5	5	0	100 %	0 %
E'in al A'rab	10	1	9	10 %	90 %
Assfira	11	9	2	81.8 %	18 %
Sama'an (E)	12	12	0	100 %	0 %
Sama'an (W)	15	15	0	100 %	0 %
Total rural	120	99	21	82.5 %	17.5 %
Total Governorate	146	124	23	84.4 %	15.7 %

The expansion in the smear service is due to the training courses which were approved by the central administration and the following table shows the health centers expansion:

Year	1999	2000	2001	2002	2003	2004	Total
Number of centers	14	16	32	12	25	25	124

Number of beneficiary ladies of this service in the last years:

Year	1999	2000	2001	2002	203	2004	Total
Number of beneficiaries	120	1857	2559	3873	2868	6458	17735

The head of the Reproductive Health section is directly observing the smear service when it is at the health center until the result is delivered to the lady. This procedure is taking place weekly in the urban areas and monthly in rural ones. Smears are collected and transferred to laboratories for coloring, then to the anatomy laboratory at Ibn Annafis hospital.

Number of smears according to health districts in the last years:

Year	2001	2002	2003	2004
First district	616	680	404	582
Second district	207	329	195	942
Third district	276	599	382	902
Fourth district	427	519	637	883
E'freen	149	187	214	358
E'zaz	207	334	353	627
Al Bab	62	222	182	528
Manbej	0	67	69	97
E'in al Arab	67	34	49	94
Jarablos	0	0	8	64
Assfira	120	262	254	379
Sama'an (E) Sama'an (W)	0	133	121	477 525
Syrian Family Planning Association	427	507	0	0
Military Hospital	35	0	0	0
Total	2559	3873	2868	6458

The following table shows the total smears tests in the third (third) of 2004:

Total	Irregular smears	Natural smears	Inflammatory smears	Marginal changes	Un accepted for evaluation
6458	37	364	5487	267	303

Distribution of irregular smears:

Total	Mal Production (Simple)	Mal Production (Medium)	Mal Production (Severe)	Epithelium Cancer	Cancer	Glandular Cancer
37	35	1	1	0	0	0

Percentage of Smears analysis:

Total Number	Un acceptable for evaluation	Normal	Inflammable	Marginal Changes	Irregular
6458	4.6%	5.6%	84.9 %	4.1 %	0.5 %

The following table shows number of laboratorians trained on reading and coloring smears and it also clarifies places of reading and coloring the smears in the health centers:

District Name	Number of technical staff	Number of centers	Number of trained staff
First district	3	2/ (Khaled Bin Al Waleed, Associations)	3
Second district	1	1/ Bustan Al Qaser	1
Assfira	1	1/ Assfira	1
Total	5	4	5

Number of doctors specialized in anatomy/4/ at Ibn Rushd Hospital.

B- Cervix scopy

The following table shows doctors and the places where cervix scopy is presented in the health centers:

District	Center	Authorized doctor	Date of starting job	remarks
First district	Associations	Ali Asfour Waleed Qabalawi	2000	
Second district	Bustan Al Qaser	Salah Abdo	2004	Equipment does not work
Fourth district	Al Malek Al Daher	Riyad Adam Yaman Khanji Sita Mkardeej	2003	

The following table shows training staff on cervix scopy during the last years:

Year	2000	2001	2002	2003	2004
Number of centers	1	1	1	2	2
Number of trained doctors	2	1	1	3	4
Number of scopy cases	50	108	128	82	102

Number of ladies who did the cervix scopy at the end of October 2004 were 102 ladies according to the following table:

Place of service	New	Follow-up
Associations	22	24
Al Malek Al Daher	28	28
Total	50	52

- In the field of referral system:
Most of the standards of the referral system in the field of Reproductive Health were completed in the approved centers according to the following table:

Referral Center	Gynecologist	Trained midwives	Smear service	Laboratory	Echo	Cervix scopy	Natural Birth
+	+	+	+	+	+	-	-
+	+	+	+	+	+	+	-
+	+	+	+	+	+	-	-
+	+	+	+	+	+	+	-
+	+	+	+	+	+	-	-
+	+	+	+	+	+	+	-
+	+	+	+	+	+	-	-
+	+	+	+	+	+	+	+

Referral system depends on transferring ladies according to approved standard cards, it was clear that most of the cases were transferred to receive echo and cervix scopy services. The following table shows number of ladies who received echo in referral centers till the end of 2004:

Center	Khaled Bin Al Waleed	Associations	Al Shuhada'a	Bustan Al Qaser	Al Firdos	Al Malek Al Daher	Hanano/Clinics	Al Waha
Number of beneficiaries (pregnant)	487	564	128	550	372	197	208	117
Beneficiaries (non pregnant)	19	55	35	600	126	13	100	4
Total	506	624	163	1150	498	210	308	121

The following table shows the total number of referred cases for receiving echo compared by last years:

Center	Khaled Bin Al Waleed	Associations	Al Shuhada'a	Bustan Al Qasr	Al Firdos	Al Malek Al Daher	Hanano/ Clinics	Al Waha	Total
2001	215	542	0	0	0	0	0	73	830
2002	528	791	44	0	72	278	0	751	2464
2003	582	586	85	0	369	554	0	510	2686
2004	506	624	163	1150	498	210	308	121	3575

(0) means that the center does not start working with referral system.

The following table shows ladies that received echo service during pregnancy and also for non pregnant for previous years compared by this year:

Year	2002	2003	2004
Number of pregnant referred ladies	2054	2353	2623
Number of non pregnant referred ladies	410	333	952
Total	2464	2686	3575
Number of referral centers	6	6	8

IV- In the field of Natural Birth:

Activities of Natural Birth center till the end of October 2004:

Month	Number of deliveries	Number of referred cases after delivery	Number of live born	New born mortality	Maternal Mortality
January	51	0	51	0	0
February	39	0	39	0	0
March	39	0	41 (twins)	0	0
April	40	2	40	0	0
May	30	0	30	0	0
June	30	0	30	0	0
July	42	0	42	0	0
August	42	2	42	0	0
September	23	0	23	0	0
October	30	0	31(twins)	0	0
November	20	0	20	0	0
Total	386	4	389	0	0

The following table shows the performance of natural birth center since started working till the end of October 2004:

Year	1999	2000	2001	2002	2003	2004
Number of deliveries	76	262	254	430	498	386

V- In the field of supervision and follow-up:

Evaluation and supervision are considered the main elements in determining the quality of health services and contribute in implementing and securing the success of reproductive health programs. The good results achieved in raising the reproductive health indicators are due to the good coordination with other primary health care sections. Special application was designed to evaluate the performance of the staff of the health centers.

The following table shows visited health districts and the frequent supervision:

District	Date of supervision	Places of supervision
E'zaz	12/2 – 16/2/2004	Al Zahraa, Nubol,E'zaz, Mangh, Mare', Um Hosh Tal Rif'at
Al Bab	29/2-1/3/2004	Al bab, Tadef,A'rran,E'isha, Bazza'a, Qabassin
Assfira		Al Waha
Sama'an (East)	14/3/2004	Al Wadihi, A'bteen, Al Hader, Balas,
E'freen	8/8/2004	Midanki, Bulbol,Deir Swan, Sharran, Kafr Janeh
Sama'an (East)	10/8/2004	Al Wadihi, A'bteen, Al Hader, Al E's , Al Zurbeh
Manbej		Manbej, Abu Kahf, Ausajli
Ein Al Arab	14/9/2004	E'n Al Arab,Al Ghasanieh, Arslan Tash,Kharabnas
Assfira	22/9/2004	Tal Hasel,Tal A'rn, Al Waha, Assfira
Sama'an (East)	12/10/2004	Al Zurbeh,Azzammar,Jazraiya,Tal Adaman,Al Batraneh,Al e'es
Al bab	23/10/2004	Qabaseen,Bza'ah, Tadef, E'ishah

VI- Reproductive Health education:

Health education is considered the backbone of the primary health care programs and also for reproductive health.

It was noticed during the past few years that it is necessary to cooperate with popular organizations in this field. Reproductive health awareness programs resulted increase in some indicators.

Hereunder we show the activities of health education in the field of reproductive health during 2004:

I- Training:

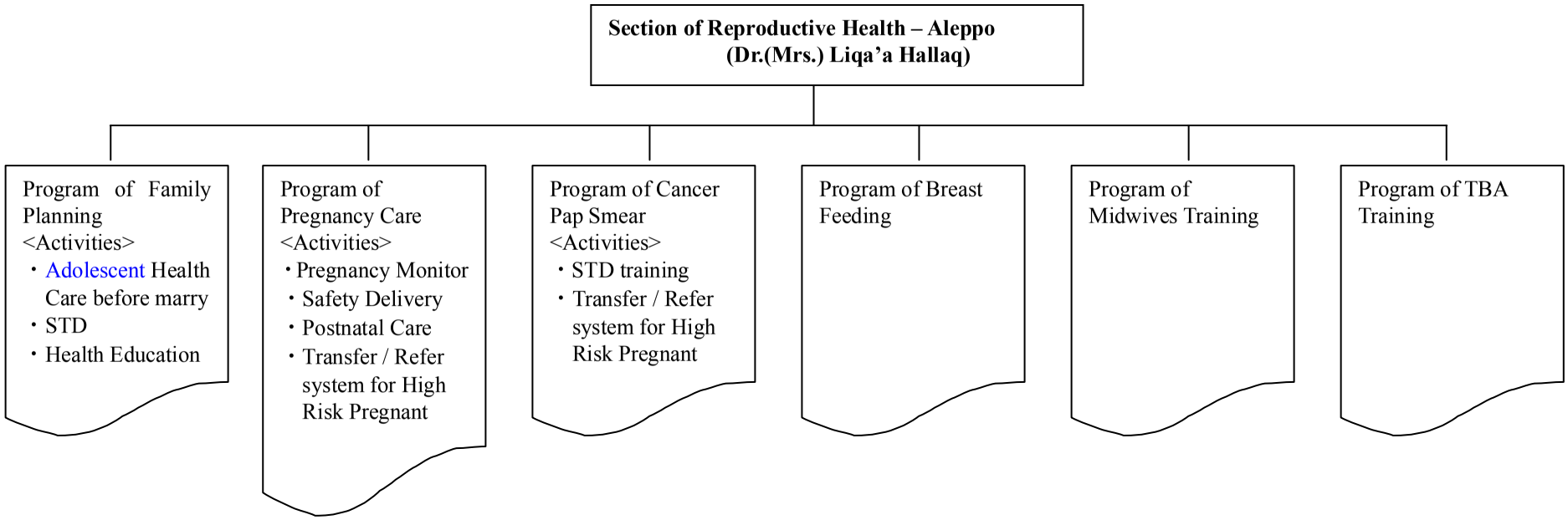
1- Training course for health educators and representatives of women federation and youth federation concerning enhancement of adolescent health (two days 11-123/5/2004).
2- Training on enhancement behaviors and supporting men's contribution in the field of reproductive health for health educators (1-2-3/8/2004).
3- Training course concerning enhancement of adolescent health (three days) in cooperation with Women Federation / Nov.07,2004.
4- Regular meeting for the selected committees of health districts attended by the head of health education section at MO Health Dr. Mousa Shamieh and committees from youth federation, Women federation, Education, agriculture and doctors (31/3/2004)- (13/5/2004).

II- Seminars:

1- Smoking and its effects on pregnant ladies.
2- Balanced nutrition and the importance of physical exercises (23.09.2004).
3- Seminars and lectures in youth camps related to smoking and medical exams before marriage in addition to adolescent health and sexually transmitted diseases .

Number of reproductive health lectures at all of the health centers in the governorate till Sep.30,2004:

Number of lectures	Number of attendants	Number of lecturers
2508	35671	1686



Family Planning	Goals	1) Training for midwives on how to use IUD tools 2) Contraceptives (it means pills, injection, IUD, foam, condoms, etc.)to be offered and delivered 3) Study Supply Situation of Contraceptives 4) To have a full staff 5) Control and Monitor of activities of each Health Center that they deliver IUD, condoms, etc. 6) Evaluation, and checking tools (IUD, etc.) and medical equipment (Hot Air Sterilizer, Examining Light, ect.) 7) Health Education
	Target	Non pregnant ladies：337,998 people (8.61% of Population of Aleppo) Achieved Numbers：103,920 (in 2004) Achieved Percentage：30.75% (in 2004) The reason of not achieving full target numbers： - There is private sector (e.g. Doctor's Clinic, private hospitals) sharing and offering the facilities for non pregnant ladies. - Also, some ladies check with other clinics such as SFPA (Syrian Family Planning Association), High Education, Hospitals, and others (e.g. Military Hospital).
Adolescent Health		There are making Health Education only.

		Dr.Liqa'a wants them each Health Center must have Adolescent Care who is separated out doors through which the Adolescent check in, and get advices, instructions, and reply to their questions and problems.
STD		There is only Health Education on STD for midwives and nurses, and check in ladies at Health Center. Also, in case of any suspect of having STD case, it will be referred and transferred to specialized program. This due to lack of staff and laboratory on Health Centers Level.
Health Education		Inside Health Center ：through direct connection of doctors, nurses, midwives with patients doing treatment, and informing patients about contraceptives and how to use, also through video demonstration. Outside Health Center：through technical cooperation with other groups such as SFPA, Laborer Union, Youth Union, Agriculture Instructors, etc. Video demonstration at hall of other center, at halls of some companies, at hall of Women Federation, and so on. 3 Types of education：pap smear, IUD, and Reproductive Health
Pregnancy Care	Goals	1) Check, clinical check on pregnancy concerning their health and pregnancy development, as cervix height and patient weight, and so on. 2) Applying necessary blood testing at concerned referral center：blood groups, hematocrit value, urine, etc. 3) To check if it is a natural pregnancy or high-risk pregnancy 4) If there is any high-risk pregnancy, she'll be sent to one of 5 Referral Centers at Aleppo. 5) To be sure that the deliver will be natural delivery
	Target	Target Numbers：135,669 people (3.47% of Population on Aleppo) Achieved Numbers：13,444 people (covering a rate of 9.91%) The reason of not achieving full target numbers： - 80% of the pregnant ladies will go to the Private Sector (e.g. Doctor's Clinic, Private Hospitals), as there are Ultrasound Apparatus , specialized Doctors, and Laboratories. Because, in Health Centers there is lack in necessary equipment, and sometimes no pills for animia prevention. - Postnatal care：Visit at home by midwives at rural area offering necessary vaccination to the birth providing the mother with contraceptives and breast feeding instructions.
Cancer Pap Smear	Goal	1) To reduce the cervic cancer cases of affected ladies through having a cervix pap smear from ladies whom didn't get from them previously any pap smear. 2) The program started at end of year 1999. 3) The number of Health Centers providing this service at end of year 2004 was 124 Health Centers out of 146. 4) Training had been offered to midwives such as how to fix pap smear through certain tools. 5) Then these pap smear will be collected from all Health Centers, and will be sent to the concerned laboratories： - Al Jameiat Center -Khaled Ibn Al Waleed Center -Safira Center at Safira Also, there is another laboratory under construction at Bustan Al Kaser. The suspected pap smear will be sent to Ibn Rushd Hospital where there are 4 specialized doctors. The results will be returned to the Health Centers, and then to the checked ladies through the Health Center. There are two Health Centers, Malak Al Daher Health Center and Al Jameiat Health Center, doing the "Colposcope".

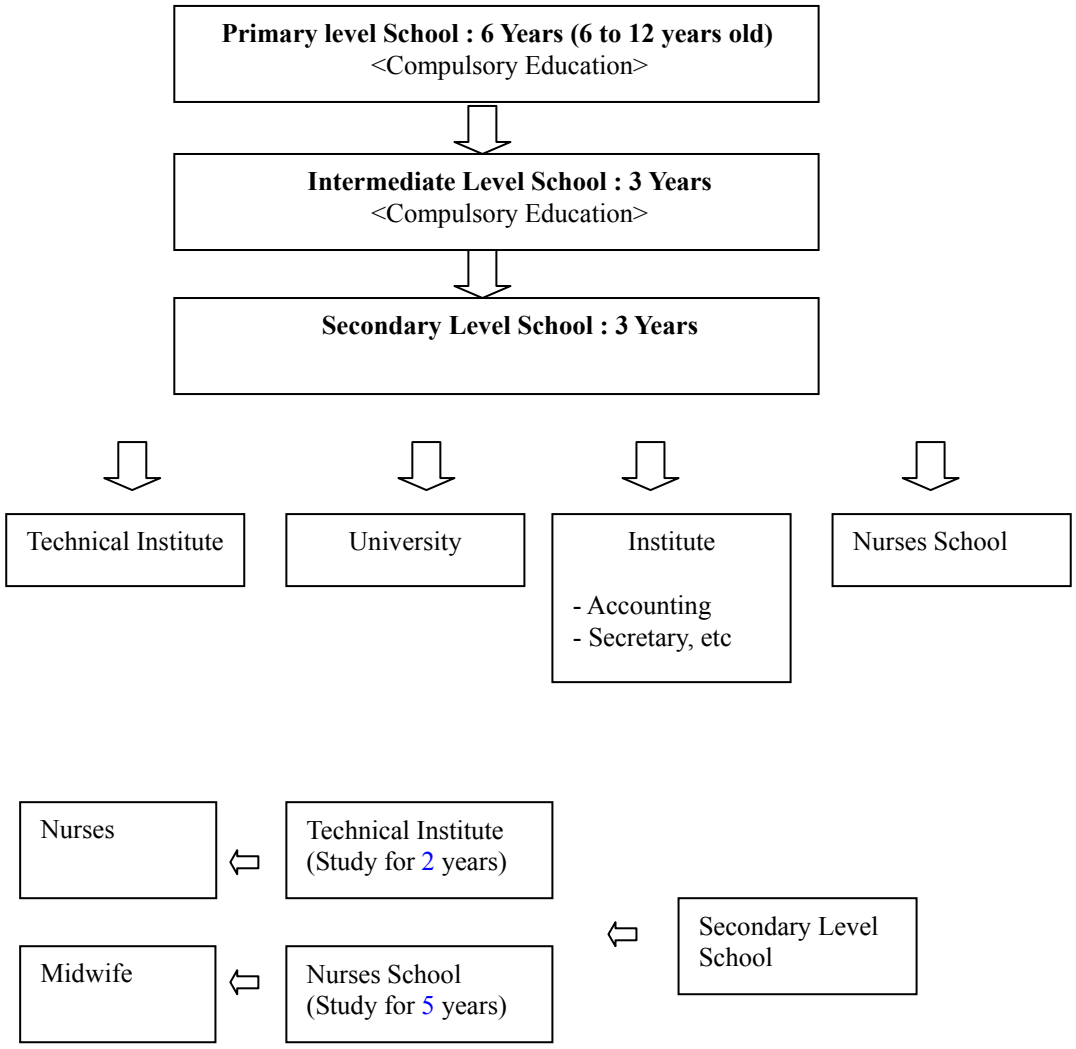
<table>
<tr><td></td><td></td><td>6) This aspect pap smear had been promoted through the Health Education to instructors.</td></tr>
<tr><td></td><td></td><td>Increasing ration of pap smear (cervical cancer)
<table>
<tr><td>Year 1999</td><td>1999</td><td>2000</td><td>2001</td><td>2002</td><td>2003</td><td>2004</td><td>Total</td></tr>
<tr><td>Beneficiaries</td><td>120</td><td>1,857</td><td>2,559</td><td>3,873</td><td>2,868</td><td>8,236</td><td>19,513</td></tr>
</table></td></tr>
<tr><td></td><td></td><td><Difficulties>
No enough specialized laboratory technicians
No laboratory available in each area for testing and reading the pap smear, especially in rural area.</td></tr>
<tr><td>Breast Cancer</td><td>Goal</td><td>1) Preparing the Program to start activities within 2005
2) We got two “Mammography Units”, one at Al Jameiat Health Center, and another one at Al Malek Al Daher.
3) We are applying training for midwives.
4) Preparing necessary data system, records, and cards.
5) Current referral cases is done by sending patients / ladies to Ibn Al Rushed Hospital where the “Mammography Unit” is available.</td></tr>
<tr><td>Breast Feeding</td><td>Plan</td><td>There is specialized program for breast-feeding and Dr. Amal is responsible on this aspect.
But, the Section of Reproductive Health assist as following;
- Through Health Education at Health Centers, the midwives team, home visits assuring on mothers importance of breast-feeding and how to follow the breast-feeding.
1) To inform and data employ
2) To enter the received figures into Computer and in the program software.
For all subjects and jobs which will be analyzed by Dr. Liqa’a later.
3) Team for Birth Attendance</td></tr>
<tr><td>Midwives training</td><td>Goal

Evaluation</td><td>Dr. Liqa’a is responsible on affecting all training courses relevant to Reproductive Health.
To have a well qualified trained team able to provide a good service on Reproductive Health and:
To have good skills such as procedures of fixing spiral (IUD), and how to get pap smear.
There are some measurement to know achievement rate as how much IUD affected, increased rate of check members at Health Centers and others; which all will be good indicators to know how much those trained midwives are active.</td></tr>
<tr><td>TBA training</td><td></td><td>There is a special team consists of well trained midwives, their job are:
- To keep in close contact with local society through connection between midwives team and rural local TBA, sending through them different Health Education messages.
- In case there is a Health Center and the area is covered by Ministry of Health Services, then TBA not allowed to work in this area.
There is statistics on number of TBA in Aleppo.
<table>
<tr><td></td><td>Aleppo</td><td>Manbej</td></tr>
<tr><td>Trained TBA</td><td>108people</td><td>people</td></tr>
<tr><td>Untrained TBA</td><td>921people</td><td>people</td></tr>
<tr><td>Total</td><td>1,029people</td><td>people</td></tr>
</table>
(Statistics of Aleppo in 2004)
To train the TBA on natural delivering and only in the area where is not covered by Health Centers Services.</td></tr>
</table>

Inventory List of Manbej Health Centers (till end of year 2004)

Health Center Name	Women Table	Woman Light	Blood pressure meter	IUD set	Pregnant scale	Child pulse tester	Sterilizer	Clinic table	Hand Light	Total
Im Hajar	0	0	1	1	0	0	0	2	0	4
Kaser Hadla	0	0	1	1	0	1	1	1	0	5
Kharfan	0	0	1	1	0	1	0	1	0	4
Abo Kalkal	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**2**	**0**	**9**
Osajli	1	1	1	1	1	1	1	1	0	8
Tal Al Rafei	1	0	1	1	1	1	0	1	0	6
Oun Al Dadat	1	0	1	1	1	1	1	1	0	7
Tal Hozan	1	0	1	1	1	1	0	2	0	7
Maskana Farms	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**1**	**0**	**3**
Al Mahdoom	1	0	1	1	1	1	0	2	0	7
Al Salheia	0	0	1	1	0	1	0	2	0	5
Abo Kahf	1	0	1	1	1	1	0	1	0	6
Al Khafsa	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**1**
Haymar Labda	1	0	1	1	1	1	0	1	0	6
Manbej	**1**	**1**	**2**	**2**	**1**	**1+1 (Elec.)**	**1**	**2**	**0**	**12**
Al Haya	1	0	1	1	0	1	0	1	0	5
Sad Tichreen	0	0	1	1	0	1	0	0	0	3
Maskana	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**2**	**0**	**9**
Farat	1	0	1	1	1	1	1	2	0	8
Muhtarak Kabeer	0	0	1	1	0	1	0	2	0	5
Total	12	4	20	20	12	18	7	27	0	120

9．シリア国における看護師及び助産師の養成課程



・シリアの義務教育は、従来は 6 年間であったが、2002 年から 9 年間となった。
・義務教育の 9 年は Primary level School(日本の小学校)と Intermediate Level School(日本の中学校)である。
・Secondary Level School は日本でいう高等学校に相当する。
・Secondary Level School を卒業後、Technical Institute、University 等へ進学する。
・看護師になるためには、Secondary Level School を卒業後、Technical Institute に入学する必要がある。
・Technical Institute で勉強し、卒業して看護師となる。
・助産師になるためには、Secondary Level School を卒業後、Nurses School に入学する必要がある。
・Nurses School で看護を 3 年間＋助産を 2 年間勉強し、卒業して助産師となる。

Project Document
for
Syrian Arab Republic/Japan International Cooperation Agency
Strengthening Reproductive Health Project
in Syria

September 2005

Ministry of Health, Syrian Arab Republic
and
Japan International Cooperation Agency (JICA)

TABLE OF CONTENTS

ABBREBIATION

ARH	Adolescent Reproductive Health
BCC	Behavioural Change Communication
CPR	Contraceptive Prevalence Rate
CWGs	Community-based Working Groups
EU	European Union
HC	Health Centre
HMIS	Health Management Information System
HP	Health Post
HVP	Healthy Village Programme
IEC	Information, Education, Communication
IPPF	International Planned Parenthood Federation
KAP	Knowledge, Attitude and Practice
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
M/E	Monitoring and Evaluation
MMR	Maternal Mortality Rate/Ratio
MOH	Ministry of Health
PAPFAM	Pan-Arab Project for Family Health
PCM	Project Cycle Management
PDM	Project Design Matrix
PSC	Project Steering Committee
PTC	Project Technical Committee
R/D	Record of Discussions
RH	Reproductive Health
SFPA	Syria Family Planning Association
SRH	Sexual and Reproductive Health
TOR	Terms of Reference

Introduction

Syria belongs to the Middle Eastern Region, with the population of about 17 million. In Syria, there exist large gaps in health outcomes, as well as in the wealth distribution, between urban/rural areas, sexes, and those who have achieved different levels of education. Bridging such gaps is one of policy priorities of Ministry of Health (MOH), and of the Syrian Government in general, and this issue is also addressed in JICA's Country Programme for Syria.

Within the country, health outcomes are poor in specific regions: in particular, northern and eastern regions, and rural Damascus are known to have the lowest level of health indicators. The national average of chances for dangerous pregnancies is 17.04%, however the figure deteriorates in the regions such as Hassake, Rural Damascus, and Aleppo (19.53%)[1].

In this context, the government of Syria requested Japan to support enhancing the reproductive health (RH) status of the northern and eastern regions in August 2004. Situational analysis was conducted, and MOH and JICA identified Manbej district of Aleppo region, located in the north of the country, as a target area of the new project. Manbej has relatively low an RH status, while health authorities in Aleppo are highly committed to improving RH in this area in spite of limited resources, the area is accessible from Damascus, and potential impacts of advocacy to the central level is expected.

This document concisely explains the background, and the framework of "Strengthening Reproductive Health Project in Syria", jointly implemented by the Government of Syria and JICA. The document is intended as a tool to clarify and facilitate the operations .

1 Background

2.1 Socio-economic Context

Syria belongs to the middle income countries in World Bank's category, and has $3,556 of GDP per year (ppp) . Major industries include agriculture and services.

Traditionally, Syria has a socialist social structure. However, since 2000 it has tried to strengthen its economy through opening the banking market to the private sector, and synthesizing the exchange markets, so on. But, the economy continues to be stagnant due to the low oil prices, weak administrative systems, and growing population (the current population growth is about 3%). The current economy growth rate is below 3% and the real unemployment rate is estimated to be more than 20%, therefore creation of employment is the priority of the country. In this context, poverty reduction should become a framework of the overall development assistance, and improved access to family planning services become important.

The quality of life in Syria is relatively high, comparing to other countries in the Middle Eastern Region. The life expectancy at birth is 68 years (World Bank, 2001), and 98.83% of girls enroll in primary school. However, even basic social services, such as health services and education, are not reaching rural areas, while unemployment rates are higher in such areas than in urban areas.

In rural areas women are further disadvantaged than men: as much as 65.6% of rural women have not enrolled in primary school, while 58% of male counterparts have not enrolled, and 65.1% of urban women have not enrolled (Pan-Arab Project for Family Health: PAPFAM, 2004). This appears to be due to gender gaps, intertwined with geographical gaps. Drop-out rates for girls in eastern and

[1] Statistical Report on Health Fertile Productivity Services/MOH 2002.

northern regions, the most disadvantaged rural parts of Syria, are said to be up to 50% (UNICEF, 2004).

The disadvantaged status of rural women is directly linked to their poor RH status, while poverty, lack of education, and poor RH situation reinforce each other.

2.2 Overview of the Health Sector

Syria has been executing its health policy based on “Health 5-year Plan” and “Plan of 2000-2020 of MOH”. Major actors in health include MOH, WHO, UNFPA, UNICEF, European Union (EU), Italy, Spain and Japan. Since the health conditions are extremely low in the northeastern areas, health programmes tend to give a focus to these regions.

“National Health Strategy 2000 - 2020” emphasizes the importance of promoting equitable access to health services for all people: especially for the vulnerable, including the poor and those who live in remote rural areas. MOH states that strengthening of PHC, including RH, is central to the health policy of Syria, in order to achieve this objective. The 9th National 5-year Plan (economic and social development) also addresses the necessity to fill geographical gaps in access to PHC including RH.

2.3 Reproductive Health Policy

Syria currently has a draft RH Strategy, which derived from a draft National Population Policy, and is currently under review for official approval. The draft strategy sets objectives in the following priority areas:

- ✓ Safe motherhood
- ✓ Family planning
- ✓ HIV/AIDS
- ✓ Early detection of women’s cancer
- ✓ Sterility
- ✓ Health care for women under menopause
- ✓ Adolescent and youth services
- ✓ Pre-marital health services

For safe motherhood, the objective is to reduce Maternal Mortality Rate/Ratio (MMR) to 32/100,000 live births by 2015. For family planning, two general objectives are set: Increase the utilization of modern contraceptives among married women up to 60% by 2015; and Increase the utilization of family planning in rural areas, up to the level of urban areas.

2.4 Prior- and On-going Assistance of Development Partners

Following organizations have been implementing programmes and projects in the RH field.

(1) UNFPA

UNFPA currently executes the Six Country Programme for Syria, for 2002 – 2006. For this programme, USD 10.8 million is allocated from regular resources. RH is the core of this programme, with USD 7.8 million allocated. UNFPA focuses on 25 priority districts with low health indicators, which were selected in consultation with MOH. Throughout the cooperation period, UNFPA will work on improving access to and the quality of RH services, and on IEC for RH issues.

(2) WHO

WHO took its initiative for the Healthy Village Programme (HVP), which has been part of MOH programmes. HVP is a comprehensive rural development programme of Syrian government since 1996. 15,000 villages of low health status and with a manageable size of population were selected, and PHC, basic education, and livelihood development activities have been implemented at the community level. HVP villages and UNFPA's intensive districts overlap with each other for increased synergies.

(3) Italy

Italy supports nurse schools and provides medical equipment to hospitals. It has been considering expanding HVP to Hassake Region through a local NGO.

(4) EU

EU has been providing loan for equipping hospitals in country. It has been also supporting strengthening the health sector, through the forthcoming "Health Services Modernization Programe".

(5) Syria Family Planning Association (SFPA)

SFPA is an affiliate of International Planned Parenthood Federation (IPPF), and works through 20 clinics in the country. Their clinics focus on antenatal and postnatal care, family planning, adolescent RH(ARH), and mobilization for male involvement in RH.

3 Current Situations and Challenges

3.1 Current Reproductive Health Situations

RH situations in Syria are relatively good comparing to other countries in the region. However, there are significant gaps in the coverage of essential RH services within the country, according to urban/rural residence, the wealth status and level of education.

Table: Essential RH Indicators in Syria

	Syria	**Urban Areas**	**Rural Areas**	**Target for 2015**	**References**
Total Fertility Rate for the five year prior to survey	3,8	3,4	4,4		PAPFAM 2004

Mean Number of children to women of 45-49 years	6,6	5,8	7,7		
	Total	Urban	Rural	Target 2015 for total	References
Crude Birth Rate	2,8 %				RH Sub-Programme Document 2002
Infant Mortality rate (IMR) / 1000 infants year 2001	18,1	16,9	19,2	12	National Millennium Development Goals (MDGs) 2003
Under five Mortality Rate /1000 children year 2001	17,9	22,2	20,2	13	
Maternal Mortality Rate (MMR) / 100,000 birth year 2001	65,4			32	
Proportion of births attended by skilled health personnel year 1999	86,5	93,4	81,2	100	
Rate of use FP methods among married women % year 2001	46,6			60	
Life expectancy year 2001	71,2				
Abortion Rate					Not Available
Percentage of Population less than 15 years	40,2	37,6	42,8		PAPFAM 2001
Percentage of Population older than 65 years	3,6	3,6	3,7		
Singulate mean age of marriage: Male	29,4	29,8	28,8		
Female	25,6	25,2	26,0		
Number of AIDS registers cases year 2001	14			0	National MDG 2003

Source: *Syria Strengthening Reproductive Health Project: Final Report February 2005*: 8-9 (Engineering Consulting and Management)

Within the country, northern and eastern regions, and rural Damascus region are known to be highly disadvantaged in terms of the RH status.

Aleppo Region is located in the north of the country, with 3,920,000 inhabitants. RH situations in Aleppo are well below the national average. Contraceptive prevalence rate (CPR) is 30.7% (2004) against 35.4% at the national level. 71% of deliveries take place at home, which is much higher than most other regions.

Manbej District is in the eastern edge of Aleppo, with 350,000 of inhabitants. CPR is 21.03%, which is even below the average in Aleppo region. In Manbej the access to basic RH services is limited,

because it is far from the centre, and because people are scattered. People's knowledge and capacity to adopt safe and responsible Sexual and Reproductive Health (SRH) behaviour is also limited; and People do not know what services are available. This has been leading to little utilization of existing RH services. Studies indicate that gender-based violence exists in Aleppo, and 23% of women have experienced at least three times of physical abuse in the previous year (Maziak and Asfar, 2002). However, gender issues including violence have not been openly addressed, also undermining the social environment for better RH.

3.2 Problem Analysis

During the Preparation Study in February 2005, two Project Cycle Management (PCM) workshops were conducted in Aleppo with MOH, Aleppo PHC Directorate, Health Centres and health managers and workers concerned, religious leader, and JICA. In this process, following four issues were identified as the causes of the low RH status in Manbej:

- ✓ Low utilization of family planning;
- ✓ Lack of accessible health services;
- ✓ Poverty; and
- ✓ Ignorance and illiteracy.

Lack of health services in Manbej leads to a lack of family planning services. Those who are at low educational level tend to be poor and socially marginalized. Therefore, one can conclude that people perceived that a lack of RH services and social and economic marginalization have been contributing to poor RH situations in Manbej. A qualitative and quantitative situational analysis of the Preparatory Study Team indicated that the public health services are hardly utilized, while people's knowledge on what services are available and on how to protect and care themselves for RH problems.

In conclusion, stakeholders agreed that in Manbej its RH status needs to be improved, and in order to do so, Maternal and Child Health (MCH)&RH services need to be utilized by more people. To increase the utilization of the MCH&RH services, it was agreed that 1) The quality of MCH&RH needs to be improved, 2) Behavioural change for adopting safe and responsible RH behaviour should be promoted and capacity of individuals and an enabling social environment for them should be built, and 3) Advocacy should take place at central level, to support the project in Manbej. Since the improvement of the RH status is strongly linked to the enhanced women's social status, combining literacy or microfinance activities to RH activities, was also proposed. M/E, the backbone of RH management was found to be weak, so strengthening this component as part of an RH project was also considered.

4 Project Strategy

4.1 Project Strategy

4.1.1. Scope of Cooperation

The project will focus on improving the RH status in Manbej District, Aleppo Region. Since Manbej is a relatively large district with scattered population, the project will be based in three communities, namely Manbej, Al Khafse and Maskane, where project activities will commence. Possibilities of increasing the number of the communities to directly work with will be considered when these three communities have achieved sufficient results and the project has capacity to expand. Training and

other activities which will be coordinated at the district/regional level, should cover the entire Manbej district, and those from Aleppo Region when possible.

The project will be for three years.

4.1.2. Project Sites and Target Populations

The project will target Manbej district of Aleppo region, whose population is about 350,000. Three communities (Manbej, Al Khafse and Maskane) will be the initial base of the project. Manbej district was selected for several resons. It is located in the northern part of Syria, where RH indicators are particularly poor. In addition, Manbej is highly secure for operations, and also accessible from Aleppo and Damascus where some of the stakeholders are based. Accessibility is to contribute to enhanced advocacy to the central level, which is key to the project. Last but least, Aleppo has highly committed health managers and health care providers, and is considered appropriate as a project counterpart.

Primary beneficiaries are: 1) married and unmarried women and men in the catchment area of the three communities mentioned above (approximately 41,000 inhabitants); and health workers in Manbej district (approximately 195).

Secondary beneficiaries are married and unmarried women and men of the age above 15 in Manbej, Aleppo (approximately 245,000 inhabitants).

4.1.3. Strategy

The project will employ the following strategies, in order to achieve its goal, purpose and expected outcomes:

- ✓ Strengthen Monitoring and Evaluation (M/E) for RH programming.
- ✓ Focus on the community.
- ✓ Empower the socially disadvantaged: women, rural residents, and the poor.
- ✓ Timely documentation and dissemination: Establish a Manbej model and scale up.

Strategy 1: Strengthen Monitoring and Evaluation (M/E) for RH programming.

In Syria, and in rural areas in particular, reliable data on RH situations and people's SRH behaviour is scarce, and this is a potential bottleneck for the project implementation. In order to overcome the issue of M/E, both evaluation and Health Management Information System (HMIS) need to be strengthened. At the outset of the project, Baseline Survey will be conducted, in cooperation with a professional research institution, in order to establish the current RH situations in Manbej and obtain the baseline figures for the indicators set in Project Design Matrix (PDM). The same figures will be collected at the end of the project, as Final Evaluation, in order to measure the achievements of the project.

HMIS will be strengthened throughout the project. Functional HMIS will help collect reliable service data on a day-to-day basis, which will feed into M/E of the project and help improving the project itself. Improved HMIS will also motivate health service providers, by showing the fruit of their efforts in the form of performance figures. In this project, an expert will be deployed, in order to review and improve the current HMIS in a feasible and sustainable manner, and to ensure HMIS properly functions throughout and beyond the project period. For details, see **Outcome 4.**

Strategy 2: Focus on the community.

This project structures itself as substantially bottom-up and community-based. Since the project aims at reaching out rural areas, and since improving reproductive health situations requires behavioural change in individuals and social mobilization at the community level, the initiative of the community becomes central to the success of the project. The project will be based in three selected communities, in Manbej District, which form Community-based Working Group (CWGs) chaired by the Head of Health Centre (HC). CWGs will include all relevant stakeholders in the community, and will make decisions over the project implementation on the ground. They will report to Project Technical Committee (PTC), which will coordinate the activities of three communities.

The linkages between CWGs and PTC, and those between PTC and Project Steering Committee (PSC) are also important, in order to support the efforts of the community at regional and national level, as well as to share and advocate on the lessons learnt in Manbej widely in the country.

Strategy 3: Empower the socially disadvantaged: women, rural residents, and the poor.

This project will give an emphasis on remote rural areas in the northern part of Syria. The intention is to help empowering the social disadvantaged such as women, rural residents and the poor, through a lens of RH. To do this, firstly needed is the data on health outcomes disaggregated by sex, residence, wealth quintile and other relevant parameters such as educational achievements. Such data will allow the project to identify who are disadvantaged and where they are. Secondly important is to integrate the component of reducing social gaps throughout the project activities, particularly in advocacy and social mobilization. Thirdly it is essential to involve those who are advantaged, as well as the disadvantaged, in order to change the social structure that perpetuates inequalities. This will be done through advocacy and social mobilization activities.

The Baseline Survey should become the first entry-point, by identifying who are disadvantaged to what extent, and how the project should tackle the problems.

The livelihood component is expected to facilitate filling the social gaps, which are affecting health gradients, synergistically contributing to the improved RH status.

Strategy 4: Timely documentation and dissemination: Establish a Manbej model and scale it up.

This project is formulated as a pilot, and may be scaled up within Aleppo Region, once the effectiveness of the approach becomes verified and the project considers that it has sufficient capacity to expand. Lessons learnt of the project are expected to be used in and outside of the project period for scaling up of the approaches.

Timely documentation and dissemination of project processes and lessons learnt are keys for this strategy. Documentations will also be a powerful tool for advocacy and social mobilization within the country, and for contributing to RH programming at global level. In this context, documentation should be based on solid data, i.e. the outcome of strengthened M/E.

4.2 Implementation Structure

4.2.1. Composition of the Project Team

The project consists of Project Director, Project Manager and other health personnel ("Counterparts") on the Syrian side, and of Chief Advisor, Project Coordinator and experts of designated areas. Their Terms of Reference (TOR) are briefly described below:

Project Director

Project Director will bear overall responsibility for the administration and implementation of the Project. Director of Directorate of Primary Health Care in Ministry of Health will bear this responsibility.

Project Manager

Project Manager will oversee the managerial and technical matters of the Project, on a day-to-day basis. Head of Reproductive Health Section, Aleppo will bear this responsibility.

Counterparts

Those who are concerned with RH in Manbej and Aleppo and are directly involved in the Project are the Counterparts of the project. The Counterparts include: Heads and health workers of HCs in Manbej, Al Khafse and Maskane, Health Educator of Aleppo, Agricultural Extension Unit, community and religious leaders and health workers of the target communities, CHVs, and the NGO that will implement non-health activities.

Chief Advisor

A Japanese Chief Advisor will provide necessary advice and recommendations to the Project Director and the Project Manager on the implementation of the Project.

Project Coordinator

A Japanese Project Coordinator will assist Chief Advisor, and will backstop the planning, monitoring, administration and financial aspects of the project, based on the discussions with the Syrian C/P. S/he will also liaise the Japanese and Syrian sides, as well as the project and other significant stakeholders.

Experts

Long-term and short-term experts will be deployed in the following areas:

- ✓ Micro Finance or Adult Literacy Education,

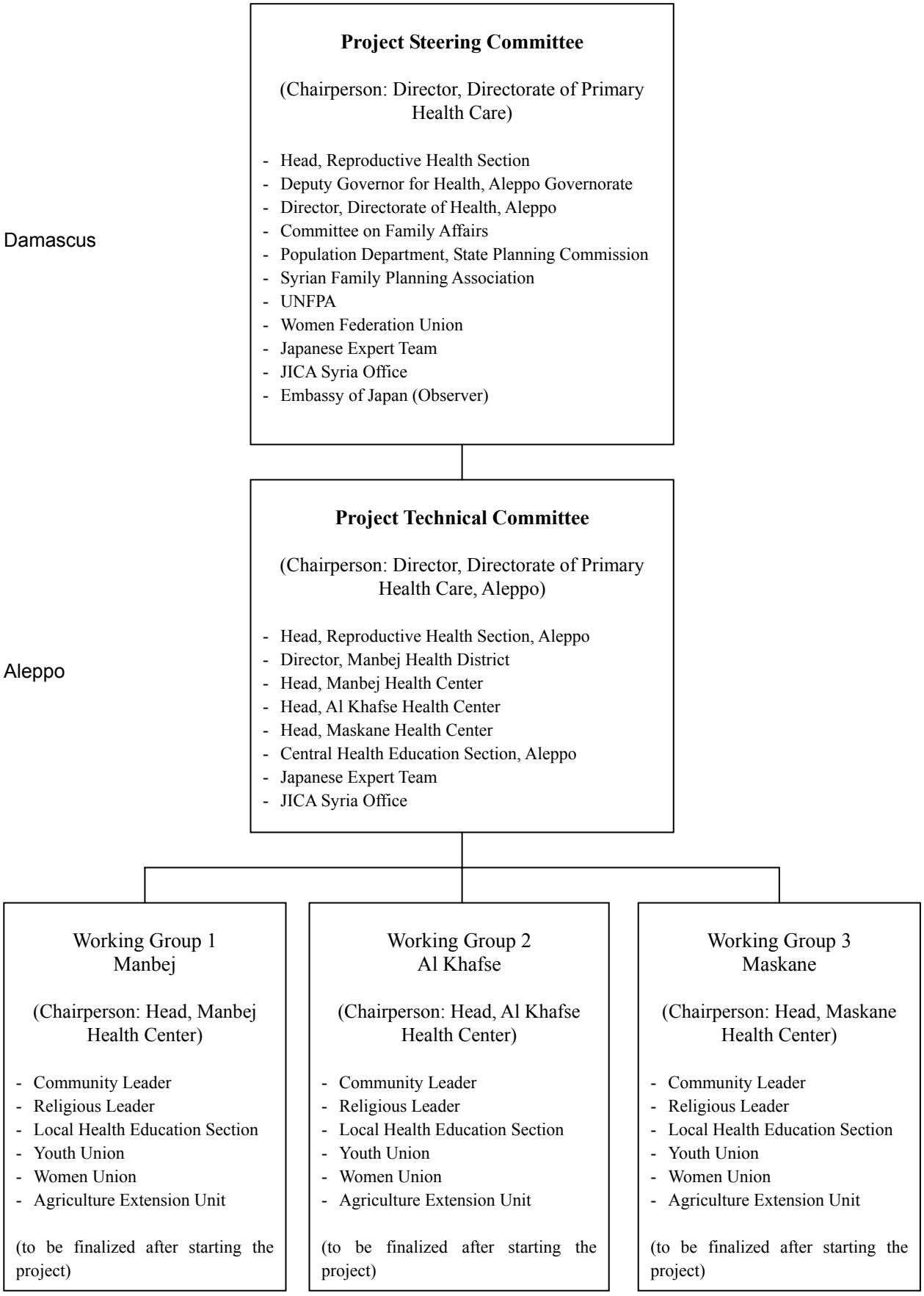
- ✓ Gynaecology/Midwifery,
- ✓ Health Behavioural Change Communication/Advocacy,
- ✓ Health Management Information System,
- ✓ Operational Research, and
- ✓ Other areas as necessary.

The designated experts will provide necessary technical advice to the Syrian counterparts for the successful implementation of the Project.

4.2.2 Organizational Structure

Project will establish Project Steering Committee, Project Technical Committee and Community-based Working Groups, in order to effectively plan, implement, monitor and evaluate its activities. The organizational structure is described in the Figure below.

Figure: Organizational Structure



4.2.3 Project Steering Committee

(1) Functions

The Project Steering Committee will be established as soon as the Project becomes inaugurated. The Committee meets regularly, at least once a year, and whenever needed. The major functions of the Committee are:

- ✓ Approve the framework of the Project, based on the recommendations of the Project Technical Committee.
- ✓ Endorse the annual work plan of the Project prepared by the Technical Committee within the framework of the “Record of Discussions” (R/D).
- ✓ Ensure the timely and effective implementation of the planned activities through the Project Technical Committee.
- ✓ Review the overall progress of the Project and make necessary decisions, based on the reports and recommendations of the Project Steering Committee;
- ✓ Ensure coordination and facilitate collaboration of RH stakeholders in the country for the effective implementation of the Project.

(2) Composition

1) Chairperson:

Director, Directorate of Primary Health Care, Ministry of Health

2) Members:

① Head, Reproductive Health Section
② Deputy Governor for Health, Aleppo Governorate
③ Director, Directorate of Health, Aleppo
④ President, Committee on Family Affairs
⑤ Director, Population Department, State Planning Commission
⑥ Executive Director, Syrian Family Planning Association
⑦ Representative, UNFPA
⑧ President (Health) Women Federation Union
⑨ Japanese Expert Team
⑩ JICA Syria Office
⑪ Embassy of Japan (Observer)

4.2.4 Project Technical Committee

(1) Functions

The Technical Committee shall meet at least quarterly, and whenever necessary as agreed by members, in order to fulfill the following functions:

1) Make necessary recommendations to the Project Steering Committee, in order to manage and implement the Project in an effective manner.

2) Formulate the annual work plan for the Project, in consultation with the Community-based Working Groups (CWGs) in Manbej, Al Khafse and Maskane.

3) Monitor the progress of the Project based on the annual work plan, PDM, reporting from the Monitoring Teams and HMIS, in cooperation with CWGs, and report annually to the Project Steering Committee.

4) Evaluate the achievement of the Project, in cooperation with CWGs, according to PDM, and report to the Project Steering Committee in the beginning and at the end of the Project period.

5) Coordinate all the major stakeholders of the Project at and below the Regional level, through and beyond CWGs, in order to effectively implement the Project.

(2) Composition

1) Chairperson:

Director, Directorate of Primary Health Care, Aleppo

2) Members:

① Head, Reproductive Health Section, Aleppo
② Director, Manbej Health District
③ Head, Manbej Health Center
④ Head, Al Khafse Health Center
⑤ Head, Maskane Health Center
⑥ Central Health Education Section, Aleppo
⑦ Japanese Expert Team
⑧ JICA Syria Office

4.2.5 Community-based Working Groups

Community-based Working Groups (CWGs) will be established in Manbej, Al Khafse and Maskane, the initial base of project activities. The final composition and TOR of CWGs will be determined after the project starts. Tentatively, CWGs will be chaired by Head of HC in each community, and will consist of community and religious leaders, representatives of Health Education Section, Directorate of Primary Health Care, Women's Union, Youth Union, Agricultural Extension Unit and other community members who are working in RH and gender fields.

CWGs will take a major role in project implementation on the ground, and for behavioural change and advocacy (**Outputs 2 and 3**) in particular. They will report to Project Technical Committee for

coordination at regional level.

5 Project Design

The framework of the project was established by Syrian and Japanese stakeholders, based on the outcomes of a series of discussions and two Project Cycle Management (PCM) workshops. PCM workshops were conducted in February 2005 in Manbej, Aleppo, with participation of MOH from both HQs and Aleppo, health workers, a health educator, NGOs, community and religious leaders, and JICA from Syria Office and HQs. Participants identified major obstacles to improved RH, namely:

- ✓ Low utilization of family planning;
- ✓ Lack of accessible health services;
- ✓ Poverty; and
- ✓ Ignorance and illiteracy.

PDM was drafted based on such discussions, and later revised taking into account the comments of MOH Syria, JICA and other stakeholders.

5.1 Overall Framework

This project aims at increasing utilization of MCH&RH services in Manbej district, Aleppo Region. In order to achieve this project purpose, the project will support the following areas:

- ✓ Improving the quality of MCH&RH services,
- ✓ Raising awareness and facilitating safe and responsible sexual behaviour in the community,
- ✓ Conducting advocacy to the stakeholders at the central level,
- ✓ Strengthening M/E, and
- ✓ Empowering the community focusing on women.

5.2 Overall Goal

Improve the Maternal and Child Health (MCH) & Reproductive Health (RH) status in Manbej district, Aleppo Region.

5.3 Project Purpose

Increase utilization of quality and satisfactory MCH&RH services in Manbej district, Aleppo Region.

5.4 Outputs

5.4.1 Output1: Improve the quality of MCH&RH services in the project areas.

In order to achieve this output, the following activities will be conducted.

Activities

1-1 Assess the training needs of health service providers.

1-2 Establish the performance standard on MCH&RH for health service providers at HC/Health Post (HP) level.

1-3 Train and re-train health service providers (doctors, nurses,midwives, etc.), according to the set performance standard on MCH&RH, for strengthening the quality of services at HCs&HPs.

1-4 Strengthen supportive supervision throug the existing Monitoring Teams, to monitor and follow-up with the health service providers who were trained and re-trained.

1-5 Review and implement a minimum package of MCH&RH services (including family planning, referral activities, detection of cancer, respectful service provision, and adolescent-friendly health services) at HCs/HPs.

1-6 Ensure and encourage the quality of MCH&RH services provided at HCs through giving recognition to the HCs which fulfilled the minimum package's requirements.

1-7 Provides basic medical equipment for Health Centers and Health Posts.

1-8 Repair major damages in major HCs and establish delivery space as necessary.

5.4.2 Output2: Raise awareness, and promote RH behavioral changes among community members in the project areas.

In order to achieve this output, the following activities will be conducted.

Activities

2-1 Conduct meetings for community/religious leaders, to brief on the project and obtain their support.

2-2 Establish Community-based Working Groups (CWG) and their workplans, in cooperation with the Health Education section in Aleppo Region, in order for the community members (including community and religious leaders, Women's Union, Youth Union and other stakeholders) to discuss and promote RH issues.

2-3 Select Community Health Volunteers (CHVs, including Health Educators, TBAs and young people) through CWGs.

2-4 Train CHVs through HCs to promote RH messages and contraceptives.

2-5 Conduct seminars, workshops, debate sessions and home visits to increase knowledge and awareness among women, men and adolescents in the community.

2-6 Conduct supportive supervision for CHVs through health service providers in HCs.

2-7 Revise Behavioural Change Communication (BCC) materials for target groups, based on the findings of a Knowledge, Attitude and Practice (KAP) survey (See the activity 4-1).

2-8 Conduct mass media campaigns with the messages on MCH&RH issues.

5.4.3 Output3: Advocate on the project activities and MCH&RH issues at the central level.

In order to achieve this output, the following activities will be conducted.

Activities

3-1 Document the project processes and lessons learnt on a half-yearly basis.

3-2 Disseminate the documentation of the project through media and workshops, targeting the general population and political leaders.

3-3 Mobilize the media, and advocate on MCH&RH issues at the national level, to create enabling social environment and increase support for MCH&RH.

3-4 Organize workshops on MCH&RH issues, to target religious leaders and other influential individuals.

5.4.4 Output4: Strengthen monitoring and evaluation of project activities in Manbej district.

In order to achieve this output, the following activities will be conducted.

Activities

4-1 Conduct necessary survey, including a baseline survey, final evaluation, feasibility studies of micro-credit/literacy activities, and KAP survey.

4-2 Review and revise, as necessary, the existing HMIS form and data collection/analysis/utilization procedure.

4-3 Train HC/HP staff on the HMIS format, data collection/analysis/utilization procedure and other necessary skills, in order to strengthen monitoring capacity.

4-4 Collect data through HMIS to monitor MCH&RH situations in Manbej district, and utilize it effectively to enhance project management.

5.4.5 Output5: Empower community members, particularly women, through non-health activities, in order to enhance MCH&RH situations.

In order to achieve this output, the following activities will be conducted.

Activities

5-1 Conduct assessment of micro-credit and literacy activities, in order to determine project activities.

5-2 Conduct non-health activities to empower community members, according to the findings of the assessment.

5.5 Inputs

Both Syrian and Japanese sides will make inputs to the project, whose details appear in the Record of Discussion.

Table: Inputs for the Project

	Inputs
Japan	Experts in the areas of: ● Chief Advisor, ● Project Coordinator, ● Micro Finance or Adult Literacy Education, ● Obstetrics Care/Gynaecology/Midwifery, ● Health Behavioural Change Communication/Advocacy, ● Health Information Management System, ● Operational Research, and ● Other experts as necessary
	Machinery and equipment
	Training in and outside Japan
Syria	Counterpart personnel, including Project Director and Project Manager
	Administrative staff and secretaries
	Land for Project Team office and facilities, such as: Office space, facilities, basic furniture and equipment for the experts Administrative and operational costs for the project, including those for electricity, water supply, telephone and furniture Other facilities and services mutually agreed upon, as necessary.

5.6 Important Assumptions and Risk Analysis

The project have the following important assumptions to be met, in order to successfully conduct the activities:

- ✓ MOH continues to support RH as a policy priority, and continues to allocate at least the current level of human and financial resources, and
- ✓ Population Department of National Planning Commission ensures a sufficient and timely

contraceptive supply to Manbej district, Aleppo Region.

6 Ex-ante Evaluation

6.1 Relevance

The project is considered relevant for the reasons described below.

Major health and development policies, such as MDGs, RH Policy draft, and 5-year National Health Plan, address improvement of the RH status, especially the promotion of modern family planning and safe delivery, as the priority issue. Therefore, this project is in line with the national policies and priorities of Syria. RH is designated as a priority area of support in JICA's Country Programme for Syria.

The project targets Manbej District in Aleppo Region. Manbej district belongs to the northern and eastern regions, which are known for the highest MMR in the country. The objective of the project, "Increase utilization of quality and satisfactory MCH&RH services in Manbej district," derived from the findings of the situational analysis and outcomes of the workshops by the stakeholders in Manbej district. Therefore, one can conclude that the project is matching the RH needs of Syria.

MOH has been trying to address the gaps in health outcomes between urban and rural areas, through strengthening health systems in northern, eastern and Damascus rural regions. In this context, MOH and Aleppo Governorate, the counterparts of the project, have high commitment to the project implementation.

Japan has rich experience in improving RH in resource-poor settings, especially MOH, which combines both safe motherhood and part of newborn care. This project, therefore, will best utilize Japan's strengths in development. The project plans to conduct necessary surveys, including the Baseline Survey and KAP survey. The findings and data from such research activities will directly contribute to project planning and formulation of BCC/advocacy activities/messages/materials , based on solid data, which will lead to the effective implementation of the project.

6.2 Effectiveness

It is essential to strengthen health systems, and to enhance the quality of RH services, in order to achieve the set project objective. It is also important to promote safe and responsible RH behaviour among married and unmarried women and men in the target area, who are the potential clients of RH services, while establishing enabling social environments. This project addresses all of these components. The project also includes those activities outside the health sector, as part of community empowerment, focusing on women. Such non-health activities will contribute to improving social basis of RH, while serving as entry points to RH activities.

This project will document its achievements and lessons learnt on a regular basis, throughout the operational processes. The documentations will be shared with stakeholders at community, regional and national levels, so that they can serve for building and implementing effective RH policies in Syria in a long term. The project is going to be implemented as a pilot, and its expansion to other parts of the country, especially northern and eastern regions that have the lowest RH status in the country, will be considered, after the approach in this project has been verified.

6.3 Efficiency

This project will benefit from the experiences and lessons learnt of a similar previous project in Jordan called “Family Planning and Gender in Development Project”. The Jordanian project was successful in improving and promoting RH and empowerment of women in the same Middle Eastern region by combining income generation activities and RH improvement, and by involving men and religious leaders in RH activities. The strategy of “Strengthening RH in Syria” Project is, therefore, based on solid experience in the past, and is considered effective. The project will also utilize an RH specialist who was trained in the Jordanian project also will contribute to south-south cooperation in the Middle East Region.

6.4 Impact

JICA has been addressing the importance of the Human Security perspective in the development framework, and has been promoting capacity building of and effective support for marginalized groups at the community level. This project will focus on empowerment of women in remote rural areas, a group particularly disadvantaged in society, and will realize the Human Security perspective. The project will actively facilitate involvement of men and religious/community leaders in the activities, and such efforts will contribute to empowerment of women in rural communities, while creating long-term impacts.

6.5 Sustainability

This project will establish and promote sustainability and ownership of the project by a wide range of Syrian stakeholders through sharing the monitoring results, achievements and lessons learnt on a regular basis.

For sustainability, the project will also best utilize existing institutions and personnel. For instance, in Manbej district, Aleppo Region, two “Monitoring Teams” for monitoring of RH service provision at HC/HP level exist. The teams consist of Head of RH Section, Aleppo Primary Health Care Directorate, Head of Manbej Health Directorate, and certified midwives. The project will closely work with these Monitoring Teams by supporting and benefiting from their activities. The project will facilitate decision making at the community level, and to formulate and implement activities through the already existing personnel. When introducing Community Health Volunteers who are central to community mobilization activities, Community Working Groups in each of 3 focus communities will select the volunteers in their locality. These volunteers will facilitate social mobilization and behavioural change for their community, and are expected to be retained for a long-term.

6.6 Overall Conclusion

Based on what has been discussed, this project is considered appropriate, and will effectively improve RH situations in Manbej. However, the implementation and performance of the project should be monitored closely, according to the PDM, on a half-yearly basis at least, and PDM and the

framework of the project be adjusted as necessary. The project should also take into consideration several potential bottlenecks e.g. relatively scarce human resources and the way households are scattered in a vast area.

7 Monitoring and Evaluation

The project will conduct monitoring and evaluation based on the set PDM. The project team will verify each of set indicators during the Baseline Survey, and Final and Impact Evaluations. The Baseline Survey will be conducted immediately after the project commences, and will contribute to project planning and management with the data. The project plans to conduct a Final and Impact Evaluation, which will take place in the last 6 months of the project, and a few years after the project ends.

Together with the evaluation activities, the project will strengthen monitoring as one of the expected outcomes. Data from day-to-day monitoring will be utilized in evaluation activities, while contributing to better management and re-designing of the project.