

第二編

第二次事前評価

(①2007年8月～9月、②2008年2月)

第1章 第二次事前調査の目的と基本方針

1-1 調査の目的

「ミ」国の基礎保健サービスは、BHS と呼ばれる公務員やボランティアで構成される多数の職種の人々によって提供されている。保健省はこの BHS の能力を向上させるために、独自にあるいは国連機関や日本などドナーの支援を得て継続教育を行ってきた。BHS の能力向上を保健省が効果的、持続的に行えるようにするために、BHS の継続教育体制を組織的・技術的に強化することを目的としている。プロジェクト開始に先立って行われるこの第二次事前調査は、2007 年 2 月に終了した第一次事前調査の成果を踏まえて、次のような目的をもって行われるものである。

- (1) ワークショップでの議論を通してプロジェクトの実施計画を作成し、その内容に関して双方の合意形成を図る。
- (2) 先方実施機関（保健省保健局 CTU を予定）の組織の立上げを促進する。

なお、第二次事前調査が 8 月 13 日より実施されていたが、「ミ」国の民主化デモ及びそれに対する政府側との衝突、混乱の事態から現地調査を遂行する十分な治安の確保が困難になったため、現地調査を予定より約 1 か月間早めに切り上げ、その段階までに収集された情報及び国連を中心とする国際社会の対ミャンマー政府に対する動向、日本政府の対ミャンマー支援方針の動きなどをもとに、総合的な観点から事前評価が行われた。ただし、カウンターパート機関との協議が現地調査日程の切り上げで行われなかったため、「ミ」国側の意向は含まれなかった。そのため、調査再開が可能となった 2008 年 2 月には、2007 年 8 月に実施することができなかった調査結果報告セミナー、合意形成のためのワークショップを開催し、PDM・PO を含むプロジェクト内容・計画を合意するための調査団を派遣した。

1-2 調査団の構成

(1) 調査団構成①

氏名	担当分野	所属	派遣期間
石田 裕	研修制度	国立国際医療センター	2007 年 8 月 13 日～21 日
高野 晋太郎	協力計画	JICA 人間開発部保健人材育成チーム	8 月 13 日～21 日
渡辺 鋼市郎	保健人材育成	グローバルリンクマネジメント株式会社	8 月 13 日～ 10 月 26 日
古谷 典子	評価分析	グローバルリンクマネジメント株式会社	8 月 13 日～ 8 月 23 日、 9 月 25 日～

(2) 調査団構成②

氏名	担当分野	所属	派遣期間
竹本 啓一	総括	JICA 人間開発部保健人材育成チーム	2008 年 2 月 5 日～23 日

仲佐 保	研修制度	国立国際医療センター	2月11日～22日
高野 晋太郎	協力計画	JICA 人間開発部保健人材育成チーム	2月5日～23日
興津 暁子	評価分析	株式会社タック・インターナショナル	2月9日～23日

*なお、2月11日～22日の日程にて、国立国際医療センター（IMCJ）馬場洋子氏が所属先負担により参団した。

1-3 調査日程

(1) 調査日程①

日程		宿泊地
8月13日	日本発	ヤンゴン
8月14日	ヤンゴン着 ヤンゴンからネピドに移動 保健省保健局 調査団派遣概要の説明	ネピド
8月15日	プロジェクト計画案及び調査方法に関する説明 トレーナーとしての経験に関する聞き取り、保健局長への表敬訪問	ネピド
8月16日	フィールド調査用質問表の作成 MEPに関する聞き取り	ネピド
8月17日	アドバイザー・コミッティー実施 ネピドからヤンゴンに移動	ネピド
8月18日	資料整理	ヤンゴン
8月19日	Dr. Hla Pe との面談	ヤンゴン
8月20日	フィールド調査に関する打合せ/JICA ミャンマー事務所報告 ヤンゴン発	ヤンゴン
8月21日	東京着	

(2) 調査日程②

	団長：竹本	仲佐	馬場	興津	高野
2月5日					到着
2月6日					伝統医療プロジェクト
2月7日					伝統医療プロジェクト
2月8日					伝統医療プロジェクト
2月9日				到着	伝統医療プロジェクト
2月10日				セミナー・WS 準備	伝統医療プロジェクト
2月11日		到着	到着	セミナー・WS 準備	セミナー・WS 準備
2月12日		WHO・UNICEF への聞き取り、セミナー・WS 準備			

2月13日		WHO・UNICEF への聞き取り、移動（ヤンゴン→ネピド）			
2月14日		9：00－12：00 セミナー 13：00－17：00 WS			
2月15日		9：30－12：00 WS 13：00－15：30 BHS 課との協議			9：30－11：30 GAVI HSS Meeting
2月16日	到着	団内協議			
2月17日	団内協議				
2月18日	JICA ミャンマー事務所打合せ、ネピドへ移動 14：00－16：00 保健局との協議・AC 準備				
2月19日	9：30－12：00 AC 13：00－16：00 BHS 課との AC 結果に関する確認 19：00－21：00 保健局関係者との会合				
2月20日	M/M 案手交・M/M 記載事項に関する協議				
2月21日	M/M 案手交・M/M 記載事項に関する協議手交、ヤンゴンへ移動				
2月22日	在ミャンマー日本国大使館・事務所報告 *伝統医療プロジェクト関連訪問	東京着	東京着	大使館・事務所報告 3DF 担当者との面談	大使館・事務所報告 *伝統医療プロジェクト関連訪問
2月23日	東京着			東京着	東京着

第2章 調査結果概要

2-1 団長総括

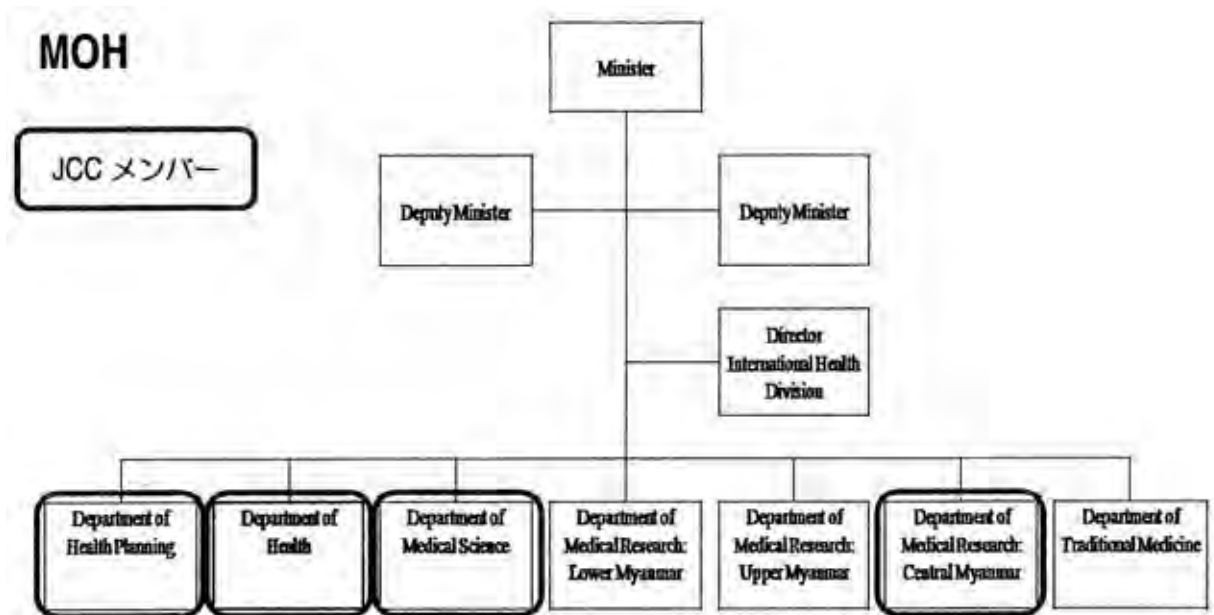
- (1) 本プロジェクト開始にあたっては、これまで2007年1月から2月に第一次事前調査が実施され、その後8月から第二次事前調査が実施されたものの、治安の悪化により中断を余儀なくされた。2008年2月には調査を再開させ、調査結果報告セミナー、及び関係者との合意形成のためのワークショップを開催し、その結果を諮問委員会（Advisory Committee : AC）に報告することで、PDM及びPOを含むプロジェクト内の計画を確定し、R/D署名の準備を行った。セミナーやワークショップ、ACでの議論は「ミ」国側の本プロジェクトに向ける熱心さを感じさせるものであった。また、保健局長は病院のため不在であったものの、保健局の現在の実質的責任者であるSan Shwey Win保健局次長と協議を行うことができ、先方の本プロジェクトへの理解が深まっていることが確認されるとともに、プロジェクト計画や方向性の概要について付属資料1. M/Mのとおり、合意を得ることができた。
- (2) 本プロジェクトは、BHSの能力向上をスーパーゴール、BHSに対する質の高い現任研修の提供を上位目標とし、保健局内のCTTの強化を通じ、州・管区レベルのS/DTT、タウンシップレベルのTTTといったBHSを対象とするトレーニングチームの強化をプロジェクト目標とした。感染症やEPI、母子保健といったすでに多く行われているバーティカルな研修ではなく、マネージメントやファシリテーションといった研修管理・実施能力に資する協力とすることにした。
- (3) WHOはMEPを実施しており、そのコンセプトや対象は本プロジェクトの想定する研修と重なる部分が多いため、重複を避けるためにも十分な連携が必要である。上記プログラムに係る今後の連携については、第二次事前調査（2回目）には、担当者が長期不在にしていたため、詳細協議をするに至らなかった。今後、連携の詳細については詰めていく必要がある。
- (4) WHO以外にも、UNICEFやGAVI等いくつかのドナーにより様々な形で研修実施されているが、モニタリングや中央へのフィードバックが十分になされているとは言い難い。したがって、今回のJICAプロジェクトにおいては、CTT及びS/D TTによるSupportive Supervisionというべき活動を促進し、研修状況のモニタリングや結果の中央へのフィードバックに重点を置くこととした。
- (5) もうひとつの大きなポイントとして、州・管区や特にタウンシップをどこまで対象とするかという課題があった。JICA本部での事前対処方針は、州・管区はすべて対象とし、CTTによるTOTを全S/D TTに対して実施するものの、モデルとするタウンシップは全国から数箇所程度選び出すというものであった。しかし、セミナー、ワークショップ等での議論の結果、すべての州・管区を対象とするに加え、各州・管区からひとつずつ対象となるタウンシップを選び出し、合計17のタウンシップを対象とすることとなった。これは、プロジェクトにより、すべてのS/D TTを強化しても、強化した成果を各S/D TTがTTTの強化に活かして実施に移さなければ、本当の意味での強化につながらないとの「ミ」国側の強い意向があったためである。
- (6) 一方で、プロジェクトが同時に17の州・管区、及び17のモデルタウンシップを対象とするのは、運営上大きな困難が予想されるため、先方と協議し、次のような実施計画とした。すなわち州・管区を4つのグループに分け、第一年次に最初のグループに対する協力を開始

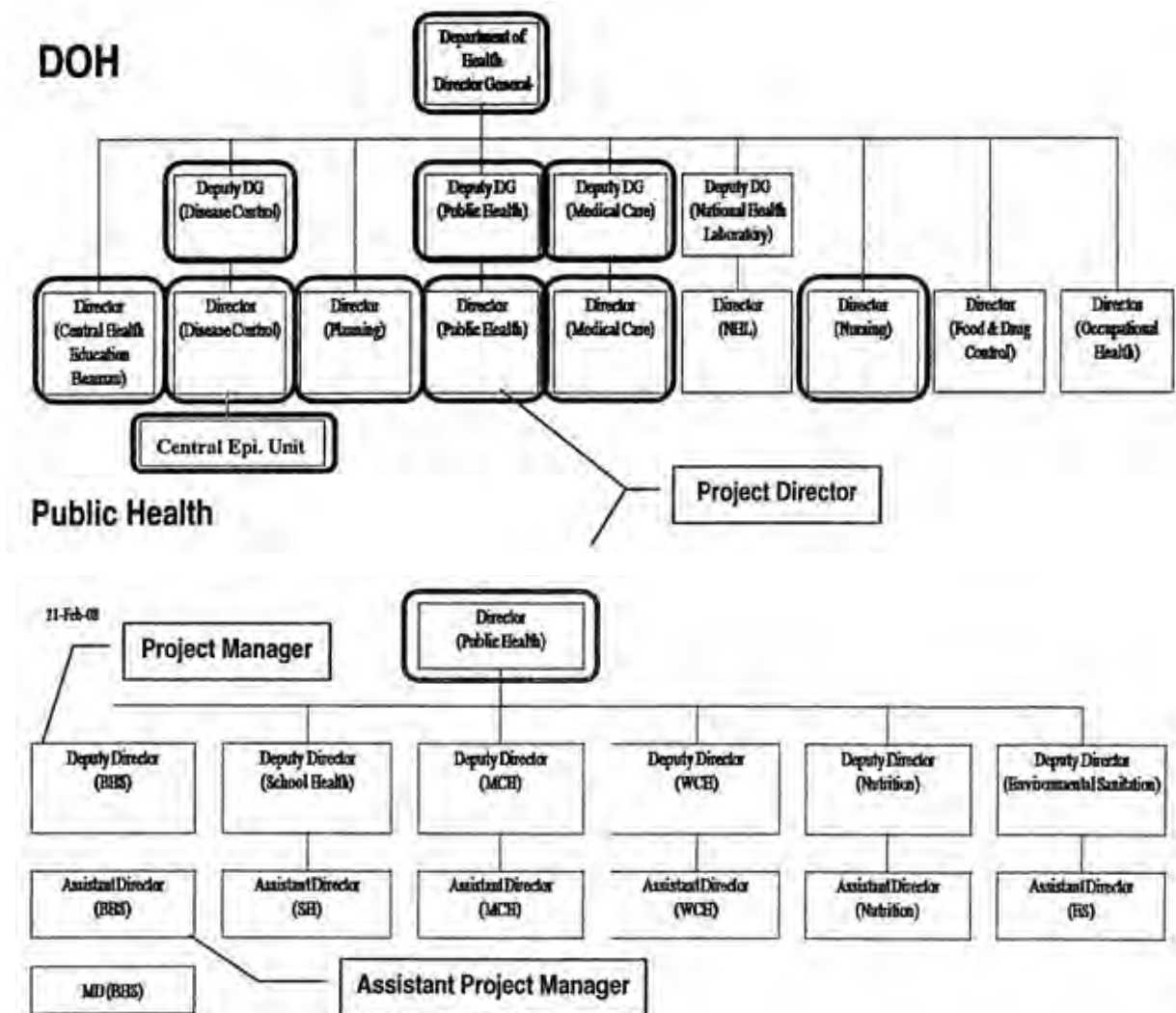
し、第二年次に次のグループに対する協力を開始する、といったスケジュールで実施することとした（詳細は PO を参照）。ひとつのグループに対する支援はモデルタウンシップに至るまでに 2 年かけることとし、4 番目のグループのタウンシップへの協力が完了する時期を目安に、全体で 5 年間の協力とし、当初の先方要望のと通りの協力期間とすることとした。

- (7) 上で触れた協力期間については 4 年程度とする議論もあったが、①「ミ」国全体を計画的にカバーするためには、上記の通り 5 年間必要、②プロジェクトオフィスはヤンゴンに置かざるを得ないが保健本省との綿密な連携が必要、また多くの地方を対象とする関係上、通信や移動、手続上の煩雑さなどを考慮すると、余裕を持った期間を設定せざるを得ないといった点から 5 年間の協力期間が妥当と考える。
- (8) なお、CTT の設置については、本プロジェクトの核となる部分であり、プロジェクト開始前に目処をつけておく必要がある。この点、AC での議論の結果、Director of Public Health をチェアとする CTT 設置に係るワーキンググループを立ち上げることとなり、M/M にもその旨記載した。
- (9) また協議の過程で、先方保健局次長に、保健省に長期専門家の机を置くことの可能性を確認したところ、予想通り絶対に不可能との答えだったが、ミャンマー人であれば机を置くことは可能であるとのことだったので、その旨、M/M に記載した。プロジェクト開始後、現地人スタッフをネピドに駐在させる方向で検討することとした。

2-2 関連する保健省内の組織図及び関係者とその位置づけ

関連する保健省内の組織図及び関係者とその位置づけは下記のとおりである。





2-3 各レベルのTTの構成メンバーと活動状況

(1) CTT

第一次事前調査で明記されたメンバーは、保健局長（Director General）に承認を得る最終案の決定者たちであり、実質的な作業及び実施者ではないと考えられる。そのため、CTTのメンバーや機能と役割、その活動について検討するためのワーキング・グループを設置した。

- Deputy Director General (Public Health) : Chair-person
- Director (Public Health)
- Director (Disease Control)
- Director (Medical Care)
- Director (Planning)
- Director (Health Education Bureau)
- Deputy Director (Basic Health Services)
- Deputy Director (MCH)
- Deputy Director (Nutrition)
- Deputy Director (Environmental Health)

- Assistant Director (School Health)
- Assistant Director (Basic Health Services) : Secretary

(2) S/D TT

チームとしては存在するものの、実質的な活動はされていない。特にトレーニング・チームの長が Deputy State/Divisional Health Officer であり、State/Divisional Health Officer を長とするほうが望ましいとの意見が聞かれた。

- Deputy State/Divisional Health Officer : Chair-person
- Regional Officer from disease control
- Nursing Officer
- Planning Officer
- Health Education Officer

(3) TTT

CME といい、毎月給料日に実施されているが、トピックや方法、実施状況は TMO または THO 個人に委ねられている状況である。

- TMO&THO : Chair-person
- School MO
- Team Leader from disease control
- Township Health Assistant
- Township Health Nurse

2-3 その他

- 「ミ」国において、BHS に対するトレーニングは予算がついた内容をアドホックに行っているのが現状である。そのため、これらの TT の存在はあまり知られておらず、特に縦割りのトレーニング（例えば、マラリア・HIV・結核対策・母子保健等）にこの TT は活用されていない。
- トレーニング手法やリーダーシップ、マネジメントの研修は、すでに WHO により MEP が 2002 年より実施中である。この内容の詳細及び実際の実施状況と実施上の問題点については、もう少し情報が必要であるが、標準化されたモジュールもある。
- 現在申請中ではあるが、GAVI-HSS 資金が UNICEF を通じてタウンシップに入る計画が予定されている。
- トレーニングの予算は、ほとんどが JICA を含む WHO や UNICEF、3DF によるものであり、保健省保健局において、卒後トレーニングに関する全体を把握するための情報（データベース）が活用されていない。CME で実施されたトレーニングは、すべて保健局公衆衛生部 BHS 課に報告されており、これらを統合して CTT が卒後トレーニングに関するマネジメントに活用するための資料（データベース）が必要とされている。
- 各ドナーにより最低限に必要なとされているトレーニングは実施されてはいるが、「ミ」国保健省保健局をはじめとする各ドナーからも、トレーニング後のモニタリング・評価、サポーティブ・スーパービジョン、フィード・バックについては不十分であるという指摘があった。

2-4 技術的観点からの考察と所感

2-4-1 考察

「ミ」国民の保健医療状況改善のためには、住民の窓口である BHS の能力強化が必須である。そのためには BHS に直接アプローチする方法も考えられるが、指示・命令系統が強固な「ミ」国においては、まずはトレーニング・メカニズムを改善し、TT の能力強化することを目指したプロジェクトが妥当であると考えられる。また、トレーニング自体は実施されているが、その内容や地域的な格差については課題があり、中央における卒後トレーニングのマネジメントができる体制の整備が急務である。

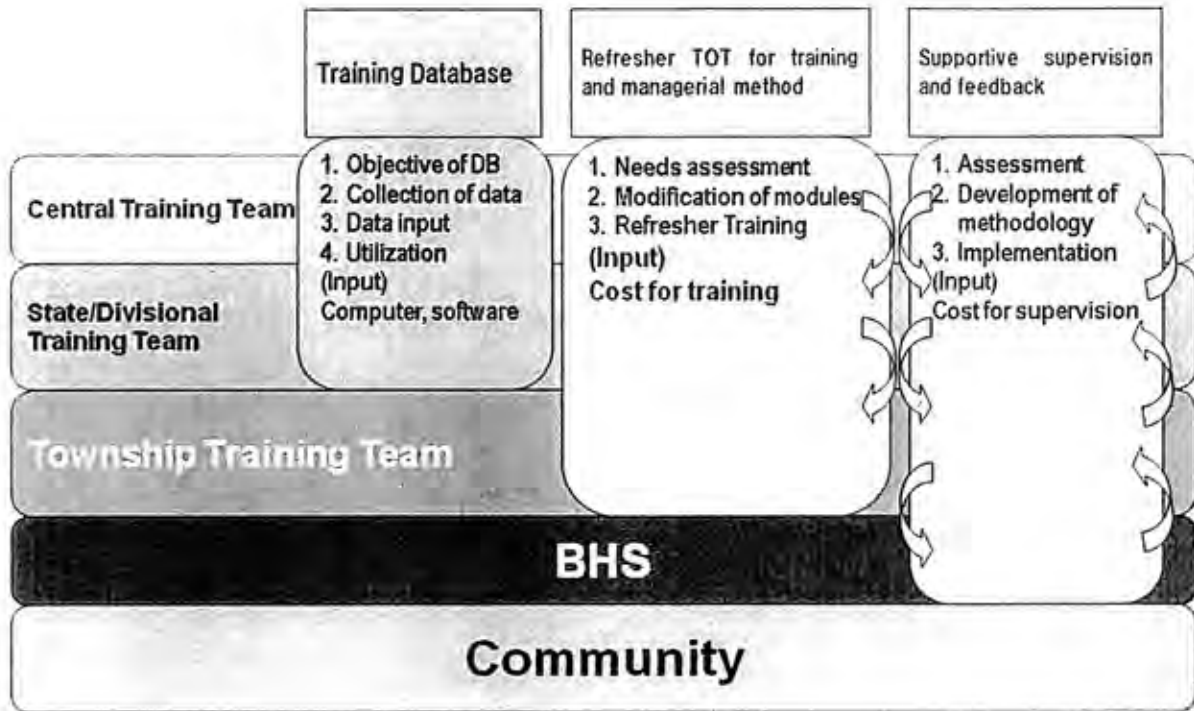
すでに WHO の MEP が実施中であり、新たに別のコンセプトを導入することは、非効率であり、「ミ」国側にとってもかえって混乱することが予想され、その定着性の妨げにもなり得る。しかしながら、MEP は 2002 年から実施しているにもかかわらず、未だ 16 タウンシップが終了したのみである。トレーニングを受けた人が異動してしまっている例もあることから、現在の実施上の問題点を整理し、モジュールの改訂や実施方法の改善などを含め、WHO とさらなる協議の上、MEP を支援する形での実施が望ましいと考える。一方、トレーニング後のモニタリングからフィード・バックに至るまでの過程は不十分であると考えられ、ここに重点を置き活動することがより効果的な TT の能力強化になるであろう。また、3DF は NGO を通じてではあるが、タウンシップ以下の末端に入り、さらに GAVI-HSS 資金がタウンシップに入る計画があり、これらのドナーと協調して実施していくことが重要である。当プロジェクトの柱としては、第一に中央 TT の機能と役割を明確にし、データベースを活用したマネジメント能力を向上すること、第二に WHO との共同でリフレッシャー・トレーニング等の実施、第三にモニタリングからのフィード・バックが考えられる（別紙 1）。CTT がマネジメントできる体制を整備し、中央からのアプローチをとることにより、包括的な「ミ」国における保健人材の質的向上に資すると考える（別紙 2）。なお、JCC メンバーには卒前教育を担う Department of Science 等の関連部局を含めることにより、さらなる発展性が確保できると考えられる。

2-4-2 所感

保健省の財政状況が非常に厳しいなか、自立発展性を確保することはかなり困難な課題ではあるが、プロジェクトをデザインする段階から他のドナーと協調して実施することをかなり意識し、工夫した結果となった。首都に外国人の長期滞在が認められていないなか、首都にいるカウンターパートとどのように一緒に活動を進めていくことができるのか？この件についてもプロジェクトのリエゾン・オフィサーを保健局内に設置する形で合意を得ることができた。このような国における協力は、プロジェクト開始後も状況の変化に臨機応変に対応していく柔軟性が求められると考えられ、JCC を定期的に行うことで常に進捗状況を確認し、適宜 PDM を見直しながら実施していくことが不可欠であると考ええる。

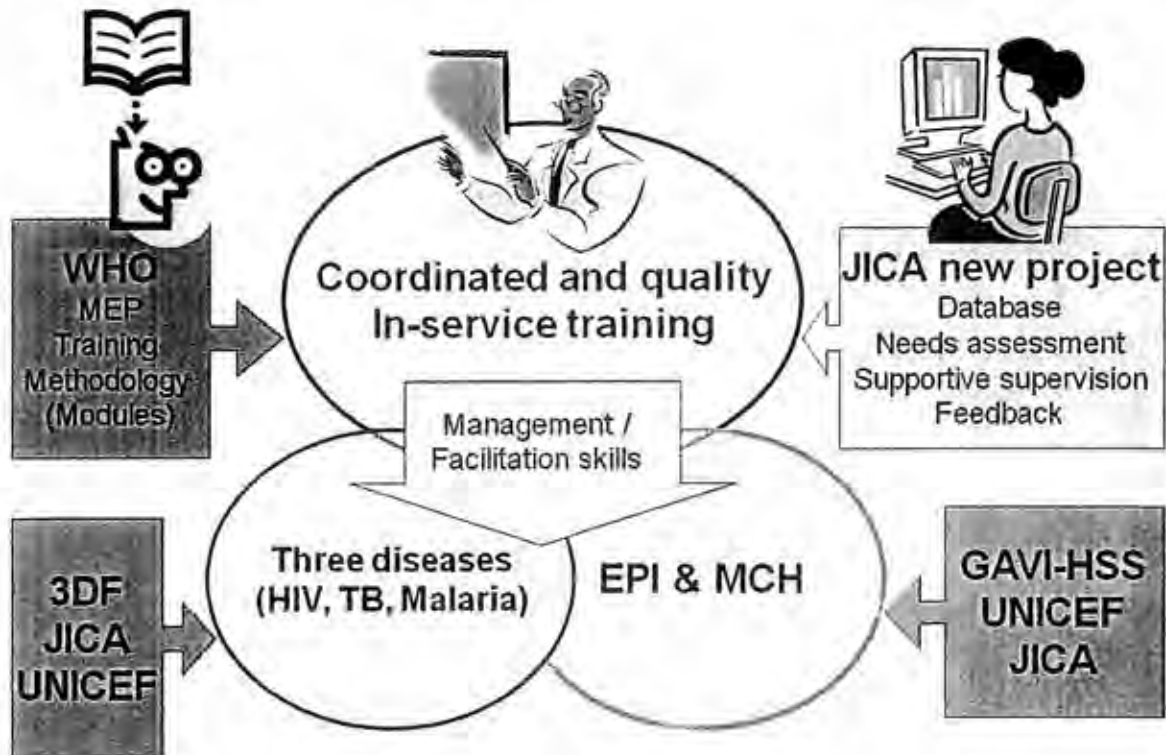
<別紙 1 >

Concept of Human Resource Development Programme for BHS



<別紙 2 >

Image of collaboration among donors for in-service training programme in Myanmar



第3章 実施協議の概要

2009年1月8日、宮本秀夫 JICA ミャンマー事務所長と「ミ」国保健大臣との間で討議議事録 (Record of Discussions : R/D) の署名・交換が行われた。

合意内容は、事前評価調査時に合意されたプロジェクトの実施枠組みを踏襲するものであったが、再度 R/D 記載内容について確認するとともに、以下の点については双方で新たに協議を行い、R/D とは別に M/M を取り交わして内容を確認・合意した。

(1) 早期 CTT の立上げの重要性

プロジェクト開始後、早期に公式文書において、CTT の役割、機能、メンバーについて明記されることが重要である。PDM 上における成果 1 に明記されている CTT の立上げは、成果 2、3、4 を達成していく上での基盤である。

(2) 事前評価調査からの変更点：PDM 指標について

第二次事前評価調査時の M/M で合意した PDM に以下の点を加えて、R/D を締結することとする。

<成果 4 の指標>

4-4. Degree of understanding on the training topics by BHS and trainers.

<入手手段>

Questionnaire

(3) PDM 指標について

PDM 上の指標について、現時点では適切な数値等を設定することができなかったものについては、“xx” という表記や空欄としている箇所がある。これらについては、プロジェクト開始後半年後を目処に協議し、確定することが望ましい。

付 属 資 料

1. 第二次事前評価 M/M
2. 第二次事前評価
コンサルタント現地レポート（和文、英文）
3. R/D、M/M（2009年1月8日署名）

1. 第二次事前評価M/M

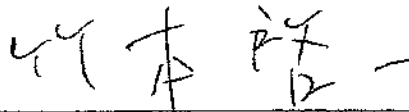
MINUTES OF MEETINGS
BETWEEN THE JAPANESE SECONDARY PREPARATORY STUDY TEAM AND
THE AUTHORITIES CONCERNED OF
THE GOVERNMENT OF THE UNION OF MYANMAR
ON JAPANESE TECHNICAL COOPERATION FOR THE PROJECT
FOR
STRENGTHENING CAPACITY OF TRAINING TEAMS FOR BASIC HEALTH STAFF

The Japan International Cooperation Agency (hereinafter referred to as "JICA") dispatched the Secondary Preparatory Study Team (hereinafter referred to as "the Team"), headed by Mr. Keiichi TAKEMOTO, to the Union of Myanmar from February 9 to February 22, 2008 for the purpose of discussing the framework of the requested technical cooperation project entitled the Project for Strengthening Capacity of Training Teams for Basic Health Staff (hereinafter referred to as "the Project").

During its stay in the Union of Myanmar, the Team had a series of discussions on the Project with the authorities concerned of the Union of Myanmar.

As a result of discussions, both sides reached common understanding concerning the matters referred to in the document attached hereto.

Nay Pyi Taw, 28 February 2008



Mr. Keiichi Takemoto
Leader
Secondary Preparatory Study Team,
Japan International Cooperation Agency
(JICA)



Dr. San Shway Wynn
Acting Director General
Department of Health, Ministry of Health
The Union of Myanmar

Attached Document

I. Background of Project

In Myanmar, the Ministry of Health (hereinafter referred to as "MOH") is concerned with in-service training for all kinds of health professionals. Basic Health Staff (hereinafter referred to as "BHS"), provide all primary health care services at the township level. In order to develop their capacity to deliver better basic healthcare services, in-service training for BHS was emphasized and training teams at different levels were established. But at the moment, State/Division and Township Training Teams are not functioning well and Central Training Team at MOH should be strengthened to supervise and coordinate them.

In view of the situation, MOH requested the technical cooperation to Japan which focuses on strengthening of the training system from Central to Township Level.

Based on the project proposal, JICA decided to conduct Primary and Secondary Preparatory Studies in order to clarify the issues and formulate the Project.

In January 2007, the Primary Preparatory Study was conducted and as a result of the study, JICA and MOH agreed that Advisory Committee and Working Group would be organized for the smooth conduct of study and Member List of Central Training Team was submitted.

Based on these agreements, the Secondary Preparatory Study team was dispatched to finalize the formulation of the Project.

II. Tentative Framework of the Project

Based on the result of the discussions, field survey and seminar/workshops, considering funding and technical feasibility and timeframe of the Project, a tentative framework of the project was worked out as follows. It could be modified through further discussions and will be finalized before exchanging Record of Discussions (R/D) as a final agreement to commence the Project.

1. Project Title

The Project for Strengthening Capacity of Training Teams for Basic Health Staff

2. Implementing Organization

Department of Health, MOH

3. Target Groups

Central Training Team (hereinafter referred to as "CTT")

State and Divisional Training Teams (hereinafter referred to as "S/DTT") (17; ANNEX 1)

Township Training Teams (hereinafter referred to as "T/STT") (17; ANNEX 1)

4. Beneficiaries

Personnel belonging to Target groups (directly), Basic Health Staff and people living in Union of Myanmar (indirectly)

5. Duration of the Project

Five (5) years (2008-2013)

6. Project Implementation Schedule

17 States/Divisions and 17 Townships identified in each State/Division are divided into 4 groups. Implementation schedule of each group is presented in ANNEX1.

7. Project Design Matrix (PDM) and Plan of Operations (PO) of the Project

Based on the result of field survey executed in August and September 2007, seminar/workshop were held on February 14, 15 and we had series of discussions, both sides formulated PDM and tentative PO shown in ANNEX 2 and 3. The narrative summary of the Project is as follows;

1) Overall Goal

The quality and coordinated in-service training are provided according to the needs of different levels

2) Project Purpose

The capacity of training teams at different levels in the in-service trainings for the BHS is strengthened.

3) Outputs

- i. Reconstitute the Central Training Team (CTT) according to the current conditions.
- ii. CTT's capacity in coordination and management is strengthened.
- iii. Training capacity of State/Division Training Team (S/D TT) is strengthened.
- iv. Training capacity of Township Training Team (T/STT) is strengthened.

III. Roles and responsibilities of related organizations

1. Implementing Organization of the Project

MOH is responsible for implementation of the Project with the following officials in charge.

- 1) Project Director (who will bear overall responsibility of the administration and implementation of the Project): Director, Public Health Division, DOH
- 2) Project Manager (who will be responsible for the managerial and technical matters of the Project): Deputy Director, BHS section, DOH
- 3) Assistant Project Manager : Assistant Director, BHS Section, DOH
- 4) Counterparts to Japanese Experts (ANNEX 6)

2. Joint Coordinating Committee of the Project

A Joint Coordinating Committee will be organized and meet at least once a year to review progress and to formulate annual plans of the Project and whenever necessity arises. The members of the Committee are as follows:

1) Chairperson:

Director General, Department of Health

2) Myanmar Member

Ministry of Health

i. Department of Health

Deputy Director General of Public Health
Deputy Director General of Disease Control
Deputy Director General of Medical Care
Director of Public Health
Director of Disease Control

- Director of Planning
 - Director of Medical Care
 - Director of Health Education Bureau
 - Director of Central Epidemiology Unit
 - Director of Nursing
 - ii. Department of Medical Science
 - Director of Training/Foreign Relation
 - iii. Department of Medical Research
 - Director of Epidemiology
 - iv. Department of Health Planning
 - Director of Health Management Information System (HMIS)
- 3) Japanese Member:
Japanese Experts assigned to the Project
Resident Representative of JICA
- 4) Observer
Representative of Embassy of Japan
WHO
UNICEF
Other personnel invited by Chairperson

IV. Inputs of the Project

Based on the PDM (ANNEX 2) and PO (ANNEX 3), the inputs are discussed and agreed as ANNEX4, 5, 6, 7.

V. Other relevant issues

1. Collaboration with other related organizations (WHO, UNICEF, etc.)
Through conducting the Project, collaboration with other related organizations and programs should be taken into account.
2. Establishment of Working Group for reconstitution of CTT
As a result of discussions in Advisory Committee Meeting, both sides agreed to establish a Working Group for CTT in DOH as ANNEX 8. The Working Group will discuss about the role, function, members and activities of CTT by the commencement of the Project.

ANNEX1 Project Implementation Schedule

ANNEX2 Tentative PDM

ANNEX3 Tentative PO

ANNEX4 Tentative list of Japanese Expert

ANNEX5 Tentative list of Machinery and Equipment

ANNEX6 Tentative list of Myanmar Counterpart

ANNEX7 Tentative list of Land, Building and Facilities

ANNEX8 Member list of Working Group for CTT Reconstitution

PROJECT IMPLEMENTATION SCHEDULE (TENTATIVE)

Year	State	Township	Division	Township
First group	Kayin	Hlaingbwe	Ayeyarwaddy	Kyaunggone
	Mon	Kyaikmayaw	Bago (East)	Kyauktagha
Second group	Kayah	Demorsoe	Bago (West)	Gyotbingout
	Shan (South)	Nyaungshwe	Magwe	Seikphyu
Third group	Kachin	Winemaw	Mandalay	Sintguu
	Shan (North)	Theinni	Sagaing	YaeU
	Chin	Teetain		
Fourth group	Rakhine	Kyauktaw	Yangon	Khayan
	Shan (East)	Minepyat	Tanintharyi	Launglone

* Townships will be confirmed based on the actual situation after the commencement of the project.

ANNEX 2

Project Title: The Project for Strengthening Capacity of Training Teams for BHS
Implementing Organization: Department of Health, MOH in Myanmar

Version 1
Project Period: August 2008 - July 2013
Target Group: Training Teams (TT) at different levels
Prepared at February, 2008

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Super Goal Capacity of BHS is strengthened.</p> <p>OVERALL GOAL The quality and coordinated in-service trainings are provided according to the needs of different levels.</p>	<p>1 xx% of T/STT receive TOT from S/D TT after 5 years of project period The in-service data base at central level is up-dated and state/division levels are expanded</p> <p>2</p>		
<p>PROJECT PURPOSE The capacity of training teams at different levels in the in-service trainings for the BHS is strengthened.</p>	<p>1 Monitoring reports are submitted regularly at different levels. 2 The implementation rates of training plans are more than xx%. 3 The satisfaction level of trainers and trainees among CTT, 17 S/D TT, T/STT and BHS in pilot areas is more than xx%.</p>	<p>Project reports Project Reports and Result of Questionnaire survey</p>	<p>The financial support is available for the expansion of trainings</p>
<p>OUTPUTS</p>			
<p>1 Reconstitute the Central Training Team(CTT) according to the current conditions.</p>	<p>1-1. The role and function of CTT is documented and authorized 1-2. The existence of formed CTT</p>	<p>MOH/DOH agreement DG</p>	
<p>2 CTT's capacity in coordination and management is strengthened</p>	<p>2-1. % of pilot areas with improved training skills exceeds xx% 2-2. No. of pilot areas completed</p>	<p>Project reports Project reports</p>	
<p>3 Training capacity of State/Division Training Team (S/D TT) is strengthened.</p>	<p>3-1. % of state/division which developed data base for in-service trainings exceeds xx% 3-2. % of state and divisions which developed of specific schedule exceeds xx% 3-3. % of managerial and communication skill trainings provided to pilot townships exceeds xx% 3-4. Average number of supportive supervision from S/D TT to T/STT exceed xx in a month 3-5. % of T/STT shows the improvement in the training skills in the pilot townships exceeds xx% 3-6. Frequency of reporting for CTT and feedback to T/STT is exceeds one in x months</p>	<p>S/D TT records and T/STT reports S/D TT documents S/D TT records S/D TT records (monitoring) S/D TT records S/D TT records</p>	
<p>4 Training capacity of Township Training Team (T/STT) is strengthened.</p>	<p>4-1. T/STT function and capacity is documented 4-2. The coverage of services provided by BHS exceeds the national norms 4-3. % of increase in community utilization of health services exceeds xx%</p>	<p>T/STT reports and records T/STT reports and records Clinical attendance record and in-depth interviews</p>	
<p>ACTIVITIES</p>	<p>INPUTS</p> <p>[Japanese Side] Long-term experts •Chief Advisor •Coordinator</p> <p>[Myanmar Side] Project director Project manager Assistant project manager Office, Office furniture</p>		
<p>1-1. To review existing set-ups and function of CTT</p>			
<p>1-2. To identify members of CTT, its role and functions and organization</p>			
<p>2-1. To request resource allocation for CTT activities</p>			
<p>2-2. To discuss and develop a needs assessment mechanism</p>			

	Monitoring and Evaluation	Local cost
<p>To conduct needs assessment of managerial and training skills for S/D TT and T/STT</p> <p>To prepare annual training plan for managerial and training skills for S/D TT and T/STT</p> <p>To prepare a pilot project and make necessary agreement for the implementation (e.g. selection of the pilot townships, etc)</p> <p>To review and revise the TOT process, and develop training guide with</p> <p>To implement TOT for S/D TT according to the in-service training plan for managerial and training skills</p> <p>To conduct supportive supervision to S/D TTs</p> <p>To establish data base for in-service trainings</p> <p>To conduct annual meetings for all related training teams with service training section</p> <p>To keep dialogues with development partners on a mechanism to expand the activities to other townships</p> <p>To conduct managerial and training skills needs assessment/baseline data for T/STT</p> <p>To develop training schedule for T/STTs in pilot areas</p> <p>To conduct managerial, technical and communication skill trainings to T/STT</p> <p>To provide supportive supervisions for T/STT in implementation of CME for BHS</p> <p>To report the monitoring results/effects of the trainings to CTT and feedback to T/STT</p> <p>To establish state/divisional level data base for in-service trainings and utilize</p> <p>To evaluate the quality of T/STT annually</p> <p>To conduct needs assessment or newly appointed staffs and existing staffs</p> <p>To make request and set-up the necessary supply and equipment for T/STT</p> <p>To give feedback the review of TOT provided by S/D TT</p> <p>To make a plan for CME for BHS</p> <p>To implement CMB to BHS</p> <p>To monitor and supervise the CME</p> <p>To evaluate the CME</p> <p>To report quarterly to S/D TT and CTT</p>	<p>Provision of Machinery, equipment and other materials</p> <p>Trainings: Local and international</p> <p>Project operation Cost</p>	<p>Local cost</p>
		<p>PRE-CONDITIONS</p> <p>Political stability is maintained and mobilization inside the country is supported.</p>

5

25/1

Plan of Operation (PO) Draft

Activities	2008			2009			2010			2011			2012			2013	
	Q3	Q4		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
1 Reconstitute the Central Training Team(CTT) according to the current conditions.																	
1.1 To review existing set-ups and function of CTT																	
1.2 To identify members of CTT, its role and functions and organization																	
2 CTT's capacity in coordination and management is strengthened																	
2.1 To request resource allocation for CTT activities																	
2.2 To discuss and develop a needs assessment mechanism																	
2.3 To conduct needs assessment of managerial and training skills for S/D TT and T/STT																	
2.4 To prepare annual training plan for managerial and training skills for S/D TT and T/STT																	
2.5 To prepare a pilot project and make necessary agreement for the implementation (e.g. selection of the pilot townships, etc)																	
2.6 To review and revise the TOT process, and develop training guide and tools																	
2.7 To implement TOT for S/D TT according to the in-service training plan for managerial and training skills																	
2.8 To conduct supportive supervision to S/D TTs																	
2.9 To establish data base for in-service trainings																	
2.10 To conduct annual meetings for all related training teams with emphasize on sharing feedbacks and the results of supervisions with in-service training																	
2.11 To keep dialogues with development partners on a mechanism to expand the activities to other townships																	
3 Training capacity of State/Division Training Team (S/D TT) is strengthened.																	
3.1 To conduct managerial and training skills needs assessment/baseline data for T/STT																	
3.2 To develop training schedule for T/STTs in pilot areas																	
3.3 To conduct managerial, technical and communication skill trainings to T/STT																	
3.4 To provide supportive supervisions for T/STT in implementation of CME for BHS																	
3.5 To report the monitoring results/effects of the trainings to CTT and feedback to T/STT																	
3.6 To establish state/divisional level data base for in-service trainings and utilize																	
3.7 To evaluate the quality of T/STT annually																	
4 Training capacity of County/District Training Team (C/D TT) is strengthened																	
4.1 To conduct needs assessment of newly appointed BHS and existing BHS																	
4.2 To make request and set-up the necessary supply and equipment for T/STTs																	
4.3 To give feedback the review of TOT provided by S/D TT																	
4.4 To make a plan for CME for BHS																	
4.5 To implement CME to BHS																	
4.6 To monitor and supervise the CME																	
4.7 To evaluate the CME																	
4.8 To report quarterly to S/D TT and CTT																	

LIST OF JAPANESE EXPERTS (TENTATIVE)

1. Chief Advisor
2. Coordinator
3. Training and Management Skills
4. Human Resource Information Management
5. Monitoring and Evaluation
6. Other experts mutually agreed upon as necessary



LIST OF MACHINERY AND EQUIPMENT (TENTATIVE)

1. Equipment for IEC (Audio Visual, projector, computer, etc)
2. Other equipments mutually agreed upon as necessary



LIST OF MYANMAR COUNTERPART (TENTATIVE)

1. DOH/CTT

2. S/DTT

3. T/STT



LIST OF LAND, BUILDING AND FACILITIES (TENTATIVE)

1. Office spaces and facilities necessary for the Japanese experts
2. Liaison desks and facilities for local staff in DOH and Project Sites.
3. Rooms and spaces necessary for installation and storage of the equipment
4. Other facilities mutually agreed upon as necessary



***MEMBER LIST OF WORKING GROUP FOR CTT RECONSTITUTION
(TENTATIVE)***

Members

- | | |
|----------------------------------------------|-------------|
| 1. Director, Public Health | Chairperson |
| 2. Deputy Director, Basic Health Services | |
| 3. Deputy Director, MCH | |
| 4. Deputy Director, School Health | |
| 5. Deputy Director, Nutrition | |
| 6. Assistant Director, Basic Health Services | Secretary |

ミャンマー基礎保健スタッフ強化
プロジェクト

第二次事前調査
現地調査レポート

2007年11月

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1. 背景・目的

ミャンマー国（以下「ミ」国）における基礎保健サービスは国や国民の発展における最大の課題のひとつになっている。基礎的な保健指標上では改善も見られ、例えば、過去30年間に平均寿命は59から62歳へ上昇し、1才以下乳児死亡率は出生1,000あたり148.6から59.7へ、妊産婦死亡率は出生100,000あたり350から255へ、そして5才未満児死亡率は出生1,000あたり96.2から77.73へ、それぞれ下降した¹。しかし、経済状況な停滞はこうした改善の障害になっており、最近では結核・マラリアといった伝統的な感染症に加えてHIVエイズの流行、そして慢性疾患の広がりなど、新しい疾病構造にまつわり多くの課題を抱えている。

周辺諸国と比較すると、「ミ」国のほうが母子の死亡率は高く、保健人材は少ない。このことからわかるように、「ミ」国の保健セクターの課題は人材育成と連関しているといえる。保健人材育成の課題は、業務内容の設定・調整不足、業務過多、能力強化機会の不足等であり、国民に対する適切な基礎保健サービスを提供できていない。保健人材の供給は拡大してきたが、求められるニーズに追いついていない。特にHAやPHS-IIなど、特定のBHSの育成数の不足が保健システム全体における技能の組み合わせに制約をもたらしている。さらに、コミュニティー・ヘルスワーカー（CHW）やAMWは十分に組織化されず、保健システムに統合されていない。

かかる状況に対応すべく、「ミ」国は基礎保健サービスへのアクセスを改善すべくRHCなどのプライマリー・ヘルスケア施設の拡大を行ってきている。保健省（DOH）は、特に全国民5,200万人の健康に直接関わる基礎保健スタッフ（BHS）の重要性を鑑み、組織内にタスクフォースを構成し、基礎保健スタッフの業務分担の見直し、増員（新規採用）、保健センターの増設・整備等に取り組み始めた。しかし、最も取り組みが必要な基礎保健スタッフの能力強化（現任教育）には手をつけられていない状況にあり、課題が残されたままになっている。

このような状況の下、「ミ」国は2000年～2005年に実施された技術協力プロジェクト「ハンセン病対策・基礎保健サービスプロジェクト」を通じ、9500人近くの基礎保健スタッフの人材育成の実績を残してきた我が国に、新たに基礎保健スタッフの現任教育の改善、業務内容の適切な設定・調整等の支援を要請した。この要請に基づきJICAは「基礎保健スタッフ強化プロジェクト」を保健局をカウンターパート（C/P）として実施する方針である。2007年1月に第一次事前調査が実施され、要請内容の確認、現任教育の実施状況等についての情報収集および第二次事前調査実施に関する協議が行われた。その結果、第二次事前調査の調査内容、地域、「ミ」国側調査支援体制が合意された。第二次事前調査は、プロジェクト実施に必要な情報の収集・分析を行うと共に、プロジェクトサイトの決定やC/Pの配置等、プロジェクトの実施体制整備も促進し、それら結果に基づき協力計画（PDM、PO）の策定を実施することを全体目的とし、具体的に現地調査は以下のような個別目的を設定した。

¹ Department of Health Planning, Ministry of Health: National health plan (2001-2006).

1. 各調査地域の保健指標、管理システム、人材育成、国際機関による支援状況などについて概括する。
2. BHS の職務遂行に必要な知識・技能・態度を、組織・職務・個人の各レベルで分析し、研修のニーズを把握する。
3. 各レベルのトレーニング・チームの資格・能力レベル、ならびに BHS 現任教育 (In-service training) を実施するうえでの役割・機能を分析する。
4. BHS への現任教育に関わる課題・問題点を見つける。

2. 方法

現地調査はバゴ管区 (Daioo タウンシップ)、モン州 (Paung タウンシップ)、マンダレイ管区 (Tadaoo タウンシップ)、シャン州 (Pindaya タウンシップ) において行われた。各州管区で、州管区、1 タウンシップ、2 つの RHC を訪問して調査を実施し、結果として 16 の施設、134 人が調査対象となった。回答者が各自質問票に回答記入した後に、その内容に基づき個別インタビューが実施された。研修記録は、まず個別に記入してもらった質問票の回答を集計した。その後、事務所に保管されている研修実施記録によりクロスチェックをかけ、最終的にインタビュー (聞き取り) により確認した。さらに、助産師 (MW) の作業記録を集め、彼女らの就労パターンを調査する目的で分析した。

表 1：現地聞き取り対象者及び期間

月日	場所	聞き取り対象者	人数
2007年8月23日	バゴ管区保健局	管区トレーニング・チーム	9
2007年8月24日	DaiU タウンシップ	タウンシップ・トレーニング・チーム	8
2007年8月27-28日	2 RHC	基礎保健スタッフ	15
2007年8月31日	モン州保健局	州トレーニング・チーム	11
2007年9月1日	Paung タウンシップ	タウンシップ・トレーニング・チーム	6
2007年9月2-3日	2 RHC	基礎保健スタッフ	17
2007年9月10日	マンダレイ州保健局	管区トレーニング・チーム	14
2007年9月11日	TadaU タウンシップ	タウンシップ・トレーニング・チーム	7
2007年9月12-13日	2 RHC	基礎保健スタッフ	18
2007年9月17日	シャン州保健局	州トレーニング・チーム	10
2007年9月18日	Pyndaya タウンシップ	タウンシップ・トレーニング・チーム	5
2007年9月19-20日	1 SHO, 1 RHO	基礎保健スタッフ	14
合計			134

3. 結果

3-1 保健人材育成

「ミ」国保健セクターの問題の多くは人材育成の課題と関係している。ここでは保健人材の不足の程度や状況を分析する。

3.1.1 保健人材の不足

周辺諸国と比較して、「ミ」国が対人口比の医師数、看護婦数が最も少ない（表2）。

表2: いくつかの周辺諸国における保健人材（人口10万人当たり）

国	医師	看護婦
Myanmar	36	38
Laos	59	103
Vietnam	53	56
Cambodia	16	61
India	60	80
Thailand	37	282
China	106	105

(出所: WHO The World Health Report 2006)

タウンシップのレベル以下で活動する約2万人の基礎保健スタッフ（BHS）が国民の健康に直接的に携わっている。「万民のための保健」の達成するために策定された国家保健計画は、その15の戦略の一として豊富な保健人材を生み出すことを掲げている。プライマリーヘルスサービスのカバレッジを拡大するために新しいRHCが設立され、その数は1337（1990年）から1452（2005年）に増加した。また、国家保健計画（2006-2010）は5年間に新たに1,500人のBHSを増加させるよう具体的な目標を設定している。表3はいくつかの主要なBHSに関して、人材育成の目標とそれに対する達成度合いをしめしたものである。これからわかるように保健人材の供給は拡大してきたが、求められるニーズに追いついておらず、2010年目標を達成する見込みは非常に低い（特にHAやPHS-IIにおいて）。MWとPHS-IIを各一人ずつSRHCに配置する方針が1988年に導入されたが、実際に採用されたRHCはまだ少ない。

表3: BHS数（実際と計画）

BHS Categories		2001	2006	Increase	
				2001-2006	2006-2011
HA	Actual	1,198	1,364	+165	
	Target			+500	+300
Leady Health Visitor (LHV)	Actual	1,209	1,694	+485	
	Target			+500	+300
PHS I	Actual	0	651	+651	
	Target				
PHS II	Actual	1,105	1,424	+319	

	Target			+2,500	+1,500
Midwife (MW)	Actual	7,059	8,890	+1,831	
	Target			+2,500	+1,500

(出所: 国家保健計画 2001-2006, 同 2006-2010)

今回調査を実施した4つのタウンシップと8つのRHCのプロファイルを分析したところ、一人当たり MW がカバーする人口は平均 5,900~6,800 と全国平均より 20-45%大きく、また 2010 年の達成目標である 4,000 人より 45-70%多いことがわかった (表 4)。また、個人レベルでは最小 2,700~最大 12,000 人と幅があり、特に山岳地域では人口密度が低いいため同じ人口でもカバーする面積が大きいことがわかった。

表 4: 調査実施地域の保健プロファイル

Data	National (2004)	Paung (Mon)	Daik-U (Bago)	Tada-U (MDY)	Pindaya (Shan)
Basic Demography					
Population	54,299,493	232,091	236,929	143,141	75,811
Urban	13,813,193	32,448	26,431	10,790	16,442
Rural	40,486,300	199,643	210,498	132,351	59,369
% rural	75%	86%	89%	92%	78%
Male	27,000,086	114,785	117,106	67,582	37,110
Female	27,299,407	117,306	119,823	75,559	38,701
Sex ratio	99%	98%	98%	89%	96%
U5 Child	8,500,163	23,646	30,326	14,787	8,788
Rural pop / RHC	29,968	39,666	32,757	30,466	46,150
Health manpower (/1.000 pop)					
Doctor	0.7	0.4	0.3	0.4	0.5
Nurse	1.3	0.5	0.3	0.6	0.7
HA	0.3	0.4	0.2	0.3	0.2
LHV	0.4	0.4	0.3	0.5	0.5
PHS I	0.1	0.1	0.1	0.1	0.3
PHS II	0.3	0.9	0.5	0.2	0.3
MW	2.2	2.4	1.8	2.2	2.0
CHW	6.9	4.4	8.7	7.2	24.3
MW catchments					
population / MW (avg)	4,651	5,908	6,340	5,078	6,837
population / MW (min.)		2,770	2,908	2,952	3,235
population / MW (max)		10,680	12,859	6,435	9,376
Area (sq.km) /MW		2	14	29	55
Number of villages /MW	7	3	5	5	12

(出所:保健省 保健プロファイル)

3.1.2 保健財政上の制約

国際ドルレートで換算した人口当たりの政府保健予算額は、「ミ」国が 10 であり、周辺諸国と比較して最も少ない (ラオス(22), ベトナム (46), タイ (160), カンボジア (36), インド (20)、中国(101))²。また、政府予算額に占める保健セクターの予算額の割合は 2.5%と少ない。逼迫

² 出所: The World Health Report 2006 (WHO)

した予算のなかで、最近公務員の給与が引き上げられたことなどから、人件費が保健予算の恒常経費のかなりの割合を占めていることが推測される。少ない保健予算全体の中で、保健人材育成に割ける予算は限定され、したがって保健サービスの拡大にとっての大きな制約となっている。

3.1.3 保健人材データの有無と品質

保健人材の不足を取り巻く課題とそれらが保健計画の達成能力に及ぼす影響などを正しく理解することが重要であるが、保健人材に関するデータや情報の不備が甚だしく、それ自体が解決することも難しくしており、人材の供給、分配（農村部-都市部、公共-民間、サービス毎など）、そしてその効果などは詳細には把握できていない。データが古い場合も多く、計画立案に利用しにくくなっている。

3.1.4 まとめと考察

厳しい財政状況もとで「ミ」国保健人材育成計画の目標を達成する見込みが低いなか、特に MW と PHS-II の数と能力のバランスを図る必要性が強く伺える。また、MW が提供できる保健サービスの量や質を均等・均質化するためにも、適切な基準に基づく MW の配置原則の見直しが求められる。さらに、保健人材の課題や保健計画達成状況などを正しく理解するうえで、保健サービス供給と保健人材の関係を示す根拠となりうる情報基盤とデータベースを確立することが求められる。

3-2 BHS 能力に影響する諸要因

保健人材の供給が限定される状況下では、既存の保健人材の能力を向上することが供給できる保健サービスの質とカバレッジの向上にとって必要な方策と考えられ、BHS の職務遂行能力はそれに関連する様々な要因や既存の人材の活用されかたによって左右される。この項は BHS が行う職務の効果を妨げうる原因や根本要因、その他課題を分析する。第一次調査の結果や保健人材育成に関連する研究などから、BHS の職務遂行能力に関連すると思われる要因には、1) 農村部の現実に即していない研修カリキュラム、2) 不十分な支援やスーパービジョン、3) 現任教育の調整の不備とそれに伴う参加機会度の不均衡や研修効果の達成を損なうような実施方法、そして4) 保健サービスの計画立案のしかたが実施やモニタリング能力を伴わないこと、などがあげられる。本調査では特に BHS への現任教育と職掌に関する実情、そして、それらがどのように BHS の職務遂行能力に関連するかを調べた。

3.2.1 BHS の知識・技能レベル

調査対象となった RHC で活動する BHS の卒然研修のレベルや経験を表 5 に示した。調査対象となった BHS は、平均すると 1.5 年の卒然研修を受け、12 年の実務経験を有し、そのうち 6 年間は現在の職場で勤務している。その上、多くの介入プログラムの研修を受講しており、その機会各プログラムの拡大にともなって近年増加している。

表 5: 現在の保健施設に平均奉職年数

(n=64)	Years of services	Years after qualified	Age	Years of pre-service training
HA	4	10	42	2.6
LHV	4	8	41	2.3
MW (RHC)	5	9	30	1.5
MW (SRHC)	8	16	40	1.6
PHS-II	3	5	28	0.5
Multiple Purpose Worker (MPW)	6	6	30	0.5
PHS-I	6	13	52	1.3
TOTAL	6	12	38	1.8

(出所: BHS に対するアンケート調査)

このように資格や経験といった観点からは BHS の知識・技能のレベルは高いといえる。一方、職務を効果的に実践する上で必要とされる知識・技能と現状の間にギャップが少なからずある。例えば、MW は一般的に日常業務に忙殺されるなか、各介入プログラムに必要な新しい知識についてゆけない部分が多い。また、新規雇用された MW は通常 3~4 年後にはじめて勤務を開始するが、待機期間中に更新される知識に対して十分なフォローアップができていないケースが多い。また、THN は最近新規に創設されたポジションであるが、それまで病院勤務をしていた看護師が勤める場合が多く、公衆保健や実践的な管理の経験が少ない。HA のなかで CH 大卒 (4 年生) のいわゆる BaHA は非常に若く、まったく社会人としての経験がないまま現場勤務を開始するため BHS を管理するうえで困難に直面するケースが多い。

また、ジョブ・ディスクリプション上で PHS-II に課された任務に比べ、実際に遂行されている役割はまだ不十分とみえた。介入プログラムの多くは疾病対策関連であり、つまり PHS-II が本来担当すべきものも含まれるが、PHS-II がこうした業務を行うに足る知識・技能を持っていない場合が多く、結果として MW への疾病対策プログラム関連の業務負荷が増加し、本来の主要担当業務である母子保健 (MCH) 活動に割ける時間が制限されるケースが多く見受けられた。

以上のような BHS の間での連携・調整の問題や個別の技術ニーズやのほか、各 BHS 全般に共通するより基礎的な技能 (Core competencies) の改善が職務の効果的な遂行にとって欠かせないことも調査から明らかになった。具体的には、以下のような課題があることがわかった。

- ① 創造的・主体的態度の醸成: BHS は上位下達型の仕事の仕方が中心で、創造的で主体的な思考に慣れ親しんでいないため、実際の問題や困難に対してオープンマインドで正直な態度を醸成しにくい傾向がある。こうした態度は、BHS が恒常的に吸収する技術知識を十分に生かすうえで妨げになる。
- ② コミュニティーとのパートナーシップ・スキル: 現在の保健サービス提供システム下においては、コミュニティーによる支援は、保健サービスのカバレッジと質において大きな影

響を与えている。ほとんどの基礎保健スタッフは、コミュニティーとの協働を重要事項として指摘しており、コミュニティー・パートナーシップやコミュニティーにおける効果的保健教育、地域住民とのコミュニケーションスキルなどに対する改善のニーズが広く認められた。

- ③ 患者とのコミュニケーションスキル：多くのBHS（特にMW）が指摘していた。例えば、予防接種、病院へのリファラル、産前健診などの日常活動において、患者の経済状況や文化・社会的な特徴などの関係で患者や家族とのコミュニケーションや対応に苦慮しているケースが多く、特に伝統的な因習の強い少数民族への対応の難しさが多く訴えられた。
- ④ 情報管理スキル：日常業務での記録・報告の業務に多くの時間が費やされている反面、それらの情報を活用したBHSに対するフィードバックが十分に行われていないケースが多い。

3.2.2 研修

研修の実施状況は、BHSの職務遂行能力に直接影響する。コミュニティー・ヘルス大学の設立に見られるようなコミュニティーや公衆保健に寄与する卒前教育学校の充実が近年見られた。しかし、聞き取り調査の対象となったBHSから、卒前教育の内容が農村各世帯の現状や保健ニーズ、患者の期待、逐次変化する保健知識に対応しておらず、学んだことを現実の保健ニーズに適應するための機会を十分には提供されていないことをうかがい知ることができた。

このギャップを埋めるのが現任教育（In-service training）といえる。各介入プログラムに付随する研修以外に保健省がルーチンとして実施している現任教育は、HA-1とTMOを対象にした管理研修とBHS全体を対象としたCMEくらいである。BHS側からみた現在の現任教育の効果を調べた結果、研修内容の妥当性、実施方法、期間、タイミング、アクセスなどの点で以下のような課題点があることがわかった。

- ① 研修内容：BHSは保健施設やコミュニティーでの日々様々な保健業務活動を行っている。研修を通して習得できる知識やスキルの多くは介入プロジェクトがあるものに限定されるので、直面する課題の解決に必要なものがすべてカバーされるわけではない。交通アクセスが悪い地域や洪水の多い地域での緊急出産と産後ケア、輸血施設が限定された地域で血液型判定技術などは他の多くの例の一部である。
- ② 研修の実施方法：短期間に知識集約型の研修が多く、その多くが一回限り（フォローアップ研修がない）ため、その内容を十分に消化しきれていないことが多い。MWの労働負荷の増大が大きな課題になっているなか、研修の一回あたりの期間が長すぎたり、時期が忙しい時期に重なったりなど、研修自体がMWに更なる付加をあたえてしまうケースも見受けられた。
- ③ 研修へのアクセス：調査対象であるBHSは、平均して過去12ヶ月間に9日間の現任教育を

受講しており（CMEを除く）、彼らの多くはより多くの研修受講機会を希望していた。表6に示されたように、BHSへの研修の半数以上が州・管区や中央からの講師によって行われており、効率性がよくないことも研修機会に少なからず影響していると考えられる。

表 6 : BHS への現任教育の講師

Trainers	Man*days	%
Township TT	271.5	47%
D/S TT	228.8	40%
Central TT	64	11%
Others	8.3	1%
Total	572.6	100%

(出所: BHS に対する聞き取り調査)

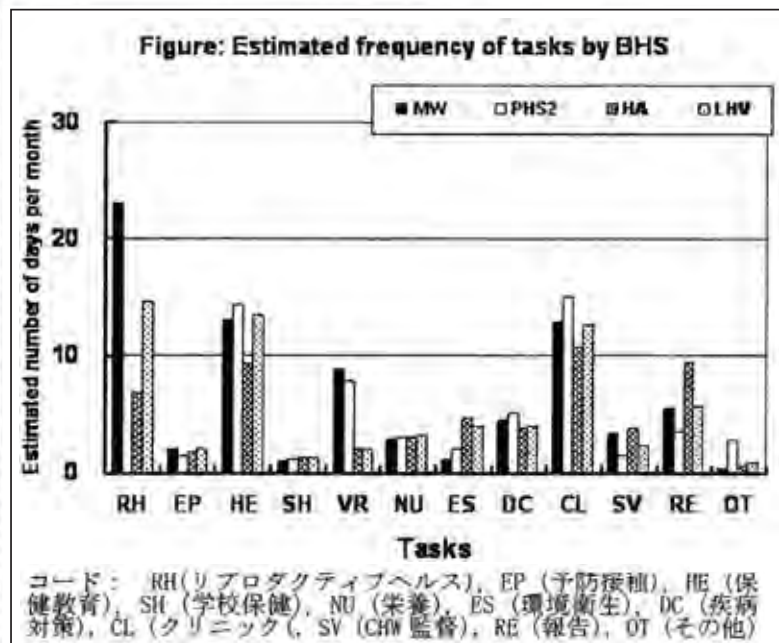
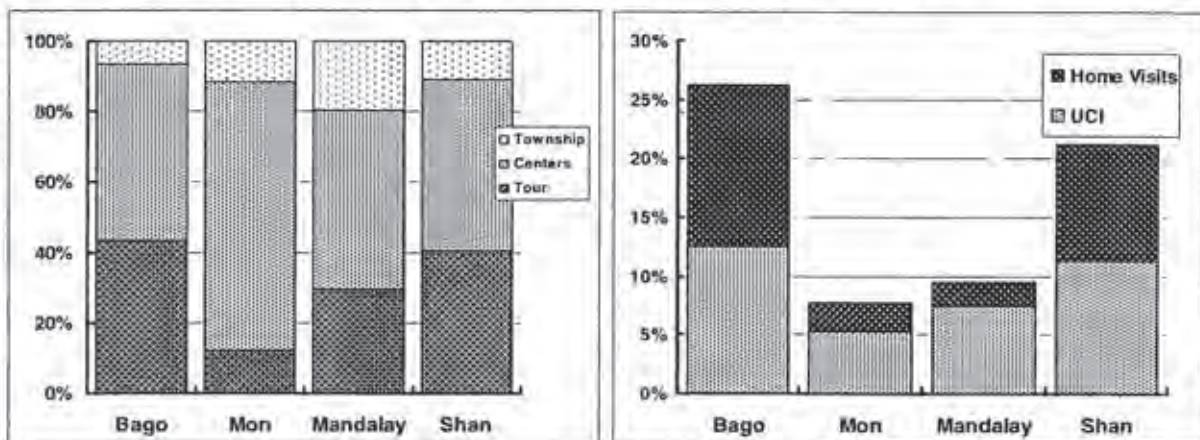
3.2.3 職掌とガイドライン

新しいジョブ・ディスクリプションがつい最近BHSに配布されている。内容を見て以前との違いを既に理解しているBHSも僅かながらいるものの、BHSの多くやタウンシップや州管区のトレーニング・チームのメンバーにおいても、ほとんどはまだその中身に慣れ親しんでいない状況であった。更に、ジョブ・ディスクリプションの中で改善のニーズがありそうな例もいくつか見られた（ボックス参照）。

ボックス 1: BHS 就業パターンを示すケーススタディー

過去においてPHS(II)やMPWを含めた複数チームが地域を小分割して予防接種行っていたケースがあった。最近のDOHの方針変更により、このやり方が取りやめになり、MWだけが予防接種を行う方針が採られ、それによってMWが全ての地域に満遍なく関与することが可能になった。こうした変化とコミュニティー・ヘルス・ワーカーの登用は地球規模で進む「万人のための保健」運動の流れに沿ったものである反面、MW過重負担という問題が起きている。今回の調査の中で、最近1ヶ月間のMW作業月報の記録、コード化、分析を行った。その結果、MWは平均して1ヶ月に2~3日(全体の5-10%)を予防接種にあてているが、その地域別の違いを示したグラフ(下左)が示すように、一人当たりの受持ち面積が大きく、村への交通アクセスが良くない地域などでは予防接種による負担は他に比べて大きいこともわかった。これはにケースによっては柔軟な対応(例えばMPWやPHS(II)が予防接種を行うことを認める)を認める制度的な工夫が求められる。

Figure: Proportions of working days per month of a MW by locations and activities

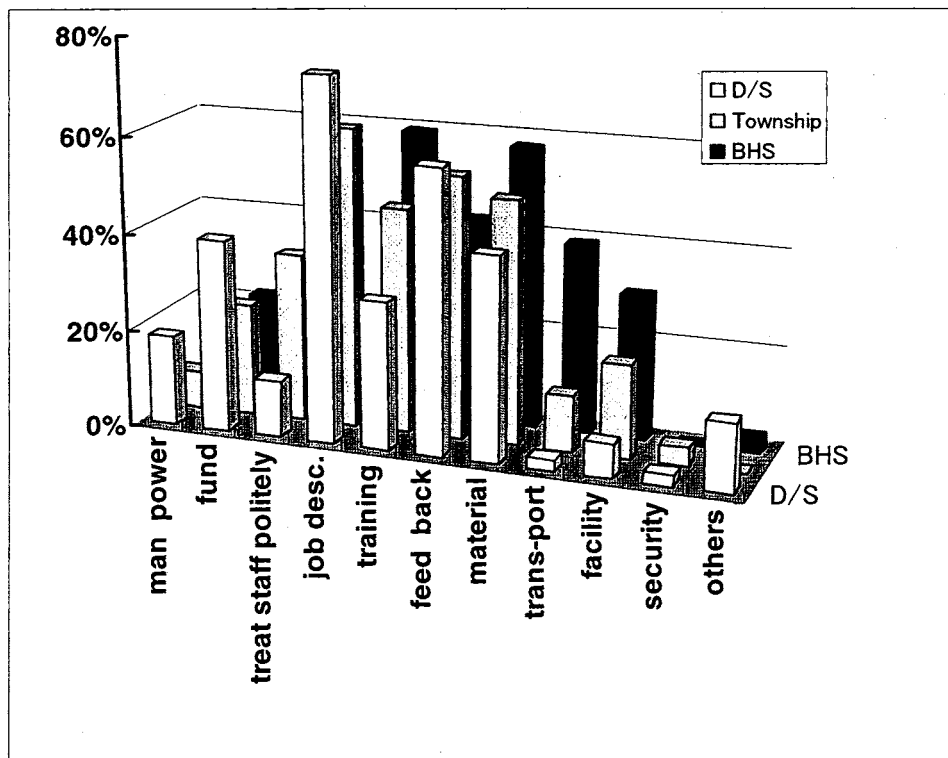


各 BHS カテゴリー別に担当作業の頻度を聞き取り調査した。回答(毎日、毎週、毎月、毎四半期、なし)をそれぞれ、25日、5日、2日、0.3日、0日に換算・集計した結果(左のグラフ)は、きわめて大まかではあるが各作業を頻度の推計である。リプロダクティブヘルス(RH)業務の頻度は他に比べて高く、これがMWとLHVの主要業務であること、そして他の業務はBHSの各カテゴリー(HA, LHV, MW, PHS-II)間で似たような分布を示すことがわかった。RH以外の業務にほぼ全てのBHSが重複して関わっているため、ここの効率的な業務分担を推進することで、特にMWによるRH業務の効果改善に繋がることになる。

3.2.4 その他の要因

基礎保健スタッフの業務遂行状況が改善されるために重要な役割を果たす要因として挙げられた中で割合の高かったものは、「資機材支援」(51%)、「支援的フィードバック」(50%)、「さらなる研修」(47%)、「明確なジョブ・ディスクリプション」(46%)であった。各レベルごとに結果を見てみると、いくつかのバリエーションが存在している。「監督者からのフィードバック」と「資機材支援」がどのレベルにおいても一定して高かったが、基礎保健スタッフの間では、「研修のニーズ」が59%と最も高い一方で、トレーニングチームメンバー間ではわずか36%であった。同様に、「施設整備への支援」「緊急リファールのための搬送手段」が、行政レベルが下位になるほど上昇している。これに対し、明確なジョブ・ディスクリプション、がトレーニングチームメンバーでは70%と最も高かったのに対し、基礎保健スタッフ間では22%と極めて低い結果となっている。

図 1: 基礎保健スタッフの業務遂行状況が改善されるために必要な 3 つの最重要要因



(出所: BHS とトレーニングチーム・メンバーに対する聞き取り調査)

各要因についてそれぞれその内容を以下に吟味する。

- ① 支援的スーパービジョン: 実際の問題や困難に対してオープンマインドで正直な態度を醸成することに役立つような支援的なスーパービジョンは慢性的に欠如しているといえる。

- ② 動機付け:その他の要因の中で、動機付けもBHSが職務を実践する上で重要なものである。BHSに対する動機付けの一環としてDOHが「優秀BHSに対する表彰制度」を実施している。しかし、その規模は小さく、そのBHSにおいては存在もあまり浸透していない。
- ③ キャリア形成に対する支援:調査を通して、MWが将来のキャリア開発として看護大学に通うケースに対し、その通学期間中に別のMWが保管する制度が整っていないため、LHVや既存のMWの負担が大きくなってしまいうケースがあった。そのほか、将来LHVや看護婦になるためのキャリア開発を考えているMWにとって、自主的な継続教育のための教材もないことがわかった。
- ④ 保健サービス提供システム全体の課題:調査の中では、BHSが日常の保健活動の中で直面するその他の大きな課題のひとつとして薬剤支給管理の安定化と緊急リファラルのための輸送手段確保が挙げられていた。また、ミャンマー国内では安全性の見地からアクセスが限定されている地域も多く、こうした地域では一般的に疾病罹患率も高い。こうした地域に対して有効な対策のひとつに、州管区トレーニング・チームによるコミュニティー・ヘルス・ワーカー(CHW)研修の強化が求められる。
- ⑤ BHSの人事管理:保健人材管理の機能の大部分は中央レベルに存在するため、各個人のニーズに応じた管理をするのが難しい。BHSは各個人の目標や職業意識を十分に持っていないことなども、職務に対する満足度という点でその能力を十分発揮させない原因となりえる。保健人材育成の管理者にとって人材育成の計画化などに必要な知識・技能も不足している。

3.2.5 まとめと考察

BHS 現任教育の内容: BHSが現在保有する知識や技能と求められるレベルの間にはいくつかのギャップが確認され、現任教育によってそれらのギャップを埋めるニーズがある。新規雇用のMWやTHN、新卒Haなどに対するリフレッシュ研修のニーズが明らかにされた。PHS(II)の強化はMWの過重負担を減らすことに資するので有用なこともわかった。その他に、BHS全般のいわゆる基礎技能の点で、いくつかの重要な研修ニーズがあることもわかった。コミュニティー・パートナーシップ、コミュニティーでの保健教育、地域住民とのコミュニケーションなどにかかわるスキルは必要不可欠なトピックスとして焦点を当てるべきである。また、それらは、極めて簡素化され、冗長にならず、実践的なものであり、研修では実地でしめされるべきものである。さらに、患者のそれぞれの特徴に応じた効果的なコミュニケーションや対応スキルの向上とそのためコミュニティーへの啓発活動は、BHSが日々の業務で直面する問題の軽減に資するところが多い。BHSが収集・報告するデータを管理者が活用してフィードバックをし、また日常のコミュニケーションを改善するニーズも大きい。

BHS 現任教育の進め方: 研修参加機会度やBHSの職務遂行能力に影響する要因についての聞き

取りからもわかるように、各 BHS がより多くの研修受講機会を得られるようにする必要性が明らかになった。そのためにカスケード方式など研修の効率化を図ることも必要である。また、研修の一回あたりの期間は許容範囲（2-3 日）内に、その内容は日々の業務に直結するものにするこゝと、そして時期はもっとも余裕のある月末 26-31 日にするなど、研修自体が MW に更なる付加をあたえてしまうリスクを軽減する工夫が必要である。研修方法については、従来の座学や講義中心の方法から、実技など多様な参加型手法を現任教育に取り入れることで知識や技術が定着するための工夫が必要である。

職掌の整理・普及：明確なジョブ・ディスクリプションは BHS の職務遂行能力の向上にとって欠かせないもののひとつであり、保健省にとって大きな関心事である。DOH による近年の改定の取り組みがあったが、改訂版のジョブ・ディスクリプションは今後さらに省みられ、恒常的な改定と改善が行われる必要があることもわかった。聞き取り調査の結果は、BHS の間でジョブ・ディスクリプションがより広く理解され浸透する必要があることを示していた。新しいジョブ・ディスクリプションを浸透させ、有効活用し、内容を更に改善するためには共有ワークショップなどを行う必要がある。また、MW と PHS-II の間の配置など BHS の適切な技能の組合せや職責分担の一部見直しなどは保健サービスの効率性、カバレッジ、質の向上に資するので、更なる検討に値する。

その他の改善ニーズ：その他に、BHS の職務遂行能力に影響するいくつかの重要な要因があること、そして、BHS、タウンシップ、州管区といったレベルによって認識に違いがあることが明らかになった。アンケート調査の結果は効果的な研修や明確なジョブ・ディスクリプションの作成などを行おうとする本プロジェクトの意図をある程度正当化する根拠を示していた。また、支援的スーパービジョンのニーズが大きいことがわかったが、これは 2 つの意味で重要であるといえよう。まず、研修を通して獲得された知識は、その後の実践において日常の支援的なスーパービジョンを通して技能として形成され、研修効果が定着する。また、支援的スーパービジョンは BHS が実際の問題や困難に対してオープンマインドで正直な態度を醸成することに役立つ。次に、より効果的な動機付けは BHS の関心や仕事への意欲の向上にとって有効であるので、そのための支援が求められよう。さらに、硬直的な教育システムが BHS のキャリア形成の障害になることも BHS の職務に負に作用する。自主的な現任教育や仕事への意欲の点で、キャリア形成にかかわる教材支援や補完制度の整備・普及が求められる。報告業務など過度に官僚的な管理システムなども仕事へ意欲や作業効率にとって課題である。同様に、CHW や AMW の管理も重要な要因であるので、これらの管理についての改善が求められる。

3.3 研修管理

BHS の職務遂行能力に影響する多くの要因の中で、研修が中心的な果たす役割を果たす。特に、研修の効果や効率性は講師の能力・質や研修管理の適切性に帰属する部分が多いので、それら

について以下に分析する。

3.3.1 各レベルのトレーニング・チーム・メンバー

トレーニングチームメンバーの資格および教育：トレーニングチームメンバーは、高い教育・研修を受けており、その保有資格は非常に高いと言える。トレーニング・チームの半数以上は、MBBS degrees（医師資格）を有しており、州・管区トレーニング・チームのほぼ 30%は修士号を取得している。トレーニングチームメンバーの平均奉職年数：平均すると州・管区トレーニングチームメンバーの現職への奉職年数はわずかに 5 年である。キーとなるポジション、例えば州管区保健局副局长 (DY)、タウンシップ・ヘルス・オフィサー (THO)、ナーシングオフィサー (NO) などは、頻繁な異動によりそれより大幅に短くなっており、それぞれ 2 年間、3 年間、2 年間という現状である。タウンシップのトレーニング・チームのメンバーの奉職期間は、ポジションと地域により異なる。Paung タウンシップ・メディカル・オフィサーの 13 年間という奉職期間が、例外的なものであるとすると、非常に短い。基礎保健スタッフレベルにおいては、年配の助産師がサブ・ルーラル・ヘルスセンターにおいて他の基礎保健スタッフよりも相当程度長期間にわたり奉職している事実はあるものの、平均的奉職年数は、わずか 7 年間である。

3.3.2 研修管理

研修管理のされかたと、それに対する課題や改善のニーズを聞き取り調査によって明らかにした。まず、研修の効率性の観点から研修への参加機会度を、そして研修内容の妥当性をそれぞれ吟味した。そして、研修の管理プロセスは、トレーニング・チーム・メンバーの連携・調整、研修サイクル（計画・実施・モニタリング・評価）、教授方法や研修手法、研修記録・報告の管理、研修環境、などの観点から調査を行った。さらに、第一次調査を通して介入の焦点として注目される継続医学教育（CME）の進め方が精査された。

研修への参加機会度：：過去 12 ヶ月間において、トレーニングチームメンバーは、平均すると州・管区レベルで 37 日間、タウンシップ・レベルでは 16 日間研修に参加している一方、基礎保健スタッフは 9 日間となっている（但し、これには CME は含まれない）。もし、準備、ロジスティックス、報告なども含めると研修のために費やされる期間は倍以上となり、多くの時間が研修のために費やされていると表現できる。また、トレーナーの時間の極めてわずかな時間しか CME での研修に費やされていないという点も着目に値する。3 回に一回の割合で、タウンシップトレーニングチームメンバーを対象として中央（ネピドーもしくはヤンゴン）において研修が実施されている。また、タウンシップのトレーニング・チームへの研修の 60%は中央トレーニング・チームによって実施されたものである。

研修の対象分野とニーズ：全研修の約半分が疾病対策に関するもので最も多かった。詳細トピックスに関しては今般調査対象となった 4 つの地域において、地域ごとに様々である（例：シャン州においては、基礎保健スタッフへの EPI 研修は極めて少ない、また、モン州でのリプロダクティブヘルス、バゴ管区での健康教育に関する研修が少ないなど）。これら

は、必ずしも当該地域の疾病パターンを反映したものではなく、外部介入プログラムに依存する形となっている。

表 7: 研修への参加機会度の詳細

	D/S training team	Township training team	Bago	Mon	MDY	Shan	TOTAL
Type of training							
(Man*day)	(1609)	(406)	(490)	(468)	(640)	(418)	(2015)
TOT (as trainee)	22%	33%	23%	19%	28%	27%	24%
Other training (as trainee)	24%	36%	20%	24%	34%	24%	26%
Multiplier (as trainer)	51%	27%	52%	53%	37%	47%	46%
CME (as trainer)	3%	4%	5%	4%	2%	2%	3%
TOTAL	100%	100%	100%	100%	100%	100%	100%
Place of training							
Central	36%	28%	33%	32%	32%	42%	34%
D/S	26%	24%	30%	22%	28%	21%	25%
Township	34%	48%	37%	46%	29%	37%	37%
Oversea	5%	0%	0%	0%	12%	0%	4%
TOTAL	100%	100%	100%	100%	100%	100%	100%
Topics of training							
Disease Control	47%	28%	36%	35%	42%	64%	43%
Immunization	7%	16%	10%	14%	9%	0%	9%
Health Education	7%	8%	2%	14%	9%	2%	7%
Reproductive Health	10%	11%	12%	1%	14%	11%	10%
WCHD	7%	2%	22%	1%	2%	0%	6%
Nutrition	8%	1%	8%	7%	6%	6%	7%
Environment Sanitation	0%	1%	0%	1%	1%	0%	0%
Others	13%	33%	9%	26%	18%	16%	17%
TOTAL	100%	100%	100%	100%	100%	100%	100%
Positions							
D/S training team							
(Man*day)	(1607)		(372)	(359)	(546)	(330)	(1607)
DY	13%		4%	17%	13%	16%	13%
THO	8%		5%	5%	16%	0%	8%
Disease Control TL/RO	46%		35%	43%	44%	62%	46%
Nursing Officer/AD	9%		26%	1%	7%	2%	9%
Nutrition. TL	7%		10%	9%	3%	10%	7%
Health Plan Officer	6%		0%	25%	0%	0%	6%
HE Officer	8%		20%	1%	9%	2%	8%
THN	3%		0%	0%	8%	0%	3%
Others	2%		0%	0%	0%	8%	2%
TOTAL	100%		100%	100%	100%	100%	100%

Township training team							
(Man*day)		(405)	(117)	(108)	(93)	(88)	(405)
TMO		31%	33%	34%	31%	22%	31%
THO		13%	12%	0%	20%	22%	13%
SMO		5%	0%	15%	5%	0%	5%
THN		23%	28%	22%	25%	15%	23%
HA1		15%	23%	19%	0%	17%	15%
HA		4%	0%	0%	19%	0%	4%
OTHER		9%	3%	9%	0%	25%	9%
TOTAL		100%	100%	100%	100%	100%	100%
Trainers							
(Man*day)	(741)	(278)	(213)	(203)	(390)	(213)	(1019)
Central	89%	59%	87%	93%	64%	94%	81%
D/S	0%	36%	13%	7%	14%	4%	10%
TS	0%	5%	0%	0%	3%	2%	1%
OS	10%	0%	0%	0%	19%	0%	7%
TOTAL	100%	100%	100%	100%	100%	100%	100%

出所: トレーニングチーム・メンバーに対する聞き取り調査、ならびに各保健施設で管理される研修記録)

トレーニング・チーム内での連携・調整: 州管区トレーニング・チームのメンバーは相互の連携が少ない。例えばメンバー間の定期的なミーティングを行っているところはなかった。各メンバーがそれぞれの抱える縦ラインの任務に忙殺されているのが現状であり、中央からの横の連携の指針がないことがこうした連携をとれない一因ともなっている。州管区トレーニング・チームのリーダー (DY) にとって、トレーニング・チームを管理監督するためには、そのための明確な役割・責任を中央から与えられることが必要であるといったコメントが多かった。

Box 2: 創造的な現任教育の好例:

調査を行った州管区の中には、個別のニーズに応じて創造的な対応の取り組みをしているケースがあった。例として、マンダレー管区は新規雇用 WM・THN を対象に、勤務開始時にリフレッシュ研修プログラムを実施していた。この研修プログラムはトレーニング・チームのメンバーが共同してデザインしていた。こうしたアクションが体系的プログラムになることでさらなる効果が期待できる。

(出所: トレーニングチームへの聞き取り)

各レベル間での連携・調整: タウンシップと州管区のトレーニング・チームの間での連携はほとんどない。例えば、CME 講師をタウンシップが州管区から招待するケースは非常に少なく、ほとんどが州管区のトレーナーが関係するプログラムのスーパービジョンのついでに立ち寄って CME を利用してそれぞれの連絡・指導を行うようなケースが多かった。定期的な TMO 会議が行われているケースはなかった。

研修スキルと手法: 州管区トレーニング・チームのメンバーは中央 (DOH) やドナーから与えら

れる既存のトレーニング計画や指示に従うのが中心であり、各タウンシップの実情やニーズに応じてトレーニング・プログラムを主体的かつボトムアップ手法で計画することができない。例えば、研修の計画は各メンバーがタウンシップからの要求に応じて研修を計画したような例は非常に少なかった。また、トレーナーの何人かは参加者各自が心を開いて現実の問題点を明らかにすることができていないと感じており、一方参加者側はトレーナーを十分信頼できないことを示すコメントがあった。こうした問題は、研修参加者の上手な扱い方や参加者の興味関心を惹きつけるような講師-参加者間の関係作りのスキルや態度の改善の必要性を示している。

研修サイクル管理: 州管区トレーニング・チームは継続的にアップデートされる新しい専門知識を習得するために中央で行われる各種の研修に参加するのに忙しく、自分が行った研修をフォローアップするためにタウンシップや RHC を訪問する機会は少ない（プロジェクトの一環として時々行うのみ）。トレーナーによっては、研修効果を事前・事後テストを通してアセスする経験を有しているが、一般的にはあまり行われていない。事後評価的なものはほとんどない。

研修記録管理: 研修参加者、内容、講師などの情報の記録は主に手書きのメモ程度のものであり、活用もされていない。研修報告は、講師がそれぞれの担当セクションに対して提出しているが、タウンシップから州管区に対して CME 報告は必ずしも行われていない。

研修環境: ほとんど全ての回答者は一様に、トレーニングに必要な基本的な教材（マニュアル、補助教材、参考資料、ガイドライン、など）や資機材（視聴覚機器）、研修施設（静かで落ち着いて研修を行える部屋）、そして研修に必要なコスト、また、参加者の人数が適切（30 人以下）であるような編成といったニーズを訴えていた。

CME 研修プロセス: タウンシップのトレーニング・チームは CME 準備のための打合せをもっているケースが多いが、当日の直前に行われ、また必要な教材もなく、準備はそれぞれが個人で行うため、効果的な研修の準備が十分にできていない。トピック選定は TMO の個人的な経験や知識に拠って行われている。ほとんどの時間がデータ収集、報告、上から降りてくる指示や手順の指導に費やされ、各 BHS が抱える問題の解決プロセスを話し合う時間は少ないケースが多い。

3.3.3 まとめと考察

トレーニング・チーム: トレーニングチームメンバーの保有資格は非常に高い一方、平均奉職年数は短くなっており、プロジェクトにとって大きな制約事項として考慮する必要がある。なぜなら、州・管区およびタウンシップ・レベルでの中核となるほとんどのトレーナーはプロジェクト期間内に異動する可能性が高いからである。自立発展性を阻害する大きな要因となろう。地元（一地域）に長く留まるポジションの人材を巻き込むことがより効果が出せると考えられる。

研修管理のありかた: 現在の研修管理のありかたは、中央レベルの講師に依存する割合が大きく、それにかかわる交通費は相当なコスト（負担）となっているが、州・管区およびタウンシップに対する効果的な TOT（トレーナーの代表を研修し、カスケード方式で研修を広

げる)はコスト削減にも大いに貢献する。ニーズと実際に提供される研修の内容にはギャップが存在しており、特に疾病対策に関する研修が非常に多く、保健管理システム強化の研修は非常に少ない実態が明らかになった。地球規模の動きとして、疾病対策や予防接種の予算の一定割合を保健システム強化に割り当てる流れがあり、こうしたギャップを埋める活動を強化するための支援の必要性を示している。特に、CMEなどの日常的に行われる研修機会を通じた現任教育強化への支援はこうしたニーズに呼応するものであろう。

トレーニング・チームのメンバー間での連携・調整を強化することは、メンバーの能力強化に資するところが多い。例えば定期的にトレーニング経験や手法を共有するためのセッションをもつことは、メンバー内に存在する有用なトレーニング手法のテクニカル・リソースを有効活用することができる点で有益である。TMO会議の恒例化・定期化ができれば、タウンシップと州管区の二つのレベル間の双方向のコミュニケーションの改善に資するであろう。また、上位レベルから期待される支援は、研修に必要な教材や教授スキル、建設的なフィードバックや評価、適切なメンタリング、創造的で効果的なカリキュラムや教授法に対する表彰などである。

研修の計画能力という点では、現地の実情やBHSのトレーニング参加機会を把握したうえで、既存のバーチャル・トレーニングでカバーできていないギャップを見つけ、それを埋める方策をとるための立案能力が求められる。教授スキルの点では、トレーニング・チームのメンバーは研修参加者個々の特徴や現地状況に対応した柔軟な研修を行うための技能を身につけることで、その研修効果を増幅できる。特に、講師-受講者間の関係性の改善も大きな課題である。トレーナーの多くが管理者であることを考慮すれば、こうした人間関係の向上は日常のスーパービジョンの技能をさせることにも繋がる重要なスキルであるといえる。研修サイクルの点では、研修後のスーパービジョンやフォローアップなどが研修の効果を増幅させる最も効果的な手段であることを考慮すれば、こうした研修後の部分で改善ニーズは大きい。さらに、研修記録の管理については、研修記録や報告の標準化やデータベース化がもとめられ、これらは各地域のニーズと研修参加機会とのギャップや不足を明らかにする上で重要である。TMOの頻繁は異動のため(2-3年毎)、トレーニング・チーム全体が標準されたCMEプロセス(トピック選定や研修技能)を共有することが必要となる。

3.4: 現任教育に対する関係機関

第一次調査により明らかにされたように、BHSの現任教育を支援する国際機関は少なくない。その多くが各介入プログラムに付随する技術研修であるなかで、WHOは保健省を支援する形でBHSの管理トレーニングに関わるマネージメント・エフェクティブネス・プログラム(MEP)を実施中である。MEPは「管理者とそのチームが保健サービス供給とその実績を改善するための能力向上するためのアプローチ」と定義され、特にタウンシップ・レベルの管理チームによる参加型の問題解決を推進するアプローチである。これまで6つのタウンシップ(6州管区)で実施され、最近新たに別の6タウンシップで開始されている。今回の調査地域には、MEPを実施してい

るタウンシップが1つ含まれており、そこではその効果や便益が観察された。しかし、MEP 実施の中核的な存在を果たしてきた人たち（メンターやファシリテーター）の多くが転勤によって異動してしまっただけのケースも多く、MEP の現任教育（リフレッシュトレーニング）の必要性も多く指摘された。WHO と保健省は MEP の全国展開のためいくつかの方策を模索してきている。例えば、「3D ファンド」は主要3疾患（マラリア、結核、HIV エイズ）プログラムに MEP アプローチを適用する動きを見せており、また、GAVI による保健システム強化（HSS）プログラムは 2008 年 3 月までにプロポーザル提出を目指して、調査を実施中であり、11 月に案件形成のためのワークショップを行う予定になっていた。国際機関によるイニシャティブが採用するであろう MEP コンセプトやアプローチは本案件のそれらと類似しているところが少なくない。保健省側パートナーも重複する可能性がある。したがって、今後こうした案件と建設的かつ相互補完的な協力を醸成してゆくことが不可欠である。

本件調査は予定期間の中で一時中断されたため、本案件に関係する関係するその他のステークホルダーの調査は十分完了できていない。一時調査で報告されているように、今後リソースとして利用可能な機関は、DOH 内では中央保健教育機構（CHEB）をはじめとする関係部局、また、卒然教育に関わる医学教育局（DMS）や各保健人材養成機関、そして、Myanmar Medical Association などの保健医療分野の関係機関などである。さらに、成人教育、参加型カリキュラム開発、コミュニティー・パートナーシップの醸成など既存のトレーニング・チーム・メンバーにとって比較的なじみの薄い新しいアプローチが本案件の中で必要になるので、こうした分野で専門性の高く、当該分野で活動する NGO などの外部リソースの投入が必要になる。

The Secondary Preparatory Study Report

'Strengthening Basic Health Staff in Myanmar' Project

(November,2007)

7 November, 2007

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Annex:

- Questionnaires

List of Abbreviation

3D Fund	3 Disease Fund (TB-Malaria-HIV/AIDS)
AMW	Auxiliary Midwife
BHS	Basic Health Staff
CHEB	Central Health Education Bureau
CHW	Community Health Worker
CME	Continuous Medical Education
D/S	Division / State
DHD	Divisional Health Department
DMS	Department of Medical Science
DOH	Department of Health
DY	Deputy Director
GAVI	Global Alliance for Vaccine and Immunization
HA	Health Assistant
KAP	Knowledge Attitude and Practice
LHV	Lady Health Visitor
MCH	Mother and Child Health
MEP	Management Effectiveness Program
MPW	Multiple Purpose Worker
MW	Midwife
NO	Nursing Officer (NO:2 years)
NPT	NaPiTau
PDM	Project Design Matrix
PHS	Public Health Supervisor
PO	Plan of Operation
RHC	Rural Health Center
SHD	State Health Department
SRHC	Sub-Rural Health Center
TB	Tuberculosis
THN	Township Health Nurse
THO	Township Health Officer
TMO	Township Medical Officer
TOT	Training of Trainers
TT	Training Team
YGN	Yangon

CHAPTER 1 BACKGROUND

The health of Myanmar is probably one of the greatest challenges to the economic development of the country and its peoples. During the past three decades, Myanmar expanded health services and access to their populations leading to improvements in health indicators. For instance life expectancy of the general population had increased from 59 years to 62.2 years; infant mortality rate had declined from 148.6 per 1,000 live births to 59.7 per 1,000 live births; maternal mortality ratio had declined from 350 per 100,000 live births to 255 in 1999; and under 5 mortality rate had declined from 96.2 per 1,000 live births to 77.73¹. These positive steps have been challenged by economic decline. The challenges currently facing the health sector in Myanmar include the resurgence of some of the older communicable diseases such as Tuberculosis (TB) and Malaria and now the recent onslaught of HIV/AIDS, combined with the increases in non communicable diseases.

These setbacks are with the challenges that the country is facing in health human resource. As compared to some of the neighboring countries in Asia, Myanmar has higher maternal and child mortality, but produces the lower numbers of basic health workers. The challenges of health human resource in Myanmar include poor supply of human resources for health, unclear job description, insufficient coordination among different positions, heavy workload and lack of training opportunities. Due to these issues, quality of the basic health services have not been responding well to health needs of rural population.

In terms of health workforce shortage, significant increases in population have not been matched with increases in health's resources. The skill mixes in Myanmar health systems have been limited or reduced by limited production of some BHS categories such as Health Assistant (HA) and Public Health Supervisor II (PHS-II). Furthermore, community-based voluntary health workers such as Community Health Worker (CHW) and Auxiliary Midwife (AMW) are often not well organized and integrated into the country's health systems.

Responding to these challenges, Myanmar had expanded its network of rural health centers and primary care services infrastructure needed for access improvements for basic services. Department of Health (DOH) of Myanmar, having recognized the importance of the BHS who are directly related to health status of the 52 million national populations, established a task force within DOH to initiate efforts to review job description of BHS, increase the number of BHS, and renovation/construction of Rural Health Center (RHC) and Sub-Rural Health Centers (SRHC). However, capacity-development of BHS through in-service training has not yet been sufficiently

¹ Department of Health Planning, Ministry of Health: National health plan (2001-2006).

dealt with despite the importance of the issue. The curriculum of health training schools tended to not directly focus on and reflect health problems and needs of rural population.

Under such circumstances, the government of Myanmar requested Japan to assist for improvement of in-service training of BHS and development of job description, based on their recognition of the achievement made during 200-2005 through the Leprosy Control and Basic Health Services Project on capacity-development of around 9,500 BHS. JICA, in response to the request, will implement the Strengthening Basic Health Staff Project in partnership with DOH. JICA dispatched the Primary Preparatory Study Team in January 2007, to collect information of the project application, status of in-service training and discuss matters on the Secondary Preparatory Study, resulting in agreement on the scope, areas and supporting personnel of the Secondary Preparatory Study. Following the agreements, the Secondary Preparatory Study was conducted to 1) collect information necessary to design a project, 2) establish implementation structures and 3) develop PDM/PO. Under the Study mission, field survey was conducted with following specific purposes;

1. To summarize status of health, health management system and health human resource development in Myanmar.
2. To understand the knowledge, skills, attitudes and norms of BHS needed to do their jobs, carry out specific tasks, and take action in certain ways through analysis of the needs of the organizations / job / individuals and identification of the gaps which can be filled through training.
3. To assess capacity of the training team members at different levels and their roles/functions to be performed for BHS in-service training.
4. Based on the above, to find issues to be addressed with regard to BHS in-service training.

CHAPTER 2 METHODS OF SURVEY

The study was carried out at the 4 Division/State (D/S) below.

- Bago Division (Daioo township)
- Mon Division (Paung township)
- Mandalay Division (Tadaoo township)
- Shan Division (Pindaya township)

At each of the 4 D/S, D/S, one township and 2 Rural Health Centers (RHC) were visited for survey. Therefore, the survey was conducted at following 16 facilities in total with schedule shown below (Table 1). Questionnaires were self-administered individually by respondents, followed by individual interviews. Data on training records were collected through the questionnaire filled in based on individual memory or notes, cross-checked with training records kept at the office, and final check done with interviews. Work diary records of MW were collected to examine their work patterns.

Table 1: Survey duration and interviewees

Date	Location	Interviewees	Number
23 Aug., 07	Bago Divisional Health Department (DHD)	Division Training Team (TT)	9
24 Aug.,07	DaiU Township Health Office (THO)	Township TT	8
27-28 Aug.,07	2 RHC	BHS	15
31 Aug., 07	Mon State Health Department (SHD)	State TT	11
1 Sep., 07	Paung THO	Township TT	6
2-3 Sep.,07	2 RHC	BHS	17
10 Sep.,07	Mandalay DHD	Division TT	14
11 Sep.,07	TadaU THO	Township TT	7
12-13 Sep.,07	2 RHC	BHS	18
17 Sep.,07	Shan SHD	State TT	10
18 Sep.,07	Pyndaya THO	Township TT	5
19-20 Sep., 07	1 SHO, 1 RHO	BHS	14
TOTAL			134

CHAPTER 3 SURVEY RESULTS

3.1 HUMAN RESOURCE FOR HEALTH

Health problems in Myanmar are attributed to human resources to meet its health objectives. The section analyses the degree and the nature of insufficient health workers.

3.1.1 Shortage of Health Personnel (Quantity of BHS)

Myanmar is one of the countries with the lowest ratios of doctors and nurses to population among

neighboring countries in Asia (Table 2).

Table 2: Estimates of Health Personnel in Selected Other Countries [per 100,000 population]

Countries	Doctor	Nurses
Myanmar	36	38
Laos	59	103
Vietnam	53	56
Cambodia	16	61
India	60	80
Thailand	37	282
China	106	105

(Source: WHO The World Health Report 2006)

Basic health services in Myanmar have been provided by around 15,000 of basic health staff (BHS) working below township level. The National Health Policy has been adapted to achieve 'Health for All' based on the primary health care approach and one of the 15 strategies is to produce sufficient health human resource. In order to increase coverage with primary health care services, new RHCs had been opened during the past 15 years. The number of RHCs increased from 1337 in 1990 to 1452 in 2005. The National Health Plan (2006-2011) set the specific numerical targets of health human resource development which includes increase of the number of BHS by adding a total of 1,500 new BHS in the 5 years. Though the supply of health workers has been growing, its rates have not kept pace with the demand as shown in the table below which summarizes the achievement of BHS human resource development targets for selected BHS categories. As indicated in the table, the likelihood to achieve the health human resource targets is very low particularly for HA and PHSII. The new organizational set-up was introduced in 1988 which allocates one midwife and one PHS-II at a Sub-rural Health Center (SRHC), there is still limited number of RHCs with the new staffing pattern.

Table 3: Actual vs. projected number of BHS

BHS Categories		2001	2006	Increase	
				2001-2006	2006-2011
HA	Actual	1,198	1,364	+165	
	Target			+500	+300
Lead Health Visitor (LHV)	Actual	1,209	1,694	+485	
	Target			+500	+300
PHS I	Actual	0	651	+651	
	Target				
PHS II	Actual	1,105	1,424	+319	
	Target			+2,500	+1,500
Midwife (MW)	Actual	7,059	8,890	+1,831	
	Target			+2,500	+1,500

(Source: National Health Plan 2001-2006, National Health Plan 2006-2010)

Health manpower profiles of the surveyed townships are summarized below to contract between the different townships. The average catchments per MW were 5,900-6,800, 20-45% larger than the national average and 45-70% larger than the target by 2011 which was set at 4,000. Also, variations were observed across the different locations. The actual catchments per MW range from 2,700 to 13,000 in the surveyed area. Besides, it is worth attention that area covered by a MW is very much larger in mountainous areas where population density is small.

Table 4: Health Profiles at national and the surveyed locality level

Data	National (2004)	Paung (Mon)	Daik-U (Bago)	Tada-U (MDY)	Pindaya (Shan)
Basic Demography					
Population	54,299,493	232,091	236,929	143,141	75,811
Urban	13,813,193	32,448	26,431	10,790	16,442
Rural	40,486,300	199,643	210,498	132,351	59,369
% rural	75%	86%	89%	92%	78%
Male	27,000,086	114,785	117,106	67,582	37,110
Female	27,299,407	117,306	119,823	75,559	38,701
Sex ratio	99%	98%	98%	89%	96%
U5 Child	8,500,163	23,646	30,326	14,787	8,788
Rural pop / RHC	29,968	39,666	32,757	30,466	46,150
Health manpower (/1.000 pop)					
Doctor	0.7	0.4	0.3	0.4	0.5
Nurse	1.3	0.5	0.3	0.6	0.7
HA	0.3	0.4	0.2	0.3	0.2
LHV	0.4	0.4	0.3	0.5	0.5
PHS I	0.1	0.1	0.1	0.1	0.3
PHS II	0.3	0.9	0.5	0.2	0.3
MW	2.2	2.4	1.8	2.2	2.0
CHW	6.9	4.4	8.7	7.2	24.3
MW catchments					
population / MW (avg)	4,651	5,908	6,340	5,078	6,837
population / MW (min.)		2,770	2,908	2,952	3,235
population / MW (max)		10,680	12,859	6,435	9,376
Area (sq.km) /MW		2	14	29	55
Number of villages /MW	7	3	5	5	12

(Source: DOH Health Profiles)

3.1.2 Fiscal Constraints (Required budget and resources)

Per capita government expenditure on health in Myanmar is 10 international dollar rate, the lowest as compared to other neighboring countries such as Lao (22), Vietnam (46), Thailand (160), Cambodia (36), India (20) and China (101)². Myanmar's general government expenditure on health as % of total government expenditure was only 2.5%. Despite the severe fiscal constraints, Myanmar has recently increased remuneration for all the government workers. It is hence inferred that remuneration costs constitutes significant portion of the recurrent budgets

² Source: The World Health Report 2006 (WHO)

of public sector health services. The poor budgetary investment in health limits room for expansion of remuneration costs. The remuneration dilemma continues to frustrate expansion of health services.

3.1.3 Health Human Resource Data Availability and Quality

It should be understood that the issues surrounding the shortages of BHS and its impact will have on its ability to reach the health development goals. The paucity of information and data on human resources for health is serious and in itself is a constraint to understanding and resolving the crisis. The supply, deployment (urban, rural, private, public, service types) and effectiveness of BHS resources cannot be readily determined. Available data is outdated and thus not useful for effective planning.

3.1.4 Summary and Discussions

Under the severe financial constraints, the likelihood to achieve the health human resource targets seems low. The health work force data clearly indicates future needs of balancing the number and capacity of MW and PHS-II. Also, the survey findings imply needs to revisit the principles to determine MW sanction to ensure balanced quality and quantity of health service delivery. Furthermore, in order to understand issues associated with health human resource development and status of achieving health goals, information base and database should be established to show evidences on the interrelationship between service delivery and human resources that have been deemed positive and from which lessons could be gained.

3.2 CAUSES AND UNDERLYING FACTORS AFFECTING BHS PERFORMANCE

Acknowledging that supply increase of trained workforce is limited, it is a reasonable path for health planners to enhance ability of the existing stock of diverse BHS to deliver quality health services. Causes, underlying factors and other issues affecting the effectiveness of BHS are looked into in this section. According to the primary preparatory study and other researches on health human resource management, possible factors associated with low BHS performance include 1) training curricula not suited for the reality of the rural communities, 2) weak support and supervisory systems, 3) uncoordinated in-service training programs to which access is not equitable among BHS, or are delivered in ways unlikely to achieve an impact, 4) skills in planning health services which have not been complemented with competence in implementation and monitoring. Particular attentions are given to the 2 main factors: job description and in-service training and how those 2 factors could contribute to the overall performance of BHS.

3.2.1 The Levels of Current Skills and Knowledge among BHS

The levels of pre-service training and experience of BHS at RHC are analyzed as below (Table 5). On average, a BHS had received 1.8 years of pre-service training, followed by 12 years of service including 6 years at the present facilities. Furthermore, a BHS also receives many in-service training courses of which frequency and duration recently have been increasing significantly due to increased vertical programs.

Table 5: Average years of services at the present health facility

(n=64)	Years of services	Years after qualified	Age	Years of pre-service training
HA	4	10	42	2.6
LHV	4	8	41	2.3
MW (RHC)	5	9	30	1.5
MW (SRHC)	8	16	40	1.6
PHS-II	3	5	28	0.5
Multiple Purpose Worker (MPW)	6	6	30	0.5
PHS-I	6	13	52	1.3
TOTAL	6	12	38	1.8

(Source: Questionnaire survey for BHS)

The data indicate that BHS has sufficient qualifications and experiences. However, interviews with BHS identified they felt there are gaps between the present and required knowledge to perform respective tasks effectively. In general, MW is overloaded with daily tasks and not able to keep up with all the new knowledge particularly required for many vertical programs. Also, since it is usually 3-4 years after the appointment that the MW starts actual operations. The new MW cannot catch up with the new knowledge during the waiting time. Similarly, the newly appointed THN (most of THN is newly appointed), training is needed on how to supervise MW and LHV since the THN has been promoted from staff nurse or trained nurse at hospital and do not have practical experience in supervision and public health. For newly graduated HA (Ba-HA) who are very young, it is often difficult to manage BHS due to a lack of practical management experiences.

Roles and duties currently performed by PHS-II are smaller than those specified in the job description. MW are not able to involve with their main duties of Mother and Child Health (MCH) activities because of the increased burdens of disease control and other vertical intervention activities which are supposed to be supported by PHS-II, but had not sufficient knowledge on certain skills/knowledge.

Together with the mode of coordination between BHS and technical needs, interview results found that it is essential for BHS to increase their individual core competencies to fill the gaps

between present and required Knowledge Attitude and Practice (KAP) among BHS. Some of those competencies are summarized below.

- 1) **Attitudes with creative and initiating thinking:** The relative advantages of constantly updated technical knowledge of BHS are often hampered by lack of attitudes toward open mind and honesty to expose real problems and difficulties. BHS has been more familiar with a top-down mode of work and less familiar with creative and initiative thinking.
- 2) **Partnership skills to effectively work with community:** Under the current health delivery situation, community support has large influence on health delivery coverage and quality. Most of BHS raised importance of community advocacy skills.
- 3) **Communication skills with patients:** The skills are another issues identified by many BHS. Since many BHS faces difficulty to have good communication and collaboration with patients and their families particularly in ethnic group area in which traditional ideas are strong.
- 4) **Information management:** While BHS spends significant amount of time for recording and reporting in their daily work, it was unlikely that the information is utilized to make feedback to BHS.

3.2.2 Training

Types of training given affect level of skills and knowledge of BHS. Positive moves were made to initiate pre-service training schools devoted to primary health care and community practice in recent years as illustrated by the newly established Community Health University. However, comments made by some BHS implied that the curriculum is not sufficiently responsive to the changing state of knowledge in health and the needs and demands emerging from community, including patients' expectations.

In-service training for BHS is supposed to fill the gaps between what was taught in pre-service training school and what they actually need to know in their daily works at health facilities. Currently, under the National Health Plan, DOH has been conducting refresher management training courses for HA-1 and Township Medical Officer (TMO) and Continuous Medical Education (CME) for all the BHS which are the only routine in-service training programs for BHS presently.

Through the reviewing effects of the training on BHS performance, it was found that the effects depend on several factors such as selection of the topics, mode of delivery, duration and timing as summarized below.

- 1) **Training contents:** Since BHS's exposure to the vertical training varies depending on

access to projects, not all the skills and knowledge are provided by training required to solve all the different health problems faced by BHS in their daily work at clinics and community.

For example, in a RHC surveyed, emergency delivery skills and newborn care are needed among MW where transport access is very bad (flooded). Another RHC identified needs of blood type identification skills for emergency blood transfusion.

- 2) **Methods of training delivery:** BHS cannot consume and internalize training contents because much of new knowledge is provided in intensive, short and one-time training (without follow-up training). While overload on MW is a big concern, the in-service training often add further burden particularly if training is conducted more than allowable duration (2-3 days), not directly related to day-to-day works, and timing not within the most suitable 26-31st of the month.
- 3) **Access to training:** Among the BHS interviewed during the survey, a BHS spent 9 days for in-service training (not counting CME) on average and many of the BHS expressed wishes for more training opportunity. As illustrated by the table below which summarizes response to training participation by BHS during the past 12 months, more than half of the in-service training for BHS has been delivered by Division/State or central level trainers. Efficiency of the training may be related to the access to training since costly training provides less training opportunity for BHS given the limited budget for health human resource development.

Table 6 : Trainers for in-service training for BHS

Trainers	Man*days	%
Township TT	271.5	47%
D/S TT	228.8	40%
Central TT	64	11%
Others	8.3	1%
Total	572.6	100%

(Source: Data from questionnaire survey for BHS)

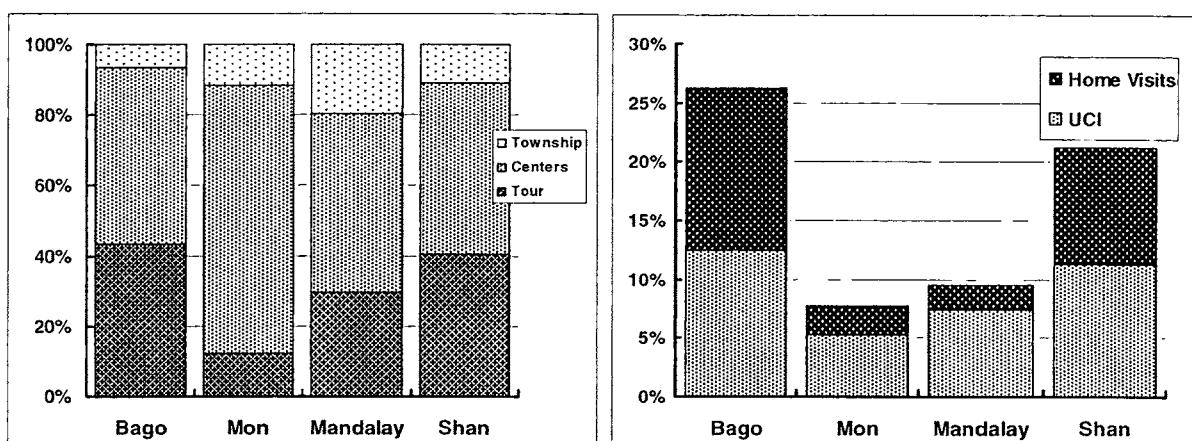
3.2.3 Job Description and Guidelines

The new job-description has just been distributed to BHS. While a few already look into the contents and understood the main differences from the previous version, most of BHS (even township and D/S TT members) have not paid sufficient attention to the contents. There are some examples showing needs of improvements in the job description which are shown in the Box 1 below.

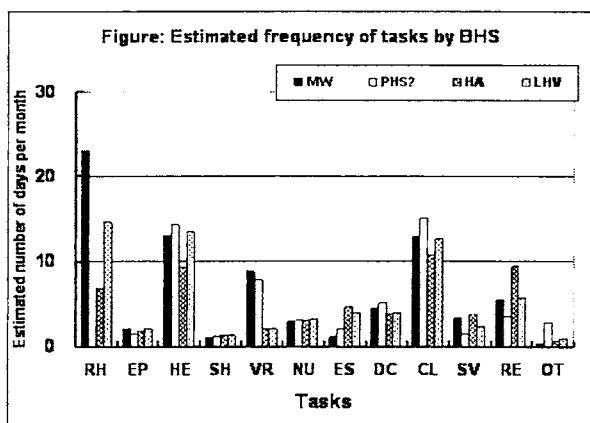
Box 1: Case study showing working patterns of BHS

In some areas, immunization has been conducted by MW, PHS-II and MPW by allocating catchments area. Recent termination of this practice according to the new policy by DOH has enabled equal services delivery by MW across all area. This change coupled with mobilization of community health workers follow global public health movement under the 'Health for All'. However, this shift also increased workload of MW significantly. During the field survey, MW monthly work diary of the recent on month period was recorded, coded and analyzed. On average, 2-3 days was spent for immunization in a month, representing around 5-10% of the monthly working days. However, the figures below indicate burdens of immunization could be heavier particularly in the area with vast geographic coverage and poor transport access to villages. These results imply that rules should be devised to enable more flexible application of the principles on special cases where immunization by MPW and PHS-II can be allowed.

Figure: Proportions of working days per month of a MW by locations and activities



(Source: Data collected from monthly work diary of MW surveyed)



(Source: Data from questionnaire survey for BHS)

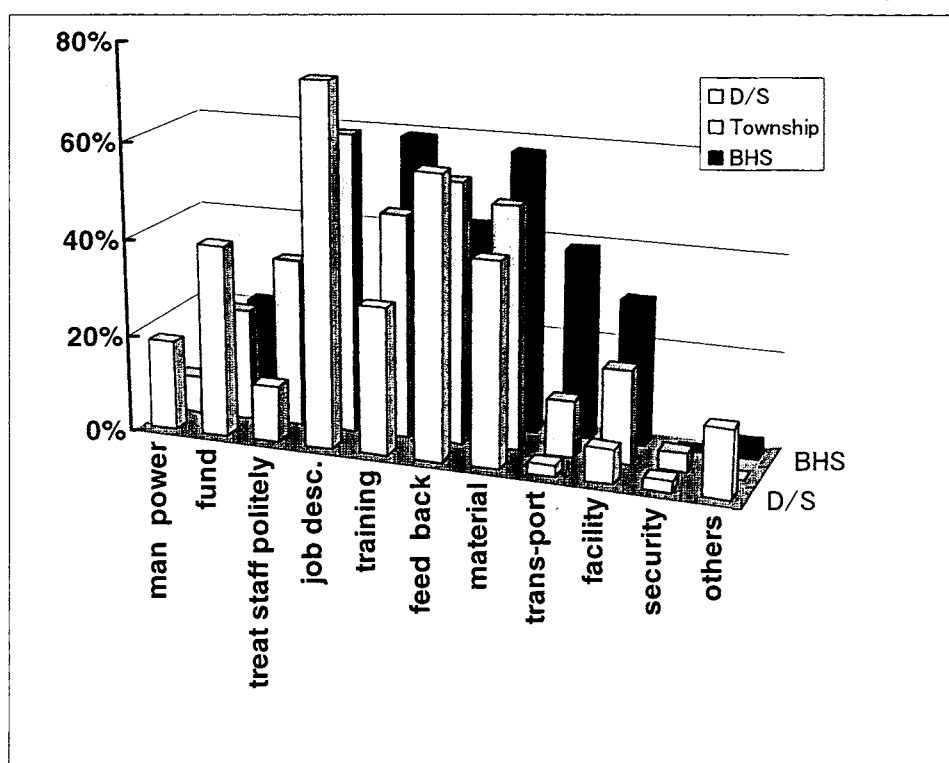
Code: RH(Reproductive health), EP (Immunization), HE (Health education), SH (School health), NU (Nutrition), ES (Environment Sanitation), DC (Disease Control), CL (Clinic), SV (Supervision of CHW), RE (reporting, OT (Others)

Similarly, interview was done on frequency of each of the tasks performed by all BHS categories. The answers of daily, weekly, monthly, quarterly and never were converted to 25 days, 5 days, 2 days, .3 days and 0 days respectively to make very rough estimation of the frequencies. The result (figure below) shows similar patterns across different BHS categories except for reproductive health which was done almost solely by MW and LHV. This outcome implies that due to the duplication at many if the tasks across all BHS categories and higher frequency of reproductive health activities than others, efficiency and effectiveness of task sharing for non-RH activities could contribute to improved performance for RH by MW.

3.2.4 Other Factors

To assess some other factors potentially affects performances of BHS, interviews were given to BHS as well as upper level health workers at township and D/S levels about what are the three most important factors to improve performances of BHS. Answers with high proportion were 'support of materials' (51%), 'supportive feedback' (50%), 'more training' (47%) and 'clearer job description (46%)'. Looking them at different levels, there are some variations. While 'more feedback from supervisors' and 'support for material' were constantly high at all levels, needs of training were highest (59%) among BHS while it was only 36% among training team members. Similarly, 'support for facility' and 'transport for emergency referrals' increase as the level goes down. In contrast, 'clearer job description' was the highest among the training team members (70%) while it was the much less common among BHS (22%). Analysis is made below for some of the factors.

Figure 1: Three most important issues need to be addressed to improve BHS performance



(Source: Data from questionnaire survey for TT members and BHS)

Supportive supervision: There is widespread absence of proper supervisions and of good performance management, which undermines building and sustaining competence at operational levels.

Incentive schemes: Among those factors, existence of incentive schemes affects motivation among BHS to perform health services. BHS section (DOH) has been organizing the

'Best-performing BHS Program'. The program is, however, relatively at small scale and the existence is not well recognized by BHS.

Supports for career development: There were cases reported by some RHC surveyed that difficulties to request substitutions for the MWs who attend nursing schools as their career development have resulted in increased burden put on LHV or other MW who have to fill the gap. For MW who wishes to be LHV or nurse as their career development, supports for reference and training materials are not available for their self-learning.

Issues associated with health management system: Some of the interviewed MW pointed out a lack of stable drug supply and emergency transport for referral as critical constraints. Also, in Myanmar there are some areas with limited access due to security concerns and usually with potentially very high disease prevalence. One of the possible solutions to this issue may be to strengthen CHW.

BHS personnel management: As the health personnel management structures are basically at central level, it is not easy to respond to performance management needs among BHS. Lacks of professional values and clear personal goals among BHS are other factors related to job satisfaction which create a working environment that is not stimulating and reduces performances of BHS. Managers for human resource development need more knowledge and skills for planning health human resource development.

3.2.5 Summary and Discussions

Contents of BHS training: Gaps were found between the present and required knowledge for BHS to perform their respective tasks effectively. Therefore, in-service training for BHS needs to fill those gaps. As examples, needs of refresh training were identified for newly recruited MW and THN as well as for newly graduated HA. Strengthening of PHS-II through refresher training will contribute to lessened workloads of MW. Besides, it was found that it is essential for BHS to increase their individual core competencies which need to be strengthened by training. Training on the community partnership, effective health education in the community, and communication skills with community members are all essential topics to be focused. They must be very simple, short and practical with demonstration. Also, BHS needs to improve skills to deal with patients' demands with effective communication with the patients and their community. The skills could benefit MW to reduce the problems associated with patients which BHS faces in their daily work. Furthermore, supervisors need to make use of the data to make effective feedback to BHS in their regular supervision and communication.

Methods of training delivery: The results of questionnaire surveys indicated needs to improve training exposure among BHS. For that purpose, efficiency of the training should be

improved through promotion of cascade system. Also, devices have to made to reduce the risks that the training adds unnecessary burdens on MW. For example, training should be short (2-3 days), directly related to day-to-day works, and the timing should be between 26th-31st of the month. Methods of training delivery should be improved; not only the traditional didactic approach in the class-room setting, but also adapt participatory approaches including practicum sessions to increase the level of internalization of new knowledge/skills and utilization of those by BHS.

Improvement and promotion of the job description: Clear job description is one of the most essential conditions to improved performance of BHS which has been one of the greatest concerns of DOH. Despite the recent efforts to revise the existing job description, the interview found further needs of improvement, and the revisions need to be continuous based on critical reflection of the current job description. The questionnaire survey indicated needs to increase awareness of the importance of job description among BHS. Workshops are needed to have sharing hearing sessions to facilitate effective utilization and further revisions of the new job-description. Also, it is worth reviewing patterns of deployment and work sharing among various BHS categories particularly of MW and PHS-II to seek appropriate skills mix for better quality, cost-effectiveness and greater coverage of health services.

Other needs of improvement: Data analysis of the questionnaire survey showed that several factors affect performances of BHS, and concepts of relative importance attached to the factors are different among the levels of BHS, township and D/S. Those results provide rationale to launch the project which aims to promote effective training and clearer job descriptions. It was also revealed that **supportive supervisions** need to be strengthened because 1) it has been recognized that new knowledge/skills acquired from in-service training become competencies only if they are reinforced with strong supportive supervisions during follow-ups practicing the knowledge/skills, and 2) supportive supervisions and training methods would both help BHS to have attitudes with open mind and honesty to expose real problems and difficulties. There are needs of supports in development of more effective non-financial **incentive schemes** that contribute to increase motivation and interests among BHS. A potential frustration for many BHS is that **career pathways** are blocked by educational systems that are not flexible enough. To maintain motivation among BHS for self-learning and career development, supports should be given for learning materials and timely substitution systems. Furthermore, excessive **administrative bureaucracy** particularly of reporting tends to create an environment of work that is not stimulating and reduce performance of BHS. Finally, **management of CHW and AMW** is another important factor which need to be improved with appropriate supports.

3.3 MANAGEMENT OF TRAINING

As described above, BHS performances are negatively influenced by many factors, among which training may play central roles. Since effectiveness and efficiency of trainings are determined in great part by quality of trainers and appropriateness of training management, this section examines them in detail.

3.3.1 Training Teams at Central, Division/State and Township Level

Levels of qualification and education of training team members were reviewed to assess the trainers' quality. In general, the training team members are highly qualified with strong training and educational background. Over the half of the training team members have MBBS degrees (medical doctor) and nearly 30% of D/S training team members have post-graduate degrees. With respect to experience, on average, the D/S training team members have served at the current office for only 5 years. The duration is much shorter for some of the key positions such as Deputy Director (DY:2 years), Township Health Officer (THO:3 years), Nursing Officer (NO:2 years) because of their frequent transfers. The years of services among the township training team members depends on positions and locality. If the Paung TMO is an exceptional case (13 years of services), the years of service are very short. At BHS level, the average service years is only 7 years while some old MW working at SRHC serve much longer than other BHS.

3.3.2 Training Management

Individual interviews were conducted with D/S and township training team members to identify main difficulties, issues and needs for improvement with regard to the current in-service training management throughout central to BHS levels. Firstly, level of training exposure was assessed based on quantitative data analysis since it is an important factor related to efficiency of training management. It was then followed by examination of appropriateness of the area of training contents. Qualitative assessment is made with particular attentions paid to several aspects of training management such as 1) coordination between training team members at each level and among different levels, 2) training cycle (plan-delivery-monitoring-evaluation), 3) training delivery skills and methodologies used, 4) data management of training records and reporting, and 5) training environment. Since the primary preparatory study identified CME as a potential focus of the intervention, the CME process was looked into.

Level of the training exposure: On average, a training team member spent 37 (D/S) and 16 (Township) days for training during the past 12 months while it is 9 days among BHS (not counting CME). If days spent for preparation, logistics and reporting of the training are also counted, the numbers could be more than doubled, indicating significant amount of days spent for training. It is also worth noting that very few proportions of trainers' time were spent

to conduct training at CME. One in the every 3 training was conducted in the central, namely either NaiPiTau (NPT) or Yangon (YGN) even among township training team members. Also, 60% of training for township training team was done by central trainers.

Area of training contents: Areas of training contents were reviewed in order to see if they meet needs of BHS. Overall about a half of the training was on disease control. The mixture of the areas of training contents are different across the 4 locations (ex. Very few training for BHS on immunization in Shan, Reproductive Health in Mon and Health Education in Bago), not necessarily reflecting disease pattern, but depending on program/intervention.

Table 7: Breakdown of days spent for training participation

	D/S training team	Township training team	Bago	Mon	MDY	Shan	TOTAL
Type of training							
(Man*day)	(1609)	(406)	(490)	(468)	(640)	(418)	(2015)
TOT (as trainee)	22%	33%	23%	19%	28%	27%	24%
Other training (as trainee)	24%	36%	20%	24%	34%	24%	26%
Multiplier (as trainer)	51%	27%	52%	53%	37%	47%	46%
CME (as trainer)	3%	4%	5%	4%	2%	2%	3%
TOTAL	100%	100%	100%	100%	100%	100%	100%
Place of training							
Central	36%	28%	33%	32%	32%	42%	34%
D/S	26%	24%	30%	22%	28%	21%	25%
Township	34%	48%	37%	46%	29%	37%	37%
Oversea	5%	0%	0%	0%	12%	0%	4%
TOTAL	100%	100%	100%	100%	100%	100%	100%
Topics of training							
Disease Control	47%	28%	36%	35%	42%	64%	43%
Immunization	7%	16%	10%	14%	9%	0%	9%
Health Education	7%	8%	2%	14%	9%	2%	7%
Reproductive Health	10%	11%	12%	1%	14%	11%	10%
WCHD	7%	2%	22%	1%	2%	0%	6%
Nutrition	8%	1%	8%	7%	6%	6%	7%
Environment Sanitation	0%	1%	0%	1%	1%	0%	0%
Others	13%	33%	9%	26%	18%	16%	17%
TOTAL	100%	100%	100%	100%	100%	100%	100%
Positions							
D/S training team							
(Man*day)	(1607)		(372)	(359)	(546)	(330)	(1607)
DY	13%		4%	17%	13%	16%	13%
THO	8%		5%	5%	16%	0%	8%

Disease Control TL/RO	46%	35%	43%	44%	62%	46%
Nursing Officer/AD	9%	26%	1%	7%	2%	9%
Nutrition. TL	7%	10%	9%	3%	10%	7%
Health Plan Officer	6%	0%	25%	0%	0%	6%
HE Officer	8%	20%	1%	9%	2%	8%
THN	3%	0%	0%	8%	0%	3%
Others	2%	0%	0%	0%	8%	2%
TOTAL	100%	100%	100%	100%	100%	100%
Township training team						
(Man*day)	(405)	(117)	(108)	(93)	(88)	(405)
TMO	31%	33%	34%	31%	22%	31%
THO	13%	12%	0%	20%	22%	13%
SMO	5%	0%	15%	5%	0%	5%
THN	23%	28%	22%	25%	15%	23%
HA1	15%	23%	19%	0%	17%	15%
HA	4%	0%	0%	19%	0%	4%
OTHER	9%	3%	9%	0%	25%	9%
TOTAL	100%	100%	100%	100%	100%	100%
Trainers						
(Man*day)	(741)	(278)	(213)	(203)	(390)	(1019)
Central	89%	59%	87%	93%	64%	81%
D/S	0%	36%	13%	7%	14%	10%
TS	0%	5%	0%	0%	3%	1%
OS	10%	0%	0%	0%	19%	7%
TOTAL	100%	100%	100%	100%	100%	100%

(Source: Data from questionnaire survey for TT members)

Coordination between TT members: TT members are not able to benefit from collaboration with other members due to a lack of the collaboration as illustrated by the fact that none of the D/S TT members has a regular meeting. A lack of collaboration/coordination is because the TT members are busy at their individual regular works and there is no instruction from DOH to facilitate the coordination. One example showing good practices of the coordination is provided in the Box 2. Many of the D/S TT leaders (DY) commented that they need clear instructions from DOH on specific roles and responsibilities with regard to management of training teams.

Box 2: Innovative/Positive Practices for In-Service Training: The survey found that some D/S are taking own creative initiatives to meet some of those specific needs as illustrated by Mandalay division which conducts refresher training for the new Township Health Nurse (THN) and MW. The training course was designed jointly by TT members. It is desired that these training will be developed into routine training programs.

(Source: Interviews with training team members in Mandalay division)

Coordination among TT at different levels: There is no routine sharing with or support from D/S TT for township TT. Very few D/S TT members conducted lectures on CME day through invitation from township. In most cases, D/S TT members provided instructions/communications through their occasional supervision visits on CME days. According to TMOs who were interviewed, no regular TMO meetings were conducted.

Training skills and methodologies used: D/S TT members mainly follow general orders or pre-designed modules given by DOH and development partners. Therefore, TT members are not sufficiently able to actively design the training programs based on needs identified through bottom-up training needs assessment. It was illustrated by the fact that very few training was planned based on requests from townships. Some of the interviewees commented that trainers often find trainees closed-mind (not able to expose reality) while trainees are afraid of trainers. These comments implied needs of making positive change of trainers' and trainees' attitudes in favor of skillful treatment of trainees and improvement of trainer-trainee relationship that attracts attentions and interest of trainees.

Training cycle: D/S TT members are usually too busy to attend TOT courses at central level to continuously keep up with technical updates while they are not able to deliver sufficient follow-ups with on-the-job training and supervisions at township and RHC levels which are usually undertaken on ad-hoc basis. Although some trainers had experiences to conduct pre- and post-tests to assess training effects, they were not commonly practiced. Impact assessments were also not exercised.

Training records: Keeping training records was practiced only on participants, contents and trainers by hand-writing memos, and the records were not utilized. Reports on vertical training were submitted by the trainers to respective sections while CME was not necessarily reported by township to D/S.

Training logistics Most of the respondents similarly raised needs of essential teaching aids (manuals, teaching materials, reference materials and guidelines), audio-visual equipment, stationery items, etc) and training facilities (quiet rooms), partial support to training cost. Also, it was pointed out that small number of participants (around 30) is favorable.

CME process: A preparatory meeting was held among TT members usually a few days before the CME day. Since TT members worked individually to prepare their assigned lectures without enough time and reference materials, the preparation was not effectively done. CME topics are given by TMO who self-considers important issues based on individual ideas and experiences. Usually much time is spent for reporting, data collection and instructions on procedures; less time is spent on problem solving process for BHS.

3.3.3 Summary and Discussions

Training team members: Despite the high qualifications among the TT members, we have to consider BHS's short duration of services at current health facilities as the serious constraint for, needless to say sustainability of, the project efforts. It is because most of the key trainers at D/S and township may transfer even during the project duration. It is effective for the project to involve those who stay at the position longer as focal persons.

Training management: Because of the high proportions of the training done by central level trainers, the cost associated with traveling was significant. By organizing training with cascade system in which trainers at central level train trainers at D/S level, who then provide training to township level through effective Training of Trainers (TOT) courses, cost reduction would be realized. The survey found some gaps between needs and training delivery. It was particularly worth attention that proportions of the training were very high on disease control and very low on health management system. Considering the global trends that certain proportions of budget for disease control programs are allocated for health management system, it should be understood there are needs of supports to fulfill the gaps through CME or alternative routine training opportunity.

TT members can benefit from collaboration with other members. For example, if regular sessions are held among TT members on their training experiences and methods, they will contribute to utilization and promotion of the present technical resources within the TT. Routine TMO meeting could contribute to improved communication between TMO and D/S TT. More efforts should be made to encourage and support TT training team members from upper level. The support includes; good material and technical support; constructive feedback and evaluation; access to mentoring; training opportunities to improve teaching; and awards for teaching as well as innovation in curriculum content.

TT needs the planning capability to find gaps among the existing vertical training programs through systematic assessment of local situations and BHS's level of exposure to trainings. Also, TT members can enhance their training effect through flexible adaptation of teaching methods responding to individual trainees' unique characteristics and local conditions. Supports are also needed to improve trainer-trainee relationship. Considering that most of the training team members are supervisors, skills of improving human relationships could benefit day-to-day supervisions as well. Since follow-up training and supervisions are one of the most effective opportunities to enhance the training effect, there are large needs to improve effectiveness in the post-training follow-ups. Standardized reporting procedures and training record database are essential tasks to be done to identify gaps between training exposures and training needs. Due to frequent transfers of TMO usually within 2-3 years, the effective team management is required

among TT to make standardized process of topic selection and delivery of CME.

3.4 International Supports and Other Stakeholders

As reported by the primary preparatory survey report, there are a number of international organizations and programs which support in-service training. Whilst most of the international supports are on technical training attached to respective vertical programs, WHO has been supporting BHS section (DOH) to implement Management Effectiveness Program (MEP) which includes training on BHS management. MEP is 'an approach to develop management capacities of managers and their teams to improve delivery of health services and performances. It has been promoting improvement of health system management initially at the 6 townships, with additional 6 new townships recently starting, with particular focuses on participatory and problem solving approaches for the township management teams. Effectiveness of the MEP was observed during the survey. However, due to very frequent turn over among MEP mentors and facilitators, it was pointed out that refresher MEP trainings are needed. WHO and DOH have been exploring the expansion of the MEP to a national scope through several possible channels. They are illustrated by recent initiatives to orient some vertical programs to MEP approach, such as 1) 3D Fund which intends to apply the MEP tools and principles for the Malaria-TB-HIV/AIDS programs and 2) GAVI initiative which is under the process of situation analysis survey followed by a project formulation workshop, and submission of proposal by March 2008. Since those new initiatives and MEP adapt concepts and approaches similar to the ones of this project, and share the same counterpart at DOH, constructive and complimentary collaboration/coordination with those programs must be promoted.

Due to temporary termination of the survey, inquiries at other potential stakeholders could not be completed. As indicated in the primary survey report, potential resource persons and organizations include 1) related sections within DOH such as Central Health Education Bureau (CHEB), 2) Department of Medical Science (DMS) and other organizations/schools conducting pre-service training, and 3) Myanmar Medical Association and other related associations in health sectors. Also, since the to-be-formulated project involves innovative approaches such as adult teaching/learning, participatory curriculum design and community partnership which most of the existing TT members may not be familiar with, external resource institutions/persons should be sought among NGOs who have experiences and technical expertise in those fields.

Annex

The survey results were supposed to be shared at a seminar with DOH and other stakeholders for the purpose of facilitating positive feedbacks as well as contribution to the planned project design during the PCM workshop, which was postponed, and rescheduling of the workshop has been uncertain at the time of completing this report. Therefore, this report is attached with some discussion points to be considered, discussed and reflected upon during the follow-ups.

- A) To start the project, it is essential to re-define, with clear instructions, the roles and responsibilities of D/S training team leaders and members. While it does not have to be described as the preconditions in the PDM, it should be reminded that it is difficult to initiate project activities without these actions made at the beginning.
- B) The survey results found issues and needs with regard training team members' individual capacities, training management/methods and organizational requirements, all of which need to be improved for better training effect. For effective solutions to those issues, following actions are suggested, indicating appropriateness of the project design.;
- Develop a kind of 'model training package' which addresses those above issues (indicator 1-2).
 - Implement the package at selected pilot townships (indicators 3-2 and 4-1).
 - Share process and results of the implementation with DOH and all D/S TT members (indicator 2-1).
 - Promote replication of the package across other areas in the country (indicator 3-3).
- C) To develop the model training modules, input of resource persons are needed, who have technical expertise to handle the issues analyzed above (PDM input). Also, the model training modules should be developed by TT members at central, D/S and township level together with active participation of community and other stakeholders.
- D) The model training should promote new and improved training methodologies including participatory learning/teaching using practicum and field-based exercises throughout the training cycle of needs assessment-planning-delivery-monitoring-evaluation and change the present didactic and class-room methods. The methodologies will contribute to improve training skills of individual training members (indicator 2-4, 3-4, 4-3). Since skills can be utilized across all the kinds of trainings by the trainers, it indicates sustainability of the activities. The model training package should focus on some of the core competencies of

BHS as illustrated by community cooperation and patients' communication. Development of modules for the training with these contents requires technical resources as necessary conditions.

- E) It is essential to discuss exit strategies at the beginning of the project with regard to how to ensure sustainability of the training package. The discussion could be made around several possible alternatives: 1) new training skills of individual trainers applied to some of the present routine training, 2) integration of the training package into CME in combination improved support system from D/S TT, 3) creation of new training programs.
- F) Since CME is conducted every month for 1-2 days, it is reasonable to promote the model training skills and methodologies through the CME. However, given already intensive contents dealt with within the short duration of CME, feasibility of this option should be carefully examined. Advocacy activities to DOH are necessary to institutionalize the integration of the model package into CME and the related support system by D/S TT together with other relevant policy and regulations.
- G) The survey results indicated needs for the new training programs such as 'Orientation training for newly recruited MW/THN', 'Practical management orientation for Ba-HA' and 'Training strengthening PHS-II'. None of other international organizations has supported these programs despite the importance of the area of focuses worth considered for support. Since those training modules have not been formerly in existence, the process of module development involving TT at central and D/S will contribute to improvement of capacities to coordinate BHS job and training (PDM output 1). However, from the sustainability perspective, DOH needs to develop policy and financial commitment to support the new training programs.
- H) Since the training is a part of the whole health management system, complimentary collaboration with MEP and other relevant program must be ensured.

BHS ASSESSMENT QUESTIONNAIRE

FACILITY IDENTIFICATION	
1. Name of Facility: _____	2. Day/Month/Year of interview: ____ / ____ / _____
3. Division: _____	4. Township: _____
5. Type of facility (CHECK ONE) Township Hospital 1 Station Health Centre 2 Urban Health Centre (MCH) 3 Rural Health Centre 4 Sub-Rural Health Centre 5 Others (specify) 6	6. Respondent category (CHECK ONE) HA 1 PHS1 2 LHV 3 MW 4 PHS2 5 MPW 6 Others (specify) 7
7. The respondent's age: <div style="text-align: right;"> _ _ </div>	8. Sex Male 1 Female 2
9.1 What is the highest level of school (NAME) attended? (BEFORE TECHNICAL TRAINING) MIDDLE (passed) 1 HIGH SCHOOL (passed) 2 GRADUATE 3 POST GRADUATE 4 9.2 technical qualification Certificate 1 Diploma 2 GRADUATE 3	10. Where did you get your current technical qualification? (TECHNICAL TRAINING) MW SCHOOL 1 DORM MW SCHOOL 2 LHV SCHOOL 3 COMMUNITY HEALTH SCHOOL 4 UNIV. OF COMMUNITY HEALTH 5 OTHERS (Specify) 6
11. What year did you graduate with this qualification? YEAR..... _ _ _ _ _	12. How many years of study was required for this qualification? (If less than 1 year, write "00" in years and Indicate number of months). YEARS _ _ MONTHS..... _ _
13. In what year did you start working in this facility? YEAR..... _ _ _ _ _	
Coverage Villages Coverage Population The distance from RHC (Miles)	

14. What health services do you currently provide?	Almost Everyday	Sometimes (once a week)	Rarely (Few times a month)	Never
A) AN, Delivery and PNC	1	2	3	4
B) EPI	1	2	3	4
C) Health education	1	2	3	4
D) School health activities	1	2	3	4
E) Vital registration	1	2	3	4
F) Nutrition	1	2	3	4
G) Environment sanitation	1	2	3	4
H) Disease control program	1	2	3	4
I) Clinic	1	2	3	4
J) Supervision of AMW/CHW	1	2	3	4
K) Reporting	1	2	3	4
L) Other	1	2	3	4

15. What in-service training for BHS have you attended in the last 12 months?				
	Duration (days)	TS	D/S	Trainers DOH Others
(1) _____	_ _	1	2	3 4
(2) _____	_ _	1	2	3 4
(3) _____	_ _	1	2	3 4
(4) _____	_ _	1	2	3 4
(5) _____	_ _	1	2	3 4
(6) _____	_ _	1	2	3 4
(7) _____	_ _	1	2	3 4

16. In the last six months have you had a supervisor speak with you about your work or observe your work?	YES..... 1	Go to 18
	NO..... 2	

17. How many times in the last six months has your work been supervised?			
	NO. OF TIMES	Topics	Supervisors
DOH	-----	-----	-----
D/S	-----	-----	-----
T/S	-----	-----	-----

18. What did your supervisor do the last time he/she supervised you?		
	Yes	No
A) Provided instructions	1	2
B) Check your records/reports	1	2
C) Observe your work	1	2
D) Provide feedback on your performance?	1	2
E) Provide updates on administrative or technical issues related to your work?	1	2
F) Discuss problems you have encountered?	1	2
G) Anything else _____?	1	2
(SPECIFY)		

19. What are the three most important issues which you feel need to be addressed for you to improve your work?	More staff 1
	Treat better staff. 2
	Clear job description..... 3
	Pay better..... 4
	More training 5
	More feedback on performance 6
(PROBE: Any other issues you think are more important than these?)	More/better equipment /supplies 7
	Emergency transport for patients..... 8
	Better physical environment 9
	Better security 10
	OTHER..... 11

TRAINING TEAM ASSESSMENT QUESTIONNAIRE

FACILITY IDENTIFICATION			
1. Name of Facility: _____	2. Day/Month/Year of interview: ____ / ____ / _____		
3. Division/State: _____	4. Township: _____		
5. Respondent category			
<p>(CHECK ONE)</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><u>Division/State</u></p> <p>D/S Director..... 1</p> <p>Deputy D/S Director..... 2</p> <p>Regional Officers..... 3</p> <p>Team Leader..... 4</p> <p>S/D THO..... 5</p> <p>Nursing Officer..... 6</p> <p>Planning Officer..... 7</p> <p>Health Education Officer..... 8</p> <p>Others (specify)..... 9</p> </td> <td style="width: 50%; vertical-align: top;"> <p><u>Township</u></p> <p>TMO..... 1</p> <p>THO..... 2</p> <p>SMO..... 3</p> <p>THN..... 4</p> <p>HA1(THA)..... 5</p> <p>HA..... 6</p> <p>MO..... 7</p> <p>School MO..... 8</p> <p>MCH Officer..... 9</p> <p>LHV..... 10</p> <p>Others (specify)..... 11</p> </td> </tr> </table>		<p><u>Division/State</u></p> <p>D/S Director..... 1</p> <p>Deputy D/S Director..... 2</p> <p>Regional Officers..... 3</p> <p>Team Leader..... 4</p> <p>S/D THO..... 5</p> <p>Nursing Officer..... 6</p> <p>Planning Officer..... 7</p> <p>Health Education Officer..... 8</p> <p>Others (specify)..... 9</p>	<p><u>Township</u></p> <p>TMO..... 1</p> <p>THO..... 2</p> <p>SMO..... 3</p> <p>THN..... 4</p> <p>HA1(THA)..... 5</p> <p>HA..... 6</p> <p>MO..... 7</p> <p>School MO..... 8</p> <p>MCH Officer..... 9</p> <p>LHV..... 10</p> <p>Others (specify)..... 11</p>
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6. The respondent's age: <div style="text-align: right;"> _ _ _ _ </div>	7. Sex Male..... 1 Female..... 2		
8. What is the highest level of school attended? HIGH SCHOOL..... 1 GRADUATE..... 2 POST GRADUATE..... 3 Third Degree..... 4 Diploma..... 5 Specify.....	9. Where did you get your current technical qualification? (TECHNICAL TRAINING) MW SCHOOL..... 1 DORM MW SCHOOL..... 2 LHV SCHOOL..... 3 NURSING SCHOOL (DIPLOMA)..... 4 NURSING UNIV.(GRAD)..... 5 COMMUNITY HEALTH SCHOOL..... 6 UNIV. OF COMMUNITY HEALTH..... 7 MEDICAL UNIVERSITY..... 8 OTHERS (Specify)..... 9		
10. What year did you graduate with this qualification? YEAR..... _ _ _ _ _	11. How many years of study was required for this qualification? (If less than 1 year, write "00" in years and Indicate number of months). YEARS..... _ _ _ _ MONTHS..... _ _ _ _		
12. In what year did you start working in this facility? YEAR..... _ _ _ _ _	13. Have you ever delivered in-service training as trainer for BHS in this Division/State or Township? YES..... 1 NO..... 2 (Go to 18)		

14.1 Which training did you attended at Central or S/D as TOT in the last 12 months?

Training Topic	Duration of Training	Place	Trainers
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____
(3) _____	_____	_____	_____
(4) _____	_____	_____	_____
(5) _____	_____	_____	_____
(6) _____	_____	_____	_____
(7) _____	_____	_____	_____

14.2 Which training did you attended in the last 12 months?

Training Topic	Duration of Training	Place	Trainers
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____
(3) _____	_____	_____	_____
(4) _____	_____	_____	_____
(5) _____	_____	_____	_____
(6) _____	_____	_____	_____
(7) _____	_____	_____	_____

14.3 What are the training you conducted as trainer in the last 12 months?

Training Topic	Duration of Training	Place	Trainees	No. Of Times	CME (Y/N)
(1) _____	_____	_____	_____	_____	_____
(2) _____	_____	_____	_____	_____	_____
(3) _____	_____	_____	_____	_____	_____
(4) _____	_____	_____	_____	_____	_____
(5) _____	_____	_____	_____	_____	_____
(6) _____	_____	_____	_____	_____	_____
(7) _____	_____	_____	_____	_____	_____

15. In the in-service training you delivered, have you used following methodologies?			
	Always	Sometimes	No /Never
A) Preliminary meeting among facilitators(trainers)	1	2	3
B) Training needs assessment	1	2	3
C) Pre-/Post test	1	2	3
D) Participatory teaching/learning methods	1	2	3
E) Evaluation after Training	1	2	3
F) Follow up visit/sessions with trainees	1	2	3
G) Provide Feed Back to trainees for Training evaluation	1	2	3
H) Follow up meeting	1	2	3
16. In the last six months has your training works supervised or assisted by upper level training teams?			
	Yes.....	1	
	No	2 (Go to 18)	
	DK.....	9	
17. How many times in the last six months has your work been supervised?			
	NO. OF TIMES	Topics	Supervisors
DOH	-----	-----	-----
D/S	-----	-----	-----
T/S	-----	-----	-----
18. What did your upper level training team do the last time he/she supervised you?			
	Yes	No	
A) Provided instructions	1	2	
B) Check your records/reports	1	2	
C) Provided curriculum / materials	1	2	
D) Provide feedback on your performance	1	2	
E) Provide updates related to your training	1	2	
F) Discuss problems you have encountered	1	2	
G) Others (SPECIFY)_____?			
19. What are the three most important issues which you feel need to be addressed to improve BHS performance?			
	More staff	1	
	Treat better staff.	2	
	Clear job description.....	3	
	Pay better.....	4	
	More training	5	
	More feedback on performance.....	6	
(PROBE: Any other issues you think are more important than these?)	More/better equipment /supplies	7	
	Emergency transport for patients.....	8	
	Better physical environment	9	
	Better security	10	
	OTHER.....	11	

20. What are the three most important knowledge, practice or attitudes which you feel need to be addressed for yourself to improve training effect?

(PROBE: Any other issues you think are more important than these?)

- Training needs assessment.1
- Adult leaching skill2
- Communication skill.....3
- Facilitation skill4
- Monitoring / Evaluation5
- Updated technical knowledge6
- Others (specify).....7

21. What are the most important support and environment which you feel need to be addressed for you to improve your training?

Open_answers: _____

22. Which BHS categories in your D/S or TS do you think should be prioritized in terms of management training target as trainee?

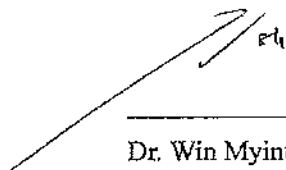
- HA1(THA)1
- HA2
- PHS13
- LHV4
- MW5
- PHS26
- MPW7
- Others (specify).....8

RECORD OF DISCUSSIONS
BETWEEN
JAPAN INTERNATIONAL COOPERATION AGENCY
AND
THE DEPARTMENT OF HEALTH,
THE MINISTRY OF HEALTH OF
THE UNION OF MYANMAR
ON THE JAPANESE TECHNICAL COOPERATION FOR
THE PROJECT FOR STRENGTHENING CAPACITY OF TRAINING TEAMS
FOR BASIC HEALTH STAFF

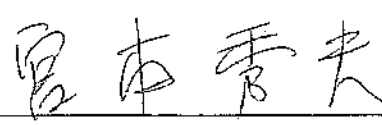
Japan International Cooperation Agency (hereinafter referred to as "JICA") exchanged views and had a series of discussions with the Department of Health, the Ministry of Health (hereinafter referred to as "DOH") with respect to desirable measures to be taken by JICA and DOH of the Union of Myanmar for the successful implementation of the Project for Strengthening Capacity of Training Teams for Basic Health Staff (hereinafter referred to as "the Project").

As a result of the discussions, JICA and the DOH agreed to recommend to their respective Governments the matters referred to in the document attached hereto.

Nay Pyi Taw, January 8, 2009



Dr. Win Myint
Acting Director General
Department of Health
Ministry of Health
The Union of Myanmar



Mr. Hideo Miyamoto
Chief Representative
Myanmar Office,
Japan International Cooperation Agency

THE ATTACHED DOCUMENT

I. COOPERATION BETWEEN JICA AND DOH

1. DOH will implement the Project in cooperation with JICA.
2. The Project will be implemented in accordance with the MASTER PLAN, which is given in Annex I.

II. MEASURES TO BE TAKEN BY JICA

In accordance with the laws and regulations in force in Japan, JICA will take, at its own expense, the following measures according to the normal procedures under the Colombo Plan Technical Cooperation Scheme.

1. DISPATCH OF JAPANESE AND OTHER COUNTRY'S EXPERTS

JICA will provide the services of the Japanese and other country's experts as listed in Annex II.

2. PROVISION OF MACHINERY AND EQUIPMENT

JICA will provide such machinery, equipment and other materials (hereinafter referred to as "the Equipment") necessary for the implementation of the Project as listed in Annex III. The Equipment will become the property of DOH, upon being delivered C.I.F. (cost, insurance and freight) to the Myanmar authorities concerned at the ports and/or airports of disembarkation.

3. TRAINING OF MYNAMAR PERSONNEL IN OTHER COUNTRIES INCLUDING JAPAN

JICA will receive the Myanmar personnel concerned with the Project for technical training in other countries including Japan.

III. MEASURES TO BE TAKEN BY DOH

1. DOH will take necessary measures to ensure that the self-reliant operation of the Project will be sustained during and after the period of Japanese technical cooperation, through full and active involvement in the Project by all related authorities, beneficiary groups and institutions.
2. DOH will ensure that the technologies and knowledge acquired by the Myanmar nationals as a result of Japanese technical cooperation will contribute to the economic and social development of the Union of Myanmar.
3. DOH will grant in the Union of Myanmar privileges, exemptions and benefits to the Japanese experts referred to in II-1 above and their families, which are no less favorable than those accorded to experts of third countries working in the Union of Myanmar under the Colombo Plan Technical Cooperation Scheme.
4. DOH will ensure that the Equipment referred to in II-2 above will be utilized effectively for the implementation of the Project in consultation with the Japanese experts referred to in Annex II.
5. In accordance with the laws and regulations in force in the Union of Myanmar, DOH will take necessary measures to provide at its own expense:
 - (1) Services of the Myanmar counterpart personnel and administrative personnel as listed in Annex IV;
 - (2) Land, buildings and facilities as listed in Annex V; and
 - (3) Supply or replacement of machinery, equipment, instruments, vehicles, tools, spare parts and any other materials necessary for the implementation of the Project other than the Equipment provided by JICA under II-2 above.
6. In accordance with the laws and regulations in force in the Union of Myanmar, DOH will take necessary measures to meet:
 - (1) Expenses necessary for transportation within the Union of Myanmar of the

Equipment referred to in II-2 above within as well as for the installation, operation and maintenance thereof;

- (2) Customs duties, internal taxes and any other charges on the Equipment referred to in II-2 above, imposed in the Union of Myanmar; and
- (3) Running local expenses necessary for the implementation of the Project.

IV. ADMINISTRATION OF THE PROJECT

1. Director General, DOH as the Project Director will bear overall responsibility for the administration and implementation of the Project.
2. Deputy Director, BHS Section, DOH as the Project Manager, will be responsible for the managerial and technical matters of the Project.
3. Assistant Director, BHS section, DOH, as the Assistant Project Manager will be responsible for the daily operations concerning the Project.
4. The Japanese experts will provide necessary recommendations and advice to the Project Director, the Project Manager and the Assistant Project Manager on any matters pertaining to the implementation of the Project.
5. The Japanese experts will give necessary technical guidance and advice to the Myanmar counterpart personnel on technical matters pertaining to the implementation of the Project.
6. For the effective and successful implementation of technical cooperation for the Project, a Joint Coordinating Committee will be established whose functions and composition are described in Annex VI.

V. JOINT EVALUATION

Evaluation of the Project will be conducted jointly by JICA and the Myanmar authorities concerned, at the middle and during the last six months of the cooperation term in order to examine the level of achievement.



VI. CLAIMS AGAINST JAPANESE EXPERTS

DOH undertakes to bear claims, if any arises, against the Japanese experts engaged in technical cooperation for the Project resulting from, occurring in the course of, or otherwise connected with the discharge of their official functions in the Union of Myanmar except for those arising from the willful misconduct or gross negligence of the Japanese experts.

VII. MUTUAL CONSULTATION

There will be mutual consultation between JICA and the DOH on any major issues arising from, or in connection with this Attached Document.

VIII. MEASURES TO PROMOTE UNDERSTANDING OF AND SUPPORT FOR THE PROJECT

For the purpose of promoting support for the Project among the people of the Union of Myanmar, the DOH will take appropriate measures to make the Project widely known to the people of the Union of Myanmar.

IX. TERM OF COOPERATION

The duration of the technical cooperation for the Project under this Attached Document will be five years from the date of arrival of Japanese Expert.

NOTE: The contents of this R/D to be confirmed annually

- ANNEX I MASTER PLAN
- ANNEX II LIST OF JAPANESE EXPERTS AND OTHER COUNTRY'S EXPERTS
- ANNEX III LIST OF MACHINERY AND EQUIPMENT
- ANNEX IV LIST OF MYANMAR COUNTERPART AND ADMINISTRATIVE PERSONNEL
- ANNEX V LIST OF LAND, BUILDINGS AND FACILITIES
- ANNEX VI JOINT COORDINATING COMMITTEE



MASTER PLAN

1. OBJECTIVES OF THE PROJECT

(1) Overall Goal

The quality and coordinated in-service training are provided according to the needs of different levels

(2) Project Purpose

The capacity in training teams at different levels in the in-service trainings for the BHS is strengthened.

2. OUTPUTS OF THE PROJECT

(1) Reconstitute the Central Training Team (CTT) according to the current conditions.

(2) CTT's capacity in coordination and management is strengthened.

(3) Training capacity of State/Division Training Team (S/D TT) is strengthened.

(4) Training capacity of Township Training Team (TTT) is strengthened.

3. ACTIVITIES OF THE PROJECT

1-1 To review existing set-ups and function of CTT.

1-2 To identify members of CTT, its role and functions and organization

2-1 To request resource allocation for CTT activities

2-2 To discuss and develop a needs assessment mechanism

2-3 To conduct needs assessment of managerial and training skills for S/D TT and T/STT

2-4 To prepare annual training plan for managerial and training skills for S/D TT and T/STT

2-5 To prepare a pilot project and make necessary agreement for the implementation (e.g. selection of the pilot townships, etc)

2-6 To review and revise the TOT process, and develop training guide and tools

2-7 To implement TOT for S/D TT according to the in-service training plan for managerial and training skills

2-8 To conduct supportive supervision to S/D TTs

2-9 To establish data base for in-service trainings

2-10 To conduct annual meetings for all related training teams with emphasize on sharing feedbacks from the results supervisions with pre-service training section

2-11 To keep dialogues with development partners on a mechanism to expand the activities to other townships

- 3-1 To conduct managerial and training skills needs assessment/baseline data for T/STT
- 3-2 To develop training schedule for T/STTs in pilot areas
- 3-3 To conduct managerial, technical and communication skill trainings to T/STT
- 3-4 To provide supportive supervisions for T/STT in implementation of Continuing Medical Education (CME) for BHS
- 3-5 To report the monitoring results/effects of the trainings to CTT and feedback to T/STT
- 3-6 To establish state/divisional level data base for in-service trainings and utilize
- 3-7 To evaluate the quality of T/STT annually

- 4-1 To conduct needs assessment of newly appointed BHS and existing BHS
- 4-2 To make request and set-up the necessary supply and equipment for T/STTs
- 4-3 To give feedback the review of TOT provided by S/D TT
- 4-4 To make a plan for CME for BHS
- 4-5 To implement CME to BHS
- 4-6 To monitor and supervise the CME
- 4-7 To evaluate the CME
- 4-8 To report quarterly to S/D TT and CTT



**LIST OF JAPANESE EXPERTS AND
OTHER COUNTRY'S EXPERTS**

Long Term Experts

1. Chief Advisor
2. Project Coordinator

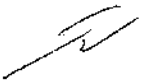
Short Term Experts

1. Experts on Training Skill and Management
2. Experts on Human Resource Information Management
3. Experts on Monitoring and Evaluation
4. Other experts mutually agreed upon as necessary



LIST OF MACHINERY AND EQUIPMENT

1. Equipment for IBC (Audio Visual, projector, computer, etc)
2. Other equipments mutually agreed upon as necessary
3. Two project vehicles



**LIST OF MYANMER COUNTERPART AND ADMINISTRATIVE
PERSONNEL**

1. Director General, DOH -- Project Director
2. Deputy Director General (Public Health), DOH
3. Director, Public Health Division, DOH
4. Deputy Director, Basic Health Section, DOH -- Project Manager
5. Assistant Director, BHS Section, DOH -- Assistant Project Manager
6. Other personnel as necessary



LIST OF LAND, BUILDING AND FACILITIES

1. Office spaces and facilities necessary for the Japanese experts
2. Liaison desks and facilities for local staff in DOH and Project sites
3. Rooms and spaces necessary for installation and storage of the equipment
4. Other facilities mutually agreed upon as necessary



JOINT COORDINATING COMMITTEE

1. Functions

The Joint Coordinating Committee meeting will be held at least once a year and whenever necessity arises. Its functions are as follows:

- (1) To formulate the annual work plan of the Project;
- (2) To review the progress of the annual work plan;
- (3) To review and exchange opinions on major issues that may arise during the implementation of the Project;
- (4) To discuss any other issue(s) pertinent to the smooth implementation of the Project.

2. Members

Chairperson: Director General, DOH (Project Director)

- Myanmar side

(1) Members of DOH

- a. Deputy Director General of Public Health
- b. Deputy Director General of Disease Control
- c. Deputy Director General of Medical Care
- d. Director of Public Health
- e. Director of Disease Control
- f. Director of Planning
- g. Director of Medical Care
- h. Director of Health Education Bureau
- i. Director of Central Epidemiology Unit
- j. Director of Nursing

(2) Member of Department of Medical Science

- a. Director of Training/Foreign Relation

(3) Member of Department of Medical Research

- a. Director of Epidemiology

(4) Member of Department of Health Planning

- a. Director of Health Management Information System (HMIS)

- Japanese Side

(1) Members of JICA:

- a. Resident Representative of JICA Myanmar Office




- b. Japanese experts and other country's experts
- c. Other personnel concerned, to be assigned by JICA, if necessary

- Observer

- a. WHO
- b. UNICEF
- c. Other personnel invited by Chairperson

Note: Official(s) of the Japanese Embassy in Myanmar and others may attend at the Joint Coordinating Committee meeting as observer(s).

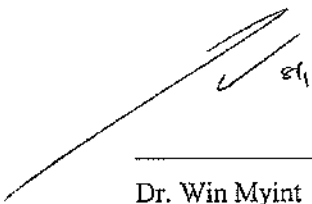


MINUTES OF MEETINGS
BETWEEN
JAPAN INTERNATIONAL COOPERATION AGENCY
AND
THE DEPARTMENT OF HEALTH,
THE MINISTRY OF HEALTH OF
THE UNION OF MYANMAR
ON THE JAPANESE TECHNICAL COOPERATION FOR
THE PROJECT FOR STRENGTHENING CAPACITY OF TRAINING TEAMS
FOR BASIC HEALTH STAFF

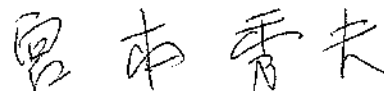
Japan International Cooperation Agency (hereinafter referred to as "JICA") had a series of discussions with the Myanmar authorities concerned for the purpose of working out the details of the technical cooperation Project for Strengthening Capacity of Training Teams for Basic Health Staff (hereinafter referred to as "the Project").

As a result of discussions, both sides reached common understanding concerning the details of the Project as written in the document attached hereto. This document is related to the Record of Discussions for the Project.

Nay Pyi Taw, January 8, 2009



Dr. Win Myint
Acting Director General
Department of Health
Ministry of Health
The Union of Myanmar



Mr. Hideo Miyamoto
Chief Representative
Myanmar Office,
Japan International Cooperation Agency

THE ATTACHED DOCUMENT

1. PROJECT DESIGN MATRIX

The Project Design Matrix (hereinafter referred to as "PDM") was elaborated through discussion by the JICA and the Department of Health, Ministry of Health. Both sides agreed to recognize PDM as the implementation tool for project management, and the basis of monitoring and evaluation of the Project. The PDM will be utilized by both sides throughout the implementation of the Project. The PDM is shown in Annex I.

The PDM will be subject to change within the framework of the Record of Discussions when necessity arises in the course of implementation of the Project by mutual consent.

2. PLAN OF OPERATIONS

The Plan of Operations (hereinafter referred to as "PO") was formulated according to the Record of Discussions. The PO includes a timetable and responsible persons. The schedule is subject to change within the scope of the Record of Discussions when necessity arises in the course of implementation of the Project. The PO is shown in Annex II.

3. IMPORTANT ISSUES DISCUSSED

1) JICA requested DOH to state the role, function and members of Central Training Team on the official document of DOH at the beginning of the Project. "To reconstitute the Central Training Team (CTT) "based on the above statement is the Output 1 on PDM, which is necessary condition to lead the Output 2,3,4.

2) Both sides agreed to modify the PDM which had been agreed on the M/M of Secondary Preparatory Study by adding the sentences as below;

(Objectively Verifiable Indicator)

4-4. Degree of understanding on the training topics by BHS and trainers.

(Means of Verification)

Questionnaire

3) Some of the Objectively Verifiable Indicators on the PDM described such as "xx" or blank, which have not been concretely set yet, are required to be discussed and set in a year after launching the Project.

Annex I. PDM

Annex II. PO

ANNEX 2

Project Title: The Project for Strengthening Capacity of Training Teams for BHS Implementing Organization: Department of Health, MOH in Myanmar

Version 1
Project Period : for 3 years
Target Group: Training Teams (TT) at different levels
Prepared at February, 2008

myhm_022 17/9

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Super Goal Capacity of BHS is strengthened.</p> <p>OVERALL GOAL The quality and coordinated in-service trainings are provided according to the needs of different levels</p>	<ol style="list-style-type: none"> xx% of T/S/TT receive TOT from S/D TT after 3 years of project period The in-service data base at central level is up-dated and state/division levels are expanded 		
<p>PROJECT PURPOSE The capacity of training teams at different levels in the in-service trainings for the BHS is strengthened.</p>	<ol style="list-style-type: none"> Monitoring reports are submitted regularly at different levels. The implementation rates of training plans are more than xx%. The satisfaction level of trainers and trainees among CTT, 17 S/D TT, T/S/TT and BHS in pilot areas is more than xx%. 	<p>Project reports Project Reports and Result of Questionnaire survey</p>	<p>The financial support is available for the expansion of trainings</p>
<p>OUTPUTS</p> <ol style="list-style-type: none"> Reconstitute the Central Training Team (CTT) according to the current conditions. CTT's capacity in coordination and management is strengthened Training capacity of State/Division Training Team (S/D TT) is strengthened. Training capacity of Township Training Team (T/S/TT) is strengthened. 	<ol style="list-style-type: none"> 1-1. The role and function of CTT is documented and authorized 1-2. The existence of formed CTT 2-1. % of pilot areas with improved training skills exceeds xx% 2-2. No. of pilot areas completed 3-1. % of state/division which developed data base for in-service trainings exceeds xx% 3-2. % of state and divisions which developed of specific schedule exceeds xx% 3-3. % of managerial and communication skill trainings provided to pilot townships exceeds xx% 3-4. Average number of supportive supervision from S/D TT to T/S/TT exceed xx in a month 3-5. % of T/S/TT shows the improvement in the training skills in the pilot townships exceeds xx% 3-6. Frequency of reporting for CTT and feedback to T/S/TT is exceeds one in x 4-1. T/S/TT function and capacity is documented 4-2. The coverage of services provided by BHS exceeds the national norms 4-3. % of increase in community utilization of health services exceeds xx% 4-4. Degree of understanding on the training topics by BHS and trainers 	<p>MOH/DOH agreement DG</p> <p>Project reports Project reports</p> <p>S/D TT records and T/S/TT reports S/D TT documents S/D TT records</p> <p>S/D TT records (monitoring) S/D TT records S/D TT records</p> <p>T/S/TT reports and records T/S/TT reports and records Clinical attendance record and in-depth interviews Questionnaire</p>	
<p>ACTIVITIES</p> <ol style="list-style-type: none"> 1-1. To review existing set-ups and function of CTT 1-2. To identify members of CTT, its role and functions and organization 2-1. To request resource allocation for CTT activities 	<p>INPUTS</p> <p>{ Japanese Side }</p> <ul style="list-style-type: none"> Long-term experts Chief Advisor <p>{ Myanmar Side }</p> <ul style="list-style-type: none"> Project director Project manager Assistant project manager <p>Short-term experts</p> <ul style="list-style-type: none"> Training and management skills 		

<p>2-2. To discuss and develop a needs assessment mechanism</p> <p>2-3. To conduct needs assessment of managerial and training skills for S/D TT and T/STT</p> <p>2-4. To prepare annual training plan for managerial and training skills for S/D TT and T/STT</p> <p>2-5. To prepare a pilot project and make necessary agreement for the implementation (e.g. selection of the pilot townships, etc)</p> <p>2-6. To review and revise the TOR, process, and develop training guide and materials.</p> <p>2-7. To implement TOT for S/D TT according to the in-service training plan for managerial and training skills</p> <p>2-8. To conduct supportive supervision to S/D TTs</p> <p>2-9. To establish data base for in-service trainings To conduct annual meetings for all related training teams with</p> <p>2-10. emphasize on sharing feedbacks from the results supervisions with pre-service training section</p> <p>2-11. To keep dialogues with development partners on a mechanism to expand the activities to other townships</p> <p>3-1. To conduct managerial and training skills needs assessment/baseline data for T/STT</p> <p>3-2. To develop training schedule for T/STTs in pilot areas</p> <p>3-3. To conduct managerial, technical and communication skill trainings to T/STT</p> <p>3-4. To provide supportive supervisions for T/STT in implementation of CME for BHS</p> <p>3-5. To report the monitoring results/effects of the trainings to CTT and feedback to T/STT</p> <p>3-6. To establish state/divisional level data base for in-service trainings and utilize</p> <p>3-7. To evaluate the quality of T/STT annually</p> <p>4-1. To conduct needs assessment or newly appointed BHS and existing BHS</p> <p>4-2. To make request and set-up the necessary supply and equipment for T/STT.</p> <p>4-3. To give feedback the review of TOT provided by S/D TT</p> <p>4-4. To make a plan for CME for BHS</p> <p>4-5. To implement CME to BHS</p> <p>4-6. To monitor and supervise the CME</p> <p>4-7. To evaluate the CME</p> <p>4-8. To report quarterly to S/D TT and CTT</p>	<p>•Coordinator</p> <p>•HR information management</p> <p>•Monitoring and Evaluation</p> <p>Office, Office furniture</p> <p>Local cost</p> <p>Provision of Machinery, equipment and other materials</p> <p>Trainings: Local and international</p> <p>Project operation Cost</p>
	<p>PRE-CONDITIONS</p> <p>Political stability is maintained and mobilization inside the country is supported.</p>

Plan of Operation (PO) Draft

Activities	2008				2009				2010				2011				2012				2013	
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2		
1. Reconstitute the Central Training Team (CTT) according to the current conditions.																						
1.1 To review existing set-ups and function of CTT																						
1.2 To identify members of CTT, its role and functions and organization.																						
2. CTT's capacity in coordination and management is strengthened.																						
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2.4 To prepare annual training plan for managerial and training skills for S/D TT and T/STT																						
2.5 To prepare a pilot project and make necessary agreement for the implementation (e.g. selection of the pilot townships, etc)																						
2.6 To review and revise the TOT process, and develop training guide and tools																						
2.7 To implement TOT for S/D TT according to the in-service training plan for managerial and trainee skills																						
2.8 To conduct supportive supervision to S/D TTs																						
2.9 To establish data base for in-service trainings																						
2.10 To conduct annual meetings for all related training teams with emphasize on sharing feedbacks and the results of supervisions with pre-service training																						
2.11 To keep dialogues with development partners on a mechanism to expand the activities to other townships.																						
3. Training capacity of State/Division Training Team (S/D TT) is strengthened.																						
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3.5 To report the monitoring results/effects of the trainings to CTT and feedback to T/STT																						
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3.7 To evaluate the quality of T/STT annually																						
4. Training capacity of Township Training Team (T/STT) is strengthened.																						
4.1 To conduct needs assessment of newly appointed BHS and existing BHS																						
4.2 To make request and set-up the necessary supply and equipment for T/STTs																						
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