MINUTES OF MEETINGS
BETWEEN
JAPANESE TERMINAL EVALUATION TEAM
AND
OFFICIALS CONCERNED OF THE DEPARTMENT OF HEALTH, MINISTRY OF HEALTH, THE UNION OF MYANMAR
ON
JAPANESE TECHNICAL COOPERATION
FOR
THE COMMUNITY-ORIENTED REPRODUCTIVE HEALTH PROJECT

The Japanese Terminal Evaluation Team (hereinafter referred to as "the Team") organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA"), headed by Ms. Keiko OSAKI visited the Union of Myanmar from 30 August to 17 September, 2009, for the purpose of the terminal evaluation of the Community-Oriented Reproductive Health Project (hereinafter referred to as "the Project").

During its stay in Myanmar, the Team and the official concerned of the Department of Health (hereinafter referred to as "DOH") had a series of discussions, jointly evaluated the achievement of the Project, and exchanged views with each other on lessons learned and further measures for improving the reproductive health in Myanmar.

As a result of the findings of the evaluation and discussions, both sides agreed upon the matters referred to in the document attached hereto.

Nay Pyi Taw, 15 September, 2009

15/9/09

Dr. Win Myint
Director General
Department of Health
Ministry of Health
Myanmar

尾崎敬子

Ms. Keiko Osaki
Leader
Terminal Evaluation Team
Japan International Cooperation Agency
Japan

ATTACHED DOCUMENT

The team compiled the result of the Terminal Evaluation in the Evaluation Report attached hereto for submission to the Ministry of Health, Myanmar and the Japanese authorities concerned.

Based upon the Evaluation Report, both sides confirmed the following for further improvement of the Project.

RECOMMENDATIONS

1) It is recommended for the Project implementers to identify the essence, a basic package of inputs (training, tools such as handbooks etc.) and challenges of the CORH approach to share with stakeholders, together with the dissemination of the implementation guide. It would be a good learning opportunity for townships hoping to apply this approach to visit the project areas to observe how the MCHP system is working .
2) In order to sustain the effects that the project accomplished in the project areas, it is necessary to formulate the CORH action plan including the training of 3rd batch MCHPs and to ensure to carry it out.
3) The CORH approach should be tested in the other areas of Myanmar to simplify it to enhance applicability.
4) It is essential to create a forum where DOH and partners jointly review the several programs/projects adopting the community-based approaches (e.g., the Community Support Group, the Community Maternal and Newborn Team, CHW in the Community-based IMCI) in order to deduce useful lessons. The comparative analysis will be helpful in designing practical MCH peer promoter systems as a part of the Myanmar's health system.

LESSONS LEARNED

The concept and structure of the CORH approach are not necessarily new in Myanmar where there are several health volunteer programs. The followings are identified as the significance of the approach.

1) Even after their assigned term of two years, about 66% of MCHPs continue to be active without any financial incentives. It is assumed that the clear selection criteria, recognition by the community, good relations with MW, and acquisition of knowledge and skills are the major factors to prevent them from quitting.
2) The impressive performance of MCHP as a peer MCH promoter is associated with the fact that they use the female-to-female and mother-to-mother approach and concentrate on a single task (MCH) .
3) Japanese experts have been closely collaborating with C/Ps of (DOH and Townships) for the project implementation, and visiting BHS and village resource persons frequently. This resulted in building trust between Japanese experts and stakeholders.
4) Fostering the ownership of communities is one of the requirements of the sustainable project effects.
5) Bridging between community practicing mutual support and BHS could contribute to enhancement of the health service coverage.

6) It is crucial to strengthen the service supply side by allocating sufficient personnel, improving the health facility infrastructure, responding to women's needs, and providing practical training for BHS.
7) The CORH approach, which has been implemented in the geographically, culturally, and economically difficult areas, is expected offer variable lessons for similar interventions.

Attached: Evaluation Report

JOINT TERMINAL EVALUATION REPORT
ON THE JAPANESE TECHNICAL COOPERATION PROJECT
FOR
THE COMMUNITY-ORIENTED REPRODUCTIVE HEALTH PROJECT
IN THE UNION OF MYANMAR

JAPAN INTERNATIONAL COOPERATION AGENCY
JAPAN

AND

MINISTRY OF HEALTH
THE UNION OF MYANMAR

SEPTEMBER 15, 2009

CONTENTS

ABBRIVIATIONS

AMW	Auxiliary Midwife
ANC	Antenatal Care
BCC	Behavior Change Communication
BHN	Basic Human Needs
BHS	Basic Health Staff
BS	Birth Spacing
CDK	Clean Delivery Kit
CHE	Continuing Health Education
CHW	Community Health Worker
CME	Continuing Medical Education
CMW	Currently Married Women
CORH	Community-Oriented Reproductive Health
C/P	Counterpart
CPR	Contraceptive Prevalence Rate
DHP	Department of Health Planning
DOH	Department of Health
DOP	Department of Population
EOC	Emergency Obstetric Care
EPI	Expanded Program on Immunization
FRHS	Fertility and Reproductive Health Survey
HA	Health Assistant
HBMR	Home-Based Maternal Record
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
INGO	International Non-governmental Organization
IUD	Intrauterine Device
JICA	Japan International Cooperation Agency
JOICFP	Japanese Organization for International Cooperation in Family Planning
LHV	Lady Health Visitor
MCH	Maternal and Child Health
MCHP	Maternal and Child Health Promoter
MDG	Millennium Development Goal
MMCWA	Myanmar Maternal and Child Welfare and Association

MMA	Myanmar Medical Association
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MW	Midwife
NGO	Non-Governmental Organization
OBGYN	Obstetrics/Gynecology
OC	Obstetric Complication
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
OVI	Objectively Verifiable Indicator
PCM	Project Cycle Management
PDM	Project Design Matrix
PHC	Primary Health Care
PHS	Public Health Supervisor
PNC	Postnatal Care
PSC	Project Steering Committee
RH	Reproductive Health
RHC	Rural Health Center
RHMIS	Reproductive Health Management Information System
SBA	Skilled Birth Attendant
SDP	Service Delivery Point
SH	Station Hospital
SPDC	State Peace and Development Council
Sub-RHC	Sub-Rural Health Center
TBA	Traditional Birth Attendant
TMO	Township Medical Officer
TT	Tetanus Toxoid
TWG	Township Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHW	Volunteer Health Worker
VTWG	Village Tract Working Group
WHO	World Health Organization

1. BACKGROUND AND SUMMARY OF THE PROJECT

In the Union of Myanmar, there continues to be a high unmet need for reproductive health (RH), due to the limited access of the people to RH services and information. It is caused by various reasons such as insufficient number of health service providers and health facilities, insufficient knowledge and skill of health service providers. As a result, reproductive health indicators of Myanmar such as Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) remain high compared to other neighboring countries.

The Community-Oriented Reproductive Health Project was launched in February 2005 for the project period of five years. The Project aimed to achieve improvement of reproductive health in the project target areas, namely Kyaukme and Naungcho Townships in Shan State, through providing quality RH services, improved awareness and knowledge on RH services among the communities.

The Project has been undertaken by the Japanese Organization for International Cooperation in Family Planning (JOICFP) under the Japanese Technical Cooperation Scheme supported by Japan International Cooperation Agency (JICA).

In order to monitor the progress of the Project, and to identify the challenges, the mid-term evaluation was conducted in August 2007, in which the evaluation team reviewed the project activities, and made recommendations in agreement with the DOH officials concerned. Two years later, as the Project term is coming to an end in January 2010, the terminal evaluation team was formed to visit Myanmar in September 2009.

2. PURPOSE OF TERMINAL EVALUATION

The terminal evaluation aimed to review all the Project activities and achievements for evaluation according to the five evaluation criteria of OECD, to make recommendations as to what needs to be done during the remaining Project period, and to identify lessons learned which would be expected to be useful for other projects.

3. MEMBER OF TERMINAL EVALUATION TEAM

Name	Job Title	Occupation
Ms Keiko OSAKI	Team Leader	Senior Advisor, Reproductive Health Team, Department of Human Development, JICA
Ms Kotoko SUZUKI	Reproductive Health	Assistant Professor, Faculty of Education Tokyo Gakugei University
Ms Yoshika UMABE	Evaluation Planning	Project Formulation Advisor, JICA Myanmar Office
Ms Akiko HAYASHI	Evaluation and Analysis	Consultant of JICA (Health and Development Service- HANDS)

4. METHOD OF EVALUATION

The terminal evaluation was conducted according to the JICA's Project Evaluation Guidelines. The following review process is taken.

(1) The Myanmar and Japan evaluation team jointly evaluated the Project based on the PDM agreed upon by the both sides on 15th September 2008 as the basis of the evaluation.
(2) Performance of the Project in terms of the Objectives, Outputs, and Activities and Inputs stated in the PDM was studied by collecting data on the verifiable indicators and other relevant information.
(3) The evaluation analysis was made according to the five criteria described below.

1) Relevance: Evaluation of whether the Outputs, Project Purpose and Overall Goal are in compliance with the national and regional priority needs and concerns at the time of evaluation.
2) Effectiveness: The extent to which the Project Purpose has been achieved in relation to the Outputs produced by the Project.
3) Efficiency: Evaluation of how efficiently the efforts and resources of the Project converted to the Outputs, and whether the same results could have been achieved by alternative methods.
4) Impact: Foreseeable or unforeseeable, and favorable or adverse effect of the Project upon the target groups and persons possibly affected by the Project.
5) Sustainability The perspective whether the positive effects as a result of the Project are likely to continue after the external assistance comes to an end.

5. SCHEDULE OF THE TEAM

Date		Activity
30 Aug	Sun	Arrive Yangon (Ms Hayashi)
31 Aug	Mon	Leave Yangon for Mandalay Introduction to Naungcho Township Medical Officer Arrive Kyaukme
1 Sep	Tue	Observation of HMIS Training in Naungcho Township
2 Sep	Wed	Meeting with Naungcho Township Medical Officer in Naungcho Visit MCH Center in Naungcho Tsp (*) Visit Kyauk Taw Sub-RHC in Naungcho Tsp (*)
3 Sep	Thu	Visit Kan Gyi RHC in Naungcho Tsp (*) Visit Naung Taw Sub-RHC in Naungcho Tsp (*) Arrive Yangon (Ms Osaki, Ms Suzuki)

Date		Activity
4 Sep	Fri	Arrival meeting at JICA Myanmar Office (Ms Osaki, Ms Suzuki, Ms Umabe) Meeting with UNFPA, WHO (Ms Osaki, Ms Suzuki, Ms Umabe) Meeting with Kyaukme District Medical Officer (Ms Hayashi) Visit Mai Teen Sub-RHC and Sa Khan Thar Sub-RHC in Kyaukme Tsp (*) (Ms Hayashi)
5 Sep	Sat	Leave Yangon for Kyaukme (Ms Osaki, Ms Suzuki, Ms Umabe) Visit Kywe Kone Sub-RHC in Kyaukme Tsp (*) (Ms Hayashi) Interview with Kho Mone Sub-RHC in Kyaukme Tsp (*) (Ms Hayashi) Interviews / meeting with Project Experts
6 Sep	Sun	Meeting with District Medical Officer and TWG members in Kyaukme Tsp Observe Kyaukme District Hospital Interviews / meeting with Project Experts
7 Sep	Mon	Visit MCH Center and Loi Khaw Sub-RHC in Kyaukme Tsp (*) Interview with Naung Pein RHC in Kyaukme Tsp (*)
8 Sep	Tue	Meeting with Naungcho Medical Officer and TWG members in Naungcho Tsp Visit Naungcho Township Hospital Visit Ohnma Khar Sub-RHC in Naungcho Tsp (*)
9 Sep	Wed	Visit Samma Sae Sub-RHC in Naungcho Tsp (*) Visit Bant Bwe RHC in Naungcho Tsp (*) Leave Naungcho for Pin Oo Lwin
10 Sep	Thu	Leave Pin Oo Lwin for Yangon Arrive Yangon
11 Sep	Fri	Meeting with UNICEF Team Meeting at JICA Myanmar Office
12 Sep	Sat	Meeting with Dr. Theingi Myint (Deputy Director, MCH, DOH) Compiling Evaluation Report
13 Sep	Sun	Compiling Evaluation Report Move from Yangon to Nay Pyi Taw
14 Sep	Mon	Preparation Meeting on Terminal Evaluation with Department of Health
15 Sep	Tue	Feedback Meeting on Terminal Evaluation Signing of M/M on Terminal Evaluation The 8th Project Steering Committee Meeting
16 Sep	Wed	Leave Nay Pyi Taw for Yangon Arrive Yangon
17 Sep	Thu	Debriefing Meeting at JICA Myanmar Office Reporting to Embassy of Japan Leave Yangon for Japan
18 Sep	Fri	Arrive Japan

(*) Meeting/interviews with MW, AMWs, MCHPs, VTWG members, and clients were conducted.

6. SUMMARY OF THE EVALUATION

6.1. Achievement of the Project

Overall Goal: Reproductive health (RH) status improves in project areas and expanded areas* of the Union of Myanmar. (*The areas where the Community-Oriented RH approach is applied.)

At this moment it is difficult to assess the degree of improvement in reproductive health status in the project areas and expanded area, because of the limited availability of the reliable data.

As for the project areas, the first indicator, MMR in the project areas reduced from 2005 (Kyaukme 187/100,000 and Naungcho 189/100,000) to 2008 (Kyaukme 143/100,000 and Naungcho 180/100,000). However, it fluctuates greatly, as the both townships recorded the best figure in 2007 (Kyaukme 137/100,000 and Naungcho 87/100,000) and then deteriorated in the following year.

The second and third indicators aggravate from 2006 to 2009 or data seems unreliable.

Improvement of RH status in the expanded areas depends on the government's efforts to apply the Community-Oriented Reproductive Health (CORH) approach and the present RH status.

Project Purpose: Utilization of quality RH services increases in the project areas.

During the four year period (2005-2008), all the five objective verifiable indicators (OVIs), (1. Contraceptive prevalence, 2. ANC coverage, 3. Percentage of deliveries attended by skilled health personnel, 4. Percentage of pregnant women referred to higher level, and 5. Coverage of TT injection among pregnant women) recorded increases. However, it would be safe to disregard the OVI 4 (the referral of pregnant women to the district or township hospital by MW), because the reasons of the referral are unknown and there is no system to monitor the referral cases to adjacent townships. With four out of five OVIs improved, it could be concluded the Project Purpose is achieved. It deserves attention that the indicators do not have numerical targets and the degree of the improvement is not necessarily great.

The Outputs 1, 2, 3 and 4 were considered achieved, since all the indicators were improved or accomplished, as described below. On the other hand, the Output 5 has not yet been accomplished, and it is necessary to continue making efforts to complete it.

Output 1: Quality of RH services with special focus on safe motherhood is improved in the project areas.

All the six indicators in relation to the proportion of the service providers with necessary RH knowledge and skills grew remarkably during the period of 2005-2008 from the time of the baseline survey to that of the endline assessment.

Output 2: Awareness and knowledge on RH issues among community people, particularly women improve in the project areas.

In the four year period (2005-2008), three indicators (OVI 1, 2 & 3) regarding RH knowledge of men and women, and two (OVI 4-5) related to women's behavior drastically improved. OVI 6, number of female participants in health education increased from 2006 to 2008, except for the decrease in Naungcho from 2007 to 2008. A great variety of IEC/BCC materials was developed and widely distributed (OVI 7).

Output 3: The linkage between RH services and community people is strengthened.

Generally speaking, the indicators, the number and coverage of ANC, PNC and deliveries by the trained health personnel (MW and AMW) increased from 2005 to 2008 with some degree of fluctuations.

Output 4: Mechanism to support the Community-Oriented RH approach is established and functioned.

The supporting committees of the CORH approach, namely Project Steering Committee (PSC), Township Working Group (TWG) and Village Tract Working Group (VTWG), were formed at the central and local levels in September 2005, and coordination meetings were held regularly. Various plans of the project activities were drawn up at the township level.

Output 5: Applicable Community-Oriented RH approaches are identified and documented for wider application under RH programme in the Union of Myanmar.

The CORH approach identified by the project is being compiled as an implementation guide for application in other areas. The first and second drafts of the guide were shared with C/Ps to be finalized in the PSC meeting in September 2009. The distribution to which the indicator referring will be done in the dissemination workshop scheduled in November 2009.

6.2. Five Evaluation Criteria

(1) Relevance

The Overall Goal and Project Purpose are in accordance with the needs of the target group (women of reproductive age 15-49 years old) and Myanmar's health policy including the Strategic Plan for Reproductive Health 2009-2013 stating the involvement of "local peers for promotion of reproductive health" as one of the priority actions. Equally the project is consistent with the Japan's aid policies and Japan possesses the technical advantage in the field of MCH.

Whereas the project areas are not necessarily the best place to identify the model of the CORH approach, because of difficulties of the formalities such as a travel permit and mountainous topography preventing remote communities from benefitting from the activities, useful lessons are learned by operating under the adverse condition.

It would be better if the PDM has numerical targets of the indicators so that whether they have been achieved or not could be assessed more preciously. One of the Important Assumptions, "secured allocation of C/P" should be addressed as an issue that could be controlled within the project framework.

(2) Effectiveness

The five Outputs effectively contributed to the achievement of the Project Purpose as described below.

Output 1: Service improvement

Enhanced skills and knowledge of BHS and AMWs due to a variety of the training sessions as well as renovation of the health facilities (9 RHCs out of 12 and 10 Sub-RHCs out of 42) and provision of the equipment to the health centers and BHS/AMW contributed to the increased service utilization.

Output 2: Awareness and knowledge enhancement

With improved health education skills, MWs can communicate RH information and knowledge to populations, especially the target group, more effectively. As a result, they came to understand the importance of RH services, danger signs during pregnancy, and the necessity of emergency referral. It is reasonable to assume that the enhanced awareness and knowledge of people resulted in the increases of the service utilization.

Output 3: Linkage with communities

The community-based human resources trained by the project are considered the core element of strengthening of the linkage between the service providers and people. In total approximately 3,800 residents in the two townships are playing a vital role for promotion of RH services.

- 90 BHS (including MWs)
- 233 AMWs
- 3,326 MCHPs in total (1st batch year 2006: 1,672, 2nd batch year 2008: 1,654)
- 200 community leaders (including PDC chairpersons)

Currently 1,715 MCHPs are functioning in all 620 villages in the two townships. Each MCHP is in charge of 30 households and on average there are 2.8 MCHPs in respective villages.

Output 4: Establishment of support mechanism of the CORH approach

By exchanging good practices of community assistance to RH needs in the experience sharing workshop, local stakeholders are motivated to work for establishment or strengthening of the supportive mechanism in each locality. The increased number of village leaders began assisting service use of pregnant women by creating or reinforcing the community fund to meet financial needs and offering shared means of transportation to enable emergency referral to the health facilities in the areas and/or the higher level.

Output 5: Identification and documentation of the applicable CORH approach

Output 5 is primarily related to the second Project Purpose "dissemination of the CORH approach to other areas" moved to Important Assumption at the time of the mid-term evaluation. This output may not be directly contributing to current Project Purpose, but it is meaningful for the CORH approach to be documented for continuous application in the project areas and dissemination to other areas.

(3) Efficiency

Most of the Inputs are adequately provided in terms of quality, quantity, timing and time-length. Strong commitment of the C/P personnel is greatly appreciated, but the number of the assigned officers is not

sufficient, and they are too overburdened and too frequently transferred to be fully engaged in the project implementation.

It would be better if two Japanese experts in the fileds of Midwifery Education and Operational Research/Monitoring could have been assigned for longer time in the former half of the project term, the accelerated progress in the areas could be accomplished.

The logistic burden caused by the formalities and flaw of communication infrastructure is another factor to hinder efficiency of the project implementation.

(4) Impact

It is difficult to assess the possibility of realization of the Overall Goal at this moment, because of fluctuation and unavailability of the reliable indicator data.

So far no negative impacts have been observed. The positive impacts include that some of the MCHPs are promoting not only MCH but primary health care. There is a new MCH project initiated by DOH and WHO based on the experiences of the CORH project.

Limitations of financial capacity and human resources of DOH could be a hindering factor to apply the CORH approach to other areas.

(5) Sustainability

1) Institutional sustainability

It could be concluded that by working together with the project team, the Township Health Departments gained the management capacity to operate the CORH on the basis of the cooperative mechanism of the volunteers (MCHP and AMW), village leaders and communities. The frequent transfer of the township C/Ps should be addressed by introducing effective means to ensure institutional retention of the managerial capacity. Equally it is crucial for DOH to elaborate the plans of dissemination of the CORH approach.

The interview with MCHPs revealed that they were highly motivated to serve for the health needs of the community. With proper support from DOH and communities, it is very likely the majority of them to continue promoting MCH services.

2) Financial sustainability

In the context that the health budget can hardly disburse the program expense, without donor funding it is impossible to maintain the current level of inputs to sustain the project effects. The townships, however, are expected to continue some of the project activities utilizing the on-going operation such as regular monitoring and Continuing Medical Education (CME) for BHS and Continuing Health Education (CHE) for AMWs and MCHPs without incurring additional cost.

3) Technical sustainability

Given the frequent transfer of government officers, it is essential that the managerial expertise with regards to the CORH approach to be established as a system enabling proper application in elsewhere. At the same time, the operational know-how of the approach is supposed to be kept in form of the implementation guide as a reference for future implementers. BHS who settled in the locality ought to be the key persons to carry out the CORH approach.

It is crucial to encourage MWs to utilize CME by DOH for the retention of their knowledge and skills. MWs are expected to teach and advise AMWs and MCHPs through the CHE on a regular basis.

It is irreplaceable to provide incentives for AMWs and MCHPs who are volunteers to maintain their active involvement in MCH service assistance. As most of the interviewed AMWs and MCHPs mentioned, training to gain and refresh their knowledge could be a good incentive for their continuous service. In spite of the lack of finance and human resources, it is expected for DOH to strive to offer such opportunities.

4) Lack of enough discussions on the Community-Oriented approach in the Myanmar's health system

Discussions with relevant stakeholders are needed on how MCHP would be placed in the Myanmar's health system, as there coexists several similar approaches. The international partners introduced the respective community volunteer systems such as the Community Support Group by UNFPA, the Community Maternal and Newborn Team by WHO and the Community-based IMCI by UNICEF. There are also AMWs, CHWs and other single purpose volunteers such as those for Malaria. However, so far, the dialogues among donors as well as within DOH have just started on that issue.

7. PERFORMANCE OF THE PROJECT

7.1 Achievement of the Activities

<table>
<tr><th>Activities</th><th>Performance</th><th>Sources</th></tr>
<tr><td colspan="3">Output 1: Quality of RH services with special focus on safe motherhood is improved in the project areas.</td></tr>
<tr><td>1-1.
Conduct the baseline and end line surveys on RH services, health facilities and community perspectives on RH</td><td>1) Conducted the Baseline Survey
・Part I (Facility/service provider) Oct - Nov 2005
・Part II (Household) Oct - Nov 2006
Survey Report printed, Dissemination Workshop organized (Jan - Feb 2007)
2) Conducted the Endline Assessment
・Part I (Household) Nov 2008 - Mar 2009
・Part II (Facility/service provider) May - Jul 2009
Assessment Report produced.</td><td>Project Annual Report 2006-2008</td></tr>
<tr><td>1-2
Re-train midwifery-trained personnel for ensuring safe delivery including early detection of high risk pregnancy</td><td>1) AMW Refresher Trainings (for 233 AMWs, 3days x 6 times in each township, in 2006 - 2007)
* Suggested revisions with more illustrations on DOH/WHO AMW refresher training manual were adopted for future refresher trainings by DOH
<table>
<tr><th>Duration</th><th>Kyaukme</th><th>Naungcho</th><th>Total</th></tr>
<tr><td>Feb 21, 2006 - Jun 15, 2007</td><td>117</td><td>116</td><td>233</td></tr>
</table>
2) Midwifery Skills Training (for 64LHVs/MWs, 2 days x 1 time in each township, in Dec 2008 - Jan 2009)
<table>
<tr><th>Participants</th><th>Kyaukme</th><th>Naungcho</th><th>Total</th></tr>
<tr><td>LHV</td><td>5</td><td>6</td><td>11</td></tr>
<tr><td>MW</td><td>26</td><td>27</td><td>53</td></tr>
<tr><td>Total</td><td>31</td><td>33</td><td>64</td></tr>
</table></td><td>Project Annual Report 2006-2008</td></tr>
<tr><td>1-3
Train Basic Health Staff (BHS) on Leadership, Management, and Counseling skills.</td><td>1) Counseling Training (for 66 LHVs/MWs, 3 days x 1 time in each township, Sept 2007)
<table>
<tr><th>Participants</th><th>Kyaukme</th><th>Naungcho</th><th>Total</th></tr>
<tr><td>LHV</td><td>6</td><td>6</td><td>12</td></tr>
<tr><td>MW</td><td>27</td><td>27</td><td>54</td></tr>
<tr><td>Total</td><td>33</td><td>33</td><td>66</td></tr>
</table>
2) Leadership and Management Training (for 73 LHVs/MWs, 3 days x 1 time in each township, in Aug - Sept 2008)
<table>
<tr><th>Participants</th><th>Kyaukme</th><th>Naungcho</th><th>Total</th></tr>
<tr><td>LHV</td><td>6</td><td>7</td><td>13</td></tr>
<tr><td>MW</td><td>33</td><td>27</td><td>60</td></tr>
<tr><td>Total</td><td>39</td><td>34</td><td>73</td></tr>
</table>
3) Training on Monitoring Skills (for 87 PHS I/HAs/LHVs/MWs, 0.5 day x 1 time in each township, in Dec 2008 - Jan 2009)
<table>
<tr><th>Participants</th><th>Kyaukme</th><th>Naungcho</th><th>Total</th></tr>
<tr><td>THN</td><td>1</td><td>1</td><td>2</td></tr>
<tr><td>PHS I</td><td>5</td><td>2</td><td>7</td></tr>
<tr><td>HA</td><td>4</td><td>5</td><td>9</td></tr>
<tr><td>LHV</td><td>5</td><td>6</td><td>11</td></tr>
<tr><td>MW</td><td>31</td><td>27</td><td>58</td></tr>
<tr><td>Total</td><td>46</td><td>41</td><td>87</td></tr>
</table></td><td>Project Annual Report 2006-2008</td></tr>
</table>

<table>
<tr><td></td><td>4) Leadership and Management Training (for 40BHS, 2 days x 1 time in each township, in Aug 2009
<table>
<tr><th>Participants</th><th>Kyaukme</th><th>Naungcho</th><th>Total</th></tr>
<tr><td>THN</td><td>0</td><td>1</td><td>1</td></tr>
<tr><td>HA</td><td>5</td><td>5</td><td>10</td></tr>
<tr><td>LHV</td><td>3</td><td>2</td><td>5</td></tr>
<tr><td>MW</td><td>28</td><td>24</td><td>52</td></tr>
<tr><td>PHS I</td><td>4</td><td>3</td><td>7</td></tr>
<tr><td>PHS II</td><td>0</td><td>2</td><td>2</td></tr>
<tr><td>Total</td><td>40</td><td>37</td><td>77</td></tr>
</table>
5) Training on Monitoring Skills-HMIS (for SMOs/HAs/LHVs/MWs, 1 day x 1 time in each township, in Sept 2009) is planned to be conducted.</td><td></td></tr>
<tr><td>1-4
Monitor BHS to support for skill development regularly by DMO/TMO and responsible persons</td><td>1) Monitoring guideline developed (2006.2) and revised (2007.5)
2) Technical discussion on CME conducted at 6th PSC (Sept 2008)
3) 2nd technical discussion on CME conducted at 7th PSC (Feb 2009)</td><td>Experts</td></tr>
<tr><td>1-5
Train BHS to strengthen referral to higher level health facilities</td><td>Midwifery Skills Training conducted (for 64LHVs/MWs, 2 days x 1 time in each township, in Dec 2008 - Jan 2009)
Refer to Activity 1-2</td><td></td></tr>
<tr><td>1-6
Renovate health facilities</td><td>The Project has renovated six (6) RHCs and thirteen (13) Sub-RHCs out of twelve (12) RHCs and forty two (42) Sub-RHCs in the targeted areas (nine (9) facilities in Kyaukme township and ten (10) in Naungcho township) in 2006 - 2008.
No. of health facilities renovated
<table>
<tr><th>Township</th><th>2006</th><th>2007</th><th>2008</th><th>Total</th></tr>
<tr><td>Kyaukme</td><td>3
(1 RHC
+2 S/C)</td><td>2
(2 S/C)</td><td>4
(1 RHC
+3 S/C)</td><td>9
(2 RHC
+ 7 S/C)</td></tr>
<tr><td>Naungcho</td><td>3
(1 RHC
+2 S/C)</td><td>3
(1 RHC
+2 S/C)</td><td>4
(2 RHC
+ 2 S/C)</td><td>10
(4 RHC
+ 6 S/C)</td></tr>
<tr><td>Total</td><td>6
(2 RHC
+4 S/C)</td><td>5
(1 RHC
+4 S/C)</td><td>8
(3 RHC
+ 5 S/C)</td><td>19
(6 RHC
+ 13S/C)</td></tr>
</table></td><td>Project Annual Report 2006-2008</td></tr>
<tr><td>1-7
Provide basic equipment</td><td>Basic equipment and commodities were provided (2004 - 2006) by the Project as follows;
<table>
<tr><th>Facility/Target</th><th>Equipment provided</th></tr>
<tr><td>Hospitals (Township and SHU)</td><td>Delivery beds, Stretchers, Wheel chairs, LSCS set, Neonatal weighing scales, Adult weighing scales, Suction machines, IV stand, Oxygen Inhalation Set</td></tr>
<tr><td>MCH Center</td><td>First Aid Kit (Ambulance bag), IV stand, Clean Delivery Kit</td></tr>
<tr><td>RHCs</td><td>Adult weighing scales, RHC Sets (Examination bed, BP instruments, Stethoscope, Mucus sucker, Health education books, Wooden book shelf), IV stand, Magnel Kit, Pregnancy simulator, Clean Delivery Kit</td></tr>
<tr><td>Sub-RHCs</td><td>Sub-RHC Sets (BP instruments, Stethoscope, Adult weighing scale, Health education books, wooden book shelf, First Aid Kit (Ambulance bag)), Examination bed, Mucus sucker, IV stand, Clean Delivery Kit</td></tr>
<tr><td>BHS / AMW</td><td>Clean Delivery Kit</td></tr>
</table></td><td>Project Annual Report 2005-2008</td></tr>
</table>

Asaki

<table>
<tr><td colspan="3">Output 2: Awareness and knowledge on RH issues among community people, particularly women improve in the project areas.</td></tr>
<tr><td>2-1
Conduct needs assessment on IEC/BCC materials</td><td>Assessment on IEC/BCC needs was conducted in 2006, based on which the plan of IEC/BCC materials to be developed by the Project was made.</td><td>Project Annual Report 2006</td></tr>
<tr><td>2-2
Develop IEC/BCC materials</td><td>The Following IEC/BCC materials were produced/revised/translated and printed by the Project and distributed to BHS, AMWs, MCHPs.
<table>
<tr><th>IEC/BCC material produced</th><th>Qty</th></tr>
<tr><td>1) Pregnancy calendar</td><td>1,000 pieces</td></tr>
<tr><td>2) MCHP Handbook
(a) 1st version (Myanmar)
(b) 2nd version (Myanmar)
(c) 2nd version (English)</td><td>
(a) 2,700 copies
(b) 5,000 copies
(c) 50 copies</td></tr>
<tr><td>3) MCHP Kit
(a) 1st version
(b) 2nd version</td><td>
(a) 2,000 sets
(b) 2,000 sets</td></tr>
<tr><td>4) Pamphlets
(a) General RH
- Shan language
- Myanmar language
(b) Safe Motherhood
- Shan language
- Myanmar language
(c) Prevention of Abortion
- Shan language
- Myanmar language</td><td>
(a)
27,500 copies
15,000 copies
(b)
27,500 copies
15,000 copies
(c)
27,500 copies
15,000 copies</td></tr>
<tr><td>5) Project Pamphlet for Stakeholders (Myanmar language)</td><td>20,000 copies</td></tr>
<tr><td>6) Project Pamphlet for Community people
- Shan language
- Myanmar language
- English language</td><td>
20,000
25,000 copies
500</td></tr>
<tr><td>7) Project Pamphlet (A4 size)
- English language
- Japanese language</td><td>
2,000 copies
2,000</td></tr>
<tr><td>8) HBMR</td><td>60,000 copies</td></tr>
<tr><td>9) Project Video ("One day of Nwe Nwe")
- DVD (Myanmar language)
- DVD (English language)
- VCD (Myanmar language)
- VCD (English language)</td><td>
295 copies
220 copies
100 copies
60 copies</td></tr>
<tr><td>10) Poster Calendar</td><td>2,100 copies</td></tr>
<tr><td>11) Pocket-size Notebook</td><td>2,000 copies</td></tr>
<tr><td>12) FAQ booklet for MCHP</td><td>2,000 copies</td></tr>
</table></td><td>Project Annual Report 2006-2008</td></tr>
</table>

2-3 Train Basic Health Staff (BHS) on IEC/BCC	1) Communication session in TOT for MCHP Initial Training (for 75 Doctor/HAs/LHVs/MWs/PHS I/PHS II, in 2006.11)	Project Annual Report 2006-2008

Participants	Kyaukme	Naungcho	Total
Doctor	0	1	1
HA	3	4	7
LHV	5	6	11
MW	26	26	52
PHS I	2	1	3
PHS II	0	1	1
Total	36	39	75

2) IEC/BCC Training for RH health session in MCH Centers (for 13 HAs/LHVs/MWs, 1 day x 1 time in each township, in 2007.8)

Participants	Kyaukme	Naungcho	Total
HA	1	0	1
LHV	2	1	3
MW	6	3	9
Total	9	4	13

3) IEC/BCC Skills Training (for 71 HAs/LHVs/MWs, 2 days x 1 time in each township, in 2008.8)

Participants	Kyaukme	Naungcho	Total
HA	4	4	8
LHV	5	6	11
MW	27	25	52
Total	36	35	71

4) Community-based IEC/BCC Training (for 84 HAs/LHVs/MWs, 1 day x 1 time in each township, in 2008.11)

Participants	Kyaukme	Naungcho	Total
HA	5	4	9
LHV	7	7	14
MW	33	28	61
Total	45	39	84

2-4 Conduct health education sessions by the trained BHS for community people including pregnant women	1) Health education sessions conducted and the number of community people attended	IEC/BCC Health Education Monitoring Sheet 2007-2009

Year	Kyaukme	Naungcho	Total
2007	4 times (F44+M5 =Total49)	4 times (F61+M15 =Total76)	8 times (F105+M20 =Total125)
2008	12 times (F240+M19 =Total259)	12 times (F310+M38 =Total348)	24 times (F550+M57 =Total607)
2009	6 times (F1000+M10 =Total1010)	6 times (F187+M15 =Total202)	12 times (F1187+M25 =Total1212)
Total	22 times (F1284+M34 =Total1318)	22 times (F558+M68 =Total626)	44 times (F1842+M102 =Total1944)

<table>
<tr><td>2-5
Provide guidance to AMWs and MCH Promoters by BHS for IEC/BCC activities on RH issues</td><td>BHS provide guidance to AMWs and MCH Promoters on IEC/BCC activities on RH issues in the regular meeting (CHE).</td><td>Experts</td></tr>
<tr><td colspan="3">Output 3: The linkage between RH services and community people is strengthened.</td></tr>
<tr><td>3-1
Conduct TOTs of BHS on trainings and refresher trainings for MCH Promoters</td><td colspan="2">1) TOT for MCHP Initial Training (for 75 Doctor/HAs/LHVs/MWs/PHS I/PHS II, in 2006.11)
<table>
<tr><th>Participants</th><th>Kyaukme</th><th>Naungcho</th><th>Total</th></tr>
<tr><td>Doctor</td><td>0</td><td>1</td><td>1</td></tr>
<tr><td>HA</td><td>3</td><td>4</td><td>7</td></tr>
<tr><td>LHV</td><td>5</td><td>6</td><td>11</td></tr>
<tr><td>MW</td><td>26</td><td>26</td><td>52</td></tr>
<tr><td>PHS I</td><td>2</td><td>1</td><td>3</td></tr>
<tr><td>PHS II</td><td>0</td><td>1</td><td>1</td></tr>
<tr><td>Total</td><td>36</td><td>39</td><td>75</td></tr>
</table>
2) TOT for MCHP 1st Refresher Training (for 77 HAs/LHVs/MWs/PHS I, 3 days x 1 time in each township, in 2007.5)
<table>
<tr><th>Participants</th><th>Kyaukme</th><th>Naungcho</th><th>Total</th></tr>
<tr><td>HA</td><td>5</td><td>4</td><td>9</td></tr>
<tr><td>LHV</td><td>6</td><td>5</td><td>11</td></tr>
<tr><td>MW</td><td>26</td><td>28</td><td>54</td></tr>
<tr><td>PHS I</td><td>0</td><td>3</td><td>3</td></tr>
<tr><td>Total</td><td>37</td><td>40</td><td>77</td></tr>
</table>
3) TOT for MCHP 2nd Refresher Training (for 84 THN/HAs/LHVs/MWs/PHS I, 2 days x 1 time in each township, in 2007.11)
<table>
<tr><th>Participants</th><th>Kyaukme</th><th>Naungcho</th><th>Total</th></tr>
<tr><td>THN</td><td>1</td><td>0</td><td>1</td></tr>
<tr><td>HA</td><td>2</td><td>4</td><td>6</td></tr>
<tr><td>LHV</td><td>6</td><td>7</td><td>13</td></tr>
<tr><td>MW</td><td>32</td><td>26</td><td>58</td></tr>
<tr><td>PHS I</td><td>4</td><td>2</td><td>6</td></tr>
<tr><td>Total</td><td>45</td><td>39</td><td>84</td></tr>
</table>
4) TOT for MCHP 2nd Initial & 3rd Refresher Training (for 83 THN/HAs/LHVs/MWs/PHS I, 2 days x 1 time in each township, in 2008.11)
<table>
<tr><th>Participants</th><th>Kyaukme</th><th>Naungcho</th><th>Total</th></tr>
<tr><td>THN</td><td>0</td><td>1</td><td>1</td></tr>
<tr><td>HA</td><td>3</td><td>5</td><td>8</td></tr>
<tr><td>LHV</td><td>4</td><td>6</td><td>10</td></tr>
<tr><td>MW</td><td>31</td><td>26</td><td>57</td></tr>
<tr><td>PHS I</td><td>5</td><td>2</td><td>7</td></tr>
<tr><td>Total</td><td>43</td><td>40</td><td>83</td></tr>
</table></td><td>Project Annual Report 2006-2008</td></tr>
</table>

<table>
<tr><td>3-2
Conduct trainings and refresher trainings for MCH Promoters</td><td>1) Training for MCH Promoters<table><tr><th>Training</th><th>Duration/times</th><th>No. of participants</th></tr><tr><td>1st Initial</td><td>Dec 4, 2006-Jan 14, 2007 (68 times)</td><td>1,672</td></tr><tr><td>1st Refresher</td><td>May 8, 2007-May 31, 2007 (49 times)</td><td>554</td></tr><tr><td>2nd Refresher</td><td>Dec 8, 2007-Jan 2, 2008 (68 times)</td><td>1,409</td></tr><tr><td>3rd Refresher +2nd Initial (*)</td><td>Dec 6, 2008-Jan 17, 2009 (70 times)</td><td>1,654</td></tr></table>2) MCHP Guidelines and Strategic Paper were developed and approved by PSC (Sep 2006)
3) Review on MCHP system and training conducted (Feb 2007)
4) Situation Analysis on MCHP system (Jun 2007)
5) Review and revision on MCHP Guidelines conducted and approved by PSC (Sep 2008)
6) Assessment on MCHP activities (Nov 2008 - Feb 2009)
7) Assessment on MCHP system/activities (May 2009 - September 2009)
(*) Although the no. of participants of the 3rd refresher/2nd initial training was 1,654, the total no. of MCH Promoters 2nd batch is 1,715. This figure includes 61 MCHPs who were absent in training, yet showed their intention to continue working as MCHP.</td><td>Project Annual Report 2006-2008</td></tr>
<tr><td>3-3
Conduct home visits by MCH Promoters to women in the community during pregnancy, delivery and post-delivery period</td><td>MCHPs started home visits to pregnant women and children under 5 after the 1st batch were trained in Dec 06-Jan 07.</td><td>Experts</td></tr>
<tr><td>3-4
Organize teamwork for effective referral from community level to the health facilities by BHS, AMWs and MCH Promoters</td><td>1) Leadership and Management Training was conducted (for 73 LHVs/ MWs, 3 days x 1 time in each township, in Aug - Sept 2008)
2) Leadership and Management Training 2 (for 77 BHS, 2 days x 1 time in each township, in Aug 2009)
* Refer to Activity 1-3.</td><td>Project Annual Report 2008</td></tr>
<tr><td>3-5
Develop action plan by BHS for effective teamwork with AMWs and MCH Promoters</td><td>1) Leadership and Management Training was conducted (for 73 LHVs/MWs, 3 days x 1 time in each township, in Aug - Sept 2008)
2) Leadership and Management Training 2 (for 77 BHS, 2 days x 1 time in each township, in Aug 2009)
* Refer to Activity 1-3.</td><td>Project Annual Report 2008</td></tr>
<tr><td>3-6
Provide necessary knowledge and information by BHS to AMWs and MCH Promoters regularly</td><td>1) Plan of regular CHE was developed in the 1st and 2nd Technical Discussion on CME conducted in Sept 2008 and Feb 2009
2) Good practices of CHE were collected (2008-2009)</td><td>Experts</td></tr>
<tr><td colspan="3">Output 4: Mechanism to support community-oriented RH approach is established and functioned.</td></tr>
<tr><td>4-1
Establish coordination committees for the effective planning, implementation, monitoring and evaluation of the project activities at each level (Project Steering Committee at central level, Township Working Group at township level and Village Track Working Group at village level)</td><td>Coordination committees were established at each level such as PSC (central level), TWG (Township level), VTWG (Village Tract level) for the purpose of the smooth</td><td>Experts</td></tr>
</table>

<table>
<tr><td>4-2
Develop guidelines for coordination committees</td><td>Draft Guidelines of TWG and VTWG were suggested by Japanese Experts, and the roles of PSC and working groups were confirmed by the PSC meeting (Feb 2006).</td><td>Project Annual Report 2005-2008</td></tr>
<tr><td>4-3
Organize regular meetings of coordination committees at each level to strengthen collaboration mechanism for community-oriented RH activities including community support system</td><td>Project Steering Committee meetings have been held half-yearly since it was established, in which the project progress and way forward were shared as well as some issues on the implementation were discussed.
TWGs and VTWGs meetings have been held quarterly at the community level.

Project Steering Committee meetings conducted:
<table>
<tr><th>No.</th><th>Date</th><th>Venue</th><th>No. of Participants</th></tr>
<tr><td>1st</td><td>17-Feb-06</td><td>Yangon</td><td>18</td></tr>
<tr><td>2nd</td><td>16-Sep-06</td><td>Mandalay</td><td>17</td></tr>
<tr><td>3rd</td><td>24-Feb-07</td><td>Nay Pyi Taw</td><td>20</td></tr>
<tr><td>4th</td><td>5-Sep-07</td><td>Nay Pyi Taw</td><td>23</td></tr>
<tr><td>5th</td><td>14-Feb-08</td><td>Nay Pyi Taw</td><td>20</td></tr>
<tr><td>6th</td><td>15-Sep-08</td><td>Nay Pyi Taw</td><td>19</td></tr>
<tr><td>7th</td><td>19-Feb-09</td><td>Nay Pyi Taw</td><td>21</td></tr>
<tr><td colspan="3">Total</td><td>138</td></tr>
</table></td><td>Project Annual Report 2005-2008</td></tr>
<tr><td>4-4
Conduct management workshop at township level for community leaders to strengthen capacities for planning, implementation, monitoring and evaluation</td><td>1) PCM workshop was conducted for project planning, in which the Project Design Matrix (PDM) was reviewed. (Aug 2005)
2) Advocacy meetings were conducted in each project township with participation of representatives of TWG, VTWGs and BHS to share the objectives of the Project and create awareness on their roles as TWG and VTWGs. (Jun 2006)
3) Dissemination Workshop was conducted in each Project township and Nay Pyi Taw for representatives of TWG, VTWGs and BHS to provide feedback on the Baseline Survey, in order to further promoter understanding and support for the Project activities. (Feb 2007)
<table>
<tr><th>Workshop</th><th>Place</th><th>Date</th><th>No. of Participants</th></tr>
<tr><td>PCM Workshop (central level)</td><td>Yangon</td><td>18-20 Aug 05</td><td>7</td></tr>
<tr><td>(for Kyaukme)</td><td>Mandalay</td><td>29-31 Aug 05</td><td>20</td></tr>
<tr><td>(for Naungcho)</td><td>Mandalay</td><td>23-25 Aug 05</td><td>20</td></tr>
<tr><td rowspan="2">Advocacy Meeting</td><td>Kyaukme</td><td>16-Jun-06</td><td>25</td></tr>
<tr><td>Naungcho</td><td>20-Jun-06</td><td>28</td></tr>
<tr><td rowspan="3">Dissemination Workshop on Baseline Survey</td><td>Kyaukme</td><td>1-Feb-07</td><td>113</td></tr>
<tr><td>Naungcho</td><td>29-Jan-07</td><td>88</td></tr>
<tr><td>Nay Pyi Taw</td><td>24-Feb-07</td><td>27</td></tr>
<tr><td rowspan="2">Seminar on Planning and Management</td><td>Kyaukme</td><td>25-May-09</td><td>101</td></tr>
<tr><td>Naungcho</td><td>26-May-09</td><td>79</td></tr>
</table></td><td>Project Annual Report 2005-2008</td></tr>
<tr><td colspan="3">Output 5: Applicable community-oriented RH approaches are identified and documented for wider application under RH programme in the Union of Myanmar.</td></tr>
<tr><td>5-1
Develop guides for project implementers to apply community-oriented RH approaches</td><td>The Project team has been working on development of the operational manual for implementing CORH approach in other townships, and is now under revision in consultation with DOH. It will be finalized by Sep 2009, so that it can be shared to concerned parties at the dissemination workshops in Nov 2009.</td><td>Experts</td></tr>
</table>

<table>
<tr><td>5-2
Conduct workshop for sharing experiences at the township level</td><td>Experience Sharing Workshops were conducted in each project township in the years 2007 and 2008, with participation of VTWG representatives and BHS, to promote good practices in their villages such as community support on emergency referral and monetary assistance, teamwork, etc.
<table><tr><th>Workshop</th><th>Township</th><th>Date</th><th>No. of participants</th></tr><tr><td rowspan="2">Experience Sharing Workshop (I)</td><td>Kyaukme</td><td>26-Jan-08</td><td>139</td></tr><tr><td>Naungcho</td><td>29-Jan-08</td><td>111</td></tr><tr><td rowspan="2">Experience Sharing Workshop (II)</td><td>Kyaukme</td><td>28-Jan-09</td><td>116</td></tr><tr><td>Naungcho</td><td>29-Jan-09</td><td>73</td></tr></table></td><td>Project Annual Report 2007-2008</td></tr>
<tr><td>5-3
Conduct dissemination workshops for sharing the experiences, outcomes and lessons learnt of the community-oriented RH project among the concerned government and non-governmental organizations</td><td>Dissemination workshop on the CORH approach is planned to be conducted in Nay Pyi Taw, in the Project areas and in the places to be applied the CORH approach, in Nov 2009.</td><td>Experts</td></tr>
<tr><td>5-4
Organize study visits in Japan and other countries to strengthen management capacity in RH programme in Myanmar</td><td>Counterpart Training/Study Visits to Japan and Vietnam were conducted in the years 2004, 2005, 2006, 2007 and 2009 with total no. of counterparts 26. The counterparts gained useful knowledge and lessons from Japan and Vietnam's experiences to better manage community-oriented RH activities, including MCH Promoter system in Wakayama Prefecture.
<table><tr><th>Year</th><th>Country</th><th>Participants</th></tr><tr><td>2004</td><td>Japan</td><td>3 (DOH/DOH)
1 (Central Women's Hospital, Mandalay)</td></tr><tr><td>2005</td><td>Vietnam</td><td>2 (DOH) 1 (TMO) 1 (MO) 2 (THN)</td></tr><tr><td>2006</td><td>Japan</td><td>1 (DOH) 1 (OG) 1 (TMO) 1 (MO)</td></tr><tr><td>2007</td><td>Japan</td><td>2 (DOH) 2 (State Health Dept.) 1 (TMO) 1 (MO)</td></tr><tr><td>2009</td><td>Japan</td><td>2 (DOH) 2 (MO) 2 (HA1)</td></tr><tr><td colspan="2">Total</td><td>26(Central 10, State 2, Township 13, Mandalay 1)</td></tr></table></td><td>Project Annual Report 2005-2008</td></tr>
</table>

7.2 Achievement of the Outputs

Indicators	Performance	Sources
Output 1: Quality of RH services with special focus on safe motherhood is improved in the project areas.		
1.1 Percentage of RH service providers who are able to use proper counseling procedures with clients is increased.	BLS=54.7% (BLS(I): Table 5.1) ELA=72.3% (ELA(II): Table 5.1)	Baseline Survey/ Endline Assessment
1.2 Percentage of midwifery-trained personnel who are able to perform ANC according to the technical guidelines is increased.	BLS=40.1% (BLS(I): Table 5.2) ELA=78.6% (ELA(II): Table 5.2)	Baseline Survey/ Endline Assessment

1.3 Percentage of midwifery-trained personnel who are able to assist childbirths according to the technical guidelines is increased.	BLS=70.0% (BLS(I): Table 5.3) ELA=85.0% (ELA(II): Table 5.3)	Baseline Survey/ Endline Assessment
1.4 Percentage of midwifery-trained personnel who are able to perform PNC according to the technical guidelines is increased.	BLS: 1) Immediate PN care=79.2% 2) PN care at 2-3 days=52.4% 3) PN care at 4-6 weeks after delivery=37.8% (BLS(I): Table 5.4 & 5.5) ELA: 1) Immediate PN care=87.5% 2) PN care at 2-3 days=61.1% 3) PN care at 4-6 weeks after delivery=92.2% (ELA(II): Table 5.4 & 5.5(a), (b))	Baseline Survey/ Endline Assessment
1.5 Percentage of midwifery-trained personnel knowledgeable about obstetric emergencies is increased.	BLS: 43.3% (BLS(I): Table 5.6) ELA: 78.6% (ELA(II): Table 5.6)	Baseline Survey/ Endline Assessment
1.6 Percentage of midwifery-trained personnel knowledgeable about the danger signs for newborns is increased.	BLS: 13.3% *Out of 30 MWs, only 4 MWs knew at least 60% of the danger signs for referral. (BLS(I): Table 5.6(a)) ELA: 71.4% (ELA(II): Table 5.6(a))	Baseline Survey/ Endline Assessment
Output 2: Awareness and knowledge on RH issues among community people, particularly women improve in the project areas.		
2.1 Percentage of men aged 15 and above and women aged between 15 and 49 who are knowledgeable about 3 and more complications of pregnancy and childbirth is increased.	BLS: KM=32.1 NC=18.3 TOTAL=24.7% (BLS(II): Table4.6, Figure 4.1) ELA: KM=69.9 NC=64.1 TOTAL=66.8% (ELA(I): Table4.6, Figure 4.1)	Baseline Survey/ Endline Assessment
2.2 Percentage of men aged 15 and above and women aged between 15 and 49 who are knowledgeable about at least one modern contraceptive method is increased.	BLS: KM=79 NC=74.8 TOTAL=76.8% (BLS(II): Table6.2, Figure 6.1) ELA: KM=92.4 NC=94.9 TOTAL=93.7% (ELA(I): Table6.2(a), Figure 6.1)	Baseline Survey/ Endline Assessment
2.3 Percentage of men aged 15 and above and women aged between 15 and 49 who are knowledgeable about 3 and more risks of abortion is increased.	BLS: KM=14.7 NC=8.9 TOTAL=11.7) (BLS(II): Table4.12, Figure 4.3) ELA: KM=54 NC=67.2 TOTAL=60.9) (ELA(I): Table4.12, Figure 4.3)	Baseline Survey/ Endline Assessment
2.4 Percentage of women who utilize home-based maternal record is increased.	BLS: KM=21.9 NC=27.4 TOTAL=25.5% (BLS(II): Table 5.22, Figure 5.5) ELA: KM=40.0 NC=60.0 TOTAL=52.5% (ELA(I): Table 5.22, Figure 5.5)	Baseline Survey/ Endline Assessment
2.5 Percentage of women who utilize the clean delivery kit is increased.	BLS: KM=66.3 NC=72.0 TOTAL=69.2% (BLS(II): Table 5.14, Figure 5.4) ELA: KM=84.0 NC=92.2 TOTAL=88.6% (ELA(I): Table 5.14, Figure 5.4)	District/ Township Hospital Stock Record

<table>
<tr><td>2.6
Number of women who participated in health education sessions is increased.</td><td>Number of women participated in health education sessions:<table><tr><th>Township</th><th>2006</th><th>2007</th><th>2008</th><th>Total</th></tr><tr><td>Kyaukme</td><td>44</td><td>240</td><td>1,000</td><td>1,284</td></tr><tr><td>Naungcho</td><td>61</td><td>310</td><td>187</td><td>558</td></tr><tr><td>Total</td><td>105</td><td>550</td><td>1,187</td><td>1,842</td></tr></table></td><td>IEC/BCC Health Education Sessions Monitoring Sheet 2007-2009</td></tr>
<tr><td>2.7
Number of appropriate IEC/BCC materials developed and distributed in the community is increased.</td><td>Refer to Activity 2-2</td><td></td></tr>
<tr><td colspan="3">Output 3: The linkage between RH services and community people is strengthened.</td></tr>
<tr><td>3.1
Number of referral from community level to health facilities increased.</td><td>No. of PNC# services provided by SBA and AMW
#Post-natal mother can receive PNC more than one time.<table><tr><th>Township</th><th>Skilled health personnel</th><th>2005</th><th>2006</th><th>2007</th><th>2008</th></tr><tr><td rowspan="3">Kyaukme</td><td>SBA</td><td>6,527</td><td>6,258</td><td>5,013</td><td>7,360</td></tr><tr><td>AMW</td><td>249</td><td>378</td><td>416</td><td>801</td></tr><tr><td>Total</td><td>6,776</td><td>6,636</td><td>5,429</td><td>8,161</td></tr><tr><td rowspan="3">Naungcho</td><td>SBA</td><td>3,484</td><td>3,472</td><td>5,338</td><td>7,570</td></tr><tr><td>AMW</td><td>707</td><td>611</td><td>1,011</td><td>1,239</td></tr><tr><td>Total</td><td>4,191</td><td>4,083</td><td>6,349</td><td>8,809</td></tr></table>No. of referral cases from AMW to health facility<table><tr><th>Township</th><th>2005</th><th>2006</th><th>2007</th><th>2008</th></tr><tr><td>Kyaukme</td><td>36</td><td>42</td><td>54</td><td>78</td></tr><tr><td>Naungcho</td><td>47</td><td>75</td><td>77</td><td>62</td></tr></table>Percentage of household members who have heard of RH messages from MCHP
ELA: KM=13.1% NC=29.1% TOTAL=21.6%
(ELA(I): Table 4.3)
Percentage of pregnant women who had recommendation of AN care provider from MCHP
ELA: KM=13.9% NC=25.3% TOTAL=20.5%
(ELA(I): Table 5.3)
Percentage of pregnant women who had recommendation of birth place from MCHP
ELA: KM=12.5% NC=30.3% TOTAL=22.8%
(ELA(I): Table 5.5)
Percentage of pregnant women who had recommendation of PN care provider from MCHP
ELA: KM=7.6% NC=25.6% TOTAL=17.9%
(ELA(I): Table 5.18)</td><td>Township Health Profile/ HMIS/ RHMIS Endline Assessment</td></tr>
<tr><td colspan="3">Output 4: Mechanism to support community-oriented RH approach is established and functioned.</td></tr>
<tr><td>4.1
Coordination committees at each level are established.</td><td>1) Project Steering Committee (Central), Township Working Group (Township), and Village Tract Working Group (Village Tract) were established (2005.9-).
2) Guidelines on TWGs and VTWGs were developed (2006.1) and reviewed/revised (2007.5).
3) Roles of TWGs and VTWGs were approved in PSC meeting</td><td>Experts</td></tr>
</table>

Osaki

	(2006.2).	
4.2 Annual plan for this project in each township is developed.	1) Project Steering Committee (Central), Township Working Group (Township), and Village Tract Working Group (Village Tract) were established (2005.9-). 2) Guidelines on TWGs and VTWGs were developed (2006.1) and reviewed/revised (2007.5). 3) Roles of TWGs and VTWGs were approved in PSC meeting (2006.2).	Project Annual Report 2005-2008
4.3 The meetings of coordination committees are organized to monitor the mechanism to support community-oriented RH approach.	No. of meetings organized PSC meeting (half-yearly): 7 times (in 2006.2, 2006.9, 2007.2, 2007.9, 2008.2, 2008.9, 2009.2) TWG/VTWG meetings (quarterly)	Project Annual Report 2005-2008
Output 5: Applicable community-oriented RH approaches are identified and documented for wider application under RH programme in the Union of Myanmar.		
5.1 Community-oriented RH documentation is distributed to other areas in the Union of Myanmar.	Applicable community-oriented RH approach identified through project implementation would be consolidated as implementation guide for wider application under RH programme in the future.	Experts

7.3 Achievement of the Project Purpose

<table>
<tr><th>Indicators</th><th>Performance</th><th>Sources</th></tr>
<tr><td colspan="3">Project Purpose: Utilization of quality RH services increases in the project areas.</td></tr>
<tr><td>1.
CPR (Contraceptive Prevalence Rate) is increased.</td><td>BLS: KM=41.1% NC=41.3% TOTAL=41.2%
(BLS(II): Table 6.5(a), Figure 6.2)
ELA: KM=56.9% NC=49.1% TOTAL=52.6%
(ELA(I): Table 6.5(a), Figure 6.2)</td><td>Baseline Survey/ Endline Assessment</td></tr>
<tr><td>2.
Percentage of women who received 4 and more times of ANC is increased.</td><td>Percentage of women who received 4 and more times of ANC
BLS: KM=49.0% NC=39.2% TOTAL=44.1%
(BLS(II): Table 5.6, Figure 5.1)
ELA: KM=44.4% NC=50.5% TOTAL=47.9%
(ELA(I): Table 5.6, Figure 5.1)

No. of women received AN+4 (coverage %)
<table>
<tr><th>Township</th><th>2005</th><th>2006</th><th>2007</th><th>2008</th></tr>
<tr><td>Kyaukme</td><td>N/A</td><td>734
(13.4%)</td><td>652
(11.7%)</td><td>974
(17.1%)</td></tr>
<tr><td>Naungcho</td><td>363
(10.4%)</td><td>821
(23.0%)</td><td>908
(24.9%)</td><td>1,177
(31.6%)</td></tr>
</table>
Percentage of women who received ANC
BLS: KM=90.4% NC=92.5% TOTAL=91.5%
(BLS(II): Table 5.6, Figure 5.1)
ELA: KM=88.9% NC=96.1% TOTAL=92.9%
(ELA(I): Table 5.6, Figure 5.1)

No. of ANC provided by skilled health personnel* (SBA and AMW) (coverage %)
*Skilled health personnel are SBA (skilled birth attendant) and AMW. SBAs include medical officers, MW and Lady Health Visitors (LHV).
<table>
<tr><th>Township</th><th>Skilled health personnel</th><th>2005</th><th>2006</th><th>2007</th><th>2008</th></tr>
<tr><td>Kyaukme</td><td>SBA</td><td>2,268</td><td>2,662</td><td>2,765</td><td>3,215</td></tr>
</table>
</td><td>Baseline Survey/ Endline Assessment
Township Health Profile/HMIS /RHMIS</td></tr>
</table>

			(42.2%)	(48.6%)	(49.5%)	(56.4%)	
		AMW	153	552	462	380	
		Total	2,421 (45.1%)	3,214 (58.6%)	3,227 (57.7%)	3,595 (60.3%)	
	Naungcho	SBA	2,125 (60.6%)	2,439 (68.2%)	2,395 (65.7%)	2,922 (78.5%)	
		AMW	451	645	626	561	
		Total	2,576 (73.5%)	3,084 (86.2%)	3,021 (82.8%)	3,483 (93.5%)	

3.
Percentage of deliveries attended by skilled health personnel* is increased.
*Skilled health personnel are SBA (skilled birth attendant) and AMW.

Percentage of deliveries attended by skilled health personnel

Township	Skilled health personnel	BLS	ELA
Kyaukme	SBA	55.8%	59.3%
	AMW	9.6%	12.3%
	Total	65.4%	71.6%
Naungcho	SBA	39.3%	72.8%
	AMW	26.2%	7.8%
	Total	65.4%	80.6%
Total	SBA	47.4%	66.8%
	AMW	18.0%	9.8%
	Total	65.4%	76.6%

(BLS(II): Table 5.13, Figure 5.3 & ELA(I): Table 5.13(a), Figure 5.3)

No. of deliveries attended by skilled health personnel (SBA and AMW) (coverage %)

Township	2005	2006	2007	2008
Kyaukme	1,464 (41.7%)	1,853 (51.8%)	1,898 (52.0%)	1,862 (50.0%)
Naungcho	1,017 (29.0%)	1,617 (54.2%)	1,514 (41.5%)	1,796 (48.2%)

No. of deliveries by SBA (at home, RHC delivery room and hospital) (coverage %)

Township	Place of delivery	2005	2006	2007	2008
Kyaukme	Home	1,122	1,290	1,297	1,114
	RHC	N/A	40	40	40
	Hospital	264	307	331	371
	Total	1,386 (25.8%)	1,637 (29.9%)	1,668 (29.8%)	1,525 (26.7%)
Naungcho	Home	502	901	892	1,119
	RHC	50	71	30	17
	Hospital	205	201	180	247
	Total	757 (21.6%)	1,173 (32.8%)	1,102 (30.2%)	1,383 (37.1%)

No. of deliveries by AMW

Township	2005	2006	2007	2008

Baseline Survey/ Endline Assessment Township Health Profile/ HMIS/ RHMIS

	Kyaukme	78	216	230	337	
	Naungcho	260	444	412	413	
4. Percentage of pregnant women referred to higher level is increased.	BLS: KM=7.7% NC=9.4% TOTAL=8.6% (Calculated using BLS(II) data) ELA: KM=6.4% NC=5.3% TOTAL=4.3% (Calculated using ELA(I) data) No. of referral cases (% to new AN cases)					Township Health Profile/HMIS /RHMIS
	Township	2005	2006	2007	2008	
	Kyaukme	93 (4.1%)	148 (5.6%)	143 (5.2%)	205 (6.4%)	
	Naungcho	67 (3.2%)	102 (4.2%)	84 (3.5%)	156 (5.3%)	
5. Coverage of T/T vaccination among the pregnant women is increased.	BLS: KM=78.7 NC=76.8 TOTAL=77.7% (BLS(II): Table 5.8, Figure 5.2) ELA: KM=76.5 NC=86.4 TOTAL=82.1% (ELA(I): Table 5.8, Figure 5.2) No. of women received T/T 2nd dose (% to Target AN)					Baseline Survey/ Endline Assessment Township Health Profile/HMIS /RHMIS
	Township	2005	2006	2007	2008	
	Kyaukme	3,715 (69.1%)	2,947 (53.8%)	3,705 (66.3%)	3,232 (56.7%)	
	Naungcho	2,552 (72.8%)	2,852 (79.7%)	2,866 (78.6%)	3,085 (82.8%)	

7.4 *Performance of the Overall Goal*

Indicators	Performance	Sources
Overall Goal: Reproductive health (RH) status improves in project areas and expanded areas* of the Union of Myanmar.		
1. Maternal mortality rate is reduced.	No. of Maternal Death	Township Health Profile/HMIS /RHMIS
	Township / 2005 / 2006 / 2007 / 2008	
	Kyaukme: 7 / 5 / 3 / 4	
	Naungcho: 5 / 6 / 2 / 4	
	Total: 12 / 11 / 5 / 8	
	MMR per 100,000 live birth	
	Township / 2005 / 2006 / 2007 / 2008	
	Kyaukme: 187 / 200 / 137 / 143	
	Naungcho: 189 / 321 / 87 / 180	
2. Percentage of women who received 4 and more times of ANC is increased.	No. of complication cases due to pregnancy	District/ Township Hospital Register 2008 Baseline Survey/ Endline Assessment
	Township / 2008	
	Kyaukme: 42	
	Naungcho: 42	
	Total: 84	
	Percentage of mothers who have birth with complications due to pregnancy BLS: KM=8.7% NC=10.3% TOTAL=9.5% (Recalculated using the data from BLS(II): Table 5.10 and 5.16) ELA: KM=17.3% NC=32.0% TOTAL=25.5%	

<table>
<tr><td></td><td>(Recalculated using the data from ELA(I): Table 5.10 and 5.16)</td><td></td></tr>
<tr><td>3.
Number of deliveries with complication is reduced.</td><td>No. of complication cases due to delivery
<table><tr><th>Township</th><th>2008</th></tr><tr><td>Kyaukme</td><td>142</td></tr><tr><td>Naungcho</td><td>49</td></tr><tr><td>Total</td><td>191</td></tr></table>
Percentage of mothers with complications during and after delivery
BLS: KM=3.8% NC=0.9% TOTAL=2.4%
(BLS(II): Table 5.16)
ELA: KM=0.0% NC=9.7% TOTAL=5.4%
(ELA(I): Table 5.16)</td><td>District/ Township Hospital Register 2008 Baseline Survey/ Endline Assessment</td></tr>
</table>

7.5 Actual Input

<table>
<tr><td>Myanmar side</td><td>1. Allocation of C/P personnel
1) Project Director 1
2) Project Manager 1
3) Technical C/P: obstetrics/gynecology, midwifery, IEC/BCC, project management, operational research, health information
4) PSC members
5) TWG members
6) VTWG members
2. Administrative/operational cost
3. Project office in Yangon till February 2006 and in two townships
4. Essential facilities for the project implementation</td><td>R/D</td></tr>
<tr><td>Japanese side</td><td>1. Dispatch of experts (February 2005-January 2010) (Refer to Annex 2.)
<table><tr><th></th><th>Expert</th><th>M/M</th></tr><tr><td>1</td><td>Project Manager</td><td>26.33</td></tr><tr><td>2</td><td>Project Coordinator</td><td>48.14</td></tr><tr><td>3</td><td>Community Health</td><td>42.82</td></tr><tr><td>4</td><td>Midwifery Education</td><td>4.56</td></tr><tr><td>5</td><td>IEC/BCC</td><td>5.84</td></tr><tr><td>6</td><td>Operational Research/Monitoring</td><td>5.70</td></tr><tr><td>7</td><td>HMIS</td><td>0.5</td></tr><tr><td>8</td><td>PCM</td><td>0.73</td></tr><tr><td>9</td><td>Project Management/ Community Organization Activities</td><td>1.7</td></tr><tr><td>10</td><td>Community Organization Activities</td><td>2.4</td></tr><tr><td colspan="2">Total</td><td>140.52</td></tr></table>
2. C/P training/study visit in Japan and Vietnam
Counterpart Training/Study Visits to Japan and Vietnam were conducted in the years 2004, 2005, 2006, 2007 and 2009. In total counterparts 26 participated. (Refer to Annex 5 and Activity 5-4.)

3. Provision of equipment (Refer to Annex 3 and Activity 1-7.)
Various kinds of equipment were provided to Hospitals, MCHCs, RHCs, Sub-RHCs, BHS, AMWs and MCHPs.

4. Renovation of RHC and Sub-RHC (2006-2008)
Renovation of health facilities US$136,158
Contract with local consultant US$32,398
Total US$168,556</td><td>Project Annual Report 2004-2008</td></tr>
</table>

	5. Local cost Local training and meetings US$74,353 Production of IEC/BCC materials US$35,122 Production DVD US$2,272 Total US$111,747 6. Baseline Survey & Endline Assessment BLS US$28,231 ELA US$34,912	

7.6 Implementation Process

Evaluation Questions	Evaluation Questions and Study Results	Sources
1. Project Management	1.1 Appropriateness of the decision making process	
	· Important issues of the project implementation have been decided through discussions and consultation with concerned parties. For that purpose, meetings of Project Steering Committee (PSC) have been held twice a year to review the progress in the past half year and to make plans for the next six months. It is scheduled to hold nine meetings in total till the end of the project, including the 8th meeting in September 2009, and the last in January 2010.	Experts Mid-term evaluation report Project annual reports
	1.2 Formulation of the project monitoring system	
	· PSC, described above, serves as a body for monitoring the project monitoring as well as project-related decision making. · Project Technical Meetings at the central level and Township Working Group meetings at the township level have been held quarterly for regular monitoring of issues related to the management and progress of the project. The discussions in the meetings were all recorded in the minutes to be shared with concerned parties. · However, the technical aspect of the project monitoring may need modification, because there is room for improvement in the reporting system of MCHPs in terms of type of information to report and who is responsible for tallying and utilizing the data.	Experts Project annual reports
	1.3 Adequacy of the communication among the project implementers	
	1) The central and local governments · The central and project site C/Ps could communicate by telephone and site visits by DOH staff. · The travel regulation to Nay Pyi Taw and the lack of infrastructure there makes the communication between the headquarters of DOH and the project experts difficult. (Refer to 3.1. 1).) 2) District/Township and HC · DMO/TMO and RHC/Sub-RHC are exchanging information on the occasions of the monthly Continuing Medical Education (CME). 3) HC/BHS and AMW/MCHP · At RHC/Sub-RHC, Continuing Health Education (CHE) conducted by MW serves as opportunities to inform AMWs and MCHPs of the project updates. In addition, MW talks to MCHPs on the occasion of outreach immunization. · At 2) and 3), CME/CHE is utilized for regular monitoring and supervision of their activities.	Experts, C/P Mid-term evaluation report Project annual reports
	1.4 Involvement of JICA	
	· The project team discussed with the JICA Myanmar office about project management once or twice a month. The persons in charge of JICA headquarters participated in the Mid-term Evaluation and several PSC meetings. As such JICA provided the project team with timely and appropriate advice which contributed to the smooth project implementation throughout the course of the project.	Experts Mid-term evaluation report Project annual reports
	1.5 Cooperation with related organizations	
	· The project and the international organizations in the fields of reproductive health have been closely cooperating through exchange of information and expertise. The project utilized an AMW training manual developed by DOH in cooperation with WHO. Afterwards the project team revised its contents based on the AMW refresher training review, and gave it to UNFPA together with the MCHP Handbook developed by the project. · The project shared information about its activities and IEC/BCC materials with UNICEF, WHO, UNDP and UNFPA from the beginning of the project, while UNICEF gave some advice on the training curriculum by the project. · The project also exchanged information and experiences regarding the guidelines and registrations for aid agencies and NGO with other organizations in the donor meetings.	Experts, C/P Mid-term evaluation report Project annual reports

	· In 2006 in order to compensate the cancellation of provision of materials which the project planned to utilize, UNICEF donated 10,000 sets of Clean Delivery Kit (CDK) and 300 AMW kits to the project.	
2. Stakeholder Participation	2.1 Commitment of DOH, DMO, TMO and focal points	
	· Generally speaking DOH, Kyaukme District Health Department, Kyaukme Township Hospital and Naungcho Township Hospital have demonstrated strong commitment to the project implementation. Despite the difficulties, DOH supported the project in relation with inter-ministerial formalities, particularly the travel permit to the project areas. · According to the C/P interviewed, the project should had been publicized widely among the township Health Department and MCHC/RHC/SHC staff other than MWs to induce their cooperation useful for its success.	Expert, C/P Mid-term evaluation report
	2.2 Participation of the target group and stakeholders	
	· Adopting the community-oriented approach, the project has succeeded in involving stakeholders such as BHS, AMWs, MCHPs and village leaders as well as the target group to its activities. · By promoting the community-oriented approaches, the project has succeeded in bringing out active participation from the local populations, particularly women of reproductive age. Currently 1,715 MCHPs, trained MCH volunteers, are serving to bridge between the public health sector and local communities. · Under the guidance of village leaders, villagers are supporting MCH services by contributing their own resources to systems such as village funds and shared means of transportation to carter for medical needs. · The team composed of MW, AMWs and MCHPs, which the project has been endeavoring to create, began functioning for promotion of MCH services in villages.	Expert, C/P, MW, AMW, MCHP, VTWG members, Service users Mid-term evaluation report
3. External Conditions	3.1 Factors contributing to/hindering to the project implementation	
	1) The transfer of the capital · The limitations of access to DOH moved to Nay Pyi Taw in 2005 and the poor communication infrastructure (the shared telephone line and neither fax nor internet) there negatively affected the project implementation till 2007. At present the project still faces the problem, since face-to-face meeting is possible only once or twice a month, although the communication has much improved with installation of direct phone and fax in DOH. 2) Limitations on entry and in-country travel of experts · Regulations concerning the experts' entry and travel seriously hampered the project activities. The experts were not allowed to visit the project areas for nine months staring from May 2005, four months after the beginning of the project, due to the security reasons. In 2006 the situation further deteriorated and it was required that all the experts travel together once a month accompanied by a DOH liaison officer. This caused a delay in the project activities. 3) Shortage and overburden of C/P and beneficiaries · C/P both at the central and township levels are burdened with heavy workload because of the shortage of the personnel. Therefore, despite their strong commitment to the project, it is difficult for them to fully engage themselves in monitoring activities and to have thorough consultation with the experts. · Among BHS, MWs are particularly overburdened with diverse tasks including immunization and village head count. This prevents them from concentrating on midwifery services. As a result, some of them are reluctant to be involved in the project being afraid of additional work. BHS's salary below the Subsistent level is another factor to influence their motivation for work. 4) Communication in the project site · The poor telephone and internet connection in the project areas hindered communication with Yangon until 2007. The condition has improved lately with mobile connection, yet both internet and fax are very slow.	Expert, C/P Mid-term evaluation report Project annual reports

8. Five Evaluation Criteria

8.1 Relevance

Evaluation Questions	Evaluation Questions and Study Results	Source
1. Needs of the Recipient Country	1.1 Appropriateness of the selected target group	
	· In Myanmar women of reproductive age (15-49 years old) constitute one of the most vulnerable groups due to the unavailability of the quality reproductive health services and the lack of knowledge of reproductive health. This has resulted in the high MMR (380 per 100,000 live births) and IMR (74 per 1,000 live births) compared to the neighboring countries. · The north and east parts of the Shan State, where the project areas, Kyaukme and Naungcho townships are situated, have been suffering from the high MMR in the country (over 500 per 100,000). Given the situation above, women of the reproductive age in the project areas deserve interventions. · On the other hand, the project areas are not necessarily the best place to identify the model RH approach to be disseminated to other areas, because of the logistic constraint hampering the project implementation. The mountainous topography is another negative element, as the project effects are unable to reach remote villages. In addition being the multilingual areas where eight languages are spoken makes communication among stakeholders difficult and complicates educational material production.	Statistics Expert, C/P Ex-ante evaluation report Mid-term evaluation report
	1.2 Consistency with the needs of the target group	
	· Both Overall Goal "improvement in RH status" and Project Purpose "increased use of quality RH services" are consistent with the needs of the target group because of the poor maternal and child health status described the previous section (1.1).	Statistics Expert, C/P Ex-ante evaluation report Mid-term evaluation report
	1.3 Equity among beneficiaries	
	· In principle the public health facilities offer services free of charge. By assisting the public health sector, the project is benefitting the poor population. · Although MCHPs to promote MCH are allocated to all the villages, some areas don't have MWs who provide services. It is estimated that places don't have access to MWs' services account for 40% of the total areas. Women and children in such areas are disadvantaged regarding service access.	Expert, C/P Ex-ante evaluation report Mid-term evaluation report
	1.4 Consistency with the policies of the government of Myanmar	
	· Improvement of reproductive health status, which the project strives to realize, is consistent with the priorities of "Health in Myanmar 2008". "Mother and children constitute over 60 percent of the total population in the country and are accorded special priority by the health care system. Maternal and child health care services are provided both in urban and rural settings and it is also a crucial component of National Health Plan." · The project is also consistent with one of the priority policy and programmatic actions "improving community and family practices" in the Strategic Plan for Reproductive Health 2009-2013. "Involve civil society, religious leaders, school teachers, local peers for promotion of reproductive health and empowering individuals, families and communities."	National policies/ Expert, C/P Ex-ante evaluation report Mid-term evaluation report
2. Mission of Japan	2.1 Consistency with the Japanese aid policies and country strategies for Myanmar	
	· The aim of the project, promotion of safe motherhood, is consistent with the concept of human security articulated in the Japan's Official Development policy. It is also in line with humanitarian assistance, one of the priorities in the Japan's aid strategies for Myanmar.	Japan's ODA policies & country aid strategies Expert Ex-ante evaluation report Mid-term

		evaluation report
	2.2 Technical advantage of Japan	
	Having succeeded in realizing remarkable improvement in MCH after the World War II, Japan has the technical advantage from which Myanmar can learn a lot. For that purpose, four Myanmar officers visited Wakayama, Japan in 2004, and later initiated the current MCHP system by modifying Japanese model started in 1968.	JICA reports Expert Ex-ante evaluation report Mid-term evaluation report
3. Project Design	3.1 Appropriateness of the PDM	
	• One of the important assumptions "C/P such as DOH staff, State Health Director, DMO, TMO and BHS are properly allocated" may not be properly placed, because it could be controlled within the framework of the project. • As the result of the Objectively Verifiable Indicator (OVI) review workshop held in February 2007, the second project purpose "Best practices and approaches identified from the Project are applied to RH programmes in the Union of Myanmar" was moved to Important Assumptions, since it cannot be controlled by the project, yet it is one of the essential factors to realize Overall Goal. • The following points in the PDM may not be adequate. ➢ Output 5 "identification and documentation of the community-oriented RH approaches" and its indicator "distribution of the documentation of the community-oriented RH approaches" are not consistent. ➢ Output 5 concerning the dissemination to other areas cannot contribute to the achievement of the project purpose "the increased RH service use in the project areas." ➢ Objectively Verifiable Indicators (OVIs) don't have numerical targets (e.g., "increases by XX%/reach XX%").	PDM Expert, C/P Mid-term evaluation report Project annual reports OVI review workshop proceedings
	3.2 Appropriateness of the project planning process	
	• Even before the start of the project, C/Ps participated in the project preparation, including the study tour to Japan in 2004. • The PDM was created through participatory workshops held in Kyaukme and Naungcho in July 2004, and revised in the PCM workshops in Kyaukme and Naungcho in September 2005. In February 2007, OVIs were reviewed based on the results of the Baseline Survey. In September 2008, the latest (4th version) of the PDM was drawn up in consultation with central and local C/Ps and JICA.	PDM Expert, C/P Mid-term evaluation report Project annual reports
4. External Conditions	4.1 Changes of the circumstances surrounding the project after the mid-term evaluation	
	• For more than half a year after the Cyclone Nargis shit the southern parts of the country in May 2008, the issuance of a visa for emergency aid workers was given priority. The consequent delay of the visas of the project experts affected the project. • For the sake of the election scheduled in 2010, in August 2009 the government started to restrict the issuance of a visa and a travel permit to the project areas (up to two weeks). It is likely to influence the dispatch of the experts.	Expert, C/P

8.2 Effectiveness

Evaluation Questions	Evaluation Questions and Study Results	Source
1. Achievement of Project Purpose	1.1 Achievement of Project Purpose	
	· During the four year period (2005-2008), all the five OVIs (1. Contraceptive prevalence, 2. ANC coverage, 3. Percentage of deliveries attended by skilled health personnel, 4. Percentage of pregnant women referred to higher level, and 5. Coverage of TT injection among pregnant women) recorded increases. However, it would be safe to disregard the OVI 4 (the referral of pregnant women to the district or township hospital by MW), because the reasons of the referral is unknown and there is no system to monitor the referral cases to adjacent townships. With four out of five OVIs improved, it could be concluded the Project Purpose is achieved. · The OVIs do not have numerical targets and the degree of the improvement is not necessarily great. · The referral of pregnant women (OVI 4) is increasing yet represents a small proportion (6% in Kyaukme and 5% in Naungcho). It is assumed that lack of means of transportation and travel expense to reach the medical facilities where they are referred to causes the low percentage. Means of transportation and financial assistance are available for those who need to be referred, but they are limited. · Although the growth is observed on average of two project sites, the coverage of TT injection (OVI 5) in Kyaukme declined from 2005 to 2008 (in fact it fluctuates a year to a year). The decline is presumed be associated with an increase in vacancy of BHS in 2008,	Achievement of Project Purpose in the Performance Grid Expert, C/P Baseline Survey Endline Assessment Ex-ante evaluation report Mid-term evaluation report
2. Coherence between Outputs and Project Purpose	2.1 Causal relationship between Outputs and Project Purpose	
	Output 1:Service improvement · Enhanced skills and knowledge of BHS and AMWs due to a variety of the training sessions as well as renovation of the health facilities (9 RHCs out of 12 and 10 Sub-RHCs out of 42) and provision of equipment to health facilities and BHS/AMW (Clean Delivery Kit) contributed to the increased service use. Output 2: Awareness and knowledge enhancement · With improved health education skills, MWs can communicate RH information and knowledge to people more effectively, especially the target group. As a result, they came to understand the importance of RH services, danger signs of pregnancy, and necessity of emergency referral. It is reasonable to assume that the enhanced awareness and knowledge of people resulted in the increases of the service utilization. Output 3: Linkage with communities · The community-based human resources trained by the project are considered the core of strengthening of the linkage between the service providers and people. In total approximately 3,800 personnel as below who have established him/herself in communities in two townships is playing a vital role for service promotion. ➢ 90 BHS (including MWs) ➢ 233 AMWs ➢ 3,326 MCHPs in total (1st batch year 2006: 1,672, 2nd batch year 2008: 1,654) ➢ 200 community leaders (including PDC chairpersons) · Currently 1,715 MCHPs are functioning in all the 620 villages in two townships. Each MCHP is in charge of 30 households and on average there are 2.8 MCHPs in each village. Output 4: Establishment of support mechanism of CORH approach · The experience sharing workshops where good practices of community support and collaboration among local stakeholders resulted in establishment of supportive mechanism in communities. The increased number of village leaders began assisting service use of pregnant women by creating or reinforcing the community fund to meet financial needs and offering shared means of transportation to enable	Expert, C/P, MW, AMW, MCHP, VTWG members Ex-ante evaluation report Mid-term evaluation report Project annual reports

Oaki

	emergency referral of pregnant women to the health facilities in the areas and/or the higher level. Output 5: Identification and documentation of the applicable CORH approach · The CORH approach identified by the project is being compiled as an implementation guide for application in other areas. The first and second drafts of the guide were shared with C/Ps to be finalized in the PSC meeting in September 2009. The distribution to which the indicator referring will be done in the dissemination workshop scheduled in November 2009.	
3. Important Assumptions	3.1 Important Assumptions for realization of Project Purpose	
	· "Access to the service delivery points (SDPs)" is still appropriate as Important Assumption. Conditions such as vacancy of BHS and limitations of health infrastructure and equipment may affect access to services. · At present Kyaukme Township suffers from absence of nine SBA (3 LHVs and 6 MWs) because of personnel transfer or leave for long-term training, which certainly hampers service delivery at their centers.	Expert, C/P Ex-ante evaluation report Mid-term evaluation report
4. External conditions	4.1 Factors contributing to/hindering the achievement of Project Purpose	
	<Contributing factors> · People greatly appreciate performance of AMWs and MCHPs serving in communities as volunteers. It helps to raise people's awareness on MCH. · Cooperation with international organizations contributed to accelerate the training of AMWs, since the project utilized an AMW training manual developed by WHO and DOH for its refresher training. The project revised it four times based on the review of the training sessions and shares the latest version with other organizations. · The project made tremendous efforts to accelerate implementation of delayed activities because of the travel regulation to the project areas at the beginning of the project. · In Naungcho Township, one RHC was upgraded to Station Health Unit. <Hindering factors> · Bad road condition and lack of means of transportation hinder access to the health facilities and outreach activities. · Vacancies of BHS, particularly at Sub-RHC where only one MW is posted, may prevent delivery of quality service. · Even if people's RH awareness rose, there are cases that pregnant women go to a hospital in the adjacent township (e.g., Pin Ow Lwin from Naungcho) that is easily accessible. These cases cannot be monitored by the two target townships and are not included in the referral indicators of the project.	Expert, C/P, MW, AMW, MCHP, VTWG members Ex-ante evaluation report Mid-term evaluation report Project annual reports

8.3 Efficiency

Evaluation Questions	Evaluation Questions and Study Results	Source
1. Achievement of Outputs	1.1 Achievement of Outputs	
	All the five outputs are considered achieved owing to the improvement of respective indicators. Output 1: Service improvement · All the six indicators in relation to the proportion of the service providers with necessary RH knowledge and skills grew remarkably four years (2005-2008) from the time of the baseline survey to that of the endline assessment. Therefore the Output 2: Awareness and knowledge enhancement · In the four year period (2005-2008) three indicators (OVI 1-3) regarding RH knowledge of men and women, and two (OVI 4-5) related to women's behavior drastically improved. · OVI 6, number of female participates in health education increased from 2006 to 2008, expect for the decrease in Naungcho from 2007 to 2008. · A great variety of IEC/BCC materials was developed and widely distributed (OVI 7).	Achievement of Outputs in the Performance Grid Expert, C/P Baseline Survey Endline Assessment

Osaki

	Output 3: Linkage with communities ・ Generally speaking, the indicators, number of referral cases from community level to health facilities increased from 2005 to 2008 with some degree of fluctuations. Output 4: Establishment of support mechanism of CORH approach ・ The supporting committees of the CORH approach (Project Steering Committee (PSC), Township Working Group (TWG) and Village Tract Working Group (VTWG)) were established at the central and local level in September 2005, and coordination meetings were held regularly. Various township level plans of the project activities were drawn up. Output 5: Identification and documentation of the applicable CORH approach ・ Output 5 is primarily related to the second Project Purpose "dissemination of the CORH approach to other areas" moved to Important Assumption at the time of the mid-term evaluation. This output may not be directly contributing to current Project Purpose, but it is meaningful for the CORH approach to be documented for continuous application in the project areas and dissemination to other areas.	
2. Coherence between Activities and Outputs	2.1 Causal relationship between Activities and Outputs	
	・ All the activities are planned in order to achieve Outputs, and therefore they are all necessary and appropriate for the aim.	Expert, C/P Ex-ante evaluation report Mid-term evaluation report Project annual reports
3. Inputs	3.1 Appropriateness of the Japanese expert assignment	
	・ Total assignment of the experts from the beginning of the project (the FY 2004) till the end of the project was 140.52 M/M in ten fields of expertise. Most of the experts were dispatched properly according to the plans in terms of expertise, timing and time-length. ・ It would be better to have the expert of midwifery training assigned longer in the former half of the project term, so that assessment and monitoring of birth attendants could be done earlier. ・ Assignment of the expert of OR/monitoring in the former half of the project term might not be sufficient to design the monitoring system. Thus sustainable health data collection including activity records of AMW and MCHP (types of data to collect, how/who to tally, analyze and feedback etc.) has not been drawn up yet.	Expert, C/P The Performance Grid
	3.2 Appropriateness of the C/P allocation	
	・ Most of the C/Ps at the townships were allocated as planned. <Refer to the attached list.> ・ Number of the C/Ps at the townships, however, is not enough. There is nobody to transfer data collection and processing techniques. In addition, they don't have enough time to be fully engaged in the project because they are overburdened. ・ C/P personnel at the central level are not enough, either, in order to realize the expected degree of involvement. There are only four officers in MCH division, DOH, who are responsible for all the MCH projects/programs in the country. The situation aggravated after they moved to Nay Pyi Taw.	Expert, C/P The Performance Grid
	3.3 Appropriateness of the equipment provision	
	・ The equipment was adequately provided according to the guideline of DOH and the recommendations of the needs assessment by the project. <Refer to the attached list.> ・ The IEC materials distributed to RHC, one set per each center, should be shared with Sub-RHC in case of need, yet it is concerned that sharing may not be always possible.	Expert, C/P The Performance Grid
	3.4 Appropriateness of the C/P training in Japan and the third country	
	・ C/P training took place four times in Japan and once in Vietnam in 2004, 2006, 2007 and 2009. (The training in Japan scheduled in 2008 was postponed to 2009 due to the cyclone.) In total 26 C/Ps took part in the training. <Refer to the attached list.> ・ Experts and C/Ps think the trainings in Japan were adequate in terms of the aim,	Expert, C/P The Performance Grid

	Subjects taught and contribution to improvement of the work performance of the returned trainees as well as their cooperation with the project. · On the other hand, the project team cannot totally control selection of the trainees and those who were not directly related to the project were included. · The challenge is that the high rate of staff transfer. Out of 20 returned trainees of the training in Japan till 2008, only four persons still remain involved in the project. One of six trainees of 2009 has already been transferred to elsewhere.	
	3.5 Appropriateness of the project expense	
	· The project expense borne by Japanese was appropriate to carry out the planned activities.	Expert, C/P The Performance Grid
	3.6 Appropriateness of the project costs sharing by Myanmar	
	· Adequate offices are provided in the both township hospitals, but the there is no space available at DOH in Nay Pyi Taw, so the project rents an office in Yangon since 2006. Telephone line has not been given. · It is difficult for DOH to bear its share of the project expense.	Expert, C/P The Performance Grid
	3.7 Cost-effectiveness of the project expense	
	· Considering the achievement, the total project expense is considered adequate. The project is managed cost-effectively in comparison with other donor projects in the field of RH/MCH, since UN agencies pay C/P salary and per diem.	Expert, C/P The Performance Grid
4. Logistics	4.1 Logistic constraint	
	· The logistic constraint caused by the rigid formalities such as a visa and travel permit of the experts laid heavy burden on the project management. If the time and energy spent for the arrangements were allocated to the activities, the project could have achieved more. <Refer to "7.6 Implementation Process, 3. External Conditions" for details.>	Expert, C/P The Performance Grid
5. Important Assumptions	5.1 Important assumptions for realization of Outputs	
	· "C/Ps are properly allocated" remains valid as an important assumption. As described earlier, the shortage of the C/P personnel has been negatively affecting the project. · The second assumption, "Provision of contraceptives and essential drugs to the project area is secured" is not fulfilled, as the population and family planning special provision scheme from which the project planned to receive contraceptives and AMW kits scaled finished in 2006. UNICEF donated 300 AMW kits and 10,000 Clean Delivery Kits in 2006, but it was not sufficient to meet the needs. Equally the supply of other contraceptives and essential drugs from DOH is not stable.	Expert, C/P Ex-ante evaluation report Mid-term evaluation report Project annual reports
6. External conditions	6.1 Factors contributing to/hindering the achievement of Outputs and Activities	
	<Refer to "8.2 Effectiveness 4. External Conditions.">"> <Contributing factors> · The renovation of the health facilities positively influences community leaders and people including volunteers and motivates them to support and more actively participate in the project activities. · Chairperson of Peace and Development Committee (PDC) who doubles as Chairperson of Kyaukme Township Working Group appealed village leaders for support to MCH service provision in the experience sharing workshop and planning seminar. The action greatly contributed to bring about cooperation from community leaders. · Some project activities brought psychological and behavioral change among stakeholders. MWs recognized that they were expected to lead the team of volunteers (MCHP and AMW) for MCH promotion in the leadership training. At the same time DMO/TMO who played the role of trainers in the training reviewed what they had done for monitoring and began adopting the concept of supportive supervision. <Hindering factors> · MCHPs face difficulties in areas where community leaders are not supportive. · In areas where MW cannot meet AMW and MCHP easily due to bad access, regular information exchange and supervision are hardly possible.	Expert, C/P, MW, AMW, MCHP, VTWG members Service users Ex-ante evaluation report Mid-term evaluation report Project annual reports

8.4 Impact

<table>
<tr><th>Evaluation Questions</th><th>Evaluation Questions and Study Results</th><th>Source</th></tr>
<tr><td rowspan="2">1. Realization of Overall Goal</td><td>1.1 Possibility of Achievement of Outputs after the end of the project</td><td></td></tr>
<tr><td>・ It is difficult to assess the degree of improvement in reproductive health status in the project areas and expanded area as the availability of reliable data is limited.
・ As for the project areas, the 1st indicator, MMR in the project areas reduced from 2005 (Kyaukme 187/100,000 and Naungcho 189/100,000) to 2008 (Kyaukme 143/100,000 and Naungcho 180/100,000). However, it fluctuates greatly, as the both townships recorded the best figure in 2007 (Kyaukme 137/100,000 and Naungcho 87/100,000) and then deteriorated in the following year.
・ The second and third indicators aggravate from 2006 to 2009 or data seem unreliable.
<table>
<tr><td></td><td colspan="2">Pregnancy complications[1] (%)</td><td colspan="2">Delivery complications[2] (%)</td></tr>
<tr><td>Year</td><td>KM</td><td>NC</td><td>KM</td><td>NC</td></tr>
<tr><td>2006</td><td>8.7</td><td>10.3</td><td>3.8</td><td>0.9</td></tr>
<tr><td>2009</td><td>17.3</td><td>32.0</td><td>0</td><td>9.7</td></tr>
</table>
[1] Bleeding, convulsion, abortion or eclampsia during pregnancy.
[2] Excessive bleeding or convulsion during child birth.
(Baseline Survey/Endline Assessment)

・ Improvement of RH status in the expanded areas depends on the government's efforts to apply the CORH approach and the present RH status.</td><td>Achievement of Overall Goal in the Performance Grid
Expert, C/P
Baseline Survey /Endline Assessment
Ex-ante evaluation report
Mid-term evaluation report</td></tr>
<tr><td rowspan="2">2. Coherence between Project Purpose and Overall Goal</td><td>2.1 Causal relationship between Project Purpose and Overall Goal</td><td></td></tr>
<tr><td>・ Quality RH services are one of the important determinants of the improvement of RH status, but not sufficient by itself. Other influential factors such as nutrition, hygiene and income need to be addressed in the project areas.</td><td>Expert, C/P
Ex-ante evaluation report
Mid-term evaluation report</td></tr>
<tr><td rowspan="2">3. Important Assumptions</td><td>3.1 Important assumptions for realization of Overall Goal</td><td></td></tr>
<tr><td>・ The first assumption, "Community-Oriented RH approaches identified by the project applied to RH programmes" totally depends on the institutional/financial capacity of DOH. It is assumed difficult without donors' assistance, since almost all the programs are externally funded.
・ The second assumption "Assistance from other donors continues as planned" is unpredictable at this moment. Donors' assistance to Myanmar is of highly political nature and it is uncertain whether the same scale of inputs continues, particularly after the election in 2010.
・ The third assumption, "DOH continues to support to RH services" is likely to be met unless the government drastically changes its policies and plans owing to the elections and entailing administrative reform.</td><td>Expert, C/P, MW
Ex-ante evaluation report
Mid-term evaluation report
Project annual reports</td></tr>
<tr><td rowspan="2">4. External conditions</td><td>4.1 Factors contributing to/hindering the realization of Overall Goal</td><td></td></tr>
<tr><td><Hindering factors>
・ Limitations of financial capacity of DOH that cannot afford other than the personnel cost only put an obstacle to dissemination of the CORH approach.
・ Equally the shortage of the C/P personnel could be a constraint on implementation and monitoring of RH programs in future.</td><td>Expert, C/P
Ex-ante evaluation report
Mid-term evaluation report</td></tr>
<tr><td rowspan="3">5. Emergence of Other Impacts</td><td>5.1 Positive Impacts</td><td></td></tr>
<tr><td>・ MCHPs promoted not only MCH but also primary health in villages. Majority of the interviewed MCHPs are interested in learning general health. MCHPs could play a pivotal role for health of the general population as well.
・ Based on experiences of the CORH project, DOH and WHO has started "Community Maternity Newborn Team" project in Sagaing Division.</td><td>Expert, C/P
Ex-ante evaluation report
Mid-term evaluation report</td></tr>
<tr><td>5.2 Negative Impacts
・ No negative impacts have been observed so far.</td><td>Expert, C/P</td></tr>
</table>

		Mid-term evaluation report

8.5 Sustainability

Evaluation Questions	Evaluation Questions and Study Results	Source
1. Institutional Sustainability	1.1 DOH management capacity for the continuation of the project	
	· Having benefitted from the project for five years, Health Departments of the target townships have learned know-how to sustain the current activities for the CORH approach. Yet, the frequent transfer of the township C/Ps should be addressed by introducing effective means to ensure institutional retention of the managerial capacity. · It is crucial for DOH to elaborate the plans of dissemination of the CORH approach. · Cooperative relationship between the public health sector and community has been further strengthened to lay the foundation of sustainability of the project effects. · The interview with MCHPs revealed that they were highly motivated to serve for the health needs of the community. With support from DOH and communities, it is very likely the majority of them to continue promoting MCH services. · Village leaders are willing to continue supporting MCH service provision in the community by facilitating service use by those who in need.	Expert, C/P Ex-ante evaluation report Mid-term evaluation report CORH approach guide
2. Financial Sustainability	2.1 Financial viability of DOH, District and Township	
	· In Myanmar as little as 3% of the national budget is allocated to the health sector. Personnel cost consumes most of the health budget and no much is left for program operation. In this context, without donor funding it is impossible to maintain the current level of inputs, but the townships can continue some of the project activities utilizing the on-going operation such as regular monitoring and CME for BHS without incurring additional cost.	DOH plans Expert, C/P
	2.2 Donor assistance	
	· At present the trends of external funding after 2010 cannot be predicted.	Expert, C/P Other organizations' personnel
3. Technical Sustainability	3.1 Retention of knowledge and skills of the trained personnel	
	· It is common for government officers to be transferred to other offices every two years. Thus it is difficult for the institution to retain knowledge and skills fostered in the course of the project implementation. It is essential that the managerial expertise with regards to the CORH approach to be kept in form of the implementation guide as a reference for future implementers. · On the contrary, BHS who settled in the locality tend to stay in one place long time. They ought to be the key persons to carry out the CORH approach. · It is crucial to encourage MWs to utilize CME for the retention of their knowledge and skills. MWs are expected to teach and advise AMWs and MCHPs through CHE on a regular basis. · It is irreplaceable to provide incentives for AMWs and MCHPs who are volunteers to maintain their active involvement in MCH service assistance. As most of the interviewed AMWs and MCHPs mentioned, training to gain and refresh their knowledge could be a good incentive for their continuous service. In spite of the lack of finance and human resources, it is expected for DOH to strive to offer such opportunities.	Expert, C/P, MW, AMW, VTWG members Service users Ex-ante evaluation report Mid-term evaluation report CORH approach guide
	3.2 Identification of the Community-Oriented RH approach	
	· The interviews with BHS, AMWs and MCHPs indicate that the teamwork of the three started working in villages with regional variations. It succeeded in reinforcing the relations between the service providers and communities to augment service use and in reducing the burden of MWs. Therefore it is reasonable to conclude the CORH approach has begun functioning in the project	Expert, C/P, MW, AMW, VTWG members Service users Ex-ante

	areas. - Given the heavy burden that MWs are currently bearing, it is desirable for the CORH approach to seek to strengthen relations between health facilities (MCHC/RHC/Sub-RHC) and the volunteers (MCHP and AMW) instead of that between MW and the volunteers. - Documentation of the approach is underway and the implementation guide is expected to help retention of the know-how of the operation as well as to facilitate dissemination of the approach. - In order to complete the effective CORH implementation guide, technical details need to be further examined through consultation with the stakeholders. One of the key issues should be discussed is practical monitoring of MCHPs and AMWs.	evaluation report Mid-term evaluation report CORH approach guide
4. External conditions	4.1 Factors contributing to/hindering sustainability	
	Political - It is uncertain how the political situation after the election in 2010 will affect programs applying the CORH approach. Social & cultural - Thanks to efforts of various organizations tackling health issues in Myanmar, health seeking behavior of the population has been changing quite rapidly. The interviews with mothers, AMWs and BHS tell that delivery assisted by SBA and utilization of health services remarkably increased in the past few years, that is a momentum for improvement of RH.	National policies Expert, C/P Ex-ante evaluation report Mid-term evaluation report

ミャンマー連邦地域展開型リプロダクティブヘルスプロジェクト（PROTECO）終了時評価調査　調査結果概要

＜基本方針＞

1. プロジェクト目標、成果指標の達成度の確認を行うために、2005 年、2006 年に実施したベースライン調査データと 2009 年 5 月に実施したエンドライン調査データを活用し、プロジェクトの開始時点と終了時点の比較を行う。また、インタビュー調査から定性情報を得て、プロジェクトの介入効果を測定する。
2. 中間評価の提言を受けて作成した「地域展開型 RH アプローチ」形成に向けたロードマップに基づき、同アプローチを取りまとめた「地域展開型 RH アプローチ実施ガイド（案）」の作成状況を確認する。特に、中間評価で指摘のあった MW、AMW、MCHP の役割が明確化され、3 者がチームとして総合力を発揮できる仕組みが整ってきているか、また、これが実施ガイド（案）に反映されているかを確認する。
3. ミャンマーMOH が「地域展開型 RH アプローチ」を今後他地域に適用（自立発展性）するための展開計画について協議し、提言にまとめる。

<table>
<tr><th></th><th colspan="4">ミャンマー連邦地域展開型リプロダクティブヘルスプロジェクト（PROTECO）</th></tr>
<tr><th></th><th>調査項目</th><th>実績・課題</th><th>対処方針</th><th>調査結果</th></tr>
<tr><td>1</td><td>プロジェクト目標
プロジェクト地区における質の高い RH・サービスの利用が増加する。</td><td>指標①CPR が増加する。
ベースライン調査：チャウメ 41.1%、ナウンチョー41.3%
エンドライン調査：チャウメ 56.9%、ナウンチョー49.1%
指標②ANC を 4 回以上受ける女性の割合（%）が増加する。
ベースライン調査：チャウメ 49.0%、ナウンチョー39.2%
エンドライン調査：チャウメ 44.4%、ナウンチョー50.5%
<table><tr><th>タウンシップ</th><th>2005</th><th>2006</th><th>2007</th><th>2008</th></tr><tr><td>チャウメ</td><td>N/A</td><td>734
(13.4%)</td><td>652
(11.7%)</td><td>974
(17.1%)</td></tr><tr><td>ナウンチョー</td><td>363
(10.4%)</td><td>821
(23.0%)</td><td>908
(24.9%)</td><td>1,177
(31.6%)</td></tr></table>指標③技術をもった保健医療従事者の出産介助を受けた出産の割合（%）が増加する。
ベースライン調査：チャウメ 55.8%、ナウンチョー39.3%
エンドライン調査：チャウメ 59.3%、ナウンチョー72.8%</td><td>・指標によっては、測定方法（ベースライン調査とエンドライン調査の比較、HMIS/RHMIS・病院統計）により実績に差異が見受けられるため、その要因を検討し、今後の課題を抽出する。
・そのうえで、プロジェクト目標がおおむね達成できていることを確認する。</td><td>・2005 年から 2008 年の 4 年間に、5 つの指標（1. CPR、2. ANC を 4 回以上受けた女性の割合、3. 技術をもった保健医療従事者の介助による出産の割合、4. 上位の医療機関に搬送された妊産婦の割合、5. 妊産婦の TT ワクチン接種率）が概ね改善した。
・5 つの指標のうち（判断対象から除外した指標 4 を除く）4 つに改善傾向が確認されたことで、プロジェクト目標はおおむね達成されたといえる。しかしながら、指標には目標値が明記されておらず、改善の度合いが必ずしも大きくない項目もあった。</td></tr>
</table>

<table>
<tr><th></th><th>調査項目</th><th>実績・課題</th><th>対処方針</th><th>調査結果</th></tr>
<tr><td></td><td></td><td>
指標④上位の医療機関に搬送される妊産婦の割合（%）が増加する。
ベースライン調査：チャウメ 7.7%、ナウンチョー9.4%
エンドライン調査：チャウメ 6.4%、ナウンチョー5.3%

<table>
<tr><th>タウンシップ</th><th>2005</th><th>2006</th><th>2007</th><th>2008</th></tr>
<tr><td>チャウメ</td><td>93 (4.1%)</td><td>148 (5.6%)</td><td>143 (5.2%)</td><td>205 (6.4%)</td></tr>
<tr><td>ナウンチョー</td><td>67 (3.2%)</td><td>102 (4.2%)</td><td>84 (3.5%)</td><td>156 (5.3%)</td></tr>
</table>
指標⑤妊産婦における TT ワクチン接種率が増加する。
ベースライン調査：チャウメ 78.7%、ナウンチョー76.8%
エンドライン調査：チャウメ 76.5%、ナウンチョー86.4%

<table>
<tr><th>タウンシップ</th><th>2005</th><th>2006</th><th>2007</th><th>2008</th></tr>
<tr><td>チャウメ</td><td>3,715
(69.1%)</td><td>2,947
(53.8%)</td><td>3,705
(66.3%)</td><td>3,232
(56.7%)</td></tr>
<tr><td>ナウンチョー</td><td>2,552
(72.8%)</td><td>2,852
(79.7%)</td><td>2,866
(78.6%)</td><td>3,085
(82.8%)</td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>2</td><td>成果1
プロジェクト地区において、安全な妊娠と出産に焦点を当てた RH サービスの質が向上する。</td><td>
指標①クライアントに適切なカウンセリング手順を使うことができる RH サービス提供者の割合（%）が増加する。
ベースライン調査：54.7%
エンドライン調査：72.3%
指標②技術指針（ガイドライン）に沿って ANC を行うことができる、助産の訓練を受けたサービス提供者の割合（%）が増加する。
ベースライン調査：40.1%
エンドライン調査：78.6%
指標③技術指針（ガイドライン）に沿って出産介助を行うことができる、助産の訓練を受けたサービス提供者の割合（%）が増加する。
ベースライン調査：70%
</td><td>・指標に沿って、エンドライン調査結果を入手し、現状を評価する。
・可能な範囲で、サービスを受けた側からのサービスに対する評価情報を入手する。</td><td>・必要な RH に関する知識または技術を備えたサービス提供者の割合に関するすべての指標が、ベースライン調査の結果に比べて、エンドライン調査時には大幅に上昇した。</td></tr>
</table>

	ミャンマー連邦地域展開型リプロダクティブヘルスプロジェクト（PROTECO）			
	調査項目	実績・課題	対処方針	調査結果
		エンドライン調査：85.0% 指標④技術指針（ガイドライン）に沿ってPNCを行うことができる、助産の訓練を受けたサービス提供者の割合（%）が増加する。 ベースライン調査：出産直後　79.2%、2～3日後　52.4%、 4-6週間後　37.8% エンドライン調査：出産直後　87.5%、2～3日後　61.1%、 4-6週間後　92.2% 指標⑤産科緊急の知識を有する、助産の訓練を受けたサービス提供者の割合（%）が増加する。 ベースライン調査：43.3% エンドライン調査：78.6% 指標⑥新生児の危険な兆候についての知識を有する、助産の訓練を受けたサービス提供者の割合（%）が増加する。 ベースライン調査：13.3% エンドライン調査：71.4%		
3	成果2 プロジェクト地区の住民、特に女性のRH に関する意識と知識が向上する。	指標①3つ以上の妊娠・出産合併症についての知識を有する15歳以上の男性及び15～49歳の女性の割合（%）が増加する。 ベースライン調査：チャウメ32.1%、ナウンチョー18.3% エンドライン調査：チャウメ69.9%、ナウンチョー64.1% 指標②少なくとも1つ以上の近代的避妊法についての知識を有する。15歳以上の男性及び15～49歳の女性の割合（%）が増加する。 ベースライン調査：チャウメ79%、ナウンチョー74.8% エンドライン調査：チャウメ92.4%、ナウンチョー94.9% 指標③3つ以上の人工妊娠中絶のリスクについての知識を有する。15歳以上の男性及び15～49歳の女性の割合（%）が増加する。	・入手できる指標のデータを評価し、プロジェクト関係者から成果達成を促進する要因が何であったか情報収集する。 ・促進要因が地域展開型 RH アプローチ実施ガイド（案）に反映されるよう確認する。	・2005 年から 2008 年までの 4 年間、15 歳以上の男性と 15 歳～49 歳の女性の間の RH に関する知識をもつ人の割合（指標 1-3）と適切な RH 関連行動を取る女性の割合（指標 4-5）は大きく増加した。さらに、2006 年から 2008 年にかけて保健教育に参加した女性の数は増加し（2007 年から 2008 年にかけてのナウンチョウでの減少を除く）（指標 6）、多数の IEC/BCC 教材が開発され、広く関係者に配布された。

<table>
<tr><th></th><th>調査項目</th><th>実績・課題</th><th>対処方針</th><th>調査結果</th></tr>
<tr><td></td><td></td><td>
ベースライン調査：チャウメ14.7%、ナウンチョー8.9%
エンドライン調査：チャウメ54%、ナウンチョー67.2%
指標④妊産婦手帳（home-based maternal record）を活用する女性の割合（%）が増加する。
ベースライン調査：チャウメ21.9%、ナウンチョー27.4%
エンドライン調査：チャウメ40%、ナウンチョー60%
指標⑤CDKを活用する女性の割合（%）が増加する。
ベースライン調査：チャウメ66.3%、ナウンチョー72%
エンドライン調査：チャウメ84%、ナウンチョー92.2%
指標⑥健康教育セッションに参加した女性の数が増加する。
<table>
<tr><th>タウンシップ</th><th>2006</th><th>2007</th><th>2008</th><th>合計</th></tr>
<tr><td>チャウメ</td><td>44</td><td>240</td><td>1000</td><td>1,284</td></tr>
<tr><td>ナウンチョー</td><td>61</td><td>310</td><td>187</td><td>558</td></tr>
<tr><td>合計</td><td>105</td><td>550</td><td>1,187</td><td>1,842</td></tr>
</table>
指標⑦プロジェクトで開発し地域に配布されたIEC/BCC教材の数が増加する。（付属資料4. IEC/BCC教材リスト参照）
</td><td></td><td></td></tr>
<tr><td>4</td><td>成果3
RH サービスと地域住民とのつながりが強化する。</td><td>
指標①コミュニティレベルから保健施設へのリファーラル数が増加する。
1回以上のPNCを受信した妊産婦数
<table>
<tr><th>タウンシップ</th><th>技術を持った保健医療従事者</th><th>2005</th><th>2006</th><th>2007</th><th>2008</th></tr>
<tr><td>チャウメ</td><td>SBA</td><td>6,527</td><td>6,258</td><td>5,013</td><td>7,360</td></tr>
</table>
</td><td>・MCHP、AMW、VTWG メンバーへのインタビューにより、定性的情報を収集する。</td><td>・2005 年から 2008 年にかけて、SBA と AMW による PNC サービス件数は大幅に増加し、AMW による保健施設へのリファー件数も上昇した。
・AMW、MCHP、VTWG メンバーなどへの聞き取り調査からは、妊産婦のピア（仲間）として MCHP が適切な妊産婦ケアの受診推進に貢献していることが確認された。</td></tr>
</table>

	調査項目	実績・課題	対処方針	調査結果

<table>
<tr><td></td><td></td><td>
<table>
<tr><td rowspan="2"></td><td>AMW</td><td>249</td><td>378</td><td>416</td><td>801</td></tr>
<tr><td>合計</td><td>6,776</td><td>6,636</td><td>5,429</td><td>8,161</td></tr>
<tr><td rowspan="3">ナウンチョー</td><td>SBA</td><td>3,484</td><td>3,472</td><td>5,338</td><td>7,570</td></tr>
<tr><td>AMW</td><td>707</td><td>611</td><td>1,011</td><td>1,239</td></tr>
<tr><td>合計</td><td>4,191</td><td>4,083</td><td>6,349</td><td>8,809</td></tr>
</table>
AMWが保健施設に照会した件数
<table>
<tr><th>タウンシップ</th><th>2005</th><th>2006</th><th>2007</th><th>2008</th></tr>
<tr><td>チャウメ</td><td>36</td><td>42</td><td>54</td><td>78</td></tr>
<tr><td>ナウンチョー</td><td>47</td><td>75</td><td>77</td><td>62</td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>5</td><td>成果4
地域展開型 RH アプローチを支援する体制が形成され、機能する。</td><td>指標①各レベルの調整委員会が設置される。
PSC
TWG
VTWG
指標②各タウンシップでプロジェクトに関する年間計画が策定される。
TWG、VTWG 運営のガイドラインが策定され、改定された。
指標③調整委員会会議が開催され地域展開型RHアプローチを支援するためのメカニズムがモニターされる。
PSC 7回
タウンシップ・VTWG 四半期ごとに開催</td><td>・タウンシップ、VTWG メンバーへのインタビューを実施し、地域支援体制の運営、活動などについて定性的評価を行う。</td><td>・地域展開型 RH の支援組織である、中央レベルでは PSC、地元においては TWG、VTWG が 2005 年 9 月に組織され、各委員会の調整会議が定期的に開催された。各タウンシップにおいてさまざまなプロジェクト活動の計画が作成された。
・タウンシップレベル、村落レベルの関係者への聞き取り調査から、MCH のための地域支援体制が機能しつつあることを確認した。</td></tr>
<tr><td>6</td><td>成果5
ミャンマーの RH プログラムの下で広く適用可能な地域展開型 RH ヘルスのアプ</td><td>指標①地域展開型 RH に関するドキュメンテーションが国内の他地域へ配布される。
実施ガイド（案）の取りまとめ中である。</td><td>・「地域展開型 RH アプローチ実施ガイド（案）」の内容、取りまとめ状況について、カウンターパート、専門家へのインタビューを通じて確認する。
・アプローチ及び実施ガイドの汎用性</td><td>・プロジェクトが形成した地域展開型 RH アプローチは、他地域での展開を念頭に、現在実施ガイドに取りまとめ中である。第１稿と第２稿は既にカウンターパートと共有済みで、</td></tr>
</table>

	ミャンマー連邦地域展開型リプロダクティブヘルスプロジェクト（PROTECO）			
	調査項目	**実績・課題**	**対処方針**	**調査結果**
	ローチが形成され、文書化される。		について、他パートナー（国連機関など）へのインタビューを通じて情報を収集する。 ・本プロジェクトは国全体のRH向上と保健サービスの改善をめざしたパイロットプロジェクトと位置づけられ、2010年1月のプロジェクト終了後にその成果を他地域へ展開していく努力を今後ミャンマーMOH（DOH）が主に担っていくことになる。プロジェクト終了時までに、全国展開に向けての体制が整っているか、残された課題やフォローアップすべき事項などについて関係者との協議を通じ、できるだけ明確化する。	2009年9月開催のプロジェクト運営委員会において最終稿の完成作業が行われる予定である。指標となっている実施ガイドの他地域への配布は2009年11月開催の普及ワークショップで実施される計画である。


ジャイカ
JICA