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An Evaluation of the Myanmar Birth Spacing Project

A Report to UNFPA

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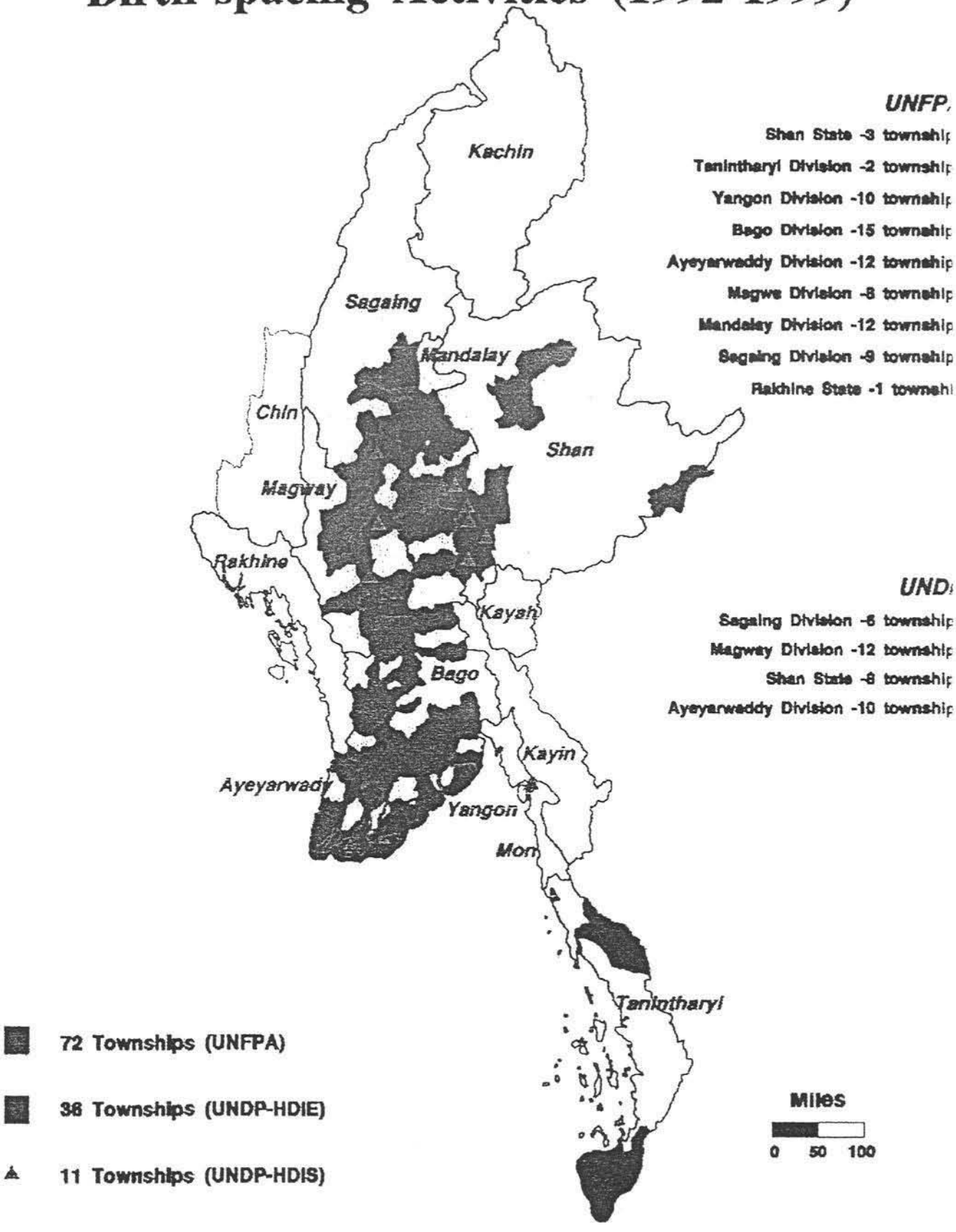
Townships with UN-assisted Birth-spacing Activities (1992-1999)



EXECUTIVE SUMMARY

UNFPA has provided US$ 3.6 million over the past four years (1996-1999) to help Myanmar expand its birth spacing (BS) services, not only in terms of additional sites (from 20 townships in 1995 to 72 in 1996), but also in terms of additional types of contraceptives (pills, injectables, IUDs and condoms). An external Evaluation Team was asked to assess progress to date in strengthening local capacity to do this. The team examined the five major targets of this capacity-building strategy: 1) training; 2) information, education and communication (IEC); 3) service delivery; 4) management information; and 5) project management. The evaluation was conducted between mid-September and mid-October 1999.

Accomplishments

Given the limited resources and the many constraints that exist in Myanmar, the BS project has had a number of significant achievements, especially in the development of BS trainers, trained providers and volunteer motivators; development and distribution of BS manuals and IEC materials; community-based education/motivation contacts; expansion of contraceptives, service sites and choice of methods; and development of relevant management information.

It is too early to measure the impact of the project on health and fertility, but there is some anecdotal evidence that the project is having some impact on fertility, abortion and maternal mortality. A number of health staff, clients and observers believe that there have been declines in all of these indicators in project areas. They believe that there have been fewer abortions and fewer maternal deaths, in particular

Project Achievements

Training	
Township physician, nurse and midwife trainers	276
Basic health service providers	3000
Auxiliary midwives	6,040
MMCWA volunteers	5,400
Information, Education and Communication	
BS manuals	29,000
BS pamphlets	560,000
BS posters	291,000
Education and counselling	35-300,000 contacts
Services	
Expansion of service sites	72 townships
Increased contraceptives	$400,000/year
Greater choice	4 modern methods
Increased access	1.5 million ELCOs
Management Information	
MIS operational	72 townships
BS Eligible Couple registration	72 townships
Surveys and studies	Five major studies

The effects on coverage, utilisation, awareness and motivation are increasing – although even there the hard evidence is difficult to come by at the moment. This should improve, however, as the project becomes established and relevant data are developed. The MIS and ELCO, in particular, should provide valuable information on a number of key indicators, including numbers of current BS users by method and source of supply, as well as percentage of eligible couples who are current users, again by method and source of supply. These sources also have the advantage of covering each of the 72 UNFPA townships, so they can be aggregated by State/Division as well as for all 72 townships.

The large effort put out by both the Department of Health (DOH) and the Myanmar Maternal and Child Welfare Association (MMCWA) volunteers should have increased awareness of birth spacing and willingness to begin using contraception. No data are available for a full year and for all project townships. But if the reported data can be taken at face value, the DOH alone probably conducts

150,000 health education events for 1.5 million listeners each year. This is just on birth spacing. MMCWA's "multiplier" approach to health education on BS should reach even more people than the DOH has.

Quite a bit of training has been carried out but actual capacity development (institutional and individual) has been limited to a few areas, all of which are important. Chief among the gains are the improvement in research capability at the Population Department (POD); strengthening of MIS recording and reporting at the local level, development of an ELCO registration capability at all levels; and development of IUD clinical skills and capabilities at township levels.

Challenges

The project has made significant progress in many areas, especially when the limited resources and the extensive constraints are taken into account. However, there are many challenges remaining. Some of these can be addressed relatively quickly and easily, but most will require significant investments of technical assistance, training and, of course, contraceptives and other commodities.

Services There are not enough contraceptives to meet the demand; the contraceptive distribution system is unable to provide a steady reliable, frequent, timely and appropriate mix of contraceptives to the townships. The BS programme is built around physicians (particularly Township Medical Officers – TMOs) and fixed facilities which severely limits the delivery of contraceptive services. Provision of services by midwives (MWs) and auxiliary midwives (AMWs) is restricted by TMOs and Department of Health (DOH) policies. This limits services to the poor and to those in rural areas, in particular. Voluntary sterilisation services are downplayed because of government restrictions. The project is doing very little directly to promote prevention of HIV/AIDS, but its indirect support is helpful. Clinical service quality appears to be satisfactory, but client knowledge of contraceptive usage, side effects and other facts appears to be poor. There is little supervision of BHS staff and AMWs. There seems to be no supervision of the Myanmar Maternal and Child Welfare Association (MMCWA) volunteers. The Community Cost Sharing (CCS) system is inadequate for sustainability purposes and may actually be driving potential users from accepting or continuing to use birth spacing.

Training. No curricula have been developed for the training courses and there are few, if any, individuals skilled in training methodology. Training has relied upon traditional, non-participatory methods of classroom teaching that often provide more knowledge and fewer skills than are necessary to do a job. The training programme is not competency-based and there is little follow-up or supervision.

IEC. Materials, while of high quality, are severely limited for training as well as distribution to potential clients. Not enough has been done to promote acceptance of the IUD, which is an appropriate method for many women. As a result, the change expected in the method mix has not yet occurred. MMCWA's outreach efforts are extensive, but the quality and accuracy of their IEC is unknown, as is the effectiveness of these efforts in recruiting women to BS.

Management information. The quality of MIS data appears quite good, but the problem is quantity, that is, underreporting and late reporting. MMCWA field activities and accomplishments are not reported and incorporated into the BS MIS. Training is the key to quality in both the MIS and ELCO registration. If the training is inadequate or incomplete then the staff have significant problems and make lots of mistakes.

Recommendations

Some of these challenges can be resolved relatively easily; others will be more difficult and may require policy and institutional changes. All of them will require substantial external support over an extended period, which the Team realises may not be forthcoming. Assuming that the necessary resources can be raised, the Team recommends 1) that the present project be extended through 2000 while a new approach is developed; 2) that the new approach be implemented in the 72 townships as soon after that as possible, say 2001-2005; and 3) that this be followed by replication of the approach in all remaining townships – together with expansion of services to include all other priority RH services – say 2006 – 2010.

Gaining Support for RH/BS in Myanmar

The Team is very aware that implementation of many of its recommendations depends on approval of a multi-year UNFPA country programme. The Team is also aware that political considerations are likely to outweigh humanitarian ones when the UNFPA Board is asked to approve such a programme. However, the Team also believes that those who examine the current project as it stands will be impressed with what has been accomplished by the thousands of highly dedicated civil servants who somehow manage to get something done under very difficult conditions. They will also be moved by the plight of the millions of needy people inside and outside of the project area who desperately need help – help that they cannot get because of events beyond their understanding and control. We hope that some way can be found to provide this help.

ABBREVIATIONS

AIDS	Acquired Immune deficiency syndrome
AMW	Auxiliary midwife
ANC	Antenatal care
BHS	Basic Health Services
BHS	Basic health staff
BS	Birth spacing
BS/RH	Birth spacing / reproductive health
CBD	Community based distribution
CBMRHS	Cross-Border Migration and Reproductive Health Survey
CCS	Community cost sharing
CHEB	Central Health Education Bureau
CHW	Community health workers
CMSD	Central Medical Store Depot
CPR	Contraceptive prevalence rate
CSO	Central Statistical Organisation
CST	Country Support Team
CTA	Chief Technical Advisor
DHP	Department of Health Planning
DOH	Department of Health
EIU	The Economist Intelligence Unit
ELCO	Eligible couple
EPI	Expanded Programme on Immunisation
ESCAP	Economic and Social Commission for Asia and the Pacific
EU	European Union
FO	Field office
FPIA	Family Planning International Assistance
FRHS	Fertility and Reproductive Health Survey
GDP	Gross domestic product
GNP	Gross national product
GP	General practitioner
HA	Health Assistant
HDR	Human Development Report
HEB / DHP	Health Education Bureau / Department of Health Planning
HIV	Human immuno-deficiency virus
HMIS	Health Management Information System
HQ	Headquarters
ICPD	International Conference on Population and Development
IEC	Information, education and communication
ILO	International Labour Organisation
IMMCI	Integrated Management of Maternal and Child Illnesses
IPPF	International Planned Parenthood Federation
IUD	Intrauterine contraceptive device
JHPIEGO	Johns Hopkins International Programme on Obstetrics & Gynaecology
KAP	Knowledge, attitude and practice
LHV	Lady health visitor
MCH	Maternal and Child Health
MCH / BS	Maternal and Child Health / Birth Spacing
MCWA	Maternal and Child Welfare Association

MICS	Multiple indicator cluster survey
MIO	Ministry of Information
MIS	Management information system
MMCWA	Myanmar Maternal and Child Welfare Association
MMR	Maternal mortality ratio
MMS	Maternal Mortality Survey
MNPED	Ministry of National Planning and Economic Development
MOH	Ministry of Health
MOIP	Ministry of Immigration and Population
MSI	Marie Stopes International
MW	Midwife
MWRA	Married women of reproductive age
NGO	Non-governmental organisation
NPD	National Project Director
OB/GYN	Obstetrician & gynaecologist
PHC	Primary Health Care
PHS	Public Health Supervisor
POD	Population Department
PSI	Population Services International
QOC	Quality of care
RH	Reproductive health
RHC	Rural Health Centre
RTI	Reproductive tract infection
STD	Sexually-transmitted disease
TA	Technical assistance
TB	Tuberculosis
TBA	Traditional birth attendants
THO	Township Health Officer
TMO	Township Medical Officer
TOR	Terms of reference
TOT	Training of trainers
TSS	Technical support services
TV	Television
U5MR	Under-5 mortality rate
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNFPA FO	United Nations Population Fund Field Office
UNFPA/M	United Nations Population Fund / Myanmar
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCR	Video cassette recorder
VS	Voluntary sterilisation
WHO	World Health Organisation

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1. INTRODUCTION

1.1 National Situation

The fact that this government supports the UNFPA birth spacing project is surprising to many observers. Prior to 1991 the government had been openly pronatalist and no family planning services were provided in the government sector. Significant changes occurred in the following years and the government is now trying to find the necessary funds to expand birth spacing services to all of the country's 324 townships. Expansion is limited primarily by the lack of resources to purchase contraceptives and to train health providers in birth spacing.

Government financial support for health care has declined over the past decade. Between 1985-1986 Myanmar was spending 19 Kyats per capita on health. By 1995-1996 that had dropped to 7 Kyats – less than 3 US cents per year. Nevertheless, the government welcomes the Birth Spacing Programme and has made significant in-kind contributions to it.

UNFPA has been the primary source of funds for birth spacing in Myanmar. Starting with 20 townships in 1991, UNFPA is now supporting birth spacing in 72 townships. UNDP supports an additional 11 and UNHCR three more townships for a total of 86. There is no doubt that the people of Myanmar desperately need – and want – this assistance. The government realises that, as does UNFPA. Both are ready to expand services to as many townships as possible, as soon as international and bilateral donors make adequate resources available.

1.1.1 Socio-economic Status

A recent World Bank Economic Mission paints a grim picture of Myanmar's socio-economic status.[1] The report states that

> "...public investment in essential infrastructure and social services has been cut back to levels that threaten viability," and "recent information about poverty and human development in Myanmar reveals that there is extensive hardship in the community. An estimated 23 percent of households – or about 13 million people – had expenditures below minimum subsistence levels in 1997" and "the level and depth of hardship...is reflected most vividly in the very high rates of mal-nourishment among pre-school aged children...This has been described elsewhere as a 'silent emergency' in Myanmar and deprivation on this scale indicates not only immediate need but also substantially adverse long-term repercussions for normal intellectual and healthy development of the children affected."

The human development index puts Myanmar in the "low" category with a rank of 131 out of 175 countries. Myanmar ranks close to Pakistan (0.445) and India (0.446), above Laos (0.459) and Cambodia (0.348) but well below that of neighbouring Thailand (0.833). Myanmar's GDP is the lowest in Southeast Asia, even lower than Laos and Cambodia. Life expectancy has improved over the last few decades but is still lower than that of most neighbours in the region. See Table 1.

[1] World Bank Economic Mission, Yangon, Myanmar, June 14-30, 1999.

Two-thirds of the rural population live in households that do not even have three acres of land – the minimum size considered viable for subsistence. High inflation (37 percent in 1997, 51.5 in 1998), and the recent increases in the price of rice and other essential goods have impoverished the self-employed and those working in the private sectors. Equally affected are government employees who receive fixed monthly salaries ranging between 600-2,500 Kyats (US$1.70-7.15).

Educational attainment has been declining. Surveys show that almost 30 percent of those aged five years and above had not received any formal education. Only about a third of those children who enrolled in the first year of primary school reached grade four. There are also serious concerns about the quality of technical and higher education. The universities have been closed for the past three years and an entire generation has missed the benefits of higher education.

Table 1: Socio-economic Indicators

Indicator	Figure	Date	Source
Human Development Index	0.475	1997	HDR
GDP per capita	1,602 Kyats	1997/98	MNPD
Growth in GDP	4.6%	1997/98	MNPD
Inflation	51.5	1998	CSO
Life expectancy	58.4	1997	HDR
Total literacy	77%	1983	Census
Low birth weight	24%	1991	

1.1.2 Demographic and Health Status

Myanmar's population is not large for the landmass available. The density is just 67 inhabitants per square kilometre. The population growth rate has also been declining over the past few decades. From 1941 to 1973 the average annual growth rate was 2.3 percent. It has declined steadily to 2.02 in the 1973-1982 decade and is now even lower, at around 1.8 percent. Total fertility has also declined steadily, from 4.68 in 1976-1980 to 3.42 in 1986-1990 and is now around 2.7. See Table 2.

These declines are surprising given the fact that the government did not encourage birth spacing until 1991. Experts believe that three factors help to explain this decline: 1) high rates of literacy and access to educational opportunities, especially for women; 2) a rise in the mean age of marriage and the proportion of women who remain single; and 3) abortion.

Migration has affected population distribution, as well. As in many countries, the movement has been from rural to urban areas and from smaller to larger towns. However, this did not lead to rapid urbanisation prior to 1991. The acceleration in economic growth after 1991, coupled with the startling increase in construction in such urban centres as Yangon and Mandalay, will no doubt show up in accelerated urbanisation.

The World Bank report cited earlier notes that there have been significant improvements in infant mortality over the past decade. However, these improvements are much less than most neighbouring countries have experienced. Myanmar and Laos are the "outliers" with respect to infant, child and maternal mortality, each of which is very high. Area studies have indicated that the main causes of maternal mortality are abortion-related complications, haemorrhage, sepsis and hypertensive disorders.

Abortion is thought to be the leading cause of the high rates of maternal mortality in Myanmar, (causing approximately 50 percent of maternal deaths). According to one estimate, abortion is the cause of up to 59 percent of all hospital admissions for women of reproductive age. For women who do need to resort to abortion, safe services are not generally available for poor women who cannot afford to see the few GPs who may be willing to provide them, because abortion remains illegal. Septic abortions cause serious maternal morbidity and mortality and are costly to the health system that must provide post-abortion care.

Table 2: Demographic and Health Indicators

Indicator	Figure	Date	Source
Population	47.3 million	1998	EIU
Population density	67/km^2	1996/97	MNPED
Crude birth rate	24.5	1997	FRHS
Annual growth rate	1.8%	1997/98	MNPED
Total fertility rate	2.7	1997	MOIP
Maternal mortality	502	1999	MMS
Infant mortality	74.7	1997	FRHS
Under 5 mortality	105.8	1997	FRHS
HIV positive pregnant women	1.9%	1997	DOH

There are many contributing factors, including extreme poverty, that makes an unwanted pregnancy impossible to carry to term. Many women have limited or no access to modern, safe contraception. Others experience unwanted/unplanned pregnancies as a result of contraceptive failures. Contraceptive failures can occur because the contraceptives are of poor quality or because women have not learned how to use them properly. For couples that have completed their desired family size, male or female sterilisation could help avoid unplanned pregnancy, but sterilisation services are extremely difficult to obtain in Myanmar. Many women admitted to hospital for abortion-related complications are women aged 35 and above. Easier access to sterilisation could reduce future unplanned pregnancies.

The emergence of HIV/AIDS is relatively recent in Myanmar, but there are indications that HIV is spreading rapidly, with an estimated seroprevalence rate among women of reproductive age of already nearly two percent. HIV started in such high-risk groups as commercial sex workers and STD patients, but is now moving into the general population of women of reproductive age. UNFPA's target population. UNAIDS estimates that 86,000 persons in Myanmar have already died of AIDS between 1988 and 1997 and HIV/AIDS is expected to contribute significantly to maternal morbidity and mortality, which UNFPA programmes are attempting to reduce in the future. Vertical transmission of HIV during pregnancy, during delivery and after delivery through breastfeeding will increase infant and child mortality, as well.

1.1.3 Birth Spacing and Reproductive Health Services

Health Service Structure

The public health system consists of central, state/division and township levels. The UNFPA supports birth spacing in 72 of the 324 townships in 9 of the 14 states/divisions. This represents approximately 30 percent of the country's population. Each township has a township hospital that provides routine services and acts as the administrative and training centre for the township. A Township Medical Officer (TMO) is the chief health officer in the township. Large townships also have a Township Health Officer (THO) who handles public health matters. Maternal and child health (MCH) services are provided at MCH centres in small towns and at urban centres in cities. There are 16-bed station hospitals located in strategically selected villages. They run MCH outpatient clinics and usually allocate eight beds for MCH-related emergencies. See Table 3.

Rural health centres supervise, on average, five rural health sub-centres, each of which has one midwife (MW) A health assistant is the team leader of the rural health centre (RHC) A Lady Health Visitor (LHV), one MW and several multipurpose public health supervisors complete the team. The key service providers for BS/RH in this system are the THO, the LHVs and the MWs. The midwives usually hold an open clinic two days each week and do home visits to surrounding villages the other days. The LHVs and MWs are responsible for the training and supervision of volunteer health workers.

Table 3: Basic Health Service Indicators

Indicator	Figure	Date	Source
Per capita health expenditure	62 Kyats	1996/97	MNPED
Access to health facilities	60%	1992	
Access to clean water	49%	1997	MICS
Access to sanitation	46%	1997	MICS
Child immunisation coverage	86%	1997	MICS
Antenatal care from trained provider	76%	1997	FRHS
Births attended by trained provider	56%	1997	FRHS
Contraceptive prevalence	32.7	1997	FRHS

The key volunteer for BS/RH is the auxiliary midwife (AMW) who is selected from and resides in villages that do not have a midwife, given six months of training (three months in a hospital and three in an RHC close to her village) and who provide antenatal care, assistance at normal deliveries, postnatal care, health education and the treatment of minor ailments. There are also a number of traditional birth attendants (TBAs) most of whom have received 60 hours of training in safe delivery and referral.

A few government organised "NGOs" are also involved in BS/RH. The most important is the Myanmar Maternal and Child Welfare Association (MMCWA) Members of the association provide information to and try to motivate community women to accept birth spacing and other health interventions.

A large, well-developed private sector also provides BS/RH services throughout the country. Most important are the OB/GYN specialists, the general practitioners (GP) and numerous drug shops.

In 1991 the government adopted a policy to make contraceptives available in the public sector in recognition that birth spacing is important to the health of women and their children. Family Planning International Assistance (FPIA) introduced the first birth spacing project that year. By 1995 FPIA was supporting BS in seven townships. The MMCWA, with assistance from IPPF, also began to provide information to community women on birth spacing in 1991. They have expanded to 146 townships. In 1992 UNFPA started its BS project in 20 townships and expanded that to 72 in 1996. MMWCA has also added its support to townships in collaboration with UNFPA. In 1994 UNDP included BS services in its primary health care (PHC) projects in 36 townships. They have reduced that to 11 townships recently. UNHCR provided BS services in its two projects in Rhakine State starting in 1997. That has expanded to three townships. UNICEF does not procure or distribute contraceptives but it does support birth spacing indirectly through its programme on Integrated Management of Maternal and Child Illnesses (IMMCI). Altogether, BS services were available in 117 townships for most of the project (see map). With the recent reduction in UNDP support, BS services are now available in 86 townships

Several international NGOs are involved in BS on a limited basis. Marie Stopes International (MSI) operates two clinics in Yangon and one in Mandalay. They provide a full range of contraceptive services. World Vision, Save the Children, and PSI also provide some contraceptives or BS services.

The largest provider of health services, including BS/RH, is the private sector, which accounts for an estimated two-thirds of all care. Contraceptives are much more expensive in the private sector because they are still subject to import duties. UNFPA has been advocating elimination of these duties to make contraceptives more affordable in the open market.

Access to BS/RH Health Services

Maternal health care services are provided at all levels of the basic health services (BHS) system. As a result, coverage for antenatal care and safe deliveries has been rising. In 1991 some 61 percent of women received antenatal care by a trained provider. In 1997 this had risen to 76 percent. Births attended by a trained provider rose from 46 percent in 1991 to 56 percent in 1997.

Use of contraceptives has risen markedly, from 16.8 percent in 1991 to almost double that, 32.7 percent, in 1997. Modern methods account for 28.4 percent. The most popular methods among current users were injectables (11.7 percent) and pills (7.4 percent). IUDs (1.3 percent) and condoms (0.1 percent) lag far behind. Surprisingly, female and male sterilisation (7.7 percent) is the second most prevalent method. This despite the fact that sterilisation requires special approval from a township board that can take several months.

The DOH has a Sexually Transmitted Disease Control Programme (STD) that co-ordinates 36 STD teams that operate in 25 townships around the country.

Health education that includes a component on sexuality has been made available to some adolescents through optional classes. Aside from that there are few interventions directed at unmarried adolescents.

A significant threat was identified by a World Health Organisation (WHO) *Assessment of the Contraceptive Method Mix in Myanmar*.[2] The "Chinese Injectable Number 1," a monthly contraceptive is very popular because it is cheap, but it is "less effective than the other monthly injectable contraceptives" and is "well known to have a high failure rate." Monthly oral tablets, also from China, are also widely available and "have very high rates of side-effects." High dose estrogen pills are available that "should be discouraged." The study also concluded that "the level of knowledge regarding the appropriate use of various contraceptives is low among private providers, and that information and counselling given to women requesting birth spacing services is limited." This combination of poor quality contraceptives, low provider knowledge and high consumer demand for cheap contraceptives is a disaster waiting to happen.

1.1.4 HIV/AIDS Initiatives

The Myanmar National Response to HIV/AIDS began officially in 1989 with the creation of a multi-sectoral National AIDS Committee that was given the responsibility for formulating and guiding national AIDS policies and for launching the Joint UNAIDS/Myanmar National Strategic Plan for HIV/AIDS. The MOH Director of Disease Control administers prevention and control activities as part of the STD Control Programme. Specific activities include education and training, sentinel surveillance, special studies and financial and personnel management. UNFPA, as well as other UN agencies (especially UNICEF), NGOs and religious groups have focused their attention primarily on the education sector, supporting school health education, HIV/AIDS IEC (including mass media campaigns) and HIV/AIDS training for health workers.

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[2] WHO, Expanding Options in Reproductive Health, Research on the Introduction and Transfer of Technologies for Fertility Regulation. 1997.

HIV/AIDS prevention is increasingly being incorporated into UNFPA's global mandate. However, UNFPA's limited financial resources for Myanmar have precluded this UNFPA project from providing substantial funding for vertical HIV/AIDS activities. Since HIV in women in Myanmar is transmitted primarily sexually, nearly all of UNFPA's existing efforts to enhance women's reproductive health services will indirectly (if not directly) contribute to HIV prevention. Despite the lack of substantial funds for HIV/AIDS, UNFPA has already made valuable contributions to HIV prevention, including:

- Inclusion of HIV/AIDS prevention messages in the training manuals that it supports;
- Provision of funding and TA for the Myanmar/Thailand Cross-Border Study of Reproductive Health (primarily HIV/AIDS);
- Close collaboration with DOH, other United Nations agencies (especially UNICEF) and NGOs in planning and supporting their HIV-prevention efforts[3];
- Promotion and provision of condoms as part of its BS efforts;
- Provision of drugs to treat STDs and RTIs (which are associated with acquisition and spread of HIV); and
- Advocacy for increasing the overall health and status of women.

1.1.5 Previous UNFPA Projects

Table 4: UNFPA Projects and Expenditures in Myanmar, 1987-1999

Number	Duration	Title	Amount
MYA/87/P01	1987-95	Population Changes and Fertility Survey (UN/DESD)	$342,981
MYA/88/P05	1990-94	Vital Registration and Statistics System (UN/DESD)	$112,003
MYA/88/P06	1989-94	Population and Human Resources Development (ILO)	$256,960
MYA/88/P04	1989-96	Strengthening of MCH Services Govt/WHO/UNFPA)	$618,161
MYA/90/P50	1990-97	Multi-Sectoral Support to Population Programme (UNFPA)	$198,244
MYA/94/P01	1995-96	Study of Contraceptive Acceptability and Reproductive Health Practices (Gov/t/UNFPA)	$61,125
MYA/94/P03	1995-96	Use of Human Resource Development Indicators for Planning (Govt/UNFPA)	$82,884
Current Program			
MYA/95/P02	1996-98	Strengthening of Birth Spacing Programme in Myanmar	$928,410[4]
MYA/97/P01	1997	Strengthening of Birth Spacing Programme	$819,739[5]
MYA/97/P02	1997	Procurement of Contraceptives	
MYA/98/P01	1998	Strengthening of Birth Spacing Programme	$935,781[6]
MYA/98/P02	1998	Procurement of Contraceptives	
MYA/99/P01	1999	Strengthening of Birth Spacing Programme[7]	$947,250
Total 1996-99			$3,631,180

[3] One example of such collaboration is UNFPA's plan to participate in a multi-agency UNAIDS effort being planned to prevent mother-to-child transmission of HIV.

[4] Funds reallocated to cover 1996 only = $928,410. Original four-year budget was $3,407,330.

[5] MYA/97/P01 and P02 combined expenditures.

[6] MYA/98/P01 and P02 combined expenditures.

[7] Contraceptive procurement included.

UNFPA has been providing limited, but continual, support to Myanmar since 1988 (see Table 4).[8] The projects tended to fund research and strengthening of MCH services. When USAID pulled out of Myanmar in 1989 the primary source of external support for basic health services ended. UNFPA stepped in to fill the gap

1.2 Project Justification

Given the drastic situation that the vast majority of Myanmar's citizens face it would seem obvious that this small project needs no further justification. It seems unconscionable to ignore the need of thousands of women for basic maternal care. The toll in unwanted pregnancies, births, abortions and deaths is severe but largely unnoticed. For political reasons that portend to advance human rights the international community is unknowingly jeopardising human life by withholding what can only be seen as humanitarian aid.

The UN agencies, together with a few international NGOs, are practically alone in assistance to these women. UNFPA, UNICEF and UNDP, in particular, are providing the bulk of foreign assistance to women and children. Birth spacing is one of the most important of these services.

At the time the UNFPA project was being developed, in 1995, UNDP was providing substantial resources to improve the quality and outreach of primary health care (PHC) services, with an emphasis on maternal and child health (MCH) in selected townships. This included birth spacing. In 1996 it was providing birth spacing in 36 townships. UNICEF, through its Child Survival Project was providing a host of health services, including training for midwives on birth spacing in a majority of the 209 townships. Family Planning International Assistance (FPIA) was supporting BS services in seven townships. UNFPA was providing BS services in 20 townships. The Myanmar Maternal and Child Welfare Association (MMCWA), with support from the International Planned Parenthood Federation (IPPF) was also providing contraceptives to a growing number of townships.

The government wanted to expand BS services nation-wide and UNFPA wanted to help. The best way to do that was to expand support for BS to more townships. UNFPA's budget was enough to expand services to an additional 52 townships, bringing the total to 72.

1.3 Evaluation Objectives

All UNFPA projects are evaluated to determine how well they have met their objectives and to identify lessons learned that could be applied to future projects.

The overall purpose of this evaluation of the Myanmar project is to: 1) assess the design, relevance, progress and performance of the project; 2) identify factors that affect the project's efficiency and effectiveness; and 3) provide data to inform future programme development and policy decisions, with special attention to the unique circumstances in Myanmar.

The Terms of Reference (TOR) call for the team to focus on the prime areas of UNFPA assistance that were designed to strengthen capacity. These are: 1) management information; 2) service delivery; and 3) information, education and communication. See Appendix A for the detailed TOR.

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[8] Previously, UNFPA provided $1.2 million to Myanmar in support of the 1973 census.

1.4 Team Composition and Methodology

UNFPA assembled a six-person team to undertake this evaluation over a four-week period (September 13-October 15). Two members of the team are independent international consultants, two are independent national consultants and two are on loan from other donor agencies (UNICEF and the European Union). The areas of emphasis for each team member are noted below together with the time they were available to work on the evaluation.

Jack Reynolds, Ph.D.	Team Leader, management information and service delivery (11/9-15/10)
Elizabeth Preble, MPH	Training and IEC (23/9-10/10)
Alessio Panza, M.D. (EU)	Training and IEC (20-28/9)
Nu Aye Khin, M.D.	Training and IEC (13/9-10/10)
Thazin Oo, MPH (UNICEF)	Logistics and IEC (20/9-12/10)
Khin Nwe Oo, M.D.	Service delivery and management information (13/9-12/10)

The evaluation was based on: a review of relevant documents, interviews with key informants from involved agencies and a six-day field trip to visit project sites. The appendix includes a detailed listing of documents reviewed (Appendix B) and a list of individuals contacted in Yangon and the field (Appendix C). After the field trip the team spent a week conducting several follow-up interviews and preparing a draft of the report. In the final week the draft was first reviewed with UNFPA and then with key stakeholders. Revisions were made based on feedback obtained during these meetings. The final report was completed by the Team Leader and submitted to UNFPA on October 15.

2. PROJECT STRATEGY AND DESIGN

The initial plan in 1995 was to develop a multi-year country programme. A project agreement (MYA/95/P02) was prepared and approved by the government and UNFPA's field office in February 1996. However, experience with UNDP's recent programme submission to headquarters indicated that the UNFPA Board (which was also the UNDP Board) would not approve a multi-year programme executed by the government. UNFPA decided not to submit the project agreement to its Board, even though the project got underway in mid-1996. Instead, it converted the project agreement into a one-year project of less than $1 million, which would not require Board approval. It also prepared a second one-year, $1 million project for 1997 (MYA/97/P01 and P02) that UNFPA headquarters approved in late 1996.

The UNFPA Field Office submitted annual project proposals for 1998 and 1999, as well, both under the $1 million ceiling. A final annual project proposal will be submitted for 2000 and a full country programme proposal for 2001-2005 will be developed next year. Thus, the current evaluation covers four individual projects for 1996-1999 that comprised the original four-year programme.

2.1 Project Objectives

The "long-term" objectives of the project are *to improve the health status of mothers and children by lowering the fertility, morbidity and mortality rates through birth spacing services.*

Three "immediate" objectives were listed in the 1995 Project Agreement:

1. By the end of the project, to have strengthened the institutional capability of MOH in MCH/BS management and Information, Education and Communication (IEC) development through training of 216 trainers and 3,600 health workers as well as in provision of high quality birth spacing services to over 650,000 contraceptive users and acceptors to increase the contraceptive prevalence rate (CPR) from around 20 percent to 30 percent in 72 townships.

2. By the end of the project, to have strengthened the capabilities of Myanmar Maternal and Child Welfare Association (MMCWA) at various levels in the implementation of the national Birth Spacing programmes, particularly involving 72 senior officials and 360 trainers and 1,440 rural health volunteers and community health volunteers from Township MCWAs, in motivating/counselling married couples to adopt or continue birth spacing practices; and

3. By the end of the project, to have strengthened IEC programme as part of the efforts of MOH in lowering the high fertility rate and reducing maternal morbidity and mortality associated with abortion resulting from unwanted pregnancies, and in HIV/AIDS prevention for the vulnerable groups.

These objectives remained the same through 1998. But they did not capture the basic objectives of the project, which were to expand birth spacing services from the existing 20 to 72 townships and to improve the contraceptive method mix so that long-term methods, especially IUDs, would be more prominent. The phrasing of these objectives also gives the impression that IEC was the major area to be strengthened, which was not the case.

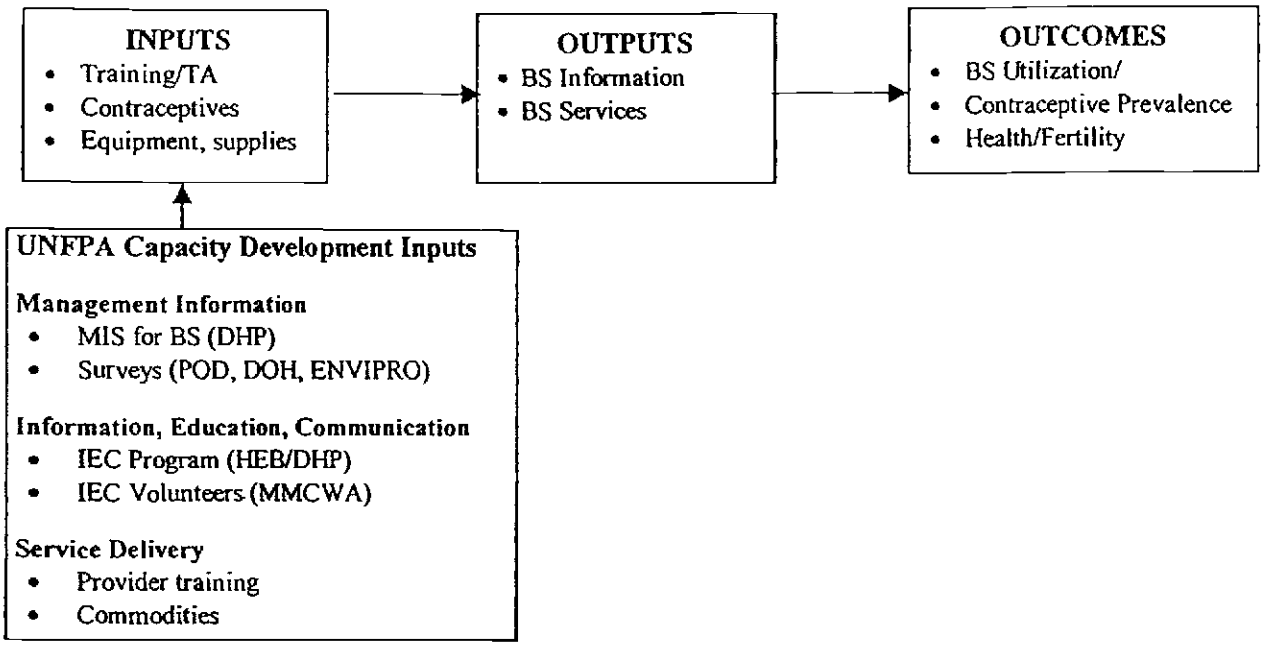
In 1999 the goal[9] was rephrased *to have contributed to strengthening of (the) birth spacing programme, thereby contributing to better reproductive health in Myanmar.* The **purpose** was:

1. To have increased the utilisation of quality birth spacing services as part of integrated reproductive health services in Myanmar; and

2. To have increased the level of awareness and knowledge regarding safe sexual and reproductive health practices.

These purposes do not reflect the basic objectives, either. The project was not designed to introduce other reproductive health (RH) services, to integrate BS into RH services, or to increase awareness of safe sexual and RH practices. In reality, the project was designed to expand birth spacing services by strengthening capacity in three areas: management information, service delivery and IEC, as shown in Figure 1.

Figure 1: UNFPA Support Strategy



It is important to make this point at the outset because the Team believes that the project's emphasis on expanding birth spacing services was the correct strategy. Myanmar does not yet have an RH programme and it would have strained the country's extremely limited resources and technical capacity to try to introduce one. The other essential elements of RH are already in place (maternal care and STD prevention and treatment). What has been notably absent is family planning. UNFPA was in the right place at the right time to take advantage of the government's unexpected decision to allow that service to be provided nation-wide.

Given its limited resources ($1 million per year), UNFPA should be congratulated for doing as much as it could to expand birth spacing services to as many townships as possible. The only tragedy is that a larger country programme could not have been implemented so that these services could have been offered in all 324 townships rather than just 72. Many more unwanted pregnancies, abortions and lives could have been saved.

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[9] UNFPA had adopted the "logical framework" approach to programming, which uses "goals" and "purposes" in place of "long-term" and "immediate" objectives.

2.2 Project Strategy

The basic strategy was to build on previous experience gained in the prior UNFPA project (MYA/88/P04), which began in 1992 and covered 20 townships. A KAP study had been conducted under that project and four types of community education materials had been developed and distributed. These materials attempted to increase awareness of contraceptive methods. The project also provided a limited amount of contraceptives.

In a dramatic change of policy in 1991, the government developed a progressive population policy that supported birth spacing as a health intervention. UNICEF and UNFPA played key roles in the process. UNICEF sponsored the development and dissemination of the RAPID population projection model in 1990. UNICEF and UNFPA sponsored back-to-back seminars on Population Information and Development shortly thereafter. UNFPA consultants helped draft a policy in 1991 and UNFPA sponsored another seminar in late 1991. A Dissemination Seminar of the draft policy was also sponsored by UNFPA in mid-1992.

Excerpt from the Draft Population Policy

The government shall ensure the availability and accessibility of birth spacing services to all married couples voluntarily seeking such services at affordable prices. It shall make available a variety of fertility regulation methods to ensure free and conscious choice by all married couples. Community-based delivery systems will be established to reach those communities and couples who are currently not being served by the conventional delivery systems. The private sector will be allowed to participate in the provision of birth-spacing services. Non-government organisations such as the Myanmar Maternal and Child Welfare Association will also be considered as part of the birth-spacing network. (Drawn from Section a.d.1).

Although the policy is technically still a draft, the birth spacing service component, in particular, has been implemented. This formal declaration, coupled with the high demand for family planning/birth spacing services, opened the door for expansion of UNFPA's modest project to an additional 52 townships. The government expressed its interest in further expansion to another 60 townships if the results were favourable and resources could be found to support it. It is obvious that the government wants to have BS services available nation-wide as soon as possible.

At the same time, UNFPA adopted a "program" approach that called for co-ordination of project activities so that BS services, logistics, IEC, training, MIS and surveys would work together in a synergistic manner. UNFPA recognised that this approach would require substantial management, co-ordination and financial skills on the part of the MOH. Therefore, UNFPA agreed to provide a significant amount of technical assistance (TA) through its local staff, Country Support Team (CST) experts in Bangkok, short-term international consultants, national consultants and a Chief Technical Advisor (CTA).

The project agreement outlines the rest of the strategy, which focused on strengthening the management information, service delivery and IEC components.

A study on Abortion Practices was added n 1998, as well as an Assessment Mission on Reproductive Health. In 1999 three more studies were approved: Cross-border Migration and HIV Transmission; Adolescent RH Practices and Perceptions; and Contraceptive Requirements Forecasting and Logistics. The last two of these were put on hold because the government couldn't come to agreement regarding who would conduct the studies. The abortion study became two studies because the initial study did not deal with abortion and was ended. The remaining funds were used to commission a new study, which examines the incidence and reasons for abortion

Table 5: Townships Covered by the UNFPA-Funded Birth Spacing Project

No.	State/ Division	Townships	No.	State/ Division	Townships	No.	State/ Division	Townships
1	Yangon	Kyauktan	26	Ayeyarwaddy	Zalun	50	Magwe	Magwe
2		Kungyangone	27		Ingapu	51		Minhla
3		Thonegwa	28		Dedaye	52		Yesagyo
4		Htantabin	29		Kyangin	53		Myaing
5		Khayan	30		Yekyi	54		Taungdwingyi
6		Kawhmu	31		Danubyu	55		Yenangyaung
7		Taikkyi	32		Kyaungkone	56		Chauk
8		Hmawbi	33		Pantanaw	57		Pwintphyu
9		Twante	34		Kyaiklat	58	Sagaing	Ayardaw
10		Hlegu	35		Nyaungdone	59		Myinmu
11	Bago	Bago	36		Kyonepyaw	60		Salingyi
12		Paukkhaung	37		Myanaung	61		Wetlet
13		Minhla	38	Mandalay	Tatkone	62		Myaung
14		Daik-U	39		Nyaung-Oo	63		Khin-U
15		Yedashe	40		Singaing	64		Ngazun
16		Was	41		Madaya	65		Tanze
17		Oaktwin	42		Myitthar	66		Monywa
18		Monyo	43		Mahlaing	67	Shan	Tachileik
19		Nattalin	44		Nahtogyi	68		Lashio
20		Gyobingauk	45		Singu	69		Thibaw
21		Nyaunglebin	46		Wundwin	70	Rakhine	Sittwe
22		Htandabin	47		Patheingyi	71	Taninthayi	Dawei
23		Pyi	48		Pyin Ol Lwin	72		Kawthaung
24		Paung Te	49		Amarapura			
25		Shwe Taung						

2.2.1 Management Information

Management information was to be strengthened in two ways. First, the current Health Management Information System (HMIS) would be expanded to include Birth Spacing and Reproductive Health indicators. This involved the development of new indicators and forms as well as the training of health staff in their use. Computer processing subsystems also needed to be developed and set up to process and analyse the new data. A system for identifying eligible couples (ELCO) also needed to be developed, tested and implemented. In 1998 the idea of involving community volunteers in ELCO registration was suggested.

Second, basic information on such critical areas as contraceptive use, abortion and maternal mortality would be collected, analysed and disseminated for use in planning and policy-making. Two key studies were high priorities from the beginning. A national fertility and reproductive health survey (FRHS) was to be conducted to assess knowledge, attitudes and practices about BS/RH as

well as to generate reliable data on fertility, morbidity and mortality indicators. A national study of maternal mortality was also to be conducted to determine once and for all the level of this important ratio as well as the causes of maternal mortality.

2.2.2 *Information, Education and Communication*

IEC on birth spacing and prevention of HIV/AIDS was to be developed and disseminated through the existing health system of the MOH, via mass media and through person-to-person communication. The latter was to be done largely by the network of MMCWA volunteers in wards and villages, supplemented by DOH health staff at hospitals, health centres and in the communities. In addition to training, some audio-visual equipment would be needed, as well as funds for the preparation, printing and dissemination of IEC materials. In subsequent years the project increased support to MMCWA to expand IEC coverage in communities.

2.2.3 *Service Delivery*

Finally, services were to be expanded in 52 additional townships by: 1) training providers in birth spacing; 2) renovating some facilities; and 3) providing needed contraceptives, other basic equipment, drugs and supplies. This included five IUD insertion kits and examination tables for each township so that providers would be able to offer this method as an alternative to pills and injectables, especially for those women who did not want to have any more children. In 1998 it became clear that refresher training would be needed.

2.3 Implementation Framework

The Government of Myanmar and UNFPA have executed the projects jointly. In general, the government is responsible for everything except the procurement of technical assistance, contraceptives and equipment. The main implementing and co-ordinating agency for the government is the DOH, which has entered into subcontracts with the various operating agencies. These include the DHP, POD, MMCWA and ENVIPRO. BS services are provided by the DOH network of hospitals (Division/State, District and Township) and health centres (urban and rural). IEC activities are under the direction of the Health Education Bureau of DHP. The MIS is the responsibility of the HMIS of the DHP. The FRHS and Cross-Border studies are managed by POD. A private research group, ENVIPRO, is undertaking the Maternal Mortality Study. Involvement of community-level volunteers is under the direction of MMCWA for its volunteers and the DOH for those that are part of its field network.

2.4 Government and UNFPA Contributions

The government pledged a significant contribution of Ks 66,072,000[10] to the project, which consists largely of staff, facilities, equipment and supplies needed to carry out the various management information, service delivery and IEC activities. In addition, the MOH covered the accommodation and some travel costs of participants who attended training workshops at township hospitals.

MMCWA in-kind contributions are also significant. Thousands of members contribute their time to the project. Many members also contribute funds to enable the poor to have access to contraceptives.

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[10] The official exchange rate is currently Ks 6/$1 and the Foreign Exchange Currency (FEC) rate is Ks 350/$1.

The Burmese culture sets a premium on giving. Every township has a number of funds to which local residents contribute. Several of these funds provide direct support to project activities, especially those directed at the poor. Health providers (physicians, nurses, midwives) also support the project indirectly by providing free services and by paying part or all of the costs of contraceptives for those who cannot afford to pay for them. All of these contributions are in addition to, and probably exceed, those provided by the government.

UNFPA has supplied most of the other direct project inputs needed in the form of technical assistance, funds for training, procurement of contraceptives and other commodities and support for surveys. UNDP and UNICEF agreed to collaborate with UNFPA in townships where their projects overlapped. UNDP agreed to provide $400,000 of needed contraceptives and UNFPA agreed to provide contraceptive services and supplies in the six townships where UNICEF supported an HIV/AIDS prevention program. The UNDP-UNFPA collaboration didn't work out but the UNICEF-UNFPA partnership did. Co-ordination was established with international NGOs that manage complementary programs in project townships. Chief among these is Marie Stopes International (MSI) and Population Services International (PSI). To date this co-ordination is limited to the sharing of information. The potential for increased co-ordination and collaboration is high among all of these agencies, however.

Table 6: UNFPA Contributions by Project Line Item, 1996-1999

Component	1996	1997	1998	1999*	Total	Percent
Personnel	141,078	154,790	168,380	215,000	679,248	18.7
Subcontracts	117,305	343,215	216,755	156,300	833,575	23.0
Training	24,590	87,249	78,559	34,500	224,898	6.2
Equipment	642,124	220,416	459,099	522,000	1,843,639639	50.8
Miscellaneous	3,313	14,069	12,988	19,450	49,820	1.4
Total	930,406	821,736	937,779	947,250	3,637,171	100.1

*Allocation. All other years are expenditures.
Source: UNFPA Field Office, Yangon

Actual UNFPA expenditures for the revised year-by-year project amounted to $3,631,181 from 1996 through 1999. Table 6 summarises these expenditures by "components." These are the standard UNFPA categories. Table 7 shows expenditures by the principal project activities. Contraceptives was the largest category followed by administration and MIS/Research. Funds for training and IEC were quite low in comparison. Detailed budget and expenditure tables can be found in the Appendix.

Table 7: UNFPA Contributions by Project Activity 1996-1999

Activity	1996	1997	1998	1999*	Total	Percent
Administration	165,873	62,066	69,018	136,662	433,619	11.9
Training	56,359	131,352	142,583	84,342	414,636	11.4
IEC	75,561	70,420	34,489	18,100	198,570	5.5
Services	147,040	83,071	68,443	18,396	316,950	8.7
Contraceptives	323,810	217,719	409,957	500,000	1,451,486	40.0
MIS & Research	159,767	255,111	211,291	189,750	815,919	22.5
Total	930,406	821,736	937,779	947,250	3,631,180	100

*Allocation. All other years are expenditures.
Source: UNFPA Field Office, Yangon

3. PROJECT ACHIEVEMENTS

Given the limited resources and the many constraints that exist in Myanmar, the BS project has had a number of significant achievements, especially in the development of trained providers and volunteer motivators, development and distribution of IEC materials, expansion of services and development of relevant management information (see Table 8). It is too early to measure the impact of the project on health and fertility, but the effect on coverage, utilisation, awareness and motivation appears to be underway – although even there the hard evidence is difficult to come by at the moment. This should improve, however, as the project becomes established and relevant data are developed.

3.1 Health and Fertility

The overall objective of the project is to improve the health status of mothers and children by lowering the fertility, morbidity and mortality rates through birth spacing services. There is some anecdotal evidence that the project is having some impact on fertility, abortion and maternal mortality. A number of health staff, clients and observers believe that there have been declines in all of these indicators in project areas. They believe that there have been fewer abortions and fewer maternal deaths, in particular.

Table 8: Project Achievements

Training
Township physicians, nurses and midwives
Basic health service providers
Auxiliary midwives
MMCWA volunteers
Information, Education and Communication
Pamphlets and posters
Client education and counselling
Services
Expansion of service sites
Increased contraceptives
Increased range of contraceptives
Increased access to BS services for more people
Management Information
BS management information system
BS Eligible Couple registration
Surveys and needs assessments

There are no reliable data to confirm this, however. The best source, the Maternal Mortality Study, was not designed to track changes in maternal mortality. The sample is too small (9,178 deaths and 23,865 births) and the time period too short (30 months) to do so in any case. The vital registration system is incomplete and unreliable. The ELCO registration system does not track maternal mortality but it does include a question on the total number of abortions. This could be used to follow trends but the system is only in its second year and the only available data are for 1998. Project townships compute their own "impact indicators," which include an abortion rate, maternal mortality and infant mortality. However, these data are based on registered cases and have been shown by the MMS to be under-reported. In addition, some of the reports show increases over the past few years while others show decreases or no particular pattern. These changes could be due to better reporting rather than project impact.

The abortion study may show the impact of the project of birth spacing on abortion practices. However, this is a small area study and is unlikely to be generalised to all project sites. Some hospital statistics show declines in abortion cases and maternal deaths, but they also show declines in attendance and admissions, which some think is a result of increased charges due to the CCS system.

Finally, some of the available data are national in coverage and the project area cannot be broken out for analysis. The FRHS and the MMS are two examples. Even if the data could be disaggregated, it would be practically impossible to attribute changes to UNFPA inputs, as they constitute a small portion of the overall inputs in any given township.

Thus, there is no way at this time to determine what impact, if any, the project has had on its long-term objectives. It is also unlikely that this will change in the foreseeable future.

Table 9: Project CPR by State/Division, September 1998

State/Division	Townships	CPR	FRHS
Ayeyarwaddy	12	33.6	36.8
Bago	15	44.8	35.5
Magwe	8	30.2	22.2
Mandalay	12	47.3	33.9
Rakhine	1	40.3	NA
Taninthayi	2		
Shan	3		
Sagaing	9	47.9	NA
Yangon	10	59.0	50.7
Total	72	42,6	NA

Source: HMIS, DHP, ELCO 1998; FRHS, 1997

3.2 Coverage and Utilisation

Coverage and utilisation data are easier to come by. The project's Management Information System (MIS) and Eligible Couple Registration System (ELCO), in particular, should provide valuable information on a number of key indicators, including numbers of current BS users by method and source of supply, as well as percentage of eligible couples who are current users, again by method and source of supply. These sources also have the advantage of covering each of the 72 UNFPA townships, so they can be aggregated by State/Division as well as for all 72 townships. Table 9 and Table 10 summarise the relevant data from the 1998 ELCO registration – the latest data available. Details on these and other indicators by State/Division are in the Appendix.

Table 10: Selected Indicators, ELCO Registration 1998

Indicator	UNFPA Townships	Percentage
Contraceptive prevalence		
No. of ELCO	1,117,029	
No. respondents	1,117,029	100
No. current users	445,073	42.6
No. current non-users	599,160	57.4
No. Users by Method	3,278,291	100
Pills	165,669	37.2
Injectables	201,335	45.2
IUDs	24,018	5.4
Condoms	11,152	2.5
Other	42,899	9.6
Source of Service	3,723,364	199.9
Health staff	282,357	57.0
General practitioner	85,008	17.2
Drug stall	57,908	11.7
Neighbour	32,300	6.5
Other	37,370	7.6

Source: HMIS, DHP

These data have not been validated and it is likely that there were errors in data collection since this was only the second year of ELCO registration and only 83 percent of the 72 townships submitted reports. The 1999 data should be more reliable and complete – and they should be available soon. It is also important to remember that there was no baseline, so it is not possible yet to determine whether there has been any improvement in contraceptive use and prevalence. In addition, most of the townships in the project are located in areas of the country where contraceptive prevalence is higher than the national average of 32.7. Yangon, for example, had a prevalence of 50.7 in 1997 (FRHS). Nevertheless, the figures are encouraging.

The data on source of supply are surprising. The public sector was thought to provide only 20 percent of BS services and supplies. The high figure shown (58 percent) could reflect increased usage due to DOH and MMCWA activity. It could also be due to error or respondent/provider bias,

since the data were collected by project personnel (midwives, in most cases).

3.3 Awareness and Motivation

The large effort put out by both DOH and MMCWA volunteers should have increased awareness of birth spacing and willingness to begin using contraception. The Team had a difficult time getting a reasonable estimate of the quantity of health education activities and the number of individuals contacted by project personnel. DOH staff record and report the "Frequency of Health Education talks" and the "No. of population attended" in the "Client Status Monthly Report" that is prepared by each MW and compiled at the RHC, township, State/Division and central levels. An example of a township report is in the Appendix.

Some townships report modest activities and audiences (8 events, 70 listeners) and some report unbelievable efforts (6,301 events, 65,638 listeners). Most are in the 2,000 event and 20,000-listener range. These are cumulative figures through September 1998 and cover only 50 or so townships. No data are available for a full year and for all project townships. But if the data can be taken at face value, the DOH alone probably conducts 150,000 health education events for 1.5 million listeners each year. This is just on birth spacing.

MMWCA keeps no records of its educational events or listeners as yet. They are planning to do so as soon as they can develop, test and install a recording and reporting system. However, its "multiplier" approach to health education on BS should reach even more people than the DOH has.

Unfortunately, there has been no assessment of the effect of these health education events on awareness, much less acceptance of birth spacing. Given the high level of awareness among the general population (93 percent of currently married women know of at least one modern method and 88 percent know at least one source of supply (1997 FRHS), there is little room for improvement in general awareness. However, there is quite a bit of room for improvement on specific issues, such as myths, proper use of methods, management of side effects and so forth. It would be very useful to assess improvements in these areas to determine what impact, if any, these health education sessions have on potential clients.

3.4 Capacity Development

Lots of training has been carried out but actual capacity development (institutional and individual) has been limited to a few areas, all of which are important. In fact, the project has actually accomplished a great deal with the limited resources it has. Chief among the gains are the improvement in research capability at POD; strengthening of MIS recording and reporting at the local level; development of an ELCO registration capability at all levels; and development of IUD clinical skills and capabilities at township levels.

Areas where further improvements are needed are in the expansion of IUD skills to the RHC level; development of training capability; development of IEC capability; development of interpersonal communication and counselling capability; and development of supervision, monitoring and evaluation capacity. All of these needs will require substantial investments of technical assistance, time and money.

3.5- Sustainability

The Community Cost Sharing (CCS) mechanism is one of the most obvious attempts at increasing

sustainability. This mechanism needs to be carefully analysed, since it is not likely to contribute much at all to financial sustainability and it may, in fact, be discouraging poor people from seeking health services, including birth spacing. See Chapter 6 for more details.

Experience to date with birth spacing projects that have closed is not encouraging. In most cases (FPIA, UNDP) once the projects closed down the services ended. There is some evidence that this may be already happening in this project. In the UNFPA project sites where contraceptive stockouts occurred, there have been subsequent declines in acceptance and use of birth spacing services, which local health staff believe has led to dropouts and likely declines in contraceptive prevalence.

Maintenance of BS management and clinical skills is difficult to sustain because of the concentration of responsibility at the TMO level where turnover is constant. IUD skills, in particular, have not been passed on to the MW levels where they are most likely to be sustainable.

3.6 Constraints and Facilitating Factors

The project has faced severe constraints. Chief among these are:

- Lack of resources, both human, infrastructure and financial.
- Government restrictions on such things as duty-free import of contraceptives, provision of sterilisation and provision of certain BS services by midwives (MW) and auxiliary midwives (AMW).
- Barriers to access due to seasonal variations, geographic distance, insurgencies and the like.

3.7 Conclusions

As stated above, the project has made significant progress in many areas, especially when the limited resources and the extensive constraints are taken into account. However, there are many challenges remaining. Some of these can be addressed relatively quickly and easily, but most will require significant investments of technical assistance, training and, of course, contraceptives and other commodities. These will all be described in the following chapters.

3.8 Recommendations

The Team's general recommendation is that the project be continued while fundamental changes in the design of the BS approach are addressed so that services can be expanded in subsequent years and quality improved.

4. TRAINING

4.1 Achievements

Table 11 summarises the total number of trainers and providers/motivators who were trained under the project. This is initial training that began in November 1996. DOH trained 276 trainers who then trained 3,000 providers. They, in turn, trained 15,728 volunteers. MMCWA trained over 1,000 trainers and 4,320 volunteers. Altogether, this is an impressive achievement.

The cost to UNFPA for this in-service training has been modest – approximately $220,000 overall, or $10 per trainee.[11]

Table 11: Training Achievements

Trainers/Providers	No.
DOH	3,276
Trainers	276
• State/Division Trainers	30
• Township Training Teams (TMO, LHV, MW)	216
• New TMOs	30
BHS Providers	3,000
• Lady Health Visitors	433
• Midwives	2,251
• Health Assistants and Public Health Supervisors	316
DOH Volunteers	15,728
• Auxiliary Midwives	6,040
• CHW	9,688
MMCWA Volunteers	5,400
• MMCWA Trainers	1,080
• MMCWA Volunteers	4,320
Total trained	21,704

4.2 General Comments

Providing training to improve institutional capability in BS has a special importance and priority in Myanmar, given the country's late entry into the BS field. Unlike neighbouring countries, Myanmar does not have long-standing cadres of health workers trained in BS. The team learned that even the senior managerial level in the health sector in Myanmar is not very familiar with contraceptives, since training in BS, even through medical schools, has been minimal or non-existent in recent years.

UNFPA training inputs have been provided for both DOH and MMCWA. They have included funds for training and IEC materials, technical assistance and for the costs of undertaking the training courses. Training costs are relatively inexpensive in Myanmar in comparison to other neighbouring countries and to such other inputs as contraceptives. For example, the cost of educating 45 Level 1 and Level 2 basic health staff in one township is estimated at only US$600, or US$13.33 per health worker trained. UNFPA was able to fund an extensive training programme in Myanmar over the period 1996-1999 for just US$415,000, or 11 percent of UNFPA's overall expenditures in Myanmar[12].

4.3 DOH Training

The major training supported by UNFPA in Myanmar has been short-term, in-country training for DOH service providers at the township and RHC levels.

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[11] These estimates do not include the costs of CTA and CST consultants.

[12] This expenditure figure for training does not include the costs of training materials, but does include the costs of related technical assistance as well as short and long-term fellowships.

4.3.1 The Integrated Training Package

The DOH developed an "integrated package" of RH/BS and related IEC and MIS topics (see Table 12 for a listing of the course content). HIV/AIDS and some other RH components are included to a lesser extent. The topic that is clearly missing is training itself. There is no training in adult learning theory, training design, methods, development of session plans, and so forth. The only training-related topic is the development of "plans of action" for multiplier training, which is largely a schedule.

4.3.2 Core Training Team

The core training team from the central level is made up of six individuals (see Table 13) who appear to be selected because of their positions rather than their training experience and/or skills. This group helped prepare the basic RH/BS manual that is the only "training" material used. As far as the

Table 12: Content of the Integrated Training Package for Reproductive Health/Birth Spacing

1	General overview of the RH concept
2	Programme design and project management
3	Syndromic approach and management of RTI, STD, including HIV/AIDS
4	Birth spacing activities and RH
5	Abortion, maternal mortality and morbidity
6	Client screening
7	Contraceptive technology and programme methods
8	UNFPA programme activities for RH/BS
9	Management information system
10	Reliability of Eligible Couple Register from user perspective
11	Group work on recording and reporting forms for MIS, group presentation and discussion
12	IEC and counselling skills
13	Observation and practical IUD insertion and issues related to IUD insertion training
14	Evaluation of the training programme
15	Plan of action for multiplier training programme

Team can tell, the core team does not have, nor did the project provide, any formal training in training methodology. It is probably more appropriate to call their approach "teaching" rather than "training." The emphasis is largely on conveying information about BS, based on the material in the manual. Individual team members were given assignments and basically took turns lecturing on the various topics presented. The core team did not include an OB/GYN specialist. Instead, the nearest OB/GYN in the State/Division was recruited on site to provide this training to Level 1 teams.

The core team conducted the first TOT for the 20 townships from the first project. This was held in Yangon. Seven other TOT events were scheduled for the new townships. One of these was scheduled in Yangon and the three township teams from the Shan and Rakhine States were included. That is, separate events were not conducted in those states because of the limited number of project townships – and the state training teams were not included. The other TOT events were held in Bago, Ayeyarwaddy, Mandalay, Magwe, Sagaing and Taninthayi. State/Division training teams were included in all six of these events.

Table 13: DOH Birth Spacing Training Structure

Core Training Team (Central level)	
Members:	Director (Public Health)
	Asst. Director (MCH) also focal point for BS project
	Focal Person (MIS) from DHP
	Focal Person (CHEB)
	One person from UNFPA
	⇓
First Level	**Training of Trainers**
Location:	Each State/Division
Duration:	5 days (3 on BS/RH, 2 on IUD insertion/removal)
Timeframe:	Only one State/Division trained per month
Participants:	Three-person team of TMO, LHV and MW from each township in that State/Division and one 5-person State/Division Core Training Team
	⇓
Second Level	**Training of Basic Health Staff**
Location:	Each project township
Trainers:	TMO, LHV and MW from each township in that State/Division
Duration:	3 days on BS/RH, no training on IUD insertion/removal
Participants:	5 HAs, 5 LHVs and 25 MWs from 5 RHCs and 25 sub-centres
	⇓
Third Level:	**Training of Volunteers**
Location:	Each project Rural Health Centre
Trainers:	LHV and MW from each RHC and sub-RHC in each township.
Duration:	2 days for AMWs, 1 day for CHWs
Participants:	AMWs and CHWs from villages in the RHC area (numbers vary)

Scheduling was sometimes difficult because all six members of the core training team needed to be available to travel together to each of these States/Divisions. The core training team could complete only one course per month, so it took about seven-nine months to complete the TOT training for all of the 72 townships and six S/D teams. In future, bringing trainees to the central level and training them all at once could minimise this delay, although training in such a large group might be somewhat less effective.

4.3.3 Level 1: Training of Trainers

Level 1 is a five-day, integrated "TOT" course that is divided into two parts. The first three days cover the material in the BS/RH manual. The remaining two days are a practicum in IUD insertion and removal. The course was offered primarily for three-person teams from each participating township (TMO, LHV and a senior MW, usually from the MCH Centre). The other target group was the five-person training team that is situated in each state/division health office. These trainers later assisted the township teams in the training of BHS staff (Level 2). Again, only six S/D teams were trained.

Level 1 training started in November 1996 and was completed in July 1997. The Evaluation Team was not able to observe any Level 1 training, but feels that three days allotted to BS/RH is only sufficient to cover the BS components.

Attrition of trained TMOs is a serious problem, as they change townships when they are promoted and are also subject to mandatory rotation every three years. This results in many UNFPA

townships having fewer trained state/divisional trainers and TMOs than originally foreseen, dilutes the results that have been obtained and inhibits sustainability.[13] The Team observed, for example, that in one division (Sagaing), two years after the TOT, only one of the five trainers at division level remains in place. DOH and UNFPA have addressed this problem of attrition by holding special TOT courses for the approximately one third of all TMOs who have been transferred to a UNFPA township after the initial training was held. These courses are separate from the annual refresher training offered to those who had already received initial training.

4.3.4 Level 2: Basic Health Staff

Between 1997 and 1999, the TMO, LHV and MW who attended a first level TOT course have been conducting three-day BS/RH courses for basic health staff (HA, LHV, and MW from the RHCs and sub-RHCs in the township). The content and methodology of this training are the same as for Level 1 but the course does not include an IUD practicum. That is held separately, often at a later date, for LHVs and MWs. More emphasis is given in Level 2 training to operational issues, including the basic elements of RH/BS, the MIS recording and reporting, ELCO registration, IEC and counselling.

The effect of this training on BHS staff is difficult to determine since there are no pre-post tests or supervision information that might indicate what the participants learned and what they have put into practice. However, qualitative information taken from various reports, as well as impressions gathered during the field visits, indicate that the BHS do, as a result of the training, gain the necessary knowledge on BS methods and do provide more BS methods to their clients, with the exception of IUDs (as discussed below).

4.3.5 Level 3: Volunteers (AMWs and CHWs)

This training has been conducted over the past few years by the BHS staff that was trained in Level 2. The participants are AMWs (two days training) and CHWs (one day). The same material and methods are used, but the course is a much shorter version. It focuses primarily on IEC and counselling for BS as well as data collection for the ELCO registration. Again, there is no information about knowledge or skills acquired, much less the effect of the training on volunteer behaviour or client acceptance of BS. The Team was told, however, that the CHWs are not the appropriate targets for BS training. They tend to be males and specialise in water and sanitation activities.

4.3.6 Level 1 and 2 Refresher Training

While refresher training was not envisaged in the Project's original training design, it was added in 1998 in response to emerging needs for periodic updates on BS. The first refresher training got underway in 1998 and is continuing this year for all Level 1 and Level 2 health staff who received initial training. At the beginning, new TMOs who had been transferred to project townships were included in the refresher training. These TMOs now get a full course for themselves that is held annually.

Three-day refresher courses are given by the central core training team for Level 1 TMOs, LHVs

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[13] Some argue that the non-UNFPA townships profit from the expertise of trained TMOs who are transferred there, however if contraceptives, IEC materials, trained BHS staff and volunteers are not available in these townships, their training will have little potential for application.

and MWs who have been trained before. Two-day refresher courses are held each year for Level 2 basic health staff including PHS1, PHS2, HA, LHV and MWs (from the RH and sub-centre levels) This training is conducted by the State/Division training teams. The content of refresher training in both cases is similar to that of the original training and the same manuals are used

Again, there are no data to ascertain improvements made in knowledge, skills or behaviour as a result of the training. However, many individuals interviewed expressed a need for additional and refresher training. So it would seem that this investment is not only appreciated, but valuable as well.

Table 14: Number of Individual DOH Staff and Volunteers Trained in Birth Spacing under UNFPA Funding, 1996-1999

Level of Training	Dates of Training	No. of Days of Training	No. of Individuals Trained
First Level initial and refresher TOT for responsible in-service personnel from State/Division Health Dept.; also one team (TMOs, LHVs and MCH MWs) from each township. Annual refresher for township teams. Annual course for new TMOs.	Nov. 1996, July 1997 and Feb. 1998	5	276 (30 S/D, 216 TMO, LHV, MW; 30 replacement TMOs); + 216 refresher
Second Level for BHS (PHS1, PHS2, HA, LHV, and MW (from RH and sub centre levels)	Various courses 1997-1999	3	433 LHVs, 2,251 MWs, 316 PH1, PH2 and HA
Third Level for voluntary health workers: AMW CHW	1997-1999	 2 1	 6,040 9,688

Table 14 summarises the quantitative training data collected by the team. Please note that these are individuals trained. Those who have received initial and refresher training are only counted once. Special IUD training for LHVs and MWs that has been organised by various townships is not included, as is other related training that has been held, such as special training on MIS and/or ELCO registration for volunteers. Thus, this is the minimal amount of training conducted. The actual amount is probably significantly greater.

4.3.7 Training in IUD Insertion

Some training in IUD insertion has taken place at Levels 1 and 2, but it is difficult to determine how much has taken place, who the recipients have been, whether they actually performed insertions as part of the training and whether they are now competent to insert and remove IUDs.

The original intent of the project was to train all LHVs and MWs in IUD insertion and removal. For a number of reasons, that has been undertaken slowly. There are a number of constraints that need to be identified, documented and overcome so that all of these providers become competent in IUD services. Among the most obvious constraints are the following:

- Training is provided largely to physicians and little effort is made by township and State/Division physicians to train MCH or RHC midwives.
- The duration of IUD training is too short to achieve competence in this technique.
- Few clients appear for IUD insertion to allow trainees sufficient practical experience.
- There are no official Government guidelines on training for IUD insertion, on what level of health workers should be trained to insert IUDs and how those who insert IUDs should be

supervised.

- Senior health staff are often not confident that their trainees (especially midwives) are capable of safely inserting IUDs, even after training.
- Some physicians only let MWs (including LHVs) observe insertions and make no attempt to train them in, or let them carry out IUD insertions.

4.4 MMCWA Training

The MMCWA, with UNFPA funding, trains its volunteer members in the 72 project townships to inform peers in urban wards and rural villages about RH/BS and to motivate them to adopt and continue with contraceptive usage. Some MMCWA branches have been allocated contraceptives by the local TMO and some volunteers have been authorised to distribute pills and condoms.

MMCWA developed and distributed its own BS manual prior to the project. That manual (known as the blue book) was used by MMCWA up to 1998. UNFPA paid to have copies of it distributed to MMCWA branches in the 72 townships. In 1998 MMCWA updated the manual (known as the yellow book) and UNFPA paid to have it printed. These manuals have been used in the training of MMCWA "trainers" and volunteers alike. They are similar in content to the DOH manual, although much shorter. They include such technical aspects of contraception as screening women to determine if they have any conditions that would be contraindications to taking the pill. Volunteers are trained to refer eligible clients to health workers for issuance of a method. MMCWA members work strictly as volunteers in the BS effort and are not financially compensated for their work.

Table 15: Number of Individual MMWCA Volunteers Trained in Birth Spacing under UNFPA Funding

Level of Training	Dates of Training	No. of Days of Training	No. of Individuals Trained	No. of Beneficiaries Expected to be Reached
First Level TOT (members who will be trainers of other members)	Phase One: Nov. 1996-Nov. 1997	5 days	360 (5 persons trained per township x 72 townships)	-
First Level TOT (members who will be trainers of other members)	Phase Two: March 1998 - Oct. 1999	5 days	720 (10 persons trained per township x 72 townships)	-
Second Level (members from villages trained to motivate others in their communities)	Phase One: 1996-1997	6 half days or 3 full days	1,440 persons (20 persons trained per township x 72 townships)	14,400 persons (10 persons motivated x 1,440 volunteers)
Second Level (members from villages trained to motivate others in their communities)	Phase Two: 1998-1999	6 half days or 3 full days	2,880 persons (40 persons trained per township x 72 townships)	28,880 persons (10 persons motivated x 2,880 volunteers)

The project uses a three-level approach. The first level is the training of five local members in each township to be BS "trainers." This is carried out by the Secretary and Joint Secretary from the central MMCWA. As with DOH training, everything comes from the manual. There are no training plans, materials, learning objectives, lesson plans, etc. The members range in training and education from trained physicians to relatively uneducated housewives and the only requirements for selection

are that the members are interested, can spare the time, are skilled in talking at the community level and are able to read and write. The content of the training is similar to that of the DOH training. It includes benefits of BS, techniques of IEC, basic facts about each contraceptive method and information about RTIs and HIV/AIDS.

The second level is "multiplier training" of MMCWA members from villages to become volunteer BS educators/motivators. At first the five trainers from each township were expected to train a total of 10 more members in their township (an average of four each). That was increased in 1998 to 40 (an average of 8 each) so as to expand coverage.

The third level is the contact by the trained MMCWA volunteers with potential clients in their own villages. Each volunteer is expected to motivate another 10 people. At least some of the trainers also make trips to villages to motivate community women.

This MMCWA system has the potential to reach large numbers of beneficiaries at very low cost and has many other advantages that are discussed in Chapter 6. However, the Evaluation Team had some concerns about the design of this outreach system. These concerns are:

- The Team questions whether the criteria used by MMCWA to select trainers and motivators are rigorous enough to result in the selection of persons who can adequately carry out the tasks assigned to them.
- By the time the RH/BS messages pass from the MMCWA central staff to the MMCWA trainers to the MMCWA volunteers and finally to the community, the comprehensiveness and accuracy of the messages may be compromised. Dilution or distortion of messages is a special concern in Myanmar since there are already many misconceptions about birth spacing methods at community level and these misconceptions need to be effectively overcome.
- The short duration of training and the limited systematic, technical supervision of MMCWA volunteers contributed to the Team's concern about accurate understanding and communication of BS messages.
- Although MMCWA members have received some training in record keeping, apparently few members are actually keeping records of their contacts with and re-supply of clients with contraceptives. As a result, the DOH system does not include this information. That could lead to confusion as to the methods used and the next re-supply needed by women who have already been enrolled in the DOH system.

4.5 Training Methods and Materials

The team received different impressions from different individuals interviewed about the appropriateness of the methods used. Some reported that the training was overly didactic, others, that it was relevant and effective. It appears that role-plays have been standardised as part of MMCWA training, but no other participatory approaches were mentioned. The Team was unable to validate these observations, as it did not have an opportunity to directly observe any training in progress. The MIS training review noted that its training module needed to be modified for basic health staff and voluntary levels to be more participatory.

Members of the UNFPA CST made many visits to Myanmar in connection with the development of the training programme and provided excellent advice on needs assessments, training strategies, curricula development and creation of training manuals. Weaknesses noted by the CST included inadequate needs assessments, lack of a training plan, inaccuracies (that were not corrected) in the content of the DOH Level 1 training manual and the inability to get the draft training curriculum finalised as the official curriculum of the UNFPA project.

Table 16: Content of DOH RH/BS Manual

Content	Levels		
	1	2	3
RH concepts	X	X	
RH management	X	X	
RTI & HIV/AIDS	X	X	
Unwanted pregnancy & its consequences	X	X	
Adolescent Health	X	X	
RH activities monitoring & supervision	X	X	
Birth spacing ▪ Methods: Pill, injectable, IUD, condom, cervical cap, spermicidal, implant, safe period, withdrawal. ▪ For each method: When and how to use, warning signs, contraindications, advantages, side effects, management of side-effects.	X	X	X
Information, education & communication	X	X	X
Counselling	X	X	X
MIS	X	X	X

Unfortunately, according to CST reports, much of the CST advice was never put into practice, so that weaknesses that were identified quite some time ago remain. These include:

- Some of the knowledge imparted is either too technical to be understood by trainees, and/or irrelevant to the tasks they are expected to perform.
- Despite the recommendation by the CST, training courses still do not include descriptions of training methods or strategies for use by both trainers and trainees. As a result, many trainers are not able to address attitudes toward clients and patients, or apply such participatory training methods as group discussions, analysis of local situations, brainstorming, games, group work, group presentations, etc.
- Training courses lack methods and tools for assessing the effectiveness of training (such as pre- and post-tests, periodic questionnaires, on-the-job observations, analyses of health staff reports, etc.).

UNFPA's major input to training materials was funding for the development and printing of RH/BS manuals, which were used in training and as reference works. Four such manuals currently in use by DOH and MMCWA were funded by UNFPA and these are summarised in Table 17.

As noted earlier, MMCWA prepared and distributed its own manual for trainers using its own funds. The large "RH manual" is used as the text for DOH training at all levels. Levels 2 and 3 use fewer sections, depending on the relevance to the participants' jobs. Level 1 participants all receive a copy of this manual. Levels 2 and 3 receive copies of the smaller "Health Education Concerning Birth Spacing Manual." MMWCA trainers and volunteers both receive the same "Birth Spacing Manual."

The Team believes that such teaching/training materials as flip charts, transparencies and videocassettes have been inadequate to meet training needs. The Team recommends that rather than develop new materials from scratch specifically for Myanmar, that UNFPA adapt materials that have already been developed by UNFPA/HQ or other agencies (such as UNICEF, WHO, IPPF, FPIA and MSI). The Johns Hopkins Program for International Gynaecology and Obstetrics (JHPIEGO) has developed a series of clinical training manuals for each contraceptive method. These are competency-based training materials that JHPIEGO has adapted to use in a number of countries, including such neighbours as Nepal and Indonesia.

Table 17: Description of UNFPA-funded Manuals

Name of Manual	Health Worker Concerned	General Content	No. of Copies Printed	Specific Comments
DOH "Reproductive Health" manual (168 pp.)	DOH Basic Health Staff Levels 1& 2	Part 1: Concepts of RH, RH management, RTIs and HIV/AIDS, consequences of unwanted pregnancies, adolescent health, monitoring & supervision. Part 2: Technical details of contraception (including advantages, side effects, contraindications, etc.)	4,000	Covers most important RH components, but overemphasises knowledge and underemphasises skills, attitudes, participatory teaching and learning. STD and HIV/AIDS sections contain inaccuracies. Post-abortion care is only outlined for married women, not single women.
DOH "Health Education Concerning Birth Spacing Manual" (30 pp.)	DOH Basic Health Staff Level 2	IEC techniques and counselling strategies.	5,000	IEC aspects are more appreciated by users than the RH aspects covered in the manual described above.
DOH "Health Education Concerning Birth Spacing Manual" (42 pp.)	DOH volunteers (AMW and CHW) Level 3	Description of IEC. Types of communication strategies & approaches. Counselling section describes principles and benefits of counselling, rights of clients, obstacles faced, and includes case studies. No section on HIV/AIDS.	10,000	This manual was developed because the IEC manual produced for basic health workers was found to be too complex for volunteers. This new manual contains more pictures and less text and is less technical.
MMCWA "Birth Spacing Manual" Yellow = 49 pp. Blue = 61 pp.	MMCWA member trainers and volunteers Levels 1& 2	Benefits of BS, IEC and counselling, recording and reporting, general information on specific contraceptive methods. Includes sections on STDs and HIV/AIDS. Includes sample MIS forms.	10,000	This manual covers BS methods and IEC/Counselling only. It is meant to serve both trainers of trainers and volunteers, but it is inadequate for the TOT because it does not include training guidelines on how to train, for example participatory teaching/learning techniques.

4.6 Fellowships and Other Short-term Training

About a quarter ($102,000) of UNFPA's project training funds were devoted to long and short-term international training, as UNFPA regional funds became available for this. Therefore, rather than funding attendance at courses, UNFPA country funds were spent on professional attachment training with the CST in Bangkok for several project staff. Most of this attachment training was research-related. The Team believes that this kind of training is especially beneficial to Myanmar because it can be individually tailored to the needs of the project staff and because of the relative lack of contact that Myanmar has had with outside BS programmes or BS research in recent years.

Government makes the selection of candidates for attachment training. To ensure that appropriate candidates are selected, UNFPA sets specific criteria that candidates must meet. UNFPA staff report that these criteria have been met in every case.

UNFPA allocated funds for one person to earn an MPH degree in the United States, but now considers such degree-related training to be inappropriate, given the small size of the UNFPA budget. UNFPA does not plan to support any more long-term degree training now that the previous commitment has been met. The Team concurs with this.

4.7 Constraints and Facilitating Factors

Major project constraints can be summarised as:

- Training capacity and resources at DOH and MMCWA are quite limited
- There is significant attrition among trained TMOs due to transfers and promotions.

Myanmar has entered the BS field relatively late, hence it was necessary to train large numbers of health workers quickly. This is challenging in terms of ensuring high quality training

Major facilitating factors can be summarised as:

- Training costs are relatively low in Myanmar;
- MMCWA volunteers are found in all townships. They already provide outreach IEC to community members. Their potential for reaching large numbers of ELCOs at low cost is very good.
- High-quality CST technical assistance was and still is available.

4.8 Conclusions

- Significant progress has been made in training several cadres of health workers and volunteers in BS in a relatively short period of time.
- There are no "master trainers" or individuals at the DOH or MMCWA who have had specialised training and experience in designing and conducting training programmes. "Trainers" are selected by position (MD, nurse, nutritionist, health educator, statistician) rather than by training skill and experience.
- TOT instruction is on RH/BS content only. Training principles, methods, etc. are not included.
- DOH and MMCWA training rely on traditional teaching, rather than modern training methods. The only "training" materials are the RH/BS manuals.
- Training concentrates on increasing knowledge (including knowledge in excess of what is needed to perform one's job) rather than building competence.
- Separate training courses are not designed for different target groups (i.e., TMOs, MW, AMWs).
- Quantitative and qualitative monitoring and evaluation systems are not tracking training activities at DOH and MMCWA.
- The MMCWA volunteer training has some shortcomings, including insufficient criteria for selection, short training courses and lack of systematic follow-up and supervision. This could result in inaccurate information being given at the community level, inappropriate contraceptive methods being chosen by motivated women and contraceptive failures due to lack of understanding of correct method use.
- IUD training, especially for midwives; is often inadequate.

4.9 Recommendations

- Continue training new TMOs who enter the 72 UNFPA townships as an interim measure, while working toward training MWs to be the primary providers of BS IEC and services.
- Recruit a long-term (one year or more) training/IEC advisor with expertise in planning and implementation of competency-based training and development, testing, use and evaluation of IEC. Obtain commitment to assign a full-time local counterpart to work with this long-term advisor.
- Develop better mechanisms to ensure that the advice of CST and other consultants is acted upon in future training programmes.
- Advocate for government approval to allow both MWs and AMWs to insert IUDs and give injectables. Provide adequate competency-based training for both.
- Conduct an assessment of overall BS training needs.
- Develop a model for a more effective long-term training programme that addresses the many concerns raised by this Evaluation Team. This would include assisting government to review the entire structure of the BS programme with a view to orienting it to a less physician-dependent model and a more competency-based, midwife-oriented system.
- Develop a plan with DOH for redirecting the current training of male HAs and CHWs and find ways to develop and train a cadre of male community motivators for BS. Experience from other countries indicates that increasing the awareness and securing the support of men for BS can increase male responsibility for contraception as well as increase their support for their female partners' choice of contraception.
- Review the appropriateness and effectiveness of the MMCWA IEC and motivation system
- Expand training in BS for private practitioners.

5. INFORMATION, EDUCATION AND COMMUNICATION

5.1 Achievements

The project's achievements in developing IEC materials and making health education contacts for BS were impressive. By mid-1999, DOH had produced and distributed over one half million copies of four different BS pamphlets and produced and distributed over 300,000 copies of two posters. Overall, the Team found the quality of the materials to be very high when assessed as to being clear, correct, complete, captivating, culturally appropriate and clarifying the benefits of birth spacing. Tens, perhaps hundreds, of thousands of IEC contacts have been made with potential contraceptive acceptors at the community level by DOH health staff and DOH and MMCWA volunteers. In some townships the efforts of the midwives and volunteers have been credited with a dramatic rise in use of contraceptives. In addition, townships that initially had an overstock of contraceptives are now having difficulty meeting demand. These project-funded IEC activities were undertaken at relatively low cost – $198,570 for the period 1996-1999 – that is only five percent of UNFPA's total project expenditures.

Table 18: IEC Achievements

Pamphlets	560,000
Posters	291,000
Community education contacts	35-350,000

5.2 Birth Spacing IEC Program (HEB/DHP)

5.2.1 Equipment and Supplies

In 1996, identified needs for audio-visual equipment for the UNFPA project included video cameras, editing and recording equipment, cassette recorders and VCRs, public address systems, televisions, slide and overhead projectors, audio cassette duplicators and tapes. In addition, three printing/duplicating machines were purchased by UNFPA (one for HEB for IEC; one for DOH for RH/BS and one for DHP for MIS).

5.2.2 Materials Development

Responsibility for the development of IEC materials for various vertical health programmes (including BS) rests with the Health Education Bureau (HEB) of the Department of Health Planning (DHP). Although this Bureau had some experience in developing educational materials in the past, in collaboration with the Ministry of Information (MOI), it was recognised that facilities and expertise were nevertheless limited.

The first step UNFPA took in this project to improve the BS programme's capacity to implement effective IEC was the funding of a workshop on IEC. This was a five-day training workshop for IEC materials development held in October 1996 at the Central Health Education Bureau. This workshop prepared HEB to develop posters and pamphlets on BS. Two posters and four pamphlets were designed, pre-tested, revised and produced in 1997.

The first poster describes the benefits of birth spacing (which, it says, can lead to a "Happy, Healthy Family" – which is the slogan of the programme). The poster includes information on service locations. The second poster highlights specific contraceptive methods and also gives contact points for service delivery.

Table 19: Assessment of the Quality of DOH IEC Materials

	Clear	Correct	Complete	Capti-vating	Culturally appropriate	Clarifies benefits
Pamphlets	+	+	+[14]	+ -	+	-
Posters	++	++	++	+	++	+
Video Cassettes	+	+	-	+	+	+
Slides for use on TV and at cinemas	+	+	+	-	+	+

++ = good + = satisfactory - = unsatisfactory

Four pamphlets have been produced by HEB with UNFPA funds, one on each of the four major birth spacing methods used in the project (oral contraceptives, injectables, condoms and IUDs). For each method, the pamphlet describes its benefits, how to use the method, contraindications to use, side effects and locations where it is available.

Other IEC materials include three videocassettes (produced by MMCWA and purchased by UNFPA for use at the township level by DOH) and a BS information slide for use on television and at cinemas.

The Team reviewed the DOH IEC materials and assessed their quality using the "6 Cs" criteria mentioned previously and shown in Table 19. The Team found the materials varied in overall quality but were generally good.

Table 20: Quantities of UNFPA-funded IEC Materials Produced and Distributed by DOH

Type of Material	No. of Copies Produced	No. of Copies Distributed
Pamphlets		
1997	300,000 (75,000 copies x 4 pamphlets)	204,800
1998	300,000 (75,000 copies x 4 pamphlets)	160,000
1999	0	195,200
Total	600,000	560,000
Posters		
1997	255,000 (127,500 copies x 2 posters)	67,000
1998	60,000 (30,000 copies x 2 posters)	120,000
1999	0	104,000
Total	315,000	291,000
Mass media		
Video cassettes on BS and HIV/AIDS*	316	316
Slide for TV and cinema	200 copies x 1 slide	183

* Produced by MMCWA and purchased from MMCWA by UNFPA for distribution

Quantities of materials produced and distributed by DOH by year are summarised in Table 20. There is universal agreement that the quantities produced and distributed were grossly inadequate. The team learned that in many townships, BS health workers and volunteers have only one sample set of pamphlets for use during their motivation and education sessions with community members. They have no additional copies to leave with the community, much less to distribute to interested

[14] There is no information on RH/BS myths and misconceptions. Pamphlets do not contain any information on HIV/AIDS, other STDs or abortion.

women. No flip charts or other educational materials have been provided for health staff or volunteers. This makes it difficult to provide complete information on each method.

The column on copies distributed refers to distribution from the central to the township levels. The Team was unable to find out how many of the copies received at that level were distributed to RHCs and to whom they were finally given. It would be useful to examine the current distribution system before placing another large order for more materials.

The same conclusion holds for MMCWA materials. Table 21 summarises the amount of these materials produced and distributed each year.

5.3 Community Education and Motivation (DOH)

The major contribution of UNFPA to the IEC component was the training of health workers in IEC and counselling. This training was part of the integrated training described in Chapter 4. Altogether 216 trainers from 72 townships and 30 trainers from the State/Division level were trained in IEC and counselling. Sixty-five basic health workers per township were then trained through multiplier courses.

Table 21: Quantity of MMCWA IEC Materials Produced and Distributed

Type of Material	No. of Copies Produced	No. of Copies Distributed
Pamphlets		
1996-7	22,000	14,400
1997-8	84,000	28,800
1998-9	30,000	86,400
Total	136,000	129,600
Posters		
1996-7	2,000	1,440
1997-8	14,000	1,440
1998-9	0	5,700
1999	0	3,000
Total	16,000	11,580

DOH volunteers (the AMWs and CHWs) are the lowest level educator/motivator in the system. Initially it was hoped that they would achieve wide coverage at the grass roots level. While there is little, if any, data from DOH on the effectiveness or performance of DOH volunteers, the general sense of the Evaluation Team is that they are not very effective. CHWs, in particular, work largely on water and sanitation. BS is unrelated and not given high priority. Since most are men, they could serve as BS educators and motivators for men at the community level, but this does not seem to be happening. In the second year of the project, the number of MMCWA volunteers expanded to provide greater IEC coverage.

It is difficult to estimate the IEC coverage of the AMWs and CHWs, but it could theoretically reach several hundred thousand people. Information about numbers of health education events and numbers of persons attending the events is reported on the "Client Status Monthly Report" and shows an average of 2,000 events and 20,000 listeners per township in 1998. Summary sheets containing these data for 60 of the 72 UNFPA townships were made available to the Team but they are difficult to interpret because the definitions of health education "frequency" and "number of contacts" are not clear and the forms very greatly in the degree of detail recorded.

The Evaluation Team observed from its own field visits, and from Back to Office Reports of the UNFPA Assistant Representative, that much more IEC is needed at the community level since detailed and accurate knowledge and education about BS is still low, especially in rural areas. Although KAP surveys indicate that most people in Myanmar are aware of birth spacing, more detailed probing reveals that this knowledge is superficial, not always technically accurate and that

many myths and misconceptions prevail. Many of these misconceptions discourage women from adopting or continuing with various BS methods.

Although the Government places a high priority on promotion of the IUD, it is not prominent in either the DOH or MMCWA IEC activities. No special promotional activities appear to have taken place during the three and one-half years of the project. It has been suggested that a special information campaign could be launched as part of the "seasonal" DOH promotion of BS in December 1999.

5.4 Community Education and Motivation (MMCWA)

MMCWA was selected as the agency to undertake a massive volunteer IEC programme, as it is a national NGO with wide-reaching membership; it has experience using volunteers and has been active in BS (with IPPF funding) since 1991. In addition to the 72 UNFPA-funded townships, MMCWA volunteers provide IEC on BS in 146 additional townships. Thus, the association has experience and IEC coverage that could make expansion of BS services much easier.

The UNFPA-funded component of MMCWA began in May 1996 with an Induction Workshop to develop a workplan. Goals of the component were:

- Training 360 trainers from 72 townships on the benefits of birth spacing, methods of contraception, techniques of demand creation and counselling for birth spacing.
- Training of rural/township MMCWA volunteers from the 72 townships.
- Conducting training workshops on programme evaluation techniques for 72 MMCWA volunteers.
- Preparation of training materials on motivation and counselling.
- Monitoring and supervision visits to township MMCWA volunteers.
- Development of a national strategy for BS/RH for extension to other townships.

Each MMCWA member trained by the project is expected to motivate and educate from 10-20 women at the community level. MMCWA members often form groups and go together to visit villages, which is not only more enjoyable, it also makes it easier for each member to achieve his or her target. MMCWA expects to have provided RH/BS education and motivation to around 48,600 women in these 72 townships by the end of 1999. The Team learned that at least some volunteers have made multiple visits to communities (sometimes the same and sometimes new communities) so that the total number of contacts could easily reach several hundred thousand by the end of the year.

However, there is no way to validate whether these targets are actually being met because there is no formal recording and reporting system in place. MMCWA recognises this and plans to develop a reporting system in the upcoming project.

Finally, as with the DOH IEC programme, the Team did not note any special emphasis on the IUD by MMCWA members. In one field visit, the Team was pleased to learn that most of the married MMCWA members eligible to use contraception were actually using a method. However, none of the volunteers in the group interviewed had ever used an IUD. Satisfied users can be very influential since they can speak from experience and explain the advantages and disadvantages of each method. However, if none of the members in a group has IUD experience, that can give an unintentional message to potential clients that the IUD is not a method they would recommend.

5.5 Monitoring and Supervision

DOH planned to supervise the IEC aspects of the project through supervisory field trips, but apparently visits have only been made to 12 townships (in conjunction with other aspects of BS/RH activities).

DOH has also prepared separate supervisory IEC checklists for use at Township, RHC, Sub RHC and community levels. For the first two levels, staff are asked to record types and numbers of posters, pamphlets and IEC materials received and distributed as well as details of any IEC training offered. For the community level, a separate checklist is meant to record information on whether posters are being displayed, whether pamphlets are being distributed, whether IEC materials are actually being used in health education sessions and any reactions of community members to the materials. The checklists have been revised, reprinted and distributed but results were not available to the Evaluation Team because they have not yet been returned to Central level and tabulated. These forms seem to be more reporting mechanisms than supervision tools.

MMCWA "evaluated the impact" of its initial training and multiplier training undertaken in 36 townships. To accomplish this, one supervisor from each township attended a monitoring Workshop in Yangon in August 1997. At that time, the achievements, strengths, weaknesses and needs of the project were discussed. Subsequently, a monitoring team consisting of the Secretary and Joint Secretaries of MMCWA, the Programme Officer of UNFPA and the Project Manager made supervisory visits to five project townships in 1997 and nine in 1998. The findings of the visits confirmed that the training had taken place and described the motivation process, but there was little detail on the qualitative aspects of the activities, much less their effects on women in the communities. On the basis of these visits, recommendations were made to expand the project.

MMCWA has distributed an "Evaluation form for the MMCWA-UNFPA Joint Programme on Birth Spacing Projects" but data were only collected once and no tabulations could be provided to the Team. The form is supposed to provide information on whether the training took place, whether trainers are still continuing to disseminate information, the number of couples counselled, and so forth. Some records are apparently kept on an ongoing basis at township and branch association, but these associations are not required to send the results to the central level. MMCWA recognises the need for better supervision and plans to request assistance from UNFPA to carry out a training needs assessment and to develop a practical supervision system that will include reporting of activities and results.

The Team also reviewed UNFPA's internal reports from periodic monitoring visits made to the field by UNFPA's Assistant Representative. These reports generally spoke positively about the quality and methods of training (both DOH and MMCWA) but continually emphasised the need for more IEC materials.

5.6 Constraints and Facilitating Factors

- DOH and MMCWA central and local offices lack sufficient resources to mount extensive IEC activities. Paper is often in such short supply that even photocopies of pamphlets are not feasible.
- Most BHS staff, AMWs and MMCWA volunteers in local communities are residents. Thus, they are familiar with the local language, culture and customs.
- Travel to outlying areas is difficult and expensive, especially in mountainous regions and during the rainy season.

5.7 Conclusions

- The DOH and MMCWA have done a remarkable job of producing and distributing informational materials and contacting potential clients about BS.
- An impressive number and range of IEC materials have been produced through the project.
- The BS pamphlets and posters are informative, of high quality and useful.
- An extensive IEC volunteer outreach system has been put into place.
- There are insufficient quantities of IEC materials for both DOH and MMCWA work.
- There is a lack of video players and monitors to show the BS videos at community levels[15].
- No IEC materials have been produced that especially promote the IUD.
- Many barriers exist for IEC to overcome in terms of counteracting misconceptions about BS.
- Monitoring and evaluation of IEC is weak at all levels.
- MMCWA volunteers do not have transportation (except bicycles) to reach distant villages to educate and motivate clients.
- The output of DOH volunteers appears to have been limited to date.
- The MMCWA programme has been very extensive in reach, but the quality and accuracy of the IEC is unknown.

There are at least three potential advantages of this MMCWA cadre: 1) There is relatively little turnover of MMCWA members, unlike there is with government's senior health workers. In any case, they can practice BS advocacy in their new location, unlike TMOs, since they do not require contraceptives; 2) MMCWA members work (an estimated 3-4 hours per week) at no cost to the project; and 3) MMCWA members often provide supplementary support beyond IEC to persons in need at community level, such as transportation to health centres and free or low-cost contraceptives.

5.8 Recommendations

- A review of the current IEC distribution should be undertaken.
- During the coming year, more copies of existing IEC materials should be produced and distributed, subject to the availability of funds.
- A review should be undertaken of the appropriateness and effects of IEC outreach activities, both by DOH and MMCWA.
- UNFPA should support MMCWA in designing and undertaking: 1) an assessment of the training and IEC material needs of its volunteers in the project area; 2) designing, testing and installing a practical supervision system that will also include recording and reporting of IEC activities and their results.

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[15] Some health staff interviewed mentioned that the videos were shown at video "houses" or "parlours" but the Team could not confirm how often this took place.

6. BIRTH SPACING SERVICE DELIVERY

The health services delivery system is described in Chapter 1. Birth spacing services in the 72 UNFPA-supported townships are provided primarily at urban and rural health centres. Hospitals do a limited number of sterilisations and IUD insertions. In the health centres the BS is not provided as a separate service. Rather it is usually integrated with other routine services, especially with MCH. As noted previously, midwives are expected to spend part of their time in the communities, which they do. They are not usually able to visit all of the villages in their jurisdiction, however, which leaves a significant gap in BS coverage. The AMWs and some of the MMCWA volunteers take up some of that gap. AMWs do not usually go beyond their own village. MMCWAs can, but they are not usually available for follow-up. Both are usually restricted from dispensing contraceptives, so the access gap remains large. Estimates are that about 30-35 percent of the population has no access to any kind of health service, including BS.

6.1 Birth Spacing Achievements

Table 22: Birth Spacing Achievements

Expansion of services	72 townships
Greater access	1.5 million ELCOs
More methods	4 contraceptives
Contraceptives	$1,451,000
IUD services	Trained providers

Significant expansion of birth spacing services has come about in the last three and one-half years due to this project. Services have been expanded from 20 townships in 1995 to 72 in 1999. This includes all of the towns in the 72 townships plus well over 8,200 villages that now have trained MW and/or AMWs. The total number of eligible couples who now have access to BS services in the project area is about 1.5 million. Many of these people are poor and live in rural areas where such services were not available previously. The quantity and range of contraceptives has also been expanded. UNFPA has been providing an average of $360,000 worth of contraceptives each year. There are now four modern methods available: oral pills, injectables, IUDs and condoms. The addition of the IUD, and the training of TMOs, LHVs and some MWs in insertion of IUDs has made this method much more accessible and affordable than it was previously.

6.2 Commodities and Logistics

One of the most important contributions of the UNFPA project is contraceptives. By making modern contraceptives available, UNFPA and the MOH hope to increase their use, and, *inter alia*, contraceptive prevalence. The IUD is included to improve the method mix, which is currently dominated by hormonal methods. As Table 23 shows, injectables account for more than all the rest combined.

Table 23: Contraceptive Procurement, 1996-1999

Type	Amount	Percentage
Injectables	$828,554	57.1
Oral pills	505,412	34.8
IUDs	75,062	5.2
Condoms	42,458	2.9
Total	$1,451,486.00	100

Getting adequate supplies to the townships in a regular and frequent fashion has been a constant problem. It can take 10-12 months from the time the contraceptives are ordered by DOH to the time they are received by the townships (see Chapter 8 for a critique of the procurement system). Many townships speed up the last step in the distribution process by going to Yangon and picking the contraceptives up themselves.

The DOH could, but has not yet, distribute contraceptives in quantities that reflect the varying needs of the townships. Instead, they continue to ship the same amount and mix to each township. This

leads to shortages of the most popular contraceptives and surpluses of the least popular. It is not possible for the townships to exchange surpluses because they must account for the contraceptives supplied. One enterprising TMO, however, "borrowed" injectables from another township that had a surplus. But he must pay them back when he receives his next shipment.

Contraceptive shipments are infrequent and usually distributed only once each year instead of quarterly, as had been recommended by the CST logistics advisor. The result is predictable – periodic stockouts. Myinmu Township, for example, had a steady supply of contraceptives from 1992-1994, then nothing in 1995-1996, then a supply in 1997, nothing in 1998 and one in 1999. This led to a loss of confidence by clients who could not rely on the DOH for supplies. The township lost clients and the CPR declined as a result.

When contraceptives run out the usual solution is to tell the clients to buy their own, which is much more expensive. Some officials told the Team that this is part of the sustainability strategy, to get people to contribute to the cost of BS services. However, according to a recent report, people tend to buy the cheapest methods they can find (such as the Chinese injection or tablet), which are less effective and/or have significant side effects.[16]

In addition to contraceptives, UNFPA has provided some antibiotics for treatment of RTIs, IUD kits and examining tables, largely for IUD insertions. Providers have asked for more IUD kits and other related paraphernalia. Midwives have asked for stethoscopes so that they can check the blood pressure of women who want pills and injectables. Apparently, the stethoscopes in the midwifery kits had been removed to be given to hospital staff.

MMCWA receives some UNFPA contraceptives from some TMOs, but the Team could not determine how prevalent this is. It appears to be relatively rare. MMCWA also receives some contraceptives from IPPF, as part of a $ 40-60,000 "core grant" that it receives each year. This money is not just for BS, much less contraceptives. The money is used for the maternity shelters run by MMCWA and the contraceptives that are purchased are usually sent there.

6.3 Facility Renovation

UNFPA provided a small amount of money ($1,500 per township, for a total of $108,000) to strengthen the physical facilities in project townships through renovation and provision of examining tables (for IUD insertion). The townships were allowed to decide for themselves what they wanted to renovate. The only restriction was that the facility had to provide BS services, but it could be a township hospital, MCH centre or an RHC.

Although the Team did not look at this topic directly, it was told that priority was given to the urban centres. Since the amount of money was so small, it probably was best to concentrate on a single centre rather than try to divide the funds among the 10 or so urban, MCH and rural centres in each township.

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[16] WHO. "An Assessment of the Contraceptive Method Mix in Myanmar," Expanding Options in Reproductive Health, 1997.

6.4 Birth Spacing Services

The package of BS services developed by the MOH is summarised in the box. For various reasons, the only service that has been emphasised so far is the provision of contraceptives. The MWs and AMWs have little time for community mobilisation and education, counselling and referrals seem to be limited, referrals for tubal ligation are rare. BS counselling for women who have had abortions does take place, but this is usually in the hospitals.

Birth Spacing Services
▪ Community mobilisation and education ▪ Provision of pills, injectables and condoms; insertion of IUDs after screening for contra-indications ▪ Counselling, management and referral for side-effects, method related problems, method switching ▪ Referral for tubal ligation ▪ BS counselling for women with complications and induced abortion.
Source: Department of Health Planning.[17]

Distribution of contraceptive services is a serious problem. The project is built around physicians, of whom there are very few. All who are in government service are located at the township levels and many, especially TMOs, are subject to frequent transfers. They control IUD services, in particular. That includes the training of all BHS staff in contraceptive service delivery. They decide which LHVs and MWs, if any, will be given practical training and allowed to insert IUDs. Since there are so few physicians in the DOH system that can insert IUDs and train others in insertion (roughly three per township), it is no wonder that the project is not having any effect on method mix. There are just too few providers who are qualified to dispense this method and they are all in the towns and cities.

The DOH policy (at least for this project) is to train LHVs and MWs to dispense all contraceptives, including injectables and IUDs. Most LHVs have been trained and some MWs at the MCH centres have been trained, but many at the RHC and sub-RHC levels have not. Local policies vary, however. Some TMOs support the policy but many do not. The fact is that most MWs either have not been trained in IUD insertion or are not allowed by the local TMO to insert IUDs. This severely limits the capacity of the project to promote IUDs in rural areas. Women either have to travel to the township hospital for an IUD (which is very expensive) or they have to wait until a physician comes to a nearby MCH centre or RHC, which is quite rare.

The Team was told repeatedly that local women would prefer to have a female MW insert IUDs because it can be done close to home, is less expensive and is more culturally comfortable. If this service were provided, they said, there would be much higher acceptance of IUDs.

Cost is also a factor. Three clients interviewed in Alone RHC said that many in their village cannot afford the contraceptives, although they want to practice BS. This was stated repeatedly at all sites visited by all BHS staff interviewed. In Gangar, users said that the LHV gives contraceptives free to women in extreme need (those who are very poor, have many children, etc.). Some LHVs and MWs help by providing small loans or accepting instalment payments, but the MW or MMCWA volunteer has to guarantee them. The OB/Gyn at Mandalay Division Hospital said that they provide IUD and injection services free but women need to buy the contraceptives themselves. Several respondents believed that some providers promote pills and injectables over IUDs because they can make more money on repeat visits, where an IUD lasts for years. Some said that the physicians do not want to have competition for IUD services, so they do not train MWs in this technique. The Team cannot confirm either of these charges, but they were mentioned often.

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[17] Htay Htay Aye, "Evaluation Meeting Report on Subcontract: Management Information System (MIS) in Strengthening Birth Spacing Programme." Department of Health Planning, 16 September 1999.

Most of those we talked to do not believe that AMWs should be allowed to distribute contraceptives at all, least of all IUDs However, experience in other countries shows that such women can be taught to provide contraceptive services, including injections and IUDs. A carefully constructed competency-based training programme, such as that developed by JHPIEGO, could be adapted for Myanmar. Those who pass the course and are certified competent should be allowed to provide these services. Those who are not certified should not be allowed to.

Anecdotal evidence seems to indicate that some AMWs and some MWs are already giving injections and inserting IUDs. It would be better if they were properly trained. The recent decision by the DOH to train TBAs in safe delivery is a precedent that should be applied to training of AMWs and MWs in IUD insertion.

The Team learned that MMCWA volunteers in most townships do not distribute any contraceptives at all. They merely refer interested women to the MW. However, MMCWA volunteers in one township that the Team visited are dispensing pills, condoms, injectables (vials and syringes) and even IUDs. The clients are told to take the injectables to a MW for the shot and the IUD to the hospital for insertion. The reason for doing this seems to be to save the client from being overcharged for the contraceptives. There is no telling whether the women do as instructed. There are injectionists in most villages and it would be tempting to ask them to do the procedures. MMCWA central says that this is not their policy. Volunteers should not dispense contraceptives. However, this could be an individual TMO decision to authorise MMCWA volunteers to dispense these contraceptives. If that is the case, then MMCWA would have no objection. MMCWA central does not believe this is happening without such authorisation, but acknowledges that it does not have a supervision system in place to find out. They plan to follow up.

The Team was unable to confirm that this practice is widespread, but several sources stated that volunteers are dispensing pills and condoms (at a minimum) to new users and not just re-supplying current users. Given the lack of medical background of most of these volunteers, the limited training they receive in their "multiplier" course, the lack of supervision and the lack of record keeping, this is a dangerous practice. The Team also believes that these volunteers should only be providing re-supplies of pills if they have the permission of the local MW, keep accurate data and provide those data to the midwife.

There is no evidence that MMCWA volunteers in the 72 townships are giving injections or inserting IUDs themselves. The Team was told that they tell their clients to take the contraceptives to the midwife for the service. During a subsequent discussion with MMCWA about this matter the Team suggested a possible explanation. Members who are also midwives, nurses, or physicians might be dispensing these contraceptives in their role as MMCWA volunteers. They might also have the authorisation of the TMO to do so. The Team learned from one informant that her aunt, who lives in a non-project area, is a MMCWA member and an AMW. She has been inserting IUDs for 20 years. She also gives injections. Thus, it could also be that some experienced AMWs like this woman, could also be distributing and administering these contraceptives with or without the blessing of the local TMO. Nevertheless, it would be best to make sure that no MMCWA member dispenses injectables or IUDs. This should be left to trained providers in the DOH system who keep records and are accountable for all contraceptives distributed through the project.

Given the frequent shortages of pills and injectables, one would expect an increase in IUD use. They are usually available and they last for up to eight years now. But that has not happened. The method mix has not changed. People still prefer pills and injectables. DOH has done little to promote acceptance of this method.

One of the DOH services noted above is "referral for tubal ligation." This is a sensitive issue. Voluntary sterilisation is a commonly-used method in Myanmar, as the FRHS shows. But it is restricted. Women must obtain approval from a Sterilisation Board and the bureaucratic requirements (five photos, certification of number of living children, etc.) are intimidating and time consuming. Nevertheless, providers are generally sympathetic and board approval is almost always forthcoming. However, the process is so daunting that most BHS staff are reluctant to suggest VS, except in the most desperate situations.

Voluntary (not forced) sterilisation is a service that should be more readily available to all women and men who desire it, especially those who have completed their desired family size and do not want any more children. There is no doubt that this is a serious decision and that counselling and informed consent are essential prerequisites. But the present system is not based on individual choice. Until that system changes and includes VS as an option that couples can select, the DOH will continue to downplay the advantages and availability of this method.

The Team observed no services or IEC sessions. However, eight users in two sites were interviewed. All seemed satisfied with their methods. The methods selected seemed to be appropriate given the physiological and mental states of the clients. However, their knowledge of the methods and such basic issues as how long an IUD lasts, common side effects, and so forth, was inadequate. Combined with irregular supply of contraceptives, limited choice of methods, high costs and limited follow-up (as well as poor supervision of staff, limited training, etc.) this raises serious doubts about the quality of the BS services.

6.5 Supervision

DOH has a supervision hierarchy, starting with the TMO and going all the way down to the AMW and CHW. In brief, the TMOs and/or THOs supervise the LHVs who supervise the MWs who supervise the AMWs. Due to the lack of funds for travel and the lack of time due to heavy workloads there is very little supervision.

Physicians, in particular, are in short supply and the TMOs and THOs have to assume greater responsibility for clinical, administrative and public health activities. In the Sagaing Division there are 353 sanctioned posts for physicians and 250 vacancies. Nyaung-Oo Township has 24 sanctioned posts for physicians and 10 vacancies. It is easy to understand why the TMOs and THOs have very little time or energy for supervision. The exception is the monthly meeting with RHC staff who come in to collect their salaries. Continuing education classes and orientations are sometimes held during these meetings, but supervision is not really feasible, since the BHS staff are not at their workstations.

LHV supervision of MWs is more feasible but the LHVs have the same constraints of limited time and travel funds. The MWs meet with the AMWs frequently, especially at immunisation and growth monitoring sessions. So there is more opportunity for supervision at that level. However, they are also busy and it is not known how much time or inclination there is for supervision.

MMCWA does not yet have a supervisory system in the field. Multipliers (those who provide health education to potential clients) seem to be pretty much on their own. They do not keep records and they do not seem to prepare reports regularly. Some information is submitted by some volunteers to the local branch, but this is not compiled and forwarded to the central office. MMCWA executives explained to the Team that it is very difficult to require volunteers to keep records and prepare reports. They volunteer to do something useful for the community and not to do paperwork. If pushed, they might stop volunteering. Nevertheless, MMCWA recognises the need for some form

of supervision and is planning to request UNFPA support for an assessment of the volunteer IEC activities and for development of a practical BS supervision and reporting system.

6.6 Community Cost Sharing/Sustainability

The government encourages community cost sharing (CCS) as a way to reduce costs and to prepare for the time when UNFPA support ends. However, the government has not developed any policy or guidelines to help the TMOs learn how to set up and manage such a fund. Thus, each of the 72 townships has set up its own version of a CCS fund. Prices are not standardised, rather each BS Committee sets them. The only guideline is that they must be no higher than the price in the open market. The RHCs have added a few Kyats to the township prices so that they, too, can set some money aside. The local BS Committee sets those increases. For example, a township might charge 50Ks for a strip of pills and the RHC might add another 10Ks to bring the total price to the client to 60Ks.

Although government officials and donors laud the CCS initiative, there is widespread concern that this system may be driving away those who cannot afford to pay the established prices. The RH Needs Assessment, for example, found that "cost (and in some cases perceived cost) present an important barrier to service access." The assessment concludes that

> *There is a need to determine the effect of current cost sharing policies for birth spacing. If it is found that the associated user fees discourage women from seeking appropriate reproductive health care, there will be a need to review and revise these guidelines.*[18]

Theoretically, there are exemptions for the poor, but there are no guidelines for the exemptions or for such alternative payment schemes as instalments and loans. Each rural BS Committee sets its own exemption rules, which are not well-known, especially among the poor. Burmese are very proud and price intimidation may be enough to drive such people away and to cause women to neglect to get their next injection or strip of pills.[19] The fact is there has been no study of the effect of the CCS on acceptance and continuity of use of contraceptives. However, many of the clients, MWs and AMWs that we interviewed said that there were people in their areas who could not even afford the least expensive contraceptive.

The prices vary significantly among and within townships. Pills range from 5-100 Ks per strip, injectables from 30-200 Ks per vial and IUDs from 100-350 Ks. The money collected is split between the township and the RHC and put into interest-bearing bank saving accounts.

The funds are all quite small. For example, Allakapa RHC = 113,222 Ks; Amarapura town = 231,760 Ks; Monywa Township = 289,000 Ks.; and Ahlone RHC = 289,000 Ks. These funds are supposed to be used to continue the BS program after UNFPA funding ends. However, 200,000 Ks will only buy enough pills or injections on the open market to serve about 100 couples for a year. The average township has from 2-5,000 active users. The total collected from all participating townships in 1998 is the equivalent of $18,000; the total balance as of the end of 1998 was $42,000. In contrast, UNFPA contraceptive contributions to these same townships is around $360,000 per year. And this is not enough.

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[18] A Reproductive Health Needs Assessment in Myanmar. P. 76.

[19] There is evidence from a project that supports child feeding centres that attendance is down because the donor videotaped women bringing their children to the centre. This was so embarrassing that they stopped bringing their children rather than admit that they were too poor to feed them.

Obviously, the small amount of money raised by the CCS is not going to go very far or last very long. In addition, the purchasing power of the funds actually declines the longer the money is kept in the bank. Bank interest is much lower than the rate of inflation, which has been running 30-40 percent per year.

Most of the funds are not being used, either. When an RHC or urban centre runs out of contraceptives some TMOs purchase quality contraceptives on the open market so that clients will not buy inferior, cheap, ineffective contraceptives. But most, according to a number of respondents, do not use the funds to purchase replacements. Instead, they advise the clients to buy their own contraceptives. Some TMOs say they have used some money to buy such supplies as paper to print more client records or MIS forms. But most are unwilling to touch the funds, reportedly because there are no guidelines as to what the funds can be used for. Some TMOs are afraid they will be criticised or have to reimburse the fund if they spend the money for something that the DOH later decides is improper.

There is also the potential for abuse of the CCS system. Because the prices are not standardised and clearly displayed, some providers charge more than the established rate and keep the difference for themselves. Providers have been known to charge 500, 700 and 1000 Kyats for an IUD insertion, for example. This puts BS out of reach for those who are unwilling or unable to pay, according to many informants, and is a significant indirect contributor to unwanted pregnancies, births and abortions. The extent of this practice is unknown. The Team interviewed five clients in one RHC who used different contraceptives and none had been overcharged. All paid the established rate. However, these same clients said that they know of many others who would not use an IUD because of its high cost. Because IUDs often can only be obtained at the township hospital, the total cost (including transportation, food, "contributions" to hospital funds, the cost of the IUD and the cost of the insertion) can total 1,000 – 2,000Ks, depending on how many times the woman must return.[20] The cost of having it removed is similar.

There are five arguments for CCS system: sustainability, replenishment of contraceptives; investments to purchase other needed supplies/equipment; psychological satisfaction and symbolic value. The first three are not happening. Client satisfaction from contributing to the cost of BS services must be counterbalanced with the alienation felt by those who cannot afford to pay and/or are too embarrassed to request free services. This latter group is probably the most vulnerable to pregnancy and abortion. Symbolic value may be important to potential donors who may require some evidence of cost sharing as a condition of their support, but this perspective should also be tempered with a qualification that such schemes do not adversely affect the poor.

The truth is that we do not know what effect the CCS system is having on acceptance and continued use of contraception. We also don't know if the charges for IUDs, which are the highest (but the lowest per year of effective protection) dissuade women from using IUDs. The RH Needs Assessment found that women would buy the cheapest contraceptive regardless of its effectiveness or safety. One way to increase acceptance of IUDs might be to lower the price (or give them away free) and increase the price of pills and injectables. Clearly, this matter deserves careful study.

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[20] Most women have to return twice to get the insertion because the provider does a pregnancy check first and then asks the woman to return after her next menses. Some have to return a month or so after the insertion to make sure the IUD has not been expelled or because of complaints/concerns about side effects.

6.7 Constraints and Facilitating Factors

- Climate, seasonal weather, distance and terrain limit distribution of contraceptives to rural and remote areas, in particular.
- Health facilities, furnishings and equipment are in such a poor state that renovation and refurbishment would cost more than the total project budget.
- Travel funds and transportation are limited for health staff.
- Inflation affects the cost of contraceptives and the purchasing power of the CCS funds.
- Costs of contraceptives in the private market affect purchasing decisions. Women choose the lowest priced brand.
- Government restrictions on male and female voluntary sterilisation inhibit health staff from suggesting this method and clients for adopting it.
- UNFPA's limited resources preclude it from providing substantial funding for HIV/AIDS activities.
- Health staff are poorly paid and need to find outside sources of support. Charging for "free" services is one popular option.

6.8 Conclusions

- BS services have been expanded significantly in 72 project townships.
- Access to modern contraceptive services has extended in rural areas and to the poor, where the need is greatest.
- The project has also expanded the range of contraceptives so that couples now have a choice of four methods: oral pills, injectables, IUDs and condoms.
- The contraceptive distribution system is seriously flawed. It is unable to provide a steady, reliable, frequent, timely and appropriate mix of contraceptives to the townships.
- DOH has not done enough to promote acceptance of the IUD, which is an appropriate method for many women. As a result, the change expected in the method mix has not yet occurred.
- The BS programme is built around physicians and fixed facilities, which severely limits the delivery of contraceptive services.
- Provision of services by MWs and AMWs seems to be severely restricted by TMOs and DOH policies.
- MMCWA volunteers in some townships are reported to be distributing condoms, pills and even injectables and IUDs. This is a potentially dangerous practice.
- Voluntary sterilisation services are downplayed because of severe government restrictions.
- The project is doing very little directly to promote prevention of HIV/AIDS. Others are taking care of this task and the project's indirect support is adequate.
- Clinical service quality appears to be satisfactory, but client knowledge of contraceptive usage, side effects and other facts appears to be poor.
- There is little supervision of BHS staff and AMWs. There seems to be no supervision of MMCWA volunteers.
- The CCS system does not seem to be effective. It is inadequate for sustainability purposes and may actually be driving potential users from accepting or continuing to use birth spacing.

6.9 Recommendations

- UNFPA should continue providing support to existing BS services while redesigning a new approach to service delivery.
- UNFPA should provide technical assistance to the DOH and CMSD to upgrade the contraceptive logistics system so that it can provide regular, timely and appropriate

contraceptives to the townships.

- DOH and DHP (HEB) should mount a major campaign to promote acceptance of the IUD by providers and consumers alike.
- The service delivery component should be redesigned so that instead of relying on physicians and fixed facilities it would be built around midwives and community-based distribution (CBD). This will expand access to services and should lead to greater use of contraception.
- UNFPA and DOH need to undertake an evaluation of the distribution of contraceptives by MWs, AMWs and MMCWA volunteers.
- UNFPA should advocate a DOH policy that would allow certified MWs and AMWs to distribute contraceptives and to provide injection and IUD insertion services.
- MMCWA volunteers should not be allowed to distribute injectables and IUDs and should only provide re-supplies of pills if they have the permission of the local MW, keep accurate records and give those records to the local MW.
- UNFPA should advocate a change in policy regarding voluntary sterilisation to allow couples that have reached their desired family size and do not want to have any more children to use this method.
- More needs to be done in the future by UNFPA and the government to develop strategies and fund interventions to prevent abortions and HIV/AIDS.
- UNFPA should support a study of the quality of care of BS services.
- Prices for project contraceptives should be fixed nation-wide to avoid confusion and to prevent corruption.
- A study is needed of the effect of the CCS system on acceptance and continued use of contraceptives. A study is also needed of the price elasticity of the various contraceptives to determine if lowering its price could raise acceptance of IUDs.

7. MANAGEMENT INFORMATION

UNFPA planned to strengthen the management of the BS programme by improving the collection, processing and analysis of management information. This assistance focused on two areas. The first was development of a management information system (MIS) for birth spacing services. This would provide local and central managers with performance information that would allow them to monitor service delivery and to take corrective action, when warranted. The second was generation of new information that could be used in policy-making and programme planning. Two key studies were priorities from the beginning: a national reproductive health survey and a prospective study of maternal mortality. UNFPA expenditures on this component come to $815,919, or 22.5 percent of total UNFPA expenditures over the four-year period.

7.1 MIS/Research Achievements

The project has been very productive in this component. A management information system for birth spacing has been developed, tested and installed in all 72 townships. So far it seems to be working very well. It will be formally incorporated into the national HMIS when BS is provided in all 327 townships. An eligible couple registration system has also been designed, tested and established in all project townships. When fully functional it should provide very useful data on BS needs and achievements in each township – and for the project overall. A number of important research projects have been undertaken and the preliminary results are already being used for policy discussion and programme planning. These studies are highlighted in Table 24 and described in more detail later in the chapter.

Table 24: MIS/Research Achievements

- Birth spacing MIS
- ELCO registration system
- Fertility and Reproductive Health Survey
- Maternal Mortality Survey
- Cross-Border Migration and Reproductive Health Survey
- Abortion Practices Study
- Reproductive Health Needs Assessment

7.2 Management Information System

Fortunately, the MIS did not have to be built from scratch. After years of development, the national Health Management Information System (HMIS)was implemented nation-wide in July 1995. This is a service statistics system based on collection and processing of data from hospitals, health centres and basic health workers. Data come from registers, field visit diaries, and the like. The HMIS is an "integrated" system in that it includes data on 18 core programmes, including primary health care, nutrition, health education, EPI, malaria, TB and so forth. It also covers service delivery, logistical supply and IEC. However, the system does not include Birth Spacing and Reproductive Health.

Thus, the plan was to develop a core set of indicators for BS/RH, develop the forms and procedures for collecting, recording and reporting information on those indicators, test the system in the 72 townships, refine it, as necessary, and then integrate it into the HMIS. The last will be done when the BS/RH services cover all of the 327 townships in the country. Registration of eligible couples (ELCO) was not part of the original plan. It was added in 1997 and is now an integral part of the MIS.

It is important to point out that MMCWA is not a part of this system. That is, their activities in support of BS are not counted. Although it is technically an NGO, it is making a significant effort in community education that should be documented.

7.2.1 Birth Spacing Indicators

The number of indicators in the HMIS has been reduced through a Delphi process undertaken in 1986 and tested over several years. The remaining indicators are called a "Minimum Essential Data Set." The BS/RH, as a new addition of core services, also needs to identify its own minimum set of indicators. The DHP has relied heavily on the suggested indicators developed by the Technical and Policy Division of UNFPA. A preliminary list of BS indicators for Myanmar was selected in national seminars and some are being tried out in the 72 UNFPA townships. Others are expected to come from special studies or other sources. The list includes 1 policy indicator, 11 input indicators, 8 process indicators and 10 impact indicators. See the Appendix for the full list of BS indicators. The indicators are broader than expected. That is, they go well beyond BS to include a number of MCH indicators (for example, percentage of ANC coverage; under 5 mortality rate) and a few general development indicators (GNP/capita, ratio of health centres/facilities: population. The Team was asked by the CTA to find out if the list has been updated recently. It has not been revised, and the HMIS director seems to believe that it does not need to be.

Indicators have also been developed for RTIs and STDs, HIV/AIDS as well as adolescent RH care. The HMIS already includes indicators for ANC, delivery and postpartum care, so it is already well-positioned to provide data on the "essential service package for reproductive health." The four priority RH services that Myanmar has selected are: maternal health (including safe motherhood and prevention of abortion complications), birth spacing, RTIs/STDs and adolescent reproductive health.

7.2.2 Recording and Reporting

Data entry and reporting forms have been developed or modified and tested. These include a client card, a user register, a register for drugs and commodities and an Eligible Couple (ELCO) register. All of these forms are simple and relatively easy to fill out. The integrated training course described in Chapter 4 includes a session on completing these forms. Those people who have been adequately trained seem to have no problems filling out the forms and monthly reports. Staff in one RHC reported that the client card, for example, only takes a few minutes and the monthly compilation and tabulation of data can be done in less than an hour.

Those who have not been trained have serious problems with the whole MIS. The TMO in Myinmu, for example, listed the MIS as his biggest problem. The THO in Nyaung-Oo also complained. Both had trouble with some concepts and definitions (new user, potential user, for example) as well as the procedures for computing commodities distributed, number of dropouts, and so forth. Neither had received the MIS training. The TMO had recently been transferred into a project township and the THO was not able to attend the integrated training course. Both received shortened training that included very little on the MIS.

The HMIS unit in Yangon has developed an attractive, standardised report summary for each of the 72 townships. It includes a small map of the township that shows the locations of DOH health facilities, basic demographic data and five tables: BS Training; Users of BS; Drug/Commodity Status; User Status; and BS Commodities – all on one page. See an example in the Appendix. These reports are also kept up to date in the HMIS computers. All of these data are compiled quarterly and annually. This is a very impressive MIS.

7.2.3 ELCO Registration

Another important element of the MIS is the annual registration of all eligible couples in each township. Registration started in April 1997. Data were collected largely by the midwives in the rural and urban health centres. Completed reports were received from 60 of the 72 townships in

1998 (83 percent). See the Appendix for a summary of 1998 data. Updating for 1999 is currently underway.

These data are used to calculate CPR by method at each township, estimate the number of potential users (unmet need), sources of methods, reasons for non-use and other relevant data. The data are watched closely by township staff and are used to develop strategies and plans for increasing coverage. Staff at the health centre level have not yet learned how to use the data for self-monitoring. This information will eventually provide annual estimates of contraceptive prevalence at the state/division and national levels, which should be very useful for strategic and operational planning as well as policy-making.

A number of problems have arisen, however. BHS staff did not always understand the ELCO terminology and their own responsibilities. For example, some did not understand the difference between a "potential user" and a "non-potential user;" some did not realise that they were to register all MWRA in a household, not just the primary couple. Most of these problems were worked out during supervisory visits and/or refresher training. However, they pointed out the need for follow-up and refresher training at the BHS as well as the township level.

Midwives found that they did not have enough time to conduct the ELCO registration, which can take a month or more. The solution was to train volunteers to help them. In most cases the MWs called on the AMWs for help. But others helped, as well. These include MCWA volunteers, village leaders, Fire Brigade, Red Cross and others. Underreporting remains a problem. The HMIS director said that this is a system-wide problem. "Data quality is good, the problem is quantity." This is especially true in remote areas. There is also a significant lag time. The central level has to allow three months lag to get complete returns. Even that is not enough. As of September, only 58 townships have submitted reports for January 1999.

7.2.4 Focus Townships

Five townships were selected to test the feasibility of doing data entry, tabulation and analysis at the township level. Computers and all necessary peripheral equipment and software were provided to these townships. The TMO and a senior nurse from each township were given a week of training at the HMIS centre in Yangon. Some also received a follow-up visit.

The Team visited one of the townships, Amarapura. The computer equipment was functioning well in a secured, closed and air-conditioned room at the township hospital. All of the software programmes were working but the TMO said that the training had not been enough. They did not feel comfortable with the computer, the software or the procedures. They also don't have the time needed to devote to this task. The TMO, who is a strong supporter of the BS programme and a natural problem solver, found a solution. He knows a monk at a nearby monastery who has a computer and a lot of free time. The monk processes the data for the TMO. Some help has also come from colleagues at the university. The long-term solution to this problem, however is to hire a dedicated staff person to handle all of the computer processing. An option would be to contract this function out to a private firm or consultant – or to nearby monasteries.

During the stakeholders' debriefing the HMIS Director stated that all five of the TMOs originally trained were no longer in their townships. One had died and the other four were transferred. The only solution to this problem, she said, is to train all TMOs and provide each township with the necessary computer equipment. Although tongue-in-cheek, this comment reflects the frustration that affects all parts of the system because of the over-reliance on TMOs who are frequently transferred.

7.2.5 Monitoring and Supervision

Monitoring and supervision is supposedly handled by the TMOs and supervisors via individual and group interviews with BHS staff as well as focus group discussions at the community level. Visits to facilities and clinic observations are also part of the supervision process. Supervision is also carried out by the TMO and THO at the regular staff meetings when BHS staff come to pick up their monthly salaries. However, the Team was told repeatedly that supervision is rarely carried out in practice due to heavy workloads and lack of travel funds. Some TMOs have refused to accept new projects because of this problem.

Two regional MIS evaluation workshops were held in September 1998 to assess progress. Representatives of all 72 townships and the central level attended.

7.3 Surveys and Assessments

Every once in awhile an opportunity comes along to do a really important and useful survey. That happened here. There has been so little information gathered in Myanmar on population, fertility, mortality and health status that the opportunities for really meaningful research are legion. UNFPA chose to fund two very important studies at the outset of the project. The Team's opinion is that this was a sound decision and money well spent. The FRHS and the MMS have already provided extremely useful information that has a myriad of practical applications – for policy making, planning and programming. The RH Needs Assessment also provided useful information for RH planning.

The other studies supported by the project have not yet been completed but they also show the same potential. The Cross-Border and abortion studies are extremely important from a development point of view and their results are likely to be very influential.

7.3.1 Fertility and Reproductive Health Survey

This study began in August 1996. Data collection was carried out between March and May of 1997. A preliminary report was distributed in April 1998 and the final report and dissemination seminar should be completed by the end of this year. From start to finish the study will have taken over three years (40 months). This delay has been due to government review and approval procedures.

The objective of the FRHS was to assess the knowledge, attitudes and practices of MWRAs with respect to BS/RH, estimate levels and patterns related to fertility and infant and child mortality, obtain data needed for selected demographic and BS/RH indicators and strengthen the capability of the Population Office in planning and carrying out surveys.

This study received a lot of assistance from the CST. Of 29 CST project assignments to Myanmar through 6/99 fully 10 were for FRHS. These included assistance in virtually all phases of the survey: design, questionnaire development and testing, sampling, programming, data entry, data analysis and report preparation. CST assistance was of exceptional quality, timely, responsive and very much appreciated by POD, which has demonstrated that it has the capability for and interest in conducting this type of research. In addition, the UNFPA CTA provided on-site technical assistance. There is no doubt that this TA made a significant contribution to the success of the FRHS.

There should be no doubt, as well, that this is an extremely important study. The fact that the government has attached its logo to the report attests to its value as well as certifying to all that the government considers the findings to be official. This certainly contributes to the credibility of the results and the likelihood that they will be used by all government agencies.

The last census was in 1983 and the last population survey was 1991. The information gap in Myanmar is extraordinary. It is practically impossible to prepare reasonable strategies and plans without these basic data. Yet, that is what has been going on for years.

The study is based on the Demographic and Health Survey (DHS) methodologies and, therefore, is credible to government and donors alike. The sample was sizeable (22,000 households nation-wide) and the design and execution were well done. The data cover a large number of health variables (not just BS) and produce some unexpected and important findings (e.g., the role of abortion and non-marriage on fertility).

There are some limitations as far as the project is concerned. Unfortunately, the data cannot be used as a baseline for the UNFPA project because it is a national survey and the data cannot be disaggregated to the 72 UNFPA provinces. That means that a follow-up survey would not be able to assess the impact of UNFPA contributions. For some reason an important variable (source of contraceptive service supply) was left out of the survey. This is unfortunate because of the pressing need to identify the role of the private sector in the provision of contraceptives and BS services.[21]

7.3.2 Maternal Mortality Survey

This study got underway in June 1996. Data collection covered 30 months, from December 1996 through May 1999. Maternal mortality is usually studied retrospectively and the available methodologies are dependent on recall of very rare events that occurred years ago. The MMS, in contrast, is a prospective study that relies on the registration of all births and deaths in 40 rural and urban townships that are nationally representative. The design conforms to WHO guidelines, which lends to its credibility. Local "registrars" were trained to collect information quarterly on all births and deaths in their assigned study areas and to do in-depth "verbal autopsies" of all deaths to females aged 10-50. The data were processed centrally and distributed to DOH and UNFPA on a quarterly basis to make sure that they were involved in the interpretation of the data. This was an extremely important tactic because many reviewers did not accept the findings initially. The consistent feeding of similar findings helped to change those views. The final report will be broadly disseminated, starting with a major seminar that will be held at the end of the year.

The Team believes that the careful design and execution of this study has enabled the researchers to produce findings that will have high credibility among political leaders, donors, health providers and researchers alike. The study was very well done.

The need for credible data on maternal mortality in Myanmar was obvious. The indirect estimates of the government and donor organisations ranged from

Table 25: Maternal Mortality Data

Variable	Urban	Rural	Total
Total population	123,494	281,211	404,705
Total births	6,090	17,775	23,865
Total deaths	2,506	6,672	9,178
Maternal deaths	28	92	120
Crude birth rate	19.7	25.3	23.6
Crude death rate	8.1	9.5	9.1
Maternal mortality ratio	459.8	517.6	502.8
Maternal deaths due to other apparent causes			14
MMR (24 months excluding other apparent causes)			444.2
Source: ENVIPRO. Final Report on Maternal Mortality Study (October 1996 to July 1999), September 1999.			

[21] Apparently, after much discussion, this variable was omitted because it was thought that knowledge of a source of supply was adequate. Of course, the fact that someone knows where a service is offered does not mean that they actually use that source.

100 to 700 maternal deaths for every 100,000 live births. With that wide a range it was impossible to determine if there was a significant problem or not. The survey results should help to put that issue to rest. However, the main purpose of the study was to identify the causes of maternal mortality. Everyone knew that the MM ratio was high and that abortion was probably a major contributor. But there were no credible data to prove that. Now there are and the policy implications are much clearer. Emergency obstetrical care, better access to maternal care, better referral procedures and prevention of unsafe abortion are likely to emerge as the most important interventions needed. The government is likely to accept those conclusions due to this study.

The CTA played an important role in the design and execution of this study. The contractor, ENVIPRO, did a very professional job in carrying it out. The government, to its credit, has acted responsibly in accepting the findings and endorsing the study. Because costs are so low in Myanmar, the study was a bargain.

Several weaknesses were identified in the course of the study. One of the most important was the burden on the registrars who had to cover several villages. The solution seems to be to recruit registrars from villagers to keep track of births and deaths in their own villages. Also, the sample, although larger than most, is still small (120 maternal deaths/23,865 live births).

7.3.3 Cross-Border Migration and Reproductive Health Survey

This study just got underway this year and will be completed in one site by December. It is clearly of high interest to the government as well as to donors and service providers. The objective is to assess the nature of cross-border migration (between Myanmar and Thailand) and its relationship to RH, especially HIV transmission. Although the emphasis is on HIV/AIDS, the questionnaires include all of the variables used in the FRHS. So it is quite comprehensive.

The CST has been providing extensive TA to this study as well as to the FRHS. The Population Department, which is responsible for the FRHS, is also conducting this study. Although it is too early to tell what will come from it, all indications are that it will be well done and well received. The government is very interested and, therefore, extremely supportive.

If there are any shortcomings it is in the limited geographic scope. The study was originally planned to be undertaken in three sites. The number was reduced to one in 1999 for lack of funds and the stretched capacity in POD. UNFPA is interested in funding another site along the Thai border and also one more on the Chinese border. Another issue is that no programmatic interventions have been identified to date, although the final report is expected to suggest some priority areas for education and services, especially in HIV/AIDS. Hopefully, this will attract donor funding.

7.3.4 Abortion Study

In 1998 a study on abortion practices was included in the project document. A $20,000 study was commissioned by DOH but it was more a KAP study on birth spacing[22] than a study of abortion practices. UNFPA negotiated a compromise whereby half of the funds went to this study and the remaining half to a new study that examines the incidence of and reasons for abortion.

The second study got underway in September 1998 and is to be completed by December 1999. The study covers three townships in the Bago Division, one of which is a UNFPA-sponsored birth

[22] Birth Spacing and its Related Issues in Khayan Area, Yangon Division. 1999.

spacing township. Among other things, the study attempts to analyse the impact of BS activities on abortion practices. In addition to measuring the overall incidence of abortion, the study examines the perceptions of clients and health providers toward abortion and abortion-seeking behaviour.

This is the first study of its kind in Myanmar and it has the strong backing of the government, which is not only interested in learning what the study produces but also in formulating strategies for preventing unsafe abortions. UNFPA should be congratulated for taking the risk to support this sensitive, but very important, study. The study design includes the formulation of interventions.

7.3.5 RH Needs Assessment

This was also introduced in the 1998 project document. It was carried out by a multidisciplinary team of national and international consultants that met with key officials and stakeholders, conducted site visits to six townships and then drafted a relatively detailed report. This was all done in May 1998. The draft report was presented to the stakeholders, revised, reviewed by the team members and submitted to UNFPA in June. The report was published in March 1999 after review by UNFPA and the government.

The assessment was commissioned because several of the UN agencies expected that a reproductive health programme of assistance would be developed soon. UNFPA, which has the mandate from ICPD to promote the implementation of reproductive health, seemed to be the logical agency to sponsor such an assessment.

The information in the report is clearly useful and timely, particularly if one or more donor agencies are willing and able to provide the necessary resources to implement its recommendations. As with other studies, this one also bears the government logo, which gives it the status of an official government document.

7.3.6 Other Studies

Two studies that were proposed in 1999 were put on hold, due to the inability to decide which agency should be responsible for conducting them. The first was a study of Adolescent Reproductive Health Practices and Perceptions. The second was on Contraceptive Requirements, Forecasting and Logistics. Both of these studies are important and UNFPA hopes to include them in the upcoming project for 2000.

7.4 Constraints and Facilitating Factors

- Staff transfers, especially of TMOs, seriously affect the momentum of the project. At a minimum they increase the need for additional training in MIS and ELCO registration.
- Distance and travel, especially in remote areas, lead to delays in MIS reporting.
- Government review and clearance of research results is very slow, thus delaying action on recommendations.
- Myanmar has very limited technical and financial resources to undertake this type of research. The DOH, as an example, has limited research capability.

7.5 Conclusions

- The BS MIS is working well. Data collection, recording and reporting all seem to be working well.
- MMCWA activities and accomplishments are not recorded or reported.

- The quality of data appears quite good. The problem is quantity, that is, there are problems with underreporting.
- Some of the preliminary BS indicators go well beyond BS itself to include MCH and general development.
- ELCO registration also appears to be quite good. This is an important source of very useful information on contraceptive prevalence.
- Training is the key to quality in this area. If the training is inadequate or incomplete then the staff have significant problems and make lots of mistakes.
- It appears difficult for TMOs and LHVs in the focus townships to enter and process MIS data for their own use. They lack time and confidence. Turnover of TMOs again points to the effects of concentrating the project on that position.
- The FRHS and MMS were well designed and implemented. Their results should be very valuable for policy, planning and programming.
- The Cross-Border and Abortion Practices studies also appear to be carefully designed and implemented. They both address issues that are of high priority to the government and should be extremely useful in formulating strategic interventions.
- The RH Needs Assessment provided interesting information that should be very useful when and if donor support can be mobilised for the expansion of RH services.

7.6 Recommendations

- UNFPA should continue to support the development, installation and refinement of the MIS and ELCO registration systems.
- The list of BS variables should be pared to include only those that deal directly with BS.
- Refresher training in MIS/ELCO registration needs to be scheduled at least once per year for BHS staff and volunteers who collect the data.
- DHP needs to appoint a dedicated computer operator to process the MIS data in each of the focus townships. An alternative would be to contract this out to a private firm or consultant.
- MMCWA activities should be incorporated into the MIS.
- The MMS should be continued, if economically feasible, for another two-three years to generate a larger, and therefore, more accurate/credible ratio.
- UNFPA should (and/or encourage other donors to) support the next round of FRHS planned for 2001.
- DOH does not have adequate research capability and world-wide experience shows that it is not worthwhile to invest in developing it. Future research projects should be assigned to organisations that have such capability and a proven track record (e.g., ENVIPRO, POD, and several international NGOs).
- If the next project includes a research agenda there are a number of topics that should receive priority. These include replication of the Cross-border and Abortion Practices studies in other areas, development of a study of Adolescent RH and Sexual Practices and a study of Contraceptive Logistics. If UNFPA cannot fund all of these studies it should encourage other donors (e.g., UNDP and UNICEF) to do so.

8. PROJECT MANAGEMENT

8.1 Procurement

Supplies funded and procured by UNFPA for the government's BS/RH programme include oral and injectable contraceptives, IUDs, condoms and drugs for RTIs. To determine the efficiency of the procurement process, the Evaluation Team tracked the general speed of the various steps of the procurement process (see Table 26). Procurement moves slowly at several key points: shipping, DOH preparation of the distribution list, and Central Medical Supply Depot (CMSD) distribution.

Table 26: Procurement and Distribution Process

Process	Time	Cumulative
DOH request to UNFPA/FO		
UNFPA FO to HQ	1 week	1 week
HQ bid process	1.5 months	7 weeks
Shipping	4.5 months	25 weeks
Port clearance	2 weeks	27 weeks
DOH distribution list	4 months	43 weeks
Township pickup	1 month	47 weeks
CMSD distribution	3.5 months	57 weeks
Total		13 months

Contraceptives (and other supplies) used to be sent from the central level to the district and then on to the township. To reduce delays, DOH decided to ship directly to the townships. But delays still occur. Two of these, DOH preparation of a distribution list and CMSD distribution, could be speeded up. DOH still sends out equal shipments to all townships, so there is no reason for the four-month delay to prepare a distribution list. Even if the list were prepared on the basis of individual need, it could be part of the original request submitted to UNFPA.

CMSD distribution is constrained by seasonal variations in the weather (rain and landslides preclude distribution to a number of townships in remote areas), budget and CMSD's routing schedule. CMSD does not have the resources for continual distribution, even on a monthly basis. The schedule calls for distribution to one or two states/divisions each month. This means that an individual township that cannot pick up its supplies in Yangon may have to wait three months for an order to arrive.

Table 27: Number of Monthly Township Reports Received, January-July 1999	
January	58
February	59
March	58
April	52
May	50
June	41
July	34

The system is also compromised by shortcomings in MIS reporting (see Table 27). The system is set up to track stock on hand but the reports do not come in to the central level as rapidly as they should. Some take 3-6 months to arrive. For example, the Team requested copies of the latest monthly reports. These include information on actual method mix (users by type of contraceptive) and contraceptive supplies (quantities distributed and on hand by type of contraceptive. DOH or DHP should be able to use this information for forecasting and procurement of contraceptives. But that is constrained by incomplete reporting. January reports from 14 townships have still not been received.

In addition, long-term commodity planning, funding and procurement are impossible with programming limited to only one-year cycles. Creation of a regional UNFPA project/fund for

contraceptives that could serve Myanmar more easily has been suggested as one solution to this problem.

8.2 Technical Assistance

Technical assistance came primarily from the CTA in Myanmar and CST in Bangkok. When needed, the project called on national consultants, external consultants and staff from UNFPA's Technical Support Services in New York. TA was requested and provided primarily in research, IEC and counselling, training, logistics and gender. The country office reported that this TA, especially that of the CST, was timely and effective.

As an illustration of CST support, from January to June of 1999, three CST members made a total of seven person-visits to Myanmar, primarily in the area of programme and project backstopping for the FRHS and Cross Border studies. In 1998, six CST members made a total of nine person-visits to Myanmar, to serve as resource persons for IEC workshops and other training and to provide backstopping to various studies and surveys.

Table 28: CST Technical Assistance Visits to Myanmar, April 1996-September 1999

Activity	Missions	Experts	Person days	Percent
MIS/Research	11	20	159	66.0
Training	6	8	46	19.1
IEC	1	2	12	5.0
Service Delivery	1	1	8	3.3
Project planning	1	2	16	6.6
Total	20	33	241	100

The most significant TA was in support of the FRHS and the CBMRHS. The CTA and the CST provided a large quantity of assistance, from study design and sample selection to analysis and report preparation. Altogether, 20 consultant visits were made between October 1996 and September 1999. The high quality of these studies reflects the high quality of this assistance as well as the increased capabilities of the POD staff. In contrast, no CST assistance was provided to the MIS, perhaps because it wasn't needed. Logistics TA was limited to two visits at the start of the project. TA in training and IEC was also limited to the start-up period. It seems clear that the achievements of the project are directly related to the quantity, as well as the quality, of TA. The FRHS, MMS and CBMRHS benefited most from CST and CTA assistance. All other areas suffered from the limited TA provided, in particular training and logistics.

8.3 Financial Management

Financial management of the UNFPA/M RH/BS project appears to work efficiently from the UNFPA and DOH sides.

Budget line item transfers are required approximately two times per year to meet changing programme needs, but these are easily and expeditiously approved by UNFPA/Bangkok. The most common transfers are from the international consultant line item (which has not been needed as much as expected) to contraceptive procurement.

Exchange rate regulations peculiar to Myanmar have forced UNFPA to find an efficient way to

transfer funds to implementing agencies. Funds provided directly to the government are exchanged at the official rate of 6 Kyats/US$ 1. Since the market exchange rate is currently 350 Ks/US$ 1, this would reduce the buying power of the funds immensely. To avoid this UNFPA issued a contract to the DOH and the DOH issued subcontracts to all of the other implementing entities (DHP, POD, MMCWA, ENVIPRO, etc.). However, this contracting mechanism has had an unexpected effect as the DOH has tried to control all of the subcontractors. UNFPA plans to prepare separate projects with more than one organisation in the future. In addition, foreign exchange regulations have been eased, which will make funding easier.

UNFPA HQ handles commodity purchases. UNFPA also pays directly for personnel, administration and related costs. The funds executed directly by the DOH are actually quite small and are monitored by UNFPA FO. Funds are allocated to various standard budget categories through a workplan that is worked out jointly between UNFPA and the various implementing agencies. When a particular activity is completed (such as first level training or data collection for a study) the subcontractor will submit a request for payment. The UNFPA FO verifies that the activity has been completed and submits a payment request to UNDP, which writes a check to the subcontractor. UNFPA keeps track of and reports all project expenditures regularly. The Team had no problem getting complete expenditure data from the UNFPA FO.

8.4 Co-ordination and Collaboration

Project collaboration with other UN agencies, such as UNDP, UNICEF and UNHCR, has been attempted, but is difficult to implement due to differences in execution modalities. For example, the initial project document called for UNFPA and UNDP to collaborate in six townships where both were scheduled to operate. UNDP agreed to provide $400,000 of contraceptives in these townships and UNFPA would provide technical and training inputs. Unfortunately, the fact that one organisation was working through the government and the other could not made collaboration problematic. UNDP and UNFPA are still interested in finding a way to work together. The Team visited a UNDP project site in Chaung-Oo where the UNDP field officer made a strong case for future collaboration, with UNDP paying for contraceptives and UNFPA providing the technical and training assistance in BS that UNDP needs.

UNFPA and UNICEF also agreed to collaborate in six other townships where both were working. This worked out better. UNICEF does not provide or distribute contraceptives, but has both funds for and ongoing relationships with providers of IEC for RH/BS. UNFPA provided the contraceptives and BS training that complements UNICEF's maternal care and HIV/AIDS interventions. Together, in these six townships, they have found areas of complementarity and have integrated their assistance. This is particularly effective, as these townships have high HIV seroprevalence. UNFPA and UNICEF have joined together to provide IEC and condoms, resulting in increased condom utilisation rates. Further expansion of this UNFPA/UNICEF collaboration has only been limited by UNFPA's funding ceiling. Technical exchanges between UNFPA and UNICEF occur both formally and informally on a regular basis.

UNFPA has attempted to participate actively in all regular mechanisms that have been established for co-ordination within United Nations agencies in Myanmar – some of these mechanisms (in particular, the UN working groups) have been more active and relevant than others. UNFPA took the lead in establishing at least one of these groups (that on gender).

Relationships with bilateral donors are limited, by definition, as there are few bilateral donors supporting Myanmar. Those external groups that are active in Myanmar are small international NGOs. Relationships with those that are active in RH/BS appear to be good and one tangible

example of this is the collaboration UNFPA achieved with the Population Council and ICOMP on the RH Needs Assessment mission.

A final example of creative collaboration is the joint UNFPA/UNICEF funding of one of the members of this Evaluation Team. The same team member will be jointly funded for a future mission on the prevention of mother-to-child transmission of HIV – a problem of concern to both agencies. Similarly, UNICEF also provided a project officer and the European Union (EU) provided a Regional Advisor as Team members for part of the mission.

Finally, the project has a Task Force that is made up of representatives from all of the project implementing agencies and UNFPA. This group meets periodically, usually to sort out problems that arise. It has been a useful co-ordination mechanism as well.

8.5 Monitoring and Evaluation

UNFPA and the DOH employ a variety of mechanisms to monitor and evaluate project performance. These include monthly reports, site visits and periodic meetings.

8.5.1 DHP MIS Reports on Birth Spacing

This is probably the most regular and consistent monitoring mechanism. The reports are produced by each township and submitted to DHP each month where they are compiled. The DHP provides quarterly and annual reports that DOH and UNFPA find useful in monitoring progress along such key indicators as contraceptive prevalence, method mix, contraceptive supplies, training events and so forth. Examples of these reports can be found in the Appendix. As mentioned earlier, a significant problem is late reporting.

8.5.2 DOH Supervision Visits

Supervision has been acknowledged as weak throughout the health care system and that is the case in the BS project. A special BS checklist for supervision and monitoring of IEC was developed, pretested, revised and distributed to the States and Divisions in 1998. The checklist is actually used as a reporting mechanism rather than an on-site supervision tool. The forms have been sent to THOs to fill out and return to the central HEB. DOH has a checklist for monitoring BS service delivery, but it is rarely used. MMCWA does not conduct any formal supervision of field activities as yet. The association is interested in developing systems to do so, however. See Chapter 4 for more details.

8.5.3 UNFPA Field Visits

The UNFPA staff, going back to 1997, makes periodic field visits. "Back to Office" reports are prepared at the end of each visit, usually by the Assistant UNFPA Representative. The visits typically cover a small number of sites (three to five townships) and last only a few days. They are not meant to produce an assessment of overall project performance as much as a snapshot of performance in a variety of settings. Nevertheless, they provide valuable insights. Because the findings are similar across townships and over time, the information is useful for monitoring and evaluation.

The reports are brief and include various types of information. There are positive findings (awareness of BS is high, IEC posters and pamphlets have been distributed), constraints that are beyond the control of the project (high turnover among TMOs; under-reporting of infant deaths),

facts (substantial prevalence of male and female sterilisation, most abortions are performed by untrained TBAs), problems in implementation (no follow-up after training, no handover mechanism for revolving funds when TMOs are transferred), needs (GPs want medicines to treat RTIs, more contraceptives are needed) and recommendations (there should be one ELCO registrar per village, LHVs and MWs should be trained to insert IUDs).

8.5.4 CST Field Visits

CST advisers also contributed to monitoring in those cases where follow-up visits were made by the same advisor. The CST reports sometimes identify actions that were recommended during a previous visit, endorsed by the UNFPA Representative/Country Director but not yet undertaken. Often, however, there was no follow-up and the advisors seemed to be cautious in raising such issues. They were rarely mentioned in subsequent reports.

8.5.5 Tripartite Project Review Meetings

Two such meetings have been held. The first was in October 1997; only a few months after the project actually began. The second was in March 1999, which was 1½ years after the first meeting. The reports of these meetings give the impression that they were largely ceremonial, descriptive and superficial. The discussion section of the first report notes that the project concept and design were fine, progress was satisfactory and there were no significant implementation problems. No special action was needed nor was an evaluation needed. This despite the fact that the start of the project had been delayed for a year, the training needs assessment was not undertaken, a training curriculum was not developed, and so on.

The second report lauds the accomplishments of all concerned ("the activities of 1998...[were] fully achieved," "there has been significant progress in every aspect of [the] project...") and the significant problems identified in this evaluation were minimised. Some external constraints are identified (transportation difficulties, shortage of IUD insertion facilities, non-affordability of certain contraceptives) but even these were said to have been dealt with by "corrective actions" that were undertaken during monitoring visits. The report ends abruptly, apparently because the National Project Director (NPD) ended the meeting abruptly. There was no discussion, even of the workplan, which was one of the key agenda items.

These meetings may serve a political purpose (bringing the government and UNFPA together) but they do not seem to serve much of a monitoring or evaluation purpose. Design and implementation problems do not seem to be identified, much less addressed. The success of these meetings also depends greatly on the interest and leadership of the NPD.

8.6 Constraints and Facilitating Factors

- Lack of resources and infrastructure, which affect all project activities.
- UN agencies have different execution modalities, which hinders joint planning and co-ordination of programming.
- There is a very short history of government experience in managing FP or BS programmes, resulting from the late entry of Myanmar into the BS field.
- UNFPA/M is required to programme only one year at a time to stay within the US$1 million/year ceiling, since UNFPA/M programmes have not been submitted for formal Executive Board approval. This makes effective long-term planning and programme management difficult, if not impossible, and creates special challenges in the area of

procurement of contraceptives and other commodities.

8.7 Conclusions

- The procurement and distribution systems are not working as well as they can under current conditions. However, much of the advice provided by the CST logistics expert has not yet been acted upon.
- Technical assistance is crucial to success in this type of project The assistance provided to the research activities of POD, in particular, was very useful. Similar contributions to training, IEC and MIS might have improved the progress of these components.
- The CTA was sorely needed and made a significant contribution to the research projects. However, in retrospect, a resident expert in training and/or IEC was also needed.
- The short-term advice provided by the CST experts in these areas was of high quality but, in many key areas, not acted upon.
- UNFPA financial management has been satisfactory.
- UNFPA collaboration with UNICEF has been effective. Similar collaboration with UNDP was attempted but infeasible due to differences in execution modalities.
- Monitoring and evaluation is relatively weak in this project, especially at the field level. This is particularly noticeable in training, IEC and service delivery.

8.8 Recommendations

- The procurement and distribution system for contraceptives (and other commodities) needs to be upgraded. A medium-term advisor, or frequent visits from a logistical consultant, is needed to bring about improvements in the system.
- UNFPA should gear its future technical assistance to those areas that are most in need, namely, training, IEC and service delivery.
- UNFPA should provide a long-term resident advisor who is an expert in training and IEC. Language training should be budgeted for this person as consultant effectiveness is directly related to communication capability.
- UNFPA should continue seeking ways to collaborate with UNICEF and UNDP in the future. For example, if UNDP can provide contraceptive support in exchange for technical and training inputs from UNFPA, that would be one way to enable UNFPA to expand coverage to additional townships.
- Monitoring and evaluation need to be strengthened, both in the national agencies (DOH and MMCWA) and UNFPA.

9. CONCLUSIONS AND RECOMMENDATIONS

9.1 General Conclusions

9.1.1 Accomplishments

Birth spacing services have been expanded significantly in all 72-project townships. This is a major achievement given that practically no such services were available before 1991 in the public sector. Well over 1.5 million couples have been given greater access to birth spacing through this project. Particularly important is the extension of access to modern contraceptive services in rural areas and to the poor, where need is greatest.

The project also expanded the range of contraceptives so that couples now have a choice of four methods: oral pills, injectables, IUDs and condoms. The introduction of a long-lasting IUD, together with trained providers who know how to insert and remove them, finally brought a long-term, non-hormonal method within reach of hundreds of thousands of women.

IEC has been a particularly visible activity. In addition to distribution of pamphlets and materials, BHS staff and MMCWA volunteers have informed tens of thousands of women about BS and BS methods. Integrated BS training has been offered to almost all front line workers, from TMOs and other township medical staff to LHVs and MWs at the RHC and sub-RHC levels. Training has also been provided to most of the AMW and MMCWA volunteers in these townships.

Significant progress has been made in setting up a viable BS management information system and an ELCO registration system. Valuable studies on fertility and reproductive health, maternal mortality, abortion and BS/HIV/AIDS in a border area have been undertaken.

All in all, the project has accomplished a great deal, especially given the limited resources UNFPA has been able to provide and the severe constraints that exist in Myanmar.

9.1.2 Challenges

However, there are a number of design and implementation problems that limit the effectiveness of the project. There are not enough contraceptives to meet the demand; the contraceptive distribution system is unable to provide a steady reliable, frequent, timely and appropriate mix of contraceptives to the townships. The BS programme is built around physicians (particularly TMOs) and fixed facilities which severely limits the delivery of contraceptive services. Provision of services by MWs and AMWs is severely restricted by TMOs and DOH policies. This limits services to the poor and to those in rural areas, in particular. Voluntary sterilisation services are downplayed because of severe government restrictions. The project is doing very little directly to promote prevention of HIV/AIDS, but its indirect support is helpful. Clinical service quality appears to be satisfactory, but client knowledge of contraceptive usage, side effects and other facts appears to be poor. There is little supervision of BHS staff and AMWs. There seems to be no supervision of MMCWA volunteers. The CCS system is inadequate for sustainability purposes and may actually be driving potential users from accepting or continuing to use birth spacing.

No curricula have been developed for the training courses and there are few, if any, individuals skilled in training methodology. Training has relied upon traditional, non-participatory methods of classroom teaching that often provide more knowledge and fewer skills than are necessary to do a job. The training programme is not competency-based and there is little follow-up or supervision.

IEC materials, while of high quality, are severely limited for training as well as distribution to potential clients. Not enough has been done to promote acceptance of the IUD, which is an appropriate method for many women. As a result, the change expected in the method mix has not yet occurred. MMCWA's outreach efforts are extensive, but the quality and accuracy of their IEC is unknown, as is the effectiveness of these efforts in recruiting women to BS.

The quality of MIS data appears quite good, but the problem is quantity, that is, underreporting and late reporting. MMCWA field activities and accomplishments are not reported and incorporated into the BS MIS. Training is the key to quality in both the MIS and ELCO registration. If the training is inadequate or incomplete then the staff have significant problems and make lots of mistakes.

9.2 General Recommendations

Some of these challenges can be resolved relatively easily; others will be more difficult and may require policy and institutional changes. All of them will require substantial external support over an extended period, which the Team realises may not be forthcoming. Assuming that the necessary resources can be raised, the Team recommends 1) that the present project be extended through 2000 while a new approach is developed; 2) that the new approach be implemented in the 72 townships as soon after that as possible, say 2001-2005; and 3) that this be followed by replication of the approach in all remaining townships – together with expansion of services to include all other priority RH services – say 2006 – 2010.

9.2.1 Immediate: Continue and Redesign – 2000

The most important immediate objective would be to continue the project in the 72 townships as currently structured. This includes provision of necessary contraceptives, conduct of new and refresher training, production and distribution of additional IEC materials and refinement of the MIS/ELCO registration system. That is, the first priority would be to maintain what has already been achieved.

At the same time, a new approach should be designed that will overcome the structural problems in the current project. Chief among these problems are the reliance on TMOs, the unbalanced method mix, the attempt to serve everyone and the lack of attention to the next generation – the adolescents and the young adults. The key elements that are suggested by the Team are:

CBD as a core strategy: The overall approach should be redesigned to focus on community-based distribution of contraceptives (CBD). This is essential if the DOH is going to expand access to BS where it is most lacking – among the poor and those in rural areas.

Midwives as the key providers: The key to the above is the shift of primary responsibility for services from the TMO, hospitals, MCH Centres and other more urban facilities to the midwives and auxiliary midwives who are the key providers in the rural areas. These women need to be trained in and allowed to provide all contraceptive services. This strategy should also reduce the excessive demand on the TMO who acts as the main manager, main provider, main administrator, main MIS operator, main trainer and main logistics co-ordinator.

IUD as a major long-term method: IUD services should be brought as close to the people as possible by training MWs and AMWs to provide this service – and by mounting a factual information campaign to educate ELCOs, providers and policy-makers about the many advantages of IUDs over other available methods – at least for those couples who do not want

to have any more children

Market segmentation: Social marketing strategies should be introduced into the public sector to help policy makers and providers understand the advantages to all of segmenting the market. The objective is to encourage those who are able to pay for BS services to shift to the private sector for their BS services and supplies. Those who cannot afford to pay would remain the prime beneficiaries of public sector services and contraceptives. Careful segmentation and marketing strategies can result in increased sales for the private sector, reduced costs for the public sector and increases in contraceptive use overall.

Young people as a special target: This strategy also needs to be extended to young people, some of whom (especially in urban areas) will prefer the anonymity of the private sector and others of whom (especially in rural areas) will prefer the convenient and less expensive public sector. The prime objective of both, of course, would be to avoid unwanted pregnancies that could lead to unwanted abortions and their complications.

These new approaches will have implications for training, IEC, service delivery, management information as well as policies, budgets, and so on. The operational issues will require the most resources and technical assistance. Hopefully, UNFPA and other donors will be able to provide the needed support. The recommendations of the Team for improvements in training, for example, need to be applied to the new approach as well. This will mean redesigning the training strategy to focus more on CBD, midwives, IUDs, market segmentation and young people The same holds true for IEC, service delivery and MIS/Research. A significant amount of technical expertise is likely to be needed in addition to local resources to develop this new approach.

Equally important is the introduction of operations research (OR) techniques to identify and then test solutions to many of the new procedures that will need to be developed. For example, supervision of MMCWA volunteer activities will need to be designed to adapt to the new approach. What would the role of MMCWA be in a system that places emphasis on CBD, MWs, IUDs, market segmentation and young people? That system will need to be designed and tested before it is implemented. That is where operations research can be helpful.

9.2.2 Intermediate: Install and Implement in 72 Townships – 2001-5

Once a "model" approach has been developed and tested in one or more townships, the next phase would be to implement that model in all 72 townships. This may be done incrementally, of course. But it is likely to take several years and to require a great deal of monitoring and adaptation to make sure that the general model fits local needs, customs and culture.

9.2.3 Long-term: Expand to All Townships, Expand RH Services – 2006-10

The final phase would expand the model to all remaining townships and expand the services to include as many of the other priority RH services as seem appropriate. These may include, for example:

Sterilisation: Increased access to surgical contraception for those men and women who have reached their desired family size, want to preserve the health and well-being of their family and do not want to be burdened by an unwanted pregnancy.

Emergency obstetrical care: Simple systems to ensure that unnecessary maternal deaths are avoided by ensuring that essential information about the woman can be sent out rapidly, that

family members, local health workers and trained providers understand the need for rapid action and transport and that women can be transported rapidly to appropriate medical facilities, if required.

Post-abortion care: Safe treatment of abortion complications together with sensitive counselling on contraceptive use and provision of appropriate contraceptives to ensure that there are no repeat abortions.

Reproductive Tract Infections: Expanded screening, diagnosis and treatment of common infections by local personnel, especially midwifes.

STDs, HIV/AIDS: Expanded prevention and detection services to cover larger portions of at-risk populations.

Other RH interventions: Expansion to include other ICPD-recommended services, such as reproductive cancer screening; infertility screening and counselling, sexuality education, prevention of harmful practices.

9.3 Specific Recommendations for Immediate Action (2000)

Service Delivery. Priorities for the new programme would include upgrading the contraceptive logistics system so that it can provide regular, timely and appropriate contraceptives to the townships. UNFPA should provide technical assistance to the DOH and CMSD to do this. DOH and DHP (HEB) should mount a major campaign to promote acceptance of the IUD by providers and consumers alike. The service delivery component should be redesigned so that instead of relying heavily on physicians and fixed facilities it would be built around midwives and community-based distribution (CBD). This will expand access to services and should lead to greater use of contraception. UNFPA and DOH need to undertake an evaluation of the distribution of contraceptives by MWs, AMWs and MMCWA volunteers. UNFPA should advocate a DOH policy that would allow certified MWs and AMWs to distribute contraceptives and to provide injection and IUD insertion services. However, MMCWA volunteers should not be allowed to distribute injectables and IUDs and should only provide re-supplies of pills if they have the permission of the local MW, keep accurate records and give those records to the local MW. UNFPA should advocate a change in policy regarding voluntary sterilisation to allow couples that have reached their desired family size and do not want to have any more children to use this method. More needs to be done in the future to develop strategies and fund interventions to prevent abortions and HIV/AIDS. UNFPA should support a study of the quality of care of BS services and assist the DOH to take appropriate steps to improve QOC. Prices for contraceptives should be fixed nation-wide to avoid confusion and to prevent corruption. A study should be commissioned of the effect of the CCS system on acceptance and continued use of contraceptives. A study is also needed of the price elasticity of the various contraceptives to determine if lowering its price could raise acceptance of IUDs.

Management Information System. UNFPA should continue to support the development and installation of the MIS and ELCO registration systems. They may need to be modified if a new BS/RH service delivery model is developed. MMCWA activities should be incorporated into the MIS. The list of BS variables should be pared to include only those that deal directly with BS and RH. This should reduce recording and reporting workloads. Refresher training in MIS/ELCO registration needs to be scheduled at least once per year for BHS staff and volunteers who collect the data to ensure that quality and accuracy remain high and that reports are submitted on time. TMOs and LHVs should no longer be trained as computer operators. If data entry and processing

are to be decentralised – which should happen eventually, in any case – then a dedicated computer operator should be appointed or this task should be contracted out to a private firm

Research Although the field research costs are relatively inexpensive, UNFPA and the government will need to decide how much of their scarce resources will be devoted to this activity. Priority should be given to those studies that support the development and installation of the new approach that the Team is proposing. This means more emphasis on operational research and evaluation rather than sample surveys.

Nevertheless, if resources permit, there are a number of studies that should be undertaken. The MMS should be continued, if economically feasible, for another two-three years to generate a larger, and therefore, more credible sample. UNFPA should (and/or encourage other donors to) support the next round of FRHS planned for 2001. Other important topics include the replication of the Cross-border Study (including expansion to sites along the Chinese border), additional abortion studies in other townships, development of a study of adolescent RH and sexual practices and a study of contraceptive logistics. If UNFPA cannot fund all of these studies it should encourage other donors to do so.

Although the DOH may wish to conduct some research studies itself, this should not be encouraged. DOH is an operational, not a research entity and its staff are already overburdened. It would take a large investment to develop an adequate research capability World-wide experience has shown that this type of investment is rarely productive or sustainable. UNFPA should contract organisations that already have an institutional research capability and proven track record

Training. For the transition year 2000, continue training new TMOs who enter the 72 UNFPA townships as an interim measure, while working toward training MWs to perform more of the TMOs' functions in the future. Recruit a long-term (one year) training advisor with expertise in planning and implementation of participatory training and development, testing, use and evaluation of IEC. Obtain commitment to assign a full-time local counterpart to work with this long-term advisor. Develop better mechanisms to ensure that the advice of CST and other consultants is acted upon in future training programmes. Train MWs and AMWs in IUD insertion and injectables and secure approval for them to deliver both.

As part of planning for the forthcoming five-year country programme (2001-2005), develop a model for a more effective long-term training programme that addresses the many concerns raised by this Evaluation Team. This would include assisting government to review the entire structure of the BS programme with a view to orienting it to a less physician-dependent model and a more competency-based system. Develop a plan with DOH for redirecting the current training of male HAs and CHWs and find ways to develop and train a cadre of male community motivators for BS. Experience from other countries indicates that increasing the awareness and securing the support of men for BS can increase male responsibility for contraception as well as their support for their female partners' choice of contraception. Review the appropriateness and effectiveness of the MMCWA IEC and motivation system to determine whether revisions are needed in this approach. Help fund and develop a simple supervision and reporting system for MMCWA IEC activities. Expand training in BS for private practitioners.

IEC. During the transition year 2000, more copies of existing IEC materials need to be produced and distributed. With the assistance of the new training/IEC advisor that the Team recommends, review the appropriateness and quality of existing IEC materials. Revise the materials in keeping with the recommendation to restructure the BS IEC and training programmes. Produce sufficient copies for the first half of 2001-2005. Review the quality of performance of MMCWA volunteers

before investing in further expansion of that programme.

9.4 Gaining Support for RH/BS in Myanmar

The Team is very aware that implementation of many of its recommendations depends on approval of a multi-year UNFPA country programme. The Team is also aware that political considerations are likely to outweigh humanitarian ones when the UNFPA Board is asked to approve such a programme. However, the Team also believes that those who examine the current project as it stands will be impressed with what has been accomplished by the thousands of highly dedicated, civil servants who somehow manage to get something done under very difficult conditions. They will also be moved by the plight of the millions of needy people inside and outside of the project area who desperately need help – help that they cannot get because of events beyond their understanding and control. The Team hopes that some way can be found to provide this help.

APPENDIX A: TERMS OF REFERENCE

Evaluation of the UNFPA-Supported Birth Spacing Project in Myanmar

14 September – 12 October 1999

Terms of Reference

Background

The Birth Spacing Project MYA/95/P02 supported by UNFPA started in mid-1996 with a budget of $3,487,230 over a period of 36 months. The project is scheduled to be completed in December 1999. The main implementing and co-ordinating agency is the BS/MCH Section of the Department of Health (DOH), Ministry of Health.

The Birth Spacing/Reproductive Health (BS/RH) services are provided by DOH through its network of Division/State, District and Township Hospitals and urban and rural health centres in 72 out of the total 324 townships. The other components are implemented by other departments and institutions: IEC activities by Health Education Bureau; MIS activities by the Department of Health Planning; Fertility and Reproductive Health Survey (FRHS) by the Department of Population, Ministry of Immigration and Population; involvement of volunteers in BS/RH and HIV/AIDS prevention by the Myanmar Maternal and Child Welfare Association (MMCWA), and the Township Medical Officers and field network; and the Longitudinal Study on Maternal Mortality by an NGO (ENVIPRO). Additional studies which were considered important and relevant were initiated during the conduct of the project, such as the Cross Border Migration and Reproductive Health Survey by the Department of Population, and Abortion Study by the Department of Health.

The project uses a co-ordinated programme approach by integrating BS/RH services with IEC, MIS and logistic system, a full fledged training programme, and the conduct of FRHS and Maternal Mortality Study.

Technical assistance and monitoring support are provided by the Chief Technical Adviser (CTA) and the UNFPA Country Director's Office. In addition, technical backstopping is provided by national consultants, TSS, and UNFPA/CST for East and South-East Asia.

Development of skills in undertaken through provision of long-term and short-term fellowships including attachment study abroad. Contraceptive supplies and equipment such as computers, audio-visual equipment, copiers, etc. including vehicles have been provided for smooth implementation of the project.

Purpose

The purpose of the evaluation of this project is to (a) assess the design, relevance, progress and performance; (b) identify factors to improve efficiency and effectiveness; and (c) provide data to inform future programme development and policy decisions, noting the special circumstances of Myanmar.

An evaluation of the project is scheduled from 14 September to 12 October 1999 (four weeks). This comprises one week of field visits and the remaining three weeks will be spent in reviewing the available materials, discussions with concerned officials and implementing partners, and preparation of the evaluation report.

The Evaluation will be undertaken by a team of international and national consultants not previously involved with the design or implementation of the project. The findings and recommendations of this Evaluation will serve as an input for future UNFPA support to the RH/BS project in Myanmar.

Terms of Reference

The Evaluation Team is expected to analyse and assess the UNFPA-assisted BS/RH project in the following areas:

1. adequacy and appropriateness of the design of the project in light of the circumstances and existing information at the time of formulation, i.e. the extent to which the outputs were derived from an accurate assessment of needs, and if project activities proposed would contribute to the achievement of the outputs;
2. implementation of the project activities, in quality and quantity, and to the extent possible, the impact of activities on the beneficiaries;
3. extent to which gender issues have been taken into account and the extent to which stakeholders have benefited from, and participated in, all stages of the project formulation and implementation;
4. extent to which the project has contributed to national capacity building;
5. adequacy, relevance and cost-effectiveness of technical assistance (Chief Technical Adviser, Technical Support Services and Country Support Team Advisers and national advisers);
6. adequacy and effectiveness of the roles and responsibilities (including the management of resources) of UNFPA, and implementing agencies, and noting the UNFPA management structure;
7. the extent and feasibility of collaboration and co-ordination with other donors;
8. sustainability of project achievements after completion of the project period;
9. achievements, constraints, and lessons learned from the project, which will be useful in addressing challenges for future programming.

The Evaluation is expected to cover various activities undertaken in the project such as training, service delivery, monitoring mechanisms, contraceptive and drugs supply and logistics, IEC and activities related to strengthening of data base. The Evaluation Team is also expected to review the following:

1. the extent to which the project has been able to accomplish training/retraining (both in- and out-of-country) of health workers in the general area of RH with particular emphasis on BS (health workers include Basic Health Workers, Health Managers, as well as Community Health Volunteers), and training of non-medical staff in IUD insertion; the extent of staff turn-over and its implications for training. The appropriateness and adequacy of different types of training materials developed for the managerial level as well as the Basic Health Workers;
2. the extent to which Myanmar Maternal and Child Welfare Association (MMCWA) has been strengthened through training programmes for their members at the Divisional/Township levels as well as rural health volunteers;
3. the extent to which the service delivery system has been strengthened through training and provision of equipment and supplies; whether accessibility to and acceptability of services have improved;

4. development, production and distribution of IEC materials; their use in training at various levels;
5. the extent to which BS/RH services have been integrated with general health services; identification of gaps and constraints in the delivery of services The extent to which gender concerns, quality of care concerns and sustainability issues have been addressed in the project;
6. the extent to which awareness concerning HIV/AIDS/STDs has been raised, and preventive and curative STDs services integrated with RH/BS services;
7 the extent to which project has been able to co-ordinate birth spacing activities with UN, NGOs, civil society, and private sector partners;
8. provision of equipment to different components of the BS project; procurement and supply of contraceptives and drug supplies; problems encountered in storage and distribution;
9. the establishment of appropriate monitoring and evaluation procedures and mechanisms; their functioning; and identification of constraints. Operational issues related to service delivery, such as recording and reporting requirements, staff workload, transportation, communication, client interaction and satisfaction, adequacy of commodities, etc.;
10. strengthening of data base at both national and sub-national levels with respect to all aspects of RH; attempts in obtaining important indicators such as TFR, CPR, IMR, MMR as well as establishing prevalence of other RH components; and with particular reference to the surveys and assessment missions, conducted by the project;
11. evidence regarding improved contraceptive acceptability and practice, whether there are indications of improvements in maternal death and unsafe abortion situations;
12. adequacy of the monitoring and evaluation components of the projects; their design, implementation and follow-up.

APPENDIX B: INDIVIDUALS CONTACTED AND SITES VISITED

Government
Ministry of Health
Department of Health
Dr. Soe Aung, Deputy Director General (Public Health / Disease Control)
Dr. Win Myint, Assistant Director (Basic Health School)
Dr. Thet Thet Zin, Assistant Director (School Health)
Dr. Theingi Myint, Medical Officer

Mandalay
Divisional Health Office
Dr. Aye Aye Myint Deputy Director
Dr. Than Tun Myint, Team leader, Nutrition

Mandalay General Hospital
Dr. Daw Khin Mi Mi Lwin, Obstetrician & Gynaecologist (O/G)
Dr. Daw Khin Thein Oo, O/G
Dr. Saw Lwin, Lecturer, O/G
Dr. Kyi Kyi Myint, Demonstrator, O/G

Amarapura
Amarapura Hospital
Dr. Zaw Win, Township Medical Officer
Dr. Mya Mya Mon, Assistant Surgeon

MMCWA
Daw Tin Tin Aye, Secretary
Daw Su Thet Khine, Joint Secretary
Daw Myint Myint Than, Chairman, Amarapura Township

Shwe Kyet Yet
RHC
U Bo Ni, Health Assistant (HA)
Daw Aye, Lady Health Visitor (LHV)

MCWA
Daw Kyu Kyu Sein, President
Daw Ye Ye Win, Member

Sagaing
Sagaing Hospital
Dr. Kyaw Shein, Divisional Health Director
Dr. Soe Lwin Nyein, Assistant Director
Dr. Khin San, Nutrition Team Member

MCWA
Daw Than Than Oo, Secretary, Divisional Supervisory Committee
Monywa
Dr. Daw Mya Yee, Deputy Divisional Health Director
Dr. Than Tun, Team Leader, STD

Myinmu
Dr. Zaw Zaw, Township Health Officer

Chaung Oo
Dr. Nu Nu Aye, Human Development Officer (HDO)
U Hoke San, HDO

Nyaung-Oo
Hospital
Dr. Nwe Ni, Township Health Officer
Dr. Naw Lay Paw, O/G

MCWA
Daw Ni Ni, Patron
Daw Nyunt Shwe, Chairman (Township)
Daw Myint Myint Than, Secretary (Township)
Daw Sit May, Chairman, Pagan (Sub-Association)
Daw Saw Ohmmar, Joint Secretary, Pagan
Daw Nyunt Nyunt Htay, Secretary, Sint-Ku
Daw San Mya, Joint Secretary, Sing-Ku

Gantgar RHC
U Kyaw Win, HA
Daw Naw Tha Wah, LHV
Daw Tin Tin Ohn, MW

Department of Health Planning
Daw Htay Htay Aye, Director
Dr. U Soe Myint, Director
Dr. Daw Khin Than Oo, Deputy Director, Central Health Bureau
Dr. Pe Thet Htoon, Assistant Director

Central Women's Hospital
Dr. Katherine Ba Thike, Obstetrician & Gynaecologist
Dr. Tracy Sein, Prof: Preventive and Tropical Medicine

Ministry of Immigration and Population, Population Department
U Tin Yee, Director General
U Myo Min, Dy. Director General
Daw Khin May Aung, Director
Daw Soe Soe Aung, Director
Daw Tin Tin Nyunt, Adviser
Daw Tin Tin Myint, Dy. Director
U Min Han, Dy. Director
U Aung Than, Dy. Director
U Myint Thein, Assistant Director
U Maung Maung Myint, Assistant Director
U Nyi Nyi, Assistant Director

International NOGs
Marie Stopes International (MSI) & staff
Dr. Daw Khin Tar Tar. Programme Director

Dr. Ye Mon Myint, Programme Manager

Population Services International Myanmar (PSI) & staff
Mr. Steven Honeyman, Country Representative
Dr. Tin Maung Win, Senior Programme Manager
Dr. Nyo Nyo Min, Reproductive Health Project Co-ordinator
Dr. Myint Myint Sein
Dr. Tin Aung, Research Officer
Dr. Khin Sandar Yee
Dr. Tin Oo, Project Officer, Mandalay

National NGOs
Myanmar Maternal and Child Welfare Association (MMCWA)
Prof. Daw Kyu Kyu Swe, President
Dr. Khin Win Kyu, Joint Secretary-2
Dr. U Saw Naing, Executive Director

ENVIPRO (Myanmar) Co. Ltd.
U Khin Kyu, Managing Director
U Ko Lay, Manager
Daw Cherry Aye

UN Agencies
UNDP
Mr. Patrice Coeur-Bizot, Resident Representative
Mr. James W. Rawley, Deputy Resident Representative
U Hla Myint Hpu, Programme Manager
Dr. San San Myint, Programme Manager

UNICEF
Dr. Juan R. Aguilar, Resident Representative
Ms. Rosella Morelli, Deputy Representative
Dr. Christiane Dricot d'Ans, Senior Project Officer
Mr. Christopher W. Davids, Planning Officer
Daw Khin Win Thin, Project Officer
Dr. Kyaw Win, Project Officer

WHO
Dr. Klaus Wagner, WHO Representative
Dr. Myo Paing, National Programme Officer

APPENDIX C: DOCUMENTS REVIEWED

Project Documents

- MYA/95/P02
- MYA/97/P01
- MYA/97/P02
- MYA/98/P01
- MYA/98/P02
- MYA/99/P01)
- 1996 UNFPA Programming Mission Report

Population Information

- 1991 Population Changes and Fertility Survey Report
- 1997 Fertility and Reproductive Health Survey Report
- Household Questionnaires and Individual Questionnaires (FRHS)
- Household Questionnaires and Individual Questionnaires Cross
- Border Migration and Reproductive Health Study
- Maternal Mortality Study – Prepared by ENVIPRO
- Maternal Mortality Study (draft) Report
- Report on Exploratory Trips to Enhance Accuracy of Registration
- and Current State of Maternal Mortality in Myanmar
- Study on Maternal Health, In-depth Questionnaire for Maternal Deaths
- MIS reporting and recording formats

Periodic Reports from activity managers

- Activity statement of MMCWA
- Activity statement on IEC component of Birth Spacing Project
- APR and TPR reports
- Progress Reports on MMS for TPR meeting 1998 (prepared by ENVIPRO)
- CST/TSS Mission Reports
- Supervisory and monitoring trips Reports - Back to office reports
- Abortion Study – Birth Spacing and Its Related Issues in Kayan Area,
- Yangon, Division, 1999

Training manuals and IEC materials

UNFPA Guidelines on Evaluation

- Present UNICEF Country Programme
- (Draft) Strategy Paper for Myanmar – UNICEF Country Programme, 2001-2005
- (Draft) Situation Analysis of Children and Women in Myanmar, August 1999
- Handbook on Human Development Indicators, 1998
- UNDP Human Development Report 1998
- Needs Assessment on Contraceptive Method Mix with WHO

National Health Plan

- Draft National Population Policy
- National Plan of Action (Draft) for ICPD, Programme of Action

World Bank Economic Mission Report, Yangon, Myanmar (Draft)

- June 14-30, (Aide Memoire and Part I – Human Development : An Overview)
- Country Report for Myanmar (3rd quarter 1998, & 2nd quarter 1999), prepared by The Economic Intelligence Unit, UK

Reproductive Health

- Implementing the Reproductive Health Vision: Progress and Future, Challenges for UNFPA, June 1999
- MYA/94/P01: Reports on "Women's Reproductive Health" and "Study on Contraceptive Acceptability"
- 1998 Reproductive Health Needs Assessment Report
- Contraceptive Acceptability Study, MYA/94/P01, DOH/DMR/UNFPA, January 1998

- HIV/AIDS
- UNAIDS National Strategy to Support HIV/AIDS Prevention and Care in Myanmar, 1999-2001 (Draft)
- A Synthesis of Social, Behavioural and Economic Research Studies on HIV Infection and AIDS Conducted in Myanmar

DESCRIPTION	1996		1997		1998		1999		Total		
	Budg	Exp	Budg	Exp	Budg	Exp	Budg	Exp	Budg	Exp	Balance
Personnel	194,550	141,078	209,980	154,790	256,050	168,380	215,000		875,580	464,248	411,332
CTA	80,000	80,000	100,000	100,000	100,000	113,560	100,000		380,000	293,560	86,440
Administrative Support Personnel	20,250	12,303	27,000	25,755	30,000	22,756	35,000		112,250	60,814	51,436
Travel (per diem for project personnel)	27,200	9,588	45,240	7,592	20,000	8,129	25,000		117,440	25,309	92,131
Mission cost	19,100	7,617	10,620	7,255	12,800	9,867	15,000		57,520	24,739	32,781
Travel (per diem for CSTF)	13,500	24,845	13,680	8,392	13,000	6,868	12,000		52,180	40,105	12,075
International Consultants	22,500								22,500	0	22,500
for FRHS					23,000		10,000		33,000	0	33,000
for RH/HS assessment					40,000				40,000	0	40,000
for Contraceptive					5,000				5,000	0	5,000
for project evaluation					2,250				2,250	0	2,250
for contraceptive req							10,000		10,000	0	10,000
National STCs	12,000	6,725	13,440	5,796	10,000	7,200	8,000		43,440	19,721	23,719
Subcontracts	219,800	117,305	354,020	343,215	209,600	216,755	156,300		939,720	677,275	262,445
FRHS	47,800	43,725	97,000	96,195	35,000	34,980	20,000		199,800	174,900	24,900
MMS	50,000	22,080	45,120	45,120	30,000	24,000	15,000		140,120	91,200	48,920
Developmt & Prod of IEC material	35,000	8,000	60,000	60,000	12,000	12,000	7,500		114,500	80,000	34,500
Strengthening MMCWA to conduct tr	25,000	12,500	22,500	22,500	15,000	15,000	33,550		96,050	50,000	46,050
Development of MIS	17,000	16,000	58,000	48,000	26,000	16,000	12,000		113,000	80,000	33,000
Construction Renovation costs	45,000	15,000	71,400	71,400	21,600	21,600			138,000	108,000	30,000
Anal& prep of FRHS main report					25,000	25,000			25,000	25,000	0
Extent related to abortion					20,000	4,000			20,000	4,000	16,000
expand training program of MMCWA					25,000	25,000			25,000	25,000	0
Hanoi B/ for I							10,000		10,000	0	10,000
BS project Evaluation seminar							750		750	0	750
Adolescent RH study							10,000		10,000	0	10,000
Study of extent & practices RE							17,500		17,500	0	17,500
Cross Border migration - RH study							30,000		30,000	0	30,000
Consultant for RH						39,175			0	39,175	-39,175
Training Component	184,400	24,590	192,650	87,249	78,600	78,559	34,500		490,150	190,398	299,752
High level workshop for project	2,000	1,476							2,000	1,476	524
Long-term fellowships	20,000		53,000		53,000	57,013			126,000	57,013	68,987
Ten short-term fellowships	20,000	18,735	34,000	26,338					54,000	45,073	8,927
Annual seminar to Review & Evaluate	7,000		750		500				8,250	0	8,250
Workshops on IEC Materials & RHHS	3,000	379	4,500						7,500	379	7,121
Prog Indicators											
Training of Trainers, BS/MCH	28,000	4,000	7,000	6,650					35,000	10,650	24,350
Training of Township/Rural Health	96,000		74,200	41,040					170,200	41,040	129,160
Attachment Training in Bangkok	8,400		19,200	13,221					27,600	13,221	14,379

DESCRIPTION	1996		1997		1998		1999		Total		
	Budg	Exp	Budg	Exp	Budg	Exp	Budg	Exp	Budg	Exp	Balance
Refresher Training for Trainer					3,500				3,500	0	3,500
Refresher Training for BHWs and					21,600	21,546			21,600	21,546	54
Seminar on Adolescent RH							750		750	0	750
RH indicator reg. Meeting							4,500		4,500	0	4,500
TPR Meeting							750		750	0	750
Refresher tr. For Sr. Health							3,500		3,500	0	3,500
Refresher tr for Basic Health							25,000		25,000	0	25,000
Equipment , other	716,355	642,124	193,000	220,416	384,500	459,099	522,000		1,815,855	1,321,639	494,216
Expenable Equipment	94,220	59,394	15,000	2,697	30,000	34,364	17,000		156,220	96,455	59,765
Printing materials											
Drugs and medical supplies											
RH/FHS books,reference materials,Journals for Reference use											
IUD insertion kits											
Non-expendable Equipment	250,300	258,920			4,500	14,778	5,000		259,800	273,698	-13,898
Data Processing Equipment	30,000	29,962							30,000	29,962	38
Equipment for surgical contraception	56,800	87,295							56,800	87,295	-30,495
Audio Visual Equipment and Printing Machines	40,000	39,762							40,000	39,762	238
Vehicles	106,000	83,916							106,000	83,916	22,084
Office equipment	17,500	17,985							17,500	17,985	-485
Contraceptives	371,835	323,810	178,000	217,719	350,000	409,957	500,000		1,399,835	951,486	448,349
Condoms	40,185	37,458	8,000		30,000		5,000		83,185	37,458	45,727
Pills	188,175	148,236	50,000	47,000	140,000	140,176	170,000		548,175	335,412	212,763
IUDs	21,875	16,952	30,000	28,110	30,000		30,000		111,875	45,062	66,813
Injectables	121,600	121,164	90,000	142,609	150,000	269,781	295,000		656,600	533,554	123,046
Miscellanious	28,600	3,313	27,200	14,069	21,200	12,988	19,450		96,450	30,370	66,080
Operation and maintenance of Eqt	10,000	13	15,000	9,893	10,000	6,476	10,000		45,000	16,382	28,618
Repair & printing costs	2,000								2,000	0	2,000
Sundry	15,000	3,300	11,000	4,176	10,000	6,512	6,450		42,450	13,988	28,462
Audit Fee	1,600		1,200		1,200		3,000		7,000	0	7,000
TOTAL	1,343,705	928,410	976,850	819,739	949,950	935,781	947,250		4,217,755	2,683,930	1,533,825

APPENDIX E: EXPENDITURES, UNFPA BIRTH SPACING PROJECT, 1996-1999

	Description	1996 Exp	1997 Exp	1998 Exp	1999 Budg	Total Exp	Percent Distribution
ADMINISTRATION		165,872	62,067	69,018	136,662	433,619	11.9%
A	Administrative Support Personnel	12,303	25,755	22,756	35,000	95,814	2.6%
A	Travel (per diem for project personnel)	9,588	7,592	8,129	25,000	50,309	1.4%
A	Mission cost	7,617	7,255	9,867	15,000	39,739	1.1%
A	CST TravPD MIS/R 66%	16,398	5,539	4,533	7,920	34,389	0.9%
A	CST TR/PD Admin 6.6%	1,640	554	453	792	3,439	0.1%
A	Hono IC for Evaluation of project				10,000	10,000	0.3%
A	BS project Evaluation seminar				750	750	0.0%
A	High level workshop for project	1,476				1,476	0.0%
A	TPR Meeting				750	750	0.0%
A	Vehicles	83,916				83,916	2.3%
A	Office equipment	17,985				17,985	0.5%
A	Operation and maintenance of Eqt	13	9,893	6,476	10,000	26,382	0.7%
A	Sundry	3,300	4,176	6,512	6,450	20,438	0.6%
A	Audit Fee				3,000	3,000	0.1%
A	Expendable equipment Admin	11,637	1,303	10,292		23,232	0.6%
A	Expendable equipment				17,000	17,000	0.5%
A	Non-expendable equipment				5,000	5,000	0.1%
CONTRACEPTIVES		323,810	217,719	409,957	500,000	1,451,486	40.0%
C	Condoms	37,458			5,000	42,458	1.2%
C	Pills	148,236	47,000	140,176	170,000	505,412	13.9%
C	IUDs	16,952	28,110		30,000	75,062	2.1%
C	Injectables	121,164	142,609	269,781	295,000	828,554	22.8%
IEC		75,561	70,420	34,489	18,100	198,570	5.5%
I	CTA IEC 10%	8,000	10,000	11,356	10,000	39,356	1.1%
I	CST TR/PD IEC 5%	1,242	420	343	600	2,605	0.1%
I	Audio Visual Equipment and Printing Machinery	39,762				39,762	1.1%
I	Developent & Prod of IEC material	8,000	60,000	12,000	7,500	87,500	2.4%
I	Expendable equipment IEC	18,557		10,790		29,347	0.8%
MIS/RESEARCH		159,767	255,111	211,291	189,750	815,919	22.5%
R	CTA MIS/Research 60%	48,000	60,000	68,136	60,000	236,136	6.5%
R	Consultant for RH:Assessment mission			39,175		39,175	1.1%
R	International Consultants: FRHS				10,000	10,000	0.3%
R	Int. Cons. for contraceptive req				10,000	10,000	0.3%
R	National STCs: MIS		5,796			5,796	0.2%
R	FRHS	43,725	96,195	34,980	20,000	194,900	5.4%
R	MMS	22,080	45,120	24,000	15,000	106,200	2.9%
R	Development of MIS	16,000	48,000	15,000	12,000	92,000	2.5%
R	Anal& prep of FRHS main report			25,000		25,000	0.7%
R	Extent related to abortion			4,000		4,000	0.1%
R	Adolescent RH study				10,000	10,000	0.3%
R	Study of extent & practices RF				17,500	17,500	0.5%
R	Cross border migration - RH study				30,000	30,000	0.8%
R	Seminar on Adolescent RH				750	750	0.0%
R	RH indicator reg. Meeting				4,500	4,500	0.1%
R	Data Processing Equipment	29,962				29,962	0.8%
SERVICE DELIVERY		147,040	83,071	68,443	18,396	316,949	8.7%
S	CTA Service delivery 10%	8,000	10,000	11,356	10,000	39,356	1.1%
S	CST TR/PD Service delivery 3.3%	820	277	227	396	1,719	0.0%
S	National STCs: Services	6,725		7,200	8,000	21,925	0.6%
S	Construction/Renovation costs	15,000	71,400	21,600		108,000	3.0%
S	Equipment for surgical contraception	87,295				87,295	2.4%
S	Expendable equipment Drugs	29,200	1,394	28,060		58,654	1.6%

	Description	1996	1997	1998	1999	Total	Percent
		Exp	Exp	Exp	Budg	Exp	Distribution
TRAINING		56,359	131,352	142,583	84,342	414,636	11.4%
T	CTA : Training 20%	16,000	20,000	22,712	20,000	78,712	2.2%
T	CST : TrPD Training 19.1%	4,745	1,603	1,312	2,292	9,952	0.3%
T	Strengthening MMCWA to conduct tr:	12,500	22,500	15,000	33,550	83,550	2.3%
T	expend training program of MMCWA			25,000		25,000	0.7%
T	Long-term fellowships			57,013		57,013	1.6%
T	Ten short-term fellowships	18,735	26,338			45,073	1.2%
T	Workshops on IEC Materials & RH/BS Prog. Indicators	379				379	0.0%
T	Training of Trainers, BS/MCH	4,000	6,650			10,650	0.3%
T	Training of Townships/Rural Health		41,040			41,040	1%
T	Attachment Training in Bangkok		13,221			13,221	0.4%
T	Refresher Training for BHWs and			21,546		21,546	0.6%
T	Refresher tr. For Sr. Health				3,500	3,500	0.1%
T	Refresher tr for Basic Health				25,000	25,000	0.7%
TOTAL		928,410	819,739	935,781	947,250	3,631,180	100.0%
Percentage		25.6%	22.6%	25.8%	26.1%	100.0%	

APPENDIX F: BIRTH SPACING/REPRODUCTIVE HEALTH SERVICES

Antenatal Care	Area Coverage
1. Counseling and education for breast feeding, Nutrition, BS, rest, exercise etc.	Community, RHC, Upper
2. Detection and referral/ management for complications	Community, RHC, Upper
3. Immunizatiobn for Tetanus prevention	Community, RHC, Upper
4. Treatment of Malaria, Tuberculosis	Community, RHC, Upper
5. Provision of AN care	Community, RHC, Upper
6. Provision of ferrous sulphate	Community, RHC, Upper
7.Diagnosis treatment of RTIs & STDs	RHC, Upper
Delivery Services	
1. Clean home delivery with delivery kits	Community, RHC
2. Institutional delivery services	Upper
3. Recognition of danger signal & referral	Community, RHC
4. Supervision of home deliveries	Community, RHC
5. Treatment for infection	Sub-center
6. Management of referral cases & feedback to referral sources	MCH, Upper
7. Treatment of pregnancy complications	Upper
8. Management of obstetrical emergencies	Station/Township/District
Postpartum Services	
1. PN care (5 Visits:<24hr.,7-10 days & 5-6 wks)	Community, RHC, Upper
2. Breast-feeding support	Community, RHC, Upper
3. BS counseling & services	Community, RHC, Upper
4. Nutrition education & Supplements	Community, RHC, Upper
5. Treatment of puerperal sepsis	Community, RHC, Upper
6. Management of neonatal hypothermia	Community, RHC, Upper
7. Management of low birth weight infants by feeding, temperature control & infection prevention methods	Community, RHC, Upper
8. Outreach care within 24 hrs of delivery	Community, Sub-RHC
9. Treatment for some & referral for other complications	Community, RHC

10. Management for mild & moderate asphyxia of the new-born	Community, RHC
11. Management of women referred with complications	RHC, MCH, Upper
12. Management of referred cases & feedback to referral source	RHC, MCH, Upper
13. Resuscitation for asphyxia of the new-born	RHC, MCH, Upper
14. PN care (5 Visits:<24hr.,7-10 days & 5-6 weeks)	Community, RHC, Upper
Birth Spacing Services	
1. Community mobilization & education.	Community, Sub-center
2. Provide pills, injectables & condoms. Insertion of IUD after screening for contraindications.	Community, RHC, Upper
3. Counseling mgt. & referral for side-effects, method related problems, & method switch.	Community, RHC, Upper
4. Referral for tubal ligation.	Community, RHC, Upper
5. BS counseling for women with complications and induced abortion	Upper (Hospitals)
RTIs &STDs	RHC, MCH
1. Referral of women with vaginal discharge, lower abdominal pain, genital ulcers, and men with urethral discharge, genital ulcers, and swelling in the scrotum or groin	Upper (Hospitals)
2. Management of referred cases and feed back to referral source	Community, sub-centre
3. Diagnosis and treatment of some infections and referral of others	Upper (Hospitals)
4. Limited laboratory diagnosis and treatment	
RH/Adolescents Care	Community, sub-centre
1. Life skill training in selected townships (69)	

APPENDIX G: TENTATIVE LIST OF INDICATORS FOR BIRTH SPACING

Policy Indicator

1. National policy for the provision of contraceptives at nominal cost or without charge.

Input Indicators:

1. Number of contraceptive methods available at Service Delivery Points.
2. Contraceptives supply, demand and use situation for effective resource utilization.
3. Percentage of AN care coverage.
4. Percentage of PN care coverage.
5. Percentage of deliveries attended by trained birth attendants.
6. Percentage of Married Women of Reproductive Age (MWRA) receiving health education and counselling services on birth spacing.
7. Percentage service delivery of contraceptive methods by service-oriented programme for MWRA to enhance BS services to motivated couples and individuals.
8. Percentage of Service Delivery Points offering birth spacing services either directly or through referrals.
9. Ratio of Health centres/ facilities : Population
10. Ratio of Basic Health Staff/ HRH : Population
11. Efforts in terms of facilities and financing system ensuring supplies for sustainability

Process / Output Indicators:

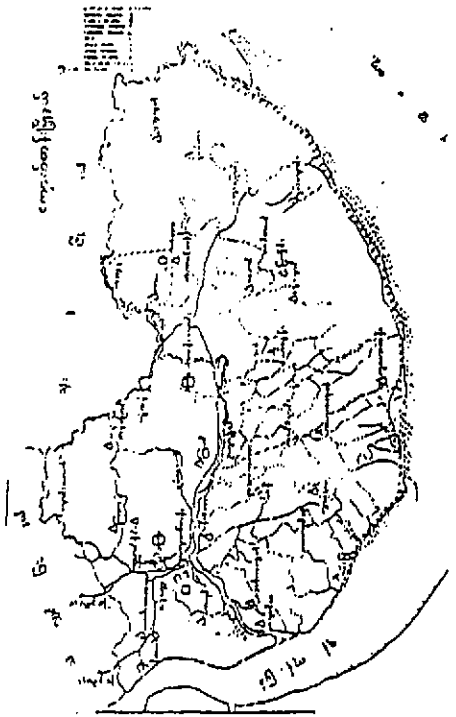
1. Contraceptive Prevalence Rate (CPR).
2. Users' practice pattern of BS methods / contraceptive behaviour of couples.
3. Associated risk factors of birth spacing methods.
4. Acceptance rate percent of MWRA.
5. Discontinuation rate percent of users of a method.
6. Demographic effects on the population in terms of births averted among contraceptive users.
7. Benefits of birth spacing to individual couples.
8. Percent of close birth intervals (pregnancy within 24 months after the last confinement) among registered AN mothers.

Impact Indicators:

1. Abortion rate.
2. Maternal Mortality Rate.
3. Infant Mortality Rate.
4. Under 5 Mortality Rate.
5. Neonatal Mortality Rate.
6. Protein Energy Malnutrition Rate.
7. Crude Birth Rate.
8. Crude Death Rate.
9. Population Growth Rate.
10. Gross National Product per capita.

REPRODUCTIVE HEALTH
(Birth Spacing Programme)

Township Kyauktan :Division Yangon
Project Started 1992
Funding Agency UNFPA
Male-67847 ,Female- 69362 ,Total-137209
15-49 Yr- 63116, Sex Ratio- 98:CPR=64%



Symbols of Health Institutions
Specialist Hospital
General Hospital
UHC
School Health
Secondary Health Center

1.BIRTH SPACING TRAINING

Sr. No	TRAINING	VENUE	TRAINEE (Number)	PERIOD
1.	Divisional Level	DOH	1	3
2.	Township Level	TMO	35	3
3.	NGO's	TMO	12	1
4	RHC Level NGO's & VHW	RHC Wise	56	1

2.USERS OF BIRTH SPACING

1.	Registered ELCO	16581
2.	Current User	10673
3.	Non Current User	5908
4.	Never User (potential)	1401
5.	Never User (Non potential)	583
6.	Contraceptive Acceptance (Project Clients)	4218
7.	Health Education (Frequencies)	916
8.	Health Education (No of population attendance)	-
9.	CCS funds at (30/9/98)	606445

3.IMPACT INDICATORS

	1995	1996	1997
1.Abortion Rate %	-	-	-
2.M.M.R	0.7	1.4	1.46
3.I.M.R	12.1	21.9	21.6
4.<5 M.R	-	-	6.7
5.L.B.W Rate	-	-	-
6.C.B.R	18.0	20.9	15.0
7.C.D.R	3.5	2.8	2.3

4.DRUG/COMMODITY STATUS
as at 30 th. SEPT., 1998
(Contraceptive Utilization)

HEALTH CENTER	Pills	Injection	IUDC	CONDOM
MCH	584	730	141	6
RHC1	408	324	125	84
RHC2	846	1059	112	45
RHC3	721	751	53	-
RHC4	516	487	15	5
RHC5	1079	605	49	12
RHC6	565	743	60	24
Total	4719	4699	555	176

5.USER STATUS as at 30 th. SEPT..,1998
(Contraceptive Clients)

HEALTH CENTER	Pills	Injection	IUDC	CONDOM
MCH	89	306	382	-
RHC1	222	206	20	-
RHC2	238	323	23	-
RHC3	196	290	-	-
RHC4	164	296	-	18
RHC5	333	401	10	-
RHC6	345	556	-	-
Total	1587	2178	435	18

6.BIRTH SPACING COMMODITIES
as at (30/9/98)

	Date	Pills	Inj	IUDC	Condom	Glove	IUD Kit
RECEIVED	1992	6000	300	300	-	-	-
	1994	70000	12000	1700	-	-	-
	1995	-	-	-	-	-	-
	1996	-	-	-	-	-	-
	1997	-	1500	-	-	-	-
	1998	1200	2350	-	-	-	-
Total Rece:		77200	16150	2000	-	-	-
Distributed		52659	15672	569	-	-	-
BALANCE	Main Sto:	13657	-	1003	1274 6	-	-
	MCH	439	24	83	-	-	-
	RHC1	1345	121	75	-	-	-
	RHC2	2185	41	180	-	-	-
	RHC3	1674	82	-	-	-	-
	RHC4	2454	10	-	-	-	-
	RHC5	2127	91	90	-	-	-
	RHC6	660	109	-	-	-	-
Total		24541	478	1431			

January (1999)

State Division	Township Name	Users					ELCO	PCP	Drugs								Cash	
		Pills	Inject	IUD	Condom	Total		%	Pills		Injection		IUD		Condom		Received	Total
									Used	Bal	Used	Bal	Used	Bal	Used	Bal		
Ayeyarwaddy	Myanaung	197	87	25	116	425	26,642	2.0	197	25	87	23	25	70	422	178		12,760
Ayeyarwaddy	Zalun	0	1,375	1,485	0	2,860	22,552	13.0	0	0	1,327	2,883	25	945	0	0		13,960
Ayeyarwaddy	Nyaungdone	3,588	867	178	620	5,253	23,979	22.0	1,501	2,971	194	2,702	9	1,202	921	6,616	17,647	190,514
Ayeyarwaddy	Ingapu	914	2,076	612	111	3,713	31,021	12.0	914	26,460	0	4,417	11	669	0	0	550	196,523
Ayeyarwaddy	Danubyu	559	395	254	22	1,230	19,659	6.0	529	2,438	90	256	11	284	305	711	17,390	17,390
Ayeyarwaddy	Kyonepyaw	509	240	195	23	967	28,757	3.0	543	2,170	205	1,877	22	1,079	428	1,866		15,730
Ayeyarwaddy	Kyangin	206	145	26	0	377	13,549	3.0	257	43	138	208	6	29	0	0	13,825	155,056
Ayeyarwaddy	Patanaw	1,246	1,069	499	404	3,218	24,160	13.0	172	1,261	170	1,343	10	866	478	10,678	0	19,850
Ayeyarwaddy	Yegi	2,349	1,105	297	38	3,789	24,398	16.0	440	446	343	479	6	246	150	117	19,160	409,709
Bago	Nyaunglebin	351	302	27	0	680	38,678	2.0	351	3,076	302	1,059	27	649	17	2,645	0	21,380
Bago	Daik-U	1,340	816	304	70	2,530	17,579	14.0	852	2,162	31	159	64	1,089	1,260	2,382	0	25,775
Bago	Bago	2,682	1,197	351	258	4,488	41,893	11.0	196	278	367	5,428	22	779	20	488	21,550	351,178
Bago	Oaktwin	890	299	1	53	1,243	14,584	9.0	839	4,408	286	1,363	1	247	50	3,989	23,625	23,625
Bago	Shewdaung	1,239	1,874	214	30	3,357	16,913	20.0	279	232	403	244	28	165	167	934	28,697	562,440
Bago	Natalin	1,199	737	49	36	2,021	20,995	10.0	522	3,065	158	1,348	0	301	30	504	29,820	461,305
Bago	Htantabin	2,101	1,426	16	304	3,847	13,654	28.0	0	0	0	0	0	0	0	0	0	19,198
Bago	Pyay	2,190	2,306	58	95	4,649	26,670	17.0	0	1,300	36	0	3	449	288	7,975	2,670	355,975
Bago	Paungde	1,332	1,035	26	225	2,618	16,090	16.0	137	576	315	1,774	0	874	636	1,981	0	17,296
Bago	Waw	398	442	33	48	921	17,108	5.0	185	741	210	360	2	16	61	2,997	2,200	66,564
Bago	Monyo	495	984	444	87	2,010	16,051	13.0	383	7,627	292	3,853	10	171	215	8,646	20,930	328,467
Magwe	Myaing	904	996	222	163	2,285	22,294	10.0	0	0	0	0	0	0	0	0	0	0
Magwe	Chauk	1,106	1,133	1,015	1,030	4,284	28,296	15.0	750	2,208	247	5,743	114	130	303	1,880	43,500	483,350
Magwe	Taungdwingyi	2,236	1,211	148	217	3,812	30,540	12.0	0	70	1,280	5,110	685	45	0	0		488,329
Magwe	Yenangyaung	491	227	1	10	729	6,265	12.0	491	3,153	227	1,320	1	447	10	1,471		14,145
Magwe	Yesagyo	1,102	290	116	55	1,563	17,460	9.0	0	3,250	0	20	0	743	0	4		0
Magwe	Pwintphyu	325	0	15	0	340	19,515	2.0	325	755	0	0	15	440	0	0	3,125	477,325
Mandalay	Myiitha	1,913	1,236	229	93	3,471	19,048	18.0	2,264	9,320	385	1,842	25	741	288	15,504	49,988	397,911
Mandalay	Mahlaing	1,880	447	94	3	2,424	17,154	14.0	1,880	5,501	182	1,285	0	1,293	300	11,950	18,560	243,710
Mandalay	PyinOoLwin	339	1,269	42	10	1,660	19,233	9.0	200	850	400	6,090	2	166	0	489		34,910
Mandalay	Singaing	1,288	193	1	153	1,636	14,163	12.0	0	3,150	0	4,600	0	944	0	720		579,624
Mandalay	Tatkone	135	448	33	24	640	4,702	14.0	659	0	130	0	30	841	0	0		278,579
Mandalay	Nahtogyi	875	658	641	46	2,220	21,421	10.0	877	5,179	306	662	39	419	630	6,818	47,910	393,799
Mandalay	Patheingyi	1,280	1,028	40	156	2,504	15,472	16.0	816	5,159	233	1,960	0	1,099	15	1,273		19,825
Mandalay	Nyaung-Oo	1,163	1,536	458	93	3,250	28,544	11.0	1,158	1,764	541	216	10	43	187	1,630	0	0
Mandalay	Amarapura	694	1,353	155	61	2,263	15,115	15.0	612	3,482	343	4,035	118	895	520	11,435	47,397	362,067
Mandalay	Wundwin	1,652	1,261	93	33	3,039	24,521	12.0	1,485	5,877	395	1,029	0	0	140	3,850		45,175
Rakhine	Sittwe	312	579	6	23	940	23,470	4.0	0	0	1,400	2,670	45	405	0	57	70,000	180,455
Sagaing	Ayadaw	2,087	1,165	0	0	3,252	19,880	16.0	1,552	4,871	237	1,141	0	0	0	0		502,406
Sagaing	Wetlet	103	660	666	3	1,432	24,355	6.0	103	203	183	548	25	480	25	11,802	23,485	500,049
Sagaing	Khin-U	268	430	34	658	1,390	15,787	9.0	39	670	312	519	69	83	780	3,928	21,000	16,861

9/15/99

January (1998)

State Division	Township Name	Users							Drugs								Cash	
		Pills	Inject	IUD	Condom	Total	ELCO	PCP %	Pills		Injection		IUD		Condom		Received	Total
									Used	Bal	Used	Bal	Used	Bal	Used	Bal		
Sagaing	Ngazun	402	205	72	200	879	13,950	6.0	848	652	1,289	3,880	73	0,475	0	200	0	20,940
Sagaing	Taze	1,464	1,199	217	47	2,927	16,455	18.0	261	394	157	214	7	101	35	540	0	10,303
Sagaing	Salingyi	692	566	0	0	1,258	12,906	10.0	0	0	0	0	0	0	0	0	0	0
Shan	Lashio	227	51	2	36	316	2,574	12.0	160	9,049	142	3,285	4	816	327	8,177	0	5,525
Shan	Tachileik	133	287	3	41	464	8,474	5.0	190	8,466	300	350	0	0	180	13,230	4,912	75,248
Shan	Thipaw	161	702	22	2	887	5,250	17.0	164	2,213	189	3,615	21	1,015	0	16,818	0	25,560
Taninthayi	Dawei	325	1,091	14	183	1,613	6,564	25.0	150	401	90	501	0	684	250	5,275	0	0
Taninthayi	Kawthaung	107	457	3	9	576	8,538	7.0	94	407	201	280	1	28	90	1,312	0	22,920
Yangon	Twante	1,147	712	88	133	2,080	22,433	9.0	19	0	477	4,943	0	1,002	0	500	24,020	181,545
Yangon	Thonegwa	89	61	5	35	190	3,074	6.0	97	3,446	63	226	35	1,071	5	13,928	8,810	506,760
Yangon	Htantabin	790	1,477	56	54	2,377	12,962	18.0	123	0	740	2,560	0	174	288	3,641	24,078	217,304
Yangon	Taikkyi	833	1,239	34	170	2,276	28,565	8.0	625	111	483	146	1	54	135	15	0	34,000
Yangon	Hmawbi	640	287	65	12	1,004	11,981	8.0	557	1,677	156	640	3	390	60	220	27,310	58,570
Yangon	Kyauktan	1,061	1,539	459	0	3,059	15,916	19.0	1,061	19,864	237	3,468	1	1,418	260	12,176	28,260	716,415
Yangon	Kungyangone	985	1,006	299	87	2,377	12,098	20.0	1,022	1,357	47	346	4	576	236	1,640	12,185	243,50
Yangon	Kawhmu	1,640	1,350	408	208	3,606	14,424	25.0	9	0	0	4,000	7	642	180	2,550	805	308,895
Yangon	Hlegu	4	533	17	0	554	14,374	4.0	4	0	183	351	17	317	0	1,469	17,145	25,265
Yangon	Khayan	2,159	252	12	118	2,541	17,718	14.0	2,159	3,270	252	4,005	12	429	118	4,487	43,008	43,008
Grand Total		56,817	7,911	0,879	6,706	122,314	070,423	11.4	29,091	166,048	3,761	1,376	1,646	8,636	10,810	215,696	713,519	1,008,982

		Users						Drugs									Cash	
									Pills		Injection		IUD		Condom			
State/Division	Township Name	Pills	Inject	IUD	Condom	Total	ELCO	CPR %	Used	Bal	Used	Bal	Used	Bal	Used	Bal	Receipt	Total
Ayeyarwaddy	Zalun	976	1502	1471	0	3949	22552	17.51	980	3020	2545	1665	348	622	0	0	0	13960
Ayeyarwaddy	Ingapu	2022	934	656	111	3723	31021	12.00	7622	23006	0	4917	55	614	0	0	7257	443282
Ayeyarwaddy	Kyangin	0	173	4	0	0	13549	0.00	522	43	693	74	11	22	0	1440	61050	209206
Ayeyarwaddy	Yegi	1511	1431	328	51	3321	24158	13.75	761	100	2264	367	44	234	1147	119	102146	269091
Ayeyarwaddy	Danubyu	1033	681	336	7	2057	19773	10.40	2520	2738	646	207	59	266	461	655	55230	22760
Ayeyarwaddy	Patanase	1392	1331	636	436	3795	25517	14.87	926	4747	1202	4811	183	779	2597	8556	87415	14390
Ayeyarwaddy	Nyaungdone	3851	977	322	675	5825	24332	23.94	6240	4078	1793	5892	218	1055	4867	3634	153697	296612
Ayeyarwaddy	Kyonepyaw	463	126	157	107	853	28800	2.96	1812	901	654	5428	89	1012	1036	1278	41110	56840
Ayeyarwaddy	Myanaung	0	383	1	55	439	26642	1.65	269	37	1011	529	77	233	2482	778	0	25440
State/ Division Total		11248	7538	3911	1442	23962	216344	13.80	21652	38670	10808	23890	1084	4837	12590	15960	510905	1351581
Bago	Bago	2815	1955	471	189	5430	41905	12.96	1245	3126	1853	2962	105	660	204	204	150759	259704
Bago	Minhla	345	150	5	0	500	5705	8.76	518	420	150	10	0	1500	0	0	7540	8400
Bago	Daik-U	4435	1771	301	58	6565	20082	32.69	4031	150	768	207	259	1034	4326	1440	57002	41320
Bago	Yedashe	1039	1509	142	0	2690	24322	11.06	140	148	552	2851	5	1156	144	12990	24910	419090
Bago	Waw	436	520	40	25	1021	17021	6.00	635	901	551	319	13	5	111	2947	32350	96714
Bago	Oaktwin	739	144	0	372	1255	13381	9.38	4190	1425	1192	446	1	720	1265	3595	75781	13099
Bago	Monyo	793	1027	625	91	2536	16051	15.80	4555	2055	2333	2312	155	426	2048	6913	195249	492786
Bago	Natalin	1231	805	57	36	2129	21309	9.99	2051	2454	871	1518	8	293	68	610	148983	610652
Bago	Nyaunglebin	359	137	20	101	617	17817	3.46	1972	5514	1527	3518	255	626	349	2260	22535	13858
Bago	Htantabin	1927	1984	34	241	4186	13654	30.66	1260	689	2664	1155	16	223	670	168	0	34305
Bago	Pyay	2256	2433	118	128	4935	26670	18.50	1825	275	2298	238	66	830	4997	3272	186748	540043
Bago	Paungde	1276	1139	26	251	2692	16114	16.71	482	231	1001	1088	0	874	1548	1069	0	13982
Bago	Shwedaung	1484	2221	277	30	4012	16980	23.63	2719	792	3676	250	123	186	2232	628	168438	784755
State/ Division Total		19135	15795	2116	1522	38568	251011	13.80	25623	18180	19436	16874	1006	8533	17962	36096	1070291	3528708
Magwe	Yenangyo	1310	194	72	55	1611	16682	9.66	0	3280	950	1370	30	713	9	576	0	0
Magwe	Myaing	1345	1602	288	179	3414	22243	15.35	759	1103	1848	2041	70	400	89	87	132745	512229
Magwe	Taungdwingyi	2146	1645	183	179	4153	27233	15.25	79180	4000	50610	700	3545	700	62850	20950	1683513	620472
Magwe	Yenangyaung	1191	616	32	728	2567	8883	28.90	1231	653	441	712	3	466	150	2651	0	7850
Magwe	Chauk	1200	1160	1224	1000	4584	28296	16.20	2905	3784	1697	4482	302	198	2020	599	234250	701605
Magwe	Pwintphyu	0	0	3	0	3	19515	0.02	402	678	0	0	51	422	0	0	7110	179910
State/ Division Total		7192	5217	1802	2121	16332	122852	13.80	84477	13498	55546	9305	4001	2899	65109	24863	2057611	2322066
Mandalay	Tatkone	230	311	17	166	724	4702	15.40	1318	694	1025	3235	110	761	0	0	0	278579
Mandalay	Nyaung-Oo	1268	1752	440	106	3566	28544	12.49	8303	2804	4217	1524	83	790	1422	28708	0	0
Mandalay	Singaing	890	157	1	0	1048	14141	7.41	1200	4300	800	4100	23	581	0	720	0	539624
Mandalay	Madaya	1412	754	238	1594	3998	25269	15.82	3859	6264	972	1681	71	806	2598	4596	102830	298358
Mandalay	Myittha	2103	1214	264	101	3682	19048	19.33	5092	6492	765	1462	43	723	500	15292	104054	451977
Mandalay	Mahlaing	1880	447	94	3	2424	17154	14.13	5249	5501	866	1285	1	1293	900	11950	69995	243710
Mandalay	Natogyi	1042	667	835	42	2586	21252	12.17	6911	5756	1674	3989	238	302	3780	3233	287635	633518
Mandalay	Wundwin	4169	1900	115	53	6237	24521	25.44	20014	4238	3653	1407	0	0	1496	4078	0	75765
Mandalay	PyinOolwin	439	1484	52	9	1979	19233	10.29	1168	1182	1529	1605	12	191	20	469		54910
Mandalay	Amarapura	741	1387	170	62	2360	15115	15.61	4754	5840	2073	2805	139	874	2705	9252	187633	493785
Mandalay	Patheingyi	1301	1083	43	56	2591	15472	16.75	2337	4236	700	1691	3	906	36	1288	2033	27345

State/ Division Total		15483	11136	2269	2292	31195	204451	13.80	39705	43827	18338	24790	723	7417	13455	79856	772553	3111539
Rakhine	Sittwe	338	716	24	20	1098	23470	4.68	1710	2290	3965	580	50	400	0	57	216600	327055
State/ Division Total		338	716	24	20	1098	23470	13.80	1710	2290	3965	580	50	400	0	57	216600	327055
Sagaing	Ayadaw	1282	1193	0	0	2475	19880	12.45	7335	4291	1504	943	0	0	9	0	40320	502406
Sagaing	Myinmu	1532	1931	351	156	3970	13290	29.87	122	1875	881	2361	10	3	0	0	250	650
Sagaing	Salingyi	1239	1005	0	150	2394	12906	18.55	2040	2290	825	3275	0	700	0	12802	0	0
Sagaing	Wetlet	489	899	785	32	2205	24483	9.01	697	3566	1250	3452	102	357	491	11370	157192	693511
Sagaing	Myaung	2218	1196	289	946	4649	12443	37.36	1380	80	1295	60	207	28	1008	24	133641	71401
Sagaing	Khin_U	0	0	0	0	0	15787	0.00	3472	3757	3444	1187	317	35	4704	4004	100224	31362
Sagaing	Ngazun	12	427	139	10	588	7825	7.51	1562	105	10980	2917	369	11959	283	176	0	13630
Sagaing	Taze	1159	1219	274	23	2675	16213	16.50	1844	1745	1109	3477	68	512	303	12255	52060	19075
State/ Division Total		7931	7870	1838	1317	18956	122827	13.80	18452	20709	21258	17672	1073	13594	6798	40631	483687	1332035
Shan	Tachileik	159	374	3	54	590	8474	6.96	430	8466	630	220	0	9	310	13130	33652	92497
Shan	Lashio	13	291	12	18	334	2532	13.19	1128	8555	734	6693	40	780	903	7601	0	5970
Shan	Thipaw	202	620	43	6	871	4004	21.75	748	1629	996	1808	43	993	6600	10218	79540	105109
State/ Division Total		374	1285	58	78	1795	15010	13.80	2306	18650	2360	8721	83	1782	7813	30949	113192	203576
Tanintharyi	Dawei	661	1241	19	246	2167	6673	32.47	590	300	315	276	2	682	1298	4235	0	0
Tanintharyi	Kawthaung	118	592	5	8	723	8029	9.00	259	408	602	578	3	26	180	1114	22080	23170
State/ Division Total		779	1833	24	254	2890	14702	13.80	849	708	917	854	5	708	1470	5349	22080	123170
Yangon	Kyauktan	1144	1479	490	0	3113	15916	19.56	7573	13352	1382	2823	32	1387	708	11728	180370	868525
Yangon	Kungyangone	700	758	269	303	2030	12059	16.83	3093	750	375	843	38	542	1431	2029	67440	298762
Yangon	Thonegwa	89	61	5	35	190	3074	6.18	97	3446	63	226	35	1071	5	13928	8810	506760
Yangon	Htantabin	619	1191	59	125	1994	12962	15.38	888	3215	3276	524	53	121	720	3209	90991	284217
Yangon	Khayan	211	327	7	0	545	17718	3.08	4843	955	2377	2816	87	372	2829	2136	246934	329905
Yangon	Kawhmu	1546	1931	484	209	4170	14444	28.87	9	4000	1239	2490	72	566	1112	8350	49652	385765
Yangon	Taikkyi	1736	1905	35	287	3983	27983	14.23	4285	55	3117	118	18	8	652	100	0	24700
Yangon	Hmawbi	799	327	72	11	1209	16119	7.50	4291	2173	1318	948	17	376	619	159	195074	186370
Yangon	Twante	1251	1108	100	0	2459	22433	10.96	19	0	2719	3078	12	991	0	500	144570	302095
Yangon	Hlegu	442	330	0	400	1172	14583	8.04	788	3016	796	3352	21	707	758	12509	68066	140596
State/ Division Total		8557	9417	1521	1370	20865	157291	13.80	25886	30962	16662	17218	385	6141	8834	47648	1051907	2777695
Grand Total		71037	60827	13563	10416	155661	1127958	13.80	240660	187494	149320	119904	8410	46211	134031	281109	6298831	14777425

APPENDIX K: ELCO REGISTRATION

Division	Aye	Bag	Mag	Man	Sag	T+R+S	Yan	Union
Number of Project Townships	12	15	8	12	9	6	10	72
Point Prevalance at mid year 1998								
Total Registered Number of Eligible Couples	204970	187753	207901	179827	143648	63486	129444	1117029
Total no. of eligible women by frequency of Pregnancies								
(1) No.	50832	37314	34015	34063	26429	11513	25451	219617
(2) Nos.	54946	41343	34508	35544	28734	12509	29023	236607
(3) No.	48253	55499	32670	31079	30571	11542	25838	235452
(4-5) Nos.	48703	31897	36444	37792	30268	14017	26798	225919
(6-7) Nos.	22567	13686	17669	16845	14824	6827	12374	104792
(8-10+) Nos.	10245	5142	6206	7902	6914	3613	5090	47112
Total no. of eligible women by frequency of Abortions								
(1) Time	16607	11254	6678	9824	7667	4283	10572	66885
(2) Times	6794	3918	1858	2157	1582	1621	3508	21438
(3) Times	2334	1393	583	520	453	626	1313	7222
(4-5) Times	735	291	351	179	116	576	431	2679
(6-7) Times	177	82	85	30	85	272	141	872
(8-10+) Times	53	43	36	21	16	515	61	750
Total no. of eligible women by frequency of Still Births								
(1) No.	5867	3278	3079	2333	2696	1394	2951	21603
(2) Nos.	1521	602	651	815	564	425	677	5455
(3) No.	539	240	358	353	156	209	217	2072
(4-5) Nos.	196	177	87	162	45	139	62	868
(6-7) Nos.	34	35	27	65	26	72	16	275
(8-10+) Nos.	198	160	10	24	28	37	44	501
No. of Under 5 Yr Children Deaths	22333	11245	15208	20777	15686	5760	12153	103163
No. of eligible women with no. of children alive								
(1) Child	53428	38288	33681	37854	27839	12964	23409	227463
(2) Children	56800	41555	34581	39389	29752	13548	25569	241294
(3) Children	50069	42572	32112	37296	26382	11351	21152	220934
(4 - 5) Children	39730	27728	35580	42581	28144	11446	22323	207532
(6 - 7) Children	13776	15685	19194	21965	12077	4195	7830	94722
(8 -10+) Children	4486	3161	5651	9899	3900	1802	2229	31128
No. of Current Users	71194	81159	46510	80576	68359	24040	73235	445073
No. of Non-current Users	140770	100191	107278	89905	74412	35684	50920	599160
No. of Ever User	74172	76809	46718	72836	64504	22282	53556	410877
No. of Past User in Last (6) mths	33044	48805	25944	49502	41465	14392	44420	257572
No. of Current Users by methods								
1. Pills	30141	30525	20802	23815	21499	9408	29479	165669
2. Injectables	28881	35947	16117	39126	33067	12329	35868	201335
3. IUCDs	4007	3811	4940	4712	3872	350	2326	24018
4. Condom	1064	3085	3009	1456	1062	404	1072	11152
5. Others	7101	7791	1642	11467	8859	1549	4490	42899
Source of Service								
1. Health Staff	42269	68491	36685	53796	35442	11978	33696	282357
2. GP	9863	19508	6646	15439	10211	5194	18147	85008
3. Drugs Stall	10686	8821	4189	7913	8806	4098	13395	57908
4. Neighbour	4421	8388	2638	5113	3615	2460	5665	32300
5. Others	5406	7107	3794	7547	8764	1633	3119	37370

Division	Aye	Bag	Mag	Man	Sag	T+R+S	Yan	Union
Number of Project Townships	12	15	8	12	9	6	10	72
Reasons for not using								
Want More Child	27171	16892	22681	19812	15978	11274	12089	125897
Pregnancy	15263	11257	17096	13672	9674	5582	8657	81201
Don't Know	20417	11545	20258	10001	8542	5028	9904	85695
Dislike	28619	18936	31404	17149	15663	7238	8911	127920
Others	40436	29804	17974	24015	23526	7051	12214	155020
Potential User								
1. Used past (6) mths	28421	33548	22500	48271	23957	8153	36170	201020
2. Used Occasionally in past (12) mths	21574	21749	13829	23061	14313	5562	13793	113881
3. Never Used	54096	39212	49871	27797	25377	8744	17042	222139
Non-potential User								
1. Used past (6) mths	13241	14907	24223	22524	8240	6469	9812	99416
2. Used Occasionally in past (12) mths	12970	11646	23783	14561	8952	4524	7387	83823
3. Never Used	40299	39830	37238	44022	36892	16087	20814	235182
INDICATORS								
CPR all methods	33.59	44.75	30.24	47.26	47.88	40.25	58.99	42.62
Ever User By Methods (%)								
Pills	14.22	16.83	13.53	13.97	15.06	15.75	23.74	15.87
Inj.	13.63	19.82	10.48	22.95	23.16	20.64	28.89	19.28
IUCD	1.89	2.10	3.21	2.76	2.71	0.59	1.87	2.30
Condom	0.50	1.70	1.96	0.85	0.74	0.68	0.86	1.07
Others	3.35	4.30	1.07	6.73	6.21	2.59	3.62	4.11
	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Source (%)								
Health Staff	19.94	37.77	23.85	31.56	24.82	20.06	27.14	27.04
GP	4.65	10.76	4.32	9.06	7.15	8.70	14.62	8.14
Drug Stall	5.04	4.86	2.72	4.64	6.17	6.86	10.79	5.55
Neighbours	2.09	4.63	1.72	3.00	2.53	4.12	4.56	3.09
Others	2.55	3.92	2.47	4.43	6.14	2.73	2.51	3.58
Reasons for not using (%)								
More Child	12.82	9.31	14.75	11.62	11.19	18.88	9.74	12.06
Pregnant	7.20	6.21	11.12	8.02	6.78	9.35	6.97	7.78
Don't Know	9.63	6.37	13.17	5.87	5.98	8.42	7.98	8.21
Dislike	13.50	10.44	20.42	10.06	10.97	12.12	7.18	12.25
Others	19.08	16.43	11.69	14.09	16.48	11.81	9.84	14.85
Never Users (%)	19.01	21.96	24.21	25.82	25.84	26.94	16.76	22.52

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[JR1]Can this be continued? How could they be effective if they [illegible] until Oct April

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[JR2]Need to follow up on this issue (MD): bias toward specialist [illegible] insertions

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[JR3]Also need to follow-up on the QXC issue, perhaps in the needs assessment

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[JR4]Need to follow-up to determine what, if any, supervision is provided [illegible]

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[JR5]Need to follow up to determine what is the best way to supervise and get reports from MMCWA volunteers. This could be an OR topic

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[JR6]To follow up: the effect of CCS on acceptance and continued use of IIS. Also, the overall value of the system which is not collecting enough to be of much use re sustainability