Myanmar - UNICEF Country Programme of Cooperation 2001-2005

Evaluation of Training Activities Supported by the Myanmar-UNICEF Country Programme

MID-TERM REVIEW REPORT

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

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January 2002

Myanmar-UNICEF Country Programme of Cooperation 2001-2005
Mid-Term Review Documents

I. Cross-cutting Themes

1. Review of Child Protection (reaching CNSP)
2. Addressing Protein Energy Malnutrition and Further Developing IECD
3. Programme Communication including Organizational Implications
4. Area-Focused Township Approach
5. Partnerships and the building of Civil Society

II. Management Issues

1. Assessment of Field Officers (Operational)
2. Management and Review of Work Process and Practices (teams/work process/ accountability)
3. Assessment of Health Supply Operations
4. CAG Analysis/Review including Counterpart Capacity, Reaching Inaccessible Area

III. Programme Specific Issues

1. Report on Progress Towards USI and Virtual Elimination of IDD in Myanmar
2. Assessment of Malnutrition
3. PMCT Process Review
4. Assessment of SHAPE
5. ECD Assessment
6. Child-Friendly Schools
7. Facts For Life Household Impact Assessment
8. Plan of Activities of Arsenic
9. Assessment of School Water Supply Maintenance

IV. Summary of Programme Reviews

- Health and Nutrition
- Basic Education & Children in Need of Special Protection
- Water, Environmental Sanitation & Hygiene
- Advocacy, Information & Communication
- Capacity Building for Planning & Monitoring

V. Other Relevant Reports

1. HIV/AIDS Strategic Shift
2. Evaluation of Training Activities Supported by the Myanmar-UNICEF Country Programme

Evaluation of Training Activities Supported by the Myanmar-UNICEF Country Programme

Final Report

1st Draft

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January 2002
Yangon, Myanmar

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Table of Contents

List of Acronyms

ACIS	All Children in School
AMW	Auxiliary Midwives
ANMW	Auxiliary Nurse Midwives
ATEO	Auxiliary Township Education Officer
BHS	Basic Health Staff
CAPS	Continuous Assessment and Progression System
CNSP	Children in Need of Special Protection
CPR	?
CSO	Civil Society Organization
DDA	Department of Development Affairs
ECD	Early Childhood Development
ECCD	Early Childhood Care and Development
ESSD	Essential Steps for Safe Delivery
FFL	Facts for Life
H&N	Health and Nutrition
HIV/AIDS	Human Immuno-deficiency Virus / Acquired Immune Deficiency Syndrome
IMMCI	Integrated Management of Maternal and Childhood Illnesses
JMUAG	Joint Myanmar UNICEF Advisory Group
MCH	Maternal Child Health
NCRC	National Committee on the Rights of the Child
NGO	Non-Governmental Organization
NID(s)	National Immunisation Day(s)
NSW	National Sanitation Week
PHC	Primary Health Care
PTA	Parent Teacher Association
SHAPE	School-based Healthy Living and HIV/AIDS Prevention Education
TBA	Traditional Birth Attendant
TEO	Township Education Officer
TMO	?
TPDC	?
WES	Water and Environmental Sanitation
WRUD	Water Resources Utilisation Department

Executive Summary

The CPR of the Myanmar-UNICEF Country Programme 2001-2005, approved by the Executive Board in September 2000, summarized the major evaluations that would be undertaken during the first half of the Country Programme period, which included an evaluation of UNICEF's support to training for 2001.

One of the principle strategies of the previous and current Country Programmes is to support training activities leading to a positive change in skills, practice, awareness, or behaviours. Recognizing the centrality of the strategy, and the magnitude of the support, it is critical that training activities are as efficient and effective as possible. Because support to training activities has been adopted as a capacity-building strategy in almost all country programmes, the results of this evaluation will also contribute to organizational learning.

Training activities in the following sectors were included in the evaluation: Health and Nutrition, Water and Environmental Sanitation, Education, Children in Need of Special Protection and Promotion of Facts for Life. While the evaluation was focused on the training activities in each of these sectors, a common framework and set of questions enabled conclusions to be drawn for the Country Programme as a whole.

The evaluation findings were consolidated under three major components: process, results and relevance.

The evaluation followed the "utilization-focused" approach, thereby emphasizing the involvement of stakeholders in the evaluation process, including the planning and formulation of questions, discussion of findings and results, and drafting of recommendations. A Steering Committee within UNICEF was established, which included Senior Management, Section Chiefs and relevant project officers, to oversee the evaluation. There were also teams formed for each of the five sectoral components of the evaluation, which included the participation of counterparts and partners.

Recognizing that Government counterparts were key stakeholders in the evaluation, and their involvement was critical to ensure the results would be utilized, there were regular meetings with the relevant counterparts throughout the process, and the sharing of findings was incorporated into the annual programme review process. The final step in the process was to present the major Country Programme-wide findings at the Annual Review Meeting of the Joint Myanmar UNICEF Advisory Group, which is Chaired by a senior Minister in the Government.

The evaluation used complementary methodologies including: (1) a desktop review of existing documentation, including annual reports, mid-term review (1998), ProMS output documents, Programme Plans of Actions for various years, related studies and evaluations, reports from other organizations; (2) Focus group discussion with the stakeholders on the process and results of training activities; (3) key informant interviews including UNICEF Senior Management, Sections Chiefs and Project Officers, Government officials, partners and donors. Interviews were also undertaken with trainers and trainees in various locations throughout the country, including those currently involved in training and with those who have completed training activities and are now utilizing those skills (after various time periods); (4) observation of training activities in various parts of the country supported by various programmes; (5) Review of training materials, including the process followed in their development, their appropriateness and effectiveness.

A scoring approach was used to allow comparisons, to facilitate understanding and discussions.

Findings

The overall efficiency (quality of processes) appears to have been good. Implementation was satisfactory, although monitoring was weak for some programmes. Modalities of training, instructional techniques and the materials developed for training were appropriate. The unit cost of the training activities has been estimated good or very good in all projects and programmes.

An impressive volume of outputs (nearly 1 million beneficiaries trained) was produced by the training activities during the 1998-2001 period.

For the main objective of the training activities, change in participants' knowledge, skill & attitude, which is the first level of result (or outcome), the overall result is fairly good.

For the other level of results (change in individual's performance and in organizational performances, the evaluation found two distinct patterns. The impact of training activities is good in the Water and Sanitation sector, where other key factors influenced a very successful change achieved in sanitation coverage in recent years in Myanmar. The impact of training is very low in the other sectors because conditions of institutional change and sustainability were not met in the Health and Nutrition sector, in the Education sector and in the CNSP project.

Regarding relevance, the evaluation confirmed that there was a clearly identified need to improve the performance of service providers, and that improving their skills would contribute to overall improvement of the service. Training was therefore deemed appropriate and relevant as a part of the strategy, but not sufficient in itself to increase capacity-building. Other influences related to the capacity of service, such as institutional constraints (e.g. mid-wives being overburdened, poor equipment), structural constraints (e.g. classroom size), low wages, motivation problems, recruitment difficulties, vacant posts, etc., must also be addressed in order to have a sustainable impact on capacity.

Recommendations based on the evaluation finding to improve efficiency, effectiveness and impact, were presented during the annual review meetings of each programme, and the overall recommendation was presented and discussed at the annual review for the Country Programme. Specific activities and modifications of strategies will be incorporated into the planning process for 2002.

1- Introduction

Why this Evaluation?

The previous Myanmar-UNICEF Country Programme (1996-2000) and the current Country Programme (2001-2005) have identified and supported capacity-building activities, particularly training, as one of the key interventions that will lead to improved services and support to children and women in Myanmar. An important portion of the Programme resources has been dedicated to finance training materials preparation, trainer experts, venues, monitoring, etc.

Given the centrality of training in the Myanmar-UNICEF strategy, the level of efficiency and effectiveness of training activities is a critical determinant of the Country-Programme performance. This is why Myanmar and UNICEF jointly decided to undertake a participative utilization-focused evaluation of training activities supported by the Country Programme. This evaluation is the first of the major evaluations to be undertaken during the first half of the 2001-2005 Country Programme period, as approved by the Executive Board in September 2000.

The results of this evaluation will contribute to organizational learning within UNICEF Yangon, with partners in Myanmar, and, recognizing that training activities have been adopted as a capacity-building strategy in almost all country programmes, within UNICEF globally. It will contribute to an improvement in the effectiveness and efficiency of systems, programmes and services for children and women.

Status and Organization of this Report

This Final Report integrates the inputs prepared by the different evaluation teams together with a synthesis of the findings and recommendations.

The report presents the training activities supported by the Myanmar-UNICEF Country Programme and the key elements of their context (section 2), the framework of the evaluation (section 3), a synthesis of the evaluation results (section 4), assessments by programmes (section 5), and a summary of the evaluation made by training component (section6).

Acknowledgements

The team of facilitators would like to warmly thank the many people whose hard work, dedication and commitment have contributed significantly to the findings and recommendations of this evaluation. Without them it would not have been possible to get to the heart of many issues, see potential opportunities and reach a consensus on the way forward.

We thank Government staff at Central, State/Division and Township levels, for their valuable and untiring help with this evaluation, their boundless knowledge when clarifying the Myanmar context, recalling decades of institutional memory and strategies, participation in field evaluation work and language translation.

We also would like to express our gratitude to UNICEF staff, for their vision, encouragement and enthusiasm during the entire evaluation, their help in focusing the evaluation questions, their commitment to finding information on past and current projects, their assistance in organizing field missions and participating in field work, translations, gathering and procesing data, their technical guidance and day-to-day supports of all kinds.

The team of facilitators feel fortunate to have had such committed support from all parties.

2- Object of the Evaluation:
The Training Activities Supported by the Myanmar-UNICEF Country Programme and their context

This evaluation had to evaluate an array of very diverse training activities, which are present in all projects and sub-projects of the Myanmar-UNICEF Country Programme and represent a significant part of the effort and resources of this Programme.

For evaluation purposes, the training activities were treated as small projects, with all the basic elements of a project (a goal, an objective, a target group, an implementation strategy, schedule and budget) and called "training component". The term "component" was used to show that the evaluation was focusing on the internal coherence of each training activity and on its articulation with and relevance to sub-projects, projects and programmes of which they were part.

The evaluation made every effort to take in account the context of each training component, which is so specific in Myanmar.

2.1- Training activities are present in most of the projects and sub-projects of the Myanmar-UNICEF Country Programme

The evaluation focused on 6 key training components in Health and Nutrition, 5 key training components in Education, 5 in Water and Sanitation, 1 specific training component for Children in Need of Special Protection, and 1 related to Facts for Life information and communication.

The selection of training components to be evaluated was based mainly upon three criteria: importance to the project objective, size of budget allocated, and; number of trainees involved.

The following table presents the training components that were selected and evaluated in detail:

Brief overview of the Training Components evaluated
a) Health and Nutrition

Name of Training Comp.	Objectives	Target Group
Integrated Management of Maternal and Childhood Illnesses (IMMCI) Training	To improve the case management as well as program management skills of health care providers through skill-based training.	- Basic Health Staff - Mid-Level progr. Manager - Trainers
Essential Steps for Safe Delivery (ESSD) training	To provide skill and knowledge to address the major cause of maternal morbidity and mortality, to manage obstetrical emergency cases, to recognize obstetrical emergency cases and to refer them in time to the first referral hospital.	- Midwives - Auxiliary Midwifes
Traditional Birth Attendants (TBA) training	To improve the knowledge and skills to conduct the deliveries safely and to recognize mothers at risk for early referral.	- Traditional Birth Attendants
Auxiliary Midwives (AMW)/ Auxiliary Nurse Midwives (ANMW) Training	To increase coverage of health services at the rural area.	- Auxiliary Midwifes - Auxiliary Nurse Midwifes
Life skill training	To provide detailed & accurate information concerning sexuality, birth spacing, sexually transmitted diseases, & HIV/AIDS, to provide skills for youth to enable them to cope with their daily lives and become proponents of cornmunity mobilization.	- Women (reproductive age) - Youth (15- 25 yr)

Instruction for National Immunization Day (NID)	To increase community participation in National Immunization Day activities.	- Community volunteers

b) Education

Name of Training Comp.	Objectives	Target Group
Primary Teacher Training	To prepare teachers for more effective teaching & learning and management of primary school classrooms	Primary teachers (mostly untrained)
PTA (Parent Teacher Association) Training	To provide knowledge and skills on community mobilization and related activities for better participation and monitoring progress of schools.	Community members selected as PTA leaders
SHAPE (School-based Healthy Living and HIV/AIDS Prevention Education) Primary & Secondary Teacher Training	To increase knowledge and skills of principals and teachers on health promoting behavior, life skills and HIV/AIDS information through participatory teaching-learning approaches	Standards 2-9 teachers from 60 townships
SHAPE PTA training	To increase participation of parents as PTA members in supporting SHAPE implementation	Community members selected as PTA leaders in SHAPE schools
Early Childhood Care and Development	To provide teachers with child-centered knowledge and methodologies for early childhood care and to improve their teaching approaches	Pre-Kindergarten teachers

c) Water & Sanitation

Name	Objectives	Target Group
National Sanitation Week (NSW)	Encourage each village leader to mobilize for construction of 15-20 family sanitary latrines, on a self-help basis, in each of the 66,000 villages nation-wide, per year; promote hygienic behaviour around sanitation, personal, food & drinking water hygiene.	- State/Division leaders and health officials - Township leaders and health officials - Ward & village leaders, basic health staff at Rural Health Centre level, and ward and village household leaders
Training for Social Mobilization	To bring about fundamental changes in knowledge, attitudes and practices relating to safe water, sanitation and hygiene. Specific objectives included undertake, per year: 15 orientation sessions, 150 training sessions for training of trainers, 39 training sessions, 780 training sessions.	- State/Division leaders and health and education officials. - Township leaders and health and education officials. - Basic health staff at RHC level, and ward and village household leaders - Community Mobilizers
School Network	- Increase awareness and improve knowledge, attitudes and practice regarding water, sanitation and hygiene among school children. - Provide water and sanitation facilities in schools. - Equip school children as "change-media" within their families and community.	- TEO's, ATEOs, TMOs, Township School Health Officers, TPDCs, 10 representatives from State/Division departments of basic education and of Health; - Parent Teacher Associations chairpersons and students.
Hand-pump Caretaker Training	- Local capacity to sustain water systems. - Promotion of messages on safe collection, storage and use of drinking water, by pump-caretakers.	- Selected village persons for training in hand-pump care taking
Water Quality & Testing	- Train key government staff in water quality testing & mapping. - Establish a national database - Contribute to the development of a national policy and standards and to decision-making.	- Selected technicians and engineers in WRUD and DDA

d) Children in Need of Special Protection (CNSP)

Name	Objectives	Target Group
CNSP Training Component	To change the care givers' knowledge, skills and attitudes, so that their individual caring performances would improve.	- Care givers working in 4 State run institutions.

e) Information and Communication

Name	Objectives	Target Group
Facts For Life Initiative Training Component	To increase awareness of the core basic life-saving messages at household level.	- Youths and adults, particularly of 18-35 years, members of CSOs/NGOs, - Potential extension communicators, manifesting interest for social work.

A total of 18 key Training Components were evaluated. Details are available for each of them in the sector reports.

2.2- Training activities represent a significant part of the resources and effort of the Myanmar-UNICEF Country Programme

Nearly a million beneficiaries received training in the last 3 years, including tens of thousands of health workers, ten of thousands of teachers, parents and school managers, thousands of water and sanitation professionals, hundreds of thousands of volunteers. This record shows the importance of training in the Myanmar-UNICEF Country Programme.

In term of resources, it is estimated that **15% of the Country Programme budget is spent directly on financing training activities**. But this percentage is far from representing the efforts that UNICEF staff and partners dedicate to training activities. With hundred of training action to prepare every year, implement and monitor, it is estimated that **training activities mobilize between 40% and 50% of the total time and efforts engaged in the Country Programme**.

2.3 Training activities are very diverse

The table above presents very different types of training components, such as:
- 7 month training to prepare Auxiliary Midwives and Auxiliary Nurse Midwives;
- 20 days training for Primary Teacher upgrading
- 5 days workshop on Facts for Life and communication for young CSO's members;
- 1 day of Sanitation Social Mobilization training in advocacy and planning for State/Division and Township level leaders
- 1 or 2 hours training for volunteers during the National Immunization Day;

These activities range from acquisition of the basic elements of job qualification (one or several months), to understanding and mastering new concepts or specific skills (5 days) and to information delivery (1 day advocacy).

This diversity must be kept in mind to understand correctly the results of the evaluation.

2.4 Training activities are closely linked to a specific context

Training for changes in capacity can only result if the proposed content and methodology are closely adapted to the specific context in which beneficiaries are involved.

Understanding the context, verifying coherence between each specific context and the training components has been a strong focus of this evaluation, especially because of three specificities of Myanmar.

a) First specificity, **Myanmar is a large country with high diversity** in its geographical and climatic conditions, human settlements, culture and languages. For example, the Facts for Life booklets had to be translated into 7 different languages; prevalent diseases are different among the townships; and religious groups cope differently with hygiene and sanitation.

b) Second specificity, **Myanmar has a limited capacity to deliver social services. A** very small part of the national budget is invested in social services for women and children, the institutional system is weak, equipment insufficient, and staff is under skilled, frequently under motivated and overloaded. Basic Health Staff, for example, is overloaded with the several programmes they have to contribute to on day-to-day basis and they have little time for training. Primary teachers have a low level of understanding of pedagogical matters which makes the implementation of a new child-centered learning model difficult.

c) Third specificity, **Myanmar has a strong central public management system**. This is a strength in terms of discipline and mobilization. But it leads to lengthy procedures, and lack of initiative at the lower management levels and at community levels.

3- Framework of the Evaluation

The terms of reference of the evaluation, prepared by the Planning Department of UNICEF in broad consultation with UNICEF staff and counterparts, are presented in annexe 1. They gave the basis and the main orientations for the evaluation framework.

The Evaluation of Training Activities Supported by the Myanmar-UNICEF Country Programme used a "utilization-focus" approach. A common understanding was first built around the evaluation questions and the logic model of training. Then methods were determined, tools designed and a work plan prepared. A Steering Committee supervised the evaluation team and emphasis was given to information and communication throughout the process.

3.1- A Utilization-focused Evaluation

The evaluation followed a utilization-focused approach. This specific approach provides for active involvement in the evaluation process of those with a stake in the programme: providers, partners, beneficiaries and any other interested party. Myanmar decision-makers in particular were enabled to take part at all key points during the evaluation.

This involvement of stakeholders in the evaluation process included the formulation of questions, choice of criteria, methods and tools, planning, data collection, discussion of findings and results and, finally, drafting of recommendations.

For instance, for Health and Sanitation, close consultation with the Division of Public Health and the IMMCI management group at North Okkalapa Hospital took place during the course of the three months of the evaluation, ranging from briefing meetings to the presentation of the methodology and the draft tools for data collection, to presenting and discussing the preliminary findings to reach consensus on final presentation of findings and recommendations.

This approach emphasizes the learning process taking place during the evaluation itself. The stakeholders participate in discovering the findings and are part of the design of the recommendations they will have to implement later.

3.2- The Evaluation questions

The formulation of the evaluation questions, starting from the questions included in the terms of reference, was an exercise used to build a common understanding at the beginning of the evaluation process. In fact, questions are the simplest way to translate stakeholders concerns.

This exercise was also necessary because while the evaluation was focused on the training activities in each sector (health, education, WES, ...), a common set of questions was required to enable conclusions to be drawn for the Country Programme as a whole.

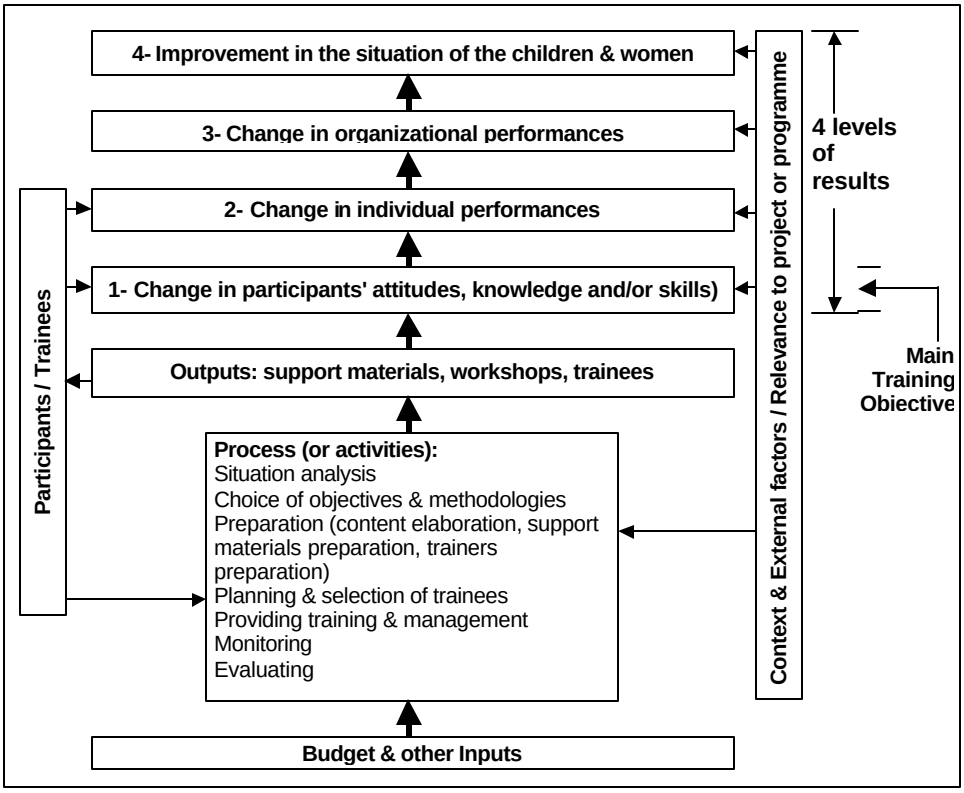
A specific Steering Committee meeting and several sector meetings took place to discuss and organize the evaluation questions. The result of this process is presented in Annex 2. It was then used by the sector evaluation teams to design methodology and tools.

Questions were organised under three major evaluation criteria: **process, results and relevance**. The same three criteria were used later on to consolidate the evaluation findings (see below sections 4, 5 and 6).

3.3- The Training Component Logic Model

In order to answer the evaluation questions, a common understanding was developed to identify common key aspects of training activities and determine how the training objectives linked to the broader objectives of the respective projects. This involved interacting with stakeholders, to draw out their understanding of the overall programme model (planned sequence of changes and assumptions) and subjecting this to an examination based on stakeholders' intuitive concerns or suspicions.

The basic **Logic Model of each training component** to be evaluated is presented below.



3.4- Methods

The evaluation used complementary methods within a specific framework for each sector. The following table give a synthesis of the **methods used by sector** to evaluate process, results and relevance.

Sector	Process assessment and outputs inventory	Result assessment		Relevance
		R1 (*)	R2 to R4 (*)	
Health & Nutrition	Observations and qualitative analysis based on a standard process (*)	"Before and after" approach using a baseline based on previous assessment reports, training needs assessment reports and retrospective accounts of a significant number of resource persons and key informants	Qualitative method based on understanding and opinions from the stakeholders and beneficiaries.	Qualitative analysis with stakeholders

Education	Observations and qualitative analysis with stakeholders, based on a standard process (*)	"Before and after" approach using a baseline based on previous assessment reports, training needs assessment reports and retrospective accounts of a significant number of resource persons and key informants		Qualitative analysis with stakeholders
Water and Sanitation	Observations and qualitative analysis with stakeholders, based on a standard process (*)	"Before and after" approach using a baseline based on previous assessment reports, training needs assessment reports and retrospective accounts of a significant number of resource persons and key informants	Impact had been measured in a separate national survey of hygiene situation and behavior of the population	Qualitative analysis with stakeholders
CNSP	Qualitative analysis with stakeholders, based on a standard process (*)	Qualitative analysis with stakeholders	Qualitative analysis with stakeholders	Qualitative analysis with stakeholders
I & C (FFL Training initiative)	Observations and qualitative analysis with stakeholders, based on a standard process (*)	"Before and after" approach using pre tests and post tests systematically done for each workshop and retrospective accounts of a significant number of key informants	Qualitative analysis with stakeholders and beneficiaries	Qualitative analysis with stakeholders

* See logic model presented above, section 3.3

3.5- Tools

To collect information, a combination of desk reviews, in-depth interviews, focus group discussions, observations and skill assessments as well as assessments of training materials were used.

Highly qualified and prepared individuals used the data collection tools in each sector evaluation team. Possible shortcomings in using the tools were addressed by posing the questions in different ways when not correctly understood, and asking for additional information or explanations when clarifications were necessary.

Sometimes the process of collecting data was sequenced and elaborate to confirm opinions and allow deeper analysis. For instance, in education, the teams first observed classroom interaction in standards K-4, and then they followed up the observations with individual and focused group interviews of the same teachers and with a few students from the observed class. Finally, the teams interviewed parents and PTA members in the community, the Cluster or Head Teacher and the ATEOs about school-community relations.

The following tools were prepared and used for this evaluation in the different sectors:

- Desktop review brief
- Key Informants Interview Form

- Management Training Interview Form
- Trainer or Teacher's Interview Form
- Trainee or Student's Interview Form
- Trainees or Student's Focus Group Protocol and Guideline
- Observation Form for Training
- Form for Evaluating Training Materials
- Skill and Knowledge Assessment Form
- Observation Form for Treatment and Care, for Teaching in a Classroom, for Maintaining a Pump
- Classroom Observation Form
- Background of School Description Form

3.6- Coverage

Sector	Geographical Coverage	Selection method
Health & Sanitation	5 townships in 3 Sates and 2 townships in 2 Divisions (Shan State : Taunggyi, Yatsauk; Mon State: Thaton, Bilin; Kayin State: Hpa-an; Yangon Division: Kyauktan; Sagaing Division: Monywa	The selection of the townships has been made with a view to the following conditions: - Geographical diversity - Status of the training (old / new) - Presence of several projects in the same location - Size of the class - Logistics
Education	70 schools in 20 townships in 4 Divisions and 4 States (Bago, Karen, Ayeyar-waddy, Mon, Sagaing, Mandalay, Kayah, Shan)	Only schools that had CAPS/ACIS/SHAPE or CFS teachers were chosen. Townships were selected purposively to represent differences in rural and urban areas, geographic and linguistic differences, and levels of community poverty and development.
Water and Sanitation	11 Villages and 13 schools in 3 Townships and 3 States/Divisions	The selection of the townships has been made with a view to the following conditions: - Geographical diversity - Presence of several projects in the same location - Logistics
CNSP	Yangon	Field observation was not possible, but a large focus group brought together representative and trainers of all the 4 beneficiary institutions.
I & C (FFL Training initiative)	Yangon	All the ongoing workshops were observed. Interviews with key informants and focus group with trainers, trainees and CSO leaders were made for Baptists, Muslims and Buddhists groups, as welle as for a large women association.

3.7- Sample sizes

Due to limitation in time and staff, it was not possible to work on representative samples. The approach adopted was small purposeful sampling in order to understand the diversity of situations and contexts. However, during the course of the interviews and assessments, the evaluation teams identified clear patterns and repetition in responses, which constitute solid findings or valid suppositions. Triangulation was used in all analysis to validate the findings. Furthermore, the consensus built along the process with all the stakeholders is another guaranty that the conclusions of the evaluation are robust.

3.8- The use of scores

A "Scoring Approach" was used to allow comparisons (across training component and sectors), to facilitate understanding and discussions, and, finally, to aggregate and consolidate all the results in a global synthesis.

Each of the evaluation facilitators was asked to "score" selected results using the same 0 to 10 scale, ranging from very poor quality or non-existent (0) to outstanding (10). The score indicated a level of qualitative opinion. The numerical score was supplemented with a description when necessary.

Facilitators and stakeholders made clear that using a "score" did not mean that results were more "scientific". But the use of scores in the discussion process with the stakeholders pushed the evaluators to provide evidence and justification to support their findings, and, finally, added clarity in the process.

Based on the scores, it was then possible to compare and consolidate results. For instance, in the education sector, for standard ECD and ECCD Network pre-Kindergarten schools a semi-structured questionnaire was used. The questionnaire included focused questions and a four point rating scale to compare differences in school facilities, materials, and student and teacher activities.

3.9- The Evaluation process and time schedule

The process of the evaluation included the following steps :

Main steps of the evaluation process	**Beginning / ending dates**
1- Taking stock of projects, systems, resources and context	July 18th, 2001 August 31st, 2001
2- Building a consensus on unit of analysis, key questions, methodologies, key Informants and field work	August September 16, 2001
First Meeting of the Steering Committee	September 17, 2001
3- Developing tools, planning the work, preparing for field work	Sept. 18, 2001 Sept. 26,2001
Second Steering Committee Meeting	September 27th, 2001
4- Field working, collecting and gathering information	October 2001
5- Making the first Analysis with stakeholder, identifying preliminary findings & lessons	Nov. 1st, 2001 Nov. 11th, 2001
Third Steering Committee Meeting	November 12th, 2001
6- Sharing the results, consultation on analysis and consensus on way forward	
Final meeting of the Steering Committee	November 22th, 2001
7- Preparing and submitting Final Evaluation Reports (5 sector reports and 1 Synthesis report)	December 2001 January 2002

3.10- Management Structure and Evaluation Teams

A **Steering Committee** within UNICEF was established, which included Senior Management, Section Chiefs and relevant Project Officers, to oversee the evaluation. The Steering Committee met regularly during the four months of the evaluation, to approve the evaluation framework (which included the evaluation questions and the process to answer the questions), and reviewed the findings. The Steering Committee also discussed recommendations based on the findings, which would be implemented immediately as well as those which would be addressed at the mid-term review in 2003.

The evaluation was undertaken by **5 sector teams** (Health & Nutrition, Education, Water & Sanitation, CNSP, FFL). Each team integrated Governments officials and specialists, UNICEF Section Chief and staff, NGO representatives and specialists and one or two evaluation facilitators.

The evaluation work was facilitated by the following **team of consultants**:

Education sector:	Dr. Matt Seymour,
Health and Nutrition sector:	Dr. Khin Nwe Oo,
	Ms. Lene Svendsen,
Water and Sanitation sector:	Mr. Brendan A. Doyle,
Information and Communication sector and Team Leader:	Mr. Christian Dessallien.

3.11- Information sharing and communication

Being "utilization-focused", this evaluation was designed with a special emphasis on information, communication and early dissemination of results to allow preparation of an action plan to improve training components within sub-projects in the country programme.

- Regular meetings with the relevant counterparts took place throughout the process.
- Four meetings of the Steering Committee took place (see table above),
- A newsletter (to all members of the Steering Committee) was created, with three issues,
- One meeting was organized to share the major findings with Donor representatives,
- Presentation and discussion of the evaluation and its results took place during the annual review meetings of the programmes and during the meeting of the Joint Myanmar UNICEF Advisory Group (JMUAG).

4- Evaluation Synthesis

4.1- Process evaluation

An analysis of the process of planning and implementing training activities, including an assessment of the quality of training materials, trainers and training methodology, was an important aspect of the evaluation.

The analysis, made on a common basis by each of the evaluation teams, led to the following findings:

Process Evaluation, Findings by Sector and for the Whole

Dimension	**Health & Nutrition**	**Education**	**Water & Sanitation**	**CNSP**	**FFL Tr. Initiative**	**All sectors**
Preparation	8 (very good)	8 (very good)	5 (fair)	6 (fairly good)	5 (fair)	**5 to 8 average 6**
Implementation	8 (very good)	6 (fair to good)	7 (good)	4 (diffi-cult)	4 (to stre-ngthen)	**4 to 8 average 6**
Trainers	6 (fair)	6 (fair to good)	5 (fair)	5 (fair)	7 (good)	**5 to 7 average 6**
Instructional Techniques	5 (fair)	6 (fair to good)	7 (good)	7 (good)	8 (very good)	**5 to 8 average 7**
Training Materials	6 (fair)	7 (good)	5 (fair)	7 (good)	8 (very good)	**5 to 8 average 7**
Monitoring and Feedback	3 (poor)	6 (fair to good)	5 (fair)	6 (fair)	6 (fairly good)	**3to 6 average 5**
Level of Unit Costs	8 (good)	7 (relatively good)	8 (good)	9 (very good)	9 (very good)	**7 to 9 average 8**
Overall Efficiency	**7**	**6-7**	**6**	**6**	**7**	**6-7**

The overall efficiency appears to be good (6 to 7 /10).

The processes were generally well conceived (planning, programming). **Preparation** appears to be very good for the training activities implemented in the Health and Nutrition and in the Education sectors. The preparation is just fair for Water and Sanitation (lack of capacity at Township level impedes sector planning) and for the FFL Training Initiative (unclear formulation of the objective).

The **implementation** processes of the training activities were also satisfactory (6/10), very good or good for Health and Nutrition and for Water and Sanitation, fair to good for Education. Implementation appeared difficult for CNSP and for the FFL Training Initiative.

The preparation and performances of **trainers** were globally satisfactory, good for the FFL Training Initiative and fair for the others sectors.

Instructional techniques were generally good. The best scores were registered for the FFL training Initiative (8/10) and the lower ones were for Health and Nutrition (5/10).

The **materials** developed for training were appropriate. The best scores were registered for the FFL training Initiative (8/10) and the lower ones were for Water and Sanitation (5/10).

It is important to highlight that the FFL Training Initiative shows some examples of excellence in selecting instructional techniques, preparing training materials, and training the trainers.

The evaluation showed that the choice of the different **modalities** of training were appropriate for the training objectives and for the institutional context. For the training implemented in the Water and Sanitation sector, "a mix of training methodologies appears to work well in the Myanmar context". For the Education sector, the facilitator noted that " the choice of the cascade model as a strategy for training implementation was also good and achieved wide coverage in a relatively short time with minimum resources". For the Health and Nutrition sector, "the cascade model is used for efficient coverage of large numbers of BHS and Voluntary Health Workers" and the trainings used "participatory approaches with various technique including lecture-discussion, demonstrations, group work discussions and presentations, role playing, games, questions and answers, drill methods, hands on practice" as well as "a fair amount of non-participatory methods used such as group reading and one-way communication. The participatory approach seems to work better at central and State/Divisional levels than at township level."

In the 3 main sectors (H&N, WES, Education) the training strategies **target** mainly the public social services and some supporting NGOs. This choice is appropriate to strengthen capacity at local, regional and central levels. For the FFL Training Initiative, due to the lack of civil society organisations in the context of Myanmar, the strategy targeted mainly religious groups and there are doubts that national coverage could be reached through these sole actors.

The processes were not well monitored in all sectors. The average for the different training components evaluated was scored at 5/10, but in Health and Nutrition, the **monitoring** and feed back activities were considered "poor", and in the Water and Sanitation sector, just "fair".

The **unit cost** of the training activities has been estimated good or very good in all sub-projects and programmes.

The training activities of the **various programmes** were not sufficiently **related** and complimentary. The assessment of the WES training activities showed that "limited inter-sectoral collaboration has resulted in missed opportunities for synergy".

Were training activities as efficient as possible? The assessments made during this evaluation indicate that the efficiency of training activities was quiet satisfactory generally speaking, good for Health and Nutrition and FFL (7/10), fair to good for the other sectors. With such a scoring method, applied on qualitative assessments, a score of 8 to 9 must be considered as a maximum and a score of 7 represents quite a good level.

This good level of efficiency is reflected in the impressive quantity of outputs that the training activities have produced. The following table inventories the training outputs and provides an estimation of the average cost per trainee.

Name of the Training Component	Budget (US$)	Beneficiaries
IMMCI Training	273,563 from 1998 to 2001	12,916 persons trained from 1998 to 2001
ESSD training	21,231 for 1998 & 1999	2,222 persons trained from 1998 to 2000
TBA training	44,748 from 1998 to 2000	5,041 persons trained from 1998 to 2000
AMW/ANMW Training	172,539 from 1998 to 2000	3,092 persons trained from 1998 to 2000
Life skill training	86,955	34,425 persons trained
Instruction NID	Not known	Not known exactly. Hundreds of thousands of volunteers
Primary Teacher Training	1,438,000 (estimate)	42,000 trained to date
PTA Training	501,000 (estimate)	74,250 trained to date
SHAPE Primary & Secondary Teacher Training	357,000 (estimate)	43,000 trained to date
SHAPE PTA training	191,000 (estimate)	37,000 trained to date
Early Childhood Care and Development	2,700 (estimate)	About 400 trained to date
National Sanitation Week	284,221 from 1998 to 2001	515,184 people were orientated/trained over 4 years
Training for Social Mobilization	491,724 from 1996 to 2000	32,000 persons were trained over the five-year period (1996-2000)
School Network	84,049 from 1998 to 2000	6,530 persons trained from 1998 to 2000
Hand-pump Caretaker Training	52,800 from 1998 to 2000	17,200 persons trained over a three-year period.
Water Quality & Testing	2,615 for 2001	55 persons trained
CNSP Training Component	22,624	132 trained to date
FFL Initiative Training Component	200,000 (estimate)	About 7,500 people trained to date.
Total	4,226,769	832,947 beneficiaries
Average cost per person trained: 5 US$		

This huge number of beneficiaries, around one million if we take into account the hundreds of thousands volunteers from the NID Training component, shows the importance of training in the strategy of the Myanmar-UNICEF Country Programme.

4.2- Result evaluation

The evaluation assessed and analysed the results of training at 4 different levels (see logic model, section 3.3 above)

The analysis, made on a common basis by each of the evaluation teams, led to the following findings:

Results Evaluation, Findings by Sector and for the whole

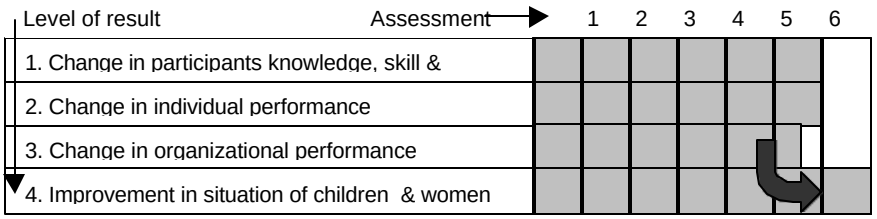
Level of result	Health & Nutrition	Education	Water & Sanitation	CNSP	FFL Tr. Initiative	All sectors
1. Change in partici-pants knowledge, skill & attitude	- Quite good improvement of knowledge (6) To sustain the knowledge refresher training is needed - Course is too	Barely satisfactory (5). Participants understand only basic elements of CCL and philosophy or objectives. Re-interpret CCL into	- There is good general knowledge and improved behaviours regarding diarrhoeal diseases (6)	Satisfac-tory (6), but at the level of under-standing only	Very good (8) A clear qualitative change has been produced for all the trainees. Sustainability	**Fairly Good (5 to 8)** Sustaina-bility will be high at first; but with limited applica-

	short to change attitudes	more teacher-centered instruction.			of those changes in knowledge and attitudes is certainly good	tions and support, trainees will forget.
2. Change in individual perfor-mance	- Some change in delivery practice; more clean and safe practices (4). With regular in-service training this change will be sustained - No increase in number of referrals	Less than satisfactory (4). Predominant pattern of traditional teacher-centered approach; then instructional approach; finally mixed CCL with instructional approach. CCL elements used selectively.	Positive trends in personal hygiene are evident especially among those who received WES promotional messages (6)	Low (1). In their work condition the beneficiaries cannot change their working attitude.	The multiplicative effect (trainees training others beneficiaries) could not be assessed during this evaluation	**Low (1 to 4), with the excep-tion of WES (6)**
3. Change in organi-zational perfor-mance	Transpor-tation from rural areas in case of referral to hospital is said to be supported by the community (2). Transpor-tation is sustainable - No change in utilization of facilities	Relatively low (2). Predominant school culture is teacher-centered approach. In a few cases, where mixed CCL approach exists, school culture exhibits CCL in most classrooms	The performance of involved organizations improved but there is a lack of capacity at Township level and insufficient involvement of State/ Division decision-makers and managers (5-6)	Probably very low (5)	NA	**Very Low (1 to 2)**
4. Improve-ment in situation of children & women	NA	Low (2). Project efforts less effective in rural and remote areas. However, HT/PTA organized "incentives" for poorest of poor do work.	In general, phenomenal results have been achieved in sanitation coverage in recent years. This has been due to several factors, including training that mobilised and supported local communities towards greater self-reliance (7).	Probably very low (5)	NA	**NA**

For the main objective of the training activities, changes in participants' knowledge, skillsl & attitudes, which is the first level of result (or outcome), **the overall result of the evaluation is fairly good**, with scores ranging from 5 (Education) to 6 (H&N, WES, CNSP) and to 8 (FFL).

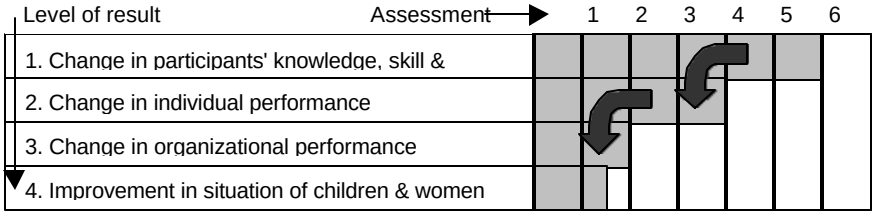
For the other levels of results, there are clearly 2 different patterns.

Pattern 1, Water and Sanitation: Important results have been achieved in sanitation coverage in recent years in Myanmar. Different key factors influenced this success: political commitment, local



design options for families, rejuvenated awareness and motivation, greater awareness and motivation among families, promotion and facilitation of the private sector. In this extremely favourable context, training activities undertaken within the Myanmar-UNICEF Country Programme contributed to the overall positive change and seem to have had an impact greater than their effectiveness. Part of this impact is due to other factors, but the real attributions could not be determined given the scope of this evaluation.

Pattern 2, Health and Nutrition, Education: In these 2 sectors, the evaluation concludes that the



training activities had a low impact on changing the performance of individuals in their work, and a still lower impact on changing the performance of organizations (e.g. school, health centres, etc.). The new skills or improved knowledge following the training, did not translate easily to other levels of results. The evaluators, in consultation with the stakeholders, offered three explanations for the difference between the expected results and the actual results at performance levels. The first explanation is that the objectives of the training components were often overly ambitious in terms of changing performance, with regard to the level of resources invested and when capacity building depends often on many other factors and constraints. This is particularly true for the education and health sectors where promoting change in such huge systems requires strong efforts, particularly in a context of low public expenditures and few donors helping to improve critical services for deserving women and children. The second explanation is that the length of the training was generally too short to lead the participants to the level of appropriation/mastery that would produce changes in behaviour at work and improved performances. Also, the content of the training should have been more practical with greater emphasis on facilitating the practice of new skills in the participant's work environment. It was also noted that the training activities must have adequate follow-up and supportive supervision in order to promote the use of new skills and knowledge on a day-to-day activity. The third explanation was that in order for training to have a significant impact on improving performance, other inputs are also necessary because capacity building is a multidimensional challenge. There is therefore a need to analyse the situation on a more global level, to identify the full array of inputs required, and to ensure that a conducive environment exists to enable the training to have sustainable results in improving performance.

4.3- Relevance of training as a capacity building strategy

The third important aspect of the evaluation was to assess the relevance of training as a capacity building strategy vis-a-vis the objectives of the respective projects, programmes and of the Country Programme as a whole. This assessment included an analysis of the significant external factors that have an influence on an individual's and an organization's performance.

The analysis, made on a common basis by each of the evaluation teams, led to the following findings:

Relevance, Findings by Sector and for the whole

Health & Nutrition	Education	Water & Sanitation	CNSP	FFL Tr. Initiative	All sectors
- The training is relevant and related to day to day practice. - Relevance could be improved by focusing more on front line health workerand by including include GPs into conten to ensure standardized and quality health care	The training of teachers is relevant The content of training, CCL model, is partially, irrelevant due to inertia of teachers, low standard of facilities and materials in rural and remote schools and the lack of adequate and quality follow up able to strengthen the teachers' commitment	All training activities were relevant for capacity building. Relevance could be improved with more adaptation to the context and better inter-sectoral coordination	The training is an essential part of a capacity building strategy. But other elements are crucial to improve performances (work overload, mix of care and services in jobs content, no monitoring of work attitudes by the management, low salaries and no additional incentives)	The FFL Training Initiative is relevant as a communication tool for FFL dissemination. With a very low unit cost, training appears to be a strong means for communicating facts, ideas and new attitudes among Myanmar groups.	**Generally training is considered very releant.** Nevertheless, more adaptation of contents and models to the context, a better understanding of acceptability by beneficiaries and actions on other major capacity building constraints are needed

Regarding relevance, the evaluation confirmed that there was a clearly identified need to improve the performance of service providers. Upgrading their skills would contribute to overall improvement of the service. Training was therefore deemed appropriate and relevant as a strategy, but not sufficient in itself to increase significantly capacity building. The evaluation concluded that the coherence of the training component needed to be strengthened. The training components were developed based on a training needs analysis and the development of clearly defined training objectives and subsequent strategies; however, other influences related to the capacity of services, such as institutional constraints (e.g. mid-wives being overburdened, poor equipment), structural constraints (e.g. classroom size) low wages, motivation, recruitment, vacant posts, etc., must also be addressed in order to have a sustainable impact on capacity.

4.4- Main findings

Specific findings can be found in each sector report. This section highlights global findings or findings common to all sectors.

1- Training activities were fully relevant, as part of the Country Programme strategy, and with a small portion of the overall budget (15%), produced an impressive array of outputs, benefiting nearly one millions trainees.

2- The overall efficiency appears to be good, with a low unit cost per trainee.

3- The implementation process of the training activities were satisfactory. Management suffered from some manpower shortagse and other constraints and it appears that monitoring activities were sometimes too weak. It is estimated that with the same budget, an additional 20 to 30% in efficiency could be obtained with improvements in preparation, focus, implementation procedures and monitoring. These improvements are different from one sector to the other and are detailed in the sector reports.

4- Almost all the training components showed a good choice of instructional technique and good quality training material, with some examples of excellence (participatory and communication workshops). In

the Water and Sanitation sector, however, it appeared that many teachers and health extension staff lack confidence in applying participatory training methodologies.

5- The effectiveness of training activities is fairly good since the main objective (i.e. change in participants' knowledge, skills & attitudes, which is the first level of result) is generally fairly well realised. In the Education sector, for the Child Friendly Schools component, the effectiveness is only "barely satisfactory" because a deeply engrained tradition of teacher-centered instruction in the Myanmar education system causes teachers to resist the child centered learning approach. Overcoming this will take more time, efforts and a more progressive strategy. For the CNSP training component and some components of the Water and Sanitation sector, the lack of commitment from the counterpart reduces effectiveness.

6- The impact of training activities (improvement in performances for individuals and organizations) is good in the Water and Sanitation sector, where other key factors, external to the Myanmar-UNICEF Programme, influenced a very successful expansion of coverage in recent years in Myanmar.

7- The impact of training is very low in the other sectors, and in certain cases the benefits of training are lost. New knowledge and skills produce little or no change in individual and organizational performance. This is because conditions of institutional change and sustainability were not met in the Health and Nutrition sector, in the Education sector and for the CNSP project. In many cases, a clear strategy to utilize training in order to change practices and improve quality of services is lacking.

4.5- General Recommendations

This section highlights the overall recommendation of the evaluation. Recommendations specific to each sector are detailed in the respective sector reports.

The evaluation of training activities supported by the Myanmar-UNICEF Country Programme confirmed the relevance of training activities in projects and programmes where they played a crucial role within the global capacity building strategy during the last 3 years. The findings on process and results shows that a number of actions could be undertaken to improve efficiency, effectiveness and impact and to identify the best way forward for training in the CP Strategy.

4.5.1- To improve efficiency and effectiveness

- Monitor and evaluate systematically all the training components. For each training component, determine a small number of performance indicators, monitor these indicators regularly and manage for results.
- Focus training on skills that can be applied; incorporate more active practices in the training activities; reduce theoretical presentations.
- Extend the duration of some training courses when it is needed to reach the learning objective (for instance at the township level of training in the cascade of teachers' training); conduct refresher training when sustainability needs to be improved.

4.5.2- To improve effectiveness and impact

- Reinforce the planning process by drafting robust logframes, determine expected results related to time schedules, identify steps if necessary, fix intermediate reachable targets, select good indicators.

- Be explicit about the working model that is promoted though training (e.g. child-centered model); communicate the model to make it more convincing; adapt the model to past experience and readiness of beneficiaries to accept new ways of performing; break down the model and apply it step by step when necessary for acceptance.
- Improve the understanding of the multi-dimensioaln capacity building process among partners and UNICEF staff; work with partners on capacity level indicators (for instance develop and introduce a proven Criterion Referenced Test for standard four students and develop and standardize it with better indicators and data-gathering methods for the assessment of primary school internal efficiency) and on management information systems.
- Integrate the Training Components into a comprehensive capacity building approach (for instance, build capacities in the Department of Development Affairs for water development).
- Deepen the collaboration with counterparts when it is necessary for more commitment (for instance in CNSP) and advocate for acceptance of a multidimensional approach to capacity building.
- Strengthen inter-sectoral training collaboration to create more synergy in specific sectors (e.g. WATSAN and Health and Nutrition).

These recommendations can be synthesized along 3 main axes :
- More adaptation (contents, methodologies, models) to the context for acceptance and effectiveness,
- More professionalism (logical framework, planning, monitoring, result management, integrated capacity building approaches) for accountability and impact
- More understanding and commitment from the counterparts on the need for a multidimensional approach to capacity building to improve basic services offered for women and children.

5- Assessment by Programme

5.1- Health and Nutrition

5.1.1- Introduction

Understanding of the Health and Nutrition Program

The UNICEF Country Programme for Myanmar is based on the Convention of the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, the Women's Equality and Empowerment Framework, the National Programme of Action for the Survival, Protection and Development of Myanmar's Children in the 1990s, and the National Plan of Action on Food and Nutrition.

Objectives and strategy of the Programme

To promote and protect the fundamental right of children and women to health and nutrition, disparity reduction and universal coverage are both the driving strategies and overall objectives of the Myanmar-UNICEF Health and Nutrition Programme, designed along the main causes of infant and child mortality[1]. The major projects conducted throughout the past years thus concerned child immunisation, control of diarrhoeal diseases and acute respiratory infections, women's health, HIV/AIDS protection, and nutrition. According to a life-cycle approach, most of the activities of the programme target the under five children[2], and the women in childbearing age (15-49).

The main thrust is to empower women, families and communities to become key actors in the process of improving their health and development by encouraging service delivery, capacity building (including participatory training), advocacy, social mobilisation, communication and participation, and strengthening alliances and partnership.

Geographic Coverage of the programme

The interventions of the Country Programme during the coming years will be at two levels: at central level for policy and capacity building as well as nation-wide activities and in area-focused townships (AFT)s [3], with special emphasis placed on underserved and hard to reach areas (border areas).

To meet the challenge of Myanmar's great socio-cultural diversity, flexible community-focused planning is of high importance. The Health and Nutrition programme therefore prioritise the promotion and improvement of health services in area-focused townships, while continuing to support the universal child immunisation, vitamin A supplementation and the use of iodised salt nationwide. Existing activities and support, such as the provision of essential drugs, will gradually be focused in AFTs.

The adoption of AFTs in 2001 pursues a shift from an emphasis on "vertical approach" to programming to a "horizontal approach", which focuses on capacity building of planning, monitoring and implementation at the various administrative levels in order to achieve significant improvement in

[1] The women and children of Myanmar continue to experience high morbidity and mortality, the immediate causes of which lie in the debilitating and synergistic cycle of diseases, inadequate dietary intake and women's reproductive health problems

[2] Studies show that the first 3 years are critical to the well-being of the child and the eventual adult

[3] Administrative level covering an average of 15000 people – 1/3 of all townships should be covered by 2005

the progressive realization of child and women's right in the selected AFTs by intensive assistance in all sectors in a coordinated and collaborative manner.

Cooperation and Intersectoral Links.

The change in strategy to AFTs in 2001 contributes to the interaction and integration of health and nutrition components into projects in the other sectors such as water and sanitation and education. The implementation of the Myanmar –UNICEF program on health and nutrition aims at increased collaboration with government representatives (need for inter-sectoral coordination across ministry lines), and work with local administration and health development councils.

Moreover, NGOs being particularly well suited to play a role in the design and implementation of the local approaches, it is necessary to enhance their role in the program.

Importance of Training in the Sectoral Strategy

A mix of specific strategies for disparity reduction and universalization of services is used in the Health and Nutrition Sector program; advocacy and social mobilization, decentralization planning and management, empowerment of communities – especially women, capacity building and monitoring at the field level is emphasised. Together these strategies aim at creating a process, that will result in long-term achievements that are sustainable. By focusing on enhance, enhancing community organization and improving managerial capacities at the grass root level, the AFT is part of a long-term vision of the program, drawing on capacity building to encourage participation and sustainability. Training, which represents half of UNICEF's activities in the program, appears as a major component of an operational strategy for capacity building, in particular through improving care practices and promoting healthier behaviours. It is concerned with enhancing the capacity of governmental and public health employee personnel as well as of partners such as NGOs on planning and managing training activities, training of health staff at various levels, and also organization of local women's groups to create a new culture for health.

Training in the Health and Nutrition Program.

The major components of the program are:
- Universal Child Immunization (UCI)
- Women and Child Health and Development Program (WCHD)
- Responding to HIV/AIDS Prevention and Control Project
- Nutrition Project

Training has a key role in the efficiency of these programs/projects, since shortage of skilled basic health staff (BHS) and inadequate in-service training are constraints to the full utilization of basic health services.

Training is a continuous process, involving a range of key actors, at home, in the family and community and at the different levels of the health system. It must respond to local conditions including terrains, available staff, cultural factors and epidemiological patterns. Activities supported by UNICEF include basic training, refresher training, on-the-job training and supportive monitoring. They focus on providing health staff with technical skills and knowledge and on providing supervision and monitoring, so as to contribute to enable the population to gain ownership of the actions towards health and nutrition. Training materials and methodologies are subsequently designed to encourage and promote informed decision making and care-seeking behaviour.

Scope of Evaluation

UNICEF's selection of training components to be evaluated was based upon two main criteria; the training where the largest amounts of the budget is allocated within the Health and Nutrition sector and secondly the training where largest amount of trainees are involved.

Six training components were selected and evaluated:
6.2- Integrated Management of Maternal and Childhood Illnesses (IMMCI)
6.3- Auxiliary Midwifery and Nurse/Midwifery training (AMW/ANMW)
6.4- Traditional Birth Attendants (TBAs)
6.5- Life Skill training
6.6- Instructions of Volunteers for National Immunization Day

Section 2.1 a) above gives a brief overview of the training components evaluated and section 6 below details the evaluation findings and recommendations for each training component.

The evaluation was done in close coordination and consultation with UNICEF personnel and all involved counterparts in the MOH at different levels as well as with the two NGOs (MMCWA and MRCS) responsible for the implementation of one of the training components. The actual data collection and interviews were done by a small group consisting of four MOH officials familiar or responsible for that particular training implementation, jointly with the two evaluators. These four MOH officials also served as key informants and in-depth interviews have been undertaken during field visits.

Members of the joint evaluation team from the DOH and UNICEF consultant were:
Dr. Thein Thein Htay, AD (MCH), Division of Public Health, DOH
Dr. Tin Tin Win, Assistant Director, Division of Public health, DOH
Dr. Tin Min, Deputy Director , Medical Care, DOH
Dr. Kyaw Thin, UNICEF Consultant for WCHD
Dr. Khin New Oo, UNICEF consultant and evaluation Team Member
Ms. Lene Svendsen, UNICEF consultant and Evaluation Facilitator.

Some of the knowledge assessments have been done with the assistance of UNICEF field officers. Translations during the interviews, when needed, was done by training team members at the state/divisional and township levels. The data collection tools have been used by highly qualified and prepared individuals. Any shortcomings in using the tools have been overcome by posing the questions in different ways when not correctly understood, or asking for additional information or explanations when clarifications were necessary. A comprehensive amount of information has been gathered and thus served as basis for the evaluation findings and recommendations.

Baseline for the evaluation as indication of results of the training (before and after) has been established using previous assessment reports, training needs assessment reports and retrospective accounts of resource persons and key informants based on their working experiences.

A close consultation with the MOH; DOH, Division of Public Health and the IMMCI management group at North Okkalapa Hospital has taken place during the course of the three months of the evaluation, ranging from briefing meetings to present the methodology and the draft tools for data collection, to presenting and discussing the preliminary findings to reach consensus on final presentation of findings and recommendations

The evaluation team, together with local MOH counterparts and project managers, visited five townships in 3 Sates and 2 townships in 2 Divisions (see section 3.6 above for details).

These visits included assessments of different training activities with different status in terms of completed or ongoing during the period 1998 - 2001.

5.1.2- Summary of Evaluation Findings and Recommendations for Training in the Health and Nutrition Sector.

a) Description of training components

Problem statement: With limited access to health services for pregnant women and children under 5 years, a quality of health services that needs improvement, a shortage of sufficiently trained health care providers and shortage of basic supplies and equipment, the provision of quality health care services is undermined and leads to an excess of maternal mortality and under 5 years morbidity and mortality.

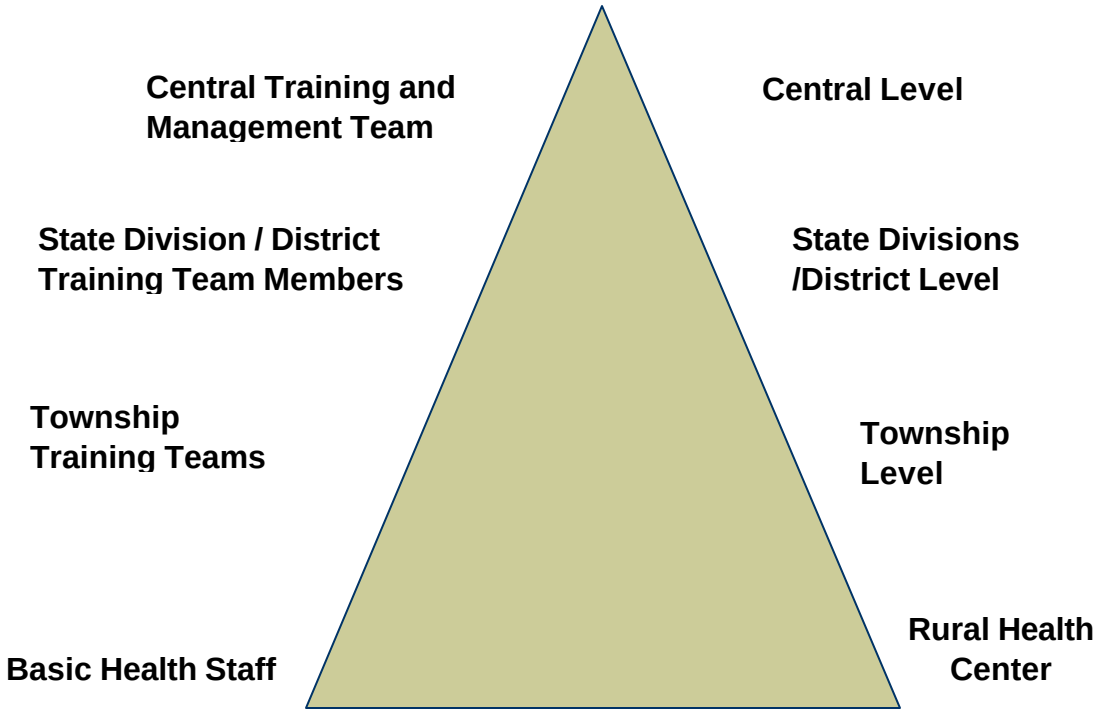
Objectives:

- To contribute to the reduction of maternal mortality, infant mortality and under 5 morbidity and mortality
- To improve the quality of and access to integrated basic health package for treatment and control of childhood illnesses
- To improve quality of and access to antenatal, postnatal and safe delivery care services and practices including the up gradation of emergency obstetric care and referral system

Implementation Strategies for training: Advocacy for policy development, capacity building through training of health personnel at different levels with emphasis on BHS and auxiliary personnel to strengthen basic health services in the peripheral as well as training of women and youth in communities.

Cascade Training Strategy.

The cascade training is used for all the training components subject to this evaluation, with the exception of training of AMWs and the instruction to volunteers in connection with the NID. The cascade usually consists of 3 – 4 levels with ToT courses at the central and state/divisional/district levels followed by training of trainees at the township and community levels. (see figure below)



For detailed information on each training component refer to section 6.

Budget: The chart below presents an estimation of UNICEF's training expenditures for each training component by year.

UNICEF's Training Budget (1US$ = 450 Kyats)

	1998 Kyats	1999 Kyats	2000 Kyats	2001 Kyats	Total Kyats	US $
IMMCI	9,204,083	8,368,327	63,437,578	42,093,444	123,103,432	273,563
ESSD	241,150	9,313,126			9,554,276	21,231
TBA	1,625,000	8,186,125	10,325,650		20,136,775	44,748
AMW		18,000,000			18,000,000	40,000
ANMW	9,385,850	9,507,000	40,750,000		59,642,850	132,539
Life skills (MMCWA)					26,980,000	59,955
Life skills (MRCS)					12,150,000	27,000
Total for training	20,456,083	53,374,578	114,513,228	42,093,444	269,567,333	599,038
Total Expenditure for H& N Program (US$)	3,177,838 US$	7,275,044 US$	7,776,874 US$			18,229,756

b) Outputs of the training (overview)

IMMCI Outputs: Number of Health Personnel Trained

Integrated Management of Maternal and Childhood Illnesses (IMMCI)	1998	1999	2000	2001	Total
Number of training courses					

conducted					
Mid-level Management course	-	-	6	17	23
• Total number trained			177	450	627
Training of Trainers	3	3	12	9	27
• Total number trained	100	81	336	241	758
Training of Basic Health Staff (BHS)	114	69	227	101	511
• Total number trained	2878	2196	5316	2526	12916

Materials Developed

	Integrated Management of Maternal and Childhood of Maternal and childhood Illnesses (IMMCI)
1.	IMMCI Manual for BHS
2.	Hand bills on diagnostic algorithms for quick reference by BHS
3.	Facilitator guides for IMMCI training sessions
4.	Supervisory Checklist and Instructions
5.	IMMCI video
6.	Cassette tapes for IMMCI songs
7.	Manual for Management of Critically Ill Child for Hospital Staff
8.	IMMCI Newsletter for Continuing Medical Education

ESSD Outputs: Number of Health Personnel Trained

	Training of Essential Steps for Safe Delivery (ESSD)	**1998**	**1999-2000**	**Total**
	Total number of townships	2	26	28
1.	Training of Trainers (Central) • No. of Medical Officers from State / Divisional Hospital trained	-	60	60
2.	Training of Hospital Staff (Medical Officers and Staff Nurses) • No. of Medical Officers / Staff Nurses trained	12	100	112
3.	Training of Basic Health Staff (BHS) • No. of Midwives trained	50	1200	1250
4.	Training of Auxiliary Midwives (AMWs) on ESSD • No. of AMWs trained on ESSD	50	750	800

ESSD Training Materials Developed and Distributed

	Essential Steps for Safe Delivery (ESSD)	Numbers
1.	Labor Ward Practices Manual	1,000
2.	Midwives Trainer's Manual on ESSD	500
3.	Midwives Manual on ESSD	1,500
4.	Posters on ESSD	5,000
5.	Pamphlets on ESSD	10,000

TBA Output: Number of Traditional Birth Attendants trained

	Traditional Birth Attendants (TBA)	1998	1999	2000	Total
	Total numbers of Townships	25	25	25	75
1.	Training of Trainers (Central) • No. of trainers trained	60	70	51	241
2.	Methodology Training • No. of BHS trained as trainers	600	600	600	1800
3.	Training of TBAs • No. of TBAs trained	1000	1000	1000	3000

Training Material Developed

	TBA Training	Number
1.	TBA trainer guide	500
2.	TBA pictorial flip chart	1000

AMW Outputs: Number of Auxiliary Midwives (AMWs) Trained

Training of Auxiliary Midwives (AMW)	1999-2000
Total Townships	160
No. of AMWs trained	2000

Training Material Distributed

	Training of Auxiliary Midwives
1.	AMW manual
2.	AMW curriculum

ANMW Outputs: Number of Auxiliary Nurse Midwives trained

	Training of Auxiliary Nurse Midwives (ANMWs)	1998 Phase 1	1999 Phase 2	2000 Phase 3	Total
	Townships	20	22	61	61
1.	Training of Trainers • No. of BHS trained	108	88	76	272
2.	Training of ANMW • No. of AMWs trained	200	220	400	820

Training Material Developed

	Training of ANMWs
1.	Manual for Auxiliary Nurse Midwives
2.	Pictorial guide for ANMWs

Life Skill Output: Number of youths and women trained

	Life Skills Training	MMCWA	MRCS
1.	Training of Core trainers • No. of core trainers trained	20	5
2.	TOT for township trainers • No. of township trainers trained	418	309
3.	Training of house wives / youth • No. of house wives / youth trained	24320 women	10080 youths

Training Material developed

	Life Skills Training
1.	**MMCWA** Life Skills training manual for township trainers
2.	Pamphlets for the trainee
3.	Calendar (Educative messages relevant to the training course)
1.	**MRCS** Manual for trainers
2.	Manual for participants
3.	Brief booklet of information for participants

Summary table of Outputs: Number trained

	Categories of trainees	Total
1.	Training team members trained for Mid Level Management Training	627
2.	Training Team members trained for TOT (IMMCI)	758
3.	BHS trained for IMMCI	12916
4.	Medical Officer from State / Divisional Hospital trained for TOT (ESSD)	60
5.	Medical Officers / Staff nurse trained	112
6.	Midwives trained for ESSD	1250
7.	AMWs trained for ESSD	800
8.	Trainers for TBA	241
9.	BHS trained for TBA (Methodology)	1800
10.	TBA trained	3000
11.	AMW trained (Basic Training)	2000
12.	BHS trained as trainers for ANMW training	272
13.	ANMWs trained	820
14.	Central core trainers (MMCWA)	20
15.	Township trainers	418
16.	women trained (life skills)	24320
17.	Central core trainers (MRCS)	5
18.	Township trainers	309
19.	youth trained (life skills)	10080

c) Process Evaluation; Main Findings for the Health and Nutrition Sector.

(Evaluation rating (ER) ranges on a scale from 1-10, where 10 is highest)

Identification (7):

Health statistics, surveys and various reports are all consistent in identifying the main causes of infant and U5Y mortality and morbidity; e.g. an ARI Health Facility survey conducted in five townships in February 1998, and used as baseline for the IMMCI, showed that BHS lacked the necessary skills in case management of sick children and that BHS were not able to recognize danger signs for when to refer to hospital for life-saving treatment. The causes of maternal illnesses and delivery complications are well known and assessed. The focus on knowledge and skill upgrading among health personnel to identify complicated deliveries and danger signs in connection with deliveries is well established in recent years. Problems with unclean and unsafe deliveries and abortions are among the main causes of the high maternal mortality rate in the country. Additional factors are few or late referral, low coverage of health services in rural areas and utilization of untrained TBA by the community. The training is all

aiming specifically towards this end, to increase access and to improve quality of health services at the grass root level.

However, the assumption that women and children seek health care in the public health system and thus will benefit from the service provided by better trained health personnel in rural areas might not hold through. It is well know, but not yet subject to research, that GPs, pharmacists, drug sellers and traditional medicine constitute a very significant part of the existing health care system in the country. UNICEF has very limited contact with these providers presently.

Preparation (9):
Existing structure for in service and basic training is strong in Myanmar vis a vis the training teams at state/divisional/district and township levels. These teams are very well utilized for all the training components that have been evaluated. The teams also perform supervision of all health personnel. This on the other hand, results in the training teams being overloaded with tasks and it appears to be creating a "bottle neck" at township level

Continuing Medical Education (CME) is another existing mechanism for in-service training. CME is provided monthly (2-3 hours) to BHS and hospital staff by the training team headed by the DMO and the rest of the team (4-6 members). It is a strong existing mechanism for systematic in-service training with countrywide coverage

Training needs are being addressed and the training is very much related to daily scope of work. The awareness, knowledge, skills and behaviors needed for strengthening of the health services were defined. Some of the training components started with pilot townships in initial phases before expanding.

Implementation (7):
The cascade model is used for efficient coverage of large numbers of BHS and Voluntary Health Workers; AMWs, ANMWs and TBAs. The two NGOs collaborating with UNICEF for Life Skill training also use the cascade approach to cover large numbers of women / youths. Central level training is quite good.. State / Division level training is better than township level training indicating that there is, as expected, a dilution effect for each level of the cascade.

Training activities are implemented more or less as planned. (Sometimes delayed)

With the change in UNICEF's implementation strategy for the entire country program to focus on a more limited number of townships by 2001 starting with 19 and expanding the coverage over the next five years to 1/3 of the total number of townships in the country, it becomes a major issue to find support for the continuation of training of ANMW/AMW, TBA and BHS/hospital staff in the non AFTs. and to identify the resource requirements.

Coordination and collaboration needs strengthening between DOH, Division of Public Health, DMS and UN agencies for determining training strategies, target groups and content/methodology of training materials

Trainers (7):
Trainers are more costly to train than trainees, but seem to be key resource persons to invest in, because they are all members of the training teams at different levels of the health system and thus responsible for all training implementation of all health personnel the central level trainers are good. Training of trainers (ToT) courses were conducted at different levels, but need to be done more

frequently and systematically to cover larger numbers and to respond better to the situation of rotation among staff. State / Division level trainers are good.

Training methodology (6):
Participatory approach with various technique including lecture - discussion, demonstrations, group work discussion and presentation, role play, game, question and answer, drill method, hands on practice, is used. However, there is also a fair amount of non-participatory methods being used as group reading and one-way communication. The participatory approach seems to work better at central and State/Divisional level than township level.

Training material used (5):
A substantial amount of training materials is being developed by the MOH and UNICEF in closely related technical areas. However, the quality of material can be improved and content updated.

Trainer's manuals or facilitator guides and trainee's manual were reviewed in terms of their presentation (illustrations, graphic), content (relevance to training objectives and practicality), and language (clarity, application with examples, and relevance to target group). Trainer's manuals or facilitator guides need to be improved. Trainee's manual should also include more illustration with colors.

For Auxiliary personnel there is hardly any material and other teaching aids available, e.g. pelvic models, pictorial guides, posters etc.

Management of the Training Components (6):
The DMO plays a key role in the management of all training. The management mechanism for implementing training is established and appears to function in-spite of manpower shortage**.** Inputs from central and state/divisional levels take place as planned. Supervision from different level (central to S/D and township, S/D to township) is established. Supervisor meeting was held every year. Micro planning to conduct IMMCI training at township level is done well. The management approach seems to be top-down and the communication follows same top-down pattern.

Monitoring and evaluation (3)
Needs to be strengthened. For most of the training there is no monitoring and evaluation that capture results or changes in practice due to training. There is no use of indicators. Forms have been developed by few of the training components and taken into use during 2001, e.g. supervisory checklists and pre/post knowledge assessments. However, the analysis and use of the monitoring data has just recently been initiated by IMMCI as the first among the training components evaluated. For the practical part of training of all trainees there is no mechanism that ensures minimum exposure to deliveries or other hands on practice.

UNICEF needs to provide capacity building for the establishment of ongoing and regular monitoring and evaluation mechanisms for all the training components. Forms for monitoring and specific requirements for review and evaluation of every training component should be provided. Likewise more technical input should be provided for the preparation and presentations for the annual program review to bring more focus on the process of training implementation, the efficiency vis a vis costs, the management, the results and the relevance.

Follow-up and Supervision (ER 3):
Follow-up after completed training is done on irregular basis and needs to be strengthened. For some of the training components the evaluation mechanisms and indicators have recently been taken into use

and thus the data has not yet been fully analyzed. For other training components there is no evaluation or supervision..

Efficiency (8): Different types of training were reviewed for the year 1999.and appears to be efficient taking the unit costs into consideration.

Sr.	Training Type	# of days	Number of participants	Total Cost (Kyats)	Unit Cost / person (Kyats)	Unit cost/ person (US $)	Unit Cost / person day (Kyats)	Unit Cost / person day (US $)
1.	IMMCI TOT for Magway District	5	24	414816	17284	49.67	3457	9.93
2.	IMMCI Training of BHS in Magway Division	5	648	5731560	8845	25.41	1769	5.08
3.	ESSD TOT (central)	3	60	642360	10706	30.85	3569	10.28
4	ESSD Training of BHS	3	916	4381456	4783	13.78	1594	4.59
5.	TBA TOT (central)	6	70	1316160	18802	54.18	3134	9.03
6.	TBA Methodology training (township)	6	600	6438825	10731	30.93	1789	5.15
7.	TBA TBA training	6	1000	8186125	8186	23.59	1364	3.93
8.	AMW AMW training	180	2000	18000000	9000	29.94	50	0.14
9.	ANMW TOT at township	7	76	975000	12829	36.97	1833	5.28
10.	ANMW ANMW training	180	400	38880000	97200	280.12	540	1.56

Overall Process Evaluation Findings: 7

Very good preparation	8
Very good implementation system	8
Fair trainers	6
Fair instructional techniques	5
Fair training materials	6
Poor monitoring and feedback	3
Good unit costs	8
Excellent time management	9

d) Results of the Training.

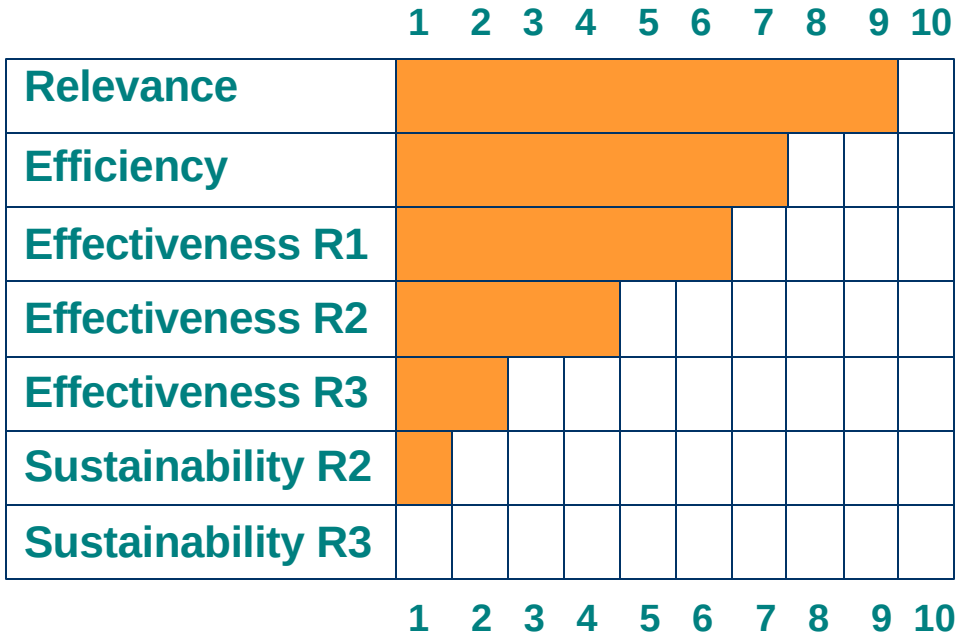
Level of Result	**Level of Effectiveness**	**Sustainability**
1. Change in participants knowledge, skill & attitude	Capacity building of training teams takes place; there is evidence of fair amount of knowledge upgrading and less of skills. Attitudes takes longer time to change than	To maintain the knowledge refresher training is needed

	most of the training courses offer.	
2. Change in individual performance	Some indications of changed practices in clean delivery practice. More confidence and better job aids. However, change in practice could be better, few referral of pregnant women per year, (1.4 referral) low no of deliveries per 3 months (2.5 deliveries)	Some improved delivery practices are sustainable but high demand from community for continuation of traditional practices, scarce resources for health and capacity constraints makes sustainability limited.
3. Change in organizational performance	No evidence	NA
4. Improvement in situation of children & women	NA	NA

e) Relevance:

- The training is relevant and related to day to day practice.
- Target group for training to focus more on front line health worker to improve outreach
- Consider including GPs in the training to ensure standardized and quality health care.

f) Conclusion



- The planning and implementation of training to a large number of trainees takes place and seem to be efficient in view of relatively low unit costs per trainee.

- The implementation system and management of the training components is functioning in spite of manpower shortage and other constraints.

- The benefits of training is lost because conditions of institutional change and sustainability is not met.

- A strategy to transform the training into changed practices and improved quality of services is lacking.

- The training component is not placed in a comprehensive context, e.g. supported by policy, job description or regulation for practice, and needs to become part of a broader capacity building approach.

g) Main Recommendations for Health and Nutrition Sector

Recommendations for UNICEF:

capacity building

1. UNICEF to be instrumental in establishing coordination and involvement of different partners in women's health and reproductive health (e.g. among the partners on reproductive health policy) for strategy and material development as well as coordination of project activities.

2. Provide to DOH and NGO counterparts monitoring and evaluation framework and **methodology for all UNICEF supported activities to be used for regular reporting and review meetings.**

3. Facilitate the establishment of a Training Coordination Committee in DOH with membership of different MOH Departments; DOH, Division of Public Health, DMS, DHP and UN Agencies; UNICEF, WHO, UNFPA.

4. Explore support to training teams and CME countrywide

5. Assesses the capacity status of the state/divisional/township training teams regularly and provide input accordingly.

6. Strengthen input to Life Skill training of core trainers and ToT courses at township level with emphasis on trainers' skills as facilitators.

7. Facilitate the coordination between MMCWA and MRCS for strengthening of training implementation, material development and monitoring/evaluation mechanisms.

practice regulation

1. Endorse revised job descriptions of midwives dated 2000 to concentrate on core functions of midwifery tasks and reallocate non-reproductive tasks to other BHS e.g. PHS grade I.

2. Continue to advocate for enabling regulation on AMW/ANMW practice in relation to UCI and injections for life saving procedures.

change in training strategy

1. Focus more on front line public health workers as target group for training.

2. Consider including General Practitioners in the training (e.g. through collaboration with MMA)

3. Merge ANMWs into the AMW training and introduce standardized training approach with potential countrywide coverage.

4. Ensure minimum delivery exposure and hand on practice norm during AMW/ANMW training.

5. Consider phasing out TBA training and upgrade existing TBAs to AMWs and develop HRH work plan and policy for this process.

6. Improve sustainability aspect and use of Life Skill trainees (youth and women in fertile age) to full potential in support of HIV/AIDS community mobilization. e.g. support groups for PLWA, condom promotion, counseling, Community Home Based Care and IEC activities

7. Conduct more follow-up and refresher training of all trainers, specifically at township level, e.g. Life Skill trainers at township level need to be strengthened in facilitation skills.

improve access to basic health services

1. UNICEF be instrumental in preparing proposal and cost estimates for AMW/ANMW training needs in Myanmar for reaching the proposed staffing norm, to be presented for funding (UNICEF and other interested agencies).

training content and methodologies (improve balance between knowledge and skills)

1. Use standardized training approach and technical inputs for material development / revision

2. Emphasize skill upgrading rather than knowledge in training

Recommendations for MOH:

human resources for health

1. Assess present ANMWs/AMWs staffing situation and estimate training needs and develop training plan to reach proposed staffing norm of 1 AMW/ANMW per village.

2. Increase present training capacity from 10 AMWs/ANMWs per township per year.

5.2- Education

5.2.1- Programme/project Background for Training in Education

Problem statement: There is a need to increase access to primary school by enrolling, retraining and completing more children in primary education; and there is a need to improve the quality of teaching and learning in primary school. There is also a need to increase and improve pre-school childcare support and learning.

Objectives 2000:

- Improve all schools in Area Focused Townships (AFTs) with at least 60 percent progressively becoming child-friendly with supportive PTA's and communities[4]

[4] Until 1998 Continuous Assessment Progression of Students – CAPS project focused on improving teacher training; and All Children in School – ACIS project focused on community supporting school. Both were combined as the Child Friendly Schools Project -- CFS in 2000. SHAPE began in 1998, but was also included in the CFS project in 2000.

- Increase appropriate practices concerning life-skills, health living and HIV/AIDS prevention among students, teachers and community members involved in SHAPE (School-based Healthy Living and HIV/AIDS Prevention Education)

- Increase and improve children participating in quality Early Childhood Care and Development (ECCD) through formation of Networks and the number of pre-Kindergarten day care learning centers or Early Childhood Development (ECD) centers.

Strategies:
- Capacity Building, advocacy for action and service delivery through improved teacher and leadership training; improved learning outcomes through Child-centered Learning (CCL) practices; enhancing school-community collaboration; provision of supplies; and improved support and monitoring.

- Capacity building, advocacy for action and service delivery through content focused teacher training on SHAPE knowledge and skills, participatory learning and community support.

- Capacity building, community mobilization and service delivery of ECCD Networks and ECD Centers

5.2.2- Brief Training Component descriptions

Training Component Types and Objectives:
- **Primary Teacher Training:** To prepare teachers for more effective teaching and learning and management of primary school classrooms
- **PTA Training:** To provide knowledge and skills on community mobilization for better participation and monitoring progress of schools
- **SHAPE Primary & Secondary Teacher Training:** To increase knowledge and skills of principals and teachers on health promoting behaviour, life skills and HIV/AIDS information and participation in teaching and learning methods.
- **SHAPE PTA Training:** To increase participation of parents as members of PTAs in supporting SHAPE implementation
- **ECCD Network Training and ECD Training:** To train ECD teachers and to orient and train facilitators and mothers to establish and operate ECCD Networks.

Target Groups:
- **Primary teachers** – usually with no previous in-service training in AFT Township schools; and Assistant Township Education Officers and selected Cluster Heads as Township Team trainers.
- **Primary and secondary school teachers** (Standards 2-9) from 60 Townships for SHAPE**;** and Assistant Township Education Officers and selected Head Teachers as Township Team trainers for SHAPE
- **Parent Teacher Association (PTA**) members selected by community in school catchment's area for both CFS and SHAPE schools
- **Pre-Kindergarten Day Care teachers and Network members –** usually teachers with Primary Teaching Certificate and Network facilitators.

Implementation Strategies: Cascade Approach
- **Central Level Training:** At the Center in Yangon, currently, 35 core trainers are members of the curriculum unit from DEPT. Formerly, it was a shared effort between the curriculum unit and the Teacher Training Colleges. The trainers train "Township Teams" consisting of 10-20 ATEOs and

Head Teachers who are Cluster Heads. About 400 Team members from 20 Townships are trained per year at the center in classes of 30-40 at a high school. All ATEOs in selected townships are trained. Cluster Heads come from core schools. A core school is selected based upon its location where township office can easily communicate with it; the core school is accessible to its satellite schools; and active communities surround the core school. Those Head Teachers of Clusters selected for training are those who are available for the training and who have a reputation of being reliable. The Township authorities use these criteria to select the Head Teachers.

- **Training at the Township Level:** At the Township level, training attempts to be a mirror image of center training but with more flexibility. Target teachers are divided into two groups: those teaching K-2; and those teaching standards 3-4. Once the Township Teams have been trained at the Central level, then they train teachers at the Township level during the three holiday periods soon after their return from Yangon during the same vacation periods. That is, Teacher training is for 20 days: 10 days in May during summer vacation; 5 days in October during Buddhist holiday; and 5 days in December during Christmas holiday

- **PTA Training:** This adds another tier. The same curriculum unit trains Township teams of 5 Cluster Heads and ATEOS. These in turn train Head Teachers and Cluster heads at the Township level. Then, these Head Teachers/Cluster Heads train community members selected as PTA representatives at the school level. Also PTA training at the bottom level is only two days.

- **SHAPE Training:** SHAPE training of teachers and PTA member follows the same tier structure as CSF training of teachers and PTA but for fewer days.

TRAINING COMPONENTS IN THE EDUCATION & EARLY CHILDHOOD DEVELOPMENT PROGRAM 1996-2000

(See Annex 6 for detailed description of components)

PROJECT	SUBPROJECT	TRAINING COMPONENT
CAPS	-------	1. Primary Teachers
ACIS	-------	2. PTAs
ACIS, SHAPE	-------	3. Orientation workshops for township teams
ACIS,CAPS,SHAPE	------	4. Orientation workshops for TEOs/SEOs on implementation of UNICEF projects
CFS	SHAPE (since 1998)	5.Teacher training in 60 townships
CFS	SHAPE (since 1998)	6. PTA training in 60 townships
CFS	SHAPE (since 1998)	7. Training School principals in 60 townships
EDC	Centre-based ECD	8. Training for ECD teachers

TRAINING COMPONENTS IN THE EDUCATION & EARLY CHILDHOOD DEVELOPMENT PROGRAM 2001-2005

PROJECT	SUBPROJECT	TRAINING COMPONENT
Child Friendly Schools (CFS)	**Improving Quality**	1.Primary Teachers
All Children in Schools (ACIS)	Improving Quality	2. PTAs
CFS	Improving Quality	3. Orientation workshops for township teams
		4. Orientation workshops for TEOs/SEOs on implementation of UNICEF projects
Early Childhood Development (ECD)	Centre-based ECD	5. Orientation on ECD

ECD	ECCD Network	6. Community toy making workshops
ECD	ECCD Network	7. Training of ECCD support Groups
ECD	ECCD Network	8.Orientation on ECD
ECD	ECCD Network	9. Orientation on ECD
ECD	ECCD Network	10. Training of ECD teachers

Summary by Type and Tier:

CFS Primary Teacher Training:

Central → ATEOs/Cluster Heads (CH) 15 days

ATEOs/CH → Teachers 20 days (10+5+5)

CFS PTA Training:

Central → ATEO/CHs 3 days

ATEOs/CH → Teachers 3 days

Teachers → PTA Members 4 days (2+2)

SHAPE Teacher Training:

Central → ATEOs/HT/Teachers 6 days

ATEOs/HT/Ts → Primary/secondary teachers 4 days

SHAPE PTA Training:

Central → ATEO/CHs 3 days

ATEOs/CH → Teachers 3 days

Teachers → PTA Members 2 days

Implementation Strategies: Orientation Workshops

These are of two types: Township Project Team Planning; and sensitization of Senior Education Officers to all UNICEF assisted projects. The Township Planning workshops clarify the objectives and philosophy of each project and discuss current situation in different townships and then develop action plans for project implementation including training. The Senior Education workshop is to raise awareness and understanding about UNICEF assisted education activities and the role of Senior Education Officers in them.

Implementation Strategies: Standard ECD Schools and ECCD Networks

Combined UNICEF and DEPT training prepares directly Pre-KG teachers through a training of about 30 days. Participants are usually university or high school graduates who may have a Primary Teaching Certificate obtained through in-service training at an Education College. Training consists of an overview of child development psychology; interrelationships between physical, psychological and cognitive growth; an understanding of "learning through play"; problem-solving, creative and discovery methods to implement learning through play; and the importance and approaches to improve child nutrition.

The ECCD Networks are more complicated and attempt to reach more children than those in school. Two purposes are envisioned:

- to provide a wider range beyond Pre-KG classes of modern childcare to very young children (12 –36 months);
- to mobilize and train mothers in the essentials of modern child care and nutritious foods.

Using a primary school with a Pre-KG class as a base, a Support Group is formed consisting of the Head Teacher, PTA members and Pre-KG teachers. To form a Network the ECCD core training team (UNICEF and DEPT) selects three leaders or facilitators from a community and trains them for three to five days—mainly in modern childcare and the preparation and use of nutritious foods for children. The Support Group provides follow up to this training to the facilitators. These facilitators in turn form and support 3-4 Mother's Circles. Each Circle consist of one influential Mother whom the facilitator orients and supports, and 10 infants or young children from the community who are brought to the Mother' home each morning for three hours. Facilitators visit Mother Circles to explain and demonstrate:

- interrelationships between physical and mental development,
- essential elements of modern child care;
- importance and preparation of nutritious food,
- recognition of malnutrition, and
- measuring and recording infants' weight and height

Thus, a ECCD Network consists of a base Primary School with a Pre-KG class; a Support Group that assists facilitators; three facilitators each of whom assists 3-4 Mother's Circles for a total 10 Mother's Circles; and 10 children in each Mother's Circle for a total of 100 children and 10 mothers in the Network who otherwise would not be assisted in modern childcare.

The ECCD Network has only been implemented for one year (2000-2001) and currently about 30 are in operation. It is premature to evaluate them, and so only a few in-depth interviews by the observers were conducted. These interviews seemed to indicate, however, that the Networks were in place and operating as planned.

5.2.3- Evaluation Approach

Past Evaluations of CAPS/ACIS Projects: These two projects underwent an extensive and highly impressive qualitative and quantitative review through mid term evaluation in 1998. The qualitative evaluation observed and interviewed almost 100 teachers in 20 schools in accessible but varying regions throughout the country. The evaluation focused upon the patterns and quality of teaching-learning processes, community-school collaboration, viability of the cluster system, and UNICEF training. The overall finding was that these two projects were making some progress in getting teachers to shift from a traditional teacher-centered approach to a child-centered approach; but that too many teachers still relied upon rote-learning and related instructional styles with only a minority beginning to breakout of the rote learning cycle to employ teaching aids, group games, competition and the like. The evaluation recommended strongly that teachers who underwent short-term in-service UNICEF training in the CAPs project be followed up with retraining and support; and that communities that benefited from the ACIS project likewise receive more follow up training and support. Other recommendations were implemented and will be noted below.

At the same time in 1998, the UNICEF Education section commissioned a study on internal efficiency (rate of flow of students through education system). When comparing the coefficient of internal efficiency, all four of the selected townships proved to be less efficient compared to the nation as a

whole in 1990/91. But in 1994/95, after the CAPS/ACIS projects started and influenced schools in these townships, the coefficients of internal efficiency for each of the four townships were significantly higher than the national figure.

SHAPE has not undergone any evaluation since its inception in 1998. However, the UNICEF project officer has attempted to monitor the SHAPE training that has taken place in 30 townships in 1998; 20 townships in 1999; and 10 townships in 2000. Monitoring exercises have consisted in school visits to see if the SHAPE materials are being used, and whether teachers could demonstrate recommended exercises to involve students in role playing, discussions and brainstorming on such topics as prevention of HIV/AIDS, use of life skills for decision-making and individual development, and preventive health and hygiene measures. The classroom observers visited a number of SHAPE schools from DEPT who gathered data from schools for this final evaluation.

2001 Current Evaluation: As part of the cross-sectoral end of term evaluation of training in education, health and water resources, the education evaluation employed two data-gathering teams of four members each. For approximately one month, the two teams visited 70 schools in 20 townships in 4 Divisions and 3 States (See Annex 1 for details). Only schools that had CAPS/ACIS/SHAPE or CFS teachers were chosen. Townships were selected purposively to represent differences in rural and urban areas, geographic and linguistic differences, and levels of community poverty and development. Data-gathering observation and interview tools were developed for classrooms, students, teachers, ATEOs and PTA members (See Annex 3)

The teams first observed classroom interaction in standards K-4, and then they followed up the observations with individual and focused group interviews of the same teachers and with a few students from the observed class. Finally, the teams interviewed parents and PTA members in the community and the Cluster or Head Teacher and the ATEOs about school-community relations. The external facilitator and his assistant monitored and supported the teams in the field in focused group interviews and upon their return visits to Yangon. Questionnaires were coded, translated and analyzed to provide summary analyses for the draft and final reports. In addition, central and township level training sessions were observed and focused group interviews provided information from trainers from both levels as well as from key DEPT officials. Finally, all training materials were reviewed and rated (See Annex 5).

For standard ECD and ECCD Network pre-Kindergarten schools a semi-structured questionnaire was developed (See Annex 3). The questionnaire included focused questionnaires and a four point rating scale to compare differences in school facilities, materials, and student and teacher activities. Four observers with ECD experience visited 10 Pre-KG schools that were purposively selected to compare differences between Network and Standard Pre-KG classes; and between above average and below schools of both types. In addition, two observers conducted in-depth interviews with Network participants to obtain a profile of their structure and operations.

For a more detailed discussion of the evaluation methodology of the Education Sector, see Annex 7.

5.2.4- Outputs: Materials Distributed and Numbers Trained

Year	No. of Head Teachers & Teachers Trained	No. of PTA Members Trained	No. of ATEOs Trained	Materials Developed & Distributed	Supplies Distributed for Project Implementation
1995	6000	16000	190	1,300,000 exercise books	51 motorcycles; 298 bicycles; 176,925 roofing sheets; 4,581 sets of latrine pans
1996	9425	14916	90	350 teacher trainers' manuals 10,000 sets of teachers guides 800,000 exercise books 1200 manuals for monitoring & supervision 1000 enumerators' manuals 800 modules for PTA training	23 motorcycles 575 bicycles 105,000 roofing sheets
1997	1715	8575	55	500 teacher trainers manuals 20,000 sets of teachers guides 480 exercise books 300 PTA training manuals 200 monitoring & evaluation manuals 650,000 textbooks for students	28 motorcycles 614 bicycles 98,500 roofing sheets 6,980 sets of latrine pans
1998	35,348	35,890	100	655,600 exercise books for students 50,871 exercise books for training 13,990 teachers' manuals	5 motorcycles 337 bicycles 4274 latrine pans 117,405 roofing sheets 8604 plain sheets
1999	23,121	25,000	68	8091 Facts for Life books 264,715 SHAPE teaching aids (2-9) 18542 Training Exercise Books 14140 Training Teachers' Manuals	44 motorcycles 582 bicycles 4438 latrine pans 9015 roofing sheets 6350 plain sheets

Year	No. of Head Teachers & Teachers Trained	No. of PTA members trained	No. of ATEOs trained	Materials Developed & Distributed	Supplies Distributed for Project Implementation
2000	9375	11365	32	850500 Student Exercise Books 250,566 Training Exercise Books 14144 Training Teachers' Manuals	47 Motorcycles 255 bicycles 3450 latrine pans 90,360 roofing sheets
Total	**84,984** (43,000 or 52% of total= SHAPE; 41,984 or 48% of total= CFS)	**111,746** (74,246 or 67% of total= CFS; 37,500 or 33% of total= SHAPE)	**535**		

5.2.5- General Findings

5.2.5.1 Process Evaluation (A score of 1-10 is given for the assessment of each item: 1=lowest score to 10=the highest score.)

Very Good Preparation (8): Overall, there was good preparation and identification of training needs for CAPS/ACIS and then for CFS that includes SHAPE. This is largely because the sound recommendations of the 1998 mid term assessment were enacted. These include:

- Combining the CAPS, ACIS and SHAPE projects into one CFS project. This consolidation contributes to more efficient management of the activities.
- The reorganization of MOE Departments to include a more broad based Department of Educational Planning and Training (DEPT). The DEPT has a stated policy to promote Child-centered Learning. The Director-General who openly supports this policy introduces each central level training session.
- UNICEF-DEPT dialogue. Relations between the UNICEF Education Section and their DEPT counterparts are very good. They work together on a regular basis to improve the Child-centered Learning approach. In fact, this evaluation could not have taken place were it not for the full cooperation of DEPT with UNICEF.
- Adequate UNICEF staff in Education for CFS and ECCD projects. This staff is committed and qualified to promote both projects with a contract person being hired as a UNICEF staff member. However, the entire staff appears overworked and could use more office support, especially in the area of budgeting and monitoring.
- Coordination with UNDP. UNICEF staff meets regularly with UNDP education staff for information sharing.
- While the 1998 evaluation underlined the cascade approach as an efficient implementation strategy for initial CFS training, it also emphasized the importance of follow up training to ensure sustained quality. The Cluster approach has attempted to provide follow up training, but this has not materialized to the extent needed.
- Independent consultants were used during planning stages of CAPS and CFS.

Fair to Good Implementation (6)

- **Cascade:** For rapid and efficient coverage of untrained teachers, the cascade approach has worked well. Central level training is very good with DEPT instructors providing models and examples of Child-centered Learning while discussing them. Township level training is more uneven with ATEO/Cluster Heads lecturing about CCL instead of providing modeling, demonstrations and examples. In addition, observation of training and the responses of participants indicated that the Cascade levels of training followed an established schedule very well at the central level.

However, at the township level there were some problems. Sometimes, Central level officials gave insufficient notice to teachers in township schools that they would be obliged to attend training. Some of these teachers had already planned to return to homes during the holidays and opted not to attend training. Also, some of the rural and remote schools in townships are quite dispersed, and teachers had difficulty travelling, or simply could not travel to the townships for training, especially during the monsoon season. Finally, education officials and teachers alike said that training at both levels was too short, and could not be expected to have sufficient impact upon participants.

The following illustrates the strengths and weaknesses of the Cascade approach as articulated by key informants:

STRENGTHS	WEAKNESSES

• Quick and efficient method to disseminate training information	• "One shot" approach that may achieve initial coverage, but unless followed up, trainees are likely to relapse back to previous behaviours
• Wide coverage, especially when strategy, methodologies, materials, etc. are worked out	• Monitoring difficulties. Because of wide spread delivery, costly to monitor properly. Quality assurance difficult to attain.
• Cost-effective to implement mainly because model uses existing personnel as trainers and monitors	• Logistical difficulties, especially when transporting trainees in rural areas
• Delegates responsibility to lower levels by encouraging local level officials to implement training with village teachers, health workers or extension workers. This legitimizes their position as "professionals", strengthens their identify with government and encourages more participation	• Trainers because of different backgrounds and experiences as one moves from the center to periphery are likely to "re-interpret" training messages into previous behavioral patterns. Hence, training messages are likely to be distorted or diluted as they move from one level to the next. Despite quality assurance efforts, likely to be "informational slippage" as training programs move from one level to next.

- **Direct Training:** These orientations do just what they are supposed to do – orient the unitiated to new material and approaches
- **Follow up Training:** While there is some follow up through refresher courses by Cluster Head Teachers to teachers in satellite schools, it is weak and irregular. This whole area needs substantial re-thinking and strengthening if the CCL approach is to become institutionally sustainable.

Fair to Good Trainers (6)

- As above, the central level trainers are well qualified both within UNICEF and in DEPT. They make some attempt to convey full understanding of CCL to ATEOs/Cluster Heads. The quality is more uneven among ATEOs and Cluster Heads even though they make up for limitations in their training expertise by approaching training from school experience and a school perspective
- It is quite apparent that at both levels trainers do not convince fully participants of the rationale, need and objectives of changing from teacher-centered approaches to child-centered approaches to learning. Evidence comes from ambiguity and questionable commitment of trained teachers to use wholly the CCL approach.

Fair to Good Instructional Techniques (6)

- Again the same problem with the two levels. At the central level CCL is conveyed through a host of methods: lecture-discussion; demonstrating and practicing in group work, teaching aids, making teaching aids; managing groups for effective learning. While the same is done at the township level, the delivery tends to be more uniform and routinized with less effective demonstrations and modeling of CCL methods..
- Also, many teachers did not remember specifics about their CCL training at the township level suggesting that if there was an initial impact upon them, it wore off after training.

Good Training Materials (7)

- Two levels of materials were reviewed comprehensively in terms of their presentation (illustrations, graphic), content (relevance to training objectives and practicality), and language (clarity, application with examples, and relevance to target group). The levels were for training of trainers at the central level; and the training of teachers or PTA members at the township and school levels, respectively. At the training of trainers' level, materials included teachers' manuals, workshop

guidelines, and courses for trainers. At the township and school level, the manuals included teachers' manuals and aids; workshop methodologies; and information books for SHAPE teachers and PTAs.

- The SHAPE materials are clearly more detailed, cogent and effective than the CFS/CAPS/ACIS materials. The most common problem with the latter is that concepts and skills are not always described and illustrated clearly. Occasionally, the objectives are not mentioned, or the explanations of concepts and skills are too brief without sufficient detail. Overall, however, the materials are above average.

Fair to Good Monitoring and Feedback (6)

UNICEF and DEPT have established feedback procedures to monitor the training in the field. These consist of:

- **UNICEF field trips:** to see whether training requirements in terms of time, content, and methodology are being met; whether in fact the required number of teachers attend training at the Township level training; and observe the classroom training of teachers. UNICEF personnel discuss process and problems with ATEOs; then they recommend adjustments.

- **DEPT core trainers field trips:** the same

- **Consulting firms:** Consulting firms assist DEPT to conduct the same monitoring but investigate special problems for which DEPT may not have the capacity (e.g. internal efficiency coefficients), or they go to more remote schools.

- **Review Workshops:** ATEOs, Cluster Heads, and teachers seconded to Township Office review problems in the training process. This includes training as well as more general project implementation issues. Also carried out at the Center level.

Relatively Low Unit Costs

- Four types of training were reviewed for the year 1998 accounting for DSA for participants; Travel allowance (for central level training only); and materials (not yet included in final calculations). Findings were:

Serial No.	Training Type	# of Days	# of Participants	Total Cost	Unit Cost (participant day)
1.	CAPS/CFS -- 10 townships TOT at central level	35	268	Ky 7035000	Ky 750
2.	CAPS/CFS -- 10 township level training of teachers	20	5101	Ky 51010000	Ky 500
3.	ACIS/CFS – 11 townships PTA members	2	8375	Ky 8375000	Ky 500
4.	SHAPE/CFS – 30 townships: primary & secondary teachers	4	34906	Ky 69812000	Ky 500

Cost of Training Materials

Sr.	Year	Training Materials	Distributed	Total	Unit

No.			No.	Cost	Cost
1	1998	Student exercise books	655600	45892	$ 0.07
2	1998	Training exercise books	40871	10217.75	$ 0.25
3	1998	Primary Level-Teacher's Manual	13990	8813.7	$ 0.63
4	1999	Teaching Aids (2+3-4)	106557	33032.67	$ 0.31
5	1999	Teaching Aids (5-9)	158158	96476.38	$ 0.61
6	1999	Primary Level-Teacher's Manual	12070	7604.10	$ 0.63
7	1999	Middle and High Level-Teacher's Manual	2070	2049.30	0.99
8	1999	Training exercise books	18542	4635.50	$ 0.25
9	2000	Student exercise books	850500	59535	$ 0.07
10	2000	Training exercise books	250566	62641.50	$ 0.25
11	2000	Teaching Aids (2+3-4)	50450	15639.50	$ 0.31
12	2000	Teaching Aids (5-9)	44049	26869.89	$ 0.61
13	2000	Primary Level- Teacher's Manual	6051	3812.13	$ 0.63
14	2000	Middle and High Level- Teacher's Manual	8093	8012.07	$ 0.99

Overall Efficiency: (6-7)

An above average overall rating is given to training because of strong elements in most of the components. Because UNICEF and DEPT enacted the key recommendations of the 1998 evaluation, the "stage was set" for a sound design. The choice of the Cascade model as a strategy for training implementation was also a good and achieved wide coverage in a relatively short time with minimum resources. Also trainers, especially at the central level are quite good and they employ good materials in their training. Finally, monitoring and feedback is systematic and produces regularly reliable information on the strengths and shortcomings of training implementation.

The weak elements have been mentioned above. These include some gaps in the cascade system at the lower or township levels. These relate to uneven scheduling, less efficient teachers than those at the central level and not enough attention to careful explanation and usage of methods and concepts in the materials. However, SHAPE exhibits less of these shortcomings than CFS. These weak elements result in limiting the trainers – at both levels—from convincing participants of the rationale, importance and philosophy of the Child Centered Learning approach. These issues need to be addressed if the entire CFS project is to move to another plateau of progress.

5.2.5.2 Results Evaluation

Level of Result	Level of Effectiveness	Sustainability
1. Change in participants knowledge, skills and attitudes	Barely satisfactory (5) in that participants understand only basic elements of CCL without fully grasping the philosophy and objectives. Many simply re-interpret CCL into their more traditional teacher-centered or instructional approaches to teaching and	Relatively high at first, but as teachers gain experience after training, they tend to lose sight of CCL objectives, understanding and skills.

	learning. Students do learn however.	
2. Change in individual performance	Less than satisfactory (4). Roughly, 50% of participants retain or revert to traditional teacher-centered practices, 30% use instructional emphasis though teacher-centered, and only 20% continue to use CCL mixed with traditional or instructional patterns. Still, in latter two patterns CCL elements are used -- though used selectively. Improvement over 1998 evaluation	Use of instructional and CCL patterns over time suggests that some teachers have incorporated selectively patterns and methods of CCL into their own teacher-centered approaches. Hence, relatively low level of sustained CCL usage in individual performance
3. Change in organizational performance	Appears to be relatively low (2). Needs further examination, but in cases where head teacher is committed to CCL, where there are more than one project trained teacher, and where ATEO and/or Cluster head is active, then "élan" or spirit of school may be more CCL. This affects attitudes, outlook and morale of teachers and students.	Cannot expect a real and sustained change in organizational performance until there is sufficient improvement in initial and follow up teacher training through Cluster system. Also, it is questionable whether GOM will continue priority on CCL once donor assistance through UNICEF and UNDP terminates.
4. Improvement in the situation of children& women	Relatively low (2). Appears that project efforts are less widespread and effective in rural and remote areas than they are in urban, town and less remote areas. However, CCL through project does reach some of the former. Also, Head Teacher/PTA organized "incentives" to waive school fees, supply books and materials, etc. for needy and poorest in community. These are effective in some cases.	

5.2.5.3 Relevance of the CCL Approach to Teacher Training as a Capacity Building Strategy

Most technological and organizational innovations in developing countries have some relevance to overcoming the countries' problems; and they also have some irrelevance to the countries' traditional ways of approaching these problems. The development problem is how to emphasize the relevant aspects and stimulants for acceptance; and to minimize the irrelevant aspects and the constraints for acceptance.

There are both broad stimulants and constraints for this project training strategy within Myanmar society and culture. The stimulants are that the Myanmar people have a long tradition of holding schooling and formal education in high regard – they really want to improve their learning for both intrinsic and extrinsic reasons. Second, the government is committed to this increase and improvement of primary education through more effective teaching and learning (including CCL) policies and methodologies. The government also has a tradition of undertaking and responding to research reports. Third and perhaps most important, there is a desire to learn and improve one's lot by students and teachers. Students emphasize that they like to come to school and to learn by being with their friends all of which underlines the high value of sociability in Myanmar society. Teachers are motivated to improve their instructional approaches though not always through the CCL approach.

At the same level, a main constraint is the "institutional inertia" of traditional teacher-centered approaches to learning. Most teachers "teach as they were taught" - through rote learning, memorizing, focused questioning and answering, looking for the "right" answer, etc through their own primary, high school and university experience. To some extent, MOE in-service training reinforces this as much of the classroom methodologies are taught through lecture-discussion. Then, they experience a short but intensive in-service CCL course in segments of a few days each through which they are to "about face" and facilitate the learning of students through group management. Most have difficulty grasping the advantage of this type of child-initiated learning as it so alien from their own experience. Others simply give up, and wonder why they should change from the teacher-centered approach that served them well in their own education to this new approach. Still others refuse and remain committed to the traditional teacher-centered approach that emphasizes rote learning. A few do change, but re-interpret selectively aspects of CCL which they like or think they understand and mesh these new elements with their traditional teaching. Hence, these teachers organize the students into groups – even stimulate competition among them – but still teach the whole class as if each student learned in the same way. Few recognize and practice methods that adapt teaching-learning methods to individual differences and varying speeds in learning so that the majority of students attain mastery of basic skills – the essence of child-centered learning.

Of course, there are other constraints such as the low standard of facilities and materials in rural schools compared with urban and less remote schools; or the lack of adequate and quality follow up to the CFS and SHAPE training that strengthens the teachers' commitment, understanding, and skill usage of CCL. But, follow on efforts by UNICEF and DEPT can address these constraints. However, unless the above constraint of "institutional inertia" is addressed head-on, CCL will continue to be irrelevant in varying degrees to Myanmar teaching and learning approaches.

Specific Findings related to CFS, ECD and ECCD Network Schools are presented in sections 6.7 and 6.8 below.

5.2.8- Conclusions

1) Although fairly efficient and coherent, the CFS training components have a lower level of effectiveness as measured by the understanding and observed classroom instruction of participant teachers. It is argued that a deeply engrained tradition of teacher-centered instruction in Myanmar education and society constrains the CFS approach to CCL from having greater effectiveness. Unless this "institutional inertia" is addressed head-on, teachers are likely to continue to resist the package of CCL approaches.

2) The capacity of the primary system still remains low. This is especially the case for:

- Township level training
- The peripheral role of CCL within the entire system – including the Education Colleges (See Annex 6 on primary pre-service and in-service teaching training)
- The monitoring and testing of primary students as a barometer of teacher training Effectiveness (See Annex 7 on testing and examinations)
- Educational planning – especially quantitative data gathering methods

3) The training of ATEOs and Cluster Heads provides nominal stature of the Cluster structure, but a weak basis for effective operations of ATEO and Cluster Head support to teachers within the cluster. As a result there is little effective "re-training" of CFS teachers with meaningful follow up sessions given at the cluster level by Head Teachers, Cluster Head or ATEO to continue strengthen teachers in their use of the CCL approach.

4).Training for PTA members, however, appears to have been more effective as evidenced by increased community participation in school operations. However, PTAs know little about the cluster system in terms of its objectives and role in the strengthening of teachers. There is a need to build upon this effective base so that PTAs become more participatory in cluster operations.

5) Training for ECCD Network and ECD standard Pre-KG classes, while small in scale compared to primary teacher and SHAPE training, is relatively effective. However, there are constraints to putting this training into every day classroom practice. These are: limited school facilities, the uneven possession and use of play materials, and desire by some teachers –especially those untrained in early childhood development methods – and by some parents to use a structured and teacher-centered approach in Pre-KG classes as a better preparation for formal schooling.

5.2.9- Recommendations

1) It is time to re-think the Child-centered Learning (CCL) approach. Different and innovative ways – perhaps combining general ways to make the CCL approach more convincing to participants at both central and township levels with practical and specific applications, such as use of video tapes of model CCL approaches – need to be developed at both levels. Rather than teachers asking "Why should I change?" they should be asking, "Why do I want to change and what do I do to change?"

In addition, this re-thinking should include a review of "what works" and "what does not work" in the CCL approach. Preferred (and effectively used CCL) methods include role-playing, use of locally made teaching aids (**realia)** and use of intergroup competition to generate responses to problems set by the teacher appear to be successful. Methods including intra-group discussion and problem solving appear to be less so – perhaps because teachers at township level training are not taught to use them effectively. It would be useful to break down and analyze the different CCL methods and adapt them appropriately to the past experience and readiness of teachers to learn and accept new ways of teaching.

2) Teacher training and related components within the primary system needs to be strengthened. This includes:

- Strengthening the township level of training in the Cascade approach and to transform what are often routinized forms of training into more interesting and effective training. Increase the number days for training allowed at this level (and also include the PTAs in this measure).
- Mainstream CCL within the primary system by diffusing the CCL approach more in the Education Colleges and into the mindsets of local educational officials.
- Develop and introduce a proven Criterion Referenced Test for standard four students that provide an accurate measure of how well primary students are learning the curriculum and what appears to contribute to learning effectiveness of students. Continue to develop and standardize with better indicators and data-gathering methods the assessment of primary school internal efficiency ("flow of students through the system").
- Introduce an Educational Management Information System (EMIS) into educational planning at the primary level. This might begin with a basic measure to develop a school census and essential linkages of data gathering and transmission from the school to township to central level.

3) Strengthen follow up training through the cluster system to improve the quality of teaching and learning in project schools. Establish a team of ATEOs, Cluster Heads, and Outreach Trainers from the Education Colleges to conduct refresher and new courses in CCL methods and cluster management. Also, promote the role of the ATEO more as a supporter of teachers in their acceptance and use of CCL rather than the current role of inspector of current teaching practices.

4) Engage the PTA and parents more in the cluster system so that they want teachers to be re-trained and refreshed in CCL methods. PTAs need to increase their role in supporting teachers for continued training and effective mobilizers of community participation in the education of their children.

5) Continue and expand ECCD Network Pre-KG teacher training so that trained teachers receive assistance and encouragement from the Network Support Groups. This provides an environment that should help them sustain their child-centered and learning through play approach to teaching.

5.3- Water and Environmental Sanitation

5.3.1- Introduction

Forewords

This Government of Myanmar – UNICEF Programme of Co-operation Water & Environmental Sanitation Training Report should be read in context of the overall Evaluation Report, particularly for the components of health and education.

This Evaluation of the water, sanitation and hygiene training components primarily covers the period of the last Country Programme cycle of1996 to 2000. However, since then the new Country Programme has already undertaken positive steps to improve the relevance, effectiveness and efficiency of the current Programme by building upon past strengths and lessons learned. Recent research in several areas such as the impact of past social mobilization and communication strategies on knowledge, attitudes and practices regarding water and sanitation have paved the way for sound decision-making for overall strategy refinements. This Evaluation also reviewed these initial research findings, as well as reviewing draft updates of pertinent sub-strategies and their development processes, which ensure optimal intra- and inter-sectoral collaboration for improved coordination and programme synergy. Our preliminary findings suggest that the WES Programme is on the right track to strategically address these issues and include all foreseeable key sectoral challenges and opportunities in a most efficient and effective manner.

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vision helped guide and focus this Evaluation and its underlying research so as to strategically enhance future support by UNICEF to the water, environmental sanitation and hygiene sector in Myanmar.

5.3.2- Overview of the Evaluation done

The sections below present findings and recommendations from a participatory and "utilisation approach" evaluation of various training activities related to water, environmental sanitation and hygiene. The majority of this training was done between 1996 and 2000 with an objective to create greater awareness and demand for sanitation and water services and also promote community self-reliance. The overall strategy placed greater emphasis on a paradigm shift away from a 'service delivery' approach to that of using indigenous skills and resources at local level to reinforce self-reliance. This approach also put into practice corporate guidelines outlined in the UNICEF WES Strategies approved by the Executive Board in May 1995. But, although these various training components were intended to contribute to capacity building in critical areas, they were not always strategically aligned to bring about synergy in the sector. In recognition of this, the UNICEF WES Section, Myanmar, decided in early 2001 to measure the impact of past training through various methods including market research, a review of communication strategies and this evaluation as a basis for enhancing future training and making it more effective and efficient.

The evaluation examined five training components:

a) Software (Social Mobilization) Training

- Orientations and Workshops associated with the National Sanitation Week
- Social Mobilization in WES
- School Networks on WES

b) Technical Training

- Handpump Caretakers
- Water Quality Analysis

This evaluation used a mix of methodologies and approaches. They ranged from qualitative analysis of research; to surveys and field observation; to focus group discussions including open-ended questions, allowing respondents give spontaneous answers. Although each training component was evaluated separately, the combined training was also evaluated to determine its impact on the WES sector as a whole, and in particular on the overall Government of Myanmar-UNICEF Country Programme goals.

In general, phenomenal results have been achieved in sanitation coverage in recent years. This has been due to the 1996 paradigm shift, including training that mobilised and supported local communities towards greater self-reliance. Today, approximately 63 percent of the population now have convenient access to sanitary latrines compared to only 36 percent in 1990 and 21 percent a decade earlier. As well, an additional 23 percent of the population use latrines deemed 'unsanitary', but which their owners could quickly upgrade to 'sanitary' with a small amount of effort or expense. Access to safe water supply has also significantly increased to 67 percent in 2000, compared to 60 percent in 1995.

The paradigm shift of 1996 spurred unprecedented demand for sanitation and proved very cost-effective. For example, had the 'business as usual' trends of the early 1990s continued using principally 'service delivery' approaches, it would have taken until about the year 2040 to reach current sanitation coverage levels with today's population. Moreover, prior strategies for sanitation would have cost approximately US$97 million (in catalytic support from external aid) or a total investment cost of approximately US$1.3 billion to achieve current coverage. By comparison, the same result of closing

the gap from 57 percent to 37 percent 'sanitary' latrines was achieved in only five years, costing less than US$8 million in catalytic support from external aid. Likewise, the same is true for safe water supply – whereby the gap has closed from 40 percent in 1995 to 33 percent in 2000.

Five key factors influenced this success:

1) **Political commitment.** This was generated primarily through the National Sanitation Week sub-strategy, from the highest to the lowest levels in Government, reinforced technical efforts by pertinent departments, especially the Ministry of Health in implementing the National Sanitation Policy. These efforts were further reinforced by past programmes that created awareness of the importance of sanitation and hygiene, as well as 'know-how' for latrine construction at community level;

2) **Local Design Options for Families.** Families were given several design options for sanitation as well as the freedom to experiment with construction techniques using local materials and expertise to reduce costs. And UNICEF facilitated technical transfer of production know-how to local private companies for manufacturing and marketing latrine plastic pans, previously imported from Malaysia at over US$7 each. This lowered costs by almost 80 percent;

3) **Rejuvenated Awareness and Motivation.** Training and subsequent mobilisation resulting from National Sanitation Weeks and ongoing Social Mobilisation strategies rejuvenated awareness and motivation Nation-wide and across most Sectors for improved sanitation and hygiene, strategically making the best impact whilst the 'political commitment iron' was 'hot';

4) **Greater Awareness and Motivation among Families.** The cumulative effect of the above resulted in greater awareness and motivation among most families on the importance of sanitation and water supply, leading them to pay the full costs of building their own latrines and making significant contributions to safe water supply development.

5) **Promotion and Facilitation of the Private Sector.** This made it possible to locally manufacture and market latrine plastic pans and handpumps, as well as provide many communities with technical solutions for construction and/or drilling of water systems.

Likewise, training in knowledge transfer on sanitation and hygiene to schoolchildren and families has shown good results, although teaching and learning materials were found to be scarce. But despite this, teachers and health extension workers and village mobilisers managed exceptionally well. Training of pump-caretakers and other technicians for water supply also enabled local communities to repair most breakdowns within a few hours and major breakdowns within a day. And initial training in water quality testing and monitoring has also been good. However, a lot remains to be done to ensure that all sources are tested and that water quality regulation is institutionalised in Government.

But these successes could not have been achieved without the commitment, determination and hard work of many Government staff at all levels, including community-based organisations. The catalytic support by UNICEF, donors and others is undoubtedly dwarfed by such commendable efforts.

5.3.3- Summary of Main Findings

Positive Results

1. **There is good general knowledge and improved behaviours regarding diarrhoeal diseases.** On the average 64 percent of schoolchildren and mothers at family level know key

preventive measures needed to avoid diarrhoeal diseases. Positive trends in personal hygiene are evident especially among those who received WES promotional messages, who are better educated and better off and who have access to television or video-parlours. The national average for handwashing with soap after defecation is 52 percent , up from the average of ?? percent in 199?. As well, teachers regularly check schoolchildren for personal hygiene of hair, nails, face, ears and body.

2. **A mix of training methodologies appears to work well in the Myanmar context.** Although it is difficult to fully unravel, it would appear that the mix of national directives along with didactic teaching methods, visual presentations, rote learning and participatory approaches seem to have struck a harmonious balance. Formal 'instructional' training and visual presentations appear to work well in institutional settings, whereas rote learning combined with participatory methodologies work better in primary schools, and the combined mix worked well with villagers. But there is need to further reinforce skills for participatory methodologies as many teachers and health extension staff lack confidence in applying them.

3. **Unit costs of the various WES training components appear cost-effective.** Water Quality training averaged less than US$48.00 per person trained; Social Mobilisation training averaged US$18.82 per person; School Network training averaged US$12.87 per person; Handpump Caretaker Training averaged US$3.07 per person; and National Sanitation Week training averaged US$1.97 per person, primarily for orientation. These costs included Information Education & Communication (IEC) materials, transportation, subsistence allowances and the hire of venues where needed, but did not include UNICEF overhead costs.

4. **Strong commitment and motivation.** This is evident among Government staff at various levels including programme managers, health extension workers, teachers, village leaders and community based health organisations.

Areas of Concern

1. **Limited inter-sectoral collaboration has resulted in missed opportunities for synergy.** Training on 'software' issues regarding sanitation, hygiene and water should be integrated in other training, especially in Integrated Management of Maternal & Child Illnesses and Early Childhood Care & Development. And they should also be institutionalised as a WES training module in courses for public health workers and training of nurses and midwives and their auxiliaries, as well as in Teacher Training Colleges.

2. **Lack of capacity at Township level impedes sector planning and management.** Although centralised planning has its advantages within the Myanmar context, it deters local efforts towards self-reliance and capacity building, particularly the adaptation of national strategies to local conditions and resource bases.

3. **Insufficient involvement of State/Division administrators and technical staff limits opportunities.** This includes for wider political commitment and technical collaboration and support for going-to-scale with tested WES strategies.

4. **There are various competing demands and priorities on key staff.** This makes it difficult, especially for health extension workers and teachers at the grassroots level, to devote sufficient time to promote sanitation, hygiene and safe water issues, in spite of their willingness to do so.

5. **Illiterate mothers and family decision-makers have benefited the least from WES.** Research and other findings show a strong correlation between low education levels, especially illiteracy and that of an inability to take advantage of WES and other programmes. This becomes more clear when National averages are disaggregated, the importance of education, socio-economic and urban status really make a difference. For example, in places where these indicators are high, on average 83 percent of child caregivers wash their hands with soap and water after cleaning infant's bottoms and 70 percent of all people in this category wash their hands with soap after defecation. Conversely, when disaggregated those in the poverty, low-literacy and remoteness groups score 49 percent and 28 percent respectively, whilst illiterates fare worse at 45 percent and 18 percent respectively. Likewise only 35 percent of illiterates associated contaminated water with diarrhoeal disease, compared to almost 50 percent of the average poor and over 83 percent of the better off.

6. **Water quality testing and facility (services) quality assurance is not institutionalised.** Nor is it regularly done, even though some good training has been completed and limited water quality analyses have been undertaken in a few States/Divisions. However it is paramount that all drinking water sources be tested especially considering arsenic risk in ground water in some zones close to rivers and the coast. Likewise, quality assurance of water-point construction was found lacking and many tube-well installations were found to be of poor design and construction, resulting in frequent breakdown, water contamination and siltation problems.

7. **Protection of village ponds was found to be inadequate.** This leaves them open to bacteriological contamination and unsafe for drinking water. As well the use of unhygienic buckets and ropes pose a similar problem for open hand-dug wells.

8. **Insufficient involvement of State/Division decision-makers and managers.** This resulted in poor awareness of Area Focussed Township Goals for water and sanitation and limited programme support, reducing the potential for synergy, overall institutional learning and National experience exchange.

5.3.4- Summary of Key Recommendations

Notwithstanding remarkable successes, there is considerable scope to further improve efficiency and effectiveness of the current training and programme strategy. UNICEF and the Government of Myanmar had already recognised this need and commissioned two mutually supporting research studies, including this external evaluation to assess past impact and explore future options. It is now clear that the following need to be undertaken.

WES Specific Recommendations

1. **Synchronise the three sub-strategies of WES training.** National Sanitation Week (NSW), Social Mobilisation (Soc. Mob.) and the School Network (SN) need to be synchronised so that they fully complement and reinforce each other for improved effectiveness and efficiency. This is key to accelerating actions for universal coverage in sanitation and water for creating the necessary social and learning environment that promotes and encourages individuals to move from 'knowledge' to 'acceptance' to 'enduring safe behaviour' in WES. This requires that intra-sectoral collaboration be strengthened through the newly formed Core Group for NSW, Soc. Mob. and SN. It also necessitates that planned training outcomes be better defined for the various target levels so as to improve programme management and to bring about specific knowledge transfer, skills and resulting safe behaviours. It is therefore recommended that priority be given as follows.

a) National Sanitation Week

- Focus on all AFTs as well as all 33 Townships with less than 50 percent sanitation coverage;
- Promote upgrading of 'unsanitary' latrines to 'sanitary' ones;
- Promote importance of WES data gathering, management and use (monitoring and evaluation), especially at the Ward/Village and Township levels;
- Use the mass media, religious groups, international NGOs and CBOs and private sector to create awareness on the need to adopt safe behaviour for sanitation and hygiene.
- Maintain political commitment (State Peace & Development Councils, Township Child Development Committees, Ward and Village Tract Leaders, etc.) from National to Village level and provide clear guidance to each level (National, State, Division, Township, Ward, Village) for NSW activities and targets.
- Advocate for de-centralised planning and programming for sanitation and hygiene.

b) Social Mobilization

- Provide specific training at Township level for BHS, international NGOs and CBOs in PHAST strategy/methodology, including the use of the 'F-Diagramme' to identify critical barriers to faecal-oral transmission of diseases.
- Target low-literacy/illiterate mothers and low-income and remote families for greater impact.
- Build capacity in the Area Focused Townships (AFTs) for adaptive WES planning and management (including assessment, co-ordination and M&E) for greater self-reliance;
- Fully integrate the 'Four Cleans' & School Sanitation & Hygiene Education (SSHE) into strategies such as SHAPE (life skills in CFS), ECCD, WCHD, IEC and the mass media;
- Institutionalise and integrate the 'Four Cleans', SSHE (and PHAST as a transformation methodology) into curricula of Teacher Training Colleges, Public Health Institutes and Nurse & Midwives Training Schools;
- Involve States/Divisions in planning and management of WATSAN activities.

c) School Network

- Strengthen inter-sectoral collaboration to ensure that SSHE is institutionalized and integrated into Teacher Training Colleges, as well as in in-service training of teachers, kindergarten supervisors and PTAs for SHAPE and CFS.
- Develop sanitation, hygiene and water-specific teaching and learning materials for schools and kindergartens. Ensure that this is done in modular form for ease of integrating/updating into SHAPE/CFS and Life-Skills teacher reference manuals. This should be in close collaboration with other key sector and departments dealing with curriculum development and teaching.
- Involve schoolchildren in school-to-community activities such as monitoring sanitation and water coverage, WES mapping, spreading of hygiene messages etc.
- Link schools with school health outreach for de-worming of schoolchildren.

2. Improve water quality assurance. This is critical to human health and consumer acceptance. In all cases, water quality assurance and periodic monitoring is essential for both chemical and bacterial pollutants. Promote the upgrading of hygiene conditions around water points, especially hand-dug wells, water extraction/collection containers, and home storage/use, as well as ensuring that Village pond-water is made safe for human consumption.

3. Build capacities in Department of Development Affairs for water development. This will enable them to provide Village drinking water supply in the AFTs. This may necessitate the transfer of critical equipment from Water Resources Utilization Department to DDA and ensure they receive appropriate training in its use.

4. **Work with the private sector to privatize pump-caretaker training.** This would transfer existing training materials and methodologies to pump manufacturers/distributors to enable them provide pertinent training to local communities and families as part of the overall package of water development.

Overall Programme Recommendations

1. **Review workloads and duties of personnel critical to ensure public health.** The fact that most training and responsibilities tend to converge on a few critical people at grassroots level necessitates that their workload, processes and responsibilities be better understood in order to help them do a better job.

2. **Strengthen adaptive inter-sectoral planning, management and monitoring in AFTs.** Not only for training but for overall programming to build capacity in adapting central-level 'general plans' to specific local level needs and conditions (physical, cultural, technical, implementation capacity, etc.). Township institutions (health, education, DDA etc.) under the guidance of the Township Child Development Committees (TCDC's) should take responsibility for further training within their respective areas.

3. **Increase involvement of States/Divisions in AFT Programmes.** The State/Division teams of Health, Education and DDA need to be more involved in supporting AFTs. However, the role of State/Division level should be to create an enabling environment for National Policy & Strategy implementation at Township level. And to monitor overall progress and experiences to further enhance State/Division level planning, technical support, resource allocation, etc. This role should also link field level experiences to National policy refinement and decision-making and is especially important considering that all Townships fall under the respective responsibility of the State/Division level. But it is paramount that such support be channeled to nurture and encourage Townships for greater innovation and self-reliance rather than perpetuating top-down domination and control.

5.4- Children in Need of Special Care

5.4.1- Introduction

A CNSP Training Component has been part of the scope of the Evaluation of Training Activities Supported by the UNICEF-Myanmar Country Programme.

This report presents a brief description of this training component, the works done to evaluate it, the findings of the evaluators regarding process, results and relevance, and, finally, recommendations for future actions

5.4.2- Brief Description of the Training Component

The CNSP Training component was undertaken to solve **a basic problem**: There are few professional social workers trained to address the psychosocial needs of the increasing number of children in need of special protection (CNSP).

The Masterplan of Operations 2000 & the Masterplan of Operations 2001-2005 had, as **a general objective** : To develop and pilot activities to strengthen the capacity of the Government (...) to assist CNSP (...). Within this capacity building approach, a **strategic choice** was made to develop the competencies of the critical actors, including care providers in 4 state run institutions, through training actions.

The **immediate objective of the training component** was to change the care givers' knowledge, skills and attitudes, so that their individual caring performances would improve, the performances of the 4 state run institutions would also improve globally, as well as the situation of the CNSP attended. This objective has not been elaborated in quantitative and qualitative terms.

The **context** is important to highlight: the 4 state run institutions targeted have few resources, their staff is overloaded, and the care givers composing the target group have low educational level.

Educational background and attainment of the training target group

Illiterate	Primary level	Lower secondary	Upper secondary	Grade 10 passed	Graduate
1%	24%	2%	36%	17%	20%

The **implementation strategy** was to hire an international consultant to analyse the situation and prepare a training manual, make a pilot test, train 12 trainers, who would then implement 4 workshops to train the 120 care givers working in the 4 State run institutions.

The budget was as follow (in US$):

Consultancies	19,739
Field testing and manual translation and printing	1,058
Training of trainers (for 12 participants) and 4 training workshops (for 120)	1,827
Total	22,624

5.4.3- Evaluation Approach

The framework designed for the evaluation of this training component was originally made of several different tasks to collect valid information on process and results. But the Government did not see the interest of such an evaluation so part of the tasks could not be realised. The following table presents what dimensions of the evaluation were undertaken.

Evaluation focus	Tasks to undertake	Tasks undertaken
Results & sustainability at care givers and institutions levels (new knowledge gained, individual performances improved, organizational performances improved)	Visit the 4 institutions	Was not authorized
	Workplace observation	Was not authorized
	Interview of care givers	One general meeting
Quality of training concept & material of the training of care givers	Training material & method analysis	Done
Results and sustainability of the training of trainers	Interviews of trainers, pre-test/post -test analysis	One general meeting
Quality of training concept & material of the training of trainers	Training material & method analysis	Done
Project preparation & management analysis	Quality analysis of the implementation	Done
	Interview with DSW	One general meeting

	Quality analysis of the preparation	Done
	Desk review	Done

The main part of the appreciation of the results came from a one extensive group discussion with the Government (DSW), trainers, trainees and principals from the 4 state run institutions, with the facilitation of the UNICEF assistant project officer.

5.4.4- Process Evaluation

Note: A score from 1 (bad) to 10 (perfect) is used to summarize the assessment of the evaluators.

Good identification (7) : Visits of institutions and assessments were performed by a specialized consultant to understand the situation at the beginning of the project. A study of the situation of the children in DSW institutions was undertaken. Low commitment from part of the counterparts was first registered. To develop partnership with the Government, advocacy activities were undertaken (study tours abroad with Gov. executives).

Fairly good preparation (6) : A specialized consultant was hired to design a curriculum and a manual ("Children in care"). This work was developed closely with partners. The consultant did not finished in time and a very short time was left to the counterpart to provide feed back on the document. The pilot test was conducted with the consultant, under UNICEF guidance.

Difficult conditions of implementation (4) : Some of the trainers trained in the first place have been transferred and were not able to train other care givers as it was originally planned. Cooperation between UNICEF and the counterpart was difficult because of bureaucratic procedures and frequent changes in availability of trainers and trainees, venues organisation, etc.

Only a few trainers well trained and remaining in service were **able to undertake further training workshop**s: 4 regular active trainers from 12 people trained **(30%)**.

Good instructional techniques (7) : Training used active adult learning methods, developed new practices with the children, and were fully appreciated by the trainees.

Good training material (7) : A facilitator's manual and participant's work book were produced, in English and Myanmar language ("Children in care"). This new documentation gave a strong basis for training. It starts from the real situation of children in the institutions, but is still too theoretical and lacks of reference reading material in Myanmar language. It could not be improved during the project implementation because there was no feedback from care givers attitudes and performances at work level (monitoring).

Good master trainer (7): The UNICEF assistant project officer took the role of a "master trainer", training the trainers and supervising the further care givers training workshop. This specialist of CNSP, with professional education background, knew already the situation of the children in the state run institutions and has been involved in all the process of developing the training documentation.

Too short training duration (3) : From a training effectiveness perspective, 5 days of training to introduce new understanding, knowledge and working attitudes, was clearly too short, especially given the education background of the trainees.

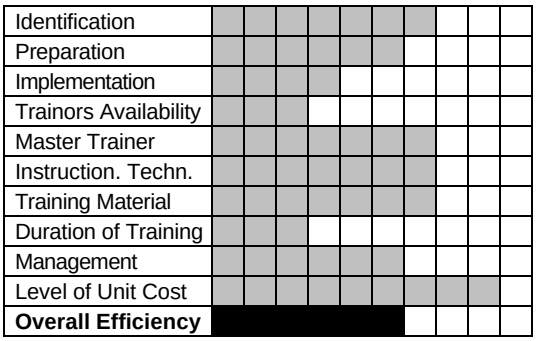
Outputs : All the targeted outputs have been produced:
- A manual (Children in care) and participants' work book,

- A pilot test (5 days),
- A Training the trainer workshop (8 days),
- 4 workshop (5 days each) to train the care givers;
- 12 trainers trained (but only 4 active in training),
- 120 care givers trained.

Fair operational management (6) : The training activities have all taken place, but with many frustrations: long delays in some stages (document development process and translation, training of trainers postponed) and unnecessary rushes in other stages. There was no monitoring after the training at the workplace level.

Very low unit cost level (9): The care givers were trained during 5 days for an average direct cost of US$ 14. The total average operation cost by trainee (including the consultancy for books development and the pilot test) was only US$ 171.

Overall efficiency of the training component: 6



5.4.5- Result Evaluation

The effectiveness appears to be very different for each level of result :

Level of result	Level of effectiveness	Sustainability
1- Change in participants' understanding, knowledge and/or skills, attitudes)	Satisfactory (60%), but at the level of understanding only	Likely low (no opportunity to apply what was learned)
2- Change in individual performances	Low (10%). In their work condition they cannot change their working attitude.	
3- Change in organizational performances	Probably very low (5%)	
4- Improvement in the situation of the children & women	Probably very low (5%)	

Considering that the main development objective of the training component should be the result n°2 (change in individual performances), **the effectiveness of this training component can be scored at 10%**. The sustainability will be low as long as professional knowledge learned is not applied and it will be quickly forgotten.

5.4.6- Relevance of Training as a Capacity Building Strategy

The stakeholders (trainers, trainees and Counterpart) consider that training is an essential part of a capacity building strategy. But they highlight the fact that **other elements are crucial and must be also adressed**:
- Work conditions are dominated by permanent work overload (too many children to accommodate), mix of care and services in jobs content,
- There is no monitoring of work attitudes by the management), ,
- Motivation of staff is low (very low salaries and no additional incentives for this very demanding kind of work).

The coherence of this project seems questionable : complementary elements that make capacity building strategy works should have been integrated jointly with training.

But this training component gave also a good **opportunity to open a partnership** with the Government in a very difficult field where initiatives had to be undertaken anyway to find solutions for improving the situation of CNSPs. These training activities contributed to open a gate **for other future initiatives**.

5.4.7- Main Findings

Although fairly efficient, this training component has a very low level of effectiveness and impact, due to a weak level of commitment of the counterpart and to an inadequate concept of the project.

5.4.8- Recommendations

- Deepen the collaboration with the Counterpart to reach a better commitment on the path to follow for measuring and improving performances of state run institutions attending CNSPs;
- Look for other committed partners, able to benefit from the training material available, and work with them on integrated capacity building projects to improve care given to CNSPs;
- Modify the training support documents: take out part of the theoretical presentations, add more reference reading material in Myanmar language, add exercises to stimulate the thinking of the trainees, propose different solutions they can use to test their skills and measure their performance.

5.5- Information and Communication

5.5.1- Introduction

The Facts for Life Initiative Training Component has been part of the scope of the Evaluation of Training Activities Supported by the Myanmar-UNICEF Country Programme.

This report presents a brief description of this training component, the works done to evaluate it, the findings of the evaluation regarding process, results and relevance, and, finally, recommendations for future actions.

5.5.2- Brief Description of Training Component

Problem Statement and Strategy

A large part of the Myanmar population does not know the core basic life-saving messages. UNICEF made available, worldwide, a simple book, prepared by specialists, presenting basic Facts for Life (FFL) information. This book was translated to Myanmar language and UNICEF decided, some years ago, to take the initiative to bring FFL information to every household in Myanmar. This is, in short, the "FFL Initiative".

To increase knowledge and awareness of household of the core FFL messages, UNICEF uses a strategy combining 3 components: i) making use of mass media, ii) communicating FFL information through education and health projects and iii) training people from religious groups and NGO partners to know, understand and communicate FFL messages.

The third component above is the "FFL Initiative Training Component", the object of this evaluation.

Goals and Objectives

This FFL Initiative Training Component is supposed to contribute to the following **goals**:
- to ensure that at least 60% of the population is aware of, and participates, in children's survival, care, protection and development.
- to mobilize communities for the dissemination of CRC, CEDAW and Facts For Life messages.

Recent objectives of this component are given by the logical framework of the 2001-2005 UNICEF Master Plan of Operations:

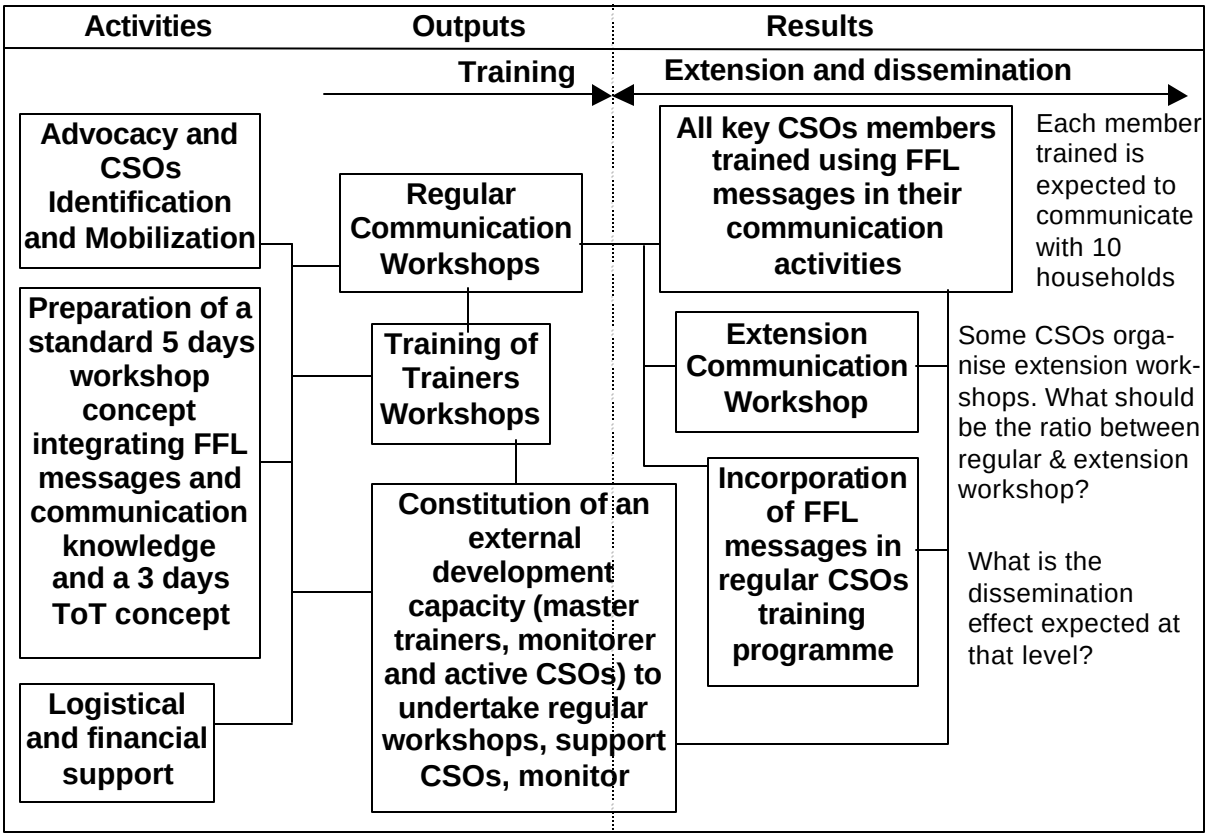
Narrative summary	**Indicators**	**Means of verification**	**Risk/assumptions**
Project objective: to increase awareness of the core basic life-saving messages at household level	- Knowledge of households of FFL messages	- KAP studies, field trips reports	
Output: All key CSOs trained using FFL messages in their communications activities	- # of CSO activities incorpora-ting FFL messages	- CSO/NGOs feedback and annual reports	Risks: Constraints & restriction on the CSOs/NGOs to work with UNICEF
Activities: - Organize and conduct FFL workshops (10.000 facilitators and motivators trained) - Support training of trainers in CSOs on using FFL (200 trainers trained)	- # of FFL workshops held - # of CSO trainers trained in FFL		Assumption: Stable environment & unrestricted NGO & CSO cooperation with UNICEF

Implementation Strategies

The present strategy (see logic model below), is based on the following activities :
- To advocate with religious groups and NGOs,
- To train trainers,
- To organise communication workshops to train extension communicators,
- To support CSO and NGO partners to conduct FFL training workshop and to disseminate FFL information.

FFL Training Initiative Logic Model (present strategy)

The logic model (below) presents a main difficulty (critical hypothesis): A development capacity is needed do develop workshops and support active CSOs. But UNICEF cannot recruit the large implementation capacities required on permanent basis. This development capacity needs to be external and the building of such a capacity relies largely on initiatives coming from CSOs, NGOs, trainers, that are partially out of the project management reach.



Target Groups

- Youths and adults, particularly of 18 to 35 years, members of CSOs/NGOs,
- Potential extension communicators, manifesting interest for social work

Results Framework (present strategy)

Type of result	Expected Result
R1- Change in knowledge and attitudes of the trainees (Regular workshops)	Qualitative change for 200 trainers and 10,000 trainees
R2- To produce a multiplicative effect by extension and dissemination and also by CSOs leader using FFL in their communications activities	(The objective has not been set yet for the different dissemination mecanism)
R3- to increase awareness of the core basic life-saving messages at household level	(Not applicable for the current evaluation.)
R4- Improvement in the situation of the children & women	(Not applicable for the current evaluation.)

Expenditures (in USD)
(to be completed for 1999 and 2000)

Items	1999	2000	2001
Printing Clothes Posters	38,325	-	-
FFL Book, Myanmar & English versions	292	-	2,955
FFL Self learning modules	66,000	-	27,768
HIV/AIDS Questions and Answers	-	29,400	-
Orientation (regular) Workshops	31,484	67,524	34,256
Moemauk FFL Dissemination Activities	-	-	18,291

FFL Muse AFT & Buddhist Institution (MoU MYSB)	-	-	21,603
FFL Dissemination Muslim Central Trust Fund	-	-	7,152
FFL Dissemination by Pathein Myoma Monastry	-	-	5365
TV Equipment	-	-	1,287
Technical support for FFL Dissemination (6 persons SSAs)	?	?	23,809
Support to CSOs in their activities to disseminate FFL information	?	?	2,174
Total			**144,660**

A Peculiar Context

The specific context of Myanmar is a dominant factor for the implementation of this training component.

Very few training specialists and organizations are available. UNICEF had to qualify a specific group of trainers able to undertake regular Communication Workshops.

Civil society cannot flourish freely and there are few CSOs and NGOs. This is why this training component works mainly with religious groups.

Observation of the training workshops and discussions with CSOs leaders showed that there is a very strong learning discipline from part of the trainees and a general enthusiasm to learn participatory and communications techniques.

5.5.3- The Evaluation Framework

For this FFL initiative Training Component, it was decided that the focus of the evaluation should be on coherence, process and immediate results. The present strategy needs time to produce all its results and an impact evaluation will be done in 2 years.

The following evaluation activities have been realised:
- Interviews of UNICEF staff
- Interviews and focus group discussions with resource persons, trainers, trainees, disseminators, CSO leaders.
- Workshop observations
- Desk review
- A field visit to Pathein was organised but had to be cancelled by the Ministry of Health.

5.5.4- Process Evaluation

Note: A score from 1 (bad) to 10 (perfect) is used to summarize the assessment of the evaluators.

Fair Preparation (5/10)

The plan to mobilize CSOs and to undertake workshops is on going (see logic model).

Strong efforts have been made to design an effective implementation strategy and several concepts have been tested successively and cleared out (Health workers training, book dissemination and exams, mobilization undertaken by a private company). From different concepts progressively tested, and with a strong input of communication and training expertise, a good design of TOT and Regular communication workshops has been built, with well-adapted instructional techniques and supports.

The recent focus on AFTs will not modify the strategy (people trained at AFT level are part of the output target of 200 trainers and 10,000 trainees. Joint operations with education and WES sectors are being studied. They could complement the FFL initiative (Radio and TV, Education and Health sector training).

But words "awareness", "dissemination", are unclear in the formulation of the objective. The main objective (level 2 of results, see section 5 below) have not been defined ("To produce a multiplicative effect by extension and dissemination and CSOs leader using FFL in their communications activities"). The contribution of the training component to household awareness, to which other components of FFL initiative should also contribute, has not been defined precisely. So, it is not possible to assess the level of results of this training component (Qualitative change for 200 trainers and 10,000 trainees).

Implementation System needs better Design (4)

The implementation system needs some strengthening. Constitution of an external development capacity (master trainers, monitoring specialist and active CSOs to undertake regular workshops, support CSOs, monitor) is on going but has not reach a sustainable level. UNICEF Management does not favour the continuing use of individuals as resource persons (master trainers) on SSA contracts (too many SSAs) but no other solution exists for implementation with the available master trainers in 2002 as there are no NGOs/COSs with master trainer expertise.

Motivated and Skilled Trainers (7)

Well trained and motivated resource persons are available for training. A large part of them are being used by the CSOs. There is a limited number of good trainers (9 masters trainers) directly used by UNICEF to undertake workshops.

Very Good Instructional Techniques (8)

The participatory instructional techniques are very efficient and appreciated. They create an enthusiasm among trainees that maintains trainer motivation and a strong momentum in workshop schedule.

Very Good Training Material (8)

Training material is appropriate, diverse and generally relevant. Translations have been made of FFL support document into 7 Myanmar languages. Some shortages occur from time to time due to planning problems.

Fairly Good Operational Management (6)

Operational management is characterized by good commitment of the team, strong efforts to plan day-to-day work and support CSOs and trainers. Controls are good. But there are tendencies to micro plan, partially due to the lack of clarity of the project framework. The UNICEF staff capacity is clearly overloaded. Time seems short to monitor correctly at field level and to think ahead.

Very Good Level of Outputs (9) (to be completed):

Item	1999	2000	2001
FFL communication book distributed (old & new version)			29,481
FFL booklets (number of modules)			43,060

Video tapes (1/Ws)	15	32	55
Cassettes (5/Ws)	75	160	275
Cloth posters (1/Ws)	15	32	55
Cloth poster bags	?	?	181
Posters (150/Ws)	2,250	4,800	8,250
TOT Workshop (3 days)	2	4	4
Regular workshop (5 days)	15	32	55
Extension workshop (3 days ?)	-	-	55
Contract/MoU signed for operation	-	1	3
Individual SSA signed for training or monitoring	?	6	6
CSO partner	13	23	34
Trainers trained (TOT)	31	60	110
Trainees trained (Regular Workshop)	758	1,647	2,750
Trainees trained (Extension Workshop)	-	-	2,322
Co-funding by CSOs	?	?	?
	1999	**2000**	**2001**

Very Good Cost Management (9)

The direct cost for a regular Workshop is between 400 and 600 USD. For one trainee, the direct cost is between 8 and 12 USD.

The total cost by beneficiary trained is around 28 USD, including printing of the support books, support in trainer, video tapes, etc…

Overall Efficiency (7)

Scores	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Preparation										
Implementation system										
Trainers										
Instructional techniques.										
Training material										
Operational Management										
Very good level of outputs										
Very good cost management										
Overall Efficiency										

5.5.5- <u>Result Evaluation</u>

5.5.5.1- Change in knowledge and attitudes of the trainees (Regular workshops and TOT)

Qualitative change for 200 trainers and 10,000 trainees

The level of **effectiveness is very good (8)**.

Referring to the year 2001, the expected results (see 2.5) were largely met with numbers of beneficiaries of 110 trainers, 2,750 trainees (regular workshops) and 2,322 trainees (extension workshop). For all those beneficiaries, but with diverse amplitude, a clear qualitative change has been produced: knowledge and understanding of key facts for life topics, knowledge and some practices of some new communication skills. It is likely that their attitudes will change in their day-to-day communication work, and some of them are willing to begin an active dissemination work.

This very good level of effectiveness is mainly due to:
i) The efficient mix of FFL messages with communication understanding and practices;
ii) Strong enthusiasm and learning discipline on the part of the trainees

However a detailed comparison by topics of the pre-tests/post-tests shows that some parts of the FFL book and workshop appear sometimes to be unnecessary for certain target groups.

The **Sustainability** of those changes in knowledge and attitudes of the trainees **is certainly good**.

5.5.5.2- To produce a multiplicative effect by extension and dissemination and also by CSOs leader using FFL in their communications activities

Good tendencies are visible for the effectiveness of this second level of result,. But **the objective has not been set** yet in quantitative and qualitative terms.

5.5.6- Relevance of the FFL Training Initiative

The FFL Training Initiative is relevant as a communication tool for FFL dissemination. With a very low unit cost, training appears to be a strong means for communicating facts, ideas and new attitudes among Myanmar groups.

5.5.7- Main findings

The FFL Training Initiative is a very good training concept, implemented with efficiency, that produce enthusiasm and mobilization and is relevant for the Myanmar context.

However, the objectives and strategy need clarification.

The effectiveness is very good for the first level of outcome, but the impact is still probably low (small number of people trained compared to the general target of the FFL Initiative). The planned impact evaluation will not be feasible without clarification of the implementation strategy and a specific preparation (establishment of a base line).

5.5.8- Recommendations

- Clarify the training component objectives among the team and with UNICEF Management, with clear articulation of the broad objectives of the FFL initiative.
- Review and strengthen the strategy to create an external development capacity to undertake workshops, support CSOs and monitor field activities.
- Systematically design a system to monitor dissemination activities and prepare the future impact evaluation.

6- Summary of the Evaluations made by Training Component

6.1- Essential Steps for Safe Delivery (ESSD)

6.1.1 Brief Training Component Description

Training on Essential Steps for Safe Delivery (ESSD) is an in-service training of hospital personnel (medical officers and staff nurses), BHS with emphasis on Midwifes and of Auxiliary Midwifes. The DOH, Division of Public Health in collaboration with UNICEF aims at ensuring routine and emergency obstetric care through the ESSD training. Specific attention is given to train BHS in recognizing danger signs in connection with delivery and to advocate strongly for timely referral to hospital.

The training was initiated in 2 pilot townships in 1998, and expanded to 26 townships in 1999 and 2000. For 2001, ESSD activities will be implemented in AFTs, however, the training has not yet been started.

Problem Statement:
The maternal mortality rate is estimated by the Myanmar Central Statistical Organization in the National Mortality Survey, 1999, at 178 per100.000 live births (urban) and 281 per 100.000 (rural), average 255/100.000, WHO/UNICEF estimate of 1990 is 580 per 100.000 live birth. Complications to unsafe abortion accounts for more than 50% of maternal deaths in hospitals. Late referral also contributes to maternal mortality. Routine obstetric care and obstetric emergency skills of the health providers is crucial to prevent maternal mortality. Medical Officers and Staff Nurses are the first line of contact for obstetrics emergencies and non-emergencies in hospital. In villages the first line of contact for antenatal and delivery care is Basic Health Staff especially; LHVs, Midwifes and AMWs/ANMWs in some villages. The knowledge and skills of this large group of health personnel needs to be updated and maintained through in-service training.

Goal: To reduce the maternal and newborn mortality and morbidity.

Target groups:
Medical Officers from the States / Divisional and District Hospitals, Medical Officers / staff nurses from the township hospitals, LHV / Township Health Nurse / Midwives and AMWs in PHC settings.

Training Objectives:
- To provide knowledge and skill to address the major cause of maternal morbidity and mortality
- To manage obstetrical emergency
- To recognize obstetrical emergency cases and refer them in time to the first referral hospital
- To organize the community to develop an emergency transportation system.

Implementation Strategies:
Advocacy and capacity building through ESSD training at different levels of the health system to the different target groups has been undertaken. The following 4 level cascade model for training has been used:
Central level: The 1st level training is ToT courses for Medical Officers from States / Divisional and District Hospital. Duration of training is 3 days and is conducted at central level. (Yangon

and State/Divisional hospitals)

District level: The 2nd level of training is done by the central level trainers to train Medical Officers and Staff Nurses from the township hospital in labor-ward practices. The training takes place at the district hospital and lasts 3 days.

Township level: The 3rd level of training is also done by the central level trainers for BHS (Township Health Nurse, LHV, Midwives) from the township. Duration of training is 3 days and the course is conducted at the township hospital.

Community level: The 4th level of ESSD training is targeting the AMWs. Duration is 2 days and the course is conducted by the at the township hospital by the BHS (LHV or Midwife).

Budget in Kyats and US$ (official exchange rate used 430 Kyats – 1 US$)

Types of Training	1998	1999&2000	Total
TOT Central	-	642,360	642,360
Training of MO/ SN	39,000	1,613,186	1,652,186
BHS training	77,400	4,381,450	4,458,850
AMW training	36,000	2,208,130	2,244,130
Advocacy meeting	88,750	468,000	556,750
Total	241,150	9,313,126	9,554,276
	US$ 560	**US$ 21,658**	**$ 22,219**

6.1.2. What has been done to evaluate?

Desk review, Interviews with key stakeholders from UNICEF and DOH, interviews with trainers and trainees and focus group discussion with trainees and knowledge assessment of trainees were done. Thaton (Mon State) and Pa-an (Kayin State) were visited. Since there was no ongoing training taking place observation of training was not possible. (see sample size in section 5 evaluation methodology).

6.1.3. Outputs of the training.

- 60 medical officers from States/ Divisional and District hospitals were trained as trainers. 112 medical officers / staff nurses from the townships, 1250 township health nurses/ LHV / midwives and 800 AMWs were trained on ESSD.

	Training of Essential Steps for Safe Delivery (ESSD)	1998	1999-2000	Total
	Total number of townships	2	26	28
1.	Training of Trainers (Central) • No. of Medical Officers from State / Divisional Hospital trained	-	60	60
2.	Training of Hospital Staff (Medical Officers and Staff Nurses) • No. of Medical Officers / Staff Nurses trained	12	100	112
3.	Training of Basic Health Staff (BHS) • No. of Midwives/ LHVs /THN trained	50	1200	1250
4.	Training of Auxiliary Midwives (AMWs) on ESSD • No. of AMWs trained on ESSD	50	750	800

Training materials developed and distributed were as follows

Essential Steps for Safe Delivery (ESSD)

	Essential Steps for Safe Delivery (ESSD)

1.	Labour Ward Practices Manual
2.	Midwives Trainer's Manual on ESSD
3.	Midwives Manual on ESSD
4.	Posters on ESSD
5.	Pamphlets on ESSD

6.1.4. Process Evaluation

Identification (9)
The ESSD training has clear objectives and is intended as refresher training of health personnel primarily in RHC and Sub-centers, secondly in hospital settings. The specific factors and conditions contributing to an excess MMR is well identified and reflected in the training through a strategic approach includes a number of key interventions.

Preparation (9):
Training needs are being addressed. The knowledge and skills required are well identified. ESSD training was piloted before expanding the training, in order to ensure successful country adaptation of the materials and the approach. Materials are targeted well.

Implementation (7):
A four level cascade model is used for coverage of large numbers of BHS and Voluntary Health Workers (AMWs). Central level ToT courses and training at district level of Medical Officers and Staff Nurses seem to be quite successful and effective. Technical expertise is better at higher level compared with district and community levels.

Human resources: The central level trainers are competent. Obstetrician and gynecologists participate as trainers in district hospitals, the training conducted at the district level were also good.

The training methodology (7)
The training methodology is popular. A participatory approach is being used with various techniques including case study presentation and group work, discussion, question and answer, role-play, and hands on practice in the hospital. The training methodologies used were similar at the different levels. However, the central and district level training is more effective in terms of obtaining desired results than township and community level. This might be due to trainers at central and district level being more capable of teaching the subjects, than at the township level. A fair amount of pre knowledge and skills is also required for this refresher training to be optimal in view of the short time given in the courses (2 to 3 days). More guidance and support to trainers at township level is needed for optimal learning process..

Training material used (7)
The Midwifery Trainer's manual and trainee's manual were reviewed in terms of their presentation (illustrations, graphic), content (relevance to training objectives and practicality), and language (clarity, application with examples, and relevance to target group). Content of the manual is rather complete. However, the Trainer’s manual is almost identical in content to the trainee’s manual, and seems to fall short of instructions and guidance on teaching approach related to each session of the manual. Trainer's manual needs to be improved. Content of the material is rather complete. Trainee's manual should also include more illustration with colors.

Management of the Training Component (4)
The training is implemented as planned. However, there is no input in term of supervision and follow up during and after the training from the different levels (central to S/D and township, S/D to township). Supervisory checklist or monitoring indicators are not used. No monitoring or evaluation has been done.

Efficiency (8)

Different types of training were reviewed for the year 1999-2000

Sr.	Training on Essential Steps for Safe Deliveries	# of days	Number of participants	Total Cost (Kyats)	Unit Cost / person (Kyats)	Unit cost/ person (US $)	Unit Cost / person day (Kyats)	Unit Cost / person day (US $)
1.	**TOT (central)**	3	60	642360	10706	**30.85**	3569	10.28
2.	**Training of MO/SN**	3	78	1613186	20682	**59.60**	6894	19.86
3.	**Training of BHS**	3	916	4381456	4783	**13.78**	1594	4.59
4.	**Training of AMWs**	2	650	2208130	3397	**9.78**	1132	4.89

The unit cost for training Medical Officers and Staff Nurses in hospitals appears to cost twice as much as compared to the same training duration at the central level. Effectiveness of training is quite good for reaching objectives (US$ 13 / MW for 3 days, US $ 10 / AMW for 2 days). There is not enough time (3 days) for skill improvement.

6.1.5- Result Evaluation (7)

Level of Result	Level of Effectiveness	Sustainability
1. Change in participants knowledge, skill & attitude	- quite good improvement of knowledge - course is too short for skill up-grading - no indication of change in attitude	fair
2. Change in individual performance	- some change in delivery practice; more clean and safe practices - no increase in number of referrals	with regular in-service training the knowledge is sustained
3. Change in organizational performance	- transportation from rural areas in case of referral to hospital is said to be supported by the community. - no change in utilization of facilities	transportation is sustainable if it works presently
4. Improvement in situation of children & women	NA	NA

6.1.6- Relevance of training as a capacity building strategy (7)

The content of the training is highly relevant, and the target group is also relevant. The ESSD is one of the only refresher training there is being offered to the AMWs and therefore very relevant. More capacity building could take place especially at the township and community levels, if the trainers were better prepared and equipped with skills and guidance in training. The duration of the ESSD is too short especially for AMWs to be effective the training content is somewhat overlapping with IMMCI and other training by WHO. It appears that there is an urgent need to coordinate and collaborate between different partners and agencies involved in maternal and reproductive health, in order to utilize scarce resources more optimally.

6.1.7- Recommendation

1. Coordination and involvement of different partners in women's health and reproductive health should be established and training done accordingly (partners for policy on reproductive health)

2. Support to ESSD training should be considered in the light of the above collaboration
3. Based on the revised job description for midwives (2000), UNICEF together with other partners advocate for a reallocation of the multi purpose health worker functions of the midwife to be taken over by other BHS, e.g. Public health Supervisor Grade 1.

4. Any training of midwives should include standards for midwifery practices, e.g. procedures for obstetric emergencies.

5. Extend the training duration for AMWs to strengthen skill practice.

6.2- Integrated Management of Maternal and Childhood Illnesses (IMMCI)

6.2.1- Short Program Overview

In 1995 WHO recognized that single diagnosis and therapy was not sufficient in responding to the high under 5 years morbidity and mortality rates (U5MR) in developing countries. The challenge to address the overall health of a child was brought forward by WHO and UNICEF resulting in the development of the Integrated Approach to Management of Childhood Illnesses (IMCI) The IMCI strategy therefore combines improved management of common childhood illnesses with other important factors influencing child health. The three main components of the IMCI include:

- Improving knowledge and skills of health workers
- Improving the health system to support IMCI and
- Improving family and community practices

The U5 MR survey 1995, showed that peri-natal conditions and consequences of maternal malnutrition and complications during pregnancy and delivery contributed 15% to the U5MR. This finding let to the expansion of IMCI in 1997/98 to include a maternal component and renaming the program to Integrated Management of Maternal and Childhood Illnesses (IMMCI). Myanmar is the only country that has adopted this approach. Most recently the IMMCI program has been modified into Women and Child Health Development program in connection with UNICEF changing it’s country program implementation strategy to be concentrating on Area Focused Townships (AFT).

The sick child and the pregnant mother is the focus of the program where resources from various related projects (under the umbrella of the IMMCI) will be accommodated and concentrated, to provide quality health care by competent and skillful health staff at the peripheral level. Four main strategies have been identified:

- Improvement of the skill and knowledge of the Basic Health Staff (BHS)
- Modification of the Health System reform
- Encouragement of Community participation and ownership
- Establishment of a Sustainable operational System

The Plan of Operation outlined areas of implementation with coverage of BHS training in all states/divisions, during the three phases of the IMMCI program (Phase 1 1998, phase 2 1999, phase 3 2000). However, few townships in border areas have not been possible to reach with the training.

The training components of the IMMCI are:

1. Training of IMMCI Facilitators (supported by WHO)
2. Training on Program Management for Mid-level Managers (supported by UNICEF)
3. Training of Trainers (ToT) on IMMCI (supported by UNICEF)
4. Training of BHS on IMMCI (supported by UNICEF)
5. Training of clinical staff on Clinical Management of the Critically Ill Child (supported by WHO)
6. Training of Mothers and Care Takers by NGOs (MMA, MMCWA, MRCS); Facts for Life training (supported by UNICEF)
7. Pre-service training on IMMCI (supported by UNICEF)

Scope of evaluation

This evaluation has focused on:
Training on Program Management for Mid-level Managers
Training of Trainers (ToT) on IMMCI
Training of BHS on IMMCI

No 1 and 5 training component is funded by WHO. No 6 and 7 have not been subject to the evaluation. No 6 because it has a limited coverage (9 townships) and the training just started in 1999. The major bulk of Facts for Life Training takes place under the Information, Communication and Policy Sector and is evaluated in that sector. No 7 pre-service training does not actually take place yet. However, the IMMCI materials have been distributed to faculties and training institutions, and they have been encouraged to incorporate and use the IMMCI materials.

Problem Statement.

Infant Mortality Rates (IMR) and under 5 years Mortality Rate (5MR) are considered high in Myanmar. However, most of the causes of death are due to preventable and curable diseases, and inaccessibility to proper health care and drugs. Maternal mortality rates are high due to complications of unsafe abortions and delivery complications. There are few referrals and limited recognition of danger signs of complicated deliveries.

Goal

To develop an integrated health care system by the year 2000

Objectives

1. To reduce the U5MR to less than 70/1000 live births
2. To support reduction of MMR to less than 1/1000 live births by 2001
3. To use IMMCI as an intermediate strategy to integrate different projects concerned with health care of women and children

Target Groups.

Main priority for training is Basic Health Staff (BHS) working outside hospital settings in the PHC sector at Rural Health Centers, Sub Centers and Urban Health Centers and MCH centers.

Implementation Strategy.

Training on IMMCI is conducted at 4 levels;

Central level: An 11days course for Facilitators in case management and some related health system issues is being conducted for central training teams and IMMCI resource persons using the 11 days course manual on IMMCI (modification of WHO manual). This 11 days course has been conducted twice in Yangon during the last 3 and ½ years (1999 and October 2001). Most recently the course was conducted in Yangon for both national and regional IMMCI Facilitators by a WHO international consultant.

State/Divisional/District level: a 7 days course for ToT in Yangon and at state/divisional level is being done using the IMMCI Handbook. The Handbook is based upon SEARO adaptation of the generic IMCI WHO/UNICEF manual for 11 days training. With this comes a Facilitator's Guide. Trainers are District Medical Officers (DMO), Township Medical Officers (TMO), Medical Superintendents of hospitals, Township Health Nurses (THN), Lady Health Visitors (LHV), Health Assistants (HA) and sometimes Midwifes (funded by UNICEF).

Township level: a five days course for BHS (HA, LHV, Midwifes, PHS grade I) in PHC settings is being done. Separate training is also done at the township level of hospital staff in IMMCI clinical practices (Hospital staff training is funded by WHO, training of BHS is funded by UNICEF)

Community level: Using Facts for Life material the national NGOs; MMCWA, MRCS, and MMA, are training community members in three townships each starting in 1999. This part of IMMCI is called operational research and is being piloted. Under the AFTs strategy this will be named community in action package. As a trial the NGOs train their trainers (members of the NGO) who then train communicators (NGO volunteers) who then again train mothers with children < five years of age. Each NGO is supposed to have trained 100 communicators in each township. The cascade starts with ToT courses at central level with a formal five days training. The trainers then train communicators, being local NGO members and volunteers, at township level in a five days course. The communicators then target mothers with children < 5 years of age, adolescents and religious leaders. Each communicator is supposed to "train" or interact with each 10 individuals and the cascade is ended at this point. There is no further capacity building intended to take place after this point. This small scale Facts for Life training has not been subject to this evaluation.

Budget (in Kyats and US$; exchange rate used: 450 Kyats to 1 US$)

Type of Training	**1998**	**1999**	**2000**	**2001**	**Total**
	Kyats	Kyats	Kyats	Kyats	Kyats
Mid level Management			2,795,910	7,196,552	9,992,462
TOT (IMMCI)	540,200	451,230	7,054,497	7,357,968	15,403,895
BHS (IMMCI)	8,663,883	7,823,833	49,591,047	27,053,468	93,132,231
TOT (Supervisor)		93,264	0	485,456	578,720
Multiplier (Supervisor)			35,000		35,000
TOT (FFL)			832,416		832,416
Multiplier (FFL)			3,128,708		3,128,708
Total in Kyats	9,204,083	8,368,327	63,437,578	42,093,444	123,103,432
Total in US$	**20,453**	**18,596**	**140,972**	**93,540**	**273,561**

6.2.2. What has been done to evaluate?

Different assessment tools have been used for the evaluation of each training component; Training on Program Management for Mid-level Managers, Training of Trainers (ToT). and Training of BHS on IMMCI, with a sample of training from the three different phases of the IMMCI program from 6 different locations; Taunggyi (Shan State), Yatsauk (Shan State), Kyauktan (Yangon Division),Thaton (Mon State), Pa-an (Kayin State) and Monywa (Sagaing Division) were visited. The evaluation team conducted 14 key informant interviews, in depth interview with 5 trainers, 4 focus group discussions with a total of 16 trainees, and knowledge assessment of 16 trainees was done.

The range of interviews have covered key informants and resource persons at central level in MOH, UNICEF and others, District Health Department, DMOs and township levels administrators and health personnel with managerial responsibility Interviews have been done with trainers of IMMCI courses, with Mid-Level managers who have received the Management course and with the BHS who have been trained. Observations of care giving to children and women have not been feasible during the evaluation period. Additionally a review of the training material have been done by the evaluators.

6.2.3- Outputs of the Training

Integrated Management of Maternal and Childhood Illnesses (IMMCI)	1998	1999	2000	2001	Total
Number of training courses conducted & Number trained					
Mid-level Management course	-	-	6	17	23
• Total number trained			177	450	627
Training of Trainers	3	3	12	9	27
• Total number trained	100	81	336	241	758
Training of Basic Health Staff (BHS)	114	69	227	101	511
• Total number trained	2878	2196	5316	2526	12916

6.2.4- Process Evaluation.

(Evaluation rating (ER) ranges on a scale from 1-10, where 10 is highest)

Identification (8)

An Acute Respiratory Infection (ARI) Health Facility survey conducted in 1998 showed that, although knowledge regarding ARI was satisfactory, the basic health workers lacked the necessary skills, as only about 30% of the BHS were able to count the respiratory rate correctly, and recognize danger signs, which indicate referral to hospital for life saving treatment. These finding indicated that training provided earlier had not been satisfactory. Lectures provide knowledge but lacked training in the required skills

This survey has served as a baseline for the evaluation of the IMMCI training Objectives for the program were clearly defined and stated. However, the objectives are very concerned with the program expansion and less with health system issues, e.g. improve access to health services and outreach in rural areas, focus on vulnerable and at risk groups. The strategies were adopted with some modifications from the WHO/UNICEF IMCI program

Preparation of the IMMCI training was done well. The ARI Health Facility survey of 1998 identified the training needs of specifically BHS, and has served as a base line for the program. An implementation strategy was identified, using the cascade model for training at various levels and using training teams at these levels of the health system. The resource requirements for the training implementation were determined, both in terms of training of trainers, material and equipment distribution and financial support.

However, the IMMCI documentation available is extremely limited, with no clear strategy formulation and no objectives for the individual training component. The project Protocol for IMMCI 1998 – 2000 is the best documentation available at present. Mentioning is made in this document of follow-up after completed training; use of standardized uniform checklists and guidelines for supervision is made. The monitoring was planned to be conducted by an officer visiting the township for administrative purposes and then combining the visits with supervisory functions. The frequency of visits is unrealistically stated.

Coherence (4)
The relation ship between program goal /objectives and actual training implementation and results appears to be inconsistent, due to lack of sustainability in training, capacity constraints within the health system that were not addressed in the training, nor in the planned supervision and follow up.

The underlying assumption for the IMMCI training seems to be, that the training is a refresher course for health staff at different levels and the sufficient basis of knowledge and skills is already there through the pre-service training. This assumption might not hold through and needs reconsideration.

Implementation System (8)
The existing Training teams at both state/divisional/district and township levels constitute a strong mechanism for implementing the IMMCI training. The state/divisional training teams conduct all IMMCI ToT training among other training and supervision tasks and the Township training teams conduct the BHS multiplier courses usually only twice in order to cover all BHS in the township. The MOH/DOH introduced training teams at the state/divisional level in the 80ties and the functioning of the teams have been varied. However, with the implementation of the IMMCI program these state/divisional training teams have been charged with the task of conducting ToT for the IMMCI training (five days courses) and in that sense the state/divisional training teams can be said to have been revitalized by the IMMCI program.

The township training team usually has 4 – 6 members; DMO, TMO. Medical Superintendent, Medical doctor (pediatrician, ob/gyn from hospital), LHV, THN, HAs and sometimes a Midwife. The team is responsible for not only the IMMCI training course to BHS (five days duration usually conducted twice to cover all BHS) but also for the **Continuing Medical Education (CME)** 2 – 3 hours every month of all BHS. And all other training of health personnel. The CME, which is not an outcome of the IMMCI, takes place by the end of each month in connection with salary payments, and is said to have been introduced by the Child Survival Project in the 80ties. At the state/divisional level CME is usually for the physicians and at the township hospital for the BHS. It is the township training team headed by the DMO/TMO that conducts the CME. However, all training activities to all types of health personnel appear to be the responsible of the DMO/TMO and his/her team. Thus is placing a heavy workload and responsibility on few key persons (usually 4 – 6 trainers) causing somewhat a “bottle neck” situation. Some of the training tasks are delegated to BHS, e.g. LHV, THN, Nurse tutors, HAs and Midwifes. With respect to medical doctors the CME is sometimes conducted twice a month for doctors in hospitals.

For General Practitioners (GPs) Myanmar Medical Association conducts in-service training once a month all over the country. Generally speaking, the CME does not involve many costs for the township. Some pharmaceutical companies have supported the CME with smaller amount for snacks and small incentives. The DMO usually find funds for convening the monthly training sessions

The content of the monthly CME varies from one township to another and is usually conducted and coordinated by the DMO with the support of the training team. However, it appears that the IMMCI topics are consistently represented in all lists that the evaluation has seen. The monthly CME seems to be potentially an excellent vehicle for in-service training and should be supported much more in terms of training content, materials and training equipment. However, it was discussed during the interviews if the CME could be extended to a full day or even to half a days training. This suggestion seems to be difficult to implement, due to working hours and duties. BHS need to be able to return from the township to their home destination within the same day. All trainers of IMMCI have expressed support for the CME and pointed out the importance of continuing the CME. It is seen as a continuation of the IMMCI training, which is very much needed in order to capture and comprehend all the different

topics. Materials available for the CME is very limited, and there is a clearly expressed need to provide more training materials, posters, charts, illustrations, picture books and videos. The importance of continuing the CME. have repeatedly been stressed by everyone interviewed and the CME is seen as a continuation of the IMMCI training, which is very much needed in order to capture and comprehend all the different topics.

The number of participants in the BHS multiplier courses varies from 40 – 65 participants with a minimum of 40 participants per course. This high number of participants is not found to be very effective for learning. (ER3)

There is an expressed need for more practical exposure to case management and hands on practice.

The time allocated for the content and for reaching training objectives seem to be too short. During the 5 days course, 3 and ½ days is used for the childhood illnesses (168 pages) and 1 and ½ days for the maternal issues and illnesses (38 pages). The general notion among BHS when interviewed is, that there is not enough time allocated for capturing the content of this course. The content is difficult for the participants and they have difficulties in using the handbill. Others give impression that the time for training is sufficient.

There is found no language difficulties due to ethnic diversity.

Project staff generally express satisfaction with the planning, programming and implementation of the IMMCI training courses.

Human Resources

Trainees (7)

The IMMCI training seems to be popular among the BHS and very much concerned with priority issues and related to day-to-day work. The trained personnel are interested in this training, and would like to have more of the same type of training.

The selection of trainees does not apply to the IMMCI training, due to the fact that all BHS is meant to be included. However, this does not seem to be the case for physicians. During the interviews it was mentioned, that the township hospital physicians have much less opportunity to attend the IMMCI training than the BHS, and that this is very much needed.

The Public Health Supervisor is not always included in the training and their role in IMMCI is not used. The PHS grade I is supposed to have responsibilities within WES, UCI, and home visits/outreach functions, but ends up with administrative tasks.

In general BHS have a very clear perception of the scope of work they are performing and they are familiar with their job descriptions. The IMMCI is very much in line with their practical day-to-day work. If the intended capacity building of BHS will take place in the coming years, there is no doubt that BHS can influence a change in the quality of health services both at the hospital and in rural health center settings. The influence of BHS on the category of health personnel considered volunteers, e.g. AMWs, ANMWs and TBAs is potentially there, due to the supervision tasks that the BHS carry. (ER8)

To sustain the new skills and knowledge it was expressed by the BHS that refresher courses were necessary. There is a perception of own skills and BHS generally think they have benefited from the training. (ER7)

Trainers (7)
There is no specific criteria for the selection of IMMCI trainers. The DMO or the TMO is requested to select among the LHVs and the HAs the ones who are interested in teaching and neither too young nor too old. The IMMCI trainers are LHVs, HAs TMO and sometimes Township Health Nurse (THN) and the medical doctors from the hospital. The BHS at the township level usually all have training obligations, and they are often members of the township training team with responsibility for all training to health staff on all topics. A good number of trainers seem to have received the ToT course. However, there is an overload of training tasks placed on the training teams, which creates a bottle neck type of situation for effective and quality training.

Training methodology (7)
The BHS express satisfaction and interest with the methodology being used. It is characterized as participatory, with questions/answers, competitions, individual and group exercises, role-play and visual material.

The classroom methodology is participatory with questions/answers during the lectures, competitions, exercises and role-play. The training tries to include skill-based training but the content of the Handbook does not really lend itself to skill training. It is said to be a mix of 50% theory and 50% practice during the 5 days course, however that's difficult to believe that time permits skill based training and hospital visits due to the range of topics being presented.

In the absence of using the Facilitator's Guide, it appears to be very much the capability of each individual teacher to explain, demonstrate and simplify the content of the Handbook as well as to provide opportunities for skill practice that determines the conduct of the training. The training of BHS would highly benefit from having a Trainers Guide with clear procedures for training section by section. Handouts, overheads and other resource materials could be annexed in the Guide. Each BHS should have a supervisory checklist to complete by the end of the course, to ensure exposure to case management and opportunities for skill practice.

Training materials (7)
The Training Materials Developed for IMMCI training in Myanmar are the following:

1.	IMMCI Handbook 6th edition
2.	Hand bills (5) on diagnostic algorithms for quick reference by BHS
3.	Facilitator guides for IMMCI training sessions, 1998 Operational Guidelines, 1998
4.	Supervisory Checklist and Instructions
5.	IMMCI video
6.	Cassette tapes for IMMCI songs
7.	Manual for Management of Critically Ill Child for Hospital Staff
8.	IMMCI Newsletter for Continuing Medical Education

The IMMCI Handbook 6th. edition is very popular and is being used extensively by all health personnel ranging from doctors to BHS to sometimes ANMWs although not distributed to them, in their day-to-day work. The Handbook and particularly the handbills are the only user friendly and colorful material readily available on child hood illnesses and to less extend on maternal illnesses. However, the Handbook is being used for all different training types, e.g. ToT courses, clinical training in hospital facilities, BHS multiplier course and to some extend in the Program Management course for Mid-Level Managers. The Myanmar adapted IMMCI Handbook appears to divert from the generic IMCI manual in content as well as concept of IMCI training methodology. Where the WHO/UNICEF generic manual provides a step-by-step process and systematically uses algorithms as guidance for the

health personnel and practical guidance, including explanations on how and why to proceed to next steps, the Handbook appears to be short of practical guidance and explanations. The content and range of topics are difficult to capture for most health personnel within five days, especially for BHS. App. 3 and ½ days is used for the child illnesses and 1 and ½ days for the maternal illnesses. It is difficult to determine whether the Handbook is meant as a textbook or a training material.

The maternal part appears to be a compilation from different existing MOH and WHO materials. It appears that the attempt is to modify and shorten textbooks into key points, without providing much explanation of content. The step-by-step approach, use of algorithms and training concepts with practical guidance is not used for the maternal part. E.g. a 15 pages table (page 75 – 90) is presented in the maternal with no explanation. There is one handbill on maternal illnesses. (ER3)

The Handbook appears to be heavily loaded with information, allocating 68 pages for childhood illnesses and 38 pages for maternal illnesses. Information on a broad variety of topics is presented without much explanation, and assumes background knowledge on, e.g. counseling. No explanations is given on how and what type of counseling needs to be used in the given situations. The content of the handbook is difficult for the participants to capture in 5 days and it is expressed that the handbills are not easy to use and it takes time to practice the use and build confidence, especially for BHS. Specific comments have been made, e.g. the growth chart presented in the manual is too small in print and presents difficulties in use. BHS are not able to use the growth chart on routine basis should it be available.

The presence of Water and Sanitation is limited app 3 pages. This section has been developed in collaboration with UNICEF WES and DOH in 1997/98.

The training courses are supported by five handbills which intend to guide the health personnel in the case management and in the treatment options as well as in decision making reg. danger signs and referral options. The handbills are popular and the only ones of their kind available. Trainers as well as trainees express that it takes time to gain confidentiality and skills to use the handbills correctly.

Additionally there are videos developed mostly to give knowledge on clinical signs and symptoms.

The Facilitator's Guide is not being used as intended. The language is too sophisticated and specifically the part related to educational science is difficult for all trainers. The training of BHS would highly benefit from having a user friendly Trainers Guide. In recent year the Facilitators guide is being used more than in 1998/99, where it was hardly used at all.

Future plans for material development.
With UNICEF's changing it's county program implementation strategy to the Area Focused Township (AFT) approach during 2001 and by introducing the Women and Child Health Development (WCHD) program as a replacement for the IMMCI, a revision of all present material has been discussed and planned for. To what extend the material is already under development is not clear. It is envisaged that there will be three main handbooks:

1. Childhood Illnesses (IMCI) using the present Handbook 6th edition without the maternal part.
2. Women's Health Handbook, using content from different existing sources e.g. IMMCI Handbook 6th edition and ESSD. The new Handbook is to go in-depth with obstetric emergencies and to use a life cycle approach to reproductive health issues.
3. Adolescent Health Handbook.

This material development and revision gives a new opportunity to have external input to ensure that the intended IMCI training concept is there with sufficient amount of skill practice in the Childhood

Handbook. A fresh look needs to be taken at the approach, content and use of the Maternal Handbook, which would be most appropriately done as a collaborative effort between the involved Departments within the MOH, UNICEF, WHO, and UNFPA.

There is no presence of learning objectives in the Handbook, because it is presented as a reference manual not a training material. This needs to be added.

The interviews show that the ToT course could be more focused on the needs of the trainers.

Training of Trainers (ToT) course takes place at the state/divisional level provided by the state/divisional training team sometimes with the support of the central level training team. The ToT course uses the Handbook and often this course is conducted within five days as the trainee's course, however meant to be a 7 days course. During interviews it was expressed that the content of the training could be more focused on the tasks they have to perform as managers and it appears that the participants could be better selected to assure that they are actually using their management skills and do not e.g. work entirely with clinical and curative tasks at the hospital.

The trainers have higher educational background, have probably received more training of different kinds and have had more exposure to clinical practice vis a vis their position and seniority. The trainers generally express satisfaction with the ToT training and find the material very useful and not too difficult to use. However, they would all like to receive more ToT in the future. The number of participants is app 48 per course with up to 10 – 12 trainers per course.

The Management course for Mid-Level Managers
The course is conducted either in Yangon by the central training team, or most commonly at the state/divisional level by the state/divisional training team. The program management training has existed for about a year and targets the state/divisional level and township level managers. The course is intended to be 7 days but in reality it is often cut down to 5 days duration and usually TMO, LHV, HA, THN from all townships are called in for the training. The number of participants are app. 21 per course. There is no use of pre/post knowledge assessment for this course.

The Management Course apparently uses a selection of handouts and exercises. Exactly what material is being used for the training is not clear. Topics of the course include; presentation skills, negotiation skills, book keeping, supervisory skills, drug management and drug registration. A **combined drug registration system** is being introduced combining the registration of Essential Drugs, IMMCI supported drugs and Central Medical Store Depot (CMSD). Township Health Development Committees and representation from the government administration is participating in the supervision of the drugs management, and a relatively new collaboration has been established for this purpose. Determining the price for the drugs is part of the tasks as well as managing the drug funds. The revolving drug funds will be used for the purchase of basic equipment e.g. blood pressure measurements and thermometers. The management course is found to be supporting the implementation of the new combined drug registration system.

The role of an IMMCI program manager and a IMMCI trainer seem to be combined and the same person performs both tasks. At each level there are regular meetings and opportunities to review, discuss and plan activities among the members of the training team. However, the communication between the different levels takes place on the annual supervisory visits from e.g. state/divisional level visiting the township. Central level is rarely involved apart from input to the first multiplier course for BHS.

It was expressed during the interviews that all training teams should have management training in addition to the ToT.

During interviews it was expressed that the content of the training could be more focused on the tasks they have to perform as managers. The selection of participants could be better in terms of ensuring that the participants were involved in management tasks after the course and not e.g. were working entirely with clinical matters.

Management structure for implementation of training activities (8).
The following structure is used for the IMMCI program management, incl. training:
at **central level:**
- IMMCI steering committee
- IMMCI technical Committee
- IMMCI working committee

at **State/Division/Districts and township level:**
- Management and training teams

The IMMCI has provided **input** to the training teams in terms of conducting ToT courses, sometimes IMMCI program management courses usually to DMO and state/divisional health officials. At state/divisional level provision of AV equipment and materials, pamphlets, posters and videos for use in support of the training activities has taken place systematically. Per diems are paid to the trainers for their involvement in specific training events like per diems is sometimes paid for supervision functions at this level. (ER8)

At township level the inputs have been similar, however there is a need for support in terms of more materials (handbooks and handbills, posters and charts and other teaching equipment). If AV equipment has been distributed, it is always seems to be available and used. Support of township training teams for e.g. micro planning before the first IMMCI training workshop for BHS (5 days course) is always done by one resource person from Yangon. The support for teaching is done for the first workshop where after the township training team will conduct the following themselves. The township team needs this kind of support in order to succeed with the course and be able to perform (ER8).

In the longer term, the frequency of visits and support given by central level IMMCI training team seems to be very limited after the event of conducting the first BHS training course. The state/divisional level training teams seem to be mostly engaged with the ToT training. No visits by these teams have been mentioned at township level. specifically for IMMCI follow –up. However, monitoring and supervision visits to the township is part of the duties of State/divisional level health departments and it appears to be done twice a year. (ER4)

The cascade and use of the training teams for the IMMCI training seems to be functioning as intended. But the trainers of BHS would certainly benefit from having more time to capture the full IMMCI content themselves and by using training guides. The number of participants for each IMMCI BHS training course varies from 65 – 40 per session during the last couple of years and with app. 27 – 28 participants in the multiplier courses in 1998. The number of participants in the mob – up courses for BHS who have never received the IMMCI training, due to rotation or other circumstances is always lower at app. 27 – 29 participants The evaluation found the number of participants in the multiplier courses is too high for effective learning and active participation. Not to mention opportunities for skill practice during the 5 days course. It is not clear why the number of participants is kept at minimally 40 per course, and what the justification is. If all BHS is usually reached with the IMMCI training in two

sessions like in Hpa-An in 1999 (65 participants per course) why can't it be spread out over the year a bit more with lower number of participants in each course? (ER4)

Health personnel are rotated from one location of work to the next on regular basis, and there is an expressed need to conduct ToT for new staff with training responsibilities. This includes ToT of medical doctors in hospitals as well as for BHS. These trainers are often members of the training teams and thus the capacity status of the training teams and their requirements for input need to be assessed regularly. ToT needs to be offered systematically to all new training team members at both township and state/divisional levels.

Decision making within IMMCI program is made at the central (Yangon) level. Request to central level are being made by state/divisional or township levels regarding e.g.. additional training of new staff or additional supplies. Suggestions are also being made from these levels to central level during supervisory visits and carried forward from township to state/divisional to central level in a hieratical manner. The **communication** is characterized to be top down and rarely bottom up. (ER7)

Monitoring and evaluation mechanisms (6)
There is no specific format for monitoring reports. However, during 2001 a supervisory checklist for monitoring the performance of BHS at Health centers and Sub centers have been taken into use. Also a pre/post assessment form has been introduced in connection with the BHS multiplier course during 2001. It is the intention that the outcome of this assessment in terms of training needs will be addressed in the monthly CME, where additional training on specific topics can be provided.

The results of the recent monitoring is being compiled and analyzed by the IMMCI management office at the North Okalaba hospital and presumably used as a basis for material development and revision. With the current edition of the Handbook being the 6th edition a substantial rewriting and modification of the material has taken place, not the least in the way the content is being presented .The fact that so much effort has gone into this continuous revision, is seen by the evaluation as an indication, that an ongoing assessment and review of the training outcomes has taken place over the years. and that these results have been incorporated into the present material and training methodologies (ER7)

The monitoring is capable of measuring the immediate impact of training in terms of knowledge upgrading and also acquired skills and practice. on a regular basis. Outcomes and impact on longer-term perspective is not being monitored at this point. (ER4)

Indicators have been developed but the use of these indicators are uncertain. Indicators are not reflected in the supervisory forms. The indicators are e.g.:
- utilization of health services; RHC, hospital
- no. of referrals (sick child cases, pregnant women with danger signs)
- pre/post knowledge assessment scores

The implementation of the training is all in all done well and usually follows schedule
short term perspective evaluation: outputs: immediate increase in knowledge (pre/post workshop assessment of skills) following the training session does take place. An in-depth review is being done of Taikkyi Township, Yangon Division and the results of this review will be shared with the evaluation team.

Follow up and monitoring after IMMCI training appears to be practiced on an irregular basis.

Supervision and follow-up (5).

There is manpower shortage for undertaking the planned supervisory and follow-up visits. Supervision of BHS takes place on an irregular basis and it has not been possible to estimate the frequency of the visits Supervisory checklists have been prepared by the program and taken into use in the beginning of 2001. The data has just recently started to be analyzed.

In 1998 there were no plans for follow-up, and in 1999 when follow-up started to become part of the training implementation it was not done. The intention was to do follow-up after training within 6 weeks after the course, with a visit to the BHS work site to assess if skills acquired were used by the BHS. In 1999 the facilitators made follow-up visits for few training courses in areas in Rhakhine, Mon State, Mandalay, Sagaing, Magway, and Yangon Divisions together with members of the training teams at township and state/divisional levels. These visits continued during 2001, and a total of 159 visits were made. During these visits trainers used pre-coded checklists. TOT for supervisors and multiplier courses for supervisors were also given in 1999 and 2001. In 1998, no specific training was given for "follow-up after training" visit.

Professional networks exist, that brings the IMMCI personnel together to share lessons & experiences and to learn from each other. Two main examples can be given; one is the monthly CME, which gives the BHS an opportunity to meet and discuss. Another, example is study tours that were arranged for IMMCI managers and trainers, mostly from central level .to Nepal and Indonesia to visit similar IMMCI projects.

Efficiency (ER 7)

Two types of training were reviewed for the year 1999

Sr.	IMMCI Training Type	# of days	Num-ber of partici-pants	Total Cost (Kyats)	Unit Cost/ person (Kyats)	Unit cost/ person (**US $**)	Unit Cost/ person day (Kyats)	Unit Cost/ person day (US $)
1.	TOT for Magway District	5	24	414816	17284	**49.67**	3457	9.93
2.	Training of BHS in Magway Division	5	648	5731560	8845	**25.41**	1769	5.08

Unit costs per BHS trainee is approximately $25, costs for training activity per year,

The time used for implementing the training vis a vis the training objectives does not appear to be much. The IMMCI trainers at township level usually have a workload of 2-3 h /per month in connection with the IMMCI. These hours are presumably used for the CME on monthly basis. This workload after the BHS multiplier courses (usually 2) have been completed and all BHS in a township have received IMMCI training is very low. The actual BHS multiplier course implies intense work and preparation for probably 2 weeks.

Costs per training course

(official exchange rate; 1$ = 430 Kyats)

At state/divisional level the costs for a 5 days BHS multiplier course is estimated at 110.000 Kyats (US$255) at township level at 14.000 Kyats US$ 32) other estimations in Hpa-An for multiplier courses during 1998/99: 417.200 Kyats US$ 970) and in other townships; 202.800 Kyats US$471) and 148,800 Kyats US$429)

Mid-level management course is estimated at 240.770 Kyats (US$560) for 21 participants

Per diem rate for BHS is US$ 3.5/day, out of this BHS is supposed to pay for their own lodging during the course.

The efficiency is found to be relatively good, due to the low costs for training implementation, the timely implementation and the fair amount of immediate knowledge up grading

6.2.5- Results

(Evaluation rating (ER) ranges on a scale from 1-10, where 10 is highest)

Level of Result	Level of Effectiveness	Sustainability
1st level: Change in participants knowledge, skill & attitude	Fair amount of immediate knowledge upgrading (Mean score on pre/post assessment of BHS 38.6% - 48.4% Trainees feel they have gained more skills and Confidence Limited change in attitudes	Sustainable in the shorter perspective, but needs refresher and more in-service training to be sustainable in the long term.
2nd level; Change in individual performance	BHS feel more confident and use handbills No evidence of increase in referral of pregnant women. Perhaps slightly more U5Y children being referred.	Limited
3rd level; Change in organizational performance	Probably an improvement in case management of sick children in some facilities and among some BHS. No change related to maternal illnesses Utilization patterns of public facilities unchanged.	None
4thlevel; Improvement in situation of children & women	NA	NA

6.2.6- Relevance of training as a capacity building strategy (ER 8)

The content of the IMMCI training is certainly relevant and highly related to daily practice in health facilities. There is a good match between program goal /objectives and focus of training, in terms of integrating of health services and delivering an integrated basic health care package. There is a fair knowledge up grading taking place and less skill up grading. Over time it seems difficult for BHS to maintain the practice in health facilities that have severe capacity constraints, e.g. staffing shortage, limited supplies and maintenance, low salaries and poor utilization.

The collaboration and coordination mechanisms for IMMCI related training between the involved departments in MOH; Dept of Health, Dept of Medical Sciences, Dept of Medical Research, Division of Public Health, Dept. of Health Planning and the UN agencies; UNICEF, WHO, UNFPA leaves room for improvement. With app. 27 different projects falling under the IMMCI umbrella, there is a recognized need to coordinate and collaborate in order to avoid overlap and duplications in project activities as well as in the training. (ER 3)

6.2.7- Main Findings:

Process:

Achievements:

1. IMMCI Handbook and handbills popular and the training methodology is participatory.
2. Widely used by all health personnel.
3. Used as reference manual and job aids.

4. Numerous revisions of handbooks have incorporated findings of monitoring results.
5. Strengthening township training teams.
6. Plans for revision of present materials:
   - Childhood Illnesses Handbook
   - Women's Health/Illnesses Handbook
   - Adolescent Health Handbook
7. Introduction and use of pre/post knowledge assessment and supervisory check list.
8. Systematic Continuing Medical Education to BHS and hospital staff is a mechanism for sustained in-service training.

Issues:

1. The handbook is used for training of all categories of health personnel at all levels, limited use of Facilitator's Guide.
2. The underlying assumption; that IMMCI training is a refresher course and sufficient knowledge/skills are already present to build upon, might not hold
3. The use of algorithms and IMCI training content is inconsistent and content not always appropriate for level
4. Facilitator's Guide is not used systematically
5. Basic health staff express IMMCI training is difficult.
6. Need for more practice and hands-on.
7. Lack of regular follow-up and long term evaluation mechanism using indicators
8. Duplications and overlap in IMMCI training materials and training activities among all involved partners.
9. Program documentation is limited and needs strengthening in e.g. overview of planning, management and organization as well as description of strategy
10. Efficiency good in view of low unit cost/trainee, BHS = $25

6.2.8- Recommendations for IMMCI Training

1. Related to Training Strategy/Target Group.

1. Strengthen the IMMCI content in pre-service training of health personnel e.g. the curriculum for Medical Doctors, Bachelors degree nurses, Diploma Nurses, Health Assistants, and Midwifes as well as Auxiliary Midwifes and Auxiliary Nurse Midwifes.

2. Provide in-service training to ANMWS and AMWs on regular basis by using the occasion when ANMW/AMW report to the Midwife at the RHC on delivery outcomes and referrals of pregnant women. This reporting takes place app. every 2 – 4 months

3. As part of rethinking the IMMCI program strategy to strengthen outreach to pregnant women and ensure safe and clean delivery practice, to include TBAs, who are widely used by the community for delivery assistance, in the IMMCI training

4. Target the General Practitioners for the IMMCI training through Myanmar Medical Association, to ensure outreach to a large part of the population not seeking treatment at the public health facilities and in order to ensure standard quality case management of the sick child.

2. Related to Training Methodology

5. Use standardized training approach for the (revision) and development of the WCHD program materials; specifically to ensure that the Childhood Illnesses Handbook follows the intended IMCI training methodology,

6. Reconsider the training in reproductive health and involve relevant partners in both the MOH and among the UN agencies

- prepare the trainers,
- use Trainers Guide
- ensure exposure to skill practice to normal and complicate deliveries
- use the life cycle approach in the reproductive health
- include follow-up and supervision after the training.

3. Related to Training Content/Materials

7. UNICEF to facilitate collaboration and coordination between the involved MOH departments (Division of Public Health, DOMS, DOMR, and DOH), and involved UN agencies; WHO and UNFPA for the development of the future WCHD material, specifically with respect to the Women's Health Handbook,

4. Related to Training Implementation.

8. To ensure a sustainability perspective of the IMMCI training, and in order to maintain a potentially very strong existing mechanism for systematic and focused in-service training, UNICEF, in partnership with other interested agencies and NGOs, to provide support and capacity building country wide of training teams at all levels with specific emphasis on township training teams who are responsible for Continuing Medical Education.

9. Develop Trainers' Guide for the different types of training at different levels

10. Each BHS should have a supervisory checklist to complete by the end of the multiplier course, to ensure exposure to case management and opportunities for skill practice.

11. Reduce the number of participants for the IMMCI multiplier course and ToT and determine a minimum number of participants for each type of training that is realistic and manageable for effective learning and skill practice.

12. Future training activities should be systematically followed up and monitored 3 and 6 months after the training and be budgeted as part of the training.

5. Related to Results

13. Strengthen the collaboration for reproductive health among the front line public health workers; ANMWs, AMWs, TBAs, and Midwifes.

14. Ensure essential obstetric supplies and facility maintenance.

15. As part of the strategy for reducing MMR and in order to achieve expected results, UNICEF to endorse and advocate for the implementation of the revised job description for Midwifes of 2000 (revision provides less focus on UCI, WES, TB, Leprosy, malaria etc and more emphasis on core functions of midwifery in order for the Midwife to be more available for assisting deliveries).

16. Collaborate with MOH in processing, implementing and endorsing the midwifery standards for practice and professional regulation, specifically in relation to enabling obstetric emergency practices. Support material and equipment to health facilities as needed.

6.3- Auxiliary Midwifery and Nurse/Midwifery training (AMW/ANMW)

6.3.1- Description of Training Components.

The AMW and the ANMW training components have been evaluated separately, but the presentation of the evaluation findings will be done jointly, because there are more similarities than differences between the role and functions of the two types of health workers and their training.

The training of AMWs/ANMWs can best be characterized as on the job training. The AMW/ANMW has apart from delivery and (for the ANMW; reproductive health related tasks) a range of other duties related to most of the national health programs, including Water and sanitation, and is a multi purpose front line health worker

In the rural areas throughout Myanmar, health services are provided by the midwives. In border areas by an ANMW. Since each midwife is assigned to 4 or up to 7 villages, it is recognized that the midwife has difficulties in covering all the villages assigned to her. The midwife carries a variety of responsibilities and tasks as a multi purpose health worker, which allows only limited time for antenatal, delivery and post-natal services. Therefore, the AMWs/ANMWs are trained to assist the midwife and in order for villages to have some access to health services within the community by at least on trained health personnel.

The training of ANMWs and AMWs is undertaken by the DOH for 6 months and the content is almost similar. After completed training the ANMW/AMW returns to her village to practice from her private home or visit households in her community. The AMWs and ANMWs are considered volunteers and are thus paid by the communities for their services.

UNICEF started supporting the training of ANMWs in 1997 by training of trainers and the actual training of trainees started end of 1997 beginning of 1998. At that time training of ANMWs was one of the activities of the Border Areas Primary Health Care and Development Project (1996 - 2000). Since 2000 the training of ANMWs is done by the DOH. UNICEF has supported the training of AMWs since 1999.

RHCs and sub-centers have long been operating in rural communities in Myanmar. However, as a result of insecurity and inaccessibility, these rural health facilities have not expanded in the border areas. There, the few existing RHCs cover wide areas where populations are scattered. Many villages in the boarder areas have never seen public health workers. The socio-cultural diversity of the border areas, and particularly the variety of languages, constitutes a barrier to the delivery of health services. Lack of consideration of the local culture' attitudes and practices regarding health also hampers support to family and community health.

Development of appropriate human resources for health in the border areas is one of the strategies to achieve better health outcomes and in order to make available and accessible a package of basic health services ANMWs are trained and recruited in border areas. According to the MPO (1996- 2000), 20 ANMWs / township per year should be recruited and trained over five years. UNICEF has been committed to bear the cost of the training and equipping the ANMWs. with a midwifery kit and basic immunization equipment.

The contents of the training not only includes midwifery, but also treatment of minor ailments, disease surveillance and immunization sessions. ANMWs are supposed to be supervised by Midwives. Immunization activities were intended to be used as an entry point for delivering other health services. Training was meant to be task-oriented and suitable for those workers who have low literacy or are even non-literate. Therefore, the training manual was meant to be mostly graphic, stressing applied topics rather than theory. The training also includes simple register of delivery outcomes and performed tasks for monitoring and evaluation purposes. Training content may vary somewhat from one area to another, depending on the culture, level of education of the trainees and epidemiological specificities. ANMWs are supposed to be equipped with flip charts for interpersonal communication with non-literate families.

UNICEF has provided basic essential drugs to border areas via the ANMWs with the financial support of Japan, with the intention of expanding their work activities related to drug administration.

It was the intention of UNICEF in collaboration with DOH to train initially 1000 ANMWs/year (approximately 20 per township in 50 out of 61 boarder area townships) in immunization and subsequently in antenatal care, delivery, CDD and ARI control activities. It was then planned that every year, an additional 1,000 ANMWs could be trained, if the experience proved successful. According to midterm evaluation done in 1998, 200 ANMWs were trained in Shan and Kayah states and 200 were undergoing the training. These young women usually have an education level below the midwives, but their comparative advantage is that they belong to the area where they work and are accepted by their communities as opposed to other types of health workers coming from other parts of the country. The intension is to utilize ANMWs as front-line health workers for basic services, including immunization. UNICEF is advocating for the ANMWs to be allowed to apply injectable vaccines following appropriate training. Training has also been given to BHS to enhance their capacity to supervise the ANMWs and enable them to conduct crash immunization activities. This is still pending, however, waiting for authorization from the MOH.

Problem Statement

The maternal mortality rate is 1.2 / 1000 live births and abortion accounts for more than 50% of maternal deaths in hospitals. Since unsafe delivery and abortions are the major cause of the access maternal mortality rate, the government in collaboration with UNICEF focuses on the interventions to increase access and to improve quality of health services in rural areas.

Goal: To reduce the maternal and newborn mortality and morbidity.

Objectives:

1. To increase the coverage of health services at the rural area with trained voluntary health workers
2. To be able to practice antenatal care, delivery and post natal care of the women and the newborn by AMW/ANMW at her residential village.

Implementation Strategy

For the ANMW training there is ToT courses, which is not the case with AMW training. However, the 6 months basic training of the ANMW/AMW is parted up in two sections; the first 3 months are spent at a township hospital with a mix of theory and practice. The township training team is responsible for both ANMW and AMW training. Secondly, another 3 months are spent at a Rural Health Center (RHC) or Sub center for practice with the supervision of a Midwife and a Health Assistant.

Target Groups
For both ANMW/AMW the trainee is a healthy young woman age 16 – 27 years (for ANMW minimum age 18), who is residing in the village of where she will practice, she has at least middle school basic education and has interest in health related work as a volunteer. The trainee should be able to read and write, should have good character and be trusted by the community in which she lives and should be interested in health care and volunteerism and actively participate in PHC activities. The ANMW/AMW is selected jointly by the local administrative body and the community.

Budget (in US$)

Types of Activities	1999 & 2000 (Kyats)
AMW training	18,000,000
	US$ 41,860.00

Types of Training	Phase I 1998	Phase II 1999	Phase III 2000	Total (Kyats)
Training of trainers (ANMWs)	1,315,350	740,000	975,000	3,030,350
Training of ANMWs	7,680,000	8,448,000	38,880,000	55,008,000
Advocacy Meeting	90,000	99,000	285,000	474,000
Supervision	200,500	220,000	610,000	1,030,500
Production of training manuals	100,000			100,000
Total (Kyats)	9,385,850	9,507,000	40,750,000	59,642,850
Total (US$)	**21,827.00**	**22,109.00**	**94,767.00**	**138,704.00**

6.3 2- What has been done to evaluate?

Desk review of available documentation has been done; e.g. job descriptions, training materials, curriculum documentation, and DOH materials. Interviews with key stakeholders from UNICEF and DOH, interviews with trainers and trainees and focus group discussion with trainees and knowledge assessment of trainees were done. Visits to Yatsauk (Shan State), Kyauktan (Yangon Division), Thaton (Mon State), Pa-an (Kayin State) and Monywa (Sagaing Division) were done. Since there was no ongoing training, observation of training could not be done.
(see sample size in section 5, evaluation methodology)

6.3.3- Outputs of the Training

Outputs: Number of Auxiliary Midwives (AMWs) Trained

Training of Auxiliary Midwives (AMW)	1999-2000
Total no of Townships	160
No. of AMWs trained	2000

Training Material Developed

	Training of Auxiliary Midwives
1.	AMW manual
2.	AMW curriculum document

Outputs: Number of Auxiliary Nurse Midwives trained

	Training of Auxiliary Nurse Midwives (ANMWs)	1998 Phase 1	1999 Phase 2	2000 Phase 3	Total
	Tow Townships	20	22	61	**61**
1.	**Training of Trainers:** No. of BHS trained	108	88	76	**272**
2.	**Training of ANMWs:** No. of ANMWs				

	trained	200	220	400	**820**

Material developed

	Training of ANMWs
1.	Manual for Auxiliary Nurse Midwives
2.	Pictorial guide for ANMWS

6.3.4- Process Evaluation

(Evaluation rating (ER) ranges on a scale from 1-10, where 10 is highest)

Identification (ER 7)

Training of front line public health workers in rural areas is essential and can potentially improve health outcomes and increase the access to basic health care. The training of AMW/ANMW focuses on most of the priority health issues to be addressed in rural areas. No specific base line or situation analysis was done prior to the training. The training needs of ANMWs/AMWs were well understood as well as the level of education of trainees. Estimates of health statistics in rural and boarder areas is done currently, and provides an overview of priority health problems and issues to be addressed.

The objectives for the training of ANMW/AMW are not stated in the training materials, but there seem to be a clear notion that AMWs assist deliveries and do multipurpose health work incl. water and sanitation. The ANMWs do the same, but they tend to have additional tasks added in terms of vaccinations and injections in life saving situations. The requirements for care of an ANMW practicing in the border areas, is higher compared with the requirements of an AMW. The ANMW is the only basic health worker available and needs to be able to work independently.

Preparation (ER 6)

Training needs were determined. The selection procedures for trainees were well defined. The initial plans of training 20 AMW/ANMW per township/year was probably overestimated in view of the present capacity for training at the township level. Trainers are members of the training team and perform a variety of other types of training throughout the year. Part of the limited capacity for training is founded in the practical part, due to difficulties in ensuring sufficient exposure to deliveries and hands on practice. This part of the training could be prepared better.
The requirements for training implementation were defined in terms of materials, trainers, and per diem support to trainees. There was no monitoring and measurements of results inbuilt in the training and no follow up was planned for.

Coherence (ER 3)

The consistency in implementing the AMW training is lacking. UNICEF did not support the printing of the AMW manual during the last years. Presently, the manual is not readily available to either the Midwifery trainers nor to the AMW trainees. If the manual is available it is the 1998 Sep. edition, and there is one copy per class. As substitute the ANMW manual is used. This unavailability to training materials has resulted in the AMW trainees having only their own notes in most cases.

Per diem payment for AMW training has been supported by UNICEF since 1999. The payment covers only 1 month out of 6 months training; paid as 300 Kyats/day (30 days) over a 3 months period, total 9000 Kyats, compared to ANMW per diem of 500 Kyats/day every day throughout the 6 months, total 90,000 Kyats. The DOH provides a complimentary per diem support to AMWs of 20 Kyats/day for the remaining months. However, the per diem support to AMW training from UNICEF has not been provided during 2001 due to un-liquidated funds for more than 6 months duration (UNICEF funding regulation; that in the case of unliquidated funds exceeding 6 months duration, funding will be terminated).Moreover, it was suggested during the evaluation, that the lower per diem rates for the

AMW is a contributing factor to the present situation of difficulties in recruitment of AMW trainees, and consequently delays in the training implementation.

Implementation System (ER 5)
The township training team is responsible for the ANMW/AMW training, and seem to be doing well in terms of planning, organizing and implementing the training. The training is delayed at times and the capacity is low at around 10 trainees per township per year.
AV-equipment has not been made available, nor any other teaching aids. Usually, training models, posters and pictures are borrowed from other programs.

There is a need to train more ANMWs/AMWs because they are the only front line health worker in villages, particularly in view of a new staffing norm determined by the DOH, increasing the norm from 1 AMW/ANMW per 2 villages to 1 ANMW/AMW per village. However, with the present level of production of ANMWs/AMWs (app. 10 per township per year) it will take unrealistically long to reach the target.

The present training capacity is limited and needs to be strengthened both in terms of capacity to produce more AMWs/ANMWs, but also in terms of ensuring and planning for exposure to deliveries and hands on practice during the 6 months of training.

The ANMW and AMW Kits supplied by UNICEF are received and maintained by the volunteers, including drugs in ANMW Kits. There is a number of Kits available at RHC level; UNICEF supported Midwifery Kit and AMW Kit, and WHO Clean Delivery Kit (disposable) supported by UNICEF and WHO. However, the latter is only introduced in few pilot areas.

ANMWs/AMWs have a sense of duties and responsibilities in connection with Water and Sanitation; would like to both learn and do more of this type of work,

Trainers:
AMW trainers are not provided TOT, but ANMW trainers are. However, the trainers are the same, namely members of the township training teams and specifically LHV, midwifes. The trainers have very little guidance in conducting the training due to absence of a facilitator guide. The manual is not intended as a standardized training manual and can be modified as seen necessary. At the RHC the trainers are midwifes. The curriculum document for the AMW training was not known at the RHC visited by the evaluation. The trainers at both township and RHC had not received the AMW trainee's manual.

Trainees
The both types of trainees their education level is not high, but they are trained in midwifery skills, treatment of minor ailments in the context of primary health care. Selection of ANMWs and AMWs is usually carried out by the local communities themselves and also responsible for monitoring and supervision of their work. Recruitment of village residents ensured that communities receive health services from trainees. In the un-reached villages the selection process is carried out by the local community leaders under criteria developed by township health staff and community leaders. Some trainees did not get the AMW manual. UNICEF is not providing the training materials. DOH had tried to provide training manuals to AMWs but sometimes not sufficient for all AMWs.

Training methodology
Lectures, discussions, explaining, practical demonstration and case taking and role-play
There is limited exposure to deliveries during the 3 months hospital training and often the exposure is even more limited during the 3 months at the Rural Health Center resulting in deviation from the

standard of attendance of 5 – 10 deliveries during hospital practice and 5 – 6 deliveries during RHC practice. The minimum hand on practice norm for deliveries is 5 during the six months AMW training

Training materials
The vast majority of the content of the training materials used for AMWs and ANMWs .is similar. However, the main difference is the role and practice of ANMWs reg. UCI and injections. These subjects are not included in the training manual.

The main differences in the curricula are the following:

ANMW curriculum:	AMW curriculum:
Immunization	no Immunization
ARI management	no ARI management
Diarrhea case management	no diarrhea case management
no Reproductive Health	Reproductive Health

Training material needs improvement and up dating for both ANMW and AMW. However, a revision of the AMW manual is planned for and is needed to bring content up-to-date with appropriate focus. Comments received during the evaluation, stressed that the content on prevention of common illnesses, e.g. diarrhea, malaria should be included. Water and sanitation could be expanded and topics like HIV/AIDS needs to be added The material contains hardly anything on principles of care and support as well as home based care.

The AMW/ANMW manual is intended as a guideline for the training. The DMO/TMO has free choice of training content for AMWs/ANMWs. As a result of this the training is not standardized and the content varies from one state/division to another

There is shortage of all kinds of training materials/demonstration models, and lack of distribution of training manual

Management of the training component (ER 7)
The overall responsibility for AMW and ANMW training lies with the Deputy Director General (DOH), Director (Public Health), and Director (Medical Care); they are the administrative resource personnel. The technical resource personnel for the training are medical officers of related projects of maternal and child health who have developed the training material and jointly determined the strategy for training implementation. States/ Divisional Training team and township training team members are directly involved in the day-to-day implementation and organization. It appears that there is limited involvement by nursing/midwifery personnel at the central level, both for development of regulation for practice, policy, training strategy and training material.

There are delays in implementing the AMWs training, budget is not spent within time frame, the recruitment of new AMWs for training is sometimes difficult and more trainers of AMWs are needed to manage present courses.

UNICEF Health and Nutrition sector staff appears to have more involvement in the management of the ANMW training program and less in the training of AMWs.

Monitoring and evaluation mechanisms (ER 2)
There is monitoring report on the production of trainees, but no other requirements for monitoring and evaluation.

Supervision and follow-up (ER2)
The ANMWs visits the township hospital regularly to; report on delivery outcomes and other health statistics, collect vaccines and other necessary supplies. On these occations informal supervision and sometimes refresher training is given by the midwife. For AMWs who is also obliged to report to the midwife regularly informal supervision can also be sought by the AMW.

There is no planned refresher or other training being offered to ANMWs/AMWs after the basic training has been completed. Supervision and follow up is rarely done and happens more on an opportunistic basis. However, it was stressed by all ANMW and AMW that there is a need for refresher training and supervision.

Efficiency ER 6)
There is a significant difference in the estimated unit cost of AMW and ANMW due to UNICEF's limited support of AMW. The training results are almost similar for the two types of training.

AMW training

Sr.	Training Type	# of days	Number of participants	Total Cost (Kyats)	Unit Cost / person (Kyats)	**Unit cost/ person (US $)**	Unit Cost / person day (Kyats)	Unit Cost / person day (US $)
1.	ANMW TOT at township	7	76	975000	12829	**36.97**	1833	5.28
2.	ANMW ANMW training	180	400	38880000	97200	**280.12**	540	1.56

6.3.5- Results (ER 6)
(Evaluation rating (ER) ranges on a scale from 1-10, where 10 is highest)

Level of Result	**Level of Effectiveness**	**Sustainability**
1. Change in participants know-ledge, skill & attitude	Knowledge assessment shows a fair amount of knowledge, but some reluctance in recognizing danger signs	Knowledge needs to be refreshed regularly to sustain.
2. Change in individual performance	1.Trainers express that trainees have gained skills and confidence after completed training. 2. Safe and clean delivery practice related to: - washing of the women before labor, - umbilical cord cutting practices, - hand washing practices. 3.Routine ANC lacks urine/BP measurements. 4. Physical examination of pregnant women very limited. 5. Few referrals of pregnant women (1.4. referral by AMW last year) 6. Wide use of medication to control postnatal bleeding. 7. Limited number of attended deliveries (2.5. by AMW per 3 months)	Sustainability is challenged by demand for traditional practice and shortage of supplies
3. Change in organizational performance	**NA**	**NA**

4. Improvement in situation of childn & women	No evidence	NA

6.3.6- Relevance of the training as a capacity building strategy (6)

To improve the relevance of the training, the ANMW and in particular the AMW need to be equipped with a higher level of knowledge/skills and self esteem in order to be better prepared for her role and responsibilities. This is also necessary in view of utilizing the AMW/ANMW to full potential as only front line public health worker in rural areas. A number of preconditions for the training and later practice of the ANMW/AMW need to be in place to obtain the expected results. These have not been met, e.g. related to HRH planning, job descriptions, regulation of practice, supervision and supplies.

The AMW/ANMW is usually a young women age 17 – 22 years, selected by the Village Head and local administration. The AMW is supposed to minimally serve for 4 years, the ANMW for longer. Relationship with older TBA is not an easy one and there is often competition for attending deliveries. The AMWs/ANMWs are not as popular as the TBAs There are indications that the TBA is the health worker, who attends to most deliveries in rural areas. The TBAs are more popular, because they have extended services apart from assisting the delivery of washing, cooking and cleaning in the household. Additionally, they are older and considered more experienced. It is per tradition that every home delivery must be attended by a TBA. Other indications point in the direction that the AMW attend to less deliveries than both midwifes and TBAs.

As explained during the focus group discussions with the trainees, it usually takes a new AMW a couple of years to gain confidence and build up good reputation in her village and before her services are in request. The AMW relies to some extend on the Midwife during her first year of practice, and refers to the midwife if there are complications.

Transportation to hospitals appears to be assisted by the community whenever needed, so in that sense the precondition for training on detection of danger signs in connection with deliveries is present.

Presently, there is no policy and practice regulation of the role and responsibilities of ANMW related to UCI and the administration of other injections, despite several attempts by UNICEF to raise the issue with the DOH.

The training of auxiliary health volunteers is relevant and must continue with countrywide coverage, with a strengthened emphasis on danger signs and when to refer complicated deliveries. So far there are modest results of more clean delivery practices, and there are plans for improving the materials.

6.3.7- Recommendations.

1. Merge the training of ANMWs into the AMW training and introduce standardized training approach with country wide coverage:
   - Endorsement of selection criteria

- Extend per diem support for entire training period (6 months)
- Revision of training materials and use of a Trainers Guide,
- Provision of necessary demonstration materials/equipment e.g. pelvic model, visual materials e.g. picture books, posters and AV equipment (the latter for hospital based training).
- Systematic distribution of training materials for all ANMW courses
- Systematic use of knowledge/skill assessments after completed practice at hospital and health center level and follow – up after training.
- Increase the number of ANMW trainers and introduce ToT course.
- Introduce refresher training twice a year at the township level in connection with reporting to the Midwife on delivery outcomes.

2. Establish mechanism for support to planning, organization and management of training program in collaboration with the MOH and DMOs and township training teams.

3. Assess present coverage of ANMWs/AMWs according to staffing norm and estimate training needs and develop training plan to reach staffing norm

4. Increase present training capacity from 10 AMWs/ANMWs per township per year

5. UNICEF be instrumental in preparing proposal and cost estimations for AMW/ANMW training needs in Myanmar for reaching the norm, to be presented for funding (UNICEF and other interested agencies).

6. Ensure minimum delivery exposure and hand on practice norm during training by:
- introducing supervisory check lists for procedures attended and skill practiced
- distribute the ANMWs/AMWs more evenly among RHC and Sub-centers during practice period
- Introduce TBA collaboration e.g. notification by TBA to the RHC/Sub-center of delivery to ensure attendance by ANMW/AMW under training.

7. UNICEF to help clarify, develop and submit policy to MOH for ANMW practice in relation to UCI and injections for life saving procedures.

6.4- Traditional Birth Attendants (TBAs)

6.4.1- Description of the Training Component.

Traditional Birth Attendants (TBA)s have been trained since People's Health Plan (PHP I) in 1979, however, that was terminated in 1988. The training of TBAs resumed in 1997, with the support of UNICEF and was implemented by the Women's Health Project, under the Division of Public Health, Department of Health.

Problem Statement
The maternal mortality rate is estimated by the Myanmar Central Statistical Organization, National Mortality Survey, 1999, at 178 per100.000 live births (urban) and 281 per 100.000 (rural), average 255/100.000, and by WHO/UNICEF in 1990 at 580 per 100.000 live births. Late referral and complications to abortions contribute to excess maternal mortality. In villages, transportation difficulties, family duties, traditions and restricted family economy are some of the reasons, why women chosen to deliver at home. TBAs are residents of the village and mostly elderly persons. The role of a TBA is passed on through generations in the same families; the

grandmother trains the mother who trains her daughter. A TBA commands respect and are utilized by most pregnant women in the rural areas, and the pregnant women trust and rely on them, as they are well known. Moreover TBA's services include cleaning, washing clothes and their fees are reasonable.

More than 50% of the deliveries are assisted by untrained TBAs according to estimates in Division of Public Health. Some of the traditional practices of TBAs are harmful to the pregnant women, and also to the infants. The TBA overlaps in scope of work with the ANMWs/AMWs and tend to be more popular, although the auxiliary workers are better trained. This is the case especially if the ANMW/AMW is a young woman just recently trained without much experience. Since unsafe delivery and complications to abortions are the major cause of maternal mortality in the country, the government in collaboration with UNICEF focuses on the interventions to improve quality of routine delivery care and identification of danger signs that need referral.

Goal: To lower the maternal and newborn mortality and morbidity

Objectives

To help the TBA

1. To develop an overview of the importance of the concept of good health and to understand her role in the health care system.
2. To communicate to the community in her area, the ways that lead a healthier lives.
3. To improve her knowledge and skills to conduct deliveries safely.
4. To identify harmful midwifery practices and correct them.
5. To recognize abnormalities and refer sick mothers or those at risk to health facilities.
6. To advice mother on proper nutrition during pregnancy and lactation.
7. To advice mother about prevention of diarrhea and use of ORS.
8. To motivate mothers to have their infants immunized.
9. To encourage correct breastfeeding practices.
10. To motivate pregnant mother for Tetanus Toxoid immunization.
11. To promote the utilization of existing health care facilities and promote health in her area.

Implementation Strategy.

Central level:

Training of trainers for TBA training takes place at the central level and lasts 6 days. The central level trainers are chosen from related projects of maternal and child health usually from the States/ Divisional training teams, from Township Health Offices or from the Assistant Director (Nursing) office. Typically it is the Township Medical Officer together with the Township Health Nurse / LHV who are responsible for the planning and implementation of the TBA training.

The training plan for the townships is drawn up at the end of the central level ToT course, together with the trainees.

Township level:

Two types of training takes place at the township level; one is ToT courses for BHS with priority to LHVs and Midwifes in educational techniques and methodology. Usually 24 trainees per course, which lasts 6 days and is conducted by the trainers at central level.
The second; is training of TBAs by the Midwifery trainers at the township hospital for 6 days.

Target Groups

Women who are practicing as Traditional Birth Attendants but never trained are targeted for the training. They acquire their profession by family tradition. Most of them are illiterate but some can read and write.

Budget (in US$)

Type of training	Training Budget (in Kyats)		
	1998	1999	2000
TOT Central)	235,250	1,316,160	1,266,432
Methodology training	1,442,500	6,438,825	7,066,450
TBA training	1,625,000	8,186,125	10,325,650
	US$ 3611	**US$18191**	**US US$ 22945**

Type of training	**Training Budget (in US $)**		
	1998	1999	2000
		US $ 1 = 347 K	
TOT Central)		3,793	
Methodology training at township		18,556	
TBA training		23,591	

6.4.2- What has been done to evaluate?

Desk review, Interviews with key stakeholders from UNICEF and DOH, interviews with trainers and trainees and focus group discussion with trainees and knowledge assessment of trainees were done. Thaton (Mon State) and Monywa (Sagaing Division) were visited. Since there was no ongoing training observation could not be done of the training methodology. (sample size, refer to section 5 evaluation methodology).

6.4.3- Outputs of the Training

Number of Traditional Birth Attendants trained

	Traditional Birth Attendants (TBA)	1998	1999	2000	***Total***
	Total numbers of Townships	25	25	25	**75**
1.	**Training of Trainers (Central)** • **No. of trainers trained**	60	70	51	**241**
2.	**Methodology Training** • **No. of BHS trained as trainers**	600	600	600	**1800**
3.	**Training of TBAs** • **No. of TBAs trained**	1000	1000	1000	**3000**

Training Material developed

	TBA Training
1.	TBA trainer guide
2.	TBA pictorial flip chart

6.4. 4- Process Evaluation

(Evaluation rating (ER) ranges on a scale from 1-10, where 10 is highest)

Identification (8)

No specific assessment or study was done prior to initiating the TBA training. However, the traditional practices and her popularity are well recognized. The strategy for training is taking it's main orientation from reality, that untrained TBAs are practicing and attending to 50% of deliveries, thus they need to be offered skill and knowledge upgrading to reach desired health outcomes. The objectives for the training are well defined. The training emphasizes identification of danger signs for complicated deliveries and routine safe and clean delivery practices. Less emphasis is given to assisting complicated deliveries based upon the assumption that the TBA would have referred the complicated delivery case in advance.

Preparation (6)
Training needs have been determined and translated into clearly formulated objectives for TBA training: knowledge upgrading in clean and safe delivery practices, recognition of danger signs in connection with complicated deliveries and of need for referral of pregnant women, prevention of tetanus and other health promotion aspects.
However, the training material does not adequately respond to the basic level of education or illiteracy, that is the case for a large group of the TBAs.

In terms of resource requirements for the training e.g. materials and training aids (use of illustrations, posters and if possible videos) could be far better prepared. The trainers are usually experienced trainers and they are well prepared.

There is no in-build monitoring and measurements of results.

Implementation System (5)
The selection of TBAs is done by the village head, and it appears that the selection criteria need further endorsement. The target group for training is not fulfilled, and approximately 50% of the trainees are not untrained practicing TBAs, as the strategy is intended to reach. They are young women with no previous exposure to deliveries.
TBA training is too short 5- 6 days (72 hours) with too little focus on actual delivery assistance. The size of the class (40 trainees) is too high for effective learning. There is a need for more skill upgrading and a supervisory period following the training.

All trained TBAs have received TBA Kits and cover maintenance themselves. However, the distribution of TBA reference manual and other materials are lacking. What is available is the pictorial guide.

Training methodology (8)
The training methodology takes into consideration the TBA's level of literacy and their unfamiliarity with reading and studying. During the training opportunities are given to "see and touch". The training seeks to involve each TBA in discussions and explanations, demonstrations, practices, role-play, questions/answers, repetitions and "drill method". Also keeping the TBAs interested and alert by make the learning situation as close to reality as possible through examples and stories. However, the methodology of group reading is still practiced "to get through the manual". An issue of not criticizing the TBA's traditional beliefs and practices is stressed throughout the training. But rather make the TBAs engage in discussions on how and why they do certain procedures the way they do. The TBAs are encouraged to share their working and life experiences as part of the learning process.

Training materials (7)
TBA trainer's manual was reviewed in terms of it's presentation and lay-out (illustrations, graphics), content was revised in terms of (relevance for day-to-day functions and tasks, training objectives and practicality), and the language for improving (clarity, application with examples, and relevance to target

group) Still the content is not up-to-date and needs to contain e.g. STDs and HIV/AIDS information and prevention, universal precautions and family planning methods. It is expressed by trainers and trainees, that there is a severe lack of reference material, and more illustrations and other kinds of training aids.

Management of the training component (7)
The Deputy Director General DOH, Director (Public Health) and Director (Medical Care) are the administrative resource personnel. Trainers and coordinators of TBA training are Project Managers, Medical Officers of related projects of maternal and child health from the State/Divisional Training Teams. The directly involved managers are members of the Township training team headed by the TMO. The Lady Health Visitors and the Midwives carry both training and coordination responsibilities. Apart from not endorsing the selection criteria for the trainees, the management of the training appears to operate well in spite of severe resource shortage and without giving the priority to TBA training that it deserves.

Monitoring and evaluation mechanisms (2)
UNICEF and DOH have no specific requirements for monitoring and evaluation of TBA training apart from reporting on the number of trainees. selected and trained by township.

Supervision and follow up (2)
The overall supervision of all health personnel including the volunteer personnel lies with the state/divisional and township level training teams. However, supervision after completed TBA training seems to be of low priority, and it is not done from central, S/D and township level. The respective midwives in the RHC or Sub center closest by does some supervision in conjunction with other project activities and tasks. Supervision of TBAs is not a straightforward task to perform, due to the relative independent status of the TBA. It is well recognized that the relationship between TBAs and auxiliary personnel (volunteers) and BHS is not always smooth.

Efficiency (8)
Very low unit costs with some positive results

Sr.	Training Type	# of days	Number of partici-pants	Total Cost (Kyats)	Unit Cost/ person (Kyats)	Unit cost/ person (US $)	Unit Cost/ person day (Kyats)	**Unit Cost/ person day (US $)**
1.	**TBA TOT (central)**	6	70	1,316,160	18,802	54.18	3,134	**9.03**
2.	**TBA Methodology training (township)**	6	600	6,438,825	10,731	30.93	1,789	**5.15**
3.	**TBA training**	6	1000	8,186,125	8,186	23.59	1,364	**3.93**

6.4.5- Results

Level of Result	**Level of Effectiveness**	**Sustainability**
1. Change in participants know-ledge, skill & attitude	There is a fair amount of knowledge upgrading less skill upgrading difficult to change attitudes in 5 days course	to some extend
2. Change in	- TBAs have improved practices:	sustainable if

individual performance	o Hand washing o Clean deliver surrounding o Plastic sheet used o Gloves used o Cord cutting practice o Cord treatment o Advice mother regarding TT immunization - Traditional practices continue in spite of the training; e.g. pushing on the abdomen, "sweating", and vaginal examination. - Trainers all use Trainers Guide which is of good quality	supervision and follow-up was strengthened.
3. Change in organizational performance	- No indications that TBAs refer pregnant women	**NA**
4. Improvement in situation of children & women	No evidence	NA

6.4.6- Relevance of Training as a Capacity Building Strategy (8)

In areas visited by the evaluation, TBAs seem to be assisting the majority of deliveries compared to AMWs and Midwifes. This "impression" is being supported in other existing studies and assessments from rural areas. However, the utilization of TBAs as opposed to AMWs and Midwifes for assistance of home deliveries needs to be looked into in-depth.

No doubt, the TBAs constitute a very important group of volunteers, who potentially and presently are impacting significantly on delivery outcomes (maternal and infants). The TBAs are therefore important to train and it is of high priority to provide the most optimal training strategy and resource allocation to this front line health volunteer, in the context of the present health system.

In view of the TBA's role (trained or untrained) in home deliveries, her involvement in unsafe abortion practices and absence of evidence of increased referral of complicated deliveries or late referral of abortion complications, the focus of TBA training could be even more relevant if it reflected more sufficiently the work and role of a TBA. e.g. delivery practice and obstetric emergencies with emphasis on basic life saving procedures.

7.4.7. Recommendations

1. Consider phasing out TBA training and upgrade existing TBAs to AMWs.

2. UNICEF to provide technical input to DOH for comprehensive Human Resources for Health work plan (concerning the phasing out of TBAs and upgrading to AMWs in terms of required time, numbers, distribution of volunteers, and financial requirements as well as development of policy).

3. In selection of volunteers for TBA training encourage selection of untrained TBAs and advocate families with TBA traditions to receive AMWs training.

4. As part of the present TBA training, the trainee should have supervised practice with a Midwife 2 days/week for 6 months.

5. Continue support to Clean Cord Kits.

6.5- Life Skill training

6.5.1. Brief Description of the Training Component.

The two NGOs; Myanmar Red Cross Society (MRCS) and Myanmar Maternal and Child Welfare Association (MMCWA) have conducted Life Skill training with the financial support of UNICEF since 1994. During the years 1998 – 1999 a participatory qualitative evaluation of the life skill training was conducted by the NGOs jointly with UNICEF and this evaluation has served as a reference and baseline for the present evaluation. The training continued in 2000 with a revised curriculum and a more participatory training methodology. The life skill training has been expanded during 2000-2001.

As the name implies life skills are taught in relation to reproductive health matters in terms of building capacity of individuals for a healthier life, knowing what risk-. behaviors are, how to prevent HIV/AIDS and how to solve problems and be and be able to say no. **MMCWA** is training core trainers to train women in the fertile age in reproductive health and birth spacing, HIV/AIDS incl. care and support to PLWHA, TB and topics like counseling, giving health education and happy health living. Each women trained is expected to have friend-to-friend education about these subjects with at least five other women.

Likewise MRCS is training core trainers at central level to train youths in the age 15 – 25 years in STDs, HIV/AIDS, TB, family planning and use of contraceptives, counseling, friend-to-friend education, decision making and happy healthy living. Each youth is expected to give friend-to-friend education to minimum five persons.

Problem Statement:
Among the general population there is a lack of detailed and accurate information concerning sexuality, birth spacing, sexually transmitted diseases and HIV/AIDS. Preliminary surveys and assessments show that there is limited knowledge of and desire to use condoms, there is unwillingness to change sexual risk behaviors. In general decision making among women and youth in reproductive health matters is difficult and dominated by the male Moreover, there is a considerable high level of misconceptions regarding HIV transmission and likewise high level of social stigmatization.

Goals: To enable communities with specific focus on women and youth to live happy and healthy lives through making informed decisions and choices.

Target groups:
Youth in the age 15 – 25 years and women in the reproductive age; 15 –45 years in communities

Training Objectives:

1. To provide detailed and accurate information concerning sexuality, birth spacing, STDs, and HIV/AIDS, and
2. To provide skills for youth to enable them to cope with their daily lives
3. To become proponents of community mobilization through the life skills training.

Implementation Strategy.

Central level
Within the NGOs at central level a selection of core trainers ranging from 5 – 20 resource persons, with dual functions as trainers and coordinators, are selected via interviews. They are trained as trainers for 5 days using the trainer's manual. MRCS had external technical input from Thailand to do this training once. These core trainers then train township trainers for 5 days by using the trainer's manual.

Township level
The township trainers train; women in reproductive age (largely housewives) usually 40 women per session (MMCWA), and youth in the age 15 – 25 years, usually 40 per session (MRCS).

Community level
Each women or youth trained is expected to provide friend –to- friend education related to the content he/she has been taught to at least five friends or neighbors.

Budget in Kyats and US$ for 1998 – 2000
(official exchange rate used 450 Kyats – 1 US$)

	Total Kyats	US$
Life skills (MMCWA)	26,980,000	59,955.56
Life skills (MRCS)	12,150,000	27,000.00

6.5.2- What has been done to evaluate?

Desk review of documentation produced by the NGOs, UNICEF and evaluation rapport of 1998/99, Interviews with key stakeholders from MMCWA, MRCS, UNICEF and other involved resource persons, and interviews with trainers. It has not been possible due to time limitations to undertake interviews with trainees (women and youths) However, observation of training was done within Yangon division (see sample size in section 5 evaluation methodology)

6.5.3- Outputs of the training.

	Life Skills Training	**MMCWA**	**MRCS**
	Total number of townships	38	29
1.	Training of Core trainers • No. of core trainers trained	20	15
2.	TOT for township trainers • No. of township trainers trained	418	309
3.	Training of house wives / youth • No. of house wives / youth trained	24320	10080

Training materials developed and distributed were as follows

	Life Skill Training
1.	Revised Trainer's manual of 2000
2.	Manual for Participants
3.	Brief Booklet of information for participants
4.	Flip charts
5.	Role plays and games
6.	Calendar; Educative messages relevant to the training course.
7.	Supervisory guide (MMCWA)

8.	Pamphlet for the trainees

6.5.4- Process Evaluation.

(Evaluation rating (ER) ranges on a scale from 1-10, where 10 is highest)

Identification (8)

The Life Skill training has clear objectives. The need for information and knowledge of STDs and HIV/AIDS cannot be stressed enough, Few surveys related to STD and HIV/AIDS risk behavior, knowledge and attitudes have been presented and underlines that there is a great deal of misconceptions, stigmatization and unchanged behavior among youths and in general population. No specific assessment has been done prior to initiating the training.

Preparation (7)

Training needs are being addressed. The knowledge and skills required are well identified. Life Skill training was piloted before expanding the training, in order to ensure successful country adaptation of the materials and the approach. Materials are targeted well.

Implementation (6)

A three level cascade model is used for coverage and potential outreach to very large groups of women and youth. Central level ToT courses are ambiguous and intense training during 5 days. The ToT of township trainers emphasizes more knowledge than skills in e.g. facilitation, problem solving, negotiation, and refusal techniques.

Sometimes the implementation of training is delayed or not following implementation plan, e.g. MMRC only in urban areas, not both urban /rural as planned. There is a need for stronger input and capacity building of central level management group (MRCS) to increase their capacity to assist the township level implementation.

UNICEF is supporting a total number of 8 training sessions at township level for both MMCWA and MRCS implementation. After these 8 sessions have been completed there is no further training or follow-up intended. However, the request in communities for Life Skill training has been high, and a continuation of training takes place sometimes on the initiative of the NGOs.

The selection of participants is supposed to be done by the township branch of the NGO according to UNICEF's universal criteria of targeting vulnerable, low income and at risk groups. However, these criteria need endorsement, because the selection of trainees for both NGO training is done by the local government administration and the participants are often members of the local MMCWA.

Trainers (6)

There tends to be a relatively high turn over rate among the central level core trainers in both NOOs. In MRCS, because they are younger people under education or in career development situations. In MMCWA the core trainers are often medical personnel who sometimes contributes to creating a distance between the trainer and the trainees (women from the community). MMCWA conducted refresher training for trainers in 22 townships of Kayin and Mon, states and Thanintharyi Division between 2000 and 2001. It was through these refresher training they found that, there was a large number of drop outs among the township trainers and township project coordinators

The township trainers in MRCS must have at least 10th grade education, with high motivation, and have available time for the activity. It was expressed by the trainers during the interviews, that more ToT is needed. The trainers are being challenged by the participants and need to be prepared to answer questions and facilitate group discussions and group work often concerning difficult subjects

e.g. related to reproductive health, HIV/AIDS, behavioral issues and use of condoms. During observation of the training it was found that the township trainers are weak in facilitation skills and the quality varies. The MRCS ToT courses need improvement and input from UNICEF to place more emphasis on providing the trainers with skills as facilitators, instead of concentrating on knowledge up grading.

The training methodology (8)
The training is popular because it is different from most training. The methodology is participatory and offers discussions, presentations and group work, questions and answers, role-play, and games. However, the training tends to focus more on knowledge than actual skills in refusal skills (being able to say no) and negotiation, counseling and friend-to-friend education techniques.

Training material (7/8)
The generic Life Skill training material has been developed by UNICEF. In Myanmar this material was adapted in a "black manual ". Later each NGOs modified this original manual for their own target audience. However, according to MMCWA the manual they use presently is a direct translation of the original English version.

MRCS; A revision of the present materials is planned for during November 2001 by Mr. Greg Carl, UNICEF Thailand, who is specialized in Life Skill Training.

On the basis of the qualitative evaluation in 1998/99 the trainer's manual was revised in both NGOs, however, not the participant's manual. **The MRCS participant's manual** appears to be overloaded with information for a 5 days course. There is use of a lot of technical wording, and thus not too appropriate for the target group. It is difficult to personalize the information, and the training manual is teacher's centered. There is little difference in the participant's manual; and the trainer's manual, which leaves the trainers with little guidance in performing the training and the facilitation of large groups.

The MMCWA manual is a translation of the original English manual. It is culturally appropriate with careful wording. It has user-friendly designs, and is written in spoken language appropriate for the target group. The amount of information is manageable within 2 days. The trainer's manual is teacher centered.

A MMCWA revision of the training materials has incorporated results of monitoring in 200/2001

Management of the Training Component (7).
MMCWA's central management and township level structure for managing the training is strong. However, MMCWA is way behind of the original implementation schedule. MRCS central management is limited in capacity due to manpower shortage. There is input to township training mostly within MMCWA; core trainers visit the training sessions and provide supervision and complete supervision check lists for monitoring purposes. These check lists sets standards for good trainer performance

Communication is top down in both NGOs, and it is central level decision making. In MMCWA core trainers are physicians creating distance to township trainers and trainees.

Monitoring and evaluation (3).
Monitoring and evaluation has not been done systematically in the past and there is no assessment of outreach to women and youth through the friend-to-friend talks. An estimate of the average number of friend-to-friend educations done per trainee is not available or possible to calculate. Therefore it is not possible to assess whether the last part of the cascade works as intended and what the possible

outcome of it is. Assessment of behavioural change among trainees have not been done. However, MRCS has just started outreach monitoring (number of friend-to-friend educations per trainee) and supervisory checklists. Monitoring of pre/post knowledge assessment of trainees has also been initiated by MRCS this year and will be shared with MMCWA.

The few monitoring reports that are available are unclear, and project documentation found to be limited.

UNICEF provided technical input to monitoring and supervision of township trainers in MMCWA in 2000/20001. The findings of this monitoring were incorporated into a revision of the training manual.

MMCWA has monitoring guidelines (field visits, reports, periodic reviews, incl. trainers check list) as a result of evaluation in 98/99. To what extend they are being used and analyzed is not clear.

Efficiency (7)
Different types of training were reviewed for the year 2000

Sr.	Training on Life Skill	# of days	Number of partici-pants per training.	Total Cost (Kyats)	Unit Cost/ person (Kyats)	Unit cost/ person (US $)	Unit Cost/ person day (Kyats)	Unit Cost/ person day (US $)
1.	**TOT (central)**	5	15	120,000	8,000	17.78	1,600	3.6
2.	**ToT township level**	5	55	359,000	6527	**14.5**	1305	2.9
3.	**Training of women**	2	40	38250	956	**2.12**	478	1.1
4.	**Training of youths**	2	40	43500	1088	**2.42**	544	1.2

Effectiveness of training is questionable; unit cost per trainer is 10 US$ (with potential high drop out. The is no planned role or use of trainees after the completed 8 sessions per township)

6.5.5- Result Evaluation (6)

Level of Result	**Level of Effectiveness**	Sustainability
1. Change in participants know-ledge, skill & attitude	- High knowledge upgrading after completed training - Township trainers are weak in facilitation skills	without refresher training or involvement in community work limited sustainability
2. Change in individual performance	- no monitoring of change in behavior and attitudes - no monitoring of friend to friend education - training is sometimes continued after the 8 sessions supported by UNICEF	-No use of trained community members for other related HIV/AIDS work - If the NGO continues to support from own budget it might be sustainable
3. Change in organiza-tional performance	- NA	NA
4. Improvement in situation of children & women	NA	NA

6.5.6- Relevance of training as a capacity building strategy (7)

Training and communication related to HIV/AIDS and STDs is highly relevant and needed and plays a role in decreasing the level of stigmatization towards PLWHA. All in all the content of the training is highly relevant, and the intended target group is also relevant. Impressive numbers of community members (women and youths have been covered by this training) However, MMCWA is training MMCWA members as their target group and there is no involvement of men as recommended in 98/99 evaluation

The relatively high (potential) drop out rate among core trainers in both NGOs should be monitored closely among specifically township trainers. The training implementation and management is compromised if the drop –out rate persists

Whether there is an effective outreach to intended target groups vis the friend-to-friend education is not clear, and the results in terms of behavior change needs to be assessed to determine relevance.

Sustainability is questionable; because what is expected to take place after the planned and completed 8 sessions supported by UNICEF. Would it be possible and desirerable to make use of the "investment" made in trainee for other purposes? The trainees in MRCS express keen interest in being involved in community activities related to HIV/AIDS counseling and other care support work. The potential for strengthening community involvement and increase the sense of responsibility for PLWA and input to a range of other activities e.g. IEC activities are not present and has not been explored.

6.5.7- Recommendation

1. UNICEF to provide more capacity building and input to training of core trainers and ToT courses at township level with emphasis on skill, e.g. negotiation, facilitation problem solving and refusal skills.

2. Selection procedures of trainees need revision and endorsement

3. Coordination between MMCWA and MMRC should be facilitated by UNICEF for strengthening of training implementation, material development and monitoring/evaluation mechanisms

4. Include and encourage untrained TBA in Life skill training (MMCWA)

5. Reformulate project strategy to improve sustainability aspect and use of trainees to full potential in support of HIV/AIDS community mobilization. e.g. support groups for PLWA, condom promotion, counseling, Community Home Based Care and IEC activities

6. Introduce more theatre and role play in the training of trainees

7. Emphasize skill upgrading rather than knowledge in training

8. UNICEF to provide technical input to new manual for TOY with pictures and illustrations which are culturally acceptable

9. Introduce male participation to be comprehensive in reproductive matters and HIV/AIDS (MMCWA)

10. Strengthen project management and capacity in MMRC

11. UNICEF to integrate part of their ongoing PMCT activities in Life Skill training (MMCWA is also doing PMCT activities are these separate from L.S training?)

6.6- Instructions of Volunteers for National Immunization Day (NID)

6.6.1- Short description of the Instruction.

UNICEF has supported instruction of volunteers in connection with the National Immunization day (NID) program annually on the administration of Vitamin A capsules and polio drops with 500 Kyats/day per volunteer. The evaluation team was requested to assess the effectiveness of the instruction and the implementation of the instruction.

Objective.
To increase the community participation in NID activities.

Implementation strategy.
The volunteers are instructed on individual basis usually by one member of the township training team; e.g. DMO/TMO, midwife, LHV or Health Assistant on how to administrate the polio drops, the dosage of the Vitamin A capsules (blue or red capsules) and the importance of the cold chain.

6.6.2- What has been done to evaluate?

A skill and knowledge assessment form for UCI was used for assessment of 26 volunteers, key interview form for interviews with 1 key informant and trainers interview form for interview with 2 trainers.

6.6.3- Output and Budget

There is no specific budget information available for this instruction. But it is known that a very large number of volunteers receive the instruction, and thus the costs must be considerable.

6.6.4- Main finding.

- Volunteers receive the instruction on an individual basis, and not in a separate group session.

- The duration of the instruction average 5 minutes

- Basic knowledge and practical skills are appropriate.

6.6.5- Recommendation.

1. UNICEF should integrate the NID instruction of volunteers into the general preparation for NID, and not allocate specific budget this instruction.

6.7- Child Friendly Schools (CFS)

6.7.1- Specific Findings: Child Friendly Schools (CFS)

This section looks at the previous findings in a more in-depth approach. It compares what teachers say they do in the classroom with their observed classroom behavior. It also compares what ATEOs and PTAs say they do with their prescribed roles. Overall, the hypothesis – that UNICEF & DEPT sponsored child-centered primary teacher training results in a more participatory and child-centered learning environment in the classroom – was not confirmed. Rather, three dominant teaching-learning patterns emerged: (i) traditional and teacher-centered learning as portrayed in Annex 2; (ii) instructional but also teacher-centered learning; and (iii) a mixed pattern that combines elements of instructional and child-centered learning – but not truly child-centered learning as envisioned in the CAPS/CFS model as also portrayed in Annex 2. These findings are consistent with those of the 1998 evaluation of the CAPS/ACIS projects, but indicate that teachers are using elements of the child-centered and participatory learning approach more so than they did in the past. In addition, cluster development is nominal in structure but needs to be strengthened although PTAs appear to function quite well.

6.7.2- Classroom Setting

The two field teams observed an uneven distribution of UNICEF textbooks for "needy" or poor children: in some cases they were evident in classrooms while in others they were not. They did see more evidence of needy children having exercise books and pencils, however. Also, in varying degrees the following teaching aids were evident:

Charts	Blackboard drawings	Maps	Sticks/scented sticks	Stones & bottle caps
Color cards	Alphabet cards	Leaves, plants	Scented sticks	Water bottles
Drums (sound waves)	Colored Plastic balls	Jig saw puzzles	Cut cake (fractions)	Torch light

Most of the above come under the Myanmar term "realia" or locally made or derived teaching aids to illustrate arithmetical operations, to provide stepping-stones for learning basic science or to illustrate local and national geographic phenomena. In fact, the most common teaching aids are subject matter charts, blackboard drawings (usually drawn during class) and realia. Many teachers said that they did not use teaching aids very much because of added expense and time required to produce them. There is also a rough correlation between increasing use of teaching aids for the instructional and mixed patterns of teaching and learning. The classroom structure correlates in much the same way: traditional teaching patterns are usually marked by students sitting in rows facing the teacher while instructional and mixed patterns are usually marked by students sitting in groups of six to eight students.

Individual teams' cursory review of student exercise books indicate that students were learning the rudiments of Myanmar language and arithmetic although this was less the case with basic science and social studies. The teams' same review also revealed that Teachers' Guides and Manuals were not much in evidence in most classrooms. Teachers said that they used them, especially during their first year of teaching, but after they got used to their teaching routines, they did not refer to them regularly.

One surprise finding was the small but obvious growth of pre-Kindergarten classes in a few of the primary schools. Their installation at the schools appeared to be a result of the schools' initiative and not one formally taken by DEPT. Teachers of these classes included a few trained teachers with DEPT credentials (Primary Teaching Certificate) as well as untrained high school graduates who volunteered to teach these classes. Where they existed, the principal organized the use of a spare room for the pre-KG class. This apparently spontaneous development achieved three functions:

- Caring for younger siblings of students who otherwise would be encumbered with their presence while in class, or be forced to stay at home during critical periods in the family agricultural or work schedule to watch the younger siblings;
- Preparing the younger siblings (and others of pre-school age) for the routine and practices of primary school; and
- Providing recruitment of motivated but untrained teachers to enter the teaching force.

6.7.3- Observed Patterns of Teaching and Learning

6.7.3.1 Traditional pattern: This is still the predominant pattern of teaching and learning in primary schools (See Annex 1 for model). Two examples should illustrate this type of rote learning by reciting back to the teacher words, phrases, sentences or whole paragraphs:

"First, the teacher reads a paragraph in Myanmar language, and she explains what it means. Then, students read the paragraph by repeating the teacher's explanation sentence by sentence. Next, the teacher asks questions to verify the students' comprehension, and repeats the same procedure for each row of students. The teacher then writes questions and answers on the blackboard about the passage, and commands students to memorize the questions and answers for homework. As follow up, the teacher may show in which paragraph students will find the answer to assist their homework. The teacher assumes that through their oral responses, students have understood the answers, but confirms this by correcting their written homework the next day. Again, the teacher asks students to repeat the questions and answers orally so that they fully understand the story."

"Teacher reads aloud the story of the Monkey King. All students repeat after the teacher paragraph by paragraph. Then, teacher asks a student to read a paragraph from the story, and then other students repeat row by row after the one student. Teacher then asks whole class to read the story from beginning to end, and they recite it. Finally, teacher writes down the main vocabulary words from the story on the blackboard, and then students copy them in their exercise books. Teacher commands students to study and revise the story at home."

6.7.3.2 Instructional pattern: While this pattern is still teacher-centered, there is active learning as the teacher leads students to search for "correct" answers:

"In Myanmar language the teacher attempts to explain the difference between traditional and modern toys as identified by the materials. She questions students randomly to find out what kind of toys they have seen in their experience. Students respond with a variety of responses, and then teacher explains the difference between traditional and modern (mostly plastic) toys and how to use them. Teacher elicits from students different types of toys regarding their substance, such as clay, straw, bamboo, wood, metal and plastic; then teacher illustrates different types with a few toys. The teacher elicits questions logically and meaningfully without referring to the text or memorization but draws from the children's experience. Finally, she asks one student to summarize the different types of toys which he does by using a prepared chart."

"(Also in Myanmar language) the teacher asks what students know about poultry without explicitly referring to the topic. First, the teacher asks what kinds of animals they keep at home, and then what kind of poultry they keep. When children mention poultry, she says that today they will talk about poultry raising. She asks a number of questions regarding what do chickens eat, and how do healthy and sick chickens differ in appearance. Next, she reads a passage describing modern methods of raising poultry. She then asks a few students to describe in their own words what she read, and then

questions the whole class about modern methods of raising poultry. She concludes the lesson by asking them to write a few sentences in their own words as to how they would raise poultry."

While teacher-centered, the instructional pattern differs from the traditional pattern in a few significant ways:

- Students are engaged and interested in the lesson.
- Teacher draws upon the experience of the students to learn something new.
- Teacher probes and asks in different ways for students to arrive at the "correct" answer (e.g., different types of toys, modern poultry raising).
- Teacher questions inductively for students to survey, categorize and evaluate alternatives.
- Teacher is likely to use teaching aids as concrete symbols of ideas.

6.7.3.3 Mixed Pattern: This is similar to two patterns found in the 1998 evaluation whereby teaching-learning processes contain significant child-centered elements although they mix these with traditional and/or instructional patterns:

"The teacher introduces the lesson by showing a real football (soccer) ball to students. Teacher asks students whether they have ever played football. Then, teacher asks a student from one group to come to the blackboard and draw a football field; and then asks another from a different group, 'how many teams do we need for a football match and how many members make up one team?' When student gives correct answer, all students clap. Next, teacher asks another student from a different group to state the rules and tactics of football playing. Finally, teacher asks each group to organize themselves after school (boys and girls together) and play a football match on the playground."

"Teacher explains in Myanmar language differences between 'good' and 'bad' friends. Then, teacher asks each of six groups to identify from their own experience characteristics of good and bad friends. After that, representative from each group presents what they have discussed in their group to the whole class. Teacher summarizes each presentation. Teacher discusses these characteristics with whole class, and adds to the students' points. Finally, teacher asks them questions about these characteristics and students write down what they know about good friends and bad friends."

The mixed pattern differs from the instructional pattern in a few significant ways:

- Teacher has a lesson to get across, but there is no apparent "correct" answer.
- Students are encouraged to come up with alternative responses to the problem– different football tactics or different kinds of 'good' and 'bad' friends.
- Students are encouraged to try out through their own experience lessons learned (football match).
- Teacher uses groups to promote or reinforce learning (clapping) or to elicit individual responses (good vs. bad friends).

A word on the last point or use of groups. The great majority of classroom observations indicated that teachers did not really understand nor realize the potential of intra-group discussion as means of eliciting individual responses as a basic ingredient for critical thinking. To many – especially those who organized classes into groups but used traditional or instructional patterns of teaching-learning – groups mattered more in form than in substance. In some cases and when asked independently from teachers, students said that the teachers were using groups to impress the observers and did not use them everyday as they preferred to organize students by rows. Where groups were organized and used, teachers were more likely to play one group off against another to stimulate competition in learning among them. There was an explicit purpose among teachers, however, to organize groups

heterogeneously so that each group had bright and less bright students. Again, this was to balance groups for inter-group rivalry and not to encourage intra-group tutoring.

6.7.3.4- Teacher Strategies

When teachers articulated their teaching strategies, it was difficult to disentangle UNICEF training from their own educational and training experiences – particularly those that had primary teaching certificates from an Education College. The primary teachers are relatively well educated with at least a high school diploma or more likely a university degree; and relatively well trained with almost 70% having a primary teaching certificate from an Education College and UNICEF training in CAPS or CFS. In addition, many have about 10 years of teaching experience. The most general strategy was that they introduce the subject or topic, and then pose questions for group, individual and class responses; then students come to the blackboard (in upper primary standards) to work out exercises or problems; and then teachers summarize the lesson and give students questions to answer or problems to solve for classroom and homework exercises.

Regarding specific child-centered learning strategies, most teachers could not respond with detail or clarity. A few endorsed them whole-heartedly and averred that students learn more effectively with this approach. A few openly disagreed with child-centered learning and stated that traditional methods were the most effective – especially when they were pressed to complete a section of the curriculum according to schedule, when classroom space is limited or when they must manage multi-grade classrooms. Few understood the purpose and proper management of groups to improve student learning, and this vagueness about group usage was underscored by classroom observations.

Few teachers understood the purpose and nature of "continuous assessment". With few exceptions, they did not see it as a regular process of monitoring student group and individual behavior as a basis for assessing and adjusting instructional methods to individual differences. The great majority of teachers saw it as a means of measuring student achievement through review of exercise books or "chapter end" tests. Instructional assessment for most meant remedial work whereby teachers correct exercise books and indicate how students should arrive at the "correct" answer. They saw little connection between continuous assessment as a means of encouraging and stimulating critical thinking.

Teacher-parent consultations do take place, but mostly between the head teacher and parents either through the PTA (see below) or with individual parents. Consultations mostly take place to assist slow learners, to find out why students are absent or what the family can do to help students who are likely to drop out. Some teachers reported that they sent report cards home to parents for their signature or to inform parents about the slow progress of their children as students. A few even mentioned that they might meet with parents as occasion permits in the shops or market.

Nutrition and health issues are met through the Life Skills portion of the primary curriculum. It is mainly addressed, however, through the SHAPE curriculum that is taught one or more classes per month from standards 2 through 9. While the curriculum encourages a participatory approach to the teaching of SHAPE content, most of the instruction follows the traditional approach. Some SHAPE teachers said that they follow up lessons by checking students' lunch boxes to ensure that they include nutritious foods.

Regarding their CAPS or CFS training, most teachers simply could not remember specifics of this training, and it became pointless to continue asking them about it. They were equally divided regarding the length of this training with some saying it was sufficient in length while others said it was too short and should be extended or repeated through "refresher" courses. Others were quite critical about the

quality of training at the township level and believed that they should have received more substantive training.

Based upon the interviews with primary teachers regarding CFS training, at least two points became clear:

- A major value of CFS (and before it CAPS) training is its "refresher" function. Teachers appreciated the attempt of this training to introduce them to a different way of looking as to how children can learn and what they can do to enable children to learn more effectively. While they may not remember specifics regarding CFS teaching-learning approaches or classroom management, they do remember of being exposed to new approaches to schooling.
- The majority of UNICEF trained primary school teachers think they know what child-centered learning is about, but they either do not or they misunderstand it. Teacher interviews revealed that few trained teachers had full understanding of the child-centered approach, what are the benefits to children regarding changing their outlook towards learning as a lifelong process, and a conviction that it is important for teachers to practice this approach and continuous assessment systematically. This is especially the case regarding their use of classroom groups more as a matter of form than of substance. In a word, most do not appear convinced of the philosophy, strategy and practical applications of the child-centered approach to learning.

6.7.3.4- Assistant Township Education Officers (ATEOs)

Potentially, the ATEOs play a vital role to strengthen and improve primary teacher training at the township level. Those ATEOs interviewed knew their roles—what they were supposed to do. These are to:

- Implement township level training along with cluster heads of UNICEF-DEPT training during school holidays;
- Supervise data gathering at the township and school level of enrolments, retention and completion;
- Visit township schools under their supervision at least once a year to work with cluster heads on the gathering of data, provision of training to teachers and strengthening cluster management (some ATEOs are provided with UNICEF motorcycles or bicycles for this);
- Observe and support teachers to ensure they practice DEPT approved instructional methods (including CFS) and that they follow the curriculum schedule. They also check teachers' diaries and lesson plans and conditions of school facilities and grounds;
- Attend to outstanding problems between the community (through the PTA) and the school such as teacher absenteeism or ineffective teaching.

ATEOs do not always perform these roles as prescribed. Perhaps the biggest problem is that ATEOs play a greater inspection role than one of supporting head teachers and teachers. The latter need regular and supportive guidance to encourage them to come to grips with the relatively new (for teachers) child-centered methods. ATEOs do not provide this regularly and constructively to cluster teachers. In addition, the ATEOs often have non-educational but competing duties such as the buying of rice from the farmers. These may interfere with their educational duties.

Many of the PTAs interviewed said that they rarely, if ever, see the ATEO visiting their community and providing advice to the PTA. If the cluster concept is to survive and grow, then the ATEO needs to play a more active role in mobilizing the community, supporting the instructional methods of teachers, and strengthening cluster and school management by head teachers and PTAs.

6.7.3.5- Head Teachers and PTA Members

Roles: Head teachers (cluster heads in core schools) appear to know their roles clearly. They are to:
- mobilize the community for increasing student enrolments and completion;
- collect data on the same subjects;
- organize PTA and community meetings, particularly regarding the assistance to children of "poor" or "needy" parents through the distribution of incentives;
- share educational resources within the cluster including short training courses for satellite schools;
- supervise and deploy teachers in their schools;
- conduct school enrolment day activities or competitions;
- ensure school facilities and grounds are clean and presentable;
- and perhaps most important, to solicit and manage community contributions in labor, kind or cash for school construction or renovation.

Generally, the PTA members complement the Cluster Head or Head teacher regarding most of these roles. While PTA members were not as articulate as were head teachers regarding their roles, they in fact carried them out – especially in the vital areas of generating funds or resources for poor families and for school construction. The glaring omission was that the PTAs were not always aware of the school cluster concept, its benefits and the role of the head teacher and ATEO in promoting and implementing the school cluster concept. If school clusters are to play a needed role to strengthen and improve child-centered training, then the PTAs needs to be more aware of the clusters and what they can do to strengthen them.

Training: As noted above, head teachers remembered more their training in SHAPE than in CAPS/CFS management methodologies. Perhaps this is because SHAPE is quite specific in content, meaningful in terms of physical well being, and practical in the provision of hygienic skills. Related to the absence of cluster training, those cluster and head teachers interviewed said that they did not remember receiving specific training on the establishment and management of school clusters. PTA members repeated this regarding their own training.

One positive outcome of PTA training was its "sensitizing" effect upon PTA members. Many said that before they were trained, they kept their distance from school operations and left these up to teachers. After training, they felt more empowered regarding the community management of school operations, and that they wanted to continue to learn about school operations. Like the SHAPE teachers, PTA members also remember some preventive health measures taught to them. Overall, PTA members said that after their training school-community relationships improved – particularly regarding school repairs.

Mobilization and Contributions: These appear to be the most successful undertakings by the Head Teacher (HT) and PTAs. The HTs and PTAs collaborate to mobilize the community to enroll and keep school age children in school. They do this separately or through joint efforts whereby village leaders and the PTA chairman use loudspeakers to announce enrolment day to the community. The HT and PTA members also encourage those families whose children are not attending school to send them to school. They mobilize community resources to provide the "needy" families with incentives to send and keep their children in school. Incentives include provision of texts, materials, uniforms and the waiving of school fees. Generally, "needy" families are those without a father, those that not in good health, those with meager wages or part time employment and those with many children. The HT is responsible for setting enrolment, retention and completion targets while the PTA only assist in gathering information related to these targets.

Cluster Schools: The HTs were able to articulate the basic functions of the cluster:

- Cluster HT explains to teachers when they meet on the monthly pay day at the Township Education Office priority activities of the ATEO, as for example the selection of outstanding students, sports competitions and data gathering
- Sharing teaching methods, aids and resources among core and satellite schools within the cluster
- Supervision and support by the Cluster HT of cluster teachers
- Setting and agreeing upon a curriculum schedule for teachers to complete within the cluster schools
- Refresher courses of up to 10 days given in the township by the ATEO and Cluster Heads for teachers (generally not done)
- Sharing of UNICEF materials among the clusters – especially those for needy families.

6.8- Early Childhood Care Development (ECCD) Network

7.8.1- Specific findings: ECD and ECCD Network Schools

Ten ECD and ECCD Network Schools were observed; five of both types had the reputation of being above average schools and five of both types had the reputation of being below average schools. The purpose was to compare "what was working" according to project objectives with "what was not working." A summary of observations that compares these schools to the project model is listed below. The following are the salient findings:

1/ Training makes a difference: There is a difference between teachers with UNICEF and DEPT training in early childhood development (ECD) and those without it. While both may be well educated (some trained and untrained teachers have university degrees and/or Certificates in Primary Teaching), the trained ECD teachers appear to understand the objectives and benefits of "learning through play" and to apply this understanding through practical and meaningful methods of ECD teaching. Teachers untrained in ECD did not practice these methods, did not understand the approach, and a few almost had a disdain for it. Indeed, the latter managed the Pre-KG class as if it were a traditional teacher-centered primary school.

There is also a difference between teachers trained through the ECCD Network subproject and those trained by standard ECD methods, some of whom were trained by the Department of Social Welfare (DSW). The former appeared more committed and motivated to practice ECD methods and a few displayed excellent teaching and handling of pre-school age children. The latter appeared to carry out their roles more perfunctorily and mixed structured teacher-centered approaches with child-centered approaches.

2/ School facilities make a difference: In all but one of the schools observed, the learning room was smaller than specifications (40'x60') – and a few considerably so. In addition, all but one school had no storage space for materials and outside equipment (e.g., climbing ropes), and these were kept in the learning room. As a result, the already small room was cluttered and limited children to move about freely. A high teacher:student ratio in most schools added to this sense of a crowded room. Some of the schools had no play areas outside, or if they did, they were not kept clean and the grass was not cut. This also hampered teachers' efforts to use freely outside areas for learning through play. In the good schools, where there were adequate outside areas, teachers took advantage of them to allow children free play and exercise.

3/ Materials make a difference: The better schools had an adequate quantity and quality of materials to encourage creative play through discovery and self-initiated activities. Hence, the children were active and participated in individual or group learning activities. Where materials were inadequate, children were distracted, non-attentive or simply bored. Materials by themselves will not

make the difference as motivated teachers must use them. But, they are a necessary ingredient to promote learning through play.

4/ Hidden Agenda: Some teachers untrained in the ECD approach, especially those in the below average schools, used traditional teacher-centered learning methods. Pre-KG classes were to them just another kind of formal schooling where the teacher dominates and orders children about; and play activities consisted of looking at picture books or watching television. It also appeared that these teachers were not motivated to teach in Pre-KG classes and were waiting for an opportunity to teach in primary school or to do something else all together. In addition, some of the parents shared their sentiment about using a more structured and teacher-centered approach to learning rather than the model child-centered and learning through play approach. In effect, both saw Pre-KG classes as a preparation for formal schooling that employed the structured approach. While not properly sampled, these parents were the more affluent ones who saw Pre-KG learning as a necessary preparation for entering good schools later in their lives; hence, Pre-KG classes should be structured like the formal school system.

SUMMARY OBSERVATIONS AND RATINGS OF 12 SELECTED DAY CARE CENTERS
Purposive Samples of Above Average (+) Network & Standard ECD Centers; and of Below Average (-) Network & Standard ECD Centers
Ratings: Excellent; Good; Fair; Poor

Model Conditions	**Network: (+) (BEPS 5, 38)**	**ECD: (+) (Lab, BEHS 1,6)**	**Network: (-) (BEPS 15,11,44)**	**ECD: (-) (BEPS, 1 BEHS 2)**
Building/Center: required space of 40'x60'; 2T per 30 children. Adequate light/ventilation. Safe & clean . Potable water, clean latrines.	**Fair to Good.** Smaller space. High Teacher:Student ratio	**Excellent**, with exception of small space.	**Fair.** No latrines with children using pot. Not so clean and comfortable. Pond nearby – dangerous. One school located on second floor.	**Fair to Good** conditions except for limited space. Good Teacher:Student ratio.
Center Facilities: Outside play area, equipment, sand/water play, safe; Inside divided into discrete play areas (blocks, games/toys, books, etc**.)**	**Fair to good**. Some play equipment outside. Include slides, swings, climbing rope. Roll a tyre. Inside divided into discrete play areas	**Fair.** Outside no sand and water play area. Inside divided into discrete play areas. 2 out of 3 schools have adequate outside play areas.	**Poor to Fair.** Poor or nonexistent area for outside play. No equipment.	**Poor to Fair**. Outside area has equipment, but unsuitable for ECD children. Inside area not organized into discrete play areas.
Materials: Adequate quantity & quality of play materials including **realia**. Displayed and put in storage room. Materials allow for creative, discovery, problem-solving learning	**Fair** in number and in kind.. **No storage area & materials clutter up Center room**. Old clothes, dolls and miniature cooking materials for pretend play. Materials good for creative learning. Sand box inside. Have cooking materials for feeding. .	**Fair to Good**. **No storage area & materials clutter up Center room**. Materials are good for creative, discovery and problem-solving learning. Use real leaves for cutting & pretending.	**Poor to Fair**. . **No storage area & materials clutter up Center room**. Lack of adequate number and quality of materials. Selected toys not used for creative learning –only a few dolls and miniature pots.	**Poor**. Ironically, available storage space for toys. Poor in terms of quality and quantity. What they have are stored in cupboard – not used. Teachers do not want to take out & return materials.
Children's Activities: They appear engaged, happy, use materials, choose their activities, and learn through play activities. Blend of Teacher and child-centered learning	**Good to Excellent**. Learn through play and self-initiated activities. Blend of teacher and child-centered activities as well as active and quiet periods. Most children are active and attentive. If problem arises, children solve by themselves. They clean up on their own materials or food utensils.	**Excellent.** Children participate actively. Display confidence. Blend of teacher & child-centered activities. Some structured learning as preparation for primary school.	**Very good**. While number of materials limited, children improvise to use them. Play through building blocks and painting. Use scissors to cut materials from books/pictures. Little evidence of learning through play. More structured. Children happy and participate; play with each other.	**Poor to Fair**. Few opportunities for self-initiated and creative activities. Either watch TV or write down alphabet or numbers in the exercise books. More a preparation primary school than ECD.
Teachers: Involved with children; respects and nurtures them. Encourage child-centered learning and provide opportunities for creative, discovery and problem-solving learning. Consult with parents and encourage them to participate in learning and school feeding. College or High School graduate with PTC and UNICEF ECD training.	**Very Good**. Teachers well educated with PTC and UNICEF training. Teachers care and nurture children's learning. Involved in their activities. Parents invited into center and participate in learning or feeding. Teachers instruct parents on nutritious habits for children at home. HT active and supportive of ECCD center. Parents are poor, and not sure what kind of preparation children should have.	**Fair to Good with Lab school being excellent**. Not as well educated, some PTC, DSW & UNICEF training. In one case, teachers do not use the materials very well. Underlying sentiment shared by parents is to prepare students for primary school. In some ways, more like a standard classroom than an ECD center. Affluent parents prefer more structured learning for kids to enter good primary schools.	**Fair.** Well educated with some PTC and UNICEF training. Most teachers appear interested in pre-KG learning with one exception. Get some guidance from HT at primary school.. Another HT does not. Parents are poor, and only a few parents participate in school activities.	**Poor.** Well-educated teachers but no ECD training. Simply not interested in ECD. While room is not crowded, teachers do not take advantage of space to introduce creative learning. Teachers run center like a traditional primary school with commands and scolding of children. Parents are affluent but not allowed to participate. Must wait outside to pick up children at end of day.
Overall Rating of Center	**Very Good** Teachers well trained in ECCD and motivated.	**Fair to Good.** BEHS teachers do not use ECCD methods. Well-known schools	**Fair.** Poor physical condition of school, uneven teacher performance, but children are active.	**Poor to Fair.** Teachers are not motivated. Preparation for primary school, not learning through play.

6.9- National Sanitation Week Training

6.9.1- Training Component Description

This orientation/training is primarily aimed at mobilizing the masses for improved sanitation, as well as to muster political commitment and technical support to facilitate that goal. NSW is done in close collaboration with the Social Mobilization training in sanitation, hygiene and safe water. In fact, it is difficult to fully separate the two because of their complementary roles. The NSW that began in 1998 provides an annual nation-wide one-week effort to boost the overall sanitation programme (comparable to the 'National Immunization Day' concept).

Problem Statement: With only 45 percent of the population having access to a 'sanitary' means of sanitation in 1997, the immense challenge of reaching universal coverage by the year 2000 was virtually impossible to reach if past strategies, policies, implementation rates and resource allocations, at that time, were continued. This called for a radical change in approach towards greater self-reliance whereby families would be motivated to improve sanitation primarily at their own expense.

Goal: 'Sanitation for All by the year 2000' (Universal Coverage).

Objectives:

- During NSW, mobilize communities and households to construct sanitary latrines and maintain existing ones in order to enhance national efforts to reach universal sanitation coverage.
- Encourage each village leader to mobilize for construction of 15-20 family 'sanitary' latrines, on a self-help basis, in each of the 66,000 villages' nation-wide, per year.
- Promote hygienic behaviour around sanitation, personal and food hygiene and drinking water.

Target Groups:

- State/Division leaders and health officials on NSW.
- Township leaders and health officials on NSW.
- Ward & village leaders, basic health staff at Rural Health Centre level, and ward and village 100- and 10-household leaders, on NSW.

Implementation Strategy: This consisted of cascade orientations/training at the following four levels:

- ***Central Level:*** An official one-day launch of NSW, each year, by the Chairman of the National Health Committee to mobilize political commitment and technical support, as well as to create national awareness and mobilize the masses for sanitary latrine construction.
- ***State/Division Level:*** One-day orientations/training of state/division level leaders. This included the Training of Trainers (ToTs) for further training of mobilizers (ToM) at the Township level. This also included planning of the sanitation week and setting of targets in each state/division level and mobilizing the necessary political and technical support to reach those targets.
- ***Township Level:*** One-day orientation/training on planning for sanitation week, setting of township targets, and mobilizing political, technical and public support for sanitary latrine construction.
- ***Ward/Village Tract Level****:* One-day orientation/training of basic health staff (BHS), the '100 household leaders' and '10 household leaders' in planning for sanitation week, setting of village targets, identification of families to target, implementation techniques, standards to follow and reporting on results etc.

The above was also reinforced by the production, dissemination and use of communication materials such as posters, pamphlets, slogans, photo-exhibitions, billboards and videos on 'how to build your own sanitary latrine'.

Budget (in US$):

1998	1999	2000	2001	IEC Materials	Total US$
16,521	14,160	38,220	35,320	180,000	**284,221**

This budget does not include UNICEF nor Government of Myanmar staff and overhead costs, nor the hiring of training facilities from State/Division level to Ward/Village tract level.

6.9.2- What was done to evaluate

It was not possible to actually observe any orientation/training for NSW as this is normally done in January or February of each year. But it was possible to analyze past progress, training and communication materials, ongoing research on the impact of NSW activities, verify these findings through evaluation visits to eleven Villages, three Townships and three States/Divisions and interview key Government and UNICEF staff at central level.

6.9.3- Process

(Evaluation Rating (ER) ranges on a scale of 1 to 10, where one is lowest)

Planning for orientation/training needs was complete and well executed at both National and Sub-National levels. In particular, the identification of key political leaders and supporters at National level who endorsed the NSW and provided directives for action and follow-up by their administrative subordinates at all levels including Village, was critical to the implementation of NSWs. This political commitment coupled with technical support, primarily through Ministry of Health staff and Community-Based Organisations was strategic in mobilizing communities to build the 'village allocated target' of new sanitary latrines and /or in upgrading and maintaining existing ones. **ER 6**

Objectives and targets for the NSW were clear and doable (15-20 new sanitary latrines/village) and complemented the overall WES programme goal, and specifically that of the Social Mobilization sub-strategy. And although the macro-targets were decided upon at the central level, there was opportunity at the Sub-National levels, especially at Township level, to adapt these to local conditions. **ER 7**

Orientation/training materials were appropriate for the majority of the population who had easy access to NSW electronic audio-visual materials and for those who could read Myanmar. But they did not adequately reach low-income, low-literacy groups especially in remote impoverished areas. **ER 4.**

Training Achievements can be seen in the following approximate numbers oriented/trained at different levels each year:

- 96 State/Division level officials, including Health Directors, DDA, others
- 2,700 Township level officials TMOs, TEOs and DDA staff
- 18,000 Ward and Village tract leaders
- 108,000 household leaders (100- & 10 HHL) and BHS

In total 515,184 people were orientated/trained in NSW promotion over four years. **ER 6.**

Unit costs for NSW orientation/training are approximately **US$0.60 per capita.** This expenditure, when combined with training costs in Social Mobilization, is considered good value for money considering that for every one catalytic dollar spent on NSW/SM training it indirectly resulted in approximately three new sanitary latrines being constructed. **ER 7.**

6.9.4- Results

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest)

Level of Result	Level of Effectiveness	Sustainability
1- Change in partici-pant's know-ledge, attitudes and/or skills.	The vast majority of administrative and health and education staff orientated to NSW were familiar with their terms of reference. **ER 6**	Moderately high in the short-term, but follow-up is critical to boost confidence among those trained, especially in using participatory methodologies aimed at low-literacy/illiterate and impoverished groups for behaviour change. Although the knowledge and skills for latrine construction is good in the majority of villages, sustainability of construction/upgrading of latrines depends on four key issues: • Continued political commitment & follow-up. • Capacity of local health staff and village committees to analyze, plan, manage & monitor improvement. • Availability of affordable latrine pans. • Family demand and appreciation for sanitary latrines. Sustainability of sanitary latrine construction skills **ER 7**, and attitudes in favour of sanitation nation-wide **ER 4**.
2- Change in individual perfor-mance.	As a result of this orientation /training, trainees give priority to national directives (political and sectoral) and the majority acted upon. **ER 6**	The primary impetus of the NSW success has been political commit-ment and follow-up of directives. 'Demand' for sanitation on the basis of health or social reasons is less obvious. And this may under-mine long-term sustainability of both the implementation strategy, and of latrine maintenance if people do not fully appreciate their value **ER 5**
3- Change in organi-zational perfor-mance.	NSW has built upon existing organizational structures (admin., health & educ.). And has resulted in effective per-formance in reaching targets for latrine construction. **ER 6**	Sustainability of organizational arrangements is good because it dovetailed into existing administrative, health and education structures. Capacities are, therefore, relatively high for sanitary latrine construction. Moreover, because these institutions are already established to deal with many community problems, it is relatively easy to sustain them. **ER 6**
4- Improve-ment in the situation of children & women.	Since 1998, NSW has been a major catalytic factor behind the phenomenal efforts to accelerate the closing of the 'sanitary' sanitation coverage gap from 55% in 1997 to a 37% gap by 2000. This has especially benefited children and females. **ER 8**	***Firstly,*** the NSW was successful in reaching privileged groups (urban/metropolitan/educated and better off). With annual increments of 10% per year in urban & 5% per year in rural areas, over 3 years. It had less success in reaching impoverished people (remote rural/less educated and illiterates) and those with limited access to audio-visual media. ***Secondly,*** sustainability of family and school latrines will depend on how much families, PTA's and individuals appreciate good sanitation (i.e. KAP). This is especially challenging in remote areas where low-literacy and poverty prevails. And necessitates a special focus on these groups using S&H promotion methodologies such as PHAST, which cuts across all literacy and socio-economic levels. **ER 6**

Overall, effectiveness and sustainability of this 1-week, per year, orientation/training is around **ER**

6.9.5- Relevance

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):

The orientations/training were relevant to the situation during the 1996-2000 period for the following reasons: The urgent need to accelerate action for universal coverage of sanitation was recognized in the early 1990's with the goal of 'universal coverage by the year 2000'. However, past strategies of principally using a 'service delivery' approach, whereby family sanitation was subsidized by government, external support agencies, international and local NGOs, and complicated by insufficient resource allocations, poor performance in coverage trends and limited demand and/or importance given to sanitation. Had this approach continued, it would have taken until about 2040 to reach the present coverage rate, at today's population size. Therefore, a radical shift in strategy direction was called for. This shift abandoned the 'service delivery' and subsidy approach and moved towards a more 'self-reliance' strategy, whereby local communities and families were mobilized for sanitation and they covered the full costs of their new latrines. **ER 6.**

However, the current strategy only deals with mobilization and political commitment, it does not adequately address (from a national perspective) the challenge of changing people's knowledge, attitudes and practices regarding sanitation and hygiene. It also lacks sufficient emphasis on creating genuine 'demand' for improved sanitation and hygiene based on health and social convenience, gender needs and privacy reasons. Therefore, sustainability of NSW efforts, and more importantly, sustainability of safe behaviour and upkeep of latrines is contingent upon the following key issues:

- That the NSW not just rely on principally 'national directives' as the key to accelerating coverage. It must also use the mass media and other influential channels (religious groups, INGOs and CBO's and the private sector e.g. latrine-pan manufactures and soap producers) to strategically address attitudes and practices (behaviour) regarding sanitation and hygiene. And to create greater awareness of the importance of sanitation, to lay the foundation for behavioural change strategies, and to further stimulate genuine 'demand'.
- That satisfactory knowledge and skills exist at village level for sanitary latrine construction or upgrading (primarily the role of Social Mobilization). This challenge becomes more difficult to achieve as the programme reaches out to more remote population groups, and especially when other factors such as illiteracy and poverty are rife.
- That families and individuals understand what the NSW directives are, and more importantly why they should build sanitary latrines – i.e. understand the relationship between poor sanitation and unhygienic conditions and that of diarrhoeal diseases and parasitic infestation i.e. Knowledge Attitudes Practices (primarily the role of Social Mobilization).
- That appropriate capacity exists for planning and management (and assessing, analyzing, and M&E), particularly at township and village levels (primarily the role of Social Mobilization).

6.9.5- Main Finding:

- Phenomenal results in closing the 'sanitary' sanitation gap from 55% in 1997 to 37% in 2000.
- That an additional 23% of latrines classified as 'non-sanitary' could be quickly upgraded to 'sanitary' if a specific focus is given to this during the next NSW. This, in itself, would further close the coverage gap to just 14%.
- Strong commitment and motivation of government administrative and technical staff, at all levels.
- NSW was less successful, than Social Mobilization, in reaching disadvantaged groups, especially low-literacy levels and those living in remote locations where poverty is rife. For example, between 1998 and 2000, sanitation coverage grew by 31% in urban areas compared to15% in rural areas. Although overall results are very good, the influence has been greater in the urban setting.

6.9.6- **Key Recommendations:**

The NSW should now give priority to the following:

- Focus on all AFTs, as well as all Townships with less than 50% sanitation coverage;
- Promote upgrading of 'unsanitary' latrines to 'sanitary' ones;
- Promote importance of information gathering and management, especially at ward/village and Township levels;
- Use the mass media, religious groups, international NGOs and CBOs and private sector to create awareness on the need to adopt safe behaviour for sanitation and hygiene.
- Maintain political commitment (SPDCs, TPDCs, ward and village tract leaders etc.) from national to village level and provide clear guidance to each level (national, state/ division/ township/ ward/ village) for NSW activities and targets.
- Advocate for de-centralised planning and programming for sanitation and hygiene.

6.10- Social Mobilization Training

6.10.1- Training Component Description:

This training primarily targeted those townships with the worst sanitation, hygiene and drinking water coverage indicators. Unlike the NSW, which primarily focuses on latrine promotion, Social Mobilization covers the full range of awareness creation, knowledge transfer and skills development for behavioural change in sanitation, personal and food hygiene and drinking water safety (i.e. 'Four Cleans'). And although SM training has taken place at the State/Division levels, the main focus has been on Township and sub-township levels. SM training began in 1996 and since then has been the main thrust of local level action in WATSAN and is inextricably linked to the NSW training.

Problem Statement: There is no easy or quick way to change people's behaviour. The 'magic bullet' theory has long been laid to rest. We now know from many years of experience in sanitation and hygiene that strategies for behavioural change demands time, effort, person-to-person communication, money, proven communication strategies and above all, the full participation of target groups or individuals if perceptions, attitudes and practices are to be improved. Simply put, it's a long, difficult and costly road ahead with few short-cuts, but a necessary one. More recent experiences in HIV/AIDS behavioural change programmes need to be carefully studied and drawn from in order to build upon proven WES methodologies such as PHAST (participatory sanitation and hygiene transformation). And recognizing that in 1996 only 54% of the population washed their hands after defecation (18% with soap and 36% with water alone), the Social Mobilization training for sanitation, hygiene and drinking water improvement was pertinent.

Goals: 'Sanitation for All' and universal coverage of safe water supply, by the year 2000. But recognizing that that these goal were impossible to reach by 2000 with limited resources and strategies at that time, therefore interim goals of 80 percent for sanitation and 81 percent for water by year 2000 was set.

Objectives: The 1996-2000 Master Plan of Operations strategy for communication and social mobilization stated: The water and sanitation programme will focus on national social mobilization campaign involving relevant departments, NGOs, communities, UNICEF and other donors. The campaign will be designed to bring about fundamental changes in knowledge, attitudes and practices relating to safe water, sanitation and hygiene. Special attention will be given to addressing the campaign to prevailing patterns within the various cultural communities of Myanmar. This strategy also included

women's participation, promotion of self-reliance, involvement of the private sector and cooperation among various WES sector stakeholders. Specific to Social Mobilization, objectives included, **per year**:

- Undertake 15 orientation sessions for State/Division level leaders in advocacy.
- Undertake 150 training sessions for Training of Trainers (ToTs) for Township level staff.
- Undertake 39 training sessions for Training of Mobilizers (ToMs).
- Undertake 780 training sessions for Community Mobilizers.

Target Groups:

- State/Division leaders and health and education officials.
- Township leaders and health and education officials.
- Basic health staff at RHC level, and ward and village 100- and 10-household leaders.

Implementation Strategy: This consisted of cascade training and planning activities at the following levels:

- ***State/Division Level:*** One-day SM training in advocacy and planning for State/Division and Township level leaders (TMO, TEO, TPDC from each Township, and about 10 representatives from related departments at the S/D level and NGOs). It also included training for mobilizing political and technical support. Expected outcomes included: State/Division plans for SM; Township plans for Training of Trainers (ToTs); the assignment of Township officials for follow-up activities; and a report to central level on planned activities for Social Mobilization.
- ***Township Level 1:*** Three-day training of trainers (ToTs) in SM. These included the TMO, TEO, TPDC, DDA from each Township and about 10 representatives from related departments, as well as NGOs. Expected outcomes included the transfer of basic knowledge and skills on: training and communication techniques for SM; information sharing on sanitation, hygiene and water issues; and planning and organization skills.
- ***Township Level 2:*** Two-day training of mobilizers (ToMs) for Ward/Village tract leaders, HA's, BHS and CBOs, where available. Expected outcomes included: simple assessment and action plans; selection of appropriate technology options; assignment of follow-up activities for Ward/Village leaders.
- ***Ward/Village Tract Level****:* Two-day training of mobilizers (ToMs) in family/community mobilization techniques for ward/village leaders. Expected outcomes included: basic knowledge and skills on sanitation, hygiene and water issues; how to construct various latrines; communication techniques and use of IEC materials for mobilizing families and communities for WATSAN activities.

Budget (US$):

1996	**1997**	**1998**	**1999**	**2000**	**Total US$**
46,370	86,000	113,102	138,543	107,727	**491,724**

This budget does not include UNICEF's nor GoM's staff and overhead costs, nor the hiring of training facilities from State/Division level to Ward/Village tract level.

6.10.2- What has been done to evaluate?

It was not possible to actually observe any orientation/training in Social Mobilization because no training activities were undertaken during the evaluation period. But, it was possible to analyze past progress, training and communication materials, ongoing research on the impact of SM activities, as well as to verify these findings through evaluation visits to eleven villages, three townships and three states/divisions. And, by interviewing key government and UNICEF staff at central level.

6.10.3- Process

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):

Planning of training needs and strategy development for SM was undertaken through pertinent workshops at the central level using data from the townships for decision making. The overall plan and implementation strategy was appropriate to the situation and trends that prevailed during the 1996-2000 programme cycle. Townships subsequently adapted these 'central-plans' to their specific needs and situations. **ER 6.**

Objectives and targets for Social Mobilization training in approximately 30 Townships per year were ambitious considering the difficulty with logistics, staff time and limited resources. Although these targets were achieved, the training could have been more suited to addressing such challenges as capacity gaps especially those in planning, management and monitoring and evaluation at the Township and ward/village levels. **ER 6**

Training materials, developed for SM, was appropriate for the majority of the population and was further enhanced by inter-personal communication and skills training at local levels. The use of video parlours at village level also enhanced awareness creation among the masses. And unlike the NSW, the SM training and subsequent outreach mobilization has managed to reach the less educated, low-income populations – where SM training took place. But despite this, there is still need to develop better communication strategies for improving knowledge, attitudes and practices, especially among low literacy or illiterate populations. This requires that strategies such as PHAST (participatory hygiene and sanitation transformation) be used at community level. It will also necessitate that materials are translated into local languages, adapted to cultural and local conditions and that video/radio educational materials on WATSAN be made more easily available for use in remote and impoverished areas. **ER 6.**

Achievements: approximately 6,500 people were trained each year in Social Mobilization or 32,000 over the five-year period. **ER 7.**

Unit costs for Social Mobilization training is slightly over **US$ $15.00 per capita** and this is quite good considering that this training was more intensive than that of NSW training, and that it reached out to those working in more remote and impoverished areas. When this expenditure is combined with NSW training costs it can be considered reasonably good value for money i.e. for every one (1) catalytic dollar spent on SM/NSW training, it indirectly resulted in approximately three (3) new sanitary latrines being constructed. And these figures do not include the added value of hygiene education from that same dollar. However, these costs could be further significantly reduced if the WES training is integrated (module) into other training strategies for WCHD/ECCD and SHAPE (CFS). **ER 6.**

6.10.4- Results (Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):

Level of Result	**Level of Effectiveness**	**Sustainability**
1- Change in partici-pant's know-ledge, attitudes and/or	Basic health staff (trained) in most villages have an elementary knowledge of sanitation, hygiene and water issues and skills in mobilization, but lesser in participatory methodologies for	Relatively high in the short-term, but follow-up is critical to boost confidence among those trained, especially in using participatory methodologies aimed at low-literacy/illiterate and impoverished groups for behaviour change. This is critical when national averages on behaviour are dis-aggregated. The importance of education, socio-economic status and urbanity really make a difference, e.g. in places where these indicators are good, on average 83% of child caregivers wash their hands

skills.	behaviour change. However, latrine construction skills are evident in most villages. **ER 6.**	with soap and water after cleaning infant's bottoms and 70% of all people in this category wash their hands with soap after defecation. But, when dis-aggregated, the converse (poverty, low-literacy and remoteness) is 49% and 28% respectively, and illiterates fared worse at 45% and 18% respectively. Likewise, only 35% of illiterates associated contaminated water with diarrhoeal disease, compared to almost 50% of the average poor and over 83% of the better-off. **ER 5.**
2- Change in individual perfor-mance.	As a result of SM training, trainees give priority to sanitation, hygiene and water issues. **ER 6.**	At all levels including the lowest, trainees have a tendency to use instructional approaches for WATSAN rather than participatory methodologies. And, although instruction and directives are well accepted in Myanmar and often results in reaching relatively impressive physical targets such as latrine construction – the risk of not giving due support and attention to strategies for behaviour change, may, in the long-term, undermine sustainability of both WATSAN services and safe sanitation and hygiene behaviour. But where more intensive SM training has taken place, families and other community members show better signs of greater self-reliance including the continuation of sanitation and hygiene promotion even after external assistance is withdrawn e.g. Wet-Ka-Thay village. As well, it is doubtful that going-to-scale, for ***behaviour change,*** is possible without strategically integrating the software for 'Four Cleans' into curricula of public health and education institutions and ensuring that this is put into practice through mainstreaming the 'four-cleans' into strategies such as ECCD, WCHD, SHAPE and of the mass media. **ER 6.**
3- Change in organi-zational perfor-mance.	SM has built upon existing organizational structures (admin., health & educ.) and has resulted in effective performance in WATSAN. **ER 3.**	Notwithstanding the above, sustainability of organizational arrangements is relatively good because it dovetailed into existing administrative, health and education structures. Capacities are therefore relatively high in SM for WATSAN. **ER 6.**
4- Improve-ment in the situation of children & women.	SM has been a major contributor to sub-national efforts to accelerate the closing of the 'sanitary' sanitation coverage gap from 57% in 1995 to a 37% gap by 2000. This has especially benefited children and females. **ER 7**	***Firstly,*** the SM training was reasonably successful in reaching impoverished groups (remote rural/less educated and illiterates) and those with limited access to audio-visual media. But a lot more remains to be done. ***Secondly,*** sustainability of family and school latrines will depend on how much families, PTA's and individuals appreciate good sanitation. This is especially challenging in remote areas where low-literacy and poverty prevails and necessitates a special focus on these groups using S&H promotion methodologies such as PHAST, which cuts across all literacy and socio-economic levels. **ER 6.**

Overall, effectiveness and sustainability of SM training is **ER 6**.

6.10.5- Relevance

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):

The building of local capacity for self-reliance in WATSAN and the promotion of safe behaviours in sanitation, personal and food hygiene and the safe handling and use of drinking water (i.e. 'Four Cleans') is very relevant to overall national goals to improve public health. But despite the considerable efforts of the Social Mobilization training over the past five years, a lot remains to be done to ensure that behaviour change is adequately addressed (see below). **ER 6.**

- It is critical that families and individuals have a clear understanding of the relationship between poor sanitation, unhygienic conditions/behaviours and contamination of drinking water - and that of diarrhoeal diseases and parasitic infestation. This is especially important regarding the washing of hands after defecation, - as most people do not consider this necessary -, even though over 90% of them wash their hands before eating. But, the time delay in washing of hands could be a major contributing factor to spreading of disease. If hands are not washed immediately after defecation the risk is high of spreading millions of germs onto door handles, food, eating/drinking utensils, children's feeding containers, other people's hands etc. therefore the 'F-Diagramme' needs to be better understood.
- Townships need to take the lead role and responsibility for promoting and facilitating sanitation, hygiene and safe water. And to do this, they need greater capacity in planning and management, including M&E.
- Communities need to have greater capacity to identify, assess and take appropriate action regarding water, sanitation and hygiene related problems. This could be achieved through the building of capacity, at that level, for use of strategies and methodologies such as PHAST (participatory hygiene and sanitation transformation).

6.10.6- Main Finding:

- Phenomenal results in closing the sanitation gap from 57% in 1995 to 37% in 2000.
- Strong commitment and motivation of government administrative and technical staff, in Townships, wards and villages.
- The challenge of changing attitudes and behaviours in S&H necessitates an intensive inter-personal participatory approach to overcome the problem. Therefore, the use of participatory methodologies such as PHAST is paramount, particularly among low-literacy and impoverished groups.
- That an additional 23% of latrines classified as 'non-sanitary' could be quickly upgraded to 'sanitary' if a specific focus is given to this. This, in itself, would further close the coverage gap to just 14% in the shortest possible time frame.
- Intersectoral collaboration is not as strategic as it could be, especially for ensuring that the 'Four Cleans' and SSHE are institutionalized and integrated into other public health and education strategies.
- Capacity for planning and management (including coordination and M&E) is weak in many Townships and very limited in most villages.

6.10.7- Key Recommendations - that SM give priority to the following:

- Provide specific training, at Township level, for BHS, international NGOs and CBOs in PHAST strategy/methodology.
- Build capacity in the Area Focused Townships for adaptive WES planning and management (including assessment, co-ordination and M&E) for greater self-reliance;
- Fully integrate the 'Four Cleans' & SSHE into strategies such as SHAPE (life skills in CFS), ECCD, WCHD and the mass media;
- Institutionalise and integrate the 'Four Cleans', SSHE (and PHAST as an implementation methodology) into curricula of Teacher Training Colleges, Public Health Institutes and Nurse & Midwives Training Schools;

- Involve States/Divisions in planning and management of WATSAN activities.

6.11- School Network Training

6.11.1- Training Component Description:

This training has evolved over the years. In1998 it began as a potential network of local resource persons (teachers and PTAs) to promote improved sanitation, hygiene and safe water in the communities as part of Social Mobilization outreach. But, initially, SN & SM were not always implemented jointly. The initial benefit to schools included the provision of water and sanitation services. Teaching of children on sanitation, hygiene and water was, at that time, considered a spin-off and therefore was not integrated into teaching in the schools. Post 2000 brought new thinking whereby School Network was envisaged as an opportunity to influence children's knowledge, attitudes and behaviour at an early age. Thus, in-school teaching of sanitation, hygiene and water issues became the central focus of life-skills development, in this context.

The training for School Network primarily targeted teachers and parent teacher association (PTA) chairpersons with the aim that they, in turn, would promote sanitation and hygiene in the community. The post 2000 focus places schoolchildren at the centre of this effort. Therefore, teachers and PTA chairpersons are being trained for further teaching/facilitating of school sanitation and hygiene education, including key life-skills development such as handwashing at critical times. Currently, the in-school teaching on water, sanitation and hygiene (as part of the 'Life-Skills' curriculum) is about 30 minutes of class instruction each week.

Problem Statement:
The challenge of addressing unsafe behaviour in sanitation, personal and food hygiene and handling and use of drinking water in the population at large has greatest potential in schools. Teaching of life-skills coupled with water and sanitation facilities enables schoolchildren to put learning into practice and thus provides opportunities for influencing behaviours at an early age. It is also hoped that children equipped with this new knowledge and skills would later become 'change agents' in their respective family and community.

Goal:
To promote water and sanitation related hygiene among school children.

Objectives:
- Increase awareness and improve knowledge, attitudes and practice (KAP) regarding water, sanitation and hygiene (WES) among school children.
- Provide water and sanitation facilities in schools to enable children put WES learning into practice.
- Equip school children as 'change-media' within their families and community.

Target Groups:
- TEO's, ATEOs, TMOs, Township School Health Officers, TPDCs, and 10 representatives from State/Division departments of basic education and of Health;
- Parent Teacher Associations (PTA) chairpersons (head teacher) and students.

Implementation Strategy: As mentioned earlier, the initial main focus of the SN was on outreach to communities as part of the overall SM effort. However, it has now evolved into training in sanitation and hygiene promotion techniques in schools; the use of IEC teaching materials; how to organize and conduct training workshops; and related information on various latrine construction and maintenance.

SN now consisted of cascade training at two levels:

- ***State/Division Level:*** One-day training of trainers (ToT) workshop (for TEOs, ATEOs, TMOs, Township School Health Officers, TPDCs, and 10 representatives from State/Division departments of basic education and of Health). It includes training in sanitation and hygiene promotion techniques in schools; the use of IEC teaching materials; how to organize and conduct training workshops; and related information on various latrine construction and maintenance. Expected outcomes include increased awareness and commitment among State/Division and Township authorities for the School Network programme. State/Division plans of action for School Network.
- ***Township Level:*** This includes 3-6 one-day training workshops for PTAs in all targeted schools in each Township. PTA chairpersons trained as mobilizers were, in most cases, also the headmasters/mistresses of target schools. They were provided with IEC materials for further training of other teachers in their respective school, as well as PTA members. Class teachers, in turn, trained schoolchildren on water, sanitation and hygiene and further discussed WES issues with parents during regular PTA meetings.

Budget (US$):

1998	**1999**	**2000**	**Total US$**
23,462	39,685	20,902	**84,049**

This budget does not include UNICEF's nor GoM's staff and overhead costs, nor the hiring of training facilities from State/Division level to Ward/Village tract level.

6.11.2- What has been done to evaluate?

Thirteen schools in three Townships were visited during the evaluation period. As well, a review of past progress reports and ongoing research on the impact of SN activities, and interviews of key government and UNICEF staff at central level was undertaken.

6.11.3- Process

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):

Planning of training needs and strategy development for School Network (SN) post 2000 has been done in close collaboration with education for CFS and SHAPE. The planning was undertaken through pertinent workshops at the central level using data from schools in target townships for decision making. Each Township subsequently adapted these plans to their own specific needs and situations. **ER 5.**

Objectives and targets for SN training in approximately 30 Townships per year were ambitious considering the difficulty with logistics, staff time and limited resources. Although these targets were achieved, the training could have been more strategically integrated (as a WES module) into other training strategies for teachers and PTA such as for Child Centred Learning, SHAPE etc. **ER 5.**

Training materials, most of the teaching and learning materials for water, sanitation and hygiene being used in schools are standard posters and pamphlets used in the overall Social Mobilization programme. In schools, the most common reference and teaching materials are Facts for Life and the life-skills teachers' reference book. Most of the schools visited had only one copy of the life-skills reference book and two copies of FFL – not enough for ease and effectiveness of teaching and learning. However, within SHAPE, the section on sanitation, hygiene and water should be expanded if SHAPE is to be introduced into all schools. **ER 3.**

Achievements:

- 130 ATEOs and TMOs from 65 Townships trained in water, sanitation and hygiene related issues for in-school teaching of children and in promoting of latrine and water point construction/upgrading;
- 6,4000 PTA chairpersons trained in water, sanitation and hygiene related issues for schools;
- Water and sanitation facilities constructed in 5,797 schools (over twice the original target);
- Children are knowledgeable about hygiene, sanitation and water issues and that of related diseases, on average 64 percent could answer key questions. And over 90 percent of schoolchildren wash their hands before eating, but more than 40 percent wash hands after defecation and this need to be improved.
- Where sanitation and water facilities have been provided in schools, their maintenance is relatively well taken care of. It is estimated that over 90 percent of latrines are kept clean and that water pump breakdowns are repaired within one-day. **ER 8.**

Unit costs for School Network is slightly less than **US$ $13.00 per capita** and this appears to be acceptable, but could probably be reduced significantly if training is integrated with other training for CFS/SHAPE. **ER 5.**

6.11.4- Results

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):

Level of Result	Level of Effectiveness	Sustainability
1- Change in partici-pant's know-ledge, attitudes and/or skills.	Teachers and PTA members are better versed on issues of sanitation, hygiene and water compared to others in the community. Although teachers have some knowledge of participatory methods, they rarely use them. **ER 5.**	Relatively good at first, but longer-term sustainability will depend on whether teachers have both sufficient time and teaching/learning materials and tools to teach about water, sanitation and hygiene in a child-centred way. This also implies that teachers be given follow-up support to enable them, and to reinforce their confidence, in using participatory methodologies for WES, as many teachers continue to use instructional (teacher-centred) approaches. And, although instruction often results in reaching relatively impressive immediate achievements, in the Myanmar context, there is a risk of not giving due attention to strategies for behaviour change and this may, in the long-term, undermine sustainability of knowledge and skills transfer to children and their ability to judge what is appropriate sanitation and hygiene behaviour. **ER 5.**
2- Change in individual perfor-mance.	As a result of SN training, trainees give priority to sanitation, hygiene and water issues in schools, and many take the initiative to improve sanitation on their own. **ER 7.**	Where SN training has taken place, teachers and PTAs have participated in decision making and activities for water, sanitation and hygiene in schools. And because SN engages PTAs in group-discussions there is a greater chance of empowering them for self-reliance in sanitation, hygiene and water in schools. However, PTA's in impoverished areas still have to be reached and many schools in the poorer areas do not have any water or sanitation facilities at all. **ER 6.**
3- Change in organi-	SN has built upon existing organizational structures (admin., health & educ.) and has resulted in	Sustainability of organizational arrangements is good because it dovetailed into existing administrative, health and education structures. Capacity is therefore relatively good for water,

zational perfor-mance.	effective performance in WATSAN. **ER 7.**	sanitation and hygiene in most areas where training has occurred. **ER 6.**
4- Impro-vement in the situation of children & women.	SN has been a major contributor to improving the learning environment in schools, as well as increasing children's knowledge about diseases and other problems related to water, sanitation and hygiene. School latrines have especially benefited girls. **ER 8.**	This appears to be relatively good. But, as mentioned earlier, the tendency to use instructional approaches for WES rather than participatory methodologies may undermine children's ability to fully understand the importance of good sanitation and hygiene, as well as the behaviour that is necessary to adopt to prevent or avoid related diseases. **ER 5.**

Overall, effectiveness and sustainability of SM training is **ER 6**.

6.11.5- Relevance (Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest): The teaching of public health issues related to water, sanitation and hygiene, as well as the provision of water and sanitation services is very relevant to the holistic development of schoolchildren. However, the approach to doing this could be improved through integrating a teaching module on water, sanitation and hygiene into Teacher Training Colleges in order to equip new teachers with the knowledge and skills before they enter service. As well, for in-service training on WES, it would be more relevant, efficient and effective if the WES module were fully integrated in training for CFS/SHAPE strategies. **ER 8.**

But despite the considerable efforts of the School Network since 1998 a lot remains to be done to ensure that:

- Schoolchildren have a clear understanding of the relationship between poor sanitation, unhygienic conditions and contamination of drinking water and that of diarrhoeal diseases and parasitic infestation (i.e. the 'F-Diagramme').
- That there be requisite skills in every PTA to plan, manage, monitor and evaluate school water and sanitation services and maintain/upkeep school water and sanitation services.

6.11.6- Main Finding:

- Very good results in providing water and sanitation services in 5,797 schools (over twice the original target).
- Strong commitment and motivation of teachers and PTAs for school water and sanitation improvement.
- The challenge of changing attitudes and behaviours in S&H necessitates an intensive inter-personal participatory approach and therefore teachers need to use participatory (child-centred) teaching/learning approaches. In this case, the use of the PHAST methodology would be most beneficial.
- Intersectoral collaboration needs to be better, especially for ensuring that SSHE (school sanitation and hygiene education) is institutionalized and integrated into Teacher Training Colleges, as well in-service training of teachers and PTAs for CFS and SHAPE.
- Teaching and learning materials for schools (sanitation, hygiene and water) needs to be developed specifically for this purpose. These materials should also be in modular form to facilitate their integration into such strategies as CFS, SHAPE and others.

6.11.7- Key Recommendations - the SM should now give priority to the following for:

- Strengthen intersectoral collaboration to ensure that SSHE (school sanitation and hygiene education) is institutionalized and integrated into Teacher Training Colleges, as well in-service training of teachers and PTAs for CFS and SHAPE.

Develop WES (sanitation, hygiene and water) specific teaching and learning materials for schools and kindergartens and ensure that this is done in modular form for ease of integrating into SHAPE/CFS and updating of the 'Life-Skills' teacher reference manual. This process should be done in close collaboration with other key sector and departments dealing with curriculum development and teaching.

6.12- Pump Caretaker Training

6.12.1- Training Component Description:

This training targeted village pump-caretakers (elected for training by villagers) in communities which were given new or rehabilitated water systems under the GoM-UNICEF WES programme. Since 1998, 17,200 pump-caretakers were trained in basic pump maintenance and repair, including for piped water systems. The Water Resources Utilization Department (WRUD) and the Department of Development Affairs (DDA) conducted this training.

Problem Statement:
To reduce dependency on local government for the maintenance of community water supply by building village capacity for self-reliance.

Goal: Universal access to safe drinking water.

Objectives:
- Local capacity to sustain water systems.
- Promotion of messages on safe collection, storage and use of drinking water, by pump-caretakers.

Target Group/s:
- Selected village persons for training in hand-pump caretaking (decision by villagers themselves).

Implementation Strategy: This one-day training course took place in respective Townships where UNICEF provided water development assisted. Training was very basic and did not require much technical aptitude by the trainees, as the handpumps are very simple to assemble and disassemble. As well, initial training of trainers (ToT) and planning took place at the central level in a one-day workshop.

- ***Township Level:*** Trainees were given a one-day basic course on: identification of various components of the handpump and on how to dismantle and assemble it. Trainees were also instructed on where to procure spare parts and/or back-up support, if needed. On completion, each trainee received a simple leaflet on handpump maintenance and a certificate.

Budget (US$):

1998	**1999**	**2000**	**Total US$**
9,500	21,500	21,800	**52,800**

This budget does not include UNICEF's nor GoM's staff and overhead costs, nor the hiring of training facilities at the Township level.

6.12.2- What has been done to evaluate?

Pump caretakers and villagers were interviewed and pumps were inspected in eleven villages of three Townships in three States/divisions. As well, progress reports and local records were reviewed.

6.12.3- Process

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):

Planning of training needs for Pump Caretakers was done in close collaboration with Township officials and representatives from each respective village. **ER 7.**

Objectives and targets for Pump Caretaker training were set against physical targets and completion of tube-well development and therefore appropriate. **ER 7.**

Training materials, the training materials were well developed and very simple to follow, even for low-literacy trainees. **ER 7.**

Achievements:

- 17, 200 Pump Caretakers trained over a three-year period.30. **ER 8.**

Unit costs for Pump Caretaker training was **US$ $ 3 per capita** and this appears to be acceptable, but could probably have been significantly reduced had the training been provided by the pump manufacturers/distributors as part of the overall pump costs. **ER 6.**

6.12.4- Results

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):

#	Level of Result	Level of Effectiveness	Sustainability
1	**Change in participant's knowledge, attitudes and/or skills.**	Trainees were well versed and capable of undertaking all repairs to handpumps. **ER 7.**	Relatively good, but longer-term sustainability will depend on the availability of affordable spare parts and the necessary back-up services for repair to the tube-well in case of siltation or filter-screen malfunction – which is beyond the capability of pump caretakers. **ER 6.**
2	**Change in individual performance.**	As a result of Pump Caretaker training, trainees know how to repair pumps and give priority to safe water. **ER 7.**	Same as above. **ER 6.**
3	**Change in organizational performance.**	Villagers no longer have to depend on technical support from Township level for pump repairs. **ER 7.**	Sustainability of organizational arrangements is good because it is institutionalized in existing village management structure **ER 7.**
4	**Improvement in the situation of children & women.**	The provision of safe water supply in villages has been a major contributor to reducing the time and energy spent in water collection, especially by women and girls. Safety of	This will depend on the ability of villagers to purchase spare parts when needed so as to continually sustain the pump and also reduce the breakdown to repair time. **ER 6.**

		water will contribute to reducing diarrhoeal and personal hygiene related diseases. **ER 8.**	

Overall, effectiveness and sustainability of SM training is **ER 7**.

6.12.5- Relevance

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):
The training of handpump caretakers is very relevant to the sustaining of village water supplies. However, future training should be privatized as part of the pump purchase price **ER 8.**

6.12.6- Main Finding:

- Pump Caretakers were able to make simple repairs within a few hours and undertake more complicated repairs within one-day.

6.12.7- Key Recommendation

- UNICEF should make pump caretaker training part of the overall pump purchase costs and/or that of the cost of developing new water systems. Therefore it is recommended that this training be privatized.

6.13- Water Quality Training

6.13.1- Training Component Description:

This training is very technical and specialized and is given to technicians and engineers attached to the Water Resources Utilization Department (WRUD) and the Department of Development Affairs (DDA) at the central and State/Division levels.

Problem Statement:
Up to now, the government of Myanmar has not had a clear policy and/or standards for rural drinking water supply. The quality of drinking water from most sources (tube-wells, hand-dug well or gravity systems, village ponds etc.) are not tested for bacteriological and/or chemical contaminants and therefore may pose unknown risks to the general population. Arsenic, for example, may be a particular risk to groundwater supply in the coastal and delta regions, but also elsewhere, considering those neighbouring countries such as Bangladesh, India and Thailand have particular problems with arsenic.

Goal:
Universal access to safe drinking water.

Objectives:
- Train key government staff in WRUD and DDA in water quality testing and mapping.
- Establish a national database on water quality, by hydro-geological zone.
- Contribute to the development of a national policy and standards for rural water supply.
- Contribute to government decision-making regarding the establishment of a water-quality regulatory mechanism, within the most appropriate government institution.

Target Group/s:

- Selected technicians and engineers in WRUD and DDA.

Implementation Strategy: These five-day intensive-training courses took place at central and State/Division levels and covered all relevant aspects of water quality standards, health implications, testing procedures and the use of specialized testing equipment and reagents. It also covered international standards for drinking water in context of the prevailing situation in Myanmar.

Budget (US$):

2001	**Total US$**
2,615	**2,615**

This budget does not include UNICEF's nor GoM's staff and overhead costs.

6.13.2- What has been done to evaluate?

Reviewed training materials, course contents and interviews of trainees and trainers.

6.13.3- Process

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):

Planning of training needs for Water Quality testing/analysis was well carried out and very relevant to the local situation. **ER 9.**

Objectives and targets for Water Quality testing/analysis training were appropriate and completed within the planned timeframe. **ER 9.**

Training materials, the training materials were adapted from international recognized training courses in water quality testing/analysis and were therefore very appropriate to the Myanmar situation and the education levels of selected trainees. **ER 9.**

Achievements:

- 13 Resource Trainers of Trainers (ToTs) trained.
- 42 State/Division level trainees trained in water quality testing/analysis. **ER 9.**

Unit costs for Water Quality analysis/testing was slightly more than **US$ $47.00 per capita** and is very acceptable for such intensive and technical training. But these costs could probably be improved upon over time as resource people' increase in the State/Divisions thus reducing the daily subsistence costs. **ER 8.**

6.13.4- Results

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):

#	Level of Result	Level of Effectiveness	Sustainability
1	**Change in participant's knowledge, attitudes**	Trainees had the requisite knowledge and skills, and were fully committed to improving and maintaining safe drinking	Very good, but longer-term sustainability will depend on: setting of and applying national standards for water quality; the continual application of acquired skills; the availability of reagents and other spares for water quality analysis/testing;

	and/or skills.	water quality standards. **ER 9.**	and, periodic updates in information and/or refresher courses. **ER 8.**
2	**Change in individual performance.**	As a result of Water Quality training, trainees are now fully capable of applying new skills and are applying them in field-level testing. **ER 9.**	Same as above. **ER 8.**
3	**Change in organizational performance.**	WRUD appears to be well organized for water quality testing and has already tested approximately 4,5000 water sources in 10 states/Divisions. However, DDA appear to have problems in putting their water quality-testing plan into action. To date, they have not managed to carry out their plan. DDA **ER 5** and WRUD **ER 9.**	Government has yet to decide the division of labour and responsibilities between WRUD and DDA regarding water quality analysis/testing, as well as regulatory functions. Sustainability of water quality analysis/testing will depend on the setting of national (and/or regional standards) as well as the establishing of a regulatory system and responsibilities. **ER 7.**
4	**Improvement in the situation of children & women.**	The setting of drinking water standards and its subsequent regulation is vital to the protection of health of children, women and the population at large. This training is a critical first step in this process. **ER 8.**	This will depend on follow through activities that lead to the setting of national water quality standards and the establishment of regulatory functions in government and its application to all current and future drinking water systems. **ER 7.**

Overall, effectiveness and sustainability of SM training is **ER 9**.

6.13.5- Relevance

(Evaluation Rating (ER) ranges on a scale from 1 to 10, where one is lowest):
Water Quality analysis/testing training is vital to public health. **ER 9.**

6.13.6- Main Finding:

- Those trained in water quality analysis/testing are fully competent in carrying out their duties.
- Water Quality standards are not yet established, but the correct process is in place to help do that.
- No government institution is yet responsible for water quality regulation.

6.13.1- Key Recommendation/s

- UNICEF should continue to support the GoM in establishing water quality standards.
- Testing for arsenic should be continued, particularly in known vulnerable hydro/geological zones and where necessary close–off any water supplies that are contaminated above the accepted international standards (until such time as national standards are established and enforces).
- Institutionalize water quality regulation in the most suitable institution/s in government.

A1- Terms of Reference

Evaluation of Training Activities Supported by the Myanmar – UNICEF Country Programme
Draft 2: 25/5/01

1) Introduction

Myanmar is a least developed country, with GNP per capita of US$263. The capacity to plan, implement, monitor and evaluate basic social services is limited – particularly after years of limited public funding to the social sector. The previous Myanmar-UNICEF Country Programme 1996-2000 and the current Country Programme 2001-2005, have therefore identified and supported capacity-building activities, particularly training, as one of the key interventions which will lead to improved services and support to children and women in Myanmar.

One of the principle strategies of the previous and current Country Programme is to support training activities leading to a positive change in skills, practice, awareness, or behaviors. Recognizing the centrality of the strategy, and the magnitude of the support, it is critical that training activities are as efficient and effective as possible. Attachment A is a list of training activities that will be supported by the Country Programme in 2001. All five programmes in the Country Programme 2001-2005 support training activities.

Training materials have been developed for the majority of the training activities and will also be assessed as part of this evaluation. Different programme and projects have used a variety training methodologies, including "cascade training"; the use of expert trainer, participatory, group oriented etc. The evaluation will make conclusions on the different models and methodologies, and provide recommendations that will lead to improvements in the efficiency and effectiveness of the results of training activities supported by the Country Programme.

Recognizing that training activities has been adopted as a capacity-building strategy in almost all country programmes, the results of this evaluation will contribute to organizational learning.

2) Framework for evaluating training as a capacity building strategy

It is well accepted that there are certain conditions which optimize training results, such as:
· undertaking an adequate training needs assessment
· integration of training as part of programme design
· selection of trainees based on individual and organizational training needs
· institutionalization of learning outcomes
· building a learning culture

The results of training activities can be observed at the following conceptual levels:
· change in participants attitudes, knowledge and/or skills
· change in an individuals performance
· change in organizational performance
· change in situation of the respective stakeholders

Some training activities, particularly those at "grass-roots level" may have a more direct relationship to impact results, and therefore not requiring the third step above which relates to the change in the organizational performance (i.e. moving directly from a change in individual performance to a change in the situation of the stakeholders).

3) Objectives

The overall objective is to assess the effectiveness and efficiency of training activities supported the Myanmar - UNICEF Country Programme, and to provide ideas and recommendations that will contribute to improving training programmes particularly with regard to their relevance, purpose, processes and the monitoring systems to measure the results (including output, outcome and impact)

More specifically, the evaluation will answer the following questions:

3.1) Assess the relevance of training as an operational strategy for capacity-building.

An important aspect of the evaluation will be to assess how appropriate the training activities are vis-à-vis the broader context and situation which influences the expected results (i.e. can the trainees' practice their improved skills?). An assessment and analysis of the significant external factors which have an influence on an individual's and organizational performance will be important when considering the relevance of training as a strategy.

Other Specific questions:
· How strategically are training results linked to the Country Programme goal and objectives? Are the capacities targeted by training activities situated at the level of individuals, an organization, institutions or a broad network of organizations and actors working to achieve a common objective?
· What is the relative importance and potential impact of the capacity constraint addressed by training (eg. attitudes, skills, knowledge or simple numbers of existing human resources)? Are there other critical capacity constraints (e.g. organizational structure and definition of roles, leadership, organizational culture, incentive systems - in the broadest sense including non-monetary) and how are they related to the capacity constraints targeted through training? How are these other constraints being addressed, by UNICEF or other partners? Are results in one area contingent on results in the other?
· Can training realistically bring about a change in the relevant capacity constraints to produce sustainable change? How sustainable will this change be (e.g. distinction between one-off training and establishment of a training function)?
· How does the training strategy contribute towards "giving voice to vulnerable groups", or towards involving them in a broader network of actors?
· Did the training compliment strategies of other partners and the government?
· Were the training activities of the various programmes related and complimentary? (i.e. training of Basic Health Staff supported by the Water and Sanitation programmes compliment the training of Basic Health staff supported by the Health programme?)

A simplistic link is often drawn between training outputs and an explicit or implicit objective of changing national (or an institution's) capacity, yet this direct sequence has not been borne out by experience world-wide – therefore the above evaluation question is necessary and useful.

3.2) Assess the process of planning training activities, including training materials, processes, participants, trainers and methodology.

An assessment into the process of planning the training, and the way in which the training is conducted will be important input into the evaluation. Analysis should include a comparison of different modalities of training (i.e. cascade, or experts from Yangon etc.)
Other specific questions:

· How were the various training activities delivered? How can the methodologies be characterized? Were the methodologies appropriate for the training objectives? Were they appropriate for the institutional context?
· How were the participants identified? Does the training strategy target the appropriate actors given the particular capacity it is intended to strengthen?
· What materials were developed and were they appropriate?
· How participatory and interactive was the training?
· Was the training gender sensitive?
· Was there a systematic monitoring system to monitor quality and results of training? Was there a process of assessing the effectiveness of the training, such as assessing whether there as an immediate increase in the trainees knowledge, awareness or skills? Was a baseline included? Was an evaluation of the training undertaken? Were the results incorporated into future training activities?
· Were participants able to evaluate the training and was this input taken into consideration?

3.3) Assess the contribution of the training activities vis-à-vis the objectives of the respective project and of the Country Programme as a whole (i.e. assess the effectiveness of the training)

The evaluation will assess the results of the training at the various levels mentioned above.

Other specific questions:

· Did they training lead to a positive change in attitudes, knowledge or skills? Did the participants feel that they had benefited from the training?
· Did the training activities result in sustainable change in behaviour or practice of the trainees? Did the process of training contribute to other sustainable changes?
· Did the training have an impact on the performance of the respective organization? Did the stakeholders perceive a difference in the performance of the organization?
· Did the change in organizational performance contribute to the project objectives, or to an improvement in the situation of the children and women?
· What was the unit cost of the training activities vis-à-vis the results at the various levels?
Regarding assessing results of training at the level of individual and organizational performance, great care must be taken in attributing changes to the effects of training. It will be important to weigh the influence of the results of other intervention strategies addressing related capacity constraints and capacities.

4) <u>Evaluation Methodology</u>

To the extent possible, this evaluation will follow the "utilization-focused evaluation" process, (see attached flow chart), ensuring that the stakeholders will be involved in all aspects of the evaluation, including the planning; discussion of findings and results; and drafting of recommendations.

Further refinement of the evaluation questions, which may differ depending on the sector, is needed in consultation with all stakeholders.

In order to answer the evaluation questions, the evaluation facilitator will need to facilitate a process of developing a common understanding as to how training objectives were intended to and should link to the broader objectives and goals of the Country Programme. This would consist of interacting with stakeholders, to draw out their understanding of the overall programme model (planned sequence of changes and assumptions) and subjecting this to an examination based on stakeholders' intuitive concerns or suspicions. The examination of the programme model should benefit from experience and

theory from sources outside of Myanmar's context - such as captured in relevant literature. Developing the Programme Model (logic model) will facilitate the process of further focusing the evaluation and to develop hypothesis. Following the establishment of the programme models, the stakeholders should help define what are the other factors that influence the change at the various levels. The outcome would be a framework against which to assess the training strategy and training activities. The various influences could also be assessed as to their relative importance or influence, thus contributing to a picture of the relative importance of the capacity constraints addressed by training.

The evaluation will be based on the following complementary methodologies in order to cover both the breadth and depth of the experience as much as possible: (1) a desktop review of existing documentation, including annual reports, mid-term review (1998), ProMS output documents, Programme Plans of Actions for various years, related studies and evaluations, reports from other organizations; (2) Focus group discussion with the stakeholders on the process and results of training activities. (3) key informant interviews including UNICEF Senior Management, Sections Chiefs and Project Officers, Government officials, partners and donors. Interviews should also be undertaken with trainers and trainees in various locations throughout the country, including those currently involved in training and with those who have completed training activities and are now utilizing those skills (after various time periods). (4) Observation of training activities in various parts of the country supported by various programmes. This will provide useful information on the skills of the trainers, the process of training, and the immediate outputs. (5) Review of training materials, including the process followed in their development; their appropriateness and effectiveness.

The evaluation will answer the questions and related issues raised in Section 3, and offer recommendations which can be immediately implemented as well as other recommendations which can be acted upon over time.

5) <u>Expected Outputs</u>

This evaluation should produce the following:

· Opportunities for discussion on the process and effectiveness of training activities in the Country Programme; opportunities for greater coordination and collaboration, and ways to improve and enhance results.
· First Report based on desk review and interviews with stakeholders in UNICEF, including a revised TOR, detailed plan and format for final analysis, including clear definitions for efficiency and effectiveness and who these would be measured (based on a consensus of all stakeholders). The process of undertaking a desk review and consultative process with stakeholders in developing this First Report will further focus the evaluation, based on what is feasible and most appropriate and pertinent. There will also be an appropriate balance between the need for activity-specific questions, findings and conclusions with the broader, cross-cutting questions. It will be important, based on the utilization-focused evaluation approach, to ensure that the evaluation will answer questions about future programming, for example:
· What should be the preconditions for UNICEF to support training?
· What should UNICEF focus on in the process of training?
· What methodologies work - in what situations?
· How can efficiency and effectiveness be improved?
The First report will also include an evaluation matrix which will link the evaluation questions to the methods that will be used to ascertain answers. The First Report will also include a detailed evaluation workplan.

· Draft Final report based on the evaluation process, including a one-day retreat with participation of all key stakeholders in the evaluation.
· Final report with executive summary

6) Use of the Evaluation Results

· Within UNICEF Yangon:
· to provide useful input to improve the planning, management and monitoring of training activities
· to contribute to identification of potential areas of coordination and collaboration between programme activities
· to increase skills and knowledge of staff members and partners on participatory evaluations and managing by results
· to increase skills on costing and cost-analysis
· Within UNICEF globally:
· Provide lessons learned on effectiveness of training activities – across different sectors and different levels
· Provide lessons on the use of evaluation as a managing tool
· Provide analysis on costing which will provide information on the tool as well as on the costs of training
· Provide lessons learned on planning and implementing training activities in Myanmar with partners and donors, thereby contributing to enhanced capacity of government officials and partners on planning and managing training activities; on evaluation processes; and on managing by results

7) Evaluation – Team composition and qualifications

The management structure of the evaluation is summarized in appendix 3.

A team of consultants will conduct this evaluation, consisting of the following:

Evaluation facilitator (one expatriate)

Please see appendix 2 for the detailed TOR for the evaluation facilitator.

Responsibilities: as the leader of the team - overall coordination of the evaluation, including review and finalization of the TOR; development of the evaluation workplan and review the composition of the evaluation team, development of evaluation tools, including an evaluation matrix which will link the evaluation questions with the tools that will be used to ascertain answers; planning and monitoring the evaluation process including information collection exercises; the final drafting of the outcome documents ensuring high quality and utlization-focused document.

Qualifications and experience: knowledge and experience with participatory evaluations; good quantitative, interview and analytical skills, experience in evaluations involving evaluation field work; experience in multi-cultural settings, excellent writing skills

3 sector specialists (education, health, water and sanitation)

Responsibilities: provide technical assistance in the respective programme area, including assessment of appropriateness of training in current situation, appropriateness of materials etc,. Draft a brief report on the evaluation findings and recommendations that relate to the respective sector.

Qualifications and experience: knowledge and experience with sector; good quantitative, interview and analytical skills; experience in evaluations involving evaluation filed work, experience in multi-cultural settings, excellent writing skills

8) TimeTable

Activity	**Dates/Deadlines**
1. First draft TOR	March 30, 2001
Final draft of TOR (in consultation with stakeholders)	July 31, 2001
2. Selection of evaluation team	May 31, 2001
3. Evaluation	August-November, 2001
Finalization of TOR by team	August 15, 2001
Desktop review	August, 2001
Development of evaluation tools	August, 2001
Sharing of tools and discussion with stakeholders	September 15, 2001
Interviews, Field data collection	September-October, 2001
Compile and analyze of results	October, 2001
4. Sharing of results and drafting of report	
Sharing of results with stakeholders	October 31, 2001
Drafting of draft report	November 10, 2001
Discussion on draft report	November 15, 2001
Final evaluation report	November 20, 2001

A2- The Evaluation Questions

(classification of the ToR's questions)

Process Evaluation (Efficiency and Coherence):

- Were the processes (planning, programming, implementing...) **well conceived**?
- Are the processes well **implemented and monitored**?
- Were the **materials** developed appropriate?
- What was the **unit cost** of the training activities vis-à-vis the results at the various levels?
- Were training activities as **efficient** as possible?
- How compare the different **modalities** of training (i.e. cascade, or experts from Yangon, etc.), What methodologies work - in what situations?
- Does the training strategy **target** the **appropriate actors** given the particular capacity it is intended to strengthen?
- Were the **methodologies** appropriate for the training objectives? ... for the institutional context?
- Were the training activities of the **various programmes related and complimentary**? (i.e. training of Basic Health Staff supported by the Water and Sanitation programmes complimenting the training of Basic Health staff supported by the Health programme?)

Results Evaluation (Effectiveness, Impact and Sustainability)

- What were the **results** of training at the level of **individua**l
- Did the participants **feel that they had benefited** from the training?
- Did the training lead to a positive **change in attitudes, knowledge or skills**?
- Can the trainees' **practice** their improved skills?
- Did the training activities result in **change in behaviour or practice** of the trainees?
- Were training activities as **effective** as possible?
- Can training realistically bring about a change in the relevant capacity constraints to **produce a change**?
- Did the process of training contribute to **other changes**?
- Did the training have an **impact** on the performance of the respective organization?
- Did the stakeholders perceive a difference in the **performance of the organization**?
- Did the change in **organizational performance** contribute to the project/programme objectives, or to an improvement in the situation of the children and women?
- How does the training strategy contribute towards "giving voice to **vulnerable groups**", or towards involving them in a broader network of actors?
- Did the training **compliment** strategies of other partners and the government?
- Did the training activities result in **sustainable** change in behaviour or practice of the trainees?
- Did the process of training contribute to other **sustainable** changes?
- How **sustainable** will this change be (e.g. distinction between one-off training and establishment of a training function)?

Relevance:

- Was the training **relevant** as an operational strategy for capacity building?
- How **strategically** were training results **linked** to the Country Programme goal and objectives?
- Were the training activities **appropriate** vis-à-vis the broader context and situation which influence the expected results?
- What is the relative importance and potential **impact** of the capacity constraints addressed by training (eg. attitudes, skills, knowledge or simple numbers of existing human resources)?
- Are there **other critical capacity constraints** (e.g. organizational structure and definition of roles, leadership, organizational culture, incentive systems - in the broadest sense including non-monetary) and how are they related to the capacity constraints targeted through training?
- **How** are UNICEF or other partners **address**ing these other constraints? Are results in one area contingent on results in the other?

- Was there **a training action every time a change is sought** in the country programme?

A3- Main Definitions

Baseline data: Initial information on program participants or other program aspects, collected prior to receipt of services or program intervention. Baseline data are often gathered through intake interviews and observations and are used later for comparing measures that determine changes in participants, program, or environment.

Benchmark: A reference point or standard against which progress or achievements may be compared.

Capacity Development: The process by which individuals, organizations, institutions and societies develop their individual and collective abilities to perform functions, solve problems and set and achieve objectives.

Cost-Benefit/Benefit-Cost Analysis: Analysis that compares program costs (typically in monetary terms) to all of its effects and impacts, both positive and negative.

Cost-Effectiveness Analysis: Analysis that compares program costs to the extent to which planned objectives were achieved.

Effectiveness: The extent to which objectives or planned outputs have been achieved.

Efficiency: The extent to which resources have been optimally used to achieve a goal or objective. Good efficiency aims maximum use of resources with minimum cost, time and effort.

Impact: The ultimate planned and unplanned consequences of a program; an expression of the changes actually produced as a result of the program, typically several years after the program has stabilized or been completed.

Lesson Learned: "What works" A general hypothesis based on the findings of one or more evaluations, but which is presumed to relate to a general principle that may apply more generally.

Monitoring: An on-going process to verify systematically that planned activities or processes take place as expected or that progress is being made in achieving planned outputs.

Objective: Expresses a particular effect that the program is expected to achieve if completed successfully according to plan.

Output: The physical products, institutional and operational changes or improved skills and knowledge to be achieved by the project or program as a result of good management of the inputs and activities; The immediate, visible, concrete, and tangible consequences of project inputs.

Outcome: Outcomes are a result of the program, services, or products provided and refer to changes in knowledge, attitude, or behaviour in participants. There may be short term and long-term outcomes. Long-term outcomes usually refer to organizational changes.

Program Model (or logic model): A diagram showing the logic or rationale underlying the particular program. It is a picture of a program that shows what it is supposed to accomplish. A logic model describes cause-and-effect chain proceeding from inputs to outputs, outcomes and impacts (the links between program objectives, program activities, and expected program outcomes).

Relevance: The degree to which the purpose of a project or program remains pertinent or appropriate to larger goals, constraints and situation.

Sustainability: The durability of positive project or program successes after a source of core funding has terminated.

A4- References for the evaluation of the Health and Nutrition Sector

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3. Guilbert, J.-J. Educational handbook for health personnel. Sixth ed. Geneva: World Health Organization, 1987. 7.08p. (WHO Offset Publication No. 35)

4. IMMCI supervisor's checklist. Yangon: Department of Health, n.d. 14p.

5. Integrated management of maternal and childhood illnesses: evaluation report 2000. 8p.

6. Integrated management of maternal and childhood illnesses in Myanmar. Yangon: Department of Health, 1999. 16p.

7. Kyi May Thein, Daw. Report on assessment of training needs of basic health staff and community volunteers in selected project townships (May 1999 to June 1999). Yangon: PHC Project, MYA/96/001 (MMR/DHS/002), [1999]. 25p + annexes.

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10. Myanmar – UNICEF country programme of cooperation 2001 – 2005: master plan of operations. Final version. Yangon: UNICEF, 2001. 177p.

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12. Myanmar – UNICEF country programme of cooperation 1996 - 2000: mid-term review, 1 – 2 July 1998, Yangon. Programme reviews. Yangon: UNICEF, 2000. various pagings.

13. A Participatory evaluation of the life-skills training programme in Myanmar. Yangon: Population Council/UNICEF, 2000. 27p.

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15. Protocol IMMCI/WCHD project. 7p.

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19. UNICEF. Office implementation plan 2001. Yangon: UNICEF, 2001. Various pagings.

20. UNICEF. Operational research on reinforcing IMMCI performance of first level health workers & KAP of mothers. Yangon: UNICEF, 1999. 23p.

21. UNICEF. UNICEF Yangon mid year review of country programme as at 30 June 2000. Yangon: UNICEF, 2000. 14p.

22. Wheeler, Christopher W. Interview and observation instruments for the mid-term evaluation of the ACIS and CAPS programs. Yangon: UNICEF, 1998. 38p.

A4- Overview Chart for Evaluation of Health and Nutrition Sector

2001 Sample size / Location / Data Sources and Evaluation Tools for different Training Component

Project	Data Sources	No. of Respon-dents	Evaluation Tools	Status
IMMCI				
Training on Program Management	**Key Informants**	**14**	Key Informants Interview	Completed and ongoing
Training of Trainers on IMMCI	Central level		- Semi-structured interview	Phase I (1998-1999)
Training of BHS on IMMCI	UNICEF stakeholders		Form (1)	Phase II (1999-2000)
	MOH stakeholders			Phase III (2000-2001)
	Individual resource persons			
	Central Training Team Members			
	Medical Superintendents of S/D Hospitals			
Places Visited	States/Divisions			
	S/D Training Teams Members			
1. Shan State	District Training Team Members			
• Taunggyi	Township Training Team Members			
• Yatsauk				
2.Yangon Division	**Trainers**	**5**	- Management Training Interview	
• Kyauktan	S/D Training Teams Members		Form (2)	
3. Mon State	District Training Team Members		- Trainer's Interview Form (3)	
• Thaton	Township Training Team Members		- Instrument for Evaluating	
4. Kayin State			Training Materials (12)	
• Pa-an	**Trainees**			
5. Sagaing Division	Medical Officers	**16**	- Trainee's Interview Form (4)	
• Monywa	Staff nurse			
	Midwives			
		4	- Focus group discussion (5)	
		16	- Knowledge Assessment	
			Form (8)	

Project	Data Sources	No. of Respon-dents	Evaluation Tools	Status
ESSD				
	Key Informants	**1**	Key Informants Interview	Completed
Training of trainers on ESSD	Central level		- Semi-structured interview	1999 & 2000
Training of BHS on ESSD	DOH stakeholders		Form (1)	
	Trainers	**1**	- Trainer's Interview Form (3)	
Places Visited	TMO		- Instrument for Evaluating	
1. Mon State	THN		Training Materials	
• Thaton				
2. Kayin State	**Trainees**	**18**	- Trainee's Interview Form (4)	
• Pa-an	LHV			
	Midwives			
		3	- Focus group discussion (5)	
		11	- Knowledge Assessment	
			Form (6)	
BASIC TRAINING				
ANMWs	**Key Informants**	**3**	Key Informants Interview	Completed & Ongoing
AMWs	Central level		- Semi-structured interview	ANMW
	UNICEF stakeholders		Form (1)	
Places visited	DOH stakeholders			Phase II (1998)
1. Shan State				Phase III(1999-2000)
• Yatsauk	**Trainers**	**6**	- Trainer's Interview Form (3)	
2. Mon State	TMO, Staff nurse, HAs, LHVs,MWs		- Instrument for Evaluating	Completed
• Thaton			Training Materials (12)	AMW
• Bilin				1999
3. Kayin State	**Trainees**		- Trainee's Interview Form (4)	2000
• Pa-an	ANMWs	**20**		
4. Sagaing Division	AMWs	**26**		
• Monywa		**7**	- Focus group discussion (5)	
5. Yangon Division		**46**	- Knowledge Assessment	
• Kyauktan			Form (7)	
Project	**Data Sources**	**No. of Respon-dents**	**Evaluation Tools**	**Status**

TBA Training of Trainers for TBA training Training of TBAs Places Visited 1. Mon State • Thaton 2. Sagaing Division • Monywa	**Key Informants** Central level DOH stakeholders **Trainers** TMO, HAs, LHVs,MWs **Trainees** TBAs	**2** **9** **11** **1** **9**	Key Informants Interview - Semi-structured interview Form (1) - Trainer's Interview Form (3) - Instrument for Evaluating Training Materials (12) - Trainee's Interview Form (4) - Focus group discussion (5) - Knowledge Assessment Form (14)	Completed 1999
Life Skills Training Life-skills training for youth Life-skills training for women Places Visited 1. Mon State • Thaton • Bilin	**Key Informants** Central level UNICEF stakeholders NGOs (MRCS, MMCWA) Resource person **Trainers** Central Core group Township Facilitators/Communicators	**5** **12**	Key Informants Interview - Semi-structured interview Form (1) - Trainer's Interview Form (3) - Instrument for Evaluating Training Materials (12)	Ongoing MMCWA (99- 00)
Project	**Data Sources**	**No. of Respon-dents**	**Evaluation Tools**	**Status**
NID Instruction on administering Vit A Instruction on administering Polio drops	**Key Informants** Central level	**1**	Key Informants Interview	Completed

Places Visited 1. Mon State • Thaton • Bilin 2. Kayin State • Pa-an 3. Sagaing Division	UNICEF stakeholders DOH stakeholders **Trainers** TMOs, BHS **Trainees** Volunteers (members of MRCS, MCWA)	 **2** **26**	 - Knowledge Assessment Form (9)	

A6- Education Sector: Description of the training components

EDUCATION AND EARLY CHILDHOOD DEVELOPMENT PROGRAM (Summary) 1996-2000

PROJECT	SUBPROJECT	TRAINING COMPONENT
CAPS	-------	1. Primary Teachers
ACIS	-------	2. PTAs
ACIS, SHAPE	-------	3. Orientation workshops for township teams
ACIS,CAPS,SHAPE	------	4. Orientation workshops for TEOs/SEOs on implementation of UNICEF projects
CFS	SHAPE (since 1998)	5.Teacher training in 60 townships
CFS	SHAPE (since 1998)	6. PTA training in 60 townships
CFS	SHAPE (since 1998)	7. Training School principals in 60 townships
EDC	Centre-based ECD	8. Training for ECD teachers

EDUCATION & EARLY CHILDHOOD DEVELOPMENT PROGRAM (Summary) 2001-2005

PROJECT	SUBPROJECT	TRAINING COMPONENT
Child Friendly Schools (CFS)	Improving Quality	1.Primary Teachers
All Children in Schools (ACIS)	Improving Quality	2. PTAs
CFS	Improving Quality	3. Orientation workshops for township teams
		4. Orientation workshops for TEOs/SEOs on implementation of UNICEF projects
Early Childhood Development (ECD)	Centre-based ECD	5. Orientation on ECD
ECD	ECCD Network	6. Community toy making workshops
ECD	ECCD Network	7. Training of ECCD support Groups
ECD	ECCD Network	8.Orientation on ECD
ECD	ECCD Network	9. Orientation on ECD
ECD	ECCD Network	10. Training of ECD teachers

MYANMAR –UNICEF EDUCATION SECTION: TRAINING COMPONENTS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)	ON-GOING/PLANNED (2001-2005)
1. Project Title:		**Early Childhood Development**
2. Sub-project Title:		**ECCD Network**
3. Training Component:		Community Toy making Workshops
4. Training Objective:		To make parents understand importance of play in early childhood To make toys for children with locally available materials
5. Target Group:		parents from communities
6. Methodology:		Brainstorming, Discussion , Practical Work
7. Training Provider:		DEPT Core Team----> Parents
8. # Trainees Trained:		120
9. Budget		$500
10. Content	1. Importance of play (1 dog) 2. Materials Development with locally available materials 3. Practical session tomdevelop materials	

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENTS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)	ON-GOING/PLANNED (2001-2005)
1. Project Title:		**Early Childhood Development**
2. Sub-project Title:		**ECCD Network**
3. Training Component:		Training of ECCD support Groups
4. Training Objective:		To raise awareness on ECD To prepare them to be able to facilitate ECD activities and mobilize communities to participate
5. Target Group:		ECCD support Group members-mainly volunteer mothers from the communities
6. Methodology:		Lecture, Discussion, Group discussion, video-show, Brain-stroming, problem solving
7. Training Provider:		DEPT Core Team----> Township Trainers-----> Mothers
8. # Trainees Trained:		500
9. Budget		$6,000
10. Content	1. Adualt development milestones/differences 2. Nutrition/feeding/growth/monitoring 3. Role in ECD Network	

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENTS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)	ON-GOING/PLANNED (2001-2005)
1. Project Title:		**Early Childhood Development**
2. Sub-project Title:		**ECCD Network**
3. Training Component:		Orientation on ECD
4. Training Objective:		To raise awareness on ECD and prepare the principles to facilitate ECD activities in schools
5. Target Group:		School principals
6. Methodology:		Lecture, Discussion, Group discussion, brainstorming, video-show
7. Training Provider:		DEPT Project Team -----> School principles
8. # Trainees Trained:		50
9. Budget		$400

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENTS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)	ON-GOING/PLANNED (2001-2005)
1. Project Title:		**Early Childhood Development**
2. Sub-project Title:		**ECCD Network**
3. Training Component:		Orientation on ECD
4. Training Objective:		To raise awareness on ECD and prepare the principles to facilitate community mobilization for participation in ECD project activities
5. Target Group:		Member of school PTAs
6. Methodology:		Lecture, Discussion, Group discussion, brainstorming, video-show
7. Training Provider:		DEPT Core Team -----> Township Trainers----> PTA
8. # Trainees Trained:		250
9. Budget		$2,000

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENTS

TRAINING TOPIC	**COMPLETED/ON-GOING (1996-2001)**	**ON-GOING/PLANNED (2001-2005)**
1. Project Title:		**Early Childhood Development**
2. Sub-project Title:		**ECCD Network**
3. Training Component:		Training of ECD Teachers
4. Training Objective:		To provide teachers child-centred methodologies for early childhood care to improve their care practices.
5. Target Group:		Teachers from Pre-KG classes
6. Methodology:		Lecture, Discussion, Group discussion, Brainstorming, video-show, field-visits, practicum sessions
7. Training Provider:		DEPT Team
8. # Trainees Trained:		100
9. Budget		$10,000
10. Content	1. Milestones/ difference in child development 2. Importance of play in learning 3. Importance of environment in learning 4. Adult-child interaction - Coverage - Social skill 5. Establishment of learning corners based upon subject 6. Story telling 7. Basic Health Care/ Nutrition 8. First Aide Training	9. Parental communication 10. Practical work on material development (tops) 11. Observation skills 12. Day care practicum

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENTS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)	ON-GOING/PLANNED (2001-2005)
1. Project Title:	**Early Childhood Development**	**Early Childhood Development**
2. Sub-project Title:	**Centre-based ECD**	**Centre-based ECD**
3. Training Component:	Training for ECD teachers	Training
4. Training Objective:	To provide teachers child-centred methodologies for early childhood care to improve their care practices	To provide teachers child-centred methodologies for early childhood care to improve their care practices
5. Target Group:	Teachers from DCCs, Pre-school, Pre-schools, Pre-KG classes, ECD centres	Teachers from DCCs, Pre-school, Pre-schools, Pre-KG classes, ECD centres
6. Methodology:	Lecture, Discussion, Group discussion, Brainstorming, video-show, field-visits, practicum sessions	Lecture, Discussion, Group discussion, Brainstorming, video-show, field-visits, practicum sessions
7. Training Provider:	Trainers from DSW, DEPT and NGOs	Trainers from DSW, DEPT and NGOs
8. # Trainees Trained:		30 (on going) 600 (expected in 2001)
9. Budget		$6,000
10. Content	1. Milestones/ difference in child development 2. Importance of play in learning 3. Importance of environment in learning 4. Adult-child interaction - Coverage - Social skill 5. Establishment of learning corners based upon subject 6. Story telling 7. Basic Health Care/ Nutrition 8. First Aide Training	9. Parental communication 10. Practical work on material development (tops) 11. Observation skills 12. Day care practicum

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENTS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)		ON-GOING/PLANNED (2001-2005)
1. Project Title:	**Continuous Assessment and Progression system Project**		**Child Friendly School Project**
2. Sub-project Title:			**Improving the Quality of Primary Education in AFTs**
3. Training Component:	Training of primary school teachers		Training of primary school teachers
4. Training Objective:	To prepare teachers for more effective teaching learning and management of primary school classrooms.		To provide teachers child-centred methodologies for early childhood care to improve their care practices.
5. Target Group:	Primary schools teachers		Primary school teachers
6. Methodology:	Lecture, Discussion, Group works, practicum sessions		Lecture, Discussion, Group works, practicum sessions
7. Training Provider:	DEPT CORE Training Team----> Township Trainer-----> Teachers		DEPT CORE Training Team----> Township Trainer-----> Teachers
8. # Trainees Trained:			
9. Budget			
10. Content	1. EFA Rationale 2. Learning Theories 3. CAPS model	6. Specific teaching learning Activities -games -problem solving -Stones -group work 7. Development/use of materials projects 8. Assessment (Received less attention)	9. Classroom management- group work, gender balance, mixed ability 10. Discipline 11. Practical- Micro teaching, Peer teaching

	4. Process Based Learning	- series, not/short tests - Ascent to parents' complaint	12. PTA relations
	5. Participatory/cooperative learning/ experimental learning	-- Emphasis on formal testion -- but afte-watch exercises -- Monitor progress/remedial -- Teachers have problem solving	

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENTS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)	ON-GOING/PLANNED (2001-2005)
1. Project Title:	**All Children in School**	**Child Friendly School Project**
2. Sub-project Title:		**Improving the Quality of Primary Education in AFTs**
3. Training Component:	Training of PTA members	Training of PTA members
4. Training Objective:	To provide knowledge and skills on community mobilization for better participation and monitoring progress of schools in ACIS project	To provide knowledge and skills on community mobilization for better participation and monitoring progress of schools in ACIS project
5. Target Group:	Parents from school PTAs	Parents from school PTAs
6. Methodology:	Lecture, Discussion, Group discussion, Brainstorming, Role play, Problem solving	Lecture, Discussion, Group discussion, Brainstorming, Role play, Problem solving
7. Training Provider:	DEPT CORE Training Team----> Township Trainer----> Cluster heads --------> PTA	DEPT CORE Training Team----> Township Trainer----> Cluster heads --------> PTA
8. # Trainees Trained:		
9. Budget		
10. Content	1. CFS School Healthy Schools (SHAPE PTA) 2. Community mobilization	4. Child Development stages 5. Enabling learning Environment

	3. Role of PTA	

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENTS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)		ON-GOING/PLANNED (2001-2005)
1. Project Title:	**All Children in School CAPS, SHAPE**		**Child friendly schools**
2. Sub-project Title:			**Improving the Quality of Primary Education in AFTs**
3. Training Component:	Orientation workshops for township project teams		Orientation workshops for township project teams
4. Training Objective:	To prepare townships team to facilitate the implementation of respective project in the townships.		To prepare townships team to faccilitate the implementation of respective project in the townships.
5. Target Group:	ATEOs, project staff (seconded teachers), cluster heads		ATEOs, project staff (seconded teachers), cluster heads
6. Methodology:	Lecture, Discussion, Group discussion, Brainstorming, Problem solving		Lecture, Discussion, Group discussion, Brainstorming, Problem solving
7. Training Provider:	DEPT CORE Training Team-- --> Township Teams		DEPT CORE Training Team----> Township Teams
8. # Trainees Trained:	400		63
9. Budget			
10. Content	1. EFA Rationale 2. Learning Theories 3. CAPS model	6. Specific teaching learning Activities -games -problem solving -Stones -group work 7. Development/use of materials projects 8. Assessment (Received less attention)	9. Classroom management- group work, gender balance, mixed ability 10. Discipline 11. Practical- Micro teaching, Peer teaching

	4. Process Based Learning 5. Participatory/cooperative learning/ experimental learning	- series, not/short tests - Ascent to parents' complaint -- Emphasis on formal testion -- but after-watch exercises -- Monitor progress/remedial -- Teachers have problem solving	12. PTA relations

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENTS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)	ON-GOING/PLANNED (2001-2005)
1. Project Title:	**All Children in School CAPS, SHAPE**	**Child friendly schools**
2. Sub-project Title:		**Improving the Quality of Primary Education in AFTs**
3. Training Component:	Orientation workshops for TEOs and senior education officials on implementation of UNICEF assisted projects	Orientation workshops for TEOs and senior education officials on implementation of UNICEF assisted projects
4. Training Objective:	To increase understanding about UNICEF assisted education projects and identify their roles in monitoring and supervison of project implementations	To increase understanding about UNICEF assisted education projects and identify their roles in monitoring and supervison of project implementations
5. Target Group:	Assistant State / Division Education Officers, TEOs and mid level managers from DEPT and DBE1, 2, 3	Assistant State / Division Education Officers, TEOs and mid level managers from DEPT and DBE1, 2, 3
6. Methodology:	Lecture, Discussion, Group discussion	Lecture, Discussion, Group discussion
7. Training Provider:	UNICEF and DEPT CORE Training Team----> Township Teams	UNICEF and DEPT CORE Training Team----> Township Teams
8. # Trainees Trained:		
9. Budget		

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENTS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)	ON-GOING/PLANNED (2001-2005)
1. Project Title:	**Child Friendly Schools**	
2. Sub-project Title:	**SHAPE(since 1998)**	
3. Training Component:	Teacher Training (30/20/10) in 60 townships	
4. Training Objective:	Increase knowledge and skills of teachers on health promoting behaviour, life skills and HIV/AIDS information and participation teaching and learning methods.	
5. Target Group:	70% primary, middle and high school teachers in each township.	
6. Methodology:	Activity based participatory teaching and learning methods. (cascade model)6 days central, 4days township) Lectures, group discussion, role play, brainstorming, problem solving, practicum section	
7. Training Provider:	DEPT for township trainers, teachers and school heads for teachers training. DEPT Core team-----> Township team-----> Teachers	
8. # Trainees Trained:	45,101 (teachers) 1,995 (township trainers)	
9. Budget	4.5 US$ per	
10. Content	Training Curriculum (TOT, 6 Days, Training= 4 days) 1. Definitions, objectives, strategies 2. Effect of changing 3. Health Promoting School (Hygine, nutrition, healthy living, food vendors)	4. HIV/AIDS 5. Delivering methods: role playing, simulation, group discussion 6. Curriculum Practica: Healthy living, discussion, life skills, material health 7. Role of facilitator MATERIALS: Training manual, teacher guides, hand-out of topics

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENETS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)	ON-GOING/PLANNED (2001-2005)
1. Project Title:	**Child Friendly School**	
2. Sub-project Title:	**SHAPE (since 1998)**	
3. Training Component:	Training of PTA members 60 townships	
4. Training Objective:	Increase participation of parents as members of PTAs in supporting SHAPE implementation	
5. Target Group:	5 PTA from each school (parents)	
6. Methodology:	Cascade model (5, 3, 2 days) Brainstorming, group discussion , activity based lectures, problem solving	
7. Training Provider:	DEPT for township trainers, teachers and school heads for teachers training. DEPT Core team-----> Township team----> Teachers	
8. # Trainees Trained:	18,546 (PTA), 1,346 (TOT) 24,570(PTA), 1,487(TOT)	
9. Budget	3.4 US$ (per)	
10. Content	Training Cascade (5-3-2 days) 1. SHAPE/HIV/AIDS 2. Safe and Healthy Environment 3. CFS Concept 4. Health promoting school 5. Improving children's participation	6. How parents can help children hearing 7. How community help children to have healthy habit education 8. Health Education 9. Social mobilization and community participation 10. Role of PTA- Adult, Facilitator MATERIALS: PTA capacity Building ( ) PTA information Booklet

MYANMAR -UNICEF EDUCATION SECTION: TRAINING COMPONENETS

TRAINING TOPIC	COMPLETED/ON-GOING (1996-2001)	ON-GOING/PLANNED (2001-2005)
1. Project Title:	**Child Friendly School**	
2. Sub-project Title:	**SHAPE (since 1998)**	
3. Training Component:	Training School Principals in 60 townships	
4. Training Objective:	To improve school based management on implementation of SHAPE	
5. Target Group:	School principals (primary, middle, high, ATEOs)	
6. Methodology:		
7. Training Provider:	DEPT core team	
8. # Trainees Trained:	8,821(Principals), 451 (TOT)	
9. Budget	3.25 US$ (per)	
10. Content	1. Curriculum objectives, strategic, HIV.AIDS 2. SHAPE Curriculum 3. Life skills 4. Participatory learning - How child learn; principles' process skills 5. Child Friendly Environment 6. Health Promoting School	7. SHAPE for Action - How teachers help children 8. Community participation 9. School-Based Managed (model) 10. Monitoring and evaluation MATERIALS: Trainees/ principles manual/ Handouts

TRAINING OBJECTIVES SHAPE TEACHERS	
1	To promote understanding of rational, objectives, strategies and components of SHAPE curriculum
2	To increase knowledge and skills on child-centred participatory teaching learning methodologies in order for them to improve teaching learning process in conducting SHAPE lesson in classrooms.
3	To find ways to support clusters in developing healthy habits and safe behavior.
4	To facilitate change process in schools to become health promoting schools
CFS TEACHERS	
1	To identify the characteristic of CFS strategies to promote CFS concepts and undertake teachers role and responsibility for CFS movements.
2	To apply child centred participatory teaching methodologies activities and materials for effective teaching and learning
3	To participate in management of classrooms and school to create effective enabling learning environment.
4	To monitor students learning achievement through systematic use of continuous assessment and organize remedial instructions and learning activities for children with learning difficulties.
REVIEW SHAPE WITH TEACHERS	
1	To findout teachers perception and understanding about SHAPE curriculum
2	To identify constraints and needs regarding teaching learning process in implementation of SHAPE curriculum and recommend strategies to solve those problems and need.
3	Recommend strategies, activities and follow-up action to promote healthy habits among students after receiving lessons on SHAPE.
SHAPE PRINCIPALS	
1	To promote understanding among school principals on life skills education SHAPE implementations

2	To increase school principals knowledge on child-centred activity based participatory learning and facilitate creating child friendly learning environment.
3	To increase their knowledge and skills in management of school to become health promoting schools.
SHAPE PTA	
1	To mobilize communities and parent on SHAPE implementation with understanding of why the SHAPE curriculum is integrated.
2	To assist and participate in promoting healthy habits of children, parents and community
3	To identify community mobilization strategies
4	To participate in SHAPE-in-action in the community
5	To mobilize resources necessary for implement of school activities.
ACIS PTA	
1	To promote understanding on the objectives and the activities of primary education projects.
2	To provide necessary, knowledge and skills for community mobilization
3	To increase communication skills to motivate parents to send school-age children to school
4	To participate more in school activities.
5	To promote understanding about objective, responsibilities and activities of parent teachers association
CFS PTA	
1	To promote understanding characteristic of CFS and health promoting school.

A7- Education Sector: Evaluation Methodology

At the outset of this evaluation the external facilitator, UNICEF Education officers, and DEPT has worked in a collaborative and participatory approach. This has put all team members on a parity basis though with each playing different roles. This meant that when decisions had to be made about emphasizing results and relevance of training rather than the process of training; or deciding what assistance was needed to collect data; or which townships to visit for school observations, a discussion and consensus had to be reached to move on. This was done readily and openly so that a consensus was reached. This continued the movement of Myanmar ownership of the evaluations rather than something thrust upon them by an outsider and hopefully will lead to the ultimate objective of utilization. That is, the evaluation will result in lessons learned and recommendations which UNICEF officers and DEPT decision-makers will want to plan, implement and support because these lessons and recommendations are based upon their findings, discussions, review and evaluation effort. This has been an overriding theme in this evaluation methodology.

1 Central Hypothesis

Since Colonial times foreign observers have noted that in government, mission and monastic schools students learn by chanting in unison responses from the teacher. This style of learning persists today with the teacher lecturing or questioning students most of the time and with students responding in chorus to demonstrate their learning. The designers of the past and current UNICEF teacher training projects decided to break this teacher-center cycle –- as student Myanmar pupil chants choral responses; later as teacher same pupil leads choral responses with instructional cues – with the "participatory teaching-learning".

All teachers have essentially three aspects to their role: instruction; classroom management; and evaluation. Under the traditional teacher-centered style, the teacher dominates the instruction being the source of knowledge and skill acquisition and controlled student responses. Management is relatively easy as all students sit in rows facing the teacher who usually remains in the front to instruct, correct papers and direct or discipline students who remain in their seats. Monitoring and evaluation is mainly done through verbal assents or corrections to student responses, workbook correction, and the all-important written test. Under the participatory child-centered style, the onus and initiative of teaching-learning was shifted from teacher to student. Students are encourage to learn in various ways depending upon their abilities, speed, inclinations and styles. The teacher still controls the learning but by facilitating it and setting conditions for different or for individual and group learning. Management is much more difficult because the students are arranged in groups to compete with one another and to learn from one another, and so the teacher has to move around from group to group to assist a group or an individual or monitor their performance. Monitoring and evaluation also are more difficult as they become continuous and positive as well as corrective and appropriate to each child who learns differently. There is less reliance on formal testing and more on verbal interchange, observation and tutoring from other students. The teacher becomes less dependent upon testing and more alert to behavioral or attitudinal changes among students so as to adjust her strategies accordingly.

This is summarized in the following table:

ELEMENT	TRADITIONAL	CHILD-CENTERED
Classroom	• Rows of desks/chairs all facing the front • Teacher's desk facing students	• Desks/chairs arranged in groups to facilitate group work
Teacher	• Mainly **instructor/evaluator** as sole source of knowledge • Stands in front • Predominantly, instruction by "chalk and talk" method step-by-step of words or sentences for language or math operations • Alternatively, sits at desk, grading exercises, calling up individual students to point out corrections but mostly to return corrected exercises	• Mainly **facilitator** to manage different learning modes adapted to group and individual differences, but still controls content and activities • Moves about classroom to work with groups or individuals • Direct instruction mixed with facilitating or managing group or individual learning • Use proven methods, but experiment with new activities or revising less effective ones • Challenge or encourage students to come up with different answers, particularly when there is "no right answer".
Students	• Rote learning • Choral responses to teachers word or sentence statements • Individual responses only when called upon by teacher. After individual responds, whole class may repeat same response in unison • Noise level of responses from neighboring classes may hinder students hearing of teacher • Alternatively, students sit at desk, copy words or phrases, do math problems, fill in blanks for exercise • If not enough teachers, students wait for teacher to come, read passages aloud, do exercises or just sit quietly or talking and playing	• Critical thinking • Work in groups for specific assignment. May work individually • Present results of group work to whole class, engage in discussion, encouraged by teacher as to whether their answers made sense or not • Key is frequency of student initiated responses with emphasis on searching in different ways variety of possible answers • Students and teacher together contribute to creation of knowledge
Materials	• Blackboard & chalk. • Student texts & workbooks • Teacher's syllabus guide	• Same three, but many more & varied that permeate classroom • Current/relevant to content and learning methodology • Many created by students
Assessment	• Instructional assent or correction (sometimes deprecating) • Correct of work exercises • Formal tests	• Same, but also teachers assess individual differences and learning • Sensitive to differences in student behavior and learning • Encouraging not judgmental

Thus, the basic hypothesis of this evaluation is that as a result of Child-Centered teacher training, teachers and students become more participatory in their classroom behavior and strategies for teaching-learning. Teachers demonstrate palpable instructional, management and monitoring methods to move from the traditional teacher-centered approach to the child-centered

N=13	Sampling	
• Classroom interaction N=142	Observation	To identify predominant teaching-learning patterns
• Groups of Students N=588	Focused group interview	To confirm if patterns are regular or occasional
• Teachers observed N=127	Interview	To identify if observed patterns are regular strategies; and to determine if training contributed to them
• Head Teachers N=25	Interview	To identify if they understand support strategies for sustaining child-centered learning; and whether they work with PTA to support school development and student participation
• PTA groups & community members N=173	Focused Group Interview	To confirm what teachers say about support strategies and school development; to determine if they know their roles. Try to include other community members
• Assistant Township Education Officer (ATEO) N=21	Interview	To detail his knowledge of support strategies (cluster system); to determine extent to which he actually implements these; to match responses with Head teachers and PTA members.

3- Sampling

Selection of schools to visit for observation and interview is not based upon probability sampling. It is based upon purposive sampling or the selection of schools that are likely to be representative within the criteria below, but can still provide differences based upon UNICEF and DEPT officers' knowledge of the Teacher Training projects (See Section 3). The sampling unit for selecting schools is the township where there are a few or many schools depending upon the population concentration. Key criteria for selection is:

- Townships where schools have a concentration of teachers who have been trained under these projects
- Townships where there are a mix of urban-rural and cluster core-satellite schools
- Geographic and ethnically diverse townships.

The approximate numbers of teachers, students, etc. selected for observation and interview are listed above. The names of the townships and schools and related information are in Annex 2.

4- Data Gathering Tools

Within the period of field preparation data gathering tools were developed. The interviews were focused but unstructured protocols organized in a funnel approach. They follow the same procedures and incorporate many of the items used in the Basic Education program mid term evaluation of 1998. Each one was tailored to the perspectives, needs or problems of the above groups to promote child-centered learning in the classroom and to support it with parental actions from the community; and to support it with Head teacher and ATEO actions from the Township. The most difficult tool was the

5- Data Gathering

DEPT released eight education officers working in the planning unit to serve as data gatherers. They were divided into two teams of four each. There were two initial orientations where they were briefed on the project and the evaluation. Then, the tools were reviewed item by item to ensure that they understood what they would be using. Finally, team members broke into pairs to role play as interviewer and informant so as to try out the protocol. The biggest difficulty lay with the observation lay with the observation protocol and could not be tried until arrival in the field. First attempts were not very good as the external facilitator visited them. After the first visit the observers themselves arrived at the idea of identifying tasks or patterns within small time chunks. Classroom observations improved after that. A senior retired Teachers College principal but working on contract for DEPT was also released to monitor data gathering activities within each team and to coordinate activities between the two teams.

6- Translation

Most educated Myanmarese speak some English, but few a proficient to take notes in Myanmar and translate them during or after the interview/observation into English. Hence, DEPT released another planning officer who had just return from India and was fluent both in spoken and written English. After categorizing the completed formats by township and school, she developed her own recording forms and began labor-intensive of translating each set by school. Translation was slow in the beginning, but as she became more familiar with the forms and expected responses, her speed accelerated. Later she was able to collapse some into agreed upon categories and this shortcut sped the whole process. Unfortunately without this translation the external facilitator would have been at a total loss to make any sense of what was going in the classroom or in the minds of the informants – most of whom spoke no English at all.

7- Analysis

Analysis began by breaking key units of observations and interviews up and to begin comparisons in classroom interaction, Head teacher- PTA understandings and interaction regarding raising school enrolments or contributing to school maintenance or renovation, or ATEO support to Head teachers, especially regarding procedures among cluster schools. Because the field notes and their translations were relatively simple, clear and in some cases quite rich, a collapsed category approach was used. This enabled the analysis to identify sharper patterns and variations regarding the central hypothesis as well as support measures. UNICEF officers took part in the exercise, and so they were able to provide insight into the motives, constraints and problems of the actors that were hidden from a face value reading of the information.

8- Quantitative Data

Ideally, one would have wanted to compare schools with trained teachers with a comparative of those without trained teachers according to the established indicators of access, internal efficiency, and quality. It will be some time before Myanmar will be able to do this. Nevertheless, based upon a midterm evaluation of internal efficiency using cohort analysis, the retention data of that study was expanded to include the same schools for the next three years – 1998 – 2001. There were some statistically significant differences between the trained teachers and the untrained teachers which suggested that training contributed -- along with other changes related to training, such as better