

2013

Evaluation report Community Based Health Development Project Magway, Myanmar

Covering period Yrs 2007–2012

The document analyses and comments on project achievements and provides recommendations for future programming in either the same or similar contexts. This document provides information that can also be used as part of organisational learning.



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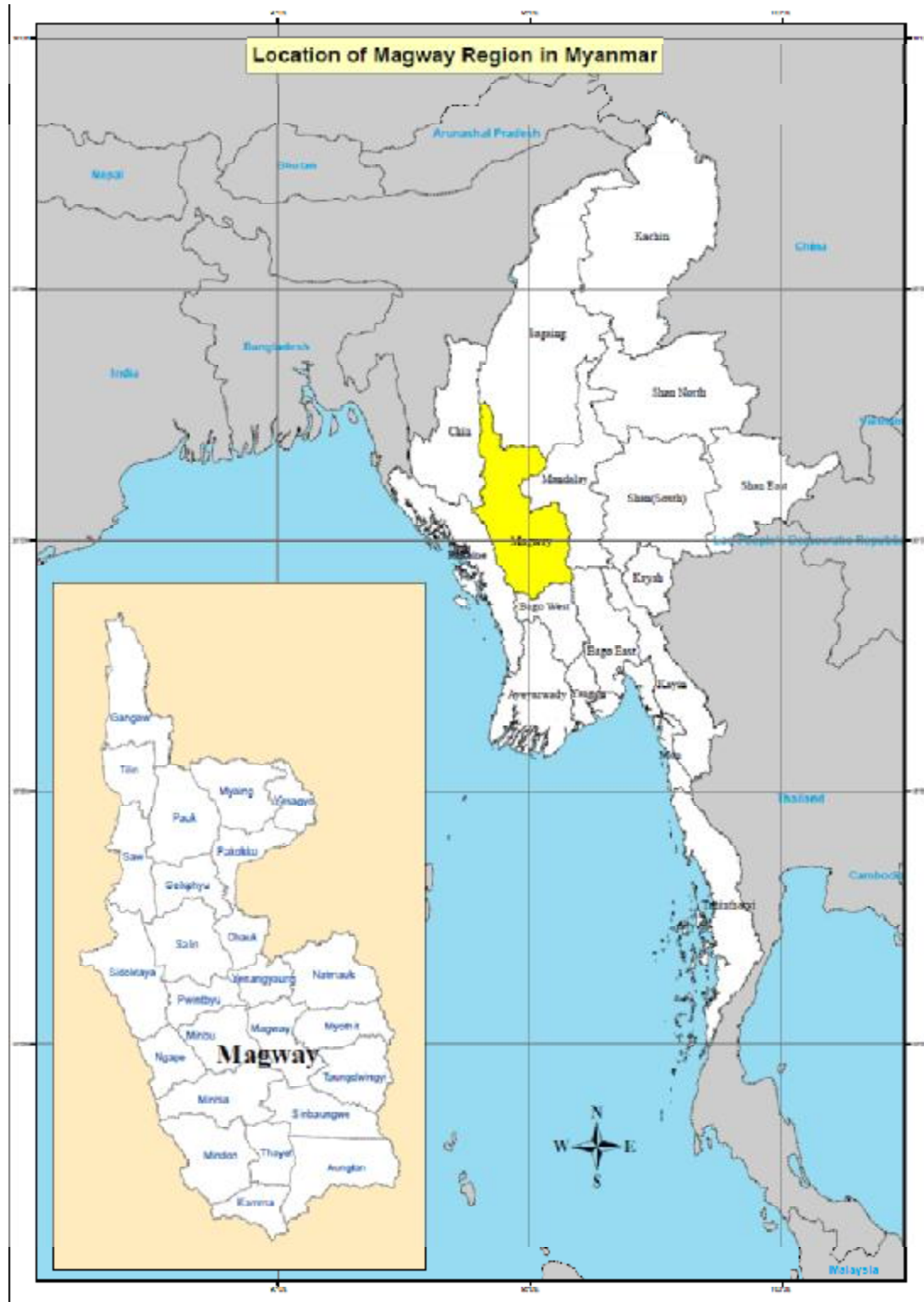
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Disclaimer: The views expressed in this report are those of the evaluator. They do not represent those of any of the institutions and people referred to in the report.

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Maps

Location of Magway region in Myanmar



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Executive Summary

The Task

This report is the evaluation of the project “Community based health development in Myanmar” implemented in 20 villages each of Natmawk and Pwintphyu townships during the period 2007 to 2012 by the Myanmar Red Cross Society (MRCS) with multilateral support (I.e. through IFRC) from the Finnish Red Cross (FRCS). The purpose of the final evaluation is to analyze and comment on project achievement based on the delivery of project outcomes, review the process of implementation, identify significant factors facilitating or impeding implementation and recommendations for similar programmes. The evaluation also assesses the alignment with and appropriateness of, IFRC policies and guidelines and determines extent of coordination, collaboration and partnerships with other partners. The 8 key standards and criteria laid down under IFRC framework for evaluation have been followed and maintained¹. Please refer to Annex for a full copy of the TOR with criteria for this evaluation.

Project Data

The project budget was CHF 5,42,511. It initially started as a pilot with support from Australian Red Cross in Keng Tung and later expanded to Magway Division in 2007, given the vulnerability and need of other communities pertaining to lack of health services and health information. The programme aimed on strengthening the capacity of local communities through behavior change for preventing prevalent health problems, to provide relevant supportive services responsive to community needs and in developing the capacity of Red Cross branches to respond to locally identified health needs.

Overview of the report

The chapter on introduction explains the reason evaluation was done, the country and local context within which the CBHDP programme was planned and implemented. The chapter details on the scope of work, methods used and recognises the limitations. In subsequent headings various nuances are discussed under relevance, effectiveness, impact, efficiency,

¹ IFRC framework for evaluation (www.ifrc.com/mande)

gender and sustainability. The key findings are based on review of provided documents, field visits and interviews. The work has also touched on soft issues of human commitment, passion and social values. Under Conclusions a summary on the programme's high relevance and effectiveness is provided with some key areas that are discussed again. Every section in the document discusses issues and provides some suggestions to improve on areas that can enhance service delivery by improving quality and contribute in creating a larger impact.

Key recommendations

Programmes rolled out with a premeditated package based on evidence of needs from secondary information and some research should later morph to include more community involvement and before they phase out transit into complete community based projects that are capacitated for sustainability.

Initiatives such as establishing village health committees or forming community based organisations (CBOs) require training and mentoring on administrative aspects and accounts management which should be reflected as an important outcome of the programme and planning.

Moving from coordination to collaboration with as many actors in the area should be explored. Essentially a formal method of engagement with structures in MOH and other actors working in health and WASH is critical for sustaining the achievements and developing further. This can help procurement of support in form of hard ware and materials from various other humanitarian organisations for increasing efficiency and achieving sustainability.

Linking up with the wider public health system should be an essential part to obtain information on how the programme is contributing to the wider health and social development.

Programmes should have a formal community feedback mechanism that can help study and plan subsequent course of working. For which the underpinning requisite is 'participation'

and not 'consultation'. This could include mechanism such as including community representatives in all committees, at meetings of all levels and setting up a confidential complaint/ feedback mechanism at the village level.

Developing a decentralized operational strategy should be encouraged by the donors to reduce time delays on planning, implementation and distribution at field level. 'The money should follow the client'.

The distribution of materials in the programme should be based on house hold (HH) requirements and not a blanket cover. The idea has to base on 'different need for different people' instead of same for all.

Project locations/ villages that were covered in the last phase had a short implementation period and hence some needs unaddressed. If possible with support in future, this project maybe reinitiated through the CBHFA approach in those areas. This will help properly embed the concept of self-reliance in these communities which is not yet achieved and the gains made so far can easily be lost.

The NS must consider developing one harmonized approach to community health programming irrespective of geographical area. CBHFA being more inclusive and a bottom up approach should be the way forward in community based health programmes.

It may be noted that inter unit/ department integration is important and experts form WASH, OD and DRR could be included as technical advisors and should be requested for support. Strengthening of village level Committees with adequate training should begin early within the programme. This could be achieved through an integrated plan with Organisational Development (OD) unit in Red Cross. They should be continually supported by technical skills in account management and in administration.

At the branch level there can be some income generation methods introduced for strengthening the office and increasing sustainability. This should begin early and can be done by introducing methods such as transport carriers, photocopiers and telephone/

internet booths etc. The income can contribute towards maintaining a core position and sustaining some key activities after phase out.

The PMER is a critical component of any implementation and must be strong and consistent right from beginning. Monitoring of the quality of program needs to be included into the health advisor's and delegates in IFRC and the NHQs program staffs' Job Descriptions too. For the field RCVs it is important to have formats that are not lengthy and easy to use.

A monitoring system must be included in future projects to follow-up on progress at biannual or yearly intervals. This would help the project staff have a clearer picture, make immediate contextual changes in the project and at the same time record benefits and negative implications.

Ensure that Key Performance and quality indicators are agreed and the staff is well capacitated to follow and report on them.

Training curriculums and plans should be reviewed once annually so that they adhere to needs, are responsive and follow the ideology of community based programmes. Special emphasis should be in building capacity of village health units and volunteers on community mobilization, participatory need assessment, community dialogue, BCC etc. Quality control mechanisms such as different types of tests and training feedback should be included into the trainings and should be a part of the monitoring systems.

WASH is the most popular activity and most effective when combined with health sessions.

A more systematic finance management at NHQ and townships with detailed formats and accompanied with a training would contribute towards better organization of work and increase financial accountability.

Gender and Diversity mainstreaming must be addressed at all levels in the programme within the framework of organisational development for any project that is rolled out. Donors must include this as a prerequisite for fund availability and implementation. It is important in any community based programme to identify issues specific to groups of men

and women of different age and social backgrounds during community assessments and action plans which must be taken into account to improve effectiveness.

Introduction

Purpose of final external evaluation

The purpose of this External Evaluation is to document the progress Community Based Health Development Programme has made in implementing its health program, identify areas of improvement and provide recommendation on possible modifications. This is done through assessment of the relevance, efficiency, effectiveness, impact and sustainability of the program. The Evaluation also assesses the alignment with, and appropriateness of, policies and guidelines on the health program and determines the extent and depth of coordination and collaboration for partnerships. The findings from this Evaluation are also intended to inform future planning in same or similar programmes.

Context of Health Programme

The population of Myanmar in 2011-2012 is estimated at 60.38 million² with the growth rate of 0.8% to 2% according to different resources. About 70 percent of the population resides in the rural areas. Tuberculosis (TB) is a major health problem in Myanmar. Although it is now within the Global targets, however notification levels are low and inconsistent. The prevalence of HIV among new TB patients was 9.7% according to the sentinel surveillance done at 25 sites in 2012. Prevalence of multi-drug resistant TB (MDR-TB) is estimated at 4.2% among new TB patients and 10% among those that were previously treated³. National Tuberculosis Programme (NTP) is currently running almost in all townships of 14 Regional & State TB centres with 101 TB teams at district and township levels. Malaria is still a leading cause of mortality and morbidity in Myanmar. It's a public health concern that has multiple determinants for its re-emergence such as; climatic and ecological changes, population migration, development of multi-drug resistant *P. Falciparum* parasite, development of insecticide resistant vectors and changes in behaviour of malaria vectors. Approximately 76 per cent of the population in Myanmar lives in high-risk malaria areas and national statistics indicate over 200,000 laboratory-confirmed cases every year. Myanmar is striving towards achieving objectives halving the cases by 2016 (compared to those in 2009) through its

² CIA world fact book

³ second nationwide drug-resistant survey completed in 2008

National Malaria Control Program and contribute to achievement of health related MDG in 2015. The prevalence of HIV was reported at about 0.61 per cent (387,800) of the adult population aged 15-49 years⁴. Four percent of those in need received antiretroviral treatment from figures at the end of 2009. The National Strategic Plan (2011-2015) has a vision of achieving the HIV related MDG targets by 2015. Its main aims are to cut new infections by half of the estimated level of 2010 with a special focus in reducing transmissions and social impact⁵.

Inadequate funding for health is one main underlying challenge in Myanmar. Government spends less than 2% of GDP on health which is one of the lowest rates in the world. This works out as around US\$2 per person⁶. This low level of investment means that there is not enough money to train and hire enough skilled health workers. It also means that 81% of all spending on health in Myanmar comes straight out of people's pockets⁷. A mixture of official charges, unauthorized fees and the opportunity costs of seeking health care discourage people from using health services that push them further into poverty.

Natmauk and Pwintphyu are located in Magway division and hence the programme is quiet often referred as the Magway CBHDP programme. Magway as a division is set in the middle of Myanmar with a very dry weather and scarce rainfall. Since scarcity of water has been always an issue, latrine utilization is low in villages and sanitary latrines were uncommon. Since the people have less chance of acquiring safe water supply, both quantity and quality of water have been a problem, burden of communicable diseases specifically water related such as diarrhoea, trachoma and skin diseases were identified as prevailing primary health issues. Other common health problems identified are Snake bite, TB and malaria in the division. Existing health facilities have been insufficient compared to the needs of the population. Natamuak and Pwint Phyu each have 25 bedded township hospital, one station hospital each, a MNCH centre each, 6 and 5 rural health centres and 31 and 27 rural health sub centres respectively⁸.

⁴ Unaids.org

⁵ Health in Myanmar 2013

⁶ www.who.int

⁷ Data.worldbank.org

⁸ Base line and end line survey reports MRCS/IFRC/Fin RC

At the time of inception of the CBHDP programme there were no international NGOs, local civil society organisations or other UN agencies working in health issue within Natmauk and Pwint Phyu. Therefore MRCS and IFRC with support of Partner National Society (Finnish Red Cross) set up to implement a Community Health Based Health development Project. The purpose of which was improving capacity of vulnerable communities on prevention of communicable health issues and to mitigate health impact of common health issues. The initiative was rolled out after getting approval from Ministry of Health (MOH) and Department of Health (DOH) in Myanmar. Below is a short description of the townships.

Natmauk Township is bounded in the south by Myothit Township, in the north by Kyaukpandaung Township, in the east by Yemethin Township, Meiktila Township and Pyawbwe Township and the west by Magway Township and Yenanchaung Township. Total population residing in Natmauk Township is 226,018. Population density is 254 per square mile. It has 7 ward and 73 village tracts comprising 234 villages⁹. Pwint Phyu Township is bounded in the south by Salin Township, in the north by Minbu Township and in the west by Sidoktaya Township. Total population is 207,054. Population density is 440 per square mile. It has 4 wards 56 village tracts comprising (202) villages¹⁰.

The townships represent an area with high health problems. Under five mortality rate for Natmauk and Pwint Phyu are at 39.6 and 16.8 respectively. The local health systems are highly understaffed and under sourced with 1 station hospital each and 6 and 5 rural health centers that cover 230 and 204 villages in Natmauk and Pwin Phyu. The population is scattered with a population density of about 100 per square kilometer. The largest proportion of population is of a young age group. Although primary school enrolment is good, however, enrolment in higher education is very low¹¹. 85 to 90 percent of people dwell in villages and depend on climate for agriculture.

The community leadership structure is male dominated. Men direct both in sphere of the conventional leadership and represent as elected village leaders. At the village level and in

⁹ Township Profile and end line survey reports MRCS

¹⁰ Township Profile and end line survey reports MRCS

¹¹ MIMU Dev Info Data base as of September 2012Health

the townships it is the men who control decision-making related with resource allocation and infrastructure development. However, women representation at every level of society is present and regarded. Village meetings are attended by either man or woman from families depending on availability. Women often speak at the meetings however a lot is influenced by the elderly or the male members. Women can have higher incidences of low education compared with their male counterparts. Malnutrition and lack of access to work sometimes make women more vulnerable. The two townships and its villages have a large young population of which many travel outside the state/ region to other cities and abroad for work and visiting homes to help family with the harvest. Many young people are not well equipped with the knowledge and life skills to manage the risk of HIV.

Of the 40 villages where the CBHDP was implemented, 7 Villages were selected for the evaluation. The selection was on accessibility, their phase of implementation between 2007 and 2012 and based on village committee preparedness.

Rationale for the CBHDP in Magway

Red Cross Federation had handy, evidenced based and refined approach for conducting health promotion activities through Community Based Health Development approach (CBHDP) which later formed base of the well known and regarded Community Based Health and First Aid approach (CBHFA) introduced in 2011. The approach was developed and implemented within the Red Cross Red Crescent movement to empower communities take control of their health issues and apply evidence based good practices along with behavior change to prevent health issue. The CBHDP approach was based on using simple tools adapted to local context to address priority needs. The CBHDP as is CBHFA is an approach that seeks to create healthy, resilient communities worldwide thus playing a vital part in the International Federation of Red Cross and Red Crescent Societies' (IFRC) Strategy, Strategic Operational Framework (SOF) for Health 2015 and contributes to Millennium Development Goals 4, 5, 6 and 7.

The pilot project model of Community Based Health Development, based on the concept of Primary Health Care, was implemented in Keng Tung with the support of Australian Red

Cross since February 2003. After it was found to be relevant and appropriate it was expanded to Magway Division, which is situated in the middle part (Dry zone) of Myanmar with hot and dry weather, and with scarcity of rain. Based on the situation analysis findings, MRCS Executive Committee selected Pwintphyu and Natmauk Townships in consultation with Magway Division Red Cross Supervisory Committee and after approval was given by Ministry of Health (MoH). A total of 20 villages in Natmauk and 20 villages in Pwintphyu were covered by the project through its six-years of implementation (2007-2012).

The Baseline survey (2006) was carried out for phase one villages in December 2006. In phase one, CBHDP project was being implemented in one ward (Myoma) and 4 villages in Natmauk and 5 villages in Pwintphyu during first year. Villages were selected based on community vulnerability due to lack of existing local health services, poor access to health services and poor health knowledge. After an year, in phase 2, the implementation was expanded to another 10 villages i.e. 5 villages from Natmauk and 5 villages from Pwintphyu. The Midterm evaluation (MTE) was carried out on the phase one project areas in October and November 2008. The Baseline survey (2008) for phase two villages was also carried out in December 2008. A village called Wetchoke, in the Natmauk cohort, was inactive in implementing the project activities and was excluded from the project villages by Natmauk Township CBHDP Supervisory Committee. Phase three was implemented during 2010 expanding to another ten villages, 5 villages from Natmauk and 5 villages from Pwintphyu. An Impact survey (2010) was conducted in all villages of phase one to three in October 2010. Phase four was implemented during 2011 expanding to another ten villages, 5 villages from Natmauk and 5 villages from Pwintphyu. Phase one villages were phased out in August 2011. At the end of 2012, there were 30 villages in the Magway Community Based Health Development Project — 15 villages each in Natmauk and Pwintphyu Townships. The End line survey (2012) was conducted in all villages of phase one to four in November and December 2012. During the six years period of January 2007 to December 2012, a total of 46,698 people from 10,065 households of 40 villages/ward villages, located in two townships in Magway region have benefited from a range of project activities. Table below provides an overview of the villages where CBHDP was implemented.

Sr. No	Started Year	Villages in Natmauk	Villages in Pwint Phyu
1	2007	Myoma	Yeabokeyi
2		Na-Thahmonegone	Chaungsone (n)
3		Taungoo	Oakpho
4		La-Tagundaing	Thanawa
5		Wetchoke	Pyilonekyaw
6	2008	Zaythar	Setaw
7		Pa-Kyarhtoo	Lema
8		Thetyintaw	Nabelkone
9		Ywarthit	Kanpyae
10		Kyaukdaga	Ashaylayaein
11	2010	Tharsi	Yeaphyutwin
12		Sankan	Zeegyun
13		Bawaing	Innkone
14		Gwaykone	Chaungsone (s)
15		Shawchounglay	Anoutlayaein
16	2011	Yaengan	Zaungchankone
17		Pa-Phonkone	Ywartharkyi
18		Pakechintaw	Zeekine
19		Nabutaung	Anoutkaine
20		Kampyo	Makyirone

Daily programme management was done by the project team, a project officer based in NHQ, 2 field supervisors in each township and 2 assistant field supervisors in each townships based at the township offices. The regional Red Cross (RC) branch office at Magway and the MRCS Health Department at Naphy tawa were responsible for overall management and as link with IFRC and Finish Red Cross (FRC). The FRC has provided technical support and funds through IFRC and MRCS.

Scope, Methods Used & Constraints

Scope and Method Used

Final evaluation of CBHPD supported by Finnish Red Cross in Magway, Myanmar was conducted from 3 July to 18 July 2013. A representative 17.5% of the villages was included for final evaluation. Different methods such as interviews, focus group discussions and post-program knowledge questionnaire were used. The evaluation team comprised of 2 members from IFRC. 1 evaluator from IFRC South Asia Regional Delegation and health officer for translation and support from IFRC CD Myanmar. They were accompanied with 2 MRCS representatives from national HQs and Magway division, and project staff from respective townships. The teams conducted the evaluation at 7 villages, 2 township offices (Natmauk and Pwintphyu) in Magway division (Please refer to annex for evaluation schedule). With support from the local staff and good management of the schedule, the evaluation in all sites was completed on time.

The Finnish Red Cross (FRC) has been supporting the CBHDP programme in Magway since year 2007. As a follow up after the end line review done in December 2012, the FRC proposed an evaluation in July 2013. The evaluation took place from 3 to 18 July 2011 in field. The terms of reference laid down the purpose/ objectives of the evaluation as below (Complete Terms of Reference of the evaluation can be found in Annex).

- § Review the effectiveness, efficiency and relevance of the project by reviewing the outputs achieved in relation to inputs provided, and the outcomes achieved as a result of project outputs delivered to date.
- § Review how the community-based approach has been implemented in the project communities?
- § Provide recommendations for further improvement in the design, delivery, quality and resourcing of the project to increase effectiveness, efficiency, relevance or impact.

The review team from Federation consisted of:

1. Dr Arvind Bhardwaj, Health Adviser, IFRC SARD. (Evaluator)
2. Ms. Myo Ei Ei Kywe, Health Officer, IFRC Myanmar Delegation. (Support and translations)

The methodology for the review included the below mentioned approach for data collection and analysis combined with research from the secondary data and information available in public domain. It involved a large group into a consultative and participative feedback. There were briefing at the IFRC Myanmar delegation on TOR and schedule, discussion and planning with MRCS, alongside programme document analysis/review; critical review of some agreed documents such as baseline and end line study comparison, interviews with key stakeholders at the NHQ, interviews at Township RC offices with Executive committees, project staff and volunteers, interviews with village committees, stakeholders and interview of village community members in the field. Some data sources consulted while going through the process are listed below:

- § Project proposal, log frame, budget
- § 2 Pledge based reports, some monitoring reports
- § Baseline and end line survey results
- § Midterm evaluation (MTE) and Impact survey reports
- § Township profiles for Natmauk and Pwint Phyu
- § Specific project related documentation: programmes of organised trainings etc.

Gathering primary data and information from community members was done through focus group discussions and individual interviews in 7 villages of 2 Townships and 15 Households. Observation and transact walk in the field informed many questions and complemented the information from families/ Households.

Limitations¹²

- 1 Selection of volunteers and households: Not selecting interviewees among volunteers and households randomly may have brought in bias and may have affected the information.
- 2 Paid staff interviews: Presence of high level/ authoritative health department representatives during the visit and in course of discussions could have either been a motivator or in contrary a discouragement for good answers.
- 3 Language: Since translation was important there were times when the translator would have to put effort in conveying and receiving the information. The translator was a part of the evaluation team, and has not worked in this project. Since there was just one translator it got a bit tiresome to do the same work repeatedly. However the quality of translation was adequate. Nevertheless, professional and independent/ neutral translators may have increased the quality of interviews.
- 4 Culture: Since the interviews with households and volunteers (usually young people) were done in close proximity to the Red Cross teams (Representatives from NHQ, Township or village health committee) the answers received may have been biased. The culture of the region traditionally has been to be very thankful and being extremely polite as a sign of respect to older people and foreigners which may have contributed to bias in replies.
- 5 Time Limitations: Relatively tight schedules in villages did not always allow enough time to trace more sub-groups such as youth that are out of formal stream; women's groups and those considered the most vulnerable to voice their experiences. Even though 5 days were allocated for the review, the time was a limitation because of inaccessible terrain and long journeys. The need to get back to the place of stay before dark also limited the working time during field visits.

¹² The Evaluator visited 7 villages in 2 townships that were selected based on different years of programme implementation. The comments made in this report are general and influenced with an overall perspective from all places visited and the research and discussions at township and national levels.

Relevance

Appropriateness of the Health Program

The Constitution of the Union of Myanmar recognises 'right to health' under the health policy as laid down by the government. The Constitution addresses health specifically in several of its sections such as education and religion. Most significantly, it embeds health and care for its citizens in chapter 1, article 17 on improving health of people and including people to participate in making their health care decisions. Other articles that have broadly addressed right to health are 28, 32, 35, 351 and 367. The MRCS strategy 2011 - 2015 lays down under strategic goal 1 and 2 within key strategies 1.5, 1.6, 1.7, 1.8 and 2.3 principles to strengthen capacities, maintain structure, identify areas of need and optimise prioritisation of service and programmes that improve health status of vulnerable groups (rural populations, women, children, etc). Other documents that support bringing health closer to communities through a primary health care approach and legally upholding public health service are the Governments Health policy 1993 and the Public Health Law of 1972. Communicable disease control and prevention has been specifically addressed under the Prevention and Control of Communicable Diseases Law 1995 (revised 2011).

Ministry of health in Myanmar has specific emphasis on control of communicable diseases and explicit plans have been developed for preventing and controlling diseases like malaria, tuberculosis, leprosy, filariasis, dengue haemorrhagic fever, water borne epidemic diseases - diarrhoea, dysentery, viral hepatitis- and other preventable diseases. Communicable diseases are ranked the as the third priority in the National Health Plan (2006 – 2011). Under its Disease Control Division with support from Central Epidemiological Unit the disease control teams have been active in providing monitoring and technical support at central and state/regional levels. Furthermore, the Government is committed at the highest level to achieving the Millennium Development Goals (MDGs)¹³.

MRCS, since its establishment in 1959 under 'Burma Red Cross Act', recognises its role as an auxiliary to the Government and has been a committed health partner of the MoH by being

¹³ <http://www.moh.gov.mm/>

a part of health subcommittee in areas of primary health and health education. The above has been achieved mostly through community-based approaches that are consistent with both MRCS vision and mission and that of the overall Red Cross Movement's Mission and relevant to national priorities, policies and plans.

Community Based Health and Development Programme (CBHDP)

The Community Based Health and Development Programme (CBHDP) is aligned with both MRCS mission and the overall IFRC global agenda of developing resilient and better prepared communities and in efforts of revitalise and mobilising the spirit of volunteerism to promote health and prevent common preventable health issues. The Program also aligns well with MoH's Primary Health Care efforts with "ultimate aim of ensuring health and longevity for the citizens with help from the basic health staff (BHS) down to the grassroots level in providing promotive, preventive, curative and rehabilitative services".¹⁴

The CBHDP programme has very well linked with the school health programme (started in 2006) and the MOH youth health initiative on improving access of youth to information, skills and improving physical and social environment for prevention. The CBHDP was supportive at most basic health care level which starts with the Rural Health Centres and functions basically the same as the elements of primary health care. And the Public Health Supervisors Grade II form the government public health systems in the two townships were well assisted through CBHDP in reach out to communities on prevention of common communicable illnesses, water and sanitation accessibility, environmental cleanliness and prevention of snake bites a common prevalent issue. The CBHDP was further complemented by CBHFA from 2011 across villages to add rigour to the initiative through its more organised tools.

The programme is regarded very useful by the village communities by helping them become aware on reasons of common health ailments in the two township villages that the CBHDP covered; such as water borne diseases (namely diarrhoea), vector borne issues such as

¹⁴ Health in Myanmar 2013

malaria and Dengue, acute respiratory infections, HIV, snake bites and issue related with unclean drinking water and poor hygiene and sanitation. It has helped communities gain adequate information on modes of transmission and on prevention which has led to change in their attitude and practices. As reported by the villagers in all the villages the incidence of common health issues particularly malaria, diarrhoea and snake bites has come down and the villages are much cleaner than before. Selections of target villages through different phase of the project were based on need assessment and there access to health services or larger hospital in towns.

The CBHDP established a village health committee and a cadre of approximately 30 volunteers in each village known as Red Cross Volunteers (RCVs) that were trained on health topics and WASH related issues and each being responsible for 10 to 15 houses. The township Red Cross (RC) staff visited the villages to provide technical and planning support to the village health committees and the RCVs in their activities. Some village committees and volunteers have been extremely motivated and established close working relationships with midwife, auxiliary health staff and rural health centre staff; on occasions technical knowledge on prevention of common ailments, good nutrition and safe birth were provided by these staff from the rural health centres. RCVs helped in distribution of necessary items such as bed nets, latrine pans & pipes, gum boots and IEC materials. The Regional health director of Magway and the Township health officer of Pwint Phyu reported that the work of the CBHDP volunteers, especially dissemination of information and health promotion interventions was extremely relevant to the health needs within Magaway townships of Natmauk and Pwint Phyu. They mentioned that TB, malaria, ARIs, diarrhoea and snake bites were the most common health problems in the District with as many as 1000 snake bites being reported each year in the area.

Challenges

Although that the programme is so well accepted and regarded in the community but volunteers reported that gaining complete engagement and the involvement of community requires including areas that are closer, as issues, to villagers. The CBHDP project was implemented with a defined package on Health and WASH, which if could have been kept

more flexible to include other developmental issues, or those that are of concern in some communities would have given enhanced results.

Although the CBHDP programme has achieved its targets during the implementation and subsequently had a smooth phase out. However, volunteers seem unsure of their capacity in some villages (particularly with short programme phase) for next steps forward with their work. Direction is needed from the branch RC to guide volunteer efforts and build their capacity in required areas to ensure they carry on with activities and can deliver minimum required support to bring health benefits to their communities.

In quiet a few villages, the families and villagers reported of inadequate drinking water (quality) especially in summers. Although there was a lot of work done on safe drinking water thorough the project, however use of chlorine tabs was no where discussed and provided. Local solutions that were suggested by the villagers such as having a deep bore public tube well was not planned and implemented. The other common issue that came out from interviews was on extremely poor access to health centres during an emergency because of damaged roads which was clearly visible during visits and no transport. Although this has been a part of discussion since long within the RC CBHDP team, however not much thought was given to resolve this ever lingering issue. Important to mention that the Red Cross Volunteers (RCVs) in some villages have been part of the road repair local projects and some have lent their bikes or accompanied in transportation.

Another issue reported by the township RC staff and the volunteers is around distribution of accessories and equipments to the community through the programme such as bed nets, gum boots, latrine construction materials (pans and pipes). The HHs that received the above, were selected on need basis but since this selection could have been purely judgemental, there are families that were missed and have later complained of being left out. Some volunteers have faced issues on community engagement and were ignored after the distribution by families that were left out. Linked with the above, the other issue is on number of boots provided to a family. One pair was given where more than one member worked at the same time in paddy fields. Many families and RCVs reported that gloves that

should accompany boots because of snake bites on hands while sowing paddy was not considered.

Although there are anecdotal evidence of good working relationships with government partners and others at all levels, however there has not been any mention of more formal working relationships such as an 'MOU' or 'Communiqué' etc that could have better assisted in ensuring volunteers efforts were relevant to the community's health needs. Volunteers in majority of the villages reported that they wish to do some work around chronic long term illnesses and receiving some formal training and support in future, if possible, on diseases such as hypertension, diabetes, joint pains etc will be useful.

Village health committees have been established in this programme, which is a great achievement that is well recognised by the community and the township RC. However, with the close of programme the relevance of these committees may get faded since none of them reported confidence and self resilience to carry on with the activities except the management of small revolving fund in every village.

Recommendations

Programmes are rolled out either as community based projects with strong community mobilisation component from the beginning or implemented with a premeditated package based on needs from secondary information and some research. However, the later ones should morph with time to include community and before they phase out transit into complete community based projects.

The RCVs after the phase out should be followed up at regular intervals (although less frequent) to ensure engagement, moral uplift and adequate levels of health knowledge to be used in the field in course of their activities. The RCVs are mix of adolescents and young people for whom self esteem and confidence is very important and decisive. They will require support and confidence through regular information, updates etc.

Moving from coordination to collaboration with as many actors in the area must be explored. Essentially a formal method of engagement with structures in MOH and other actors working in health and WASH is critical for sustaining the achievements and developing further. This can help procurement of support in form of hard ware and materials from various other humanitarian organisations and with good linkages can be made sustainable.

A programme must have a formal community feedback mechanism that can help study and plan subsequent course of working. This can help join issues in health identified and prioritised by community, for example work on prevention and care for people with hypertension, diabetes and joint pains in these townships. A part of the activity is to support volunteers in choosing health topics that relate to the health needs of families and common major health problems that present at the Health centres.

The distribution of materials in the programme should be based on house hold (HH) requirements and not a blanket cover. The idea has to base on 'different need for different people' instead of same for all.

Initiatives such as establishing village health committees or forming community based organisations (CBOs) require training and mentoring on administrative aspects and accounts management. This should be reflected as an outcome of the programme and due efforts must be given to it.

Programmes as CBHDP and CBHFA could ensure volunteers can be a part of meetings conducted with individual department (inter-departmental/ unit communication and integration occurs) so that there is awareness and the activities remain relevant to national priorities and to the needs of communities.

Given the government's ongoing challenge to provide adequate levels of healthcare service provision in Myanmar's Magway region and its limited ability to reach out timely due to various issues discussed above, the need for first aid education and practice is essential in building safer and healthier communities. An important need that can possibly be a part of

the RC minimum package after phase out is to provide quality First Aid (FA) education and FA kits keeping with up to date evidence based guidelines and practice.

Effectiveness

The CBHDP has been successful in entering with a well identified and designed plan which was very relevant and effective in gaining the confidence of communities. One great success is the effectiveness with which it was able to set up local village health units and develop a cadre of young confident RCVs. The use of RCVs in health activities and WASH has not only helped them gain knowledge on critical health and developmental issues but has also earned the young group lot of self esteem and confidence. This group is now also a respected source of reliable information and support. That project staff and volunteers have been effective in achieving community participation in rural areas which is evident in village cleaning campaigns, participation in water supply activities, construction of sanitary latrines, road repairs, distribution of materials such as bed nets and boots etc. The effectiveness of the programme has been regularly gauged with baseline, midterm, impact study and end term reviews. Below is summary of achievements in relation with the log-frame on effectiveness of the programme.

By logical framework

The effectiveness of the programme is evident form data gathered at the end term and comparisons made with earlier reviews. By the end of December 2012 CBHDP had covered 100.65% of the households and 93.4% of the population in both township target areas. Total direct beneficiaries reached out were of 10,065 households with 46,698 individuals¹⁵.

Objective one: Improved capacity of target community to reduce the incidence of priority communicable diseases and effectively respond to emergency life threatening cases (by improve health knowledge, behavior and practices at household level through health education and promotion campaigns including water and sanitation).

¹⁵ End term review of CBHDP 2012

Water and Sanitation, Diarrhea and Dysentery: Number of households in both town ships using sanitary latrine was increased up to 92.9% in End line survey (2012) compared with only 37.0% in Midterm survey (2008).

ORS: 87.5% in both township (87.0% in Natmauk and 88.0% in Pwintphyu) could prepare ORS correctly in End line survey (2012).

Malaria: 96.9% in Natmauk and 94.8% in Pwintphyu of all respondents slept under mosquito nets the night before, higher than findings of Impact survey (2010).

Tuberculosis: RCVs were providing Health Education sessions on TB, taking sputum to townships for investigation and referred to the health facility for treatment. 91.5% from both townships know TB treatment is available free-of-charge.

HIV: Number of household for both townships who expressed on increased acceptance of PLWHA was 44.1% for both townships in this End line survey (2012) compared to 31.2% in the baseline survey and an increase in number of people to mention source to buy condom.

Snake-bite: 91.4% in both townships are aware of wearing boots to protect themselves.

All the project villages had established Village Health Committee. Committee provided assistance for referring sick and/or injured community members to health facility with the help of RCVs and had established revolving funds that were used to help poor and needy.

Health seeking behavior: Percentage of household aware of symptoms of diseases reported appropriately seeking assistance of a Basic Health Staff (BHS) has increased. In this End line survey (2012), seeking for Hospital was 32.0%, health centers 49.2% and General Practitioners was 33.6% for both townships.

Objective Two: Increased the capacity and self-reliance of Natmauk and Pwintphyu Township Red Cross branch staff and volunteers in Magway Division to effectively support a participatory response to locally identified health needs of vulnerable communities.

In both townships numbers of RCVs trained and actively participated in community health and hygiene promotion was 89.8% of the target at the end of December 2012. In Natmauk Pwint Phyu ratio of HH to RCVs was at 10 to 15 to one. Field supervision and monitoring were carried out by Project Officer and Project Staff in line with the logical framework.

Challenges: However most of the household were drinking water by straining through the cloth sieve which would not give safe water. Boiling methods was used only in 52.6% in Natmauk and 59.9% in Pwintphyu. Also, Percentage of households who could report 3 ways to prevent diarrhea infection was 39.6% in both townships.

Percentage of households who could report 3 ways to prevent malaria infection was 40.4% in both townships. Young people had poor access to free condoms from the programme and percentage of households who could report 3 ways to prevent HIV infection was 58.9% for both townships.

From Field Assessment

The project has been very useful and relevant to the township for the knowledge base it has created around the most prevalent health issues in villages. To develop and then increase number of RC volunteers in the areas has established a good image for RC. A good source of trained people ready to be mobilized in need and referred as resources for information and support has been established. An indirect benefit of the programme has been setting up of a revolving fund in all villages that is also used for the poor and needy. Another indirect benefit is the rise in the number of blood donor recruitment in the 2 townships. The increased timely referrals to hospitals some of which were accompanied have been very useful.

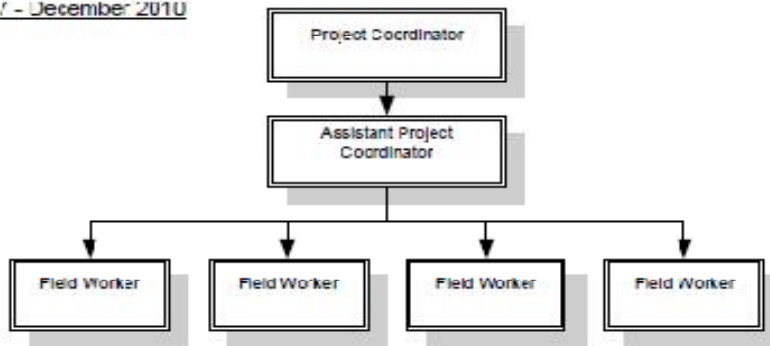
As reported by the TMO in Pwint Phyu the work on prevention has helped local health staff by reducing number of cases of communicable diseases at the Rural Health Centers and they were able to put efforts on other health issues. At an executive committee group discussion in a township the committee's members ranked satisfaction level at 9 on scale of 0 to 10. Exec Committees have made monitoring visits to villages to observe activities and have

provided suggestions. The Township MO provided technical information as and when needed and equally assisted in various events and campaigns. The health authorities and health centre staff interviewed had a general knowledge and were very appreciative of RC activities. However, the TMO and others highlighted the need for raising awareness on issues such as safe deliveries and ANC in MNCH which they thought was yet not well addressed and an issue in the area. Also, there were no formal arrangements/ agreements on partnership or roles of stakeholders. At the discussion with the executive committee many of the members suggested that the programme should be more intensive with longer project period in one coverage area which should be large enough, depending on the capacity of the organization and financial support, to have villages with bigger populations in one township could get much more better benefits under consolidated programming thereby becoming more efficient and make a larger impact.

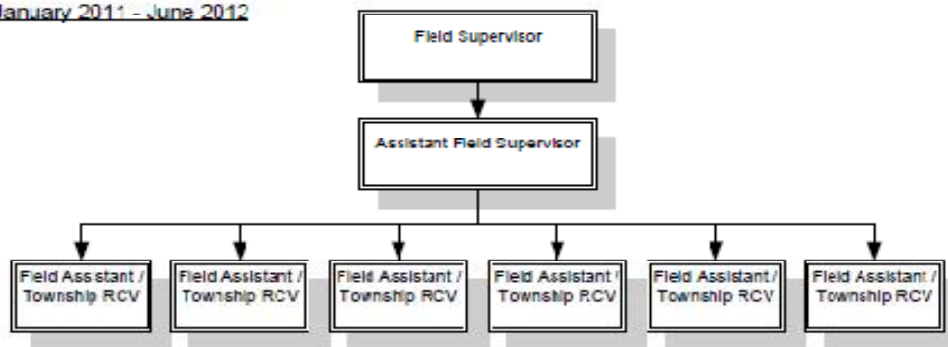
Project implementation has been done through a structured system where salaried staff exists at NHQ and regional level and with volunteer positions at the township as well as in villages. Since a large cadre of 600 volunteers was formed and with a large turnover, volunteers management was an important area. However this was not addressed adequately. Below is the structure from the field level in course of programme years.

Organizational Structure

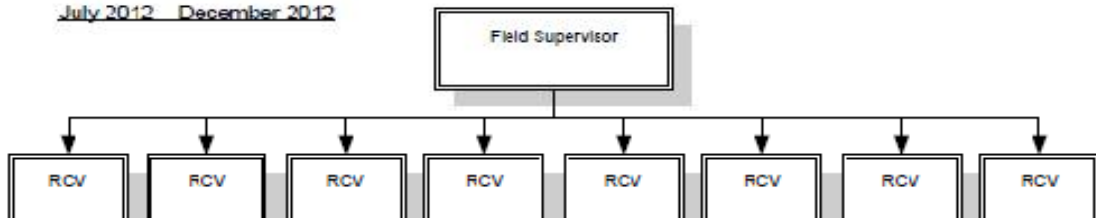
January 2007 - December 2010



January 2011 - June 2012



July 2012 - December 2012



The overall management responsibility of the project is with Head of Health Department in MRCS HQ. Daily coordination and managing of the team was done by a Project Officer also based in NHQ with regular visits to the project areas. Field work and management at township was done by four full time staff, 2 field supervisors and 2 assistant supervisors. The Project officer's and other positions were core project position and staff salaries fully covered by the project hence these positions are not expected to continue beyond project timeframe. A large staff turnover was reported during the course of the programme with 4 project officers leaving.

- First for about 2 yrs

- Second for 8 months
- Third for 3 to 4 months
- Fourth for more than 2 years

Because of the turnover activities had a setback in the middle of the programme. However the last phase went very well. Since all staff was in place in the last phase for 2 years. It provided good continuity for the project. The present team during the phase out and today has a project officer who had been earlier the field supervisor in Natmauk and is still based out of the same township; Natmuak has a field supervisor who was previously an assistant field supervisor. Pwint Phyu has 1 field supervisor and 1 assistant field supervisor.

At the evaluation a good team spirit and high motivation among the project staff was obvious. Monthly meetings are done every month with a village committee member and an RCV representing each village. Executive committee was invited quarterly for meetings in the two townships to share programme updates, sharing future plans and to avail suggestions on programme matters. The CBHDP Programme was implemented by the project staff and RCVs keeping with the work plan mentioned in the logical framework. They reported and presented monthly activities report and monthly financial report which were shared at the evaluation. Project staffs of the both townships were trained. Capacity of Project Staff and RCVs had increased in mobilizing target communities and their technical skill in relation to latrine construction, water supply and maintenance and household water treatment and storage had improved.

The project team felt that the last 2 visits from FRC and subsequent feedback were helpful. The support from IFRC and FRC during implementation was timely and very valuable to the project. The technical missions undertaken during the course were appreciated by the project team and deemed adequate. The team also felt there have been sufficient communication and feedback mechanisms from the technical delegate to the project team. The perception was that this support has enriched the implementation and the recommendations made have contributed to improvement of project performance.

The field township RC team reported delays on planning and delivery of materials. The RCVs reported that delivery of materials quite often did not synchronize with the period of need and the sessions that were conducted in field which would have impacted on programme effectiveness to some extent.

The RCVs are closely attached to RC local township units which are responsible of organising and planning of RC activities at village level. This provides a good coordination base for effective volunteer activities and provides RC volunteers a sense of belonging and motivation, which was found very important for successful implementation. The RCVs interviewed in the visited villages are very motivated and active and well known by the community members.

Training of RCVs is a very critical part of the programme. Consistent support from regional RC has been able to provide trainings to RCVs on various topics. These trainings were in some villages passed on to other volunteers at villages by the trained RCV peers. However the villages in the last phase have had not enough opportunity to get enough training and especially after the phase out they would require more support on technical capacity building (such as VCA, FA etc).

The sessions done by RCVs in villages were chosen thematically to rotate and according to need. The number of sessions conducted each month, its frequency and time spent at each session by the RCVs in the community proved very effective. On an average 2 sessions were conducted each month and 2 topics covered in each session for about 30 mins a session repeated every 3 months.

Based on the findings trainings were later a part of CBHFA approach from 2011. However, none of the staff at provincial level were trained as CBHFA facilitators although they were the ones responsible of training of RCVs. There are some people in NHQ trained as CBHFA master trainer and have supported trainings but it wasn't enough. Discussions with educators suggest that they mostly use didactic methods in conducting community and house hold/ group sessions where passing on information rather than facilitating or using dialogue to promote change process should be done. Currently the trainings seem to be

concentrated on technical knowledge and key messages. However, facilitations techniques were not adequately emphasized.

There are monthly visits to villages from townships by Field Supervisors for monitoring and supervision and monitoring is by the log frame. It was observed that there are well maintained formats on reporting with RCVs. The reporting is done by RCVs to the Field Supervisor who collates data and reports to the Project Officer in well developed formats. These formats have been introduced in the last phase of the programme. There wasn't any formal system of systematic reporting earlier and during the large part of the programme. As alleged by some RCVs, there were no established system for recording and reporting of priority communicable diseases in project villages until 2011. The health information management system for CBHDP was not methodically established. The clear weakness in terms of the operational effectiveness was observed in monitoring and reporting as well as in quality control mechanisms. No systematic way of collecting information for set quality indicators were established and reporting mostly concentrated on activities implemented rather than providing analysis of the progress to achieve the expected objectives.

A comprehensive M&E plan and user friendly data collection mechanisms from the beginning of the project would have helped the programme during the period and informed future course. As alleged, PMER was poor from 2007 to 2010 although it seemed to have improved in phase 4 with introduction of formats after the introduction of CBHFA approach from 2011. Quality control and supervision of the implementation has been dependent on Field Supervisors who have wide areas to cover in limited time and resources. During the phase out, monitoring and quality control purely depended on volunteers themselves, although most likely sustainable, brings questions in terms of accountability and quality.

Gender and Diversity mainstreaming was not very well addressed in the CBHDP. The evaluation could not ascertain information on how different issues for different groups were considered, discussed and innovatively resolved. There is a large representation of women among non paid staff i.e. Township volunteers and village RCVs. However, no women are at any decision making levels in the programme structure. Also, the village committees and the township committees are all male dominant.

Recommendations

Project locations/ villages that were covered in the last phase had a short implementation period and hence some needs unaddressed. If possible, with support in future the project maybe reinitiated through the CBHFA approach in those areas. This will help properly embed the concept of self-reliance in these communities which is not yet achieved and the gains made so far can easily be lost.

The NS must consider developing one harmonized approach to community health programming irrespective of geographical area based on one agreed approach. CBHFA being more inclusive and a bottom up approach should be the way forward in community based health programmes. It may be noted that inter unit/ department integration is important and experts form WASH, OD and DRR could be included as technical advisors and should be requested for support.

The project was spread across the townships and as explained in the evaluation, it was a selection based on need. However in scattered target populations the monitoring is weak and deliverables to each individual gets decreased thereby making them less effective and less efficient. Having said that, It may be noted that although consolidation of programme is definitely more efficient and the impact can be better, however not consolidating the coverage has its own benefits. For example, in this case there has been a cascade (spill over) effect of knowledge to other adjoining villages from targeted ones in the remotest of areas. There is a cadre of easily deployable RCVs in those villages that can be trained in health, emergency response etc and this works well for topography in which these villages are situated. It repeatedly came out in the interviews with villagers and with the township members, having a health and WASH project was extremely beneficial and they would want it extended to other needy communities/ to other villages.

Strengthening of village level Committees with adequate training should begin early within the programme. This could be achieved through an integrated plan with Organisational

Development (OD) unit in Red Cross. They should be continually supported through skill building in account management and in administration. Sharing of information and asking of feedback from the village committees and the RCVs must be more formalized and documented. Community members must be well informed through RCVs in group sessions, meetings and use of newsletters.

Developing a decentralized operational strategy should be encouraged by the donors to reduce time delays on planning, implementation and distribution at field level. 'The money should follow the client'.

At the branch level there can be some income generation methods introduced for strengthening the office and increasing sustainability. This should begin early and can be done by introducing methods such as transport carriers, photocopiers and telephone/internet booths etc. The income can sustain people positions to some extent. The teams of FS in township RC are the front line staff in such projects. Their technical skills must be refreshed and strengthened. They can also be used as resource people by the NHQ for other townships.

In RC, Township audit is done by a treasurer who if supported with minimal honorary wage (20 USD/Month) can be used to supervise finance and this can help the Field Supervisor (FS) to focus on implementation.

For a project area greater than 2 townships a Project Assistant position should be included to support the Project Officer who is busy handling strategic decisions, finance, procurement, checking deliveries, working advance requests and distribution etc. Similarly in large coverage areas a PMER person should be included for data collection, entry and reporting.

The PMER is a critical component of any implementation and must be strong and consistent right from beginning. Monitoring of the quality of the program needs to be included into the health advisor's and delegates in IFRC and the NHQs program staffs' Job Descriptions too. For the field RCVs it is important to have formats that are not lengthy and easy to use.

Training curriculums and plans should be reviewed once annually so that they adhere to needs, are responsive and follow the ideology of community based programmes. Special emphasis should be in building capacity of village health units and volunteers on community mobilization, participatory need assessment, community dialogue, BCC etc. Quality control mechanisms such as different types of tests and training feedback should be included into the trainings and should be a part of monitoring systems.

Ensure that Key Performance and quality indicators are agreed and the staffs are well capacitated to follow and report on them.

Partnership with other NGOs in same places and developing formal linkages with health systems that exist in primary and secondary levels should be an important outcome. Relationships must be strengthened for integrated working with more formal agreements and move from simple cooperation to collaboration and complete involvement.

WASH is the most popular activity and most effective when combined with health sessions.

Efficiency

The project has successfully developed effective and efficient volunteer capacity at township and village levels, which was very well utilized to its full potential. The project team has committed and discharged their duties to great satisfaction of the village committees, RCVs and community members. During the complete programme period, total of 46,698 people from 10,065 households of 40 villages/ward villages within Natmauk and Pwint Phyu have benefited. Though, the NHQ team has actively supported the project in every way possible, however quick staff turnover in the middle of the programme at PO level slowed down activities, during the project period. Generally, the planned activities were well implemented within the stated time frames i.e. keeping to deadlines. However there have been a couple of periods with delayed activities which were majorly due to the delayed remittances of funds and/or materials from head office. The financial support from FRC and IFRC has been efficient as reported by the programme team. Allegedly the

programme accounts were submitted timely from the field to the NHQ on a monthly basis. However, this could not be confirmed from the finance team in NHQ.

Interviews with the project team suggest that the procurement procedures were followed based on the NS procurement guidelines. Project materials were procured from the head office as the amount of money involved required authorization at NHQ level. It was reported that all programme materials were procured centrally from the head office. However, there was no evidence shared that requirement on securing three quotations and the necessary approval were followed. The major challenges were related to supply chain management especially for stocks requiring storage before delivery to the field. There is no storage capacity in the project site and as such, most materials procured from the head office were either stored at the nearby RC provincial branch or transported directly to the site and handed over to beneficiaries.

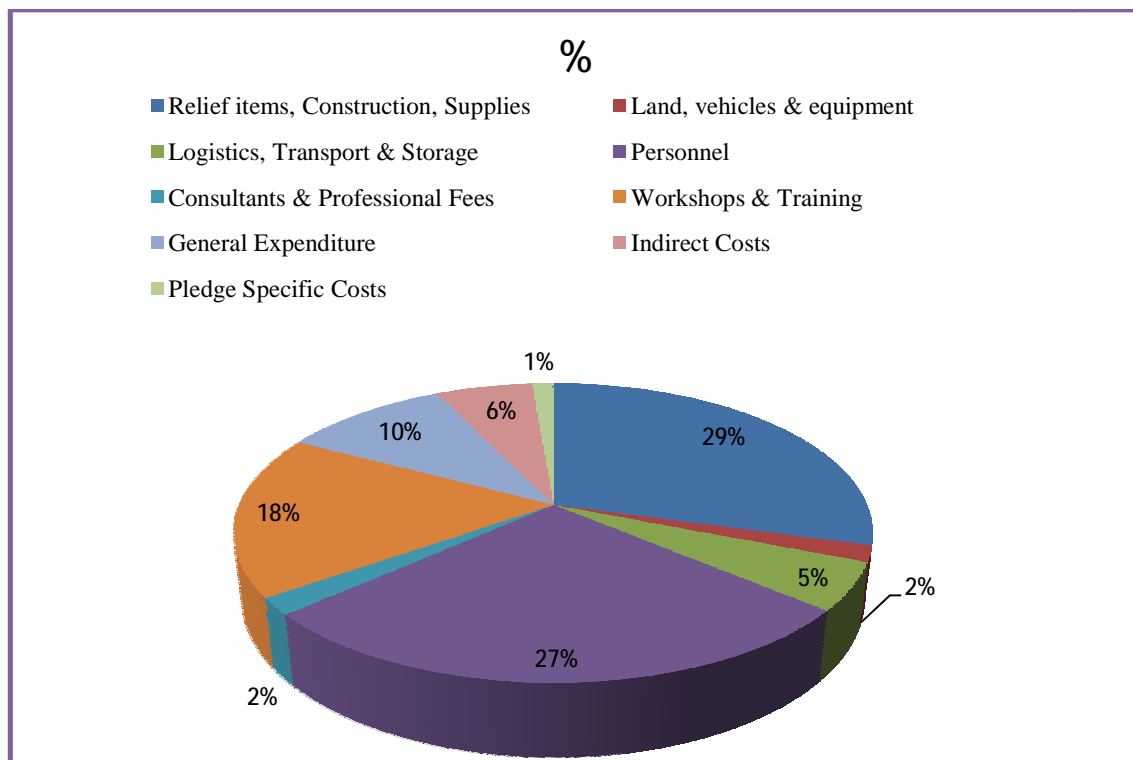
Covering all the villages in the 2 towns have also had its challenges due to the wide distribution of villages and related with quality. Based on the findings, sufficient resources required were not planned well to match with the beneficiary numbers or targeted area to be covered and the volume of the trained volunteers. As an example, the material provision left out houses since the need assessment was not done very well. Also, materials were given out without acknowledging the size of the family in households. Also the ability to provide follow-up and refresher trainings for RCVs and township teams were kept very modest.

The total budget for the programme was approximately 542,511 CHF. Matrix below has disaggregated the costs by various lines for evaluation purpose.

Description	2007	2008	2009	2010	2011	2012	Total	%
Relief items, Construction, Supplies	10,920.78	39,974.42	12,574.65	65,617.37	15,813.53	14,105.93	159,006.68	29%
Land, vehicles & equipment	6,044.87	-	-	3,223.50	-	-	9,268.37	2%
Logistics, Transport & Storage	1,063.63	2,931.18	4,660.89	9,517.94	7,311.28	2,370.04	27,854.96	5%
Personnel	11,908.71	10,991.87	23,752.70	27,730.17	37,438.03	36,059.68	147,881.16	27%
Consultants & Professional Fees	-	666.45	3,414.77	1,571.41	1,652.28	2,571.38	9,876.29	2%
Workshops & Training	12,234.69	6,674.66	8,889.14	17,084.12	27,514.02	22,847.14	95,243.77	18%
General Expenditure	5,724.23	9,232.28	7,042.84	8,114.43	13,802.33	10,434.06	54,350.17	10%
Indirect Costs	-	5,664.84	4,822.97	8,905.94	6,729.54	5,745.24	31,868.53	6%
Pledge Specific Costs				2,042.55	2,635.32	2,483.88	7,161.75	1%
	47,896.91	76,135.70	65,157.96	143,807.43	112,896.33	96,617.35	542,511.68	100%

The Pie chart below shows budget expense by different thematic components such as personnel, Trainings, Logistics, transport, supplies etc. The 'relief items, construction and supply' is the largest at 29% followed by the 'personnel' costs at 27%. The cost for personal is high (1/3) relative to the total programme cost, but is below 30%. 'Trainings and workshops' at all levels is third at 18%. Other areas have very less expenses and this reflects that over 2/3 of the budget was used in programme implementation. As mentioned above, the total population covered in the programme is 46,698 bringing the rough financial input

per beneficiary to CHF 11.6. The figure is a good indicator; however it doesn't necessarily prove efficiency.



For purpose of analyzing the cost per person trained from the RCVs and staff. Total cost for trainings and workshops is at CHF 95,243.77 in which 3216 people were trained which comes to CHF 30 per person cost. The training cost is high as anticipated in development projects, as it is one key activity and is required for developing a large base of skilled volunteers in communities. Also, high turn over in staff and RCVs should be considered which requires more training. Training is a sustainable investment and any reduction will eventually work their way down to the bottom line.

The largest expense at 29% is of materials at a total of CHF 159006. Three indicators on materials distributed were chosen for the sake of analysis (latrine construction pans and pipes, bed nets and boots) numbers distributed over the programme period are 8810, 12682 and 12924 respectively. With CHF 159006 as total figure spent the average cost spent on the three main supplies comes at CHF 4.6. If the same CHF 159006 is distributed through

all supplies inclusive (plus first aid kits, ORS, condoms, super tabs for safe drinking water and expense on rehabilitation of water resources) the average cost will be at CHF 2.

It was not clear on what the 'general expenditure' includes and how is that accounted. It being at 10% is high relatively and would be worth knowing the details.

The programme staff reported a well planned phase out and downscaling of staff and some paid positions towards the programme end which was very efficiently managed.

Recommendations

A more systematic finance management at NHQ and townships with detailed formats and accompanied with a training would contribute towards better organization of work and increased financial accountability.

The break up on a spread sheet should reflect more detailed references and not left ambiguous under terms such as 'general expenses'. For example as below:

SL	Activity	Budget	
		In local currency	In US\$/ CHF
1.	Branch development		
2.	Vehicle costs		
3.	Office equipment		
4.	Water		
5.	Sanitation		
6.	CBHDP/ CBHFA		
7.	PHAST		
8.	IGA		
9.	Material distribution		
10.	RCV training		
11.	Staff training		
12.	Volunteers insurance		

SL	Activity	Budget	
		In local currency	In US\$/ CHF
13.	Branch salaries and benefits		
14.	HQ salaries and benefits		
15.	Admin		
16.	M&E		
17.	Review meetings		
18.	Dissemination		
19.	Experience sharing		
20.	Consultant costs		
21.	Miscellaneous		

Outcomes and impact

The programme has a well conducted baseline and subsequently has been reviewed at various intervals with midline, impact survey and an end line study. All of the above provide clear positive evidence of changes in knowledge, attitudes, practices and community resources. RCVs and the Interviewed village communities in particular, also describe an increase in knowledge and change in practices to prevent form the common health issues covered by this programme. The community and RCVs mention increased participation of people in communal activities and a stronger social connection. This strengthening of social capital is of great importance for long-term maintenance of health and development gains.

Interviews with the village communities and the executive committee at the township during the evaluation support the findings of positive impact in improved sanitation and hygiene practices with decreased cases of diarrhoea, malaria, Dengue fever, ARIs and snake bites. The project has had other benefits such as an increase in health seeking behaviour, improved immunisation coverage, timely referrals to the hospital and increase in blood donation volunteers. The household were also quite satisfied with the materials provided to them (bed nets, boots, latrine pans and pipes) and improved access to safe water for drinking. The RCVs

role in accompanied referrals and on tracing of TB cases and facilitating investigation and treatment was very appreciative and considered very important by everyone.

In addition to the impact on the health of the communities the findings suggest that the project has had positive impact on MRCS as an organization by strengthening the capacities of the RC Local Township and regional branches. It definitely has increased the profile of Red Cross in the region and provided visibility to the successful RC work in target areas. The impact of the CBHDP has been so positive that neighboring villages have started consulting committees at the target villages on health issues. Some RCVs and health committees have extended health sessions to neighboring villages on their demand. People interviewed in all the visited villages have reported in their suggestions to extend the project to more new locations within the townships.

Recommendations

In future programmes, a proper assessment must be done before deciding on geographical spread of target areas. The assessment must include a thorough analysis of resources and funds. The projects must have quality standards built in at all levels.

Internally programme must include CBHFA approach in future and integration of PHAST tools for WASH. Externally, must explore partnerships to increase coverage with help of public systems and other civil society organisations.

Community participation needs to be ensured from the assessment to throughout the program period. CBHFA monitoring tools should be useful to gauge effectiveness and coverage.

Sustainability

The evaluation findings suggest that the sustainability is likely since the programme has been successful in increasing knowledge source in villages which has a potential to sustain may activities. Also, except trainings and some material support, the work of RC volunteers has not been based on any funds. The project was able to tap synergies from existing RC

structures at the NHQ and township levels. It has successfully established village level small set ups (health committees) and trained local people as RC volunteers and leaders at local village health committees. The support on health and WASH issues and establishing of the revolving fund has highly raised the significance of this project in villages. One good example of sustainable action could be that the village now procure anti venom for snake bites by themselves through the revolving funds.

Almost all those interviewed at the villages and townships wanted to continue the project activities even after the absence of MRCS' supports. However, the village committees are still nascent in phase 4 villages and not very strong in capacity and skills in others. The need for technical administrative and accountancy support is obvious which if provided can contribute to sustainability.

The current programme has been able to recruit new volunteers and train them from outside the township levels which of course will be a challenge in future. As reported, the project had not addressed or supported the sustainability of Regional or Township structures. The project people have no employment anymore and this will have effects on the created links between village and townships. If sustainability of the townships RC activities would have been one outcome of the project this may not have been a troubling issue.

The project has developed links with local health system and its staff at health centres and has been well regarded for the added value brought by RC trained volunteers. This can be one reason for support from the MoH. Also, the township medical officer is the chairperson in RC at council level so collaboration with MOH has been strong and well supported.

A minimum service package which includes 5 to 7 activities was developed in the last phase of the programme that would be supported by RC. However, now with ending of the project the village committees and RCVs in some villages have themselves developed plans with continuation of needed activities but less in frequency. It is anticipated that the supervision would be consistent from the Township RC level, but the HQ will not have much overseeing. HQ will sometimes support with FA Kits, ORS and some IEC if possible. An evaluation after 3

years should be conducted to gauge the impact covering health indicators and community ownership.

Recommendations

Future programmes should include a detailed transit action plan. It is important to ensure that one of the outcomes of any community based development project is on strengthening the local community based organization or committee through trainings and minimal infrastructure support.

Programme proposal and plans should include from the start a strong humanitarian diplomacy/ advocacy aspect. It should detail on present stakeholders, support that is available from them and prospective stakeholders that would be targeted for including them into the projects in various ways for sustainable support (A stakeholder analysis). This plan should align with the overall NS and IFRC policy on partnership development.

It would be important to keep monthly meetings at the township level for the village health committees and RCVs ongoing. Village committees must be supported with some minimal training on accounts management and administrative issue.

The NS can explore some opportunity to create a fund on sustainability which must be at the township levels. This fund could be developed further through local fund raising activities through petty and/ or moderately big local initiatives. To begin with, some funds could be channeled to the account from other programmes, if possible.

Future programmes in these villages should be channelled through the same Village Committees that have been setup by RC in the CBHDP programme. Any project or external support in villages should continue to target the capacity building of volunteers and must support village and township level income generation activities to ensure self-reliance.

Gender and Social inclusion

The villages visited had a large representation of women as volunteers. As reported in the interview by field staff, this was same in all villages. However, there were no women in the project implementing team at NHQ or township levels. The last but one was a project officer some years ago who left in 3 months. It was observed that although in some villages 2 to 3 women were included in village health committees, the decision making was done by males. In the township executive committee there was just one woman, the medical officer, and rest were all men. Women interviewed in the villages at the meetings or in house visits were happy with the programme and those who were RCVs seem very active and were smart in their replies and in providing ideas. However, it was difficult to establish whether women (RCVs or from communities) have been playing significant roles in decision making process. It was reported in the village interviews that RCVs and the health committees actively support the most vulnerable in their communities and marginalized groups have been actively targeted through the project activities. At the township levels the township volunteers are from various religious and ethnic back grounds which mirror the distribution of communities. From information collected at the project level, no systematic gender analysis has been done in regards to the planning project activities or for developing implementation strategies.

Recommendations

Gender and Diversity mainstreaming must be addressed at all levels in the programme within the framework of organisational development for any project that is rolled out. Donors must include this as a prerequisite for fund availability and implementation. It is important in any community based programme to identify issues specific to groups of men and women of different age and social backgrounds during community assessments, action plans and to analyse outcomes. This will help to improve effectiveness.

Programmes should include gender analysis and ways to address its issues as a part of capacity building trainings for the project staff. They should ensure that the analysis is done at the assessment stage and planning phase.

It is important to ensure representation of different groups of men and women at meetings and forums where all can be involved for decision making. The messages and other information through IEC or in sessions must be made gender sensitive.

Partnership with civil societies that are working on gender related themes and issue should be explored for a collaborative way of working in the communities.

Conclusions

The project has been successful in achieving its objectives in improving health status of people and strengthening the local RC systems in the implementation area. On examining the major components of the programme around health and water, sanitation and hygiene, there is enough data and information to verify the benefits that the projects in the two townships have brought. The project was appropriate to the need of the community and has been effective. The programmes underpinning RC values were maintained and no negative influence/ impact was observed.

The project has been well planned, implemented and documented in its course and through systematic reviews from the beginning. It was operational for a good length of time since 2007 to 2012, with exception in some last phase villages where it was quiet short. The baseline, midterm and end term reviews along with the impact study make it extremely positive and scientific in approach. It is also noted and observed that the above reviews have guided the course of implementation and has helped to make the programme responsive to the communities. Satisfaction of people in the covered area is high. There is evidence suggesting high satisfaction at village health committees too. The project has contributed to better coverage of improved water sources, almost complete coverage in sanitation use and improved environmental cleanliness. At interviews (all levels) people appreciate the decrease in communicable health problems as a result of this initiative. At the evaluation, well maintained water points and clean family latrines with hand washing facilities were observed in random household visits.

However, lack of data on overall picture of health issues from local health systems or at the MOH level for the townships makes it difficult to understand the exact contribution in figures that this programme has made, in complementing the health systems, for decreasing child morbidity or mortality due to water borne diseases, reduction in communicable diseases and reduced number of snake bites. At the same time there is a great deal of satisfaction and appreciation reported by Township health officers and community health staff (midwife and auxiliary midwife). It may be recalled that in Myanmar there are Public Health Grade II supervisors in local levels, but the project lacked any formal evidence to suggest good linkages and sharing of information at this level.

With RC initiatives on establishing village health committees in all targeted villages, training passionate young people in large numbers as RCVs and starting revolving funds in villages has highly enhanced its image. RC is recognised and regarded in the remotest areas, where it was not known earlier. The village health committees and volunteers were provided good space to contribute to the project. Volunteers and village committees actively support the most vulnerable in their communities. Marginalized groups have been actively targeted through the project activities. At interviews it was expressed that previously marginalized and isolated groups have subsequently started to participate in community activities. They also respond to the health and sanitation needs of their families. As large numbers of volunteers have been trained and they reside in the villages with their families, this knowledgeable resource of passionate people can be utilised in future for additional public health works such as immunisation, control of epidemics etc. The same applies for mobilising them for disaster preparedness and response.

The "spill over effect" is amazing. Knowledge on prevention of health issues, sanitation and revolving funds to support in emergencies has crossed over to other villages and they are also benefitted. Although there has been a well planned phase out, however it may be important to maintain certain supported activities for young people who are now a part of the large RC/RC family (supported through local fund raising etc). It would have been useful to support a concrete strategy development and plan in this regard.

It is important to note that the environment and cultural context of the local area has a great influence on local acceptance of projects, work practices and on integrity. Myanmar's targeted villages in Magway division, seems to have been exemplary in all the three. The programme was not only well received and supported by the people but they also wish for other villages to have the same benefits from future initiatives (through interviews).

The local township branches are well regarded and have earned a distinctive place alongside other actors working locally on health and development issues. Staff at the branches is well capacitated and skilled to take on responsibilities. It may be worth mentioning that the RC in Magway division has been a very passionate group of young people that have given their best to the programme. It will be very satisfying to see them actively involved once again in similar work and maybe more, for this gives them pleasure and makes the programme so useful. The Branch is fulfilling its mandate as a humanitarian organisation looking after the most vulnerable.

Management, monitoring and supervision were well funded and included in work plans. The programme has been lucky to get support from some efficient and hard working team members at MRCS HQ, FRC and IFRC and the branches. Regular sharing at meetings with various stakeholders is very inclusive and has earned a lot of respect for the initiatives. However, it is noticed that project coordination and finance management at the HQ have contributed to some delays in material and fund transfers that may have delays in implementation of activities. Also, there were occasions when the decisions at HQ were made on providing water points that were not exactly what was suggested by the communities.

The gender representation was well considered but was random. No further gender analysis has been done in regards to the project activities or the implementation strategies. Women were well represented in general at village RCV levels, but not at decision making levels.

Majorly, activities have been implemented within the planned time phase and the activity based budgeting has been efficient, realistic and clear. The budgets were planned and utilised in a satisfactory manner with 2/3rd of the budget planned for direct implementation

and 1/3 for operational and staff costs. However issues on staff turnover at the project officer level was realised from records and interviews. Though, the reason is not clear but it is alleged that this was due to poor staff remunerations. Present PMER systems are adequate and well kept. However, they seem unnecessarily big at the RCVs levels. There were evidence on regular and timely reporting but there were no evidence of established quality control mechanisms.

The findings show that the resources were effectively used for the covered locations the phase out was planned. Some important village level activities after the phase out are now sustained. However, the weak capacity on managing accounts and administrative matters may lose the drive and hence this needs to be addressed in community based health programmes as an important outcome.

Annex

- Terms of Reference of the evaluation
- Evaluation work schedule with visit timetable
- List of people interviewed
- MRCS organigram
- Pictures from the field visits



Terms of Reference

Final Evaluation of the project COMMUNITY BASED HEALTH DEVELOPMENT IN MAGWEY, MYANMAR

1. Summary

1.1 Purpose:

To analyze and comment on the achievement of the project and review the process of implementation of the CBHD in Myanmar country context.

1.2 Audience:

FRC, MRCS, IFRC and key stakeholders

1.3 Commissioners:

This internal evaluation is commissioned by the Finnish Red Cross (FRC)

1.4 Duration of evaluation: estimated working time

Four weeks

1.5 Time frame:

03 – 31 July

1.6 Location:

Programme areas in Magwey, Myanmar

2. Background

The pilot project model of Community Based Health Development, based on the concept of Primary Health Care, was implemented in Keng Tung with the support of Australian Red Cross since February 2003. After it was found to be relevant and appropriate, and Community Based Health Development Project (CBHDP) was expanded in Magway Division, which is situated in the middle part (Dry zone) of Myanmar with hot and dry weather, and with scarcity of rain. Based on the situation analysis findings, MRCS Executive Committee selected Pwintphyu and Natmauk Townships after consultation with Magway Division Red Cross Supervisory Committee and approval given by Ministry of Health (MoH). A total of 20 villages in Natmauk and 20 villages in Pwintphyu were covered by the project throughout the six-years project period (2007-2012).

The Baseline survey (2006) was carried out for phase one villages in December 2006. For the phase one, CBHDP project was being implemented in one ward (Myoma) and 4 villages in Natmauk and 5 villages in Pwintphyu during first year. Villages have been selected according to their vulnerability in term of lack of existing support from local health services, as well as inaccessibility and lack of health knowledge.

Project implementation expanded another 10 villages (Phase two), 5 villages from Natmauk and 5 villages from Pwintphyu, after implementing the phase one villages for one year. The Midterm evaluation (MTE) was carried out on the phase one project areas (one ward and 4 villages in Natmauk and 5 villages in Pwintphyu) in October and November 2008.

The Baseline survey (2008) for phase two villages was also carried out in December 2008. Wetchoke, phase one village from Natmauk, was found to be inactive in implementing the project activities and was excluded from the project villages by Natmauk Township CBHDP Supervisory Committee from the CBHD project on November 2009.

Phase three was implemented during 2010 expanding another ten villages, 5 villages from Natmauk and 5 villages from Pwintphyu. The Impact survey (2010) was conducted in all villages of phase one to three in October 2010.

Phase four was implemented during 2011 expanding another ten villages, 5 villages from Natmauk and 5 villages from Pwintphyu.

Phase one villages were phased out in August 2011. At the end of 2012, there were 30 villages in the Magway Community Based Health Development Project — 15 villages each in Natmauk and Pwintphyu Townships. The End line survey (2012) was conducted in all villages of phase one to four in November and December 2012.

During the six years period of January 2007 to December 2012, a total of 46,698 people from 10,065 households of 40 villages/ward villages, located in two townships in Magway Region, have benefited from a range of project activities.

Aim and Objectives of the CBHDP

The aim of the project is to improve the life of vulnerable community through self -sustainable response to prioritized health issues, water and sanitation activities by strengthening capacity of Red Cross branches.

The objectives of the project are:

- 1) to improve the capacity of vulnerable communities in selected townships resulting in behavior change in reducing the impact project of priority health issues such as Diarrheal disease, Malaria, TB, HIV, poisonous snake-bite, ARI, including water and sanitation practices and
- 2) to increase capacity of selected Township Red Cross branches in Magway Region to effectively support and sustain participatory response to locally identified health needs of vulnerable communities.

3. Purpose and Scope of the Evaluation

The purpose of the final evaluation is to analyze and comment on the achievement of the project and review the process of implementation of the community based health project in Myanmar. The evaluation will identify significant factors that are facilitating or impeding the implementation of the community-based health project and the delivery of its outcomes. Evaluation is expected to lead to recommendations and lessons learned for the future. Evaluation upholds FRC commitment to accountability and organizational learning and will be used while programming new initiatives in the field of health and social services.

The evaluation will cover a period of 2007–2012 and will be conducted in all project areas taking into consideration relevant time and logistics limitations. Inclusion of all participants, either directly or through their true representatives, is considered essential hence the evaluation methods will be varied accordingly to facilitate this participation.

Evaluation outcomes will be shared with FRC, IFRC and MRCS who in turn will take the responsibility of disseminating the outcomes to relevant interested parties. FRC will be responsible of sharing the outcome with the Ministry of Foreign Affairs of Finland. The outcomes are expected to provide lessons learned and concrete recommendations to guide FRC, IFRC and MRCS future programmes and to influence the ways of working and promote the best practice in implementing the community based health activities.

4. Evaluation Objectives and Criteria

4.1. Objectives

The main objectives of the evaluation are:

- Review the effectiveness, efficiency and relevance of the project by reviewing the outputs achieved in relation to inputs provided, and the outcomes achieved as a result of project outputs delivered to date.
- Review how the community-based approach has been implemented in the project communities?

- Provide recommendations for further improvement in the design, delivery, quality and resourcing of the project to increase effectiveness, efficiency, relevance or impact.

4.2. Evaluation criteria and specific evaluation questions

1. Relevance

- How relevant is the project regarding the beneficiary requirements, local context and needs?
- How well was the target groups identified?
- How do beneficiaries view the comprehensiveness of package of services – training, information spreading, household visits, and awareness raising campaigns, IEC materials – offered to or directed towards them?
- How does the project complement intervention of other actors, most importantly relevant Government departments?
- How has the project contributed to the MRCS strategic plans and aims?

2. Effectiveness

- Where objectives achieved on time?
- Were the activities conducted in a planned and timely manner throughout the project?
- Were the supervision and management mechanisms on all levels sufficient in relation to project needs and expectations?
- Were quality standards defined, and are activities achieving high levels of quality in implementation?
- How satisfied with the project are project beneficiaries? What is the stakeholders' viewpoint related to the performance of the project? What are the main issues raised regarding satisfaction with the project?
- How satisfied is MRCS – including local branches – with the project? What are the main issues raised regarding satisfaction with the project?

3. Efficiency

- How well were the inputs (funds, people, materials and time) used to to produce results?
- Has the scale of benefits been consistent with the cost? Cost-efficiency: (a)to what extent has the funding been utilised to directly assist beneficiaries b)Has the project support and operational costs been reasonable (%) compared to entire budget and beneficiary assistance

4. Impact of intervention

- Did the project address the needs of all intended beneficiaries in a consistent manner as per project design?
- Did the project achieve its intended impact?
- Has there been any unforeseen or indirect positive or negative impact (to the communities, volunteers, NS)?

5. Sustainability

- Is there sufficient community ownership regarding the project?
- How well has the phase out been planned and managed?
- What are the main factors affecting, either positively or negatively, the sustainability of project outcomes?
- Do lessons from implementation of this project indicate any changes in design in the future to ensure better sustainability?

In addition, this evaluation should examine the level of gender and diversity mainstreaming i.e. how issues specific to groups of men and women of different age and social backgrounds should be taken into account in future, to ensure proper needs assessment and improve effectiveness.

5. Evaluation Methodology

The evaluation will use the following data sources:

- Project proposal, log frame, budget
- Project reports (quarterly, annual), monitoring reports
- Baseline and end line survey results

- Midterm evaluation (MTE) and Impact survey reports
- Specific project related documentation: programmes of organised trainings etc.
- Reference documents: IFRC CBHFA framework

Methodology

The evaluator must adopt a consultative and participative approach. Methods of data collection and analysis to be discussed and defined by the evaluation team, however they should include at least:

- Briefing at the FRC and partner NS to discuss the TOR and the time schedule
- Document analysis/review; a critical review of agreed documents
- Baseline and end line study comparison
- Interviews with key stakeholders including HQ and project staff and volunteers, relevant authorities and other stakeholders
- Field visits and beneficiary interviews

All findings should be evidence based and methodology used and possible limitations explained in the final evaluation report.

6. Deliverables

The evaluation team will provide:

1. **A debriefing on findings** - in country to the MRCS management and project staff at the end of the mission to discuss the initial findings, conclusions and recommendations.
2. **A draft final evaluation report** – after returning from the field visit. The draft will be shared with the FRC, IFRC , MRCS and other relevant stakeholders for comments.
3. **A final (corrected) evaluation report** - The report will have a maximum length of 20 pages, including an Executive Summary. Approval for the report from the FRC, IFRC and RCST.

7. Proposed Timeline (or Schedule).

Desk review: 1 to 3 July 2013

In country evaluation: 3 to 18 July 2013

Report writing and delivery of deliverables: 19 to 25 July 2013

Proposed evaluation plan in the country: to be confirmed

The draft final evaluation report for comments from FRC, IFRC and MRCS

Submission of the final evaluation report: 31 July 2013

8. Evaluation Quality and Ethical Standards

The evaluator should take all reasonable steps to ensure that the evaluation is designed and conducted to respect and protect the rights and welfare of people and the communities of which they are members, and to ensure that the evaluation is technically accurate, reliable, and legitimate, conducted in a transparent and impartial manner, and contributes to organizational learning and accountability. Therefore, the evaluation team should adhere to the evaluation standards of the IFRC.

The IFRC Evaluation Standards are:

1. **Utility:** *Evaluations must be useful and used.*
2. **Feasibility:** *Evaluations must be realistic, diplomatic, and managed in a sensible, cost effective manner.*

- 3. Ethics & Legality:** Evaluations must be conducted in an ethical and legal manner, with particular regard for the welfare of those involved in and affected by the evaluation.
- 4. Impartiality & Independence:** Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.
- 5. Transparency:** Evaluation activities should reflect an attitude of openness and transparency.
- 6. Accuracy:** Evaluations should be technical accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be determined.
- 7. Participation:** Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.
- 8. Collaboration:** Collaboration between key operating partners in the evaluation process improves the legitimacy and utility of the evaluation.

It is also expected that the evaluation will respect the seven Fundamental Principles of the Red Cross and Red Crescent: 1) humanity, 2) impartiality, 3) neutrality, 4) independence, 5) voluntary service, 6) unity, and 7) universality. Further information can be obtained about these principles at:

www.ifrc.org/what/values/principles/index.asp

9. Application Procedures

Considering that the final evaluation need to be done as soon as possible and Finnish RC could not locate any consultant, Arvind Bhardwaj, regional health adviser from Delhi is being asked for the assignment by the IFRC Zone. This will be his mission not as a consultancy.

TOR prepared by

Nana Tsanava

Date and signature:

10 June 2013

Annex: Evaluation work schedule with visit timetable

Logbook- CBHDP evaluation				
	Who	Where	What	Remarks
Thursday 04. July 10.00- 17.00	Dr. Nana, Health Delegate IFRC Myanmar Delegation	IFRC CD, Yangon	Briefing	
	Kyaw Oo Khine, Executive Administrative Office Manager	IFRC CD, Yangon	Briefing	
	Myo Ei Ei Kywe, Health Officer	IFRC CD, Yangon	Desk Review	
Friday 05. July 10.00- 17.00	Mr Udaya Regmi. HOD IFRC Myanmar Delegation	IFRC CD, Yangon	Briefing	
	Dr. Nana, Health Delegate IFRC Myanmar Delegation Myo Ei Ei Kywe, Health Officer	IFRC CD, Yangon	Discussion	
Saturday 06. July 7.00- 17.30	Dr. Mg Mg Hla, HOD (Acting)MRCS Myo Ei Ei Kywe, Health Officer	Yangon to Nay Pyi Taw- Magway	Travel	IFRC vehicle & Driver
Sunday 07. July 9.00- 18.00	Rest	Magway Hotel		
	Dr. Mg Mg Hla, HOD-Health (Acting)MRCS		Interview	
Monday 08. July 7.00 – 8.30	Magway to Natmauk			
	Township RC Executive Member	Natmauk Red Cross Office	Interview	
8:45 - 9:30	U San Oo. Officer ,Township Fire Brigade			
	U Thurain Aung. 2 nd Officer. Township administrative Department			
	U Kyan. Headmaster .Basic Education Middle School			
	U Nyan Shein, Community Leader			
9.30 - 11.10	Township RCV (Daw Than Than Shin, Daw Kyi Kyi Myint, U Phyo Htet, U Than Htike, Daw Cherrier Win, U Ye Thiha Aung)	Natmauk Red Cross Office	Interview	
11.15 – 1.00	Natmauk to Gway Kone			
1.10 -3.00	U Moe Sein, Chair (VRC health committee): U Saw Hla, Chair (VRC committee)	Gyway Kone	Interview	
	Myint Myint Kyi, Khin Than New (Village RCV)	Gyway Kone	Interview	
	Daw Kyi Sein (Beneficiary)	Gyway Kone	Household	

Logbook- CBHDP evaluation				
	Who	Where	What	Remarks
			observation, Interview	
3.00 – 5.30	Gyway Kone village – Natmauk- Magway			
Tuesday 09. July 7.30- 9.30	Magway – Natmauk – Bawaing village			
9.30 – 11.30	Village RC committee member (U Kyaw Soe, U Kyaw Min Oo)	Bawaing village	Interview	
	Village RCV (Khin Zaw Htay, Win Win Aye)	Bawaing village	Interview	
	Kyaw Zayar (Field Supervisor, Natmauk)	Bawaing village	Interview	
	Beneficiaries (Daw Soe Thida, Daw Yu Mar, U Lu Paw)		Household observation, Interview	
12.30 – 1.00	Bawaing village – Kyar Htoo village			
1.00 – 3.00	Beneficiaries (U Nyi Aung, Daw Zin Mar Htay)		Household observation, Interview	
	Tube well & Water tank supported by RC	Kyar Htoo, Primary School	observation	
	U Kyi Lin(Treasurer), U Tin Shwe(Village RC committee member)	Kyar Htoo village	Interview	
	Villager RCV (Nwe Nwe Aye, Myint Myint Htay)	Kyar Htoo village	Interview	
3.00 – 5.30	Kyar Htoo village – Natmauk- Magway	Kyar Htoo village	Interview	
Wednesday 10. July 7.30- 9.00	Magway – Pwint Phyu			
9.00 – 10.00	Township RC Executive Member	Pwint Phyu RC Office	Interview	
	Dr. Thida Tin Win, Township Medical Officer			
	U Phan Tun, Officer- Township Audit Dept			
	U Khin Maung Zaw, Township Police Officer			
	U Kyaw Maung, Community Leader			
	U Htwe Hun, Township Education Officer			

Logbook- CBHDP evaluation				
	Who	Where	What	Remarks
	U Aung Kyee, Headmaster of Primary School			
	U Zaw Win Khaing, Second In Commander of Township RC			
	U Thein Soe Yi, Township Fire Brigade			
10.00 – 11.00	Pwint Phyu – Oak Pho village			
11.00 – 1.00	Village RC committee member & Community Leaders (U Aye Kyaing, U Hla Daung, U Phoe Hmaine, U Kyaw Nyein, U Kyaw Lwin, U Myint Shwe, U Win Zaw Htun)	Oak Pho village	Interview	
	Village RCV (Ei Ei Phyu, Khin Soe Myint, Aung Kyaw Myint, Phyo That Wai)	Oak Pho village	Interview	
	Beneficiary (Daw Kyi Shin)	Oak Pho village	Household observation, Interview	
1.00 – 1.30	Oak Pho village – Inn Gone village			
1.30 – 3.00	Beneficiary (Tin May Hla, U Min San)	Inn Gone Village	Household observation, Interview	
	Village RC committee member (U Thaung Nyunt, U Htay Lwin, U Tin Saung, U Win Aung)	Inn Gone Village	Interview	
	Village RCV (That Lin, Pyae Sithu Kyaw, Khin Zar Tun, Htwe Htwe Maw)	Inn Gone Village	Interview	
3.00 -5.00	Inn Gone Village – Pwint Phyu- Magway			
Thursday 11. July 7.30- 9.30	Magway – Pwint Phyu- Yae Phyu village			
9.30 – 12.00	Village RCV (Ohnmar Khaine, Hmie Wai)	Yae Phyu village	Interview	
	Village RC committee member (U Aung Ko Win, U San Myaint)	Yae Phyu village	Interview	
	Beneficiary (Ma Cho, Ma San San Mu, Hla Lay Thwe)	Yae Phyu village	Household observation, Interview	

Logbook- CBHDP evaluation				
	Who	Where	What	Remarks
12.00 -1.00	Yae Phyu village – Zyaung Chan Kone			
1.00 – 2.45	Village RC committee member (U Aung Htay, U Myo Myint, U Aung Soe Win, U That Naing)	Zyaung Chan Kone	Interview	
	Village RCV (Sithu Aung, Aung San Oo, War War Tun, Wai Wai Lwin, Ye Ye New, Khin Hnin Oo)	Zyaung Chan Kone	Interview	
	Beneficiary (Daw Soe Soe)	Zyaung Chan Kone	Household observation, Interview	
2.45 – 5.00	Zyaung Chan Kone- Pwint Phyu - Magway			
Friday 12. July 7.30- 9.30	Field Supervisors, Assistant Field Supervisors & Project Officer (Natmauk & Pwint Phyu)	Magway Regional RC Office	Interview	
	Regional Medical Officer			
10.30-	Magway - Yangon			

Annex: List of people interviewed

IFRC

1. Dr. Nana Health Delegate IFRC Myanmar Country Delegation

MRCS HQ

1. Dr. Mg Mg Hla Head of Division (Acting)
2. U Myo Swe Project Officer (previous Field Supervisor of Natmauk)

Townships

1. Kyaw Zayar Natmauk - Field Supervisor (previous Assistant field supervisor)
2. Aye Myat Min Pwint Phyu – Field Supervisor
3. Nyi Nyi Zay Pwint Phyu – Assistant Field Supervisor

Township RC Executive Committee member: 8 - Natmauk (7 M/1 F) and 8 - Pwintphyu (7 M/1 F)

Township RC volunteer: 6 – Natmauk (3 M/ 3 F)

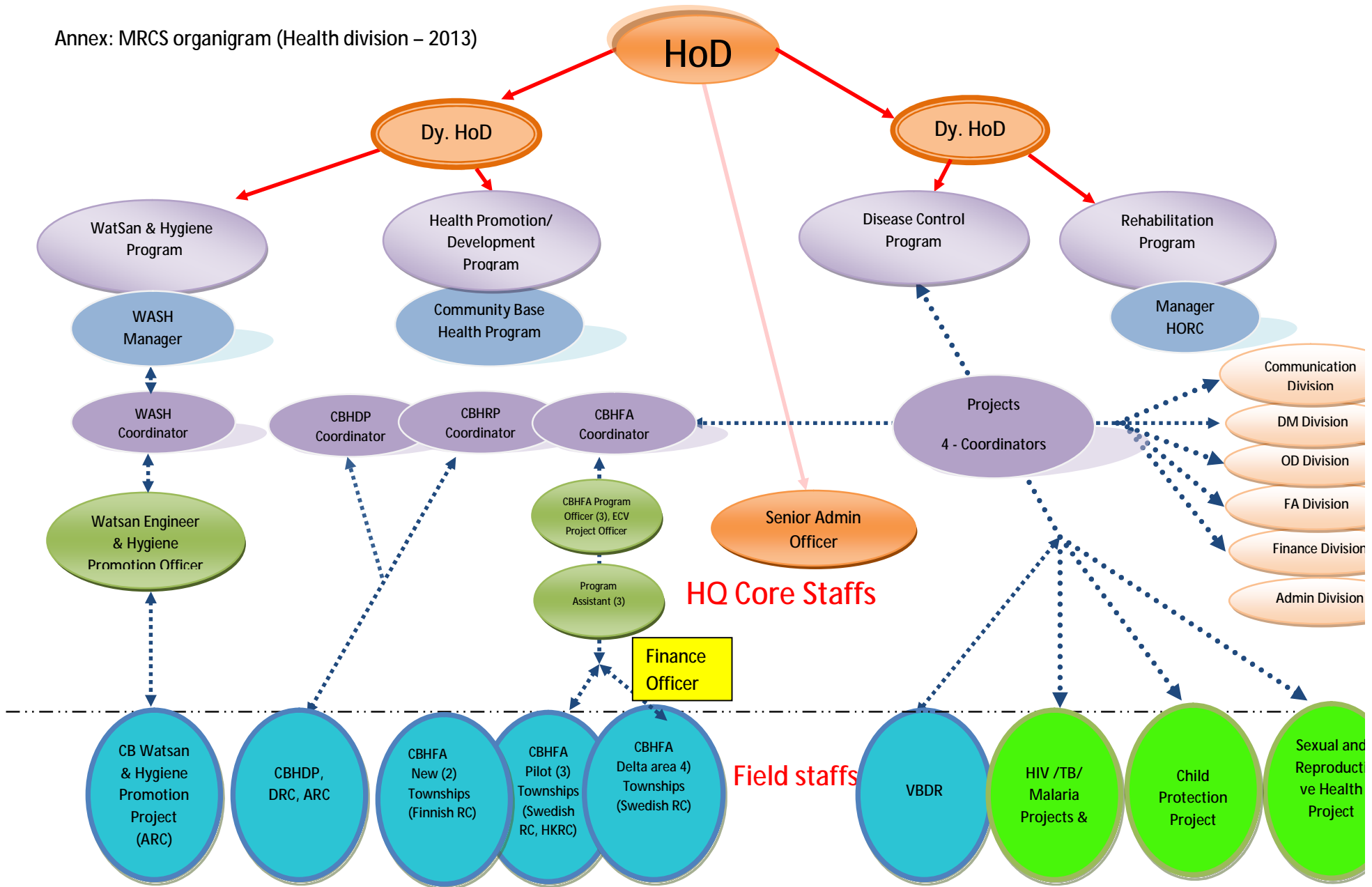
Villages

In Natmauk: 1) Gyway Kone; 2) Bawaing; 3) Kyar Htoo in Natmauk

In Pwint Phyu: 1) Oak Pho; 2) Inn Gone; 3) Yae Phyu ; 4) Zyaung Chan Kone

Interviewed Village Red Cross Committee member (23 Males)	
1. U Moe Sein	12. U Myint Shwe
2. U Saw Hla	13. U Win Zaw Htun
3. U Kyaw Soe	14. U Thaug Nyunt
4. U Kyaw Min Oo	15. U Htay Lwin
5. U Kyi Lin	16. U Tin Saung
6. U Tin Shwe	17. U Win Aung
7. U Aye Kyaing	18. U Aung Ko Win
8. U Hla Daung	19. U San Myaint
9. U Phoe Hmaine	20. U Aung Htay
10. U Kyaw Nyein	21. U Myo Myint
11. U Kyaw Lwin	22. U Aung Soe Win
	23. U That Naing
Interviewed Village Red Cross Volunteers (7 Males/ 15 Females)	
1. Ma Myint Myint Kyi	12. U Pyae Sithu Kyaw
2. Ma Khin Than New	13. Ma Khin Zar Tun
3. U Khin Zaw Htay,	14. Ma Htwe Htwe Maw
4. Ma Win Win Aye	15. Ma Ohnmar Khaine
5. Ma Nwe Nwe Aye	16. Ma Hmie Wai
6. Ma Myint Myint Htay	17. U Sithu Aung
7. Ma Ei Ei Phyu	18. U Aung San Oo
8. Ma Khin Soe Myint	19. Ma War War Tun
9. U Aung Kyaw Myint	20. Ma Wai Wai Lwin
10. U Phyo That Wai	21. Ma Ye Ye New
11. U That Lin	22. Ma Khin Hnin Oo
Interviewed Villagers in house hold visits (3 Males/ 9 Females)	
1. Daw Kyi Sein	7. Daw Kyi Shin
2. Daw Soe Thida	8. Daw Tin May Hla
3. Daw Yu Mar	9. U Min San Ma Cho,
4. U Lu Paw	10. Ma San San Mu
5. U Nyi Aung	11. Ma Hla Lay Thwe
6. Daw Zin Mar Htay	12. Daw Soe Soe

Annex: MRCS organigram (Health division – 2013)



Annex: Pictures from the field visits



