Palestinian National Authority

FY2015 Ex-Post Evaluation of Technical Cooperation Project
"Project for Improving Maternal and Child Health and Reproductive Health in Palestine (Phase 2)"

External Evaluator: Hiroko Matsuki, Kaihatsu Management Consulting, Inc.

0. Summary

This project was implemented with the objective of improving maternal and child health and reproductive health throughout the territory of the Palestinian National Authority (the West Bank and the Gaza Strip) through promoting the "Mother and Child Health Handbook" (hereinafter referred to as "MCHHB"), and by providing technical training.

Both at the time of planning and completion of the project, the objective of the project was aligned with the National Health Strategy, which focused on enhancing primary health services and development needs. The project was also highly consistent with Japan's policy of overseas development assistance of prioritizing humanitarian support at the time of planning. Therefore, its relevance is high. As a result of the project's interventions, the distribution rate of MCHHB reached 100 percent at facilities of the Ministry of Health, the implementing agency, United Nations Relief and Works Agency for Palestine Refugees (UNRWA) and non-government organizations (NGOs). Information on mothers and children was more likely to be shared between facilities through the use of MCHHB; this contributed to some improvement in continuity of perinatal care in those facilities, as well as in the number of clients who received antenatal, postnatal and child care increased. The project, however, did not implement sufficient activities to engage with private facilities - the project just introduced the MCHHB to private doctors at seminars, and gave them posters on the MCHHB. It is unlikely that these limited interventions led to improved distribution and utilization of the MCHHB in the private sector, which means that the project purpose was achieved only partially. Therefore, effectiveness and impact of the project are fair. Both project cost and period are within the plan, therefore, the efficiency of the project is high. Sustainability is fair, because the Ministry of Health, the implementing agency, does not have a system to distribute and manage the MCHHB for private facilities; there is no major concern on policy, technique, and finance.

In light of the above, this project is evaluated as satisfactory.

1. Project Description

Project Locations

Source: United Nations Geospatial Information Section

A nurse filling in the MCHHB

Source: the evaluator

1.1 Background

The "Project for Improving the Reproductive Health with a Special Focus on Maternal and Child Health in Palestine" (hereinafter referred to as "Phase 1"), which was implemented from August 2005 to July 2008, developed an Arabic version of the MCHHB and its guidelines[1] for managing utilization of the MCHHB. Phase 1 contributed to standardizing services on mother and child health, improving patient satisfaction, and raising awareness of people in the pilot areas.[2] There were still some issues such as insufficient distribution of the MCHHB in the country and lack of a system to secure sustainability of the MCHHB at the time of completion of Phase 1, as shown in Table 1.

Table 1：Remaining issues at the time of completion of Phase 1

The MCHHB had not been distributed nationwide.	・ The MCHHB had not been distributed to hospitals, private facilities or the Gaza Strip. ・ The MCHHB had been distributed with duplications. ・ Awareness campaigns, such as home visits and health education seminars for local residents (including men, women and the youth), had only been implemented in communities of the pilot areas.
Health staff did not have enough technical capacity.	・ Health staff did not have sufficient technical capacity, for example, in perinatal care, ultrasound examinations, screening of high-risk pregnancy, and communication with patients. It is necessary to strengthen their capacity to provide appropriate services, in tandem with using the MCHHB, to improve services on maternal and child health and reproductive health.

[1] The "Palestine National Manual for the MCHHB" developed by NCC in the project was based on the guidelines of Phase 1.

[2] Pilot areas were Jericho and part of Ramallah.

There was no system to secure sustainability of the MCHHB.	・ The Ministry of Health had not established a system to manage stock and monitor the MCHHB in a sustainable way.

Source: made by the evaluator based on the Preliminary Survey Report

Based on the above issues, the "Project for Improving Maternal and Child Health and Reproductive Health in Palestine (Phase 2)" (hereinafter referred to as "the Project") was implemented with the objective of improving services on maternal and child health (hereinafter referred to as "MCH") and Reproductive Health (hereinafter referred to as "RH") in the entire area of Palestine.

1.2 Project Outline[3]

Overall Goal		Health among women and children is improved in the West Bank and the Gaza Strip.
Project Purpose		Maternal and child health (MCH) and Reproductive Health (RH) services are improved in the West Bank and the Gaza Strip.
Output	Output 1	Coverage and utilization of MCHHB are improved.
	Output 2	Perinatal knowledge and technical skills of MoH/PHC[4] center staff are strengthened.
	Output 3	National Coordination Committee (NCC) is functioning as MCHHB policy making and implementing/supervising body.
	Output 4	Community awareness on MCH and RH is raised.
	Output 5	Enhance project implementation by monitoring and evaluation of Project activities.
Total cost (Japanese side)		319 million yen
Period of Cooperation		November 2008 - November 2012
Implementing Agency		Ministry of Health (MoH)
Other Relevant Agencies / Organizations		UNRWA: Provides basic social services such as education, health and social welfare for Palestinian refugees living in the Middle East. As part of its services, UNRWA manages PHC centers in Palestine, where it distributes the MCHHB.[5]
Supporting Agency/ Organization in Japan		None

[3] The PDM used by the ex-post evaluation is the final version revised in November 2009. The PDM was revised twice during the project period: in April 2009, at the first joint coordination committee, and November 2009, at the second joint coordination committee.

[4] PHC means Primary Health Care. The PHC center is a subsidiary organization of the Ministry of Health, which provides primary health care.

[5] UNRWA participated in discussions on development of the MCHHB and pilot activities in Phase 1, which led to its decision to start distribution of the MCHHB in the West Bank in 2008, and the Gaza Strip in 2009. UNRWA has expanded its distribution to its facilities in Jordan, Syria and Lebanon since 2010. UNRWA participated in the Project as a regular member of NCC, and continues to distribute and utilize the MCHHB and make a regular report to the MoH.

Related Projects	The Grant Aid Project for Improving the Control of Infectious Diseases Among Palestinian Children: The project supported printing 380,000 copies of the MCHHB in 2008.[6]

1.3 Outline of the Terminal Evaluation

1.3.1 Achievement Status of Project Purpose at the Time of the Terminal Evaluation

The terminal evaluation, which was implemented in July 2012, concluded that the prospect of achievement of the project purpose was generally high in many aspects by confirming that the Project contributed to integrating the MCHHB into a system of MCH/RH services, and improving continuity of perinatal care. The evaluation, however, identified several issues such as low completion of "Hospital Remarks",[7] which is one of the items in the MCHHB that should be filled in by hospital health staff,[8] and limited distribution of the MCHHB in private facilities.

1.3.2 Achievement Status of Overall Goal at the Time of the Terminal Evaluation

The terminal evaluation anticipated that several indicators of the overall goals, such as the distribution rate of MCHHB to pregnant women, the percentage of children receiving vitamin A and D supplements, and prevalence of exclusive breastfeeding, would be achieved to some extent. The evaluation, however, could not foresee the achievement of some health indicators, such as the prevalence of anemia, maternal mortality rate and infant mortality rate, because there were many factors that influenced women and children's health in addition to the MCHHB.

1.3.3 Recommendations at the Time of the Terminal Evaluation

The following table shows the recommendations made by the terminal evaluation, and the status of those issues at the time of the ex-post evaluation.

Recommendations made by the terminal evaluation (Summary)	Status of the issues at the time of the ex-post evaluation
(1) The function and the responsibility of the NCC secretariat should be streamlined to MoH and simplified. Procedure for periodic revision of MCHHB contents through NCC should also be elaborated.	The function and the responsibility of NCC was transferred to the Community Health Department (hereinafter referred to as "CHD)" of MoH, which continues to manage the MCHHB and its revision regularly. The

[6] This Grant Aid was given by the Japanese government through UNICEF, and supported printing 380,000 copies of the MCHHB and 1,500 copies of the monthly report format – these were enough copies until 2013, and underpinned the initial stage of national distribution of the MCHHB.

[7] The "Hospital Remarks" are divided into examination of mother and examination of newborn. Items of the mother's examination include date and hour of delivery, mode of delivery, episiotomy, perineal tear, bleeding after delivery, blood transfusion, and diagnosis. Items of newborn's examination include pregnancy outcome, weight, length, vital signs, Apgar score, starting breastfeeding, congenital malformation, medication, hepatitis B1, and diagnosis.

[8] Health staff who fill in the MCHHB are obstetricians and gynecologists, midwives and nurses.

Recommendations made by the terminal evaluation (Summary)	Status of the issues at the time of the ex-post evaluation
	department has integrated MCHHB formats into their existing documents to simplify the procedures.
(2) Efforts should be made to increase MCHHB recording by doctors in public hospitals. It is preferable to conduct activities to raise awareness among the doctors about the importance of the MCHHB, together with follow-up activities to increase their compliance.	According to the beneficiary survey (please refer to Table 11) at the time of the ex-post evaluation, data entry was 46 percent, which was lower than other pages, such as those on immunization and child measurement. MoH has not implemented follow-up activities or awareness activities for hospital staff such as obstetricians and gynecologists, midwives and nurses.
(3) Follow-up should be with the training institutions (colleges) to facilitate integration of the MCHHB into pre-service training of doctors, nurses and midwives.	The Project conducted follow-up seminars, which, however, did not lead to introduction of the MCHHB into curricula at schools apart from Ibn Sina Nursing Collage.
(4) The achievements of the Project and its lessons should be compiled and widely shared among stakeholders related to the promotion of the MCHHB, and to MCH and RH.	The Project developed a joint brochure on the MCHHB in cooperation with all seven partner organizations (JICA, MoH, UNRWA, and four NGOs), which were distributed to relevant organizations.
(5) Efforts should be initiated to secure sufficient internal budget for printing and nationwide distribution of the MCHHB after 2014. The roles and responsibilities of the relevant department within MoH for planning, budgeting, printing, distribution, and monitoring of the MCHHB should be clarified.	MoH has secured budgets for printing. There are no issues on the roles and responsibilities as CHD is in charge of planning, budgeting, printing, distribution, and monitoring of the MCHHB as a whole.
(6) Arrangements should be made with NGO partners to initiate the use of MCHHB in their PHC Centers in the Gaza Strip.	The current status could not be checked by the ex-post evaluation.
(7) Continuous training of healthcare providers on effective utilization of the MCHHB should be planned and organized by MoH. Training packages developed by the Project can be used in such training.	Although continuous training has not been planned or organized, MoH uses contents of training for On the Job Training (OJT) of new staff.
(8) Policies, strategies and practical interventions to operationalize use of the MCHHB in the private sector should be elaborated and discussed in NCC. The possibility of including private sector representatives in NCC should be considered to facilitate such a process.	Focal persons from the private sector were appointed as NCC members. NCC, however, has not established any policies, strategies or practical interventions for the private sector.

2. Outline of the Evaluation Study

2.1 External Evaluator

Hiroko Matsuki, Kaihatsu Management Consulting, Inc.

2.2 Duration of Evaluation Study

Duration of the Study: September, 2015 – November, 2016

Duration of the Field Study: January 10, 2016 – January 28, 2016, and
April 13, 2016 – April 20, 2016

2.3 Constraints during the Evaluation Study

The PDM of the Project has several indicators for which the evaluator could not find appropriate data as of the project completion and ex-post evaluation. Additionally, for some indicators the evaluator could not assess the degree of improvement at the time of project completion and ex-post evaluation due to a lack of baseline data. Due to these conditions, the ex-post evaluation filled gaps in quantitative data with qualitative data.

3. Results of the Evaluation (Overall Rating: B[9])

3.1 Relevance (Rating: ③[10])

3.1.1 Relevance to the Development Plan of Palestine

"The Palestinian Reform and Development Plan" at the time of project planning, and "The National Development Plan" at the time of project completion set the health sector as a prioritized area. At the time of project planning, "The Palestinian National Health Strategy (2008-2010)" included the provision of comprehensive primary health services, including community health, women, and reproductive health, as one of its strategic objectives. "The Palestinian National Health Strategy (2011-2013)" at the time of project completion similarly focused on improving primary health services. The objective of the Project, which was improving MCH/RH services was, therefore, in line with the policies and priorities of Palestine at the time of planning and completion.

3.1.2 Relevance to the Development Needs of Palestine

In Palestine, the movement of women and health staff such as doctors and midwives has been restricted due to conflicts, separation walls or curfews, which has affected the health of women and children.[11] At the time of project planning in 2008, the maternal mortality rate, child mortality rate and prevalence of anemia among pregnant women in Palestine was at an equivalent or relatively higher level to that in neighboring countries, as depicted in Table 2. According to the preliminary evaluation report the country faced several challenges to mother and child health, such as insufficient technical and communication capacity among health staff, and a low percentage of postnatal visits - around 30 percent - compared to that of antenatal

[9] A: Highly satisfactory, B: Satisfactory, C: Partially satisfactory, D: Unsatisfactory

[10] ③: High, ② Fair, ① Low

[11] MoH confirmed 69 deliveries carried out at checkpoints between 2000 and 2006. (Source: "Health in the Occupied Palestinian Territory 2 Maternal and Child Health in the Occupied Palestinian Territory" (2009) Lancet)

visits of more than 90 percent.

At the time of project completion there were continuing issues relating to MCH, as the child mortality rate had stayed the same, and the prevalence of stunting in children had increased.[12] Because it had been facing MCH/RH-related challenges both at the time of planning and completion, the Project, whose objective was to improve MCH/RH services, was relevant to the needs of Palestine.

Table 2 : Comparisons of health indicators between Palestine and neighboring countries

		Palestine	Jordan	Egypt	Israel
Maternal Mortality Rate /100,000	At the time of the project planning[13]	59	59	82	7
	At the time of the project completion[14]	53	53	50	5
Child Mortality Rate /1,000	At the time of the project planning	27	20	23	5
	At the time of the project completion	23	19	21	4
Prevalence of anemia among pregnant women	At the time of the project planning	29.4%	29.4%	30.7%	23.1%
	At the time of the project completion	29.2%	27.0%	30.4%	23.9%

Source : The maternal mortality rate comes from data of the United Nations Population Fund (UNFPA), and the child mortality rate from UNICEF's "State of World Children". Data on anemia is from the World Bank's "Health nutrition and population statistics", except for Palestine, where data comes from MoH annual reports (West Bank only).
Note: Child Mortality rate gives the probability of dying between birth and exactly five years of age, expressed per 1,000 live births.

3.1.3 Relevance to Japan's ODA Policy

The Japanese Government's Country Assistance Policies for Palestine (as of January 2005) at the time of project planning focused on humanitarian support for ensuring human security. The Policies highlighted that the Japanese government would show a "peace dividend" in concrete ways by supporting improvements in people's livelihoods including employment promotion to ensure movement towards peace. The Millennium Development Goals, on which the Japanese government and JICA placed importance, also focused on health improvements among pregnant and parturient women, and children. Because the Project aimed at improving MCH/RH services through distribution of the MCHHB and provision of training, it would contribute to improving people's livelihood to enjoy a "peace dividend", and the Project was consistent with Japanese ODA policy.

This project was highly relevant to the country's development plan and development needs, as well as Japan's ODA policy. Therefore, its relevance is high.

[12] Source: The National Health Strategy (2011-2013)
[13] As of 2008
[14] As of 2012

3.2 Effectiveness and Impact[15] (Rating: ②)

3.2.1 Effectiveness

3.2.1.1 Project Output

<Output 1> Achieved Partly

Output 1 was "coverage and utilization[16] of MCHHB are improved". At the time of project completion, the MCHHB was utilized at all facilities of MoH, UNRWA and four cooperating NGOs,[17] and the effectiveness of distribution and management of the MCHHB had been improved. Output 1, however, had some limitations in that there was no information about the increase of the filling rate or the number of private facilities that had started using the MCHHB. In addition, the involvement of medical and nursing schools had not been increased much. Thus, the evaluator concludes that Output 1 was achieved partly. The status of achievements of indicators are shown as follows:

- Indicator 1 : Distribution rate of MCHHB out of the number of live births is increased. <Achieved>

The distribution rate[18] of the MCHHB in the West Bank was 163 percent as of 2008, which indicated a high level of duplication and inefficiency. The rate decreased to 116 percent in 2011 by addressing the issue of duplication in distribution through providing orientation training. In the Gaza Strip, UNRWA started distribution of the MCHHB in 2009; this was followed by MoH in 2010, and then achieved the rate of 116 percent in 2011. At the time of project completion in 2012, the rate was 111 percent in the West Bank, and 113 percent in the Gaza Strip. Thus, Indicator 1 was achieved.

Table 3：Distribution rate of MCHHB per number of live births
(MoH, UNRWA, NGOs)

	2008	2009	2010	2011	2012
West Bank	163%	115%	106%	116%	111%
Gaza Strip	0%	71%	104%	116%	113%

Source: MoH CHD, MoH Gaza, UNRWA

[15] Sub-rating for Effectiveness is to be put with consideration of Impact.

[16] "Utilization" means to utilize the MCHHB as a portable medical record, health education tool, and national common tool according to the Palestine National Manual for the MCHHB.

[17] Four cooperating NGOs are 1) Palestine Red Crescent Society, 2) Palestinian Medical Relief Society, 3) Palestinian Family Planning and Protection Association, 4) Health Work Committees. All of them are humanitarian support agencies.

[18] The distribution rate = numbers of MCHHB / number of live births at all facilities. Indicator 1 aims to increase the distribution rate, which can be interpreted as that the rate should be 100 percent if there is no inefficient duplication of distribution.

- Indicator 2: Filling rate of MCHHB is increased. <Unknown>

The MCHHB evaluation survey,[19] conducted by the Project in 2012, revealed the status of two aspects of filling in the forms in the MCHHB: 1) entry rate, and 2) data entry. The entry rate means the extent to which the necessary items on each page are filled in by health staff; data entry shows the proportion of the MCHHB into which health staff entered some data (regardless of extent). According to the survey the entry rate was between 10.6 percent and 93.4 percent, and data entry was between 19.2 percent and 98.7 percent by item. There was no data, however, at the time of project planning and completion, which prevents the evaluator from assessing improvement in the rates. Thus, the status of achievement of Indicator 2 is not known.

- Indicator 3 : Number of MCH/PHC centers and hospitals of the MoH and Stakeholder which utilize MCHHB is increased. <Achieved>

In the West Bank all health facilities managed by MoH, UNRWA and cooperating NGOs were utilizing the MCHHB as of 2011. Likewise, in the Gaza Strip, all health facilities of MoH and UNRWA were utilizing the MCHHB as of the same year. Because the number of facilities of MoH and stakeholders utilizing the MCHHB increased as depicted in Table 4, Indicator 3 was achieved.

Table 4: Number of health facilities of MoH and stakeholder that utilize the MCHHB

Types of target health facilities	2010		2011	
	West Bank	Gaza	West Bank	Gaza
MoH PHC Centers	356/356[20]	36/36	356/356	36/36
MoH hospitals	0/10	NA	10/10	NA
UNRWA clinics	41/41	20/20	41/41	20/20
UNRWA hospitals	1/1	0/0	1/1	0/0
NGO clinics	21/38	NA	38/38	NA
Combined clinics	23/23	0/0	23/23	0/0

Source：Terminal Evaluation Report

- Indicator 4：Number of private clinics and hospitals[21] which use MCHHB is increased. <Unknown>

MoH does not have accurate information on the number of private facilities and the status of distribution of the MCHHB among them at the time of project planning and completion, which meant the evaluator was unable to assess the level of achievement of Indicator 4.

[19] The survey areas were 12 districts of the West Bank. Interviews were conducted with 865 mothers who came to a clinic of UNRWA or MoH for child immunization (1-4 months) and brought the MCHHB on the interview day.

[20] 356/356 means that 356 out of target 356 facilities utilize the MCHHB.

[21] Clinics provide primary health services such as antenatal and postnatal examination, pediatric services, vaccination and family planning, whereas hospitals provide secondary and tertiary medical services. In Palestine, most deliveries are carried out at hospitals (according to MoH annual report 2014, 99.6% of live births are reported at hospitals in the West Bank, and 100% at the Gaza Strip).

Interventions with private facilities were limited in that the Project only held seminars with private doctors to inform them about the MCHHB, and distributed a poster to raise awareness. The Project did not provide training in utilizing the MCHHB or monitor activities. Thus, it is hard to conclude that the Project contributed to increasing the number of private facilities that utilize the MCHHB to a considerable degree. The Project found it difficult to implement enough activities with the private sector, as the MoH did not have an adequate system to guide and supervise private facilities.[22]

- Indicator 5 : Supply and stock are controlled by the designated monitoring format. <Achieved>

The Project developed reporting formats for managing the supply and stock of the MCHHB. MoH facilities and four NGOs have used these formats since 2011 when reporting to CHD of MoH. UNRWA practices stock management using their own system, and reports the results to CHD once a year. As the supply and stock were managed, Indicator 5 was achieved.

- Indicator 6 : Number of medical and nursing schools which introduced benefits and utilization of MCHHB in their curriculum is increased. <Not achieved>

Only the Community Health Worker College managed by the Palestinian Medical Relief Society was using the MCHHB as a health education tool in its curriculum at the time of project planning. Ibn Sina Nursing College of MoH incorporated the benefits and utilization of the MCHHB in its curriculum in 2010. Although the indicator did not have a target figure, the level of achievement was not sufficient as only one school introduced the MCHHB as part of curriculum during the project period. Thus, Indicator 6 was not achieved.

<Output 2> Largely Achieved

Output 2 was "perinatal knowledge and technical skills of MoH/PHC center staff are strengthened". The Project provided technical training, which improved the knowledge and

[22] Private facilities and doctors have to get a license from MoH. All private hospitals are given licenses and MoH has information on the number of private hospitals. At the time of ex-post evaluation (April 2016), there were 52 hospitals in total in the West Bank (14 governmental hospitals, 29 private, 1 UNRWA, and 8 hospitals inside Jerusalem). Private hospitals account for more than half of the total hospitals, and play an important role in the health sector of Palestine.

The proportion of live births by type of hospital is 54.1% in government hospitals, and 45.5% in non-government hospitals in the West Bank, whereas it is 74.5% in government hospitals and 22.8% in non-government hospitals in the Gaza Strip (source: MoH annual report 2014). As non-government hospitals include private and UNRWA hospitals, we cannot identify the number of live births in private hospitals. Considering the larger number of private hospitals mentioned above, it can be said that a sizable number of deliveries are carried out in private hospitals.

Private doctors and clinics similarly are required to get licenses. However, MoH does not know the accurate number of those doctors and clinics because there are a significant number who provide medical services without them. According to MoH reports the total number of private clinics with licenses is 750, including UNRWA and NGOs.

technical skills of PHC center staff of MoH as well as general practitioners. In addition, health staff are able to use the equipment such as ultrasound diagnosis machines and mercury manometers provided by the Project without a problem. It is not known, however, if communication between mothers and staff has improved. Thus, Indicator 2 was largely achieved.

- Indicator 1：Knowledge and skills of trainees are improved. <Achieved>

The Project provided "Antenatal Care Technical Training" and "Obstetric Ultrasound Training" for PHC center staff and general practitioners respectively. The tests carried out after both training programs indicated improvement in knowledge and skills of participants.[23] Thus, Indicator 1 was achieved.

- Indicator 2：Patient/client satisfaction is increased.

The evaluator decided to use Indicator 2 as an indicator of the project purpose because satisfaction of patients/clients is more relevant to assess an improvement in services.

- Indicator 3：Communication between health care staff and patient/client is improved. <Unknown>

The evaluator understood that setting Indicator 3 meant that the Project expected the provision of training to contribute to improving communication between staff and patients or clients. According to the MCHHB evaluation survey in 2012, most visitors (71.3 percent) responded that they had consultations with doctors and/or nurses using the MCHHB at PHC centers. The evaluator, however, could not appraise the extent to which communication had improved due to lack of baseline data. At interviews in the ex-post evaluation survey, a few staff and mothers answered that the frequency of communication increased after starting to use the MCHHB; this, however, was not sufficient to conclude that capacity building through training contributed to improving communication between staff and clients. Therefore, the status of Indicator 3 is not known.

- Indicator 4：Allocated equipment are used as planned. <Achieved>

At the time of project completion, as expected, PHC center staff of MoH were able to operate equipment allocated by the Project such as ultrasound diagnosis machines and mercury manometers without difficulty. Thus, Indicator 4 was achieved.

[23] According to JICA documents, the evaluation points of Antenatal Care Technical Training increased from average 71.0 ± 17.5 to average 88.5 ± 10.2 after the training (total number of participants was 538). Similarly, all 23 participants passed the post evaluation test (both the paper examination and practical examination) after the training in Obstetric Ultrasound.

<Output 3> Achieved Partly

Output 3 was "NCC is functioning as MCHHB policymaking and implementing/supervising body". As shown in Table 5, NCC was expected to promote and supervise nationwide implementation of the MCHHB, and to coordinate stakeholders in order to improve MCH/RH services through the MCHHB in a sustainable way. At the time of project completion, a management system promoting utilization and supervision of the MCHHB had been established with the development of the "Palestine National Manual for the MCHHB". On the other hand, NCC was not able to supervise supply and stock management on its own initiative,[24] even though this was part of their supervisory role. As NCC functioned below the expected level, Output 3 was achieved partly.

Table 5: Outline of NCC for the MCHHB

Basis of establishment[25]	Decision of Minister of Health
Mission of NCC	(1) Promote and supervise nationwide implementation of the MCHHB as the national common tool. (2) Coordinate with other national programs related to RH/ MCH within the MCHHB such as antenatal care, postnatal care, continuum care (PHC & Secondary care), family planning, immunization, integrated management of childhood illness, child growth monitoring, maternal & child nutrition, health education & health promotion (community awareness), etc.
Role of NCC	(1) Approve the suggested policy, strategy, activities and work plan including financial plan that are prepared by the Taskforce for MCHHB. (2) Strengthen coordination among members and stakeholders (government, non-government, national and international agencies, including donors). (3) Facilitate the Taskforce in order to discuss work on some technical tasks such as development and revision of the MCHHB and related materials.
Role of Taskforce	(1) Develop and revise the MCHHB and related materials. (2) Analyze the MCHHB related data and submit the result of the analysis as a report (or minutes of meetings) to the NCC. (3) Based on the analysis, submit the suggested countermeasures to the NCC for approval, if necessary. (4) Execute the tasks assigned by the NCC, such as implementation of the MCHHB related workshops and trainings.
Regular Members	(1) Chairperson：Director General of Primary Health Care & Public Health Directorate, MoH (2) Deputy Chairperson：Director General of Women's Health and Development Directorate, MoH (3) Secretariat：CHD, Primary Health Care & Public Health Directorate, MoH (4) Main members：Primary Health Care & Public Health Directorate, Hospital General Directorate, Director of Nursing Unit, Director of Licensing Unit, UNRWA, four cooperating NGOs, and the Obgyn Society

Source : "The National Coordination Committee for the MCH Handbook Terms of Reference" as of April 6, 2010 and the member list as of April 27, 2012

[24] The JICA expert team took the lead in this instead of NCC due to a lack of human resources in CHD. (source: JICA documents)

[25] NCC is a committee established through a decision of ministers in order to coordinate activities and opinions of various stakeholders.

- Indicator 1 : Defined coverage criteria (supply/stock, distribution and filling) of MCHHB is complied among different stakeholders. <Achieved>

Indicator 1 means that the NCC knows the status of coverage criteria, which indicates numbers of supply/stock, distribution and filling of forms that are reported by each stakeholder complying with the "Palestine National Manual for the MCHHB"[26]. The Taskforce of NCC compiled the "Palestine National Manual for the MCHHB", which was authorized by NCC in April 2010. MoH facilities and NGOs started using the reporting format developed for managing the supply and stocks of the manual from 2011 to make a report to CHD. UNRWA managed stock of the MCHHB using their own system and reported the results to MoH once a year. As NCC received these reports, they knew the status of coverage criteria regularly.[27] Thus, Indicator 1 was achieved.

- Indicator 2 : Defined monitoring method of MCHHB is complied for nationwide monitoring and evaluation of MCHHB. Indicator 3 : Compliance of defined coverage criteria and monitoring method is supervised by NCC. <Partially Achieved>

Both Indicator 2 and 3 meant that each stakeholder implements monitoring activities of the MCHHB under supervision of NCC. At the time of project completion, MCH supervisors of each directorate were making regular visits to PHC centers of MoH, in which they checked how staff performed and utilized the MCHHB. It seemed that NGOs and UNRWA similarly monitored utilization of the MCHHB using their own system, whose details, however, were not reported to NCC. Thus, Indicator 2 and 3 were achieved partially.

- Indicator 4 : MCH/RH Services with MCHHB is sustained by securing budget. <Achieved>

In 2008, the Project printed 380,000 copies of the MCHHB and 1,500 copies of the monthly reporting format with a financial support of Grant Aid from the Government of Japan through UNICEF; this number of copies will be enough until 2013. Because budget was secured to sustain provision of MCH/RH services through the MCHHB at the time of project completion, Indicator 4 was achieved,

<Output 4> Not Achieved

Output 4 was "community awareness on MCH and RH is raised". The original plan was that the Project would subcontract to an NGO to implement intensive awareness campaigns in specific areas. After that, MoH would expand a national health promotion based on experiences

[26] It was confirmed by JICA that Indicator 5 of Output 1 is for stakeholders, whereas Indicator 1 of Output 3 is for NCC.

[27] It was confirmed by JICA that the "filling" in Indicator 1 means whether the MCHHB has been started to be used at facilities, which was checked by JICA project team directly.

of these campaigns.[28] The plan for subcontracting to an NGO, however, was cancelled due to an objection from MoH.[29] Furthermore, at the time of the mid-term review, it was decided to put a priority on Output 1 and 2 because project activities had fallen behind schedule.[30] This led to scaling down the activities of Output 4, without implementation of intensive awareness campaigns. Instead, the Project developed calendars and brochures related to MCH/RH and distributed these to governmental facilities and other stakeholders. Outcomes of raising awareness and improving knowledge at a community level were not measured. The evaluator concludes that Output 4 was not achieved because the Project neither implemented planned activities fully, nor measured the degree of improvement in awareness and knowledge. As mentioned below, level of achievement of indicators is not known due to lack of information.

- Indicator 1：Bringing rate of MCHHB to the MoH's MCH/PHC centers, hospitals and high risk clinics is increased. (mothers, children) <Unknown>

The bringing rate of the MCHHB was 97.4 percent and 98.3 percent in 2009 and 2010 respectively. The MCHHB evaluation survey of 2012 revealed the frequency of bringing the MCHHB: "always bring" 69.0 percent and "sometimes bring" 25.3 percent. The evaluator, however, was not able to assess changes in the bringing rate because the definition of the rate and scope of interviews were different between those surveys.[31]

- Indicator 2：Ownership rate of MCHHB is increased. <Unknown>

The Palestine Family Health Survey, which was conducted by the Palestinian Central Bureau of Statistic nationwide in 2010, revealed that, from women aged 15-49 with experience of delivery within the previous two years, 83.5 percent of the respondents owned an MCHHB in the West Bank, and 62.3 percent in the Gaza Strip. It is not possible to tell, however, if the ownership rate has increased due to lack of either baseline data or data at the time of project completion.

- Indicator 3：Communication (sharing information related to MCH/RH issues) among family member is improved. <Unknown>

[28] The target area, beneficiaries and purpose of the activities were not decided at the time of project planning, as the detailed plan was to be made in the first year of the project.

[29] MoH's reasons for the objection were that 1) MoH has a broader area coverage than an NGO, and 2) MoH should take the initiative as an implementing agency of the Project.

[30] The reasons for the delay in activities were that 1) the Project took time to develop a national manual for the MCHHB, and 2) it took time to make a detailed plan of training.

[31] Data for 2009 and 2010 comes from annual reports of MoH. The scope of the survey was only MoH PCH centers in the West Bank. The bringing rate indicates the proportion of women who receive the MCHHB at clinics and bring it to the following visit. MoH does not collect this data after 2010. On the other hand, the MCHHB evaluation survey in 2012 asked about the frequency of bringing by targeting mothers who visited MoH or UNRWA PHC centers in the West Bank.

In the MCHHB evaluation survey of 2012, most of the pregnant women (64.5 percent) of those owning the MCHHB responded that they had shown the MCHHB to their family members. The evaluator, however, cannot determine whether communication among family members has improved, because showing the MCHHB does not necessarily mean an improvement in communication. In addition, data was not collected at the time of project planning and completion.

- Indicator 4：Knowledge on MCH and RH is improved. <Unknown>

The MCHHB evaluation survey in 2012 showed that 92.6 percent of pregnant women owning the MCHHB had read the pages on health education and information on pregnancy, which, however, does not necessarily indicate that their knowledge has improved. It is not possible to tell whether knowledge has improved due to lack of data both at the time of project planning and completion.

<Output 5> Not Considered

Output 5 was "enhance project implementation by monitoring and evaluation of Project activities". The evaluator decided not to consider Output 5 for evaluating achievements of the project purpose. Monitoring and evaluation of activities, holding of joint coordination committees, and recording of minutes of meetings are supposed to be conducted in any technical cooperation project. Though the activities of Output 5 such as recording of minutes of meetings were implemented, these should not be considered as an output.

3.2.1.2 Achievement of Project Purpose

The project purpose of the Project was "maternal and child health (MCH) and reproductive health (RH) services are improved in the West Bank and the Gaza Strip". The achievements of the project purposes are summarized in the following table:

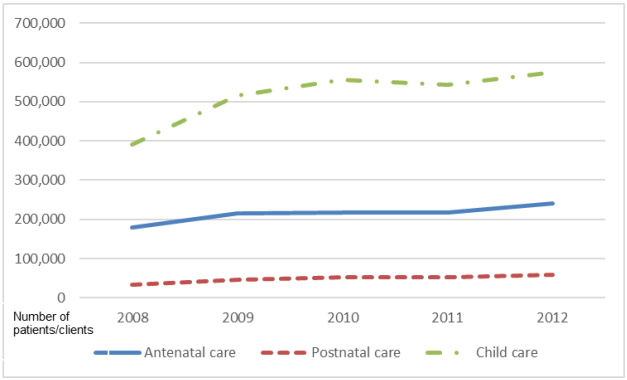
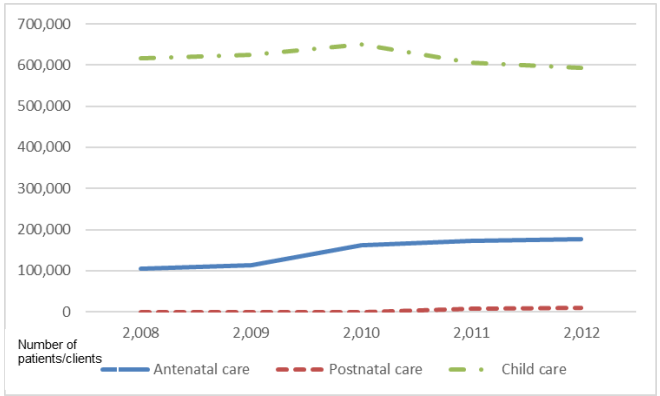
Table 6：Achievement of Project Purpose

Project Purpose	Indicator	Actual
Maternal and Child health (MCH) and Reproductive health (RH) services are improved in the West Bank and the Gaza Strip	**【Indicator 1】** Continuity of perinatal care among health care providers (the MoH, UNRWA, NGOs and private) is improved. (Referral, feedback rate by utilizing MCHHB)	**<Achieved to some extent>** ・It was not clear what data was supposed to be used to evaluate the indicator, therefore the evaluator selected two kinds of data: 1) the proportion of pregnant women bringing the MCHHB when going to hospital for delivery (bringing rate), and 2) proportion of entry of "Hospital Remarks" in the MCHHB (filling rate). The reason for selecting this data is that sharing information between clinics and hospitals through the MCHHB is essential to improve continuity of perinatal care, which was aimed at by the Project.

Project Purpose	Indicator	Actual
		・Data of the bringing rate, however, has not been collected by either the Project or MoH. The filling rate increased from 6.1 percent in 2008 to 18 percent in 2012, although it falls below the level of 50 percent that was anticipated by MoH. ・At the time of the ex-post evaluation, the filling rate (e.t., a proportion of data entry) of "Hospital Remarks" was 46 percent (n=116), which had improved from 18 percent in 2012, but remained lower than that of other pages such as "Immunization schedule" (97 percent), "child's measurements" (90 percent), "postnatal examination" (74 percent), and "newborn assessment" (72 percent). ・Although data does not show full achievement of the indicator, the terminal and ex-post evaluation teams were told of several cases that reflected improvement in continuity of perinatal care.[32] Thus, the evaluator concludes that Indicator 1 was achieved to some extent.
	【Indicator 2】 Distribution rate of MCHHB to pregnant women is increased.	**<Achievement cannot be known due to lack of data>** ・The Palestine Family Health Survey in 2010 revealed that 46 percent of women owning the MCHHB received those handbooks when they were pregnant. The MCHHB evaluation survey in 2012 showed that 58.7 percent of respondents received the MCHHB when they were pregnant. But the evaluator cannot assess improvement of the rate because those surveys had different scopes: the survey in 2010 targeted women nationwide, whereas that in 2012 targeted only mothers who visited MoH or UNRWA clinics. Additionally, relevant data had not been collected at the time of project completion.[33] ・Neither the Project nor MoH has collected data on private facilities, even though the indicator includes distribution rates at both clinics of MoH, UNRWA and NGOs, and private facilities. With insufficient data as well as limited interventions with the private sector, as described in Output 1, it is hard to conclude that the Project contributed to improving the distribution rate at private facilities. ・Thus, the status of achievement of Indicator 2 is unknown.

[32] The ex-post evaluation team received a report of one case where a mother who had a cardiac disorder was saved with adequate care after showing a doctor her medical records in the MCHHB.

[33] Indicator 2 of the project purpose seems similar to Indicator 1 of Output 1, which was "distribution rate of MCHHB out of the number of live births is increased". Indicator 2 of the project purpose, however, cannot be replaced with that of Output1 because it targets only pregnant women, considering that it is essential to receive the MCHHB when pregnant to enjoy improvement in continuity of perinatal care by utilizing the MCHHB.

Project Purpose	Indicator	Actual
	【Indicator 3】 Number of Antenatal care, Postnatal care and Child care (Growth monitoring, EPI) visit is increased.	**<Achieved largely>** ・The total number of patients/clients who received antenatal care, postnatal care and childcare has increased in the West Bank as depicted in the following figure. Similarly, the number of patients/clients who received antenatal and postal care has increased in the Gaza Strip; however, the number receiving childcare there has slightly decreased. ・Because the number of patients/clients who received antenatal care, postnatal care and childcare has increased as a whole, Indicator 3 was achieved largely.  Figure 1: Trend in the number of patients/clients who received antenatal care, postnatal acre and childcare in the West Bank Source: MoH West Bank (CHD)  Figure 2: Trend in the number of patients/clients who received antenatal care, postnatal acre and childcare in the Gaza Strip Source: MoH Gaza

Project Purpose	Indicator	Actual
	【Indicator4】 Patient/client satisfaction[34] is increased.	**<Achieved>** ・The MCHHB evaluation survey in 2012 indicated that 99.9 percent of women who wanted to become pregnant expressed their preference for using the MCHHB for the next baby. Likewise, the client satisfactory assessment, which was conducted by MoH in 2012, revealed that 91.8 percent of clients who visited PHC centers evaluated MCH services as "excellent" or "good". ・Because the data shows a high degree of satisfaction among clients, Indicator 4 was achieved.

The Project improved the distribution rate and utilization of the MCHHB at facilities of MoH, UNRWA and NGOs, in parallel to strengthening knowledge and technical capacity on perinatal care of MoH staff. As a result, continuity of perinatal care among health care providers has been improved to some extent. The Project also contributed to increasing the number of clients who take perinatal and child care, raising their awareness by using the MCHHB. Additionally, the degree of client satisfaction, especially among women using the MCHHB and health facilities, is high.

On the other hand, due to a lack of data the evaluator cannot confirm to what extent awareness and knowledge of local residents has been improved with the limited intervention of the Project on awareness campaigns on MCH/RH. In addition, the Project did not implement enough activities for private facilities, which was attributed to insufficient capacity in MoH to supervise the private sector, even though the Project aimed at improving MCH/RH services nationwide including private facilities. The evaluator, therefore, cannot conclude that the Project improved the distribution rate of the MCHHB for women who use private facilities. Thus, the Project achieved the project purpose at a limited level only.

3.2.2 Impact

3.2.2.1 Achievement of Overall Goal

The overall goal of the Project was "health among women and children is improved in the West Bank and the Gaza Strip".

(1) Achievement of indicators

The overall goal has 7 indicators. From health Indicator 1 to 6, Indicators 3 and 4 show a

[34] Although the PDM does not define the meaning of the patient and client, it says that one of the target populations is "women in reproductive age, children under 5 years old and their family members". The evaluator uses the definition for the patient and client, as these targets are recipients of services on MCH/RH, which were to be improved by the Project.

trend toward improvement, whereas others have not improved. Indicator 7 was “distribution rate of MCHHB to pregnant women is 100 percent”. Though it cannot be indicated by data due to lack of information, it is clear that Indicator 7 has not been achieved, as distribution and usage of the MCHHB had not been fully expanded to private facilities at the time of the ex-post evaluation. Table 7 shows achievement of each indicator.

Table 7: Achievement of Overall Goal

Overall Goal	Indicator	Achievement
Health among women and children is improved in the West Bank and the Gaza Strip.	**【Indicator 1】** Prevalence of antenatal and postnatal women and children under 3 years old with anemia is decreased.	**<Decreasing in the West Bank, and worsening in the Gaza Strip: Not Achieved>** ・West Bank: The prevalence of anemia among antenatal and postnatal women and children under 3 years has been decreasing. ・Gaza: The prevalence of anemia among antenatal women has increased in 2014, which might be caused by the worsening economic situation as a result of conflicts, whereas anemia prevalence among children under 3 years does not have a tangible change. There is no data on that of postnatal women.
	【Indicator 2】 Number of stunting, wasting and underweight children under 3 years old is decreased.	**<Not changed in the West Bank, and stunting worsening in the Gaza Strip: Not Achieved>** ・West Bank: The prevalence of stunting, wasting and underweight has not changed. ・Gaza: The prevalence of stunting has been worsening, whereas that of wasting has decreased since 2011. The prevalence of underweight has no tangible change.
	【Indicator 3】 Prevalence of children who have completed exclusive breastfeeding during age 0-5 months is increased.	**<Increasing in the West Bank and the Gaza Strip: Being Achieved>** ・The prevalence of exclusive breastfeeding has been on the increase in both the West Bank and Gaza Strip, though there are years lacking data.
	【Indicator 4】 Percentage of children aged 0-11 months receiving vitamin A+D supplementation is increased.	**<Increasing in the West Bank and the Gaza Strip: Being Achieved>** ・Because data on percent of children aged 0-11 months receiving vitamin A+D supplements was not available, the evaluator used here the number of vitamin A+D supplements distributed. ・The number of vitamin A+D supplements distributed has been increasing in the West Bank and the Gaza Strip in the long term.

Overall Goal	Indicator	Achievement
	【Indicator 5】 Number of facility visit of children under 3 years old for diarrhea and respiratory infection is decreased.	**<No tangible change in the West Bank, and increasing in the Gaza Strip: Not Achieved>** ・West Bank: There is no data on the number of cases of diarrhea because it has not been considered a public health issue. Instead, the evaluator checked data of intestinal parasitic diseases that cause diarrhea. There is no major change in the number of those cases. Similarly, the number of visits for care of URTI (Upper Respiratory Tract Infection) does not show a big change in these years. ・Gaza: The incident rate of diarrhea among children under 3 years has slightly increased. Likewise, the incident rate of influenza and URTI has been rising.
	【Indicator 6】 IMR and MMR are decreased.	**<Stagnant or decreasing in the West Bank and the Gaza Strip: Not Achieved>** ・West Bank: Overall, infant mortality rate has stayed the same though it rose slightly in 2011. Maternal mortality rate has been on the decrease. ・Gaza Strip: Infant mortality rate has a downward trend, whereas maternal mortality rate remains the same.
	【Indicator 7】 Distribution rate of MCHHB to pregnant women is 100 percent.	**<Not known due to a lack of data>** ・Distribution rate of the MCHHB to pregnant women at all types of facilities including private sectors: The Palestine Family Health Survey in 2010 revealed that 46 percent of women owning the MCHHB received those handbooks when they were pregnant. There is no data after 2010 because the following survey in 2014 did not include questions about the MCHHB. ・Distribution rate of the MCHHB to pregnant women at MoH or UNRWA clinics: The MCHHB evaluation survey in 2012 showed 58.7 percent of the respondents received the MCHHB when they were pregnant. There is no data after the survey.

(2) Contribution of the Project to Achievement of the Overall Goal

Among the indicators of the overall goal, macro Indicators 1 to 6 may have other contributing factors besides MCHHB-related ones. Table 8 shows how the Project and other factors could contribute to achieving the indicators of the overall goal.

Table 8: Contributing factors to achievement of the Overall Goal

Indicators	Possible contributions of the Project (MCHHB)	Possible contributions of other factors
【Indicator 1】 Prevalence of antenatal and postnatal women and	・The MCHHB has guidance for women to take iron tablets to prevent them becoming anemic.	・MoH has implemented a micronutrient deficiency program since 2006, in which MoH distributes iron tablets for pregnant women and iron drops for infants.

Indicators	Possible contributions of the Project (MCHHB)	Possible contributions of other factors
children under 3 years old with anemia is decreased.	・The MCHHB has guidance to practice exclusive breastfeeding.	・MoH implemented a major campaign for 6 months in 2014, and conducted awareness activities and distribution of tablets.
【Indicator 2】 Number of stunting, wasting and underweight children under 3 years old is decreased.	・The MCHHB has guidance on breastfeeding and foods for infants.	・Followings are considered as general factors: economic situation, educational level of mothers, inadequate foods, insufficiency of foods, diseases, and unhygienic conditions.
【Indicator 3】 Prevalence of children who have completed exclusive breast feeding during age 0-5 months is increased.	・The MCHHB has guidance to practice exclusive breastfeeding.	・MoH has implemented a promotion activity on exclusive breastfeeding since 2006; the activity included publication through media, distribution of brochures, posting notices and provision of guidance at clinics. ・Since 2011, a regulation has been applied to prevent early introduction of breastmilk substitutes to promote breastfeeding. ・Since 2012, MoH also has implemented a program of “baby friendly hospitals”, which promotes breastfeeding through skin to skin contact.
【Indicator 4】 Percentage of children aged 0-11 months receiving vitamin A+D supplementation is increased.	・The MCHHB has guidance to give vitamin A+D tablets to infants.	・MoH has distributed vitamin A and D supplements free of charge for infants of 0-12 months at clinics.
【Indicator 5】 Number of facility visit of children under 3 years old for diarrhea and respiratory infection is decreased.	・The MCHHB has an explanation that breastfeeding can prevent children from having diarrhea and respiratory infections.	・The following are considered as general factors: drinking water, sanitation condition, hand-washing practices, breastfeeding, vitamin A and immunization.
【Indicator 6】 IMR and MMR are decreased.	・The MCHHB improves continuity of perinatal care, which can lead to decreasing cases of inappropriate treatment and miscarriages. As a result, infant and maternal mortality rate could be decreased. ・The MCHHB can increase the number of care visits and	・The medical facilities at hospitals such as ICU (Intensive-Care Unit), blood transfusion and specialized staff can be main factors in maternal deaths because more than 90 percent of deliveries are carried out at hospitals. High rate of caesarean operations could also influence maternal deaths.

Indicators	Possible contributions of the Project (MCHHB)	Possible contributions of other factors
	vaccinations, which could lead to decreasing infant and maternal mortality rates.	

The health indicators of the overall goal are being achieved only partially, as shown in Table 7. As depicted in Table 8, though distribution and utilization of the MCHHB could lead to some improvements in the health indicators, these indicators could be influenced more directly by other factors such as improvement in nutritional conditions and hospital facilities. Furthermore, the MCHHB has not been distributed fully to the private facilities, despite the fact that the private sector has an important role in the health sector in Palestine. The evaluator, therefore, concludes that the Project contributed to improving health indicators of the overall goal at a limited level only.

Thus, the Project has achieved the overall goal only partially, as the Project contributed to achieving the overall goal at a limited level, in addition to a failure to achieve Indicator 7.

3.2.2.2 Other Impacts

The Project brought positive impacts as described below. Negative impacts were not found.

(1) Dissemination of the MCHHB in other countries through UNRWA

UNRWA started using the MCHHB at its clinics in the West Bank in 2008, followed using it in the Gaza Strip in 2009. UNRWA expanded the usage of the MCHHB to its clinics in Jordan, Syria and Lebanon in 2010. The results of distribution of the MCHHB in these countries are shown in Table 9. The expansion of the MCHHB through UNRWA reflects the efforts of the Project, in that it had intended to have a series of discussions with UNRWA since Phase 1, and then sent representatives of UNRWA to training in Japan with MoH counterparts.

Table 9：Distribution of the MCHHB by UNRWA in other countries

	2010	2011	2012	2013	2014
Jordan	30,822	28,758	25,857	25,777	26,634
Syria	8,968	8,611	4,684	N/A	3,600
Lebanon	5,535	5,444	5,418	5,167	5,165
Total	45,325	42,813	35,959	30,944	35,399

Source: UNRWA（using the registered number of pregnant women as a substitute for the numbers of distribution）

Colum 1：The Mother and Child Handbook, a passport for life, goes across borders

In September 2015 the Huffington Post, an American online news site, reported what Syrian refugees brought when they run for their lives. A mother who escaped with her husband and their 10-month old daughter showed a few personal belongings, in which a Mother and Child Handbook was included in addition to medication and baby foods. The handbook was the first of its kind in Arabic developed by assistance of JICA. The mother probably got the handbook from a UNRWA clinic in Syria. The article implied the mother hoped that her baby could receive appropriate medical care at their destination by showing the handbook, which has important records of the baby such as immunization history.

The Mother and Child Handbook is called “a passport for life” because it is supposed to be distributed to all Palestinian women including refugees. The handbook has a unique usefulness in that all medical history can be recorded in one book, and can be easily kept and carried. Mothers are likely to bring the handbooks when they go across borders. Cases were reported at the ex-post evaluation survey as well. Health staff and mothers said that the handbook was useful for keeping medical records to hand when forced to flee for refuge in the country or overseas. Even if medical records are lost due to demolition of health facilities, mothers can keep alternate records through the handbook, which is significant for mothers and children. The ex-post evaluation could not confirm the kind of impact the handbooks had at destinations of refugees or displaced people, though we expect that the handbooks could help mothers or children to receive appropriate medical care there.

<Reference> JICA webpage http://www.jica.go.jp/english/news/field/archive/2007/071116_2.html

JICA version on the left. The UNRWA version of the MCHHB on the right is almost the same as the JICA version, but has several adjustments for other countries

(2) Change in knowledge and behavior

The beneficiary survey at the ex-post evaluation asked whether the MCHHB brought changes to the knowledge and behavior of mothers and their families. When asked through multiple-choice questions about reasons for the usefulness of the MCHHB, 56 percent of the 108 mothers who recognized usefulness of the MCHHB selected “I am aware of the importance of breastfeeding”, and 49 percent selected “I can get health education about taking care of children”. This shows that the MCHHB has contributed to improvement of mothers’ knowledge.

Regarding changes in their behavior, 40 percent of mothers selected “I am able to talk much more with my husband (or male family members) about maternal and child health and family planning”. This implies that the MCHHB encourages communication between mothers

and their husbands in some cases.

To find out if the MCHHB has an impact from a gender perspective, the survey also included questions on the voice of mothers and husbands' participation in matters such as maternal health and childcare. The results show that 44 percent of mothers selected "I have become able to make my opinion on maternal and child health, or family planning, known inside my family", and 29 percent selected "my husband (or male family members) has changed in his attitude or involvement about maternal and child health, childcare, or family planning". Examples showing changes in husbands' behavior were "he has become more cooperative on childcare", "he has come to show his concern about my health and that of our child", and "he has come to ask me about child development". These results show that husbands have also changed their behavior or attitude to some degree through communicating with their wives by using the MCHHB.

In short, the results of the beneficiary survey show that the MCHHB has contributed to improving knowledge of mothers and communication with husbands, as well as enhancing the voice of mothers and participation of husbands in matters such as maternal health and childcare.

Colum 2: Do mothers think the handbook is useful?

According to the Beneficiary Survey, which had 115 respondents, most of them (74 percent) considered the MCHHB to be very useful, while around 20 percent considered it somewhat useful. When we look at results by area, the West Bank had response of "very useful" of 72 percent, and "somewhat useful" of 20 percent from 85 respondents, whereas the Gaza Strip had responses of "very useful" of 80 percent, and "somewhat useful" of 20 percent from 30 respondents. It indicates the handbook has been accepted by mothers in both areas because of its effectiveness.

Among mothers who responded that the MCHHB was very or somewhat useful, 71 percent of them selected "I can follow up development and growth of children" as a reason for its usefulness. Similarly, 69 percent selected "all of the documents I need are in one record", and 56 percent selected "I am aware of the importance of breastfeeding". It shows that mothers recognize the functions of the MCHHB: 1) portable medical/home-based record, and 2) health education tool.

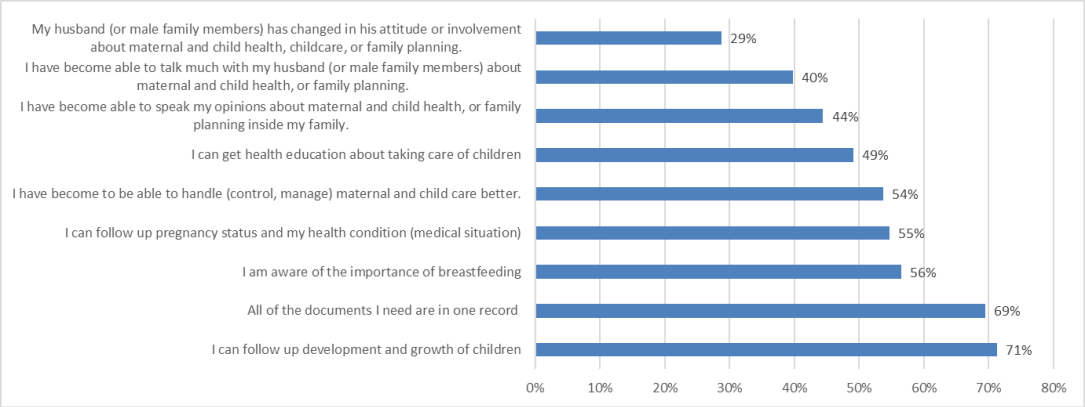


Figure 3：Mothers' recognition of usefulness of the MCHHB
(Multiple answers possible, n=108)

The Project aimed at improving MCH/RH services in Palestine nationwide. At the time of project completion, the distribution rate of the MCHHB had reached 100 percent at all facilities of MoH, UNRWA and four cooperating NGOs. As a result of the distribution, continuity in perinatal care among health care providers had been improved to some extent, and the number of clients who visit clinics for perinatal and child care had increased, which reflected improvements in MCH/RH services. Those results could possibly contribute to improving health among women and children in the West Bank and the Gaza Strip, which was the overall goal of the Project. The Project had additional positive impacts through distribution of the MCHHB into neighboring countries by UNRWA. The Project, however, could not implement enough activities for private facilities to promote utilization of the MCHHB, even though the private sector plays an important role as MCH/RH service providers in Palestine.

Since the Project has achieved the project purpose and overall goal to some extent, effectiveness and impact of the project are fair.

Colum 3 : Functions of the mother and child health handbook, a Japanese appropriate technology, for improving maternal and child health in developing countries

The origin of the mother and child health handbook in Japan is the "maternity handbook", developed before the Second World War. In 1948, after the war, the "mother and child handbook" was issued for health management of both mother and child. In 1965, the mother and child health law was established, which changed the name of the handbook into the "mother and child health handbook", and improved the content to make it easier for mothers to read and understand, as well as adding information on pregnancy, delivery and childcare into medical records (Isahai and Nakamura 2009). As of 1964 the infant mortality rate in Japan fell below that in the USA; it was said that one of the contributing factors was the mother and child health handbook, in addition to the universal health insurance system, and a high prevalence of medical check-ups[1].

Using the Japanese experience, JICA has supported the development of a handbook in Indonesia since 1992; this was followed by projects in Palestine and the Philippines. JICA also has provided assistance on distribution and utilization of the handbook in Mexico, Cambodia, Laos, East Timor, Kenya and Thailand. The handbook is expected to function in various ways, depending on the situation in different countries. The common functions among JICA projects are to provide a technology to assist with: (1) monitoring, (2) health education at home, (3) family members' participation in childcare, (4) health guidance and communication, (5) referral among facilities, and (6) surveillance. JICA notes that it is important to customize and use the handbook as a tool for improving mother and child health in response to the needs and objectives in developing countries (JICA document 2012).

One of the scientific verifications of outcomes of the handbook is the cluster-randomized controlled trial conducted in Mongolia in 2015[2]. The trial revealed that the intervention of the handbook led to an improvement in the number of antenatal care visits.

The mother and child handbook, which is an appropriate technology developed in Japan, is expected to be distributed and used further as a tool to address various needs on mother and child health in developing countries.

<Reference>

- Isahai Sayaka and Nakamura Yasuhide (2009) "The history of the mother and child health handbook in Japan" (2009), Japanese Journal of Pediatrics, Vol.62 No.5
- Nakamura Yasuhide (2009) "The mother and child health handbook spreading in the world" Japanese Journal of Pediatrics, Vol.62 No.5
- JICA Human Development Department (2012) "Research on utilization of the mother and child health handbook for projects of mother and child health, knowledge, lesson learnt and challenges"
- The Maternal and Child Health Handbook in Mongolia: A Cluster-Randomized, Controlled Trial (2015) Rintaro Mori, Naohiro Yonemoto, Hisashi Noma, Tumendemberel Ochirbat, Emma Barber, Gochoo Soyolgerel, Yasuhide nakamura, Oyun Lkhagvasuren

1) The mother and child handbook is "an appropriate technology developed in Japan for improving mother and child health at economically challenged times after the war". (Nakamura 2009)

2) A type of randomized-controlled trial in which groups of subjects, rather than individual subjects, are randomized to make a comparison of outcomes between an intervention group and control group.

3.3 Efficiency (Rating: ③)

3.3.1 Inputs

Planned and actual inputs for the Project are as follows:

Inputs	Plan	Actual
(1) Experts	Chief Advisor, Project Coordinator, Maternal and Child Health Service Management, Maternal, Child Health/Partnership Coordination (Total 182.13 MM)	5 long-term experts (119.0 MM) 13 short-term experts (20.5 MM) 18 experts in total
(2) Trainees received	・ Training in Japan (MCHHB Management, Maternal and Child Health Policy) ・ Training in third countries (RH regional seminar in Jordan)	・ Training in Japan (MCHHB Management): 7 personnel ・ The International Conference on Mother and Child Health Handbook in Kenya
(3) Equipment	To provide equipment and supplies for improving service at PHC centers (the amount was not stated)	・ Ultrasound diagnosis machine (set-up type): 1 ・ Ultrasound diagnosis machine (portable type): 9 ・ Training equipment such as simulators, pelvis models, fetal heart monitors, mercury manometers and measure tapes for circumference
(4) (Other)	Overseas Activities Costs: 79.8 million yen	Overseas Activities Costs: 125.8 million yen[35]
Japanese Side Total Project Cost	370 million yen	319 million yen
Palestinian Side Operational Expenses	・ Allocation of Palestinian project personnel: Project Director, Project Manager ・ Personnel expenses of counterpart personnel ・ The establishment and management of the Joint Coordination Committee ・ Provision of facilities (such as project office space), vehicles and equipment ・ Provision of data and material	・ Allocation of Palestinian project personnel: 17 (Project Director, Project Manager, Project staff) ・ Provision of Project office space in the annex facility of MoH in Ramallah ・ Utility costs for Project office space ・ Appropriation of operational cost ・ Provision of operating expenses for project activities

Source: JICA documents, the preliminary survey report、the terminal evaluation report * MM stands for man month.

[35] Total amount of 4,316,729 NIS converted by JICA rate of 29.146 yen as of March, 2016.

3.3.1.1 Elements of Inputs

The Japanese experts were dispatched for 139.5 MM, which was within the plan of 182.13 MM. Seven persons were sent to training in Japan. There were three participants from MoH, and two from UNRWA and NGOs respectively. The Project expected to send personnel to training in Jordan at the time of project planning; this was replaced by the "International Conference on Mother and Child Health Handbook" that was held in Kenya in October 2012. The conference was attended by one from MoH and UNRWA respectively. Equipment was provided as planned for improving services at PHC centers. In addition, overseas activity costs covered expenses for training equipment such as simulators, pelvis models, fetal heart monitors, mercury manometers and circumference measuring tapes, which were distributed to each directorate of MoH.

3.3.1.2 Project Cost

The actual total project cost of the Japanese side was 319 million yen, which was within the planned amount of 370 million yen (86 percent). The reason for the reduced cost seems to be suspension of the subcontract to an NGO for awareness campaigns and activities in the Gaza Strip, which, however, cannot be confirmed without information about the planned budget for those activities.

3.3.1.3 Period of Cooperation

The actual period of cooperation was 60 months as planned (100 percent).

Both the project cost and project period were within the plan. Therefore, efficiency of the Project is high.

3.4 Sustainability (Rating: ②)

The evaluator assesses sustainability of the Project by confirming whether there are constraints on policies, institutional systems, organizations of MoH including NCC, and technical capacity of MoH staff, which may prevent MCH/RH services continuing to use the MCHHB effectively in Palestine nationwide.

3.4.1 Related Policy and Institutional Aspects for the Sustainability of Project Effects

The "National Development Plan" and "Palestinian National Health Strategy" at the time of project completion ensure the sustainability of project effects. The "National Development Plan" (2014-2016) cites strengthening of primary health services (especially MCH/RH) as a priority area in the health sector. Likewise, the "Palestinian National Health Strategy" (2014-2016) is planning a program called "High Quality Primary Health Care Services and

Healthy lifestyles" as one of three main programs, in which MoH aims to ensure sustainability of primary health care and public health through activities such as provision of efficient human resources, and community awareness on health education.

In November 2015, the vaccination card was integrated into the MCHHB by the decision of the deputy minister of MoH. Immunization is obligatory under the public health law, and vaccination status is checked prior to admission to primary school; this has led to achieving a notably high immunization rate that is almost 100 percent. As a result of the integration, it is estimated that the MCHHB will be distributed more extensively as a replacement for the vaccination card, and is certain to be given to women at the time of mandatory vaccinations after delivery regardless of type of facility.[36]

It is concluded, therefore, that there is no concern on policy and institutional aspects.

3.4.2 Organizational Aspects of the Implementing Agency for the Sustainability of Project Effects

MoH has not held any formal meetings of NCC since the time of project completion, though the main functions of NCC continue to be carried out as regular tasks of CHD. CHD is engaging in management of distribution, stock, revision and printing of the MCHHB without any major issues; this was expected to be executed by NCC. NCC also had a function of facilitating various stakeholders and gathering their opinions to be reflected into improvement of the MCHHB; this, however, does not seem to be fully carried out by CHD currently. For instance, when MoH revised the MCHHB in 2015, it only had a meeting with UNRWA, not with other organizations such as NGOs and the association of obstetricians and gynecologists. The MCHHB has diverse items that are related to many stakeholders such as UNRWA, NGOs, the nutrition department, the health education and promotion department, and private sector. It is, therefore, important for CHD to arrange a meeting of NCC or any joint meeting to meet and share opinions among those stakeholders for further improvement of the MCHHB.

In addition to the constraints on NCC, MoH has a challenge due to not having established a system to supply the MCHHB to private facilities, to supervise and monitor its utilization, as well as lacking accurate information on the current situation on the private sector. It hampers MoH from distributing the MCHHB on a large scale to cover the whole health sector of the

[36] Because on the first day after delivery, infants are supposed to get vaccinations of BCG Tuberculosis and Hepatitis B1, the MCHHB has been distributed to all types of hospitals including private hospitals since the integration with the vaccination card. When the evaluator visited two major private hospitals in Ramallah (Palestinian Red Crescent Society Hospital and Arab Care Hospital) in April 2016, it was confirmed that both had already received the MCHHB from the directorate of MoH as a replacement for the vaccination card.
Even before delivery at hospitals, women who use private clinics are able to get the MCHHB from MoH related facilities or UNRWA clinics if they get a vaccination of tetanus during their pregnancy. This, however, does not mean that all pregnant women using private facilities receive the MCHHB, because tetanus is not a mandatory vaccination.

country.

It is concluded, therefore, that the management system of the MCHHB largely functions well at MoH, but there is still a need to facilitate various stakeholders and gather their opinions to improve the MCHHB.

3.4.3 Technical Aspects of the Implementing Agency for the Sustainability of Project Effects

The Project provided MCHHB orientation training, antenatal care technical training, and obstetric ultrasound training mainly to MoH staff in order to improve their knowledge and technical capacity to utilize the MCHHB and provide MCH/RH services. As summarized in Table 10, at the time of the ex-post evaluation the MCH supervisors at each directorate of MoH have been continuing to give technical guidance to PHC center staff based on what they learnt from training when they visit clinics for regular monitoring. Likewise, MoH staff still use the "Palestine National Manual for the MCHHB" and training packages developed by the Project, as well as books provided by the Project for training. Machines and equipment provided by the Project are largely operated and maintained well.

Table 10：Technical aspects necessary for sustainability, and its current status

Use of the Palestine National Manual for the MCHHB	・The manuals have been distributed to all partner organizations (MoH, UNRWA, four NGOs), and health staff refer to the manual when needed.
Use of training packages	・Follow-up cooperation, which was implemented by JICA from 2013 to 2014 in the Gaza Strip, used the training packages to maintain quality of training.
Provision of technical guidance by MoH staff trained by TOT	・MCH supervisors make regular visits to clinics, and give guidance to PHC center staff as necessary based on what they learnt from TOT (Training of Trainers).
Provision of technical guidance by MoH staff who participated in training	・MoH continues to use contents of MCHHB orientation and antenatal technical training for OJT (on the job training) of new staff. ・MoH conducted ultrasound training as OJT in five districts in 2015. Several staff who participated in training of the Project played a role of trainers by using knowledge and materials provided by the Project.
Use and maintenance of machines and equipment provided by the Project	・One (1) ultrasound diagnosis machine (set-up type): MoH is requesting to repair a prop broken two years ago. This is not a major problem for the hospital as it has two other machines. ・Nine (9) ultrasound diagnosis machines (portable type): seven machines function without issues whereas two need maintenance; this is expected to be provided by MoH. ・There is no problem on availability of spare parts.

The beneficiary survey (Table 11) revealed that most of the respondents (77 percent) reported receiving an explanation on the MCHHB from staff at clinics (n=116). Among the mothers who received an explanation, 69 percent found the explanation clear, whereas 26 percent considered it clear to some extent. This implies that staff are technically able to give clear explanations to mothers on the MCHHB. It is concluded, therefore, that there is no issue on technical aspects of MoH.

Table 11：Outline of the Beneficiary Survey

Objective	To assess effectiveness and impact of the MCHHB on the direct beneficiaries (i.e. mothers), especially in terms of the functions of the MCHHB: 1) portable medical/home-based record, and 2) health education tool.
Term	From January 16, 2016 to January 28
Method	Interview with questionnaire with observation to look inside the MCHHB
Place	3 districts in the West Bank (Jericho, Bethlehem, Nablus), and 1 district in Gaza Strip (Gaza)
Sample	Mothers who brought their MCHHB to their visits to the clinics of MoH or UNRWA mainly for postnatal care, assuming that those mothers have experience of using the MCHHB for a certain period.
Sampling method	Non-random selection (Reasons: (1) the evaluator and enumerators had access only to limited areas due to security concerns, and (2) the team had to select relatively bigger clinics that receive many mothers and can cooperate in the survey because of limited budget and interview days).
Sample size	116[37]

3.4.4 Financial Aspects of the Implementing Agency for Sustainability of Project Effects

As shown in Table 12, MoH paid for printing 100,000 copies of the MCHHB from their own budget in 2014, after completion of the Project. In 2015, MoH printed 300,000 copies with financial support from UNICEF. MoH plans to pay for the next printing in 2017 using donor support or budget of the ministry. At the time of the ex-post evaluation the probability of

[37] Sample distribution is as follows:

	District	Number of sample	Average age	Average number of children
West Bank	Jericho	28	28.5	3.4
	Bethlehem	28	29.0	2.9
	Nablus	30	27.2	2.1
	subtotal	86	28.2	2.8
Gaza Strip	Gaza	30	27.0	2.7
	subtotal	30	27.0	2.7

securing financial resources for the printing is high, in that the deputy minister had said that MoH would pay for this from its own budget if MoH fails to secure donor funds, because the value of MCHHB has been highly recognized because of its integration with the vaccination card.

Table 12：Printing of the MCHHB after completion of the Project

year	Financial source	Number of copies	Amount expended (USD)
2014	MoH	100,000	130,000
2015	UNFPA	a few	1,000
2015	UNICEF	300,000	100,000

Source: Told by MoH for data for 2014, which amount was estimated at 1.3 USD per copy, and response of UNICEF for data for 2015

The total amount of budget and expense of MoH have increased as depicted in Table 13. The budget for 2015 and 2016 exceeded 1.7 billion NIS.[38] Similarly, the total amount of budget and expense for printing, stationery, training and equipment maintenance at MoH has increased in these years (Table 14). There is no concern about disbursement. It is considered, therefore, that there is no issue on financial aspects of printing the MCHHB or MoH in general, both at present and in the near future.

Table 13：Trend of total budget and expenditure of MoH

(Unit: NIS)

	2010	2011	2012	2013	2014	2015	2016
Budget	1,277,358,982	1,203,463,826	1,558,409,995	1,514,311,450	1,456,970,000	1,745,621,000	1,711,900,000
Expenditure	1,233,976,526	1,106,915,722	1,582,862,176	1,299,581,555	1,356,990,069	－	－

Source : MoH annual reports for data from 2010 to 2014, and finance department for data of 2015 and 2016. Amounts of expenditure for these years are being calculated.

Table 14：Trend of budget and expenditure of printing, stationary, training and equipment maintenance

(Unit: NIS)

	2012	2013	2014	2015
Budget	2,937,324	2,756,027	3,205,615	4,547,259
Expenditure	2,595,164	2,584,712	3,031,179	4,023,574

Source：Finance department, MoH

[38] NIS is a currency of Israeli and Palestine, short for New Israel Sheqel.

Although there are no tangible issues on aspects of policies, institutions, techniques and finance, a few challenges have been observed in organizational aspects of MoH. Thus, sustainability of the project effect is fair.

Colum 4: The meaning of follow-up cooperation in a conflict-affected area

The Project aimed at promoting the Mother and Child Health Handbook in Palestine nationwide. The Project, however, could not make direct interventions in the Gaza Strip from November 2009, with the decision to suspend activities in the area, because of the deteriorating situation following the military operation of Israel that started in December 2008. JICA experts could not enter the Gaza Strip and provide training there until the final year of the Project.

JICA implemented a follow-up cooperation project from 2013 to 2014 to make up for insufficient activities in the Gaza Strip in order to complement activities of the Project. The follow-up cooperation provided orientation training on the MCHHB and antenatal care technical training. This was using the same method as that in the West Bank, which was to provide two-level training: TOT (Training of Trainers) and lateral training. To carry out programs of quality equivalent to the West Bank, the follow-up project used the training packages developed by the Project, and asked a local consultant who had engaged in training of the West Bank to manage a session of training.

As a result of those efforts, mothers in the Gaza Strip highly evaluate the effectiveness of the MCHHB (please refer to Colum 2). This case shows that follow-up cooperation can play a meaningful role when projects are forced to discontinue some activities due to inevitable reasons in conflict-affected areas.

Antenatal care technical training in the Gaza Strip

A brochure made by the follow-up cooperation

4. Conclusion, Lessons Learned and Recommendations

4.1 Conclusion

This project was implemented with the objective of improving maternal and child health and reproductive health throughout the territory of the Palestinian National Authority (the West Bank and the Gaza Strip) through promoting the MCHHB and by providing technical training.

Both at the time of planning and completion of the project, the objective of the project was aligned with the National Health Strategy, which focused on enhancing primary health services and development needs. The project was also highly consistent with Japan's policy of overseas development assistance of prioritizing humanitarian support at the time of planning. Therefore, its relevance is high. As a result of the project's interventions, the distribution rate of the MCHHB reached 100 percent at facilities of the Ministry of Health, the implementing agency,

UNRWA and NGOs. Information on mothers and children was more likely to be shared between facilities through the use of MCHHB; this contributed to some improvement in continuity of perinatal care in those facilities, as well as in the number of clients who received antenatal, postnatal and child care increased. The project, however, did not implement sufficient activities to engage with private facilities - the project just introduced the MCHHB to private doctors at seminars, and gave them posters on the MCHHB. It is unlikely that these limited interventions led to improved distribution and utilization of the MCHHB in the private sector, which means that the project purpose was achieved only partially. Therefore, effectiveness and impact of the project are fair. Both project cost and period are within the plan, therefore, the efficiency of the project is high. Sustainability is fair, because the Ministry of Health, the implementing agency, does not have a system to distribute and manage the MCHHB for private facilities; there is no major concern on policy, technique, and finance.

In light of the above, this project is evaluated as satisfactory.

4.2 Recommendations to the Implementing Agency

4.2.1 Recommendations to the Implementing Agency

(1) Provision of training to improve the rate of filling in "Hospital Remarks" of the MCHHB

The MCHHB cannot contribute enough to improving continuity of perinatal care unless hospital staff write important information on delivery and the newborn in the form of "Hospital Remarks" of the MCHHB. At the time of the ex-post evaluation, however, one shortcoming is still that the "Hospital Remarks" is not filled in fully at either governmental hospitals or private ones. This is attributed to lack of understanding among management staff and insufficient human resources at hospitals. Although the Project provided a one-day training about utilization of the MCHHB for staff of governmental hospitals, MoH has not continued to conduct similar training since the completion of the Project. This shows insufficient activity of MoH to address the issue of the low filling rate at hospitals. The CHD, therefore, should resume training and awareness activities for staff of governmental hospitals in consultation with the Hospital General Directorate of MoH, which is in charge of managing governmental hospitals. With regard to the private hospitals, MoH will be able to incorporate relevant training to improve the filling rate as part of activities to promote the MCHHB in the private sector, which is explained below.

(2) Promotion of the MCHHB to the private sector

The private sector plays an essential role as providers of MCH/RH services in Palestine, as private hospitals account for more than half the total number of hospitals in the country. Thus, the MCHHB should be promoted in both governmental facilities and private ones, in order to

improve MCH/RH services nationwide. Nevertheless, MoH has not developed a system to supply and manage the MCHHB for private facilities, and it is unlikely to be established soon considering the limited human resources of the ministry. Given this situation, it is better to select a few leading private hospitals or clinics, for which MoH should provide orientation training, and pilot activities to manage and monitor utilization of the MCHHB, so that MoH and private facilities can jointly develop a success story. The good practice should be published for other private facilities or doctors, to motivate them to utilize the MCHHB on their own initiative.

(3) Improvement of MCHHB through discussion among various stakeholders

NCC was responsible for managing and monitoring the MCHHB, and facilitating coordination of stakeholders. Of these basic functions, management and monitoring of the MCHHB was being carried out by CHD without a problem at the time of the ex-post evaluation, whereas coordination among stakeholders is not fully facilitated by NCC or CHD. The MCHHB has diverse items that are related to many stakeholders such as UNRWA, NGOs, nutrition department, health education and promotion department, and private facilities. CHD should strengthen coordination of these stakeholders and arrange a meeting of NCC or any other joint meeting for them to meet to share their opinions and improve the content of the MCHHB prior to the next printing of the MCHHB.

4.2.2 Recommendations to JICA

As mentioned above, the MCHHB has not been distributed fully to the private facilities. JICA should provide MoH with assistance in getting the private sector involved further in activities of the MCHHB by sharing case examples or good practices, if any, based on its experience of similar projects in other countries.

4.3 Lessons Learned

4.3.1 Setting a clear target and designing necessary activities for the private sector

The Project aimed to improve MCH/RH services nationwide by targeting both governmental and private facilities. Nevertheless, interventions with the private sector were limited in that the Project did not implement any training or monitoring activities for private facilities, but just held seminars for medical practitioners and distributed a poster to share information on the MCHHB. At the time of project planning, completion and the ex-post evaluation, MoH did not have information about the total number of private facilities, and status of distribution and usage of the MCHHB in the private sector.

When JICA designs a project to improve health services at facilities including private ones, it is important to confirm whether the implementing agency has enough information about the private sector, as well as a system to train and manage those facilities at the time of project

planning or the early stages of the project. If any shortcoming is found in the capacity of the agency to intervene in the private sector, the project should include necessary activities such as capacity-building to collect information and strengthen the management system.

4.3.2 Confirming availability of data and designing necessary activities to collect data

The PDM of the Project has several indicators that could not be measured due to a lack of data, because neither baseline survey nor follow-up survey had been implemented.

At the time of project design, it is important to confirm carefully the availability of data and not use any indicators that are not likely to have relevant data. The project can include an activity to support the implementing agency to collect necessary data as part of regular tasks of the agency, which can lead to an institutional capacity development. Similarly, if the PDM has indicators that are expected to show whether a project causes some positive changes, the project should conduct a survey to collect data before and after project interventions.

4.3.3 Facilitating various stakeholders

The Project needed to strengthen a system to encourage cooperation between MoH, UNRWA and NGOs in order to improve MCH/RH services nationwide, as UNRWA and NGOs play a substantial role in providing health services along with MoH in Palestine.[39] When Phase 1 developed the MCHHB, the project team had a series of discussions with UNRWA and NGOs to build a cooperative relationship. Following Phase 2 cooperation was enhanced by setting up NCC, which was made up of representatives from each stakeholder, so that the Project could compile the national manual, and revise the MCHHB jointly with those stakeholders. These efforts through the two phases made it possible to foster coordination among stakeholders and their ownership of the MCHHB, and to encourage their continuous utilization of the MCHHB.

When a project has various important stakeholders, it is important to get them involved in the project in an early stage through activities such as pilot programs and development of manuals, in addition to arranging a system to share opinions and coordinate activities among stakeholders.

(End)

[39] 47 percent of antennal care is carried out at governmental facilities, whereas UNRWA, NGOs and private facilities account for 53% of that in the West Bank (source: MoH annual report 2014).