Country Programme Evaluation: Myanmar

Volume 2: Annexes

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Annex 1: Terms of Reference

I. Introduction

1. Country Programme Evaluations (CPE)[1] are part of the Evaluation Office workplan for 2018-2019, approved by the Executive Board in January 2018. The workplan clarifies that CPEs "will focus on the outcomes/results achieved by the respective country office, as well as contributions through global and regional inputs in the country. In addition, the evaluations will aim to analyse the effectiveness of WHO programmes and initiatives in the country and assess their strategic relevance within the national context".[2] They encompass the entirety of WHO activities during a specific period. The CPEs provide lessons that can be used in the design of new strategies and programmes in-country.

2. The Myanmar CPE covers the period of the Country Cooperation Strategy (CCS) 2014-2018 and will include activities to date in 2019.

II. Myanmar Country context

3. Myanmar is a lower-middle-income country that experienced strong economic growth between 2005 and 2015, which translated into a reduction in the number of people living below the national poverty line from 48% to 32%. However, the gains of economic progress have varied considerably between and among population groups and geographic areas, with 70% of Myanmar's poor living in rural areas. Myanmar's economic growth remains strong by regional and global standards and real GDP growth is estimated to reach 6.6% by 2020-2021. Myanmar has been more deeply affected by subnational conflict than any other country in Asia, with almost one-third of the country being conflict-affected, and this has shaped Myanmar's institutional and development trajectory. Myanmar is also one of the world's most disaster-prone countries, exposed to multiple hazards, including floods, cyclones, earthquakes, landslides and droughts.[3]

4. At the ministerial level, the "Myanmar's Health Vision 2030" document was drawn up in 2000 to meet future health challenges and is implemented through 5-year national health plans.[4] Myanmar's National Health Plan 2017-2021 aims to strengthen the country's health system and pave the way towards universal health coverage, choosing a path that is explicitly pro-poor. Its main goal is to extend access to a basic Essential Package of Health Services to the entire population by 2020 while increasing financial protection.[5] Its predecessor, the National Health Plan 2011-2016, had the following priorities: (i) solving priority health problems of the country; (ii) rural health development; (iii) realizing the Millennium Development Goals; (iv) strengthening health systems; and (v) improving determinants of health.[6]

5. Myanmar is currently in demographic transition as well, as it gradually becomes an ageing population. The leading causes of death and illness in the country are communicable diseases such as tuberculosis (TB), HIV/AIDS and malaria. The country has made remarkable progress in reducing malaria-related morbidity and mortality. However, the TB prevalence rate is three times higher than

[1] Previously called Country Office Evaluations.
[2] Evaluation: update and proposed workplan for 2018–2019. EB 142/27
[3] The World Bank in Myanmar (https://www.worldbank.org/en/country/myanmar/overview, accessed 7 November 2019).
[4] [4] World Health Organization (2014). WHO Country Cooperation Strategy Myanmar 2014-2018 (http://apps.who.int/iris/bitstream/10665/136779/1/ccs_mmr_2014-18_9789290224495.pdf).
[5] Ministry of Health and Sports, Republic of the Union of Myanmar (2016). National Health Plan (2017-2021) (https://themimu.info/sites/themimu.info/files/assessment_file_attachments/NHP_2017-2021_ENG_0.pdf).
[6] Ministry of Health, Republic of the Union of Myanmar. National Health Plan (2011-2016) (http://mohs.gov.mm/Main/content/publication/national-health-plan-2011-2016-english-version, accessed 7 November 2019).

the global average and one of the highest in Asia. The HIV/AIDS epidemic is considered to have stabilized nationally since 2000, with "hot spots" of transmission in several locations. Other significant threats to health are viral hepatitis and antimicrobial resistance and Myanmar faces the double burden of communicable and noncommunicable diseases. Despite making significant progress, Myanmar missed the targets of Millennium Development Goals 4 and 5 (child and maternal health, respectively).[7] Some of Myanmar's key health indicators compare poorly with those in other countries in the region and, in keeping with the broader pattern of inequities in economic gains, there is considerable variability in health gains between and among the country's geographical areas and socio-economic groups.[8]

Table 1: Myanmar health statistics[9]

Population (in thousands) total (2016)	52.885
Population proportion under 15 (%) (2016)	27.4
Population proportion over 60 (%) (2016)	14.0
Life expectancy at birth (years) (2016)	68.9 (Female)
	64.6 (Male)
Socioeconomic	
Gender inequality index rank (2014)	85
Human development index rank (2014)	148
Health	
Neonatal mortality rate (per 1000 live births) (2018)	23.1
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2018)	46.2
Maternal mortality ratio (per 100 000 live births) (2017)	250
Infants exclusively breastfed for the first six months of life (%) (2015)	51.2
Health systems	
Physicians density (per 1000 population) (2012)	0.568
Nursing and midwifery personnel density (per 1000 population) (2012)	0.93
Births attended by skilled health personnel (%) (2015-2016)	60.2
(DTP3) immunization coverage among 1-year-olds (%) (2018)	91
Health financing	
Total expenditure on health as a percentage of GDP (2014)	2.28
Private expenditure on health as % of total expenditure on health (2014)	54.09
General government expenditure on health as % of total government expenditure (2014)	3.59

6. Allocation of ODA within the health sector in Myanmar is in the areas of HIV/AIDS, malaria and other diseases, reproductive health and other health purposes.[10] Total ODA for health in Myanmar amounted to some US$ 197 million in 2017 with the three largest contributors of ODA for health in Myanmar being the Global Fund (65%), the USA (12%) and Japan (4%).[11]

7. The UN Country Team (UNCT) efforts in Myanmar have since 2012 been guided by the UN Strategic Framework (2012-2015). Health was covered under Strategic Priority 2, increase equitable

[7] World Health Organization (2018). Country Cooperation Strategy at a Glance. Myanmar (2018). WHO/CCU/18.02 Myanmar (http://apps.who.int/iris/bitstream/10665/136952/1/ccsbrief_mmr_en.pdf).

[8] Ministry of Health and Sports, Republic of the Union of Myanmar (2016). National Health Plan (2017-2021) (https://themimu.info/sites/themimu.info/files/assessment_file_attachments/NHP_2017-2021_ENG_0.pdf).

[9] Global Health Observatory, WHO, http://apps.who.int/gho/data/node.cco.ki-MMR?lang=en accessed 11 November 2019

[10] World Health Organization (2014). WHO Country Cooperation Strategy Myanmar 2014-2018 (http://apps.who.int/iris/bitstream/10665/136779/1/ccs_mmr_2014-18_9789290224495.pdf).

[11] OECD data (https://www.oecd.org/dac/financing-sustainable-development/development-finance-data/Asia-Development-Aid-at-a-Glance-2019.pdf, page 15)

access to quality social services.[12] As the lead agency in the health sector in Myanmar, WHO was actively involved in UNCT work towards achieving Outcome 2 under Strategic Priority 2, namely "health systems ensure that the poor, the vulnerable, most at risk, and the geographically remote populations have access to and utilize quality, uninterrupted and affordable health services, including reproductive health care and HIV prevention and treatment." Key UN agencies working with WHO in Myanmar are FAO, UNFPA and UNICEF.

III. WHO activities in Myanmar

8. The WHO Myanmar Country Office (WCO) is based in Yangon. It currently comprises 61 staff members. At national level, WHO Myanmar collaborates with the Ministry of Health and Sports and other entities, including other ministries, academic institutions and nongovernmental organisations (NGOs) and civil society organisations (CSOs).

9. The Country Cooperation Strategy (CCS) is WHO's key instrument to guide its collaboration with the Government, in support of the national health agenda and it provides the strategic direction for WHO's contribution in-country. During the period covered by this CPE, the work of the WCO was guided by a Country Cooperation Strategy 2014-2018; Myanmar's Health Vision 2030, implemented through its 5-year national health plans; the UN Strategic Framework 2012-2015; WHO's General Programmes of Work (i.e. 12th and 13th GPWs), and WHO Regional priorities. The five strategic priorities of the CCS 2014-2018 were:

1) Strengthening the health system;
2) Enhancing the achievement of communicable disease control targets;
3) Controlling the growth of noncommunicable disease burden;
4) Promoting health throughout the life course; and
5) Strengthening capacity for emergency risk management and surveillance systems.

10. The WCO implements its work through biennial workplans and budgets. The workplans reflect the corporate strategic objectives of the WHO biennial programme budget. Table 2 outlines the linkage between the main focus areas under each of the five CCS strategic priorities and the categories in the WHO biennial programme budgets.

Table 2: Links between CCS Myanmar priorities and WHO Programme Budget priorities

Focus areas under each strategic priority in Myanmar CCS 2014-2018	Programme areas under each category in the biennial programme budgets 2014-2015 and 2016-2017	Programme areas under each category in the biennial programme budget 2018-2019
Strengthening the health system	4 Health systems	4 Health systems
1.1 Improve access to quality care	Integrated people-centred health services	Integrated people-centred health services
1.2 Strengthen implementation of the National Health Plan	National health policies, strategies and plans	National health policies, strategies and plans
1.3 Support Government efforts to promote traditional and herbal medicine	Access to medicines and other health technologies and strengthening regulatory capacity	Access to medicines and other health technologies and strengthening regulatory capacity
Enhancing the achievement of communicable disease control targets	1 Communicable diseases	1 Communicable diseases
2.1 Attain 80% coverage of people needing antiretroviral therapy (ART) under national guidelines and minimize HIV transmission from infected mothers	HIV/AIDS (2014-2105)/HIV and hepatitis (2016-2017)	HIV and hepatitis

[12] United Nations Strategic Framework 2012-2015, United Nations Country Team in Myanmar.

Focus areas under each strategic priority in Myanmar CCS 2014-2018	Programme areas under each category in the biennial programme budgets 2014-2015 and 2016-2017	Programme areas under each category in the biennial programme budget 2018-2019
2.2 Further reduce TB prevalence and mortality to achieve the TB impact targets	Tuberculosis	Tuberculosis
2.3 Intensify control of malaria in high transmission areas and along international borders; and control and eliminate neglected tropical diseases	Malaria	Malaria
2.4 Strengthen immunization systems to achieve at least 90% DTP coverage nationally and 80% in all townships; and expand planning and implementation of other VPD programmes	Vaccine-preventable diseases	Vaccine-preventable diseases
Controlling the growth of noncommunicable disease burden	2. Noncommunicable diseases	2. Noncommunicable diseases
3.1 Support the Government to expand activities for promoting practices of health lifestyles in the community, including tobacco control	Noncommunicable diseases	Noncommunicable diseases
3.2 Support the Government to expand national efforts for prevention of injury, violence and disability	Violence and injuries Disabilities and rehabilitation	Violence and injuries Disabilities and rehabilitation
3.3 Support the Government to strengthen the prevention and control of NCD	Noncommunicable diseases	Noncommunicable diseases
Promoting health throughout the life course	3 Promoting health through the life course	3 Promoting health through the life course
4.1 Develop a comprehensive, integrated package of interventions for birth spacing and MNCH, particularly child nutrition and growth monitoring	Reproductive, maternal, newborn, child and adolescent health Nutrition	Reproductive, maternal, newborn, child and adolescent health Nutrition
4.2 Improve sexual and reproductive health including adolescent and women's health and health care for elderly	Reproductive, maternal, newborn, child and adolescent health Ageing and health	Reproductive, maternal, newborn, child and adolescent health Ageing and health
4.3 Support the Government to enhance safe water supply, water quality control, improved sanitation and personal hygiene, and health education promotion	Reduced environmental threats to health (2014-2015)/Health and the Environment (2016-2017)	Health and the Environment
Strengthening capacity for emergency risk management and surveillance systems against various health threats	5. Preparedness, surveillance and response	WHO Health Emergencies Programme
5.1 Enhance preparedness, surveillance and response	Alert and response capacities Epidemic-prone and pandemic-prone diseases Emergency risk and crisis management Food safety	Country health emergency preparedness and the International Health Regulations Infectious hazard management Emergency operations Health emergency information and risk assessment Food safety

11. Table 3 identifies the main areas of activities undertaken in the WCO and corresponding levels of investment. During the period covered by the evaluation, the WCO was mainly funded from voluntary contributions (particularly from DFID, the Vaccine Alliance, USAID and UN agencies).

Table 3: Expenditure Myanmar Country Office 2014-2019 (US$ 000)[13]

Workplans	Expenditures (US$ 000)				
	2014-15	2016-17	2018-19*	Total	% allocation
1. Communicable Diseases	9,124	14,272	11,365	34,761	29.2%
Pass through EPI	59	2,528		2587	2.2%
Pass through Measles	2,896			2896	2.4%
2. Noncommunicable Diseases	674	1,385	1,305	3364	2.8%
FCTC			66	66	2.8%
3. Promoting Health through the Life-course	878	1,013	718	2609	2.2%
4. Health Systems	3,801	7,021	1,990	12812	10.8%
Pass through HSS GAVI	4,611	2,632		7243	6.1%
5. Preparedness, Surveillance & Response	1,155	713		1868	1.6%
WHO Health Emergencies Programme			763	763	0.6%
PIP	147	269	244	660	0.6%
Polio workplan		3,109	1,238	4347	3.7%
OCR activities	1,257	661	784	2702	3.7%
6. Corporate Services/Enabling Functions	1,720	1,812	761	4293	2.3%
In-Kind/In-Service	5,377	4,939	2,997	13313	11.2%
Salaries	7,793	9,078	7,716	24587	20.7%
	39,492	**49,432**	**29,947**	**118,871**	**102.8%**

* Utilization (encumbrances and expenditures) as at 11 November 2019

IV. Objectives and scope of the CPE

12. The main purpose of this CPE is to identify achievements, challenges and gaps and document best practices and innovations of WHO in Myanmar. These include not only the results of the WHO Country Office (WCO) but also contributions from the regional and global levels to the country programme.

13. As with all evaluations, this CPE meets accountability and learning objectives. It will be publicly available and reported on through the annual Evaluation Report. This evaluation will build on an analysis of existing documents and data of relevance to the purpose of this evaluation, complemented by the perspectives of key stakeholders, to:

- Demonstrate achievements against the objectives formulated in the CCS 2014-2018 (and other relevant strategic instruments) and corresponding expected results developed in the WCO biennial workplans, while pointing out the challenges and opportunities for improvement.
- Support the WCO and partners to operationalize the various priorities of future CCS (and other relevant strategic instruments) based on independent evidence of past successes, challenges and lessons learned.
- Provide the opportunity to learn from the evaluation results at all levels of WHO. All programmes can benefit from knowing about their successes and challenges at global, regional and country levels. These can then usefully inform the development of future country, regional and global support through a systematic approach to organizational learning.

[13] Source: GSM.

14. The evaluation will cover all activities undertaken by WHO (WCO, regional office and headquarters) in Myanmar, as framed in the CCS 2014-2018 and other strategic documents covering activities not part of the CCS that took place over that period. In addition, it will also consider activities undertaken in 2019, with a stronger focus on the 2016-2017 and 2018-2019 bienniums in order to generate learning for the future.

V. Stakeholders and users of the evaluation

15. Table 4 shows the role and interest of the main evaluation stakeholders and expected users of the evaluation.

Table 4: preliminary stakeholders' analysis

Internal stakeholders	**Role and interest in the evaluation**
WCO Myanmar	As lead for the development and implementation of the CCS, the WCO is the main stakeholder of the evaluation because it has an interest in enhancing accountability of WHO in-country as well learning from evaluation results for future programming
WHO Regional Office for South-East Asia	As a key contributor to the development of the CCSs the Regional Office has a direct stake in the evaluation in ensuring that WHO's contribution in-country is relevant, coherent, effective and efficient. The evaluation findings and best practices in Myanmar will be directly useful to inform other WCOs in the Region as well as regional approaches in health.
Headquarters management	The results of the evaluation should be of interest as headquarters management is in charge of the strategic analysis of country cooperation strategy content and implementation and is responsible for promoting application of best practices in support of regional and country technical cooperation.
Executive Board	The Executive Board has a direct interest in being informed about the added value of WHO's contributions in countries and being kept abreast of best practices as well as challenges through the annual evaluation report.
External Stakeholders	
Government of Myanmar	As a recipient of WHO's action, the Government of Myanmar has an interest in ensuring that the partnership with WHO, both in the current and in future CCSs, is the most relevant, effective and efficient. In addition to the Ministry of Health and Sports, all public health partners in-country have an interest in the evaluation.
All individuals in Myanmar	WHO's action in Myanmar should ensure that it benefits all population groups, prioritizes the most vulnerable and does not leave anyone behind. The evaluation will look at the way WHO addresses equity and ensures that all population groups are considered in the various policies and programmes.
UN Country Team	WHO contributed to several outcomes of the UN Strategic Framework 2012-2015 alongside other UN agencies. There is therefore an interest for the UNCT to be informed about WHO's achievements and be aware of Myanmar's best practices in the health sector.
Donors and partners	Multilateral and bilateral donors and philanthropic foundations have an interest in knowing whether their contributions have been spent effectively and efficiently and if WHO's work contributes to their own strategies and programmes.

VI. Evaluation questions

16. All CPEs address the 3 main Evaluation Questions (EQs) identified below. The sub-questions are then tailored to the country's specificities and detailed in an evaluation matrix to be developed

during the inception phase by the evaluation team. Good practices and lessons learned will be identified across the findings.

EQ1 - Were the strategic choices made in the CCS (and other relevant strategic instruments) the right ones to address Myaanmar's health needs and coherent with government and partners' priorities? (relevance)

17. This question assesses the strategic choices made by WHO at the CCS design stage and its flexibility to adapt to changes in context. The evaluation sub-questions focus on the following elements:

1.1 Are the CCS and other relevant strategic instruments based on a comprehensive health diagnostic of the entire population and on Myanmar's health needs?
1.2 Are the CCS and other relevant strategic instruments coherent with Myanmar's National Health Plan and any other relevant strategies as well as the MDG and SDG targets relevant to Myanmar?
1.3 Is the CCSs coherent with relevant UN strategic frameworks? Are the key partners clear about WHO's role in Myanmar?
1.4 Is the CCSs coherent with the General Programme of Work and aligned with WHO's international commitments?
1.5 Has WHO learned from experience and changed its approach in view of evolving contexts (needs, priorities, etc.) during the course of the CCS 2014-2018?
1.6 Is the CCS strategically positioned when it comes to:

- Clear identification of WHO's comparative advantage and clear strategy to maximise it and make a difference?
- Capacity of WHO to position health priorities (based on needs analysis) in the national agenda and in those of the national partners in the health sector?
- Specificities of the partnership between WHO and the Government of Myanmar?

EQ2 - What is the contribution/added value of WHO towards addressing the country's health needs and priorities? (effectiveness /elements of impact/progress towards sustainability)

18. To address this question the evaluation team will focus on best practices and innovations observed for the following:

2.1 To what extent were the country biennial workplans (operational during the evaluation period) based on the focus areas as defined in the CCS (and other relevant strategic instruments) or as amended during course of implementation?
2.2 What were the main results achieved for each outcome, output and deliverable as defined in the country biennial workplans?
2.3 What has been the added value of regional and headquarters contributions to the achievement of results in-country?
2.4 What has been the contribution of WHO results to long-term changes in health status in-country?
2.5 Is there a national ownership of the results and capacities developed?

EQ3 – How did WHO achieve the results? (efficiency)

19. In this area the evaluation sub-questions will cover the contribution of the core functions, the partnerships and allocation of resources (financial and staffing) to deliver the expected results and, for each, will seek to identify best practices and innovations.

3.1 For each priority, what were the key core functions most used to achieve the results?
3.2 How did the strategic partnerships contribute to the results achieved?
3.3 How did the funding levels and their timeliness affect the results achieved?
3.4 Was the staffing adequate in view of the objectives to be achieved?

3.5 What were the monitoring mechanisms to inform CCS implementation and progress towards targets?

3.6 To what extent has the CCS been used to inform WHO country workplans, budget allocations and staffing?

VII. Methodology

20. Guided by the WHO Evaluation Practice Handbook, the evaluation will be based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives of accountability and learning.

21. During the inception phase the evaluation team will design the methodology which will entail the following:

- Adapt the **theory of change** developed for the evaluation of WHO's presence in countries. The theory of change to frame the CPE Myanmar will: i) describe the relationship between the CCS strategic priorities, the focus areas and the activities and budgets as envisaged in the biennial workplans; ii) clarify the linkages with the General Programme of Work and programme budgets, and iii) identify the main assumptions underlying it.
- Develop and apply an **evaluation matrix**[14] geared towards addressing the key evaluation questions, taking into account the data availability challenges, the budget and timing constraints.
- Adhere to WHO cross-cutting strategies on **gender, equity and human rights** and include to the extent possible disaggregated data and information.
- Follow the principles set forth in the *WHO Evaluation Practice Handbook* and the United Nations Evaluation Group (UNEG) *Norms and standards for evaluation* and *Ethical guidelines for evaluation*.

22. The methodology should demonstrate impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using a mixed methodological approach to ensure triangulation of information through a variety of means.

23. The CPE will rely mostly on the following **data collection methods**:

- Document review will include analysis of key strategic documents, such as the general programmes of work, the programme budgets, the WCO workplan and budget, the CCS (and other relevant strategic instruments), narrative and financial progress reports, any available UN Country Team (UNCT) strategic planning frameworks, relevant national policies, strategies and other relevant documentation.
- Stakeholder interviews. Interviews will be conducted with external and internal stakeholders at global, regional and country levels of the Organization. External stakeholders for this evaluation are: officials of the Ministry of Health and Sports and officials of other relevant governmental institutions; healthcare professional associations and other relevant professional bodies; relevant research institutes, agencies and academia; health care provider institutions; nongovernmental organizations and civil

[14] An **Evaluation Matrix** is an organizing tool to help plan for the conduct of an evaluation. The Evaluation Matrix forms the main analytical framework for the evaluation. It reflects the key evaluation questions and sub-questions to be answered and helps the team consider the most appropriate and feasible method to collect data for answering each question. It guides analysis and ensures that all data collected is analysed, triangulated and used to answer the evaluation questions, and make conclusions and recommendations.

society; UN agencies and other relevant multilateral organizations; donor agencies; and other relevant partners.

- Mission in-country. Following the document review and some stakeholder interviews, the country visit will be the opportunity for the evaluation team to develop an in-depth understanding of the perspectives of the various stakeholders around the evaluation questions and collect additional secondary data, in particular from external stakeholders..

24. **Stakeholder consultation**. In addition to acting as key informants during the evaluation process, key internal and external stakeholders will be consulted at the drafting stages of the terms of reference, inception note and evaluation report and will have the opportunity to provide comments.

25. **Limitation.** No major primary quantitative data collection is envisaged to inform this evaluation. The evaluation team will mainly use data (after having assessed their reliability) collected by WHO and partners during the timeframe evaluated

VIII. Phases and deliverables

26. The evaluation is structured around 5 phases summarized in Table 5 below.

Table 5: summary tentative timeline – key evaluation milestones

Main phases	Timeline	Deliverables
1. Preparation	October-November 2019	Draft and final TOR Evaluation team contracted
2. Inception	December 2019	Desk review of existing literature Draft and final inception note
3. Data collection and analysis	January 2019	Document review Key informant interviews with headquarters and Regional Office staff Country visit
4. Reporting	February-March 2020	Draft and final evaluation report
5. Management response and dissemination	April 2020	Management Response Evaluation report online

27. **Preparation**. These TOR are prepared following the *WHO Evaluation Practice Handbook*. The final version of the TOR takes into consideration results of consultations with key internal and external stakeholders.

⇨ **1st deliverable: Final TOR**

28. The **inception phase** will start with a first review of key documents and briefings with headquarters, Regional Office and WCO key stakeholders. During the inception phase, the evaluation team will assess the various logical/results frameworks and their underlying Theory of Change. The inception note will close this phase. Its draft will be shared with key internal stakeholders (at the three levels of the Organization) for their feedback. The inception note will be prepared following the Evaluation Office template and will focus on methodological and planning elements. Taking into account the various logical/results frameworks and evaluation questions, it will present a detailed evaluation framework and the evaluation matrix. Data collection tools and approaches will be clearly identified in the evaluation matrix.

⇨ **2nd deliverable: Inception note.**

29. **Data collection and analysis**. This phase will include additional document review, key stakeholder interviews at headquarters and Regional Office levels and a country visit. The in-country mission will start a briefing to the WCO and key partners and end with a debriefing with the same group.

30. **Reporting**. This phase is dedicated to the in-depth organization of key findings and results according to the evaluation questions identified above and identification of key lessons learned. It will include conclusions based on the evidence generated in the findings and draw actionable recommendations. These will be presented in the draft evaluation report, which will be shared with key internal and external stakeholders for fact-checking. The evaluation report will be prepared in accordance with the *WHO evaluation practice handbook*.

⇨ **3rd deliverable: Evaluation Report**.

Note: The revisions of any of the deliverables produced by the evaluation team will be accompanied by feedback on each comment provided. This feedback will succinctly summarize if and how comments were addressed and, if they were not, it will justify why.

31. **Management response** and dissemination of results. The management response will be prepared by the WCO and posted on the website of the Evaluation Office once finalized, alongside the evaluation report. Dissemination of evaluation results and contribution to organizational learning will be ensured at all levels of the Organization as appropriate.

IX. Evaluation management

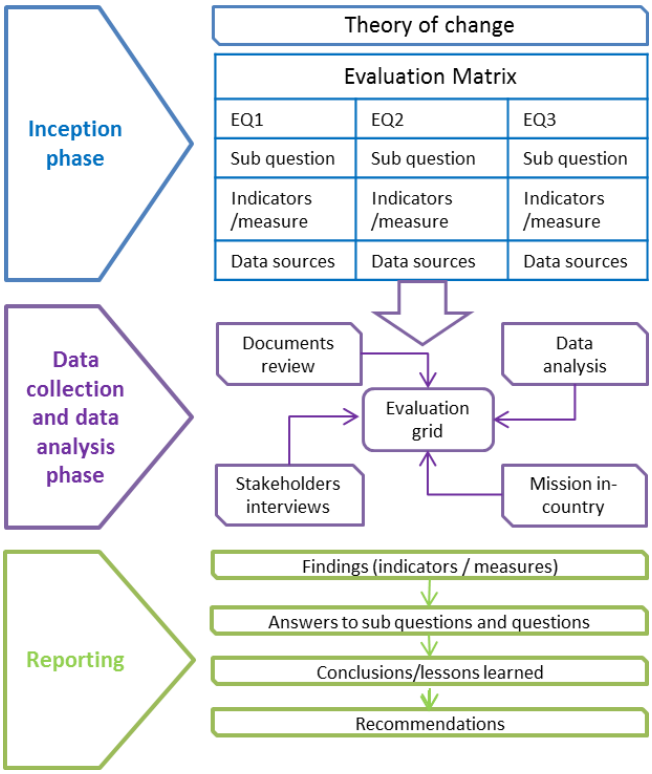
35. The CPE will be commissioned and managed by the WHO Evaluation Office (EVL). EVL will establish an evaluation team formed by independent external evaluation consultants and EVL staff. The evaluation team will report to the Director-General's Representative for Evaluation and Organizational Learning in his capacity as Evaluation Commissioner. A WHO Senior Evaluation Officer will act as the Evaluation Manager, representing to the Evaluation Commissioner in the management and day-to-day operations of the evaluation. Technical oversight will be provided by the Chief Evaluation Officer.

Annex 2: Evaluation methodology and evaluation matrix

This Annex summarizes the approach adopted in this CPE and the main methods and tools employed. It draws on the inception note.

Guided by the *WHO Evaluation Practice Handbook*, the overall methodological approach adopted by the evaluation team is summarized in Figure 1. This shows the sequencing and interrelationship of activities under each of the three main phases of the evaluation process. Concretely, the evaluation was conducted between December 2019 and June 2020 by a core team from the WHO Evaluation Office supported by two external consultants.

Figure 1: Methodological approach



Inception phase

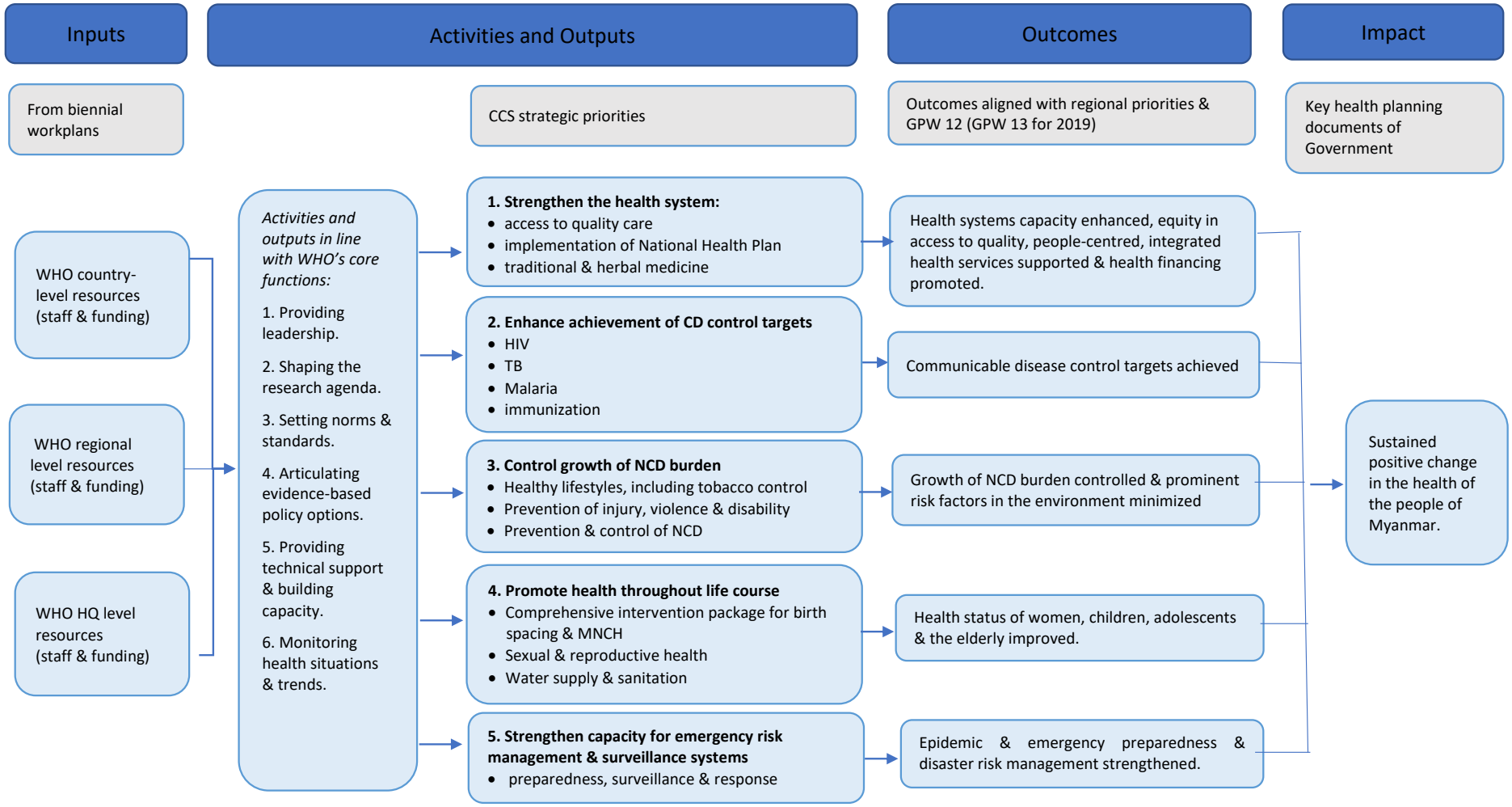
a. Theory of change underlying WHO's contribution in Myanmar

The evaluation adopted the CCS as a primary criterion for the evaluation. However, in the absence of an explicit logic model or theory of change to frame the contributions of WHO in Myanmar over the evaluation period, during the inception phase the evaluation team proposed a theory of change (see Figure 2). This theory of change describes the relationship between the CCS strategic priorities, the focus areas and the activities and budgets as envisaged in the biennial workplans; clarifies the linkages with the GPW and programme budgets; and identifies the main assumptions underlying it.

The theory of change aims to encompass contributions from all levels of the Organization and all strategic contribution areas of WHO in the country. It is aligned with that validated by WHO in the context of the evaluation of WHO's presence in countries[15] and previous CPEs.

[15] WHO (2015). Evaluation of WHO's Presence in Countries. Geneva: WHO Evaluation Office (http://www.who.int/about/evaluation/prepublication-country-presence-evaluation.pdf?ua=1).

Figure 2: Theory of Change (TOC) – WHO contribution in Myanmar 2014-2018



Assumptions

WHO staffing, resources & priorities relevant to country priorities

Effective collaboration within WHO (HQ, RO & WCO) & between WHO & health/other ministries, UNCT members, development partners & civil society for a whole-of-society, whole-of government approach.

MOH willing & able to accept and use WHO products & services. Programme budget outputs/outcomes support CCS focus areas.

MOH policies responsive to priority health needs of population, considering gender, equity & human rights, & aligned with international norms & guidance.

b. Evaluation matrix

Using the theory of change, the evaluation team developed an evaluation matrix which defines specific indicators/measures for assessing each sub-question and indicates what data collection method and data sources were used to inform each of these. The evaluation matrix is available at the end of this Annex.

c. Inception note

The inception note was prepared following the Evaluation Office template and focused on methodological and planning elements of the evaluation. It presented, taking into account the various logical/results frameworks and the evaluation questions, a detailed evaluation framework and the evaluation matrix. Data collection tools and approaches were clearly identified in the evaluation matrix. It was shared with the WCO prior to the mission.

Data collection phase

The evaluation team used a pragmatic mixed-methods approach in addressing the evaluation questions. The evaluation matrix details for each sub-question the main data collection methods. To this end, different instruments have been employed and evidence from different sources triangulated.

a. Documents review

The evaluation matrix identified key documents that were reviewed prior to the mission. Relevant information has been extracted to address the corresponding sub-questions. A preliminary review of documents available had shown limitations in terms of data availability as some of the sub-questions do not easily lend themselves to quantitative assessment. This reinforced the case for combining careful review of different data sources.

b. Stakeholder interviews

These were the main form of primary data collection. The evaluation team conducted a large number of interviews (list available in Annex 5) with WHO colleagues at the three levels of the Organization as well as with all main partners in-country. Care was taken to ensure that the interviewees felt comfortable to express their opinions. The evaluation used a combination of individual and group interviews across the different activities. In practice, individual interviews were usually the most useful in providing detailed information and opinions. Group interviews, on the other hand, provided helpful insights into retrospectively understanding the processes of decision-making (which have often not been systematically recorded) as well as the implementation processes (where participants identified what elements fed into decisions, and how the implementation process took place over time). By default, all interviews have been treated as confidential by the evaluation team.

c. Country mission

Planned after the document review, the country mission took place in January 2020 and was the opportunity for the evaluation to complement the information gathered through stakeholder interviews. The mission started with a briefing with the WCO. An in-country feedback session was organized at the end of the mission with the WCO. The mission also included a visit to the WHO Office in Naypyidaw.

d. Data analysis

The evaluation team triangulated all information collected and compiled information in an evaluation grid structured by evaluation question, sub-question and indicators. Evaluation findings were then drawn only after a thorough cross-checking and triangulation of all information related to each evaluation question. This ensured that answers to evaluation questions were based on solid and cross-checked evidence. The evaluation team identified a certain number of challenges to address some of the evaluation questions, which are described below.

Reporting

On the basis of the cross-checked evaluation findings, the team formulated answers to the evaluation questions. These answers informed the drafting of the conclusions. These included, to the extent possible, lessons learned and best practices identified in the course of the evaluation.

Finally, the evaluation team provided practical, operational recommendations for future adjustments and actions. Each recommendation is based on the answers to evaluation questions and overall conclusions, which in turn will be linked to evaluation findings per evaluation question and ultimately to the data collected.

Gender, equity and human rights

The evaluation ensured that gender, equity and human rights issues were addressed to the extent possible and through several means. A number of sub-questions within the evaluation matrix are gender sensitive with appropriate related indicators. The document review paid specific attention to how these issues were addressed at planning, implementation, monitoring and evaluation stages of WHO contributions. Finally, these dimensions have been reflected in the interviews.

Limitations of the evaluation

The evaluation encountered a few other relevant issues:

- The lack of a theory of change to identify and assess the value chain of WHO work and in particular of the WCO in Myanmar represents an important challenge. This constraint was mitigated by proposing a theory of change, including assumptions, to be tested during the evaluation.
- Another constraint is the absence of performance indicators for CCS focus areas, means of verification and targets (including baseline values). Whilst WHO programme budgets contain global output and outcome indicators, targets are not specified for India. This constraint was mitigated by stakeholder interviews, analysis of secondary data and triangulation of available evidence to assess progress towards CCS priorities and focus areas.

Considering the limitations identified above, the evaluation team could only assess progress for each of the main outcome groups identified in the theory of change but was not able to measure them against planned targets as they were not identified in a measurable manner.

Evaluation matrix

Evaluation sub-questions	Indicator/measure	Main source of information
EQ1 - Were the strategic choices made by WHO in the CCS (and other relevant strategic instruments) **the right ones to address Myanmar's health needs and coherent with government and partners priorities? (relevance)**		
1.1 Are the CCS and other relevant strategic instruments based on a comprehensive health diagnostic of the entire population and on Myanmar's health needs?	Availability in the CCS of a comprehensive health diagnostic inclusive of gender-related issues and covering all population (minorities, migrants) living in Myanmar and based on evidence-based data available such as data from the Global Health Observatory or other reliable and valid sources (e.g. Demographic and Health Survey)	**Document review** -
1.2 Are the CCS and other relevant strategic instruments coherent with Myanmar's National Health Plan and any other relevant strategies, as well as the MDG and SDGs targets relevant to Myanmar?	Level of alignment of health priorities identified in the CCS, and other relevant strategic documents, with - Priorities of the National Health Plan - MDG targets in Myanmar - SDG targets in Myanmar	**Document review** -
1.3 Is the CCS coherent with relevant UN Strategic Frameworks?	Level of alignment of the CCS with the UN Strategic Framework 2012-2015	**Document review** - **KII**: -
1.3.1 Are the key partners clear about WHO's role in Myanmar?	Level of clarity among partners about the role of WHO in Myanmar	**Document review** - **KII**: -
1.4 Is the CCS coherent with the WHO General Programme of Work and aligned with WHO's international commitments?	Level of coherence between the CCS and - GPWs 12 and 13 - MDG & SDG targets	**Document review** -
1.4.1 Does the CCS support good governance, gender equality and the empowerment of women?	Availability of explicit reference in the CCS to - good governance, - gender equality and empowerment of women - equity concerns and human rights	**Document review** - **KII**: -
1.5 Has WHO learned from experience and changed its approach in view of evolving contexts (needs, priorities, etc.) during the course of the CCS 2014-2018	- Changes or orientation in the implementation of the CCS and rationale for these changes - Consider changes with regard to the SDG agenda	**Document review** - **KII**: -
1.6 Is the CCS strategically positioned when it comes to:	- Indication of best practice in terms of strategic positioning	**Document review** - **KII**:
1.6.1 Clear identification of WHO's comparative advantage and clear strategy to maximise it and make a difference?	- Explicit elements of WHO's comparative advantage identified in the CCS - Explicit strategy to value the comparative advantages identified	

Evaluation sub-questions	Indicator/measure	Main source of information
1.6.2 Capacity of WHO to position health priorities (based on needs analysis) in the national agenda and in those of the national partners in the health sector?	- Clear linkages between CCS priorities and most important health needs in the country as identified in the health diagnostic (see 1.1) - Indication of role played by WHO in the development of the national health agenda - Indication of role played by WHO in development of main national partners in the health sector	-
1.6.3 Specificities of the partnership between WHO and the Government of Myanmar?	- Indication of partnerships elements in the CCS - indication of evolution in the CCS - Reasons for change in partners - Reasons for evolution within continuing partners	
EQ2 - What is the contribution/added value of WHO towards addressing the country's health needs and priorities? (effectiveness/elements of impact/progress towards sustainability)		
2.1 To what extent were the country biennial workplans (operational during the evaluation period) based on the focus areas as defined in the CCS (and other relevant strategic instruments), or as amended during course of implementation?	- Availability of explicit linkages between the workplans and the focus areas described in the CCS - Weight (and trend) of activities in workplans not included in the CCS and rationale for their inclusion in the workplans	**Document review** - **KII**: -
2.2 What were the main results achieved for each outcome, output and deliverable for the WCO as defined in the country biennial workplans?	- Level of achievement for each CCS priority and any other key activities within and outside the CCS - Identification of key results and best practices - Identification of added value of WHO contributions	**Document review** - **KII**: -
2.3 What has been the added value of regional and headquarters contributions to the achievement of results in-country?	- Indication of HQ/RO contribution to CCS development and to the design of other strategic documents - Indication of HQ/RO contribution to specific activities in Myanmar - Indication of participation of national partners in regional or global initiatives/capacity development opportunities directly linked to CCS priorities - Identification of added value from key results and best practices	**Document review** - **KII**: -
2.4 What has been the contribution of WHO results to long-term changes in health status in-country?	- Indication of long term WHO engagement in selected areas or work - Perception of stakeholders on WHO's role to changes in these areas - Identified key results and best practices	**Document review** - **KII**: -
2.5 Is there national ownership of the results and capacities developed?	- Indication of key areas of national capacities developed - Indication of changed practices among partners following WHO support and capacity development activities - Indication of continued activities by national partners following end of WHO support - Identified key results and best practices	**Document review** - **KII**:

EQ3 – How did WHO achieve the results? (efficiency)		
3.1 For each CCS priority, what were the key core functions[16] most used to achieve the results?	- Reference to core functions supporting achievement of results in biennial reports and other WCO, RO and HQ documents - Linkages between activities in programme budgets and core functions - Perception of stakeholders about WHO functions most used - Identified best practices	**Document review** - **KII**: -
3.2 How did the strategic partnerships contribute to the results achieved?	- Reference to the strategic partnerships identified in the CCS, and to others as identified by the WCO, including the UNCT - Indication of their contributions to the results - Perception of strategic partners about the contribution of the partnerships to the achievements	**Document review** - **KII**: -
3.3 How did the funding levels and their timeliness affect the results achieved?	- Level of funding compared with budget planned for CCS and other activities - Timing of funding over the BCA period - Main funding mechanisms used - Perception of stakeholders on level of funding, timeliness and relationship with WCO performance	**Document review** - **KII**: -
3.4 Was the staffing adequate in view of the objectives to be achieved?	- Level and number of staff available for CCS implementation and other activities - Perception of stakeholders on staffing situation and relationship with WCO performance	**Document review** - **KI**I: -
3.5 What were the monitoring mechanisms to inform CCS implementation and progress towards targets?	- Availability of monitoring mechanisms - Availability and usefulness of monitoring reports on progress towards targets - Identified best practices	**Document review** - **KII**: -
3.6 To what extent have the CCS been used to inform WHO country work plans, budget allocations and staffing?	- Availability of explicit linkages between CCS and work plans, budget allocations and staffing - Weight of the CCS versus other activities undertaken by WCO	**Document review** - **KII:** -

[16] **Core functions**: 1) Providing leadership and engaging in partnerships; 2) Shaping the research agenda, and simulating the generation transition & dissemination of knowledge; 3) Setting norms & standards and promoting implementation; 4) Articulating evidence-based policy options; 5) Providing technical support & building capacity; 6) Monitoring health situations & trends

Annex 3: WHO's main planning instruments and associated challenges

This Annex presents briefly the main planning instruments WHO has developed to frame its action at the various levels of the Organization and the main implications for the Myanmar CPE.

Figure 1: Timeframes of key planning instruments at the different levels of the Organization

The WHO high-level strategic planning document is the **General Programme of Work (GPW)**. It sets out priorities and provides an overall direction for a given period. The CCS 2014-2018 fell essentially within the timeframe of the 12th GPW,[17] which encompassed six years (2014-2019),[18] and defined six categories as high-level domains for technical cooperation and normative work (e.g. communicable diseases, health systems). These categories were divided into individual programme areas (e.g. malaria, nutrition) and provided a programmatic and budget structure for the work of WHO. Through a results chain, the GPW furthermore explained how WHO's work would be organized over the specific timeframe and how the work of the Organization would contribute to the achievement of a set of intended outcomes and impacts.[19] The 13th GPW (2019-2023)[20] represents a shift from categories and programme areas and is structured around three interconnected strategic priorities to ensure healthy lives and well-being for all at all ages: achieving universal health coverage, addressing health emergencies and promoting healthier populations. Under this structure, WHO's work is organized around nine health outcomes and three leadership and enabling outcomes. Hence, the GPW is the high-level strategic vision for the work of the entire Organization.

At country level, the main strategic planning document to guide WHO's work is the **Country Cooperation Strategy (CCS)**.[21] It is a medium-term strategic vision for technical cooperation in and with a given Member State, responding to the country's specific needs and the national targets under the Sustainable Development Goals. The time frame of the CCS is flexible to be aligned with national

[17] WHO (2014). Twelfth General Programme of Work 2014-2019. Not merely the absence of disease. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/handle/10665/112792/GPW_2014-2019_eng.pdf?sequence=1).
[18] Superseded by the 13th GPW (2019-2023) in 2019.
[19] WHO (2014). Twelfth General Programme of Work 2014-2019. Not merely the absence of disease. Geneva: World Health Organization (http://apps.who.int/iris/bitstream/handle/10665/112792/GPW_2014-2019_eng.pdf?sequence=1).
[20] WHO (2018). Thirteenth General Programme of Work 2019-2023 (http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1).
[21] WHO (2016). WHO Country Cooperation Strategy. Guide 2016. Geneva: World Health Organization (http://www.who.int/country-cooperation/publications/ccs-formulation-guide-2016/en/).

and United Nations planning cycles and to accommodate changing circumstances (e.g. emergencies, humanitarian crises or post-conflict situations).

The priorities and expected results in the GPW find their operational expression for a particular biennium in WHO's **Programme budget (PB)**, which puts in concrete terms how intended outcomes and impacts shall be achieved. Under the 12th GPW, the PB was structured by category and programme area, each one with a set of outcomes, which were a joint responsibility of Member States and the Secretariat, and outputs defining what the Secretariat would be accountable for delivering during the respective biennium. As already mentioned, the 13th GPW is structured around three interconnected strategic priorities.

The PB then serves as the biennial instrument for the development of **workplans**. Each workplan consists of a set of products and services, with associated activities and related costs but these are not related to the CCS in any explicit way. In WHO's internal planning system, all products, services and associated activities are considered as tasks.[22] Each task is explicitly linked to one output in the programme budget at corporate level, which means the task should support its expected achievement. The workplans ultimately break down the desired results of WHO's strategic planning into sets of corresponding tasks. Workplans are developed and implemented by budget centres, which are generally organizational units (for example, the WHO country office is one such budget centre).

Some challenges

As discussed, planning at WHO is based on various instruments, which are connected through linkages at different organizational levels. WHO's planning framework seeks to ideally establish an explicit interaction between the strategic plans at country (CCS) and corporate level (GPW/PB). Concretely, CCS priorities and focus areas should provide the strategic basis for the country-level input into the PB bottom-up planning process and thus ideally into the identification of corporate priorities and budget allocations. On the other hand, the GPW/PB priorities in turn should inform new CCS agendas if they are outdated and about to be renewed.[23] However, the concrete processes of the mutual interaction between the CCS and the PB have not been not consistent. All workplans and their respective tasks must relate to outputs in the PB, regardless of the organizational level at which they are being developed and implemented. This implies that the PB is directly influencing activities at country level (insofar as they must at least be linked to it). However, the extent to which the worldwide heterogeneous CCS agendas inform the biennial PB planning process varies and the process is not always harmonized.

Figure 1 visualizes the various planning cycles and timeframes of WHO for the period of the Myanmar CPE. As can be seen from this Figure, the timeframes of the main planning instruments are not totally aligned. This can cause programmatic divergences between the different levels insofar as perennial planning instruments, once drafted and adopted, cannot take into account upcoming strategic shifts being introduced on another level.

A common problem at country level, including for the Myanmar WCO, has been the lack of a consistently clear link between workplans drafted at country level and the strategic priorities established in the CCS. WHO's organization-wide planning system is designed in such a way that all workplans and their respective tasks relate to outputs in the PB (see left side in Figure 2). Before the 13th GPW, the programmatic structure in this process were the categories that represented the high-level domains for WHO's work (e.g. communicable diseases). These categories were often not congruent with CCS priorities. Instead, each CCS was supposed to explicitly specify how its various focus areas were connected to one or more outcomes in the GPW, thus providing another link

[22] WHO (2015). Programme Management. Glossary of Terms. Unpublished internal document. Geneva: World Health Organization.

[23] WHO (2016). WHO Country Cooperation Strategy. Guide 2016. Geneva: World Health Organization (http://www.who.int/country-cooperation/publications/ccs-formulation-guide-2016/en/).

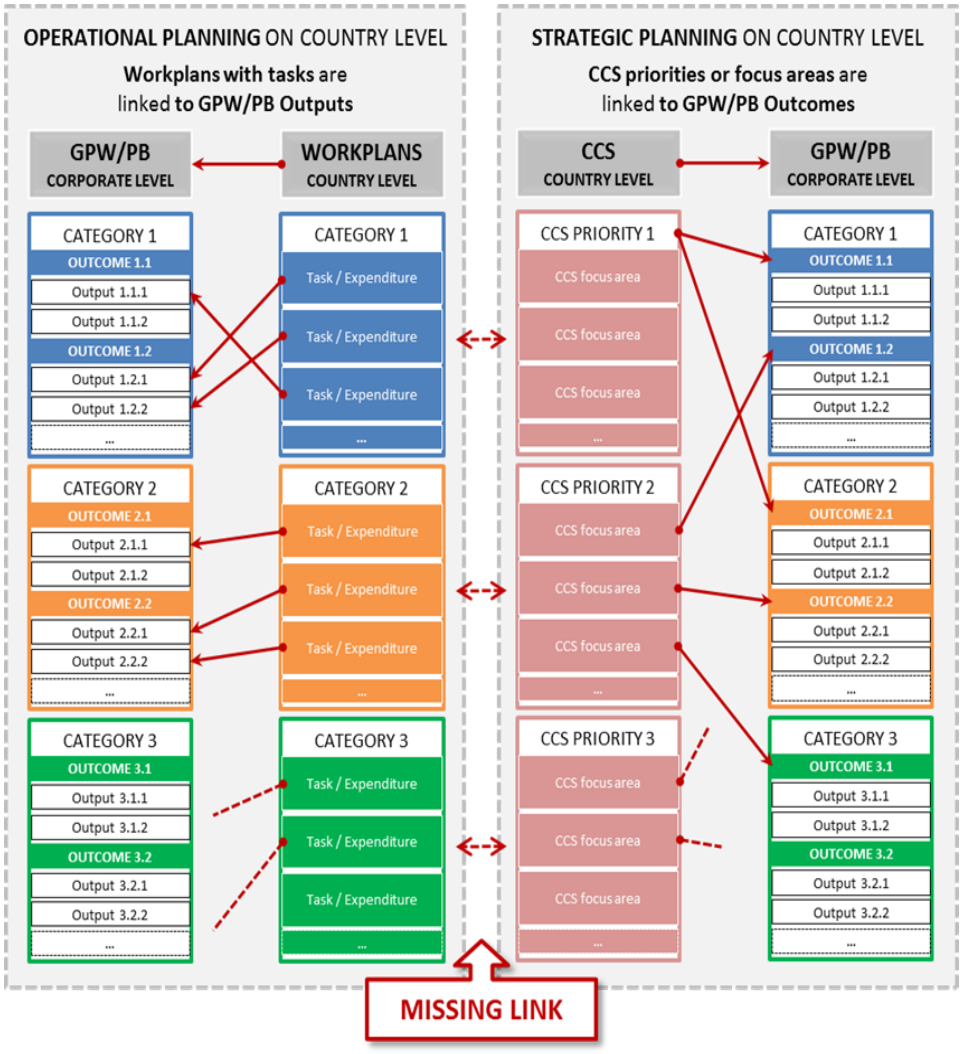
between the country and corporate level (see right side in Figure 2). However, this did not allow drawing conclusions regarding the link between workplans and the agenda of a specific CCS.

Hence, there is often no documented traceability of how individual tasks in the workplans at country level were supposed to support CCS priorities or their focus areas. In such instances, there was no systematic way to assign financial figures to CCS priorities. Furthermore, most country level biennial workplans also included other critical country level activities beyond the focus areas identified in the CCS.

Finally, whilst annual and biennial reporting of results takes place through the mid-term review and the PB performance assessment reports to the governing bodies, there was, in general, no systematic monitoring and reporting against results at country level. Indeed, the tasks included in the workplans were not framed together against a specific objective or expected outcome in the CCS expressing the expected contribution of WHO in-country over a period of time in a specific area of engagement. Nor were there any indicators associated with these except for expenditures and self-reporting under the form of a narrative.

However, it is intended that the impact and outcome-focused approach of the 13th GPW will provide a better base for priority setting and programming at country level, and align more clearly with country planning and delivery of the work needed through the development of country support plans involving the three levels of the Organization.

Figure 2: Relation between strategic and operational planning on country level (12th GPW*)*



Annex 4: Programmatic achievement in the CCS 2014-2018 priority areas[24]

Priority 1: Strengthening the health system
Objective 1.1: Improve access to quality care
• Conducted Service Availability and Readiness Assessment to provide policy makers a better understanding of service readiness at the township level (2014) • Supported MoHS in the development of the human resources for health strategy and medical education of front-line staff through training of community health workers and auxiliary midwives • Supported the review of the national medicines policy as part of the MoHS' efforts to address stock-outs of essential medicines and supplies • Supported drafting the health financing policy to ensure quality services are affordable by all and piloting health financing schemes such as the Maternal Voucher Program and the Hospital Equity Fund that aim to reduce out of pocket expenditure and increase access to services • Advocated for patient safety and provided technical assistance to improve infection control at all levels of the heath system
Objective 1.2: Strengthen implementation of the National Health Plan
• Provided technical support, fellowship opportunities and study tours to strengthen understanding of UHC, key components of health systems, and technical skills in areas such as health financing, human resources for health, health information systems and governance and leadership • Supported the development of the National Health Plan, 2017 -2021 which outlined a 15-year phased approach to achieve UHC through strengthening community health care • Supported development of Strategic action plan for strengthening health information, 2017-2021, and development of second version of Myanmar E-health architecture blueprint
Objective 1.3: Support Government efforts to promote traditional and herbal medicine
• Supported in-service training and capacity building in research and development • Supported updating of training curriculum for traditional medicine for University of Traditional Medicine • Supported quality assurance of formulation of traditional medicines (pre-qualification and post-marketing quality assurance)
Priority 2: Enhancing the achievement of communicable disease control target
Objective 2.1: Attain 80% coverage of people needing antiretroviral therapy (ART) under national guidelines and minimize HIV transmission from infected mothers

• Data from mid-2019 suggest 73% of PLHIV is under ART and, as regards mother-to-child transmission, 95% of the pregnant females were submitted to HIV Testing and positive rates of mother-to-child transmission were 0,52 in 2018
• Supported development of several national strategic plans, guidelines and operational plans addressing HIV/AIDS and hepatitis, such as:
  ○ National Strategic Plan for HIV and AIDS, 2016-2020
  ○ National Strategic Plan on Viral hepatitis, 2016-2020 (2017)
  ○ Simplified Treatment Guidelines for viral hepatitis B and C infections (2019)
  ○ Myanmar National Action Plan for Viral Hepatitis Response, 2017-2020 (2017)
  ○ National Monitoring and Evaluation Plan for Viral Hepatitis, 2017-2020 (2017)
  ○ National Testing Guidelines for Viral Hepatitis (2018)
  ○ Guidelines for Clinical Management of HIV infections (updates in 2014, 2017 and 2018)
  ○ HIV drug resistance survey: Pre-treatment (2016) and Acquired (2019)
• Ensured full commitment from the Government to procure ARV and Methadone

[24] As reported in WCO self-assessment report, internal review of CCS 2014-2018 (contained in draft CCS 2019-2023), programme budget performance assessment reports for 2014-2015, 2016-2017 and 2018-2018 for the WCO, annual reports of the Regional Director for South-East Asia (2014-2018).

- Ensured free Hepatitis treatment in the country

Objective 2.2: Further reduce TB prevalence and mortality to achieve the TB impact targets

- Supported national TB prevalence survey, 2017-2018 which suggested annual reduction of estimated TB incidence of 4% since 2009-2010 prevalence survey - significant decline of TB prevalence in States and among ethnic minorities, owing to the expansion of basic TB service in mid 2010s
- Supported development of National Strategic Plan for Tuberculosis, 2016-2020, which adopted End TB Strategy
- Supported key interventions such as MDR-TB care and TB-HIV collaborative service expanded to every township by 2016
- Supported release of policy order of mandatory case notification for TB as a notifiable disease (2018)

Objective 2.3: Intensify control of malaria in high transmission areas and along international borders; and control and eliminate neglected tropical diseases

- Since 2012, the reported number of malaria cases and deaths has dropped by 84% and 95% respectively.
- Supported development of National plan for malaria elimination, 2016-2030 and National strategic plan for intensifying malaria control and accelerating progress towards malaria elimination, 2016-2020 - targets set in the National Strategic Plan, 2016-2020 have been achieved and elimination activities had been started in 211 townships by 2019 (total of 211 townships out of 330 had API<1/1000 population (in elimination phase))
- Supported strengthening of malaria surveillance system through transforming paper-based reporting system to electronic, web-based (including DHIS2 in some townships) reporting system
- Scaled-up cross border collaboration with China and Thailand, as well as countries in the Greater Mekong Sub-region
- Provided training and capacity building provided to improve overall programmatic capacity in case management, entomology and vector control and surveillance of malaria and neglected tropical diseases
- Supported development of strategic plans for dengue prevention and control and elimination of lymphatic filariasis; guidelines for clinical management of dengue; and trachoma prevalence survey

Objective 2.4: Strengthen immunization systems to achieve at least 90% DTP coverage nationally and 80% in all townships; and expand planning and implementation of other VPD programmes

- As per DHIS2 data of October 2019, Myanmar had achieved 91% of DPT3 coverage at the national level and 83% of the 330 townships had achieved >80% DPT3 coverage
- Supported development of multi-year plan for immunizations (2016)
- Supported tOPV –bOPV switch (2016)
- Supported PCV and IPV introduction to routine vaccine programme (2016)
- Supported development of National polio transition plan (2017) (in draft)
- Supported two polio vaccination campaigns in Rakhine state which achieved 94% and 89% coverage respectively (2017)
- Supported two-phased JE vaccination campaign 2017 (92% coverage) and introduction of JE to routine vaccination programme (2018)
- Supported two-phased nationwide MR follow up campaign (2019)
- Supported the cVDPV1 outbreak response (2019)
- Supported introduction of two additional vaccines (Rotavirus and HPV) to the routine programme as of 2020 (now 13)

Priority 3: Controlling the growth of noncommunicable disease burden

Objective 3.1: Support the Government to expand activities for promoting practices of health lifestyles in the community, including tobacco control

- Supported MOHS to conduct: STEP survey (2014), Global Youth Tobacco Survey (2016), Global School-based student health survey (2016) and national oral health survey (2017) – findings informed design of behavioural change interventions at community level
- Supported MOHS to strengthen its multisectoral approach for tobacco control in the context of 2030 development agenda (FCTC2030 project) - political commitment for tobacco control along with

collaboration of national and international partner has become stronger (e.g. pictorial health warnings on tobacco packages covering 75% of major display areas).
- Supported 1st national conference on tobacco control and prevention of NCDs (2018)
- Supported advocacy and coordination mechanisms for introduction of healthy diet particularly reduction in consumption of salt, sugar and fat
- Supported formation of SUN Business network in Myanmar and collaborated with WFP, UNICEF and FAO on developing the protocol, ToRs and strategy to include prevention of diet related risk factors for NCDs as a key action area in the SUN strategy
- Supported development of National Eye Health Plan, 2017-2021

Objective 3.2: Support the Government to expand national efforts for prevention of injury, violence and disability

- Supported revitalization of the National Injury Surveillance System (2016)
- Conducted training and provided guidelines to improve acute emergency trauma care.
- Supported MoHS in leading the National Road Safety Council, a multi-sector collaboration to reduce road injuries and improve post-crash care.
- Supported National Road Safety Council to develop a National Action Plan, 2014-2020, linked to injury data
- Supported development of National Rehabilitation Strategic Plan, 2019-2023.
- Supported development of health service guideline and advocacy factsheet for prevention and care of gender-based violence (GBV) survivors - used for State and regional level training for strengthening health sector response to GBV and for setting up One Stop Crisis Centers for GBV survivors.

Objective 3.3: Support the Government to strengthen the prevention and control of NCD

- Supported development of national strategic plan for prevention control of NCDs, 2017-2021.
- Supported MOHS in developing technical guidelines and training packages on secondary prevention of cervical cancer for public health facilities (Myanmar is also among the six countries globally receiving support for UN joint programme on cervical cancer)
- Supported national initiatives on childhood cancer (WHO global initiative for childhood cancer has identified Myanmar as first focus country for South-East Asia)
- Supported scaling up of epilepsy initiative to cover three States
- Supported introduction of behavioural change interventions focused on addressing healthy eating, exercise, and reduction in use of tobacco, tobacco-related products and alcohol
- Supported introduction of PEN interventions in selected townships and developed plans to scale up nationwide in 2019

Priority 4: Promoting health throughout the life course

Objective 4.1: Develop a comprehensive, integrated package of interventions for birth spacing and MNCH, particularly child nutrition and growth monitoring

- Supported development of:
  - Five-year strategic plan for reproductive health, 2014-2018
  - National strategic plan for newborn and child health development, 2015-2018
  - Five-year strategic plan for young people's health, 2016-2020
  - Myanmar Newborn Action Plan, 2014-2020
  - National strategic plan for birth defect prevention and surveillance, 2014-2018
  - Strategy to end preventable maternal mortality, 2017-2021, which includes an evidence-based package of interventions for maternal and reproductive health.
- Supported nationwide launch of maternal death surveillance and response system (2016-2017) and local capacity building and the development of national technical guidelines and a training and advocacy package
- Supported bottom-up planning process to operationalize national Multi-Sectoral National Plan of Action for Nutrition (MS-NPAN), inclusive of townships, ethnic health organizations and local agencies/partners. Provided further technical support during the subnational workshops with innovative approaches to integrate nutrition interventions and actions across other national programmes and projects

- Supported the Myanmar Micronutrient and Food Consumption Survey, 2017-2018, the interim report of which was released in 2019
- Supported, in collaboration with the UN Nutrition Network, the development of an updated Myanmar Food Based Dietary Guidelines in order to establish a common overarching document with national nutrition recommendation across the age groups
- Supported updating (2017) and scale-up of facility-based IMNCH in hospitals

Objective 4.2: Improve sexual and reproductive health including adolescent and women's health and health care for elderly

- Supported MOHS towards achieving SDG targets:
    - *Maternal mortality* reduced from 340/100,000 live births in 2000 to 250/100,000 live births in 2017 (26% reduction). SDG target for MMR is less than 92/100,000 live births by 2030
    - *Newborn mortality* reduced from 48/1,000 live births in 1990 to 23/1,000 live births in 2018 (52% reduction). SDG target for NMR is less than 12/1,000 live births by 2030
    - *Under five mortality* reduced from 115/1,000 live births in 1990 to 46/1,000 live births in 2018 (60% reduction). SDG target for U5MR is less than 25/1,000 live births by 2030
- Supported development of the National Sexual and Reproductive Health and Rights Policy was developed in 2018-2019 and planned to be launched in 2020
- Contributed to the development of Family planning guideline for service providers (2018) (Myanmar became signatory to FP2020 commitments in 2013) - Modern contraceptive prevalence rate has improved to 56% (2019) compared to 51% in 2015 [goal 60%]

Objective 4.3: Support the Government to enhance safe water supply, water quality control, improved sanitation and personal hygiene, and health education promotion

- Supported implementation of Water safety plan in selected States and regions
- Supported establishment of water surveillance system and finalization of Myanmar drinking water quality standards
- Conducted trainings for MoHS staff on occupational safety, indoor air pollution, and waste management
- Supported health component of National adaptation plan to climate change
- Supported, in collaboration with UNICEF, development of a national strategy for rural water supply, sanitation and hygiene (WASH), WASH in schools and WASH in health facilities, including national investment plan and national minimum standard guidelines (2016)

Priority 5: Strengthening capacity for emergency risk management and surveillance systems against various health threats

Objective 5.1: Enhance preparedness, surveillance and response

- Supported Joint External Evaluation of International Health Regulations (2005) in 2017
- Supported development of costed, comprehensive & coordinated National Action Plan for Health Security, 2018-2022 (first in the Region)
- Supported annual IHR reporting by IHR National Focal Point in collaboration with concerned stakeholders
- Supported strengthening of Influenza Like Illness/Severe Acute Respiratory Infection sentinel surveillance
- Supported rapid control of H1N1 influenza outbreak (2017)
- Supported development of National Strategic Plan for Zoonotic Influenza and Human Influenza Pandemic Preparedness and Response (2017)
- Supported development of National Risk Communication strategy for public health emergencies (draft) for effective and efficient response to outbreaks
- Supported development of National Policy on Health Laboratories, National Strategic Plan for Health Laboratories, 2017-2022 (draft) and National Biosafety and Biosecurity Guidelines (2017) to provide clear guidance and direction for laboratory system strengthening
- Supported development of National Action Plan for Containment of AMR (2017) and national AMR surveillance guideline (2019)

- Supported development of National One Health Strategic Framework and Action Plan of Myanmar, 2017-2021 (draft)
- Conducted surveillance and response system assessment focusing on food borne diseases
- Supported capacity building of public health professionals in surveillance and outbreak response through participation of public health officials from MoHS in regional and local Field Epidemiology Training Programmes

Annex 5: List of people interviewed

WHO Country Office, Yangon and Naypyidaw	
Aye Moe Moe Lwin	National Professional Office, Injury and Violence Prevention
Buddh, Nilesh (and Naypyidaw team)	Deputy WHO Representative
Chacko, Stephen (and team)	Technical Officer, EPI
Gocotano, Allison (and team)	Technical Officer, WHO Health Emergencies Programme
Jost, Stephan	WHO Representative
Hla Hla Aye	National Consultant, Human Resources for Health and Reproductive, Maternal, Newborn, Child and Adolescent Health
Jeyakumaran, Dinesh	Technical Officer, Diet and Nutrition
Kockelkoren, Maarten	Administrative Officer
Mesquito, Fabio (and team)	Medical Officer, HIV and Hepatitis
Myo Paing	National Professional Officer, Planning and Noncommunicable Diseases
Onozaki, Ikushi (and team)	Medical Officer, Tuberculosis
Rahman, Mohamed	Technical Officer, Malaria
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