Country Programme Evaluation: Myanmar

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Acronyms

AMR	Antimicrobial resistance
CCS	Country Cooperation Strategy
CPE	Country Programme evaluation
DFID	UK Department for International Development
EQ	Evaluation question
Gavi	The Vaccine Alliance
GDP	Gross domestic product
GFATM	The Global Fund to fight AIDS, Tuberculosis and Malaria
GPW	General Programme of Work
HQ	WHO headquarters
IHR	International Health Regulations
JEE	Joint External Evaluation
MDG	Millennium Development Goal
MoHS	Ministry of Health and Sports
MHSCC	Myanmar Health Sector Coordinating Committee
NCD	Noncommunicable disease
NHP	National Health Plan
NPO	National professional officer
ODA	Overseas Development Assistance
PB	Programme budget
SDG	Sustainable Development Goal
SEARO	WHO Regional Office for South-East Asia
SSA	Special Service Agreement
TSG	Technical and Strategy Group
UNDAF	United Nations Development Assistance Framework
UHC	Universal health coverage
UNCT	United Nations Country Team
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
US CDC	US Centers for Disease Control
WCO	WHO Country Office
WHO	World Health Organization
WR	WHO Representative

Executive Summary

Country programme evaluations were included in the WHO Organization-wide evaluation workplans for 2018-2019 and 2020-2021, approved by the Executive Board in January 2018 and January 2020 respectively. The workplans clarified that country programme evaluations "*will focus on the outcomes/results achieved by the country office, as well as contributions through global and regional inputs in the country. In addition these evaluations aim to analyse the effectiveness of WHO programmes and initiatives in the country and assess their strategic relevance within the national context"*. They encompass the entirety of WHO activities during a specific period. The country programme evaluations aim to provide findings, recommendations and lessons that can be used in the design of new strategies and programmes in-country.

This country programme evaluation was the third of this type undertaken in the South-East Asia Region by the WHO Evaluation Office. Its main purpose was to identify achievements, challenges and gaps and document best practices and innovations of WHO in Myanmar. These include not only results of the WHO country office (WCO) but also contributions at the regional and global levels to the country programme of work. As with all evaluations, this country programme evaluation meets accountability and learning objectives and it will be publicly available and reported on through the annual Evaluation Report.

The scope of the evaluation covered the period of the Country Cooperation Strategy (CCS) 2014-2018 and included activities undertaken in 2019 with a stronger focus on the 2016-2017 and 2018-2019 bienniums in order to generate learning for the future. The activities of the WCO in supporting the national response to the COVID-19 pandemic do not fall under the scope of this report. The evaluation built on an analysis of relevant existing documents and data, complemented by the perspectives of key stakeholders, to:

a. 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 highlighting the challenges and opportunities for improvement.

b. Support the WCO and partners to operationalize the various priorities of future CCSs (and other relevant strategic instruments) based on independent evidence of past successes, challenges and lessons learned.

c. Provide the opportunity to learn from the evaluation results at all levels of the Organization. These can then usefully inform the development of future country, regional and global support through a systematic approach to organizational learning.

The main expected use for this evaluation is to support the WCO as it considers the finalization of the draft CCS 2019-2023 and for future planning. Other main users of the evaluation are the WHO Regional Office for South-East Asia and WHO headquarters in order to enhance accountability and learning for future planning. The Government of Myanmar, as a recipient of WHO's actions, as well as the people of Myanmar, and other organizations, including donors, partners, national institutions and civil society, have an interest to be informed about WHO's achievements and be aware of best practices. Also, the Executive Board has direct interest in learning about the added value of WHO's contributions in Myanmar. Finally, over the medium-term, this evaluation will contribute to build a body of evidence around possible systemic issues to be addressed corporately, such as the development of models of WCOs work/presence in countries.

Guided by the WHO evaluation practice handbook, the evaluation was based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives

of accountability and learning. The methodology demonstrated impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using a mixed methodological approach (e.g. quantitative and qualitative data) to ensure triangulation of information through a variety of means.

Relevance of the strategic choices

The strategic priorities identified in the CCS 2014-2018 were relevant at that time when the CCS was developed, considering the macro-economic, social and political context in the country at that time, and they addressed Myanmar's major health needs and were consistent with government and partners' priorities. They were also coherent with WHO's high-level strategic vision outlined in its GPW12 and Regional priorities.

The relevance of the CCS was affected over the period under review as a result of several factors including: Myanmar's rapid economic development; emerging health issues; socio-demographic and epidemiological transition; evolving strategies and priorities at national level and within WHO; and the shift from MDGs to SDGs. The WCO was able to accommodate those changes in its biennial workplans.

The draft CCS (2019-2023) which is under development is also aligned with the SDG Framework, the draft UNDAF 2018-2022, GPW13 and Regional priorities, the Myanmar NHP 2017-2021 as well as subsector national strategic plans.

While the CCS 2014-2018 was developed in close consultation with the MoHS and reflects input from all levels of WHO, the extent of engagement of other partners such as United Nations agencies, development partners and civil society organizations in the preparation, endorsement and subsequent promulgation of the Strategy was not obvious. If relevant stakeholders are not fully engaged and consulted during the entire process of development of the CCS, this represents a major challenge in terms of future endorsement of the Strategy.

Areas of particular relevance and growing importance for Myanmar that are not considered to be adequately addressed in the CCSs include an articulation of the strategic role of WHO: at state and regional levels; in strengthening intersectoral collaboration and convening partners; and in advocating for a stronger engagement of the growing private sector in the delivery of health services.

An analysis of the CCS strategic priorities, focus areas, activities planned in the biennial workplans and human resources and budget allocation, reveals that there was no established correlation between the level of available resources (human and financial) and the volume of deliverables expected from the various programmes.

The CCS 2014-2018 and the current draft CCS 2019-2023 draft do not explicitly refer to good governance, gender equality and human rights, although there are some broad references to health inequalities and the importance of providing services to the entire population.

WHO's contribution and main achievements

WHO is considered a reliable and trusted partner and its role as lead technical agency for health is well recognized among Government and development partners. In addition, WHO's role as co-lead of the Health Cluster in Myanmar is widely acknowledged and appreciated. The Organization's good working relations with the MoHS represents a valuable entry point to facilitate the dialogue between the Government, health partners and the private sector in Myanmar. In addition, WHO has access to regional and global expertise when needed to complement its role at country level.

Specific achievements are outlined below, many of which came about as a result of a highly effective collaboration with the MoHS and other partners and with the involvement of the three levels of the Organization.

In respect of Strategic Priority 1 (strengthening the health system), the most notable achievements include the development of the National Health Plan 2017-2021, which highlighted the need to

strengthen various components of the health system to improve service delivery and achieve UHC, and the elaboration of national strategies and plans on human resources for health, health financing, health information and medicines. Critical areas of strengthening health systems that require a stronger WHO engagement include: improvement of quality of health services, including capacity building; strengthening data quality and health information systems to facilitate evidence-based policy decisions and allocation of resources; identification of mechanisms to ensure the financial sustainability of the health system; and regulatory strengthening.

With regard to Strategic Priority 2 (enhancing the achievement of communicable disease control targets), in addition to the development of several national strategic plans and guidelines, Myanmar has made significant progress in reducing the burden of HIV/AIDS, TB and malaria in the country during the period under review. Myanmar is on target to achieve the 2020 benchmark of 20% reduction of TB incidence compared to the 2015 baseline and the reported number of malaria cases and deaths dropped by 84% and 95% respectively between 2012 and 2018. As regards immunization, the targets of 90% DPT3 coverage at national level and 80% at township level were both achieved in 2019. A cVDPV1 outbreak in 2019 was rapidly and effectively controlled with WHO support. Finally, the introduction of the Rotavirus and Human Papilloma Virus vaccines in 2020 will bring the number of routine vaccines to 13.

Despite limited human and financial resources in the WCO for Strategic Priority 3 (controlling the growth of noncommunicable disease burden), the WCO supported national and sub-national initiatives on the introduction of a healthy diet, addressing gender-based violence, rehabilitation, road safety and the participation of Myanmar in global initiatives on tobacco control, cervical and childhood cancers. Following the successful pilot of the Myanmar Epilepsy Initiative, services are now being expanded to the state and regional level.

In relation to Strategic Priority 4 (promoting health throughout the life course), WHO supported the development of national strategies and plans in this area and the Maternal Death Surveillance and Response system was launched nationwide in 2016-2017. While the SDG targets for maternal, newborn and under-five mortality have yet to be met in Myanmar, considerable progress has been made in this regard but a sustained effort will be required to achieve these targets.

Finally as far as Strategic Priority 5 is concerned (strengthening capacity for emergency risk management and surveillance systems against various health threats), in addition to the development of national strategies and plans, significant achievements include the Joint External Evaluation of the IHR (2005) in 2017 and the resultant development of a costed National Action Plan for Health Security 2018-2023 (Myanmar was the first country in the South-East Asia Region to achieve this). The influenza A (H1N1) outbreak in 2017 was also swiftly controlled with WHO support.

At the level of the Health Cluster, humanitarian health assistance was rapidly provided in response to the armed conflict in the Rakhine State in August 2017. National health emergency response plans were developed and strategic support was provided to the MoHS to strengthen its Health Emergency Operations centre and the Early Warning Alert and Response System in Rakhine and Kachin States.

In terms of national capacity development, this is an area where the Regional Office could play a stronger role in bringing countries together to facilitate exchange, capacity building and regional cooperation through additional opportunities such as online platforms in which national counterparts can exchange lessons and best practices.

Ways of working and programme management challenges

Key contributions of core functions. WHO has been able to implement the different programmes in Myanmar through all six of its core functions, with a considerable number of highly relevant and valuable outputs. The relative contributions of the six functions continuously evolved during the period under review as a result of the socio-demographic, epidemiological and economic transition in

Myanmar and the predominant role that the country has been playing at the subregional, regional and global levels.

However, there is broad recognition that the limited resources available to the WCO affect WHO´s capacity to effectively deliver and maintain its leadership position. This is compounded by a vast workplan with fragmented budget allocations, largely based on ongoing requests for support from the MoHS, some of which are undertaken where WHO's comparative advantage is unclear, and its technical capacity is insufficient. There is also a certain ambivalence in both CCSs about WHO's mandate to work at state and regional levels and no apparent discussion about the role and relevance of WHO support to state governments versus at Union level.

Partnerships. Stakeholders' expectations of WHO are very high, not only in relation to the provision of technical advice but also the fulfilment of additional roles beyond its mandate, particularly in terms of supporting implementation, monitoring and evaluation of health indicators in the country and providing financial assistance. However, there are increasing requests for WHO to be more engaged in playing a leading role in support of broad health issues following a cross-sectoral and Government-wide perspective; to coordinate partners; and to advocate for resource mobilization and support to ensure the adequate implementation of the country's health policies and strategies.

WHO enjoys constructive and effective relations with the MoHS, its main partner in-country. As co-chair of the Health Cluster in Myanmar, WHO fulfils a highly appreciated coordination role in this regard. WHO also co-leads the state-level health clusters in Kachin and Rakhine States. However, other than the example of the health cluster, partnerships at State and regional levels were not evident, even though health inequalities among States are significant. Likewise, there were some concerns that WHO was not engaging sufficiently with other ministries and sectors in terms of the intersectoral engagement required to address the challenges of tackling health issues such as AMR or NCDs.

Overall WHO's technical capacity and coordination role in the health sector is well recognized by the different UN agencies working in Myanmar and there is a good delineation of respective roles. The outputs of the draft UNDAF 2018-2023 clearly focus on the promotion of intersectoral action, which is extremely important in the context of several cross-cutting issues in terms of addressing SDG3.

There is a sense among civil society partners that, despite significant progress in recent years, WHO needs to enhance its efforts in advocating for the stronger participation and engagement of the civil society in the health sector in Myanmar, for example with ethnic health organizations whose presence and added value in health interventions in conflict-affected areas of the country where the Government has no access is universally recognized.

Funding. Given the significant transition that the country is currently undergoing and the high demand for WHO support, there are concerns about the limited financial resources available to effectively support the implementation of WHO's work in-country and enable the Organization to maintain its leadership role, particularly in strategic areas such as strengthening health systems and addressing noncommunicable diseases. In 2018-2019, reduced funding for HSS limited the WCO's capacity to contribute to Myanmar's efforts to advance UHC, coinciding with a critical time when the Government was committed to strengthening key areas of the health system and resulting in lost momentum in some technical areas, such as essential medicines, health financing, and health information systems. Given its strong reliance on earmarked funding, the WCO would benefit from enhanced resource mobilization efforts and a strategic shift from funding small projects to more long-term and sustainable funding mechanisms to ensure that all CCS priorities are equally addressed.

Staffing. Staffing has been a challenge for WCO throughout the period under evaluation. Delays have been encountered in filling a number of key positions, key technical areas are understaffed and the WCO is heavily reliant on SSA contracts which generate significant administrative workloads. While recent improvements in HR practices to ensure fairness and transparency in recruitment processes were noted, understaffing and the related work overload and job insecurity are critical issues affecting

the performance of the WCO. This is compounded by the uncertainty surrounding the timing and arrangements for the move of staff from the Yangon Office to Naypyidaw and the fact that Naypyidaw continues to be seen as a challenging duty station by international professionals with families. The introduction of a deputy WR position in Naypyidaw addresses the need for proximity to the MoHS, however greater clarity on the division of labour between the WR and his Deputy is required.

Senior MoHS officials who are often highly skilled and experienced, place high expectations on WHO counterparts. As Myanmar continues to build its own human capital, it looks to receive highly-skilled and politically astute support from WHO.

Monitoring. The CCS 2014-2018 did not contain a result framework, with indicators for success, baselines and outcome and impact targets, thus precluding rigorous monitoring of achievements and limiting WHO's capacity to demonstrate results and contribution to health improvements at country level. The main monitoring mechanisms were the internal mid-term and end-of biennium programme budget performance assessment exercises and the end-of-term internal review of the CCS 2014-2018.

However, in line with the organizational shift to place greater emphasis on measuring outputs and country level impact, the draft CCS 2019-2023 does include a Country Results Framework complete with indicators, baselines and targets.

Recommendations

1. To address the long-term health needs in Myanmar, the WHO Country Office should concentrate on areas in which WHO has a comparative advantage. In the development of the next Country Cooperation Strategy, 2019-2023, it is recommended that the WHO Country Office:

    I. ensure wide consultation and participation of senior management of the Ministry of Health and Sports, as well as other relevant government sectors, UN agencies, development partners, donors, civil society organizations, the private sector and academia;

    II. include a robust and evidence-based priority-setting process, clearly defining the critical areas in which Myanmar requires technical support from WHO, such as improvement of quality of health services, including capacity building; strengthening data quality and health information systems to facilitate evidence-based policy decisions; identification of mechanisms to ensure the financial sustainability of the health system; and regulatory strengthening; and ensure the availability of adequate human and financial resources to support this;

    III. define targets and indicators for the expected outcome and output levels, to better address WHO´s contribution towards the achievement of (i) the health-related Sustainable Development Goals in Myanmar, including articulation of support to the Government to develop a clear accountability framework and stronger monitoring and evaluation mechanisms to this end; and (ii) the triple billion goals of the Thirteenth General Programme of Work;

    IV. in consultation with the Ministry of Health and Sports, articulate the strategic role of WHO at the State level, including in conflict-affected areas, to address the gaps that States are facing and complement the work being done by local authorities and other health partners.

2. To enhance WHO's leadership role in health, its relevance and effectiveness in Myanmar and its presence where and when high-level decisions are made, it is recommended that the WHO Country Office, with technical and financial support from the Regional Office for South-East Asia and headquarters:

    I. finalise, through open discussion with each staff member and in close concertation with the UNCT and UNDSS in Myanmar, the plan for the relocation of the WHO

Country Office from Yangon to Naypyidaw, including a detailed time line for staff movement, appropriate incentive mechanisms, financial implications and potential sources of funding and gaps;

II. communicate on a regular basis with senior officials of the Ministry of Health and Sports on the process for the relocation of the WHO Country Office to the capital and the challenges being faced that may require Government support.

3. To ensure that the WHO Country Office has the adequate human and financial capacity to implement its workplans beyond the priorities and activities outlined in the Country Cooperation Strategy, it is recommended that the WHO Secretariat:

I. support the WHO Country Office to review its human resource capacity to ensure an adequate skill-mix and appropriate balance between international and local professionals, including those engaged through Special Service Agreements, and that technical areas of critical importance for Myanmar such as health systems, noncommunicable diseases, climate change, and antimicrobial resistance are appropriately staffed;

II. review the current role and added value of the national professional officers operating at the WCO, considering their technical capacity to appropriately advise the MoHS professionals who are often highly skilled and experienced, and support them through training and Regional Office visits;

III. analyse current funding mechanisms and develop a resource mobilization strategy to ensure the strategic shift from funding small projects to more long-term and sustainable funding mechanisms so that all strategic priorities are equally addressed.

4. To better contribute towards improving the health status in Myanmar, the WHO Country Office should enhance its strategic partnerships at country level to include a broader range of partners and national stakeholders. It is recommended that:

I. the WHO country Office strengthen its advocacy and convening role to ensure greater intersectoral collaboration and a holistic governmental approach to addressing health challenges and stronger participation and engagement of the civil society and ethnic health organizations operating in conflict-affected areas where their presence and added value is well recognized;

II. WHO continue to assist the Ministry of Health and Sports to strengthen the Government´s role in coordinating different health partners and the private sector operating in the country to ensure complementarity of activities and greater rationalization of the limited resources;

III. the WHO Country Office continue to invest in sharing information on main activities performed by the Organization, provide information on new policy and strategic decisions on health-related matters as well as on the status of main Sustainable Development Goal 3 targets and indicators;

IV. the Regional Office for South-East Asia enhance its efforts in bringing countries in the subregion together to for cross-border activities and to facilitate exchange, capacity building and regional cooperation through additional opportunities such as online platforms in which national counterparts can exchange lessons and best practices.

5. The WHO Secretariat (regional offices and the headquarters Country Strategy and Support Department) should work together to better define the role and responsibilities of Deputy WHO Representatives in countries where they are assigned.

1. Introduction

1. Country programme evaluations (CPEs) were included in the WHO Organization-wide evaluation workplans for 2018-2019 and 2020-2021, approved by the Executive Board in January 2018 [1] and January 2020 [2] respectively. The workplan clarified that CPEs "*will focus on the outcomes/results achieved by the country office, as well as contributions through global and regional inputs in the country. In addition, these evaluations will aim to analyse the effectiveness of WHO programmes and initiatives in the country and assess their strategic relevance within the national context"*. They encompass the entirety of WHO activities during a specific period. The CPEs aim to provide findings, recommendations and lessons that can be used in the design of new strategies and programmes in-country.

1.1 Evaluation features

2. **Purpose.** This CPE was the third of its type undertaken in the South-East Asia Region by the WHO Evaluation Office. Its main purpose was to identify achievements, challenges and gaps and document best practices and innovations of WHO in Myanmar. These include not only results of the WHO country office (WCO) but also contributions from the regional and global levels to the country programme. As with all evaluations, this CPE meets accountability and learning objectives. It will be publicly available and reported on through the annual Evaluation Report.

3. **Objectives**. This evaluation built on an analysis of relevant existing documents and data, complemented by the perspectives of key stakeholders, to:

a. Demonstrate achievements against the objectives formulated in the Country Cooperation Strategy (CCS) 2014-2018 (and other relevant strategic instruments) and corresponding expected results developed in the WCO biennial workplans, while highlighting the challenges and opportunities for improvement;

b. Support the WCO and partners to operationalize the various priorities of future CCSs (and other relevant strategic instruments) based on independent evidence of past successes, challenges and lessons learned; and

c. Provide the opportunity to learn from the evaluation results at all levels of the Organization. These can then usefully inform the development of future country, regional and global support through a systematic approach to organizational learning.

4. **Expected use**. The main expected use for this evaluation is to support the WCO as it considers the finalization of the draft CCS 2019-2023 and for future planning. Other main users of the evaluation are the WHO Regional Office for South-East Asia (SEARO), and WHO headquarters (HQ) in order to enhance accountability and learning for future planning. The Government of Myanmar as a recipient of WHO's actions, as well as the people of Myanmar, and other organizations, including donors, partners, national institutions and civil society, have interest to be informed about WHO's achievements and be aware of best practices. Also, the Executive Board has direct interests in learning about the added value of WHO's contributions in Myanmar. Finally, over the medium-term, it will contribute to build a body of evidence around possible systemic issues to be addressed corporately, such as the development of models of WCOs work/presence in countries.

[1] Evaluation update and proposed workplan for 2018-2019. Document EB142/27 (http://apps.who.int/gb/ebwha/pdf_files/EB142/B142_27-en.pdf).
[2] Evaluation update and proposed workplan for 2020-2021. Document EB146/38 (https://apps.who.int/gb/ebwha/pdf_files/EB146/B146_38-en.pdf).

5. **Scope**. The evaluation covered all activities undertaken by WHO (WCO, SEARO and HQ) 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 also considered activities undertaken in 2019, with a stronger focus on the 2016-2017 and 2018-2019 bienniums in order to generate learning for the future. The activities of the WCO in supporting the national response to the COVID-19 pandemic are therefore not covered in this report.

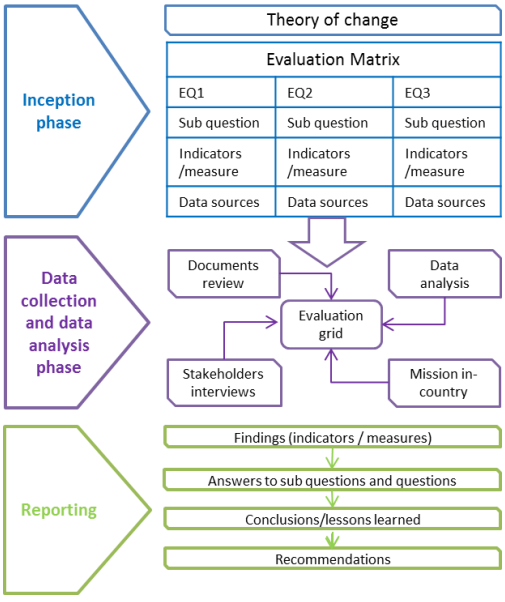
6. **Evaluation questions**. All CPEs address the 3 main evaluation questions (EQs) identified below. The sub-questions are then tailored according to country specificities and detailed in an evaluation matrix (see Annex 2).

- **EQ1 - Were the strategic choices made 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) This question assessed the strategic choices made by WHO at the CCS design stage and its flexibility to adapt to changes in context.
- **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) To address this question, the evaluation built on earlier analyses of results per programme area of the CCS 2014-2018 and focused on best practices and innovations observed.
- **EQ3 – How did WHO achieve the results**? (efficiency) In this area the evaluation sub-questions covered the contribution of the core functions, the partnerships and allocation of resources (financial and staffing) to deliver the expected results and, for each, sought to identify best practices and innovations.

1.2 Methodology

7. Guided by the *WHO Evaluation Practice Handbook*, the evaluation was based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives of accountability and learning. The methodology (summarized in Figure 1 below and developed further in Annex 2) demonstrated impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using a mixed methodological approach (e.g. quantitative and qualitative data) to ensure triangulation of information through a variety of means.

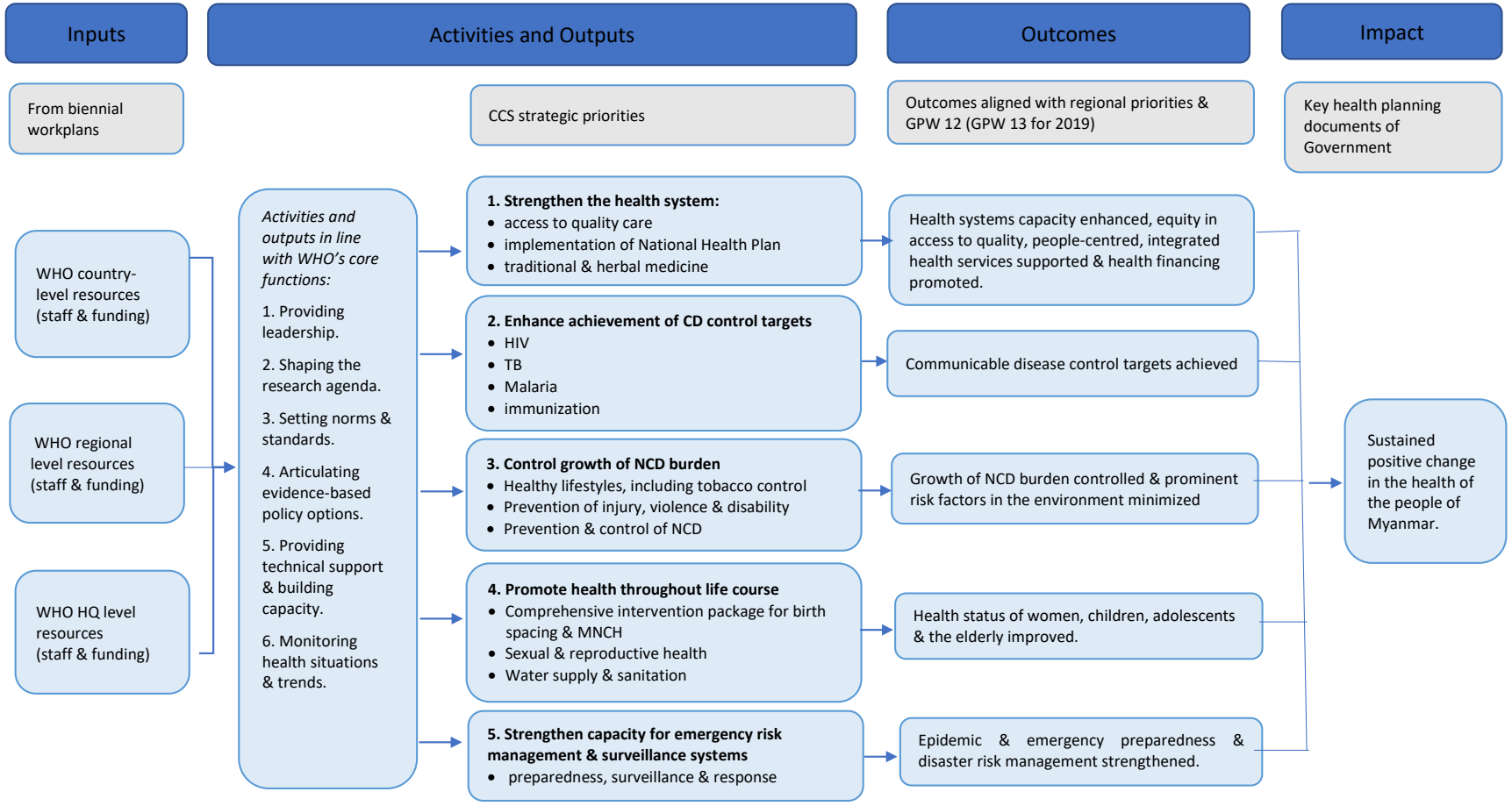
Figure 1: Methodological approach



8. The evaluation was conducted between October 2019 and June 2020 by a core team from the WHO Evaluation Office supported by two external consultants. 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 retrospective 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 General Programme of Work (GPW) and programme budgets; and identifies the main assumptions underlying it. The theory of change is aligned with the one validated by WHO in the context of the evaluation of WHO's presence in countries[3] and in previous CPEs. Using the theory of change, the team developed an evaluation matrix, unpacking for each evaluation question the specific indicators/measures for assessing each sub-question, as well as the data collection method and data sources used. The evaluation mainly used existing data collected by WHO and partners, complemented with direct feedback from Ministry officials, WHO staff and other development partners, during the timeframe evaluated. After a comprehensive document review, the team conducted a ten-day mission in-country (12-21 January 2020), comprising visits to the WHO Offices in Yangon and Naypyidaw, during which time it conducted a large number of interviews (list available in Annex 5). All the data were then analysed to produce the present report.

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

Figure 2: Theory of Change – WHO contributions 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.

1.3 Country context

9. Myanmar is a lower-middle-income country that experienced strong economic growth since 2005, which translated into a reduction in the number of people living below the national poverty line from 48% in 2005 to 25% in 2017. 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. Prior to the COVID-19 pandemic, Myanmar's economic growth was strong by regional and global standards and real GDP growth was projected to reach 6.4% 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 partly affected by conflict or, if post conflict, its after-effects, 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.[4]

10. The first democratically elected government took office in April 2016. Among the many priorities of the new government, social sectors including health and education are repeatedly emphasized as being critical. The new government sees health as a conduit for peace and harmony, as improved access to health without financial hardship is directly felt by citizens.[5]

11. 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.[6] 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.[7] 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.[8]

12. 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 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).[9] 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

[4] The World Bank in Myanmar (https://www.worldbank.org/en/country/myanmar/overview, accessed 9 November 2020).
[5] Ministry of Health and Sports, Republic of the Union of Myanmar (2016). National Health Plan (2017-2021), p.2 (https://themimu.info/sites/themimu.info/files/assessment_file_attachments/NHP_2017-2021_ENG_0.pdf).
[6] 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).
[7] 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).
[8] 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).
[9] 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).

considerable variability in health gains between and among the country's geographical areas and socio-economic groups.[10]

Table 1: Myanmar health statistics

Population[11]	
Population (in thousands) total (2020)	54.4
Population proportion under 15 (%) (2020)	25.5
Population proportion over 65 (%) (2020)	6.2
Life expectancy at birth (years) (2020)	69 (Female)
	64 (Male)
Socioeconomic[12]	
Gender inequality index rank (2018)	106
Human development index rank (2018)	145
Health[13]	
Neonatal mortality rate (per 1000 live births) (2019)	22.4
Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2019)	44.7
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[14]	
Physicians density (per 10 000 population) (2018)	6.770
Nursing and midwifery personnel density (per 10 000 population) (2018)	9.993
Births attended by skilled health personnel (%) (2016)	60
(DTP3) immunization coverage among 1-year-olds (%) (2019)	90
Health financing[15]	
Current expenditure on health as a % of GDP (2018)	4.79
Out-of-pocket expenditure on health as a % of current expenditure on health (2018)	76.48
Government current expenditure on health as % of total government expenditure (2018)	3.35

13. 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.[16] 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 to fight AIDS, Tuberculosis and Malaria (GFATM) (65%), the USA (12%) and Japan (4%).[17]

14. The UN Country Team (UNCT) efforts in Myanmar were guided by the UN Strategic Framework (2012-2015) during that period. Health was covered under Strategic Priority 2, increase equitable access to quality social services.[18] 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

[10] 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).
[11] UNFPA World Population Dashboard (2020), https://www.unfpa.org/data/world-population/MM, accessed 9 November 2020.
[12] UNDP Human Development Report (2019), http://hdr.undp.org/en/2019-report, accessed 9 November 2020.
[13] Global Health Observatory, WHO, http://apps.who.int/gho/data, accessed 9 November 2020.
[14] Global Health Observatory WHO, WHO, http://apps.who.int/gho/data, accessed 9 November 2020.
[15] Ministry of Health and Sports (2020). Myanmar National Health Accounts 2016-2018, https://mohs.gov.mm/docs?url=http://mohs.gov.mm/su/heip3603HE, accessed 9 November 2020.
[16] 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).
[17] OECD data (https://www.oecd.org/dac/financing-sustainable-development/development-finance-data/Asia-Development-Aid-at-a-Glance-2019.pdf, page 15)
[18] United Nations Strategic Framework 2012-2015, United Nations Country Team in Myanmar.

populations have access to and utilize quality, uninterrupted and affordable health services, including reproductive health care and HIV prevention and treatment."

15. The WCO contributed to the drafting of the first UN Development Assistance Framework (UNDAF) for Myanmar (not yet approved).[19]

1.4 WHO activities in Myanmar

16. The WHO Myanmar Country Office (WCO) is based in Yangon, with a workforce of 76 (as of January 2020). Since 2018, the WCO has also established a presence in Naypyidaw with a workforce of 16 as of January 2020. At national level, WHO Myanmar collaborates with the Ministry of Health and Sports (MoHS) and other entities, including other ministries, academic institutions and nongovernmental organisations (NGOs) and civil society organisations.

17. The WCO's partners include the Japan International Cooperation Agency, the United States Agency for International Development, the United Kingdom Department for International Development, the Korea International Cooperation Agency, The Canadian International Development Agency, the World Bank and the Asian Development Bank. The Vaccine Alliance (Gavi) the GFATM and the Access to Health Fund (and its predecessor the 3MDG Fund) were the main multilateral partners supporting health in Myanmar during the period under review.[20]

18. 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. the 12th and 13th GPWs), and WHO Regional priorities, including the SEARO Regional Flagship priority programmes. 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.

19. 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 focus areas under each of the five CCS strategic priorities and the categories in the WHO biennial programme budgets.

[19] See Myanmar Country Cooperation Strategy 2019-2023 (in draft).
[20] See Myanmar Country Cooperation Strategy 2019-2023 (in draft).

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
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	Reduced environmental threats to health (2014-2015)/Health and the Environment (2016-2017)	Health and the Environment

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
and personal hygiene, and health education promotion		
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

2. Findings

20. The findings of the evaluation are presented following the three main evaluation questions and sub-questions identified in the Terms of Reference (see Annex 1 for the full list).

2.1 Relevance of WHO's strategic choices

Is the CCS (and other relevant strategic instruments) based on a comprehensive health diagnostic of the entire population and on Myanmar's health needs?[21]

21. The CCS 2014-2018 and CCS 2019-2023 (currently in draft) cover the period of this evaluation.

22. The CCS 2014-2018 builds on the lessons learned from the previous two CCSs and contains a comprehensive and detailed analysis of the health status of the population in Myanmar. It also addresses the macro-economic, social and political context in the country, including social and economic determinants of health. The document highlights the significant prevailing disparities between states, regions and groups in access to, and quality of, health services, particularly affecting ethnic minorities, poor people and people living in remote areas. The demographic and epidemiological transition is also well addressed and provides the basis for the formulation of the different strategic priorities. Although gender is mentioned in the CCS, a detailed analysis of gender issues or broader inequalities is lacking.

23. However, the draft CCS for 2019-2023 currently lacks a detailed situation analysis, particularly in terms of the trends of the health indicators, and a critical analysis of the health situation at the state and regional level. There is no detailed analysis of the inequities between urban and rural areas, gender and age group inequalities, or the situation of ethnic minorities and those living in conflict-affected areas, including internally displaced people and migrants. Without this detailed information, it is difficult to understand the rationale for selecting the focus areas of intervention under the different strategic objectives identified in the CCS. While it does make reference to the burden of disease, it is not clear that priority-setting was consistently evidence-based. Finally, while the draft CCS includes a section on the review of the previous CCS, it neither addresses the main changes in the health situation since the period covered by the previous CCS, the factors contributing to those changes, nor the challenges that the country is facing towards improving the health indicators of the country.

Is the CCS (and other relevant strategic instruments) coherent with Myanmar's National Health Plan and any other relevant strategies?

24. The CCS 2014-2018 is in line with the national health priorities defined in the "Myanmar Health Vision 2030",[22] as well as with the National Health Plan (NHP) 2011–2016.[23] Furthermore, the CCS underscores the need to strengthen various components of the health system to improve service delivery and to help move the country towards universal health coverage (UHC). This was subsequently well reflected in the NHP 2017-2021.

25. Given Myanmar's rapid economic development over the period of the CCS 2014-2018, the relevance of the CCS 2014-2018 was affected during that time by a variety of factors including:

[21] The World Health Organization (WHO), has a Basic Agreement which was signed with the Government of the Union of Burma on 20 September 1957, which supports the work of WHO in Myanmar and is the basis of the long collaboration which is reflected in the Country Cooperation Strategies, that have been jointly developed by the Organization, the Ministry of Health and Sports, as well as other national institutions, development partners, donors and the civil society organizations among others.

[22] The « Myanmar Health Vision 2030 » is implemented through 5-year national health plans.

[23] The National Health Plan 2011-2016 had the following priorities: i) solving the priority health problems of the country; ii) rural health development; iii) realizing the MDGs; iv) strengthening health systems; v) improving the determinants of health.

emerging health issues; socio-demographic and epidemiological transition; evolving strategies and priorities within WHO; and the shift from Millennium Development Goals to Sustainable Development Goals.

26. It is clear that the CCS 2014-2018 was developed in close consultation with the MoHS, and reflects input from all levels of WHO. Less clear, however, is the extent to which there was active engagement by other partners such as the United Nations and civil society organizations. During the interview process, many partners indicated that they were not aware of the CCS 2014-2018. Almost all partners interviewed indicated that they were neither involved in the formulation of the proposed strategies nor in any evaluation process. Similarly, few of them were aware of the draft CCS 2019-2023.

27. The CCS 2014-2018 was well aligned with the health-related MDGs, particularly in addressing the infant, under-five and maternal mortality rates and the MDG6 targets (combating HIV/AIDS, malaria and other diseases). The CCS also took into consideration the Myanmar Framework for Economic and Social Reforms which, in the health sector, gave particular attention to allocating more resources to rural primary health care, infectious disease control and maternal and child health, in view of the acute need to improve health indicators in all these areas.[24]

28. Similarly, the draft CCS 2019-2023 is also aligned with the National Health Plan 2017-2021 and the Myanmar Sustainable Development Plan 2018-2030. However, it does not indicate with which specific health-related SDG targets and indicators the focus areas under each strategic priority are linked, thus making it more difficult to assess the CCS role in addressing WHO´s contribution towards achievement of the health-related SDGs in Myanmar.

Is the CCS coherent with relevant UN strategic frameworks?

29. Even though the time frames were different, the CCS 2014-2018 was aligned with the UN Strategic Framework 2012-2015, which identified four priority areas, namely: inclusive growth; equitable access to quality social services; vulnerability to natural disasters and climate change; and good governance, democratic institutions and human rights.

30. 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 “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.”

31. The draft CCS 2019-2023 also aligns with the new draft UNDAF for Myanmar, which is the strategy of cooperation for the five-year period 2018 to 2022, that seeks to ensure a closer alignment of national priorities with UN normative standards and operational contributions. As a UNCT member, WHO was actively engaged in the drafting of the health component of the UNDAF.

32. It should be noted that the draft UNDAF 2018-2022 is still awaiting formal approval. It proposes using the 2030 Sustainable Development Agenda/SDG framework to support implementation of the Government’s vision, through applying the programming principles and approaches of the UNDAF to achieve the core principle of the 2030 Agenda of ‘leaving no one behind’. This core principle is addressed through applying the other three UNDAF programming principles: i) Human rights and gender equality and women’s empowerment; ii) Sustainable development and resilience; and iii) Accountability.

33. Overall, key partners are clear about WHO’s role in Myanmar and seek normative guidance as well as technical support from the Organization in priority areas identified in the NHPs, and other main

[24] Myanmar Framework for Economic and Social Reforms – Policy Priorities for 2012-2015 towards the Long-Term Goals of the National Comprehensive Development Plan, January 14, 2013 (final draft).

policies and country strategies related to health. Several stakeholders from Government, development partners and civil society referred to the 'brand value' of WHO, and the neutrality and credibility of WHO's technical expertise and policy advice.

34. WHO is well recognized as an active contributor to the UNCT as well as the Humanitarian Country Team (HCT). Since 2017, WHO has carried out secretariat functions of the Myanmar Health Sector Coordinating Committee (MHSCC). The MHSCC is the formal health sector coordinating body in Myanmar chaired by the Union Minister for Health and Sports, with 35 members from Government, multilateral and bilateral agencies, NGOs, private sector, academia, parliament and civil society. The MHSCC has eight technical and strategy groups (TSGs) that coordinate strategic approaches in specific areas including HIV/AIDS; TB; malaria; reproductive, maternal, neonatal, child and adolescent health; research and development; health systems strengthening; noncommunicable diseases; and public health emergencies and disaster preparedness. WHO provides technical and secretariat assistance to the TSGs on TB, malaria, health systems strengthening, NCDs and the health cluster. WHO also co-leads the health cluster with the MoHS and its contribution in this regard was widely acknowledged (see Box 1).

Box 1 – Myanmar Health Cluster

The Myanmar Health Cluster was activated in 2012 and operates primarily in areas of protracted conflict and in new onset emergency situations such as seasonal monsoon flooding and cyclones. Through coordination of all national and international, governmental and nongovernmental health actors working in these settings, the Health Cluster's mission is to collectively prepare for and respond to humanitarian and public health emergencies to improve the health outcomes of affected populations through timely, predictable appropriate and effective coordinated health action. The Health Cluster seeks to provide primary health care including reproductive, maternal and child health, disease surveillance, immunization, HIV, TB and malaria services, mental health and psychosocial support and emergency patient referral.

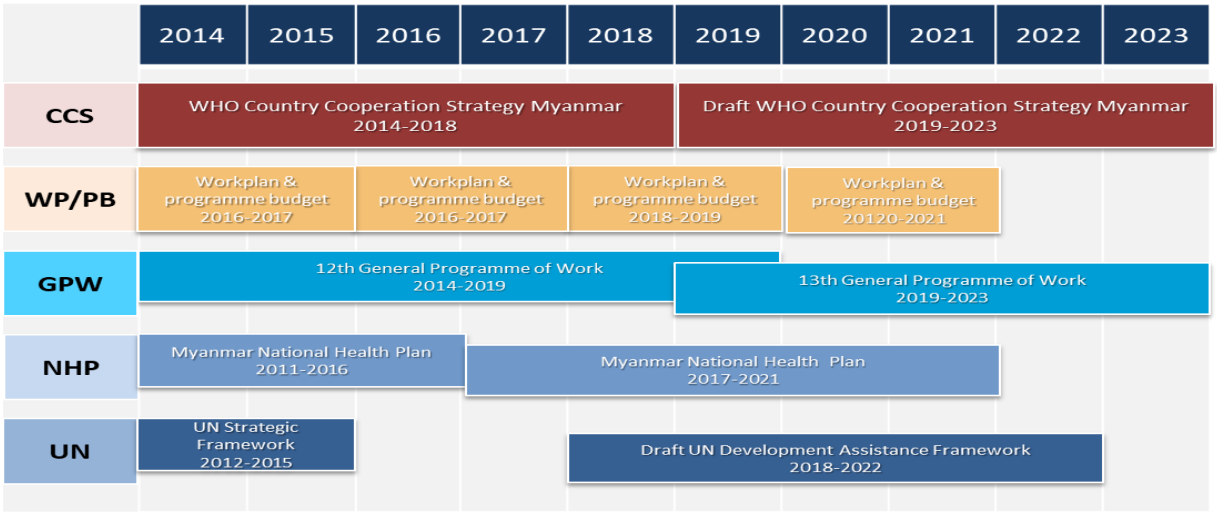
Jointly with the MoHS, WHO co-leads the national Health Cluster. In this role, WHO facilitates coordination and communication between the MoHS and the Health Cluster and among partners to deliver quality health services to vulnerable groups. WHO also co-leads with the State Health Departments the State-level Health Clusters in Kachin and Rakhine States.

Is the CCS coherent with the WHO General Programme of Work and aligned with WHO's international commitments?

35. The CCS 2014-2018 was developed around the same time as WHO's 12th General Programme of Work (GPW12) at a time when WHO reform was also gathering pace. The CCS strategic priorities are fully aligned with the five 'programmatic categories' set out in GPW12 (communicable diseases; noncommunicable diseases; health through the life course; health systems; preparedness, surveillance and response). While those categories shaped the overall approach set out in CCS 2104-2018, they are not used as a result framework.[25] The work of WHO in Myanmar is guided by national policies and priorities as well as associated WHO planning documents. Figure 3 presents the main internal planning instruments that sit alongside Myanmar's own national strategies to frame WHO's action in Myanmar. The associated challenges these instruments present are further elaborated in Annex 3.

[25] The difficulty in measuring results against planned targets and assessing WHO's contributions to the same are indications of a number of systemic challenges in planning and monitoring processes within WHO at both corporate and country levels. This weakens WHO's capacity to demonstrate results and contribution to health improvements in any given country.

Figure 3: WHO's main planning instruments in Myanmar and their alignment with national health plans and UN frameworks



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36. The draft CCS 2019-2023 advances WHO's "triple billion" goals as outlined in the GPW13. In support of the Government, and in partnership with development partners, the private sector, civil society and nongovernmental organizations, WHO will work towards ensuring: a) one billion more people benefit from universal health coverage; b) one billion more people are better protected from health emergencies, and c) one billion more people enjoy better health.

37. The proposed monitoring framework for the CCS 2019-2023 gives some indication of the indicators that are aligned to GPW13 targets and the National Health Plan indicators. If this is further developed, the CCS 2019-2023 will enable measurement of the contribution of the Myanmar CCS to achieving the triple billion goals of the GPW13 as well as the targets of the NHP 2017-2021 and the SDGs.

38. It was noted that, although both CCSs include a section on implications for the WHO Secretariat at country, regional and headquarters levels, as well as external implications, there is only limited explicit consideration of financial or human resource requirements to ensure adequate, timely and sustainable implementation of the identified strategic areas and focus areas of intervention of WHO.

39. Although the CCS 2014-2018 was developed before Regional Director, SEARO articulated her 4x1 strategic vision, this vision is fully reflected in the CCS: (i) addressing the persisting, emerging epidemiological and demographic challenges; (ii) promoting UHC and building robust health systems; (iii) strengthening emergency risk management; and (iv) articulating a strong voice in the global health agenda.

40. The draft CCS 2019-2023 also refers to the eight SEARO flagship priorities: (i) measles and rubella elimination by 2023; (ii) prevention and control of noncommunicable diseases through multisectoral policies and plans, with a focus on "best buys"; (iii) accelerate reduction of maternal, neonatal and under five mortality; (iv) universal health coverage with a focus on human resources for health and essential medicines; (v) building national capacity to prevent and combat antimicrobial resistance; (vi) scaling up capacity development in emergency risk management in countries; (vii) eliminate neglected tropical diseases and other diseases on the verge of elimination; and (viii) accelerating efforts to end TB.

41. Neither of the CCSs refer explicitly to gender equality and human rights, although there are references to inequalities in health and the importance of providing services to the entire population.

Although gender is mentioned in the CCS 2014-2018, it is viewed primarily from a maternal health perspective.

Has WHO learned from experience and changed its approach in view of evolving contexts during the course of the CCS 2014-2018?

42. During the implementation period of CCS 2014-2018, several internal and external missions took place to assess aspects of the work of the WCO in Myanmar. The following are important to highlight: WCO Administrative and Programme Management Review, 13-17 July 2015; the external audit conducted in October 2016; a SEARO Country review mission in December 2016 (which focused on resource management and operational issues); the Strategic HR Review of WCO/Myanmar's Operations, 5 July-8 August 2017, and the subsequent mission report, 29 October-9 December 2017, and the internal audit of July 2018.

43. The 2015 Administrative and Programme Management review concluded that: i) the WCO should be more effective as a partner for the MOHS, as it faces a period of rapid transition; ii) the WCO should have in place a plan identifying priority outcomes that WHO will strive to achieve, and the strategies to attain them; and iii) the efficiency of the WCO should be improved through better management of technical programmes and administration, a change of focus to improved delivery of services; elimination or reduction of bureaucratic processes and fostering a better team spirit in the office. In addition, the 2017 Strategic HR Review concluded that the WCO workforce model was not optimal and did not seem sustainable. Finally, three high-risk areas identified by the 2018 internal audit included the lack of a formal change management process and a formal plan of transition for the transfer of location from Yangon to the new capital city in Naypyidaw; the number of key vacant positions in the WCO; and direct financial contribution assurance activities.

44. A number of key strategic documents and other initiatives were launched during the time of the CCS 2014-2018. They include, among others: the Myanmar National Health Plan 2017-2021, the Myanmar Sustainable Development Plan (2018-2030), the Thirteenth General Programme of Work (GPW13), the Sustainable Development Goals launched in 2016 and the draft United Nations Development Assistance Framework (2018-2022).

45. More recently, high-level international and national initiatives towards the achievement of UHC through increased access to services, improved referral processes, and better financial protection have required a deeper engagement by WHO in order to provide the necessary technical assistance to the national authorities, which has been a key factor in shaping priorities for the development of the CCS 2019-2023.

46. During the period of CCS 2014-2018, Myanmar recorded an economic growth of 6.4% (in 2016-2017). On the other hand, the demographic transition and ageing of Myanmar´s population have been accompanied by an increase in incidence of noncommunicable diseases that puts tremendous pressure on the already stretched health care system.

47. New areas of intervention during the period of the CCS 2014-2018 included an increase in the emphasis placed on sanitation; environmental health (in response to emerging health threats due to growing air pollution); antimicrobial resistance (AMR); road traffic injuries and deaths; hepatitis B associated with HIV/AIDS and substance abuse; e-health; and addressing health financing and the associated high out-of-pocket expenditure.

48. In October 2018, the WCO conducted an internal review of CCS 2014 – 2018 with the following objectives: (1) take stock of achievements and challenges, and (2) inform the development of CCS 2019-2023. The qualitative review reflected key findings from interviews with WHO programme managers and technical advisors; the review of programme evaluation reports; and consultation with key stakeholders.

49. The outcome of this review is reported in the draft CCS 2019-2023, which identifies the following areas that require strengthening in the next CCS: i) fostering of multisectoral collaboration; ii) investment in health systems to strengthen the health workforce, improve health financing, integrate the health information system, and improve access to medicines, supplies and vaccines; iii) research capacity, through working with the MoHS and research institutions; and iv) encouragement of national ownership to increase impact and sustainability, making full use of WHO's comparative advantage in setting norms and standards and coordinating collaboration.

50. The draft CCS 2019-2023 indicates that while it represents the main areas where WHO will focus its efforts and resources over the next five years, it does not cover all of the areas that WHO will continue to support. As context changes and health needs emerge, the WCO will adjust course and, in partnership with the MoHS, respond to the population's needs.

Is the CCS strategic regarding identification of WHO's comparative advantage with a clear strategy to maximise it and make a difference?

51. The CCS 2014-2018 defines the added value and role of WHO in Myanmar as: i) a reliable and credible source of high-quality health-related data and information (to influence and advocate for policy change and programme improvements – both with the Government and with other development partners); ii) the lead UN technical agency for health (to convene and work across a range of government ministries and agencies); iii) a source of expertise in a range of technical areas, drawing upon experts from headquarters, SEARO, and the network of WHO Collaborating Centres. The CCS also reiterates the on-the-ground support to all states through its field-based workforce (e.g. for TB, malaria, HIV/AIDS and Immunization).

Is the CCS strategic regarding capacity of WHO to position health priorities in the national agenda and in those of the national partners in the health sector?

52. The CCS 2014-2018, and the draft CCS 2019-2023, both emphasize an important role for WHO in terms of leadership and policy development, through evidence generation and high-level international expertise. The WCO has a formal standing within the development partner community, as reflected through its role in co-chairing the Health Cluster, and thus plays an important role in strengthening coordination and communications between the MoHS and the Health Cluster and enhancing coordination among UN, development agencies, and other key stakeholders.

53. The landscape of developmental partners in health in Myanmar has dramatically expanded in recent years. WHO has remained a strong advocate and coordinated with both the Government and partners in conducting dialogue on health policy, strategies and plans across the broad range of areas in communicable and noncommunicable diseases, and in health systems as a whole.

54. WHO has also effectively committed to aid coordination, and has actively facilitated national ownership in setting priorities, and in all stages of the process of developing strategies, formulating plans, resource mobilization, implementation and monitoring and evaluation. This role is most strongly articulated in the CCS 2014-2018.

55. One important policy issue mentioned in the CCS 2014-2018 is private sector involvement in Myanmar's health system, which has been gradually increasing in recent years. The draft CCS 2019-2023 does not address this issue. Some stakeholders indicated that WHO could do much more in this area, acting as a bridge between the public and private sectors, for example on TB and malaria, as this is crucial for the design and implementation of UHC initiatives.

56. Even though WHO has personnel on the ground in all states, neither the CCS 2014-2018 nor the draft CCS 2019-2023 address the strategic role of WHO's presence in the states and the contribution to be provided by WHO in addressing the gaps that states are facing, in coordination with the local authorities, as well as with other partners working in the same townships.

Is the CCS strategic regarding the partnership between WHO and the Government of Myanmar?

57. Both CCSs clearly state the role of WHO in supporting the Government of Myanmar to carry out health reforms and achieve Myanmar Health Vision 2030, moving towards UHC.

58. They also indicate that the WCO will reposition itself as necessary in order to foster the provision of health policy advice to the Government of Myanmar, and advance health policy dialogue. To ensure this, the WCO has been engaged in the process of harmonization and integration of policy recommendations across groups, agencies and social sectors, and shifting the focus to technical assistance rather than budgetary support in strengthening the country's capacity. During the implementation of CCS 2014-2018, more emphasis was placed on policy dialogue and providing technical advice to the MoHS and other key partners.

59. During the interviews, it was made clear that partners and donors are expecting WHO to take a stronger advocacy and convening role with the Government to strengthen intersectoral collaboration. Most of the health challenges require a holistic approach, that can only be achieved through more frequent interministerial collaboration and enhanced partnerships.

Summary of key findings

- *The CCS 2014-2018 and the draft CCS 2019-2023 build on the lessons learned from the previous CCSs and overall articulate the health priorities of the country. However, an analysis of gender issues or other broader inequalities in health is lacking.*
- *Both CCSs are aligned with the National Health Plan 2017-2021, the UN Strategic Framework 2012-2015 and its successor the draft UNDAF 2018-2022, the Twelfth and Thirteenth GPWs and reflect the general directions of the SDG agenda.*
- *While it is clear that there has been dialogue with MoHS staff in reviewing and developing the CCSs, other partners, including the United Nations sister agencies, development partners and civil society organizations, reported little awareness of the CCS.*
- *WHO is considered a reliable and trusted partner and its role as the lead technical agency for health is well recognized among Government and development partners. WHO's leading role in the Health Cluster is also acknowledged. As a result, WHO has been able to articulate health priorities with all partners.*
- *There is scope for WHO to play a greater role in promoting intersectoral collaboration, public-private initiatives and to enhance collaboration at state level.*

2.2 WHO's contribution and added value (effectiveness and progress towards sustainability)?

To what extent were the biennial workplans (2014-2019) based on the focus areas as defined in the CCS or as amended during course of implementation?

60. As already indicated in paragraph 19 and Table 2, the main focus areas under each of the five CCS strategic priorities and the categories in the WHO biennial programme budgets are closely aligned. The biennial workplans were structured per programme budget category.

61. Priority areas that were not addressed explicitly or in detail by the CCS 2014-2018 but which gained prominence during the period included road traffic injuries, e-health, environmental health, AMR and hepatitis.

62. In addition, the WCO plays an important role in co-leading the Health Cluster with the MoHS.

What were the main results achieved for each CCS priority and other key activities within and outside the CCS?

63. Objective assessment of achievements is complicated by the fact that the CCS 2014-2018 does not have a results framework which specifies indicators, including targets and baselines, for each objective. This is a systemic problem. However, it is noted that the draft CCS 2019-2023 does provide baselines, targets (2023), disaggregation factors and indicators of alignment with GPW13, the draft UNDAF 2018-2022, and the NHP 2017-2021 for the five strategic priorities.

64. Apart from the internal mid-term reviews and end-of-biennium programme budget performance assessments, the only review of progress in implementing the CCS 2014-2018 was an internal review, conducted in October 2018 as part of the planning for the CCS 2019-2023.

65. The main programmatic achievements that were identified by the internal review and other WCO reports and validated during the evaluation as having been achieved in relation to each strategic priority of the CCS 2014-2018 are summarized in Annex 4. As an example, some of the key achievements per strategic priority are highlighted below.

66. With regard to Strategic Priority 1 (strengthening the health system), WHO supported the development of the National Health Plan 2017-2021 which was the result of an extensive consultation process and outlined a tailored 15-year phased approach to achieving UHC through strengthened community health care (see Box 2). WHO also provided technical support for the development of the Human Resources for Health Strategy 2018-2021, the Health Financing Strategy 2019-2028, Myanmar Health Information Strategy 2017-2021 and the National Medicines Policy and its Strategy and Implementation Plan 2018-2021. WHO also provided support for the medical education of front-line staff, particularly community health workers and auxiliary midwives. However, stakeholders

Box 2 – Good practice: consultative process for NHP development

The National Health Plan, 2017-2021 was launched in March 2017, after an extensive consultation process involving, parliamentarians, health-related ministries, state and regional authorities, development partners, NGOs and ethnic health organizations. It outlines Myanmar's vision to accelerate progress towards UHC through the delivery of an essential package of health services to the entire population while increasing financial protection. This requires the concurrent strengthening of the health system in order to support effective delivery of quality services and interventions. These efforts are largely organized along four pillars, namely human resources, infrastructure, service delivery and health financing.

called for a more consistent and substantive WHO presence and support at state and regional levels, where several gaps persist, which hampers the achievement of the UHC in the country. Some stakeholders identified critical areas that requires a stronger WHO engagement, such as: improvement of quality of health services, including capacity building; strengthening data quality and health information systems to facilitate evidence-based policy decisions and allocation of resources; identification of mechanisms to ensure the financial sustainability of the health system and regulatory strengthening.

67. Achievements in respect of Strategic Priority 2 (enhancing the achievement of communicable disease control targets) include the development of several national strategic plans and guidelines, addressing HIV/AIDS, viral Hepatitis, TB, malaria, neglected tropical diseases, and the development of the national polio transition plan. Repeat prevalence surveys showed significant reduction of TB burden since 2010 in the region of 4% per annum and Myanmar is on target to achieve the 2020 benchmark of 20% reduction of TB incidence compared to the 2015 baseline (see Box 3). Data from mid-2019 suggest that the MoHS, with the support of WHO and partners, achieved 73% coverage of people needing ART under the revised treatment guidelines (against a target of 80%) and testing for mother-to-child transmission reached 95%. However, even though indicators are improving, several challenges at national level are reported to compromise programme performance, such as a disconnection between the Union Ministry and the states in service delivery and reticence to apply innovative interventions for HIV testing. Another significant challenge for Myanmar is substance abuse and its relation with HIV transmission. The reported number of malaria cases and deaths dropped by 84% and 95% respectively between 2012 and 2018. In addition, the malaria surveillance system has been strengthened through moving from paper-based reporting to an electronic reporting system, and cross-border collaboration with China, Thailand and countries in the Greater Mekong Sub-region was scaled up. Routine immunization coverage was also strengthened, including capacity-building, and the targets of 90% DPT3 coverage at national level and 80% at township level were both achieved in October 2019. In 2017, WHO supported a nationwide two-phase Japanese Encephalitis vaccination campaign targeting 14 million children and 92% coverage was achieved. In 2019, WHO supported the

Box 3 –Good practice: tailored TB project in Yangon Region

While Myanmar continues to be one of the 30 high burden countries for TB, it has made significant progress in reducing this burden in the past decade. The national TB prevalence survey (2017-2018) showed that the bacteriological TB prevalence had halved compared to the 2009-2010 survey and Myanmar is on track to be the first country in the Region with a high TB burden to achieve a 20% reduction in TB incidence in 2020 compared to 2015.

However, while targeted interventions resulted in significantly decreased TB incidence in States, TB prevalence remains high in the Yangon Region among the urban poor. In collaboration with the Government and multiple stakeholders, WHO is developing a tailored project for Yangon region which focuses on populations in need, including internal migrants and populations displaced due to conflict in other areas of the country. Furthermore, WHO supported the development of a consortium with civil society organizations and NGOs to address the needs of at-risk and vulnerable populations. The consortium performs active screening of people in high-risk areas with mobile digital X-ray, weekend clinics and mobilizes communities to prevent and seek TB diagnosis, treatment and care, in close collaboration with the Yangon Health Department and the National Tuberculosis Programme.

This builds on a unique approach that uses a succession of surveillance and surveys to inform policy and programme development, thus leading to better TB diagnosis and care.

cVDPV1 rapid outbreak response (see Box 4). The introduction of the Rotavirus and Human Papilloma Virus vaccines in 2020 will bring the number of routine vaccinations to 13.

Box 4 – Good practice: National Polio/Public Health Surveillance Project

As part of the CCS 2014-2018 strategic objective to enhance the achievement of communicable diseases control targets through the strengthening of immunization systems, WHO has been supporting national efforts to sustain the polio-free status (Myanmar is polio-free since 2014).

During the 2019 cVDPV Type 1 outbreak in Kayin State, with technical support from WHO and UNICEF and in collaboration with the Thai Government and local ethnic health organizations, Myanmar conducted four consecutive rounds of mass vaccination with bivalent oral polio vaccine: two initial rounds in 12 townships in Kayin state and nearby region targeting 300 000 children, and two additional large-scale vaccination campaigns targeting 1.2 million children under five years of age in 96 susceptible townships including 10 high risks townships (including Myanmar-Thailand border crossing points).

68. As far as Strategic Priority 3 is concerned (controlling the growth of noncommunicable disease burden), support was provided to the Government to strengthen the multisectoral approach for tobacco control in the context of the FCTC2030 initiative, [26] and advocacy and coordination mechanisms for the introduction of a healthy diet, in particular the reduction in the consumption of salt, sugar and fat were initiated and supported. Health service guidelines and an advocacy factsheet for the prevention and care of survivors of gender-based violence were developed and used for state and regional level training. A national multisectoral rehabilitation strategy was launched, and the national injury surveillance system was revitalized. WHO provided technical support to the MoHS in leading the National Road Safety Council and in improving acute trauma care. Support was also provided for the development of a national strategic plan for the prevention and control of NCDs and the introduction of the WHO package of essential NCD interventions in selected townships, with plans to scale up to nationwide coverage in 2019. Further, WHO supported the MoHS in developing technical guidelines and training packages on secondary prevention of cervical cancer for public sector health facilities.[27] Following a successful pilot of the Myanmar Epilepsy Initiative, epilepsy care and support services are now being expanded to the state and regional level.

69. With regard to Strategic Priority 4 (promoting health throughout the life course), WHO supported the development of strategies and plans for reproductive health, newborn and child health development, and young people's health; the Strategy for Ending Preventable Maternal Mortality 2017-2021, and the National Sexual and reproductive Health and Rights Policy (to be launched in 2020). The Maternal Death Surveillance and Response system was launched nationwide in 2016-2017. Cognisant of the fact that the SDG targets for maternal, newborn and under-five mortality have yet to be met in Myanmar despite significant progress, an evidence-based essential package of interventions was developed for maternal and reproductive health and, with WHO's support, the MoHS is currently developing a package of interventions for the accelerated reduction of maternal and child mortality. WHO provided technical support for the operationalization of the Multisectoral National Plan of Action for Nutrition Promotion, a national initiative with a holistic approach to diet and nutrition, and supported the MoHS to conduct the Myanmar Micronutrition and Food Consumption Survey 2017-2018. WHO and the UN Nutrition Network jointly initiated and supported the development of updated Myanmar Food-Based Dietary Guidelines. WHO also supported the establishment of a water surveillance system and finalization of the Myanmar drinking water quality standards.

[26] Myanmar is one of 15 countries worldwide to receive dedicated and financial support to accelerate the implementation of the WHO FCTC.

[27] Myanmar is among 6 countries globally receiving support from the UN Joint Programme on cervical cancer.

70. As far as Strategic Priority 5 is concerned, (strengthening capacity for emergency risk management and surveillance systems against various health threats) a Joint External Evaluation (JEE) of the International Health Regulations (2005) was undertaken in 2017, to assess Myanmar's capacity to prevent, detect and rapidly respond to public health risks (see Box 5). Acting on the recommendations of the JEE, a costed National Action Plan for Health Security 2018-2022 was developed (the first country in the WHO South-East Asia Region to do so). The Influenza A (H1N1) outbreak in 2017 was also swiftly and effectively controlled. A national risk communication strategy for public health emergencies was developed (draft), along with a national strategic plan for prevention and control of avian influenza and human influenza pandemic preparedness and response (draft), a National Policy on Health Laboratories, and a National Strategic Plan for Health Laboratories 2017-2022, and national biosafety and biosecurity guidelines. As AMR gained prominence during the period, a national action plan for containment of AMR was developed in 2017, based on the One Health approach, and a national AMR surveillance guideline in 2019.

Box 5 – Good practice: Joint External Evaluation

Myanmar was the third country in the South-East Asia Region to conduct a Joint External Evaluation (JEE) of the International Health Regulations (2005), with the purpose of assessing Myanmar's capacity to prevent, detect and rapidly respond to public health risks. This exercise took place in 2017 and was co-led by the MoHS and WHO.

The recommendations included the need to finalize key legislation, policies, guidelines and standard operating procedures as critical steps to fulfil Myanmar's IHR obligations. The evaluation also highlighted the need for increased collaboration between the human and animal sectors and for building capacity in surveillance, food safety, the laboratory system and the surveillance and control of AMR using the "One Health" approach.

Myanmar has made significant progress in responding to the recommendations of the evaluation, notably through the finalization of various policies, strategies and plans. In particular, Myanmar developed a costed National Action Plan for Health Security, 2018-2023, the first country in the Region to do so.

71. At the level of the Health Cluster, which is co-led by the MoHS and WHO, humanitarian health assistance was rapidly provided in response to the armed conflict in the Rakhine State in August 2017. A national multi-hazard health emergency preparedness and response plan was developed, and support was provided to the MoHS to strengthen its Early Warning Alert and Response System in Rakhine and Kachin States. Strategic support was also provided for the Health Emergency Operations Centre of the MoHS.

What has been the added value of regional and headquarters contributions to the achievement of results in-country?

72. During discussion with WCO technical teams it was noted that, in general, regional and HQ have provided prompt technical assistance upon request, particularly on matters relating to norms and standards, as well as in adapting global and regional strategies to the country´s context. In addition, the Global Drug Facility, hosted at WHO headquarters and managed by the Stop TB Partnership, was recognized for its crucial support for the national TB programme in Myanmar since 2001 through yearly grants of anti-TB drugs.

73. Ministry and civil society counterparts also acknowledged the good technical support received from the Regional Office and HQ. However, they also noted that it sometimes takes a long time to organize in-country missions and administrative delays were often experienced in the area of procurement.

74. The Regional Office was also acknowledged for the support provided to the MoHS, during the period when Myanmar was undergoing dramatic socio-political changes by providing valuable

opportunities to national staff to learn from other countries in the Region as part of the south-south collaboration. For example, the Regional Office initiated a dialogue with the Mahidol University in Thailand to establish a fellowship visit for staff of the NNC laboratory to its nutrition training centre.

75. The participation of national partners in regional or global initiatives which provided valuable capacity development opportunities was also welcomed. For example, a representative of the MoHS participated in a regional forum on prevention of NCDs organized by the Regional Office, with the involvement of HQ. This forum provided updated evidence and guidance on how to strengthen the national action plan for NCD prevention.

76. Finally, as already mentioned, the Regional Office also provides valuable support for cross-border initiatives such as the synchronized polio immunization activities at border crossing points in Myanmar and malaria surveillance activities in the Greater Mekong Subregion.

77. However, during the interviews with senior MoHS and other partners, it was suggested that the Regional Office could play a more proactive role in bringing countries in the subregion together to facilitate exchange, capacity building and regional cooperation, including through additional opportunities such as online platforms, in which national counterparts can exchange lessons learned and best practices, in order to benefit from each other's experiences.

78. Key informants also observed that communication challenges between SEARO and WCO have sometimes compromised timely programme implementation. For example, delays in getting approval for missions supported by the Regional Office, in the disbursement of funds, and in procurement of supplies and other commodities for the programmes when the purchase is done through WHO, were mentioned. The decentralization of purchasing of supplies was encouraged, as part of the delegation of authority to the WHO Representative (WR).

79. With regard to the establishment of a WHO office in Naypyidaw, in 2018 the Regional Office provided guidance for the development of the "Building a meaningful WHO presence in Naypyidaw" planning document, which makes recommendations on the stepwise approach to move staff from Yangon to the new capital. In this regard, it was noted by senior officials of the MoHS as well as other partners that WHO was not consistently represented in high-level meetings in Naypyidaw. Reasons given for this included delays in approval of internal travel. Since the arrival of the Deputy WR in Naypyidaw in December 2019, the participation of WHO in such meetings had become more regular. However, many respondents considered that the attendance of the WR at these senior-level meetings was important for WHO's key health leadership role in Myanmar.

What has been the contribution of WHO results to long-term changes in health status in-country?

80. All respondents credit WHO's leading role in the Health Cluster, as well as its contribution to recent achievements in Myanmar with regard to TB, malaria, immunization and strengthening of the health system.

81. For example, WHO supported the development of the National Strategic Plan for Elimination of Malaria by 2030 and, with WHO's strong technical guidance, Myanmar has continued to make significant progress towards reducing its malaria burden. Between 2012 and 2018, morbidity declined by 84% and mortality by 95%, largely due to universal access to malaria services, improved surveillance, partnership and coordination.

82. With regard to TB, WHO supported development of national TB strategic plans, and the End TB Strategy with a vision to eliminate TB by 2030. The introduction of mandatory case notification with GeneXpert machines has improved the quality of TB surveillance and detection of multidrug-resistant TB. Drug-resistant TB and TB-HIV case detection and treatment services have been expanded to all districts in Myanmar, leading to increased coverage for both drug-resistant TB and TB-HIV treatment.

83. With support from the Regional Office, and following the regional vaccine action plan, 2016-2020, the WCO strengthened Myanmar's immunization systems and services over the last decades. As of 2020, the routine immunization programme in Myanmar includes 13 lifesaving vaccines for children, which is significantly contributing to the health status of the country. Myanmar has achieved and maintained polio free status as well as maternal and neonatal tetanus elimination status, and is currently working towards measles and rubella elimination.

84. In addition, WHO supported the MoHS in the development of the NHP 2017-2021, which underscored the need to strengthen various components of the health system to improve service delivery, and in the elaboration of strategic plans for HRH, health financing and access to essential medicines, with the aim of paving the way for the country to realize its goal of UHC by 2030. The MoHS has established a new Implementation and Monitoring Unit to coordinate the implementation of the National Health Plan.

Is there national ownership of the results and capacities developed?

85. All stakeholders interviewed considered that WHO's advocacy and strategic support has contributed to health becoming recognised as a Government priority, resulting in the development of strong national health policies and strategies. This national ownership has resulted in an increased demand for WHO's technical and normative support, as indicated in the CCS 2014-2018.

86. WCO staff indicated that ensuring Government participation and wide, inclusive consultations, further increased MoHS ownership of technical strategies, for example the development of the national NCD agenda.

87. The 2018 internal audit noted that most WCO-led projects and initiatives had a sustainability plan included in the project design, which increases the likelihood of scale-up and national uptake, after WHO's support has ended.

88. Even though the Polio Transition Plan, which sets the stage for the MoHS to take over full responsibility of polio control activities in 2021, has not yet been endorsed by the MOHS, the MoHS shows adequate capacity to continue running the EPI programme effectively, with only limited technical support from WHO.

Summary of key findings

- *The main focus areas under each of the five CCS strategic priorities and the categories in the WHO biennial program budgets are closely aligned. However, the lack of a results framework with specific indicators, targets and baselines for each objective renders an objective assessment of achievements difficult. This is noted as a systemic issue.*
- *A significant area of work of the WCO not covered by the CCS is its role as co-lead of the Health Cluster with the MoHS.*
- *Notable achievements include the development of national policies, strategies and guidelines for each strategic priority, significant progress in the control of HIV/AIDS, TB and malaria, increased immunization coverage, progress in the prevention and control of noncommunicable diseases and in the reduction of maternal and child mortality, and the development of a costed national action plan for health security.*
- *The technical support received from the Regional Office and HQ is well recognized and the opportunities for exchange of experience among countries of the Region much appreciated.*
- *As a result of the effective collaboration with MoHS and other partners, significant improvements in health status have been achieved in Myanmar, particularly with regard to the control of TB and malaria and in terms of improved immunization coverage throughout the country*.

2.3 How did WHO achieve the results? (elements of efficiency)

What were the key core functions most used to achieve the results?

89. On review of the CCS 2014-2018, all core functions demonstrated their relevance for WHO's work in Myanmar. It was noted that WHO was able to implement the different programmes through the Organization´s core functions, with a considerable number of highly relevant and valuable outputs, despite human and financial resource constraints in the Country Office. However, the limited resources affect WHO´s capacity to effectively achieve results and maintain its leadership position. This is compounded by a vast workplan with fragmented budget allocations, largely based on ongoing requests for support from the MoHS, some of which are undertaken where WHO's comparative advantage is unclear, and its technical capacity is insufficient. This has led to unequal support to different health areas, and more importantly to a gap between the expectations of the MoHS and WHO's capacity to respond accordingly.

90. Based on discussions held with different development partners and national authorities, Table 3 below summarizes the role played by the WCO, using the core functions in support of the CCS strategic priorities and focus areas.

Table 3: Linkage between CCS strategic objectives and core functions

CCS objectives	Core functions					
	Leadership & partnership	Research & knowledge	Norms & standards	Policy options	Capacity building	Monitoring
1. Strengthening the health system	X	X	XX	XX	XX	X
2. Enhancing the achievement of communicable disease control targets	XX	XX	XX	XX	XX	X
3. Controlling the growth of noncommunicable disease burden	X	XX	XX	XX	XX	X
4 Promoting health through the life course	X	X	XX	XX	XX	X
5. Strengthening capacity for emergency risk management and surveillance systems against various health threats	XX	XX	XX	XX	XX	XX

Note: rating relates to information available on the contribution of core functions and this is reflected as follows: xx substantial contribution and x some contribution. The intent is not to be exhaustive but to reflect where emphasis was laid during the 2014-2018 period.

91. In the discussions with the national authorities, as well as with development partners, while there was no explicit reference to WHO's six core functions, there seemed to be overall consensus that they had impacted positively across a wide spectrum of Myanmar's NHP goals.

92. During the evaluation it became clear that stakeholders recognized WHO' effective leadership and convening power, most notably in the areas of communicable diseases and emergencies, and acknowledged its normative and policy advice, technical support and capacity building activities along the key strategic priority areas identified in the CCS 2014-2018. However, efforts in respect of research and monitoring the health status and trends were uneven across the CCS objectives.

93. Furthermore, it was noted that the relative contributions of the six functions had evolved during the course of the CCS 2014-2018. While some stakeholders acknowledged that WHO support had become very progressive, particularly in the area of TB control which is now more of a technology than a management issue, others expressed the need for WHO to be more proactive and solution-oriented in terms of strengthening Myanmar´s national institutions, to sustain the gains recorded so far, recognizing that there is still a way to go in order to achieve the health-related SDGs targets and goals. Several stakeholders identified opportunities for WHO to become a stronger advocate for unmet health priorities through intersectoral engagement, such as for AMR, NCDs and social determinants of health.

How did the strategic partnerships contribute to the results achieved?

94. WHO's coordination role in the health sector is well recognized in Myanmar and its role as co-Chair of the Health Cluster, which prepares for and coordinates response to humanitarian emergencies, is particularly appreciated.

95. At the Government level, WHO's main partnership has been with the MoHS. While this relationship has been characterized as constructive and effective, a similar relationship at the state and regional levels is less clear.

96. During the interview with senior officials from the Ministry of Education, they emphasized that most of the collaboration with WHO on health-related matters is coordinated through the MoHS. The Ministry of Education currently runs a health promotion and awareness programme for schools, addressing seven main priorities, where WHO's technical assistance is very much welcomed, in the areas of tobacco, narcotics and alcohol consumption; road safety; sexual education for adolescents and healthy lives, including immunization. However, relationships with other ministries and sectors are much less evident leading to some concerns in terms of the intersectoral engagement that would be required to address the social determinants of health and the challenges of NCDs as an example.

97. The linkages between SDG3 (health) and SDG4 (education) highlighted the need for WHO to continue working in collaboration with relevant partners to overcome prevailing challenges, such as: the high rates of adolescent unplanned pregnancy and abortions; the high prevalence of STI; HIV/AIDS, and hepatitis B co-infection; the increasing trends of obesity and diabetes among youth and adolescents; and substance abuse, all of which require a multisectoral, coordinated intervention.

98. The Organization's partnership with the different UN agencies operating in Myanmar was seen to be effective, with a good delineation of respective roles. WHO plays an active and leading role in the UN Country Team and actively participates in all health-related thematic working groups. The outputs of the draft UNDAF, which WHO is expected to support in the development of the CCS 2019-2023 and which clearly focus on the promotion of intersectoral actions, are extremely important in addressing SDG3.

99. Numerous UN stakeholders raised the issue of the role of UNOPS both as primary recipient of GFATM funds/responsible for funding and also attempting to provide technical and policy guidance on health matters.

100. Gavi, the GFATM, and the Access to Health Fund were the main multilateral partners supporting health in Myanmar during the period under evaluation. Funding from Gavi has supported immunization and surveillance, including the introduction of Rotavirus and HPV vaccines. Funding from the GFATM and the Access to Health Fund are accelerating progress towards ending HIV, TB, and

malaria, and advancing sexual reproductive health. Other bilateral partners included USAID, US CDC and DFID.

101. The feedback received from the civil society during the interview process showed significant appreciation of the work of WHO. However, some civil society representatives felt that WHO is too focused on its close working relationship with the MoHS and pays insufficient attention to civil society partners. WHO was encouraged to advocate for the stronger participation and engagement of the civil society in the field of health; and to further strengthen collaboration with the ethnic health organizations working in conflict-affected areas, where their presence and added-value is well recognized (see Box 6).

Box 6 – Ethnic Health Organizations

As a country deeply affected by sub-national conflict, with approximately 135 ethnic groups, ethnic health organizations have a very important role to play in ensuring access to health services for vulnerable populations in remote communities and in conflict-affected areas, where Government access is limited. Indeed, the NHP acknowledges the essential role of ethnic health organizations for achieving UHC.

Ethnic health organizations provide primary health care services in local languages and are trusted members of the community. As such, they also provide invaluable support during routine and emergency immunization campaigns.

WHO has an important role to play in advocating with the MoHS for strengthened involvement of ethnic health organizations in health-related interventions.

102. There is a reported need for WHO to clarify with the Government, development partners and donors, what are the most strategic roles it can and should play moving forward, taking into account its comparative advantage, and the evolving context with regard to the 2030 Agenda. There are increasing requests for WHO to: i) play a leading role in support of broad health issues, fostering a cross-sectoral and government-wide perspective; ii) coordinate partners in the health sector; iii) advocate for resource mobilization; and iv) provide support to ensure the adequate implementation of the country's health policies and strategies. The draft CCS 2019-2023 provides the momentum to address these challenges and to strengthen WHO´s contribution to the health sector in Myanmar.

103. To keep partners abreast of developments on health and prevailing challenges, WHO regularly hosts knowledge sharing sessions and regularly shares the WCO Newsletter that has been well received by development partners.

104. WHO's achievements are the result of the integrated support provided by the three levels of the Organization and coordinated through the WCO, particularly in terms of the provision of technical support and capacity-building opportunities to the MoHS, and other national partners. Overall, this was well recognized by all stakeholders. WHO support for cross-border collaboration was considered good practice (see Box 7.)

Box 7 – Good practice: cross-border collaboration

Cross-border activities with Bangladesh, China, Thailand and other neighbouring countries, addressing issues such as health among internally displaced people, immunization, malaria control, MDR and XDR TB, have been seen as a good practice to be emulated in other priority areas. The Government views South-South, triangular and regional partnerships as offering innovative approaches for joint development cooperation efforts through diverse, flexible, cost-effective models of support. South-South cooperation is therefore an important avenue for learning and collaboration, especially in the context of ASEAN, and the Government expressed the desire to receive more support from the UN and WHO through this mechanism.

How did the funding levels and their timeliness affect the results achieved?

105. In recent years, funding has remained critical for WHO's catalytic engagement in Myanmar, particularly given the current transition phase that the country is undergoing, and the need for WHO to support the MoHS in strengthening health care systems in the country towards achievement of UHC, as part of the Myanmar Health Vision 2030.

106. Several stakeholders considered that the financial resources available to the WCO were insufficient to effectively support the implementation of its workplan. The current level of financing is one of the biggest challenges for WHO as it strives to fully achieve its objectives and maintain its leadership role, particularly in the areas of strengthening health systems and addressing noncommunicable diseases.

Level of funding

Table 4: Funding sources for WCO in Myanmar

Donor	PB 2014-15 (US$ million)	PB 2016-17 (US$ million)	PB 2018-19 (US$ million)
Funds channelled through UNOPS[28]	10.2	11.6	8.6
Partnerships	5.7	13.1	4.6
Member States – assessed	6.7	6.5	7.7
Member States – specified	2.8	4.1	3.0
Unspecified funding (PSC/CVCA)	1.5	2.5	2.2
Philanthropies	0.3	0.7	0.4
Private sector	0.4	0.3	0.4
NGOs		0.3	0.6
Others	0.4	0.2	0.3
TOTAL	**28.0**	**39.3**	**27.8**

Source: WHO Programme Budget Web Portal

107. As can be seen from Table 4 above, the level of funding for the WCO increased by over US$ 11 million in the 2016-2017 biennium compared to the previous biennium, largely due to the timing of the receipt of earmarked funds. For example a significant increase in funds received in the 2016-2017 biennium from Gavi related to the 2017 vaccination campaigns, but was also a result of increased emergency support due to the 2017 influenza A (H1N1) outbreak and the conflict in Rakhine State. In the 2018-2019 biennium, funding returned to the level of the 2014-2015 biennium. The largest source of funds is through UNOPS which represents to a very large extent (about 90%) funds from the GFATM and to a much smaller extent Access to Health funds and the funds received from the GFATM Regional Artemisinin-resistance Initiative. Voluntary funding from Member States accounts for approximately 10% of total funding with the major contributors being USAID and US CDC (essentially for communicable disease control) and DFID (polio).

Expenditures

108. When comparing the last two biennia, a substantial decrease in the level of expenditures has been noted in 2018-2019 compared to previous biennia, as shown in the table below. This is largely explained by the significant increase in funds received from Gavi in 2017 as described above. A total of US$ 39.5 million was spent in 2014-2015, compared to US$ 30.5 million in 2018-2019. It should also be noted that, in 2014-2015, roughly US$ 7,6 million in pass through funds were recorded for Myanmar but, by 2018-2019, the practice of recording pass through funds within the programme budget had been discontinued throughout the Organization.

[28] This relates to funds received from: the GFATM; the Access to Health Fund since 2019 (and its predecessor the Multi-donor consortium funds for 3MDG until 2018); and the GFATM's Regional Artemisinin-resistance Initiative (for malaria elimination in the Greater Mekong Subregion by 2030).

Table 5: Expenditure Myanmar Country Office 2014-2019

Workplans	Expenditures (US$ 000)				
	2014-15	2016-17	2018-19	Total	% allocation
1. Communicable Diseases	9,124	14,272	10,895	34,291	28.7%
Pass through EPI	59	2,528		2,587	2.2%
Pass through Measles	2,896			2,896	2.4%
2. Noncommunicable Diseases	674	1,385	1,264	3,323	2.8%
FCTC			52	52	2.8%
3. Promoting Health through the Life-course	878	1,013	654	2,545	2.1%
4. Health Systems	3,801	7,021	1,941	12,763	10.7%
Pass through HSS GAVI	4,611	2,632		7,243	6.1%
5. Preparedness, Surveillance & Response	1,155	713		1,868	1.6%
WHO Health Emergencies Programme			765	765	0.6%
PIP	147	269	240	656	0.5%
Polio workplan		3,109	1,216	4,325	3.6%
OCR activities	1,257	661	783	2,701	3.6%
6. Corporate Services/Enabling Functions	1,720	1,812	763	4,295	2.3%
In-Kind/In-Service	5,377	4,939	3,447	13,763	11.5%
Salaries	7,793	9,078	8,499	25,370	21.2%
	39,492	**49,432**	**30,519**	**119,443**	**102.8%**

Source: GSM

109. Some senior officials in the MoHS indicated the need to have a better understanding of the correlation between the amount of funding mobilized by WHO and its impact in-country. Therefore, in-depth discussions between WHO and the senior officials of the MoHS, to address the best ways to work together to monitor performance and impact of activities supported by WHO in Myanmar are encouraged. Otherwise, this negative perception of WHO´s role in the country will have an impact on resource mobilization at the local level.

110. In addition, a strong reliance on earmarked funding resulted in unequal resource allocation to individual programme areas. For example, there was a substantial decrease in funding from 14% in the 2016-2017 biennium to 6.3% in 2018-2019 for one of the key strategic priorities in both CCS 2014-2018 and the draft CCS 2019-2013: “Advancing Health Systems Strengthening for UHC” (see Table 5 above). This reduction in funding for health systems strengthening in 2018-2019 limited the WCO’s capacity to contribute to the country’s efforts towards advancing UHC at a critical time when the Government was committed to strengthen key areas of the health system. As a result, the WCO lost momentum in some technical areas, such as essential medicines, health financing, and health information systems.

111. The need for WCO to improve its resource mobilisation efforts was raised by several stakeholders as the ongoing limited availability of flexible funds remains a cause for concern. In addition, it was considered that a strategic shift from funding small projects to more long-term and sustainable funding mechanisms is necessary in order to equally address all CCS priority areas. Indeed, the 2018 internal audit identified several issues related to funding including sub-optimal resource mobilization, resulting in unequitable funding across the programmes.

112. Potential new approaches through pooled funding mechanisms require greater planning and monitoring as indicators at outcome level need to be identified, and their achievements documented for funding instalments to be released during implementation of the CCS 2019-2023. This will require enhanced resource mobilization at country level, taking into account the strong presence of donors in the country willing to contribute to health.

113. Some senior officials at the MoHS noted that WHO funds are sometimes not disbursed in a timely manner, resulting in delayed implementation of activities and absorption of funds. Indeed, some stakeholders considered that the WCO has a limited capacity to manage the financial resources, citing long bureaucratic delays involved in the disbursement of funds, resulting in resources being

allocated to international NGOs instead. In recent comprehensive negotiations with Gavi, MoHS and UNICEF, it became clear that new standard operating procedures had to be developed and agreed with the MoHS as well as Ministry of Planning & Finance, to ease disbursement delays to region-state and townships levels, as far as EPI is concerned.

Was the staffing adequate in view of the objectives to be achieved?

114. The WCO has offices in Yangon and Naypyidaw and two small subregional offices in Myitkyina and Sittwe. In terms of WHO workforce, as of 13 January 2020 76 staff (81%) were based in Yangon compared to 16 (17%) in Naypyidaw and two (2%) in field offices (see Table 6).

Table 6: Staff distribution by contract type and location

Type of contract	Yangon	Naypyidaw	Field Officers	Total	%
International Professional staff	11	2	0	13	4
National Professional Officers	10	6	2	18	7
General Service staff	34	4	0	38	14
Special services agreement (SSA)	21	4	184*	209	75
Total	76	16	186	278	100

Source: WCO Myanmar, 13 January 2020

* This refers to SSA holders embedded in MoHS programmes and systems, not all of whom are field officers, and includes regional surveillance officers, national technical officers, administrative assistants and drivers.

115. With regard to the staff located in Yangon and Naypyidaw, 57% are General Service staff compared with a reported 65% at the time of the Strategic Human Resources Review of the WCO in July-August 2017 (SSA holders excluded). A key recommendation of that review was the reduction of the level of representation of the General Service segment in the overall workforce composition and distribution, bearing in mind that WHO is expected to deliver technical assistance. The General Service staff are responsible for assisting in administrative functions supporting recruitment, administration and duty travel of 184 SSA holders embedded in MoHS programmes and systems.

116. However, a very significant 66% of the overall WCO workforce is composed of SSA holders embedded in MoHS programmes and systems, resulting in job insecurity due to the unpredictability of funding for such contracts. This high proportion of SSAs can result in a greater legal risk for WCO, as some SSA holders have been continuously performing the same functions for many years.

117. International Professional staff represent 14% and National Professional Officers 19% of the overall WCO workforce, excluding SSA holders embedded in MoHS programmes and systems. However, the specific, competitive and complex context of Myanmar and its hybrid (combination of upstream and downstream interventions) service delivery model requires highly skilled and experienced technical staff to ensure necessary guidance to nationals in their different capacities and areas of work.

118. A number of key vacant positions in the WCO have proved difficult to fill, in part due to lengthy processes for recruitment of national and international staff, and this compromises WHO's capacity to respond in a timely manner to requests for technical expertise. In addition, heavy reliance on SSA contracts generates significant administrative workloads. While recent improvements in HR practices to ensure fairness and transparency in recruitment processes were noted, understaffing and related work overload and job insecurity remain critical issues affecting the performance of the WCO.

119. Senior authorities in the MoHS and development partners and donors contacted during the evaluation stated that WHO's comparative advantage lies in its core functions of leadership, including partner coordination, provision of technical advice for policy actions, setting norms and standards, and capacity building. However, it was emphasized that in order for WHO to effectively respond to these expectations, it is essential that the WCO have the necessary financial and human resources to provide the essential functions. This fact was also highlighted by the 2017 Strategic Human Resources

Review of the WCO. Capacity constraints in certain technical areas, most notably health systems, have been negatively affecting the performance and credibility of the WCO, resulting in gaps that have sometimes been filled by organizations with less expertise than WHO.

120. Senior MoHS officials, who are often highly skilled and experienced, place high expectations on their WHO counterparts. As Myanmar continues to rapidly develop, building its own human capital, there are even higher expectations from the MoHS and development partners that WHO will rapidly strengthen its workforce with skilled and experienced national and international professionals.

121. Most technical positions in the WCO are staffed with NPOs (58% of all professional staff). Though most of the NPOs are technically competent, it may be challenging for them to present WHO's position in national fora, where they may be (or are perceived to be) more junior and/or less technically expert than their government counterparts, and when often there is also participation in the same fora of international professional staff from other agencies/partners. There is a need to consider ensuring the appropriate balance of international professionals and NPOs, in order to adequately respond to the emerging needs of the country.

122. It was noted that the MoHS often participates as an observer in the selection process for SSAs embedded in MoHS programmes and systems, even though the final decision is taken by the WHO Representative.

123. Due to concern regarding the technical quality of WHO staff, the MoHS is now granting the extension of visas or renewal of contracts of WHO staff working in the country, based on staff performance assessed by their own national staff. This is creating frustration among staff and requires high-level discussion to find an appropriate way forward.

124. Myanmar is the third largest country in the South-East Asia Region in terms of operations and thus benefits from a newly-created position of Deputy WR, which was filled in December 2019. The Deputy WR is based in Naypyidaw which also addresses the need for proximity to the MoHS. However, the need for greater clarity on the division of labour between the WR and his deputy was expressed by many stakeholders.

125. The movement of staff from Yangon to Naypyidaw represents a tremendous challenge, particularly for nationals with families and property in Yangon. Staff have expressed their concern about the lack of detailed information with regard to timing and arrangements for the move to Naypyidaw. In addition, Naypyidaw continues to be seen as a challenging duty station by international professionals with families, particularly in terms of the available educational, public transportation and medical facilities at these duty stations.

Availability of monitoring mechanisms and monitoring reports on progress towards targets

126. The CCS 2014-2018 did not contain a result framework, with indicators for success, baselines and outcome and impact targets, thus precluding rigorous monitoring of achievements and limiting WHO's capacity to demonstrate results and contribution to health improvements at country level.

127. Despite having been foreseen in the CCS 2014-2018, the mid-term review to assess WHO's contribution to the NHP, through the implementation of the CCS strategic agenda did not take place. The main monitoring mechanisms were the internal mid-term and end-of biennium programme budget performance assessment exercises and the end-of-term internal review of the CCS 2014-2018.

128. The objectives of the end-of-term review were to: i) take stock of achievements and challenges, and ii) inform the development of the CCS 2019 – 2023. In terms of overall performance, this internal review concluded that the majority of the strategic priorities set out in the CCS were achieved and that the WCO was able to adjust the course of the strategies, and focus areas of intervention to support the evolving social and political context.

129. The draft CCS 2019-2023 presents the Country Results Framework, which will provide the main indicators, baselines and targets to be monitored, based on agreed strategic priorities. Achievement of the outputs is expected to be monitored on a quarterly basis and reported to the Regional Office on an annual basis. It is expected that a final evaluation will be conducted at the end of the CCS cycle.

Summary of key findings

- *All core functions demonstrated their relevance for WHO's work in Myanmar with the relative contribution of the six core functions evolving during the course of the CCS 2014-2018. Nevertheless, efforts in respect of research and monitoring the health status and trends were uneven across the CCS objectives.*
- *While WHO's main partner in-country is the MoHS, it engages actively with other UN agencies, development partners and civil society organizations in the country. However, the need for WHO to play a more strategic role with regard to these partnerships and the importance of continuing to strengthen collaboration with ethnic health organizations working in conflict-affected areas were highlighted.*
- *Given the current transition phase that the country is facing, and the need for WHO to support the MoHS in strengthening health care systems in the country towards achievement of UHC, as part of the Myanmar Health Vision 2030, funding remains a critical issue. The strategic shift from funding small projects to more long-term and sustainable funding mechanisms was considered necessary in order to equally address all CCS priority areas.*
- *Staffing has been a challenge for WCO throughout the period under evaluation in terms of achieving the optimum workforce composition and also due to lengthy procedures for filling key vacant positions.*

3. Conclusions

130. Based on the findings presented in the previous section, the following conclusions are articulated around the three main evaluation questions all of which inform the recommendations presented in Chapter 4.

Relevance of the strategic choices

131. The strategic priorities identified in the CCS 2014-2018 were relevant at that time when the CCS was developed, considering the macro-economic, social and political context in the country at that time, and they addressed Myanmar's major health needs and were consistent with government and partners' priorities. They were also coherent with WHO's high-level strategic vision outlined in its GPW12 and Regional priorities.

132. The relevance of the CCS was affected over the period under review as a result of several factors including: Myanmar's rapid economic development; emerging health issues; socio-demographic and epidemiological transition; evolving strategies and priorities at national level and within WHO; and the shift from MDGs to SDGs. The WCO was able to accommodate those changes in its biennial workplans.

133. The draft CCS (2019-2023) which is under development, is also aligned with the SDG Framework, the draft UNDAF 2018-2022, GPW13 and Regional priorities, the Myanmar NHP 2017-2021 as well as subsector national strategic plans.

134. While the CCS 2014-2018 was developed in close consultation with the MoHS and reflects input from all levels of WHO, the extent of engagement of other partners such as United Nations agencies, development partners and civil society organizations in the preparation, endorsement and subsequent promulgation of the Strategy was not obvious. If relevant stakeholders are not fully engaged and consulted during the entire process of development of the CCS, this represents a major challenge in terms of future endorsement of the Strategy.

135. Areas of particular relevance and growing importance for Myanmar that are not considered to be adequately addressed in the CCSs include an articulation of the strategic role of WHO: at state and regional levels; in strengthening intersectoral collaboration and convening partners; and in advocating for a stronger engagement of the growing private sector in the delivery of health services.

136. An analysis of the CCS strategic priorities, focus areas, activities planned in the biennial workplans and human resources and budget allocation, reveals that there was no established correlation between the level of available resources (human and financial) and the volume of deliverables expected from the various programmes.

137. The CCS 2014-2018 and the current draft CCS 2019-2023 draft do not explicitly refer to good governance, gender equality and human rights, although there are some broad references to health inequalities and the importance of providing services to the entire population.

WHO's contribution and main achievements

138. WHO is considered a reliable and trusted partner and its role as lead technical agency for health is well recognized among Government and development partners. In addition, WHO's role as co-lead of the Health Cluster in Myanmar is widely acknowledged and appreciated. The Organization's good working relations with the MoHS represents a valuable entry point to facilitate the dialogue between the Government, health partners and the private sector in Myanmar. In addition, WHO has access to regional and global expertise when needed to complement its role at country level.

139. Specific achievements are outlined below, many of which came about as a result of a highly effective collaboration with the MoHS and other partners and with the involvement of the three levels of the Organization.

140. In respect of Strategic Priority 1 (strengthening the health system), the most notable achievements include the development of the National Health Plan 2017-2021, which highlighted the need to strengthen various components of the health system to improve service delivery and achieve UHC, and the elaboration of national strategies and plans on human resources for health, health financing, health information and medicines. Critical areas of strengthening health systems that require a stronger WHO engagement include: improvement of quality of health services, including capacity building; strengthening data quality and health information systems to facilitate evidence-based policy decisions and allocation of resources; identification of mechanisms to ensure the financial sustainability of the health system; and regulatory strengthening.

141. With regard to Strategic Priority 2 (enhancing the achievement of communicable disease control targets), in addition to the development of several national strategic plans and guidelines, Myanmar has made significant progress in reducing the burden of HIV/AIDS, TB and malaria in the country during the period under review. Myanmar is on target to achieve the 2020 benchmark of 20% reduction of TB incidence compared to the 2015 baseline and the reported number of malaria cases and deaths dropped by 84% and 95% respectively between 2012 and 2018. As regards immunization, the targets of 90% DPT3 coverage at national level and 80% at township level were both achieved in 2019. A cVDPV1 outbreak in 2019 was rapidly and effectively controlled with WHO support. Finally, the introduction of the Rotavirus and Human Papilloma Virus vaccines in 2020 will bring the number of routine vaccines to 13.

142. Despite limited human and financial resources in the WCO for Strategic Priority 3 (controlling the growth of noncommunicable disease burden), the WCO supported national and sub-national initiatives on the introduction of a healthy diet, addressing gender-based violence, rehabilitation, road safety and the participation of Myanmar in global initiatives on tobacco control, cervical and childhood cancers. Following the successful pilot of the Myanmar Epilepsy Initiative, services are now being expanded to the state and regional level.

143. In relation to Strategic Priority 4 (promoting health throughout the life course), WHO supported the development of national strategies and plans in this area and the Maternal Death Surveillance and Response system was launched nationwide in 2016-2017. While the SDG targets for maternal, newborn and under-five mortality have yet to be met in Myanmar, considerable progress has been made in this regard but a sustained effort will be required to achieve these targets.

144. Finally as far as Strategic Priority 5 is concerned (strengthening capacity for emergency risk management and surveillance systems against various health threats), in addition to the development of national strategies and plans, significant achievements include the Joint External Evaluation of the IHR (2005) in 2017 and the resultant development of a costed National Action Plan for Health Security 2018-2023 (Myanmar was the first country in the South-East Asia Region to achieve this). The influenza A (H1N1) outbreak in 2017 was also swiftly controlled with WHO support.

145. At the level of the Health Cluster, humanitarian health assistance was rapidly provided in response to the armed conflict in the Rakhine State in August 2017. National health emergency response plans were developed and strategic support was provided to the MoHS to strengthen its Health Emergency Operations centre and the Early Warning Alert and Response System in Rakhine and Kachin States.

146. In terms of national capacity development, this is an area where the Regional Office could play a stronger role in bringing countries together to facilitate exchange, capacity building and regional cooperation through additional opportunities such as online platforms in which national counterparts can exchange lessons and best practices.

Ways of working and programme management challenges

147. **Key contributions of core functions**. WHO has been able to implement the different programmes in Myanmar through all six of its core functions, with a considerable number of highly relevant and valuable outputs. The relative contributions of the six functions continuously evolved during the period under review as a result of the socio-demographic, epidemiological and economic transition in Myanmar and the predominant role that the country has been playing at the subregional, regional and global levels.

148. However, there is broad recognition that the limited resources available to the WCO affect WHO´s capacity to effectively deliver and maintain its leadership position. This is compounded by a vast workplan with fragmented budget allocations, largely based on ongoing requests for support from the MoHS, some of which are undertaken where WHO's comparative advantage is unclear, and its technical capacity is insufficient. There is also a certain ambivalence in both CCSs about WHO's mandate to work at state and regional levels and no apparent discussion about the role and relevance of WHO support to state governments versus at Union level.

149. **Partnerships**. Stakeholders' expectations of WHO are very high, not only in relation to the provision of technical advice but also the fulfilment of additional roles beyond its mandate, particularly in terms of supporting implementation, monitoring and evaluation of health indicators in the country and providing financial assistance. However, there are increasing requests for WHO to be more engaged in playing a leading role in support of broad health issues following a cross-sectoral and Government-wide perspective; to coordinate partners; and to advocate for resource mobilization and support to ensure the adequate implementation of the country's health policies and strategies.

150. WHO enjoys constructive and effective relations with the MoHS, its main partner in-country. As co-chair of the Health Cluster in Myanmar, WHO fulfils a highly appreciated coordination role in this regard. WHO also co-leads the state-level health clusters in Kachin and Rakhine States. However, other than the example of the health cluster, partnerships at State and regional levels were not evident, even though health inequalities among States are significant. Likewise, there were some concerns that WHO was not engaging sufficiently with other ministries and sectors in terms of the intersectoral engagement required to address the challenges of tackling health issues such as AMR or NCDs.

151. Overall WHO's technical capacity and coordination role in the health sector is well recognized by the different UN agencies working in Myanmar and there is a good delineation of respective roles. The outputs of the draft UNDAF 2018-2023 clearly focus on the promotion of intersectoral action, which is extremely important in the context of several cross-cutting issues in terms of addressing SDG3.

152. There is a sense among civil society partners that, despite significant progress in recent years, WHO needs to enhance its efforts in advocating for the stronger participation and engagement of the civil society in the health sector in Myanmar, for example with ethnic health organizations whose presence and added value in health interventions in conflict-affected areas of the country where the Government has no access is universally recognized.

153. **Funding**. Given the significant transition that the country is currently undergoing and the high demand for WHO support, there are concerns about the limited financial resources available to effectively support the implementation of WHO's work in-country and enable the Organization to maintain its leadership role, particularly in strategic areas such as strengthening health systems and addressing noncommunicable diseases. In 2018-2019, reduced funding for HSS limited the WCO's capacity to contribute to Myanmar's efforts to advance UHC, coinciding with a critical time when the Government was committed to strengthening key areas of the health system and resulting in lost momentum in some technical areas, such as essential medicines, health financing, and health information systems. Given its strong reliance on earmarked funding, the WCO would benefit from

enhanced resource mobilization efforts and a strategic shift from funding small projects to more long-term and sustainable funding mechanisms to ensure that all CCS priorities are equally addressed.

154. **Staffing**. Staffing has been a challenge for WCO throughout the period under evaluation. Delays have been encountered in filling a number of key positions, key technical areas are understaffed and the WCO is heavily reliant on SSA contracts which generate significant administrative workloads. While recent improvements in HR practices to ensure fairness and transparency in recruitment processes were noted, understaffing and the related work overload and job insecurity are critical issues affecting the performance of the WCO. This is compounded by the uncertainty surrounding the timing and arrangements for the move of staff from the Yangon Office to Naypyidaw and the fact that Naypyidaw continues to be seen as a challenging duty station by international professionals with families. The introduction of a deputy WR position in Naypyidaw addresses the need for proximity to the MoHS, however greater clarity on the division of labour between the WR and his Deputy is required.

155. Senior MoHS officials who are often highly skilled and experienced, place high expectations on WHO counterparts. As Myanmar continues to build its own human capital, it looks to receive highly-skilled and politically astute support from WHO.

156. **Monitoring**. The CCS 2014-2018 did not contain a result framework, with indicators for success, baselines and outcome and impact targets, thus precluding rigorous monitoring of achievements and limiting WHO's capacity to demonstrate results and contribution to health improvements at country level. The main monitoring mechanisms were the internal mid-term and end-of biennium programme budget performance assessment exercises and the end-of-term internal review of the CCS 2014-2018.

157. However, in line with the organizational shift to place greater emphasis on measuring outputs and country level impact, the draft CCS 2019-2023 does include a Country Results Framework complete with indicators, baselines and targets.

4. Recommendations

1. To address the long-term health needs in Myanmar, the WHO Country Office should concentrate on areas in which WHO has a comparative advantage. In the development of the next Country Cooperation Strategy, 2019-2023, it is recommended that the WHO Country Office:

    I. ensure wide consultation and participation of senior management of the Ministry of Health and Sports, as well as other relevant government sectors, UN agencies, development partners, donors, civil society organizations, the private sector and academia;

    II. include a robust and evidence-based priority-setting process, clearly defining the critical areas in which Myanmar requires technical support from WHO, such as improvement of quality of health services, including capacity building; strengthening data quality and health information systems to facilitate evidence-based policy decisions; identification of mechanisms to ensure the financial sustainability of the health system; and regulatory strengthening; and ensure the availability of adequate human and financial resources to support this;

    III. define targets and indicators for the expected outcome and output levels, to better address WHO´s contribution towards the achievement of (i) the health-related Sustainable Development Goals in Myanmar, including articulation of support to the Government to develop a clear accountability framework and stronger monitoring and evaluation mechanisms to this end; and (ii) the triple billion goals of the Thirteenth General Programme of Work;

    IV. in consultation with the Ministry of Health and Sports, articulate the strategic role of WHO at the State level, including in conflict-affected areas, to address the gaps that States are facing and complement the work being done by local authorities and other health partners.

2. To enhance WHO's leadership role in health, its relevance and effectiveness in Myanmar and its presence where and when high-level decisions are made, it is recommended that the WHO Country Office, with technical and financial support from the Regional Office for South-East Asia and headquarters:

    I. finalise, through open discussion with each staff member and in close concertation with the UNCT and UNDSS in Myanmar, the plan for the relocation of the WHO Country Office from Yangon to Naypyidaw, including a detailed time line for staff movement, appropriate incentive mechanisms, financial implications and potential sources of funding and gaps;

    II. communicate on a regular basis with senior officials of the Ministry of Health and Sports on the process for the relocation of the WHO Country Office to the capital and the challenges being faced that may require Government support.

3. To ensure that the WHO Country Office has the adequate human and financial capacity to implement its workplans beyond the priorities and activities outlined in the Country Cooperation Strategy, it is recommended that the WHO Secretariat:

    I. support the WHO Country Office to review its human resource capacity to ensure an adequate skill-mix and appropriate balance between international and local professionals, including those engaged through Special Service Agreements, and that technical areas of critical importance for Myanmar such as health systems, noncommunicable diseases, climate change, and antimicrobial resistance are appropriately staffed;

II. review the current role and added value of the national professional officers operating at the WCO, considering their technical capacity to appropriately advise the MoHS professionals who are often highly skilled and experienced, and support them through training and Regional Office visits;

III. analyse current funding mechanisms and develop a resource mobilization strategy to ensure the strategic shift from funding small projects to more long-term and sustainable funding mechanisms so that all strategic priorities are equally addressed.

4. To better contribute towards improving the health status in Myanmar, the WHO Country Office should enhance its strategic partnerships at country level to include a broader range of partners and national stakeholders. It is recommended that:

I. the WHO country Office strengthen its advocacy and convening role to ensure greater intersectoral collaboration and a holistic governmental approach to addressing health challenges and stronger participation and engagement of the civil society and ethnic health organizations operating in conflict-affected areas where their presence and added value is well recognized;

II. WHO continue to assist the Ministry of Health and Sports to strengthen the Government´s role in coordinating different health partners and the private sector operating in the country to ensure complementarity of activities and greater rationalization of the limited resources;

III. the WHO Country Office continue to invest in sharing information on main activities performed by the Organization, provide information on new policy and strategic decisions on health-related matters as well as on the status of main Sustainable Development Goal 3 targets and indicators;

IV. the Regional Office for South-East Asia enhance its efforts in bringing countries in the subregion together to for cross-border activities and to facilitate exchange, capacity building and regional cooperation through additional opportunities such as online platforms in which national counterparts can exchange lessons and best practices.

5. The WHO Secretariat (regional offices and the headquarters Country Strategy and Support Department) should work together to better define the role and responsibilities of Deputy WHO Representatives in countries where they are assigned.