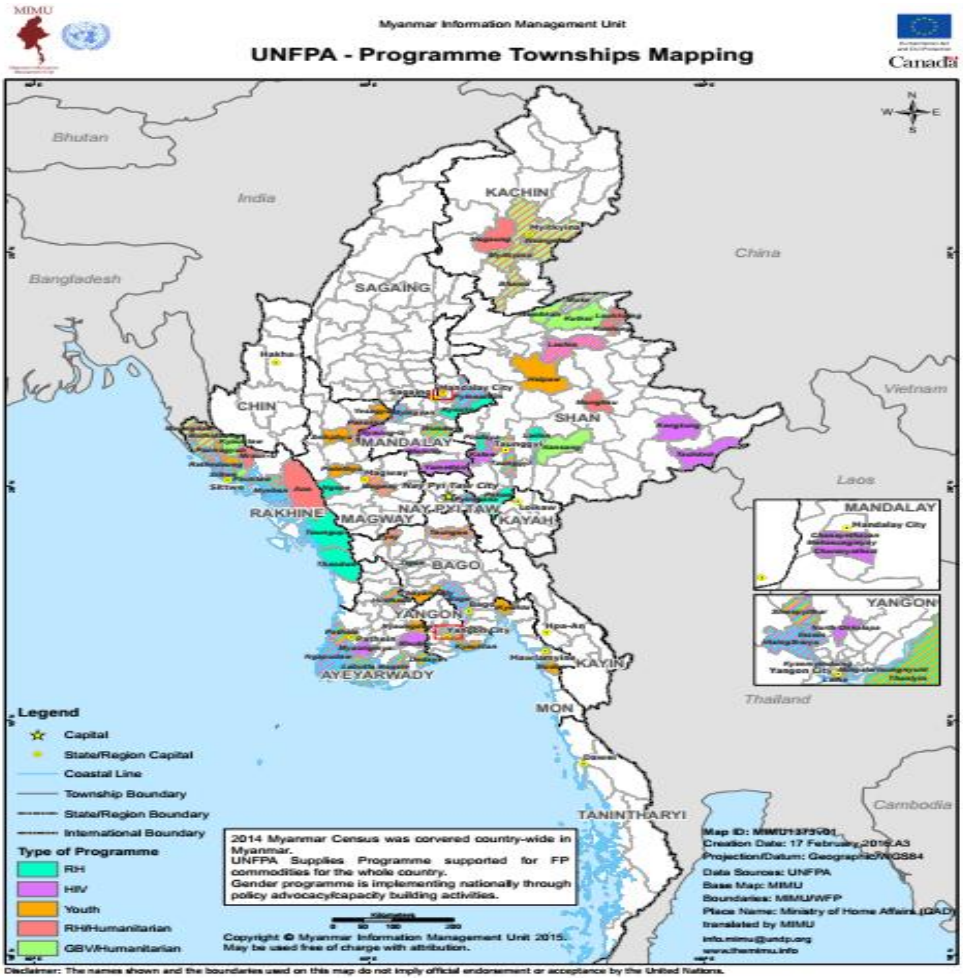
UNFPA Country Programme Evaluation: Myanmar

CP3: 2012 - 2017

FINAL EVALUATION REPORT

March, 2017

Myanmar Country Map



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Abbreviations and Acronyms

APRO	Asia Pacific Regional Office
AEM	Asian Epidemic Model
AFXB	*Aassociation Francois-Xavier Bangnoud*
ANC	Ante Natal Care
ARH	Adolescent Reproductive Health
AIDS	Acquired Immune Deficiency Syndrome
ASEAN	Association of South East Asian Nations
ASRH	Adolescent Sexual Reproductive Health
AYFHS	Adolescent Youth Friendly Health Services
AWP	Annual Work Plan
BEmOC	Basic Emergency Obstetric Care
CBR	Crude Birth Rate
CBO	Community Based Organization
CCA	Common Country Assessment
CCP	Comprehensive Condom Programming
CCPE	Clustered Country Programme Evaluation
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHEB	Central Health Education Bureau
CO	Country Office
CP	Country Program
CEmONC	Comprehensive Emergency Oobstetric Care
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CCPE	Clustered Country Programme Evaluation
CPE	Country Program Evaluation
CMSD	Central Medical Store Department
CSE	Comprehensive Sexuality Education
CSO	Central Statistical Office
CSO	Civil Society Organization
DOP	Department of Population
DOPH	Department of Public Health
DMR	Department of Medical Research
DHPRDM	Department of Health Professional Resource Development and Management
DHS	Demographic and Health Survey
DAC	Development Assistance Committee
DFID	The Department for International Development
DSWRRD	Department of Social Welfare Relief and Resettlement Department
EHSP	Essential Health Service Package
EMOC	Emergency Obstetrics Care
EmoNC	Emergency Obstetrics and New Born Care
ERG	Evaluation Reference Group
ERH	Essential Reproductive Health
ET	Evaluation Team
FP	Family Planning
FRHS	Fertility and Reproductive Health Survey
FSW	Female Sex workers
GAVI	Global Alliance for Vaccines and Immunizations
GBV	Gender Based Violence

GBV IMS	Gender Based Violence Information Management System
GBV SS	Gender Based Violence Sub-sector
GE	Gender Equality
GEN	Gender Equality Network
GEWE SWG	Gender Equality and Women Empowerment Sector Working Group
GoM	Government of Myanmar
GSA	Gender Situation Analysis
GPRHCS	Global Programme on Reproductive Health Security Commodity System
HACT	Harmonized Approach to Cash Transfer
HCT	Humanitarian Country Team
HMIS	Health Management Information System
HRBA	Human Rights Based Approach
HRP	Humanitarian Response Plan
HIV	Human Immune Deficiency Virus
HSS	Health System Strengthening
IASC	Inter Agency Standing Committee
IBBS	Integrated Bio Behavioral Survey
ICPD	International Conference of Population and Development
INGO	International Non-Governmental Organization
IP	Implementing Partner
IUD	Intra-Uterine Device
JSI	John Snow International
KI	Key Informants
KP	Key Populations
KM	Knowledge Management
LARC	Long Acting Reversible Contraceptive
LMIS	Logistics Management Information System
LSMP	Life-saving Midwifery Practices
MANA	Myanmar Anti Narcotic Association
MAPDRR	Myanmar Action Plan on Disaster Risk Reduction 2009-2015
MDHS	Myanmar Demographic and Health Survey
MDG	Millennium Development Goal
MDSR	Maternal Death Surveillance and Response
MDM	Medecins du Monde
M&E	Monitoring & Evaluation
MICS	Multiple Cluster Indicators Survey
MOE	Ministry of Education
MOHS	Ministry of Health and Sports
MOLIP	Ministry of Labour, Immigration and Population
MMA	Myanmar Medical Association
MNMA	Myanmar Nurses and Midwives Association
MMCWA	Myanmar Maternal and Child Welfare Association
MPA	Minimum Preparedness Action
MRCS	Myanmar Red Cross Society
MSI	Marie Stopes International
MSM	Men who have sex with men
MTSP	Mid-Term Strategic Plan
MWAF	Myanmar Women Affairs Federation
NGO	Non-Governmental Organization
NSPAW	National Strategic Plan for the Advancement of Women
ODA	Official Donor Assistance

OECD	Office of Economic Cooperation and Development
OP	Output
PCPNC	Pregnancy, Childbirth, Postpartum and Newborn Care
PD	Population and Development
PoVAW	Protection and Prevention of Violence against Women Law
PMTCT	Prevention of Mother to Child Transmission of HIV
PSE	Population Size Estimation
PSI	Population Services International
RRT	Rapid Response Team
PLHIV	People Living With HIV
PWID	People Who Inject Drugs
RH	Reproductive health
RHR	Reproductive Health and Rights
RM	Resource Mobilization
RMNCAH	Reproductive Maternal Newborn Child Adolescent Health
RHC	Rural Health Center
RHCLS	Reproductive Health Commodity Logistic Information System
RRD	Relief and Resettlement Department
RRT	Rapid Response Team
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendants
SDGs	Sustainable Development Goals
SDP	Service Delivery Point
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
SP	Strategic Plan
SSC	South-South Cooperation
TMFR	Total Marital Fertility Rate
ToR	Terms of Reference
ToT	Training of Trainers
TSG	Technical and Strategy Group
UN	United Nations
UNCT	United Nation Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNGTG	United Nations Gender Theme Group
UNICEF	United Nations Children's Fund
UNSCR	United Nation Security Council Resolution
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WGC	Women and Girls Centre
WGFI	Women and Girl First Initiative
WPTWG	Women's Protection Technical Working Group
YIC	Youth Information Center

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Box 1: Structure of the Myanmar Country Programme Evaluation Report:

The present report comprises an executive summary, six chapters, and annexes and follows the structure recommended in the evaluation handbook by UNFPA Independent Evaluation Office, version October 2013.

Chapter 1, the **Introduction,** provides the background to the evaluation, objectives and scope, the methodology used including limitations encountered and the evaluation process. The **second chapter** describes Myanmar country context including the development challenges it faces in the UNFPA mandated areas. The **third chapter** refers to the response of the UN system and then leads on to the specific response of UNFPA through its country programme to the national challenges faced by the country given its vulnerability context; in sexual and reproductive health area, population and development and in gender equality. The **fourth chapter** presents the findings for each of the evaluation question specified in the evaluation matrix (annex 4); the **fifth chapter** discusses conclusions and the **sixth chapter** concludes with recommendations under strategic and programmatic level, based on the conclusions.

Finally, the annexes present the evaluation terms of reference, evaluation matrices, programme logic models, documents reviewed, and tables related to the country programme achievements/results and finances, and the list of people interviewed. Please note that this is a Clustered Country Programme Evaluation (CCPE) and includes additional questions specifc to CCPE. With an attempt to limit the length of the report, the details of the findings are moved to Annex 7, specifically for the benefit of the Country Office for additional reference.

Table 1: Key Facts about Myanmar

Geographical location	the largest country in mainland Southeast Asia –bordering the Andaman Sea and the Bay of Bengal and located at the intersection of China and India
Land area	676578 sq. km (Human development report 2014)
Terrain	Central lowlands ringed by steep, rugged highlands
Demographics	
Population	51. 5 million (2014 Census)
Urban/ rural ratio	30/70 (2014 Census)
Total Fertility Rate	2.5 (2014 Census)
Government	
Type of government	Democratically elected government
% of seats held by women in national parliament	4.6% (UNDP HDR 2014), 433:43 (9.9% lower house), 224:23 (10.3% Upper house) (http://www.ipu.org/wmn-e/classif.htm)
Economy	
GDP per capita (USD)	824.19 (World Bank 2013)
GDP Growth rate	7.031% (Economic indicators for 2015, http://www.economywatch.com/economic-statistics/country)
Main industries	
Social indicators	
Human Development Index Rank	*0.524 (HDI) Myanmar is positioned 150 out of 187 countries (UNDP* Human Development Report 2014)
Gender Inequality Index Rank	85/187 countries (2014 Gender Inequality Index) 44/86 countries (2012 Social Institutions and Gender Index) 8/9 countries in East Asia and Pacific (2012 Social Institutions and Gender Index)
Unemployment rate (overall and for youth (age 15-24)	4.02 in 2013 (Central Statistical Organization, Myanmar) (http://www.tradingeconomics.com/myanmar/unemployment-rate) (ILO modeled estimate for Youth (15-24) female 10.7 % in 2014 and that for male Youth 8.3% in 2014. Overall unemployment rate for female 3.6% and for males 3% in 2014, ILO modeled estimates)ILOSTAT
Life expectancy at birth	Total 64.7, male: 60.2, female : 69.3 (Census 2014)
Under-5 mortality (per 1000 live births)	72 (Census 2014)
MMR	282/ 100,000 live births (2014 Myanmar Population and Housing Census) 193/100,000 live births (Urban), 310/100,000 live births (Rural)
Health expenditure (% of GDP)	2.28% (WB report 2014)
% of births attended by skilled health personnel	77.9 (2010 MDG data report)
Antenatal care coverage by at least 4 visits	39.5% (2010 MDG data report)
Total Fertility Rate	2.5 (Census 2014), 1.9 (Urban), 2.8 (Rural)
Adolescent fertility rate	22 (Census 2014)

Executive Summary

Introduction

UNFPA third country programme 2012-2017 (CP3) consists of interventions covering sexual and reproductive health and rights; population and development; and gender equality. Given the country's high vulnerability context, CP3 includes humanitarian response as well. The objective of the CP3 evaluation is to assess the programme performance; determine the factors that facilitated or hindered achievement, and document the lessons learned from the past cooperation and UNFPA strategic positioning in the country that could inform the formulation of the next Country Programme, CP4 for the period 2018-2022, which will form the basis for further UNFPA's support in Myanmar. The intended audience for the evaluation and its uses are the UNFPA Country Office, Government partners, relevant UN Agencies, other development partners, Asia Pacific Regional Office (APRO) and UNFPA Head Quarters. The CPE process had five phases: preparation, planning/design, field work, reporting and management response, dissemination and follow up.

Scope of the Evaluation

The scope is to cover the country programme implementation period from 2012 to 2016, a year before CP3 ends in 2017. The UNFPA evaluation office launched a new approach of Clustered Country Programme Evaluation (CCPE) that focuses on UNFPA engagement in highly vulnerable contexts. Myanmar is selected to be one of the six countries that will be assessed in CCPE. Focusing on two components, country programme and UNFPA's strategic positioning in the country, the evaluation covers six evaluation criteria Relevance, Effectiveness, Efficiency and Sustainability, UNCT Coordination and UNFPA's Added Value to the development community and national partners. UNFPA engagement in the highly vulnerable context is assessed only for two of the evaluation criteria - Relevance and Effectiveness. Responsiveness to both gender and humanitarian concerns are cross cutting and is reflected in the report as appropriate based on the nature of the programme plan and implementation. Nine key evaluation questions, covering the above are addressed in the evaluation.

The evaluation team (ET) selected seven field sites, based on purposive sampling method, for data collection. They were townships of Yangon, Nay Pyi Taw, Pyay, Magwe, Pathien, Sittwe, and Myitkyina in the regions and states of Yangon, Bago, Magwe, Ayeyarwady, Rakhine, and Kachin including Nay Pyi Taw.

Methods of Data Collection

The methods of data collection and analysis were determined by the type of evaluation questions, assumptions, and the indicators chosen to test the assumptions. Data sources are both primary and secondary, with a mix of quantitative and qualitative data. The evaluation triangulated data sources, data types, and data collection methods by employing multiple-method approach including documentary review, group and individual interviews, focus group discussions, observations and site visits. Validation of data and interpretation of those were sought through regular exchanges with the Country Office programme officers and ERG members. The triangulation of data minimized the weaknesses of one method, and offset by the strengths of another, enhancing the validity of the data.

Total number interviewed, representing UNFPA CO and other UN Agencies, line ministries, INGOs, NGOs, Academic institutions, Faith groups, donors and other stakeholders were 254, out of which 164 were females.

Limitations: A few limitations to the evaluation were unclear logic models; too many activities and interventions in AWPs with unclear links to each other and other programmatic areas; and the changes in the results framework during the process of CP realignment of with the 2014-2017 Strategic Plan. The short timeframe of this evaluation did not allow the team to collect primary quantitative data for related areas and accessing data with some consistency was a major challenge. Reliability as well as the lack of secondary data was a limitation in general. To mitigate these limitations, the evaluation team had extensive and regular discussions with CO staff and collected qualitative data where secondary data was limited or absent. In consultation with Country Office, the evaluation team sought for numerous data sources to report what is appeared to be most reliable. To overcome the language barrier, the international team members worked closely with the national team and when it was not possible an external interpreter provided translation when required.

Country Context

Characterized as a Lower Middle Income Economies by the World Bank[1], Myanmar was under a military rule for decades until 2010. Since 2011, transition to democracy took place launching fundamental political and economic reforms aimed at increasing openness, empowerment, and inclusion by the new government. With the general election of November 2015, long-awaited "nationwide cease-fire agreement" (NCA) with eight armed ethnic groups was signed as part of a bid to end decades of civil war. During the period 2015-2016 the country has begun to open up to foreign direct investment and investments increased from 4.64 billion USD in 2011 to 22.12 billion USD in 2015. As a result of increased investments and other reform measures taken by the government, per capita nominal income has increased from 800 USD (2011) to 1270 USD (2015[2]). Despite all this, huge disparity remains between different states and regions and urban and rural areas. Myanmar's development has to be seen within its vulnerability context as it poses challenges to the realization of any development effort. The country is characterised by a combination of vulnerability to natural disasters, armed conflicts, inter-communal tensions, statelessness, trafficking and migration.

Myanmar has a total population of 51.4 million[3] (Census, 2014) and females comprise of a higher percentage (51.8%) than the males (48.2%). Twenty eight percent of total enumerated population is composed of young people aged 10-24 years while the slow population growth is leading to a declined proportion of children.

Country Programme

The key programme areas of CP3, noted above, are synchronized with the United Nations Strategic Framework (UNSF) for Myanmar 2012-2015 and in alignment with UNFPA Strategic Plan 2008-2013 and the revised UNFPA Strategic Plan 2014-2017. It contributes to three strategic priorities of the United Nations Strategic Framework: (a) increase equitable access to high-quality social services; (b) reduce

[1] World Bank Countries Classifications

[2] As indicated in the TOR.

[3] Includes enumerated population and estimated populations not counted in the census

vulnerability to natural disasters and climate change; and (c) promote good governance and strengthen democratic institutions and rights.

UNFPA has selected five regions and three states (see table 6 below) out of the 14 regions/states in the third country for programme interventions: namely, Yangon, Mandalay, Ayeyarwaddy, Bago, Magway, Rakhine, Shan and Kachin.

The basis of selection criteria for CP interventions had been high MMR and HIV prevalence; high poverty incidence; highly populated rural and peri-urban poor; limited access to RH and HIV information and services; high unmet need for birth spacing services and low CPR; high abortion rate; vulnerability to natural disasters and remoteness including areas with mobile population and ethnic minorities; and availability and adequacy of health personnel and infrastructure to facilitate achievement of sustained results.

Key Findings

Overall, the current CP is in line with UNSF and consistent with the government priorities, and policies. The CP interventions are found to be relevant to the country priorities and UNFPA strategic priorities and UNFPA has made fairly good use of its human, financial and technical resources to peruse the achievement of the outputs and outcomes defined in the CP. Some limitations were observed in the programme design and implementation, where the establishment of the theory of change and the programme logic were found to be weak. The communication with and regular monitoring of IP activities, specifically on fund transfer mechanisms were areas needing more attention. However, most interventions of CP are implemented efficiently in both development and humanitarian settings. UNFPA's successful advocacy in leveraging resources from government and other development partners is evident in all programmatic areas. Good examples include the FP 2020 agenda; Census implementation. (human rights, conflict sensitivity); and taking leadership roles in at the GBV sub-sector and GEWE sector working group.

The country programme has made credible achievement in the area of Family Planning. Country is on-track to meet Myanmar's FP 2020. Myanmar is still short of meeting its target to achieve 70% of deliveries attended by SBA. Availability of emergency obstetric care is very much limited and needs to be addressed urgently.

UNFPA's support and inputs led to building the capacity in four states and regions to implement MISP at the onset of a crisis. While GBV and SRHR are implemented in a vertical fashion, UNFPA is in unique position to close the gap and facilitate between MoHS and DSW to integrate GBV programme in health sector. Plans are already in place to mainstream GBV in SRH interventions in emergency settings. Services on STI, HIV prevention, SRHR including ARH are still very limited. UNFPA, holding a strategic position as co-chair of sexual transmission group, is seen and acknowledged by the National AIDS Programme as a long-term partner in the prevention of sexual transmission of HIV and PMTCT.

The gender component has contributed to improving policy and legislative frameworks. UNFPA support to the development of NSPAW and drafting of PoVAW are noteworthy achievements. The program has been implemented in a very dynamic political environment at the national level. The interventions have evolved according to the country context and implemented different course of actions by reflecting the

needs and priorities of the country, contributing to increased awareness of and improved responses to GBV, particularly in emergency situations. The GBV programme is making improvement in its design and implementation and now being framed with a clear strategy under the "Women and Girls First Initiative" (WGFI) as a comprehensive, integrated, and a continuum approach covering humanitarian, recovery, peace building and development phases, recognizing that these phases cannot be de-linked in Myanmar context. While at the time of the evaluation this intervention was not fully implemented and too premature to evaluate the outputs or outcomes, the approach was planned in ways that included integration of SRH with GBV, integration of GBV with broader gender equality outcomes, integration of GBV across humanitarian, peace building and development.

There is room for improvement in the technical capacity building of national institutions related to gender equality and women's empowerment. The weak gender mainstreaming at the institutional level still constitutes a barrier to NSPAW implementation and UNFPA's effort to improve that situation through DSW can be seen as a positive step.

Humanitarian contingency plans developed by the Ministry of Health and Sports and UN HCT includes elements to address sexual and reproductive health needs of women, adolescents and youth including services for survivors of sexual violence in crises. UNFPA's policies and procedures, and supportive mechanisms, partnerships have been responsive to crisis and emergency situations. The Country Office initiated a RH-GBV integrated project in both normal and conflict disaster areas; however, the integration of GBV and RH components into humanitarian programming has room for improvement for the full realization of its goals and objectives. Noteworthy mention is the availability and the use of sex disaggregated data for planning in the humanitarian setting and the recent improvements in monitoring and reporting using sex-disaggregated data. UNFPA has been effective in responding to humanitarian needs and is a leading advocate for women in emergencies.

As for the Youth programmes, UNFPA's work on development of policy documents, protocols and standards of delivering SRH/ARH services is commendable. Youth policy development is in progress with greater participation of young people from different sectors.

The country office has worked effectively to achieve the objectives of population and development outputs and noteworthy achievements of UNFPA during this country program is the completion and dissemination of census data in line with international standards and the production of much needed maps and thematic reports using census data. A unique feature is the engagement of conflict sensitivity teams in the process of census implementation and dissemination of results.

The results of UNFPA supported activities are likely to be sustainable in all programmatic areas, subject to the continued government support and national ownership. UNFPA has demonstrated its policy advocacy work with Government and partners to increase ownership and commitments linked to global and regional priorities and commitments in all programmatic areas.

Country Office coordination with other UN agencies and the added value of UNFPA to the development community were reflected as satisfactory. Notable areas of recognition were the strong advocacy role, especially in sensitive issues such as human rights; input in conflict sensitivity assessments; SRH, GBV,

programmes for sex workers, and youth; strong partnership with the government - especially in the area of support to Census and generating internationally compatible data for planning; bringing the development partners together; capacity development of national partners supported by UNFPA; and the coordination with different religious groups.

Conclusions

CP3 is well aligned with national and UNFPA strategic priorities. The integration of human rights based approach that encompasses responsiveness to gender issues in the programme interventions and conflict sensitivity assessments during and after census operations had provided a good strategy for the CP3 implementation. CO with its limited staff, managed to achieve most of the planned results in the CP3 implementation. Room for improvement was noted in the area of communication with IPs and monitoring progress for further increase in programme effectiveness and efficiency. Similarly, more clarity on theory of change and programme logic to demonstrate clear linkages of the interventions would have enhanced the cumulative programme results. CO's focus on upstream advocacy had allowed the programme to maintain its strong presence in all policy and key decision related functions.

Despite good initiatives, the availability and access to emergency obstetric care services are limited and the country is still short of meeting its target to achieve deliveries attended by SBA. The expansion of service delivery points and PPP have contributed to quickly move the family planning agenda and make the country on track to meet FP 2020 targets. UNFPA may need to think through how best HIV and AIDS should be addressed given the CO's strategic shift, it's comparative advantage, presence of Global Fund and other partners.

UNFPA work on development of policy documents, protocols and standards of delivering SRHR/ARH services is commendable. Youth policy development is in progress with greater participation of young people from different sectors. Building on national data which demonstrates a "demographic dividend", UNFPA is well placed to advance the national agenda for youth.

Country office built effective partnership with donors by establishing confidence on providing technical expertise and trust on the management of financial resources on census. Completion and dissemination of census has been accomplished with internationally accepted standards. Disaggregated data by age, sex and other demographic and socio-economic characteristic are being produced and made available. Increased use of sex-disaggregated data in the country office monitoring reports is notable. Thematic reports are prepared using census data for purposes of planning and further analyses on specific needs.

The Gender component has contributed to improving policy and legislative frameworks. UNFPA support to the development of NSPAW, drafting of PoVAW are noteworthy achievements. Despite the advocacy efforts of NSPAW, the programme is still not reaching its full potential in-terms of strengthening national capacity and institutional mechanism for advancing reproductive rights, gender equality and GBV.

The GBV programme is now being formulated with a clear strategy under the "Women and Girls First Initiative" (WGFI) as a comprehensive and integrated approach. Addressing GBV requires a coordinated response that promotes changes at different levels. To accelerate the achievements of SRH-GBV programme, there is room for greater coordination with MoHS and other actors. Further support is required to integrate GBV-SRH interventions and initiate formulation of a national referral system.

Quality of care to deliver five core elements of RH[4] has been a challenge in emergency settings. The Country Office is perceived to have its strongest comparative advantage in advocacy and has established healthy grounds for lobbying in areas that are sensitive and difficult to be reached by others.

Transition from humanitarian response to development context is slow as the programme's major emphasis had been on responding to the humanitarian needs. There is a need to ensure smooth transition as well as continuity and coordination between interventions on humanitarian and development work on the ground. Protracted conflicts and natural disasters in Myanmar have expanded the demands on humanitarian relief and slowed down the countries' development gains. While there are practical challenges to integrating development work in humanitarian settings, strategic decisions by donors may offer various options for meeting these challenges by funding the gaps in transition. WGFI could be an example of such an effort.

Transferable Lessons Learned: Integration of conflict sensitivity assessments to understand various opinions of multiple stakeholders in areas that are sensitive to the culture and social fabric of a country could produce expected results minimizing the anticipated conflicts and maximizing the opportunities for acceptance and ownership. Mainstreaming conflict sensitivity as part of HRBA could produce more sustainable outcomes. Strong monitoring process of IP activities, including fund transfer mechanisms and the use of multi-year work plans instead of annual work plans (AWPs), with well coordinated effort to share information between and among IPs and programme staff on a regular basis would contribute to more efficient and effective programme outputs and outcomes.

Recommendations

In CP4, instead of "doing different things", the strategy would be to "do things differently." A strategic shift in programme implementation is recommended. On a positive note, the Country Office has already made a strategic shift towards upstream advocacy, with a focus on service delivery on a few programmes as necessitated by the nature of the intervention. CP4 to prioritize and focus on a few key high impact results/outcomes yielding interventions continuing the institutional capacity development with clear sustainable strategies.

Involve more partnerships, based on each partner's comparative advantage to enhance coordination and programme design for efficiency, effectiveness, sustainability paying attention to improving access to and utilization of all major programmes: GE, GBV and SRHR including ARH and HIV in protection of women's rights. Human rights and equity are deeply rooted in SDGs and right from the beginning SDGs paid attention to the engagement of civil society actors around the world. UNFPA CO should continue to support institutional capacity building of civil society organizations to claim and advance the rights of most disadvantaged and marginalized groups, specifically to increase access to and utilization of SRH and HIV prevention, treatment and protection services. To enhance the impact of adolescent and youth

[4] Five core elements of RH includes: (1) FP; (2) pregnancy, delivery, postpartum & newborn care; (3) prevention of unsafe abortion and post abortion care; (4) RTI, STI and HIV&AIDS (5) SRH including ARH

programme, GE and GBV programme interventions and support, institutional capacity and local capacity building should be the focus in the next country programme.

CO to step up External Resource Mobilization, go beyond traditional partnerships and include systematic partnerships with the private sector, anticipating the budgetary changes/reductions in the next cycle (in-line with UNFPA RM strategy and to obtain support from HQ or RO depending on available technical expertise).

Maintain the current level of coordination in planning and implementation within UNCT to enhance programme efficiency and effectiveness. Continue the current approach to working with the media and further strengthen UNFPA visibility at upstream level in its advocacy role for advancing the ICPD agenda.

Engage Youth as a partner –in the formal peace process (resolution on Youth, Peace, and Security) and make the optimum use of the demographic dividend. Support the establishment of an integrated and harmonized data-base to monitor ICPD Post 2015 and SDGs indicators.

As part of the emergency preparedness plan, readiness and availability of services in health facilities in emergency prone areas should be assessed and finding should be used to support and ensure full functionality of selected health facilities for life-saving maternal and newborn health. Support transition from humanitarian response to development programme where feasible, this would need engaging development expertise to build on the gains made on the humanitarian phase to build resilient communities, and continue support strengthening of health system capacity to plan, implement and respond to emergency and humanitarian situation.

Chapter 1: Introduction

In line with the Paris Declaration of Aid Effectiveness, UNFPA has continued to work closely with the Government of Myanmar and other development partners, supporting the national development priorities. UNFPA third country programme, CP3 (2012-2017), has been developed according to national development policies, the goals and objectives of ICPD PoA, MDGs, UNFPA Strategic Plan 2008-2013, Mid-term review and Business Plan 2012-2013, and SP 2014-17. CP3 has been harmonized with the priorities of the Government and the programmes of the UN agencies in the country linking to United Nations Strategic Framework 2012-2015 (UNSF). In 2016, on 5th year of the CP implementation, the Country Office is conducting an end-line evaluation.

CP3, approved in 2011 by the Executive Board and implemented in cooperation with the implementing partners (IPs)- including the government departments and INGOs and NGOs, consists of three key corporate priority strategic areas: Sexual Reproductive Health and Rights; Gender Equality; and Population and Development including the programmes' overall response to disasters given the country's vulnerability context. The initial country programme was from 2012 to 2015 with a total budget of 29.5 million USD dollars and the programme was extended to 2017 with an additional funding of USD 14 million. This CPE, the evaluation of the UNFPA Myanmar Third Country Programme (2012-2017), is undertaken in accordance with the UNFPA evaluation policy DP/FFA/2013/5 to provide independent and actionable recommendations as inputs to formulation of the next country programme for the period 2018-2022, which is the basis for further UNFPA's support in Myanmar.

1.1 Purpose and Objectives of the Country Programme Evaluation (CPE)

The UNFPA programme management guidelines state that final evaluation of the country programme should be undertaken before the next country programme cycle is planned. With the extension approved for 2012-2017, this CP is a six year programme and this evaluation is undertaken during the fifth year (2016) of the cycle, to highlight lessons learned and thereby contributing to the development of the next Country Programme Document (CPD). The final report outcome will be presented to the Executive Board together with the CPD outlining the CP4. The evaluation will be conducted following the processes and guidance articulated in the UNFPA Handbook on "How to Design and Conduct a Country Programme Evaluation at UNFPA," updated in October 2013; ensuring high quality evaluation with the highest level of objectivity, independence and impartiality.

The purpose of this country programme evaluation is to assess the programme performance; determine the factors that facilitated or hindered achievement, and document the lessons learned from the past cooperation and UNFPA strategic positioning in the country that could inform the formulation of the 4th Country Programme. Myanmar is a country subject to multiple disasters on a frequent and increasing basis. Given this highly vulnerable context, this evaluation also assesses the UNFPA country programme's engagement on humanitarian response in highly vulnerable contexts. The UNFPA evaluation office, with agreement of Executive Committee and Executive Board, has launched a new approach of Clustered Country Programme Evaluation (CCPE) that focuses on UNFPA engagement in

highly vulnerable contexts. Myanmar is selected to be one of the six countries[5] that will be assessed in CCPE and a meta-analysis is planned in the future to compare the results of the evaluation which will be led by the UNFPA evaluation office.

The intended audience for the evaluation and its uses are the UNFPA Country Office, Asia Pacific Regional Office (APRO) and Head Quarters, Government partners, relevant UN Agencies and other development partners.

Specific Objectives

With the overall objective of creating a broadened evidence-base for the design of 4th Country Programme of UNFPA support to the Government of Myanmar, the specific objectives of the CPE are:

- To provide an independent assessment (to the UNFPA country office in Myanmar, national programme stakeholders, UNFPA APRO, UNFPA headquarters and a broader audience of the progress of the programme towards the expected outputs and outcomes set forth in the results framework of the country programme;
- To assess the relevance, effectiveness, efficiency, and sustainability of the approaches adopted by the current CP and to assess performance of the CP;
- To provide an assessment of the country office (CO) strategic positioning within the development community and national partners, in view of its ability to respond to national needs while adding value to the country development results;
- To provide an analysis of how the UNFPA country office took into account and addressed the factors that leave Myanmar vulnerable to disasters and emergencies: and finally,
- To draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next program cycle.

1.2 Scope of the Evaluation

The scope of the evaluation is to cover the country programme implementation period from 2012 to 2016, a year before the current county programme (CP3) ends in 2017, with a focus on two components covering six evaluation criteria. The first component is the analysis of UNFPA strategic outcome areas Reproductive Health and Rights, Population and Development (PD) and Gender Equality (GE) using OECD/DAC evaluation criteria of Relevance, Effectiveness, Efficiency and Sustainability. In this analysis, UNFPA engagement in the highly vulnerable context will be assessed for only two of the evaluation criteria - the Relevance and Effectiveness. Both gender and humanitarian programme are cross cutting and will be reflected in the report as appropriate based on the nature of the programme plan and implementation.

The second is the analysis of UNFPA Strategic Positioning in the country with a focus on UNCT Coordination and UNFPA's Added Value to the development community and national partners in responding to national needs.

[5] Bangladesh, DRC, Haiti, Liberia, Myanmar, and Nepal

Conducted by independent evaluators in close cooperation with the Country Office staff and Evaluation Manager and the Regional Office, the evaluation covered seven geographic areas where programme interventions were supported or implemented by UNFPA for the period 2012 up to October 2016 (time of the evaluation). The areas visited, based on purposive sampling method, were townships of Yangon, Nay Pyi Taw, Pyay, Magwe, Pathien, Sittwe, and Myitkyina in the regions and states of Yangon, Bago, Magwe, Ayeyarwady, Rakhine, and Kachin including Nay Pyi Taw.

1.3 Methodology and Process

As noted above, this evaluation addressed two components each with specific criteria as laid down in the TOR. Assumptions were developed assessing the programme focus areas related to evaluation questions based on DAC evaluation explained below:

- Relevance - the degree to which the outputs/outcomes are in line with national needs/priorities, UNFPA priorities, and relevant to stakeholders.
- Effectiveness - verification of whether planned outputs and ideally outcomes were achieved.
- Efficiency - linked outputs to expenditures/resources and assessed whether these occurred as economically as possible, as well as within the time limits of the programme.
- Sustainability - the extent to which programme/project results were likely to continue/remain after termination of external assistance.

The second component of the CPE assessed UNFPA's strategic positioning in the country using the criteria *coordination* and *added value as explained under the objectives.*

Nine key evaluation questions are addressed in the evaluation:

EQ 1: To what extent is Myanmar CP consistent with beneficiaries' needs in particular the needs of the vulnerable groups, government's policies and priorities, UNFPA's policies and strategies; the global priorities including the goals of the ICPD Program of Action?
(Questions 2 and 3 below are CCPE specific questions related to Vulnerability Context. Given the integrated manner the CP is designed and implemented, these issues will be addressed as cross-cutting interventions across all programmatic areas. In addition, any relevant stand alone programmes under humanitarian context will be addressed separately).

EQ 2 (Relevance -Vulnerability context): How did UNFPA take into account the country's vulnerability to disasters and emergencies both at the planning and implementing its interventions?

EQ3 (Effectiveness - Vulnerability context): To what extent was the Country Office along with partner's able to (likely to) respond to crisis during the period of the country programme (2012-2017)?

EQ4 (Effectiveness): Were the CP's intended outputs and outcomes achieved? If so, to what degree? To what extent did the outputs contribute to the achievement of the outcomes and what was the degree of achievement of the outcomes? What were the constraining and facilitating factors and the influence of context on the achievement of results?

EQ5 (Efficiency): To what extent UNFPA made good use of its human, financial and technical resources to pursue the achievement of the outputs and outcomes defined in the CP?

EQ6 (Sustainability): To what extent the results of the UNFPA supported activities are sustainable and how has the programme incorporated the mechanisms to ensure sustainability?

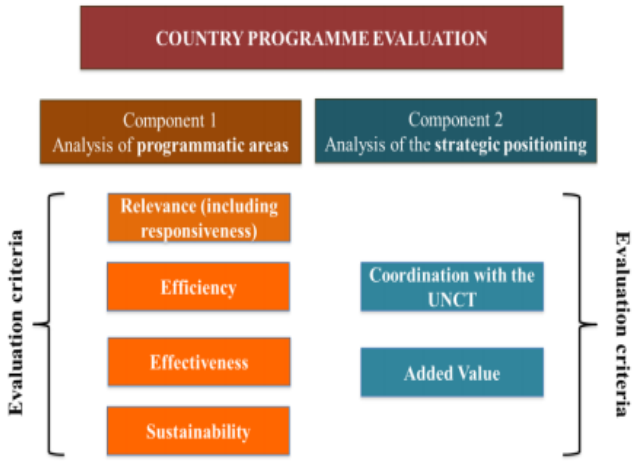
Questions 7, 8, and 9 below are directed to Strategic Positioning of UNFPA within UNCT (added value and Coordination issues).

EQ7 (Coordination): To what extent has the UNFPA country office contributed to the existing and consolidation of UNCT coordination mechanism?

EQ8 (Added Value): What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies? Are these strengths results of UNFPA corporate features or are specific to the CO features?

EQ9 (Added Value): What is UNFPA's main added value in the county context as perceived by national stakeholders?

Figure 1: Evaluation Criteria for the CPE



Source: CPE Handbook (UNFPA, October 2013)

1.3.1 Methods for Data Collection, Sources and Analysis

Upon desk review of key documents and several meetings with CO programme staff, the team prepared evaluation design matrices (see Annex 4) which include the evaluation questions, assumptions, indicators, data sources and data collection methods. The methods for data collection and analysis are determined by the type of evaluation questions formulated and the indicators identified to test the assumptions, as described above.

Selection of the Sample

In consultation with the country office and ERG, the evaluation team (ET) selected the sites for field visits for data collection. The selection of sites employed purposive sampling method, based on programme interventions, beneficiary populations, and the characteristics of geographic locations to represent the country programme and to answer the evaluation questions in an unbiased way. The sites illustrated a mix of interventions on reproductive health and rights, including adolescents and youth; population and development; gender equality including GBV; and humanitarian and emergency management.

Myanmar is prone to disasters (human-made and natural), UNFPA interventions related to humanitarian context have been carried out nation-wide. Given the time schedule, visit to all areas were limited and a sampling procedure took into account of the country's vulnerability context to capture and address the relevant evaluation questions. Furthermore, gender, human rights approach and vulnerability were treated as cross cutting issues throughout the evaluation. Specific effort was taken to visit populations affected by natural disasters as well as crises prone/highly vulnerable areas that were identified and where CP3 interventions were present. Based on review of documents and consultations with CO staff, ET covered seven Regions/States with the selection criteria as below:

Presence of more than three UNFPA programme interventions, both urban and rural representation; vulnerable and humanitarian context including conflict affected and ethnic diversity. Yangon is included as most of the implementing agencies are based in Yangon and Nay Pyi Taw is included mainly to conduct interviews with officials from line ministries and government departments.

UNFPA operates in selected townships in the regions and states and the initial criteria for selection of these for programme intervention have been described under the Third Country programme. The team visited the following townships indicated below taking into consideration these criteria including the geographic terrain that represents factors for the country's vulnerability context. The site selection is a non -probabilistic sample based on knowledge and informed decisions.

Table 2: Selected sites for field visits

Regions & States (Geographic Terrain)	Township	Criteria
Yangon Region (Delta)	Yangon	Presence of UN agencies, donors, INGOs and NGOs
Nay Pyi Taw	Nay Pyi Taw	Presence of main Government offices
Bago (West) Region (Central Planes)	Pyay	Presence of more than three UNFPA programme interventions: MSI, PSI, MOHS, MCH, NAP
Magwe Region (Central Planes)	Magwe	Both urban and rural representation, Census, other programs-RHCS,SRH, NGOs, flood prone area, DSW
Ayeyarwady Region (Delta)	Pathein	Vulnerable and humanitarian context, presence of MSI,MMA, MNMA, MMCWA, DSW, DOP, MRCS: both urban and rural representation
Rakhine State (Coastal)	Sittwe	Vulnerable context, SHD office, TMO, IRC, WHO,IOM, DSW, MMA,MNMA, Refugee Camps, both urban and rural representation
Kachin State (Hilly)	Myitkyina	Vulnerable context, hard to reach populations, IDP camp, Metta, Dept of Immigration, Health Dept, Police Dept, DSW

Data Sources, Collection and Analysis

Sources of data are both secondary and primary[6] based on a mix of quantitative and qualitative, derived from multiple sources. The evaluation triangulated data sources, data types, and data collection methods and adopted the triangulation approach through the application of three criteria: Perceptions, Validation, and Documentation. Perceptions were elicited though interviews with internal and external stakeholders and key informants. Validation was achieved through stakeholder meetings, such as debriefing meetings with UNFPA CO staff, ERG members and other key stakeholders.

Desk reviews include CP-related documentation, relevant national policies, strategies and action plans, national statistics, review reports etc. A detailed list of documents reviewed is attached (Annex 3). The questions generated in the interview schedules for this phase of data collection are based on the TORs, existing secondary literature as well as interactions with programme officers of the different components of the CP. The following table provides the institutions and agencies participated in the evaluation process.

Table 3: List of Institutions/Agencies and Number of People[7] Participated in the Interviews

Institution/Stakeholder	**# of respondents in interviewes/ FGDs**
UNFPA CO staff	22
UNFPA Nay Pyi Taw office	5
UNFPA Sub Offices (Humanitarian)	4
Strategic partners:Line ministries, UN agencies, Donors, other key development partners	
MOH (DPH, DHPRDM, NAP, CMSD), DSW, CSO, DOP, FERD, State Police Office	67
Midwifery School	11
UNICEF, UNDP, UNHCR, UNHABITAT, UNWomen, UNOCHA, UNAIDS, WHO, and The World Bank	18
INGOs (IRC, MSI, PSI, JSI, JHPIEGO, IOM, AFXB, Leprosy Mission)	20
NGOs (Metta, MMA, MMCWA, MNMA, MRCS, MCC,	47
Donors: DFAT, DFID, Swiss Development Cooperation (SDC), and the Government of Finland	4
Others: Gender Equality Network, Academic Institution Staff	6
Young people, Women and Girls' Centres (WGC) users	51
Total	**254** Male (90) Female (164)

The evidence in this study includes data collected from the field, desk review of documents, direct observations, structured and semi-structured interviews, focus group discussions, questionnaires and secondary sources. Depending on time availability, a judgmental sample of beneficiaries was used for focus group discussions to gather information on service quality and its accessibility and utility. The evaluation also made use of the monitoring reports (quarterly reports, standard progress reports, annual reports, trip reports by programme staff) submitted by IPs and UNFPA staff and relevant surveys and

[6] primary data will mainly be qualitative in nature

[7] The detailed list of interview participants (by male and female) is attached in the annex.

assessments conducted during the period. The triangulation of data collection minimized the weaknesses of one method, and be offset by the strengths of another, enhancing the validity of the data. The following planned data collection exemplifies the mix methods that were employed during the data collection stage. Further details of the data collection methods can be found in the Annex 6.

Conclusions and recommendations were made based on findings, judgments and lessons learned, appropriately reflecting the quality of the methodology, procedures, and analysis used during collecting and interpreting data. The team followed the evaluation handbook that provided guidelines on how to design and conduct the CPE which was a useful tool to come to a consensus on the terminology and methods used in the evaluation and reported results.

Limitations

There may have been gaps in the results chain. Too many activities and interventions in AWPs with unclear links to each other programmatic area that have somewhat similar objectives and final expected outcomes. ET mitigated this problem by having extensive discussions with the programme staff and reviewing progress monitoring reports and other related documents.

The size of the country and the spread of the programme interventions in geographically remote areas was constraint in establishing a representative sample for data collection. Thorough understanding of the programme interventions and areas characteristics was helpful in the selection of the purposive sample in order to avoid or minimize the selection bias.

The results frameworks of CP3 have changed in response to the changes in the UNFPA Strategic Plans 2014-2017. Furthermore, aligning with the implementation/business modality (country color quadrants – Myanmar is an Orange country) in the context of the new Strategic Plan, the CO and IPs have changed the focus on service delivery to advocacy and capacity development in order to achieve the results defined in the results framework. As such, the evaluation team observed a mix of programme interventions and strategies given that CP3 covers the years from 2012 to date. As discussed above, a good exposure to and understanding of the transitions that took place during CP3 and their implication on the programme and the results helped the evaluation team, prior to the data collection.

The short timeframe of this evaluation did not allow the team to collect primary quantitative data for related areas and accessing data with some consistency was a major challenge. Reliability as well as the lack of secondary data was a limitation in general. In order to mitigate these limitations, the evaluation team collected qualitative data where secondary data was limited or absent. In consultation with Country Office, the evaluation team sought for numerous data sources to report what is appeared to be most reliable.

To overcome the language barrier, the international team members worked closely with the national team and when it was not possible an external interpreter provided translation when required.

The Evaluation Process

The CPE process, in general, has five phases: 1) preparation, 2) Planning/design, 3) field, 4) reporting and 5) management response, dissemination and follow up. The preparatory phase was already completed by the country office.

Planning/Design Phase which includes desk review of key documents; stakeholder mapping; analysis of the programme/intervention logic; finalization of the evaluation questions and development of data collection, analysis strategy and a plan for field phase; preparation of the evaluation matrix and presentation of the design report to the ERG and country office. ET met with each programme group to go over the outputs and expected results in detail to come to an agreement on the indicators to be used and key stakeholders for interviews during the first week of October 2016. Upon approval of the design report, data collection tools were refined and field work started based on sample sites agreed by the team and CO/ERG, HQ CCPE designated officer and by APRO.

The Implementation Phase/ Data collection and Analysis Phase: The team did field visits, for 3 weeks in October, based on the samples selected. At the national level, data was collected from lead ministries, selected donors, UNFPA staff and other strategic partners (UN agencies). At the end of the field phase, on 31 October, a debriefing on the preliminary results was done for CO staff to validate the findings and testing tentative conclusions.

Reporting Phase: After the presentation of the preliminary analysis of data collected and the debriefing session the draft report was presented for the review by Country Office staff, ERG, Regional Office M&E advisor, and Evaluation manager for quality assurance. Findings, Conclusions and Recommendations were presented to the national stakeholders and CO staff on 13th of December for validation and dissemination. Finalization of the CPE report is being done integrating the feedback.

A management response to the recommendations will be prepared by the Country Office.

Preparation of the management response and organizing the dissemination of the final recommendations will be the CO responsibility. The team leader presented the CPE findings and recommendations (NPT presentation). The Evaluation Team will work in close consultation with the Evaluation Reference Group in each of the phases and steps of the entire evaluation process. Key stakeholders will be involved in all stages to enhance ownership as well as local capacity building.

The evaluation team understands the utility and applicability of this evaluation as the lessons learned from the current CP and recommendations from the evaluation will be incorporated into the new Programme Cycle (CP4). In order to ensure the evaluation's utility and applicability, specific attention will be given to the needs of UNFPA as well as those of key stakeholders in the design and process of evaluation.

Chapter 2: Country Context

Myanmar, the largest country in mainland Southeast Asia is characterized as a Lower Middle Income Economies by World Bank[8]. Myanmar was under a military rule for decades until 2010. Since 2011, a transition to democracy took place launching fundamental political and economic reforms aimed at increasing openness, empowerment, and inclusion by the new government. A new chapter in the country's democratic journey opened up with the general election of November 2015 and signing of long-awaited "nationwide cease-fire agreement" (NCA) with eight armed ethnic groups as part of a bid to end decades of civil war in the transitioning Southeast Asian nation. During the period 2015-2016 the country has begun to open up to foreign direct investment. The GDP growth rate has been increasing from 5.9% in 2011 to 7.0% in 2014/15[9] due to the measures of government reforms as well as investments invited. Lifting of economic sanctions by the European Union and the US also led to investment in Myanmar. Foreign investment increased from 4.64 billion USD in 2011 to 22.12 billion USD in 2015. As a result of increased investment s and other reform measures taken by the government, per capita nominal income has increased from 800 USD (2011) to 1270 USD (2015[10]). However, despite all this, huge disparity remains between different states and regions and urban and rural areas. The poverty ratio of Myanmar has decreased to 19.6% in 2015 (MPLCS 2015), with poverty concentrated in rural areas, where poor people are relying on agricultural and casual employment for their living.

Growing steadily in the last few years, the most important sector of the economy is services accounting for over 31 per cent of GDP in 2014. The share of agriculture to GDP has been declining from 37% in 2010.While industrial sector contributed significantly in the economic. The share of industrial sector to GDP increased from 37% in 2010 to 41% in 2014. The service and trade sector share to GDP is stable over the last 5 years from 26% in 2010 to 29% in 2014 (Myanmar Economic Monitor 2015)[11].

With a total population of 51.4 million[12] (Census, 2014) and females are of a higher percentage (51.8%) than the males (48.2%). Twenty eight percent of total enumerated population is composed of young people aged 10-24 years while the slow population growth is leading to a declined proportion of children.

Among ASEAN countries, Myanmar has the lowest life expectancy and the second-highest rate of infant and child mortality. Moreover, health expenditure in the state budget as a percentage of the GDP is still less than one per cent[13]. As a consequence of lack of public funding, WHO reports that users of health services pay as much as 87 percent of health costs through out-of-pocket expenses, with women of lower economic status affected most of all.
However, the ranking of human development index (HDI) in Myanmar has increased slightly from 150 in 2014 to 148 in 2015[14], while in the generosity index, Myanmar ranks first in giving.

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8 World Bank Countries Classifications
9 http://data.worldbank.org/country/myanmar?view=chart
10 As indicated in the TOR.
11 Myanmar Economic Monitor report Oct 2015
12 Includes enumerated population and estimated populations not counted in the census
13 Health in Myanmar (2014)
14 UNDP Human Development Report 2014

2.1 Development challenges and national strategies

To reiterate what is noted above, CP3 consists of three programme priority areas: Reproductive Health and Rights covering maternal health, family planning, HIV and AIDS and Adolescent Reproductive Health, including in humanitarian settings; Population and Development, and Gender Equality (GBV including humanitarian setting). Following discussion will highlight the country situation related to these programmatic areas.

Vulnerability Context

Myanmar's development has to be seen within its vulnerability context as it poses challenges to the realization of any development effort. The country is characterised by a combination of vulnerability to natural disasters, armed conflicts, inter-communal tensions, statelessness, trafficking and migration. Biggest challenge faced is its vulnerability context, as shown below - the country is prone to a wide range of disasters caused by various natural and human-made hazards. Over the last 10 years, the country has been impacted by two major earthquakes, three severe cyclones, floods and other smaller-scale hazards From 2015-2016, the El Niño phenomenon has been one of the strongest recorded since 1950, with a significant influence on weather patterns (OCHA, 2016). Heavy rains and winds brought by Cyclone Komen 2015 severely affected 12 of the country's 14 states and regions and displaced over 1.6 million people. The already high level of disaster risk is further compounded by climate change and variability, environmental degradation, and haphazard development (ADPC, 2015).

Biggest challenge faced by Myanmar is its vulnerability context; the country is prone to a wide range of disasters caused by various natural and human-made hazards. Over the last 10 years, the country has been impacted by two major earthquakes, three severe cyclones, floods and other smaller-scale hazards (OCHA, 2016). Myanmar has been the second country most affected by extreme events within the period 1995-2014[15].

With a total population of 51.4 million[16], about 8.5 million people live in conflict areas. About 1.02 million people, which includes 460,000 affected by 2015 floods, are in need of humanitarian assistance which requires about USD 190 millions to serve them.[17] The country's vulnerable situation, as discussed above, could negatively impact the development outcomes unless robust risk mitigation plans are in place.

The following table provides the situation of the impact and the likelihood of risks from natural as well as human-made hazards.

467998792817/pdf/99930-WP-MEM-Box393214B-PUBLIC.pdf"Myanmar Economic Monitor report Oct 2015

[17] Includes enumerated population and estimated populations not counted in the census

[17] Health in Myanmar (2014)

[17] UNDP Human Development Report 2014

Table 4: Impact and Likelihood Risk Analysis

Impact ↑						
	5. Critical		Tsunami	Earthquake	Cyclone	
	4. Severe			Conflict & Civil Unrest		Floods
	3. Moderate				Storm Surge	
	2. Minor		Pandemics (including Zica)	Landslides & Drought & Fire		
	1. Negligible		Forest Fire			
		1. Very Unlikely	2. Unlikely	3. Moderately Likely	4. Likely	5. Very likely
		Likelihood →				

Likelihood :
1 = *Very unlikely* (a remote chance of an event occurring in the current year from 0-5%)
2 = *Unlikely* (5-15%)
3 = *Moderately likely* (15-30%)
4 = *Likely* (30-50%)
5 = *Very likely* (over 50%)

Impact :
1 = *Negligible* (minor humanitarian impact; gov. capacity sufficient to deal with the situation)
2 = *Minor* (minor humanitarian impact; current country level inter-agency resources sufficient to cover needs beyond gov. capacity)
3 = *Moderate* (moderate humanitarian impact; new resources up to 30% of current operation needed to cover needs beyond gov. capacity – regional support not required)
4 = *Severe* (substantive humanitarian impact; new resources up to 50% of current operations needed to cover needs beyond gov. capacity – regional support required)
5 = *Critical* (massive humanitarian impact; new resources over 80% of current operations needed to cover needs beyond government capacity – L3 scale emergency)

Source: Myanmar HCT Risk Assessment Update (May 2016)

For most of the population there are no other forms of social insurance for health, unemployment or pensions. The lack of safety net coverage leaves a large percentage of the population extremely vulnerable in the face of natural disasters, illness and other socio-economic shocks.

Maternal health

Myanmar is a signatory to the ICPD, CEDAW and to the Millennium Declaration. The country faced challenges in achieving the MDG target of reducing the MMR to 105 maternal deaths per 100,000 live births that was set for 2015. According to Myanmar Population and Housing Census 2014, maternal mortality is high at 282 per 100,000 live births. Well-functioning maternal death surveillance and response systems promote continuous monitoring to identify trends in and causes of maternal mortality, and to prevent future death. Quality of care and strengthening health infrastructure with more efficient and effective health management information system has been a challenge.

Despite the significant proportion of births attended by skilled health personnel, 63.9 in 2007 (FRHS 2007)[18]to 60% in 2015(MDHS 2015), access to maternal health care remains highly inequitable across the regions and among women who are poor and residing in rural area utilize such services at much lower level.

National Health Plan (NHP) 2016-2021 aims to fulfill the Universal health Coverage Goal by year 2030 through a progressive realization by every five years cycle. NHP will focus on the four key components: Human Resource for Health; health infrastructure; health service delivery; health financing with M&E framework and costed implementation plan.

[18] Fertility and Reproductive Health Survey 2007, Ministry of Immigration and Population, Myanmar

Family planning

In 2013 Myanmar government committed to Family planning 2020 and and joined a global partnership that supports the rights of women and girls to exercise their full sexual reproductive health rights. Myanmar pledged to improve mix efforts and to reduce the unmet need for family planning by half by 2020.

Myanmar RH national strategic plan (2014-2018) has clear objectives to: reduce rates of maternal, perinatal and neonatal mortality and morbidity; reduce unmet needs; strengthen management of miscarriage and post abortion care; expand access to RTI/STI and HIV services; expand RH information and services for adolescents and youth; increase services for screening and treatment of cervical cancer; and support access to investigation and management of infertile couple.

HIV and AIDS

Myanmar has a concentrated HIV epidemic, which ranks among the most severe in the Asia and Pacific region. National HIV prevalence among key populations (People who inject drugs (PWID), Men who have sex with men (MSM) and Female Sex workers (FSW) is on the rise and significantly higher than the national average prevalence (0.6%). HIV prevalence among key populations is estimated at: 28.5% in PWID; 14.6% in FSW and 11.6% in MSM[19]. Myanmar has a concentrated HIV epidemic, which ranks among the most severe in the Asia and Pacific region. The country is facing with new challenges with risky behavior among young people (aged 10- 24), especially young boys. The high prevalence among young PWID (16.8%), relative to the other young KP indicates the high HIV risks associated with injecting drug use and HIV vulnerability among young PWID[20]. Proportion of key populations who reported condom use at last sex by age group, 2014-2015 indicates only 22% of young PWID used condom at last sex[21].

Youth engagement

Youth participation in political and economic reforms has not been seen as active though the youth comprises a large portion of the population. Myanmar is composed of 28 per cent of total enumerated population[22] as young people aged 10-24 years while the population growth is slowing down leading to a decline in the proportion of children. In Myanmar, the definition of Youth is not yet well defined and different from how UN defines it.[23] Almost half of the population, according to 2014 Myanmar census, is below 27 years with a large group between 5-14 years age. The high proportion of young people could bring capitalization of demographic dividend with access to education, health services and employment of youth. Otherwise, this youth bulge could create high employment needs of youth as a burden, which if not sufficiently addressed, could lead to disempowerment of young people. Investment in young people with different socio-economic background in Myanmar is important and has the potential to enhance the country's economic growth. If this is not addressed, Myanmar could miss reaping the benefits of

[19] Asian Epidemic Model (AEM 5.41, 2016)

[20] 2014,HSS, NAP

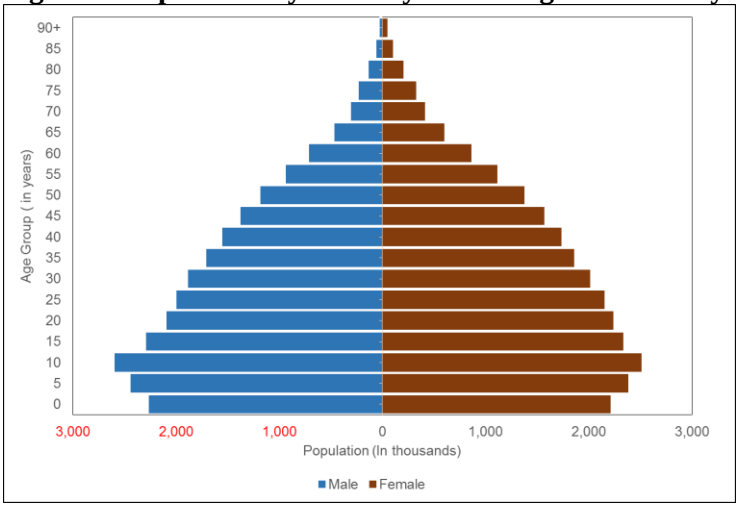
21 HIV and AIDS, Data Hub for Asia Pacific

[22] Myanmar Population and Housing Census 2014

[23] The UN, for statistical purposes, defines "Youth" as those persons between the ages of 15 and 24 years, without prejudice to other definitions by Member states. In Myanmar, the "Youth" is defined, in the Child Law of 1993, as a person who has attained the age of 16 years but has not attained the aged of 18 years.

demographic dividend. An illustration, as shown below, depicts a picture of diminishing youth in the country (source Myanmar Census, 2014).

Figure 2: Population Pyramid by 5-Year Age and Sex-Myanmar



Source: Myanmar Census, 2014

Adolescent Sexual and Reproductive Health (ASRH)

At global level, unprecedented progress has been made since 2000 in generating evidence about the main causes of, and trends in, deaths and ill-health in adolescents.

The UN Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) has expanded to include attention to adolescent health. Good intentions at the global level have not yet been transformed into a major groundswell of action in countries and Myanmar is no different from other countries in the world.

Policy makers face the challenge of understanding the nature of adolescents' specific needs, the implications of these for policies and programmes in the health and other sectors, and how to respond to adolescents' priorities in the face of competing demands. Adolescents are largely invisible in national health statistics, and are the only population group that health care providers are not routinely trained to serve. The wide range of issues that need to be tackled requires an integrated response that would address many health outcomes.

National strategic plan for RH in Myanmar 2014-2018, national strategic plan for young people's health (2016-2020), national strategic plan on HIV and AIDS (2011-2016) addressed young people's access to SRH and HIV AIDS information and services.

Ministry of Social Welfare, Relief and Resettlement is taking a lead in preparation and development of Youth Policy together with Ministry of Health and Sports and Ministry of Education. (UNFPA is providing the financial and technical assistance)

Population and Development

In the recent years, Myanmar has undergone a striking demographic transition phase. Myanmar's rapid population growth, during the second half of the 20th century, can largely be explained by the conventional demographic transition theory i.e. rapid decline in mortality rate combined with a gradual decline in fertility. Consequently, the country's population has been growing since independence i.e. from 28.9 million reported in the first census in 1973 to 35.3 in 1983. The recent census reported the total population of 51.4 million in 2014. With an average annual population growth rate of 0.89 percent between 2003 and 2014, Myanmar is one of the slowest growing countries in the Southeast Asia. This demographic transition phenomenon posses challenges of ageing population and a rise in the economic support ratios.

As part of the demographic transition, the country is witnessing mortality transition; however the pace is unfortunately slow among the regional countries: experience low life expectant at birth (64.7 years), the highest infant mortality (61.8) and the highest maternal mortality ratio (282 maternal deaths). A striking aspect of Myanmar's mortality is the large gender gap in life expectancies at birth (60.2 years for male and 69.3 years for female). The country is facing a new challenge of slow mortality transition and rapid pace of fertility decline.

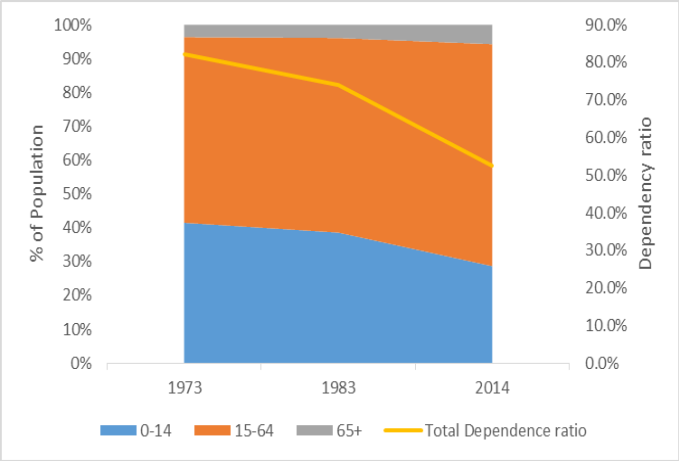
Total fertility rate dropped from 3.52 children per women in 1991 to 4.73 in 1983 (census). TFR according to the 2014 census is estimated to be 2.5 children per women at the Union level, 1.9 children per women for urban areas and 2.8 children per women for rural areas. Significant variation was observed within States and Regions: total fertility for States and Regions varies from a high of 5 children per women for Chin State to a low of 1.8 children per women for Yangon Region (DoP and UNFPA 2016).

The contraceptive prevalence for modern methods has increased significantly from 38 percent in 2007 (FRHS 2007)[24] to 51% in 2015 (MDHS 2015)[25] and unmet need for family planning was reduced to 16% in 2015 from 18% in 2007. One of the important dynamics of Myanmar fertility is the high proportion of never married women; the proportion of women never married at the age of 50 has been increasing over the years. Very little is known about the prevalence of induced abortions, fertility preferences and unwanted childbearing in Myanmar, particularly the geographical distribution, ethnic/religion and other socio-economic diversity. Keeping in view these dynamics, there is a greater need to understand the proximate determinants of fertility in Myanmar at national as well as States/regional level in order to design the policies and programmes. These wide range of issues of fertility transition in Myanmar particularly for ethnic, religious and other social classes are hindering the pace of fertility transition. Without deep understanding of those factors it is highly unlikely to accelerate the fertility transition, which has several social and economic implications.
Figure 3 below shows specifically the proportion of different age groups in Myanmar from 1973 to 2015 with associated total dependency ratios. Total dependence ratio in 1973 was 82 percent and declined to 52 percent in 2014. The proportion of children aged 0-14 decreased very substantially during the last four decades. The decline in the total dependency ratio may be attributed to the decline in the child dependency ratio. There is a greater need for a systematic study on how demographic dividend can be

[24] Fertility and Reproductive Health Survey 2007
[25] Myanmar Demographic and Health Survey 2015

capitalized and further suggestions are required as to what policy measures would be taken to address the issue of ageing.

Figure 3: Proportion of population by different broad age groups withtotal dependency ratio- 1973 to 2014.



Source: and 2014 Myanmar Housing and Population Census; Dependency ratio is calculated as the ratio of population age 0-14 and 65+ to 15-64.

In 2014, Myanmar conducted a census after almost 30 years providing up-to-date information on population size and growth and other demographic indicators. Other surveys collected data on different socio-economic and demographic/RH indicators by separate ministries supported and financed by different UN agencies. Since 1990 Fertility and Reproductive Health Surveys (FRHS) were implemented by UNFPA and DoP to collect demographic indicators for policy formulation and development planning, and providing information on changes in fertility, morality and RH related indicators. The Multiple Indicator Cluster Survey (MICS) conducted by UNICEF produced MDGs related indicators concerning women, and children. Further, UNDP and World Bank implemented IHLCS and MPLCS[26] surveys to capture the extent of poverty in Myanmar.

Beyond data availability, there is a lack of technical expertise at the government department level to analyze the population dynamics and its interlinkages with other development sectors (such as health, education and economy) and translate the findings into policy.

Context of Census in Myanmar

Four major factors are summarized the context of the census in Myanmar: 1) Censuses have not been conducted in more than 30 years, 2) the absence of reliable census and other type of data, 3) limited institutional capacity and 4) highly politically/ethnicly sensitive country context.

The absence of reliable census data has been a recurrent challenge in Myanmar for several reason. The foremost challenge is the politically and ethnically diverse situation in the country. It is very difficult to create more harmony and acceptability of the census data, because proportion of the ethnic population has

[26] Integrated Household Living Condition Survey 2009-10 and Myanmar Poverty and Living Conditions Survey 2016

important dimension as it serve as the basis forpower sharing in Myanmar, sustain ethnicity and distribution of financial resources[27]. Further, the diversity of census enumeration methodologies and the discontinuity of the censuses created loopholes for the reliable time series and comparing census data over time. Thus, demographers depended on adjustment techniques, resulting in flawed estimates that were debated widely across the government and other development partners in the country. The deficiency of accurate vital statistics and the internal migration flows in the political context of the country (military domination) prevented the estimation of reliable population growth indicators. Consequently, population estimates depended on such varied growth assumptions that ultimately resulted in a range of implausible population figure, particularly for state/regions.

Second, state institutions were weak in implementation and producing high quality census data. Because, lack of new technology and updated software for data processing and analysis before the census 2014, there was a gap in capacity as well as trust deficit on the government regarding census.
Further, full participation of the population (excluding the conflict zones) was problematic for a number of reasons, including lack of infrastructure and distrust in the Government.

Gender Equality

Myanmar is a signatory to the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), the Beijing's Declaration and Platform for Action, the International Conference on Population and Development (ICPD) and the Millennium Declaration and the Sustainable Development Goals (SDGs). Myanmar is an active member of the Association of Southeast Asian Nations (ASEAN) Committee on Women and the ASEAN Commission on Protection and Promotion of the Rights of Women and Children, 2010. To date, Myanmar ratified 3 out of 9 core international human rights treaties – the CEDAW main treaty but not yet the Optional Protocol to CEDAW, the CRC and only of its Optional Protocols, on child prostitution and child pornography, and the CRPD.

The 2008 Constitution of Republic of the Union of Myanmar includes Section 348, which explicitly provides that the Union shall not discriminate any of its citizens based on race, birth, religion, official position, status, culture, sex and wealth. Sections 350, 351, 352 and 368 are also prescribed for ensuring respect of the equal rights of men and women[28]. Government of Myanmar has been making the amendments to or repealing existing laws, rules and regulations, and procedures, as well as drawing up new laws since 2011, in line with laid down ten programmes of legislation. A total of 8 laws, which are related to women's rights have been amended or enacted[29].

As Myanmar's legal framework is drawn from a mix of colonial and traditional sources, many of its laws are not compatible with CEDAW. Some provisions incorporate restrictive gender stereotypes and are inconsistent with the promotion and protection of women's rights to substantive equality[30]. Gender inequalities persist, such as in legislation, access to economic opportunities and political representation.

[27] Sharing the Wealth: A Roadmap for Distributing Myanmar Natural Resources In the face of such centralized control over revenue, many ethnic groups have long asserted their right to make decisions over resource management in their states. Combatants in areas of active conflict and leaders from several ethnic minority parties—particularly those associated with Kachin, Rakhine and Shan states—have openly called for greater resource revenue sharing.
[28] CEDAW/C/MMR/4-5, parag. 6.
[29] CEDAW/C/MMR/4-5, parag.8.
[30] Myanmar Laws and CEDAW- GEN 2013

There are major challenges, which include contradictory messages in the legal framework, the plural legal system with different gender equality and women's rights standards, policy–practice deficits, gaps between sectors (education versus leadership and political participation), highly skewed results within a sector (such as education), and contradictory trends between related sectors (such as education and employment)[31]. Although Myanmar Customary Law and Penal Code take actions against discrimination and violence against women as a criminal case[32], there is no specific enacted law to prevent violence against women, including domestic violence. On the gender inequality index Myanmar ranked 85 out of 187 countries in 2014[33].

In 2012, Myanmar developed a medium-term strategy to advance gender equality and women's rights through the National Strategic Plan for the Advancement Women (NSPAW) 2013-2022, outlining an integrated approach to improve the situation of women and girls in Myanmar. The plan aims to create enabling systems, structures and practices for the advancement of women, for gender equality and realization of women rights. The plan provides an overarching framework and detailed interventions and targets.

The women development division has been separately established in the Department of Social Welfare under the Ministry of Social Welfare, Relief and Resettlement; the section will be extended to Region and State level. In addition, an action has been included in the National Strategic Plan for the Advancement of Women (2013-2022) so that the Ministries that are to implement the National Strategic Plan for the Advancement of Women (2013- 2022) can establish a gender unit respectively.[34]

Gender-Based Violence

Gender-based violence (GBV) is widespread in Myanmar, including sexual violence and rape in conflict, and accompanied by a culture of silence and impunity. Such cases are often underreported, and women are reluctant to seek justice in court. There has been no regular and systematic effort to collect comprehensive national data on the incidence or characteristics of gender-based violence (GBV) in Myanmar. Data that exist concern small scale surveys and studies to secure the relevant data in specific programme contexts. The Department of Social Welfare (DSW), in collaboration with the Gender Equality Network (GEN), undertook a qualitative research on violence against women and women's resilience in Myanmar, as well as research on cultural norms, social practices and gender equality in Myanmar in 2014.The women interviewed for this study had experienced many forms of violence throughout their lives, in different places and by a range of men. The types of violence they experienced included emotional, economic, physical and sexual intimate partner violence, and sexual assault and harassment. All women who were interviewed experienced more than one type of violence, demonstrating how violence is not a one-off incident and how different types of violence tend to overlap.[35] The research has shown that even when Myanmar women are left with severe physical wounds

[31]The Republic of the Union of Myanmar2016 .Gender equality and women's rights in Myanmar-a situation analysis
32 CEDAW/C/MMR/4-5, parag.17.

33 http//hdr.undp.org/en/composite/GII
[34]CEDAW/C/MMR/4-5, para. 36.
[35]Gender Equality Network, October 2014. Behind the Silence Violence Against Women and their Resilience, Myanmar Briefing Paper, page 4. Retrieved from http://www.burmalibrary.org/docs20/GEN-2014-11-Behind_the_Silence-en-ocr-tpo.pdf

after sexual assault, they rarely seek medical assistance[36]. The laws as they stand in Myanmar are inadequate in preventing and protecting them from violence and do not meet the needs of women[37].

Statistics on gender-based violence in Myanmar is very limited as most cases are under-reported. There are, however, standard operational protocols for survivors of sexual abuse who generally end up at hospitals as police cases, rather than with a reproductive health care provider (GEN 2014). Presumably, this is due to the reluctance to report violence to the authorities. A major point of concern is the legal handling of gender-based violence cases, when a survivor reports to a clinic, the medical service provider is required to report the case to the police before treating the survivor. Due to the reluctance to lodge a report, most survivors are unable to get access to health care. This results in under-reporting as many women are afraid of being exposed, and, if reported, they settle the cases out of court. Although there was a change in Emergency care and Treatment Law, which abolishes the mandatory reporting to police, the same procedure is still practicing in most parts of Myanmar. Human trafficking, especially of women, remains a major gender issue. During the period from 2008 to 2013, a total of (820) human trafficking cases were reported. [38]

2.2 The role of external assistance

The UN Strategic Framework takes note of the changing aid environment over the past years. The number of international non-governmental organizations (NGOs) operating in-country has increased in the aftermath of Cyclone Nargis, as have the number and capacity of the civil society actors. There are over 60 international NGOs and an estimated 455 community based organizations in Myanmar. The UN agencies work in partnership with Myanmar and international NGOs, particularly at the field implementation level, which inter alia adds value through capacity development and knowledge transfer to many local organizations.

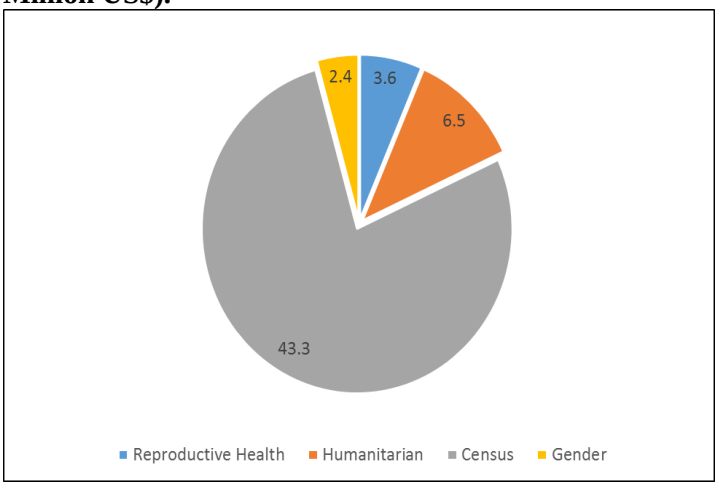
In 2013-14, the country ranked first on the list of the countries receiving the most foreign assistance (2013-14 average: US$ 4,714 million). Official Development Assistance (ODA) represented on average about 0.3% of the Gross National Income (GNI) in 2014 (OECD). The top donors to the country are Germany, Japan, UK, USA, Australia and EU. In 2014, about 87 percent of the aid was distributed through the DAC countries and rest will be from multilateral partners. The development assistance keeping the view the vulnerability context of the country plays significant role in the Myanmar development programmes. About 20% of the development assistance went to Education, Health and Population, about 19 percent were spent on economic infrastructure and approximately 11 percent on Humanitarian sector. Rest of the distribution were spent on other sectors. Further details are in Annex 8.

The volume of aid disbursement in 2012-2014 reached a total of US$ 9,927 million, of which UN contribution was US$ 114.9 million (1%). Among the UN contribution from 2012-2014, UNICEF has the highest contribution (42%), while UNDP is the second highest contribution (24%). The contribution of UNFPA over the same period was about 20%.

[36] ibid
[37] Gender Equality Netowrk 2013. Myanmar Laws and CEDAW, the case for anti-violence against women laws Myanmar, Yangon, the Gender Equality Network.
38 CEDAW/C/MMR/4-5, paras. 56-57

The UN Strategic Framework (2012-2015) provides a framework for coordinated UN assistance in line with UN Reform processes and the commitments of the Paris Declaration on Aid Effectiveness and Accra Agenda for Action. The UN Strategic Framework aims to address some of the key development challenges identified by the UNCT and the Government, with inputs from other stakeholders. Resources mobilized by various donors during CP 3 are shown below (detail list is in annex.8).

Figure 4: Resources mobilized by four thematic areas from external resources during 2012-2015 (in Million US$).



Source- UNFPA Country Office

Chapter 3: UN/UNFPA response and programme strategies

3.1 UN and UNFPA Response

In line with the Paris Declaration of Aid Effectiveness, UNFPA continues to closely work with the Government of Myanmar and other national implementing partners supporting Government development priorities. UNFPA supports the furthering of the International Conference on Population and Development (ICPD) agenda, and supporting the attainment of Millennium Development Goals (MDGs) UNFPA CP3 (2012-2017) has been developed taking into account national development policies, the goals and objectives on ICPD and its reviews, MDGs and UNFPA Strategic Plans. The country programme is synchronized with the United Nations Strategic Framework (UNSF) for Myanmar 2012-2015 and in alignment with UNFPA Strategic Plan 2008-2013 and the revised UNFPA Strategic Plan 2014-2017.

The UN Strategic Framework (2012-2015) provides a framework for coordinated UN assistance for the key development challenges identified by the UNCT and the Government, with inputs from other stakeholders. Due to the new context within which UN operates, in 2014 the UNCT developed a *Strategy for Repositioning the UN in Myanmar (2015-2017)* to align the UN's programme planning cycle (UNDAF) with the government's planning cycle, allowing the UN to factor in support to the SDGs.[39]

3.2 UNFPA Response through the Country Programme

As an "Orange" country, based on UNFPA country classification, the business model states that UNFPA, since 2015, will be primarily engaged in policy and advocacy work, capacity building and knowledge management. Thus the programme is shifting away from supporting implementation of services to that of a broker of expertise. Given the country context, UNFPA also responds to country needs via its work on humanitarian programming and has a key role to play in issues related to sexual and reproductive health and reproductive rights, and gender-based violence in emergency situations.

3.2.1 Brief description of UNFPA previous cycle strategy, goals and achievements

UNFPA 2nd Programme of Assistance

UNFPA implemented its 2nd programme of assistance to Myanmar 2007-2010, which was extended until the end of 2011. The programme focused on Reproductive Health (RH), Adolescent Reproductive Health (ARH) and HIV/AIDS, to promote the status of RH of women and men including adolescents and youth (establishment of Youth programmes; Ypeer, Youth Information Centres, leadership) in selected project areas. Gender equality, humanitarian assistance and population and development (establishment of P&D Committees), were introduced as new focus areas in the 2nd programme of assistance. Implementation of the 2nd programme, was delayed by two years due to the reallocation of its resources to respond to cyclone Nargis that hit the country in 2008. In the aftermath of the cyclone, UNFPA provided life-saving reproductive health services, strengthened disaster preparedness and established rapid response teams.

[39] Strategy for Repositioning the UN in Myanmar, December 2014.

The main programme achievements include: (a) provision of maternal health and birth-spacing services in 132 townships out of 330 townships; (b) improving knowledge over 400,000 young people on RH and HIV; (c) contributing to reduction of HIV prevalence among FSWs from 18.4% to 11.2% and among MSM from 28.8 percent to 22.3 percent; (d) increasing availability of data through FRHS ; (e) supporting establishment of national working committee for RH and development of national strategic plan for RH (2009-2013) and NSP on HIV/AIDS (2011-2015); and (f) mobilizing 90,000 community support group members who helped bridge between communities and RH service delivery points.

3.2.2 Current UNFPA country programme

The 3rd current country programme builds on the 2nd country programme and UNSF identified jointly by the Government and UN agencies. The 3rd CP is developed based on: the situation analysis of RH, population and development and gender conducted in 2010; the end of programme evaluation and lessons learned (2011); and the United Nations thematic analysis and UNSF 2012-2015.

The Programme: **UNFPA 3rd Programme of Assistance**

UNFPA's third Country Programme in Myanmar, as noted earlier in the report, was approved by the Executive Board in 2011 for 4 years from 2012 to 2015, with a total budget of 29.5 million USD. Out of 29.5 million USD dollars, 16.5 million US dollars is from regular resources and the remaining 13 million USD dollars is to be mobilized through co-financing modalities. The programme was extended to 2017 for which phase the Executive Board approved to fund an amount of 8 million USD from regular resources, with an additional 6 million USD to be provided from other resources, totaling 14 million USD for the programme extension phase of the programme.[40]

The third Country Programme consists of three main components, namely 1) sexual and reproductive health and rights, 2) population and development and 3) gender equality. The country programme is synchronized with the United Nations Strategic Framework (UNSF) for Myanmar 2012-2015 and in alignment with UNFPA Strategic Plan 2008-2013 and the revised UNFPA Strategic Plan 2014-2017. It contributes to three strategic priorities of the United Nations Strategic Framework: (a) increase equitable access to high-quality social services; (b) reduce vulnerability to natural disasters and climate change; and (c) promote good governance and strengthen democratic institutions and rights.

Geographical coverage of CP3 Interventions

UNFPA 3rd Programme has selected five regions and three states (see table 6 below) out of the 14 regions/states in the country for programme interventions.

Selection criteria for the interventions have been based on high MMR and HIV prevalence; high poverty incidence; highly populated rural and peri-urban poor; limited access to RH and HIV information and services; high unmet need for birth spacing services and low CPR; high abortion rate; vulnerability to

[40] The reasons of extension of the UNFPA country programme were related to decision of UN Country Team that deferred 2 years for UNDAF (UNSF) formulation exercise, and to be in line with the existing political context including possible national ceasefire accord and also hoping to harmonize with UNDP and UNICEF programme.

natural disasters and remoteness including areas with mobile population and ethnic minorities; and availability of adequate health personnel and infrastructure to facilitate achievement of sustained results.

Table 5: Regions and States covered under the County Programme (CP3)

No.	Region	No.	State
1	Yangon	6	Rakhine
2	Mandalay	7	Shan
3	Ayeyarwaddy	8	Kachin
4	Bago		
5	Magway		

There are 89 townships under those selected Regions and States for implementation of UNFPA's supported activities. Based on the consultations with IPs and government departments, and funding availability, townships to implement the activities have been selected by UNFPA yearly, giving special attention to those townships where immediate needs of humanitarian assistance are required.

Below provides a brief description of the three programmatic areas under CP3 - Reproductive health and rights, population and development and gender equality. While humanitarian response under emergency setting is integrated into the regular programme, a separate description is also provided as appropriate. Annex

Sexual and Reproductive Health and Rights (SRHR)

SRHR programme component (2012-2015) has two outputs:

1. Strengthened health system to improve the availability of high quality, equitable sexual and reproductive health information and services among target groups including in emergency settings.
2. Improved availability of sexual and reproductive health services, including the prevention of HIV transmission among populations that are most at risk and their partners, and from mothers to their children.

Above two outputs contribute to UNFPA SP (2014-2017) outcome 1: Increased availability and use of sexual and reproductive health services (including family planning, maternal health and HIV) that are gender responsive and meets human rights standards for quality of care and equity in access.

UNFPA intends to achieve the output (1) by strengthening national coordination mechanisms; supporting national government in developing national strategies, updating standards and guidelines; supporting the establishment of quality assurance systems for quality RH/ARH services including EmONC; strengthening reproductive health commodity security; strengthening Reproductive Health Management Information System (RH HMIS) and Logistic Management Information System (LMIS); capacity building of basic health staff and doctors to provide live saving maternal and newborn care at antenatal, during delivery and post-natal period; integrated RH-HIV service provision and promotion of public private partnership; and creating demand for services through community support mechanisms and media; and strengthening humanitarian preparedness and response. The programme focuses on 89 selected townships in seven states and regions.

Output (2) supports implementation of the targeted interventions among the most at-risk young people and aims to increase availability of RH and HIV services among them - FSWs, MSMs, FSWs' clients and partners - by strengthening behavior change communications; promoting comprehensive condom programming (CCP); strengthening capacity of service providers to deliver minimum package of services including contraceptive counseling and services, voluntary HIV counseling testing and HIV prevention services (condom), STI diagnosis and treatment. This output area also thrives to prevent new HIV infection among newborn babies from their mothers living with HIV infection (PMTCT).
To be in line with the UNFPA SP 2014, the strategic shift and realignment exercise was done in end 2014 and new CP outcome and corresponding two outputs are re-formulated as:

Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access.

Output 1. Strengthened health systems to deliver quality and equitable integrated sexual and reproductive health information and services among target groups as well as in humanitarian settings
Output 2. (Added -SP OP 6) : Increased national capacity to review the situation of comprehensive sexuality education(CSE) programmes and conduct evidence-based advocacy for incorporating adolescents and youth and their human rights/needs in national laws, policies, programmes, including in humanitarian settings

Above (added) output 2 directly contribute to the UNFPA SP (2014-2017) outcome 2: Increased priority on adolescents, especially on very young adolescent girls in national development policies and programmes, particularly increased availability of comprehensive sexuality education, sexual reproductive health services.

With reference to (added) output 2, UNFPA supports Ministry of Health and Sports in development of national standards and guidelines in ARH service provision; pilot implementation of these projects in selected townships and regions; support quality assurance of ARH services through training of staff, monitoring and supervision; and support integration of selected ARH indicators into HMIS to keep track of achievements. For further details, refer to Annex 5, programme theory.

Population and Development

The UNFPA 3rd Country Programme was designed with the aim of helping Government of Myanmar to develop national capacity to produce high quality disaggregated data on population, reproductive health and gender issues. The outcome area of country program will contribute to the fourth strategic priority of the UN Strategic Framework "promote good governance and strengthen democratic institutions and rights" and to the following UNSF outcome: Strengthened national statistical system for data collection, processing, and analysis and coordination. Because, Myanmar has not implemented census since 30 years, the output primarily focus on the data generation intervention. UNFPA focused the assistance on one output: "Strengthened national capacity to increase availability of high quality disaggregated data on population, reproductive health and gender issues for policy formulation, planning and monitoring and evaluation".

This output is expected to achieve through three strategies as follows:

1. Strengthening institutional capacity to conduct a population census and a migration survey. Since 1983, population and housing census was not conducted in Myanmar and UNFPA has been leading in assistance to Department of Population to carry out Fertility and reproductive health surveys. With sustained advocacy with government on the implementation of the census, government was planned to implement the census. Thus, 3rd country program was dedicated the assistance to census. The output included several cluster activities such as preparing census document, hiring of resident Chief Technical Advisor (CTA), and providing technical, financial and logistics management to the department of population in the census.
2. Strengthening Institutional capacity for population research, advocacy and policy dialogue. Research and academic institutions in the public sector are often weak in Myanmar with little evidence for policy being generated. CP3 addressed this gap through building capacity of government at national level to generate evidence on population and SRH/FP with youth/Adolescent focus through provision of technical assistance, developing capacity of research staff and support to dissemination of research findings.
3. Providing technical assistance for the establishment of an integrated and harmonized data base to monitor ICPD and MDGs indicators.

Overall, data generation system is weak in Myanmar to monitor the development progress such as ICPD, and MDGs. Few standalone surveys existed in the country and with the intension of census implementation, this sub output is expected to focus on developing synergies between different available survey data and to develop an integrated and harmonized database by combinging all these surveys and a census to monitor ICPD and MDGs indicators.

Gender Equality

Gender Equality (GE) and Gender Based Violence (GBV)

According to Gender Equality (GE) programme component (2012-2015), the expected programme outcome is "gender equality and human rights of women, particularly their reproductive rights are addressed in national legal frameworks, social policies and development plans".

In pursuit of this outcome, UNFPA focuses its assistance to the output, "strengthened national capacity and institutional mechanism for promoting gender equality and advancement of women". The extension programme (2016- 2017) modified the output of the CPAP (2012-2015). The revised output combined GBV and described as "strengthened national capacity and institutional mechanism for advancing reproductive rights, promoting gender equality and addressing gender-based violence, including in humanitarian settings".

This output is expected to be achieved through three strategies and a number of cluster activities which can be described as follows:

1. Strengthening institutional capacities of the government and civil society in the area of gender analysis and mainstreaming.
2. Strengthening capacity for evidence-based advocacy for formulation and revision of policies and legislation to advance gender equality.

3. Building/strengthening capacity of community based organizations to improve awareness on gender equality and women's empowerment, reproductive rights, violence against women, promote male responsibility in sexual reproductive health.

At the national level, in partnership with the United Nations Gender Theme Group (UNGTG) and Gender Equality Network (GEN), UNFPA supports the development and implementation of National Strategic Plan for the Advancement Women (NSPAW) 2013-2022. The Department of Social Welfare drafted a national law on Protection and Prevention of Violence Against Women Law (PoVaw) with support from UNFPA, UNDP, UNWomen and the GEN.

While the policy and law development in compliance with international norms and standards is a critical role of UNFPA at the national level, UNFPA also manages and implements programmes to support women and girls at the state and regional levels and particularly those affected by natural disaster, inter-communal violence and conflict. UNFPA has taken a leadership and coordination responsibility of GBV sub-sector in humanitarian setting since October 2013. Realising the close relation between SRH and GBV interventions in humanitarian settings, UNFPA Country Office has initiated a SRH-GBV integrated project, with support from five donors, in both development and conflict/disasters affected areas. The integrated project has enabled UNFPA to provide better and more comprehensive services to the affected populations, better referral and follow up mechanism. UNFPA ensures the rights and needs of women and girls are at the forefront of humanitarian responses to maintain their dignity and restore safety and access to sexual and reproductive health, including services for safe pregnancy and childbirth, as well as protection from gender violence, as quickly as possible.

Interventions in Humanitarian Setting

The CP (2012-2015) output "Strengthened health systems to improve availability of high quality and equitable sexual and reproductive health information and services among target groups including in emergency settings" was expected to contribute to the outcome "equitable access to and utilization of high quality sexual and reproductive health and HIV prevention information and services for women, men, young people and most-at-risk populations with the special focus on the poor, vulnerable and the geographically remote areas." With the alignment to the SP 2014-2017 and with the extension of CP from 2015-2017, the expected outputs were more sharply focused and made specific to meeting the needs of populations under humanitarian response.

Evident from the planned outputs and the design of the implementation of the interventions, there is an intentional focus on integrating the humanitarian response within the development interventions. The following expected outputs in the programme bear evidence for such a shift.

- Increased access of women and girls to comprehensive, rights-based package of SRH and GBV services in Kachin, Northern Shan and Rakhine States.
- Increased referrals of GBV survivors to information, services and justice in Rakhine, Kachin and Northern Shan States.

Following interventions are carried out to realize the expected results under the current CP.

a) address SRH needs of women, adolescents and youth, (including services for survivors of sexual violence in crises;
b) enhance national capacity to implement MISP at the onset of a crisis
c) establish having the provisions in place to set up interagency GBV coordination body, led by UNFPA, in anticipation of crisis;
d) enhance capacity to collect and use quality disaggregated population related data for appropriate preparedness and response to emergency situations.

The selection of the programme intervention areas, in the CP, based on vulnerability to natural disasters indicates that focus on risk component and mitigation of risks have been taken into consideration in the planning stages of the CP. As part of joint humanitarian assistance efforts (the Humanitarian Response Plan), UNFPA's humanitarian work focuses on two main geographic areas: Rakhine State and Kachin and Northern Shan States. However, based on the Humanitarian Response Plan, when natural disasters happen, UNFPA provides humanitarian assistance to the government of Myanmar and beneficiaries through UNFPA local partners, nationwide.

Three of the outcomes stated in the Strategic Plan 2014-2017 are related to UNFPA engagement in vulnerable settings. UNFPA Country Office is responsible to deliver four outputs to strengthen the emergency preparedness. Outputs to strengthen emergency preparedness include increased capacity to implement the Minimum Initial Service Package (MISP) in humanitarian settings; strengthen national capacity for addressing GBV and providing quality services in humanitarian settings, and enhancing national capacity to produce, utilize, and disseminate quality statistical data on population dynamics, youth, gender equality, and SRH in humanitarian settings.

3.2.3 The Country Programme Financial Structure

The initial proposed country program commitment from 2012-2015 was $28.1 million from its core resources. On the onset of the programme, donor commitment was not finalized therefore it is not considered in the programme. The distribution of the total budget among core programme areas: $14.7 million for RH including ARH and Humanitarian (52% of the total allocation), $6.95 million for Population and Development (25% of the total allocation) and $3.29 million for HIV/AIDs (12% of the total allocation). Gender equality and GBV consisted of total $1.9 million (7% of the total allocation) and programme coordination was 4% ($1.2 million). From 2012-2014, RH component was included adolescent reproductive health and humanitarian. However, after 2015, as part of the realignment, RH programme was broadened to reflect the three programmes: RH, Adolescent and Young People, and Emergencies & Humanitarian. Gender program was also split into gender equality and GBV.

Because of the effective resource mobilization from the country office, donors have contributed significantly particularly in census, RH and gender including humanitarian. The overall donor assistance from 2012-2015 was $55.8 million, with 78% contribution in census. Table 6 illustrates the total allocations and expenditures from 2012 to 2015 for both core and non-core resources for four thematic areas. The highest share was dedicated to census operation under Population and Development (42% of the total expenditures), about $41.13 million. However the implementation rate was only 74% from 2012-2015 under P&D. Further, the implementation rate of Gender was 66% over the same period ($2.2 million

expenditures). However, RH and HIV/AIDs programmes were observed most efficient in terms of the budget spending, 92% under RH and 99% under HIV/AIDs. There is still one year left for the programme and for P&D, 11 thematic reports are in process as well as other advocacy and training/dissemination activities are to be completed. Similarly, under the GE there are planned programmes to be completed and the implementation rate will be improved. Overall, the country office implementation rate was about 80% from 2012-2015. Please note that the evaluation is undertaken in the last quarter of 2016 and one more year is left for the completion of CP3 planned interventions.

Table 6: Overview of the budget (Allocation, expenditures and implementation rate) for the programmatic areas of CP3-Myanmar: 2012-2015

	2012	2013	2014	2015	Total
Sexual Reproductive Health including ARH & Humanitarian					
Allocations	7,304,579	8,390,672	5,867,329	4,205,433	25,768,013
Expenditures	7,042,075	8,314,313	5,446,744	2,819,064	23,622,196
Imp. Rate	96.4%	99.1%	92.8%	67.0%	91.7%
HIV/AIDS					
Allocations	1,132,338	641,556	686,788	212,226	2,672,908
Expenditures	1,134,840	650,137	653,882	206,350	2,645,209
Imp. Rate	100%	101.3%	95.2%	97.2%	99%
Population and Development					
Allocations	1,694,448	9,850,930	37,095,127	7,403,164	56,043,669
Expenditures	1,633,463	6,897,368	28,388,674	4,457,689	41,377,194
Imp. Rate	96.4%	70.0%	76.5%	60.2%	73.8%
Gender					
Allocations	15,115	116,063	723,433	2,603,676	3,458,287
Expenditures	14,863	100,048	632,974	1,533,796	2,281,681
Imp. Rate	98.3%	86.2%	87.5%	58.9%	66%

Source: Cognos report from 2012-2015, provided by UNFPA country office. The details budget and expenditures by IPs from 2012-2015 can be found in the Annex 8.

Table 7 : Resources mobilized by type of donor and area of support (USD)

YEAR	Donor	Area of support	Amount*
2012	Germany	Reproductive Health	1,171,643
	Three Diseases Fund	Reproductive Health	83,133
	Australian Agency for International Development (AUSAID)	Reproductive Health	1,050,813
	The Underfunded Emergencies Window of the Central Emergency Response Fund (CERF)	Humanitarian	282,842
	Global Programme on Reproductive Health Commodity Security (GPRHCS)	Reproductive Health	48,232
	Joint fund from the Governments of Norway, New Zealand and Finland	Humanitarian	49,885
2012 Total			**2,686,548**

2013	Germany	Census	2,853,206
	Australian Agency for International Development (AUSAID)	Census	998,563
	The Underfunded Emergencies Window of the Central Emergency Response Fund (CERF)	Humanitarian	437,176
	Global Programme on Reproductive Health Commodity Security (GPRHCS)	Reproductive Health	53,392
	The Government of Denmark	Humanitarian	484,993
	Department for International Development (DFID), United Kingdom	Humanitarian	35,056
	Census Fund- Australian Agency for International Development (AUSAID), Department for International Development (DFID), Swiss Development Cooperation (SDC), AND THE GOVERNMENTS OF Finland, Italy, Norway and Sweden	Census	5,481,965
2013 Total			**10,344,351**
2014	The Underfunded Emergencies Window of the Central Emergency Response Fund (CERF)	Humanitarian	368,815
	Global Programme on Reproductive Health Commodity Security (GPRHCS)	Reproductive Health	265,609
	Department for International Development (DFID), United Kingdom	Humanitarian	827,540
	Unified Budget, Results and Accountability Framework (UBRAF)	Reproductive Health	30,000
	Census Fund- Australian Agency for International Development (AUSAID), Department for International Development (DFID), Swiss Development Cooperation (SDC), AND THE GOVERNMENTS OF Finland, Italy, Norway and Sweden	Census	33,761,754
2014 Total			**35,253,718**
2015	3 MDG Fund	Reproductive Health	909,500
	CERF/OCHA	Humanitarian	1,633,097
	DFAT	Humanitarian	710,732
	DFID	Humanitarian	1,682,816
	Government of Finland	Census	236,220
	Government of Italy	Gender	437,158
	Government of Sweden	Humanitarian & Census	1,976,983
2015 Total			**7,586,506**
Grand Total 2012-2015			**55,871,123**

Chapter 4: Findings: answers to the evaluation questions

This chapter on Findings, as shown in Figure 1, focuses on two components: Answering nine evaluation questions at the programmatic and strategic level.

CPE Component 1:

To reiterate, the first component analyzes CP programme areas against the evaluation criteria Relevance, Effectiveness, Efficiency and Sustainability. For CCPE, UNFPA's engagement in the highly vulnerable context is assessed for two of the evaluation criteria - the Relevance and Effectiveness.
The second component analyzes the strategic positioning of UNFPA Country Office using criteria: *coordination* with the UNCT and *added value* of UNFPA. Detailed evaluation matrices for Programmatic Areas and Strategic Positioning indicating the assumptions that were considered during the evaluation are in Annex 4.

4.1 Answer to evaluation question on Relevance

Relevance*: EQ1*: To what extent is Myanmar CP consistent with beneficiaries' needs, in particular the needs of the vulnerable groups, government's policies and priorities, UNFPA's policies and strategies; the global priorities including the goals of the ICPD Program of Action?

The above evaluation question was assessed for each programmatic area, Sexual Reproductive Health and Rights; Population and Development; and Gender Equality, as well as for Humanitarian Response. Since the Humanitarian Programme interventions are embedded in the development work programme to a certain extent, these are discussed under the relevance sections, specifically under SRHR and GE. Where appropriate, humanitarian programme is discussed separately. With regard to Relevance, Efficiency and Sustainability, due to the overlap under these criteria, the findings will be summarized at the programmatic level, once the analysis is made separately. There are two specific questions related to Myanmar's vulnerability context, on Relevance and Effectiveness that are discussed under the respective evaluation criteria.

4.1.1 Sexual Reproductive Health and Rights- Relevance

Summary findings –Relevance of Sexual Reproductive Health and Rights
SRHR programme in CP3 is highly relevant. The needs of beneficiaries - women, young people, adolescents and vulnerable groups are well taken into account in line with Government policies and priorities. Implementation strategies are in line with the goals of ICDP Programme of Action. The objectives and strategies of the programme areas are consistent with the UNFPA strategic plan 2014-2017. The discussion below bear evidence to this. While the focus on upstream advocacy is relevant to the UNFPA strategic objectives, IPs feel that service delivery is still relevant in some interventions such as procurement and supplies of family planning commodities for National FP Programme and supporting integrated service delivery model of IPs to reach out to the most vulnerable and at risks populations and in emergency settings.

The needs of women, young people, adolescents and vulnerable groups are well taken into account, in line with Government policies and priorities; and the goals of ICDP. UNFPA country programme SRHR component addresses ICPD Programme of Action papa 7.3, 8.3 and para 85 promoting reproductive

rights, increasing accessibility, availability, acceptability and affordability of health care services and implementation through a broader strengthening of health system.

The CP interventions are well in line with National Health Plan and the National Strategic plan for Reproductive Health 2014-2018 where it clearly outlines its strategies: Strengthening health system to enhance the provision of an essential package of SRH interventions; increasing access to quality integrated SRH services at all levels of care; engaging the community in promoting and delivery of SRH services; incorporating gender perspectives in the SRH strategic plan and integrating SRH in humanitarian settings.

The choice of target groups for UNFPA supported interventions in the area of SRHR is consistent with identified needs as well as national priorities in the CPAP and AWPs. Developed in line with the UNFPA Strategic plan 2008-2013, the CP3 was re-aligned, at the end of 2014, with participation of key stakeholders. The outcomes and outputs were reformulated to be in line with UNFPA SP 2014-2017 strategies: evidence based policy advocacy, capacity building and knowledge management. South-South cooperation has been mainstreamed in the SRHR component of the CP implementation but there is not enough evidence that such cooperation were implemented based on proper country's capacity assessment. When it comes to UNFPA's strategic shift (AP, CD and KM) in line with "orange" country classification, majority of IPs expressed the need to continue service delivery (SD) in some particular areas such as procurement and supplies of family planning commodities (as there is still a budget deficit in this area) and supporting integrated service delivery model of IPs to reach out the most vulnerable and at risks and in emergency settings. However, IPs felt that their assessments on the ground were not fully endorsed and expressed the need for much more participatory and transparent engagement of partners in work planning exercises.

4.1.2 Population and Development- Relevance

Summary finding –Relevance of Population and Development

The population and development component of the country programme was adapted to the needs of the government, in particular to the census implementation with international standards, in a context of limited resources and institutional changes in partner ministries. Recognizing the need of population and development linkages, UNFPA adopted P&D as a separate component in the CP3. UNFPA support was strongly aligned with the needs of national public institutions addressing and reversing inaccurate population estimates, and generating reliable socio-economic baseline data for the development of national plans and strategies. UNFPA support also responded to demands for data from academia, development partners including UN agencies and civil society organizations.

The country programme is aligned with ICPD and UNSF objectives in the areas of strengthening the system to produce valid, reliable, timely, culturally relevant and internationally comparable population data for policy and programme development. UNFPA supported DoP in implementation of census successfully and enhanced the capacity of the government to deliver quality work. Evaluation findings revealed that the interventions under Population and Development work plan for 2012-2016 respond to the national and international requirements and with a high degree of relevance.

Linkages with ICPD Goals, UNSF and UNFPA Strategic Plan 2014-2017:

One of the core action of the ICPD Plan of Action (PoA) is to strengthen system to produce valid, reliable, timely, culturally relevant and internationally comparable population data for policy and programme development, implementation, monitoring and evaluation. The implementation of the census, providing much needed data, is very relevant in the country context as well as to the ICPD international agenda.

In CP3 the P&D activities fall under UNFPA Strategic Plan Outcome 4 that focused on strengthening the national policies and international development agendas through integration of evidence-based analysis of population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality: *"Improved data availability and analysis around population dynamics, RH (including family planning) and gender equality."* The intention was that Government and NGOs and other stakeholders accelerates the national policies and development agenda, through evidence based analysis on population dynamics with a focus on achieving development goals (MDGs/SDGs) and pro-poor growth.

The third outcome of UNSF (Strategic Priority 4, Outcome 3)[41] addresses national statistical systems. As the economy of Myanmar grows in complexity, the Government as the key player in promoting equitable growth and in the provision of social services will need to strengthen data and information management systems.

Consistency with national and sectorial policies:
The P&D component, particularly census, is in line with national policies (e.g. NSDS 2009, NPT Accord, Framework for Economic and Social Reforms (FESR) 2012-2105) and sectoral plan of Ministry of Labour, Immigration, and Population, Myanmar. The component contributed with population data related to population dynamics, health, education and others for developing country's development policies, plans and programmes.

Use of the needs assessments in the program design:
In 2010, UNFPA commissioned an independent assessment of *"Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar",* which served as the baseline for the development of the third country programme. One of the key recommendations of this situational analysis was: "*the need to strengthen data systems and improve availability and quality of data. A population and housing census should be conducted to obtain comprehensive population and demographic data at the national and sub-national levels. Census data should be disaggregated by age, sex and locality and be gender sensitive to reflect the situation of women and men."* CP3 integrated implementation of Census in 2011-2014 plans.

Introducing P&D as a separate programming area:
The P&D component is aimed at contributing to increased data analysis on P&D. Data analysis is primarily centered on Population Dynamics, SRH and Gender. This component of P&D included two parts: i) producing the disaggregated data on population and interrelated sectoral areas; ii) Conduct

[41] UNSF-Myanmar

research and data analysis on population dynamics, SRH and Gender to produce evidence based policy recommendations in each area. However, the program theory (logical framework) for the population and development thematic area is not clear in line with strategic direction and content. Further, the programme is also output focused particularly in relation to integration of population dynamics into development programmes.

4.1.3 Gender Equality-Relevance

Summary findings –Relevance of Gender Equality

The country Program interventions of the gender component, are in line with the principles of UNFPA strategic plan, alignment with international frameworks and linkages to CEDAW and NSPAW being the most notable. Both the national and the field-level activities fit evolving national priorities, regional contexts, and aligned with NSPAW. The interventions are designed to address the needs of the vulnerable groups, women and girls in the camps and national challenges on GBV in the humanitarian setting. It is commendable that vulnerable groups of women and girls are reached particularly in combating GBV in humanitarian setting. These are validated by those interviewed national partners and stakeholders and beneficiaries and found to be highly relevant. It is observed that MOHS identified strategies to respond to GBV in health sector and interventions were well reflected in Five Year Strategic Plan for RH (2014-2018). However, the Maternal and Reproductive Health department expressed the need to build the capacity of the MRH staff to take leadership role in moving the agenda and translating the policy and strategies into action. UNFPA is seen in the strategic position to bring together all the relevant Ministries to act together in moving the GBV agenda on ground.

Gender has been heighted in the third country programme although there was no separate programme on gender equality in CP 2. Gender equality and gender based violence have become a specific component, which is appropriate provided the magnitude of the issues of gender equality and GBV in Myanmar. Although gender equality in disaster and emergency response was not fully considered in the gender equality component of the CPAP (2012-2015), this gained prominenceon the agenda during the realignment and extension up to 2017. In the Integrated Results Framework, CPAP outputs were newly formulated and connected to SP outcomes. Emergency preparedness work was extended and integrated in to the gender equality component (see Annex 5 Programme theory).

UNFPA's planned and supported interventions are well aligned with international and national agendas, policies, plans, and programs regarding gender equality, reproductive rights, gender-based violence and promotion of equal access to basic services. The ICPD and MDGs goals provide the overall context for identifying the results in the development results framework of UNFPA Strategic Plan, gender equality being one of the three defined outcomes. It is commendable that the programme considers and paid attention to the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), the 1995 Beijing Declaration and Platform for Action and contextualization of UNSCR 1325. UNFPA gender component does meet the demands of those agendas. Concrete examples include the UNFPA's pivotal role in the development and support of the National Strategic Plan for the Advancement Women (NSPAW) 2013-2022 and the drafted national law on Protection and Prevention of Violence Against Women Law (PoVAw). UNFPA has been contributing to support the government's compliance with the requirements of CEDAW, international norms and standards of the PoVAw Law.

The interventions implemented by UNFPA address issues at stake in policies and strategies which UNFPA has helped design and develop. Both at the national and regional level, there is a close harmonisation of activities between government policies and UNFPA's policies and strategies. The programmes are planned with government priorities, and the CP's interventions are aligned to the NSPAW areas of 'women and health', 'violence against women', and 'women and emergencies'. National level intervention includes to support GoM to prepare the CEDAW report, help GoM meet the CEDAW recommendations, and support NSPAW interventions. One of the successes includes the capacity building support to the Department of Social Welfare (DSW) in the areas of GBV intervention of NSPAW plan. In line with that, UNFPA's expertise on the GE and GBV is well recognized by the partners and MOHS expects to work closely with UNFPA to respond the GBV in health sector as per the national RH strategic plan 2014-2018.

The field-level activities fit evolving national priorities, regional contexts, and aligned with NSPAW. The three regions where GBV programme is implemented are all susceptible to natural disasters, armed conflicts and communal conflicts, though to different degrees. In relation to scale and coverage, the GBV programme was able to reach all three areas (Rakhine, Kachin and Northern Shan State), where there was outbreak of conflicts during the CP period. It seems relevant given the fact the precarious living conditions in the camps exacerbate GBV issues and makes it more difficult to tackle them with lack of GBV related services under humanitarian settings. Interviews with beneficiaries of two regions (Rakhine and Kachin) – confirmed the relevancy of the UNFPA's interventions to adressing identified, and priority needs of women and girls. At the field level, Women and Girl Centre (WGC) and its available services are highly appreciated. A woman from the camp commented as, "*Only because of the WGC, I've strength to keep alive in this miserable camp setting. I always long for the day I could visit the centre and get relaxed"* .

Based on several initial needs assessment carried out before designing and/or delivering specific training as part of GBV programme, the training provided on GBV awareness raising to the Police, health care providers as well as the involvement of men in GBV, is seen as highly appropriate and relevant. Based on the stakeholders interviews with management and service-level stakeholders at the national and regional level, and site visits to the camps, it has been confirmed that UNFPA's activities to address GBV are closely aligned with priorities of Government of Myanmar and that UNFPA has addressed the GBV cases through the health sector in support of the implementation strategy of the NSPAW and CEDAW recommendations. The programme is found to be very relevant and timely, given the context.

4.1.4 Vulnerability Context – Relevance

In addition to the EQ1 above related to the Relevance, the following specific question is asked under the vulnerability context.

EQ 2: (Alignment) How did UNFPA take into account the country's vulnerability to disasters and emergencies both at the planning and implementing its interventions?

Summary findings –Relevance of Vulnerability Context

Programme cooperation between UNFPA and the Government reflects the Government commitment on human rights and the advocacy work by UNFPA. UNFPA's interventions under the humanitarian

response are highly relevant focusing the support in an integrated manner, laying ground for mainstreaming humanitarian response in the development agenda. The interventions under humanitarian response are gradually being mainstremed as evident by the discussions above (under GE and RH), however, there is room for improvement to ensure the most vulnerable and at risk population have access and utilization of integrated standard core packages of SRHR (FP, antenatal care, delivery including EmOC, post-natal care, post abortion care, STI and HIV and sexual health) & GBV. Overall, UNFPA has taken into consideration the country's vulneability context into the CP3 programme design and implementation.

CPAP clearly outlines the linkages to the UNSF Strategic priority (3) Reduce vulnerability to natural disaster and climate change. In respond to the current changing political context, Kachin state which was not initially included in the CP3 focus areas, was brought into one of the UNFPA focus area to respond to the need of conflict affected population. As a result of its increasing commitment to preparedness, UNFPA Country Office has strengthened the country's capacity to provide services on SRHR and Gender-Based Violence (GBV) via working with IPs. UNFPA supported interventions are in line with the priorities of Government policies on protection of women and girls and in line with UNFPA mandate. UNFPA's interventions in this area have been viewed as relevant by stakeholders, particularly the CO support on addressing key gaps in policy and service provision relating to Women and Girls.

UNFPA and UNHCT Contingency Plan documents mention that CO is responsible for incorporating emergency preparedness into the country programme design and national development frameworks. In particular, CO is responsible for implementing UNFPA minimum preparedness actions (MPAs), developing a contingency plan(s) when necessary. In CP3, it is evident that country's vulnerability to disasters and emergencies are taken into consideration both at planning and implementation – CP output 1 ensure strengthening health system to deliver integrated SRHR in humanitarian settings; Expanding geographical area coverage of UNFPA interventions in Kachin State (armed conflict affected area); the use of indicator 6 (to keep track of national capacity to implement MISP) and indicator 7 to monitor development and implementation of humanitarian contingency plans to address SRHR (including services for survivors of sexual violence).

In preparation for responding to disasters and emergencies, UNFPA Country Office has strengthened the capacity to provide services on SRH and Gender-Based Violence (GBV) via working with IPs. Feedback at the ground level and observation confirms that UNFPA has integrated the humanitarian work in the plans; however, individual programmes ran separately without coordinating well. However, actions have been taken to do better coordination and to mainstream SRH and GBV in both emergency and development setting. UNFPA, as a member of the (IASC), is also committed to the Transformative Agenda, which emphasizes the development of inter-agency preparedness capacities. In line with these principles and with its mandate, UNFPA Country Office, during CP3, has worked in partnership with United Nations agencies, governments, national and international NGOs, and other regional and national entities to enhance the effectiveness of its own interventions and that of overall humanitarian operations within the framework of established United Nations and inter-agency arrangements. UNFPA uses IASC materials and manuals for training the field staff providing humanitarian assistance.

UNFPA plays a key role flagging up sexual reproductive health and rights, women's protection and gender issues during emergency preparedness, acute emergency, chronic humanitarian situations and

transition and recovery phases. UNFPA has played a crucial role in: coordination, capacity building, procurement and distribution, partnership, resource mobilization, and reporting. Support to census has provided the much needed age and sex disaggregated data for planning in disaster and emergency setting. UNFPA represents several clusters (as also mentioned under SRHR and GE sections) to address gaps and strengthen the effectiveness of humanitarian response.

UNFPA response to the recent disasters indicates how the country office considered the country's vulnerability to disasters and emergencies both at the planning and implementing its interventions**.** At the CP3 planning stage, CO has reviewed and followed national strategies and plans for emergency preparedness to ensure that they adequately address the needs of women and their reproductive health at the programme design stage.

At the implementation, the programme focused on building capacity of national partners in the **Minimum Initial Service Package (MISP)** which puts forth a number of essential activities to be put in place to protect the reproductive health and overall well-being of women in emergencies, on providing reproductive health and other life-saving commodities to persons affected by emergencies and in particular, to provide basic necessities to women to protect their dignity during these crises times. The implementation of this is explained under SRH section.

Since there is much overlap in the findings of all focus areas under Relevance, overall summary for the programmatic area is given below.

Overall Summary findings Relevance of all Programmatic Areas
Overall, the current CP is in line with UNSF and consistent with the government priorities, and policies. The CP interventions were found to be relevant to the country priorities and UNFPA strategic priorities. While the relevance is high at policy making level, whether it is fully in line with the IPs felt needs and the expectations of key stakeholders is difficult to confirm. However, the majority of the interventions supported by UNFPA, according to the interviews with end-users and observations on the ground, though not representative of the programme population, indicated relevance to the needs of the end users. Work plans and interventions on the ground show that CP3 covered areas vulnerable to disasters and emergencies. UNFPA has set up sub-offices to operate and oversee the humanitarian work on the ground.

4.2 Answer to evaluation question on Effectiveness

EQ 4: Were the CP's intended outputs and outcomes achieved: if so, to what degree? To what extent did the outputs contribute to the achievement of the outcomes, and what was the degree of achievement of the outcomes? What were the constraining and facilitating factors, and the influence of context on the achievement of results?

Effectiveness is discussed separately under each programme area as each has specific outputs to be achieved during the period under evaluation.

4.2.1 Sexual Reproductive Health and Rights- Effectiveness

Country Office SRHR programme consists of five key components: Family Planning, Maternal Health, Adolescents & Youth, and HIV and AIDS and RH in Humanitarian Context. These components contribute to the Outcome 1: Increased availability and use of integrated sexual and reproductive health

services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access. Two corresponding outputs contribute to the outcome 1. SRHR programme theory is attached (Annex 5.)

Family Planning

Summary Findings – Family Planning
UNFPA country programme has made credible achievement in the area of Family Planning. Country is on-track to meet Myanmar's FP 2020. UNFPA is strategically positioned in coordinating and facilitating policy advocacy role (Co-chair SRH TSG, Co-chair HIV prevention group); procurement and distribution of FP commodities sufficient to cover a quarter of country's need of FP. Continued support is required with greater attention and efforts to improve supply chain management system. UNFPA's comparative advantage of promoting SRH rights in the area of FP is well recognized among the partners. RHCLS, the first real-time supply monitoring system is in place and currently operational in 30 townships. However, irregularities of stock replenishment and addressing stock imbalances still remain as major challenges and need to be addressed.

UNFPA country programme has made credible achievement in the area of Family Planning. Country is on-track to meet Myanmar's FP 2020[42]. CO has achieved the outcome indicator 1, to raise the modern CPR to 50 percent by 2015. Reference to outcome indicator 2 target "80percent of public service delivery points have no stock-outs", achievement at the time of evaluation is 35 percent[43]. This indicates continued support is required with greater attention and efforts to improve supply chain management system.

UNFPA's training programme for basic health staff contributed to the increasing number of health facilities providing family planning services. As per Health Facility Assessment in 2015, 87 percent of tertiary facilities, 53 percent of HFs in secondary level and 75 percent of primary level facilities has trained staff to provide Family Planning. However, number of staff trained on long acting reversible contraceptive (LARC) is still limited. Only 17 percent of health facilities has trained staff on implants with significant difference between urban and rural areas (47percent vs.11percent)[44]. In 2016, 50 Medical doctors from 39 townships were trained on implants[45].

As part of the health system strengthening, UNFPA together with JSI and other development partners worked with MOHS to improve procurement planning, forecasting, quantification and distribution to ensure uninterrupted supplies of RH commodities. These activities led to increased availability of RH commodities at service delivery points. 84 percent of all primary health facilities could provide at least three modern contraceptive methods. However, regional variations are observed among the different regions where Rakhine, Kayin and Kayah areas were identified that required more attention[46].

[42] FP 2020 targets: To increase CPR from 41% to 50% by 2015 and over 60 % by 2020; Reduce unmet need to less than 10% by 2015 (currently 12%); Increase demand satisfaction from 67% to 80% by 2015; and Improve method mix with increased use of LAPMs (long acting permanent methods) and decentralization to the districts

[43] Health Facility Assessment for RHCS 2015
[44] Health Facility Assessment for Reproductive Health Commodities and Services 2015
[45] CO Progress report data
[46] Health Facility Assessment for Reproductive Health Commodities and Services 2015

UNFPA supports MOHS in development and implementation of Reproductive Health Commodity Logistic Information System (RHCLS) - 1st automation supply chain real-time monitoring system. RHCLS is currently operating in 30 townships of 4 states and regions -Ayarwaddy, Mandalay, Southern Shan and Mandalay and rapidly expanding. The system allows keeping track of 35 RH commodities and supplies.

RHCLS is well appreciated by the Ministry of Health and Sports as it allows the project managers and stakeholders to keep track of the stock status at township level, rural health center and sub- rural health center level and alerts to re-allocate supplies to minimize the stock-outs at the health facilities. However, irregularities of stock replenishment and addressing stock imbalances still remain as major challenges and need to be addressed. Based on the discussions with key stakeholders, the presence of other players in country with the mandate and interests to strengthen the procurement and supply chain management system in Myanmar is seen as good opportunities for UNFPA to expand the partnership and exchange technical knowhow of current RHCLS and continue support the Ministry of Health and Sports for advancement of more comprehensive harmonized supply chain management system. Interviews and discussions confirm that UNFPA's comparative advantage of promoting SRH rights in the area of FP is well recognized among the partners. Detail findings and discussions of FP and RHCLS are described in Annex 7: SRHR Findings- Effectiveness.

Maternal Health

Summary Findings – Maternal Health

Myanmar is still short of meeting its target to achieve 70% of deliveries attended by SBA. Availability of emergency obstetric care is very much limited and needs to be addressed urgently. Pre-service midwifery training and in-service trainings on PCPNC, QRH and BEmOC training have strengthened the skills of midwives to provide essential maternal and newborn care services. However, the skills and scope of life-saving midwifery practices is limited to four signal functions whereas ASEAN WHO standards allow midwives to conduct all seven signal functions. The role and functionality of Station Hospitals and Township Hospitals to provide CEmoNC become much more critical and fundamental to save lives of pregnant women in rural areas.

3rd Country programme of maternal health programme focus on strengthening midwifery; capacity building of basic health staff to provide quality services on antenatal, delivery and post-natal maternal and newborn care; strengthening emergency obstetric care by training, procurement and distribution medicines and supplies including life-saving maternal drugs, essential reproductive health care kits, clean delivery kits;and establishment of maternal death surveillance system.

UNFPA targets to contribute to increase deliveries attended by SBA to 70 percent by the end of the country programme. At the time of evaluation, the percentage of deliveries attended by skilled health personnel is still short to meet the target[47]. Detail description of the indicators and achievement are described in Annex 7: SRHR Achievement - Outcome and Output Indicators.

[47] DHS 2015

UNFPA's flagship programme to strengthen Midwifery skills and competencies has been well known among the MOHS and implementing partners and its contribution in line with the Government initiatives of Human Resource development plan was well praised in Myanmar.

UNFPA supported Department of Medical Science/Department of Health Professional Resource Development and Management (DHPRDM) to conduct Training of Trainers sessions for instructors and faculty members from 22 out of 46 MW training schools. UNFPA's coordination and partnership with JHPIEGO in pre-service midwifery training has created synergy to enhance the teaching-learning skills in the midwifery schools and most respondents in the interviews appreciate the support they received. To enhance the clinical skills of tutors and faculty members, four months hands-on training was conducted in Central Women Hospital and North Okkalapa Teaching Hospital. During the time of evaluation, 324 (75 percent of all faculty members in country) have attended Training of Trainer course on BEmOC and ENC and 192 completed four months hands-on training course.

The importance and the value of above trainings were well recognized and appreciated by all the faculty members in the Midwifery schools visited by the evaluation team. A faculty member in one of the nursing and midwifery school said *"Not having much practical clinical experience in dealing with emergency obstetric care, I was not quite confident in teaching the students. Now, I'm really happy that I can pass on my knowledge and skills to the students. It makes a lot of difference".*

Faculty members expressed the need to re-new the commitments from the Teaching Hospitals to ensure all hands-on trainings are conducted with standard quality and compulsory clinical skills acquired. One Tutor said *"It was unfortunate! Most of us ended up with doing other things and not getting the chance to do the examination of the pregnant women, antenatal care, particularly missing to attend the deliveries".*

ASEAN Regional Guideline for minimum requirements for Training and Accreditation of Skilled Birth Attendants (SBA) is one of the achievements of UNFPA's collaboration with ASEAN to promote the maternal health of women in the ASEAN Member States. This has led to the development of National Midwifery Standards in Myanmar in 2016, however, Myanmar standards is still short to meet ASEAN WHO standards which allow midwives to conduct seven signal functions of BEmONC[48].

UNFPA's effort to leverage technical resources from JHPIEGO and financial resources from World Bank has increased programme efficiency and secured the nationwide in-service training for midwives. Evidence showed that in-service trainings on PCPNC, QRH and BEmOC training have strengthened the skills of midwives to provide essential maternal and newborn care services.
Midwives in health facilities appreciate the training they have received. A trained midwife echoed the voice of many others: "*The training has refreshed my knowledge on the antennal, delivery, and post-natal care of mothers and babies. On top of that, I now see the value of using partograph as it helps us to immediately identify the need for emergency care and referral. I always use it. We can save lives*". *"Before, I did not use oxytocin. Now, I use oxytocin to manage third stage of labour. It helps*."

[48] Seven signal functions of BEmONC includes: (1) administering antibiotics, (2) uterotonic drugs (oxytocin) and (3) anticonvulsants (magnesium sulphate); (4) performing assisted vaginal delivery; (5) manual removal of placenta; (6) removal of retained products following miscarriage or abortion; and (7) basic neonatal resuscitation care

In 2015, a significant reduction of the availability of two life-saving drugs (MgSO4 and Oxytocin) is observed in all level of health facilities (from 62 percent in 2014 to 49 percent in 2015)[49]. In the second year of GPRHCS, UNFPA procurements started to limit to the contraceptives and agreement was done with the MOHS to take over the procurement of life-saving maternal medicines.

Maternal Death Surveillance and Response (MDSR) is a good example of UN collaboration and moving the agenda in the country at national level. MDSR is one of the key interventions for reducing maternal mortalities that has been promoted by WHO[50]. The functionality of MDSR is expected to start by the end of 2016 and too soon to assess the programme achievement.

Despite all the good initiatives done by UNFPA and partners, ***availability of emergency obstetric care is very much limited and needs to be addressed urgently***. Only 60 percent of RHCs can offer four out of seven signal functions; and only 41 percent of Station Hospitals and 78 percent of Township Hospitals can provide standard CEmONC[51]. In such situation, to save lives of pregnant women especially in rural areas, the role and functionality of Station Hospitals and Township Hospitals to provide CEmoNC become much more critical and fundamental.

Facilitating factors: UNFPA is in the strategic position for the advancement of agenda with the Ministry of Health and Sports and other partners. UNFPA's strategic partnership with WB and JHPIEGO leveraged technical and financial resources to secure completion of nationwide in-service training for midwives.

Hindering factors: Interrupted availability of maternal life-saving drugs; insufficient number of skilled personnel to provide full package of emergency obstetric care; inadequate infrastructure and limited medical facilities with less than half of station hospitals providing full emergency obstetric care package are limiting the women to access to emergency obstetric care services.

Sexual Reproductive Health in Humanitarian context

Summary Findings – SRH in Humanitarian context

UNFPA's support and inputs led to build the capacity in four states and regions to implement MISP at the onset of a crisis and Humanitarian contingency plans developed by the Ministry of Health and Sports and UN HCT includes elements to address sexual and reproductive health needs of women, adolescents and youth including services for survivors of sexual violence in crises. GBV and SRH are implemented in a vertical fashion. UNFPA is in unique position to close the gap and facilitate between MOH and DSW to integrate GBV programme in health sector. Services on STI, HIV prevention, SRHR including ARH are still very limited. Referral system is established for the IDP camps with clear guidelines and arrangements to transfer the patient to the District/ Township hospitals whereas in the non-IDP villages there is no proper/standard referral system established to transfer the patients/ pregnant women to higher level health facilities. Human resource constraints and rapid staff turn-over of staff caused inadequate

[49] Health Facility Assessment for reproductive Health Commodities and Services 2015

[50] World Health Organization, UNICEF, UNFPA, World Bank, United Nations Population Division. Trends in Maternal Mortality: 1990 to 2015. Geneva:WHO2015
www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/

[51] Nation-wide services availability and readiness assessment (SARA 2015).

institutional capacity of RRTs to address related reproductive health needs in humanitarian settings.

SRH in Humanitarian context includes capacity building of States and Regions to implement MISP at the onset of crisis; development of humanitarian contingency plans that reflects the elements of sexual and reproductive health needs of women, adolescents and youth including services for survivors of sexual violence in crises; procurement of Reproductive Health Commodity and Emergency Reproductive Health Kits and delivery of services through IPs.

UNFPA has established a good relationship with implementing partners in response to the emergency situations. UNFPA's physical presence in the emergency prone areas was appreciated by the State Public Health Department and other implementing partners. Its technical support especially on GBV and SRH is well acknowledged on ground. However, GBV and SRH are implemented in a vertical fashion. As one of the collective efforts with WHO, major achievement is the establishment of SRH subgroup that serves as a venue for the technical forum on SRH issues in emergencies.

UNFPA supports capacity building and formation of Rapid Response Teams in 4 selected States and Regions, MISP training of RRT teams, prepositioning of ERH kits in MOHS warehouse in Yangon and training of UNFPA partners on clinical management of rape survivors.

First respondents: Magway floods

Natural disaster response projects are implemented in Magway, Saggine, Rakhine and Chin and Conflict response projects are implemented in Rakhine, Kachin and Shan. UNFPA works with MMA, MNMA, MSI and MRCS to implement SRH implementation in humanitarian context.

Delivering services through IPs, via mobile and static clinics, clearly address the equity issues and promoting access to essential reproductive health care for those people in hard to reach area and those living in the humanitarian context. Services are provided under extreme challenges in terms of geographical accessibility, safety, security and political hardship situation.

Quality of care to deliver five core elements of RH[52] has been a challenge in emergency settings. The Services provided by the implementing partners are more focus on the education, pregnancy care and short term family planning methods whereas STI, RTI and HIV/AIDS prevention were not usually provided. Patients are being referred to hospital for delivery, postpartum and newborn care services. Clinical medical facilities in RHCs and untimely arrival of medical supplies, test kits and family planning commodities confine the IPs to deliver the full package of essential RH interventions. Geographical accessibility to hospitals that can provide all seven signal functions of life-saving maternal and newborn health (BEmONC) and comprehensive life-saving functions (CEmONC) constrained timely accessibility and utilization of obstetric emergency services. Referral system is established for the IDP camps with clear guidelines and arrangements to transfer the patient to the District/ Township hospitals whereas in the

[52] Five core elements of RH includes: (1) FP; (2) pregnancy, delivery, postpartum & newborn care; (3) prevention of unsafe abortion and post abortion care; (4) RTI, STI and HIV&AIDS (5) SRHR including ARH

non-IDP villages there is no proper/standard referral system established to transfer the patients/ pregnant women to higher level health facilities.

MMA established a referral mechanism to promote women's access to emergency obstetric care. Whereas MNMA also provides health education, antenatal care and training of TBAs as community health promotors. MNMA interventions lack of establishing community support to functioning referral system in the villages which is the most critical intervention to save lives of women who needs emergency obstetric care during the delivery, child birth and post-partum services.

Most of the targets planned by the IPs were achieved in 2015 except for two critical interventions to reduce maternal mortality - referral (7 percent) and women's access to family planning services (14percent)[53].

UNFPA's collaboration with donors to boost the skills of midwives and deployment of midwives in hard to reach areas in Mon, Kayah, Shan, Chin and Ayeyawady and Rakhine has made increasing access to SRH services. In addition, 40 pre-service MWs were trained and deployed to areas in need, in partnership with the Myanmar Nurse and Midwife Association, Department of Medical Science and the Department of Health. This modality solved the issue of human resource gap to some extent.

MRCS provides training on MISP, coordinate RRT in states and regions and distribute Dignity kits, clean delivery kits and RH kits. More than 1010 IPs and health providers were trained on MISP. Though implementing partners were trained on MISP, it seems the application of MISP principle is lacking in development of project strategies leading to inadequate service delivery package and failure to meet the five MISP objectives[54]. Running parallel as independent programmes, there is not enough consultations and joint planning done between gender and SRH programme to address GBV in SRH interventions. This is a missed opportunity to implement/mainstream GBV in SRH projects delivered by IPs. However, plans are in place to mainstream both programmes in emergency and development setting. UNFPA's comparative advantage in leading gender and SRHR is seen as unique to close the gap by facilitating between MOHS and DSWRR to advance GBV agenda in health sector response.

Facilitating factors: Technical coordination in GBV sector and SRH sector, good relationship with the State Health Directors and other implementing partners have facilitated some of the achievements of RH in humanitarian context.

Constraining factors: Safety and security of staff and political hardship situation on top of physical geographical accessibility (road infrastructure and transportation) are preventing availability and accessibility of services in humanitarian context. Limited availability of physical space, limited clinical medical facilities in RHCs and untimely arrival of medical supplies, test kits and family planning commodities confine the IPs to deliver the full package of essential RH interventions. Delay funds transfer and delay arrival of drugs and commodities to IPs lead to delay implementation of projects on

[53] Annex 7 SRHR Findings- Effectiveness Source: UNFPA Country office annual review meeting 2015

[54] Five MISP objectives: *Identify lead agency to coordinate; prevent and manage consequence of sexual violence; reduce transmission of HIV; prevent maternal and infant mortality; plan for comprehensive integrated RH services in PHC level*.

ground. Human resource constraints and rapid staff turn-over of staff caused inadequate institutional capacity to address related reproductive health needs in humanitarian settings. In some regions, it was found that more than 3 trained RRT members were transferred out or promoted to other places within one year period.

Detail description of the indicators and achievement are described in Annex 7: SRHR Achievement - Outcome and Output Indicators.

Adolescents and Youth

Summary Findings – Adolescents and Youth

UNFPA work on development of policy documents, protocols and standards of delivering SRH/ARH services is commendable. Youth policy development is under process with greater participation of young people from different sectors. Pieces of good work in BCC and media programmes implemented by partners are constrained to continue because of limited resources. Use of new technology and innovation "mobile App" is promising to reach out adolescents and youth at scale. A wide range of advocacy, greater involvement and participation from different stakeholders will advance wide scale implementation of community based and school based CSE programme.

UNFPA work on development of policies and strategies related to adolescent and young people is commendable. Youth policy development is under process with greater participation of young people from different sectors. Policy documents, protocols and standards of delivering SRH/ARH services available and in use by implementing partners - National Strategic Plan for young people's health (2016-2020); National Service Standards and Guidelines on Adolescent and Youth Health Care; AYFHS Manual for BHS; and National Youth Policy development process in place.

National Strategic Plan for young people's health (2016-2020) clearly outlines the seven strategic priority areas and corresponding program objectives and goals; and the strategies to achieve the goal. The strategic plan reflects the programmatic indicators to keep track of the progress of implementation but it lacks the costing and budget which could be used for resource mobilization for programme implementation.

UNFPA implements behavioral change communication and ARH service provision in partnership with Central Health Education Bureau (CHEB)/ Health Education Division(HED), MMCWA, MSI, MMA, AFXB, Consultancy and Carrier Development Firm (CCDF), and Positive Action group with different implementation models. The work of partners focus on the behavioural change communication around sexual reproductive health, HIV and STI prevention, and prevention of gender based violence.

Despite all the efforts, adolescent interventions are small scale and time limited because of inadequate financial resources and limited capacity of human resource. Number of functioning youth information centers has reduced from 71 to 21 centers in 9 states and regions. YIC Assessment conducted in 2015 captured issues related to the functionality, sustainability and management and implementation

arrangement of YICs[55] and lessons learned should be used to address the adolescent strategies in next CP. UNFPA may need to review the implementation arrangement with partners to make the programme to be more cost effective and sustainable in local context.

Pieces of good work in behavioural change communication and media programmes are implemented by partners. However, inadequate resources do not allow to continue the good work that partners have done before. For example. MMA radio programme "Youth Garden" aired twice a week through Shwe FM radio was appreciated by young people.

SRH mobile App "Love question – life answer", a product of UNFPA innovation and use of new technology allows adolescents and youth to access wide range of information including FP, RH, STI and HIV, GBV without violation of their privacy. The programme was developed in full participation of adolescents and youth and launched in 2016.

Eighteen year old university student from Yangon also likes the privacy aspect of the app: "*We do not want to discuss our physical development and all our emotions, not even with our parents. Among friends we can talk, but it is usually a dead-end road. We want information about many things, but it is difficult to find it on the internet or on Facebook. Now, for the first time, it is all available in one place."*

Evidence of joint programming with other UN agencies, and line Ministries to advance the CSE agenda has been minimal. UNFPA has shown its advocacy work and enhanced partnership with WHO and MOHS in development of AYFHS manual. However, establishment of community based and school based CSE programme required wide range of advocacy, greater involvement and participation from different stakeholders. Recent initiatives on revitalization of H6 partnership (WHO, UNICEF, UNFPA, UNAIDS, World Bank) and the interest of MOHS to advance the adolescent agenda and revitalization of school health teams are good opportunities for UNFPA and partners to advance CSE agenda in reaching out adolescent at scale.

Facilitating factors: Global initiatives and agenda to advance adolescents and youth, available policy and strategies to address adolescents and youth's need in SRH, gender and HIV; and technical support and guidance from UNFPA regional office have made a progress of adolescent and youth programme.

Constraints: Inadequate financial resources to institute and expand youth programme; limited capacity of human resources; inadequate number of teachers competent to conduct life skills and sexuality education; high turn-over of trained youth peer educators affect the quality and sustainability of the adolescent programme. In addition, lack of accurate data on the adolescent knowledge about the contraceptive methods (especially in case of unmarried adolescents); their knowledge on drug use and abuse, alcohol and tobacco are constraining factors to advance the agenda.
Detail description of the indicators and achievement are described in Annex7 : SRHR Achievement - Outcome and Output Indicators.

[55] Situation Analysis on Youth Information Corners 2015

HIV and AIDS

Summary Findings – HIV and AIDS

UNFPA is seen and acknowledged by the National AIDS Programme as long-term partner in prevention of sexual transmission of HIV and PMTCT. UNFPA holds strategic position - Co-chair of sexual transmission group. A stronger leadership role, adequate technical support with greater coordination and facilitation is expected by partners. Considering the UNFPA's comparative advantage in promoting rights for SRH, UNFPA should consider *to mainstream HIV & SRH in protection of women's rights; advocating for reducing stigma and discrimination*; *creating enabling environment to protect SRH rights of young people & the most vulnerable and marginalized*.

UNFPA is seen and acknowledged by the National AIDS Programme as long-term partner in prevention of sexual transmission of HIV and PMTCT.

During the first half of CO, UNFPA HIV programme focused on the CCP and PMTCT in 34 townships. In line with that, UNFPA procured condoms, STI tests and HIV tests to ensure MARPs have access to condoms, HIV counseling and testing, STI diagnosis and treatment in both public and private sectors. Activities were implemented through the National AIDS Programme, Population Services International (PSI) and Myanmar AntiNarcotics Association (MANA), Alliance, Pyi Gyi Khin (PGK) and Myanmar health Development Group (MHDC)/Aye Myanmar Association (AMA). The interventions include: Peer education among MARPs; condom distribution; health education through IEC materials; and referral to other services.

PSI operates "TOPs" Targeted Outreach Programme and 17 drop-in centers across Myanmar. TOP was supported by UNFPA and other partners such as USAID, Global Fund and other partners. In 2013-2014, UNFPA partially contributed to following TOP achievements: 14 million condoms distributed; 92,000 HIV tests done; 8000 cases of HIV identified for treatment; 10400 cases treated for STIs[56]. With support from UNFPA, more than 1.14 million male condoms, nearly 7000 female condoms (in 2013); 817,000 condoms (in 2014) and 3.8 million male condoms (in 2015) were distributed[57].

PMTCT programme achieved beyond its target. Pregnant women who received voluntary HIV counseling and testing has increased from 20 percent in 2012 to 36 percent (vs target 30 percent) in 2013 and 52 percent (vs target 40 percent) in 2014. After the realignment exercise done in 2014, the indicator has changed from percentage to numbers and it was recorded 74,980 pregnant women tested HIV (vs. its target 70,000) in PMTCT programme.

When the CO shifted its focus to policy and CD, UNFPA used UNFPA used the implementation of GF to exit its support to the National AIDS Programme and discontinued to support IPs in CCP implementation. UNFPA continued its direct service delivery model to CSOs led by FSWs and. It is observed that the number of MSM and FSWs reached by HIV prevention programme has declined by year (2013, 2014 & 2015) and the same pattern is seen in HIV tests coverage among them[58]. As

[56] UNFPA in Myanmar 2013 & 2014

[57] UNFPA Myanmar annual report 2013, 2014 and 2015

[58] Data Source: Annual Programme Review Meetings 2013, 2014 and 2015

mentioned above, the main reason for this decline is the discontinuation of support service provision on public sector under GF management.

To be in line with the UNFPA SP 2014, the strategic shift and realignment exercise was done in 2014 and CP output indicators to address HIV programme achievements were re-aligned accordingly under the new output 1 and new output 2. Detail description of the indicators and achievement are described in Annex 7: SRHR Achievement - Outcome and Output Indicators.

2015-2016 UNFPA HIV programme shifted its strategy to focus more on the policy advocacy work in development of guidelines; facilitate regional and sub-national level coordination meetings; and empower community based sex workers led organization.

In line with UNFPA SP 2014, UNFPA provides secretariat support to "sexual transmission prevention TWG" among four coordination TWGs: Treatment, PMTCT, M&E and prevention. UNFPA is responsible to organize quarterly meetings with full participation from wide range of partners; help raise issues that need to be addressed to Technical and Strategy Group (TSG) chair by Director, Disease Control and vice chair by the NAP Manger. The process need to be follow through. Close follow up, better coordination and technical leadership is expected to ensure relevant issues are addressed with full participation and involvement from a wide range of partners. Discussion and interviews revealed that a stronger leadership role and adequate technical support from UNFPA is expected by partners in the area of prevention especially to address the issues of adolescents and young people. UNFPA is in a unique position to serve as bridging agency between NAP and CBOs.

Technical support or South-South-Cooperation should lead to build the decentralization and technical leadership competencies of central and regional level to advance rights based programme planning and monitoring; reducing stigma and discrimination. Organizational performance and technical capacity assessment was conducted for sex workers led partner organizations. Organizational capacity development training and peer education training were conducted for PGK/SWIM/Alliance/AMA. Series of coordination meetings –- ***were*** conducted[59] but it is difficult to assess how these meetings outputs and the outcome are linked to relevant programme achievement.

4.2.2 Population and Development-Effectiveness

Summary of Findings: UNFPA country office has worked effectively to achieve the objective of population and development outputs of 3rd country programme (2012-2016). A biggest success of the UNFPA during this country program is the completion and dissemination of census data in line with international standard. Due to extensive census operation, UNFPA has contributed significantly in building the capacity of DoP in data processing and analyses. Also high quality technical advice provided by UNFPA has a positive impact on quality of the product produced and attitudinal changes of the DoP staff in understanding the importance of data use and generation to guide decision making.
Census data is used substantially for the development of plans and programmes. The age and sex disaggregated data are been used by line ministries as baseline data for socio-economic indicators

[59] Regional Level Coordination meeting PMCT (Yangon), Coordination meeting on RH-HIV-TB (Pyinmana), Coordination Meeting on CCP(Yangon).

(Ministry of Health and Sports, Education, Humanitarian field and Planning). Census enumeration blocks provided the credible basis to generate a sampling frame which has been a basis for sample surveys data collection, such as Myanmar Ddemographic Health Survey (MDHS), LFS and Drug Use Survey. Pilot Census was conducted for the first time in the history of census in Myanmar and served as the critical approach to census quality. Conflict Sensitivity is a unique feature of the CO in implementing the census. CO engaged a team to assess the conflict sensitivity during and after the census process – it had mitigated risks and the ensured the smooth implementation. Evaluation team also reviewed the two other evaluations[60] of census data and found that quality of census data is good. Thematic reports adds value to the future analysis and evidence based planning using current national data .

During March-April 2014, Myanmar successfully conducted its 3rd Population and Housing Census. The enumeration was a success in most areas of the country and met international standards. The response to and the participation of the community in the census process were largely positive and enthusiastic, contributing to make the 2014 census a success. Further, census coverage was very high with almost 98 percent of the population counted during the census. Integration of conflict sensitivity approach from the onset of the census operation to the dissemination of the results improves the acceptability of the census results at wider level.

Addressing the limited National Institutional Capacity for census implementation: Earlier, the institutional capacity of DoP to conduct census was weak. In 2014, The World Bank has developed the overall statistical capacity scores[61] for all countries around the world. The overall score for Myanmar to produce reliable and accurate data was low, scoring 47 on a scale of 0 to 100. The average score for developing countries in East Asia and the Pacific was 72.3.[62]

The Department of Population (DoP) under the Ministry of Labour, Immigration and Population (MoLIP) holds responsibility for the population census. However, after 30 years without a census DoP Institutional memory on census methodology virtually disappeared, and the actual capacity to conduct one had to be rebuilt in a way that integrated new technologies, methods and standards presently available for data collection, processing and dissemination. During the census process, UNFPA made intensive use of dialogue with government authorities and non-state armed groups, particularly to ensure compliance with international census recommendation (with inclusiveness of the entire population a key issue).

Computer lab facilities at DoP

With the support of UNFPA, DoP has sufficient technical capacity to implement the census with established computer labs with latest data processing software and GIS applications. State of the art computer lab, data processing machine were provided and extensive capacity building interventions in census implementation were implemented. Several staff members has attained trainings on data processing, data analysis and demographic research. With these high level technical capacity building, first preliminary

[60] UNFPA (2014), Census Observation Mission report, 2014 Population and Housing Census, Repbulic of the Union of Myanmar and Evaluation of UNPFA suppot to population and housing census data to inform decision-making and policy formulation 2005-2014: Myanmar Country Report, 2016

[61] The Statistical Capacity Indicator (SCI)-World Bank

[62] In 2016, the Statistical capacity indicators is 57, which shows a remarkable progress in two years.

census results have been published about in six months after the implementation. Several stakeholders rated this census as good quality compared to the earlier censuses.

UNFPA support was also essential in developing the entire census cartography infrastructure (GIS was introduced at the DoP in a second stage). This occurred in a context where full coverage of the Myanmar territory was technically difficult given the absence of administrative borders at village level within which to draw enumeration area maps. Also there is a shortage of staff in immigration department to draw village boundaries and with current human resources the mapping exercise is very difficult and consequently enumerator faced some of the issues is area selection. Evaluation findings also revealed that enumeration area maps was still created manually at township level. On one hand this exercise was very cumbersome with low human resources. While on the other hand, because of human error, identification of the enumeration block is difficulty for the enumerators.

Across the board, It is widely appreciated the role and supported provided by UNFPA in organizational and logistic support. With support of UNFPA, DoP has established appropriate structure for the organization and supervision of the census operation throughout the country. Moreover, and adequate and creative system to pay field staff despite poorly developed banking system was also put in place by UNFPA with support of DoP/MoIP.

Creating Enabling environment for census

UNFPA took the lead and was a key player in pooling funds from donors to implement the 2014 census. Because of the fact that Myanmar has very challenging political/ethnic and religious diverse context, the implementation of census was very challenging. To mitigate the risk, UNFPA adopts the following approaches:[63]

Positioning the census: UNFPA has extensively involved in dialogue with government for the implementation of census and created an environment conducive to the census, when the country office representatives held discussion with Myanmar national authorities. Government of Myanmar and UNFPA has agreed on the different modalities for the census including relevant legal basis for the census.

Resource mobilization: UNFPA played a leading role in mobilizing the external resources for the census. UNFPA has also contributed by providing a permanent resident Chief Technical Advisor and mobilizing a significant amount of resources from donors group. To ensure the donor compliance, UNFPA created pool fund and maintained accordingly. UNFPA was also instrumental in generating trust in the census financial management structure required by donors, thus allowing that funds were sufficient and disbursed in a timely manner.

Governance mechanisms: UNFPA established the International Technical Advisory Board (ITAB) and National advisory committee and civil society engagement (NAC) forum on the census operation to ensure the quality and to maintain the international census standards as well as to solicit advice on the census operation and any other logistic, management, political issues that may arise from the field.

[63] This section is primarily adopted from the evaluation studies of the census, conducted by the UNFPA HQ evaluation office in Feb 2016.

UNFPA also held Donor Coordination meetings with representative of donor agencies and these meetings have been recognized as a mechanism to discuss relevant issues and report back to donor on implementation progress and financial expenditure.

A country wide outreach campaign: On the onset of the census, UNFPA recognized very timely the political and ethnic diversity situation of the country. Consequently, country office in collaboration with Govt. of Myanmar authorities launched a massive awareness raising campaign (including media campaign, community awareness and community dialogue at township level) to inform the community of the purpose and scope of the census. These interventions created more harmony and acceptance in the community about the census and build trust on the government. Further, UNFPA has adopted conflict sensitive approach to mitigate the risk during the census operation, before and after the dissemination of the census results. A team of professional communication experts were also involved to develop and edited the publication which have more sensitive to the local cultural and addressed ground realities.

An Independent observation of census enumeration: To assess the quality of the census data operation, the organization of an independent census observation mission additionally contributed to raise the confidence of many stakeholders in the enumeration process, which was also important for the census data quality. The observation mission was praised among UN, donor group and Government.

Use of census data in the evidence-based plan, policies and programmes

The use of the census data for the development of plans, programmes and policies appears to be very good (expressed in the majority of interviews by stakeholders) by policy makers and civil society organization. The age and sex data have reportedly been used already by line ministries as baseline data for socio-economic indicators (Ministry of Health and Sports, Education and Planning). Evaluation team has been observed that township public health department has used the census report for their planning and validation purposes. Moreover, Ministry of Social Welfare, Relief and Resettlement recently produced the report titled "Gender Equality and Women's rights in Myanmar: A situational analysis" with the assistance from ADB and several UN agencies including UNFPA and UN Women. The report used the census data extensively in the analysis and acknowledge the availability of the quality disaggregated data by several background characteristics.

Many line ministries praised that the availability of the census data in excel files seemed to be very useful and handy. Central Statistic Organization has developed central database based on the census and other datasets in the country (MMSIS). Ministry of Planning has also used population dynamics and population projections in the development of next 5-year development plan and 2030 SDGs agenda. Census data on disability is also used to formulate the disability policy in 2016.

Two prominent examples are worth mentioning here. The Ministry of Health and Sports has used the Myanmar Population and Housing Census 2014 sampling frame for the first Demographic and Health survey 2015-16 conducted with the assistance of USAID. Further, sampling frame of census 2014 was also used in the Labor Force Survey 2016 conducted with the assistance of the International Labor Organization and UNDP. UNICEF also has used the sampling frame for the situation analysis of children with disabilities and for other thematic studies related to the children. Evaluation team also noted that the

census sampling frame will soon be used in the Integrated Household living condition survey (IHLCS-3) conducted by the Ministry of National planning and Economic Development in collaboration with UNDP and The World Bank. Moreover, UNODC has used the census sampling frame for first National Drug Use survey implemented in early 2016.

The main census results were published in May 2015, providing much-needed evidence-based data for planners and policymakers to formulate, implement, monitor and evaluate development programmes and policies. The country office in collaboration with DoP planned to conduct 13 in-depth thematic reports on key areas such as fertility, mortality, maternal, migration, disability, population projections, gender, housing conditions and assets, youth, and elderly. At the time of the evaluation, three thematic reports had been published (fertility, mortality and maternal mortality) and others were being generated. Though, these thematic reports are of great significance, the evaluation team noted (responses from UN agencies, policy makers and civil society) that these reports are too technical for the non-technical audience to understand. It is suggested that two pager brief in simple and non-technical language would be highly effective for policy advocacy.

As the post-enumeration survey was not implemented and census results is not provided a level of confidence when utilizing the data, and to explain errors in the census results. It is imperative to conduct demographic analysis for census results to offer the reader's a sense of the effectiveness of the results. Demographic Analysis offers a powerful methodology for evaluation the quality of a census results and are encouraged to use demographic analysis as part of their overall census evaluation methodology. Please find more in-depth analysis in the annexes.

Capacity building on research, evidence generation and integration of population dynamics in development plans.

Several trainings for government officials (from DoP, CSO and FERD) were arranged by UNFPA. According to some evidences, there were positive changes in the staff understanding regarding population issues, and to some extent the understanding of the statistical methods in social sciences. Staff at DoP has good practical experience in data processing software (CSPro). The pre and post training capacity assessment was not done, and it is not clear to what degree the training curriculum is tailored to the needs or merely replicated. Follow-up to these trainings programmes should be continue and systematic impact assessment mechanism would be advantageous for the effectiveness of those capacity buildings interventions, which is currently missing in the programme.

Additionally, it is imperative to generate the research and evidence on emerging population issues and assessment of the integration of population dynamics into development plans and policies. Results of the evaluation revealed that there is little evidence to produce by the public institutions and weak national capacity to integrate the population dynamics into development programmes.

UNFPA supported the organization of an international census observation mission[64], which was useful to assess the level of compliance of data collection process with census rules, definitions and principles, as well as together valuable lesson learned for the future censuses. Overall, the findings of the mission

[64] Census Observation Mission Report – 2014 Population and Housing Census. May 2014

shows that data collection in the selected areas was good. The mission highly acknowledge that data collection exercise was good –from publicity and advocacy campaign to the dedication of the census personal and the positive attitude of the respondents to the logistical organization and financial management. Evaluation findings revealed that the trainings period of enumerators was very short (3 to 5 days) and in many instance, enumerators had not completely understood the essence of the questions to be asked. This is understandable because almost one generation has had no familiarity with the census (last census was held in 1984) and beyond the UNFPA control.

Establishment of an integrated and harmonized data-base to monitor ICPD and MDGs indicators.

With the support of UNFPA, DoP plan to carry out systematic work on the establishment of an integrated and harmonized database to monitor the ICPD and MDGs indicators. Assessment of the numerous documents revealed that three thematic reports and pre-defined tables from census on several indicators have been published. These documents has its own significance but not serve the essence of the database, which should aim to generate several indicators from the micro-level census and other survey data. The ideal database should be a combination of census and other survey data (MDHS, LFS etc) to generate the indicators related to the ICPD and MDGs.

Demographic Analysis of the Census Data and Results:

Observations on Census Results: The intention of this analysis is not to evaluate the thematic reports published based on census data nor evaluate the micro level census data of Myanmar to assess the content and/or coverage error. However it is imperative to do first hand demographic analysis to assess if there is any distortion in the indicators of fertility and morality in context of demographic transition model. The rationale of this secondary analysis of the 2014 Myanmar census data is twofold. First, several evidences have been suggested that to some extent the errors observed in the census data. For instance, census observation mission-2014 report concluded that training of the enumerators were short and this leads to inability or misunderstanding of the specific questions.

The evaluation team also noted that from the mortality thematic report based on the recent census data, the difference between female and male life expectancy at birth is very wide (about nine years in 2014: 69.3 for female and 60.2 for male). Given the context of demographic transition in Myanmar, the gender gap in life expectancy at birth and the results of infant and child mortality were considered very high (Infant and child mortality rate 62 and 72, respectively). Further, the level of infant and child mortality is also contested among government departments and UN agencies in Myanmar. It is important to note that this is not because the quality of the census data is poor, but because of the concerns on the methodolgies of the mortality estimates. Further, the recent findings of Myanmar Demographic and Health Survey 2015 also revealed that the level of infant and child mortality is lower in compared to the census estimates. In summary, it is contradictory according the demographic transition model that countries with low level of the fertility, and very large gap in life expectancy, and have very high infant and child mortlaity. This requires in-depth analysis of the census data as well as to conduct through demographic analysis of the census results. More sophisticated methods will be recommended to analysis the quality of census results such as stable population model, forward and backward population projection, and cohort survival regression methods.

More detailed analysis can be found in **Annex 7.** Evaluation of the census results: A demographic Perspectives.

4.2.3 Gender Equality- Effectiveness

Summary findings: The Gender component contributed to improving policy and legislative frameworks. UNFPA support to the development of NSPAW, drafting of PoVAW are noteworthy achievements. The program has been implemented in a very dynamic political environment at the national level. The interventions have evolved according to the country context and implemented different course of actions by reflecting the needs and priorities of the country, contributing to increased awareness on GBV, and improved responses to GBV, particularly in emergency situations.

The interventions have successfully expanded the stakeholder base for combating GBV, extending its training interventions to a variety of groups including the police forces, health care providers, camp management committee members and men from the camps. The programme demonstrates a high level of trust and confidence between UNFPA, government, donors, partners and beneficiaries. The GBV programme is now framed in a clear strategy under the "Women and Girls First" (WGF) as a comprehensive and integrated approach. There is room for improvement in the technical capacity building of national institutions related to gender equality and women's empowerment . The weak gender mainstreaming at the institutional level still constitutes a serious barrier to the NSPAW implementation and UNFPA's effort to improve that situation, through DSW can be seen as a positive step.

The scope of GE component was defined across national and regions levels and the strategies identified in the CPAP for the gender component are being implemented. The output with its indicators from which effectiveness was assessed as outlined below.

While the outcome remains unchanged, the output has been modified and the indicators of the CPAP (2012-2015) have been significantly changed into three newly defined context-specific indicators in the extended CPAP (2015-2017). For example:

Output 1 (CPAP 2012-2015): strengthened national capacity and institutional mechanism for promoting gender equality and advancement of women. This output is measured by two indicators.
Indicator 1: number and percentage of UNFPA supported government departments and institutions that have staff with the knowledge and skills needed to incorporate aspects of the NSPAW (2012-2021), relevant to their programmes;
Indicator 2: number of community based centers in UNFPA supported areas where gender sensitive information, counseling and referral on reproductive health and rights and violence against women integrated into programmes addressing women livelihoods, skill training, income generation, psychosocial needs.

Output 1 (Extended CPAP 2015-2017): strengthened national capacity and institutional mechanism for advancing reproductive rights, promoting gender equality and addressing gender-based violence, including in humanitarian settings, measured by three indicators.

Indicator 1: number of organisations with capacity needed for strengthening a reporting system to follow up on the implementation of reproductive rights recommendations and obligations, and in line with NSPAW (2013-2022).

Indicator 2: number of townships with available gender-based violence prevention, protection and response programme.

Indicator 3: number of functioning gender-based violence, gender and women's empowerment coordination bodies as a result of UNFPA guidance and leadership.

Measuring effectiveness over the full course of 2012 through 2016 towards the output and outcome is challenging due to the changes in indicators. Neither explicit program logic nor results chain was available to see the linkages to interventions and expected results. The CP has implemented different set of activities and in new locations which were not planned under the CPAP (2012-2015). On the other hand, the old output is still used in different occasions; for example (in annual review workshop). There is inconsistent application and reference of the output. Any justification or documentation mentioned the changes in output, indicators and activities would have made easier to assess interlinked and focused contribution to achieving the output. The biggest challenge for the evaluator is whether to assess the output according to specific strategies and activities mentioned in the CPAP (2012-2015) or measure the output considering the specific country context. The evaluator is challenged to establish whether the output has been achieved, because the indicators were already changed before their achievement. It seems the programme has evolved according to the country context and implemented different course of actions by reflecting the needs and priorities of the country.

For this significant reason, the evaluator took into consideration the challenging operational environment in assessing the output and outcome of the gender equality component. When CPAP (2012-2015) was designed in 2011, it was just a year Myanmar transit to a newly democratic regime from the military regime, followed by the country's first multi-party election in 2010. Since the inception of the CPAP, Myanmar has changed dramatically and it continues to change fast. New actors and spaces for action are emerging. The civil society becomes very active and vocal, on a broadening range of issues including gender equality and gender based violence. New dynamics and opportunities for citizens' engagement and for improving governance are appearing.

Myanmar transitioned to multi-party democracy after its second election in 2015. The country has been experiencing the new political set up by the President Htin Kyaw and the State Counsellor Aung San Suu Kyi in 2016, resulted in some government personnel changes. The fact that this evolving context is still fragile and evolving till to the date of evaluation, offers both opportunities and challenges to UNFPA's gender interventions and UNFPA's position in promoting gender equality and addressing gender-based violence.

The evaluation of the effectiveness of the gender component of the programme recognises the country political context and analysed the CPAP intervention based on its consideration. Although these are not strategized in the CPAP, the activities under CP3 are designed and implemented to achieve the expected CPAP output. Among the different activities, key achievements can be identified under five areas; 1)

advocacy and policy, 2) knowledge management, 3) capacity development and 4) service delivery and 5) coordination.

Key achievements under five areas

UNFPA interventions have contributed to increased awareness on gender equality and GBV, advocacy efforts to improved legal frameworks, improved responses to gender-based violence (GBV), in particular in emergency situations and strengthened coordination at different levels.

1) Advocacy and Policy

With support from UNFPA and Gender Equality Network (GEN), NSPAW 2013-2022, a medium-term strategy to advance gender equality and women's rights, was developed in 2012. The plan serves a foundation to create enabling systems, structures and practices for the advancement of women, gender equality, and the realization of women's rights.

Legal Framework – UNFPA has been an instrumental in formulating Myanmar's first comprehensive national law to prevent violence against women and implement CEDAW's provision on gender equality and women's rights to freedom from violence. UNFPA's policy work, together with other UN sister agencies and women's network, includes drafting of the Protection and Prevention of Violence Against Women (PoVAW) law, advocacy on the highly contested 4 bills under the "Race and Religion Protection Law" through the provision of a technical review commissioned by UN agencies in Myanmar, as well as the Suppression of Prostitution Act.

Demographic Health Survey (DHS) –UNFPA's strong advocacy has achieved an inclusion of a Domestic Violence Module in the DHS which preliminary findings were disseminated in 2016 .

2) Knowledge Management

Gender Situation Analysis (GSA) - To fill the gap in gender statistics and research, UNFPA as part of UNGTG, undertook a gender situation analysis in 2014. The analysis provided the gender equality status of women under four thematic areas of the NSPAW (health; education; economic and livelihood; decision making; and violence against women), with reference to CEDAW and made recommendations in line with CEDAW, the Beijing Platform for Action and the NSPAW. It becomes a valuable reference tool to serve as baseline and a means to further Myanmar's efforts on gender equality by informing policy processes and implementation of the NSPAW.

3) Capacity Development

CEDAW report writing - UNFPA, together with other UNGTG members, has provided technical and financial support to the government CEDAW report writing committee to submit the CEDAW periodic reports in 2016. UNFPA and UNGTG played a major role in bringing civil society organizations and the government together to discuss the progress and challenges in CEDAW implementation.

GBV - UNFPA, together with the DSW and the Myanmar Women Affairs Federation (MWAF), provides gender-based violence Training of Trainers (TOT) to DSW, IPs and other civil society groups. As part of the humanitarian flood response, UNFPA provided GBV case management and psychosocial support training for 50 DSW case workers to support the GBV response in flood affected areas.

In 2015, UNFPA trained 1,000 police officer cadets (340 female and 760 male police officers) to ensure that Myanmar police officers have the necessary tools to respond effectively and appropriately to survivors of GBV[65]. The training was held at regional Police Officer Institute (Zee Pin Gyi) and focused on GBV as well as sexual and reproductive health. However, it was not possible to assess the effectiveness of the training.

4) Service Delivery

Women and Girls Centers (WGC) - To help women and girls cope with life in emergency settings, UNFPA has supported the establishment of Women and Girls Centres (WGCs) through its IPs: 7 in Rakhine; 8 in Kachin and in Northern Shan State. The centres provide safe spaces for women and girls, many of whom are survivors of GBV. Women from the camps have accessed the WGCs and receiving services (health, counselling or legal referrals as well as psychosocial support). By the end of 2015, 1,791 dignity kits were distributed and 7500 women and girls have accessed services in Kachin and 2,292 dignity kits distributed and 1847 women and girls accessed WGCs in Rakhine[66].

A break from camp life:WGC

Humanitarian response - When devastating floods swept across Myanmar in 2015, UNFPA was able to respond effectively and immediately in those areas most severely affected. Through its IPs, UNFPA in Sagaing, Magway, Rakhine and Chin States/Regions supported a total of 13,812 women and 6,512 men in GBV and psychosocial support (PSS) through DSW, and a further 407 men and 1,826 women in partnership with Marie Stopes International[67]. Over 12,000 dignity kits were distributed and in addition, UNFPA, in partnership with the International Organization for Migration (IOM), distributed more than 11,000 blankets to the affected population in Chin State[68]. UNFPA also trained Clinical Management of Rape(CMR) and Minimal Initial Service Package (MISP) to its IPs and government counterparts.

5) Coordination

Gender Equality and Women Empowerment Sector Working Group (GEWE SWG) - Under the joint development partner-government coordination mechanism, UNFPA, co-chairs the GEWE SWE together with the Embassy of France Embassy. UNFPA provides support to identify implementation

[65] Progress report on Italian-government funded GBV prevention and response programme, 30 June 2016
[66] Data from annual review workshop – December 2015
67 UNFPA briefing pack - 2016
[68] ibid

modalities and priorities areas for each UN agency in line with the NSPAW to accelerate the coordination mechanism.

GBV Sub-Sector (GBV SS) - Under the Protection Cluster within the Humanitarian Coordination Structure, UNFPA leads the GBV Sub-sector at the national level and in 3 states (Kachin, Rakhine, Northern Shan State). For this, UNFPA leads monthly meetings with a broad participation of GBV actors, primarily on the regional level. The GBV SS has been working closely with the GBV Information Management System (GBV IMS) Steering Committee at Headquarters level (an interagency team) to support the roll out of the GBVIMS in Myanmar. The group, under the leadership of UNFPA, developed referral pathways and supports the integration of GBV mitigation practices into other sectors and clusters of response. UNFPA also works to ensure compliance with minimum standards. This group has been instrumental in developing consolidated referral pathways in the UNFPA's programme areas.

SRH Working Group (SRH WG) - UNFPA is also chair of the SRH WG under the Health Cluster in the Humanitarian Coordination. The group convene to discuss technical issues and coordinate a set of prioritized activities, such as HIV/AIDS and family planning. One focus area for the SRH WG has been building capacity to implement MISP and prevent health related consequences of GBV.

Interventions' effectiveness:

GBV: In addressing GBV, UNFPA's coordinated response has contributed to the change at different levels. UNFPA support is effective in responding to the needs of the GBV survivors specifically in humanitarian settings. Through training on clinical management, raising awareness on referral pathways, provision of psychosocial support, and the establishment of WGCs, GBV survivors seek support at the camps and relevant health services at mobile clinics operated at the camps. As an unintended outcome of male involvement, it achieved some attitude and behaviour changes The interview with a male camp educator in Rakhine elaborated that, "*I tried very hard to bring this alcoholic man into the awareness-raising session. He came three times. I've heard that he talked with the village headman about abusive behaviors of men in the village and confessed his beating to his wife. His wife told me that he hardly beats her now."*

The interventions have successfully expanded the stakeholder base for combating GBV, extending its training interventions to a variety of groups including the police forces, health care providers, camps management committee members and men from the camps. The interventions have been effective in terms of addressing the needs of the target groups, as well as adapting and re-adapting in line with emerging needs. The training interventions have contributed to increasing gender sensitivity and awareness on GBV amongst service providers. The programme demonstrates a high level of trust and confidence between UNFPA, government, donors, partners and beneficiaries. Partnership with the DSW has been largely effective at the national level. DSW underlines that UNFPA staff actively support national level interventions and acknowledged its assistance. An officer from DSW remarked that *"UNFPA's support to DSW to provide awareness raising activities on NSPAW, CEDAW and GBV, among inter-ministries level is really appreciated."*

On the other hand, more emphasis needs to be placed on collaboration with other concerned ministries such as Ministry of Health and Sports (MOHS), as well as Relief and Resettlement Department (RRD) to enable them to better advocate for their roles and the importance of streamlining gender issues in sectoral policies in humanitarian settings. While the MOHS has been an active and pivotal partner of UNFPA's reproductive health component, it is not the case in the gender component. Since GBV becomes one of the priorities of MOHS, closer coordination would create significant synergies and opportunities for the promotion of efforts to combat GBV. While organizing collaborative work involving various stakeholders, including key government actors such as police and justice and legal actors, the critical involvement of DSW and MOHS in GBV SS coordination is important. UNFPA needs to accelerate its coordination with DSW members and MOHS members at the state and regional level. The encouraging changes at the national level are yet to be felt positively at the DSW at the state/ region level and community level. While there was insufficient collaboration between GBV and SRH on the programming and implementation levels, including in humanitarian interventions, coordination and collaboration are strengthened through joint activities, field visits, and workshops in the current WGFI programme. Observed, in general was the presence of male participation on the part of IPs at national and regional level, there are very few men engaged in serving the communities at the ground/community level. Male volunteers have been recruited to work in close cooperation with male community members, however this is not adequate and there is room for improvement.

UNFPA's technical support to adopt and adapt the WGC model into the specific context of the state and region is commendable. While UNFPA has partly contributed to improved response to GBV, but more emphasis needs to place on monitoring and follow-up of training and programme interventions, which are currently not uniform across the different geographic locations of the programmes and various partners. These efforts still needed to be intensified to generate learnings from different models in humanitarian settings so as to build knowledge base of UNFPA to provide valuable contribution to vulnerable countries such as Myanmar. For this, rigorous monitoring and evaluation would be required. A well-designed evaluation should be supported and results should be well documented and widely disseminated so that they can lead to concrete changes in programme design and policy.

The innovative approach to integrate GBV with SRHR programming and service delivery can increase coverage and access, as well as address the key linkages between women's rights to access health and the right to be free from violence. Although it is early to appreciate if, and how, the SRH-GBV integrated model in humanitarian responses has benefited communities, it is especially important to conduct follow-up monitoring on the application of this model, the relevancy of this model to the community and the impact on GBV. This learning can be beneficial for Myanmar to see whether the SRH-GBV integrated model in humanitarian offers an opportunity to replicate elsewhere as a case of good practice. Many government respondents felt that UNFPA needs to expend GBV response into community level (not only in emergency settings) to build community capacity to prevent and respond to gender based violence and support community mechanism on GBV.

The GBV programme is now framed as a clear strategy under the "Women and Girls First Initiative" (WGFI) programme and addresses GBV response and service delivery, and increased access to justice, economic empowerment and protection and participation in the peace process. It seems it is an innovative

model of integration of GBV programming into SRH programmes. The WGF programme offers enormous potential for informing and enabling government to take a strong and active position on GBV, both in terms of informing communities and the government on better practices and approaches they might take response natural and conflict disasters, in applying new approaches and skills. It also gives an opportunity to work with the government authorities particularly at the field level, to equip them and enhance their capacity to be better duty bearers. The expansion of GBV interventions to a new dimension of regular setting can open up new potentials for advocacy and visibility, increasing the quantity and quality of women's protection services, such as shelter. This should be further exploited in the remaining period of this CPAP and the upcoming programming cycle. While representing utmost relevance in the context of this country at this point in time, the full potential of this (WGFI) programme is expected to reach at the remaining period of the CP3.

GE: Although the strategies and guidelines have been produced at the national level, it is not yet evident whether gender-related issues have really been streamlined into policy making and strategic planning including allocation of resources under NSPAW. There is a need for continuous lobbying and advocacy on NSPAW for its full implementation and passing the PoVaw law. Awareness on gender issues is clear at the DSW staff level, but it is not the case at other Ministries. The effectiveness of gender focal points in sectoral ministries can be questioned as they have had difficulties in understanding their roles and implementing activities within their ministries without having a term of reference. The weak mainstreaming of gender-related issues at the institutional level still constitutes a serious barrier to the implementation of NSPAW. UNFPA's effort to helping to improve that situation, both national and regional level through the DSW offices can be seen as a positive step.

The interview with the respondents also highlight the need for increased education and awareness-raising on laws and policies on issues relating to gender and GBV. Some respondents at national level remarked that there was the Emergency Care and Treatment Law and NSPAW and yet these remained unknown to the state/ regional level and general population. Although Emergency Care and Treat Law provides a way in which women can access lifesaving treatment without first reporting to police, this is still unknown to many government stakeholders and civil society actors including UNFPA's IPs. UNFPA have also been using the guidance note in training with health and police in the states and regions since 2015. UNFPA has been currently making efforts to make improvements in this areas. UNFPA has developed the guidance note and have presented to MoHS for approval.

Overall, analysing the gender component from the political context is important for Myanmar Programme as the CP has exploited the provided opportunity and expanded in a much needed area in order to facilitate a rights based approach by engaging with the duty bearers (government) as well as rights holders (beneficiaries). The delays and modifications to adapt to the volatility in the context are justified. While targets are being achieved for GBV interventions, even surpassing some targets as defined at the extended CPAP (2014-2017), there is a need to implement capacity building interventions to achieve the indicator one. It is important to emphasise as it is the key indicator determining achievement of the output. As the programme has one more year to go with on-going activities, it is expected that the programme output and indicators will be achieved by the end of CP3. The evaluator found indications that the UNFPA programme has contributed to "strengthened national capacity and institutional mechanism for advancing

reproductive rights, promoting gender equality and addressing gender-based violence, including in humanitarian settings" as stated in the output.

Facilitating and Constraining Factors

Facilitating factors: partnership with local NGOs/CSOs/network, government counterparts, UN agencies and Gender Equality Network (GEN), open dialogue with government institutions such as DSW, IPs and donors, UNFPA's close cooperation with other UN Agencies such as UNICEF, WHO, UNOCHA, UNDP, participation with UN GTG and law drafting committee, working with parliamentarians, resources; drafting policies, guidelines and guidance notes, male engagement at the camps, leading roles at coordination bodies, facilitative role between MOHS and DSW, technically strong and practical program design.

Constraining factors:
The change of government officials and personnel within concern ministries responsible for NSPAW, inconsistency in political goodwill among concerned ministries for NSPAW, government personnel changes at state/regional DSW and MOHS, ongoing conflicts in GBV programme implementation areas, lack of a capacity development strategy, not well-integrated across other components of CPAP, variable quality of support provision to its IPs to reflect their needs, the nature of UNFPA' making decisions by themselves which activities to be funded or not and taking too long for funds release, absence of explicit programme logic nor results chain to see the linkages to interventions and expected results. Lack of male participation at the community level, specifically on GBV related interventions.

4.2.4 Vulnerability Context – Effectiveness

EQ3: To what extent was the Country Office along with its partners able to (likely to) respond to crisis during the period of the country programme?

Summary Findings: The Country Office initiated a RH-GBV integrated project in both natural and conflict disaster areas. Building on past experience during emergency situations, CO has a wealth of information and established systems and has an updated humanitarian contingency plan[69] that includes elements addressing sexual and health needs of women, adolescents and youth including services for survivors of sexual violence in crises. UNFPA's policies and procedures, and supportive mechanisms, partnerships have been responsive to crisis and emergency situations. Integration of GBV and RH components into humanitarian programming is not yet been fully realized.

Response to Cyclone Giri, as well as response to the Shan State Earthquake (March 2011), have reflected many lessons learned from the experience of Cyclone Nargis and are a testament to the capacities developed in the areas of early warning, emergency preparedness and response at both the central and regional levels. The Government is placing high priority on further strengthening disaster risk reduction efforts, including in finalizing the Myanmar Action Plan for Disaster Risk Reduction (MAPDRR).

[69] UNFPA and UNHCT Contingency Plan documents

With a long history of providing support in cases of emergency and crisis, UNFPA as mandated, has highlighted the needs of women during times of crisis and ensured that reproductive health services and commodities are available to protect their health. UNFPA's humanitarian assistance program is part of 3rd Programme of Assistance 2012-2015 and has continued to advocate for adequate protection measures and safe spaces for women given that emergency situations give rise to increased harm to women and girls due to physical and sexual abuse and violence.

Integration of GBV and RH components into humanitarian programming enhances effectiveness of response; however the delivery of this on the ground in an integrated manner has not yet been fully realized.

The focus on gender equality in disaster and emergency response did not fully reflect in CPAP (2012-2015), however, when the results and resource framework was aligned to the UNFPA SP 2014-17 Integrated Results Framework, CPAP outputs were formulated to address GE component as it was recognized that it is in important part of emergency preparedness work.

UNFPA's role as the chair for SRH TWG, ensuring its commitment to SRH in crisis settings and coordinating actors in the area of SRH has been recognized by the stakeholders including donors, government and humanitarian organizations.

In emergency situations, the country office is responsible for the implementation of the operational components such as activation of Fast Track Procedures (FTP)[70] on human resources, cash management, procurement and the delivery of operational commitments. However, interview respondents expressed delays in the procedures, mainly due to the demand and the need for volume of quantities from local markets, the quality of goods and the lack of human resources to expedite the processes within the expected and desired speed.

Contents of a Dignity Kit

As noted earlier, UNFPA, via its IPs in Sagaing, Magway, Rakhine and Chin States/Regions supported a total of 13,812 women and 6,512 men in GBV and psychosocial support (PSS) through DSW, and a further 407 men and 1,826 women in partnership with Marie Stopes International[71]. Over 12,000 dignity kits were distributed and in addition, UNFPA, in partnership with IOM, distributed more than 11,000 blankets to the affected population in Chin State[72]. UNFPA also trained Clinical Management of Rape (CMR) and Minimal Initial Service Package (MISP) to its IPs and government counterparts.

[70] The Fast Track Procedures are a set of procedures that offer UNFPA country offices in special situations greater delegation of authority and flexibility in specific programme and operational areas for a time-bound period. They represent a modification to the standard policies and procedures in the PPM and are designed to facilitate a rapid response to country demands.

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[72] ibid

HCT have developed the inter-agency MPAs and Inter-agency Emergency Preparedness and Response Plan (contingency plan is included) at National level as well as some specific disaster prone States and Regions. The inter-agency emergency Preparedness and Response Plan was developed since 2014 and updated in 2015 and 2016 respectively. The program implementation on GBV is not mainstreamed into SRH programme/project yet. However, with the program design of coming Women and girls first program, the GBV will be mainstreamed into SRH in 2017-18 activities.

MOHS, UN HCT and UNFPA have humanitarian contingency plans[73] that include elements addressing sexual and health needs of women, adolescents and youth including services for survivors of sexual violence in crises. Working with MOHS and IPs, target is that 100% of reporting GBV survivors receives case management and GBV related health services in line with their needs and wishes by the end of the project cycle. However, on the ground level, implementation of GBV and RH services run parallel and less well coordinated. More on this is discussed under Gender Equality programmer area.

UNFPA's current humanitarian assistance includes:Rakhine: Dignity and Reproductive Health Kits provision, providing lifesaving re[productive health services to affected population in Sitwe and Rathedaung and providing technical support to state health directorate and humanitarian community in Rakhine.Kachin: Reproductive Health Kits provision, capacity building training to health volunteers to provide emergency obstetric care, emergency referral service support and rehabilitation of clinics in IDP camps in Kachin. UNFPA liaise with government and nongovernment IPs to serve in these areas.

Staff preparation:

UNFPA has a requirement that all in-coming staff members who work in humanitarian setting to pass online courses such as the module on ICPD and Humanitarian Action, part of the Distance Learning on Population Issues; the MISP on-line module; the GBV e-learning course; and the ASRH in emergency e-learning course. The orientation packet contains the information for all incoming staff. Feedback from the responsible staff members confirmed completing and passing those online courses.

UNFPA expanded the staff working in humanitarian response areas; however, with the expansion in sub-offices, there have not been any changes to the existing operational capacity at CO level. Given the limited human resources, the implementation of fast track procedures as well as the efficiency and the effectiveness of the routine work could be affected due to capacity issues.

The work load and the increasing demands in the areas needing humanitarian assistance have created additional administrative systems to meet the needs. Difficulty in setting timeline for clear exit strategies may pose challenges to sustainability and phasing out when the emergency no longer exist and when normal development activities can meet the needs of the population. Transferring responsibility solely to the relevant ministries does not seem viable given the capacity of the ministries. Apparent solutions to increase capacity are not there and without assistance, the government structures are weak to address the issues around humanitarian response.

[73] UNFPA and UNHCT Contingency Plan documents

UNFPA has engaged only a few male members to work in the humanitarian setting and has not targeted enough resources to working with men and boys, with husbands who exert strong influence on women's reproductive health choices. Female caseworkers also finds it difficult to disseminate the message as only a few men and boys attend information sessions due to lack of interest and perception that GBV is a 'woman's issue.'

UNFPA response to the recent disasters

UNFPA has played its role flagging up reproductive health, women's protection and gender issues during emergency preparedness, acute emergency, chronic humanitarian situations and transition and recovery phases, by playing a crucial role in: coordination, capacity building, procurement and distribution, partnership, advocacy, resource mobilization and monitoring.and participating in cluster meetings where the cluster approach was proposed as a way of addressing gaps and strengthening the effectiveness of humanitarian response through building partnerships.

Facilitating and Constraining factors:

Facilitating factors:–IPs on the ground close to the communities in need, cumulative experience-from past humanitarian responses interventions, donors participation, committed UNFPA staff.

Constraining factors: Absence of a timeline and plan for clear exit strategies where the need for humanitarian response is gradually decreasing in some areas. Weak government structures and inadequate staff in the government to absorb the service needs of these people. With the resources available, there should at least be a dedicated staff member to handle all documentation and funding work Implementation delays at the beginning of the programme (due to challenges in recruitment for UNFPA and IPs)

4.3 Answer to evaluation question on Efficiency

EQ 5: *to* ***what extent UNFPA made good use of its human, financial, and technical resources to pursue the achievement of the outputs and outcomes defined in the CP?***

Summary: Efficiency for all focus areas

UNFPA has made fairly good use of its human, financial and technical resources to peruse the achievement of the outputs and outcomes defined in the CP. Most interventions of CP are implemented efficiently in both development and humanitarian settings. UNFPA's successful advocacy in leveraging resources from government and other development partners is evident in all programmatic areas. Good examples include the FP 2020 agenda; Census implementation; and taking leadership roles in at the GBV SS and GEWE SWE.

UNFPA has demonstrated its strength in the use of collective interests, joint initiatives and partnerships to peruse the achievement of the CP outputs and outcomes and has demonstrated its capacity to respond quickly and in a flexible manner to national needs in the context of evolving priorities in humanitarian settings.

The use of evidence-based proven interventions; use of existing government health system to deliver

health services; joint initiatives with partners; good co-ordination and relationship with line Ministries; and partnership with local NGOs and CSOs are facilitating factors to foster the efficiency of achieving the CP3 outputs and outcomes.
Also noted were delays in AWP approvals and disbursement of funds impacting the efficiency of some programme implementation. Silo working style and vertical structures in implementation has reduced the coordination and joint efforts. High staff turnover, limited number of staff who has the rights/authority to use the financial and administrative management procedures have caused some inefficiencies in the speed of the work. That said, because of the facilitating factors mentioned above, CP was able to overcome and achieve planned outcomes. Census implementation was one of the largest undertakings using resources effectively and efficiently, a great achievement that UNFPA is appraised for by all partners in country.

UNFPA has made fairly good use of its human, financial and technical resources to peruse the achievement of the outputs and outcomes defined in the CP.

All across different programmes (SRHR, P&D, and Gender), most interventions of CP3 are implemented efficiently in both development and humanitarian settings. UNFPA's successful advocacy in leveraging resources from government and other development partners is evident in all programmatic areas. Good examples include the FP 2020 agenda, Census implementation; and taking leadership roles in at the GBV SS and GEWE SWE.

UNFPA has demonstrated its strength in use of collective interests, joint initiatives and partnerships to peruse the achievement of the outputs and outcomes defined in the CP. Joint initiatives with WHO to support MOHS in planning and implementation of Maternal Death Surveillance and Response (MDSR) is a good example of UN initiatives to avoid duplications and develop synergies to achieve identified outputs and outcome. Agreement with JHPIEGO to provide nationwide in-service training for midwives is a good evidence of UNFPA's advocacy in leveraging financial resources from World Bank in implementation of UNFPA's priority interventions.

Partnerships with DoP, other line ministries, donor and civil society organizations have demonstrated implementation of census through proper management of funds and the satisfactory undertaking of a large and complex procurement operation in the enumeration and data processing phases. Interviews expressed openly their views that UNFPA did an excellent job—both technically and logistically—supporting the census. The first preliminary results were made possible in fourth months after the census, through use of the updated new technology. UN agencies and donors satisfied the results are credible and consider census operation to date a major technical achievement.

UNFPA has demonstrated its capacity to respond quickly and in a flexible manner to national needs in the context of evolving priorities in humanitarian settings. Evaluation and interviews with the respondents showed that UNFPA worked as a team with other implementing partners and relevant stakeholders had paved a platform for stimulating and facilitating public debates and policy dialogue within important key groups including government, donors and camp management on sensitive issues as GBV in conflicts and the need for response. Partnership with DSW, local NGOs and International NGOs and cross fertilization of experiences on GBV response, their perspectives and strength of each of the IPs in GBV interventions are collectively used to achieve the high quality outcome of the interventions.

In humanitarian settings, it is observed that partnership with local NGOs and CSOs have contributed to successful implementation of programme interventions by overcoming logistical and operational difficulties through building trust and familiarly with local culture and context. Despite inaccessibility to some implementation areas for regular monitoring, the presence of regional office of UNFPA has brought continuity enabling follow-up of activities conducted at the field level through local IPs. UNFPA is providing most required resource by focusing on technical assistance and capacity building. The training provided by UNFPA to local partner on GBV response in emergency setting is highly useful for the newly recruited staff and volunteers of the local NGOs. However, these circumstances do not apply to all GBV programmes and all IPs. IP such as IRC has in-house technical and logistical capacity and can run activities overcoming challenges.

Total allocation and expenditure of CP3

Figure 8 and 9 illustrate the total expenditure of the country office from 2012 to 2015 for four thematic areas, namely SRH/ARH including humanitarian context, HIV/AIDS, P&D and Gender and percentage expenditure against allocation. During 2012-2015, because of the census operations, 59 percent of the total expenditures of CP3 were spent on population and development; 34 percent (23.6 millions) on SRHR; 3.3 percent on Gender and 3.8 percent on HIV and AIDS. Overall CP 3 expenditure against allocation was 79 percent with all programme expenditure level against its allocation was 74 percent and above except Gender which is 66 percent expenditure against allocation. 2016 expenditure not included here.

Figure 5: Total Allocation and Expenditure of the Country Office (2012-2015) for four thematic areas (in million - US$)

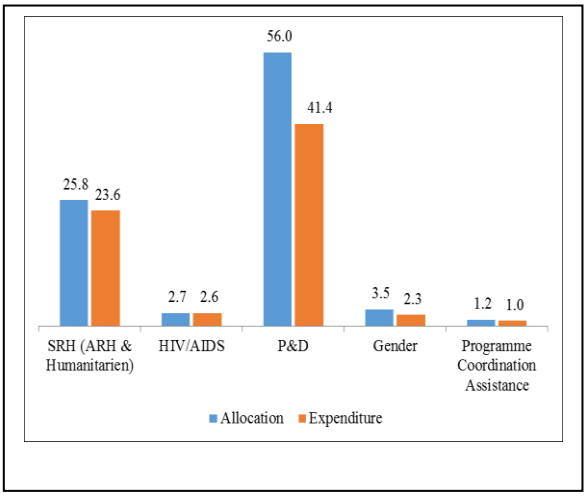
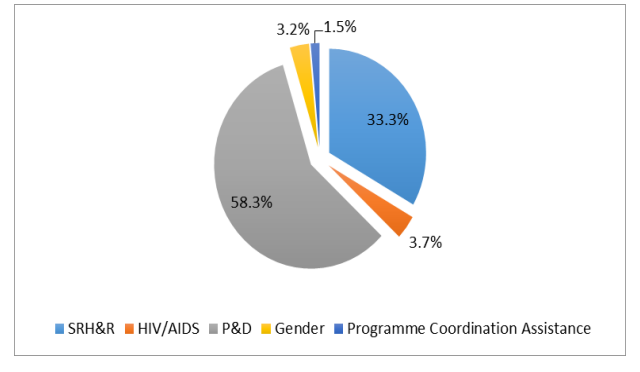


Figure 6: Percentage of expenditure by thematic areas of the Country Office (2012-2015) (in million - US$)



Capacity of CO

The CO operates with limited HR capacity. Approval for staffing structure had been received three years ago, but it is being operationalized only now and the restructuring process is going on currently (at the

time of the evaluation reporting, November 2016). Based on contractual modalities, several short term contractual arrangements had been functioning as long-term for some time, as a results many SSA's are performing routine work. Operations unit runs under-staff and given the demands under the humanitarian work, the response had been slow in some instances due to the under-capacity of CO. For example, one procurement staff member handles routine work as well as the requirements of the humanitarian needs. The nature of the contractual arrangements is such that support staff, who are on SSA, do not have access to the office operating systems and the work has to be performed by the designated staff members only. Sometimes delayed had occurred but feedback was that it did not have any negative impact on the progamme as the delays were not related to emergencies.

While the private sector has grown in Myanmar, with the multinationals presence in the country, the UN salary structure is no longer competitive nor attractive to local staff. Due to the nature of the contractual agreements, it is more conducive for astaff member to leave the organization once some experience is gained. In the long-run this has been a loss to the Agency, as the capacity development of staff has not always contributed to the realization of programme results.

Facilitating and Constraining Factors

Facilitating factors: The use of evidence-based proven interventions; use of existing government health system to deliver health services; joint initiatives with partners; and partnership with local NGOs and CSOs are facilitating factors to foster the efficiency of the CP 3 outputs and outcomes. Effective use of the communication unit and the media.

Constraining factors: Vertical interventions are implemented in "silo" and there is not enough evidence that situation analysis, programme planning and development of integrated implementation plan/ model/ strategies to address cross cutting issues (Gender, SRH, and HIV) exist. In some cases, long lead time to complete the implementation arrangement and contractual agreements with IPs, existing administrative and financial management mechanism incurs delays in implementation of planned activities. However, the interview with the IPs remarked that this did not have an impact on the quality of the results in GBV and GE but it has impact in quality of services provided by SRH partners.

4.4 Answer to evaluation question on Sustainability

EQ 4: Did programme design include strategies to ensure sustainability? Were any of these strategies on sustainability used in the course of programme implementation? To what extent has UNFPA Country Office been able to support its partners and the beneficiaries in developing capacities and establishing mechanisms to ensure ownership and the durability of effects?

Summary Findings – Sustainability all focus areas

Given the context of the government, being newly established, it is premature to be definitive about sustainability of the programmes. However, with regard to MOHS and its work related to UNFPA, systems have been established and shows positive trends toward sustainability.

Since UNFPA mandate has high relevance to the government's priorities and the people in general, there is opportunity for sustainability as the needs match the CP interventions to a great extent.

The results of UNFPA supported activities likely to be sustainable in all programmatic areas. UNFPA has demonstrated its policy advocacy work with Government and partners to increase ownership and commitments linked to global and regional priorities and commitments in all programmatic areas. A few to mention are Government's commitment to FP 2020, SDG, ICPD PoA and CEDAW. In addition, most UNFPA priority interventions are well addressed in national policies and strategies.

To ensure sustainability, all focus areas have incorporated advocacy and developing capacities of key stakeholders. One-off capacity building of individuals have not seen as sustainable, unless in cases where specific needs were identified and applied, like in the Census operations. Focused institutional capacity building initiatives have shown sustainable outcomes, for example, increased competencies of counterpart line Ministries, IPs, both local NGOs and CSOs. Unless there is a strategy to fill the identified capacity gaps institutional capacity for sustainability of outcomes related to UNFPA priority programmatic areas, UNFPA investments in capacity building could be less efficient. SSC in Census and SRHR has shown some sustainable approaches, such as engagement of technical consultants to work side by side with local experts. Knowledge management and generating of data was used to promote knowledge transfer and development of evidence based planning and interventions.

Sexual Reproductive Health and Rights

To ensure sustainability, UNFPA continue its evidence based advocacy, create enabling environment for government to implement interventions to meet the commitment in FP 2020, reducing maternal mortality and prevention of HIV and AIDS. Government budget allocation for FP is an evidence of successful advocacy and effective way of sharing responsibility and ownership of programme implementation. Based on the interview, stakeholders expressed that UN and other partners may need to continue support family planning commodity security to close the gap to ensure FP 2020 target is met.

Considerable number of health staff and IPs were trained to provide SRH services including family planning, maternal health and HIV. Partnership agreement with JHPIEGO has secured to conduct nation-wide in service training for Midwives and pre-service MWs training. Capacity development of RRTs and IPs on implementation of MISP will likely be able to respond to crisis during the emergency situation. However, rapid turn-over and attrition of trained staff are the threat to sustainability.

There are very many good initiatives and strong programs focus that Government is taking leadership: School health and health education targeting adolescent and young people; developing and fine tuning of basic essential health package for UHC; HR development initiatives for reducing maternal mortality; and to address GBV in health sector etc. UHC and development of Essential Health Service Package (EHSP) is a real good opportunity to ensure women from disadvantaged and poor community get access to maternal health. However, UNFPA is not seen as partner at this stage. UNFPA could use its comparative advantage of advocating rights of women to ensure evidence based priority interventions for advancement of women and adolescent health are included in the UHC package.

Population and Development

With reference to implementation of census, a wide range of capacity development interventions to DoP addressed to close the gap in evidence generation and integration of P&D into development planning. To ensure sustainability, knowledge transfer approach was adopted by UNFPA and indicated as effective. However, identification of strategic priorities in relations to P&D, integration of population dynamics in all development planning is still insufficient. To ensure the sustainability of results, the outcomes are reliant on the long-term capacity development plans which will require resources and support for follow-up action.

The sustainability of UNFPA assistance depends primarily on how government initiatives evolve on national strategy for the development of statistics. UNFPA effectively demonstrated how census model is worked and how the national strategy for the development of statistics has reinforced the statistical system on the census model (with an appropriate legal basis). However, integration of the population dynamics and capacity of DoP to produce data, evidence and cross-sectoral linkages of population issues are still in early stages and the government ownership and long-term support is yet to be realized.

Department of Population has limited human resources in demography and statistics and overdependence on a few key staff for census skills is a risk. The census team relied primarily on two highly skilled national staff. In one hand, because of the over burden of administrative responsibilities, these two demographers were produced very little research on emerging issues of population. On the other hand, the remaining team members involved in census lacked the specific educational background that would needed to take on census methodologies, data processing, data analysis, and demographic issues.

Findings of the evaluation revealed that both DOP staff and other national stakeholders are aware to increase the overall skills and knowledge of research staff and explicitly mentioned the desire to receive support from UNFPA. Despite extensive capacity building over the last four years on census operation, DoP is still not precisely confident to conduct census independently. It is imperative for DoP to conduct next census in a more autonomous way. However, evaluation team noted that DoP has no specific capacity building plan for their staff and long-term capacity building mechanism to broaden staff expertise. It is vital that government recognizes the important dimension of institutional strengthening and develop robust plan with dedicated budget.

Sustainability of use of the new technologies provided by UNFPA depends primarily on the following factors:

- As DoP has all new equipment's and software, and this can be used to carry out new surveys, the services will also provide to other line ministries for implementation of household surveys. The DoP has the technical capacity, however this a matter of cooperation between producers of statistics to better integrate statistical information in the country.
- To strengthen the skills with new updated software entirely depends on the demand for such services within DoP and outside of the ministries.
- To maintain the upgraded software license and equipment in order to avoid obsolescence, which requires sufficient budget.
- To organize the appropriate transfer or sharing of knowledge and/or staff with other institution (e.g. The CSO) to conduct sample based household surveys.

These are all feasible pre-conditions, yet they are at present external factors that were out of control of UNFPA.

Gender Equality

Aligning GE and GBV programme with national priorities and focus on building capacity and involving the government is a strategy adopted by UNFPA to ensure sustainability. UNFPA plays a leading role in supporting the government to strengthen the gender equality mechanisms and to implement treaty obligations. Capacity building interventions are indicated as an effective overall strategy towards building national ownership of the country Program. Although there is still no evidence that much has changed at the output and outcome levels, approach such as training of trainee utilised in the UNFPA supported programmes could lead to sustainability of the programmes; for example, GBV ToT.

Although DSW involves in identifying the strategic priorities, mainstreaming of gender issues in all ministries is still insufficient. Both gender equality and GBV work are still in young stages and the government ownership and long-term support is yet to be seen. There is a lack of a national coordination mechanism on GBV and institutional structures providing counseling/rehabilitation services for GBV survivors are only in early stages at national institutions. It may take a few years to come to full realization. Most respondents are of the view that capacity building work and coordination role of the UNFPA plays a critical role in gender equality work in Myanmar and still needs to continue. This means that there is still much more scope of work and relevance for UNFPA. A continuous advocacy work as well as technical assistance for full implementation of NSPAW and comprehensive GBV prevention and response would be needed. While the progress may be slow, a systematic follow up will be necessary to achieve long-term benefits. Both programme support as well as institutional capacity building are needed to continue. Greater emphasis needs to pay attention to explicit inclusion of sustainable strategies in their planning stages.

CPE Component 2:

This section presents the analyses of strategic positioning based on the evaluation criteria *coordination* and *added value*.

The first part assesses the extent to which UNFPA has been an active member of, and contributor to the existing coordination mechanisms of the UNCT. The second part, ***added value*** assesses the extent to which the UNFPA Country Office adds benefits to the results from other development actors' interventions.

4.5 Answer to evaluation question on Coordination

The following question assesses coordination criteria. EQ7) To what extent has the UNFPA country office contributed to the existing and consolidation of UNCT coordination mechanism?

Summary: Country Office coordination with other UN agencies was reflected as satisfactory. UNFPA Country Office is contributing positively to the UNCT, especially technical cooperation through coordinated programmes and by the leadership role it plays. Country Office represents in several technical groups and committees that contribute to the better coordination mechanisms of the UNCT.

Strategically, UNFPA has maintained its strong presence in all policy and key decision related functions and is well recognized and acknowledged by other UN members for its contribution to improving the UNCT coordination mechanism, its active engagement in working groups playing a lead role in advocating and lobbying key issues related to Myanmar development. "*Within UN agencies, UNCT is the main decision making body in the country, and UNFPA promotes cohesion through coordinating mechanism. There is a real willingness to contribute to the collective effort,*" is how a key member of UNCT expressed UNFPA's position and agreeing with this feedback another expressed how UNFPA communication unit is promoting the visibility of what UN does in the country.

The role played by UNFPA in steering committee with donors and RC; task coordinating the comments on Race and Religion and legislative review of gender; Rahkine State Development Plan etc. were examples of contribution that UNFPA had provided to UNCT. Bringing multiple donors together, and r*epresenting several cluster coordination, the practical approach that UNFPA CO brings to UNCT coordination mechanism have been* valued and UNFPA's leadership is seen as a *"very strong advocate of Human Rights issue" and several UNCT members acknowledged UNFPA contribution in the risk mitigation and do no harm approach in coordinating of the Census exercise.* A key informant expressed UNFPA as "*Positive, valuable role representing several cluster coordination; practical approach to protection and referral pathways. At national level – on humanitarian, very good support, swift feedback"* . UNFPA is in strategic position in coordinating and facilitating role at policy advocacy level of different programmes (Co-chair SRH TSG, Co-chair HIV prevention group).

4.6 Answer to evaluation questions on Added Value

EQ 8) What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies? Are these strengths a result of UNFPA corporate features or are they specific to the Country Office features? EQ 9): What is the UNFPA's main added value in the country context as perceived by national stakeholders?

Summary Findings Areas of recognition were the strong advocacy role, especially in sensitive issues such as human rights, SRH, sex works, youth, GBV etc. strong partnership with the government, especially in the area of support to Census and generating internationally compatible data for planning; Reproductive Health sector; bringing the development partners together; Capacity development of national partners supported by UNFPA; and the Coordination with religious groups.

The relationship UNFPA has established within the government working system that could provide an opportunity for other partners, who do not have the same comparative advantage, to be on board. UNFPA's established partnerships with the government offers unique opportunities for local IPs and CSOs in general to join hands with UNFPA in development activities to strengthen the development results and to enhance the national ownership and sustainability of outcomes.

UNFPA has been successful working with the government in advocating and lobbying for the country's development agenda and is in a strong position to leverage this position/capacity to bring on board the IPS supported by UNFPA to have a voice on the table at higher level. A key informant's feedback is in line with many others who expressed the concern that with UNFPA's visibility as a UN agency: *"UNFPA is well positioned to both support the government of Myanmar and to facilitate "building bridges" between the Government and Civil Society."*

UNFPA brings in technical expertise that is needed by other agencies to enhance their work. All key UN agencies reiterated the positive contribution of UNFPA in the overall development agenda of the country. Specific examples are the Country Office's supportive role in generation of internationally compatible, sex and age disaggregated data for evidence based planning, and advocacy for sensitive topics such as SRH, FP and GBV which adds to the value of the areas that other agencies have undertaken to improve. The technical expertise supported by UNFPA, providing consultants' service at NPT was specifically mentioned by interview respondents.

UNFPA's work in bringing interfaith groups together; engaging conflict sensitivity teams; and bringing on board politically and culturally sensitive topics were value added by UNFPA to the development community. In addition, repetitive and common themes that emerged from respondents' feedback on added value that UNFPA brings in are: facilitation of policy dialogue on sensitive issues, raising human rights issue, bringing in technical expertise and capacity building and knowledge with specific reference to generation of internationally compatible data for evidence based planning.

The responses from UN agency staff members, implementing partners, donors and review of documents, there is strong evidence supporting the added value that UNFPA as a development partner brings to the country programme. The responses echoed by almost all the respondents provided evidence to the positive contribution that UNFPA has made so far.

UNFPA has particularly contributed to strengthening advocacy in several areas that are useful to other development partners. UNFPA corporate strengths are well identified, however its interventions are perceived as being spread too thinly to produce strong results, area other than Census, thus UNFPA is recommended to "continue to work to build up the evidence base, taking more sensitive issues and ensuring that areas of corporate mandate are addressed. As priority, agree on division of labor with other partners working in close cooperation."

UNFPA also plays a key role to improve age and sex disaggregated data collection, analysis and utilization before, during and after humanitarian emergencies. With the census, disaggregated data is available down to the village tract level for the users for better coordinated programme and policy planning by government and relevant humanitarian and development partners. In this direction country office is making an effort to collect and advocate for the incorporation of sex and age disaggregated data and reliable demographic data (population size, composition and distribution) needed for appropriate responses to the emergency situation within sub-clusters.

As mentioned above, this contribution comes from both comparative strength resulting from generic corporate features of UNFPA (those characteristics of UNFPA as an agency) as well as country specific comparative strengths such as working with interfaith groups, conflict sensitivity, and strong leadership that enabled to bring on board politically and culturally sensitive topics.

Repetitive and common themes that emerged from respondents' feedback on added value that UNFPA brings in are: facilitation of policy dialogue, in-country as well as outside technical expertise, capacity building and knowledge with specific reference to data, and active participation in working groups.

Overall, bringing the development partners together (good coordination and leadership role), the key role played by UNFPA Country Office in upstream advocacy, technical expertise in the mandated areas, networks and relationship with the Government institutions, and specifically for being a forerunner in advocating for sensitive issues such as human rights, sexual and reproductive health, GBV have been noteworthy contributions.

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Chapter 5: Conclusions

UNFPA country programme employs key strategic approaches to achieve the programme's intended results. They are advocacy and policy dialogue/advice (upstream work); capacity development; support to IPs on service delivery; knowledge management -mainly by supporting census, surveys and research, and dissemination of their results. The conclusions and recommendations chapters synthesize and summarize learning from Chapter 4 Findings.

1) Alignment

The country program is well aligned with national priorities, UNFPA SP, ICPD and UNSF objectives. CPAP outcomes and outputs are relevant to the government development agenda. Realignment process was good and provided clarity in terms of the new direction. However, weak documentation of both theory of change and programme logic were limitations in demonstrating clear linkages between the interventions, outputs and outcomes.

With CO's emphasis on human rights issues, and integration of gender perspectives in programme components, the country programme has integrated Human Rights Based Approach in the CP interventions. Human rights and equity are deeply rooted in SDGs. UNFPA had been in the forefront advocating for human rights agenda when it was a sensitive issue in the country and the risks of not embracing the HRB approach was well understood by the country office. The conflict sensitivity assessments during and after census operations is also an example of such an approach.

Operations and Management

CO, with its limited staff, managed to achieve most of the planned results in the CP3 implementation. However, the process of fund transfer system needs improvement and some delays had been noted in fund disbursements thus slowing down IP's contribution to programme implementation. While there had been multiple reasons for this delay, including IPs' part as well, irregular communication (with IPs) on the transfer processes and the reasons for delays has created some minor misunderstandings. Limitations in the monitoring system to capture and minimize the inefficiencies at an early stage also contribute to the delays.

Expansion in sub-offices in humanitarian response areas without relative expansion in the Operations at CO level could hamper the fast track procedures as well as the routine work. Fast track procedures are active when relevant; however there had been instances where delays were experienced, fortunately with no apparent negative impact on the programme.

With the strategic focus on the business model, and shifting to more upstream advocacy work and with reduced funding for the next CP, resource mobilization will be an added role for operations.

2) SRHR -Maternal Health

Despite all the good initiatives by UNFPA and partners, Myanmar is still short of meeting its target to achieve deliveries attended by SBA. Availability of and access to emergency obstetric care services are limited. The situation calls for urgent attention to strengthen the functionality of Station Hospitals and

Township Hospitals to provide comprehensive CEmONC and expanding competencies of midwives in reference to the global standards.
There are many good initiatives and strong programmes such as Universal Health Coverage, HR development initiatives for reducing maternal mortality, undertaken with the government leadership. There is room for UNFPA to contribute, engage in policy and strategy level, particularly be involved in such government led processes as well as maximize the relationship with H6 partners to advance the maternal health agenda.

3) SRHR-Family Planning

Political commitments, presence of policy guidelines, RH Strategic Plan (2014-18), costed implementation plan, timely availability of FP commodities, capacity building of service providers, expansion of delivery points, PPP and availability of data through yearly surveys such as "Health Facility Assessment for Reproductive Health Commodities and Services" and "NIDI Family Planning Resource Flow Survey" have contributed to quickly move the FP agenda and make the country on track to meet FP 2020 targets.

Continued collaboration and support to MOHS; more focus on the availability and provision of LARC methods & strengthening supply chain management will lead to increase availability of FP commodities and services in rural areas. Noted were the presence of other in-country players with the mandate and interests to strengthen the procurement and supply chain management system that can provide good opportunities for UNFPA to expand the partnership and exchange technical know how to support the MOHS for advancement of more comprehensive harmonized supply chain management system.

4) SRHR-HIV

UNFPA HIV programme focused on the CCP and PMTCT during the first half of CP3. Later, when CO shifted its focused interventions to AP/CD/KM, the programme formulation lacked relevant outputs and outcome indicators which needed to be used as a road map to advance the programme achievement. Current programme structure is not tailored to maximize the use of UNFPA's strength and comparative advantage to advance the SRH rights of the most vulnerable and marginalized except FSWs.

UNFPA may need to think through how best HIV and AIDS should be addressed given the CO's strategic shift, it's comparative advantage, presence of Global Fund and other partners.

5) SRHR – Youth

UNFPA work on development of policy documents, protocols and standards of delivering SRHR/ARH services is commendable. Youth policy development is under process with greater participation of young people from different sectors. Continuation of good work in BCC and media programmes implemented by partners is constrained by limited resources. UNFPA innovation and the use of new technology "SRH mobile App" is promising the access to wide range of information including FP, RH, STI and HIV, GBV to adolescents and young people. The outcome of this innovation needs to be followed through and the findings and lessons learned should be used in the development of next CP.

UNFPA has shown its advocacy work and enhanced partnership with MoHS and other sister agencies in the development of National Strategic Plan for Young People's Health (2016-2020), Adolescent and Youth Friendly Health Services Manual, and the youth policy development process. CSE was introduced after the re-alignment of CP. Evidence on joint programming with other UN agencies, strategic partnership with wide range of stakeholders and resource mobilization has been inadequate to move the agenda on a large scale implementation.

Establishment of community based and school based CSE programme required wide range of advocacy, greater involvement and the participation of different stakeholders and different line ministries. Recent initiatives on revitalization of H6 partnership (WHO, UNICEF, UNFPA, UNAIDS, World Bank) and the interest of MoHS to advance the adolescent agenda and revitalization of school health teams are good opportunities for UNFPA and partners to advance CSE agenda in reaching out adolescents at scale.

Building on national data, which demonstrates a "demographic dividend", UNFPA is well placed to advance the national agenda for youth, including and especially as related to their SRHRs.

7) Population & Development

Generation and Use of Census Data: Completion and dissemination of census has been accomplished and reported to be in compliance with internationally accepted standards. Disaggregated data by age, sex and other demographic and socio-economic characteristic are being produced and made available. The competed thematic reports are available for use and more reports are in the process of being finalized. Several line ministries are now utilizing the census data in their sectoral plans.

Partnership and Resource Mobilization for Census Implementation: Country office built effective partnership with the donors by establishing confidence on providing technical expertise and trust on the management of financial resources. Consequently, donors have invested a significant amount of budget in the UNFPA pool fund for census operation. The institutional and individual capacity development in the process of planning and operation of census has been commendable.

Integration of Population and development into development planning: UNFPA CP3 interventions led to a momentum and recognition of population and development as an important national priority with some very affirmative actions. The efforts to institutionalize evidence, generation, and integration of population dynamics into planning and attitudinal changes towards improved evidence –based programming results remain weak, however it is understandable that it takes a long time, more than a CP cycle and is beyond the control of the UNFPA alone to make that change. The political economy context of the country that may favour low accountability, short-term interest and low institutional capacity might result in producing output level changes of the programmes, missing the expected results at outcome /impact level.

8. GE-GBV

The Gender component has contributed to improving policy and legislative frameworks. The interventions have evolved according to the country context and implemented different course of actions by reflecting the needs and priorities of the country, contributing to increased awareness on and improved responses to GBV GBV, particularly in emergency situations. UNFPA support to the development of

NSPAW, drafting of PoVAW are noteworthy achievements. Despite the advocacy efforts of NSPAW, the programme is not reaching its full potential in-terms of strengthening national capacity & institutional mechanism for advancing reproductive rights, gender equality and GBV.

The GBV programme is now framed in a clear strategy under the "Women and Girls First Initiative" (WGFI) as a comprehensive and integrated approach. Addressing GBV requires a coordinated response that promotes changes at different levels. To accelerate the achievements of SRH-GBV programme, there is room for greater coordination with MoHS and other actors. Further support is required to integrate GBV-SRH interventions and initiate formulation of a national referral system.

9. Humanitarian Response

UNFPA has been effective in responding to humanitarian needs and is a leading advocate for women in emergencies. Although the possibility of increase in GBV in humanitarian settings is acknowledged, GBV is treated as a standalone component rather than as part of and within the whole development context. At community level, GBV and RH run parallel and not well coordinated. While plans are on the way for integration, there is room for better coordination. Increased male participation, both from the side of community as well as those providing community services should be a focus in the next CP. Transition from humanitarian response to development context is slow and there is a felt need and desire among the staff to build the capacity to make this transition. The links between humanitarian and development programs are weak partly due to the recurrent conflicts and frequent natural disasters that call for the limited staff to attend to humanitarian response. Disable and ageing populations were not much referred to in the humanitarian engagement.

SRHR- Humanitarian Context

Availability and use of Humanitarian Contingency Plan that addresses sexual and reproductive health needs of women, adolescents and youth including services for survivors of sexual violence in crises, and capacity building in states and regions to implement MISP is seen as a milestone to advance the SRHR programme in humanitarian context.

Quality of care to deliver five core elements of SRH[74] has been a challenge in emergency settings. Clinical medical facilities in RHCs and untimely arrival of medical supplies, test kits and family planning commodities confine the IPs to deliver the full package of essential SRH interventions. In such situations, functionality of Station Hospitals and Township Hospitals to provide comprehensive life-saving maternal and newborn health become much more critical.

10. Coordination & Added Value

UNFPA Country Office contributes to improving the UNCT coordination mechanism.

[74] Five core elements of RH includes: (1) FP; (2) pregnancy, delivery, postpartum & newborn care; (3) prevention of unsafe abortion and post abortion care; (4) RTI, STI and HIV&AIDS (5) SRH including ARH

Strategically, UNFPA has maintained its strong presence in all policy and key decision related functions in UNFPA mandated areas and has been well recognized and acknowledged by other UN members for UNFPA's contribution to improving the UNCT coordination mechanism.

The added value of UNFPA as a development partner is high, particularly where UNFPA has taken the lead in advocating sensitive issues on human rights, GBV, FP and operations such as the Census.

11. Contribution to upstream advocacy work

The Country Office is perceived to have its strongest comparative advantage in advocacy and has established healthy grounds for lobbying in areas that are sensitive and difficult to be reached by others.

Successful in bridging and facilitating various players engaged in the census exercise. Front runner in advocating for human rights. CP3 has clearly followed the human based approach as evident by the efforts put into safeguarding human rights. UNPFA's ability to lead the census (both technical and operational) and commitment to advocacy and lobbying, particular on priority themes on the national agenda, technical expertise and capacity buildings are viewed as great strengths and recognized as a major player and lead agency in data generation and integration of population into development nexus.

12. Capacity Building

Capacity building constitutes a fair amount of budget where most was allocation was for the Census: technical and advisory support towards enhancing the capacity to implement the census operation which had produced positive results.

From the documentation and feedback from respondents, there is room for improvement of the staff capacity in the area of results based planning and managing and monitoring of programme interventions.

Several capacity building interventions on research, data analysis and demographic concepts were completed for different line ministries, however, due to the lack of institutional capacity development plans, the outcomes of these interventions are not visible.

With regard to the support to monitoring SDGs in the future, the existing capacity in the relevant line ministries is not adequate.

Humanitarian staff is interested in improving the capacity and the skills to make the transition from humanitarian response to development programmes.

13. Sustainability

Since UNFPA mandate has high relevance to the government's priorities and the people in general, there is opportunity for sustainability as the needs match the CP interventions to a great extent. However, given the context of the government, being newly established, it is premature to be definitive about sustainability of the programmes. With regard to MOHS and its work related to UNFPA, systems have been well established and show positive trends toward sustainability. There are several good initiatives with MOHS leadership. One is Universal health coverage and EHSP that will lead to the sustainable health care and financial protection to all citizens. UNFPA should seek the opportunity to support that essential SRH interventions/services are included in the package.

Some programmes under Gender Equality and Youth engagement are still in early stages and the government ownership and long-term support is yet to be seen. Sustainable strategies were not explicit in programme intervention plans.

14. KM and Coordination

Overall, the countryoffice has generated a large amount of knowledge products and a dedicated unit to disseminate information and work with media is available. While there has been tremendous accomplishments in sharing and management of knowledge via this mechanism, the main emphasis had been on the census implementation and census data. Much could be offered in other programmatic areas and within the CO the knowledge sharing is weak. For example, there is little Knowledge management on GBV in emergencies and room for improvement as there are many lessons learned in this area, in the region as well as globally. Addressing GBV requires a coordinated response that promotes changes at different levels and lessons learned in this broad complex area would benefit all actors in this field. Currently, not many good practices are available in the country for application at the ground level.

There is room to make greater coordination with MoHS and other actors to accelerate the success of RH-GBV programme. Further support is required to integrate GBV-RH and initiate to formulate a national referral system.

Transferable Lessons Learned:

Integration of conflict sensitivity assessments to understand various opinions of multiple stakeholders in areas that are sensitive to the culture and social fabric of a country could produce and enhance expected results minimizing the anticipated conflicts and maximizing the opportunities for service receivers' acceptance and national ownership. Mainstreaming conflict sensitivity as part of HRBA could produce more sustainable outcomes. Strong monitoring process of IP activities, specifically on fund transfers, multi-year work plans instead of annual work plans (AWPs), and coordinated effort to share information between and among IPs and programme staff on a regular basis would contribute to a more efficient and effective programme outputs and outcomes. If the SRH-GBV integrated model in humanitarian responses has benefited communities in Myanmar (intervention was too immature to evaluate the benefits), the learning of this integrated model could offer an opportunity to replicate elsewhere as a case of good practice.

Chapter 6: Recommendations

6.1 Strategic Level

These recommendations are made with due consideration to the current national context, SDGs, UNFPA Business Model, SP-MTR and SP 2018 – 2021. SDGs are evermore relevant to UNFPA mandate than MDGs. SP 2018-2021 does not have drastic changes from the previous SP. There will be changes in the way UNFPA conducts corporate business and support to SDG monitoring in a country classified as "Orange." Overall, CO could contribute to the country programme by **s**trengthening the delivery of the "bull's eye" in a changing humanitarian and development context; addressing the humanitarian and development nexus - enabling an integrated response to the ambition of 2030 Agenda and continuing leadership for the follow up to the ICPD Programme of Action. CP4 will not have "different things in the agenda, but things will need to be done differently." Therefore, strategic shift is recommended in line with the UNFPA country classification and the business model. On a positive note, the country office strategy had already been focused on upstream advocacy, implementing a few service delivery programmes as necessitated by the nature of the interventions (e.g. humanitarian response and FP). The following recommendations, at strategic and programmatic level, are based on the evaluation findings and conclusions discussed above and feedback received from key stakeholders.

Recommendation 1 (Linked to Conclusions 1,2,12) **CP Design Related: CP 4 to prioritize and focus on a few key high impact results/outcomes yielding interventions -** Accompany with theories of change that encompass the entire results chain down to output level, ensuring adequate skills and capacity of staff that participate in the formulation of the results framework. Advocacy and policy dialogue/ negotiating, lobbying, advocating role for the Country Office will be a major part of next country programme cycle which needs targeted plan for this transition.	Responsibility To Country Office Priority level: High
What has to be done? How/Who UNFPA Country Office: To achieve the above recommendation the country office will need to draw up an action plan including the following. • With due consideration to UNFPA comparative advantage, roles and responsibilities, prioritize 3 to 4 "high impact results yielding interventions," in CP4 (including high impact change management) that changes lives of people, *for eg., (1) contribution to reduction in maternal deaths –identify the* "social *determinants" of maternal mortality*, and by *analyzing and acting* on the most influential of those social determinants that are within UNFPA mandate and agenda - looking beyond sectoral borders in order to create synergies across health, development, and human rights of communities , *(2) reduction in HIV cases, (3) increase in the number of programs with gender mainstreamed (4) reduction in number of GBV cases (5) number of institutions that have the capacity to integrate population dynamics into the program planning; inclusion of vulnerable populations (disabled, elderly, women and children)* – • Based on theory of change and the assumed connections and logical linkages between various activities which build upon each other that is clearly in the direction of achieving the intended/planned results; focus on getting baselines and targets in place, at CP4 design stage,	

prior to the implementation.

- Country Office to conduct an evaluability assessment for each outcome, assessing availability of data for measuring progress (with built in M&E, monitoring tools for assessing quality improvement needs to be included. Improve on programme design related issues: based on identified programme gaps/needs, *develop clear and simple logic model with TOC, risk assumptions and mitigation plans included.*

- CO to continue engaging conflict sensitivity teams, as a short-term measure, in the humanitarian conflict areas when development plans are drawn and implemented. Make an effort to mainstream conflict sensitivity component in the country programme, enhancing the capacity of the programme staff in this area.
- Improve timing of AWP approval (*multiyear plan- though financial commitments will not be guaranteed - most countries have established two year work plans)* and fund transfer mechanisms, strengthen HR capacity, IP coordination and effective communication. Given the shift in focus on upstream advocacy, prioritize UNFPA input with explicit sustainability strategies in the work plan.

- Organize capacity development of staff as this shift in focus will require a change in mindset as well as some adjustments to the skill sets possessed by current UNFPA CO staff. Develop a mechanism, with clear guidelines and sustainable strategies, for transfer of responsibilities from international to national staff in order not to have gaps when international staff complete their assignment period.

Recommendation 2 (linked to conclusions 3,4,5,6,7,8,9,12) **Institutional Support/Institutional Capacity Development:** Establish a national capacity development plan that is based on identified gaps to enhance coordination and harmonization and to avoid overlaps.	To Country Office/Regional Office Priority level: High

What has to be done? How/Who (applies to all institutions closely working or planning to work with the CP)

UNFPA Country Office:

- Continue institutional capacity development with clear sustainable strategies. A national capacity building plan should be in place based on comprehensive need assessment to avoid overlapping and to enhance coordination and harmonization of training programs. Develop a strategic approach, long-term, multi-staged, participatory and partnership-based process with built-in needs assessment and monitoring plan to measure outputs and outcomes, finally the impact on institutional capacity development.

- Build institutional capacity and local capacity for an impact of programme intervention UNFPA to expand the partnership and exchange technical knowhow to support the MoHS for advancement of more comprehensive harmonized supply chain management system. Develop a more comprehensive, sustainable supply chain management system with broader involvement and greater coordination with other in-country partners working on supply chain management; support to promote FP and maternal health.

- Step up capacity building for DoPH staff (MRH, NAP) at regional level to implement GBV in health sector as reflected in the RH NSP, in addition to oversee, plan, implement, monitor and take leadership role with reference to RH NSP and HIV and AIDS strategic plan.

- Continue supporting DSW: DSW and concerned ministries for NSPAW are not yet well equipped to integrate gender into their policies and action plans. Gender mainstreaming to be a priority in the agenda and to support the relevant ministries and DSW to enhance the capacity to mainstream gender.

- Gender equality is a long-term goal, UNFPA should develop a capacity building strategy covering the UNFPA programme cycle for its government and CSO partners promoting systematic change/institutional change with careful screening of individual and one-off capacity building investements. Training should be accompanied by a broad effort to review a given institution's policies and resources, including infrastructure, service protocols, screening tools and referral directions.

- Support academic institutions for the generation of new scholars in the area of population studies, policy analysis and statistical analysis capabilities. Support DoP for strengthening demographic analytical capacity and CSO for enhancing statistical capacity. Enhance stakeholder engagement in thematic analysis of census data and strengthen census data quality (by conducting in-depth demographic analysis and evaluation of content error).

Recommendation 3 (Linked to Conclusion 2, 13) **Operations and Management related:** CO to step up External Resource Mobilization, go beyond traditional partnerships, anticipating the budgetary changes/reductions in the next CP cycle	To Country Office Priority level: High

What has to be done? How/Who (in-line with UNFPA RM strategy and to obtain support from HQ or RO depending on available technical expertise)
UNFPA Country Office:

- Review existing and potential partnerships as multipliers of impact. Seek support of traditional and non-traditional partnerships.
- Leverage innovation across the organization and with partners to amplify the impact.
- Given the Human Resource situation, step up the capacity of the operational unit, increase supervision and management with M&E–for higher efficiency
- Enhance required skills and capacities at all levels of the organization to deliver
- Understanding the cultural context/ nuances – not all cross cultural experience will fit in Myanmar– complex situation demands/requires international staff to work very closely with national staff; with close guidance and supervision provided by the national staff in decision making specifically on the ground.

Recommendation 4 (Linked to Conclusions 1, 10,11,13,14 **)** **Coordination and Advocacy Role** Maintain the current level of coordination in planning and implementation, within UNCT, to enhance programme efficiency and effectiveness while continuing the	To Country Office Priority level: Medium

current approach to working with the media to further strengthen UNFPA visibility at upstream level in its advocacy role for advancing the ICPD agenda. (medium priority as CO is already doing this)	

What has to be done? How/Who

- Country Office to work jointly with current level of internal coordination (within UN agencies who are working on similar issues) to increase efficiency and effectiveness of the interventions. Gender equality, maternal mortality, adolescent and youth programmes, and HIV and AIDS are specific technical areas that would benefit from enhanced coordination among UN.
- UNFPA to develop and implement a robust advocacy programme for the ICPD agenda especially for integration in the Post 2015 National Development Agenda.
- Continue the HRBA in all prorgamme interventions and make an effort to mainstream conflict sensitivity approach where most feasible and appropriate.

6.2 Programmatic Level

Programmatic level recommendations include feedback and suggestions from the key informants and other stakeholders.	
Recommendation 5 (Linked to conclusions 3,6,7,8,9,11,12) Strategic interventions to make data accessible and available for evidence based planning and policy making. (This applies to all programme areas, SRH, GE and GBV,PD and Humanitarian response)	To Country Office Priority level High

What has to be done? How/Who

UNFPA Country Office:

- Support strengthening national statistical systems, the limited national capacity for data generation, analysis, and dissemination, as well as the lack of use of data to inform policy development.
- Continue to support build national capacities for data collection, analysis, dissemination, and in fostering the use of data to inform evidence-based policies. Advocacy efforts will be supported by national and regional capacity-building programmes aimed at improving the availability of timely and quality data, as well as strengthening the capacities of regional intergovernmental coordination bodies in the fields of statistics and population and development.
- Formulate technical advisory panel which consists of the government, civil Society, UN Agencies for the future application of findings of the Census thematic reports**.**
- Continue to support increased availability of disaggregated quality data for evidence-based policymaking, planning, implementation, monitoring and evaluation. Data harmonization to be achieved through inter-agency work on data acquisition, analysis and dissemination with DHS, MICS, and UNDP among others, as well as inter-agency collaboration and partnerships to move forward the ICPD agenda.
- UNFPA has strong technical capacity and the relationships in place to support the Government to strengthen the evidence-base for national development planning. Census provides key data for development planning across sectors. Building on this work and the

relationships in place, UNFPA would be well placed to support other studies, e.g. on SRHRs, GBV etc.

Recommendation 6: (linked to conclusion 8, 9,12) **Assess readiness, availability and support functionality of services with a focus on transition from relief to development where appropriate.**	To Country Office Priority level High

What has to be done? How/Who

UNFPA Country Office:

Advocate and lobby for services: key government bodies MoHS and DSW.

- CO to focus on planning for transition from relief to development where appropriate. This would need engaging development expertise to build on the gains made on the humanitarian phase to build resilient communities.
- while UNFPA continues support to training of Minimum Initial Service Package, there is a need to develop a strategy to mainstream SRH (including HIV) and gender into acute emergency responses**.**
- As part of the emergency preparedness plan, readiness and availability of services in health facilities in emergency prone areas should be assessed and findings should be used to support and ensure full functionality of selected health facilities for life-saving maternal and newborn health.
- Assessment of clinical medical facilities (Township and Station Hospitals and RHCs) in the emergency prone areas must be included as part of the preparedness plan/resilience strategy and necessary support are provided.
- Training, Human Resource availability, prepositioning of medical equipment and supplies with regular monitoring and replenishment of stocks.
- CO to focus on staff training on how to make the transition from humanitarian response to development.

Recommendation 7: Youth Engagement (linked to conclusion 6) Engage Youth as a partner –in the formal peace process (resolution on Youth, Peace, and Security).	To Country Office Priority level-High

What has to be done? How/Who

UNFPA Country Office to:

- Empower Youth- given the country context and the political unrest diverting youth energy into productive activities; peace process. Especially young girls to be treated not as a target group but as Agents of Change and empowerment of them to know their human rights – sexuality and reproductive rights – has the potential to save lives.
- Identify and social norms where behavior change is anticpated for the desired outcomes and develop mesuares to monitor progress.
- Maximize on Demographic Dividend
- Follow up on “SRH mobile App” - UNFPA innovation and use of new technology “SRH mobile App” is promising to access wide range of information including FP, RH, STI and HIV, GBV to adolescents and young people. This process needs to be followed through the end of CP3 and findings should be used in designing CP4.

Recommendation 8 (Linked to conclusions 1,5,6 ,8,11,13) Mainstream HIV in protection of women's rights	To Country Office Priority level: High

What has to be done? How/Who

UNFPA Country Office:

- Considering the UNFPA's comparative advantage in promoting rights for SRH, UNFPA should consider mainstreaming HIV (through FP programme to ensure key populations and women living with HIV benefits from FP programme and interventions.; Gender equality and GBV interventions to reach the most vulnerable populations (FSWs, women living with HIV, migrant women etc) to ensure these populations benefit such interventions; young people programme to empower young people to protect themselves from HIV (through information, prevention services etc.); Ensure P&D programme generate data to support evidence based HIV programming/interventions etc in the context of promoting the rights of key populations/ women living with HIV, young adolescent girls etc.

- HIV in protection of women's rights; advocating for reducing stigma and discrimination; creating enabling environment to protect SRH rights of young people & the most vulnerable and marginalized, particularly adolescent girls, ethnic minorities, migrants, young key populations (FSWs, MSM), persons living with HIV. More emphasis on engaging men in educational activities.

- UNFPA to build partnerships with other Ministries beyond MOHS- with NGOs, CSOs, youth networks, advocates and champions; strengthen partnership with UNAIDS and other UN agencies such as WHO, UNICEF and IOM, and media, generating evidence based information and using the data to move the advocacy agenda.

Recommendation 9 (Linked to conclusion 3,5,9) **To reduce health inequalities (Reduce health inequalities, specifically to ensure access to sexual reproductive health , maternal and newborn care services.)**	To Country Office Priority level: High

What has to be done? How/Who

UNFPA Country Office:

- to step up its policy and strategy level engagement in recent Government led initiatives and processes such as UHC and development of EHSP which is a good opportunity to ensure women from disadvantaged and poor community get access to sexual reproductive health and maternal and newborn care services. Health equity and social determinants are acknowledged as a critical component of the post-2015 sustainable development global agenda. To reduce health inequalities, both social determinants of health and progressive achievement of universal health coverage (UHC) need to be addressed in an integrated and systematic manner.
- Immediate attention should be paid to ensure functionality of all District Hospitals and Township Hospitals to provide full package of emergency obstetric and newborn care services. UNFPA to step up its coordination and relationship with H6 partners and use its strategic position (together with WHO) to lead policy and strategy level engagement and support MOHS to ensure increasing access and availability of quality SRH services in rural settings and hard to reach areas[75].

[75] With reference to WHO-UNFPA-UNICEF-World bank Joint Country Support for Accelerated Implementation of Maternal and Newborn Continuum of Care, UNFPA is identified as focal agency for FP (with WHO), BEmONC (with UNICEF), CEmONC (with WHO) & Post-partum care (with WHO)

Recommendation 10 (Linked to conclusion 4,5,6,7,8,9) **Expand partnerships, in all programmatic areas (SRH, ARH, GE and GBV, PD and Humanitarian Response) for increased programme efficiency, effectiveness and sustainability.**	To Country Office Priority level High

What has to be done? How/Who

UNFPA Country Office:

- In general, applicable to all areas, but specifically on GE,GBV**:** Address the attitudes and behaviours that sustain violence against women and girls. Increase its emphasis on changing the social norms that drive violence against women and girls. Consider strategising a behavioral change and communication approach for GBV programming with development of community and media engagement plan, increase male participation in GBV prevention programmes; assessment of both the implementation and impact of the theory of change, to see where the gaps are, would be useful.
- Help identify the right strategy for addressing social norms, which will vary from state/region to state/region. UNFPA must also ensure it can monitor these changes. This applies in Youth empowerment programme as well. Youth programmes should address issues beyond ARH.
- Address GBV through the support to reproductive health services and the enactment and the enforcement of policies and laws.
- Accelerate the platforms it currently has, ensuring coordination and setting these platforms to serve beyond information sharing such as joint activities and policy advocacy to make GBV as legitimate public health and human rights issue.
- Build up on CP3 experience in formulation of a national referral mechanism, defining whether and how UNFPA intends to support economic empowerment of women and their accessing to psychosocial, health and legal services. Seek other national counterparts who are active and competent for this purpose to define a systematic and strategic approach through clear actionable steps and policy dialogue for a national referral system.

Recommendation 11 (linked to conclusion 7,12, 14) Knowledge management to ensure effective utilization of knowledge for development results.	To Country Office Priority level High

What has to be done? How/Who

UNFPA Country Office:

- The large amount of knowledge products generated by CO should be better used within CO as well as outside. The current communication unit (which has accomplished a lot in sharing and management of knowledge realted to census) should be able design a plan for the CO.
- Specifically with regards to GBV- Currently there is not much good practices are available in the country for application at ground level. For example lessons learned in Sri Lanka (field visit- joint mission by UNFPA and DSW relevant staff members/SSC) would benefit Myanmar situation.
- Strengthen the evidence base for addressing GBV in conflict, post-conflict, disaster and recovery contexts. Document intervention models on engaging with men and boys

around GBV prevention and SRH/FP programmes.

- Develop a common understanding of SSC to enhance consistent strategies across programmes and regions, which includes deepening staff capacity to support SSC, mainstreaming SSC activities, and documenting good practices;
- Partnerships with identified academic institutions are encouraged for knowledge management.

Regional Office **(APRO)** could play an active role in identifying good practices in the region and promoting SSC. An indicator to measure SSC is in the integrated results framework and all SSC interventions should be monitored and follow-up action plans should be included for optimum utility of the input.

Recommendation 12. (linked to conclusion 7,11,12,13) Integrate Population dynamics within SDGs 2030 agenda at national/state/regional development and planning processes.	To Country Office Priority level High

What has to be done? How/Who

UNFPA Country Office:

- Support establishent of a high level technical committee to oversee the monitoring process of SDGs indicators. Review and develop monitoring indicators of SDGs in context of Myanmar.
- Support CSO in the development of harmonized data-base including micro level data from census, DHS, and other nationally representative surveys.

- Key steps to address are i) placement of overall responsibility for coordinating the implementation of SDGs in Myanmar to regional/state level ii) establish monitoring and reporting mechanism iii) coordination mechanism with govt. departments, civil society, donors and private sector iv) advocacy that links civil society and communities in the process of change.

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ANNEXES (1-10)

Annex 1: TERMS OF REFERENCE

Terms of Reference for Country Programme Evaluation in Myanmar (2012-2017)

1. Introduction

The Myanmar Country Office is planning to commission the evaluation of the UNFPA Myanmar Third Country Programme (2012-2017) in 2016 in accordance with the UNFPA evaluation policy (DP/FPA/2013/5). In line with the practice in UNFPA, the Country Programme Evaluation (CPE) serves three main purposes that support the country office drive to achieve its intended results: (a) It is a means to demonstrate accountability to stakeholders on performance achieved; (b) It supports evidence-based decision-making; and (c) It contributes important lessons learned to the knowledge base of the organization. The evaluation aims to provide independent inputs to the next UNFPA country programme cycle and the strategic direction of the continued role for UNFPA support in Myanmar in the context of support to the Government in its commitments towards attaining the goals of ICPD and the SDGs as well as any ICPD Beyond 2014 and the post-MDG agenda.

The 3rd Myanmar Country Programme (CP) was approved in 2011 by the Executive Board and implemented in cooperation with the implementing partners (IPs) including government departments, INGOs/NGOs. The country programme consisted of 3 components: Sexual Reproductive Health and Rights, Gender Equality and Population and Development. As mentioned in the current programme document, the CP is part of the United Nations Strategic Framework (UNSF) 2012-2015 and the CPE will be undertaken as a part of the CP. This CPE intends to take stock of performance and actual achievements and provide independent and actionable recommendations as inputs to formulation of the next country programme for the period 2018-2022, which is the basis for further UNFPA's support in Myanmar.

The UNFPA evaluation office, with agreement of Executive committee and Executive Board, has launched new approach of clustered country programme evaluations (CCPE), which is focused on UNFPA engagement in highly vulnerable contexts. Myanmar has been selected as one of the countries to be included in the CCPE. The cluster approach aims at supporting cross-country learning in relation to key developmental challenges in highly vulnerable contexts based on the findings of the synthesis of CPEs of selected countries. As part of the CCPE, the CPE in Myanmar will include additional evaluation questions linked to the specific high vulnerability context.

The evaluation will be managed by Myanmar Country Office and conducted by a team of independent evaluators, in close consultation with the evaluation reference group, which will be established to guide the evaluation process. The results of this evaluation are expected to be used by UNFPA country office, regional office and headquarters, Government partners, and other development partners. The findings from the evaluation will be considered for lessons learned and capturing good practices from past implementation as well as in determining the way forward for the next programming cycle.

2. Context

Myanmar, the largest country in mainland Southeast Asia and located at the intersection of China and India, is characterized as a Least Developed Country (LDC). It was under a military regime for decades until 2010. Since 2011, a transition to democracy has been taking place launching fundamental political and economic reforms aimed at increasing openness, empowerment, and inclusion by the new government. During this period the country has begun to open up to foreign direct investment. The GDP growth rate has been increasing from 5.6% in 2011-12 to 8.5% in 2015-16 due to the measures of government reforms as well as investment invited. Foreign investment increased from 4.64 billion USD in 2011 to 22.12 billion USD in 2015. As a result of increased investment in Myanmar and other reform measures taken by the government, per capita nominal income has increased from 800 USD (2011) to 1270 USD (2015).

The most important sector of the economy is services, which has been growing steadily in the last few years, and now accounts for over 41 per cent of GDP. The share of agriculture to GDP has been declining, and now shows 38 per cent of GDP, while industry contributed the remaining 21 per cent of GDP.
It is noted that the poverty ratio of Myanmar has decreased from 26 % in 2011 to 18% in 2015, with poverty concentrated in rural areas, where poor people are relying on agricultural and casual employment for their living.

The ranking of human development index (HDI) in Myanmar has increased slightly from 150 in 2014 to 148 in 2015. Among ASEAN countries, however, Myanmar has the lowest life expectancy and the second-highest rate of infant and child mortality. Moreover, health expenditure in the state budget as a percentage of the GDP is still less than one per cent[76].

Recently the estimated value of maternal mortality rate in Myanmar is high at 200 per 100,000 live births[77]. In Myanmar the total fertility rate is approximately 2 children per woman and fertility among married women is 4.7 children per woman. At present, only 39.5 per cent of women of reproductive age are able to access modern methods of contraception that enable them to practice voluntary family planning. However, unmet need of contraception has increased from 17.7 per cent to 24.2 per cent during 2007 to 2010

The data from HIV Sentinel Sero- Surveillance (HSS) report 2014 indicated that HIV prevalence in adult population aged 15 years and older was estimated at 0.54 per cent in 2014, a decline from 0.94 per cent in 2000. However, HIV prevalence continues to remain high among people injecting drugs due to contaminated injecting equipment, MSM and female sex workers due to unsafe sex, at 23.1 per cent, 6.6 per cent and 6.3 per cent respectively. Myanmar is facing with new challenges such as HIV/AIDS transmission through injecting drug users among young people (aged 10- 24), especially young boys, are exposed to such risks.

Even though the definition of Youth defined in Myanmar and in the UN is different[78], Myanmar is composed of 28 per cent of total enumerated population[79] as young people aged 10-24 years while the

[76] Health in Myanmar (2014)
[77] Trends in Maternal Mortality (1990-2015) , Estimates by WHO, UNICEF, UNFPA, the World Bank group and UN population division
[78] The UN, for statistical purposes, defines "Youth" as those persons between the ages of 15 and 24 years, without prejudice to other definitions by Member states. In Myanmar, the "Youth" is defined, in the Child Law of 1993, as a person who has attained the age of 16 years but has not attained the aged of 18 years.

population growth is slowing down leading to the proportion of children declining. The high proportion of young people could bring capitalization of demographic dividend with access to education, health services and employment of youth. Otherwise, this youth bulge could create high employment needs of youth as a burden, which if .not sufficiently addressed, could lead to disempowerment of young people. Investment in young peoples in Myanmar is important and has the potential to enhance the country's economic growth.

Myanmar is a signatory to the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), the Beijing's Declaration and Platform for Action, the International Conference on Population and Development (ICPD) and the Millennium Declaration and the Sustainable Development Goals (SDGs). Gender inequalities persist, such as in legislation, access to economic opportunities and political representation. On the gender inequality index Myanmar ranked 85 out of 187 countries[80] in 2014. In 2012, Myanmar developed a medium-term strategy to advance gender equality and women's rights through the National Strategic Plan for the Advancement Women (NSPAW) 2013-2022, outlining an integrated approach to improve the situation of women and girls in Myanmar. The plan aims to create enabling systems, structures and practices for the advancement of women, for gender equality and realization of women rights. The plan provides an overarching framework and detailed interventions and targets.

There has been no regular and systematic effort to collect comprehensive national data on the incidence or characteristics of gender-based violence (GBV) in Myanmar. Data that exist concern small scale surveys and studies to secure the relevant data in specific programme contexts. Recently, the attention has turned towards addressing the root causes of GBV issues, gender inequality and managing GBV programmes as part of sustainable development process.

In order to fulfil the needs of evidence based policy/ programme formulation using demographic and socio economic information, decision making in planning and administrative processes, Myanmar conducted the population and housing census in 2014. International community including UNFPA supported the census processes to be in line with international norms and standards.

Even though Myanmar has had a draft national population policy since 1992, it is necessary to revise and put in place a new national population policy due to the outdated version reflecting the situation of past decades. It should be brought in line with more recent changes in Myanmar society. This policy should contribute to the quality of life of the people in Myanmar through better health conditions, higher level of education and increased employment opportunities. The main challenge of draft national population policy is not adopted officially and the draft policy is focusing on the health sector and there are many changes in socio- economic dimension and political setting. Myanmar faces a large range of policy challenges such as in alleviating poverty, in improving health and education outcomes and in deepening gender equality and women's empowerment that all have population policy implications. Myanmar lacks a modern and holistic framework for addressing the population aspects and making the necessary linkages to the ICPD through putting necessary policies and programmes in place.

The internal conflict between Myanmar's national army and the major ethnic armed groups is recognized as one of the world's longest civil wars and has been affecting the lives of people living in various pockets of the county for the last six decades since Myanmar's independence in 1948. As armed conflict continues in Myanmar and in some areas it has intensified as communication has deteriorated between certain key stakeholders. Mass internal displacement continues to be a challenge, while tensions and

[79] Myanmar Population and Housing Census 2014
[80] http//hdr.undp.org/en/composite/GII

clashes continue in different areas of the country. In particular, while Myanmar is proceeding with political and economic reforms and nationwide ceasefire negotiations, conflict in Kachin and northern Shan states are ongoing, and tensions in Rakhine persist. Up to 642,600 internally displaced people (IDPs)[81] in these areas as well as in the south-eastern part of the country still need support to rebuild their lives. Those people were in need of humanitarian assistance in 2015, primarily in Rakhine, Kachin and northern Shan states.

Myanmar is prone to natural disasters such as earthquakes, floods, cyclones, droughts, fires and tsunamis. For instance, in 2015, cyclone Komen and heavy monsoon rains brought devastating floods across the country, affecting 12 of Myanmar's 14 States and Regions. A large number of people were affected, Myanmar government requested the humanitarian assistance to the international community for support to respond to those disasters.

On the basis of this context, it is crucial to assess the country programme with a view of engagement of UNFPA CO in highly vulnerable context focusing on humanitarian responses. In this respect, Myanmar's CPE was selected for the clustered CPE (CCPE) process in order to draw lessons and to produce learning in relation to key developmental challenges in comparable contexts. Thus the evaluation will include few additional evaluation questions and provide data for the meta- analysis of the CCPE which process will be led by the UNFPA evaluation office.

UNFPA support to Myanmar

The early days from 1973 to 2006

In terms of UNFPA's support to Myanmar, UNFPA began supporting population activities in Myanmar on an ad-hoc basis in 1973. The Fund supported the 1973 and 1983 Population and Housing censuses. In the 1990s, UNFPA supported the 1991 Population Changes and Fertility Survey, the 1997 Fertility and RH Survey, and the 1999 RH Needs Assessment. In 2001, a second Fertility and RH Survey was conducted making it possible to study trends of various demographic data over the previous decade.

In addition, UNFPA provided support to procurement of RH commodities, training of basic health staff and addressing needs for safe motherhood and prevention of sexually transmitted infections (STIs) and HIV/AIDS. The above-cited activities were implemented through various projects. In 2002, UNFPA changed its project based approach and adopted a programmatic approach. The first UNFPA Special Programme of Assistance to Myanmar was implemented during the period 2002-2006.

UNFPA 2nd Programme of Assistance

UNFPA implemented its 2nd programme of assistance to Myanmar 2007-2010, which has been extended until the end of 2011. The programme focused on Reproductive Health (RH), Adolescent Reproductive Health (ARH) and HIV /AIDS, in order to promote the status of RH of women and men including adolescents and youth in selected project areas. During the period of implementation of the 2nd programme, the cyclone Nargis hit Myanmar in May 2008 and forced the country office to reallocate its resources to humanitarian response, putting the regular country programme on hold for a period of around 2 years until a rehabilitation Programme started.

[81] http://www.internal-displacement.org/south-and-south-east-asia/myanmar/figures-analysis

UNFPA programme activities strengthened the provision of reproductive health services including safe motherhood, birth spacing, HIV/AIDS prevention among vulnerable populations (at risk groups), Adolescent Reproductive Health (ARH), Prevention of Mother to Child Transmission of HIV (PMCT), Voluntary Counseling and Confidential Testing for HIV (VCCT) and behavior change communication interventions (BCC) which included training and mobilizing community support groups. HIV prevention component promoted access to HIV information and services which include training of targeted at risk groups such as sex workers, men who have sex with men (MSM), young people and mobile populations, peer education, STI treatment, and voluntary HIV testing and condom distribution through various channels. Female and male condoms were distributed free of charge in public health facilities and at subsidized prices through social marketing approaches in cooperation with the private sector in order to enhance accessibility, availability and affordability of quality condoms by targeted beneficiaries.

UNFPA 3rd Programme of Assistance

UNFPA's third Country Programme in Myanmar was approved by the Executive Board in 2011 for 4 years from 2012 to 2015, with a total budget of 29.5 million USD. Out of 29.5 million USD dollars, 16.5 million US dollars is from regular resources and the remaining 13 million USD dollars is to be mobilized through co-financing modalities. The programme was extended to 2017 for which phase the Executive Board approved to fund an amount of 8 million USD from regular resources, with an additional 6 million USD to be provided from other resources, totaling 14 million USD for the programme extension phase of the programme.[82]

The third Country Programme consists of three main components, namely 1) reproductive health and rights, 2) population and development and 3) gender equality. The country programme is synchronized with the United Nations Strategic Framework (UNSF) for Myanmar 2012-2015 and in alignment with UNFPA Strategic Plan 2008-2013 and the revised UNFPA Strategic Plan 2014-2017. It contributes to three strategic priorities of the United Nations Strategic Framework: (a) increase equitable access to high-quality social services; (b) reduce vulnerability to natural disasters and climate change; and (c) promote good governance and strengthen democratic institutions and rights.

Results Framework of 3rd country programme

The following table represents the relationships among programme outcomes and outputs under SP 2008-2013.

CP/CPAP Outcomes	CP/CPAP Outputs(2012-2015)
RH outcome 1: Increased equitable access to and utilization of quality reproductive health and HIV prevention information and services for women, men, young people and	**RH Output 1**: Strengthened health systems to improve availability of high quality and equitable sexual and reproductive health information and services among target groups including in emergency settings.

[82] The reasons of extension of the UNFPA country programme were related to decision of UN Country Team that deferred 2 years for UNDAF (UNSF) formulation exercise, and to be in line with the existing political context including possible national ceasefire accord and also hoping to harmonize with UNDP and UNICEF programme.

most at risk population	**HIV Output 2**: Improved availability of sexual and reproductive health services, including the prevention of HIV transmission among populations that are most at risk and their partners, and from mothers to their children
PD outcome 2: Strengthened national statistical system for data collection, processing, analysis dissemination, coordination and utilization.	**PD Output3**: Strengthened national capacity to increase availability of high quality disaggregated data on population, reproductive health and gender issues for policy formulation, planning and monitoring and evaluation
Gender outcome 3: Gender equality and the human rights of women, particularly their reproductive rights are addressed in national legal frameworks, social policies and development plans	**Gender Output 4**: Strengthened national capacity and institutional mechanism for promoting gender equality and advancement of women

Below table indicates the relationship between outcomes and outputs under the framework of SP (2015-2017).

CP Outcomes	**CP Outputs(2015-2017) extension phase**
SP Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access	**Output 1**: Strengthened health system to deliver integrated sexual and reproductive health services including family planning, maternal health and HIV prevention programmes as well as in humanitarian settings (aligned with SP OP 2,3,4,5)
SP Outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health	**Output 2:** Increased national capacity to review the situation of comprehensive sexuality education(CSE) programmes and conduct evidence-based advocacy for incorporating adolescents and youth and their human rights/needs in national laws, policies, programmes, including in humanitarian settings (aligned with SP OP 6,7)
SP Outcome 3: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth	**Output 3:** Strengthened national capacity and institutional mechanism for advancing reproductive rights, promoting gender equality and addressing gender-based violence, including in humanitarian settings. (aligned with SP output 9,10)

SP Outcome 4: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality	**Output 4 :** Strengthened national capacity to increase availability of high quality disaggregated data on population, reproductive health and gender issues for policy formulation, planning and monitoring and evaluation (aligned with SP output 12,13)

Key Implementing Partners

Under the third CP, CO has entered into strategic partnership with a number of key implementing partners in order to deliver the intended results. Those implementing partners are divided into three groups: Government IPs and NGO/INGO IPs and intergovernmental organizations. The partnership is mentioned in below table.

#	**Agency**
	Government
1	Department of Health Professional, Resource Development and Management (DHPRDM) (previously known as Department of Medical Science), Ministry of Health and Sports
2	Department of Medical Research (DMR), Ministry of Health and Sports
3	Department of Population (DoP), Ministry of Labour, Immigration and Population
4	Department of Public Health (DoPH) (previously known as Department of Health), Ministry of Health and Sports
5	Department of Social Welfare, Ministry of Social Welfare , Relief and Resettlement
	NGOs
6	Association Francois Xavier Bagnoud (AFXB)
7	International Rescue Committee (IRC)
8	John Snow Inc. (JSI)
9	Marie Stopes International (MSI)
10	Metta Development Foundation
11	Myanmar Anti-Narcotics Association (MANA)
12	Myanmar Medical Association (MMA)
13	Myanmar Nurse and Midwife Association (MNMA)
14	Myanmar Red Cross Society (MRCS)
15	Malteser
16	Population Services International (PSI)
17	Trócaire
18	Myanmar Maternal and Child Welfare Association
	UN agencies
19	IOM Myanmar

Geographical coverage of Interventions

The intervention's areas (townships/ regions/ states) of the UNFPA 3rd Programme were selected based on the following criteria and those selected states and regions (out of 14 states/ regions of Myanmar were shown in below table.

- high MMR and HIV prevalence

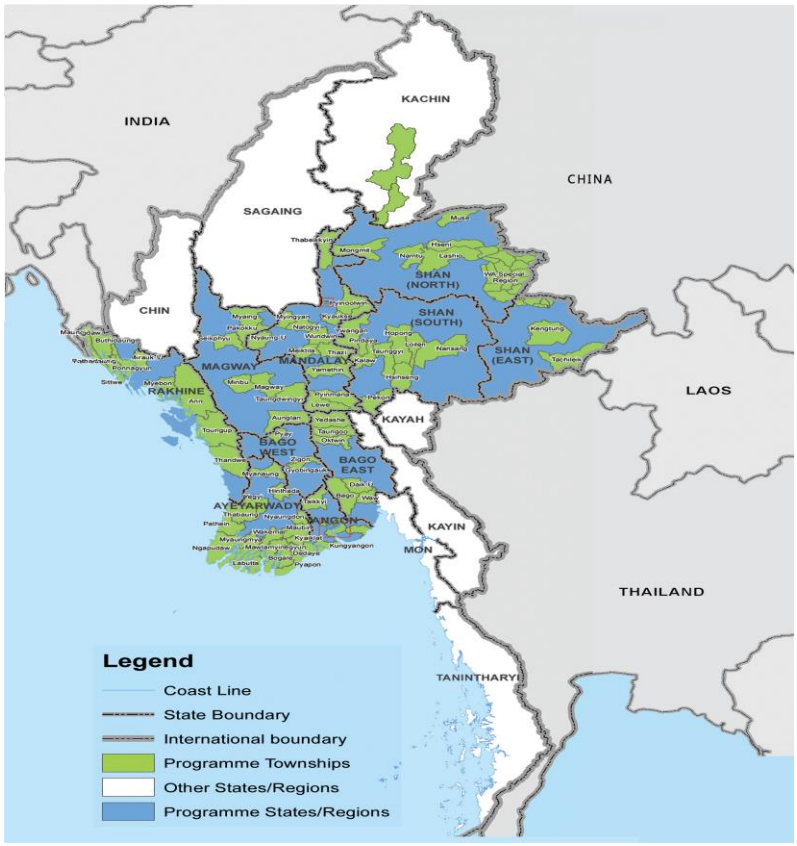
- high poverty incidence
- highly populated rural and peri-urban poor
- limited access to RH and HIV information and services
- high unmet need for birth spacing services and low CPR
- high abortion rate
- vulnerability to natural disasters and remoteness including areas with mobile population and ethnic minorities
- availability of adequate health personnel and infrastructure to facilitate achievement of sustained results

No.	Region	No.	State
1	Yangon	6	Rakhine
2	Mandalay	7	Shan
3	Ayeyarwaddy		
4	Bago		
5	Magway		

There are 89 townships under those selected Regions and States for implementation of UNFPA's supported activities. However, depending on the consultations with IPs and government departments, and funding availability, townships to implement the activities are selected yearly. In addition, special attention is given to those townships where immediate needs of humanitarian assistance are required, and provided in line with UNFPA mandates.

In addition, since Myanmar is prone to disasters (manmade or natural), UNFPA interventions on humanitarian context have been carried out all over the country. In particular, UNFPA provided life-saving reproductive health services and supported women's protection interventions including the establishment of women friendly spaces (women and girls center) for vocational training, psycho-social counselling and reproductive health education, raising awareness among staff of government and civil society on gender issues.

As Myanmar is vulnerable to natural disasters, UNFPA assisted in strengthening disaster preparedness and response to the emergencies situations which resulted from floods, earthquakes, cyclones, in the areas of reproductive health and women's protection through: a) development of contingency plans by regions; b) training of health personnel and humanitarian actors on Minimum Initial Service Package (MISP) for RH in emergencies; and c) establishment of rapid response teams including pre-positioning, stockpiling and timely distribution of supplies in case of emergencies. Moreover, the most vulnerable states, Kachin and Chin States were provided with humanitarian assistance. The following map represents the UNFPA CO's interventions areas.



3. Objectives and Scope of the evaluation

The present CPE is meant to ensure both the accountability of UNFPA Myanmar to its donors, partners and other stakeholders and to facilitate learning with a view to improve the relevance and performance of the country programme in its next cycle.

3.1 Objectives

The overall objectives of this CPE are:

- Enhanced accountability of UNFPA for the relevance and performance of the country programme 2012-2017;
- Broadened evidence-base for the design of the next programming cycle (2018-2022) in line with the corporate and national needs and strategies.

Specific objectives of CPEs:

Towards the achievement of these overall objectives, this CPE will be able to:

- Provide an independent assessment based on the Organization for Economic Co-operation and Development (OECD)/Development Assistance Committee (DAC) / UNEG evaluation criteria (relevance, effectiveness, efficiency and sustainability) including the progress of the country programme (2012-2017) towards the expected outputs set forth in the results framework;
- Provide an assessment of the CO positioning within the developing community and national partners, in view of its ability to respond to national needs while adding value to the country development results;

- Draw key lessons from past and current cooperation and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next programming cycle (2018-2022) by well taking into account relevant aspects of the UNFPA Strategic Plan 2014-2017.
- Test for relevance and performance of CO interventions addressing vulnerability issues and recommendations for future interventions in highly vulnerable contexts.

3.2 Scope

The evaluation will cover UNFPA assistance funded either from its own resources or with complementary/other resources. Geographically, the evaluation will include all 7 states/regions of Myanmar where development programmes have been supported and additional 2 states where humanitarian assistance has been provided by UNFPA.
The evaluation will take into account the relevant UNFPA Strategic Plans (2008-2013 and 2014-2017), the UNSF 2011–2015 for Myanmar, and key government and sectoral strategic plans.

The evaluation will focus on the outputs achieved through the implementation of the CP to date and contributions to outcome level changes. The evaluation will cover all activities planned and/or implemented during the period 2012-2017 within each of the programme components. Besides the assessment of the intended effects of the programme, the evaluation also aims at identifying potential unintended effects.

The evaluation will assess the extent to which the current CP, as implemented, has provided the best possible modalities for reaching the intended objectives, on the basis of results to date. At the end of the programme evaluation, the evaluators will provide recommendations for the upcoming CP (2018-2022) development and subsequent annual work plans and direction for the design of future UNFPA interventions in Myanmar in line with the national context and the UNFPA Strategic Plan 2014-2017 including its Business Model.

The scope of the evaluation will include an examination of the relevance, effectiveness, efficiency, sustainability, coordination with UNCT and added value of UNFPA support as well as its ability in delivering the results as stated in the agreed outputs under the current CP. In addition, the evaluation should provide feedback regarding the contribution of the CP to Myanmar's efforts to attain the goals of the ICPD, including the relevant UNFPA Strategic Plans (2008-2013 and 2014-2017).

In order to support cross-country learning in relation to key developmental challenges in highly vulnerable contexts, Evaluation office, with agreement of Executive board, developed new approach (CCPE)[83] conducting meta-analysis and drawing complementary learning from a set of country programme evaluations. As Myanmar is one of the selected countries for the first CCPE for UNFPA, the CPE will add few evaluation questions to inform substantive lessons relating to relevance and performance of UNFPA country programmes in highly vulnerable contexts, deriving lessons that can lead to the refining of the UNFPA's programming in such contexts.

[83] Concept note: clustered country programme evaluation on UNFPA engagement in highly vulnerable contexts

4. Evaluation Criteria and evaluation questions

UNFPA is strongly committed to complying with principles of the OECD/DAC and UNEG's criteria in terms of development programme evaluation. A number of key evaluation questions/ issues are proposed below and the evaluation team will initiate their own steps and approaches toward getting answers to those questions, which will thereafter lead to conclusion and recommendations. However, these evaluation questions are indicative at this stage and will be finalized during the design phase of the evaluation after proper consultation with the CO evaluation manager (EM) and the evaluation reference group (ERG). . There should be a maximum of 10 questions in the final list to be developed by the evaluation team at the end of the design phase. Under each evaluation criteria, there are a number of questions which are to be explored for evaluation.

RELEVANCE

The evaluation will assess the CP's relevance in terms of the alignment of the CP with the UNFPA Strategic Plans, government development plans, the UNSF 2011-2015 and other key sectoral plans.

- Are UNFPA's interventions in the different programme components aligned with the priorities as set in: a) national needs and priorities of Myanmar, b) the needs of target populations; and whether the focus of the CP outputs are in line with the organizational and regional strategies manifested in the ICPD-PoA, relevant UNFPA Strategic Plans (2008-2013 and 2014-2017), and the UNSF in the country?
- To what extent was the country office able to respond to changes in the national development with regard to the political, economic and social context in Myanmar?
- Were gender, equity and human rights dimensions effectively incorporated into the CP's design?

EFFECTIVENESS

The CP evaluation will examine the degree of achievement of the country programme outputs, and progress made towards achieving the programme outcomes given the changes in the global and national policy environment, and identify reasons for this progress and/or discrepancies between plans and achievements.

- To what extent have the expected results of the programme been achieved or are likely to be achieved? If so, to what degree? What were the factors that influenced the achievement and/or the non-achievement of the results?
- What was the intervention coverage – were the planned geographic areas and target groups especially those of marginalized populations/groups appropriately and equitably reached?
- What were the constraining and facilitating factors and the influence of context on the achievement of results?

EFFICIENCY

- To what extent has the UNFPA CO made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country programme?

- What was the timeliness of inputs; timeliness of outputs?
- How could more efficient use of resources be made given the country context?
- What was the quality of outputs achieved in relation to the expenditures incurred and resources used?

SUSTAINABILITY

- To what extent are the results of the UNFPA CO supported activities likely to last after their termination?
  - Has the programme incorporated appropriate exit strategies and developed the capacities of partners to ensure the sustainability of outputs?
  - Have conditions and mechanisms been developed and enhanced to ensure that national partners will take ownership of them upon completion of UNFPA intervention?

UNCT COORDINATION

- To what extent has the UNFPA CO contributed to the good functioning of coordination mechanisms and to an adequate division of tasks within the UN system in Myanmar?
- To what extent does the UNSF fully reflect the interests, priorities and mandate of UNFPA in the country?

ADDED VALUE/COMPARATIVE ADVANTAGES

- What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies?
- What is the main UNFPA added value in the country context as perceived by national stakeholders?

ENGAGEMENT IN HIGHLY VULNERABLE CONTEXTS

CCPE Specific Questions

- Relevance: How did UNFPA take into account the country's vulnerability to disasters and emergencies in planning and implementing its interventions?
- Effectiveness: To what extent was UNFPA, along with its partners, able (or likely able) to respond to crises during the period covered by the country programme?

The evaluation team should organize the questions into an evaluation matrix (see template #5 in the UNFPA Handbook for CPEs) that indicates: evaluation questions, assumptions to be assessed, its respective indicators (both qualitative and quantitative), proposed data sources and tools for data collection (document review, key informant interviews, field visit, etc.) to address each of the evaluation questions. Evaluators must use this matrix throughout the data collection process with a view to structuring and recording all collected information. At the design phase, the matrix displays the data requirements (sources and collection methods) to respond to the evaluation questions (and included as an annex in the design report) while at the field phase evaluators shall use it to organize the data and

information collected with a view to responding to the evaluation questions. In the reporting phase the matrix can guide the analysis of the data gathered and inform the responses provided to each of the evaluation questions. The completed evaluation matrix shall be included in the final report as an annex.

5. Methodology and Approach

The evaluation will adopt multiple methods to respond to the evaluation objectives and provide answers to the evaluation questions. These will include qualitative as well as quantitative approaches and make use of a variety of data gathering methods such as documentary review, group and individual semi-structured interviews, focus group discussions, case studies, field visits and observations.

The evaluation should be conducted legally, ethically, and with due regard for the welfare of those involved in the evaluation, especially women, children, and members of other vulnerable or disadvantaged groups, and in accordance with the UNEG's Ethical Guidelines for Evaluation. In line with UN Ethical Guidelines for Evaluation, the evaluation will ensure informed consent of participants. The purpose of evaluation will be outlined to beneficiaries, government counterparts and other stakeholders. Target groups for the evaluation are informed of the evaluation purpose, rights and obligations of participating in the evaluation and agreed to participate voluntarily. The identity of persons making individual comments will be kept confidential.

The standard criteria is set under OECD/DAC and UNEG that have been applied in conducting the evaluation. Depending on the evaluation criteria and questions, the evaluation could aim to find out the qualitative and quantitative information on the extent to which UNFPA's assistance offered. This is to use available primary and secondary data appropriately.

Data collection: The evaluation will use a multiple-method approach including (though not necessarily limited to):

- the review of documents including the relevant Strategic Plans, UNSF, Country Programme Documents, Country Programme Action Plan, Annual Work Plans, standard progress reports, country office annual reports, annual review reports, mission reports, sectoral plans and their progress reports;
- Site visits to UNFPA targeted areas, covering a selection of sub-national areas included in the country programme *(number and identification of Townships for selection is to be determined in the design phase)*; and
- Interviews with key stakeholders including national counterparts, implementing partners and development partners and target beneficiaries at national and sub-national levels.
- Visits to Nay Pyi Taw (and other selected capitals of states/regions) to discuss with concerned government officials who are residing in there
- Observations in particular in health facilities at national and sub-national level.

Selection of sub-national locations /Townships will be guided by the priorities of the UNFPA programme, ensuring coverage of all components of the programme cycle. The selection criteria and process will be finalized in the design phase, in consultation with the CO, government counterparts and other stakeholders represented in the ERG. The collection of evaluation data will be carried out through a

variety of techniques that will range from direct observation to informal and semi-structured interviews and focus group discussions.

The focus of the data analysis process in the evaluation is the identification of evidence. The evaluation team will use a variety of both quantitative and qualitative methods to ensure that the results of the data analysis are credible and evidence-based. The analysis will build on triangulating information obtained from various stakeholders' views as well as cross checking of primary data with secondary data and documentation reviewed by the evaluation team.

Validation mechanisms: The Evaluation Team will use a variety of methods to ensure the validity of the data collected. Besides a systematic triangulation of data sources and data collection methods and tools, the validation of data will be sought through regular exchanges with the CO programme managers.

Stakeholders' participation: An inclusive approach, involving a broad range of partners and stakeholders, will be taken. The evaluation team will perform a stakeholder mapping in order to identify both UNFPA direct and indirect partners (i.e. partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). These stakeholders may include representatives from the government, civil-society organizations, the private-sector, UN organizations, other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the programme.

The evaluation process will be conducted on an independent basis. It will involve the Myanmar CO and members of the evaluation reference group in the design, field and reporting phases of the evaluation. Parties involved will abide by the independent nature of the evaluation process.

The evaluation team will need to properly consult with the methodological guide – *Handbook on How to Design and Conduct a Country Programme Evaluation at UNFPA* - introduced by the Evaluation Office of UNFPA, which provides clear steps, recommended methodologies and tools and templates to be used for UNFPA country programme evaluations.

Limitations and constraints to the Evaluation exercise

Limited data availability as well as reliability of data could be challenges for the design and conduct of a country programme evaluation in Myanmar. In particular, various data sources could be applied to measure the progress of most CP indicators. A limited level of the documentation for country programme including monitoring documents could be considered as limitation, with regard to the UNFPA supported activities. The results frameworks of Country Programme have been changed depending in response to changes in the Strategic Plans. Regarding implementation modality, the CO and IPs have changed to focus on advocacy and capacity development from services delivery in order to achieve the results defined in the results framework, in a process of alignment with the new UNFPA strategic plan.

In terms of the operationalization of field exercise, approval from the government for official travel in Myanmar should be obtained in a timely manner in order to undertake the field visits to states/ regions as scheduled of evaluation exercises. Due to security reasons, some project areas cannot be visited to examine the effect of UNFPA assistance. Local travel can be time consuming when it comes to accessing villages during the field work due to the means of transportation as well as road condition. With government offices located in NPT (around 350km from Yangon) and evaluation team stationed in Yangon face to face contact with representatives of government agencies will be limited. Lastly, if there are field visits, translation of Myanmar language will be required which can increase time required to gather data.

6. Evaluation Process

The timeframe for the evaluation is **nine months**, from the start of the preparation phase through to distribution of the final evaluation report. Those phases are 1) preparation, 2) Design, 3) field, 4) reporting and 5) management response, dissemination and follow up. However, the present TOR focuses on three phases, i.e. design, field and reporting phase, each consisting of various stages.

Phase 1: Design Phase

This phase will include

- **Documentary Review** of all relevant documents available at CO and UNFPA HQ level regarding the country programme for the period being examined. The review will include an assessment of general documentation on the human development situation, national planning documents, studies and a full overview of UNFPA country programme during the period under evaluation.
- **Stakeholder mapping -** Extended mapping of the country stakeholders relevant to the evaluation will be performed by the evaluation team, informed by an overview of stakeholders provided by the country office. The mapping exercise will include state and civil society stakeholders and will also indicate the relationships between different sets of stakeholders. It should go beyond traditional UNFPA partners.
- An analysis of the intervention logic of the Programme i.e., the theory of change meant to lead from planned activities to the intended results of the programme at output and outcome levels.
- Finalization of evaluation questions.
- Development of a data collection and analysis strategy as well as a concrete work plan for the field phase.
- Development of an evaluation matrix, which should display the evaluation questions and corresponding assumptions to be assessed, indicators, and sources of information, etc. it should be mentioned as an annex of the design report.
- At the end of the design phase, the evaluation team will produce a design report, displaying the results of the above listed steps and tasks. Specifically, it will contain the analysis of the intervention logic of the programme, background to the evaluation, evaluation questions, detailed methodology, information sources, instruments and a work plan for data collection, data analysis and reporting. The design report will need to be discussed with the Evaluation Reference group and agreed upon with the Myanmar CO prior to the start of the field phase.

Phase 2: Field Phase

- After the design phase, the evaluation team will undertake data gathering in field visits for three weeks in Myanmar (both in Yangon and in selected field sites) to collect and analyze the data required in order to answer the evaluation questions. This phase is for the team to gain an in-depth understanding of the development challenges regarding the themes addressed by the programme and the different perspectives of the stakeholders regarding the role of UNFPA in meeting these challenges within its specific mandate.
- The field visits will include, but not be limited to, visiting health centers, referral hospitals, villages where programme activities have been implemented, IPs centers which will provide an opportunity for interaction with target beneficiaries as well as visits to other relevant stakeholders. During the visits, data will also be collected and validated. The team will visit

selected sub-national areas where interventions and activities have been implemented in order to obtain a comprehensive view of the execution of the programme.

- At the end of field phase, the evaluation team will provide the CO with a debriefing presentation on the preliminary results of evaluation, with a view to validating findings and testing tentative conclusions and recommendations

Phase 3: Reporting Phase

- Analysis and report: during this phase, evaluation team will continue the analytical work initiated during the filed phase (data collected will be analyzed, cross-checked and triangulated) and prepare a first draft of the final evaluation report, taking into account comments made by member of the CO Myanmar at the debriefing meeting. The evaluation team will submit the first draft of the final evaluation report to the evaluation reference group through Myanmar CO for their review and comments. Comments made by the members of the reference group and consolidated by the evaluation manager will then allow the evaluation team to prepare a second draft of the final evaluation report. This second draft will form the basis for an in-country dissemination seminar, which should be attended by the Myanmar CO as well as all the key programme stakeholders (including key national counterparts). The final evaluation report will be drafted shortly after the seminar, taking into account comments made by the participants.
- **Management response:** The Myanmar CO will need to prepare a management response to the recommendations contained in the final evaluation report.
- **Communication and dissemination:** The evaluation report will be distributed to the relevant stakeholders. The evaluation report will be available to the Executive Board as a companion document to the Myanmar CO new country programme document (2018-2022). In addition, the evaluation report and the management response will be published on the CO web page and will be available to the public.

The provisional timeline is provided in a section below in order to guide the evaluation process. However, this is a mere indication and may be subject to further refinement by the evaluation team in order to meet the actual requirements as deemed necessary and in consultation with the evaluation manager.
The members of the evaluation team shall have no conflict of interest or any connection to the design, planning, or implementation of the current or upcoming country programme. Any such conflict should be brought to UNFPA's attention as part of the recruitment process.

7. Expected outputs/deliverables

The **evaluation team** will assume overall coordination and evaluation responsibilities of the UNFPA CP evaluation. The **lead international consultant (LC)** in consultation with the CO Evaluation Manager and with inputs from the international member consultant (IMC) and **national consultant (NC)** team members**,** will be responsible for the following tangible outputs at an acceptable level of quality and in a timely manner[84]:

[84] Outlines of the design and final reports are presented in the annexes and are, moreover, available in the Handbook on How to Design and Conduct a CPE at UNFPA.

- Design Report (including data collection instruments, evaluation matrix and clear timeline of activities)
- Evaluation Matrix
- Debriefing presentation at the end of the field phase;
- Draft of the CPE report (with inputs from the team members) (i.e. 1st and 2nd draft)
- Debriefing Presentation of Stakeholder workshop (PowerPoint)
- Final CPE report and evaluation brief

Design Report:

The **evaluation team (LC, IMC and NC)** shall commence the assignment as soon as contract started and shall submit an electronic copy of a draft design report to UNFPA after 5 working days. The evaluation team will work at their home for preparation of draft design report after consultation with team members of evaluation team through electronically. CO will provide necessary documents to the evaluation team via email, google drive and/or skype if necessary, and by pouch. The design report should include a clear work plan specifying methodological and organizational aspects of its work, including any provisions for needed meetings, interviews, and travel, formal events of consultations etc., as well as the necessary working days foreseen for key components of the work plan. The design report provides an opportunity for UNFPA, the reference group and the evaluation team to ensure that their interpretations and understanding of the CPE ToR are mutually consistent. While evaluation team leader should be in country for 5 working days, the team should consult each other for fine-tuning (finalize) the evaluation design report and preparation for data gathering in country before starting the actual field visit for data collection. It could make understanding thoroughly the evaluation design report by all team members which will set up team spirit for the evaluation exercise to get better result. The design report, once agreed and approved, will serve as an agreement between UNFPA and the evaluation team on how the evaluation will be conducted. This design report shall be structured as mentioned in Annex 4.

Evaluation Matrix: This is to be shared by the evaluation team with the CO for a last facts checking before embarking on the drafting of the evaluation report.

Debriefing Presentation (PowerPoint): The PowerPoint presentation is to be expected from the evaluation team at the end of the field phase

Draft evaluation report: The LC shall draft and submit an electronic copy of a draft evaluation report to UNFPA (see timeline below). The draft report should be thoroughly copy edited to ensure that comments from the UNFPA and other stakeholders especially the Reference Group on content, presentation, language, and structure can be reduced to a minimum. The LC is required to develop a strong first draft report, since this has proved very useful in facilitating clear and constructive feedback and generating confidence by the reviewers in the competence of the evaluation team. Moreover, the stakeholder workshop/seminar should be held on the basis of the second draft final report.

Stakeholder workshop: The stakeholder workshop with implementing partners, donors, UN agencies' staff, as well as other relevant stakeholders. The workshop is hosted by the UNFPA

country office, possibly in partnership with the partner government where appropriate. The evaluation team leader presents (PowerPoint presentation) the main findings, answers to the evaluation questions, conclusions and recommendations. The country office shall, in turn, present its response to the evaluation recommendations, and discuss the implications for UNFPA programming, taking stock of the evaluation results.

Final report: After UNFPA and the Reference Group reviewed the draft report, UNFPA office will provide the consolidated written comments to the evaluation team. Based on these comments, the team shall correct all factual errors and inaccuracies and make changes related to the report's structure, consistency, analytical rigor, validity of evidence, and requirements in the ToR. In line with the independence of the evaluation team, the team will not be required to make changes to conclusions and recommendations, unless they are regarded as qualitative improvements. After making the necessary changes, the evaluation team will submit a revised draft evaluation report to UNFPA. After the second round of review and, if necessary, further revision to the draft evaluation report will be made and the evaluation team can then submit the final report pending UNFPA's approval.
The final report will follow the outline presented in the annexes, based on the UNFPA Evaluation Guidelines and should be maximum 70 pages excluding the annexes. The evaluation report should go beyond a mere description of implementation and outcomes and include an analysis, based on the findings, of the underlying causes, constraints, strengths on which to build on, and opportunities.

An abstract of the evaluation shall be produced by the LC and submit to UNFPA along with the full final evaluation report. UNFPA will provide the evaluation team with the recommended outlines for the final report and the abstract. All deliverables must be in English and in provided in electronic (editable) copies.

8. Indicative Work plan timelines

The following table is an indicative timeline which covers the whole process of the country programme evaluation. However, there may be some adaptation in order to respond to the actual situation. The design phase of the CPE exercise is expected to commence in **June 2016**.

Phases/deliverables	Dates (weeks)
1. Preparatory Phase - Drafting of the ToR - Approval of the ToR by APRO and the EO - Selection and recruitment of the evaluation team	 - 7 weeks (Feb-Mar 2016) - 11 weeks (Mar-June 2016) - 6 weeks (July - Aug 2016)
2. Design Phase - Desk review and submission of the draft design report - Comments from the ERG/Final design report - Finalization of draft design report and preparation for data collection	 - 1 week (Aug 2016) - 1 week (Aug 2016) - 1 week (Sep 2016)
3. Field Phase - Data gathering and preparation of preliminary findings to CO and ERG	 - 3 weeks (Sept 2016)
4. Reporting phase - 1st draft final report - Comments from the ERG - 2nd draft final report - Stakeholder workshop - Final report (including reporting of CCPE part)	 - 2 weeks (Oct 2016) - 2 weeks (Oct 2016) - 2 weeks (Nov 2016) - 1 week (Nov 2016) - 2 weeks (Nov-Dec 2016)

9. Composition of evaluation team

The evaluation will be carried out by a team consisting of **an International Consultant as a team leader (LC)**, one **International Member Consultant (IMC)** and two **National Consultants (NC)** as team members who bring profound knowledge of UNFPA works in national context and relationships with stakeholders concerned. They will be assisted by one interpreter. The evaluation team will be working under the UNFPA Individual Consultants Contract with 65 working days for **LC,** 40 working days for IMC and 45 working days for two NCs respectively. The evaluation team will sign a contract with UNFPA CO for a period of 25 weeks and will be paid based on the number of working days cited above. DSA at prevailing UN rate will be paid to consultants during travel for the purpose of this evaluation. The Lead consultant as a team leader should undertake 5 weeks in-country mission (with 2 visits which envisage as 4 weeks for 1st visit, and 1 week for 2nd visit) respectively for field work and for the presentation to the stakeholders' workshop. On the other hand, the international member consultant should undertake 3 weeks in country mission (1 visit) concurrently with the first visit of the lead consultant in country. All deliverables to be produced by the evaluation team under this ToR should be submitted to UNFPA Myanmar within the contract period.
Generally, it is envisaged that all consultants will have technical expertise in at least one area among the programme component of Reproductive Health, Population and Development, and Gender/GBV.

The **Lead Consultant (LC)** will be an international expert in monitoring and evaluation of development programmes with:

- Advanced degree in development studies, business administration, public health , or any other social science studies

- At least 15 years' proven experience in leading evaluations in the field of development for UN organizations or other international organizations
- Experience in conducting complex programme and/or country level evaluations including knowledge of evaluation methods and techniques for data collection and analysis
- Knowledge of Myanmar country-specific development context
- Experience in the Southeast Asia region and preferable in Myanmar
- Strategic vision, strong technical and analytical capacities and demonstrated ability to collect, analyses and interpret data and information
- Excellent leadership, communication ability and excellent drafting skills in English
- Expertise in humanitarian programming and vulnerable contexts for more than 10 year experiences
- Familiarity with UNFPA or UN operation systems
- Ability to work within a team

The team leader will be responsible for

- Provide overall leadership on the independent evaluation of the UNFPA CPE based on inputs and insights from the national consultants
- Responsible for covering at least one component of the CP
- Supervise and coordinate the work of evaluation team members and responsible for the quality assurance of all evaluation deliverables
- Develop the design report including assessment framework
- Collect information, conduct desk reviews of relevant documents and interview with the government partners, UN/UNFPA staff, donors and other partners based on the developed assessment framework
- Responsible for combining the first comprehensive draft of the evaluation report, 2nd draft and final draft of evaluation report based on the inputs from other evaluation team members
- Producing and ensuring completion of all the deliverables including design report, draft evaluation report, evaluation brief/ presentation and final evaluation report that meets all of UNFPA's evaluation quality standards.
- Ensure that all the evaluation team members selected to work under his/her supervision are fully briefed about the whole evaluation process, objectives, methodology framework, and key milestones/deliverables.
- Responsible, with support of the member consultants, for submitting all the deliverables under this consultancy at acceptable quality and in a timely manner.

One **international member consultant** (on Population and Development) and two **individual national consultants** (one Consultant on RH and another Consultant on Gender/GBV) will be recruited and those consultants should have expertise in their specific thematic areas, respectively.

The **international member consultant (IMC)** will have the following criteria*:*

- Master's Degree in social sciences (with specialization in population and development area)
- At least 10 years' proven experience in leading evaluations in the field of development for UN organizations or other international organizations

- Experience conducting complex evaluations/research in the field of development for UN organizations or other international organizations in the relevant areas (health, population & development or gender/GBV)
- Strategic vision, strong technical and analytical capacities and demonstrated ability to collect, analyses and interpret data and information
- Experience in the relevant areas (health, population & development or gender/GBV)
- Preferably previous experiences with UNFPA programming in the areas of Health, Youth, P&D and Gender/ GBV matters
- Experience in/knowledge of the region especially the Myanmar development context
- Excellent reporting skills in the language of the report and communication ability

The two **national consultants** (preferably with a mix of male and female candidates) will have the following criteria*:*

- Master's Degree in social sciences (with specialization in relevant health and gender/GBV areas)
- At least 10 years' proven experience in leading evaluations in the field of development for UN organizations or other international organizations
- Experience in conducting complex evaluations/research in the field of development for UN organizations or other international organizations in the relevant areas (health or population & development or gender/GBV)
- Experience in the relevant areas (health, population & development or gender/GBV)
- preferably previous experiences with UNFPA programming in the areas of Health, youth, P&D and Gender /GBV matters
- Strategic vision, strong technical and analytical capacities and demonstrated ability to collect, analyses and interpret data and information
- Excellent communication reporting skills in English
- Preferable, more than 10 years of experiences in respective thematic areas
- Fluent in English and Myanmar language
- Familiarity with UNFPA or UN operation systems
- Ability to work within a team

One international member consultant and two national consultants in each thematic areas will be responsible for:

- Providing inputs and insights (based on the context of UNFPA CP to independent evaluation of UNFPA's programme in Myanmar)
- Participating in meetings with governments counterparts, UNFPA staff, donors and other partners with the team leader
- Providing support and assistance to finalize the mission agenda, meetings and required visits
- Provide inputs to the deliverables: design report, draft evaluation report, evaluation brief and final evaluation report
- Undertake/assist with interviews and site visits with the **Lead consultant**
- Provide expertise in the respective programme thematic area
- Take part in the data collection and analysis work during the design and field phases.

- Responsible for drafting key parts of the design report and of final report, including (but not limited to) sections relating to reproductive health and rights.

Interpreter's requirement:

- Profound knowledge of English and skill of translation to and from Myanmar language
- Long term experience with translation in evaluations
- Experience with results based management terminology in English as well as Myanmar language
- Relevant knowledge and experiences in national development context and good relationships with stakeholders concerned.

Interpreter will be responsible for:

- Assist the team leader for translation during field phase, for conducting group/individual meetings with beneficiaries and translation of selected secondary materials.
- Provide support and assistance to finalize the mission's agenda, meetings and required visits
- Assist the evaluation team for general administrative/logistic work in coordination with UNFPA CO
- Organize evaluation team meeting as guided by the evaluation team leader when required
- Coordinate with all stakeholders to organize and arrange of meeting/ focus group/ key informant meeting with various stakeholders

The work of the evaluation team will be guided by the norms and standards established by the UNEG. Team members will adhere to the ethical guidelines for evaluation in the UN system and to the code of conduct established by UNEG. The evaluators will be requested to sign the code of conduct prior to engaging in the evaluation exercise.

10. Payment of consulting fees

Partition of working days among the team of experts and provision of time for each deliveries will be following;

- 65 working days for team leader (international consultant): *(10 working days for preparation of design report of which 5 at home base and 5 in Yangon, 20 working days for field phase in country mission , 10 working days for preparation of 1st draft of evaluation report at home base, 10 working days for preparation of 2nd draft of evaluation report , 5 working days for stakeholders' workshop in country mission and 10 working days for draft final report preparation at home base)*

- 40 working days for international member consultant for Population and Development: *(10 working days for preparation of design report at home base, 20working days for field phase in country mission , 5 working days for preparation of 1st draft of evaluation report at home base, 3 working days for preparation of 2nd draft of evaluation report and 2 working days for draft final report preparation at home base)*

- 45 working days for national consultant for Sexual Reproductive Health and Rights: *(10 working days for preparation of design report at home base , 20 working days for field phase in country mission , 7 working days for preparation of 1st draft of evaluation report at home base, 5 working days for preparation of 2nd draft of evaluation report and 3 working days for draft final report preparation at home base)*

- 45 working days for national consultant for Gender/GBV*: (10 working days for preparation of design report at home base , 20 working days for field phase in country mission , 7 working days for preparation of 1st draft of evaluation report at home base, 5 working days for preparation of 2nd draft of evaluation report and 3 working days for draft final report preparation at home base)*

- 25 working days for interpreter: *(20 working days for field phase, and 5 working days for stakeholders' workshop)*

Payment of fees for the consultants will be based on the delivery of outputs, as follows:

- Upon satisfactory delivery of the design report: 20%
- Upon satisfactory finalization of the field phase: 20%
- Upon satisfactory delivery of the draft final evaluation report: 30%
- Upon satisfactory delivery of the final evaluation report: 30%

11. Management and conduct of the evaluation

A CO evaluation manager will be assigned to interact on a day-to-day basis with the evaluation team and who, together with the evaluation reference group, will ensure that all the necessary aspects of CP evaluation are well taken into account by the evaluation team.

The evaluation manager is M&E Officer under the supervision of the Deputy Representative, in the country office and he will manage the overall evaluation, and will carry out the following functions:

- To ensure consistency throughout the evaluation process (from ToR to dissemination of results and follow-up of recommendations) and assumes day-to-day responsibility for managing the evaluation
- To coordinate the development of the ToR for the Country Programme Evaluation, with support from APRO and EO
- To correspond with the reference group members at strategic points throughout the evaluation
- To provide/facilitate the provision of documents and other resources available in the country office
- To support the evaluation team in the development of the evaluation design report,
- To support all phases of the evaluation and assesses the quality of related deliverables (design report, draft and final evaluation reports)
- To be the first point of contact and bridge the communication between CO staff, senior management, APRO, EO and evaluation team throughout the evaluation

For the conduct of the CPE, an evaluation reference group (ERG)[85] will be constituted with members from relevant national implementing partners, development partners, civil society organizations, UNFPA regional office and CO evaluation manager, which is charged with providing guidance to the entire evaluation process and provide necessary inputs to all evaluation deliverables.

[85] Document on Terms of Reference for Evaluation Reference Group

The evaluation team will need to properly consult and involve this ERG throughout the evaluation phases.

There will be the parts of roles for participants in the formulation of design report (questions/objectives, methods, data collection instruments, evaluation matrix, and so on), or developing recommendations, and other roles as appropriate for the evaluation. However, involvement and consultation of the ERG should not affect the independence and impartiality of the evaluation.

The above evaluation reference group (ERG) will be tasked with the following activities:

- To review and provide comment on draft design report technically and feedback to the evaluation team;
- To provide the evaluation team with relevant information and documentation on the programme under assessment;
- To facilitate the access of the evaluation team to key informants during the field phase; and
- To review and provide comment technically on draft evaluation report, its conclusion and recommendations and feedback to evaluation team;
- To assist in feedback of the findings, conclusions and recommendations from the evaluation into future programme design and implementation.

Members of this reference group will be composed of the representatives from the following Organizations of government, non-government, UN agencies, donors and UNFPA:

No	Agency	Role
1	UNFPA Myanmar	Chair
2	Foreign Economic Relations Department (FERD)	Member
3	Ministry of Planning and Finance (Central Statistical Organization-CSO)	Member
4	Ministry of Health and Sports (Department of Public Health -DoPH)	Member
5	Ministry of Social Welfare, Relief and Resettlement (Department of Social Welfare -DSW)	Member
6	Ministry of Labour, Immigration and Population (Department of Population- DOP)	Member
7	DFAT	Member
8	MSI Office	Member
9	MMA Office	Member
10	UNDP Office	Member
11	UNICEF Office	Member
12	UNFPA Office	Member
13	UNFPA Asia Pacific Regional Office	Member
14	UNFPA Myanmar	Secretary (Evaluation Manager)

Proposed meetings of the reference group:

In addition to a few necessary physical meetings (noted below), members of the evaluation reference

group (ERG) will mainly communicate through email correspondence.

1. **First meeting:** introduction between the RG and evaluation team; and review of the design report (design report).
2. **Second meeting:** presentation of draft findings, conclusions and recommendations by evaluation team; ERG to provide feedback to evaluation team.

The overall guidance will be provided by the UNFPA CO Representative and CO deputy Representative, the CO evaluation manager will coordinate the evaluation process. UNFPA CO will provide the evaluation team with all the necessary documents and reports and refer it to web-based materials as part of the desk review exercise. One programme Assistant will be assigned as the evaluation team's counterpart to provide support in terms of gathering documentation as required.

The UNFPA evaluation manager will liaise with the UNFPA programme managers to ensure that the thematic component reports are provided to the evaluation team as these are critical inputs to the programme evaluation. UNFPA management and staff will make themselves available for interviews and technical assistance as appropriate. The CO will also provide necessary logistical support in terms of providing space for meetings, assistance in making appointments, arranging travel and site visits. Appropriate office space and computer equipment (if needed) with access to internet and printing services will be provided to the evaluation team.

The UNFPA Asia and Pacific Regional Office (APRO) and EO/HQ will support the quality assurance of evaluation deliverables to be in line with the UNFPA quality guidelines.

12. Documents to be reviewed include (but not limited to) the following:

CO will provide the following documents (not limited) to be reviewed by the evaluation team and other relevant documents/ materials will be provided when evaluation team is on board.

1. Handbook: How to design and conduct a country programme evaluation at UNFPA (2013)
2. End of programme evaluation of 2nd country programme cycle
3. Management response to the recommendations of 2nd country programme evaluation.
4. AWPs , WP progress reports, joint monitoring reports (2012,2013,2014,2015)
5. Standard Progress Report by outputs (2012,2013,2014)
6. Various SPRs and Annual Programme Review meeting reports
7. Draft Report on Baseline data collection (2013)
8. UN strategic Framework (2012-2015)
9. UN thematic Analysis (2011)
10. Country Programme Document (2012-2015)
11. CPAP (2012-2015)
12. Documents on CPD extension (2015-2017)
13. Framework for Economic and Social Reforms (2012-15)
14. Country COAR (2012,2013,2014)
15. Country annual report from SIS (2015)
16. Reproductive Health Supply Chain Assessment and Recommendations (2013)
17. National Service Standards and Guidelines on Adolescent and Youth Health Care (2013)

18. 2014 Facility Assessment for Reproductive Health Commodities and Services
19. RH policy
20. RH NSP
21. Myanmar midwifery Situation 2014 - Synthesis report (October 2014)
22. Mid-Term Review of the Myanmar National Strategic Plan on HIV and AIDS 2011-2015 (Consolidation Report) 2013
23. Global AIDS Response Progress Report Myanmar (National AIDS Programme) 2015
24. Myanmar Revised NSP II 2011-2016
25. Myanmar Revised NSP II OP 2011-2016
26. NSP MMR Draft MASTER File (15-Dec 21) (1)
27. National Service Standards and Guidelines on Adolescent and Youth Health Care (2013)
28. National Strategic Plan for the Advancement of Women (2013-2022)
29. Census project documents
30. Assessment of the Existing Situation of the Data Computing System for Census
31. Assessing the Advocacy and Publicity capacities for the census 2014(advocacy strategy)
32. Assessment on census mapping and cartography
33. Communication strategy
34. Pilot Census report
35. Census enumeration monitoring reports by observation team
36. Final Census results
37. Thematic analysis of census results (soon)
38. Conflict sensitivity analysis and strategy options in the context of data processing, analysis, release and dissemination of the 2014 Myanmar population and housing census (2014)
39. Levels, Trends and Patterns of Internal Migration in Myanmar (2013)
40. Ageing Transition in Myanmar (2012)
41. Assessment of Statistical System by ADB consultant
42. NSDS core strategies document
43. Concept note on Clustered Country Programme Evaluation

13. Annexes.

1. Ethical code of conduct for UNEG/UNFPA evaluation
2. Short outlines of the design report
3. The format of the evaluation matrix
4. The structure of the final evaluation reports
5. Evaluation quality assessment template and explanatory note
6. Management response template

[Annex 1]

Ethical Code of Conduct for UNEG/UNFPA Evaluations

Evaluations of UNFPA-supported activities need to be independent, impartial and rigorous. Each evaluation should clearly contribute to learning and accountability. Hence evaluators must have personal and professional integrity and be guided by propriety in the conduct of their business. In particular:

1. To avoid **conflict of interest** and undue pressure, evaluators need to be **independent,** implying that members of an evaluation team must not have been directly responsible for the policy-setting/programming, design, or overall management of the subject of evaluation, nor expect to be in the near future. Evaluators must have no vested interests and have the full freedom to conduct impartially their evaluative work, without potential negative effects on their career development. They must be able to express their opinion in a free manner.

2. Evaluators should protect the anonymity and **confidentiality of individual informants**. They should provide maximum notice, minimize demands on time, and respect people's right not to engage. Evaluators must respect people's right to provide information in confidence, and must ensure that sensitive information cannot be traced to its source. Evaluators are **not expected to evaluate individuals**, and must balance an evaluation of management functions with this general principle.

3. Evaluations sometimes uncover suspicion of wrongdoing. Such cases must be reported discreetly to the appropriate investigative body.

4. Evaluators should be **sensitive to beliefs, manners and customs** and act with integrity and honesty in their relations with all stakeholders. In line with the UN Universal Declaration of Human Rights, evaluators must be sensitive to and **address issues of discrimination and gender equality**. They should avoid offending the dignity and self-respect of those persons with whom they come in contact in the course of the evaluation. Knowing that evaluation might negatively affect the interests of some stakeholders, evaluators should conduct the evaluation and communicate its purpose and results in a way that clearly respects the stakeholders' dignity and self-worth.

5. Evaluators are responsible for the clear, accurate and fair written and/or oral presentation of study limitations, evidence based findings, conclusions and recommendations.

For details on the ethics and independence in evaluation, please see UNEG Ethical Guidelines and Norms for Evaluation in the UN System
http://www.unevaluation.org/search/index.jsp?q=UNEG+Ethical+Guidelines
http://www.unevaluation.org/papersandpubs/documentdetail.jsp?doc_id=21
[Please date, sign and write "Read and approved"]

Annex 2: List of Persons/Institutions Met

1. National Level- Yangon

	Names	Male/ Female	Institution/Organization	Title
1	Janet E. Jackson	F	UNFPA	Country Representative
2	Kaori Ishikawa	F	UNFPA	Deputy Representative
3	Dr. Hla Hla Aye	F	UNFPA	Assistant Representative
4	Carlos Valencia	M	UNFPA	International Operations Manager
5	Khin Zar Naing	F	UNFPA	Sr. National Programme Officer
6	Alexandra Robinson	F	UNFPA	International GBV coordinator
7	Mi Mi Thin Aung	F	UNFPA	National GBV Coordinator
8	Seng Aung Sein Myint	M	UNFPA	Programme Analyst (Gender)
9	Dr. Ye Myint Oo	M	UNFPA	National Humanitarian Response Coordinator
10	Dr. Tin Maung Chit	M	UNFPA	National Programme Officer
11	Dr. Aung Thu Htun	M	UNFPA	National Programme Officer
12	Dr. Win Aung	M	UNFPA	National Programme Officer
13	Daw Yu Myat Mon	F	UNFPA	National Programme Officer (RH/ARH)
14	Dr. Sithu Swe	M	UNFPA	National Programme Officer (Young people)
15	Dr. Ni Ni Khine	F	UNFPA	National Programme Officer (HIV and AIDS)
16	Dr. Haling Htike Hta Khin	F	UNFPA	Field Coordinator
17	Daw Yin Yin Swe	F	UNFPA	Programme Assistant
18	U Win Myint	M	UNFPA	National Programme Officer (M &E)
19	Daw Tin Thuzar Lwin	F	UNFPA	Programme Assistant
20	Daniel Msonda	M	UNFPA	Census Coordinator
21	Paul Lund-Steinheuer	M	UNFPA	Conflict Sensitivity Team
22		F	UNFPA	Conflict Sensitivity Team
23	Gretchen Emick	F	IRC	WPE Coordinator
24	Robert Driscol	M	IRC	Grants Manager
25	Dr. Kyaw Linn Tun	M	FXB Myanmar	Programme Manager
26	U Win Aung	M	FXB Myanmar	Financial Controller
27	Dr. Moe Moe Aung	F	Marie Stopes Myanmar	Operations Director
28	Dr. Sid Naing	M	Marie Stopes Myanmar	Country Director
29	Dr. Myo Yazar	M	Marie Stopes Myanmar	Project Coordinator
30	Dr. Kaythi Myint Thein	F	Gender Equality Network	Programme Manager

31	Ding Rin Naw Ja	M	Metta	Head of Finance, HR & IT
32	Seng Hkam	F	Metta	Project Coordinator
33	Dr. Myint Myint Win	F	PSI	Programme Deputy Director (RH/Maternal Health)
34	Dr. Myat Min Zaw	M	PSI	Programme Deputy Director (HIV and AIDS)
35	Dr. Khine Haymar Myint	F	JHPIEGO	Sr. Technical Advisor
36	Dr. Kyaw Kyaw Cho	M	JHPIEGO	Sr. Programme Manager, Programme Lead
37	Dr. Zar Ni Soe,	M	JSI	Sr. Programme Advisor
38	Dr. Tin Moe Aung	F	JSI	Programme Manager, Health Logistics
39	Saw Pe Kaw Htoo	M	JSI	Programme Officer, Health Logistics
40	Dr. Sai Win Zaw Hlaing	M	State Public Health Office, Shan State	Deputy State Public Health Director
41	Dr. Kyaw Lwin	M	Central medical Store Department CMSD, MOH	Director
42	Dr. Yan Naung Htun	M	CMSD, MOH	Deputy Director
43	U Aung Shwe	M	CMSD, MOH	Logistic Officer
44	Dr. Anoma Tayathilaka	F	WHO	Technical Advisor
45	Dr. Shwe Zin Yu	F	WHO	Technical Officer
46	Eamonn Murphy	M	UNAIDS Myanmar	Country Director
47	Dr. Ne Win	M	Myanmar Medical Association	Project Coordinator- Youth Development
48	Dr. Myint Zaw	M	Myanmar Medical Association	Project Coordinator- Humanitarian
49	Penelope Campbell	F	UNICEF	Chief of Health
50	Anna Maria Levi	F	UNICEF	*Child Rights Monitoring specialist, social policy section*
51	Aniruddha Bonnerjee	M	UNICEF	*Senior Consultant*
52	Pablo Barrera	M	Office of UNRC	Head of Dev. Coordination Cluster
53	Dr. Kaythi Myint Thein		GEN	Program Manager
54	Ms. Nasantuya Chuluum	F	UNDP	Operation Manager
55	Thuy Hang To	F	UNDP	Deputy Res Pep (Operations)
56		F	UNDP	M&E Officer
57	Flex Schmieding	M	UNDP	*Consultant – Statistics*
58	Geraldine Petruccelli	F	UNHCR	Protection Coordinator
59		F	UNHCR	
60	Kyoko Yokosuka	F	Australian Embassy, Yangon	Programme Manager
61	U Myint Kyaing	M	Ministry of Labour, I & P	Permanent Secretary
62	Ding Rin Naw Ja	F	Metta Development Foundation	Head of Finance, HR & IT
63	Jean D' Cunha	F	UN Women	Head of UN Women
64	David Craven	M	TMAP	Managing Director
65	Silja Rajander	F	Finish Develolpment Missoin	

66	Ben Powis	M	DFID,Yangon	
67	Tomas Lundstrom	M	Embassy of Sweden,Yangon	
68	Reena Badiani_Magnusson	F	The World Bank	Senior Economist, Poverty & Equity Global Practice
69	Rene Mous	M	Regional Supply Chain Strengthening Project (RSCS) Partnership for Supply Chain Management	Project Manager
70	Rev Saw Shwe Lin	M	Myanmar Council of Churches	Former General Secretary
71	Prof. Dr. Khin May Than	F	Department of Statistics, Yangon University of Economics	Professor of Statistics
72	Zaw Moe Aung	M	The Leprosy Mission Myanmar	Country Director

2. National Level – Nay Pyi T*a*w

	Names	**Male/ Female**	**Institution/Organization**	**Title**
1	Daw Tin Tin Win	F	Myanmar Maternal and Child Welfare Association	Secretary
2	Dr. San San Aye	F	Department of Social Welfare	Deputy Director General
3	Daw Naw Tha Wah	F	Department of Social Welfare	Director
4	Daw Phyo Thu Nandar Aung	F	Department of Social Welfare	Assistant Director
5	Daw New New Oo	F	Department of Social Welfare	Assistant Director
6	Maggie Ndwiga	F	UNFPA	Consultant -Census Gender Report
7	Daw Thwe Thwe Chit	F	FERD	Deputy Director General
8	Daw Moh Moh Naing	F	FERD	Deputy Director
9	U Aung Wai Phyo	F	FERD	Officer
10	Daw Zin Phyu Thi	F	FERD	Officer
11	U Nyi Nyi	M	Dept. of Population Ministry of Imm & Population	Director
12	Dr. Wah Wah Maung	F	CSO	Director General
13	Dr. Yin Thandar Lwin	F	Department of Public Health, MOH	Deputy Director General
14	Dr. Hla Mya Thwe Eindra,	F	Maternal and Reproductive Health, DOPH, MOHS	Director
15	Daw Ei Ei Swe,	F	Health Education Department, DOPH, MOHS	Assistant Director, HED
16	Daw Su Su Naing,	F	Health Education Department, DOPH, MOHS	Assistant Director, HED

17	Daw Khin Su Hlaing,	F	Health Education Department, DOPH, MOHS	Assistant Director, HED
18	Dr. Htun Nyunt Oo	M	National AIDS Programme, DOPH, MOHS	Programme Manager, NAP
19	Dr. Daw Mya Thu,	F	Myanmar Red Cross Society	President
20	Dr. Maung Maung Hla,	M	Myanmar Red Cross Society	Director, Health
21	Dr. Zaw Htoo Oo,	M	Myanmar Red Cross Society	Programme Manager
22	Daw Phyo Phyo Win Cho	F	Myanmar Red Cross Society	Admin and Finance Officer
23	Daw Hsu Myat Win Naing	F	Myanmar Red Cross Society	MISP Preparedness Officer
24	U Ye Lin	M	Myanmar Red Cross Society	MISP Response officer
25	Dr. Kyaw Shwe	M	Department of Health Professional Resource Development and Management (DHPRDM), MOHS	Deputy Director General
26	Dr. Kyaw Soe Nyunt	M	DHPRDM, MOHS	Deputy Director (Training and Medical Education Division)
27	Dr. Kyaw Khaing Oo,	M	DHPRDM, MOHS	Director
28	Daw Htay Htay Hlaing,	F	DHPRDM, MOHS	Deputy Director, Nursing
29	Daw Mya Mya Nyo,	F	DHPRDM, MOHS	Assistant Director, Nursing
30	Daw Nant Kyu Kyu Khaing,	F	DHPRDM, MOHS	Assistant Director, Nursing
31	Dr. Thet Nay Oo	M	Myanmar Maternal and Child Welfare Association (MMCWA)	Assistant Surgeon
32	Daw Khin Myo Htay	F	MMCWA	Executive Committee Member
33	Daw Ahmar	F	MMCWA	Junior Secretary
34	Dr. Toe Toe Su	F	MMCWA	Joint Secretary
34	Daw Htwe Htwe Nyunt	F	MMCWA	Patron
35	Daw Wai Myo Han	F	MMCWA	Head of Office),
36	Daw Phyo Thandar Aye	F	MMCWA	Asst. Programme Officer, IPPF
37	Dr. Zay Yar Moe	F	MMCWA	Assistant Surgeon
38	Dr. Khine Nwe Han	F	MMCWA	Assistant Surgeon
39	Daw Ei Ei Maung	F	MMCWA	Assistant Director
40	Daw Aye Thiri Myat	F	MMCWA	Communication Officer

41	Fredrick Okwayo	M	UNFPA	Chief Technical Advisor
42	Daw Khaing Khain Soe	M	DOP	Director

Focus Group Discussion (With staff from DoP-capacity building)

I	Names	Male/Female	Institution/Organization	Title
1	Daw Sandar Myint	F	DOP	Deputy Director
2	Tia Tia	F	DOP	Assistant Director
3	Mutunda	F	DOP	Staff Officer
4	Daw Yin Yin Kyaing	F	DOP	Deputy Director

3. State/Regional Level- Rakhine

	Names	Male/Female	Institution/Organization	Title
1	Sarah Baird	F	UNFPA	Programme Specialist, GBV
2	Dr. Allison E Gocotano	M	WHO	Technical Officer (EHA)
3	Dr. Kyaw Min Thu	M	UNFPA	Humanitarian Coordinator
4	Dr. Melissa Miranda-Poot	F	UNFPA	RH Specialist
5	Mary	F	IRC	WPE Coordinator
6	Htike Htike Wai Kyaw	F	IRC	WPE senior Officer
7	Kyaw Soe Hlaing	M	IRC	Male Outreach Worker- camp
8.	Htay Myint	M	IRC	Male Outreach Worker- camp
9.	Ei Ei Phyu	F	IOM	Field Project Coordinator
10	Aung Ko Myat	M	IOM	Field Project Officer
11	Khin Thiri New	F	IOM	Field Project Officer
12	U Thet Hlaing Tun	M	Department of Social Welfare	Deputy Director
13	Dr. Tun Lynn Kyaw	M	MMA- Rakkhine	Team Leader
14	Dr. Sai Kaung Thar	M	IRC	Health Coordinator (RH/ERH)
15	Dr. Kyi Kyi Thar	F	Township Public Health Department, DOPH	Township Public Health Officer
16	Daw Yee Yee Lay	F	MNMA	Team Leader

Focus Group Discussion (three groups)

	Names	Male/Female	Institution/Organization	Title

1	Aye Nu Khine	F	IRC (WGC)- Sittway	
2	Bu May	F	IRC (WGC)	
3	Khin Khin Hla	F	IRC (WGC)	
4	Daw Kyi Kyi	F	IRC (WGC)	
5	Ma Cho Aye Phyu	F	IRC (WGC)	
6	Ma Moe Moe	F	IRC (WGC)	
7	Daw Khin Mya Than	F	IRC (WGC)	
8	Daw Yaing Nu	F	IRC (WGC)	
9	Daw Khin Swe Win	F	IRC (WGC)	
II	**Names**	**Male/Female**	**Institution/Organization**	**Title**
1	Nyo Nyo	F	IRC (WGC)- Sittway	Case Worker
2	Nyo Nyo Aye	F	IRC (WGC)	Centre Attendant
3	Khin Than Nwe	F	IRC (WGC)	Centre Attendant
4	Cho Mar Win	F	IRC (WGC)	Outreach worker
5	New New Soe	F	IRC (WGC)	Outreach worker
III	**Names**	**Male/Female**	**Institution/Organization**	**Title**
1	Dr. U Htun Wai	M	MMA- Rakkhine	President
2	Dr. Myo Nyunt	M	MMA	MO
3	Thein Kyaw Aung	M	MMA	HA
4	Ohnmar Yee	F	MMA	CA
5	Ma Mi Aye Soe	F	MMA	ROF
6	Tun Kyaw Thein	M	MMA	GW
7	Maung Myint Sein	M	MMA	GW
8	Zaw Than Aung	M	MMA	CA
III	**Names**	**Male/Female**	**Institution/Organization**	**Title**
1	Thazin Phyu	F	MNMA- Rakhine	Midwife
2	Hnin Nu Nu Lwin	F	MNMA- Rakhine	Midwife
3	Soe Myint Yee	F	MNMA- Rakhine	Midwife
4	Aye Kyaut Yin	F	MNMA- Rakhine	Midwife
5	Aye Thein	F	MNMA- Rakhine	Midwife
6	Hla Hla	F	MNMA- Rakhine	Midwife
7	Aye Aye Mon	F	MNMA- Rakhine	Midwife
8	Phyu Mi Lin	F	MNMA- Rakhine	Midwife
9	Win Thida	F	MNMA- Rakhine	Midwife

4. State/Regional Level- Kachin

	Names	Male/Female	Institution/Organization	Title
1	Dr. Kyaw Wai Aung	M	UNFPA	GBV Programme Officer
2	Lu Ja	F	UNFPA	Branch Office Coordinator
3	Seng Hkam	F	UNFPA	Project Coordinator
4	Mr. Cecil Dunne	M	UNOCHA	Head of Kachin Office
5	Dr. Win Lwin	M	State Public Health Department	State Public Health Director
6	Dr. Zin Moon	M	State Public Health Department	Team Leader (Occupation & Environment)
7	U Aung Soe	M	Department of Social Welfare	Deputy Director

Focus Group Discussion (four groups)

I	Names	Male/Female	Institution/Organization	Title
1	Hkawng Gan	F	Metta (WGC -Myitkyina)	Centre Manager
2	Bawn Wang	F	Metta (WGC)	Case Worker
3	Htu Ra	F	Metta (WGC)	Response Officer
4	Naw Lawn	M	Metta (WGC)	Male Volunteer-camp
5	Hkun Mai	M	Metta (WGC)	Male Volunteer-camp
6	Roi Mai	F	Metta (WGC)	Volunteer
7	Zung Myaw	F	Metta (WGC)	Prevention Officer
8	Law Bai	M	Metta (WGC)	Security Guard
II	**Names**	**Male/Female**	**Institution/Organization**	**Title**
1	Hkawng Nan	F	Metta (WGC)- Wai Maw	Center Manager
2.	Daw Nyi	F	Metta (WGC)	Protection Officer
3.	Lum Nan	F	Metta (WGC)	Response Officer
4.	Lu Bu	F	Metta (WGC)	Response Officer
5.	Ze Maw	F	Metta (WGC)	Volunteer
III	**Names**	**Male/Female**	**Institution/Organization**	**Title**
1.	Daw Daung Lan	F	Metta (WGC)- Wai Maw	(women's group participants)
2.	Daw Kaung Naw	F	Metta (WGC)	
3.	Daw Daung Nwai	F	Metta (WGC)	
4.	Daw Ah Rone	F	Metta (WGC)	
5.	Daw Ywein Maw	F	Metta (WGC)	
6.	Daw Kaung Mai	F	Metta (WGC)	

7.	Daw Kaung Nwayi	F	Metta (WGC)	
8.	Daw Htu Bu	F	Metta (WGC)	
9.	Daw Bauk San	F	Metta (WGC)	
IV	**Names**	**Male/Female**	**Institution/Organization**	**Title**
1.	U Win Tin	M	State Police Department	Chief Police Officer
2.	U Kyaw Ko Ko	M	State Police Department	Police Officer
3.	Daw Win Yu	F	State Police Department	Police Officer

5. **State/Regional Level- Pathein**

	Names	**Male/Female**	**Institution/Organization**	**Title**
1.	U Tin Zaw Moe	M	Department of Social Welfare	Director
2.	Daw Khin Moh Moh	F	Department of Social Welfare	Staff Officer
3.	U Thein Tun Aung	M	Department of Social Welfare	Staff Officer
4.	Daw Lae Lae Mon	F	Department of Social Welfare	Staff Officer
5.	Dr. Aye Naing	M	State Health Department, DOPH	Assistant Director
6.	Dr. Tin Ma Ma Nyein	F	National AIDS Programme, DOPH, MOHS	Team Leader, AIDS/STD Team
7.	Dr. Aye Thin Khine	F	Myanmar Medical Association	Team leader
8.	Daw Tin Tin Khine	F	Myanmar Medical Association	Nurse
9.	U Win Myat Thu	M	Myanmar Medical Association	Case worker
10	Daw sandar Aung	F	Myanmar Medical Association	Finance Assistant
11	Nan Rosalin	F	Myanmar Medical Association	Clinic Assistant
12	Dr. Khin Wai Wai Htun	F	Marie Stopes Myanmar	Center Manager
13	U Aung Myint Khine	M	Marie Stopes Myanmar	Outreach Manager
14	Daw Maw Ni	F	Marie Stopes Myanmar	Case Manager
15	Dr. Aung Phone	M	PSI	Medical Officer
16	Daw Sandar Htun	F	PSI	Center Manager

Focus Group Discussion

I	**Names**	**Male/Female**	**Institution/Organization**	**Title**
1	Daw Htay Htay Mon	F	Midwive and Nursing Training School- Pathein	Principal - Academic
2	Daw Soe Moe Htwe	F	Midwive and Nursing Training School	Principal -Administration
3	Daw Soe Sandar	F	Midwive and Nursing Training School	Senior Tutor
4	Daw Aye Myat Kalyar	F	Midwive and Nursing Training	Tutor

			School	
5	Daw Khine Thazin	F	Midwive and Nursing Training School	Tutor
6	Daw New Ni Hlaing	F	Midwive and Nursing Training School	Instructor

6. **Township Level- Pathein**

	Names	Male/Female	Institution/Organization	Title
1	Dr. Myint Aung	M	Township Health Department, DOPH	TMO
2	U Soe Lwin Tun,	M	Township Health Department, DOPH	Health Assistant
3	U Hla Aye,	M	Township Health Department, DOPH	Township Health Assistant
4	Daw Kyi Kyi Win	F	Township Health Department, DOPH	Township Health Nurse

Focus Group Discussion

I	Names	Male/Female	Institution/Organization	Title
1	Nant San San Win	F	RHC	Health Assistant
2	Daw Aye Mar Win	F	RHC	Lady Health Visitor
3	Daw Thin Thin Khine	F	RHC	Midwife
4	Naw Zu Zu Zin	F	RHC	Midwife
5	Daw Poe Ei san	F	Sub-RHC	Midwife
6	Daw Aye Thazin maung	F	Sub-RHC	Midwife
7	Daw San San Yee	F	Sub-RHC	Midwife
8	Daw The Su Kyaw	F	Sub-RHC	Midwife
9	Daw Win sandar Shwe	F	Sub-RHC	Midwife
10	Daw Khin Moe Hnin	F	Sub-RHC	Midwife
11	Daw Khin Soe Thet	F	Sub-RHC	Midwife
12	U Nyunt Maung	F	Sub-RHC	Midwife

7. **State/Regional Level- Pyay and Magway**

I	Names	Male/Female	Institution/Organization	Title
1	Thein Win	M	District Immigration Department	District Immigration Officer

2	Zaw Zaw Woe	M	District Immigration Department	
3	Dr. Thint woe	F	District Health Department	District Health officer
4	Aye Aye Win	M	Education Department	Deputy Township Education Officer
5	Ye Yint Thein	M	Department of Immigration	Chief, regional immigration office
6	Aye Thuzar Ko	F	Marie Stopes Myanmar Magway Region	Center Manager
7	Dr.	F	Ministry of Public Health, Magway region	MS, General Hospital
8	Dr.	F	Township Public Health Department, Magway	Town Ship Health Officer
9		F	Township Public Health Department, Magway	Head, Midwife
10		F	DSW regional Office Magway	Deputy Chief

Focus Group Discussion (With staff from Township Education Dept. Pyay) – Census Enumerators
(names to be inserted)

I	Names	Male/Female	Institution/Organization	Title
1		M	Township Education Dept.	Deputy Township education officer
2		M		Head Teacher
3		F		Teacher
4		F		Teacher
5		F		Teacher

Focus Group Discussion (With Midwifes, Urban Health Unit, Magway) – Flood Response

I	Names	Male/Female	Institution/Organization	Title
1		F	Urban Health Unit, Magway	Midwife
2		F		Midwife
3		F		Midwife

Academic Institution (Yangon University of Economics)

I	Names	Male/Female	Institution/Organization	Title
1	Dr. Maw Maw Khin	F	Yangon University of Economics	Professor/Head Department of Statistics
2	Dr. Mya Thandan	F		Professor, Dept. of Statistics
3	Daw Aye Aye Than	F		Associate Professor, Dept. of Statistics
4	Daw Aye Thida	F		Lecturer, Dept. of Statistics

5	U Maung Maung Thwin	M		Lecturer, Dept. of Statistics

Annex 3 : List of Documents Consulted

1. Handbook: How to design and conduct a country programme evaluation at UNFPA (2013)
2. End of programme evaluation of 2nd country programme cycle
3. Management response to the recommendations of 2nd country programme evaluation.
4. AWPs , WP progress reports, joint monitoring reports (2012,2013,2014,2015)
5. Standard Progress Report by outputs (2012,2013,2014)
6. Various SPRs and Annual Programme Review meeting reports
7. Draft Report on Baseline data collection (2013)
8. UN strategic Framework (2012-2015)
9. UN thematic Analysis (2011)
10. Country Programme Document (2012-2015)
11. CPAP (2012-2015)
12. Documents on CPD extension (2015-2017)
13. Framework for Economic and Social Reforms (2012-15)
14. Country COAR (2012,2013,2014)
15. Country annual report from SIS (2015)
16. Reproductive Health Supply Chain Assessment and Recommendations (2013)
17. National Service Standards and Guidelines on Adolescent and Youth Health Care (2013)
18. 2014 Facility Assessment for Reproductive Health Commodities and Services
19. 2015 Facility Assessment for Reproductive Health Commodities and Services
20. RH policy
21. RH NSP
22. Myanmar midwifery Situation 2014 - Synthesis report (October 2014)
23. Mid-Term Review of the Myanmar National Strategic Plan on HIV and AIDS 2011-2015 (Consolidation Report) 2013
24. Global AIDS Response Progress Report Myanmar (National AIDS Programme) 2015
25. Myanmar Revised NSP II 2011-2016
26. Myanmar Revised NSP II OP 2011-2016
27. NSP MMR Draft MASTER File (15-Dec 21) (1)
28. NSP for Young People's Health (2016-2020)
29. National Service Standards and Guidelines on Adolescent and Youth Health Care (2013)
30. National Strategic Plan for the Advancement of Women (2013-2022)
31. Census project documents
32. Assessment of the Existing Situation of the Data Computing System for Census
33. Assessing the Advocacy and Publicity capacities for the census 2014(advocacy strategy)
34. Assessment on census mapping and cartography
35. Communication strategy
36. Pilot Census report
37. Census enumeration monitoring reports by observation team

38. Final Census results
39. Thematic analysis of census results
40. Conflict sensitivity analysis and strategy options in the context of data processing, analysis, release and dissemination of the 2014 Myanmar population and housing census (2014)
41. Levels, Trends and Patterns of Internal Migration in Myanmar (2013)
42. Ageing Transition in Myanmar (2012)
43. Assessment of Statistical System by ADB consultant
44. NSDS core strategies document
45. Concept note on Clustered Country Programme Evaluation
46. CEDAW/C/MMR/4-5, Combined fourth and fifth periodic reports of States parties due in 2014, Received on 8 January 2015. Retrieved from: http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/MMR/CEDAW_C_MMR_4-5_713_E.pdf
47. Gender Equality Network, October 2014. Behind the Silence Violence Against Women and their Resilience, Myanmar Briefing Paper. Yangon, Myanmar.
48. _____ 2013. Myanmar Laws and CEDAW, the case for anti-violence against women laws, Myanmar.Yangon, The Gender Equality Network.
49. Save the Chidren Foundation, Inc., 2015. The Urban Disadvantage. State of the World's Mothers 2015 ,http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/SOWM_EXECUTIVE_SUMMARY.PDF
50. The Republic of the Union of Myanmar 2016. Gender equality and women's rights in Myanmar-a situation analysis
51. UNDP, 2015. Work for human development .Briefing note for countries on the 2015 Human Development Report – Myanmar.
52. UN interim strategy (2015-2017),
53. Gender situation analysis
54. Humanitarian Response Plan (2013, 2014, 2015, 2016)
55. Technical note on 4 bills
56. Census thematic report on maternal mortality, Universal Periodic Review, SG report on Myanmar
57. Census Observation Mission Report, 2014 Population and House Census, UNFPA
58. Myanmar Case Study, Evaluation of UNFPA Support to population and housing census data to inform decision-making and policy formulation 2005-2014, Evaluation Office (Jan 2016).http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3847191/
59. WHO. Global Health Observatory Data Repository: Country Statistics (Myanmar) World Health Organization; http://www.who.int/gho/countries/mmr/country_profiles/en/
60. https://knoema.com/WBHNPStats2016May/health-nutrition-and-population-statistics-world-bank-august-2016
61. United Nations Development Programme. *Human Development Report 2013. The Rise of the South: Human Progress in a Diverse World*. New York, 2013.
62. Garenne M. 2004. "Sex ratios at birth in populations of Eastern and Southern Africa", *Southern African Journal of Demography* **9**(1):91-96. http://www.commerce.uct.ac.za/Organisations/Demography/SA_Journal_of_Demography/SAJD/Volume%209/SAJDem_2004_9_1_Garenne_b.pdf
63. Minnesota Population Center. 2010. Integrated Public Use Microdata Series, International. Version 6.0 [Machine-readable database]. Minneapolis: University of Minnesota.

64. Sen A. 1992. "Missing women", *British Medical Journal* **304**(6827):587-588. doi: http://dx.doi.org/10.1136/bmj.304.6827.587
65. Shryock HS and JS Siegel. 1976. *The Methods and Materials of Demography (Condensed Edition).* San Diego: Academic Press.

66. UN Population Branch. 1955. *Manual II: Methods of Appraisal of Quality of Basic Data for Population Estimates.* New York: United Nations, Department of Economic and Social Affairs, ST/SOA/Series A/23.
67. http://www.un.org/esa/population/techcoop/DemEst/manual2/manual2.html
68. UN Statistics Divison. 2008. *Principles and Recommendations for Population and Housing Censuses v.2.* New York: Department of Economic and Social Affairs, ST/ESA/STAT/SER.M/67/Rev.2. http://unstats.un.org/unsd/publication/SeriesM/Seriesm_67rev2e.pdf
69. United Nations. 2010a. *Handbook on Population and Housing Census Editing, Revision 1.* New York: United Nations, Department of Economic and Social Affairs, ST/ESA/STAT/SER.F/82/Rev.1. http://unstats.un.org/unsd/publication/SeriesF/seriesf_82rev1e.pdf
70. UN Population Division. 2015. *World Population Prospects: The 2015 Revision, Volume I: Comprehensive Tables*. New York: United Nations, Department of Economic and Social Affairs, ST/ESA/SER.A/313.
71. US Bureau of the Census. 1985. *Evaluating Censuses of Population and Housing.* Statistical Training Document ISP-TR-5. Washington, DC: US Bureau of the Census. http://www.census.gov/srd/papers/pdf/rr85-24.pdf

Annex 4 : Evaluation Matrix

Relevance			
EQ 1(Alignment) : To what extent is Myanmar CP consistent with beneficiaries' needs in particular the needs of the vulnerable groups, government's policies and priorities, UNFPA's policies and strategies; the global priorities including the goals of the ICPD Program of Action?			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for data collection**
1.The needs of beneficiaries- women, young people, adolescents and vulnerable groups- are well taken into accounts in line with government policies an priorities, UNFPA's policies and strategies; and the goals of ICDP	1.1 Evidence of the choice of target groups in UNFPA supported interventions under the key programme components that is consistent with the identified needs as well as national priorities in the CPAP and AWPs	-CPD; CPAP 2010 – 2015; CP extension 2016-2017 - AWPs ; Annual Reports - UNFPA Strategic Plan 2014-2017 - Integrated Household Living Conditions Survey in Myanmar (2009-2010) - CPD baseline report UNFPA 3rd Country - National reports on MDG implementation: Countdown to 2015 Maternal, newborn and child health; Global AIDS Response Progress Report Myanmar 2015; - CEDAW reports - CEDAW Concluding Observations -Gender situation analysis	- Documentary analysis - Key informant Interviews - Observation

		report - NSPAW - Government counterparts - Identified relevant UN agencies - UNFPA CO staff	
2.The objectives and strategies of the three programme areas and the interventions under the humanitarian work are consistent with the UNFPA strategic plan 2014-2017	2.1. ICPD goals and principles in Programme of Action are reflected in all components of the programme; 2.2 The CPAP strategies include building national capacities, policy advocacy; knowledge management	- CPAP - UNFPA strategic plan 2014-2017 - AWPs ; Annual Reports - ICDP document - Government counterparts - Identified relevant UN agencies - UNFPA CO staff Implementing partners	- Documentary analysis - Key informant Interviews
EQ 2: (Vulnerability context): How did UNFPA take into account the country's vulnerability to disasters and emergencies both at the planning and implementing its interventions?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
1.Strategies in place to take into account the country's vulnerability to disasters and emergencies, both at the planning and the implementation	1.1Strategy papers specifically mention the plans for accounting for vulnerability to disasters and emergencies. 1.2 CPD and CPAP show evidence that assessment of country's vulnerability is utilized in design and planning 1.3. AWPs and annual reports show evidence that address the country's vulnerability and the implementation progress of emergency situation (yearly situation may have changed and AWPs	- UNFPA strategy paper CPD and CPAP 2012-2015; and extension (2016-17) - AWPs - Annual reports - RRF - Needs assessments - Risk analysis report, HRP, HCT reports, - Government	- Documentary analysis - Key informant Interviews

	reflect those changes) 1.4. Evidence that the revised RRF reflects country's vulnerability.	counterparts - Identified relevant UN agencies - UNFPA CO staff - Implementing partners	
EQ3: (Vulnerability context): To what extent is the Country Office along with its partners able to (likely to) respond to crisis during the period of the country programme (2012-2017)?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
1.Where applicable, UNFPA successfully responded to crisis during the period covered by CP 3	1.1 Evidence of policy guidelines in respond to crisis situation 1.2. Evidence of operation and administrative support to fast track the CO response during humanitarian crisis situation 1.3. Evidence of vulnerable target groups benefited from the UNFPA emergency implementation	- UNFPA policy guidelines in emergency situation - SOPs in emergency settings - FTP plans and other docs on procedures - Reports from implementing partners - Beneficiaries - Government counterparts - Identified relevant UN agencies - UNFPA CO staff - Implementing partners	- Documentary analysis - Key informant Interviews - FGD with beneficiaries - Observations in the field
Effectiveness			
EQ4 (Effectiveness): Were CP's intended outputs and outcomes achieved? If so, to what degree? To what extent did the outputs contribute to the achievement of the outcomes and what was the degree of achievement of the outcomes? What were the constraining and facilitating factors and the influence of context on the achievement of results?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
1.Health system is functional	1.1 Reproductive health commodity security	- RHCS strategy;	- Documentary analysis

to deliver SRHR services to vulnerable groups, women, young people and adolescents	system is operational as per the CPAP targets 1.2 Percentage of reproductive health and facilities using computerized reproductive health commodity security logistics management information system 1.3 Increased availability of RH commodities at health facility level and Service delivery points (SDPs) 1.4 Functional MDSR system	- AWPs; - SPRs; - Monitoring reports; - Health Facility Survey 2014 & 2015	- Key informant Interviews - FGD with end users - clients of family planning services - exit interviews -
2.Quality gender-sensitive reproductive health information and services available to address related needs both in development settings and humanitarian settings	2.1 Policy documents/protocols/standards of delivering SRH/ARH services available and in use 2.2 Number of Health facilities/SDPs with trained health care personnel on SRH/ARH/ life-saving skills 2.3. The percentage of RH facilities working in compliance with clinical protocols introduced 2.4 Gender and Reproductive health issues and implementation of MISP are fully addressed in Disaster Management Plan of the Ministry of Health and Sports 2.5. Strengthened institutional capacity to address related reproductive health needs in humanitarian settings 2.6. Number and percentage of states and regions where rapid response teams are able to implement the minimum initial service package for RH in crisis situations	- SPRs - COAR - UNDAF review reports - Monitoring reports - Training report - Myanmar Action Plan on Disaster Risk Reduction 2009-2015 - Government counterparts - UNFPA CO staff - Implementing partners - Ministry of Social Welfare, Relief and Resettlement Department. - OCHA (Convener of UNSF SP3: Reduce vulnerability to natural disaster and climate change)	- Documentary analysis - Key informant Interviews - FGD with end users
Key populations have	- The condom usage rate among key	- IBBS (integrated bio	- Interview with

improved access to HIV information and prevention services	populations - The percentage of people among key population with accurate knowledge on HIV - The percentage of key population knowing their HIV status - The percentage of FSWs receive PMTCT services - Availability of means for protection and information materials National plan on monitoring and evaluation HIV/AIDS is in place	behavioral survey 2010) - Outreach annual reports (2010; 2011) - COARs - SPRs - UNSF review reports - 2013-14 MTR of the Myanmar National Strategic Plan on HIV & AIDS	representatives (activists) of vulnerable groups - Interviews with experts in HIV prevention (specialists of the national AIDS prevention Centre) - Interview with implementing partner agencies: NGOs, CSOs - Overview of records in centers for vulnerable groups
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for data collection**
1.National law, policies and strategies promoting gender equality and women's human rights, particularly reproductive rights are in place.	1.1 Existence of laws, policies and strategies promoting gender equality and implementing CEDAW.	-Prevention and protection of violence against women Law (PoVAW Law) - NSPAW -CEDAW reports	-Document Analysis -Key informant Interview
2.Strengthened national capacity and institutional mechanism for promoting gender equality and addressing gender-based violence, including in humanitarian settings	2.1 Capacity of DSW to incorporate aspects of NSPAW into their programme. 2.2 Evidence of Functioning gender and women's empowerment coordination bodies as a result of UNFPA guidance and leadership 2.3 Number of CSOs and CBOs trained to address Gender equality and GBV. 2.4. Evidence of functioning systems, structures to prevent and respond to GBV at the national and	- CEDAW reports - Reports from Department of Social Welfare - UNFPA COARs and implementing agency reports -UNFPA Gender Focal Point -UNFPA Asst. Rep - implementing partners -Beneficiaries/community	-Document Analysis -Key informant Interview -FGD

	community level.	members -Myanmar Action Plan and Disaster Risk Reduction (2009-2015) -DRR response plan of DSWRR -DSW focal person	
3. The national capacity to collect and analyze data by sex, age, economic status and location is strengthened.	3.1 Evidence that staff at all levels in relevant departments use up to date data collection and validation techniques. 3.2 Regularly updated population data disaggregated by sex, age, economic status and location are available. 3.3 .Number of issue-specific monographs produced (baseline and targets) 3.4 Regularly updated nationally representative data on gender-based violence and harmful practices are available. 3.5Compliance of census program with internationally accepted standards	-Evaluation of Census in Myanmar by UNFPA. -Activity/progress report -Publications -Ministry of national planning and Economic development-Ministry of Health and Sports**, DOP,** immigration and population-Research Institutions -Relevant UN Agencies -Relevant CSOs and NGOs	Document Analysis -Key informant Interview
4. Strengthened capacity building activities have led to improved outcomes in evidence generation, use and policy reforms.	4.1 No. strategies/policies that have evidence-based planning, design or learning (documented) 4.2 Population dynamics are explicit in the national/regional development plan 4.3 No. of policy papers or documents with evidence based	-National and regional documents -Policy papers or documents -State Statistics Committee documents, Ministry of Health and Sports strategies Plans - 2012-2016, up to 2020 and 2030	- **Document Analysis** - **Key informant Interview**
Efficiency			
EQ5 (Efficiency): To what extent UNFPA made good use of its human, financial and technical resources to pursue the achievement of the outputs and outcomes defined in the CP?			
The interventions of CP are implemented efficiently in	- Number of joint (formal and informal)	- CPAP	- Document Analysis

both development and humanitarian settings	initiatives undertaken to achieve the results - Evidence of UNFPA's successful advocacy in leveraging resources from government/or other development partners in implementation of UNFPA's priority interventions. - Evidence of harmonized Terms of Partnerships with other implementing partners/development agencies operating in the same geographical areas (to avoid duplications and synergies support to the same geographical areas). - Average lead time to complete the contractual agreement/implementation arrangement with implementing partners in regular programme and emergency setting - Evidence of Planned resources utilized as planned in timely manner - Evidence of allocation of tasks and management responsibilities for cross cutting issues and integration of services	- Annual reports - AWPs - SPRs - MOUs, HACT - UN Coordinating mechanisms - Guidance notes/ meeting minutes on Division of Labor among UN agencies/other partners - Progress and completion reports from IPs. - Financial reports - Minutes of WG meetings; - Audit reports IPs - UNFPA staff (NPOs, Admin and finance staff) - Development partners - Government counterparts - -	- Budget analysis - Key informant Interview

Sustainability			
EQ6 (Sustainability): To what extent the results of the UNFPA supported activities are sustainable and how has the programme incorporated the mechanisms to ensure sustainability?			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for data collection**
1.UNFPA interventions have contributed or are likely to contribute to sustainable effects	1.1 Evidence of national counterparts, institutions and community organizations capacity to continue the practices launched with UNFPA support 1.2 Percentage of relevant faculty members of Midwifery schools trained on new Midwifery curriculum 1.3.Existence of exit strategy in on-going programmes supported by UNFPA	-Policy documents/Strategies in relevant line ministries -Protocols endorsed by Government counter parts and introduced into practice - Beneficiaries - Signed MoUs between UNFPA and the Government -Curriculum of relevant departments of the Institutions; - Trainings reports; - List of trainees; (ET to ask for CO's input on this)	- Document Analysis - Budget analysis - Key informant Interview
- **Coordination**			
EQ7: (Coordination): To what extent has the UNFPA country office contributed to the existing and consolidation of UNCT coordination mechanism			
Assumptions to be assessed	**Indicators**	**Sources of information**	- **Methods and tools for data collection**

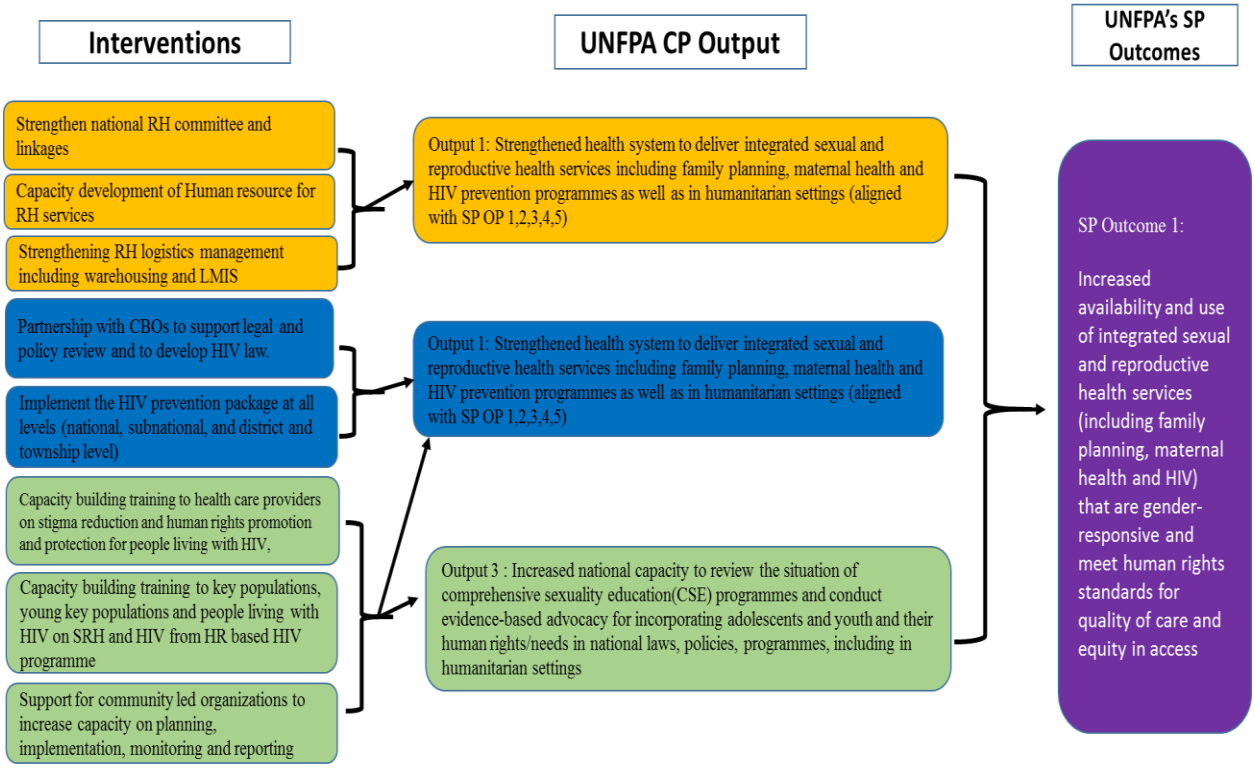
1.UNFPA CO has actively contributed to UNCT working groups and joint initiatives.	1.1 Evidence of active participation in UN working groups 1.2 Evidence of leading role by UNFPA in the working groups/joint initiatives corresponding to its mandated areas UNSF Operation Plan (2012-2015)	-UNSP Outcome working groups -UNCT members CO staff - Documents - Minutes of UNSP outcome groups meetings - Program documents M&E reports SPR/COAR- Interviews with UNRC, UNCT, UNFPA CO snr staff Other UN agencies UNSF Annual Reports	-Key informant interview -Document review
3 UNFPA mandated areas are fully integrated in the UNSF and attributed to UNFPA.	2.1 Evidence of alignment of UNFPA outputs and outcomes to UNSF outcome areas	-Programming documents and implementation progress reports, CPAP, UNSF documents, UNSF evaluation document, UNCT Annual Reports UNFPA CO staff, UN Agency representatives, documents, minutes	-key informant interviews with UNFPA Senior management staff, UN Coordination Officer, UNCT members, -Document review Interviews, document review
4 UNFPA has positioned itself well to enhance the UNCT's emergency preparedness and response	3.1. Evidence that UNFPA is an active contributor to UNCT coordination mechanisms and joint initiatives in the area of emergency preparedness and response 3.2.Evidence of UNFPA's participation in strategy development of emergency preparedness and response plan	-Programming documents and implementation progress reports, CPAP, UNSF documents, UNSF evaluation document, UNCT Annual Reports	-key informant interviews with UNFPA Senior management staff, UN Coordination Specialist, UNCT members, -Document review Interviews, document review
Added Value			

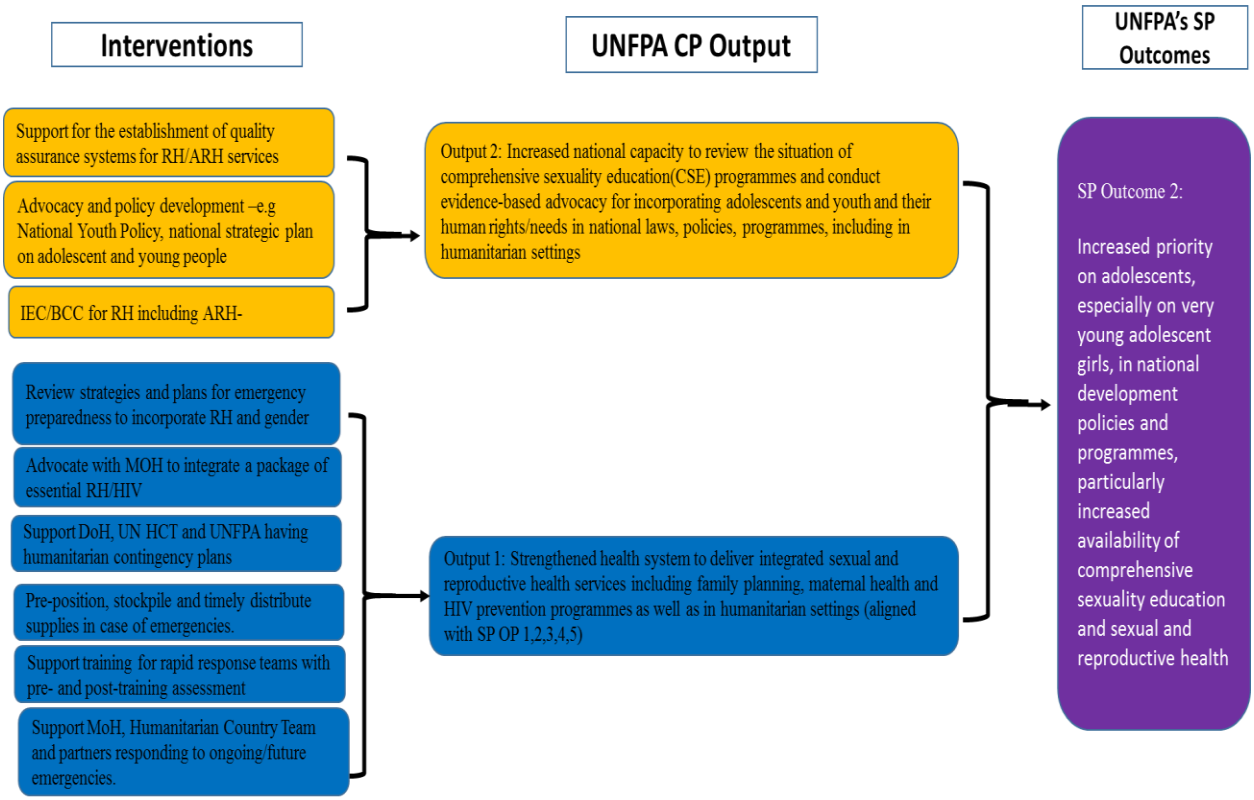
EQ8: (Added value) What are the main UNFPA comparative strengths in the country – particularly in comparison to other UN agencies? Are these strengths a result of UNFPA corporate features or are they specific to the CO features?			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for data collection**
1.Compared to other UN agencies (such as i.e. UNICEF, UNDP as well as WHO) working in similar programmatic areas; UNFPA has demonstrated specific technical contribution to the country's development agenda 2.UNFPA took into account the country's vulnerability to disasters and emergencies, both at the planning and the implementation stages 3.UNFPA adds benefits to the humanitarian interventions of other development/humanitarian partners	UNFPA role/contribution to national priorities Specific technical skills in CO Status of exiting national capacities to contribute to the issues/areas that UNFPA is contributing to Reference made to UNFPA planning documents, UNCT meetings and discussions minutes, Evidence that UNFPA is an active contributor to coordination mechanisms in the area of emergency preparedness and response List of UNFPA comparative strengths and weaknesses in emergency preparedness and response as	UN agency staff -Documents including Media News -key informants from implementing agencies Relevant UN agency for relief and rehabilitation	-key informant interview News media
EQ9: (Added value): What is the UNFPA's main added value in the country context as perceived by national stakeholders?			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for data collection**
1. National counterparts and other development actors perceive, recognize and recall UNFPA's performance as a unique, or	-Specific examples by other development partners about UNFPA unique contributions -Reference to UNFPA contribution in interventions that were not available with other partners	UN staff -Implementing agency staff -Media reports -Beneficiaries (at	- Interviews within the UN and non UN agencies - Strategic partners (donors

inherent contribution for the country. 2.UNFPA is perceived as a champion in responding to crises situations in the country	-Reference to UNFPA contribution that enhanced the other partners' contribution to the development results -timeliness of UNFPA contribution and quality of response (subjective)	institutional level) -Donor community	and policy makers) - Interviews within the Government Institutions - Desk review of the results of the joint cooperation Documentary review

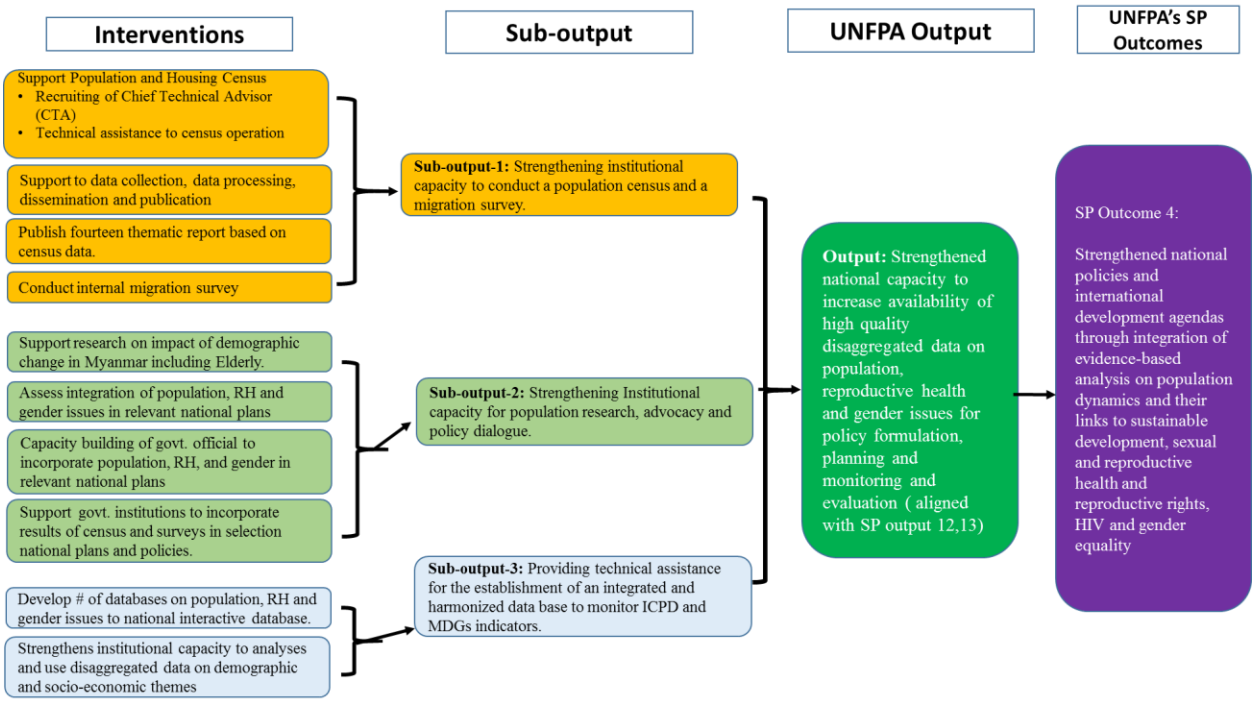
Annex 5 : Programme Theory

Sexual and Reproductive Health Rights – Programme Theory (SP outcome 1 &2)

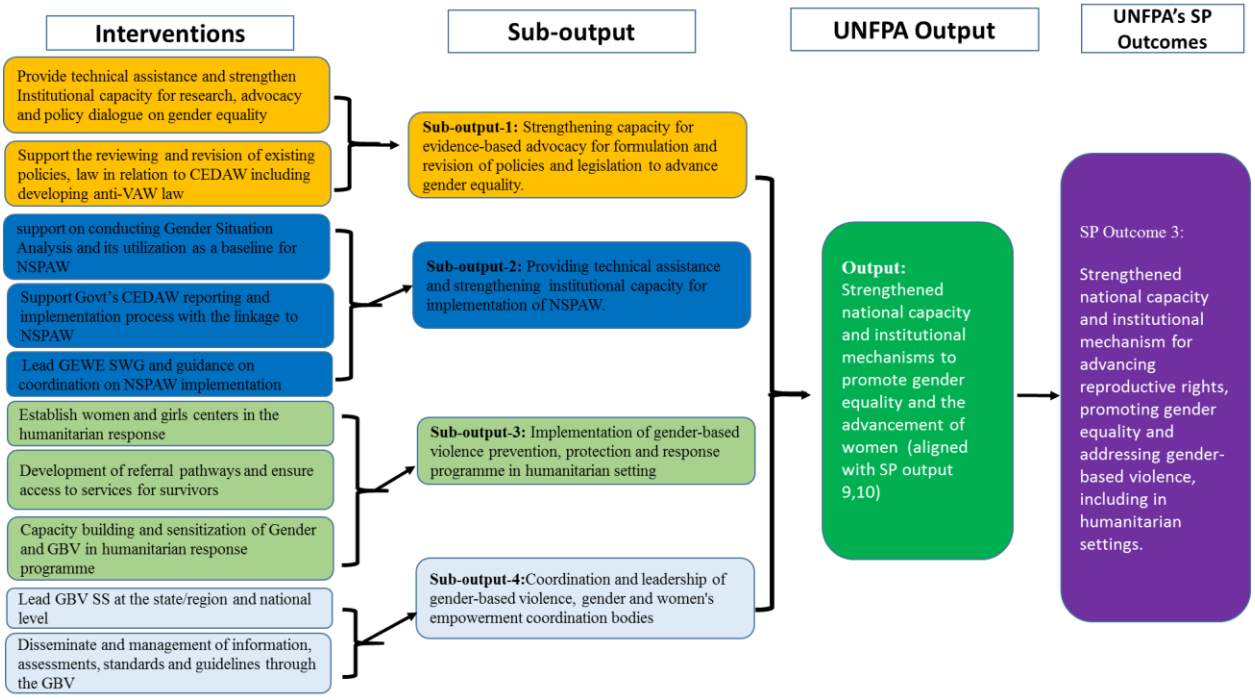




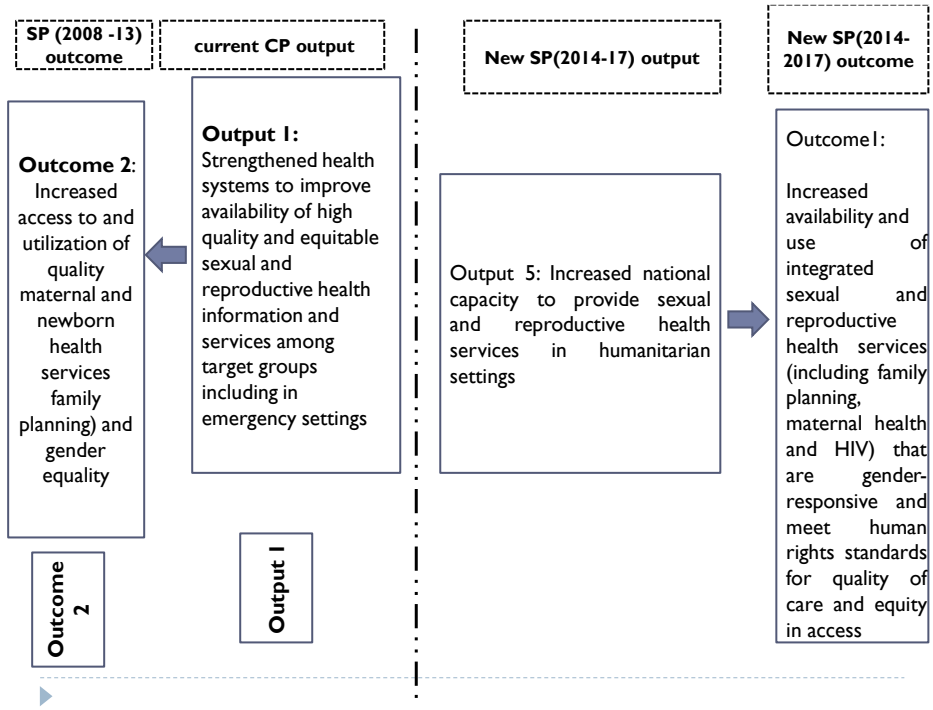
Population & Development – Programme Theory (SP outcome 4)



Gender Equality – Progamme Theory (SP outcome 3)



Humanitarian Setting: Programme Theory -Aligned Outcomes and Outputs (SP outcome 1)



Annex 6: Data Collection Methods details:

The Evaluation Team (ET) together with the CO programme staff went over the complete list of all the programme interventions and also identified the stakeholders based on review of documents and discussions with UNFPA programme staff. The evaluation focused on a few major categories of stakeholders distributed across the CP3 programme themes. The selection covered all three focus areas, though not a representative sample, a purposive sample was selected based on the detailed background information collected to reflect the interventions and the participants involved.

The filed visits sites were chosen based on the broad criterion defining on programme interventions beneficiary populations, the characteristics of geographic locations to represent the country programme including accessibility, and to answer the evaluation questions in an unbiased way. More specifically, the inclusion criteria was included where presence of more than three UNFPA programme interventions, both urban and rural representation; vulnerable and humanitarian context including conflict affected and ethnic diversity. In addition, centain places where main offices of most of the implementing agencies, I/NGOs, donors, UN agencies, and government agencies are presence, were considered as the sites to be visited.

Stakeholder interviews (e.g.IPs, civil society, Programme participants, Donors etc.) followed a participatory approach where stakeholder input is sought in data collection and interpretation of data in certain cases as appropriate. The team carried out ; Interviews with Programme Staff and other relevant UNFPA staff; Focus Group Discussions with Beneficiaries and other stakeholders as appropriate; Focused Discussions with Service Providers, In-depth interviews with Key Informants (line ministry staff, other development partners, UNCT etc) and Observations. The evaluation adopted an inclusive approach, involving a broad range of partners and stakeholders. The evaluation team used the stakeholder list provided by CO and did a mapping in order to identify both UNFPA direct and indirect partners (i.e., partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). These stakeholders included representatives from the government, the private-sector, UN organizations, and other multilateral organizations, bilateral donors, NGOs and most importantly, the beneficiaries of the programme.

Upon desk review of key documents and several meetings with Country Office programme staff, ET prepared evaluation design matrices (see Annex 4) which included the evaluation questions, assumptions, to be assessed, indicators, and sources of information, methods and tools for data collection were used as reference framework for data collecting and reporting phases.

The evaluation team (ET) undertook field visits, upon consultation with ERG and CO staff, to selected areas for data collection. The team had a shared responsibility to collect data using the tools developed, especially where there is an overlap and similar questions were needed to be asked under each focus area. In order not to be repetitive, the questions were discussed among the team in advance and responsibility was shared as to who collects the data for that particular question.

Retrospective and prospective analysis and the evaluation criteria

Evaluation team assessed the extent to which effects have been sustainable – provided that the effects have been already generated – also looked at the prospects for sustainability i.e. the likelihood that the

effects of UNFPA interventions continue once the funding comes to an end. Questions were formulated to elicit this information; however, this was mainly based on respondents' perceptions. The same with effectiveness: evaluators assessed the extent to which objectives have been achieved or the extent to which objectives are likely to be achieved, if in case the time period was inadequate to realize the expected results.

Validation mechanisms

The Evaluation Team used a variety of methods to ensure the validity of the data collected. Besides a systematic triangulation of data sources and data collection methods and tools as mentioned above, the validation of data was sought through regular exchanges with the CO programme officers. A stakeholder workshop, with implementing partners, donors, UN agency staff, and other relevant stakeholders, were held to present the preliminary findings, finalized findings, conclusions and recommendations of the evaluation.

Ethical Considerations

During the study, several precautions were taken to ensure the protection of respondents' rights. Ethical principles of respect, beneficence, and justice were applied in the selection of the respondents. Informed consent was sought prior to the interviews and the data collected was treated confidentially, with no identifiers ensuring access to authorized persons only. Informed consent was obtained by Country Office (from those identified during design phase), prior to ET's field visit. ET looked for credible information based on reliable data and observations and protected the anonymity and confidentiality of individual informants following UNEG Ethical Guidelines and Norms for Evaluation in UN System. Where written consent was not applicable or feasible, verbal agreement was sought. The interview respondents were informed of the evaluation purpose, rights and obligations of participating in the evaluation. The evaluation team adhered to mechanisms and measures to ensure that the evaluation process conformed to relevant ethical standards observing privacy and confidentiality considerations.

Conclusions and recommendations were made based on findings, judgments and lessons learned, appropriately reflecting the quality of the methodology, procedures, and analysis used during collecting and interpreting data. The team followed the evaluation handbook that provided guidelines on how to design and conduct the CPE which was a useful tool to come to a consensus on the terminology and methods used in the evaluation and reported results.

Annex 7 : Findings (Results and Detailed Descriptions)

Due to the page limit of the main report, details of the findings are included as an Annex. The country office requested the details to be kept in the report as they were useful for the Country Office. For those needing additional information please refer to the findings on all key programmatic areas in Annex 7 below.

Table 1: SRHR Achievements – Outcome and Output Indicators			
Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access			
Indicator	**Baseline**	**Target**	**Actual**
1.1 Contraceptive prevalence rate for modern methods	**41%**	**50%**	**51% (DHS 2015)**
1.2 Percentage of public service delivery points (within UNFPA supported townships) with modern contraceptive methods in stock [no stock out] in last six months	**30.6% (2012 CP baseline report)**	**80%**	**35% (HFA for RHCS 2015)**
1.3 Number of (percentage) of births attended by skilled health personnel (SP OCI 1.5)	**64.8 % (World Health Statistics 2011)**	**70%**	**60% (DHS,2015)**
Output 1. Strengthened health systems to deliver quality and equitable integrated sexual and reproductive health information and services among target groups as well as in humanitarian settings			
Indicator	**Baseline**	**Target**	**Actual**
1.1. Number of states and regions under UNFPA supported areas that have functional Logistics Management Information Systems (LMIS) for RH commodities (aligned with SP OCI 2.1)	**0**	**4**	**4**
1.2 (added) National Midwifery standards as per ASEAN-WHO guidelines developed (SPOCI 3.1)	**0**	**1**	**Yes***
1.3 Costed national action plan for Family planning developed (aligned with OPI 2.2)	**0**	**1**	**1**
1.4 (added) Number of states and regions under UNFPA supported areas that have maternal death review in place	**0**	**2**	**Yes****
1.5 (added) Number of community based sex worker-led organizations engaged in the design, implementation, and monitoring of programmes that address HIV and sexual and reproductive health needs of sex workers (SP OPI 4.3)	**1**	**4**	**4*****
1.6. Number of states/regions that have capacity to implement MISP at the onset of a crisis (SP OPI 5.1)	**1**	**3**	**4**
1.7. (added) Ministry of Health and Sports, UN HCT and UNFPA has humanitarian contingency plans that include elements for addressing sexual and reproductive health needs of women, adolescents and youth including services for survivors of sexual violence in crises (SP OPI 5.2)	**Not reflected**	**Reflected**	**Yes**
1.8 Number of and [percentage] of pregnant women offered voluntary HIV counseling and testing services in UNFPA supported areas	**60000**	**70000**	**74980**
1.9 Number of female sex workers reached by HIV prevention programme through community based sex worker lead organization	**2200**	**3700**	**7,786**
1.10 No. of coordination meeting at central and State/Regional level on HIV prevention organized	**0**	**3**	**3**
(Added) Output 2 (SP OP 6) : Increased national capacity to review the situation of comprehensive sexuality education(CSE) programmes and conduct evidence-based advocacy for incorporating adolescents and youth and their human rights/needs in national laws, policies, programmes, including in humanitarian			

settings			
2.1 (Added) Indicator 2.1 (SP OPI 6.1): Number of organizations that advocate for increased investments in marginalized adolescents and youth, within development and health policies and programmes.	**3**	**6**	**7**
2.2 Indicator 2.2 (SP OPI 6.2) : Number of young people including marginalized young girls to have non-discriminatory access to SRH and HIV to marginalized young girls	**0**	**30000 (2015) 35000 (2016)**	**89,908 (2015 achievement)**
2.3 (Added) Indicator 2.3: CSE programmes reviewed	**0**	**1**	**1**

Data Source: CO annual review report
*note: The standards allows MWs to conduct 4 out of 7 life-saving signal functions of BEmONC whereas ASEAN WHO standards is for MWs to conduct all 7 signal functions
**Note MDR is now replace with MDSR in 2014
***Aye Myanmar Association (AMA), Sabei Phyu , Sex Worker Network in Myanmar (SWiM), No partnership with PSI in 2015.

Country Office SRHR programme consists of these key components: Family Planning, Maternal Health, Youth and Adolescents and HIV and AIDS.

Family Planning

Key Findings- Family Panning

UNFPA country programme has made credible achievement in the area of Family Planning. Country is on-track to meet Myanmar's FP 2020.
UNFPA's strategic position in coordinating and facilitating role at policy advocacy level (Co-chair SRH TSG, Co-chair HIV prevention group); procurement and distribution of FP commodities sufficient to cover a quarter of country's need of FP; alternative distributions using NGO partners; institutional capacity building for basic health staff to provide FP services; implementation of assessments and surveys to keep track of the progress in UNFPA programmatic areas; seizing opportunities in rapidly changing environment to improve policy and programme; and working with partners to reach out the most vulnerable are found to be the facilitating factors that contribute to programme achievement.

RHCLS, the first real-time supply monitoring system is in place and currently operational in 30 townships. However, irregularities of stock replenishment and addressing stock imbalances still remain as major challenges and need to be addressed.

Table 2: Achievement of family planning services in Myanmar in CP3

Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access			
Indicator	**Baseline**	**Target**	**Actual**
1.1 Contraceptive prevalence rate for modern methods	41%	50% (2015)	51% (DHS 2015)
1.2 Percentage of public service delivery points (within UNFPA supported townships) with modern contraceptive methods in stock [no stock out] in last six months	30.6% (2012 baseline report)	80%	35% (HF Assessment for RHCS 2015)

Source: 2012 UNFPA CO baseline report, Health Facility Assessment Report 2015

UNFPA country programme has made credible achievement in the area of Family Planning. Country is on-track to meet Myanmar's FP 2020[86]. Table 2 above shows that CO has achieved the outcome indicator 1 to raise the modern CPR to 50% by 2015. However, with reference to indicator 2, there is a room for improvement to ensure that 80% of public service delivery points have no stock-outs in last 6 months. Achievement at the time of evaluation is 35%[87]. This indicator shows the additional effort required to improve supply chain management system.

UNFPA's training programme for basic health staff contributed to the increasing number of health facilities providing family planning services. As per Health Facility Assessment in 2015, 87% of tertiary facilities, 53% of HFs in secondary level and 75% of primary level facilities has trained staff to provide Family Planning. However, number of staff trained on long acting reversible contraceptive (LARC) is still limited. Only 17 percent of health facilities has trained staff on implants with significant difference between urban and rural areas (47% vs.11%)[88]. In 2016, 50 Medical doctors from 39 townships were trained on implants[89].

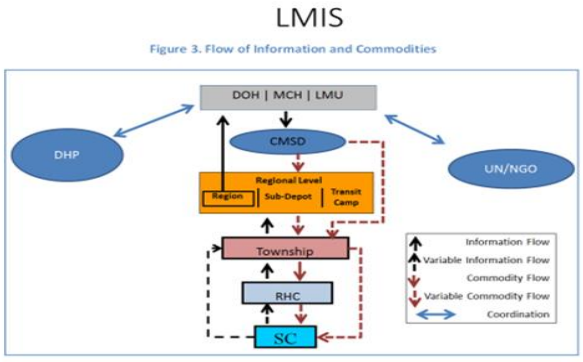
Table 3: Current situation of HSS including LMIS

Output 1. Strengthened health systems to deliver quality and equitable integrated sexual and reproductive health information and services among target groups as well as in humanitarian settings			
Indicator	**Baseline**	**Target**	**Actual**
1. Number of states and regions under UNFPA supported areas that have functional Logistics Management Information Systems (LMIS) for RH commodities (aligned with SP OCI 2.1)	0	4	4
3. Costed national action plan for Family planning developed (aligned with OPI 2.2)	0	1	1

Source: UNFPA CO M&E data.

Table 3 shows CO has achieved its intended outputs: LMIS functionality in 4 states and regions and costed implementation plan for family planning.

Figure 1: LMIS information and commodities flow



As part of the health system strengthening, UNFPA together with JSI and other development partners worked with MOH to improve

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6 by 2015 and over 60 % by 2020; Reduce unmet need to satisfaction from 67% to 80% by 2015; and Improve manent methods) and decentralization to the districts

nmodities and Services 2015

89 CO Progress report data

procurement planning, forecasting, quantification and distribution to ensure uninterrupted supplies of RH commodities. These activities led to increased availability of RH commodities at service delivery points. 84 percent of all primary health facilities could provide at least three modern contraceptive methods. However, regional variations are observed among the different regions where Rakkhine, Kayin and Kayah areas were identified that required more attention[90].

UNFPA supports Reproductive health commodity logistic information system (RHCLS) and developed in-country 1st automation supply chain real-time monitoring system in 4 states and regions -Ayarwaddy, Mandalay, Southern Shan and Mandalay. 1500 BHS were trained on RHLMIS System in 30 townships. Current system allows keeping track of 35 RH commodities and supplies. The presence of RHCLS is appreciated by the Ministry of Health and Sports as it allows the project managers and stakeholders to keep track of the stock status at township level, rural health center and sub- rural health center level and alerts to re-allocate supplies to minimize the stock-outs at the health facilities.

Figure 1 shows the current LMIS information and commodities flow. The RHCLS system currently does not allow real-time monitoring of the stock status at CMSD, the tertiary and secondary hospitals yet. Irregularities of stock replenishment and stock imbalances still remain to be major challenges. Most health facilities are concerned to re-allocate their stock to other health facilities. Lack of trust in sustained replenishment mechanism from central level and cost implications related to re-allocation of stocks are found to be the major bottlenecks.

Limited availability of infrastructure requirement especially at township level such as electricity and internet system to operate the RHCLS; requirement for labor intensive data entry at the Township Public Health Office using the facility stock reports submitted from all RHCs and sub-RHCs; insufficient manpower at RHC level to update inventory cards of 35 commodities on top of existing LMIS which caters more than 110 essential medicines were the main concerns from the DOPH township departments and RHCs.

The presence of other players in country with the mandate and interests to strengthen the procurement and supply chain management system in Myanmar is observed as good opportunities for UNFPA to expand the partnership and exchange technical knowhow to support the Ministry of Health and Sports for advancement of more comprehensive harmonized supply chain management system. USAID Global Health Supply Chain Programme, CHAI (mSupply), 3 MDG, Global Fund, GAVI HSS also address supply chain management component as part of their respective programme implementation. Series of workshops conducted by the Ministry with involvement of all partners working in supply chain management in Myanmar were seen as good initiatives to work together in finding the most strategic solutions leading to develop a more comprehensive sustainable self-reliant supply chain management system.

Facilitating factors: UNFPA's strategic position in coordinating and facilitating role at policy advocacy level (Co-chair SRH TSG, Co-chair HIV prevention group); procurement and distribution of FP commodities sufficient to cover a quarter of country's need of FP; alternative distributions using NGO

[90] Health Facility Assessment for Reproductive Health Commodities and Services 2015

partners; institutional capacity building for basic health staff to provide FP services; implementation of assessments and surveys to keep track of the progress in UNFPA programmatic areas; seizing opportunities in rapidly changing environment to improve policy and programme; and working with partners to reach out the most vulnerable are found to be the facilitating factors that contribute to programme achievement.

Hindering factors: Limited human resources, infrastructure development such as information technology and communication networks are major limitation for the development of Logistimo automation supply system. No budget allocation for township for re-allocation of stocks, donor driven fragmented supply chain management system causing the additional burden to the basic health staff.

Maternal Health

3rd Country programme of maternal health programme focus on strengthening midwifery; capacity building of basic health staff to provide quality services on antenatal, delivery and post-natal maternal and newborn care; strengthening emergency obstetric care by training, procurement and distribution medicines and supplies including life-saving maternal drugs, essential reproductive health care kits, clean delivery kits; and establishment of maternal death surveillance system.

Key Findings- Maternal Health

Myanmar is still short of meeting its target to achieve 70% of deliveries attended by SBA. ASEAN Regional Guideline for minimum requirements for Training and Accreditation of Skilled Birth Attendants (SBA) is one of the achievements of UNFPA's collaboration with ASEAN to promote the maternal health of women in the ASEAN Member States. In line with that, National Midwifery standards were developed, however, it is noted that the skills and scope of life-saving midwifery practices in Myanmar is limited to four signal functions whereas ASEAN WHO standards allow midwives to conduct all seven signal functions.

Evidence showed that pre-service midwifery training and in-service trainings on PCPNC, QRH and BEmOC training have strengthened the skills of midwives to provide essential maternal and newborn care services. UNFPA has leveraged technical resources from JHPIEGO and financial resources from World Bank to complete the nationwide in-service training for midwives.

Despite all the good initiatives done by UNFPA and partners, ***availability of emergency obstetric care is very much limited and needs to be addressed urgently***. Only 60% of RHCs can offer four out of seven signal functions; and only 41% of station hospitals and 78% of township hospitals can provide standard CEmONC (SARA Myanmar 2015). Therefore, the role and functionality of station hospitals and township hospitals to provide CEmoNC become much more critical and fundamental to save lives of pregnant women.

Interrupted availability of maternal life-saving drugs; insufficient number of skilled personnel to provide full package of emergency obstetric care; inadequate infrastructure and limited medical facilities with less than half of station hospitals providing full emergency obstetric care package are limiting the women to access to emergency obstetric care services.

UNFPA targets to contribute to increase SBA to 70% by the end of the country programme. Table 4 shows at the time of evaluation, DHS 2015-2016 indicates the percentage of births attended by skilled health personnel is still short to meet the target.

Table 4: Skilled Birth Attendants in Myanmar during CP3.

Outcome 1: Increased availability and use of integrated sexual and reproductive health services (including family planning, maternal health and HIV) that are gender-responsive and meet human rights standards for quality of care and equity in access			
Indicator	Baseline	Target	Actual
Outcome indicator 2: Number of (percentage) of births attended by skilled health personnel (SP OCI 1.5)	64.8 % (Ref. World Health Statistics 2011),	70%	60% (DHS,2015-2016)

Source: World health statistics 2011, DHS 2015-2016

During the CO re-alignment exercise, CO added output indicator 2 and 4 to keep track of the progress and achievement of maternal health interventions. Table 4 shows both UNFPA CO output indicators 2 and 4 targets have achieved.

Table 5: Achievement of National Midwifery standard and maternal death review in Myanmar

Output 1. Strengthened health systems to deliver quality and equitable integrated sexual and reproductive health information and services among target groups as well as in humanitarian settings			
Indicator	**Baseline**	**Target**	**Actual**
2. (added) National Midwifery standards as per ASEAN-WHO guidelines developed (SPOCI 3.1)	0	1	Yes**
4. (added) Number of states and regions under UNFPA supported areas that have maternal death review in place	0	2	Yes*
*Note MDR is now replace with MDSR in 2014, **note: The standards allows MWs to conduct 4 out of 7 life-saving signal functions of BEmONC whereas ASEAN WHO standards is for MWs to conduct all 7 signal functions			

Source: CO annual review data 2015-2016

In 2012, with support from UNFPA, a new two years competency based Midwifery Diploma curriculum was developed and implemented. UNFPA's advocacy and technical assistance has led Myanmar to participate in the State of The World Midwifery Report (SOWMY) in 2014, a global survey looking at the effectiveness of Midwifery across the country. The findings of the survey were used to promote strategic options in order to increase effective coverage of midwifery services in Myanmar.

UNFPA supported Department of Medical Science/Department of Health Professional Resource Development and Management (DHPRDM) to conduct Training of Trainers sessions for instructors and faculty members from 22 out of 46 MW training schools. UNFPA's coordination and partnership with JHPIEGO in pre-service midwifery training creates synergy to enhance the teaching-learning skills in the midwifery schools and most respondents in the interviews appreciate the support they received. To enhance the clinical skills of tutors and faculty members, four months hands-on training was conducted in Central Women Hospital and North Okkalapa Teaching Hospital. During the time of evaluation, 324 (75

percent of all faculty members in country) have attended Training of Trainer course on BEmOC and ENC and 192 completed four months hands-on training course.

The importance and the value of above trainings were well recognized and appreciated by all the faculty members in the Midwifery schools visited by the evaluation team. A faculty member in one of the nursing and midwifery school said *"Not having much practical clinical experience in dealing with emergency obstetric care, I was not quite confident in teaching the students. Now, I'm really happy that I can pass on my knowledge and skills to the students. It makes a lot of difference".*

Faculty members expressed the need to re-new the commitments from the Teaching Hospitals to ensure all hands-on trainings are conducted with standard quality and compulsory clinical skills acquired. One Tutor said *"It was unfortunate! Most of us ended up with doing other things and not getting the chance to do the examination of the pregnant women, antenatal care, particularly missing to attend the deliveries".*

ASEAN Regional Guideline for minimum requirements for Training and Accreditation of Skilled Birth Attendants (SBA) is one of the achievements of UNFPA's collaboration with ASEAN to promote the maternal health of women in the ASEAN Member States. This has led to the development of National Midwifery Standards in Myanmar in 2016, however, Myanmar standards is still short to meet ASEAN WHO standards which allow midwives to conduct seven signal functions of BEmONC.

UNFPA supports in-service trainings for basic health staff on PCPNC, QRH and BEmOC training. During 2012-2014 more than 1800 BHS trained on PCPNC, nearly 2,000 trained on QRH and nearly 700 trained on BEmOC in UNFPA supported townships. In 2015, UNFPA leveraged technical resources from JHPIEGO and financial resources from World Bank to complete the nationwide in-service training for midwives.

UNFPA procures RH medicines including the life-saving critical maternal medicines, and BEmOC supplies. In the second year of GPRHCS, UNFPA procurements started to limit to the contraceptives and agreement was done with the MOH to take over the procurement of life-saving maternal medicines. In 2015, a significant reduction of the availability of two life-saving drugs (MgSO4 and Oxytocin) are observed in all level of health facilities from 62% in 2014 to 49% in 2015 and the health facilities in the rural area are much more effected[91].

Maternal Death Surveillance and Response (MDSR) is a good example of UN collaboration and moving the agenda in the country at national level. MDSR is one of the key interventions for reducing maternal mortalities that has been promoted by WHO[92].

[91] Health Facility Assessment for reproductive Health Commodities and Services 2015
[92] World Health Organization, UNICEF, UNFPA, World Bank, United Nations Population Division. Trends in Maternal Mortality: 1990 to 2015. Geneva:WHO2015
www.**who.int/reproductivehealth/publications/monitoring/maternal-mortality**-2015/en/

Ministry of Health and Sports initiated MDSR in 100-day Health Plan of the current Government. UNFPA in collaboration with WHO supported launching of MDSR, national guideline development, training and supports implementation in all states and divisions. The functionality of MDSR is expected to start by the end of November 2016. Eleven states and divisions will be supported by UNFPA and the rest of the country will be supported by WHO.

> Emergency obstetric care (EmOC) services are a vital part of responding to MMR issues. All five major causes of maternal mortality – post-partum hemorrhage, sepsis, unsafe abortion, hypertension disorders and obstructed labor – can be managed when well trained staff with adequate equipment are available to provide the necessary emergency obstetric care. BEmONC can be provided in the health centers with health workers capable of providing following 7 signal functions: administering antibiotics, uterotonic drugs (oxytocin) and anticonvulsants (magnesium sulphate); performing assisted vaginal delivery; manual removal of placenta; removal of retained products following miscarriage or abortion; and basic neonatal resuscitation care.(Ref. WHO)

Availability of basic emergency obstetric care services are still limited. 60% of RHCs and quarter of sub-RHCs offer four out of seven basic emergency obstetric signal functions: parenteral administration of antibiotics, oxytocic drugs, anti-consultants (magnesium sulphate), and neonatal resuscitation[93]. RHCs are staff with Midwives where scope of midwifery practices to provide life-saving midwifery practices (LSMP) is limited to four signal functions mentioned above. MOH does not expect RHCs and sub-RHCs to perform assisted vaginal delivery, manual removal of placenta and removal of retained products following abortion. In such situation, station hospitals and township hospitals are expected to provide comprehensive emergency obstetric care (CEmONC) which include caesarean section (CS) and safe blood transfusion on top of seven basic signal functions. CEmONC services are available in 78% of township hospitals and 41% of station hospitals[94].

Facilitating factors: UNFPA is in the strategic position for the advancement of agenda with the Ministry of Health and Sports and other partners. UNFPA's strategic partnership with WB and JHPIEGO leveraged technical and financial resources to secure completion of nationwide in-service training for midwives.

Hindering factors: Interrupted availability of maternal life-saving drugs; insufficient number of skilled personnel to provide full package of emergency obstetric care; inadequate infrastructure and limited medical facilities with less than half of station hospitals providing full emergency obstetric care package are limiting the women to access to emergency obstetric care services.

Sexual Reproductive Health in Humanitarian context

Key Findings - RH in Humanitarian context

UNFPA's support and inputs led to build the capacity in four states and regions to implement MISP at the onset of a crisis and Humanitarian contingency plans developed by the Ministry of Health and Sports and

[93] Nation-wide services availability and readiness assessment (SARA 2015)
[94] Nation-wide services availability and readiness assessment (SARA 2015).

UN HCT includes elements to address sexual and reproductive health needs of women, adolescents and youth including services for survivors of sexual violence in crises.

GBV and SRH are implemented in a vertical fashion. UNFPA is in unique position to close the gap and facilitate between MOHS and DSW to integrate GBV programme in health sector. The selected components of Minimum Initial Service Package are implemented by IPs. Mobile and static clinics clearly address the equity issues and promote access to essential reproductive health care in the humanitarian context. However, implementation of 5 core elements of RH components has been a challenge especially prevention of unsafe abortion & post-abortion care, STIs, HIV and sexual health including ARH services are still very limited in emergency setting.
On top of technical assistance to State Public Health Department and social welfare departments on Gender and SRH, UNFPA's contribution to socio economic development plan was acknowledged by partners.

RH in Humanitarian context provides services in response to natural disaster and conflict affected areas. Projects are implemented through implementing partners: MMA, MNMA, MRCS, Merlin, JOICEP and Medecins du Monde.

UNFPA's physical presence in the emergency prone areas was appreciated by the State Public Health Department, TMO and other implementing partners. UNFPA has established a good relationship with implementing partners in response to the emergency situations. Its technical support especially on GBV and SRH is well acknowledged on ground. As one of the collective effort with WHO, major achievement is the establishment of SRH subgroup that serves as a venue for the technical forum on SRH issues in emergencies.

Table 6: Institutional capacity to implement RH in humanitarian context

Output 1. Strengthened health systems to deliver quality and equitable integrated sexual and reproductive health information and services among target groups as well as in humanitarian settings			
Indicator	**Baseline**	**Target**	**Actual**
6: Number of states/regions that have capacity to implement MISP at the onset of a crisis (SP OPI 5.1)	1	3	4
7: Ministry of Health and Sports, UN HCT and UNFPA has humanitarian contingency plans that include elements for addressing sexual and reproductive health needs of women, adolescents and youth including services for survivors of sexual violence in crises (SP OPI 5.2)	Not reflected	Reflected	Yes

Source: CO annual review data 2014-2015

Table **6** shows CO met its achievement in MISP implementation in 4 states and regions and elements of addressing sexual and reproductive health needs of women, adolescents and youth including services for survivors of sexual violence are reflected in the humanitarian contingency plan.

UNFPA's support in formation of Rapid Response Teams in 4 selected states and regions, MISP training for 40 members of RRT teams, prepositioning of ERH kits in MOH warehouse in Yangon and training of 15 UNFPA partners on clinical management of rape survivors contribute to the above achievement.

Natural disaster response projects are implemented in Magway, Saggine, Rakhine and Chin and Conflict response projects are implemented in Rakhine, Kachin and Shan. UNFPA works with MMA, MNMA, MSI and MRCS to implement SRH implementation in humanitarian context.

MMA provides life-saving essential reproductive health services through mobile and static clinics in underserved areas and IDP camps. MNMA deployed 10 midwives to Sittwe to provide pregnancy care, education and training to traditional birth attendants. Such interventions clearly address the equity issues and promoting access to essential reproductive health care for those people in hard to reach area and those living in the humanitarian context. In 2014, more than 19350 clients are reached by MMA static and mobile clinics and 19747 clients reached through MNMA.

Services are provided under extreme challenges in terms of geographical accessibility, safety, security and political hardship situation. Quality of care to deliver five core elements of RH has been a challenge in emergency settings. The Services provided by the implementing partners are more focus on the education, pregnancy care and short term family planning methods whereas STI, RTI and HIV/AIDS prevention were not usually provided. Patients are being referred to hospital for delivery, postpartum and newborn care services. MMA established a referral mechanism to promote women's access to emergency obstetric care. Whereas MNMA also provides health education, antenatal care and training of TBAs as community health promotors. MNMA interventions lack of establishing community support to functioning referral system in the villages which is the most critical intervention to save lives of women who needs emergency obstetric care during the delivery, child birth and post-partum services. Table 13 shows most of the targets planned by the IPs are achieved in 2015 except for two critical interventions to reduce maternal mortality - referral (7%) and women's access to family planning services (14%).

Table 7: SRH Humanitarian project achievement (MMA, MNMA, MSI) in 2015

Indicators	Target	Achieved	%age
# of women, men, boys and girls received RH services	33010	30151	91
# of women, men, boys and girls received RH education sessions	19500	27126	139
# of referral of RH cases to higher health facilities	7083	498	7
# of pregnant women access ante-natal care	8000	7076	88
# of women access post-natal care	3200	1485	46
MISP PLUS: # of women accessed family planning services	7500	1087	14

Source: UNFPA Country office annual review meeting 2015.

MRCS provides training on MISP, coordinate RRT in states and regions and distribute Dignity kits, clean delivery kits and RH kits.

UNFPA's collaboration with donors to boost the skills of midwives and deployment of midwives in hard to reach areas in Mon, Kayah, Shan, Chin and Ayeyawady and Rakhine has made increasing access to SRH services. In addition, 40 pre-service MWs were trained and deployed to areas in need, in partnership with the Myanmar Nurse and Midwife Association , Department of Medical Services and the Department of Public Health. This modality solved the issue of human resource gap to some extent.

More than 1010 health providers were trained on MISP. The participants are all mix from DOH, GP, MMCWA, department of social welfare, General Administration Department, MMWA, Information and communication department, DSW, RRD, fire service department, Police, local social organization.

UNFPA provides Reproductive Health Commodity and Emergency Reproductive Health Kits for both Emergency Response and Preparedness. *A* total of 139 ERH kits in 2014 for Emergency Response as well as Emergency Preparedness for both Rakhine and Kachin - 39 ERH kits distributed to Rakhine and 87 ERH kits to Kachin and a stock piled total of 19 kits for Rakhine, Aweyarwady and Yangon to be ready for use during unforeseen disasters.

Facilitating factor: Technical coordination in GBV sector and SRH sector, good relationship with the State Health Directors and other implementing partners have facilitated some of the achievements of RH in humanitarian context

Constraining factors: Safety and security of staff and political hardship situation on top of physical geographical accessibility (road infrastructure and transportation) are preventing availability and accessibility of services in humanitarian context. Limited availability of physical space, clinical medical facilities in RHCs and untimely arrival of medical supplies, test kits and family planning commodities confine the IPs to deliver the full package of essential RH interventions which can threaten the quality of care provided by IPs in humanitarian context. Inadequate number of hospitals in the area that can provide all seven signal functions of life-saving maternal and newborn health (BEmONC) and comprehensive life-saving functions (CEmONC) constrained the timely accessibility and utilization of obstetric emergency services to save lives of pregnant women. Referral system is established for the IDP camps with clear guideline and arrangement to transfer the patient to the District/ Township hospitals whereas in the non-IDP villages there is no proper/standard referral system established to transfer the patients/ pregnant women to higher level health facilities. Delay funds transfer and delay arrival of drugs and commodities to IPs lead to delay implementation of projects on ground. Not enough consultations and joint planning were done between gender and SRH programme to address GBV in SRH interventions and missed the opportunity to implement/mainstream GBV in SRH projects delivered by IPs. Human resource constraints and rapid staff turn-over of staff caused inadequate institutional capacity to address related reproductive health needs in humanitarian settings. In some regions, it was found that more than 3 trained RRT members were transferred or promoted to other places within one year period.

Adolescents and Youth

Summary Findings – Adolescents and Youth

UNFPA work on development of policies and strategies related to adolescent and young people is commendable. Youth policy development is under process with greater participation of young people from different sectors. Policy documents, protocols and standards of delivering SRH/ARH services available and in use by implementing partners.

Despite all the efforts, adolescent interventions are small scale and time limited because of inadequate financial resources and limited capacity of human resource. Evidence of joint programming with other UN agencies, strategic partnership with wide range of stakeholders and resource mobilization has been inadequate to move the agenda at large scale implementation.

National Strategic Plan on young people's health (2016-2020) is a good piece of work and evidence of collective work of all partners working on adolescents and young people. It clearly outlines the seven strategic priority areas and corresponding program objectives and goals; and the strategies to achieve the goal; and indicators to keep track of the progress of implementation but it lacks the costing and budget which could be used for resource mobilization for programme implementation.

Revitalization of H6 partnership (WHO, UNICEF, UNFPA, UNAIDS, World Bank); MOH interest to advance the adolescent agenda; and revitalization of school health teams are opportunities for UNFPA to advance evidence-based CSE for adolescent at scale.

Pieces of good work in behavioural change communication and media programmes are implemented by partners. However, inadequate resources do not allow to continue the good work that partners have done before. For example. MMA radio programme "Youth Garden" aired twice a week through Shwe FM radio was appreciated by young people.

SRH mobile App "Love question – life answer", a product of UNFPA innovation and use of new technology allows adolescents and young people to access wide range of information including FP, RH, STI and HIV, GBV without violation of their privacy. It has been a success among adolescents and young people.

UNFPA implements behavioral change communication and ARH service provision in partnership with Central Health Education Bureau (CHEB)/ Health Education Department (HED), MMCWA, MSI, MMA, AFXB, Consultancy and Carrier Development Firm (CCDF), and Positive Action group with different implementation models. The work of partners focus on the behavioural change communication around sexual reproductive health, HIV and STI prevention, and prevention of gender based violence. UNFPA works closely with the Ministry of Health and Sports and Sports in development of policies, standards and guidelines and also support the Youth policy development which MSWRR is taking a lead with participation from young people from different sectors.

In end 2014, to be in line with SP 2014, with the aim to address CSE, UNFPA added a new output (SP OP6) and corresponding indicators to 3rd CP. Table 14 shows output 2, additional indicators and their achievement at the time of evaluation.

Table 8: National capacity to review comprehensive sexuality education for youth and adolescent and Provision of services of SRH and HIV to adolescent and Youth

(Added) Output 2 (SP OP 6) : Increased national capacity to review the situation of comprehensive sexuality education(CSE) programmes and conduct evidence-based advocacy for incorporating adolescents and youth and their human rights/needs in national laws, policies, programmes, including in humanitarian settings			
Indicator	Baseline	Target	Actual
(Added) Indicator 2.1 (SP OPI 6.1): Number of organizations that advocate for increased investments in marginalized adolescents and youth, within development and health policies and programmes.	3	6	7
(Added) Indicator 2.2 (SP OPI 6.2) : Number of young people including marginalized young girls to have non-discriminatory access to SRH and HIV to marginalized young girls	0	30000 (2015) 35000	89,908 (2015 Achievement)

		(2016)	
(Added) Indicator 2.3: CSE programmes reviewed	0	1	1

Data Source: CO annual review report

UNFPA met its targets reference to all three output indicators. Indicator 2.2 achievements overshot the target. In 2014 annual review, reference to indicator 2.2, CO staff re-defined the target group to ensure "marginalized" includes wide range of young target groups as defined in SP 2014-2017.

UNFPA has made a good progress in the area of policy advocacy work. Policies and strategies are in place to address youth and adolescent agenda - National Strategic Plan for young people's health (2016-2020); National Service Standards and Guidelines on Adolescent and Youth Health Care; AYFHS Manual for BHS; and National Youth Policy development process in place.

National Strategic Plan for young people's health (2016-2020) clearly outlines the seven strategic priority areas and corresponding programme objectives and goals; and the strategies to achieve the goal. The strategic plan reflects the programmatic indicators to keep track of the progress of implementation but it lacks the costing and budget which could be used for resource mobilization for programme implementation.

National Service Standards and Guidelines on Adolescent and Youth Health Care and AYFHS Manual for Basic health staff were developed and introduced to the health system with UNFPA support. During 2015-2016, 100 BHS per township were trained on adolescent health care guideline and AYFHS manual and 50 youth were trained to provide basic CSE information and knowledge at the RHC and sub-health centers and during outreach activities. In collaboration with MMA and MSI, capacity building for adolescent and youth friendly health services were provided to service providers from private sectors in 2016. 375 general practitioners were trained on AYFHS manual through MMA. 89 medical doctors from MSI, from private hospitals and general practitioners were trained through MSI in 2016.

Development process of National Youth Policy is led by the Department of Social Welfare under the Ministry of Social Welfare, Relief and Resettlement and UNFPA has been supporting the process of youth policy development in collaboration with Joint UN team to ensure full participation of young people from different socio economic groups.

As mentioned earlier, UNFPA provides IEC and ASRH services to adolescents and young people through implementing partners. CHEB/HED and MMCWA operate YICs attached to RHCs. Number of functioning youth information centers has reduced from 71 to 21 centers in 9 regions. YIC Assessment conducted in 2015 captured issues related to the functionality, sustainability and management and implementation arrangement of YICs[95] and lessons learned should be used to address the adolescent strategies in next CP. UNFPA may need to review the implementation arrangement to make the programme to be more cost effective and sustainable in local context.

MSI provides outreach health educations and runs six youth centers attached to MSI SRH clinics that provides family planning, STI treatment, HIV and AIDS counseling and testing and antenatal care.

[95] Situation Analysis on Youth Information Corners 2015

During the ET's visit adolescents and youth showed their enjoyment of using the center and most of them are comfortable to use the center and clinics because of the arrangement not to expose their privacy. Adolescent and youth from urban and rural areas can easily access one stop ASRH services at MSI youth centers attached to MSI clinics. MSI service providers and SRH promoters were trained the national standards and guidelines for adolescent and youth friendly health services. Young people are trained for the CSE and local young people (including marginalized young people) are reached to non-discriminatory access to SRH and HIV prevention services through center based educational activities, outreach activities and peer education.

MMA implements the youth development programme (YDP) for adolescent and youth to address the challenges they face in their life through a structured, progressive series of activities. The programme aims to assist them to strengthen social, emotional, ethical, physical and cognitive competencies. Activities includes: peer education, awareness creation and empowerment (seven star programme), spots, youth library, edutainment activities and four different levels of training – basic adolescent health training "Happy and Healthy Adolescent Life" (HHAL), ToT for peer educators, youth leadership development training, and capacity development training. YDP appears to be effective for young people -more than 60% of HHAL participants had high level of adolescent reproductive health knowledge, and there is a significant correlations between the level of knowledge and intention to avoid risky behaviors[96] .

Reference to Behavioural Change Communication, HED produced and aired four episodes of on adolescent reproductive health and HIV. With support from MMA, radio programme "Youth Garden" was aired twice a week through Shwe FM radio. Telephone hotlines for boys and girls were developed with full participation from young people.

In 2015, UNFPA's seize the opportunity of available technology and developed a mobile phone application "Love question – life answer" as UNFPA's innovation project to reach out immense number of adolescents and youth to access information on sexual reproductive health and rights. The programme was developed in full participation of adolescents and youth and ready to be launched in 2016. The "Love question – life answer" allows adolescents and youth to access sensitive information without violation of their privacy.

"This application educates me in a real way. I have been using it time and time again since I installed it", says one adolescent male.

Eighteen year old university student from Yangon also likes the privacy aspect of the app: "*We do not want to discuss our physical development and all our emotions, not even with our parents. Among friends we can talk, but it is usually a dead-end road. We want information about many things, but it is difficult to find it on the internet or on Facebook. Now, for the first time, it is all available in one place."*

The adolescent interventions are small scale and time limited due to limitation of resources to scale at large. Evidence of joint programming with other UN agencies, and other line Ministries is very minimal. However, revitalization of H6 partnership (WHO, UNICEF, UNFPA, UNAIDS, World Bank) and MOHS

[96] Intention to avoid premarital sex among "Happy and healthy Adolescent Lives" (HHL) Trainees in Yangon, Myanmar, Myat Yee Lwin.

interest to advance the adolescent agenda and revitalization of school health teams are opportunities for UNFPA and partners to advance evidence-based CSE for adolescent at scale.

Facilitating factors: Global initiatives and agenda to advance adolescents and young people, available policy and strategies to address adolescents and young people's need in SRH, gender and HIV; and technical support and guidance from UNFPA regional office have made a progress of adolescent and youth programme.

Constraints: Inadequate financial resources to institute and expand youth programme; limited capacity of human resources; inadequate number of teachers competent to conduct life skills and sexuality education; high turn-over of trained youth peer educators affect the quality and sustainability of the adolescent programme. In addition, lack of accurate data on the adolescent knowledge about the contraceptive methods (especially in case of unmarried adolescents); their knowledge on drug use and abuse, alcohol and tobacco are constraining factors to advance the agenda.

HIV and AIDS

Summary- HIV/AIDS

UNFPA is seen and acknowledged by the National AIDS Programme as long-term partner in prevention of sexual transmission of HIV and PMTCT. During the first half of CO, UNFPA HIV programme focused on the CCP and PMTCT. When the CO shifted its focus to advocacy work, but continue its direct service delivery model to CSOs led by FSWs and discontinued to support IPs in CCP implementation. It is observed that the number of MSM and FSWs reached by HIV prevention programme has declined and the same pattern is observed in HIV tests coverage among them (Source: annual review data 2012- 2015). PMTCT programme achieved beyond its target. Pregnant women who received voluntary HIV counseling and testing has increased from 20% in 2012 to 36% (vs target 30%) in 2013 and 52% (vs target 40%) in 2014 & 74980 pregnant women tested HIV vs its target 70000. (Note: starting from 2015, the indicator was mentioned in number instead of %).

In line with UNFPA SP 2014, UNFPA provides secretariat support to HIV prevention TWG. A stronger leadership role, adequate technical support with greater coordination and facilitation from UNFPA is expected by partners to ensure relevant issues are addressed with full participation and involvement from wide range of partners especially to address the issues of adolescents and young people. UNFPA is in a unique position to serve as bridging agency between NAP and CBOs. A national guideline on A Core package of HIV prevention among key population in Myanmar (2013) was one of the achievements. Technical support or S-S cooperation should lead to build the decentralization and technical leadership competencies of central and regional level staff to advance rights based programme planning, monitoring, and reducing stigma and discrimination.

At the beginning of the country programme, following two outcome indicators were recorded to measure the achievement of the UNFPA's contribution to the national AIDS Programme.

- Percentage of female sex workers and men in high-risk groups who used condom during their last sexual encounter
- Percentage of HIV positive pregnant women who received services to prevent mother-to-child transmission of HIV

During the first half of the CP (2012-2014), the following output indicators were recorded to contribute to CP Output 2:

- Percentage of facilities in UNFPA-supported areas that provide services to prevent HIV to populations that are most at risk
- Percentage of populations, in UNFPA supported areas that are most at-risk and that have knowledge about preventing unwanted pregnancies and HIV
- Percentage of pregnant women who received voluntary HIV counseling and testing in UNFPA-supported areas

Table 9 shows the achievement of HIV programme using the old indicators before re-alignment 2012-2014.

Table 9: Provision of information, services and counseling to prevent HIV

CP Output 2: Improved availability of sexual and reproductive health services, including the prevention of HIV transmission among populations that are most at risk and their partners, and from mothers to their children. **(Old output: 2012-2014)**			
Indicator	**Baseline**	**Target**	**2012-2014**
1.Number [and percentage] of facilities in UNFPA-supported areas that provide services to prevent HIV to populations that are most at risk	34 Facilities (Ref. standard progress report 2013)	40% (2015)	34 out of the 80 target townships provide (42.5)% comprehensive services to MARPS (FSW, MSM)
2.Percentage of populations, in UNFPA supported areas that are most at-risk and that have knowledge about preventing unwanted pregnancies and HIV	N/A	N/A	N/A
3.Percentage of pregnant women who received voluntary HIV counseling and testing in UNFPA-supported areas	20% (Ref. 2012 Baseline survey for UNFPA CP	30%(2013) 40% (2014)	**36% (2013) 52% (2014)**

Source: annual review data 2012-2014. Note: Indicator 2 is recorded as not relevant.

Table 9 shows that UNFPA maintains the number of townships to support PMTCT and HIV prevention services. Pregnant women who received voluntary HIV counseling and testing has increased from 20% in 2012 to 36% and 52% in 2013 and 2014.

As reference to annual review 2012, UNFPA CO added new output indicator "Number of most at risk population reached by HIV prevention programme" and the data was recorded since 2013. When the CO shifted its focus to advocacy work, but continue its direct service delivery model to CSOs led by FSWs and discontinued CCP implementation with other IPs, the number of MSM and FSWs reached by HIV prevention programme has declined by year (during 2013-2015) and the same pattern is seen in HIV tests coverage among them[97].

[97] Data Source: Annual Programme Review Meetings 2013, 2014 and 2015

To be in line with the UNFPA SP 2014, the strategic shift and realignment exercise was done in 2014 and CP output indicators to address HIV programme achievements were re-aligned accordingly under the new output 1 and new output 2.

Table 10: Monitoring of programmes that address HIV and sexual and reproductive health needs of sex workers

Output 1. Strengthened health systems to deliver quality and equitable integrated sexual and reproductive health information and services (including family planning, maternal health and HIV prevention) among target groups as well as in humanitarian settings			
Indicator	**Baseline**	**Target**	**Actual**
(added) Indicator 1.5 (SP OPI 4.3): Number of community based sex worker-led organizations engaged in the design, implementation, and monitoring of programmes that address HIV and sexual and reproductive health needs of sex workers	1	4	3 Aye Myanmar Association (AMA), Sabei Phyu , Sex Worker Network in Myanmar (SWiM) (No partnership with PSI in 2015)
Indicator 1.8 Number of and [percentage] of pregnant women offered voluntary HIV counselling and testing services in UNFPA supported areas	60000	70000	74980 (Jan to 30 Sep, PMCT Programme data)
Number of **female sex workers reached** by HIV prevention programme through community based sex worker lead organization	2200	3700 (NAP 1000+MANA 1200+ Alliance 500+ PGK 500 MHDC/AMA 500	7,786
No of **coordination meeting** at central and State/Regional level on HIV prevention organized	0	3	3 (Regional Level Coordination meeting PMCT (Yangon), Coordination meeting on RH-HIV-TB (Pyinmana), Coordination Meeting on CCP (Yangon)

Source: UNFPA CO M&E data 2014-2015

Table 10 above shows HIV Programme achieved target reference to all indicators and performed well in PMTCT reaching more pregnant women received voluntary HIV counseling and testing.

Table 11: Provision of services of SRH and HIV to adolescent and Youth

(Added) Output 2 (SP OP 6) : Increased national capacity to review the situation of comprehensive sexuality education(CSE) programmes and conduct evidence-based advocacy for incorporating adolescents and youth and their human rights/needs in national laws, policies, programmes, including in humanitarian settings			
Indicator	Baseline	Target	Actual
(Added) Indicator 2.2 (SP OPI 6.2) : Number of young people including marginalized young girls to have non-discriminatory access to SRH and HIV	0	30000 (2015) 35000 (2016)	89,908 (2015 Achievement

Source: UNFPA CO M&E data 2014-2015. Note: both HIV and SRH (adolescent & young people) contribute to the achievement of results.

UNFPA supported 34 townships to provide HIV prevention services to MARPs and prevention of mother to child transmission of HIV. On first half of the CP, UNFPA procured condoms, STI tests and HIV tests to ensure MARPs have access to condoms, HIV counseling and testing, STI diagnosis and treatment in both public and private sectors. Activities were implemented through the National AIDS Programme, Population Services International (PSI) and Myanmar AntiNarcotics Association (MANA), Allianc, Pyi Gyi Khin (PGK) and Myanmar health Development Group (MHDC)/Aye Myanmar Association (AMA). The interventions include: Peer education among MARPs; condom distribution; health education through IEC materials; and referral to other services. PSI operates "TOPs" Targeted Outreach Programme and 17 drop-in centers across Myanmar. TOP is supported by UNFPA and other partners such as USAID, Global Fund and other partners. In 2013-2014, UNFPA partially contributed to following TOP achievements: 14 million condoms distributed; 92,000 HIV tests done; 8000 cases of HIV identified for treatment; 10400 cases treated for STIs and UNFPA are proud to be part of it[98]. With support from UNFPA, more than 1.14 million male condoms, nearly 7000 female condoms (in 2013); 817,000 condoms (in 2014) and 3.8 million male condoms (in 2015) were distributed[99].

2015-2016 UNFPA HIV programme shifted its strategy to focus more on the policy advocacy work in development of guidelines; facilitate regional level coordination meetings; and empower community based sex workers led organization.

UNFPA is seen and acknowledged by the National AIDS Programme as long-term partner in prevention of sexual transmission of HIV and PMTCT. UNFPA use implementation of GF to exit its support to the national AIDS Programme. However, when there was a gap, UNFPA also stepped in and procured HIV tests to ensure continuous availability of HIV tests in country.

In line with UNFPA SP 2014, UNFPA provides secretariat support to "sexual transmission prevention TWG" among four coordination TWGs: Treatment, PMTCT, M&E and prevention. UNFPA is responsible to organize quarterly meetings with full participation from wide range of partners; help raise issues that need to be addressed to Technical and Strategy Group (TSG) chair by Director, Disease Control and vice chair by the NAP Manger. The process need to be follow through. Close follow up, better coordination and technical leadership is expected to ensure relevant issues are addressed with full participation and involvement from a wide range of partners.

A stronger leadership role and adequate technical support from UNFPA is expected by partners in the area of prevention especially to address the issues of adolescents and youth. UNFPA is in a unique position to serve as bridging agency between NAP and CBOs.

Technical support or S-S cooperation should lead to build the decentralization and technical leadership competencies of central and regional level to advance rights based programme planning and monitoring; reducing stigma and discrimination. Organizational performance, technical capacity assessment and development training were conducted for sex workers led organizations, and peer education training was conducted for PGK/SWIM/Alliance/AMA. Series of coordination meetings – (Regional Level Coordination meeting PMCT (Yangon), Coordination meeting on RH-HIV-TB (Pyinmana) , Coordination Meeting on

[98] UNFPA in Myanmar 2013 & 2014
[99] UNFPA Myanmar annual report 2013, 2014 and 2015

CCP(Yangon)- were conducted[100] but it is difficult to assess how the outputs and the outcomes of the meetings are link to relevant programme achievement.

Population and Development –Details of Findings

Table 1 below shows the recent progress on the different indicators related to the sub-output 1 under population and development thematic areas. It is worth noted that some of the indicators are not quantified in the CPAP. We have formulated the indicators for ease of the readers.

Table 1: Sub-output-1: Strengthening institutional capacity to conduct a population census and a migration survey.

Output: Strengthened national capacity to increase availability of high quality disaggregated data on population, reproductive health and gender issues for policy formulation, planning and monitoring and evaluation.			
Sub-output-1: Strengthening institutional capacity to conduct a population census and a migration survey.			
Indicator:	**Baseline**	**Target**	**Actual**
1.Quality census data is available	Census data was not available since 1983	2014 census data is available.	Census is conducted in March-April 2014. Provisional results published in August 2014. Detailed data is published in May 2015 included user friendly excel tables.
2.Number of thematic reports, analysis and statistical data produced through UNFPA support	0 (2014)	13	3 thematic reports[101] published including Fertility, Mortality and Maternal Mortality. A Gender Situational Analysis report is also published.
3.Conduct Migration Survey		One	Onset of country program, it was planned, however when census planning has been finalized, migration survey is postponed. The thematic report is planned using census data.

Table 2 shows the recent progress on the different indicators related to the sub-output 2 under population and development thematic areas. It is worth noted that some of the indicators are not quantified in the CPAP. We have formulated the indicators for ease of the readers. For examples, it was mentioned the country program document that strengthening institutional capacity for population research, advocacy and policy dialogue. However, it is not quantify the number, department, and themes etc.

Table 2: Sub-output-2: Strengthening Institutional capacity for population research, advocacy and policy dialogue.

[100] UNFPA CO annual review presentation, 2015

[101] At the time of CPE data collection (end of October 2016)

Output: Strengthened national capacity to increase availability of high quality disaggregated data on population, reproductive health and gender issues for policy formulation, planning and monitoring and evaluation.			
Sub-output-2: Strengthening Institutional capacity for population research, advocacy and policy dialogue.			
Indicator:	**Baseline**	**Target**	**Actual**
1.# of govt officials trained to incorporate population, reproductive health and gender issues in national plans and programmes	No baseline available.	Target was not defined.	10 Staff from DoP, CSO and FERD trained on demographic and research methods. However, *need to capture the outcome, focus on long-term knowledge transfer and sustainability. Institutional capacity development strategy.*
2.# of institutions supported by UNFPA to incorporate results of the population census and surveys in selected national and provincial policies and plans	0	Target was not defined.	4 Line ministries (MOHS, DSW, and Planning Ministry, and CSO) 3 sample surveys used census Sample frame (MDHS, LFS, Drug Use Survey) till October 2016

Table 3: Sub-output-3: Providing technical assistance for the establishment of an integrated and harmonized data base to monitor ICPD and MDGs indicators.

Output: Strengthened national capacity to increase availability of high quality disaggregated data on population, reproductive health and gender issues for policy formulation, planning and monitoring and evaluation.			
Sub-output-3: Providing technical assistance for the establishment of an integrated and harmonized data base to monitor ICPD and MDGs indicators.			
Indicator:	**Baseline**	**Target**	**Actual**
1.Number of data-bases on population, RH and gender issues that are loaded to the national interactive databases	Not available.	2	1
2. Number of national and local level institution which have institutional capacity to analyses and use disaggregated data on demographic and socio-economic themes including a) adolescents and youth and b) gender-based violence.	1	8	4

Evaluation of the 2014 Myanmar census results: A demographic Perspectives

Background

The acceptability and reliability of demographic indicators based on population and housing census data is very important for many reasons: it builds public trust on the national statistical system, improve programmes implementation and above all it help to track the progress of socio-economic progress of the countries. However, a prefect census is impossible particularly in developing countries: errors inevitably

occur. Nevertheless, census figures that are subject to error still highly valuable—because of its coverage—if the limitation of the data are understood by the users. Therefore, it is imperative for the producers of the census data to identify the source of errors in the census data. Census errors are classified as follows, a) coverage versus content error b) net versus gross error.

Most fundamental source of error in the census is the error of coverage and errors of content. Coverage errors is illustrated as the error in the count of person or housing units from cases having been "missed" during census enumeration or counted mistakenly either through duplication or erroneous inclusion. Content errors are described as the error in the recorded characteristics of those persons that were enumerated in the census. It can be the result of erroneous or inconsistent reporting or characteristics by respondents, failure on the part of enumeration to obtain or record accurately the required information, and error produced due to clerical and processing operation. One of the important sources of content error is the imputation of the missing values of the respondent's characteristics and hence influences the indicators.

The second vital component of the census error is the distinction between gross and net error. Gross error refer to the total number of errors made in the census (either in coverage and content error), while the net error refers to the total effect of these errors on the resultant statistics. To illustrate the concept of the gross and net error, consider gross census coverage error. It consists of the total of all person omitted plus all duplicates and erroneous enumeration. In measuring net census coverage error, however, the fact that one of these types of error results in an underestimate of total population (omission), while the other two types (duplications and erroneous enumerations) results in overestimates is taken into account.

There exist a fairly large number of methods available in the literature which can apply to evaluate the errors in the census data. These methods differ in terms of the data requirement and technical sophistication. Comprehensive overview of range of methods found elsewhere (U.S. Census Bureau 1985). However, in case of Myanmar, where the only source of the data is census itself, methodological options are limited. Therefore, we decided to utilize the demographic analysis to evaluate the results of recent census of Myanmar.

Demographic analysis of the census data offers a powerful methodology to provide considerable insight into magnitude and nature of errors in census data. In case of a single census data is available, it is usually possible to recognize to some extent of error in the census. However, one of the weaknesses of demographic methods for census evaluation purpose is that they generally do not provide sufficient information to separate errors of coverage from errors in content.

The intention of this analysis is not to evaluate the thematic reports published based on census data nor evaluate the micro level census data of Myanmar to assess the content and/or coverage error. However it is imperative to do first hand analysis to assess if there is any distortion in the indicators of fertility and morality in context of demographic transition model.

The rationale of this secondary analysis of the 2014 Myanmar census data is twofold. First, several evidences have been suggested that to some extent the errors observed in the census data. For instance, census observation mission-2014 report concluded that training of the enumerators were short and this

leads to inability or misunderstanding of the specific questions. In addition, the preliminary findings the country programme evaluation also revealed that the capacity of the enumerators were weak in order to capture some of the responses from census questionnaire.

Second, the evaluation team also noted that from the mortality thematic report based on the recent census data, the difference between female and male life expectancy at birth is very wide (about nine years in 2014: 69.3 for female and 60.2 for male). Given the context of demographic transition in Myanmar, the gender gap in life expectancy at birth and the results of infant and child mortality were considered very high (Infant and child mortality rate 62 and 72, respectively). Further, the level of infant and child mortality is also contested among government departments and UN agencies in Myanmar. It is important to note that this is not because the quality of the census data is poor, but because of the concerns on the methodolgies of the mortality estimates. Further, the recent findings of Myanmar Demographic and Health Survey 2015 also revealed that the level of infant and child mortality is lower in compared to the census estimates.

These distortion inclined us to conduct the demographic analysis on the census results. This analysis has two main objectives. 1) To conduct indepth analysis of age and sex data of 2014 Myanmar census, 2) To identify the relationship between gender differential in life expectancy at birth and fertility transition, and evaluate the level of mortality and fertility in Myanmar.

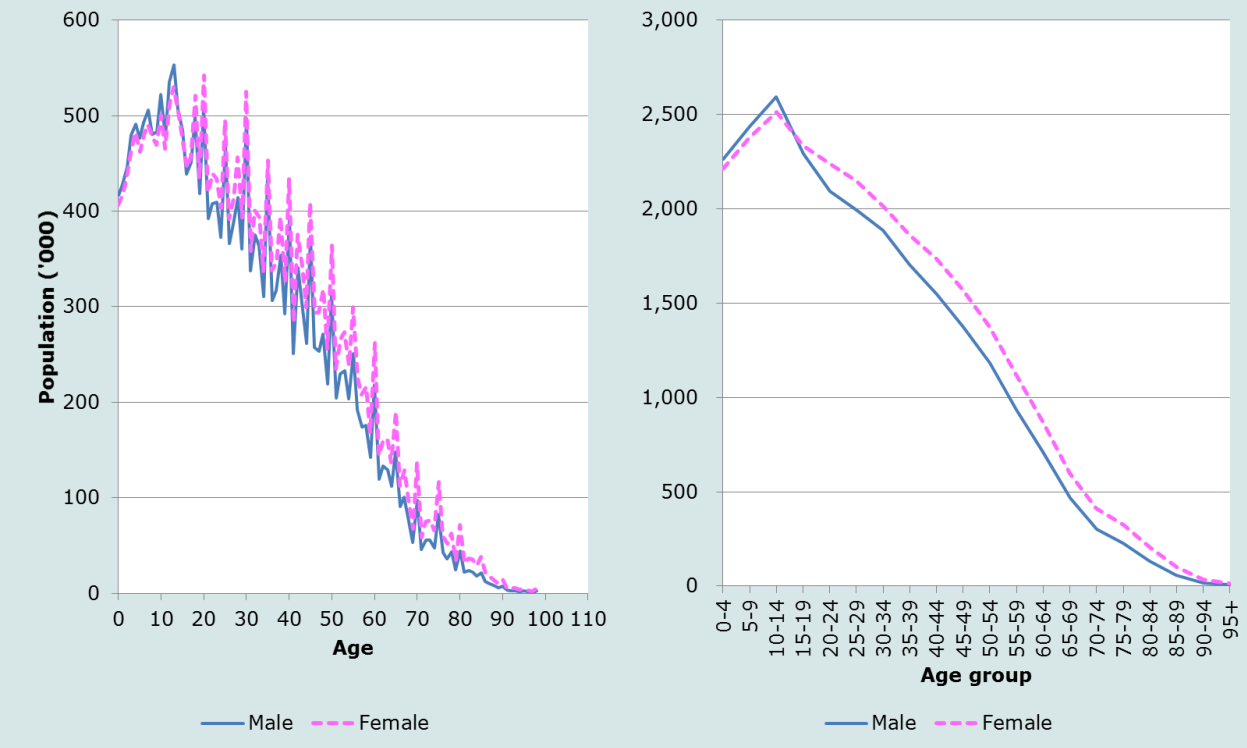
Analysis of the Age and Sex distribution of Myanmar Census

The wide variety of demographic techniques including the graphical analysis of the population pyramid and age heaping are available, such as,Whipple's index, Myer's Blended Index and United Nations Age-Sex accuracy index. We utilized these indices on singe year age and sex distribution of 2014 Myanmar census.

Figure 1 illustrates the age and sex distribution of Myanmar from 2014 census data by single year and five year age group. Visual inspection of the left hand figure highlights the digit preferences for age ending in 0 and 5 in the data. By look on to the figure, two patterns emerged prominently. First, the digit preferences in the younger ages (from 0 to 10 years) is lower compared to the older ages for both male and female population. It reflects the fact that birth registration is the recent years has improved. Second, in the older ages, the digit preference of females is higher than male population. Figure 1b plot the age and sex distribution in five-year age group to smooth the data. Again, the sharp fall-off in the population aged under 5 is visible. It is important to keep in mind that the pattern in Figure 1 is the universal patterns emerge almost in every developing country. However, improving the trainings of enumerators on census data collection and raising the awareness among the population on the importance of the age reporting could reduce the age heaping.

Figure 2: Age-Sex distribution of the population of Myanmar, 2014 Census

a) Single year age and sex distribution b) 5-year age and sex distribution



Apart from visual inspection, we also compute the age heaping indices. According to three indices of age reporting in Myanmar, it clearly shows the accuracy of age reporting in 2014 was at the moderate level (Table 1). Please keep in mind that these indices is useful for comparative purpose, they do not provide any insights into the pattern of error in the data. This analysis is mainly depended on the secondary analysis of age heaping. However, it is imperative to analyze the effects of editing/imputations on final data set and hence on indicators. In combination of both methods, it informs potential data users about the quality of the census data and hence improving the acceptability of the census results.

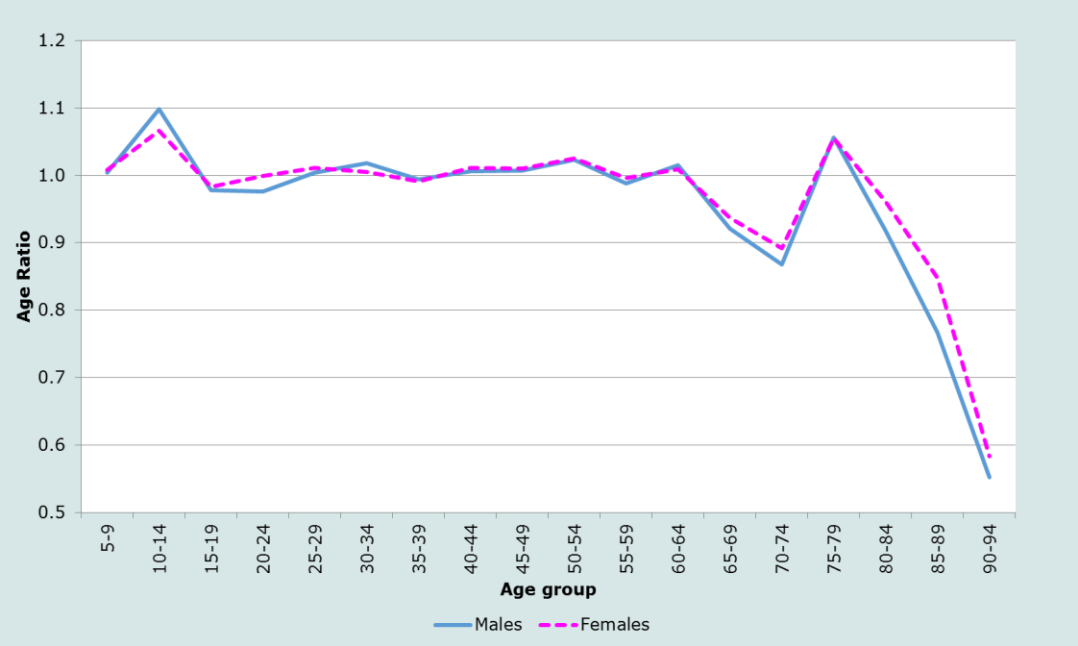
Table 15: Indices of Age Heaping by Male and Female, 2014 Myanmar Census

Indices	Sex	2014
Whipple's Index	Male	124.0
	Female	122.6
	Total	123.3
Myer's Index	Male	9.6
	Female	9.9
	Total	9.8
UN Index		13.2

The age ratio is also a useful indicator of possible undercounts or displacement between age gropus.. The age ratio for a given age group is the ratio of twice the population in that age group to the sum of the

population in each of the adjacent age group. Based on the assumption that population change is rougly linear between agr gropus, the ratio should be fairly close to 1. Deviation from 1, in the absence of plausible exogenous factors (e.g. migration, past calamities affecting particular age groups) are indiative of undercount or dispalcement errors in the data. Except age group 10-14, the age ratio for both male and female is close to 1, indicating that the accuracy of the count. The fall-off in the age ratio at the older ages is anticipated given the rapid increase of mortality in those ages.

Figure 3: Age ratio of the population of Myanmar by five-year age groups, 2014 Census

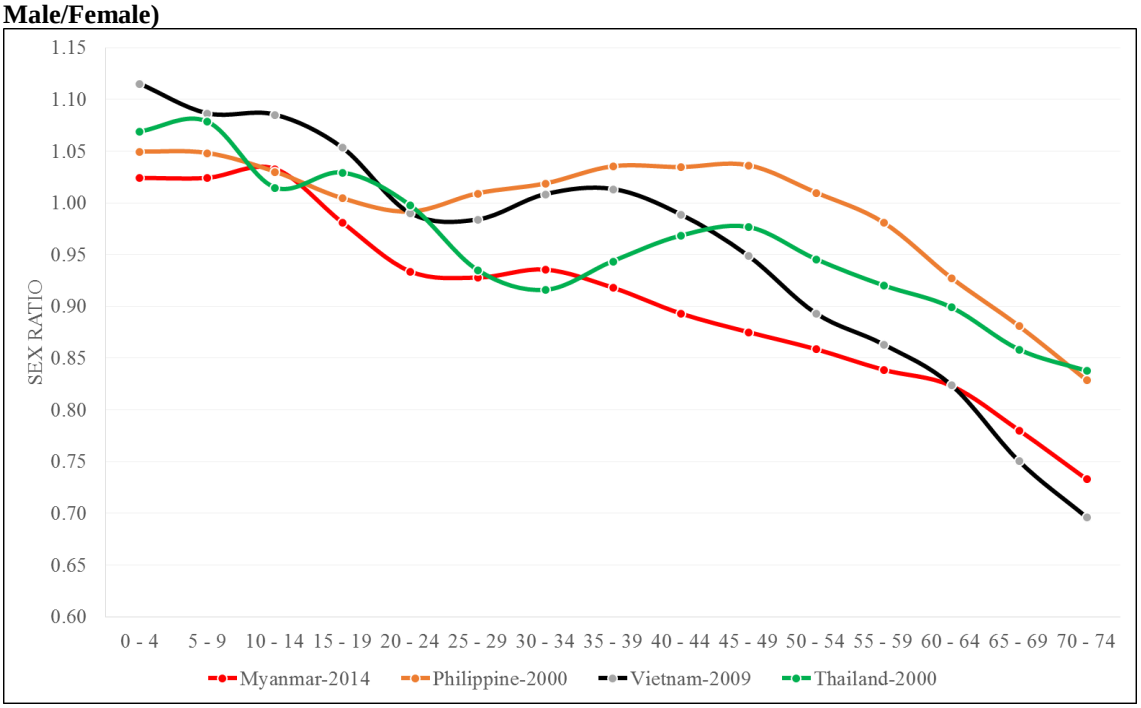


Second and most important characteristic of the census data is the ratio of males and female ratio by age group. In aggregate the sex ratio of the enumerated census population is 105 men per 100 women. In 2014, the aggregate sex ratio of the enumerated census population of Myanmar is 93 male per 100 female. Myanmar also experienced significantly low sex ratio for age group 0-4 years, 102 male per 100 female. In general, the sex ratio for age group 0-4 year is ranged from105 to 107 in most of the developing countries. The census data also revealed that there is a noticeable surfeit of enumerated males until age 15. From age 20 onward particularly until the ages of 60, there are more females than males. This could be due to several consequence: labor out-migration (for male), higher mortality in adult ages or a differential undercount of young adult men. One explanation for low sex ratio particulate at younger ages (from 0-14) could be the sociological phenomena described by Sen (1992). The lower sex ratio at the older ages is anticipated given the rapid increase of mortality in those ages. The analyses presentent above on age and sex ratio illustrated that the in-depht analysis should seek to find explanations and also the applicatability of Sen's hypothesis in Myanmar should also be investigated.

Moreover, it is imperative to get insights into the nature and quality of the age and sex data from the 2014 Myanmar Census can be gained from a comparison of the these data with neighboring ASEAN countries. For this purpose, we utilized the micros level data from IPUMS International database for four countries

including Philippine (2000), Vietnam (2009) and Thailand (2000) and compare with Myanmar 2014 census data. The results are presented in Figure 3. It shows that sex ratios for all ages were very low in Myanmar compared to other four selected countries. For instance, the sex ratio for age group 0-4 years in Myanmar was 102 (102 males for 100 females). Whereas, sex ratio was highest in Vietnam (112) and lowest in Philippine (105). Thus, further work is certainly required to understand what may account for widely divergent accounts of the demographic structure of Myanmar.

Figure 4: Sex ratio by five-years age group from 2000 to 2014: Four ASEAN Countries (Sex ratio = Male/Female)



Source: IPUMS International

Level of Fertility and Mortality in Myanmar: Perspective of demographic transition model

This type of assessment examines the consistency of the data, by using demographic transition theory. The transition theory leads us to expect that—classically—birth rates and deaths rates (and hence population growth rates) will decline in a coherent, orderly pattern, without major discontinuities. Virtually, in absence of clearly identifiable exogenous factors (e.g. war, famine or epidemics), deviation from this orderliness therefore held strongly suggest problem in the methodology and/or data.

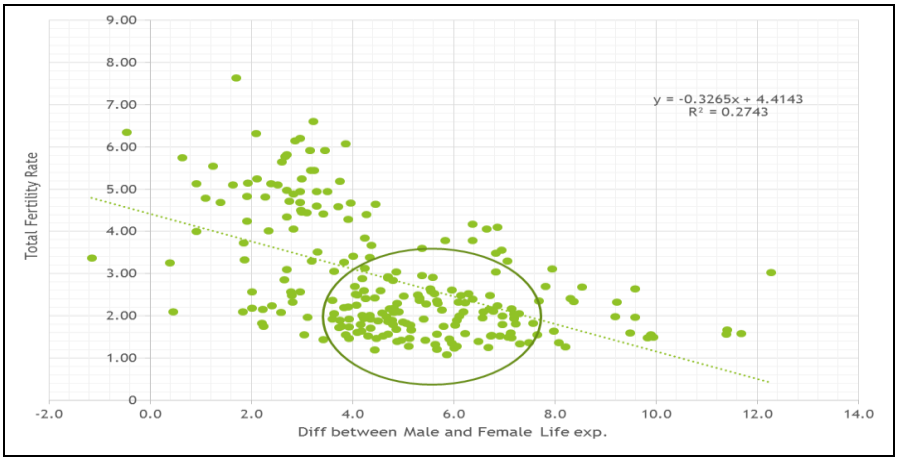
In 2016, UNFPA country office has commissioned a Fertility and Mortality thematic report based on the data from 2014 census data. Both reports have adopted rigorous methodology to arrive at the estimates of the fertility and mortality level at country and state/regional level.

Myanmar witnessed a high fertility in the past and and rapid population growth since the 1980s. The fertility transition did not keep pace with the mortality decline in the past. In Myanmar, it was expected to start in the late 1970s as a response to mortality transition. The total fertility rate (TFR) was very high in the decades of 1980s and 1990s, TFR had declined from 4.7 in 1983 (Census 1983) to 3.5 in 1991 and 2.8

in 2001[102]. Further, FRHS 2007 shows the further decline of the fertility rate to 2 children per women. However, the 2014 census estimated a higher fertility rate, 2.5 children per women. The rate of decline is very rapid, approximately one child per decade from 1980s to 2000. The recent census also shows significant variation in the fertility rate among urban and rural areas and between States and Regions. The fertility rate in urban areas is 1.91 vs. 2.78 in rural areas. The highest fertility rate (5 children per woman) was observed in Chin State, while lowest was noted in Yangon (1.85). Therefore, based on the above discussion, it is well accepted fact that fertility decline Myanmar has been gained momentum in recent years.

The large difference in life expectancy at birth between female and male is possible when the countries are at advance stage of the demographic transition model, with low fertility. To reinforce this findings, we used the data from UN WPP 2015 for more than 200 countries of the world. The preliminary comparative analysis on the relationship between fertility and mortality confirmed that for countries that have low fertility, the gap in female-male life expectancy is wide. For countries where the different between female and male life expectancy is between 4 to 6 years, the level of fertility rate is between 2 to 3 children. The model predicted that for total fertility rate of 2.5, the gap in life expectancy at birth approximately close to 6 years. Thus, gender gap in life expectancy—about nine years in Myanmar— clearly requires in-depth analysis of morality and fertility level in Myanmar and identify the problems in the methodology and/or in the data.

Figure 5: Linear Relationship between difference of Female-Male life expectance and total fertility rate: 2010-2015



Source: UN WPP 2015—230 Countries and Regions

Because of the fact that countries at a later stage of the mortality transition, infant and child mortality are in general low. However, the levels of the infant and child mortality in Myanmar was found to be very high. To assess the level of infant and child mortality in relation with the given level of difference in life expectancy at birth for male and female, we again used the UN WPP 2015 data for more than 200 countries of the world. The linear relationship shows that infant and child morality is highly correlated with the difference of life expectancy at birth of female and male.

[102]Fertility rate from 1983 census was direct calculations from the number of births during one years preceding the census date. While, fertility rates for PCFS and FRHS are from birth histories of women.

Figure 3 illustrates very interesting results. The graph illustrates that for the give level of gap in female and male life expectance of 9 or more years, the infant mortality was very low for majority of the counties. The average level of infant mortality was below 30, even for the outlier countries in the graph has low level of infant mortality. Contrarily, the level of infant and child morality is Myanmar was very high. In summary, it is contradictory according the demographic transition model that countries with low level of the fertility to have very high level of mortality. This requires in-depth analysis of the census data as well as to conduct through demographic analysis of the census results. More sophisticated methods will be recommended to analysis the quality of census results such as stable population model, forward and backward population projection, and cohort survival regression methods.

Figure 6: Linear Relationship between difference of Female-Male life expectance and Infant Mortality rate—200+ countries

Source: UN WPP 2015—200+ Countries

Conclusion

Evaluation team noted striking results from the 2014 census data. First, overall sex ratio and sex ratio at birth in Myanmar appeared to be low. Empirical evidences show that low sex ratio is not very common particularly at birth. Comparative analysis of the ASEAN countries shows that Myanmar has very low sex ratio at all ages. Second, very large difference between female and male life expectancy at birth was observed in Myanmar in 2014. The difference in life expectancy is possible when the countries are at advance stage of the demographic transition model, with low fertility. To reinforce this findings, we used the data from UN WPP 2015 for more than 200 countries of the world. The preliminary comparative analysis on the relationship between fertility and gender gap of life expectancy confirmed that for countries that have low fertility, the gap in female-male life expectancy is wide. According to the level of fertility and mortality, demographic transition in Myanmar is at later stages. Because of the fact that countries at a later stage of the mortality transition, infant and child mortality are in general low, the levels of the infant and child mortality in Myanmar was found to be very high. In summary, it is contradictory according the demographic transition model that countries with low level of the fertility, very large gap in life expectancy and high infant and child mortlaity. This requires in-depth analysis of the census data as well as to conduct through demographic analysis of the census results. More sophisticated methods will be recommended to analysis the quality of census results such as stable population model, forward and backward population projection, and cohort survival regression methods.

Gender Equality – Key Findings

Table 1: Gender Equality, outcome 3, output 1

Outcome 3: Gender equality and the human rights of women, particularly their reproductive rights, are addressed in national legal frameworks, social policies and development plans			
Output 1: Strengthened national capacity and institutional mechanism for advancing reproductive rights, promoting gender equality and addressing gender-based violence, including in humanitarian settings.			
Indicators (2014-2017)	**Baseline (2014)**	**Target (2017)**	**Performance at Evaluation (2016)**
No. of organisations with capacity needed for strengthening a reporting system to follow up on the implementation of reproductive rights recommendations and obligations, and in line with NSPAW (2013-2022).	1	7	Not yet
No. of townships with available gender-based violence prevention, protection and response programme.	3	9	9 (4 Kachin: Myitkyina, Waing Maw, Bhamo and Mansi; 3 NSS: Lashio, Kutkai, Muse 2 Rakhine: Sittway, Pauktaw)
No. of functioning gender-based violence, gender and women's empowerment coordination bodies as a result of UNFPA guidance and leadership.	3	4	6 (2 National - GEWESWG, GBV SS, SRH WG 3 Regional – GBV SS Kachin, Rakhine, NSS)

Annex 8 : ODA Contribution and resources mobilized by type of donor

Table 1: Resources mobilized by type of donor and area of support (USD)

YEAR	Donor	Area of support	Amount*
2012	Germany	Reproductive Health	1,171,643
	Three Diseases Fund	Reproductive Health	83,133
	Australian Agency for International Development (AUSAID)	Reproductive Health	1,050,813
	The Underfunded Emergencies Window of the Central Emergency Response Fund (CERF)	Humanitarian	282,842
	Global Programme on Reproductive Health Commodity Security (GPRHCS)	Reproductive Health	48,232
	Joint fund from the Governments of Norway, New Zealand and Finland	Humanitarian	49,885
2012 Total			**2,686,548**
2013	Germany	Census	2,853,206
	Australian Agency for International Development (AUSAID)	Census	998,563
	The Underfunded Emergencies Window of the Central Emergency Response Fund (CERF)	Humanitarian	437,176
	Global Programme on Reproductive Health Commodity Security (GPRHCS)	Reproductive Health	53,392
	The Government of Denmark	Humanitarian	484,993
	Department for International Development (DFID), United Kingdom	Humanitarian	35,056
	Census Fund- Australian Agency for International Development (AUSAID), Department for International Development (DFID), Swiss Development Cooperation (SDC), AND THE GOVERNMENTS OF Finland, Italy, Norway and Sweden	Census	5,481,965
2013 Total			**10,344,351**
2014	The Underfunded Emergencies Window of the Central Emergency Response Fund (CERF)	Humanitarian	368,815
	Global Programme on Reproductive Health Commodity Security (GPRHCS)	Reproductive Health	265,609
	Department for International Development (DFID), United Kingdom	Humanitarian	827,540
	Unified Budget, Results and Accountability Framework (UBRAF)	Reproductive Health	30,000
	Census Fund- Australian Agency for International Development (AUSAID), Department for International Development (DFID), Swiss Development Cooperation (SDC), AND THE GOVERNMENTS OF Finland, Italy, Norway and Sweden	Census	33,761,754
2014 Total			**35,253,718**
2015	3 MDG Fund	Reproductive Health	909,500
	CERF/OCHA	Humanitarian	1,633,097
	DFAT	Humanitarian	710,732

	DFID	Humanitarian	1,682,816
	Government of Finland	Census	236,220
	Government of Italy	Gender	437,158
	Government of Sweden	Humanitarian & Census	1,976,983
2015 Total			**7,586,506**
Grand Total 2012-2015			**55,871,123**

Table 2: Official Development Assistance to Myanmar 2012-2015 , selected donors[103]

Source	Amount (US$ m)	% GDP[104]
1. Bilateral - DAC countries	**9,332.4**	3.86%
Japan	5,674.0	
Germany	1,098.2	
France	616.6	
UK	525.0	
USA	313.8	
Australia	272.7	
Austria	142.8	
Denmark	131.9	
Norway	129.7	
Other bilateral	427.7	
2. Multilateral	**1,931.2**	0.76%
World Bank	532.3	
ADB	530.5	
EU	333.1	
United Nations	167.0	
UNFPA	**28.2**	**0.01%**
Other multilateral	368.2	
3. Non-DAC countries	**32.2**	0.01%
Thailand	20.6	
Turkey	4.3	
UAE	1.1	
Total ODA	**11,295.8**	4.63%

Table 3: Total ODA in Myanmar from 2012-2014 and UN contribution in the ODA

	US$ (million)	Contribution of Different UN Agencies in ODA among the overall UN Budget in Myanmar: 2012-2014	
Total ODA in Myanmar (2012-2014)	9,927.1		
UN Contribution in ODA (2012-2014)	114.9 (1%)	UNAIDS	2.9%
		UNDP	24.0%
		UNFPA	19.7%
		UNICEF	42.4%
		UN Peacebuiling Fund (UNPBF)	2.4%
		WFP	1.0%
		WHO	7.5%

Source: Official Development Assistance (ODA) database-OECD

[103] Source http://stats.oecd.org/Index.aspx?datasetcode=TABLE2A
[104] US$ 16.93 billion as of 2014

Annex 9

UNFPA: Annual Budget and expenditure by IP from 2012 to 2015

	IP	2012			2013			2014			2015			Total (2012-2015)		Overall (2012-2015) Imp. Ratre	Average (2012-2015) Imp.
		Budget	Expenditure	Imp. Rate	Budget	Expenditure	Imp. Rate	Budget	Expenditure	Imp. Rate	Budget	Expenditure	Imp. Rate	Budget	Expenditure		
Sexual Reproductive Health and Rights including ARH																	
PGMM01	Maternal & Child Health Section	278,496	271,589	97.5%										278,496	271,589	97.5%	85.4%
PGMM03	Department of Health Planning	150,540	150,540	100.0%	101,237	86,481	85.4%	51,744	50,925	98.4%				303,521	287,946	94.9%	
PGMM04	Department of Medical Science	33,381	33,381	100.0%	67,168	66,351	98.8%	78,267	77,738	99.3%	83,622	49,802	60%	262,438	227,272	86.6%	
PGMM06	Central Health Education Bureau	55,000	50,074	91.0%										55,000	50,074	91.0%	
PGMM08	Ministry of Health				236,415	235,807	99.7%	234,100	225,665	96.4%	85,120	17,616	21%	555,635	479,088	86.2%	
PGMM09	DMR-UM/MoH							99,573	85,720	86.1%	62,565	56,826	91%	162,138	142,546	87.9%	
PN0238	JSI				251,821	234,480	93.1%	183,287	178,756	97.5%	244,058	165,981	68%	679,166	579,217	85.3%	
PN4668	MYA Red Cross Society	30,525	29,098	95.3%	64,540	64,896	100.6%	49,584	40,707	82.1%	68,356	27,552	40%	213,005	162,253	76.2%	
PN4669	Assoc. Franc-xavier Bonau - MMR	126,021	119,718	95.0%	222,169	215,085	96.8%	118,295	118,289	100.0%	97,515	65,484	67%	564,000	518,576	91.9%	
PN4672	JOICEFP	320,096	312,433	102.5%	289,653	280,733	96.9%							609,749	593,166	97.3%	
PN4673	MSI	212,109	202,754	95.6%	260,853	258,889	99.2%	276,766	275,977	99.7%	347,840	139,956	40%	1,097,568	877,576	80.0%	
PN4674	PSI	288,371	278,790	96.7%	315,000	309,358	98.2%	359,997	355,416	98.7%				963,368	943,564	97.9%	
PN4675	MYA Anti-Narcotics Assoc.	98,837	98,742	99.9%	94,808	93,512	98.6%	116,222	115,841	99.7%	94,499	66,923	71%	404,366	375,018	92.7%	
PN4676	MMA	1,264,392	1,235,557	97.7%	1,098,303	1,086,440	98.9%	676,398	669,194	98.9%	490,798	335,114	68%	3,529,891	3,326,305	94.2%	
PN5780	Nurse & Midwife Assoc.	76,308	76,286	100.0%	157,071	154,742	98.5%	217,596	211,410	97.2%	237,059	135,845	57%	688,034	578,283	84.0%	
PN5823	MI THA										197,965	2,547	1%	197,965	2,547	1.3%	
PN6107	MMCWA							49,960	49,483	99.0%				49,960	49,483	99.0%	
PU0074	UNFPA	4,370,503	4,183,113	95.7%	5,231,634	5,227,539	99.9%	3,355,540	2,991,623	89.2%	2,196,036	1,755,417	80%	15,153,713	14,157,692	93.4%	
Sub-Total (SRH&R)		7,304,579	7,042,075	96.4%	8,390,672	8,314,313	99.1%	5,867,329	5,446,744	92.8%	4,205,433	2,819,064	67.0%	25,768,013	23,622,196	91.7%	
HIV/AIDS																	
PGMM05	Nat'l AIDS Programme	59,286	58,221	98.2%										59,286	58,221	98.2%	98.2%
PN4732	Aide Medicale Internationale	220,171	214,483	97.4%										220,171	214,483	97.4%	
PU0074	UNFPA	852,881	862,136	101.1%	641,556	650,137	101.3%	686,788	653,882	95.2%	212,226	206,350	97.2%	2,393,451	2,372,505	99.1%	
Sub-Total (HIV/AIDS)		1,132,338	1,134,840	100.2%	641,556	650,137	101.3%	686,788	653,882	95.2%	212,226	206,350	97.2%	2,672,908	2,645,209	99.0%	
Popualtion and Development																	
PGMM02	Department of Population	112,600	111,461	99.0%	268,885	206,578	76.8%	1,692,371	1,448,311	85.6%	306,842	211,850	69%	2,380,698	1,978,200	83.1%	78.3%
PU0074	UNFPA	1,581,848	1,522,002	96.2%	9,582,045	6,690,790	69.8%	35402756	26940363	76.1%	7,096,322	4,245,839	60%	53,662,971	39,398,994	73.4%	
Sub-Total (P&D)		1,694,448	1,633,463	96.4%	9,850,930	6,897,368	70.0%	37,095,127	28,388,674	76.5%	7,403,164	4,457,689	60.2%	56,043,669	41,377,194	73.8%	
Gender																	
PGMM07	Department of Social Welfare	15,115	14,863	98.3%	24,344	15,501	63.7%	20,847	20,477	98.2%	141,691	18,588	13%	201,997	69,429	34.4%	52.3%
PN6106	Metta Dev. Foundation							253,449	223,757	88.3%	204,508	105,159	51%	457,957	328,916	71.8%	
PN6198	IRC							303,161	244,436	80.6%	135,661	128,179	94%	438,822	372,615	84.9%	
PN6478	Malteser										209,600	-	0%	209,600	-	0.0%	
PU0074	UNFPA			#DIV/0!	91,719	84,547	92.2%	145,976	144,304	98.9%	1,912,216	1,281,870	67%	2,149,911	1,510,721	70.3%	
Sub-Total (Gender)		15,115	14,863	98.3%	116,063	100,048	86.2%	723,433	632,974	87.5%	2,603,676	1,533,796	58.9%	3,458,287	2,281,681	66.0%	
Programme Coordination Assistance		263,969	228,791	86.7%	357,880	289,502	80.9%	321,606	270,194	84.0%	300,000	258,271	86.1%	1,243,455	1,046,758	84.2%	
Country Programm Total		9,278,111	8,919,192	96.1%	18,715,545	15,601,231	83.4%	44,007,495	34,738,586	78.9%	14,512,273	9,068,820	62.5%	86,513,424	68,327,829	79.0%	

Annex 10 : MDG table

Millennium Development Goals (MDGs): Progress by Goal	
1 - Eradicate Extreme Poverty and Hunger	National poverty incidence has reduced from 32% to 26% between 2005 and 2010. Rural poverty remains considerably higher than urban poverty, at 29% and 16% respectively.
2 - Achieve Universal Primary Education	The literacy rate of 15-24 year-olds increased from 91.9% to 95.8% between 2005 and 2010. Literacy rates of the poor are significantly lower than the non-poor, at 91.3% and 97.7% respectively. Literacy rates in rural areas are lower than in urban areas, at 95.1% and 98.2% respectively, but have increased at a higher rate in rural than urban areas at 5.0% and 2.3%, respectively. (IHLCA, 2009-2010)
3 - Promote Gender Equality and Empower Women	The ratio of girls to boys in primary education, or the Gender Parity Index, declined from 96.1% to 92.6% between 2005 and 2010 (IHLCA,2009-2010). This ratio is higher for the poor than nonpoor at 96.7% and 91% respectively. IHLCA,2009-2010)
4 - Reduce Child Mortality	Off track. Myanmar has shown some progress and showing downward trends of the under-five mortality from 115 per 1,000 live births in 1990 to 80 in 2000 and 54 in 2010. However, it is unlikely to reach the overall U5MR target of 38 per 1,000 live births by 2015. Similarly, the infant mortality rate (IMR) declined from 77 per 1,000 live births in 1990 to 62 in 2000 and 41 in 2012; still it remains off-track to fulfill the MDG IMR target of 26 per 1,000 live births by 2015. (WHO Observatory).
5 - Improve Maternal Health	Myanmar faces challenges in achieving the MDG target of reducing the MMR to 105 maternal deaths per 100,000 live births by 2015. According to 2014 Myanmar Population and Housing Census, MMR is high at 282 deaths per 100,000 live births.
6 - Combat HIV/AIDS, Malaria and other Diseases	Myanmar has shown progress toward MDG 6 targets – in the areas of HIV/AIDS, malaria, and tuberculosis. The country's HIV prevalence among adults aged 15 to 49 years peaked at 0.8% in 2000, but rates fell to 0.53% in 2011 (Modeling UNAIDS 2011). Surveillance data from 2011showed HIV prevalence in the sentinel groups at 9.6% in female sex workers, 7.8% in men who have sex with men, and 21.9% in male injecting drug users. All sentinel groups have shown a considerable decrease in prevalence over the last years (UNAIDS Myanmar GAPR 2012). Total incidence in key populations at risk has peaked in 1999 and since then, there has been a steady decline of new infections every year. This will continue in future years, provided the services coverage of prevention interventions for key populations at risk remains at least at the level of 2010 (Asian Epidemiological Model (AEM) estimates, UNAIDS)
7- Ensure Environment Sustainability Improved drinking water source (%) Improved facility for sanitation (%)	Target by 2015 was to reduce by half those without an improved water source. Baseline in 1990 (the earliest year data available) was 50% and in 2014 it is 69.5% (source: Census data 2014, DOP May 2015). Target by 2015 was to reduce by half those without an improved sanitation. In 1995 49% and in 2014 according to analysis of 2014 Census data it is 74.3% (source: DOP, Min of Immigration and Population 2015).