
Prepared for:
UNFPA Country Office, Yangon

Edmund Attridge, PSM

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Map of Myanmar</td>
<td>iii</td>
</tr>
<tr>
<td>UNFPA Country Programme 2 Project Townships (2007-2011)</td>
<td>iv</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>v</td>
</tr>
<tr>
<td>List of abbreviations and acronyms</td>
<td>vi</td>
</tr>
<tr>
<td>A. Executive Summary</td>
<td>ix</td>
</tr>
<tr>
<td>B. Introduction</td>
<td></td>
</tr>
<tr>
<td>1. Purpose of Evaluation</td>
<td>1</td>
</tr>
<tr>
<td>2. Methodology</td>
<td>2</td>
</tr>
<tr>
<td>3. UNFPA’s Second Programme of Assistance to Myanmar</td>
<td>5</td>
</tr>
<tr>
<td>4. Country Context and Strategic Outlook</td>
<td>6</td>
</tr>
<tr>
<td>C. Findings and Conclusions</td>
<td></td>
</tr>
<tr>
<td>1. Findings on Reproductive Health</td>
<td>10</td>
</tr>
<tr>
<td>2. Findings on Adolescent Reproductive Health</td>
<td>24</td>
</tr>
<tr>
<td>3. Findings on HIV Prevention</td>
<td>31</td>
</tr>
<tr>
<td>4. Findings on PMCT</td>
<td>38</td>
</tr>
<tr>
<td>5. Findings on Population and Development</td>
<td>41</td>
</tr>
<tr>
<td>6. Findings on Gender Equality</td>
<td>46</td>
</tr>
<tr>
<td>7. Findings on Emergency Humanitarian Response</td>
<td>52</td>
</tr>
<tr>
<td>8. Conclusions</td>
<td>55</td>
</tr>
<tr>
<td>D. Recommendations</td>
<td>57</td>
</tr>
<tr>
<td>E. Annexes</td>
<td></td>
</tr>
<tr>
<td>1. Terms of Reference, EOP Evaluation, UNFPA’s 2nd Programme of Assistance</td>
<td></td>
</tr>
<tr>
<td>2. Maps of UNFPA Interventions in Myanmar</td>
<td></td>
</tr>
<tr>
<td>3. Documents accessed in EOP Evaluation</td>
<td></td>
</tr>
<tr>
<td>4. Evaluation Instruments</td>
<td></td>
</tr>
<tr>
<td>5. List of Participants in EOP Evaluation Process</td>
<td></td>
</tr>
</tbody>
</table>
Map of Myanmar
ACKNOWLEDGEMENT

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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTED</td>
<td>Agency for Technical Cooperation and Development</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AFXB</td>
<td>Association Francois-Xavier Bagnoud</td>
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<tr>
<td>AMI</td>
<td>Aide Medicale Internationale</td>
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<tr>
<td>AMW</td>
<td>Auxiliary Midwife</td>
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<td>AN</td>
<td>Ante Natal</td>
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<td>ARH</td>
<td>Adolescent Reproductive Health</td>
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<td>APR</td>
<td>Annual Programme Review</td>
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<td>APRO</td>
<td>Asia Pacific Regional Office of UNFPA</td>
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<td>ARV</td>
<td>Antiretroviral drugs</td>
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<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
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<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<td>AWP</td>
<td>Annual Work Plan</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>BHS</td>
<td>Basic Health Staff</td>
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<td>BSS</td>
<td>Behavioural Surveillance Survey</td>
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<td>CBO</td>
<td>Community Based Organization</td>
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<tr>
<td>CCA/UNDAF</td>
<td>Common Country Assessment &amp; the UN Development Assistance Framework</td>
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<td>CD</td>
<td>Capacity Development</td>
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<tr>
<td>CEDAW</td>
<td>Convention on Elimination of all Forms of Discrimination against Women</td>
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<tr>
<td>CERF</td>
<td>Central Emergency Response Fund</td>
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<td>CHEB</td>
<td>Central Health Education Bureau of the Department of Health</td>
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<td>CO</td>
<td>Country Office (of UNFPA, Myanmar)</td>
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<td>CP1</td>
<td>1st UNFPA Programme of Assistance</td>
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<td>CP2</td>
<td>2nd UNFPA Programme of Assistance</td>
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>CSO</td>
<td>Central Statistical Organization</td>
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<td>CSG</td>
<td>Community Support Group</td>
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<td>C4D</td>
<td>Communication for Development</td>
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<tr>
<td>DEPT</td>
<td>Department of Education and Training</td>
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<tr>
<td>DHP</td>
<td>Department of Health Planning</td>
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<tr>
<td>DIC</td>
<td>Drop-in-Center</td>
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<tr>
<td>DFID</td>
<td>UK Department for International Development</td>
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<tr>
<td>DMO</td>
<td>District Medical Officer</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>DoL</td>
<td>Department of Labor</td>
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<td>DoP</td>
<td>Department of Population</td>
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<td>DSW</td>
<td>Department of Social Welfare</td>
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<td>EmOC</td>
<td>Emergency Obstetric Care</td>
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<td>EOP</td>
<td>End of Programme Evaluation</td>
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<td>ET</td>
<td>Evaluation Team</td>
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<td>FERD</td>
<td>Foreign Economic Relations Department</td>
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<td>FHAM</td>
<td>Fund for HIV/AIDS in Myanmar</td>
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<td>FRHS</td>
<td>Fertility and Reproductive Health Survey</td>
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<td>FSW</td>
<td>Female Sex Worker</td>
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<td>FYS</td>
<td>Family and Youth Survey</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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</tbody>
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GoUM Government of Union of Myanmar
GTG Gender Theme Group
HCT HIV Counseling and Testing
HIV Human Immuno-deficiency Virus
HMIS Health Management Information System
ICPD International Conference for Population and Development
IEC Information Education Communication
INGO International Non Government Organization
IOM International Organization for Migration
IWD International Women’s Day
LHV Lady Health Visitor
JOICFP Japanese Organization for International Cooperation in Family Planning
MANA Myanmar Anti Narcotic Association
MARP Most-At-Risk-Population
MCH Maternal and Child Health
MDG Millennium Development Goal
M&E Monitoring and Evaluation
MISP Minimum Initial Service Package for Reproductive Health in Crisis Situations
MMA Myanmar Medical Association
MMCWA Myanmar Maternal and Child Welfare Association
MMR Maternal Mortality Rate
MNCWA Myanmar National Committee for Women’s Affairs
MNPED Ministry of National Planning and Economic Development
MNWAF Myanmar National Women’s Affairs Federation
MoH Ministry of Health
MoIP Ministry of Immigration and Population
MRCS Myanmar Red Cross Society
MSI Marie Stopes International
MSM Men who have Sex with Men
MSWRR Ministry of Social Welfare Relief and Resettlement
MTR Mid Term Review
MW Midwife
NAP National AIDS Programme
NGO Non-Governmental Organization
NRS Northern Rakhine State
NSP National Strategic Plan for HIV/AIDS
OCHA Office for the Coordination for Humanitarian Affairs
ODA Overseas Development Assistance
P & D Population and Development
PHC Primary Health Care
PMCT Prevention of Mother to Child Transmission of HIV
PLHIV People living with HIV
PN Post Natal
PSI Population Services International
QA Quality Assurance
RH Reproductive Health
RI Relief International
RHC Rural Health Centre
RHMIS Reproductive Health Management Information System
SC Save the Children
SCWP Sub Cluster for Women’s Protection
SIDA  Swedish International Development Cooperation Agency
SMO  Station Medical Officer
SRH  Sexual and Reproductive Health
STI  Sexually Transmitted Infections
SW  Sex Worker
TB  Tuberculosis
TBA  Traditional Birth Attendant
TMFR  Total Marital Fertility Rate
TFR  Total Fertility Rate
THN  Township Health Nurse
TMO  Township Medical Officer
TOP  Targeted Outreach Program
TOR  Terms of Reference
TOT  Training of Trainers
VCCT  Voluntary Confidential Counseling and Testing
UN  United Nations
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNCT  UN Country Team
UNDP  United Nations Development Programme
UNEG  United Nations Evaluation Group
UNGASS  United Nations General Assembly Special Session
UNICEF  United Nations High Commissioner for Refugees
UNIFEM  United Nations Development Fund for Women
UNFPA  United Nations Population Fund
WHO  World Health Organization
WP TWG  Women’s Protection Technical Working Group
VCCT  Voluntary Confidential Counseling and Testing
YIC  Youth Information Corner
A. EXECUTIVE SUMMARY

This is an end of programme (EOP) evaluation of the UNFPA Second programme of Assistance to Myanmar 2007 – 2011 (CP2). The EOP evaluation is intended to assess the validity of design, relevance, efficiency, effectiveness, sustainability and impact of strategies, approaches and interventions and to guide decisions on development, management, coordination, monitoring and evaluation of the 3rd programme of assistance, 2012 -2015.

From the ad-hoc assistance provided to Myanmar since 1973, UNFPA moved to a programmatic approach in 2002 through CP1 which was implemented during the period 2002-2006. CP2 was originally to be implemented over the period 2007 – 2010 but has been extended to 2011. CP2 did not start until 2008 due to a Government delay in approval. Cyclone Nargis which hit Myanmar in May 2008 also led the Country Office (CO) to reallocate resources to the humanitarian response. Even though there was some delay, programme activities were completed nevertheless.

CP2 has 5 outputs related to reproductive health (RH), adolescent reproductive health (ARH), HIV prevention, collection of disaggregated data, and support for prevention of mother to child transmission of HIV (PMTC). However, new areas of focus emerged during CP2 implementation related to gender equality; to humanitarian assistance; and to population and development (P&D) more generally.

There are a number of important contextual factors to be taken into account in evaluating CP2. These include significant developments in the governance environment such as the gradual relocation since 2006 of the central government and public servants from Yangon to the newly constructed administrative capital of Nay Pyi Taw. As well, there has been the development of the 2008 Constitution; the holding of national elections in 2010; and the establishment of the new Parliament in 2011. In addition, there are plans for decentralization of powers and functions to the State level. Myanmar has achieved considerable economic growth since adopting a market-oriented system in 1988 but human development conditions remain low. Poverty has fallen but is still high at 25.6 percent, with there being sub-national inequalities mainly at the rural level. By 2007 there had also been significant demographic changes to the 57.5 million strong population with an increase in the mean age of marriage for women to 26.1 years; an increase in the age of first birth to 22.8 years; an increase in life expectancy to 65 years; a decline in total fertility rate to 2.03 children; and with 10 percent of the population now being over 60 years of age.

Myanmar’s overseas development assistance (ODA) level is one of the lowest in Asia at US$4.06 per capita in 2007. UNFPA plays an active and influential role in supporting strategic planning within the UN community with the prospect that the new UN Strategic Framework 2012-2015 being developed will lead on to greater joint programming activity. There is also the prospect of increased funding from donors such as AusAID, DFID and the 3MDG fund. The scope for enhanced levels of partnership across development partners, INGOs and NGOs in Myanmar stands at an all time high. However, travel, geographic constraints, rent-seeking behavior, natural disasters and communication difficulties make provision of assistance in Myanmar challenging. UNFPA also faces funding and resource constraints and needs additional management and technical resources to help it further upstream the support, policy assistance and advocacy it can provide, while ensuring high levels of accountability are maintained.
CP2 has provided highly relevant assistance to Myanmar, including in the most recent and new areas of focus such as gender equality. The high level of relevance of CP2 to Myanmar's priorities is recognized by government officials and partners. Programme design was assessed as generally valid, sound and realistic. Some intended outputs as to improved access to services could have been expressed more precisely. Better mapping of existing service provision is also needed to support programme decision-making. Management of CP2 was generally regarded as sound but more exacting relationships with implementing partners should have been required, including a stronger focus on results based management. The specification of performance indicators also needs improvement in the next programme of assistance.

UNFPA’s RH strategies under CP2 have included supporting RH services in the 112 townships that were covered by CP1, plus 20 additional townships that have so far been added with German funding support. There have been increases both in the contraceptive prevalence rate (from 32 percent in 2001 to 38.4 percent who were using modern methods in 2008, but there remains an unmet need demand of 17.7 percent) and, also, an increase in the proportion of births attended by skilled personnel (64 percent in 2007 HMIS). New WHO/ UNICEF/ UNFPA/ World Bank (H4) estimates in 2010 show a new trend of MMR at 2.5/1,000 for 2005 and 2.4/1,000 for 2008; however, Myanmar lags behind other countries in the region in accelerating the rate of decline. Meeting the MDG 5A goal of reducing MMR by 75% is a huge challenge for Myanmar. This could require the provision of significant additional budget and human resources.

There is increased access and utilization of MCH, birth spacing and other RH services, in part because of outreach activities, although EmOC improvements are still incomplete. There have been difficulties in stock outs in some RH commodities that a new logistics management system to be supported under UNFPA assistance should help to resolve. There are major funding gaps in commodities looming in the future that need early discussion between partners. There are also condom shortages for HIV prevention. There is scope for a stronger strategic focus in progressing RH priorities under the leadership of MoH but more effective and inclusive partnership management is also required.

New donors (in particular AusAID, DFID and the 3 MDG Fund (successor of the 3 Diseases Fund) may be preparing to make significant new funding contributions to maternal and child health (MCH). If so, there is an opportunity for UNFPA to consider realigning some of its RH support to better reflect the comparative advantage that its well-recognized expertise offers to Myanmar. This could be achieved by re-focusing RH assistance to better support the Ministry of Health (MoH) through providing more upstream strategic, policy, advocacy & equity-related support; by helping to strengthen partnership coordination; and by assisting to enhance service quality standards over a range of important RH issues.

UNFPA may also wish to rescale and to shift UNFPA’s support for RH service provision to focus more on particular geographic areas, to vulnerable populations and to piloting innovative RH service initiatives. This may also offer scope for efficiency gains, including by reducing the number of implementing partners. UNFPA also needs to support the MOH in action needed to achieve the MDG targets at national and local level (in particular the MMR and HIV targets), including by strong advocacy to encourage significantly higher levels of government budget and the increased human resources to boost the rate of skilled attendance at birth, and budget support to overcome the funding gap in RH commodities and contraceptives including condoms required to support HIV/AIDS prevention. There is scope also for improving linkages between RH and HIV prevention and PMCT services.
Community involvement in supporting RH care also needs attention. Despite the commitment shown by the 90,000 Community Support Group (CSG) members, some role confusion and service quality issues have emerged that need to be resolved. Other requirements include updating of the BCC Master plan, ongoing upgrading of BCC materials and exploring other communication options that will extend the reach of BCC programmes. The evaluation team’s (ET) observation of the level and effect of BCC interventions at the community level generally across Myanmar suggests the knowledge situation may be slowly improving but that the full range of HIV/AIDS messages may not be yet reaching significant proportions of the population. New communication strategies need to be considered. Capacity development generally under the CP also requires a more systematic approach through setting service standards, upgrading training modules and curriculum, and providing for independent quality assurance.

Through its behavioral change communication (BCC) interventions provided in Myanmar across 62 townships, in particular in rural and urban youth centres and in youth information corners, UNFPA has sought to support improved adolescent reproductive health (ARH). CP2’s outcome indicator for ARH, which is the percentage of population between 15 to 24 years of age who are HIV positive, is in decline at 0.91 percent. UNFPA estimates that outreach activities achieve a multiplier effect of 10 for the 400,000 young people with whom it has had direct contact through its ARH-supported activities. However, establishing the precise effect of the UNFPA's support on ARH, and the level of behavioral change actually achieved, is problematic in the absence of a recent valid survey. Nevertheless, there is scope to enhance the effect of UNFPA’s ARH interventions in Myanmar by focusing more on youth at risk and by the use of new communication strategies (including use of the different channels of media) that reach larger youth audiences; by updating the evidence base on ARH trends; by promoting more strategic-level partnership responses to ARH trends; and following up on changes required to achieve more user-friendly ARH services.

The HIV epidemics in Myanmar continue to remain largely concentrated among people identified with high risk behaviors, but now appears to be in decline. The CP2 outcome (reduced high risk behavior), and output (increased access to HIV knowledge), were met. Both the drop in centres (DICs), targeted outreach programmes and condom programmes were assessed as efficient, as effective and as offering good quality services. Access to HIV prevention services supported by UNFPA including condom distribution programmes increased significantly over the life of CP2. This seems to have had most effect on the behavior of female sex workers (FSWs). However, prevention interventions related to men who have sex with men (MSM) appear to have achieved less coverage so far and need further scaling up. The UNFPA's support for prevention amongst high risk groups remains appropriate having regard to the National Aids Programme’s (NAP) recent work which indicates that the major routes of HIV transmission in Myanmar remain among the population with high risk behavior and their sexual partners. The new national strategic plan (NSP), to which CP2 is aligned, will now give more focus to the partners of high risk groups but how that is best achieved is problematic. The UNFPA, as with other partners, needs to continue to advocate for increased funding and human resources to be devoted to HIV prevention and other services, particularly as regards the large gap in condom funding. Take up of VCCT services also needs to be increased.

Both the intended outcome and output for PMCT under CP2 have been met in that access to PMCT services has been improved under CP2. The PMCT services supported by the UNFPA have been significantly scaled up from 24 to 80 townships through NAP/Department of Health (DOH) and other implementing partners. When account is taken of UNICEF support for PMCT services in other townships, over 200 townships are being covered in Myanmar. There is still significant unmet demand for PMCT services for pregnant women with the possibility both of
more scaling up of services and of developing linkages with MCH services needing to be discussed by partners.

The UNFPA has made significant and effective contributions to improving the extent of disaggregated P&D data that is available in Myanmar. This is due to its support both for the Fertility and Reproductive Health Survey; the 2010 Report on Situational Analysis of Population and Development, Reproductive Health and Gender in Myanmar (Report on Situation Analysis); the UNCT’s draft Thematic Analysis, the RH MIS; and for research on migration, ageing, women’s protection and gender equality. However, the sustainability of work in P&D is being constrained – there has been no census conducted since 1983 and there is weak P&D capacity within government agencies. Through its leadership of the UN MDG M&E group, the UNFPA and other UN agencies need to encourage the early conduct of a capacity assessment in P&D and, then, the development in consultation with government of a practical work programme of P&D surveys and related research.

An effective and efficient catalytic role has been played by the UNFPA in encouraging the advancement of gender equality in Myanmar over the life of CP2. With support from the UNFPA through a Steering Committee of the Women’s Protection Technical Working Group (WP TWG) and the Gender Theme Group (GTG), the Ministry of Social Welfare Relief and Resettlement (MSWRR) has led development of a draft National Plan of Action for the Advancement of Women 2011-2015. This most welcome endeavor involved 12 Ministries, UN agencies and NGOs. That Plan now awaits endorsement by government as a clear signal to its population and the international community that Myanmar is committed to gender equality and to women’s empowerment. UNFPA assistance has also supported gender awareness-raising and evidence-based advocacy. Further support will be needed from the WP TWG and the UN GTG, both of which are led by UNFPA, in developing capacity within government in gender analysis and mainstreaming; in building up the gender-related evidence base including on women protection issues; as well as in community based interventions related to women’s empowerment at the local level such as the “women’s friendly space” initiative. The UNFPA will also need to continue work on mainstreaming gender equality within its own areas of assistance, such as through male involvement in RH and women’s protection, and that of other UN agencies.

The UNFPA has been highly responsive and efficient in addressing RH, HIV and gender issues in the aftermath of the sad events of cyclone Nargis in May 2008. Its package of support services and equipment was singularly effective, including maternal and neonatal health services and the distribution of clean delivery kits, dignity kits, condom supplies, pills and injectables. These met the urgent RH, HIV and gender needs of a large number of women and their families. The women’s protection assessments that the WP TWG produced were well crafted and helped to focus donor’s attention on major vulnerabilities that were faced by women such as possible gender based violence (GBV) and the importance of helping to support women to recover from the natural disaster by developing new livelihoods. The UNFPA has since worked with government and UN agencies in developing their and the UNFPA’s contingency plans for dealing with emergencies through rapid response teams and pre-positioned supplies. This new component of UNFPA’s work must now be recognized in the next CP.

There are three management issues that need attention in development of the next CP. The first is instilling in all UNFPA managers an approach to their support of the CP that is programmatic, employs results-based management and practices sound partnership principles. There is a need also to reframe the UNFPA’s expectation of implementing partners so that they manage and report more on results and the quality of service delivery rather than just on activities.
Thirdly, the structure & human resources of the CO need review to ensure the office is properly resourced to deal with the range & complexity of a more broadly framed CP.
B. INTRODUCTION

B.1 Purpose of Evaluation

1. This report is an end of programme (EOP) evaluation of the UNFPA Second Programme of Assistance to Myanmar 2007 – 2011. UNFPA has committed itself to conducting such an evaluation before any new Country Programme (CP) is submitted to the Executive Board.

2. Under the Terms of Reference (see Annex E1), the evaluation is intended to assess whether the desired results of the 2nd Programme of Assistance have been achieved, and specifically:
   - To assess the validity of design, relevance, efficiency, effectiveness, sustainability and impact of strategies, approaches and interventions under UNFPA 2nd Programme of Assistance in promoting maternal health and HIV prevention.
   - To guide decisions on development, management, coordination, monitoring and evaluation of 3rd Programme of Assistance 2012 -2015.

3. The evaluation is to cover the period of the UNFPA 2nd Programme of Assistance to Myanmar from its inception in 2007 until the time when the evaluation is completed. It is also to cover geographical areas where UNFPA intervention activities have been implemented in selected townships around the country. The end-of-programme evaluation will cover the broad areas of RH and HIV/AIDS prevention as well as cross cutting issues, such as data in relation to the Fertility and Reproductive Health Survey (FRHS), the Reproductive Health Management Information System (RH MIS), etc and gender.

4. The primary users of this evaluation are the UNFPA Country Office in Myanmar, the UNFPA Regional Offices and Headquarters as well as programme implementing partners in the Government, the NGOs and the INGOs, UN agencies as well as the donors.

5. Major issues to be addressed in the course of the evaluation include:
   - The relevance of the 2nd Programme of Assistance and its planned results.
   - The progress towards achievement of the programme’s intended results, the extent to which planned results were achieved and the quality of outputs and outcomes.
   - The effect of various behavioral change communication (BCC), capacity development and static and mobile outreach interventions.
   - The programme management arrangements, implementation management and modalities, and actual effect of management of the programme.
   - Good practices identified and lessons learned.
   - Validity of the programme design.
   - Effect of the Targeted Outreach Programmes (TOP) and Drop In Centres (DIC).
   - Effect of programme on access to services related to reproductive health (RH), HIV prevention and Prevention of Mother to Child Transmission of HIV (PMCT) and quality of these programmes.
   - The effect of various interventions intended to increase knowledge about RH, HIV and PMCT.
   - The effect of different training approaches on capacity development.
   - Whether the outputs and outcomes justified the costs incurred.
• Sustainability of programme achievements, particularly in areas affected by cyclone Nargis.
• Other factors or events affecting programme results.

B.2 Methodology

6. The evaluation comprised four parts:

(1) The inception stage, involving preparatory briefing, consultation and preparation of an Inception Report;
(2) Evidence collection, consultation and analysis covering accessing relevant documents, interviews and discussions with stakeholders, the conduct of field work and the preparation of a field report. Consultation covered the Country Office (CO) of UNFPA, the Asia Pacific Regional Office (APRO) of UNFPA, the government of Myanmar (GoUM), UN agencies, donors and other implementing partners and stakeholders, and the beneficiaries amongst the people of Myanmar which the CP is intended to assist;
(3) The development of a draft evaluation report that addresses the key questions raised by the evaluation and makes findings, based on UNFPA guidelines and evaluation criteria;
(4) Consultation on, the draft report with UNFPA and other stakeholders, before finalization of the report and its submission to UNFPA.

7. The evaluation was 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 included informed consent of participants. The evaluation’s purpose was outlined to beneficiaries, government counterparts and other stakeholders. Target groups for the evaluation were 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 has been kept confidential.

8. The standard UNFPA criteria that have been applied in conducting the evaluation are as follows:
• Relevance of the programme to national needs and priorities, to UNFPA strategies, to target populations and as being complementary to other stakeholders interventions;
• Validity of design, including whether programme results (outcomes, outputs and impact) are clearly stated and describe solutions to identified problems;
• Management of the programme;
• Effectiveness in terms of actual results, including outputs achieved and their quality;
• Efficiency in terms of cost incurred for the actual outputs and outcomes achieved;
• Sustainability of programme achievements after withdrawal of external support, especially in areas affected by cyclone Nargis;
• Impact of programme in the sense of its positive or negative long-term effects, which may be economic, socio-cultural, institutional, environmental, technological, or other effects;
• Other factors affecting the programme’s results, internal or external to the programme.

9. Methodologies applied in conducting the evaluation are as follows:
• A documentation review covering Myanmar’s relevant national policies, plans and guidelines, survey reports and local implementation arrangements; UNFPA’s programme and project-related documents, data collection materials, reports, research and surveys; work plans of implementing partners and annual reports; related documents from UN partners and donors including the recent UNCT’s Thematic Analysis and draft UN
Strategic Framework; evaluation reports; research papers; and various UNFPA programme reviews. The documents are listed at Annex E2.

- Conducting structured interviews involving 107 persons. These covered senior Government officials in various Departments in Nay Pyi Taw based in the Ministry of Health (MOH), the Central Statistical Office, the Ministry of Immigration and Population (MoIP) and the Ministry of Social Welfare, Relief and Resettlement (MSWRR). Interviews also covered UN agencies in Yangon such as UNICEF, WHO, UNAIDS and UNDP as well as the office of the UN Resident Coordinator; donors such as AusAID and DFID; and the Three Diseases Fund (3DF). Interviews also extended to UNFPA’s implementing partners such as the Japanese Organization for International Cooperation in Family Planning (JOICFP), Marie Stopes International (MSI), Population Services International (PSI), Myanmar Red Cross Society (MRCS), Myanmar Medical Association (MMA), Myanmar Anti Narcotics Association (MANA), Save the Children (SC), and Aide Medicale Internationale (AMI). UNFPA staff were also interviewed, including four programme and technical staff in APRO in Bangkok and 20 programme staff in UNFPA’s CO in Myanmar.
- Field work over seven days involving 18 focus group discussions covering service providers, youth volunteers, village health committees and Community Support Group members (CSGs); structured interviews with service providers, beneficiaries and implementing partners; and discussions in three community meetings.
- Observation during field work of hospital facilities, clinics, drop-in centres, youth centers, youth information corners and equipment and supplies in use that had been supported through UNFPA assistance.
- A workshop with 40 participants, including Government officials, UNFPA programme staff and implementing partners to present and discuss the preliminary findings, which was held at Nay Pyi Taw on 14 March 2011;
- Circulation of a draft report with comments received taken into account in finalization of the report.

10. The work programme outlining interviews, focus group discussions and meetings undertaken is at Annex E4. The evaluation was undertaken over 48 days, including 25 days in Myanmar and four days in Bangkok. The ET used triangulation to check and clarify initial observations with a range of participants in interviews and focus group discussions and against available data, as well as seeking comments from participants in the Nay Pyi Taw workshop. Of particular concern was to establish the extent, if any, to which particular results could be attributed to UNFPA’s programme work. Counter-factual issues were also raised in EOP interviews and focus group discussions in an effort to identify the extent to which particular results might have occurred anyway, regardless of UNFPA efforts. Weaknesses in performance information is discussed below.

11. Field work was undertaken over seven days in four States: Yangon, Bago, Magway and Mandalay. This involved visits to a number of hospitals at State, township and station levels; to youth centres and youth information corners; to birth spacing clinics; to Sexually Transmitted Disease (STD) clinics; to villages to meet with community members, community support groups (CSGs), and village health committees; to Rural Health Centres; to Non Government Organizations (NGO) project offices; and to drop-in centres (DICs). Opportunities were taken to observe maternity wards, labour wards, testing laboratories, clinics and operating theatres; and facilities used by Rural Health Centres, Community Support Groups, youth groups, birth spacing services and drop in centres. Health facilities were also examined as to their adequacy and the availability of necessary equipment and commodity supplies. Statistics for persons consulted during the field visits are set out in Table 1 below.
<table>
<thead>
<tr>
<th>Service Providers</th>
<th>Community</th>
<th>Beneficiaries (incl. meetings)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor (TMO, DMO, SMO)</td>
<td>Health Assistant</td>
<td>Nurse (THN/LHV)</td>
<td>MW</td>
</tr>
<tr>
<td>56</td>
<td>12</td>
<td>22</td>
<td>30</td>
</tr>
</tbody>
</table>

12. There were a number of limitations to the methodology. The time taken obtaining necessary approvals both for official travel to Myanmar (which included travel to Bangkok) and also to the schedule for field travel significantly constrained the time that was left available for field work and analysis. Proposed visits to other States thus did not proceed, meaning for example that the opportunity to examine the effect of UNFPA’s extensive assistance in the heavily populated Ayeyarwady Division, in particular the issues of sustainability that were raised by the EOP evaluation’s term of reference and the effectiveness of maternity waiting homes, were not pursued to the extent desirable. There were also some time consuming difficulties in accessing villages during the field work due to poor local roads requiring use of various modes of transport such as a jeep, a trawlergy (locally assembled motorized vehicle) and a bullock cart to complete various journeys.

13. Other limitations flowed from the lack of information on some aspects of programme performance related both to gaps in performance information available under CP2 and on P&D data issues generally, with the last census having been conducted in 1983. Some of the recent evaluation work undertaken on the UNFPA programme in Myanmar contained helpful material but was not totally convincing on the qualitative issues that were examined. Another limitation was that the evaluation was mainly conducted from Yangon, where the CO is located- meaning that face-to-face contact with more senior government officials in Nay Pyi Taw was constrained. Efforts to overcome limitations mainly related to the effort made to cross-check information and views provided to the ET and then to consult on the preliminary findings and the draft report.

14. The UNFPA was extensively involved in all stages of the evaluation process, starting with the drafting of the TOR. The CO’s evaluation management committee provided oversight, including through close involvement in the drafting of the inception report. Government counterparts based 350 kilometres away in Nay Pyi Taw were not able to participate in committee meetings but were consulted on the TOR and at other stages, including on the preliminary findings. Throughout the evaluation the ET held regular meetings with relevant CO staff to discuss emerging issues and possible findings. Some CO staff and a government counterpart also participated in the field work and provided explanations on any programme issues that were raised, as well as assisting in translation. There was also extensive consultation with the CO in the course of drafting preliminary findings made on completion of the field work, as well as their participation in the Nay Pyi Taw workshop. The CO commented at length on the draft report, as well as on particular programme implementation issues that were raised in further correspondence. APRO was consulted and provided written comments on the draft IR, the preliminary findings and the draft report.
15. In the light of the work that has been undertaken, after outlining the content of CP2 and making some contextual comments, this report outlines findings and conclusions by reference to each of the sub-components of CP2 as well as to gender equality and humanitarian assistance, before offering some conclusions, and making 15 recommendations for further action.

B.3 UNFPA Second Programme of Assistance to Myanmar

16. The UNFPA began supporting population activities in Myanmar on an ad-hoc and occasional basis in 1973, involving support for the 1973 and 1983 Population and Housing censuses and later on for other RH surveys. 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. In 2002, UNFPA changed from a project approach to a programmatic approach with the implementation of UNFPA Special Programme of Assistance to Myanmar (CP1) during the period from 2002-2006. The programme focused on humanitarian assistance rather than development covering training, RH commodity supply, IEC materials/tools development, BCC interventions at the community level, data collection and access to emergency obstetric care.

17. UNFPA 2nd Programme of Assistance to Myanmar has shifted its focus from RH-related humanitarian assistance to development. CP2 was intended to apply from 2007-2010 but has been now extended until the end of 2011. The programme focuses on Reproductive Health (RH), Adolescent Reproductive Health (ARH) and prevention of HIV/AIDS, to promote the status of RH of women and men including adolescents and youth in the selected project areas. While the programme was planned to start in 2007, actual implementation began in 2008 due to Government delay in approval and the programme agreement was signed in February 2008.

18. Cyclone Nargis which hit Myanmar in May 2008 led the CO to reallocate resources to the humanitarian response. Even though there was some delay, activities were completed nevertheless. The UNFPA provided humanitarian assistance under CP2 within the areas of Myanmar affected by cyclone Nargis, in particular in Ayeyarwady Division. The Cyclone Nargis response phased out in 2010.

19. CP2 is being implemented by various implementing partners in 138 townships, representing 42 percent of Myanmar’s townships and about 60 percent of the population. The following five outputs and four outcomes are provided for CP2’s results and resources framework.

<table>
<thead>
<tr>
<th>Table 2: CP2 Results and Resources Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Output</strong></td>
</tr>
<tr>
<td>1 Improved access to reproductive and maternal health services, including birth spacing, pre and post natal care, delivery services and emergency obstetric care</td>
</tr>
<tr>
<td>2 Improved availability of disaggregated data for RH programming</td>
</tr>
<tr>
<td>3 Increased access by young people to RH and HIV-prevention information</td>
</tr>
<tr>
<td>4 Improved access by vulnerable populations to knowledge about and ways to prevent HIV</td>
</tr>
</tbody>
</table>
20. The results framework of CP2 extended UNFPA’s level of engagement in Myanmar to cover EmOC and PMCT services. However, CP2 contained no separate programme components on P&D and gender. CP2 programme document made it clear though that UNFPA and its partners would design all initiatives within a framework that empowers women, promotes gender equality and equity, and promotes male involvement in RH.

21. CP2’s results and resources framework cover only RH, with 5 outputs and four outcomes to be achieved. Some of the results set out in the framework are broadly expressed- for example what sort of disaggregated data or what particular vulnerable populations is not made clear. In fact, UNFPA has supported disaggregation of data under CP2 by sex, age, sex and region. The vulnerable groups that UNFPA has supported are female sex workers (FSW) and men who have sex with men (MSM).CP2’s framework also lists a number of indicators to be used to test the programme achievements but these do not cover some aspects of the outputs and outcomes such as access to youth friendly services. Moreover, in retrospect, CP2 began in Myanmar at a time when some of the necessary baseline data was not readily available (eg. the proportion of caesarean sections conducted). This has had an effect on the level of performance measurement that was undertaken and, thus, on the information available to this evaluation.

**B.4 Myanmar’s Context and Strategic Outlook**

22. In evaluating CP2, there are some important contextual factors to be taken into account. The first is that CP2 has itself evolved significantly since approved by the Executive Board in 2006 as Myanmar has gradually taken a greater interest in P&D and gender. CP2 assistance on P&D was limited to one output related to improving disaggregated data for RH programming. But there is now a gradually emerging government interest in more evidence based approaches to decision-making. Second, the UNFPA’s humanitarian work after cyclone Nargis led on to assistance in examining women’s protection issues and to support for strategic planning for the advancement of women. This evaluation report includes a review of these new areas of work.

23. There have also been significant developments in the governance environment, including the gradual relocation since 2006 of the central government and public servants from Yangon to the newly constructed administrative capital of Nay Pyi Taw. The physical distance involved has posed real challenges to development partners in how to maintain close communication and ongoing support for particular functions of the government while the partners instead remain based in Yangon. The development of the 2008 Constitution; the holding of national elections in 2010; and the establishment of the new Parliament in 2011 have been other major events affecting governance in Myanmar in recent years. Appointments to the new Government Ministry have recently been made. There are also plans for decentralization of powers and functions to the State level. The Parliament has begun to meet and has already showed interest in accountability issues relating to government services. It is not possible to predict at this early stage how this new governance environment might develop, and, whether it might provide opportunities for example for helping to improve health service delivery. But the nature of the new Ministerial appointments; the role to be taken by the new Parliament; and the likelihood that there will be more governments at different levels, will have implications for the way that the aid community needs to operate.
24. Myanmar has achieved considerable economic growth since adopting a market-oriented system in 1988. Growth rates have been generally strong, combined with a trade surplus in recent years, significantly reduced inflation, and ensuring relatively minor impacts from the global financial crisis. However, as the draft UNCT’s Thematic Analysis reports, human development conditions remain low. Nationally, poverty has fallen significantly to 25.6 percent, with rural poverty declining to 29.2 percent and urban poverty down to 15.7 percent.

25. Despite these recent improvements, sub-national inequalities remain substantial. The Thematic Analysis further notes that most poor people, many of them smallholder farmers or agricultural laborers, live in rural areas and face multiple challenges. These include low education and limited access to land, capital, credit, technology, information and basic social services. The poor are also highly vulnerable to internal as well as external shocks such as cyclones. Overall, development deficits include both inadequate growth of a nature that is beneficial to poor people and also weak remunerative employment opportunities. Other deficits include continued prevalence of multi-dimensional poverty and pockets of hunger; inadequate coverage and quality of social and health services; and incomplete policies (such as in relation to women and an aging population), programming and participatory frameworks.

26. The lack of a census being conducted in Myanmar since 1983 has led to considerable uncertainty about the size of the population. The population was estimated by Myanmar’s Central Statistical Office’s Annual Yearbook to stand at 57.5 million in 2007-08 with an annual growth rate of 1.52 percent. However, the UNFPA’s 2010 State of the World Population has a significantly lower estimate at 50.5 million.

27. Demographic factors which the UNFPA’s 2010 Report on Situation Analysis indicates have been at work over the life of CP2 in Myanmar include:

- **Changes affecting Marriage.** The mean age of marriage for women increased slightly between 2001 (25.8 years of age) and at 2007 stood at 26.1 years. The proportion of the population aged 15-49 who had not married stood at 45 percent in 2007.
- **Increase in age at first birth.** The average age of the mother at her first birth increased from 21.2 years in 2001 to 22.8 years in 2007.
- **Declining fertility rate.** The total fertility rate (TFR) declined to 2.03 children in 2007, with the rural rate at 2.18 and the urban rate at 1.68.
- **Total dependency ratio.** This had reduced from 61.2 percent in 2001 to 58.7 percent in 2007. The number of children born to a married woman over her RH life has declined from 7.0 in 1983 to 4.7 children in 2007.
- **Increasing life expectancy.** Life expectancy at birth increased between 1991 and 2007 from 61 years to 65.0 years for both sexes.
- **An aging population.** The median age in Myanmar had increased from 21 years in 1991 to 26 years in 2007. There were 5.6 million people over 60, or close to 10 percent of the population, with this figure expected to continue to rise.
- **An increase in the working age population.** The proportion of working age population had increased from 61.2 percent in 2001 to 63 percent by 2007.
- **A large youth population.** There were over 10.1 million young people aged between 15-24 years in 2007, with most unmarried and seeking employment.
- **An increasing urban population.** According to the UNDP Development Report, the urban population has risen from 24.9 percent of the population in 1990 to 34 percent in 2010.

28. Comparisons of nearby Asian Pacific countries taken from UNFPA’s 2010 State of the World Population are:
Table 3: Country Comparisons in P&D

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>164.4</td>
<td>1.4</td>
<td>2.25</td>
<td>28</td>
<td>18</td>
<td>58/56</td>
<td>87,635</td>
<td>10.5</td>
<td>163</td>
<td>80</td>
</tr>
<tr>
<td>Cambodia</td>
<td>15.1</td>
<td>1.6</td>
<td>2.81</td>
<td>20</td>
<td>44</td>
<td>92/85</td>
<td>63,618</td>
<td>5.4</td>
<td>358</td>
<td>65</td>
</tr>
<tr>
<td>Laos PDR</td>
<td>6.4</td>
<td>1.8</td>
<td>3.35</td>
<td>35</td>
<td>20</td>
<td>88/61</td>
<td>8,194</td>
<td>9.9</td>
<td>-</td>
<td>60</td>
</tr>
<tr>
<td>Myanmar</td>
<td>50.5</td>
<td>0.9</td>
<td>2.26</td>
<td>34</td>
<td>57</td>
<td>120/10</td>
<td>14,345</td>
<td>2.5</td>
<td>319</td>
<td>80</td>
</tr>
<tr>
<td>Vietnam</td>
<td>89.0</td>
<td>1.1</td>
<td>2.01</td>
<td>30</td>
<td>88</td>
<td>27/20</td>
<td>86,759</td>
<td>19.7</td>
<td>655</td>
<td>92</td>
</tr>
</tbody>
</table>

(Source: UNFPA, State of World Population, 2010. Please note, as foreshadowed above, there are some differences in UN figures for Myanmar from those quoted earlier).

29. Myanmar has committed itself to meeting the Millennium Development Goals (MDG), as well as to meeting the ICPD goals. So far as maternal mortality rate (MMR) is concerned, figures quoted in the draft UNCT’s Thematic Analysis indicate a decline in Myanmar from 1990 figures of 420 per 100,000 live births to an estimated 240 per 100,000 live births in 2008. This improvement has been assisted by increases in:

- The rate of skilled attendance at birth from 57 percent in 2001 to 64 percent in 2007.
- The Contraceptive Prevalence Rate (CPR) for married women of reproductive age from 37 percent in 2001 (any methods) to 41 percent (any methods) in 2007. However, the unmet need for contraception in 2007 was estimated at 17.7 percent of all currently married women of reproductive age.
- Ante natal (AN) coverage across Myanmar was 75.6 percent in 2001 FRHS, and 79.8 in 2007 FRHS. RH MIS 2008 indicates that sixty-eight percent of pregnant mothers attended for at least one visit.

30. The previous Prime Minister and the Minister for Health had publicly committed the Government to the further effort needed to reach the MDG target of 105 deaths per 100,000 live births by 2015. This will require significantly increased funding and an enhanced resource effort at all levels. The additional budget and human resources that may be needed to achieve this goal are discussed in the RH part of this report.

31. Reducing the under five mortality rate to the 2015 MDG target of 38.5 per 1000 live births is similarly challenging. In 2007 the under five mortality rate stood at 65.8 per 1000 live births. Similarly, there is a challenge to be faced in reducing the Infant Mortality Rate (IMR) for Myanmar to the MDG target of 28.3 per 1000 live births in 2015, despite the reduction made from 70 per 1000 live births in 2001 to 53 in 2007 FRHS.

32. Myanmar also has a number of special features affecting the context for development assistance. Myanmar’s ODA level is one of the lowest in Asia at US$4.06 per capita in 2007, with there being no World Bank or Asian Development Bank presence. Donors like AusAID, DFID, European Union, Sida, Germany, Netherlands and Norway do have programmes that include assistance in particular fields that include health care. However, there are special restrictions on the European Union Member States and on some UN agencies operating in Myanmar, in particular the UNDP which operates mainly at the grassroots level on sustainable development initiatives. Some UN agencies such as UN Women (previously UNIFEM) do not operate in
Myanmar. UNFPA does not contract the government as executing agency for projects. Rather, UNFPA executes its projects through NGOs and INGOs. UNFPA's assistance under CP2 is provided in close partnership with UNICEF and WHO. The ET was told a number of times that UNFPA is regarded favorably within the UN community because of its contributions to furthering joint UN activities.

33. One constraint to collaboration within the UN community was that the Common Country Assessment and the United Nations Development Assistance Framework (CCA/UNDAF) had not been undertaken in Myanmar prior to CP2 development. This may have inhibited the CP2 in making a stronger strategic alignment with other UN agencies to provide harmonized assistance to achieve national goals. However, the recent collaborative work within the UN community on developing a new Strategic Framework may lead on to greater joint programming activity. There are also indications that some donors such as AusAID and DFID are considering the possibility of making substantial injections of funds into maternal and child health in the foreseeable future but wish to work within broad partnership contexts that involve UN agencies, the INGOs and the NGOs. Thus, the scope for enhanced levels of partnership across development partners, INGOs and NGOs in Myanmar stands at an all time high, with good prospects for joint programming.

34. Myanmar is a challenging aid environment for development partners to work in. Parts of Myanmar are remote and difficult to access due to the terrain, the weather and local-level conflicts. While development partners do have memoranda of understanding there are not the same aid cooperation arrangements to work within as for other countries. Little progress has been made in pursuing aid effectiveness agendas. Consultation with the government has taken reiterative effort and has sometimes been lengthy. UNFPA has found that gaining agreement at government level to IEC material for publication has been sometimes protracted.

35. The UNFPA has an office in Yangon with 45 staff. It has a total budget drawn from core and other resources of $29.97m (2007-2010). UNFPA has no field presence which makes monitoring of its operations in the 14 States that UNFPA works difficult. Seeking approval of visas for UNFPA officials from APRO and elsewhere, as well as foreign consultants contracted to work with the Myanmar Office, has to be undertaken well in advance. Foreigners also need to seek official approval for field visits to townships and rural areas well in advance of travel.

36. As well as changes in the environment in which it works, the UNFPA Country Office in Myanmar has also to respond to changes in its own working environment. Country Offices are increasingly expected to upstream their programming work with greater involvement required at a country level in pursuing more strategic activities that are directed at results and in building supportive coalitions for change. There is more working through partnerships and external technical providers and greater focus on pursing conceptually-related policy work and advocacy and fostering service quality improvement while providing leadership in RH, P&D and gender equality at the country level. More recently, UNFPA headquarters has been emphasizing the immediate improvements required in accountability for programme performance at country level. It was immediately clear to the ET on commencement of the evaluation that the Country Office has a heavy workload. Despite having committed staff, the CO is finding it challenging to cope with the multiple conflicting priorities that they are expected to meet.

C. FINDINGS AND CONCLUSIONS

37. This part of the report reviews the assistance provided under CP2 in each area of assistance.
C1. Findings on Reproductive Health (RH)

38. CP2 provides as the intended outcome in RH “Increased utilization of high-quality RH services, including maternal health services”. The intended output 1 is “Improved access to reproductive and maternal health services, including birth spacing, pre- and post-natal care, delivery services and emergency obstetric care”. There are at least five features of the RH outcome and output of CP2 that are important-the emphasis in RH services on access; on increasing utilization; on quality; on maternal health; and on comprehensive RH care.

39. The RH services are one of the 12 parts of Myanmar’s National Health Plan 2006-2011 which is implemented by MoH through its seven Departments (maternal health is oversighed by the Maternal and Child Health Section in the Department of Health). MoH works collaboratively with 34 INGOs and 7 UN organizations in providing health care to the population. Effective partnership in RH is obviously, therefore, critical to success.

40. Myanmar’s first five-year National Strategic Plan for RH 2004-2008 implemented strategies to strengthen and expand the provision of RH services and to improve the performance of the health system. RH assistance was provided by UNFPA in 112 project townships under CP1. One lesson that UNFPA said it had learned in CP1 was that it was possible to reach the poorest and most vulnerable population groups through the service delivery points in the public health system, although, as will be discussed, the CP2 experience has been that costs are constraining the use of health services by the poor. Another lesson UNFPA said it learned was that community mobilization was a successful mechanism in Myanmar to build demand for services and empower people to take control of their own RH.

41. Myanmar is a signatory to the ICPD and to the Millennium Declaration. MDG5 focuses on reducing maternal mortality ratio (MMR) - the latest estimates of WHO, UNICEF, World Bank, and UNFPA show an estimated MMR of 240 per 100,000 live births in 2008. Over 1.3 million births occur in Myanmar each year. The number of women of reproductive age (15 - 49 years of age) is 16.2 million. The Crude Birth Rate (CBR) per 1000 live births is 17.3, with a total marital fertility rate (TMFR) of 4.7 children per married women. The burden of managing RH still falls disproportionately on women in Myanmar.

42. The MOH takes the lead role in RH strategic management and policy development with the DOH acting as the main provider of health services. MCH services are delivered in urban settings through Maternal and Child Health Centres in small towns; and 83 Urban Health Centres. In rural areas, MCH services are delivered through Station Hospitals; through about 1500 Rural Health Centres (RHCs) which serve populations of around 25,000 and whose staff includes health assistants, lady health visitors and midwives. Under one rural health centre, there are about 4 sub-rural health centres managed by one midwife each. Where there are no sub-rural health centres, some villages rely on volunteer auxiliary midwives (AMWs) and community health workers.

43. As the 2010 Report on Situation Analysis indicates, while AMWs have only three months training and are not skilled health workers, they are heavily relied on in Myanmar in the absence of other health workers at village level. EmOC services require referral to the township or Divisional hospitals. The RH MIS indicates that 76 percent of deliveries take place at home.

44. UNFPA’s strategies under CP2 have included supporting RH services in the 112 townships that were covered by CP1 plus 20 additional townships that have so far been added with German funding support. UNFPA supports capacity development of those service providers who are
mostly in the public sector but also in the private sector, including doctors, midwives and health workers in relation to birth spacing, pre and post natal care and safe delivery; providing RH services including maternal health and birth spacing services; providing RH commodities and building capacity to better manage supplies; supporting BCC interventions that encourage women, men and young people to make healthier RH choices; carrying out related RH research; providing access to emergency obstetric care (EmOC) through improved facilities, skills and equipment; and examining the feasibility of using maternity waiting homes. Output 1 is implemented in partnership with 3 departments of MoH, 4 local NGOs (MMA, MMCWA, MANA and MRCS) and INGOs (PSI, MSI, JOICFP, SC, AMI) who provide RH support in particular townships.

45. The UNFPA’s programme activities support the implementation of the GoUM’s Strategic Plan for RH 2009-2013, as well as the earlier strategic plan. Output 1 in particular supports the strengthened provision of RH services. These include safe motherhood, mobile RH services, IEC and BCC interventions covering training and mobilizing community volunteers, including community support groups (CSGs), MCH promoters and male frontline health promoters. BCC interventions are also made to workforces at factory level. RH commodities including equipment, drugs and supplies for antenatal care, emergency obstetric care and contraceptives are also provided under Output 1. Birth spacing support is provided through township and station hospitals, Rural Health Centres and BHS, as well as by franchised providers like PSI and INGOs such as MSI.

46. The percentage of GDP spent on health was estimated by the World Bank at only 0.23 percent of GDP in 2008. In 2011, only 1.3 percent of the Government budget was allocated to health care.

47. **Relevance.** UNFPA’s RH assistance is consistent with its global RH priorities and the national priorities that are set out in Myanmar’s Strategic Plan for RH 2009-2013. UNFPA also provided significant support to MoH in developing that second Plan. The Plan sets objectives in relation to improving antenatal, delivery, post-partum and newborn care; providing quality services for birth spacing; including prevention and management of unsafe abortions; preventing and reducing sexually-transmitted infections (STIs), including HIV, reproductive tract infections (RTIs); and promoting sexual health; including ARH.

48. Some participants in the structured interviews suggested that RH partners, including UNFPA, needed to work more closely with the MOH in its role of setting RH strategic directions under the Plan. At the moment, the RH Strategic Plan is not perceived as being sufficiently relied on as the leading document that shapes relevant national RH priorities and related assistance. By contrast, setting and implementing strategic directions under the National Strategic Plan 2011-2015 (NSP) for HIV in Myanmar seems to be more effective. However, the ET’s discussions with partners suggested the Strategic Plan for RH as less the issue than is having an effective mechanism for dialogue between all relevant partners under the Strategic Plan.

49. The RH Strategic Plan would become more central to RH assistance provided by partners if the National Working Committee on RH was seen to be working more effectively. This is a matter which needs discussion between the partners. The particular institutional mechanism must be led by MOH and to be directed to the “big picture” issues in RH. It must involve all of the major partners that are contributing to implementing RH services rather than just some of them. Its work must be focused on ensuring there is timely dialogue on the key RH strategic issues. The committee’s work should help to build common ground between partners on achieving key strategic results. Its strategic work should also help to build the basis for more effective, more complementary and better integrated and coordinated RH services at the local level. The
committee’s work must be linked also to the work of the two RH working level committees which are having useful discussions on RH performance information and commodities management. Achieving broader ownership for that RH strategic focus is dependent on building a stronger sense of partnership between the government, UN agencies, donors, INGOs, NGOs and the community. This means that the institutional mechanism must be inclusive (at least of the main stakeholders).

50. The relevance of UNFPA interventions to national objectives would be enhanced if Myanmar’s RH Strategic Plan were further strengthened by more operational-level planning and early mapping of RH inputs of various stakeholders. It should be of real concern for example that it is not possible on currently available information to establish whether or not UNFPA’s RH interventions are entirely complementary to the work of other partners. Mapping of all existing and planned interventions is needed as soon as possible.

51. Validity of the Design. No fundamental issues of concern were identified in the way that CP2 had been designed as regards services in RH. CP2’s outputs in RH are similar to those in CP1, but with some scaling up and strengthening of EmOC. The design issues that were raised with the ET related more to the programme implementation experience with CP2 in so far as it affected the next steps to be taken in improving RH services across Myanmar and what that might mean for future programme design.

52. MOH stressed to the ET that it is concerned to see the continued upscaling of RH care under the CP through coverage of more townships. Important as this matter is, there is no explicit commitment in CP2 about what level of coverage might be provided. In any event, coverage issues are for all partners working in RH care to consider through discussions and negotiation, including the MOH, INGOs, NGOs, UNFPA, UNICEF, WHO and other pertinent UN agencies and donors. The objective of MOH and partners collectively must be to meet the overall needs in RH of the population in a coordinated and complementary fashion so as to achieve ICPD goals and MDGs, especially universal access to RH services. An early discussion is required between parties. In that context, the respective partners obviously each need to consider what their respective comparative advantages are in planning and supporting future delivery in RH in Myanmar. In the interests of aid effectiveness, it would be useful for the RH partners to consider developing a shadow alignment of all RH assistance so as to ensure that they address RH in a coordinated manner under the RH Strategic Plan, in liaison with the RH Technical Working Group.

53. The Programme design issues that arose during the evaluation related to identification of any specific gaps in RH assistance that now needed attention, particularly gaps affecting vulnerable groups. While the MTR of CP2 had recommended the adoption of a common methodology to identify such vulnerable groups, these gaps are often not easy to address effectively in local circumstances in the absence of up-to-date data. Moreover, it is not clear in reading project documents under CP2 as to what extent equity considerations such as poverty have been considered in selection of RH service coverage, with the exception of the recent German-funded townships. Obviously, the poorest States such Chin State which has 73 percent poor followed by Shan (East) and Shan (North) with about 50 percent would be high priorities for RH support.

54. Moreover, if it is feasible to seek to identify and to phase out localities which have adequate RH services and now can be self-reliant and sustain themselves, it may then be possible to divert RH interventions and inputs to other localities where there are unmet needs that affect vulnerable groups in the population. For example, the Sagaing Division, Magway Division, Kayah, Rakhine
and Shan State, Ayeyarwaddy Division, and sub-urban areas of Yangon and Mandalay Division have MMR and abortion rates that are high.

55. RH interventions in poorer States can be particularly demanding. The operational environment can be complicated by difficult terrain and transportation, bad weather, local level conflicts and restrictions on travel. For example UNFPA supports projects in the Wa Special Region and the Northern Rakhine State. Wa has constraints of terrain, conflict and travel. Nevertheless, AMI’s evaluation in December 2009 of the Wa project found that access to RH services had increased and was being well utilized; that staff were dedicated but that midwife capacity constraints needed to be addressed; that a maternity waiting home had been poorly sited and that it had failed; but that community networks were now in place, notwithstanding the impact of poverty and the difficult security situation in the Region. In the Rakhine State, despite difficult weather and transportation being limited to the water way, a range of life saving RH services were provided through an MMA-implemented project in the second half of 2010, including birth spacing services to over 15,000 women and AN support to nearly 5000 pregnant women.

56. In considering what the UNFPA’s CP objectives in RH should be for the future, there are real questions about UNFPA’s ability (and mandate) to continue to upscale its RH assistance to cover more of Myanmar’s townships without significant increases on its existing funding level. UNFPA also has no field presence. There are also constraints flowing from significant shortages in Myanmar’s health system of human resources and funding, as well as a relatively inadequate infrastructure to work with.

57. UNFPA is currently working on a joint programming proposal with UNICEF and WHO that will provide, $15m of AusAID funding between 2011-2013 for more holistic coverage for RH services that are supported by the three agencies in 150 townships, including 70 hard-to-reach townships, 15 intensive interventions townships and 4 new townships.

58. Of great interest in the medium term are the programme proposals now being developed by other partners (with the possibility of substantial funding being available) that may enable extending RH assistance to more of Myanmar’s 330 townships. The ET was told that AusAID, DFID and the 3 MDG Fund are looking at possible provision of such RH support. If these possibilities develop further and mutual expectations can be met, the MOH’s additional RH coverage concerns might be able to be more effectively addressed from other sources.

59. If so, it may also be opportune for the UNFPA to review and redirect its current RH assistance over time. As well as possible scaling down of service provision and/or refocusing assistance to geographical areas or vulnerable population groups that have greater RH needs, there is a particularly critical issue that UNFPA could help to address more. The ET was told both by government and by partners (including donors) that the quality of RH services needs to continue to improve. UNFPA’s RH expertise and technical advice, and their policy advocacy skills, were seen as likely to be particularly valuable to seeking to devise improvements in service quality. Thus, any realignment in UNFPA support should be directed to assistance to MoH in improving service quality. In that regard, the ET’s discussions identified many areas for quality improvement such as RH management (RH MIS, RH logistics, and supply system including LMIS); enhancing curricula for pre-service and in-service training; and helping MOH to develop protocols and guidelines to standardize RH care); and piloting in particular localities model RH interventions.
Another programme design challenge is how to achieve more effective partnership across government and the various UN agencies, donors, INGOs and NGOs that provide RH support. Effective partnership practices need to be applied that emphasize open communication; timely consultation; sharing research findings; working in a complementary way; and ongoing dialogue between partners to build and shape effective solutions. The fact that MOH is based some distance away in Nay Pyi Taw is a geographic reality but should not be insurmountable. For example, specially developed programme liaison arrangements may be needed. In addition, it is crucial that all UN agencies (particularly UNFPA, WHO and UNICEF) who are providing development assistance related to the work of a number of areas of the MoH should maintain strong coordination and necessary cooperation, They must also seek to ensure that different parts of the MoH's organizational structure do not become "projectised" in a way that leads to competition that is inimical to sector-wide coordination.

There is a risk that programme design under CP2 has also tended to emphasize project work in RH rather than leading towards health sector-wide approaches. As the MTR on CP2 recommended, a programmatic approach is needed by UNFPA. Some of the issues in RH identified in the discussions on the field visits such as providing transportation to health facilities and overcoming financial constraints for clients and better organizing and resourcing the health work force are manifestations of broader health system and institutional issues that are just as important to consider and to resolve for other areas of health care delivery. Helping the MOH to develop appropriate solutions to these issues could best be handled through drawing on a broader programme-wide approach to health care and through linking to development assistance that is being provided at that level.

Management. The UNFPA has a large project oversight role to play in relation to RH programme delivery extending over 132 townships. But it has limited capacity to become fully involved in delivery issues in particular townships. The ET examined annual work plans of implementing partners which outlined required results, activities and indicators. Structured interviews held with each partner and also with the UNFPA suggested there had been necessarily a great deal of attention to coordination of implementation of programme activities. However, the attention given to the actual CP2 results achieved was less clear, as exemplified by reporting that the ET reviewed. This tended to be activity reporting rather than concerned for example with service quality.

Given UNFPA lacks a field presence, implementing partners need to play at least a limited role in providing feedback on quality of service at the local level. The partners do not appear for example to have played a role in drawing to attention any obstacles to quality in service delivery; in reporting on local factors that affect the MMR; and in monitoring and reporting on trends at the local level in the RH MIS. Other possibilities where partners might have played a role include supporting MOH in greater integration of different RH services and identifying service delivery issues that affect vulnerable populations. Other possible roles that might have been considered include improving information within the community on RH services; making linkages between RH services and PMCT and HIV prevention; and facilitating RH partner coordination.

There is also scope for improving M&E in RH. Performance indicators are not linked to service quality. Implementing partners do not appear to have linked their work to the information on programme results under RH MIS. A regular programme of evaluations in particular parts of RH services has recently been initiated. The evaluations should provide further valuable information on performance and should be continued, in collaboration with MoH, including that proposed for maternity waiting homes.
65. There was some mixed feedback offered during some of the structured interviews on communication issues affecting UNFPA. Implementing partners were complimentary about UNFPA efforts to meet with them regularly and keep them informed about programme developments. But some implementing partners said they would like to see more timely involvement and greater dialogue in settling annual work plans.

66. The MoH also outlined areas to the ET where they believed improvements in communication with UNFPA on some work issues are required. Some of the claimed communication issues go to tight timeframes for responses that the Ministry was not able to meet. They also relate to the ending of support for field officers that had recommended by an earlier UNFPA oversight mission in May 2009. They also relate to the stronger emphasis that is now given within the UNFPA at all levels on the meeting of accountability requirements. Greater trust and mutual understanding must be built up between the partners by a continued determined effort in ongoing communication and liaison.

67. In addition, given the possibility of increasing contact on H4+ issues, MoH would benefit from a single focal point for communication with partners on strategic H4+ issues, this being a role that UNFPA may be best placed to assist on.

68. **Effectiveness.** The discussion of RH effectiveness is under two headings: (a) strengthening RH services in the health system; and (b) creating demand for RH services.

69. (a) **Strengthening RH Services in the Health System.** In regard to CP2’s outcome indicators, the 2007 FHRS indicates the CPR was 41 percent (38.4 percent use the modern methods); and the proportion of births attended by skilled personnel was 64 percent. According to the MOH’s *2008 RH Statistics*, the third indicator relating to caesarian births as a proportion of all births, was 5.3 percent.

70. The results achieved through UNFPA supported assistance as indicated by the output indicators are as follows:

<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>End-line data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage of service delivery points (SDPs) with at least three contraceptive choices and no stock-outs</strong></td>
<td>30%</td>
<td>90% in project township SDPs</td>
<td>92% project township with no stockout</td>
</tr>
<tr>
<td><strong>Percentage of service delivery points with information, education and communication materials on full range of RH issues</strong></td>
<td>60% SDPs in 112 townships</td>
<td>90% in project townships SDPs (at least 5 kinds of RH IEC materials)</td>
<td>All Project townships have at least 2-3 kinds of IEC materials – poster, booklet, flipchart, VCD</td>
</tr>
<tr>
<td><strong>National coordination mechanism for RH commodity security</strong></td>
<td>Did not exist (200^46)</td>
<td>Functioning RHCS sub-committee</td>
<td>Functioning RHCS sub-committee National RH Working Committee, National RH TWG are also formed and functioning</td>
</tr>
</tbody>
</table>
71. The UNFPA’s RH interventions in townships have thus achieved intended outputs and targets to a significant extent. Structured interviews and focus groups conducted with the DoH, the DMOs, TMOs, SMOs, hospital staff, BHS and beneficiaries indicated general agreement that the assistance that been effective, as outlined below.

72. There is extended access and usage of UNFPA-supported RH services including birth spacing, by reason of the addition of 20 German funded townships in CP2 to now reach a total of 132 townships covering 40.6 percent of the population. Interviewees also gave examples of how mobile services had significantly extended coverage to the village level. Townships that the ET visited had AN coverage rates at least at the level of the 2007 FHRS (67 percent), with some showing increases up to 80 percent in 2009-2010.

73. Pregnant mothers told the ET that they accessed AN services from 4 to 7 times. They were also able to outline the services provided including basic information about the birthing process, nutrition and risks in pregnancies; history taking; checking of blood pressure and blood testing; weight; urine routine examination, examination of the abdomen, supply of ferrous sulphate and folic acid. They said they were appreciative and confident about the services provided. Nearly all indicated they wanted to give birth at home (where 76.4 percent of births in Myanmar occur) but would take seek institutional help if risks arose in the birthing process.

74. The ET also inspected an RHC where labor ward equipment had been installed thus enabling birth to occur in a local sanitized environment, with skilled attendants at hand. UNFPA advised of interest at the local level from BHS and pregnant mothers for these facilities to be extended to other RHCs.

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<table>
<thead>
<tr>
<th>Output Indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>End-line data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of providers with knowledge of and skills for emergency obstetric care</td>
<td>NA</td>
<td>90% of doctors for Comprehensive EmOC, 80% of nurse, midwives and LHV for selected basic EmOC skills</td>
<td>EmOC training not yet conducted. Planned to be conducted in 2011</td>
</tr>
<tr>
<td>Number of referrals to hospitals with a full range of emergency obstetric care services</td>
<td>21,156 referrals for AN, delivery, PN, post abortion care and others (2007 RHMIS)</td>
<td>30% increased from baseline</td>
<td>27,670 referrals for AN, PN, post abortion care and others</td>
</tr>
<tr>
<td>Percentage of villages with community support groups (each covering 30 households) promoting deliveries by skilled attendants, RH&amp;HIV prevention in the community</td>
<td>All villages of 27 project townships</td>
<td>All villages of 78 project townships</td>
<td>All villages of 64 project townships</td>
</tr>
</tbody>
</table>

(Source: UNFPA Country Programme Performance Summary)
75. EmOC services are a vital part of responding to MMR issues. Despite the priority given by CP2, Myanmar appears to date to have fallen short of fully meeting the ambitions on upgrading EmOC facilities and related equipment in some hospitals still waiting for improvements to be made. The evaluation team visited some of the hospitals that have in fact already benefited from improved facilities and equipment which the team able to inspect. Greater impetus must be given to completing the enhancement of EmOC facilities and equipment and to finalizing the related capacity development curriculum. Hospitals advised that the new EmOC facilities improved the standard of RH care they could offer.

76. It is of real concern that EmOC services are being subjected to a fee that is likely to be discouraging some poor people from accessing EmOC, despite trust arrangements that some hospitals said they had put in place and the efforts made by individual CSGs to raise funds to pay for emergency referrals. It appears from the comments made by beneficiaries that the costs associated with accessing RH services in hospitals and informal fees changed at local level are inhibiting access to the services. In Myanmar, as noted by a 2006 WHO report users of health services pay 87 percent of health costs through out-of-pocket expenses, with women of lower economic status affected most of all. User fees are thus impeding poor people from accessing RH services. This is a consequence of a lack of public funding. How to ensure that accessing RH services is cost-free for poor people needs early follow up with the MOH, particularly as regards EmOC services.

77. Some of the issues related to health costing in Myanmar may come from the lack of a rights-based approach to SRH in Myanmar. The ET heard little about rights-based approaches to SRH in discussions with service providers although UNFPA has undertaken advocacy on RH rights. More work is needed to build a supportive rights-based culture.

78. It was encouraging to see that the RH MIS, which UNFPA helped to support in development, is being utilized in managing RH services at township levels. The ET was able to have useful discussions in townships visited about the RH profile and what local issues affected a particular statistic. Midwives presented the detailed records on the RH services they make in accordance with MIS training they have been provided with. The DHP in Nay Pyi Taw also described to the ET the quality assurance checks they make on MIS. However, some of the discussions with hospitals and BHS suggested the figures on MMR and on skilled birth attendance were possibly still not as accurate as they needed to be. However, the MIS data on the MMR seems to vary from surveys that have been undertaken. Ensuring there is reliable MMR data is one area where technical assistance could be helpful to Myanmar.

79. The MoH’s expressed interest in better integrating and coordinating service delivery is a welcome move towards improving effectiveness. PMCT and HIV services also need to be included in any new arrangements. Comments made by the DMOs and TMOs indicated that they were conscious that a greater management and leadership role in RH was emerging for them at the local level. Appropriate capacity development assistance would appear to be needed to help further that leadership and management work.

80. A number of human resource management issues came to attention during the field visits. A typical RHC looked after MCH in villages. The BHS midwives based in RHCs felt that they were often unable to cope with a workload that was spread across up to 5,000 people in a geographical area that was physically difficult to travel around. Relying on AMWs to fill in the gap in RH support was not seen as a satisfactory solution, given their limited training. However, as identified by a 2007 DoH study, there is scope for job re-design that would free up midwives to focus more on interaction with patients. Moreover, if auxiliary midwives received more capacity
development, a more professional status and access to some basic RH supplies, they might be better placed to make a stronger contribution. Whether there is a way to provide at least some limited incentives to AMWs and to volunteers also bears examination.

81. As will be discussed in relation to Myanmar’s MMR, there is also a shortage of skilled RH personnel employed within the public health system even though, as we were told, there are in fact many midwives and doctors that cannot obtain employment. One alternative suggestion that came up informally in discussion between the MMA and UNFPA is whether unemployed midwives and doctors might be prepared, if provided with some basic RH supplies, to undertake RH work in rural areas, perhaps with limited compensation where the person comes from outside the locality.

82. In fact, the entire field of health financing and provision of human resources is a major issue for RH services in Myanmar. The low level of human resources is said to be particularly affecting the rate of progress towards the MDG and ICPD goals related to the MMR. As has also been noted, the overall budget for health care in Myanmar is one of the lowest in the Asia Pacific region. It stands at 1.3 percent of the total government budget and at 0.2 percent of GDP.

83. According to WHO, a rate of 80 percent skilled birth attendance must be reached to reduce the MMR- this requires that there should be 23 doctors, nurses and midwives per 10,000 population. While the Government’s stated aim is to secure at least 1 midwife per village to provide AN and birthing services, a WHO report suggests that there are only 14 health personnel of all categories for a population of 10,000 people. Most doctors, for example, live in urban locations where only 30 percent of total population resides. The importance of there being a skilled attendant at all births should continue to be promoted, including compulsory skilled attendance at birth for all high risk mothers. The advantages of institutional delivery should also be promoted.

84. The ET found in discussions that the MMR is being strongly focused on within the public health system at national and local levels. The Nationwide Cause Specific Maternal Mortality Survey published by MOH/UNICEF in 2006, shows that 90 percent of maternal deaths occur in rural areas where 70 percent of the total population lives, often with inadequate care. Thus, the death rate in rural areas in the home is much higher where a skilled birth attendant is not present at the childbirth (as opposed to a traditional birth attendant being present); and/or there were delays in referring the pregnant mother for institutional care.

85. There are three vital delays affecting the MMR which arise from the impact of poverty, difficult transportation and lack of quality care. The delays are: (1) the delay in decision making at home due to lack of knowledge, cultural barriers and lack of capacity to meet costs; (2) the delay in reaching the health facility due to remoteness and lack of transportation; and (3) the delay in accessing adequate care at the health facility. The main causes of maternal death are post partum hemorrhage, eclampsia, and abortion and obstructed labor. The Study showed that although 48 percent of the deceased women were seen by a skilled provider at least once during her pregnancy, only 22.5 percent were actually delivered by skilled care providers and 33.8 percent by TBAs.
86. The discussions the ET had across government, implementing partners and the UNFPA suggested that effective action to reduce the MMRs needs to be a combination of nation-level and local level strategies. At the national level, as well as improving the human resource level related to skilled attendance at births, there may be value in devising new service delivery protocols and also some scope for arranging for training to be provided to traditional birth attendants to alert them to danger signs in pregnancy and birthing situations. At the local level there is a need to review, in those States with a high MMR such as Kayah State, Chin State, and Shan State, what are the local actions that would help most to reduce the MMR. For example, research shows that only 38 percent of women with complications were referred to a hospital—only 24 percent reached the hospital for proper management, while 14 percent died on their way due to late referral and delays in transportation. It may also be for example that the positioning of additional rural health centres or the relocation of existing ones in a Division would greatly assist. Using a task force approach to examine the issues at the local level so as to draw on appropriate medical and support skills might be useful.

87. The ET was also informed during field visits that there is a need for additional guidance on RH service quality standards that would help to improve the adequacy of RH services. They include issues such the procedures for referral of emergency cases to a hospital and when to refer a patient to a maternity waiting home. A recent UNFPA research paper notes other service quality issues such as, for example, that sometimes the quality of midwifery services is confronted by inadequate supplies of essential drugs; non-adherence with the established standards due to limited knowledge and skills; and availability of authorization for a staff to perform the clinical interventions.

88. The EOP evaluation’s terms of reference included a number of questions as to the effectiveness and relative quality of UNFPA supported CD interventions related to RH such as training for BHS, training in use of the RH MIS, and capacity building of implementing partners. It was not possible for this EOP evaluation, which was covering an extensive range of issues, to examine in sufficient depth all CD activities undertaken by a range of partners. One other constraint was that some of the curriculum and training materials were in the local language and only an outline of the training curriculum was available. A review of some of the annual reports made by implementing partners indicates a high CD activity level was being undertaken but that offers no basis for drawing conclusions about the extent of CD coverage of the target group or the adequacy or the quality of the learning undertaken. Nor can too much comfort be drawn from the fact that at every interview and focus group discussion, questions were asked about the
quality of the particular CD activity with answers indicating attendance at relevant training and general satisfaction with the training received.

89. The recent evaluations that UNFPA commissioned of BCC training and of capacity development indicate, though, that quality in RH care for example cannot be improved without enhancing the curriculum development, learning methodologies and delivery arrangements that are now being used. They also offer useful guidance on particular development issues such as course content and learning methodologies.

90. The evaluation’s review of CD activity suggests much CD has developed in an ad hoc way. There is scope, therefore, for putting CD activity on a more systematic basis, with appropriate quality assurance arrangements also being put in place. In establishing a more systematic approach, the CD issues that the EOP evaluation identified for further attention are as follows:
- Establishing what are the competencies that are required to perform particular functions.
- The expected objectives and outputs of any learning activity.
- The current capacity levels of those who need to undertake the learning.
- Best modalities for delivering the learning.
- Curriculum, materials and the training aids that will be needed.
- Establishing the capacity and training needs of those facilitating the learning.
- The venue and other delivery arrangements.
- Evaluation and reporting.

91. Adopting a more systematic approach to CD would mean that standards as to the quality of the CD would be put in place, including as to consistency and coherence. It would for example help to follow through on ensuring that RH implementing partners are fully capable of playing their partnership roles. It would also help to ensure that clinical-related CD is delivered by professionals. The standards might also ensure that “training of the trainers” approaches as a way of multiplying the audience reached should be used sparingly and only in areas where the learning objectives for those who will be the trainers or peer educators are not too ambitious. After training has taken place, there should be appropriate evaluation, based on observation of performance rather than just the participant’s reaction to the training. The standards might also cover necessary in-service training to provide updated trends on RH care. In technical areas such as nurse and midwife training, training of medical practitioners and in BCC, there may a need for technical advisors to provide independent quality assurance over curriculum, materials, the training providers and the quality of learning imparted.

92. (b) Demand for Health Services. UNFPA supports CSGs in 62 project townships with over 94,000 members. CSGs work on a voluntary basis. Selection of CSG members depends on criteria like reading and writing ability and relationships in the community. After selection and 2 days training of members, individual CSGs each support the RH interests of about 30 households at the local level. Both the MOH at a national and a local level and beneficiaries confirmed that CSGs can provide valued and low cost assistance through providing basic RH information within communities and most of all through acting as a link point at the local level in referral of pregnant women or other persons with RH-related concerns on to RH services.

93. Much of the current modality for community involvement in RH care is quite old. For example the BCC Master Plan was developed in 2003 before CSGs were introduced. Thus, it does not refer to CSGs or to the importance that should be given to skilled attendance at birth, although of course the CP2 indicator for CSGs then seeks to measure the extent to which CSGs are advocating attendance at birth.
94. The effectiveness of the CSG’s linkage to the BHS is recognized by RH partners as critical although it is important that CSGs are not seen as a substitute for providing and resourcing local RH services. CSGs at village level told the ET of instances where they had helped to transport emergency cases to hospital. They explained that transport difficulties this often posed; the resort to modes of transport such as trawlergies; and how they raised or helped to meet the health costs posed by an emergency referral. Focus group discussions that were conducted showed the CSG members knew reasonably well about a range of RH, and HIV prevention issues. They also showed high levels of commitment to their work and wore their uniform with considerable pride.

95. However, of concern to the effectiveness of UNFPA assistance is that the role played by the CSGs appears to have become somewhat confused. CSG members in focus group discussions also acknowledged that they knew of some CSGs close by that were operating much less effectively than they were. As well, a recent evaluation of CSGs in a number of Divisions suggests a more mixed understanding of roles and mixed level of knowledge of RH issues such as STIs and post-natal (PN) care, which in turn may reflect on the quality of the BCC training that they received. However, this evaluation’s conclusions obviously beg the question of what is the intended nature and true extent of the CSG role and what they should be expected to know about. Clarification of roles and learning needs is required at a national level and then follow up on the implications for the content of BCC programmes.

96. The EOP evaluation’s terms of reference asked that the evaluation should specifically assess the relative effectiveness of the different BCC interventions that are being utilized by the programme. BCC interventions in RH by and large seem to be effective in regard to the particular audiences they reach. UNFPA’s recent evaluation of IEC/BCC interventions recommended the BCC Master Plan be re-examined, in consultation with MoH. This is an opportunity for the role of CSGs to be revisited and clarified. The Master Plan is still a helpful document. But the data used is out of date and the messages to be imparted to different audiences need to be massaged to take account of contemporary RH wisdom. Moreover, the training curriculum and related IEC materials must provide learning that is consistent with the modern roles and expectations set for CSGs as well as reflecting current-day RH concerns such as teenage pregnancy; the increasing HIV risks faced by partners of high risk people; advancing gender equality; and other contemporary issues outlined in discussing improvements to ARH training.

97. MOH no doubt wants to ensure that CSGs are properly trained and are operating effectively. The ET was also told that maintaining CSG commitment was sometimes challenging. CSGs must be seen as having good linkages to all RH services at local level. The DMOs in association with the BHS thus have a monitoring role to play in relation to the effectiveness of training and the ongoing performance of CSGs. CSGs may also need succession-planning and refresher training every few years. In addition, there may be value in formal recognition at the local level of the longstanding CSGs who have dedicated five years of community support.

98. As well, as the BCC Master Plan had intended, beyond BCC training the use of other communication modalities at the community level should be explored, including the mass media. Use of folk media and theatre groups are other possibilities at the village level. According to communication theory, the use of a combination of interpersonal communication and media has a greater impact on behavior change than using each channel alone.
99. **Efficiency.** The evaluation team believes that the UNFPA’s management load related to RH projects is large and unwieldy given the number of projects being implemented with different implementing partners. This could be lessened by having fewer implementing partners and by reconsidering the UNFPA’s geographical coverage of RH and other programme components in the next programme as discussed earlier.

100. There have been ongoing efficiency issues in a number of States relating to maintaining adequate levels of commodity supplies in hospitals. Stock outs were in fact an issue at every health facility that the ET visited. The issues seem to be partly forecasting and partly supply and inventory management, and also distribution issues. Where stock outs do occur, clients say for example that they can obtain contraceptives from franchised providers like PSI and from the private sector but at some cost to them. These issues have gone on too long. But a solution may now be in sight in that MOH has recently accepted the longstanding proposal of UNFPA that a logistics management information system should be set up to better manage supplies. Further capacity building on forecasting, supply management, inventory control and distribution arrangements will also required.

101. **Impact.** The EOP evaluation team was told repeatedly in interviews with public sector health providers, by CSGs and by beneficiaries that the impact of birth spacing services is very beneficial in Myanmar. However, we were also told of constraints related to lack of coverage of some townships, to limitations on free contraceptive supplies and the effect of charging for contraceptives on poor people. There are also limitations on levels of development assistance available to support free commodity services; The table below outlines trends in the CPR rate.

### Table 9: Trends in Contraceptive Prevalence Rate and Unmet Need for Contraceptives, 1991-2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>20.6</td>
</tr>
<tr>
<td>1997</td>
<td>32.7</td>
</tr>
<tr>
<td>2001</td>
<td>37.0</td>
</tr>
<tr>
<td>2007</td>
<td>41.0</td>
</tr>
</tbody>
</table>

(Source: FHRS)

102. Oral and injectable contraceptives, condoms and IUDs have been made available through the public sector since 1991 and currently are provided in 132 of the country’s 330 townships, including 20 townships supported through the German bi-lateral assistance. Last year, MOH announced that contraceptives would be provided free of charge through public health facilities. MSI birth spacing clinics in 6 townships are supported with UNFPA funding. PSI-Myanmar supports 193 townships with social marketing of contraceptives. Taking account of overlaps in this service provision, there is a gap of 103 townships that needs support for contraceptive commodities.

103. Moreover, as the table above indicates, Myanmar has significant unmet need for contraceptives including currently married woman who either do not want children or may want to space their births but do not use contraceptives. Only small improvements in the CPR have been
made in the last two rounds of FHRS. However, one consequence of the unmet need for contraceptives may be a higher induced abortion rate which particularly affects adolescents including university students and older women who want no more children.

104. The ET was told that access to and use of contraceptives depends in part on RH knowledge levels; the accessibility of service delivery points that offer counseling and contraceptive services; as well as the availability and affordability of contraceptives. Depo provera injections followed by birth control pills are the most popular. UNFPA provides injectables, pills, male and female condoms, and IUDs to the DoH and selected INGOs such as MSI, PSI, AMI and the MMA. Scaling up is needed to meet this unmet need, including through the provision of more contraceptives. This requires strengthening partnerships to share the cost of contraceptives and other RH commodities and employing viable mechanisms for cost recovery to ensure RH commodity security.

105. Extensions to RH services are required to help to reduce the unmet need for contraceptives. However, UNFPA’s estimates suggest there is a large gap in funding required to support future commodities provision. National budget assistance will be needed to help to meet the estimated shortfall of $26m, which is about 60 percent of contraceptive requirements in 2010-2013. The plans for introduction of a logistics management information system will strengthen the case for seeking other support though international health trust funds for higher levels of birthing services and commodity supplies. Funding requirements for commodities need discussion at an early date.

106. **Sustainability.** Sustainability issues need greater attention in assistance provided for RH care. There is little said about sustainability in project documents. There needs to be greater attention in project design to inclusion of design features that foster sustainability through building ownership, capacity development, management systems and institutionalization of the project activities. The greater attention that is suggested to service quality issues will also help to address sustainability.

107. **Lessons Learnt.** Lessons to be learnt from the experience in provision of assistance for RH care include the importance of having strong and well coordinated strategic directions for RH service delivery to which all partners are contributing. As well, there is a need for greater attention to improving RH service quality. Meeting the funding and human resource needs of the health system is critical, including funding for commodities including contraceptives. Moreover, addressing and responding to the underlying service delivery issues that are affecting the MMR are essential to meeting the MDG goal.

**C2. Findings on Adolescent Reproductive Health (ARH)**

108. CP2 states as the intended outcome for young people, who are defined as men and women aged between 15 and 24 years of age, “Safer sexual behavior and increased use of RH services by young people”.

109. In implementing ARH support, UNFPA works with partners like the Japanese Organization for International Cooperation in Family Planning (JOICFP), the Myanmar Red Cross Society (MRCS), the Myanmar Medical Association (MMA), Association Francois-Xavier Bagnoud (AFXB) and Marie Stopes International (MSI), as well as the Central Health Education Bureau
(CHEB) in the Department of Health. The range of ARH activities that have been implemented across 62 townships include basic ARH training; training of trainers for peer education and refreshers for those who conduct outreach activities in the community; peer education/outreach education; youth leadership development training; and training of health providers in ARH. Training includes gender equality issues. Other ARH promotional activities include song contests, activities at township festivals and fairs, participation in the HIV/AIDS Knowledge Fair, World AIDS Day, International Youth Day, as well as outreach visits by volunteers to villages.

110. There are 10.1 million young people in Myanmar: 5.1 million are males; and 5.0 million are females. This represents about 19 percent of the population. Most are part of the workforce. They are also at the initial years of their reproductive life. About 60 percent of male and female youth in urban areas have high school and above education. Less than 25 percent have education at that same level in rural areas. About 5 percent of youth in total have no education, although the proportion is higher in rural areas. Most youth are unmarried. Only 11 to 13 percent of male youth and about 20 percent of the female youth have ever been married. As noted earlier, the mean age of marriage for women in 2007 stood at 26.1 years. For males, it was 27.6 years.

111. The age specific fertility rate for young people has declined. There were in 2007 for example 16.9 live births per 1000 female adolescents aged 15-19 who made a contribution to total fertility of 4 to 5 percent of all live births, which is a comparatively low figure compared to most neighboring countries. According to the 2007 FRHS 11.39 percent of pregnancies in married adolescents aged 15-19 ended in abortion or miscarriage.

112. As the 2010 Report on the Situation Analysis confirms, young people’s capability to manage their SRH is dependent on their knowledge of human physiology, their awareness of SRH issues, their behaviors related to SRH and on being able to access youth friendly SRH services. Youth aged 15-24 years reported in the 2004 Family and Youth Survey (FYS) that virginity is considered to be still an important issue for both sexes, particularly for women when marrying. Nearly all male and females knew of HIV but some lacked a detailed understanding of HIV and ARH issues. The FYS found that 95 percent of youth had heard of HIV but only 11.3 percent knew when women were most likely to conceive. Seventy-five percent knew of the risks that anemia posed in pregnancy. A higher percentage (85 percent) knew of up to 5 contraceptive methods, but with females having slightly better knowledge of modern contraceptive methods than males.

113. The FYS indicated that only a small proportion of males aged 15-24 years adopted high risk sexual behaviors. But less than 30 percent of that small number of males who were sexually active said they had used a contraceptive at last intercourse to prevent pregnancy or to avoid STIs/HIV/AIDS. On the other hand, when having sex outside wedlock, 83 percent of males who were sexually active reported that they had used a condom. The FYS did not ask young women these same questions. The FYS reported that 3 percent of unmarried boys and 2.5 percent of unmarried girls had their first sexual experience before marriage, whereas in what may seem like a contradiction, for those who had married 45 percent of married boys and 21 percent of married girls then reported they had in fact had had their first sexual experience before marriage.

114. There are no comprehensive tracking surveys that show precisely how ARH knowledge and behavior has developed since the 2004 FYS was conducted. The 2010 Report on Situation Analysis, which was supported by UNFPA, noted that youth participants in focus group discussions that the technical team had conducted perceived that an increasing number are engaging in premarital sex, particularly those youth who are university students. This is perceived as having resulted in some young women seeking unsafe abortions. Responses of young people in the youth focus group discussions that were conducted by the ET indicated that they perceived
that, socio-culturally speaking, Myanmar youth should not be involved in pre-marital sex, particularly females. However, many agreed that more young people today, and in particular males, are more sexually active.

115. In supporting ARH services, UNFPA and its implementing partners work closely with relevant government agencies and UN agencies. These include the National AIDS Program (NAP). The 2011-2015 National Strategic Plan for HIV/AIDS has identified as one key intervention reducing HIV-related risk and vulnerability for young people. UNFPA programme focuses on out of school youth whereas UNICEF supports school health education including prevention of HIV and support of adolescent reproductive health through participation in curriculum development with the Maternal and Child Health Section, the School Health Section of DOH, the NAP and the Department of Educational Planning and Training (DEPT) in the Ministry of Education. DEPT in collaboration with UNICEF delivers a School Based Healthy Living and AIDS Prevention Education” (SHAPE) Programme. The UNFPA also works with CHEB which manages the peer education programme of the YICs.

116. Relevance. UNFPA’s ARH assistance is consistent with national priorities set under Myanmar’s Adolescent Health and Development Strategic Plan 2009 - 2013 Strategy, as well as with UNFPA’s global priorities. The Plan has three objectives, all of which are relevant to UNFPA’s ARH support. These are to promote the health and development of young people by providing accurate and culture specific information; to increase utilization of health services by young people through orientation of existing ones to youth friendly health services; and to reduce the morbidity and mortality in adulthood resulting from preventable conditions and behaviors during adolescence.

117. The level of attention given under CP2 to advancing solutions to ARH strategic issues, as opposed to managing operational delivery, is questionable. In part, this may reflect some strategic confusion flowing from the overlapping responsibilities in government. There are three units concerned with youth issues in government with which UNFPA coordinates- MCH in DOH for ARH services; CHEB in DOH on ARH education; and the School Health Unit on school education in the DEPT. It would be most helpful if the government provided some guidance that explained how the various aspects of government policy were to be applied both strategically but also cohesively. This would greatly assist all ARH partners in ensuring they met government expectations under the Strategic Plan on Adolescent Health and Development 2009-2013 , the National RH Strategic Plan 2009-2013 and the National Strategic Plan on HIV/AIDS 2011-2015.

118. Validity of the Design. The ARH outcome and output specified in CP2 might be thought to imply achieving a high level of coverage of the 10.1 million young people in Myanmar. In fact, 400,000 young people have been reached so far through ARH activities in youth centres and youth information corners (YICs). The exact level of coverage is problematic because of the casual drop-in nature of the centres. There are also many unreported and informal outreach contacts on ARH issues that were described by peer educators as having happened at township or village level. Even if the UNFPA’s view that the training, education and outreach work has had a multiplier effect of 10 times beyond those who attend youth centres is accepted, the ARH information seems to be reaching less than 50 percent of young people. Peer educators and outreach volunteers reiterated in focus group discussion that they had continuing contact with significant numbers of youth who do not have a good understanding of ARH. This same finding came from the focus groups undertaken as part of the 2010 Report on Situation Analysis published by the UNFPA.
119. While UNFPA and UNICEF undertook a mapping exercise of youth services in 2007, the current coverage level of youth services across Myanmar is unclear. Only 62 townships out of a total of 330 townships across Myanmar are currently covered under UNFPA assistance with little prospect of further scaling up. There is a need to update previous mapping to assist in programme planning. It is essential that youth services across Myanmar are best located in the current context to respond to various social inequities or to best serve those young people who are at high risk of contracting HIV/AIDS. However, it is important to acknowledge that there has been some attention to inequities with 9 out of 62 youth centres (14.5 percent) that are run by CHEB situated in the remote or border areas where ethnic minorities live.

120. Youth focus groups and structured interviews with DMOs, TMOs, BHS and implementing partners indicated linkages are made between ARH and RH services such as birth spacing services, STI clinics, counseling, AN care. Advocacy with local authorities on youth-related issues is also pursued. Gender concepts are included in ARH training, including male involvement in RH.

121. What does seem debatable about CP2’s design in retrospect is whether the performance indicators set by CP2 should have extended to other issues that are central to the output and outcome set under the programme. There is no indicator for example on the number of young people with STIs or who fall pregnant or who have abortions. No indicator, nor data collection process, was set in place under CP2 that related to establishing whether safer sexual behavior were adopted by young people (such as use of commodities at last sex) or to the level of access by young people to RH services. Furthermore, performance information should have been disaggregated by sex and between adolescents (15-19 years of age) and youth aged 20-24 years of age.

122. In any event, indicators cannot on their own give a complete sense of how ARH services are influencing knowledge of ARH and HIV issues amongst young people, as might have been assessed by conducting a further FYS. The indicators also give no sense of the extent to which adequate youth-friendly RH services are in fact being made available to young people across Myanmar.

123. Management. The ET’s interviews with partners established there is ongoing coordination by UNFPA on ARH issues and a satisfactory level of interaction on operational management issues in provision of ARH assistance.

124. There were for example three coordination meetings involving implementing partners held in 2010. At these meetings partners discuss indicators; reporting issues and the use of the AWP monitoring tool. Other matters discussed included implementing common activities like development of an ARH booklet, the youth forum, leadership training and the HIV Knowledge Fair. While implementing partners spoke favorably as regards the level of communication, it is questionable as to what extent more strategic level interaction is also needed between partners which focuses more on the results that are being achieved.

125. UNFPA has sought to involve youth in influencing the nature of ARH support through a youth working group which is composed of youth leaders from five implementing partners. This group successfully conducted two youth forums in December 2008 and February 2009. It held a workshop on intergenerational partnership in July 2009. It has also developed a draft ARH booklet which will be published in 2011. There is also coordination amongst UN agencies who are working in the area of HIV prevention among young people. Under the UNCT, a working group for prevention of HIV among young people has been recently set up, with UNICEF as the
secretariat, to provide strategic information and technical assistance on experiences in HIV prevention among young people, as well as enhancing partnership coordination.

126. The EOP evaluation confirmed that implementing partners monitor and report on performance. However, the reporting by implementing partners tended to be more directed at the activity level rather than focusing on the results achieved. A greater focus on results achieved against country programme targets is needed in reporting, perhaps also with independent evaluations on the performance of individual implementing partners being conducted every two years.

127. **Efficiency.** Consideration should also be given to scaling down the number and range of implementing partners as a more efficient way to provide ARH services. This would reduce transactions costs and improve the efficiency of UNFPA’s management assistance.

128. **Effectiveness.** The CP2 outcome indicator is the percentage of people under age 25 who are HIV positive. This figure was reported in 2009 as being in decline, at 0.91 percent. The 2009 HIV Sentinel Sero-Surveillance Survey also indicates that HIV prevalence was significantly high although declining between 2007 and 2009 amongst those youth who are in high risk groups. HIV prevalence amongst high risk groups is set out in Table 5 below.

### Table 5: HIV Prevalence in Young People

<table>
<thead>
<tr>
<th>Type of MARPs</th>
<th>HIV prevalence by age group (Young People)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15-19</td>
</tr>
<tr>
<td>Male STI patient</td>
<td>1.79</td>
</tr>
<tr>
<td>Female Sex Workers</td>
<td>5.1</td>
</tr>
<tr>
<td>Injecting Drug Users</td>
<td>5.26</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>14.6</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>0.46</td>
</tr>
<tr>
<td>New Military Recruits</td>
<td>0.7</td>
</tr>
</tbody>
</table>

(Source: NAP, HIV Sentinel Sero-Surveillance 2009. Myanmar)

129. CP2 set as the intended ARH output “Increased access by young people to RH and HIV prevention information.” So far as increasing access to opportunities for seeking ARH information, there was a steady expansion from 27 youth centres to 62 over the life of CP2. This comprises 10 urban centres (MSI, MRCS, AFXB and MMA) and 52 rural health centres (CHEB/JOICFP). In response to feedback from youth, new IEC materials were also developed. Over the course of CP2, more than 400,000 out-of-school young people were reached by programme education activities in 62 townships. This means that ARH support over four years reached about 49.4 percent of the total youth population in 62 townships. Youth forums and discussion sessions were also conducted as well as the other awareness-raising activities. Peer educators also had frequent local contact with young people who were seeking informal advice on ARH issues. More than 20,000 young people participated in special events, the HIV/AIDS Knowledge Fair, the World Population Day and the International Youth Day.

130. The position on the indicators that are prescribed under CP2 for measuring the ARH output across UNFPA-supported townships is as follows:

### Table 6: ARH Output Indicators under CP2
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>End-line data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of youth information corners in rural health centres</td>
<td>27</td>
<td>48</td>
<td>62</td>
</tr>
<tr>
<td>Percentage of trained peer educators who can demonstrate communication skills about condom use</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Percentage of young people knowing at least three methods of HIV prevention</td>
<td>40%</td>
<td>80%</td>
<td>88%</td>
</tr>
<tr>
<td>Percentage of young people who can correctly identify ways of HIV transmission</td>
<td>40%</td>
<td>80%</td>
<td>88%</td>
</tr>
<tr>
<td>Percentage of young people who can reject major misconception on HIV transmission</td>
<td>50%</td>
<td>80%</td>
<td>92%</td>
</tr>
<tr>
<td>Percentage of young people who have correct knowledge on adolescent RH</td>
<td>Not set</td>
<td>Not set</td>
<td>86%</td>
</tr>
</tbody>
</table>

(Source: UNFPA Country Programme Performance Summary)

131. These are sound results in respect of the particular ARH services offered. While information is not given above on the extent of peer educators who can communicate about condom use, it would be surprising if these communication skills were not uniformly of a high order. The ET held discussions with over 50 peer educators working variously with MSI, MMA, MRCS, JOICFP and AFXB. All demonstrated excellent working knowledge and communication skills related to ARH and HIV services.

132. The youth focus group discussions and discussions with the CHEB and implementing partners established that YICs and youth centres work well as a way to encourage youth to develop their ARH knowledge. The UNFPA-supported 2010 Report on Situation Analysis reached a similar conclusion. The centres are well accepted across Myanmar. The library services, karaoke, educational games, sports and recreational facilities and social activities offered variously by youth centres and corners are well patronized by local youth. Youth volunteers and educators are dynamic and energetic. While community acceptance at first took time and effort, the centres and YICs are now well regarded in local communities.

133. Some concerns were expressed about maintaining commitment to the youth centres and YICs in the long term. Another issue was how to handle turnover amongst educators, as young people get older, take on other responsibilities and move on in life. These issues need to be managed. The possibilities include refresher training and ongoing recruitment and succession planning within the centres. In addition, it would help morale if there were ways of formally recognizing the contributions made by educators and volunteers where basically the same people have provided ARH services for longer than five years. Peer educators also indicated that they would like to do more outreach work but lack transportation, this being an issue that is discussed further under RH services.

134. Judging the effectiveness of the reach of UNFPA-supported ARH services into the target group is difficult. One pertinent issue is whether youth centres, YICs and other ARH activities are targeting those male and female youth who most need access to ARH information as a basis for avoiding risky behavior. Assisting in higher risk areas for contracting HIV was a factor in considering location of UNFPA-supported ARH services but that does not necessarily mean the services are being accessed by those who need them most, even given outreach activity. Moreover, messages that might most influence a young person at risk such as one who is using drugs and sharing needles may need to be more customized than those offered to other youth in the general population who are less at risk. These issues need ongoing attention, particularly having regard to linkages that should be made to NSP II.
135. The ARH services did reach and affect 400,000 youth. However, even though the ET heard many individual success stories on outreach activities influencing risky behavior of other young people, any claim on the multiplier effect for the UNFPA's ARH assistance beyond this 400,000 young people is difficult to judge precisely. Moreover, it is also difficult to be confident about crediting a UNFPA-supported training programme as a principal factor in the development of particular level of ARH knowledge as opposed to a person being affected by a whole range of contributing life experiences.

136. How best to assess behavioral change in relation to ARH was much discussed with peer educators who said they relied on responses given to training course questionnaires or through counseling that was provided. The MMA cited its seven star program, which assesses behavioral change across seven lifestyles (eating a balanced diet, taking daily exercise, utilizing time fairly for working, eating, leisure and sleeping etc, avoiding smoking, drugs alcohol and risky sexual behaviors), as likely to be a more accurate gauge of behavioral change. However, perhaps the more objective way to judge the extent of behavioral change would be to conduct regular sampling surveys through implementing partners or to agree with government to support undertaking further Family and Youth Surveys at regular intervals.

137. Moreover, there is some contradiction in the research related to ARH knowledge conducted in Myanmar about the true state of youth’s knowledge about ARH and HIV. The survey research already cited might suggest it is adequate. However, by contrast, in the Behavior Surveillance Survey (BSS) in 2008 that targeted out-of school youth of 15-24 years of age, only 48 percent could correctly identify ways of preventing the sexual transmission of HIV and could reject major misconceptions about HIV transmission. Only 52 percent reported using condom at last casual sex. The BSS also suggested that stigma and discrimination still existed among out-of school youth towards people living with HIV.

138. The use of other forms of communication in delivering ARH information, such as the media, should be explored. This may offer a way to reach and to influence a larger proportion of young people. It also could be linked to the priority that the new NSP for HIV is giving to reaching and influencing the partners of HIV high risk groups. Moreover, PSI have made tremendous inroads over the past 10 years with their work promoting condoms through a range of well-targeted public awareness materials and campaigns (from a completely non-enabling environment, to an more 'accepting' one, over a period of about 5 years). They have considerable skills in the area of communication and could provide an excellent resource in terms of researching communication and marketing strategies.

139. The question of how youth might best gain relevant information about ARH needs further examination. For example UNFPA has already used radio to a limited extent. UNFPA is also working with JOICFP in Mon State to examine more generally how people receive information about SRH issues. The use of the mass media as well as other channels of communication (eg. traditional media, small media, internet, telephone hotlines, SMS services, billboards) should be examined as possible options for future communication about ARH. The channels of communication that are used should be appropriate to the audience in Myanmar with the message tailored to audience need and receptiveness. Tailoring of communication modes and messages will be particularly important in endeavoring to reach those young people most likely to engage in high risk behavior.

140. A related ARH effectiveness issue is the extent to which young people can access youth-friendly, gender-responsive SRH services in public health facilities. MSI, PSI and AFXB have
already given this attention in respect of their services. In respect of MSI clinics for example over the course of CP2 53,444 young people received ARH services (such as birth spacing, avoidance of STIs/HIV or AN care) and 2314 were referred for VCCT. The need to follow up on achieving more youth friendly SRH services in public health facilities was recognized as a concern by UNFPA’s MTR and in the 2010 annual programme review. The issue must be pursued with greater urgency than appears to have occurred to date. Some of the EOP youth focus group discussions suggested that particular rural health services were not always as well disposed to unmarried young people who sought, for example, to gain access to sexual and reproductive health services. Young people thus were sometimes inclined to go to private providers like MSI if these were available and affordable. However, the focus group discussions indicated that sometimes other provider options were said not to be able to be accessed, with unfortunate and even fatal consequences said to have ensued.

141. While the training and capacity building of providers, whether BHS, general practitioners or youth educators already emphasizes the importance of providing youth friendly services regardless of whether youth are married, it is apparent that this important issue needs even more emphatic action. Guidance needs to be developed by the partners, in consultation with young people, on provision of youth friendly SRH services followed by an intensified focus on SRH friendly services for youth in service provider training. Checks are then required, perhaps through a short survey, on whether satisfactory services are then in fact being provided. There is merit also in examining further suggestions made in annual reviews of ARH services regarding possible linkages between ARH services and social franchising of reproductive health services through a network of general practitioners through PSI.

142. Implementing partners advised that participants generally evaluated ARH training, peer education and refresher curriculum favorably. One implementing partner suggested there was some scope for improving the learning methodology and the training aids through applying CD development principles. Furthermore, there are few training programmes in any field that can be expected to remain unchanged while effectively continuing to meet learning needs in perpetuity. There are for example emerging issues of concern like teenage pregnancy levels, the health consequences of resorting to abortion, increasing STI rates, GBV and the relatively low level of VCCT usage that may need greater attention, particularly in refresher training. There is also a need to explore whether there are any separate learning needs for young women that are not being met. The MTR of CP2 for example had sought more focus in ARH on unwanted pregnancies and the spread of STIs. Implementing partners should also seek suggestions in all evaluations of training, and also from trainers and educators, on the need for upgrading curriculum and include this in their reporting to UNFPA.

143. It would be worthwhile to have an annual discussion between partners, with involvement from youth trainers and educators and young people, on the scope for further upgrading/standardizing of ARH training curriculum (including peer education) and learning methodologies across implementing partners. While it must cover RH, HIV, gender equality and lifestyle issues appropriately, culturally sensitive approaches should also be considered for different parts of Myanmar. Setting CD standards as outlined in the RH part of this report is also relevant.

144. Impact. Performance information on ARH needs to be improved to gain a better sense of impact. A survey like the FYS would provide a basis for making better assessments of short term effects and longer term impacts. In addition, further and more reliable national data on the effect of SRH services would assist programme management. Better information is also needed to ensuring that youth friendly RH services are in fact in place, with regular monitoring being required.
145. **Sustainability.** Maintaining commitment and managing turnover in youth centres and YICs are identified above as issues affecting sustainability. It is also important to build closer linkages between management of ARH delivery, the RH Committee and UN agencies such as UNICEF to ensure that there is joint ownership and appropriate coordination in common areas of work.

146. **Lessons Learnt.** As outlined, more focus is needed on youth at risk, on ensuring youth-friendly services are in place and exploring greater use of new communication techniques and mechanisms need to be considered.

### C3. Findings on Prevention of HIV/AIDS

147. The outcome for prevention of HIV/AIDS, as specified under CP2, is “reduced high-risk behavior among vulnerable groups”. The output that is specified under CP2 is “improved access by vulnerable populations to knowledge about, and ways to prevent, HIV”.

148. The experience of CP1 showed that the UNFPA can play a key role to play in providing particular services to assist HIV prevention, especially among vulnerable groups, and that these activities should be expanded. Myanmar today has the third highest HIV prevalence rate in south-east Asia behind Thailand and Cambodia, with HIV concentrated in Myanmar in border areas, large cities like Yangon and Mandalay, and northern and eastern states where there is a large cross-border mobile population, and mining areas where there is highly mobile migrant worker population. In 2009 the highest HIV prevalence rate amongst female sex workers (FSW) was to be found in Lashio (at 16.9 percent) and the highest rate to be found amongst men who have sex with men (MSM) was in Yangon (although it had declined from 23.5 percent in 2007 to 12.5 percent) and Mandalay (at 32 percent).

149. Nearly everybody has heard of HIV/AIDS and its irreversible risks to health. Yet community knowledge about HIV/AIDS is still regarded as mixed, with the 2007 Behavioral Surveillance Survey (BSS) of the National AIDS Programme (NAP) indicating that only 36 percent of the population knew about three methods of HIV prevention, while 42 percent of youth knew three such methods. The EOP’s observation of the level and effect of BCC work at the community level generally across Myanmar suggests the knowledge situation may be slowly improving but that the full range of HIV/AIDS messages may not be yet reaching significant proportions of the population.

150. The NAP is coordinated by the DoH in MoH, with support from a number of UN agencies working in accordance with the agreed UNAIDS division of labor, the 3 Diseases Fund (3DF), and INGOs and NGOs. A new NSP for HIV/AIDS 2011-2015 has been put in place, as well as an operational plan. The NSP II has been developed through a participatory process involving all partners including UNFPA.

151. The NSP II seeks to achieve the HIV-related MDG targets by 2015. This requires a significantly increased effort from all partners. The NSP thus aims to cut the new infections by half of the estimated level of 2010 and to increase intervention coverage for groups with risk behavior as well as support to those in need to mitigate the impact of AIDS. Prevention will continue to focus on the most at risk population (MARP) but now, in addition, their partners. UNFPA provided technical inputs to the draft NSP and in the recent development of national guidelines on HIV testing and counseling.

152. Termination of the Round 3 grant of the Global Fund in 2005 caused a significant reduction in funding for HIV in Myanmar. The $100 million Three Diseases Fund (3DF) (2006-2011) was
set up by six donors to address this shortfall. With the return of the Global Fund to Myanmar, 3DF support is now ending. The Global Fund is expected to bring substantial new resources for HIV prevention in Myanmar.

153. The HIV epidemics in Myanmar continue to remain largely concentrated among people identified with high risk behaviors. Report data on trends in two of the high risk groups in HIV prevalence indicates as follows:

Table 10: HIV Prevalence in High Risk Groups

<table>
<thead>
<tr>
<th>High Risk Group</th>
<th>2008 (%)</th>
<th>2009 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSW</td>
<td>18.38</td>
<td>11.2</td>
</tr>
<tr>
<td>MSM</td>
<td>28.8</td>
<td>22.3</td>
</tr>
</tbody>
</table>

(Source: 2009 HIV Sentinel Sero-Surveillance Survey)

154. HIV prevalence among MSM is highest in the age 40-44 group and amongst FSWs in the 30-34 age group. Most at risk groups tested for STIs also have a syphilis rate higher than the general population. The 2009 Sentinel Survey indicates that the prevalence of syphilis (VDRL +) amongst male STI patients was 2.0 percent FSW 2.3 percent, MSM 6.3 percent.

155. The UNFPA seeks to promote access to HIV information and services amongst particular HIV high risk groups through a number of specific activities rather than general funding. These include various coordination meetings, capacity development of implementing partners, peer education, support for outreach activities and provision of STI services and drugs and condoms both male and female, HIV counseling and testing. These groups include SW, clients or partners of FSW reached by 100%TCP outreach activities, the MSM, young people with higher risk behaviors and mobile populations. The UNFPA distributes female and male condoms free of charge in public health facilities and through social marketing approaches at subsidized prices in the private sector that promote accessibility, availability and affordability of the quality condoms by targeted beneficiaries in the community.

156. The delivery point in the public sector for UNFPA’s HIV services targeting MARPs is the 41 NAP STI clinics. The STI facilities observed in Bago, Nyaung-U, Pokkaku and Mandalay were well equipped and counselors were well trained. They gave good examples of effective behavioral interventions in which they had been involved with members of high risk groups. UNFPA contributes condoms, STI drugs and test kits to NAP STI/AIDS teams.

157. The delivery points in the NGO sector include PSI operating 19 Drop-In Centres (DICs) under the Targeted Outreach Programme (TOP) which serve as safe and friendly spaces for FSWs and MSMs in HIV prevention; and MANA operating VCCT services from seven DICs serving mainly Drug Users, DUs, and Injecting Drug Users, IDUs, including their partners who are SWs and MSM. The UNFPA has also provided financial support for technical capacity development of service providers, user friendly services and referral network strengthening through partners. The ET visited DICs run by implementing partners in Bago, Mandalay and PyiGyi Tagon. The DCIs were user friendly and well patronized. Implementing partners were able to demonstrate that they had access to a broad range of referral services that they can draw on as need be. The ET found strong support in townships like Mandalay for 100% targeted condom promotion programme.
158. **Relevance.** The UNFPA’s interventions have been aligned with the national priorities set out in both NSP I and II, with UNFPA having extended its target groups to encompass partners of people in the high risk groups. UNFPA’s focus on support for prevention amongst high risk groups remains appropriate. Recent work undertaken by NAP using the Asian Epidemic Model strongly indicates that the major routes of HIV transmission in Myanmar remain among the population with high risk behavior and their sexual partners.

159. **Validity of Design.** The programme results that are specified in CP2 are clear. They require changes in behavior at the outcome level and increased knowledge at the output level. However, the performance information listed in CP2 does not include MSM, as it should have.

160. UNFPA’s efforts have particularly focused on prevention of HIV/AIDS amongst particular high risk groups in 51 townships indicated by NAP as HIV hot spots. The particular geographic areas where UNFPA supports service delivery need to be kept under review. Implementing partners and MARPs themselves emphasized that MARPs were mobile. Use of mapping activities related to identifying geographic areas with higher prevalence and research regarding MARP behaviors is therefore important.

161. While the intended results in CP2 imply coverage of all vulnerable groups, the UNFPA’s interventions in fact related to only some of the high risk groups. The other partners that support the NSP, such as the 3DF, have made bigger investments in HIV prevention, although significant coverage gaps remain. The NSP II is critical of the shortfall in services and in funding. National budget funding for HIV/AIDS is low. Advocacy may help to increase funding and human resources to be devoted to HIV prevention and other services under the NSP, both from national and donor resources. As a consequence of these constraints, NAP reports that NGOs have mobilized to provide more extensive help through support centres to members of high risk groups.

162. Partners will no doubt want to discuss possible scaling up of HIV prevention interventions, especially for MSM, although UNFPA itself has no capacity to assist beyond current levels. With the return of the Global Fund to Myanmar, any scaling up should utilize the significant resources earmarked by the Fund for HIV, tuberculosis (TB) and Malaria to Myanmar. It is estimated that the Global Fund will allocate nearly $300m over a period of 5 years to Myanmar 2011-2015. About 50 percent of this amount will be allocated for HIV. UNFPA is not a recipient or sub recipient because UNFPA HQ and UNOPS (Principle Recipient) could not reach consensus on some legal clauses in the sub-recipient agreement.

163. Through extending coverage to partners UNFPA has ensured both genders in the high risk groups are supported. FSWs were given special attention as one high risk target group, as were PMCT cases, but otherwise no disaggregated data was collected. Gender issues were covered in training for all three risk groups. Female partners of high risk groups run increasing risk of contracting HIV. This is taken up in the draft National Plan of Action for the Advancement of Women.

164. While a high level of HIV awareness was observed, whether there were appropriate levels of integration of public and private HIV prevention and SRH services in all townships was not readily apparent. This could be taken up in the design of the next programme. Priority is required for SRH/HIV linkages in the Myanmar context to provision of SRH services for key affected populations and their partners, as well as PMTC in divisions/states with higher HIV prevalence (including male involvement such as partner counseling, HIV testing and male SRH responsibilities). The discussions with partners confirmed there was scope for a greater level of
integration of HIV prevention and care services with RH clinics, maternal and child health clinics, youth centres, workplace clinics and other centres where women and men of reproductive age have access.

165. **Management.** During EOP interview implementing partners were appreciative of UNFPA programme management, communication, monitoring, and their levels of involvement in programme implementation.

166. There is some sense of complementarity across the work of partners under the NSP in that the UNAIDS international guidelines on division of labor have been applied. There are some important strategic issues related to HIV prevention (for example level of coverage of high risk groups; national condom requirements) where more discussion with partners should be encouraged. In addition, there is a need to better focus project activities on reporting against results, with much better performance information being needed from implementing partners and PSI in particular, so that results can be better focused on at the programme level.

167. **Effectiveness.** Both the CP2 outcome (reduced high risk behavior) and output (increased access to HIV knowledge appear to be being met. Results achieved against CP2 indicators are as follows:

<table>
<thead>
<tr>
<th>CP2 indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>End of Line Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of female sex workers involved in peer education programmes</td>
<td>25,000</td>
<td>30,000</td>
<td></td>
</tr>
<tr>
<td>Number of female sex workers reached by HIV prevention program*</td>
<td>25,000</td>
<td>30,000</td>
<td>51,251</td>
</tr>
<tr>
<td>Number of condoms distributed to at-risk individuals</td>
<td>11,000,000</td>
<td>21,000,000</td>
<td>30,500,000 (accumulative)</td>
</tr>
</tbody>
</table>

(Source: UNFPA Country Programme Performance Summary)

(* New indicator in line with NSP)

168. NAP, implementing partners and UNFPA believe that accessibility of services in high risk spots, the availability of condoms and the influence of BCC and outreach interventions, have been the critical success factors. A number of partners have contributed to this well-coordinated HIV prevention effort. The UNFPA’s support for particular prevention inputs has made a useful and effective contribution to this success.

169. The UNFPA commissioned an evaluation of support to NAP, PSI and MANA in 2010. It found that both the TOP and the Comprehensive Condom Programme had helped to increase the use of condoms amongst FSWs. Work undertaken by the Aids Commission in Asia had previously showed that when correct and consistent condom use reaches more than 50 percent amongst sex workers that HIV prevalence starts to decrease. The 2010 evaluation assessed both programmes as having significantly decreased the spread of HIV in Myanmar.

170. Condom distribution under CP2 was much higher than the UNFPA targeted for. Structured interviews conducted with implementing partners suggested that support programmes amongst FSW have meant that risky sexual behaviors are more likely to be avoided. The 2007 BSS survey had already reported on more consistent condom use by FSWs. The percentage of FSWs who reported the use of condom with the most recent client was 95 percent in 2008 (BSS 2008). The presentation made by the AIDS/STI team in Nyaung-U indicated that the usage of condom by
FSW working in the township had increased from 70 percent to over 90 percent in 2008 under the 100% Targeted Condom Programme. These figures may overstate the level of behavioral change, with the 2010 evaluation conducted by UNFPA suggesting that operational research in Myanmar shows condom use by FSWs with clients is 60-90 percent on average but below 60 percent with regular partners.

171. Implementing partners outlined at interview how FSWs’ and MSMs’ knowledge levels were raised through peer education and counseling. A high proportion of FSWs attended peer education. Post programme questionnaires and subsequent ongoing contact with members of risk groups suggested significantly higher levels of HIV knowledge and claimed changes in behavior. However, the data on the effect on MSM is less clear cut than it is for FSWs.

172. Access to HIV prevention services increased over the life of CP2. Service coverage by NAP extends now to 51 townships where HIV counseling and testing are provided free of charge. The number of DICs that are run by PSI increased over CP2 to 19 and is now being upscaled again to 25. MANA’S 7 DICs also achieved better linkages with the health services such as HCT, STI treatment and diagnosis, opportunistic Infection (OI) treatment and RH services. Estimated coverage of female sex workers reached in 2009 through NAP was 6928; PSI was 43,758; and MANA was 565. There is likely to be some overlap in these figures. While CP2 mainly targeted FSW, due to increasing population of MSM, the PSI’s DIC also covers the MSM population.

173. As with this report’s discussion of BCC work affecting ARH, the use of new communication strategies bears consideration to extend knowledge of HIV/AIDS to other FSWs and MSM as well as across the community, as well as to change behaviors and reduce stigma and discrimination.

174. Interviews also demonstrated that there is high level of expertise and local knowledge related to HIV/AIDS issues amongst implementing partners. The interviews with implementing partners outlined how increased capacity had been developed through UNFPA-supported training in counseling, HIV testing, monitoring indicators, peer education training and gender basic concepts as a result of UNFPA funded capacity development. The MARP met advised that HIV prevention services provided by implementing partners were of good quality. However, as noted by the UNFPA, implementing partners need to be able to reach more than one risk group, such as the FSWs and MSMs, including through better use of relevant networks.

175. Geo-social survey maps in the Mandalay office of the DoH, indicated that the comprehensive condom programme was making significant progress in accessing people at risk across the city. Progress had also been made in Naung-U, as the presentation given by the DMO indicated.

176. But there are many constraining factors in dealing with HIV. The NSP for HIV & AIDS in Myanmar 2011-2015 notes for example that MARPs are spread over a large geographic area. As well, the MARP have diverse ethnicity including many different languages and are often mobile in nature. NSP II also identifies weaknesses in coordination between the public health sector, service providers and the private sector. The public health system and in particular NAP is poorly resourced with regard to infrastructure and equipment. There is a scarcity of appropriately skilled human resources with a need for ongoing capacity development. Widespread poverty leads to economic problems and social stigma and can force people to engage in unsafe behavior and to be in situations of high risk. The NSP also notes that poverty, a poorly resourced health system and insufficient financial, technical and service delivery capacity have all combined to limit progress in HIV prevention.
The effect of interventions programmes on the behavior of MSM seems to be beneficial as regards the level of usage of DICs and related TOP programmes and the 100% condom programmes reported by implementing partners. However, one should be cautious about then linking these results directly to general survey findings on MSM behavior. For example condom use by MSM at last anal sex was 67 percent in 2008 BSS. Furthermore, the BSS reported that coverage of the MSM group seems to be significantly lower than for FSWs and consistent usage of condoms is lower. On the other hand, NAP figures in its 2011 – 2015 Operational Plan suggest a baseline figure of 81 percent usage of condoms. However, one should be cautious about then linking these results directly to general survey findings on MSM behavior. For example condom use by MSM at last anal sex was 67 percent in 2008 BSS. Furthermore, the BSS reported that coverage of the MSM group seems to be significantly lower than for FSWs and consistent usage of condoms is lower. On the other hand, NAP figures in its 2011 – 2015 Operational Plan suggest a baseline figure of 81 percent usage of condoms. But the Plan also notes that only 60,000 out of 224,000 MSM have been reached by HIV prevention programmes in Myanmar.

There are other MSM initiatives which UNFPA has become involved in such as six cities coordination in 2010. The UNFPA facilitated the work of the sexual transmission working group through the secretariat role that it played with the MSM working group. The UNFPA also supports MSM through PSI’s and MANA’s outreach activities. One major challenge in service delivery that was raised in EOP field visits was that, while the MSM men who are open about their sexual preference are more accessible to prevention programmes, those MSM who are closed in the sense of not acknowledging their preference are less accessible. PSI’s, MANA’s and NAP’s experience is that outreach programmes are required to reach closed MSM.

The linkage of the condom distribution programme to NAP STI clinics was discussed in a number of EOP interviews with STI clinics- the linkage has proved helpful in that there appears to be a strong association between STI prevalence, and in particular syphilis, and HIV/AIDS. However, beneficiaries reported some resistance to using government services although the ET judged the NAP services in Mandalay as particularly user-friendly. Some other NAP STI clinics which UNFPA has helped to support appear to face some image problems that are constraining their use and need to build more user friendly and welcoming environments.

Partners also reported that there is a relatively low take up of VCCT services, including for the high risk group. This indicates stronger advocacy and individual counseling to use VCCT service is required. NAP and 3D regard it as an area of continuing concern. This is particularly so given the need to encourage the partners of high risk group members, to check their HIV status, recognizing that high risk groups report a lower use of condoms with their partners. Greater provider-indicated testing may be needed, provided that proper counseling support is provided.

The implications of the increased focus that will be given in the new draft NSP on HIV/AIDS to partners of high risk groups has yet to be recognized fully at local level. Implementation will be difficult without more awareness-raising. There are also some concerns amongst implementing partners as to how effectively in practice partners can be accessed. This is of real concern as NAP estimates that 50 percent of new HIV cases in 2015 will come from low risk women.

Implementing partners reported that PLHIV are often poor, are disadvantaged and cannot access free condom services. This suggests that partners to the NSP II need to address poverty implications in HIV prevention work.

Efficiency. There are ongoing issues under the NAP about what is the real level of demand for condoms that affect supply arrangements. NAP’s role in forecasting the annual condom requirements to be provided by UNFPA needs to be put on a more objective basis that all accept as credible. A logistics management information system is required as soon as possible.

PSI’s TOP DICs distributed condoms free of charge in 2011 for HIV prevention. Before then there was social marketing only. UNFPA’s partners in the public sector NAP and PSI and
MANA have different unit costs. NAP’s 2009 progress report notes that the net cost of different service providers varied to a wide range—the lowest was $16 per FSW to highest of $300 per FSW. However, some higher cost came from non-specialized providers who had a small FSW component with it being difficult to extract costs attributable to sex work interventions from their budget.

185. UNFPA conducted an evaluation of support to NAP, PSI and MANA in 2010. It found services were cost effective. The evaluation noted some costs disparities between the partners. The evaluation also found that VCCT rates are low for MARP groups in Myanmar although more could yet be done. Unit cost issues, and the M&E information to be provided in the next CP, will be important issues in negotiating delivery arrangements with implementing partners.

186. There are cost-effectiveness studies conducted in low and high income countries with concentrated epidemics that demonstrate that HIV prevention interventions are much more cost-effective than ART. Among the most cost effective prevention interventions are those targeting groups with high risk behaviours compared to those targeting the general population. Recent work using the Asian Epidemic Model strongly indicates that the major routes of HIV transmission remain among the population with high risk behavior and their sexual partners. UNFPA interventions are well focused on FSWs and are making a discernable difference, but the more recent UNFPA focus on the MSM needs further attention with partners as to coverage levels.

187. Impact. The BSS, and declining prevalence trends in HIV/AIDS, indicate that programme interventions for high risk groups to which UNFPA has made a contribution, in particular the FSWs, have had a lasting impact. The trend as regards the MSM is, in NAP’s view, less clear at this point. In addition, the results of one 2009 study in Mandalay suggest that the MSM are more likely to engage in risky behavior as only 50 percent reported consistent condom use in the last six months.

188. EOP interviewees brought up the growing mobility of HIV/AIDS into new population groups in peri-urban townships like Bago and Kawa and border areas. Men travelling to work in gold mines and other localities have increased chances of contracting HIV. UNFPA support for the DoP’s planned research on migration issues, as outlined in the P&D part of this report, will help to provide a better evidence base, when linked to with HIV studies on behavior and condom use.

189. Sustainability. The main concern already outlined with sustainability of HIV prevention is funding at the national level. One major concern is that the UNFPA does not have the budget to increase the level of free condoms beyond the levels now provided. If messages about safe sex take greater hold in Myanmar, there is a risk that any increase in demand will not be able to be met. Partners may find it necessary to discuss how increased overall funding requirements might be met, including the identification of new funding sources.

190. Lessons Learnt. Despite the encouraging progress made, as circumstances may well change, the evidence base on high risk behavior must continue to be addressed in particular as to MSM and migrant population.

C.4 Findings on Prevention of Mother to Child Transmission of HIV/AIDS (PMCT)

191. CP2’s outcome specified with respect to prevention of mother to child transmission of HIV/AIDS (PMCT) is “Increase in HIV-positive pregnant women and their newborns receiving services that prevent mother-to-child transmission of HIV/AIDS”. The output specified is
“Increased access to comprehensive services to prevent mother-to-child transmission of HIV/AIDS”.

192. The PMCT programme began in Myanmar under the leadership of the DoH. The UNFPA’s experience in CP1 showed that it has a key role to play in HIV prevention, especially among vulnerable groups, and that these activities should be expanded to PMCT. UNFPA is now one of the main agencies carrying out PMCT activities. Under CP1 it worked in 13 townships, funded by the Fund for HIV/AIDS (FHAM) in Myanmar. The UNFPA programme has sought to integrate PMCT activities into overall RH services. The UNFPA has worked with partners such as the NAP and UNICEF to build upon this integrated, comprehensive approach to preventing mother-to-child transmission of HIV/AIDS.

193. In 2008 nearly 10 percent of maternal deaths in Myanmar were associated with HIV. Less than half HIV positive women received ARV drugs to prevent transmission from mother to child.

194. All pregnant women should be screened for HIV status during AN care. However, AN care may not be sought. Alternatively, testing, which requires consent, may be refused and, in any event, may not always be available in some localities.

195. Myanmar has four prongs to its strategies related to PMCT. They include primary prevention of HIV infection amongst reproductive age women; prevention of unwanted and unintended pregnancy amongst reproductive age women; prevention of HIV infection amongst HIV positive women to new born baby; and care and support for HIV positive women and their families. These strategies are implemented by increasing access to, and scaling up, services to prevent mother to child transmission of HIV/AIDS and by providing a package of care services supporting the RH and social needs of HIV positive mothers, including counseling. Other implementation strategies involve reducing the percentage of HIV infected infants born to HIV infected mothers. In addition, there is support for capacity development of service providers, provision of test kits, provision of ARV drugs; development and distribution of appropriate behavioral interventions through service delivery points; and partnerships with the NAP and other parts of MoH. UNFPA has also contributed to the national guidelines on PMCT.

196. Under CP2 UNFPA supports the provision of some PMCT services in 80 townships working in association with the NAP and the DOH. UNFPA provides support for prong three of PMCT services, namely training for BHS, supplies provision and support, through implementing partners such as MANA, SC and the MMA, in activities related to awareness-raising to reduce stigma. This support is only one part of the complete care and support packages.

197. **Relevance.** UNFPA’s interventions are aligned with the national priorities set out in both NSP I and II. The PMCT effort in Myanmar is regarded as reasonably well coordinated across partners. Partners complement each other’s activities.

198. **Validity of Design.** Mapping of hot spots in the incidence of HIV positive women, as against townships in which the PMCT services are being provided, would assist to ensure that all high risk locations are being serviced. Equity considerations also need to be addressed.

199. PMCT services have now been extended to both genders, that is also to cover male partners of HIV positive women, with couple counseling and SRH advice being provided. There is a case for extending coverage for supporting HIV positive women beyond the birth of the baby so as to cover post natal RH services for mother and child, including ARV for mother. Government funding of PMCT services is low. The contribution of the government of Myanmar to the national response to HIV/AIDS is estimated at approximately US$1.52 million per year (UNGASS Report,
Increased funding is essential, with partners needing to be active in advocacy on this issue.

PMCT tends still to be seen as related to support of HIV objectives rather than also concerned with RH, particularly MCH. Comments made in interviews at township level suggested that linkages at the national and the township level between RH services and PMCT could be improved.

Management. Better performance information on PMCT issues is needed. It should include the number of HIV positive mothers receiving testing and the number who have further children. In addition, the reporting of implementing partners tended to focus more on the programme activities rather than the results achieved from the programme. The programme would be assisted by evaluation early on in the life of the next CP2 to examine the implementation experience across all townships.

Partnerships are important to the PMCT support, with UNICEF as the leading partner. UNFPA must maintain an effective working relationship with NAP, with UNICEF and also with WHO.

Attention is also needed to primary prevention of infection to female sexual partners who are at risk of HIV exposure, through birth spacing and MCH services, with male involvement and couple counselling. Production and distribution of IEC and BCC materials for families affected by PMCT on HIV prevention and, when relevant, ARV literature would be helpful.

Effectiveness. Both the intended outcome and output under CP2 have been met in that access to PMCT services has been improved under CP2. The PMCT services supported by the UNFPA have been significantly scaled up from 24 to 54 townships through implementing partners such as MANA, PSI and MMA, with the selection criteria for particular townships including the level of incidence of HIV in the township. UNFPA’s support in fact covered 80 townships at the end of 2010 but, from 2011, 26 of these townships are being supported by the Global Fund. When account is taken of UNFPA’s support and also UNICEF’s and Global Fund’s support for PMCT services in other townships, over 200 townships are being covered in Myanmar. Results against output indicators are as follows:

<table>
<thead>
<tr>
<th>CP2 indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>End of Line Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of providers skilled in voluntary counseling and testing</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Percentage of service facilities offering voluntary counseling and testing</td>
<td>24 project townships</td>
<td>24 project townships</td>
<td>54 project townships</td>
</tr>
</tbody>
</table>

(Source: UNFPA Country Programme Performance Summary)

More mothers needing PMCT support have accessed services under CP2. Figures of identified PMCT cases over the last four years where the mothers have agreed to testing and their babies have at a later date also been tested are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>HIV Positive mother</th>
<th>HIV Positive Baby</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>477</td>
<td>6</td>
</tr>
<tr>
<td>2008</td>
<td>811</td>
<td>13</td>
</tr>
</tbody>
</table>

52
<table>
<thead>
<tr>
<th>Year</th>
<th>Value 1</th>
<th>Value 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>653</td>
<td>9</td>
</tr>
<tr>
<td>2010</td>
<td>881</td>
<td>13</td>
</tr>
</tbody>
</table>

(Source: NAP progress reports, 2007 to 2010)

206. While at the hospital level there is reasonable data on most such births. Some mothers are not tested. The above figures should be treated with some caution as there are limitations in the data. Some HIV positive mothers may for example change their residence after birth but before the baby is old enough to be tested.

207. However, UNFPA support for primary HIV prevention work related to HIV negative women, and of birth spacing for women living with HIV/AIDS, could take effectiveness to another level and would reduce the need for PMCT services.

208. No complaints were heard from HIV positive women about the quality of the RH services provided. The gaps that exist in the coverage of the PMCT services is more the issue. Myanmar is well below UNGASS targets which envisaged a 50 percent reduction in rate of infection of mother to child by 2010. There need to be discussions with MOH and partners on the scope for further scaling up and funding of PMCT programmes in other townships where RH services are not already provided, to meet UNGASS standards.

209. Some HIV positive mothers do not receive antiretroviral (ARV) drugs. Before any extension to the programme is considered, this issue needs attention. There is still significant unmet demand for delivery of PMCT services for HIV pregnant women. The 2009 HIV Sentinel Sero-Surveillance Survey indicated an infection rate of 0.96 percent for pregnant women, with the highest numbers in the 20-43 age group.

210. There is scope for improving men’s involvement in PMCT delivery. While some men are involved, the recent Report on Situation Analysis indicates that the male involvement is low as males in rural areas still tend to regard RH as solely the women’s concern.

211. Four PMCT components (primary prevention, prevention of unintended pregnancies, ART prophylaxis to mother and baby and referral for enrolment into ART) should be available in all RH services of township hospitals. In areas with high prevalence availability should be considered for extension to stations hospitals and rural health centres if these facilities are distant from township hospitals. Consideration should be given to provision of ARV treatment to HIV positive mothers.

212. Efficiency. As outlined in relation to RH in this report, a number of stockout and logistic management issues related to commodities have been identified in hospitals. To ensure pregnant women receiving PMCT services are not disadvantaged, ongoing monitoring is required of the availability of PMCT supplies. Greater capacity for undertaking supplies planning and management also has to be developed so that PMCT service providers have constant access to supplies of HIV tests, of prophylactic ARV according to national guidelines, and of condoms and contraceptives.

213. Impact. The 2007 BSS indicates that awareness of PMCT issues is lower in townships without PMCT services. Earlier comments about the possible need to develop new communication techniques about HIV/AIDS apply also to PMCT.

214. Sustainability. Capacity has been built to provide PMCT services across townships supported by UNFPA with nursing staff (through DOH) and doctors (through information provided
Lessons Learnt. More children can have lives free of HIV/AIDS with effective treatment programmes that are linked to AN care. UNFPA believes there is a need to better link PMCT services to HIV prevention programmes that stop women becoming HIV positive in the first place.

C5. Findings on Population and Development (P&D)

Output 2 of the CP2 Results and Resources Framework, as originally framed, had sought “Improved availability of disaggregated data for RH programming”. This recognized that Myanmar had a significant shortage of data on RH which prompted UNFPA to focus on data collection. Population and Development (P&D) assistance under CP2, while relatively small in overall terms, has gradually expanded to the point where there are encouraging signs of a deepening interest in evidence based programming in the MoH, the Ministry of Immigration and Population (MoIP) and the Ministry of Social Welfare, Relief and Resettlement (MSWRR), these being the government agencies with which UNFPA works most closely on P&D. So far rather ad hoc but nevertheless useful progress has been made in improving data. But now there is a need for a more concerted and more coherent approach to the assistance that is provided to progress data improvement to be worked out between the government and development partners.

It is not just a question of improving data. The UNFPA’s 2010 Situational Analysis points out that there is also a need for government to put in place a national population policy that contributes towards the quality of life of the people of Myanmar through better health conditions, higher educational levels and increased employment opportunities. A draft policy has been in existence since 1992. As the range of policy issues outlined in the UNCT’s draft Thematic Analysis shows, Myanmar today 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 have population policy implications. Myanmar lacks a modern and holistic framework for addressing the population aspects and making the necessary linkages to the ICPD and MDG goals through putting necessary policies and programmes in place.

UNFPA has supported the Department of Population (DOP) in some of its activities since 1973 on an ad-hoc basis through funding and technical assistance, including for the 1973 and 1983 population censuses. UNFPA has for example supported the Department of Population (DOP) in its regular conduct of the FRHS to provide reliable data on basic demographic, socioeconomic, fertility, mortality, maternal and child health and RH. The DOP has also cooperated closely with population-related line ministries and institutions and NGOs to share findings and results and, in the drafting of national level reports and surveys, DOP has held workshops and meetings with data users and funding agencies, and collaborated on the preparatory and implementing stages. UNFPA has participated and monitored at every stage of survey work. Nevertheless in the evaluation’s recent discussions, DOP recognized it continued to have significant capacity constraints and sought related assistance.

When CP2 was put in place, there was some helpful but relatively patchy focus on P&D data in Myanmar. There was also inadequate analysis, coordination, harmonization and triangulation of data. The data then available on the size, distribution, composition and characteristics of the population overall was weak as there had been no census conducted since that held in 1983 with UNFPA assistance. A range of government agencies with development assistance from a number of sources had been producing P&D data- there had been a Fertility and RH Survey (FRHS) in 2001 (Department of Population; UNFPA); a 2004 Family and Youth
Survey (Department of Population, UNFPA); the Nationwide Cause Specific Maternal Mortality Survey in 2004-2005 (MOH, UNICEF); the Multiple Indicator Cluster Survey (MICS) in 2003 (Department of Health Planning, UNICEF), as well as the Integrated Household Living Conditions Survey in Myanmar, Ministry of National Planning and Economic Development (MNPED) and UNDP in 2007.

220. There were, though, some well-acknowledged capacity limitations, which had required significant technical assistance to be provided by UNFPA and other UN agencies in the design work and data collection, analysis and dissemination related to each of these surveys.

221. The FRHS data for example was used by Myanmar in the development of the National Strategic Plan for Reproductive Health 2009-2013 and in conducting analysis on emerging population issues. FRHS data was also used to detect and analyze migration trends and to develop a monograph on ageing and provide the basis for the on-going effort to develop a plan of action on ageing.

222. Relevance and Effectiveness. Output 2 of the CP2 Results and Resources Framework had sought “Improved availability of disaggregated data for RH programming” with this being met principally by the UNFPA through supporting the DoP in the conduct of a further round of the FRHS in 2007 which was published in 2009 and the publication of research studies in 2009 based on the earlier Family and Youth Survey; and the UNFPA’s 2010 Report on Situation Analysis. These publications contain considerable disaggregated data by location, gender, age and circumstances that is relevant and useful. UNFPA was also involved in 2010 in joint authorship of the WHO’s Trends in Maternal Mortality in which UNICEF and the World Bank also cooperated. Other partners such as UNICEF through the various Multiple Indicator Cluster Surveys and UNDP through the Integrated Household Survey and more recent work in train on the incidence of poverty have significantly assisted in improving the level of disaggregated data. However, there continue to be gaps in disaggregation of data, in particular as regards gender responsive data, locality, ethnicity and age.

223. The lack of a recent census continues to constrain the usefulness of disaggregated data in Myanmar in terms of population size, distribution and dynamics. Today all data on population are estimates which can vary significantly. This has already been exemplified in discussing the significantly lower UN estimate for the population of Myanmar at about 50 million people as compared to Government estimates of about 57 million. Moreover, as the work of the 2009 Data Mission on Strengthening MDG Indicators demonstrated, Myanmar has some discrepancies between data taken from different sources such as the FRHS and the RH MIS. The ET found similar discrepancies in attempting to confirm for example the extent of use of ante-natal care by pregnant mothers.

224. Without up-to-date data on population size, distribution, characteristics and dynamics, it is significantly more difficult for the government to formulate, implement and monitor useful development plans and programmes. A census would provide a reliable and up to date statistical sampling frame based on which further surveys are then carried out. It would also provide the size and main characteristics of the population at detailed geographical levels. In the absence of such a sampling frame, surveys rely on household listing in respect of which it is not possible to be sure whether it is up to date or outdated.

225. Government officials in Nay Pyi Taw advised that holding a census continued to be dependent on the government making a decision that it wished to conduct this major undertaking. The ET notes, though, that the evidence base for making policy decisions on major development issues will continue to be constrained without further work to upgrade the P&D information base.
These issues include population size, distribution and dynamics; on maternal mortality; and on migration and ageing.

226. The report of the 2009 *Myanmar Data Mission on Strengthening MDG Indicators* is instructive as to the quality of MDG data available in Myanmar. It found that some maternal health data was satisfactory, but that further strengthening was needed in respect of maternal mortality, HIV prevention and a number of other significant aspects of MDG data. This is not to say, however that other sources for data may not emerge. For example, the MDG mission noted that data on maternal mortality could be collected as part of a census process.

227. The other major P&D initiative that has significant potential has been UNFPA’s support for the design and implementation of the RH MIS across the 132 townships in which UNFPA is providing RH assistance. Data is collected and reported on by health staff using specially developed report forms and drawing on CD that has been conducted for that purpose. The DHP has made significant progress in this work and now produces, in conjunction with the DoH, a series of helpful RH statistical publications that provide significant disaggregated data at the local level. The close attention that collection, monitoring, quality assurance and review of this data is receiving at health management level and by BHS was noted in field visits. However, the ET’s discussions also identified a few statistical anomalies. Focus group discussion indicated that data quality is perceived in some townships as still requiring some further improvement, with there being some possible under-reporting of the MMR. As has been noted, there appears to be significant under-reporting on MMR as compared with data from surveys. There are also delays in issuing the HMIS reports.

228. In 2010 UNFPA supported the Department of Population (DoP) in research on internal migration patterns leading to a draft report entitled “Level, Trend, and Pattern of Internal Migration in Myanmar.” The report contains research on the predominant internal migration patterns which are said to be between urban-urban areas and between rural-rural areas rather than rural-urban or vice versa, as well as indicating that women are less likely to migrate than men. The DoP's survey on migration issues which UNFPA plans to support in 2011 should help to provide a better understanding of the way in which the population movements and urbanization are occurring.

229. As was demonstrated in interviews in townships like Bago and Mandalay, people appear to be moving to peri-urban townships close by to major urban centres to access work opportunities. HIV/STD units in township hospitals, and some of UNFPA’s implementing partners, who were interviewed during field visits also drew attention to the way that mobility of members of HIV high risk groups like female sex workers around Myanmar may be affecting the prospect of HIV infection spreading to new locations. There are organizations like Medecins sans Frontieres and Medecins du Monde which have strong experience with the migratory populations in Kachin State for example, and may be interested in collaboration in supportive qualitative research that might be productive as they work with migrant drug user and female sex worker communities. Other possible collaborators include PSI and the International organization for Migration (IOM) who are working with at risk migrant populations in other parts of the country.

230. The UNFPA has also supported the DoP in developing a paper on “The Ageing Transition in Myanmar” which found that the main features of ageing in Myanmar are a shift in the distribution of the aged, with an increasing proportion of the aged being found in the oldest of the old age groups; an increasing proportion of the aged that are female; a trend to increasing old age dependency and potential support ratios; and changes in living arrangements resulting in increasing number of older people living alone. For the first time in the history of the country, the paper estimated that the population of older persons will exceed the population of children in
around 2040. UNFPA is also working with the Department of Social Welfare on planning/policy issues on age-related matters.

231. However, notwithstanding this range of constructive research, there continue to be significant gaps in the data related to components of CP2. This is taken up elsewhere in this report in discussing the progress made in supporting gender equality, the support for HIV prevention amongst high risk groups and better understanding those in need of PMCT services.

232. In 2010, UNFPA supported the development by a technical team of a Report on Situation Analysis of Population and Development, RH and Gender in Myanmar. There does not appear to be any other publication on these subjects in Myanmar that is as comprehensive, as well-researched and objective, as thorough, and as current and as useful as this analysis, which was prepared with the active involvement of UNFPA’s APRO.

233. **Validity of Design.** The emerging work in P&D does not imply any design shortcomings in CP2. Rather, new opportunities are emerging that are being taken up by UNFPA in consultation with government. So far improvements in P&D have been gradual. While realistic priorities must be set for future P&D results, there is a strong argument for including P&D as a component in CP3, while recognizing there will also be scope for pursuing P&D support through joint programming and through the work of the UN ME Group.

234. **Management.** The establishment in 2009 of the UN Monitoring and Evaluation (M&E) Group, which is chaired by UNFPA, has enabled UNFPA to play a pivotal collaborative role in the P&D field. An examination of the work plan of the M&E Group shows it has focused particularly on progressing capacity development and on promoting information sharing and ensuring coordination and complementarily among the data collection and M&E activities of UN and other stakeholders.

235. Through the MDG M&E group, UNFPA has led the UNCT’s development of the draft *Thematic Analysis* which outlines the principal strategic challenges facing Myanmar while drawing for that purpose on considerable P&D and related data. The Thematic Analysis provides a sound basis both for the work now underway to develop the *UN Strategic Framework 2012 – 2015*, covering health, education, agriculture, food, water and sanitation, governance and human rights, as well as progressing joint programming between UN agencies and with other stakeholders.

236. Relevant Ministries advised that they had an effective and open working relationship with UNFPA on P&D. UNFPA’s management of assistance on P&D has taken a gradual step-by-step approach to strengthening the government’s use of P&D by building up the extent and the quality of the evidence base. As discussions with the CO indicated, particular sensitivity needed at first to be shown to government caution about engagement on areas of data that are seen as sensitive. Moreover, using a gradualist approach recognizes there have also been capacity limitations and lack of technical expertise within government. UNFPA has so far helped through providing relevant training and a small number of study tours.

237. A recent consultancy supported by UNFPA has drawn attention to the need for further training assistance to the DoP in data collection, processing and analysis; to the requirements for additional statistical software and hardware; as well as to the importance of improved arrangements for coordination between different data sources in government. These same needs were confirmed in discussions in Nay Pyi Taw.
238. **Efficiency.** As noted, a shortage of human resources, and in particular skilled human resources, seems to be a major constraint to provision of P&D assistance. It may be more efficient once the P&D capacity needs are better understood to consider provision of longer term institutional support, perhaps through an external academic provider, that can assist the government to build up the capacity of its human resources on an ongoing basis.

239. **Impact and Sustainability.** Whilst recognizing the importance of Myanmar itself making its own improvements to arrangements for data coordination and management, it is important before taking any further action on CD to establish what the overall capacity needs of the government are in managing data. This will help the framing of future development assistance by the UN M&E group and other development partners. As the CO emphasized in discussion, it is essential to considering future development assistance to understand what action is needed in strengthening human resources and for further capacity development in data collection, processing distribution, dissemination and analysis. In addition, it is also relevant to know what further action is required to bridge data gaps; to improve the quality of data; to ensure consistency and harmonization of national data and international estimates; as well as improving dissemination and access to data sets. The importance of giving priority to CD was confirmed in discussions with Government officials in Nay Pyi Taw.

240. General support was found amongst all interviewees for continuing with joint P&D work in Myanmar. P&D work in Myanmar was recognized by individual partners as likely to be greatly facilitated by a GoUM/development partner approach to improving data and research. As the CO noted, there is scope for improving coordination among data producers; promoting P&D dialogue amongst data users and producers; and engaging academia and civil society to bridge data and information gaps.

241. The MTR of CP2 had noted in 2009 that it would helpful to UNFPA to be informed on the government’s plans for statistical activities so that UNFPA can consider how to support them. Any programme of assistance that is developed needs to avoid trying to do too much too quickly. However, in particular there is a need to consider inclusion in any such programme of a Population and Housing census to collect data on size, distribution of population and some population dynamics; a Demographic and Health Survey (DHS) for RH data with modules on ARH and ageing; and a migration survey to collect data on internal and cross border migration. There is also a need to provide technical advice on improvements in the methodology related to estimating the MMR and to related MMR data collection in Myanmar.

242. **Lessons Learnt.** Advancing the next stages of P&D must to be done in a coherent and gradual way, with capacity development, data improvement and development of a joint work plan having to be focused on.

**C6. Findings on Gender Equality**

243. There is no separate programme on gender equality in CP2, although it is one of the three core programme areas of the UNFPA. The increased focus on gender equality emerged from UNFPA’s support for humanitarian assistance and involvement in women’s protection issues post cyclone Nargis and a high level of responsiveness from the UNFPA country team.

244. As UNFPA’s 2010 *Situation Analysis* put it, Myanmar has a rich cultural heritage which respects and acknowledges the differences between the sexes across more than 130 ethnic groups. While women notionally have equal rights under marital and inheritance laws, that heritage means that in practice decision-making in the family context is mainly a male domain.
with women having a lower status and being economically dependent on men. Women often played a different, somewhat reserved, and rather submissive role in Myanmar society.

245. The Myanmar National Committee for Women’s Affairs (MNCWA) was established in 1996 to promote the advancement of women. The Myanmar National Women’s Affairs Federation (MNWAF) was established in 2003 to assist MNCWA and to enhance cooperation with NGOs and INGOs State/Division, District and Township Working Committees for Women’s Affairs. There have been some gender-related improvements such as in women’s access to education which has been slowly improving. Myanmar is also a signatory to obligations to advance gender under the International Conference on Population Development (ICPD).

246. Myanmar is also a signatory to the Convention on Elimination of Forms of Discrimination against women (CEDAW). The UN Commission on Human Rights recently sought further information from Myanmar on the measures taken to promote women’s full and equal participation in decision-making in all areas of public, political and professional life; the opportunities taken in drafting the electoral law to increase women’s political participation; and measures taken to alleviate restrictions on movement of residents in Northern Rakhine State (NRS), especially women and girls, and to lift the orders concerning marriage authorization and restriction of pregnancy.

247. At the time that CP2 was developed the position of UNFPA’s Executive Board and the position of donors towards Myanmar involved restrictions on UNFPA’s and other UN assistance to the country. Thus, the Board approved a humanitarian programme for the UNFPA in Myanmar with one component (RH). However, the fact the government ratified CEDAW and established a committee/working group to implement and report on CEDAW is an indication of its openness to addressing gender issues. Moreover, the government demonstrated its openness to assistance from the UNFPA on gender by inviting the UNFPA to assist in responding to CEDAW Committee observations.

248. Figures taken from the Gender Gap Index, as outlined in the UNFPA Representative’s presentation on 2011 International Women’s Day, provide some basic facts about gender in Myanmar:

<table>
<thead>
<tr>
<th>Educational Attainment</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio: Female net primary level enrolment over male value (2009)</td>
<td>97.4</td>
<td>Myanmar MDGs report, 2006, MNPED</td>
</tr>
<tr>
<td>Ratio: Female gross tertiary level enrolment over male value</td>
<td>164</td>
<td>Myanmar MDGs Report, 2006, MNPED and UNDP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Political Empowerment</th>
<th>Value</th>
<th>Source</th>
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249. Women in Myanmar play the dominant role in the household in RH, in contraceptive choice and in the upbringing of their children and in the care of the elderly. In rural areas they also work outside the home in the fields. Women now have smaller families with an average size of 2 children, although rural women have a slightly higher average of 2.2 children.

250. As has been noted, despite improvements, progress towards the MDG5 target of 105 deaths per one hundred thousand births by 2015 has been behind schedule. The extent of gender based violence (GBV) is not publicly discussed in Myanmar. There are risks of unwanted pregnancy for many women due to unmet need for contraceptives, as well as growing HIV/AIDS risks for some women through the high risk sexual activities of their partners. Women are economically disadvantaged by reason of lower levels of remuneration they receive as compared to men. UNDP’s 2009 Human Development Report indicates that, while men earned an estimated income of US$1,043 in 2007, women earned only US$640. Moreover, only a small number of women hold any public positions. The Central Statistical Organization’s 2008 Statistical Profile of Children and Women in Myanmar indicates that in 2008-2009, women occupied only 31.7 percent of senior-level posts (Deputy Director and above) in the public service.

251. So far UNFPA’s engagement on gender equality issues has included responding to gender issues that emerged from cyclone Nargis including RH services and community-based interventions on women’s empowerment. It has also assisted on services, research and advocacy related to women’s protection issues such as gender-based violence (GBV) and on building new networks and partnerships amongst the UN, government and NGOs. UNFPA has played an important role in supporting policy dialogue and advocacy leading on to development of the National Plan of Action for Advancement of Women and on P&D issues such as disaggregation of data by sex. UNFPA’s support for CD of DSW staff has covered understanding of gender equality concepts and the provision of gender awareness training for women and girls at DSW institutions. In 2010, three awareness raising workshops on CEDAW and gender were jointly conducted by UNFPA and DSW in Shan (South) State, Mandalay Division and Yangon Division for 140 senior officers of DSW and other relevant Departments.

252. Relevance. UNFPA has played a catalytic and leading role in building on the at-first slender but then burgeoning interest in advancing gender equality in Myanmar. (The other UN agencies with specific roles related to the advancement of gender are not based in Myanmar). The ET noted in particular that UNFPA had built up over the life of CP2 a useful and open working relationship with the Department of Social Welfare (DSW) in the Ministry of Social Welfare, Relief and Resettlement (MSWRR) which is mandated to address gender issues and promote women’s empowerment.
253. It was the significant collaborative effort required to respond to the needs of women after cyclone Nargis that provided the tipping point on gender equality. A sub-cluster for protection of women (SCPW) was formed early on under the leadership of the UNFPA. The SCWP focused on a multi-sectoral approach (protection, gender-based violence, livelihoods, education, health and RH) and crosscutting (health, psychosocial and legal support) issues faced by women in cyclone-affected areas. Members of the sub-cluster included UN Agencies, INGOs, NGOs, and representatives from the DSW and the MNWAF. In June 2009, when the clusters that had been formed to respond to Nargis ended, the sub-cluster on protection of women was transformed into a Women’s Protection Technical Working Group (WP TWG). This TWG remains in existence. It is chaired by UNFPA. The UN Country Team’s Gender Theme Group (GTG), which is also chaired by UNFPA, has also been re-established.

254. Discussions with the Director-General and Deputy Director-General of the DSW indicated that the UNFPA’s assistance is fully consistent with emerging national objectives. Government officials, implementing partners, UN agencies and development partners confirmed that UNFPA’s support for gender equality has been implemented in complementary and mutually supportive ways. DSW also demonstrated there is now strong commitment, as well as much enthusiasm, for carrying forward the agenda for advancement of women. With the UNFPA and other partner’s active support and advice, the DSW has led the efforts to develop a National Plan of Action for Advancement of Women in line with CEDAW and the 12 areas of the Beijing Platform for Action. This endeavor has involved 12 Ministries as well as United Nations agencies, local and international NGOs. The final draft Plan is ready for submission to Government.

255. Discussions with UNFPA and partners indicated that the key to the success of UNFPA’s work on gender so far is related to adopting an incremental and coordinated approach; to providing research/evidence based interventions such as women’s protection assessment; responding to real needs of the population when affected by cyclone Nargis and the Government’s desire to implement CEDAW; and to establishing rapport and building partnerships with the Government and other interested stakeholders, including the UN agencies, NGOs and INGOs.

256. Provided the new government endorses plans for further action, and related work programmes are resourced and put in hand, there is a prospect that the position of women can be gradually advanced in Myanmar in the next few years in useful directions. However, as the October 2010 presentation made by the UNFPA Country Representative to a discussion forum on the advancement of women indicated, there is much for the government to consider including promoting equal access to employment opportunities, fair recruitment processes, equal pay for equal work; ensuring equal access to credit, assets and benefits; and fostering conducive working environments that are free from discrimination and harassment. Other important priorities include issues related to protection of women from violence and abuse and overcoming issues of social exclusion and discrimination.

257. **Validity of the Design.** UNFPA assistance in the aftermath of Nargis helped to built up both the evidence base and the programme responses to gender and to GBV issues. This assistance thus helped to break new ground both in mechanisms and in policy development. The growing dimensions of the leadership role played by UNFPA on gender issues, and the increased national interest and demand, suggest that it must be made a separate component in the next CP with results and indicators to be aligned to the National Action Plan.

258. **Effectiveness.** Since 2008, the ET found that UNFPA had played an influential and leading role in advancing the agenda towards gender equality in Myanmar. Discussions with
DSW and other partners confirmed the value of the intensive support provided by UNFPA through its leadership of the GTG and the WP TWG in the development of National Action Plan for the Advancement of Women. The Plan is a welcome and promising development. The Plan is well structured in that it sets out objectives and outlines the action required under each of the 12 areas of the Beijing Platform for Action. It sets out a set of practical steps for gradual implementation, as well as listing key measurable indicators in each sector.

259. The National Action Plan now awaits a decision on the new government’s support. This decision will in itself be a key signal as to the national mandate for advancing gender equality in Myanmar. For this purpose the DSW advised that it intends to propose putting the Action Plan before Cabinet at an early opportunity in 2011. To the international community, government support for the plan will be one positive step along the way towards responding to the three issues identified in the 2010 Asia-Pacific Human Development Report, namely women’s rights, voice and power.

260. DSW spoke highly of the usefulness to its staff of CD related training that UNFPA had so far supported. DSW would welcome extending gender-related training across the public service in Myanmar, particularly to staff in Ministries that will be involved in implementing the National Action Plan. CD needs also to extend beyond training to changes in organizational structures, work systems and the capacity of the organizations themselves. Changing attitudes to gender is not easy. It will take time as patriarchal behavior is likely to be entrenched and the promotion of promoting gender may be perceived as a challenge to traditional male roles.

261. While a formal needs assessment has yet to be undertaken, separate discussions with the DSW, the UNFPA and members of the GTG suggested that there are only a limited number of government institutions and staff that yet have knowledge and skills in gender equality analysis and in gender mainstreaming. Beyond supporting attitudinal change, DSW saw capacity development in Ministries as now needing to help to build the necessary research, analytical and policy development skills related to gender equality that will assist government in progressing the National Action Plan for the Advancement of Women. Civil society is already engaged with progressing the Plan through the MNCWA’s and the MNWAF’s membership of the WP TWG.

262. It will be important in supporting capacity development in gender to overcome any unfounded assumptions about gender that policy-makers might have for example that the interests of women are always the same as men. Policy analysis has to include analysis using a gender lens. While the incidence of poverty in Myanmar affects the same number of women as men, as the UNFPA’s 2010 Report on Situation Analysis noted, women are likely to be more affected by poverty than men by reason of lower literacy levels and food insecurity and the much less appealing jobs and lower remunerative levels that are open to them. Women also have fewer opportunities to escape poverty such as migration or by developing new skills. Moreover, women in Myanmar on average live longer than men, with a significant proportion living on their own into old age to the point where social welfare assistance and extended health care may be required. UNFPA is already working with the Ministry on the planning and policy implications related to an aging population, including as to gender.

263. Various stakeholders identified gaps in gender related data. While there are national level statistics such as those published by the National Statistics Organization, as well as sectoral-level data such as on health issues including RH, there has been little systematic research on how economic issues affect women; on how the national budget affects women; or on how the impact of poverty affects women’s livelihoods; or on the levels of GBV in Myanmar (including domestic
violence). Better understanding the situation of female-headed households which now stands at 21.2 percent of all households should also be of interest to policy-makers.

264. There are also women’s protection issues where a better understanding is required. The post Nargis women’s protection assessments suggested for example that GBV may be an issue that needs attention in Myanmar. The data on GBV is, though, far from clear. Police records on claimed assaults are not available. As happens in other countries, reporting through the hospital system may understate any level of violence that does exist. The April 2010 Report on Post-Nargis Social Impacts noted, though, that the incidence of GBV remains difficult to ascertain. The lack of data can only be overcome by a national prevalence survey.

265. The ET found that the UNFPA has helped to foster strong collaboration on gender equality issues within the UN system. The draft 2011 UNCT’s Thematic Analysis, prepared by the UN M&E Group which UNFPA chairs, sets out the range of gender empowerment issues that need to be focused on in Myanmar. The GTG, also chaired by the UNFPA, has supported gender training within UN agencies and ensured that gender is mainstreamed in developing the UN Strategic Framework and national strategic plans. The GTG is helping to build a gender knowledge base and and plans to identify opportunities for joint gender programming. The more recent work of the GTG has been directed to how best to support the Management Committee, the sectoral sub-committees and the particular Ministries that will be implementing the draft National Plan of Action for the Advancement of Women.

266. Members of the GTG from UNESCO and UNICEF stressed their keen desire to assist the government in collaboratively advancing the National Action Plan. Thus, not all progress in development assistance related to gender can be attributed just to the UNFPA. There is a high level of interest and coordination of gender-related work within the UN, with agencies such as the WHO, UNAIDS, UNDP, UNESCO, and UNICEF having previously undertaken gender mainstreaming projects. .

267. Management. UNFPA management has not only committed three staff in the CO to follow through on the range of assistance needed on gender equality, it has also provided strong advocacy and leadership including through chairing the relevant committees, in sponsoring key publications that have facilitated debate on gender-related issues and through promotional activities such as supporting International Women’s Day. For example, as part of that advocacy work, working through the Gender Theme Group, UNFPA also developed and published a Gender Briefing Kit in 2010. The Kit provides the reader with a better understanding in a culturally sensitive way of what gender equality means both in Myanmar and in the global context. It also outlines the action taken by various development partners to progress gender equality. The Kit needs more vigorous promotion and broader dissemination than it has received to date, including to Government Ministries.

268. Impact. It is too early to expect to see an impact from the relatively recent support that UNFPA has been providing in relation to gender equality. However, in assessing the effect of changes that do occur it will be important to have in place performance indicators that enable the outputs and outcomes to be assessed.

269. There is the risk, which was recognized in partner discussions, for the UNFPA and partners under CP2, that in providing assistance to support the advancement of gender equality under the draft National Action Plan, the impact of any gains that are made do not flow through to the grassroots level over time. Rather, it is essential that improvements that are made, such as on economic issues, that flow through to the grassroots level, especially to women in
disadvantaged circumstances, and are sustainable. A number of interviewees spoke highly of the “women’s friendly space” initiative that has emerged during CP2 as one possible model for empowerment of women at the community level that might bear assessment of how best it might be replicated, preferably with support from a number of development partners. The women friendly spaces which include capacity development towards women taking on new livelihoods are further discussed under humanitarian assistance.

270. **Sustainability.** If the draft National Plan of Action for Advancement of Women proceeds to implementation there is good reason to believe sustainability will be achieved, given that the necessary level of human resources is provided and related capacity building is implemented. It is important, though, that gender work is mainstreamed into Ministries rather than treated as a specialist activity.

271. **Gender Mainstreaming.** CP2 committed the UNFPA and other development partners to the design of all programme initiatives within a framework that empowers women; promotes gender equality and equity; and promotes male involvement in RH. Between 2005 and 2007, UNFPA undertook project work on male involvement in RH care with support from DOH, CHEB, DHP, UNFPA, JOICFP and MMA. Undertaking this research work recognized that it was males that usually made the decision about emergency health care and related expenditure. The studies indicated that a stronger knowledge of RH was developed amongst males who had been involved in the project. The project findings were subsequently mainstreamed into BHS training. However, answers to RH questions that were asked at village meetings suggested that while males want to support their wives in RH care, the practical expression of that involvement has not much changed. This was confirmed during discussion with heath staff. There was also general agreement amongst service providers and implementing partners that there is still more work to be done to build male involvement in RH to a more effective level.

272. There are other gender mainstreaming issues that must be addressed under the UNFPA Programme of Assistance in regard to RH, HIV prevention and PMCT related work. This was recommended by the MTR of CP2. For example, community meetings confirmed that birth spacing in relationships is still seen in Myanmar as a women’s responsibility. When it comes to emergencies that might occur in a birthing process in the home, it is often the male who decides whether or not to seek emergency assistance. In HIV prevention work, the NSP suggests higher priority now needs to be given to assisting the partners of those who engage in high risk behavior. In PMCT, services are now being extended to male partners of HIV positive women. In ARH, there is a need to better understand the ARH needs of young women and how that might affect for example the design of BCC programmes and in the delivery of ARH services.

273. **Lessons Learnt.** Taking opportunities that emerge to develop long-term working relationships with key government agencies, as well as the appropriate use of evidence based advocacy and capacity development, are clearly vital to pursuing ICPD reforms such as those related to gender equality. This relationship now needs to be extended, with the support of the UN Theme Group, to other key Ministries involved in the National Action Plan.

**C.7 Findings on Emergency Humanitarian Response**

274. The tragic events related to cyclone Nargis which hit 37 townships in the Ayeyarwady and Yangon Divisions of Myanmar left an estimated 140,000 people dead or missing and severely affected 2.4 million people. More women than men died. Not only were the lives of men, women and children ended, but homes, possessions, livelihoods, businesses, livestock, roads, bridges and public facilities were destroyed. In the Post Nargis context, 14 percent of the households in
cyclone affected areas were led by women with these being the most vulnerable in terms of poverty and protection concerns.

275. **Relevance.** The Post-Nargis Joint Assessment carried out by the Government of Myanmar, ASEAN and the United Nations (PONREPP, June 2008) emphasized the importance of using community-driven recovery strategies and ensuring cross-sectoral approaches were taken. The parts of the humanitarian response provided post-Nargis in which UNFPA played a key role were relevant to Myanmar’s national priorities and were well thought-through.

276. UNFPA’s assistance was beneficial to the recipients and timely. It complemented other development assistance. The assistance covered RH, HIV/AIDS prevention, gender equality and women’s protection. It supported local capacity development and helped to establish the facilities needed to restore RH service. It safeguarded the well-being of affected women through provision of RH services, livelihood support and psychosocial services. It provided micro-finance support. UNFPA showed sensitivity in seeking to preserve women’s dignity through provision of basic items for women’s hygiene in a dignity kit. Procurement of RH kits was also undertaken and, response/prevention mechanisms for GBV and related training were provided, in collaboration with the MSWRR. Funding support was received from the UN’s Central Emergency Response Fund (CERF) as well as core funds, AusAID and the Government of Norway. Eight humanitarian projects were launched post Nargis, partly in response to further natural disasters (including cyclone Giri in October 2010) in the Rakhine State.

277. **Validity of the Design.** The focus on provision of humanitarian assistance came about as a result of emergencies after the development of CP2. Specific outcomes and outputs related to humanitarian assistance should be reflected in the next CP.

278. **Effectiveness:** The combined UN efforts to address RH needs after cyclone Nargis included the establishment of the RH coordination mechanisms through the UN cluster approach (Sexual and RH and HIV Technical Working Group under the Health Cluster) and national and local capacity building activities. The challenges that had to be met by UNFPA and other UN agencies included arranging for and then warehousing emergency supplies; setting up static and mobile clinics; timely distribution to the hard-hit areas; and overcoming the destruction of some health facilities. The immediate measures that were taken were in accordance with the Minimum Initial Service Package (MISP) for RH in crisis situations. They addressed: 1) coordination through a cluster approach, 2) prevention of excess maternal and neonatal mortality and morbidity; 3) prevention of HIV transmission; 4) planning for comprehensive RH; and 5) gender issues and the protection of women.

279. There were a number of key achievements from the life-saving sexual and RH (SRH) care that UNFPA provided in the two years after cyclone Nargis. UNFPA worked with the MMA, MSI, and RI in providing lifesaving SRH care, and with AFXB and Agency for Technical Cooperation and Development (ACTED) in programmes empowering women through livelihood support. The evaluation report on the projects that was provided to AusAID and the UNFPA listed a number of outputs in service delivery most of which went well over the targets set, although there were variations between the efforts of different implementing partners. Over 82,000 women and over 23,000 men benefited from the SRH services; over 23,000 pregnant women received AN and PN care; SRH awareness sessions were delivered to 50,000 women; 1200 women were referred to higher health facilities; and 461 EmOC packages were provided. In addition, hospitals, rural health centres and sub-centres were provided with SRH medicines and equipment including clean delivery kits, dignity kits, condom supplies, pills and injectables. Many advocacy sessions were held with local authorities and 15,000 persons participated in BCC sessions.
280. The UNFPA was particularly cognizant of equity issues involving the groups it sought to support in the post Nargis context. Vulnerable groups that require special consideration in an emergency include very poor households, pregnant and lactating women, female-headed households, widows with young children, the elderly and people with HIV.

281. The UNFPA also played a key advocacy role after Nargis in drawing national attention to gender-related, HIV related, PMCT and women's protection issues in post-cyclone situations through the assessments it helped to support. These assessments were made in 2008 and 2009 and were funded by the UNFPA with some contribution from the UNHCR. The assessments were well crafted. They helped to bolster evidence-based advocacy on the implications of natural disasters for women's RH and livelihoods. The assessments drew attention to the psychosocial effects of the natural disaster for women, to perceived increases in violence and to increases in the number of vulnerable women forced to offer sexual favors. Many women also said they had gone into debt. Livelihood support was seen by the assessments as the key to helping women recover and to build a sustainable future. The assessments also found that there was also a critical need to raise awareness about women's protection issues. Government officials confirmed the advocacy value of the assessments in helping to build a broader interest in government in women's protection issues.

282. Myanmar is also better prepared today to manage the implications for women of future emergencies. The Steering Committee of WP TWG and the GTG have since helped to facilitate the development for use by focal Ministries in government of a Myanmar National Plan of Action for Women and Emergencies 2011 – 2015. The Plan seeks to strengthen accountability and mechanisms related to women's protection issues in an emergency through achieving outcomes related to capacity development and training. It also seeks to build understanding and to enable analysis of sex disaggregated and gender sensitive data. Other outcomes include coordination and networking with women in planning and taking action in emergencies; taking targeted action to ensure equal access and inclusion in emergencies; and providing access to information, advocacy and media in an emergency.

283. The post Nargis community projects supported by the UNFPA and donors that helped create women friendly spaces met the urgent livelihood needs of some of the vulnerable women in a post Nargis context. They also responded to an untapped and probably broader need for support and empowerment of women in Myanmar, as well as providing a previously unavailable avenue to address GBV issues. The Women Friendly Spaces provided RH, leadership, lifestyle and rehabilitation training to eligible women. The projects used microfinance as a vehicle to improve RH, to prevent HIV, to provide livelihood skills and to promote women's empowerment. Women were also provided with psychosocial counseling to help overcome their traumatic experiences and depression during and after Nargis. The ET did visit the AFXB's project site for women friendly space on the outskirts of Yangon at Shwepythar township. There the ET was able to observe women learning new livelihood skills such as silk weaving and candle stick-making.

284. The ET also conducted a focus group with young women participants from the women's friendly space site near Laputta in the Ayeyarwady Division when they visited the AFXB's women's friendly space near Yangon. Post Nargis the group had undertaken training in life skills, in RH, in rehabilitation and in taking on new livelihoods. The participants presented as confident and knowledgeable about their roles in life and RH issues. They were able to demonstrate how training provided had provided new opportunities, giving good examples of the opportunities microfinance had provided to pursue new businesses ranging from running businesses at the
market selling vegetables and other products, to hair dressing and to dress making. They presented as empowered and confident about their small business abilities.

285. A few reservations were expressed in discussions at local level about women’s friendly spaces, including as to the level of integration into the community although four spaces continue to operate in two townships. The evaluations of the Post Nargis humanitarian projects also questioned the level of male support/involvement. The evaluations offered insufficient details on project expenditures thus precluding an assessment of the long term viability of the micro finance aspects. On the other hand, extra donor funding was found to continue some of the spaces after completing initial programmes. In addition, after donor funding ceased, two other communities also chose to continue with women friendly space initiatives on their own. Unfortunately, though, the evaluations offer insufficient qualitative analysis to enable a judgment to be made about sustainability, as the EOP evaluation’s TOR had requested should be considered. The ET had programmed a visit to Laputta that might have overcome this information gap but the two days of travel required had to be abandoned, due to the time taken up in awaiting approval of the overall field visits. How the women’s friendly spaces now might best be replicated requires further examination.

286. **Management:** UNFPA’s management action post Nargis received universal praise during the ET, in particular the key leadership roles in the work of the WP TWG and the Sexual and RH TWG in providing RH, women’s protection and HIV services received much favorable comment. The CO has since dedicated staff resources to the newly emerged role in humanitarian assistance leading on to the detailed contingency planning since undertaken.

287. **Efficiency.** Responses to national disasters are more efficient when planned for and properly resourced, as has now occurred through contingency planning since undertaken in Myanmar. UNFPA participated in the development of the UN Interagency Standing Committee Country Team’s contingency plan in early 2009. UNFPA also participated in the development by the MSWRR of the *Myanmar Action Plan on Disaster Risk Reduction (MAPDRR) 2009-2015*, in corporation with its partner ministries. The national plan sets out roles and responsibilities of different Ministries, as well as coordination arrangements.

288. UNFPA has also developed its own contingency planning, having consulted with the Government in the process. The use of rapid response teams, capacity building and pre-positioning of supplies across Myanmar in warehouses (including specially developed kits for emergencies) has already been proven to be an efficient and effective method of action in responding to cyclone Giri in 2010.

289. **Sustainability.** The sustainability of the emergency measures that have been taken to date was assessed favorably by respondents in the structured interview process.

290. **Lessons Learnt.** The main lesson of the humanitarian response to the post-Nargis emergency was the importance of taking immediate action to ensure SRH services remain available and also the better understanding of the range of humanitarian issues that may need to be managed and the services and supplies needed for that purpose. Being able to take immediate action reduces the elevated risks of morbidity and mortality among displaced populations.

C8. Conclusions
291. UNFPA’s 2nd Programme of Assistance to Myanmar has many sound accomplishments to its name. Working in a difficult operating environment where travel and communication is constrained and ODA levels are low, the UNFPA has demonstrated a responsive and flexible approach to the changing circumstances of Myanmar’s population such as fertility and age, to the evolving governance context, and to the many RH and the social and economic challenges that are faced by its people including the poor.

292. Making judgments about the relative success of parts of a programme of assistance that ranged across RH, ARH, HIV/AIDS prevention, P&D, gender equality, emergency humanitarian assistance, and PMCT is not easy. CP2 has for example helped to improve some key P&D data, including disaggregated data, and to position Myanmar to make greater use of evidence-based policy development. There is much to do in regard to assisting P&D capacity development and in building a longer term P&D agenda with government covering the undertaking of a census, improving mortality statistics and other data needs. Within the UN system, UNFPA is recognized as having played a cooperative and catalytic role in leading the process of thematic analysis (CCA) and contributing to UN Strategic Framework (UNDAF) as well as some of the current strategic work on major development issues facing Myanmar. UNFPA has also handled the challenges related to emergency humanitarian response well. It has demonstrated flexibility under CP2 and that flexibility will continue to be important in responding to new challenges such as the HIV risks amongst MSMs.

293. It might still seem relatively easy to say that one part or other of CP2 performed more effectively such as for example the effect the UNFPA support for gender equality has had in terms of potentially changing the landscape for women in Myanmar through the new draft National Plan of Action for Advancement of Women. Implementation of that plan now needs to be supported through capacity development; advocacy on the gender aspects of policy issues; building the gender evidence base including on women’s protection issues such as GBV; and supporting women’s empowerment through women friendly spaces. UNFPA’s assistance has also helped to improve the ASRH knowledge base of over 400,000 young people although there is scope for exploring other communication modes such as the mass media to reach a wider audience.

294. CP2, coupled with CP1, has had a significant effect on the lives on many Myanmar people. These include women and children who may not now have been alive but for the RH services that UNFPA helped MoH to deliver. It also includes the impact of the knowledge about HIV risks that UNFPA assistance helped to share with youth who were leading risky lifestyles and the effect of the women’s empowerment programmes that helped women to get back on their feet and to learn new livelihood skills after cyclone Nargis. As well, CP2 assistance has affected the children born from a HIV positive mother but who did not contract HIV and the FSW who lives and works while infected with HIV but does not pass on that infection.

295. When account is taken of the various challenges that were faced in programme implementation, which were larger for example in relation to RH than for some other programme components, all parts of CP2 performed reasonably well.

296. UNFPA in Myanmar is well led. It has hard working and capable staff. However, the complexity of the challenges that lie ahead require some thought to its overall human resourcing. More specifically, if P&D is to be a separate component in CP3 and given the emphasis on disaster preparedness and response, there is a need to recruit more programme staff based on the country programme requirements and the approved country office typology in addition to the Deputy Representative and International Operations Manager.
Effective partnering approaches will also be crucial. There also are many linkages that need to be made by UNFPA managers between different components of CP2 such as RH, HIV, ARH and PMCT and by continuing mainstreaming of gender.

Being effective managers requires that they apply more programmatic approaches, as the MTR had recommended, and employ effective results based management. The UNFPA has already taken relevant and concrete steps in 2009 and 2010 towards such approaches. It conducted a comprehensive situation analysis of the RH, P&D and gender issues which examined the linkages between the three components and provided the basis for the 3CP. The UNFPA also conducted the first Annual Programme Review in 2010 with the participation of all partners and organized training on results based management for UNFPA staff and partners.

In summary, all parts of CP2 were assessed as relevant to Myanmar’s national needs and to UNFPA’s mandate. CP2 also seems to have been largely effective, although the performance information base for reaching that conclusion might have been better in areas such as ARH. There is scope for better specification of results; for improving performance information; and more use of evaluation. In addition, better leveraging of implementing partner arrangements related to programme delivery would help to achieve better results-based management and improved service quality. UNFPA can also decrease its transaction costs through reducing the number of implementing partners. The UNFPA should promote better coordination to enhance local level integrated service provision.

The new roles should be provided for in P&D, gender and emergency humanitarian response should be separately covered in the next CP. There is also scope for continued gender mainstreaming through male involvement in RH, in ARH, PMCT, HIV prevention.

There is also the possibility, in the new RH funding environment that seems to be emerging of re-framing the role of the UNFPA to focus more on strategic support for the MoH by advising on service quality issues in RH, while rescaling and shifting the level, nature and geographic location of UNFPA’s future service provision in RH. This requires particular attention to supporting vulnerable populations and to design features that affect sustainability than has been given to date. This is consistent with moves within the UNFPA for upstreaming of the Country Office’s work and focusing more on advocacy, policy development and quality improvement.

Work in vital fields like BCC needs to be enhanced, with the BCC Master Plan being revised and it being placed on a more contemporary basis. Ongoing upgrading of BCC and IEC materials is required to keep pace with contemporary needs as well as exploration of other communication options to reach a large audience such as through different channels such as the mass media. Capacity development in all areas of UNFPA assistance also needs to be placed on a more systematic and professionalized basis.

How to help meet the urgent need to bring down the MMR to meet the MDG target by 2015, and to significantly increase the CPR, should be a major concern of the next CP and of related advocacy. Technical support would be useful to ensuring MMR data is reliable. UNFPA also can play an important role in advising on national and local initiatives to improve service delivery in RH. However reaching the MDG5 goal on MMR will be difficult unless the Government plays a leading part through significantly increasing budget expenditure and human resources. Increased funding is also required to support commodities for birth spacing services and to provide condoms that will reduce the risks of contracting HIV/AIDS.

D. RECOMMENDATIONS
In the light of the findings made and the conclusions expressed in this report, the following recommendations are made to UNFPA and its partners:

**Reproductive Health**

1) Re-focusing RH assistance to provide more upstream strategic, policy, advocacy & equity support, to strengthen partnership coordination, and to enhance service quality standards.

2) Reviewing, after mapping, existing RH, ARH and HIV prevention services and in consultation with partners as regards the services they provide, rescaling and shifting UNFPA’s support for RH service provision in UNFPA’s Third Programme of Assistance to focus more on particular geographic areas, on vulnerable populations and on piloting innovative RH service initiatives. Ensuring alignment of interventions in various areas (RH, ARH, HIV prevention) to the extent possible to optimize the impact of UNFPA’s assistance. Supporting MOH in coordinating RH inputs provided by various stakeholders through the National Working Committee on RH, and its sub-committees on RH Commodity Security, and to promote integration of RH and HIV prevention through other existing coordination structures, such as the Country Coordination Mechanism (CCM) for the Global Fund on HIV, TB and Malaria. In addition, promote joint programming drawing on the UN Secretary General’s Global Strategy on Women’s and Children’s Health and the H4+ initiatives which assist countries to achieve access to an integrated essential package of maternal and neonatal health services especially for the most vulnerable.

3) Giving high priority with partners to resolving current RH service delivery concerns and to responding to the unmet need for contraceptives by:
   - Overcoming stockouts and enhancing the availability of commodities for birth spacing and HIV prevention through improved logistics management and supporting improved funding through partnerships with other stakeholders for commodity security.
   - Contributing to upgrading of EmOC facilities and provision of related training;
   - Subject to agreement of the Government assisting in developing a CD strategy for health personnel specifically to meet the skill needs of service providers;
   - Piloting initiatives to reduce financial barriers to accessing RH including maternal health services.

4) Supporting the MOH to achieve MDG targets, in particular the MMR reduction and HIV prevention targets, by supporting joint advocacy activities for health system strengthening including improved health finance, human resources, logistics management and health management information system for RH. Supporting the national level actions on development of service protocols guidelines, researches, technical assistance required to address MMR and HIV.

**Behavioral Change Communication**

5) Upgrading the performance of BCC interventions & monitoring by:
   - Developing a communication strategy for the UNFPA Programme based on the BCC Master Plan.
   - Continuing to upgrade/provide quality assurance on training modules and materials to reflect contemporary trends and learning approaches, including for ARH;
   - Clarifying the role and working arrangements of Community Support Groups;
   - Utilization of additional communication modes including appropriate media channels (traditional media, mass media, small media, social media) in BCC interventions.

**Capacity Development**

6) Strengthening capacity development under the CP on a more systematic, professionalized and results-oriented basis, with appropriate strategies in place in RH, ASRH, HIV, PMCT service delivery that covers skill requirements, training tools and curriculum, competency and learning standards, as well as quality assurance arrangements.
Adolescent Reproductive Health
7) Enhancing the effect of UNFPA’s interventions in ARH in Myanmar, in partnership with government and other stakeholders, by:
   - Exploring new communication strategies (including more use of the mass media, small media and traditional media);
   - Promoting more strategic-level discussion between partners, including government, to develop an ARH strategic guidance note for promoting accessibility to ARH information and services;
   - Supporting the development of guidelines for user-friendly ARH services.; strengthening relevant training for service providers; and improving monitoring of performance;
   - Applying the above-mentioned guidelines through pilot interventions on ARH services, including to better target most-at-risk young people.

HIV Prevention and PMCT
8) Advocating for scaling up HIV prevention services for high risk population and PMCT services through partners of UNFPA
9) Providing technical assistance in updating the ART, and in the development of PMCT, guidelines

P&D
10) P&D should be a separate component of the next CP. Support should be provided, subject to available resources and institutional capacities, and in partnership with government and stakeholders, for the collection, processing, analysis and dissemination of data on:
   - the population size, distribution, dynamics and characteristics including age structure including population census, RH through a Demographic and Health Survey or a similar survey (FRHS), with modules on youth and adolescent RH;
   - Internal and cross border migration and its determinants.
   - Disaggregation of data by age, sex, localities and ethnicities and producing gender statistics.

Gender Equality
11) Gender equality should be a separate component of the next Programme of Assistance, involving support for implementation of Myanmar’s draft National Plan of Action for Advancement of Women in partnership with government, UN agencies, NGOs, INGOs and donors by:
   - Providing research, evidence-based advocacy and technical assistance to formulate and revise policies and legislation to promote gender equality.
   - Strengthening the institutional capacities of the government and civil society in the areas of gender analysis and mainstreaming.
   - Raising awareness on gender equality, reproductive rights, GBV, male responsibility in SRH, and trafficking of women.
   - Establishing women friendly spaces and supporting other similar interventions for women’s empowerment with emphasis on integrating RH IEC, counseling and referral in such interventions.
   - Identifying and promoting areas of joint programming through the work of the GTG and WPTWG.
12) Continuing to mainstream gender equality under all sub-components of the Programme of Assistance.

Emergency Humanitarian Response
13) Recognizing in the next Programme of Assistance the important ongoing role in emergency humanitarian response that UNFPA now plays in Myanmar by strengthening preparedness and
the response made to humanitarian emergencies in the areas of RH, HIV, ARH, data, gender, and women’s protection.

Management Issues

14) Instilling in all UNFPA managers an approach under the CP that is programmatic, employs results-based management and sound partnership principles, including by:
   - Providing for improved specification in the next CP of intended results, targets and relevant performance information and linking these to work plans of partners;
   - Conducting assessment of the performance of programme partners based on established guidelines to determine their capacities, role and focus on results in implementing UNFPA’s programmatic interventions.
   - Building up of evidence-based advocacy roles focused on key policy and strategic issues, on mapping of service provision and promoting equity by addressing the needs of disadvantaged and underserved populations.

15) Making more efficient and effective use of implementing partners by limiting their number, by capacity building and by reframing UNFPA’s expectation under work plans to focus on their managing for and reporting on results, rather than just on activities, and on assisting in reporting on service quality and delivery at the local level.

16) Reviewing, subject to appraisal of, APRO& UNFPA HQ, the structure and typology of the CO with a view to strengthening the human resource and technical capabilities of the office in line with the programme requirements.

Annexes to
## CONTENTS- ANNEXES

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1. Terms of Reference, EOP Evaluation, UNFPA’s 2nd Programme of Assistance</td>
</tr>
<tr>
<td>E2. Documents Accessed in EOP Evaluation</td>
</tr>
<tr>
<td>E3. Evaluation Instruments</td>
</tr>
<tr>
<td>E4. List of Participants in Evaluation Process</td>
</tr>
</tbody>
</table>
ANNEX E1

TERMS OF REFERENCE

End of Programme Evaluation of UNFPA’s 2nd Programme of Assistance (2007-2010)

I. Background and context

As the Government of Myanmar aims to fulfill its commitment to the Millennium Development goals, UNFPA in partnership with other UN agencies, relevant ministries, local and international NGOs are working towards attaining those goals, specifically goal 5 on reducing maternal mortality and goal 6 on preventing HIV/AIDS.

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 approach and adopted a programmatic approach. The first UNFPA Special Programme of Assistance to Myanmar was implemented during the period 2002-2006.

UNFPA is currently implementing its 2nd Programme of Assistance to Myanmar 2007-2010, which has been extended until the end of 2011. The programme focuses 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 the selected project areas. Even though the programme was planned to start in 2007, actual implementation began in 2008 due to late Government approval and conclusion of programme agreement with the Government in February 2008. The cyclone Nargis which hit Myanmar in May 2008 forced the country office to reallocate its resources to humanitarian response, putting the regular country programme on hold for a while.

UNFPA programme activities strengthened provision of reproductive health services including safe motherhood, birth spacing, HIV/AIDS prevention among vulnerable population (at risk groups), 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 include training and mobilizing community support groups. HIV prevention component projects promoted access to HIV information and services which include various trainings, peer education, STI treatment, and voluntary HIV testing and condom distribution through various channels. These groups include sex workers, men who have sex with
men (MSM), young people and mobile populations. Female and male condoms are distributed free of charge in public health facilities and through social marketing approaches at subsidized prices in private sector that promote accessibility, availability and affordability of the quality condoms by targeted beneficiaries in the community.

The second Programme of Assistance has been implemented by various implementing partners in 138 townships representing 42 percent of the country’s townships. Please refer to the annex of map that shows the geographical coverage of UNFPA’s interventions in Myanmar. The following five outputs and four outcomes are under the UNFPA second Programme of Assistance:

<table>
<thead>
<tr>
<th>Output</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Improved access to reproductive and maternal health services, including birth spacing, pre and post natal care, delivery services and emergency obstetric care</td>
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<tr>
<td>2</td>
<td>Improved availability of disaggregated data for reproductive health programming</td>
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<tr>
<td>3</td>
<td>Increased access by young people to reproductive health and HIV-prevention information</td>
</tr>
<tr>
<td>4</td>
<td>Improved access by vulnerable populations to knowledge about and ways to prevent HIV</td>
</tr>
<tr>
<td>5</td>
<td>Increased access to comprehensive services to prevent mother to child transmission of HIV</td>
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The hallmarks of UNFPA’s assistance during the first Programme of Assistance included trainings, reproductive health commodity supply, IEC materials/tools development, BCC interventions at the community level, data collection and access to emergency obstetric care.

As stipulated in UNFPA’s programme guidelines, an end-of-programme evaluation must be conducted and should assess the relevance, effectiveness, efficiency, impact and sustainability of activities supported by UNFPA during 2nd programme cycle (2007-2010).

II. Purpose

A fundamental purpose of end-of-programme evaluation is to assess whether desired results of 2nd Programme of Assistance have been achieved, and specifically:
A. To assess the validity of design, relevance, efficiency, effectiveness, sustainability and impact of strategies, approaches and interventions under UNFPA 2nd Programme of Assistance in promoting maternal health and HIV prevention.

B. To guide decisions on development, management, coordination, monitoring and evaluation of 3rd programme cycle 2012 -2015

The primary users of this evaluation are the UNFPA Country Office in Myanmar, the UNFPA Regional Offices and Headquarters, programme implementing partners in the Government, NGOs and INGOs as well as the donors. The evaluation report should be written in such a way that it addresses the needs of these stakeholders, especially UNFPA.

III. Evaluation scope, focus and objectives

The evaluation will cover the period of the UNFPA 2nd Programme of Assistance to Myanmar from its inception in 2007 until the time when the evaluation is completed. The evaluation will also cover geographical areas where UNFPA intervention activities have been implemented in selected townships around the country. The end-of-programme evaluation will cover the broad areas of reproductive health and HIV prevention as well as cross cutting issues, such as data in relation to FRHS, RHMIS, etc and gender.

The evaluations shall:

- Assess the relevance of the programme and its planned results, which include outputs, outcomes, and impacts, in terms of improved access to RH and maternal health services, improved availability of disaggregated data, improved access to RH and HIV knowledge by young and vulnerable people, and improved access to comprehensive PMCT services with respect to national development goals and priorities, and assess the programme’s design with respect to achievement of planned results.
- Assess the progress towards achievement of the programme’s results and assess the effectiveness of the BCC interventions, capacity development and outreach and static maternal health services interventions towards achievement of the programme results, and identify factors that facilitated or hampered effectiveness of the interventions. Specifically assess the relative effectiveness of the different BCC interventions and capacity-development approaches being utilized by the programme.
- Assess the extent to which implementation of the BCC interventions, capacity development, and static and outreach services interventions have been efficient.
- Assess the programme management and implementation arrangements and modalities. Examine the programme management, including the effectiveness of the implementing partnership arrangements, the programme management’s systems and practices, the technical support, as well as the optimality of the CO’s budget and staffing.
- Identify good practices and lessons learned, and make recommendations for the next country programme.
- Evaluate the UNFPA 2nd Programme of Assistance especially in relation to its validity of design, management, effectiveness, sustainability and impact on the beneficiaries in the
community as well as factors affecting performance, alternative strategies and anticipated results.

The evaluation should address the **following questions:**

✓ **Relevance:** Do programme planned results address national needs and priorities and in line with UNFPA’s mandate are considered useful to target populations and complementary to other stakeholders’ interventions.

✓ **Validity of design:** Are programme results (outcomes, outputs and impact) clearly stated describing solutions to identified problems? Are inputs and strategies including geographical coverage of interventions, realistic, appropriate and adequate to achieve the results? Are indicators SMART (specific, measurable, achievable, realistic and time bound)? Have external factors that could affect the programme been identified and assumptions validated? Were execution and implementation modalities identified at the time of developing the programme? Does programme design address gender issues? Have gender concerns been addressed in RH, ARH, data and HIV projects. Are there linkages among programme components established to ensure synergies?

✓ **Management:** Did programme implementers discharge their duties effectively? Were sound financial, equipment and commodity management procedures practiced? Was the technical assistance provided appropriate, adequate and timely? Were monitoring and evaluation systems and processes adequate? Have data been collected on indicators of achievement and do they provide adequate evidence of achievement of programme results?

✓ **Effectiveness:** To what extent have planned outputs and outcomes been or will be achieved and what is the quality of the outputs and outcomes?

✓ Were data produced through surveys and other methods of data collection disaggregated by gender? What were the achievements in terms of capacity development?

- To what extent were Targeted Outreach Programme (TOP) and Drop-in-Centers (DICs) effective in increasing access to, and increasing knowledge about RH, HIV, and PMCT services?
- What factors affected the effectiveness of TOP and DICs?

- To what extent have the following increased: access to RH services; knowledge of RH and HIV prevention among youth and vulnerable populations; access to PMCT services; and, availability of disaggregated data?
- What is the quality of the RH, HIV, and PMCT services to which access has been increased, etc?

- To what extent have the BCC interventions (advocacy meetings, community awareness raising activities, group education sessions, individual learning) effectively contributed to achievement of the programme results, in particular increased knowledge and utilization of RH services, increased knowledge about HIV prevention among young people and among vulnerable populations, and increased access to PMCT services?

- To what extent are some interventions relatively more effective than others in increasing this knowledge about RH, HIV, and PMCT? What are possible interventions UNFPA could have implemented? What factors within UNFPA’s control explain this difference, if any?
How effective have the different training approaches, namely, training of trainers, trainings of beneficiaries, training of health staff, training manuals/tools and trainings conducted by the CO and its partners been in building capacity of partners, especially the CO’s implementing partners? What evidence supports this conclusion?

What training approaches have been relatively more effective and how do we know? How effectively and to what extent does the training contribute to the programme results, in particular, to improved knowledge about RH, HIV among the youth and among the vulnerable groups and to the increased access to PMTCT services?

**Efficiency:** Did the actual or expected outputs and outcomes justify the cost incurred? Have resources been spent as economically as possible? Did programme activities overlap and duplicate other similar interventions? Are there more efficient ways of delivering more or better results with available inputs without reducing quality?

**Sustainability:** Is it likely that programme achievements, especially in areas affected by cyclone Nargis in May 2008 will be sustained after the withdrawal of external support?

**Other:** What particular factors or events have affected programme results? Were these factors internal or external to the programme (and within UNFPA’s control or influence)?

- Identification of lessons learned, facilitating and constraining factors from the implementation of the above-cited interventions and providing recommendations for future interventions.

**IV. Methodology**

The evaluation will adopt the following methods:

- **Review of available documentation.**
  - Review, as necessary, of reports, including documents, related to the 2nd Programme of Assistance document, Annual Work Plans, situation analysis on population, RH, HIV and gender, Mid Term Review report, progress reports, completed and available reports on thematic evaluations on BCC/IEC, TOP/DIC performance, maternity waiting homes, humanitarian assistance, human resource capacity development and other information and documents available in the UNFPA country office and the offices of the implementing partners.

- **Field visits and interviews:**
  - Carry out site visits to the project areas to carry out in-depth interviews and focus group discussions with beneficiaries in the community;
  - Conduct interviews with project staff, local stakeholders, and implementing partners;
➢ Meet with relevant partner agencies, related to government ministries, other UN agencies and local and international NGOs;

➢ Meet with key players from the offices of the IPs and UNFPA programme staff

➢ Collect field data, as necessary, generated through questionnaires, and/or direct observations

**Other data collection methods that may be considered**

➢ Client Oriented Provider Efficient services (COPE) approach

➢ Key informant interviews and quantitative data collection

V. **Evaluation products (deliverables)**

There will be an international expert to conduct the end-of-programme evaluation mentioned above. He or she should deliver the following products:

- **Inception report:**
  - It should include the work plan/schedule of tasks and timetable, activities and deliverables. The inception report should be submitted to UNFPA **one week after signing the contract** and must include:
    - A description of the evaluator’s strategy for ensuring the evaluation’s utility and applicability to the needs of the CO and those of key stakeholders.
    - A brief discussion of the evaluator’s plans to engage and involve these stakeholders in the design (e.g., questions, objectives, methods, data-collection instruments), plan for field visits, criteria for selection of project sites, data collection, data analysis, and development of recommendations.
    - For each of the five evaluative criteria (i.e., relevance, effectiveness, efficiency, sustainability, and impact from the OECD’s Development Assistance Committee), a description of the measurable performance indicators or standards of performance that will be used to assess progress towards the attainment of results, including outcomes.
    - A brief discussion of (a) the limitations of the proposed methods and approaches, including sampling, with respect to the ability of the evaluator to attribute results observed to the CO’s efforts especially when there is no consideration of a valid counterfactual and (b) what will be done to minimize the possible biases and effects of these limitations.
    - An explanation of the evaluator’s procedures to ensure informed consent among all people to be interviewed or surveyed and confidentiality and privacy during and after discussion of sensitive issues with beneficiaries or members of the public.
    - An indication of the evaluator’s familiarity with an agreement to adhere to (a) the requirements of the *Standards for Evaluation in the UN System*, especially standards 4.1 through 4.18 and (b) UNFPA’s Evaluation Quality Standards, which will be provided to the evaluator.
• Inception report should be submitted to UNFPA CO and APRO for review and clearance

• Presentation of the findings of field work before the completion of the draft report.

• The evaluation expert shall submit an electronic copy of a draft evaluation report to UNFPA’s evaluation manager no later than one week before the end of contract. The draft report should be thoroughly copy edited to ensure that comments from the UNFPA and other stakeholders on content, presentation, language, and structure can be reduced to a minimum.

• Presentation of the draft report to programme partners and other stakeholders.

• After UNFPA’s and stakeholders’ review of the draft report, the evaluation manager will provide written comments to the evaluation expert. Based on these comments, the expert 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. The evaluation expert 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 expert will submit a revised draft evaluation report, which may lead to further comments from UNFPA. After the second round of review and, if necessary, further revision to the draft evaluation report, the evaluation expert can then submit the final report pending UNFPA’s approval.

• Final evaluation report to be completed and submitted to UNFPA within 3 weeks after receiving the comments on the draft report

More specifically, by the end of the assignment the international consultant should deliver an end-of-programme evaluation report incorporating inputs from UNFPA CO and various stakeholders. The international consultant should also provide inputs for the completion of the Country Programme Summary (attached).

VI. Evaluation Consultant and required competencies

The end-of-programme evaluation will be conducted by an international expert who will be responsible for producing the final report of the end of programme evaluation.

International consultant needs to travel to Myanmar at the beginning of the end programme evaluation exercise and stay throughout the evaluation process up to the time of drafting the final report. The consultant should take the field visit to project site. The international consultant needs to participate in the dissemination workshop of the draft report. The consultant will have the primary responsibility of coordinating the work of evaluation, liaising with UNFPA country office, implementing partners and other stakeholders.

The consultant will:

General requirements:
• Liaise with the various institutions to facilitate access to information required for the exercise.
• Develop necessary evaluation methods and tools for evaluating programme activities, collect and analyze data, draft report and other tasks related to evaluation.
• Carry out desk review, conduct interviews and focus group discussions.
• Draft evaluation report based on data/information from available researches, data and knowledge base and information collected through interviews and focus group discussions.
• Ensure synergies among the various issues of the analysis to form an integrated, holistic and analytical report
• Prepare discussions on the content, findings and recommendations of the evaluation.
• Organize dissemination meeting with all stakeholders
• Incorporate comments from stakeholders
• Timely deliver quality final evaluation reports incorporating inputs from the UNFPACO, APRO and stakeholders

**Specific requirements:**

• Advanced degree in health, social science or other relevant disciplines with knowledge and experience on quantitative and qualitative data collection and analysis.
• At least 15 years professional experiences preferably in the field of evaluation in health-related projects particularly in RH and HIV prevention, population and development and gender.
• Experience in design and management of evaluation processes
• Understanding of human rights-based approaches and result-based management approaches to programming.
• Familiarity with the work of the UN, especially UNFPA.

**VII. Evaluation ethics**

Evaluation exercises will be conducted in accordance with the principle outlined in the UNEG’s *Ethical Guidelines for Evaluation* that should be followed by the evaluators when addressing the design and implementation of the evaluation, including evaluation ethics and procedures to safeguard the rights and confidentiality of information providers.

No evaluator shall have had any prior involvement with the design, implementation, supervision, or financing of the programme or activities to be evaluated. UNFPA’s evaluation manager shall be informed of any situation or circumstance that may be perceived as a conflict of interest for any member of the evaluation.

Stakeholders should be engaged throughout the evaluation process until the evaluation reports are finalized. In addition to suggesting approaches to the evaluation, stakeholder will participate in individual and group interviews, field visits, focus groups discussions and rapid appraisal surveys, etc.). Stakeholders will also review and comment on draft evaluation reports and should be provided the opportunity to suggest proposed recommendations.
VIII. Implementation arrangements and management structures

- Evaluation consultant shall prepare an outline of the evaluation report which will be reviewed by UNFPA.

- Draft terms of reference of evaluation shall be discussed and finalized with evaluation management committee.

- The UNFPA Representative, the evaluation manager and UNFPA CO team will provide technical and programmatic guidance to the evaluation consultant throughout the evaluation process. The draft evaluation report will be finalized through a process of peer review under the guidance of the UNFPA Representative, evaluation manager and UNFPA M&E advisor. The draft evaluation report will be presented by the international consultant in a workshop with various stakeholders. The Final evaluation report will be circulated to stakeholders and will be posted in the UNFPA web-site. The evaluation manager will prepare management response on the evaluation report. Communication about evaluation process and UNFPA reactions will be through evaluation manager.

The evaluation consultant will work in UNFPA office in Yangon. UNFPA country office will be responsible for logistics support for field trips to the selected project sites. UNFPA will also cover the total cost of evaluation.

IX. Work plan, organization and budget

International consultant will arrange his/her working schedules that should be prepared in consultation with UNFPA country office, to be able to submit the report on time.

Duration of the evaluation process: 31 January 2011 to 25 March 2011

Estimated total working days - 40 days (Maximum)

Payment schedule of evaluation: the international expert will be paid the following schedules as mentioned in the draft evaluation guidelines (2010) of UNFPA

- 30% of total payable amount upon a satisfactory inception report
- 20% of total payable amount upon successful completion of field work submitting draft field trip report
- The remaining 50% of total payable amount upon satisfactory final report

XI. Annexes

1. Sample outline for the evaluation report
2. Suggested documents to be reviewed
3. Key stakeholders and partners
4. Sample format for Time Frame and Deliverables
5. Map on Interventions
6. Code of Conduct
7. Draft UNFPA Evaluation Guidelines June 2010

**************************************************************************

Annex .1

Sample Outline for the Evaluation Report

Title page
- Name of project, programme or theme being evaluated
- Name of the organization(s) to which the report is submitted
- Names and affiliations of the evaluators
- Period of the evaluation mission (days)

Table of Contents

Acknowledgements
- Identify those who contributed to the evaluation

List of abbreviations and acronyms

Executive summary
Summarize essential information on the subject being evaluated, the purpose of the evaluation and methods applied, major limitations, the major findings and conclusions, and recommendations in priority order. The executive summary should be concise, readable, and be able to stand alone without reference to the rest of the report.

Introduction
- Summarize the purpose of the evaluation, the key issues addressed and the methodology employed to conduct the evaluation
- Describe the structure of the evaluation report
- Describe the aims and strategies of the programme/project/intervention

Findings and conclusions
- State findings clearly based on the evidence derived from the information collected. Provide critical assessment of performance (including factors affecting performance), and the results achieved.
- In the conclusions, include a discussion of the reasons for successes and failures, especially the constraining and enabling factors

Lessons learned
- Based on the evaluation findings and drawing from the evaluator(s)’ overall experience in other contexts, provide lessons learned that may be applicable in other situations as well. Include both positive and negative lessons.
Recommendations

- Base recommendations on the conclusions and lessons learned, and discuss their anticipated implications
- List proposals for action to be taken (short- and long-term) by the person(s), unit or organization responsible for follow-up in priority order
- Provide suggested time lines and cost estimates (where relevant) for implementation

Annexes

- Attach evaluation terms of reference
- List persons interviewed, sites visited
- List documents reviewed (reports, publications)
- Attach data collection instruments, e.g., copies of questionnaires, surveys

Annex-2

Suggested documents to be reviewed

The followings are suggested documents to be reviewed by the evaluation teams:

- BCC Master Plan
- Lessons learnt: Community Operated Youth Centers in Myanmar
- Strategic plan for RH (2004-2008)
- Strategic Plan for RH( 2009-2013)
- Materials on UNFPA Special Programme of Assistance to Myanmar (2002-2006)
- UNFPA Reproductive Health Needs Assessment in Myanmar( 1999)
- UNFPA Project Documents and related AWPs
- Poverty Profile of Myanmar
- Related documents on trainings (reports, tools)
- Country reports on Fertility and Reproductive Health Surveys
- Country report on Youth and Family survey and its research papers
- On-going data collection activities (e.g. MICS by UNICEF, Household Living Conditions Survey by UNDP, etc.)
- HIV/AIDS Strategic Plan (2006-2010) Operational Research documents and findings
- Adolescent Health and Development Strategic Plan (2008-2012)
- RH Assessment in NRS (2006)
- PONREPP Report
- RH Stakeholders Analysis in Myanmar (2006) (WHO)
- Assessments on Women Protection Issues (2010)
- RH Logistic Management Assessment (2002)
- Findings of Mid Term review of UNFPA’s Programme of Assistance (2007-2010)
- UN Strategic Framework (2005-2009)
- Situation analysis report on Population and Development, RH and Gender in Myanmar once available
- Reports:
  - Quarterly and Indicators Reports of implementing partners
  - Field Monitoring Reports, APR from partners, UNFPA COAR and etc.

Annex.3

List of key Stakeholders and partners

Possible stakeholders for each output in the 2nd Programme of Assistance

<table>
<thead>
<tr>
<th>Output</th>
<th>Implementing Partners</th>
<th>Services providers/ beneficiaries</th>
<th>Donors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MOH (DOH,DHP,CHEB), MMA, MMCWA, MSI ,AMI, JOICFP, AZG, PSI, WFP</td>
<td>public sector officials, basic health staff, AMWs, logistic officials, general practitioners, pregnant women and their husband, STI patients, CSGs members, community members, factor workers, SWs, clients, migrant workers</td>
<td>CERF, Germany, Australia, Norway, Finland, New Zealand</td>
</tr>
<tr>
<td>2</td>
<td>MOIP (DOP)</td>
<td>planners, managers, and policy makers, all women of reproductive age and their partners, migrants, old aged persons, Data user, research institutions</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>MOH (CHEB,DOH), MMA, MSI, MMCWA, MRCS, JOICFP, FXB, UNICEF</td>
<td>Youth centres, trainers, trainees (youth), facilitators, youth peer educators, community members, parents, rural youth, youth volunteers, rural health center</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>MOH (NAP), MANA, PSI</td>
<td>Sex workers, MSM, drug users, mobile population&amp; their spouses, brothel house owners</td>
<td>3DF</td>
</tr>
<tr>
<td>5</td>
<td>MOH (NAP, MCH, CHEB, NHL), MMA, MANA, SC</td>
<td>Pregnant women and their spouses, VCCT service providers (medical doctors, nurses, counselors), community members, public sector trained staff (BHS), HIV+ women</td>
<td>3DF</td>
</tr>
</tbody>
</table>
## Possible Stakeholders for end programme evaluation

<table>
<thead>
<tr>
<th>Sr.</th>
<th>evaluation</th>
<th>IPs</th>
<th>Service providers/beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>End Programme Evaluation</td>
<td>DOH, DMR, DMS, CHEB, MMA, JOICFP, PSI, MSI, MRCS, MANA, MMCWA, NAP, AMI, DOP, SC, All agencies that provide trainings/capacity development activities</td>
<td>Public sector officials, health educators, BHS, community support group, CSG members, factory workers, medical practitioners, and community members, private sector officials, semi governmental organization personnel, Trainers, trainees, facilitators community members, suppliers, community members, medical practitioners, Sex workers, MSM, Drug users, Mobile population &amp; their spouses, people living with AIDS.</td>
</tr>
</tbody>
</table>

### Annex-4

**Sample format for Time Frame and Deliverables**

<table>
<thead>
<tr>
<th>No</th>
<th>Activities</th>
<th>Time/period</th>
<th>Responsible person</th>
<th>Deliverable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pre-evaluation briefings with the selected evaluation team/ evaluators by evaluation management committee (EMC) /UNFPA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Finalization of inception report</td>
<td></td>
<td></td>
<td>Inception report</td>
</tr>
<tr>
<td>3</td>
<td>Approval by EMC /UNFPA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Development of data collection methodology, tools and guidelines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Data collection activities through secondary and primary sources of information at central level and in the field</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Compilation, analysis and interpretation of data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Activities</td>
<td>Time/period</td>
<td>Responsible person</td>
<td>Deliverable</td>
</tr>
<tr>
<td>----</td>
<td>------------</td>
<td>-------------</td>
<td>--------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Regular meetings on evaluation progress with UNFPA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Mid-term meeting with EMC /UNFPA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Submission of draft evaluation report to UNFPA</td>
<td></td>
<td></td>
<td>Draft evaluation report</td>
</tr>
<tr>
<td>10</td>
<td>Sharing session with stakeholders after EMC /UNFPA review of draft evaluation report</td>
<td></td>
<td></td>
<td>Dissemination events</td>
</tr>
<tr>
<td>11</td>
<td>Submission of final evaluation report</td>
<td></td>
<td></td>
<td>Final evaluation report</td>
</tr>
</tbody>
</table>

The activities are not exhausted. Need to add more activities.
Annex-5

Map of Interventions
UNEG Code of Conduct for Evaluation in the UN System

Foundation Document

UNEG, March 2008
The Code of Conduct was formally approved by UNEG members at the UNEG Annual General Meeting 2008.
Further details of the ethical approach to evaluation in the UN system can be found in the Ethical Guidelines for Evaluation in the UN System (UNEG/FN/ETH[2008]).

CODE OF CONDUCT FOR EVALUATION IN THE UNITED NATIONS SYSTEM

1. The conduct of evaluators in the UN system should be beyond reproach at all times. Any deficiency in their professional conduct may undermine the integrity of the evaluation, and more broadly evaluation in the UN or the UN itself, and raise doubts about the quality and validity of their evaluation work.

2. The UNEG Code of Conduct applies to all evaluation staff and consultants in the UN system. The principles behind the Code of Conduct are fully consistent with the Standards of Conduct for the International Civil Service by which all UN staff are bound. UN staff are also subject to any UNEG member specific staff rules and procedures for the procurement of services.

3. The provisions of the UNEG Code of Conduct apply to all stages of the evaluation process from the conception to the completion of an evaluation and the release and use of the evaluation results.

4. To promote trust and confidence in evaluation in the UN, all UN staff engaged in evaluation and evaluation consultants working for the United Nations system are required to commit themselves in writing to the Code of Conduct for Evaluation (see Annexes 1 and 2), specifically to the following obligations:

**Independence**

5. Evaluators shall ensure that independence of judgement is maintained and that evaluation findings and recommendations are independently presented.

**Impartiality**

6. Evaluators shall operate in an impartial and unbiased manner and give a balanced presentation of strengths and weaknesses of the policy, program, project or organizational unit being evaluated.

UNEQ Code of Conduct (2008)
Conflict of Interest
7. Evaluators are required to disclose in writing any past experience, of themselves or their immediate family, which may give rise to a potential conflict of interest, and to deal honestly in resolving any conflict of interest which may arise. Before undertaking evaluation work within the UN system, each evaluator will complete a declaration of interest form (see Annex 3).

Honesty and Integrity
8. Evaluators shall show honesty and integrity in their own behaviour, negotiating honestly the evaluation costs, tasks, limitations, scope of results likely to be obtained, while accurately presenting their procedures, data and findings and highlighting any limitations or uncertainties of interpretation within the evaluation.

Competence
9. Evaluators shall accurately represent their level of skills and knowledge and work only within the limits of their professional training and abilities in evaluation, declining assignments for which they do not have the skills and experience to complete successfully.

Accountability
10. Evaluators are accountable for the completion of the agreed evaluation deliverables within the timeframe and budget agreed, while operating in a cost effective manner.

Obligations to participants
11. Evaluators shall respect and protect the rights and welfare of human subjects and communities, in accordance with the UN Universal Declaration of Human Rights and other human rights conventions. Evaluators shall respect differences in culture, local customs, religious beliefs and practices, personal interaction, gender roles, disability, age and ethnicity, while using evaluation instruments appropriate to the cultural setting. Evaluators shall ensure prospective participants are treated as autonomous agents, free to choose whether to participate in the evaluation, while ensuring that the relatively powerless are represented. Evaluators shall make themselves aware of and comply with legal codes (whether international or national) governing, for example, interviewing children and young people.

Confidentiality
12. Evaluators shall respect people’s right to provide information in confidence and make participants aware of the scope and limits of confidentiality, while ensuring that sensitive information cannot be traced to its source.

UNEG Code of Conduct (2008) 4
Avoidance of Harm
13. Evaluators shall act to minimise risks and harms to, and burdens on, those participating in the evaluation, without compromising the integrity of the evaluation findings.

Accuracy, Completeness and Reliability
14. Evaluators have an obligation to ensure that evaluation reports and presentations are accurate, complete and reliable. Evaluators shall explicitly justify judgements, findings and conclusions and show their underlying rationale, so that stakeholders are in a position to assess them.

Transparency
15. Evaluators shall clearly communicate to stakeholders the purpose of the evaluation, the criteria applied and the intended use of findings. Evaluators shall ensure that stakeholders have a say in shaping the evaluation and shall ensure that all documentation is readily available to and understood by stakeholders.

Omissions and wrongdoing
16. Where evaluators find evidence of wrong-doing or unethical conduct, they are obliged to report it to the proper oversight authority.


Evaluation Staff Agreement Form
To be signed by all staff engaged full or part time in evaluation at the start of their contract.

Agreement to abide by the Code of Conduct for Evaluation in the UN System

Name of Staff Member: ____________________________________________________________

I confirm that I have received and understood, and will abide by the United Nations Evaluation Group Code of Conduct for Evaluation.

Signed at (place) on (date)

Signature: ________________________________________________________________________

UNEG Code of Conduct (2008) 6
(Each UNEG member to create its own forms for signature)


**Evaluation Consultants Agreement Form**

To be signed by all consultants as individuals (not by or on behalf of a consultancy company) before a contract can be issued.

**Agreement to abide by the Code of Conduct for Evaluation in the UN System**

**Name of Consultant:** _____________________________________________________________

**Name of Consultancy Organisation** (where relevant): _______________________________________

I confirm that I have received and understood and will abide by the United Nations Code of Conduct for Evaluation.

Signed at (place) on (date)

Signature: ____________________________________________________________________
# Contents

II. Introduction .................................................................................................................. 98

III. The UNFPA Evaluation Process .................................................................................. 99

  UNFPA Evaluations ........................................................................................................ 99
  Conceptualizing an evaluation ......................................................................................... 99
  Evaluation planning .......................................................................................................... 100
  Annual work planning and monitoring .......................................................................... 101
  Commissioning an evaluation ......................................................................................... 102
  Establishing management structures ............................................................................ 102
  Developing Terms of Reference .................................................................................... 103
  Selecting the evaluators ................................................................................................. 104
  Overseeing an Evaluation ............................................................................................... 104
  Preparing an evaluation report ....................................................................................... 105
  Dissemination of the evaluation report ......................................................................... 106
  Management Response ................................................................................................... 106
  Use of Evaluation Results .............................................................................................. 107
  Lessons learned compilation .......................................................................................... 107
  Assuring the quality of evaluation design and methodology ........................................ 107
  Evaluation Quality Assessment (EQA) .......................................................................... 108

IV. ANNEXES ..................................................................................................................... 108

  ANNEX 1: Evaluation annual work plan, organization and budget .............................. 108
  ANNEX II – Evaluation Terms of Reference ................................................................ 109
  ANNEX III Products and reporting .............................................................................. 111
  ANNEX IV: Use of evaluation results ........................................................................... 112
Introduction

1. This document presents evaluation guidelines for UNFPA, which have been developed to operationalize the evaluation policy.

2. In 2009, the UNFPA Executive Board (EB) approved a new evaluation policy (DP/FPA/2009/4)\(^1\) for UNFPA. This policy, together with the EB decision (2009/18), provides an overarching framework of the principles and roles and responsibilities for evaluation in UNFPA, and it defines key evaluation concepts, highlighting the capacity and resource requirements. It calls for a stronger evaluation culture characterized by high quality and regularly conducted evaluations and it emphasizes the follow up to and use of evaluation findings and recommendations.

3. These guidelines will provide details and guidance on implementation of UNFPA evaluations under the new policy. UNFPA conducts/commissions different types of evaluations – independent and decentralized, programmatic and thematic; while these guidelines put an emphasis on UNFPA Country Programme evaluations, they are applicable to all UNFPA evaluations.

4. The guidelines are presented in two main sections: the Introduction and the UNFPA Evaluation Process. Four annexes are provided with description of the UNFPA Evaluation Plan, the essential elements for Evaluation Terms of Reference, for Evaluation reports, and for Management Responses to evaluations.

The UNFPA Evaluation Process

UNFPA Evaluations

5. As per the Evaluation Policy, UNFPA evaluations fall into two broad categories: independent evaluations, which are conducted by The Division of Oversight (DOS) and are mainly for corporate accountability; and decentralized evaluations, which are conducted by other Divisions/Offices of UNFPA and primarily focus on learning to improving on-going and future programmes. These guidelines focus on the latter.

6. UNFPA conducts various types of decentralized evaluations, including, country programme evaluations (CPE), project evaluations, and thematic evaluations; and, it participates in joint country programme evaluations as well as in global thematic evaluations of relevance to its mandate. As an overarching principle, all these evaluations should be utilization-focused, credible, and compliant with UNFPA policies and procedures, with the UNEG evaluation guidelines, standards, and norms and with internationally agreed evaluation standards.

7. Some UNFPA evaluations are mandatory. In particular, end line evaluation of a CPE is mandatory as is end line evaluations of a pilot project. In addition, UNFPA country offices are instructed to participate in UNDAF evaluations, where they take place.

8. The primary purpose of mandatory evaluation is to learn and feed into development of subsequent programmes. Hence, end line CPEs are required and should be completed in time for submission to the Executive Board along with the Country Programme Document (CPD).

Conceptualizing an evaluation

9. The idea of an evaluation should begin with a need for information about the entity to be evaluated. The idea should be pursued if the entity is evaluable. Evaluability requires that intended results are clearly defined and are measurable, and valid and reliable data can are available.

10. Cognizant that a sound programme results framework is critical for a good evaluation, Programme Managers should ensure sound results frameworks that spell out logical results chains, measurable indicators, baseline and target values, and robust plans for putting in place functional data systems. In this regard, as part of country programme (CP) reviews, Regional Offices are accountable for reviewing and verifying that a Country Programme Document (CPD) includes a sound results framework.

---

Evaluation planning

11. To ensure that mandatory (programme) evaluations are conducted, these evaluations should be spelled out at the stage of developing a programme. In the case of a country programme, the mandatory evaluation should be briefly described in the Country Programme Document (CPD), providing information about the parameters listed in Text Box 1.

12. Where joint programme arrangements (such as UNDAF or other joint country programmes such as SWAP evaluations) exist, a joint programme evaluation can be used in lieu of the mandatory UNFPA CP evaluation, as long as this plan is clearly spelled out in the programme document and the joint evaluation can credibly and adequately evaluate the UNFPA component. Where the joint evaluation used in lieu of a mandatory evaluation does not adequately cover the UNFPA information needs, UNFPA should conduct a supplementary evaluation to cover the information needs not covered by the joint evaluation.

13. For the purpose of allocating resources, the description of the evaluation on the CPD should provide a block figure, which should be calculated based on the key components of a typical UNFPA evaluation. A typical UNFPA evaluation takes 6 to 8 weeks and it included the following budget line items:
   - Consultant Fees
   - DSA (consultants, UNFPA staff)
   - Travel (including air tickets), if any
   - Local transportation and venue
   - Stationary, printing and dissemination costs
   - Communication

14. Evaluation costs are expected to be charged directly from the programme budget. Hence, all programme budgets should include estimated cost of planned evaluations. Where the funds are sourced from elsewhere, the programme document should specify this alternative source. It is important to remember that joint evaluations should also be budgeted for.

15. The end of country programme cycle evaluations should be properly scheduled to precede and inform development of subsequent cycle programmes. In UNDAF countries, this evaluation should precede the UNDAF evaluation, which usually occurs in the middle of the penultimate year, as shown in Table 1.
### Table 1: Suggested timeline for implementing a mandatory end-of-programme evaluation in an UNDAF roll out country.

<table>
<thead>
<tr>
<th>Activity/Milestone</th>
<th>Year 3</th>
<th>Penultimate Year (UNDAF Evaluation in June)</th>
<th>Final year</th>
<th>New CP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiate evaluation of current CPD</td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
</tr>
<tr>
<td>Evaluate CP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disseminate and Prepare Management Response</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(UNDAF evaluation)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop next CPD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submit to for editing/translation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present draft CPD to Annual Session</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EB approves CPD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of new CPAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement New CPD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Programme managers are accountable for inclusion of mandatory evaluations into programme documents. That is, in the case of country programmes, managers are accountable for including programme cycle end line evaluations in the CPDs, and Regional Offices should verify this inclusion before approving the CPD for submission to the EB.

### Annual work planning and monitoring

17. During the annual work planning exercise, programme managers should ensure that activities of planned evaluations are properly scheduled and do not conflict with other major activities. In addition, at this stage, mandatory evaluations should be included in the office management plans of the respective offices as well as in the Programme Managers’ PADs. In the case of a country programme, the evaluation will be reflected in the country’s OMP and in the UNFPA Representative’s PAD.

18. Regional offices should compile and share with headquarters lists of evaluation scheduled for the year in their respective region. The list should specify the country, programme cycle, evaluation title, type of evaluation, budget, and dates of completion. Lists from the regional office constitute the global list, which serves as the annual evaluation plan of UNFPA. (This plan will be submitted
biennially and for information only to the Executive Board.) The timeline for compiling this plan should be as follows

- Countries submit evaluation plans to regional office – November 30 (Preceding year)
- Regional Offices submit plans to headquarters – December 31 (Preceding year)
- Headquarter finalizes global list – January 15

19. The global list of the planned evaluations constitutes the basis for tracking and reporting on implementation of UNFPA evaluations, which is primarily done by the ROs and PD through an evaluation tracking system. Every six month regional offices should submit to PD implementation status updates. Based on the regional reports, PD compiles a report on the status of implementing the annual evaluation plan and submits this report to the EC for management actions, as needed.

**Commissioning an evaluation**

20. UNFPA evaluations should be formally commissioned by programme managers. To commission an evaluation, an announcement should be made to partners/stakeholders either in a meeting or through electronic communication. It is preferred that the announcement is accompanied by a 1–2 page(s) concept note spelling out the background, purpose and objectives, scope, approach, organization and management, and a preliminary work plan of the evaluation.

21. Programme managers should make sure the evaluations are commissioned in time and stakeholders and partners that have responsibilities and/or direct interest in the programme, especially the national partners, are informed and brought on board about the rationale of the evaluation to enhance national ownership. In particular, programme managers should ensure agreement with national partners on need and use of the evaluation, on the scope, and on the timing of the evaluation.

22. Commissioning of an evaluation should also be announced on the UNFPA M&E Community of Practice network.

**Establishing management structures**

23. In line with the UNFPA Evaluation policy of strengthening national evaluation capacity by using participatory and inclusive approaches and by supporting national-led evaluations, management structures should be established based on the following key principles: UNFPA evaluations must include participation of development partners, especially national partners; countries should take lead and ownership of an evaluation; UNFPA remains accountable for any UNFPA-funded activity. In this regard, It is recommended that UNFPA evaluations constitute a management structure that includes the following:

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5 Evaluation tracking system is being developed. Presently the tracking is based on evaluation reports being uploaded into Docushare, but this may change upon agreement on a new tracking system.
• An Evaluation Management Committee – should be chaired by a representative from the government (preferably from the body coordinating the UNFPA programme), should include other representatives of government and representative of sister UN Agencies available in the country, and should include the UNFPA Programme manager.

• Evaluation Manager – the UNFPA Programme Manager (or his/her delegate) is also the Evaluation Manager.

• Evaluation Team – for conducting the evaluation.

**Developing Terms of Reference**

24. Development of Terms of Reference (TOR) should precede fielding of the evaluation by at least one month. The Programme Manager is responsible for ensuring that the TOR are developed in a timely manner and that they are of high quality.

25. TOR of any evaluation in which UNFPA is involved should be peer-reviewed by at least two UNFPA M&E Advisers, with one of the two designated as the lead for compilation of the feedback to the Evaluation Manager. In the case of country programme evaluations, the regional M&E Adviser should be the lead Adviser, who compiles feedback to the country. Hence, CO should share the draft TOR with RO M&E Advisers two months before the evaluation, for comments and quality assurance. In the case of regional or other Division evaluations, the region or division should select any available UNFPA M&E Advisers who does not belong to the unit conducting the evaluation, and assign him/her to be the lead Adviser. The lead Adviser should share the TOR with at least one other UNFPA M&E Adviser, and he/she should compile and pass on to the Evaluation Manager the comments/feedback from all the Advisers consulted. Regional and Divisional evaluations should involve Evaluation Advisers at the headquarters.

26. In the case of joint evaluations, such as UNDAF evaluations, it is essential that the UNFPA Representative participates in the development of TOR and subjects these TOR to the UNFPA quality assurance mechanism of peer reviewing by at least two UNFPA M&E Advisers.

27. UNFPA evaluations should always be based on high quality TOR, details of which are presented in Annex II. In addition to the elements presented in the Annex, TORs for end line evaluations of a country programme cycle should pay particular attention to the following: *i)* TOR should be reviewed and commented on by partners; *ii)* “Support to development of next programme” should be stated in the purpose paragraph; *iii)* at the minimum, the evaluation criteria should include: relevance, effectiveness, efficiency, potential for sustainability, and leadership and management (human, financial, systems); *iv)* under the methodology paragraph, the TOR should request for an Evaluation Methodology Framework (a sample of which is presented in Annex II), and it should ask for a plan for taking into account ethical considerations; and, *v)* the TOR should require the evaluation to triangulate and take into consideration existing data such as survey data, routine health service (HMIS) data, annual programme review information, and data from relevant research studies.
Selecting the evaluators

28. The Evaluation Management Committee should select the evaluators through a transparent process on the basis of competence. The preference is to get a gender balanced team and to use locally or regionally based consultants before resorting to international ones.

29. A typical UNFPA end line evaluation of a country programme requires expertise (a consultant) for each of the UNFPA mandate areas (RH, PD, and Gender) covered by the programme and for the evaluation methodology, including data analysis. One of the evaluators should be recruited as the team leader. This leader should be experienced in the UNFPA type of evaluations and should have strong evaluation methodology background.

30. In the case of making a choice between hiring individual consultants or hiring a firm/institution, a firm/institution is preferred, especially if the institution would benefit and build national evaluation capacity.

31. It is highly recommended that consultants are selected from the vetted pool of consultants in the UNFPA consultant roster. Therefore, to increase local institutions’ chances of being selected, qualified staff of these institutions should be invited to enroll on the roster.

32. Evaluation managers should follow UNFPA procurement procedures to select evaluators. Because the procurement process may be slow, especially when it involves international bidding, managers should plan enough time to ensure the procurement process does not derail the time line for completing the evaluation.

Overseeing an Evaluation

33. The Evaluation Management Committee and the Evaluation Manager provide oversight to an evaluation. Supported by the Evaluation Manager, the Evaluation Management Committee should regularly meet as needed to undertake the main oversight activities listed in Text Box 2.

34. UNFPA evaluations require from the evaluators a minimum of three implementation milestones, namely, i) An inception report (showing the proposed design, methodology, implementation plan, deliverables, and deadlines); ii) A debrief at the end of field work (covering summary of resources spent and work covered in the field, and preliminary findings); and, iii) A final report. The Committee should convene a meeting upon achievement of each milestone to the products from the milestone. At the same time, the Evaluation Manager is encouraged to share with the Regional Office the inception report for comments and the draft evaluation report for quality assurance and clearance.
### Text Box 2: Main Oversight Activities of an Evaluation Management Committee and of the Evaluation Manager

<table>
<thead>
<tr>
<th>Evaluation Management Committee</th>
<th>Evaluation Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Approve of TOR</td>
<td>• Convene, coordinate and support the Evaluation Committee meetings</td>
</tr>
<tr>
<td>• Select and debrief Evaluation team</td>
<td>• Lead development of the TOR and the management response.</td>
</tr>
<tr>
<td>• Organize technical support</td>
<td>• Manage the evaluation budget and ensure logistical and administrative support</td>
</tr>
<tr>
<td>• Approve inception report and final evaluation budget</td>
<td>• Coordinate with UNFPA relevant units, e.g. with regional offices in the case of a</td>
</tr>
<tr>
<td>• Monitor progress and quality of evaluation activities</td>
<td>country evaluation</td>
</tr>
<tr>
<td>• Review and comment on drafts</td>
<td>• Facilitate access to background documents</td>
</tr>
<tr>
<td>• Approve evaluation reports</td>
<td>• Upload evaluation TOR and final report into UNFPA central repository</td>
</tr>
<tr>
<td>• Disseminate and follow up to evaluation finding</td>
<td></td>
</tr>
<tr>
<td>• Assess performance and approve payments to evaluators</td>
<td></td>
</tr>
</tbody>
</table>

35. UNFPA contracts with evaluators should be managed on performance-based principles. Hence, payment of the evaluators’ fees should be staggered across the three milestone, e.g. as follows:
- Upon a satisfactory Inception report – 30%
- Upon successful completion of field work – 20%
- Upon a satisfactory final report - the remaining 50%

### Preparing an evaluation report

36. A final report of a UNFPA evaluation should be prepared through at least three iterations of reports:

a. In the first iteration, the evaluator(s) prepare and submit a draft to the Evaluation Manager. The Manager should distribute the draft to partners for peer-reviewing and should give a deadline of e.g. two weeks for receiving comments and feedback. During this period, the Evaluation Manager should also send the draft to, and get feedback from the designated UNFPA M&E Adviser(s). At the end of two weeks, the Evaluation Manager should convene a meeting of the Evaluation Management Committee to discuss the comments and feedback on the draft and to prepare a response to the evaluators, outlining what needs to be done to improve and complete the report in time.

b. In the second iteration, the evaluator(s) re-submit a draft that has incorporated the comments on the first draft. The Evaluation Manager shares the second draft with the designated M&E adviser and with the Evaluation Management Committee. At least one week after sharing the second draft, the Committee is convened to prepare comments and to guide the evaluators on finalization of the report.
c. After the two rounds of reviewing of the drafts, the report may be finalized, depending on the satisfaction of the Evaluation Committee.

37. Once the report is finalized, it should be formally presented to the partners, uploaded into a UNFPA central document repository, and announced on the UNFPA M& E Community of Practice and on the UNFPA public web site.

38. The report should essentially use the outline provided by the UNFPA Programme Manager’s Toolkit, an abridged version of which is attached to these guidelines as Annex III. UNFPA evaluations should pay particular attention to include all the recommended sections of this outline, especially the Executive Summary, and the Terms of Reference, which in the past have been found missing in some evaluation reports and they should ensure the methodology is well articulated and includes the ethical considerations taken by the evaluation.

Dissemination of the evaluation report

39. The dissemination should be planned right from the beginning of the evaluation and reflected in the TOR as well as in the Inception Report. This plan should include different dissemination approaches for different types of audiences, for example, policy makers may need a one-page summary while the implementing partners may need a full report. Different channels of dissemination should be considered, including: the UNFPA public website, distribution of hard copies, dissemination workshop, media briefs, email lists, and national, regional, or international conferences and meetings. And, dissemination activities should be adequately budgeted for.

Management Response

40. All evaluations, including evaluations conducted jointly with partners, require a management response. Management responses should be prepared using the standard UNFPA management response tool and they should be uploaded into central document repository within one month of accepting the final report of an evaluation.

41. Management responses should be developed collaboratively with relevant stakeholders. In most cases, the Programme Manager drafts the management response, circulates the response together with the evaluation report, and convenes a meeting to discuss and agree on the management response. Whatever variation of this process is followed, it is essential that the management response has approval of the key stakeholders and partners.

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7 See UN ethical guidelines for evaluation: https://www.myunfpa.org/Portal/documents/docs/UNEG%20Ethical%20Guidelines.pdf
8 A UNFPA Management Response Tracking Form can be found at https://portal.myunfpa.org/web/pd/evaluation.
42. The response actions listed in the management response should be implemented and monitored. Note that for joint evaluations, the actions should be in response to recommendations calling for UNFPA’s action, including actions of supporting other partners. Implementation of the management responses will be monitored and reported on by the regional offices and headquarters.

**Use of Evaluation Results**

43. Programme evaluation results should be used to inform and improve on-going as well as future programmes. Regional Offices should certify and sign off that a CPD was indeed informed by the preceding end of programme cycle evaluations. If needed, these offices should advise countries whose CPDs were not informed by preceding end of Programme cycle evaluations to revisit and revise the CPD accordingly.

**Lessons learned compilation**

44. PD will synthesize the evaluation findings and prepare summaries showing UNFPA’s successes and challenges and listing the main lessons learned over a period of time. The summary report will be published on the UNFPA website.

**Assuring the quality of evaluation design and methodology**

45. The quality assurance of the evaluation process and products (TOR, evaluation design and reports) is the responsibility of the Evaluation Committee. However, the UNFPA programme manager is accountable for the quality of an evaluation of the programme he/she manages. The manager should ensure that the evaluation is of acceptable quality and is carried according to the UNFPA guidelines and procedures.

46. Allocation of sufficient time for planning an evaluation is critical. Preparations for an evaluation should begin at least 3 months from the start date of the evaluators.

47. The process of internal peer-reviewing of TORs, evaluation reports, and management responses is critical to the UNFPA mechanism of assuring quality of evaluations and should be strictly adhered to. In this regard, Regional Offices are accountable for the quality of TORs, the quality of management responses, and for the monitoring of the follow up to evaluation recommendations.

48. In addition to the internal review process, programme managers are encouraged to get external peer reviewers, e.g. from government representatives, UN sister agency representatives, or from academic/research institution representatives. In general, stakeholders should be involved at all stages of the evaluation, including the initial stages of focusing the evaluation, formulation of evaluation questions, identification of credible data sources, assistance in interpretation of findings and in formulation of recommendations to enhance credibility and hence quality of an evaluation.
Evaluation Quality Assessment (EQA)

49. The Division of Oversight Services (DOS) is responsible for regularly assessing and reporting on the quality of UNFPA evaluations and the performance of the UNFPA evaluation function in general. To assess quality of an evaluation DOS uses 18 EQA standards, which cover the following elements: evaluation scope, objectives, evaluation criteria, methodology, ethical considerations, stakeholder involvement, logical flow of results from the analysis and logical flow of recommendations from the findings, and well structured and comprehensive report outline. The EQA report provides feedback that is used to improve UNFPA evaluations and to revise and strengthen UNFPA evaluation guidelines. All UNFPA staff involved in UNFPA evaluations should familiarize themselves with the EQA standards.9

50. Internally, management will monitor and review performance of the evaluation function in terms of coverage, quality, use of evaluation results, and compliance with the evaluation guidelines. Based on this review management will take remedial actions, including regular revision of the guidelines, if the need arises.

ANNEXES

ANNEX 1: Evaluation annual work plan, organization and budget
The annual UNFPA work plan consists of a list evaluations planned for a particular year. The plan, which is compiled from the regions and headquarters divisions into an organizational annual plan by headquarters, is presented in an Excel table, a sample of which is shown in Table A1.

<table>
<thead>
<tr>
<th>Region/Headquarter</th>
<th>Evaluation Characteristics</th>
<th>Planned</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region Name</td>
<td>Office Name</td>
<td>Programme Cycle</td>
<td>Evaluation Title</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Columns 5 and 6 have drop down lists to ensure valid and standard descriptions of the evaluations.

Region Offices will fill this list and submit to headquarters as spelled out in the guidelines.

ANNEX II – Evaluation Terms of Reference
UNFPA Evaluations TOR should include the sections as shown in Text Box A1. Further reference on development of TOR can be found in the Programme managers Planning, Monitoring, and Evaluation Toolkit. In the paragraphs below, this Annex focuses on areas critical to quality of UNFPA evaluations.

The background
UNFPA evaluations should present a detailed background section of the TOR to enable the evaluators identify the priority issues and inquiry areas. The background should describe the programme in terms of coverage, age, intensity, cost, implementation arrangements, performance, and challenges. It should also describe the contextual factors of significance to the success or failure of a programme. The background should be rich enough to set the stage for the evaluation objectives and questions.

Purpose
Under the Purpose section, UNFPA evaluations should provide the reasons and justification for the evaluation. The best approach of thinking about the purpose is to ask the question - Why are we doing this evaluation at this point in time? Who will be the primary user of the evaluation results? What information is needed? How will the information be used? Example of a Purpose Statement:

Text Box A2: Sample Purpose Statement - The purpose of this evaluation is to conduct an end of programme cycle evaluation to assess the achievement of the programme, the factors that facilitated/hinders achievement, and to compile lessons learned so as to inform development of the next country programme cycle.

Scope
The scope of an evaluation essentially outlines what is covered and what is not covered by the evaluation. It specifies the

- **Time period** – For example, duration of one country programme cycle
- **Geographical regions** – For example, regional, national, sub-national;
- **Programme aspects** – Technical area such as Gender, P&D, RH, ASRH; funding source, e.g. Bill gates funded component or Funds for ASRH; target population (e.g. health facilities, pregnant women, e.t.c.)
- **Evaluation criteria** – The criteria defines what concept will be evaluated. For example, if the entity to be evaluated were a car, the criteria could be speed, reliability, comfort, e.t.c. For development programmes, the criteria include: relevance, effectiveness, efficiency, impact, sustainability, management systems (human resources, financial resources, systems). In addition,
coverage, coherence, coordination, and protection are usually part of evaluations of humanitarian responses programmes.

It is always very important to specify area that are part of the programme but will not be part of the evaluation. For example an end of country programme evaluation may not cover an area that was already addressed by another jointly conducted evaluation.

**Objectives**
Objectives constitute a very critical piece of a TOR because they determine the outputs of an evaluation, which should directly derive from the purpose and focus the evaluation on the decisions that need to be made. UNFPA end-of programme cycle evaluations should use the evaluation criteria to guide formulation of the evaluation objectives.

Objectives must be specific enough to guide methodology of collecting, analysis and interpreting information and data. Table A2 shows examples of generic versus specific evaluation objectives. UNFPA evaluation should always state specific objectives.

<table>
<thead>
<tr>
<th>Table A2</th>
<th>Generic Objectives (Not recommended)</th>
<th>Specific objectives (Recommended)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To assess achievement of the programme objectives</td>
<td>To assess whether availability of EOC services increased in the 10 districts supported by the programme</td>
<td></td>
</tr>
<tr>
<td>To assess the effectiveness of the programme</td>
<td>To assessment of whether the IEC interventions led to increased use of contraceptives</td>
<td></td>
</tr>
</tbody>
</table>

Objectives are sometimes stated as overarching questions. In either case, the objectives or overarching questions are then followed by specific evaluation questions.

Evaluation questions should pinpoint to the element to be measured to fulfill the objective of an evaluation and to provide the information needed by primary users of the evaluation to make decisions. Examples of questions are provided in Table A3.

**Examples of questions**

<table>
<thead>
<tr>
<th>Table A3: Evaluation questions for a typical UNFPA end of programme cycle evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness criteria</strong></td>
</tr>
<tr>
<td>• Did intervention x achieve output x as planned?</td>
</tr>
<tr>
<td>• To what extent did output x of a UNFPA programme contribute to the change observed for Outcome x?</td>
</tr>
<tr>
<td>• What external factors facilitated/hindered achievement of output x?</td>
</tr>
</tbody>
</table>

**Methodology**
The methodology directly derives from the objectives and the evaluation questions. Each specific objectives and questions calls for a specific methodology. The methodology consists of the following: evaluation objectives/overarching question, specific evaluation questions, performance indicators, data source, evaluation design, sampling plan, data collection instruments, and data analysis plan. Table A4 provides an example of an Evaluation Methodology Framework.
Table A4: Evaluation Methodology Framework

<table>
<thead>
<tr>
<th>Objective / overarching question</th>
<th>Specific question</th>
<th>Performance indicator</th>
<th>Data Source</th>
<th>Evaluation design</th>
<th>Sampling plan</th>
<th>Data collection instruments</th>
<th>Data analysis plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess effectiveness of mass media strategy in increasing use of RH</td>
<td>Did mass media msgs reach target population</td>
<td>% of women who heard an RH message</td>
<td>Sample survey</td>
<td>Pre and Post-test single group</td>
<td>Cluster sampling</td>
<td>Structured individual women questionnaire</td>
<td>t-test</td>
</tr>
<tr>
<td>Did the mass media strategy increase use of RH services?</td>
<td>Did target population increase use of RH services increase?</td>
<td>% of new FP clients</td>
<td>Facility service data</td>
<td>Time series</td>
<td>Census of all facilities in a region</td>
<td>Facility survey questionnaire</td>
<td>Analysis of distribution s over time</td>
</tr>
</tbody>
</table>

UNFPA evaluation should employ an appropriate mix of methods depending on the evaluation questions and should always indicate preference for quantitative methods, when appropriate and possible. In this regard, UNFPA evaluations should always strategize and leverage to maximize use of existing quantitative data such as the DHS and the MICS.

Also, the TOR of a UNFPA evaluation should emphasize the need for triangulations of data to increase credibility of the evidence. The TOR should emphasize the use of annual review reports as building blocks of a country programme evaluation of UNFPA.

**ANNEX III Products and reporting**

UNFPA evaluation reports should include all the following elements:

**Title page**
Should contain name of project, programme or theme being evaluated; country/ies of project/programme or theme; name of the organization to which the report is submitted; names and affiliations of the evaluators; and date.

**Table of Contents**

**Acknowledgements**
Identify those who contributed to the evaluation.

**List of acronyms**

**Executive summary**
A self-contained paper of 1-3 pages, summarizing essential information on the subject being evaluated, the purpose and objectives of the evaluation, methods applied and major limitations, the most important findings, conclusions and recommendations in priority order.

**Introduction**
Describe the project/programme/theme being evaluated, including the problems being addressed by the interventions. Summarize the evaluation purpose, objectives, and key questions. Explain the rationale for selection/non selection of evaluation criteria. Describe the methodology employed to conduct the
evaluation. Detail who was involved in conducting the evaluation and what were their roles. Describe the structure of the evaluation report.

**Findings and conclusions**
State findings based on the evidence derived from the information collected. To the extent possible measure achievement of results in quantitative and qualitative terms, and analyze the linkages between inputs, activities, outputs, outcomes and, if possible, impact. Discuss the relative contributions of stakeholders to achievement of results. Conclusions should be substantiated by the findings and be consistent with the data collected, and must relate to the evaluation objectives and provide answers to the evaluation questions.

**Lessons learned**
Based on the evaluation findings and drawing from the evaluator(s)’ overall experience in other contexts if possible provide lessons learned that may be applicable in other situations as well. Include both positive and negative lessons.

**Recommendations**
Formulate relevant, specific and realistic recommendations that are based on the evidence gathered, conclusions made and lessons learned. List proposals for action to be taken (short and long-term) by the person(s), unit or organization responsible for follow-up in priority order, including suggested time lines and cost estimates (where relevant) for implementation.

**Annexes**
Attach Terms of Reference for the evaluation; list persons interviewed, sites visited; list documents reviewed (reports, publications); data collection instruments (e.g., copies of questionnaires, surveys, etc.); web links.

(Adapted from UNFPA Programme Manager’s Planning Monitoring & Evaluation Toolkit, Tool Number 5: Planning and Managing an Evaluation Part IV: Managing the Evaluation Process.)

**ANNEX IV: Use of evaluation results**
To systematically ensure that the results of an evaluation are used to inform programming and strategic and policy decisions, UNFPA evaluation should prepare, implement, and monitor implementation of management responses, and new programme documents or new strategic or policy decisions should be reviewed to assess the extent to which they used results and recommendations from UNFPA evaluations.

UNFPA has developed a standard tool for preparing and monitoring management responses. The tool includes two sections: i) General comments to the evaluation results; and, ii) Specific response and actions to be taken against each evaluation recommendations.

The general comments section, which should be brief and no more than 500 words, acknowledges receipt of the evaluation and indicates the areas in which the evaluation results will be used. The comments can also indicate areas that need improvement in future evaluations or areas that need further discussion to supplement findings of the evaluation.

The sections on specific actions to be taken against each recommendation spell out the actions and the plan for implementing these actions.

A sample of the tool can be found at [https://portal.myunfpa.org/web/pd/evaluation](https://portal.myunfpa.org/web/pd/evaluation) (UNFPA Management Response Tracking Form).
DOCUMENTS ACCESSED IN EOP EVALUATION

UNFPA Country Documents

1. Reproductive Health Needs Assessment in Myanmar, 1999
2. Lessons learnt: Community Operated Youth Centers in Myanmar, 2004
4. BCC Master Plan, 2003
5. Minutes, Mid-term Review, Special Programme of Assistance to Myanmar, November, 2004
6. Review, Special Programme of Assistance to Myanmar, November, 2004
9. Second Programme of Assistance to Myanmar, Submission to Executive Board, August 2006
10. BCC Community Oriented Reproductive Health, Presentation on Project, 2010
11. Mid Term Review, Second Programme of Assistance, Presentations, 2009
12. Mid Term Review, Second Programme of Assistance, Recommendations, 2009
13. Mid Term Review, Second Programme of Assistance, Minutes, 2009
15. Gender Briefing Kit, 2010
16. ARH: Meeting the Needs of Adolescents, Presentation, February 2010
17. ARH: Mapping work undertaken in 2007, in collaboration with UNICEF
18. Briefing: Gender related Activities of UNFPA, 2011
20. Contingency Plan for UNFPA, Myanmar, 2010
22. ARH Project Coordination Meeting, March 2010
25. RH Logistic Management Assessment, 2002
26. UNFPA Representative, Strategic Directions to Promote the Status of Women in Myanmar, Presentation, October 2010
27. UNFPA Representative, Equal access to education, training and science and technology: Pathway to Decent work for women, IWD Presentation, March 2011
28. UNFPA Country Programme Performance Summary, 2011

UNFPA Implementing Partners Documents

29. MANA, Presentation, PyiGyi Tagon Drop-In-Centre, Mandalay Division, March 2011
30. MMA, Presentations on BCC, Workplace Projects, Mobile Service Provision, RH Training, North Rakhine RH Projects, PMCT Projects, March 2011
31. Annual Project Reports- MRCS, JOICFP, MANA, MSI, AMI, PSI, SC
32. MMA, Presentation on Youth Development Program, March 2011
35. MSI, Presentation on Reproductive Health for Young People, March 2011
36. PSI, TOP Programme – Reaching national coverage of people at risk of HIV in Myanmar, 2010

**Other UNFPA Documents**
37. Executive Board of the UNDP and UNFPA, UNFPA global and regional Programme (2008-2011), 2007
38. Executive Board of the UNDP and UNFPA, Strategic Plan 2008-2011: accelerating progress and national Ownership of the ICPD Programme of Action
39. UNFPA Evaluation Guidelines
40. UNEG, *Ethical Guidelines on Evaluation*
41. Quality Checklist for Evaluators and Country Office Evaluation Managers
42. UNFPA’s Strategic Framework on Gender Mainstreaming and Women’s Empowerment
43. UNFPA, *Leadership and Strategic Partnership for ICPD in Asia and the Pacific, Position Paper, 2010*
44. UNFPA, Asia and the Pacific at a Glance, 2010
45. *Asia-Pacific Forum Declaration on Population and Development: Fifteen Years after Cairo*, Bangkok, 2009
46. *ICPD at 15: Priority Challenges for the Asia-Pacific*, 2010
47. *Guidance on the Consequences for UNFPA’s Work at Country Level as a result of the New Aid Environment*, 2007
49. *Population Ageing in East and South East Asia*, 2006
50. AFPPD, 7th Women Parliamentarians and Ministers Conference, 2009
51. AFPPD 2009- A Review
52. ICP, *Yogyakarta Declaration*, October 2010
53. UN Global Strategy on Women and Health, 2010

**Evaluations and Reviews**
55. WHO/UNFPA, Assessment on Effective Utilization and Maintenance of Trawlergies for Emergency Obstetric and Newborn Referral in Sagaing Division, July 2008
56. Evaluation Report, Cost Effectiveness of Drop In Centres (DIC) approaches for HIV/AIDS Prevention and Management Supported by UNFPA, 2010
57. AMI, Evaluation Report of UNFPA Funded AMI Project in the Wa Sepecial region No. 2 (Myanmar, December 2009)
58. Inception Report, Maternity Waiting Homes, November 2010

GoUM Documents

64. Research Papers on *Family and Youth Survey*, 2009 (with UNFPA support)
65. 2007 Country Report, 2007 *Fertility and Reproductive Health Survey*, 2009 (with UNFPA support)
66. AIDS/STD Team, Naung-U, Presentation, *100% Targeted Condom Promotion*, March 2010
67. *National Health Plan* 2006 - 2011
70. *National Strategic Plan for Adolescent Health* 2009 - 2013
71. *National Strategic Plan on HIV and AIDS*, 2006 - 2010
77. NAP, *HIV Sentinel Sero-Surveillance Survey* 2007
78. NAP, *HIV Sentinel Sero-Surveillance Survey* 2008
79. NAP, *HIV Sentinel Sero-Surveillance Survey* 2009
80. *Reproductive Health Profiles* (various), Pakokku, Nyaung-U, Chauk, Wundwin, Kawa,
81. *National Reproductive Health TWG Meeting*, Minutes, Second meeting, December 2010, including Presentation On Monitoring achievements on MMR
82. Meeting of National Working Committee for Reproductive Health, October 2010
86. Department of Health Planning, various reports based on monitoring by *HRMIS*
88. Department of Health Planning, Health Statistics, 2009
89. Department of Population, draft Paper on Ageing Transition In Myanmar, 2010
90. Department of Population, draft Paper on Level, Pattern and Trends of Internal Migration, 2010
91. Department of Health, Mortality Study, Saging Division, 2009
Technical Working Groups

96. Women’s Protection Technical Working Group, Terms of Reference and associated papers, September 2010

UN Documents

99. Gender Theme Group, Work Plan and Minutes of Meetings
100. UNAIDS, Briefing on Country Situation, May 2008
101. Draft UNCT’s Thematic Analysis, 2011
102. Poverty Profile of Myanmar
105. UNICEF, Multiple Indicator Cluster Survey, MICS, 2003
106. TOR, Youth Working Group on HIV/AIDS
109. UN M&E Theme Group, TOR
110. Data Mission on Strengthening MDG Indicators, 2009
111. UN M&E Theme Group, Work Plan, 2010
112. Nationwide Cause Specific Maternal Mortality Survey in 2004-2005 (MOH, UNICEF);
115. UNDP, Human Development Report, 2009

Other Documents

117. Three Disease Fund Progress Report, 2010
QUESTIONS FOR STRUCTURED INTERVIEWS
UNFPA Programme Managers/Implementing Partners/Government Officials/Donors/TWG/ Managers of INGOs or NGOs

**Note:** This is a list of possible questions to be asked in structured interviews with UNFPA/Donors/TWG etc. Questions asked in a particular interview situations will depend on the role/functions of the person(s) interviewed and their level of understanding of CP2. Follow up questions will be used if clarification of an answer given is needed. Questions will be asked in English but interpreters will be used to assist discussion in the Myanmar national language, whenever required.

Questioning will follow UNEG protocols on the conduct of evaluations, in particular as regards confidentiality and protection of the sources of information gathered.

<table>
<thead>
<tr>
<th>Evaluation Criteria</th>
<th>TOR questions</th>
<th>Evaluation questions</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Programme relevance</td>
<td>Do programme planned results address national needs and priorities and are they in line with UNFPA’s mandate, are they considered useful to target populations and complementary to other stakeholders interventions?</td>
<td>To what extent do CP2’s priorities and objectives align with national priorities and policies?</td>
<td>Degree of concurrence of CPAP with national plans and priorities</td>
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<td>To what extent do the outputs and outcomes contribute towards the achievement of the ICPD goals and the MDG?</td>
<td>Degree of concurrence of CP2 with ICPD goals and MDGs</td>
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<td>Was CP2 considered beneficial to target populations? Does CP2 address equity aspects including the poor through program delivery?</td>
<td>Evidence of specific positive benefits for target population</td>
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<td>How appropriate and realistic are the program strategies and interventions, considering the socio-economic and budgetary governance environment in which the UNFPA operates in Myanmar?</td>
<td>Documentation and analysis of stakeholder opinions on appropriateness and realism of program strategies.</td>
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<td>What are major risks and constraints faced by the programme, now and in future? How are these risks being managed and mitigated?</td>
<td>Appropriate risk management and mitigation strategies</td>
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<td>To what extent do the program strategies and interventions align with UNFPA’s global mandate?</td>
<td>Degree of concurrence of CPAP with UNFPA’s global mandate</td>
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<td>What is UNFPA’s strategic advantage in Myanmar?</td>
<td>Analysis of strengths and weaknesses identifies niches where UNFPA is best placed to operate</td>
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<td>To what extent did programme activities of UNFPA complement and synergise with interventions by other agencies? Was there coordination with other donors?</td>
<td>Documentation and analysis of stakeholder opinions</td>
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<td>To what extent did programme activities of UNFPA overlap and duplicate interventions by other agencies? How could synergies have been enhanced and duplications avoided?</td>
<td>Documented evidence of synergies and/or duplication of effort.</td>
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<td>How effectively does UNFPA work with other UN agencies on joint programming? With other donors?</td>
<td>Documentation and analysis of stakeholder opinions</td>
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<tr>
<td>2. Validity of Design</td>
<td>Are programme results (outcomes, outputs and impact) clearly stated describing solutions to identified problems?</td>
<td>How are programme results articulated? To what extent do they describe solutions? To what extent was the programme designed to be cost effective and efficient? Were there any other ways of designing the programme in a more cost effective manner, without diminishing the quality of outputs? If yes, explain.</td>
<td>Programme documents identify well articulated solutions Program documents demonstrate that cost effectiveness was taken into account Alternative more cost effective options identified/not identified</td>
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<td></td>
<td>Are inputs and strategies including geographical coverage of interventions, realistic, appropriate and</td>
<td>Do the programme component inputs and strategies together form a coherent, comprehensive and sound response to identified needs? What was the effect of not including separate sub-components on PD and</td>
<td>Outputs identified and geographic coverage were sufficient to achieve desired results</td>
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118
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<tr>
<td>Adequate to achieve the results?</td>
<td>gender?</td>
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<tr>
<td>Have external factors that could affect the programme been identified and assumptions validated?</td>
<td>What relevant factors and assumptions underlying design were taken into account?</td>
<td>Documentary programme evidence that relevant external factors and assumptions were considered</td>
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<tr>
<td>Are indicators SMART (specific, measurable, achievable, realistic and time bound)?</td>
<td>Does the indicators matrix meet the SMART test?</td>
<td>Indicators meet SMART test</td>
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<td>Were execution and implementation modalities identified at the time of developing the programme?</td>
<td>What are the modalities identified at the program design stage?</td>
<td>Design documents cover modalities</td>
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<tr>
<td>Does program design address gender issues?</td>
<td>Have gender aspects been appropriately addressed in RH, ARH, PD, HIV and PMCT sub components?</td>
<td>Design documents cover relevant gender aspects</td>
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<tr>
<td>Are there linkages among programme components established to ensure synergies?</td>
<td>What is the level of synergy and between the programme component outputs?</td>
<td>Documented evidence of complementarity between programme component outputs.</td>
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<td></td>
<td>To what extent was the programme developed based on needs assessment and gap analysis?</td>
<td>Documented evidence of needs assessment and gap analysis incorporated into CP2.</td>
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<td></td>
<td>Does program experience suggest any basic changes of design are needed in the next program?</td>
<td>Major design issues identified by stakeholders, implementing partners and beneficiary interviews</td>
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<td>3. Management</td>
<td>Did programme implementers discharge their duties effectively?</td>
<td>What were the strengths and weaknesses of UNFPA’s programme management? How could management have been improved? How appropriate was the programme management structure? What were the major management issues and how were these resolved? To what extent did management support/hinder the progress of implementing CP2? To what extent is there a “management for results” focus in implementing CP2? How was accountability</td>
<td>Degree of concurrence in management support provided with management good practice and results-based management</td>
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<td>established under CP2?</td>
<td>How has management responded to recommendations of the MTR or the APRs?</td>
<td>Recommendations followed up/ acted on</td>
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<td>Were sound financial, equipment and commodity management procedures practiced?</td>
<td>Were financial practices appropriate? What have been the audit results?</td>
<td>Was equipment management appropriately handled?</td>
<td>Degree of concurrence of financial, equipment and commodity management acknowledged good practice.</td>
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<td>Was equipment management appropriately handled?</td>
<td>What has been the experience in commodity management?</td>
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<td>What was the experience in commodity management?</td>
<td>How well were these managed?</td>
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<td>Were financial practices appropriate? What have been the audit results?</td>
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<td>Was equipment management appropriately handled?</td>
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<td>How well were these managed?</td>
<td>What has been the experience in commodity management?</td>
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<td>Were monitoring and evaluation systems and processes adequate? Have data been collected on indicators of achievement and do they provide adequate evidence of achievement of programme results?</td>
<td>How appropriate and effective is programme monitoring and evaluation?</td>
<td>Documentation of M&amp;E plans.</td>
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<tr>
<td></td>
<td>How appropriate and effective is programme monitoring and evaluation?</td>
<td>Were monitoring plans adequately prepared and implemented?</td>
<td>Extent to which M&amp;E plans were implemented.</td>
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<td>Were monitoring plans adequately prepared and implemented?</td>
<td>Did monitoring allow for adequate assessment of changes in risks and opportunities in the internal environments?</td>
<td>Documented joint M&amp;E activities</td>
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<td></td>
<td>Did monitoring allow for adequate assessment of changes in risks and opportunities in the internal environments?</td>
<td>To what extent does the M&amp;E capture programme outputs and outcomes?</td>
<td>Adequate coverage of outputs and outcomes</td>
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<td><strong>4. Programme Effectiveness</strong></td>
<td>How did monitoring contribute (or hinder) the progress and/or quality of the implementation of activities? To what extent does the M&amp;E facilitate effective program decision-making? How could the M&amp;E be improved?</td>
<td>under M &amp; E</td>
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<td></td>
<td>To what extent have planned outputs and outcomes been achieved? What is the quality of outputs?</td>
<td>What were the outputs and outcomes achieved? What was their quality like?</td>
<td>Monitoring activity assisted progress and quality of CP2</td>
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<td>What are the facilitating and constraining factors that created a supportive environment or hampered the programme? What were the effects of these factors on programme effectiveness and efficiency? How did the programme attempt to manage or mitigate these factors?</td>
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<td>What was effect of delivery of CP2 on poor and other disadvantaged groups? Were there any gaps?</td>
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<td>How has the programme given effect to the aid effectiveness agenda?</td>
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<td>What were the results achieved in respect of RH?</td>
<td>Results achieved in delivery of RH services? Static and mobile services in maternal health? In EMoC services and equipment? Through CSGs? In maternity homes? In birth spacing and in provision of commodities? Has there been increased access to RH services?</td>
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<td>Extent to which RH subcomponent achieved desired outputs and outcomes.</td>
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<td>Evaluation Criteria</td>
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<td>Were data produced through surveys and other methods of data collection disaggregated by gender?</td>
<td>What examples are there of disaggregated data by other criteria (age, ethnicity)? Are there capacity constraints related to PD of counterparts or implementing partners? How have these been addressed To what extent is data fed back in policy and national planning work?</td>
<td>Documented evidence of data disaggregation Relevant capacity issues are being addressed National policies take account of relevant data</td>
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<td>What were the achievements in terms of capacity development</td>
<td>What has been the effect of individual CD initiatives on knowledge, skills, attitudes and behaviours? What has been the take-up of CD? What has the quality of CD been like?</td>
<td>Training data demonstrates positive effects Documented evidence from CD evaluations and stakeholder interview</td>
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<td>To what extent were Targeted Outreach Programme (TOP) and Drop in Centers (DICs) effective in increasing access to, and increasing knowledge about RH, HIV, and PMTCT services? What factors affected the effectiveness of TOP and DICs?</td>
<td>What has been the experience in the operation of TOP and DIC centres? What is the quality of the program and services provided and the results achieved? What factors led to greater effectiveness?</td>
<td>Evaluations and reviews and stakeholder and beneficiary interview indicate evidence of improved knowledge linked to work under TOP and DIC</td>
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<td>To what extent have the following increased: knowledge of RH and HIV prevention among youth and vulnerable populations; access to PMTCT services?</td>
<td>Is there improvement in the knowledge of RH and HIV prevention among youth and vulnerable populations? Or through changes in behaviour? Access to PMTCT services?</td>
<td>Project documentation, evaluations, beneficiary interview establishing improvements in level of knowledge or access to services Stakeholder and beneficiary interview</td>
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<td>To what extent have the IEC and the BCC interventions (advocacy meetings, community awareness raising activities, group education)</td>
<td>What has been the effect of BCC interventions on programme results? RH services? HIV services? ARH services? PMTCT services? Have interventions increased knowledge and utilization of RH services, increased knowledge about HIV prevention among</td>
<td>Evidence linked to BCC and IEC interventions of increased knowledge or behavioural change relating to RH, ARH HIV prevention, PMTCT</td>
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<td>sessions, individual learning) and IEC interventions effectively contributed to</td>
<td>young people and among vulnerable populations, and increased access to PMTCT services?</td>
<td>Extent of effect of particular interventions, as compared to each other</td>
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<td>achievement of the programme results/</td>
<td>What has been the result of IEC interventions? RH services? HIV services? ARH services? PMTCT services?</td>
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<td>To what extent are some interventions relatively more effective than others in</td>
<td>What interventions work best in increasing knowledge and why?</td>
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<td>increasing knowledge about RH, HIV, and PMTCT? What are possible interventions</td>
<td>What interventions work less well and why?</td>
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<td>UNFPA could have implemented? What factors within UNFPA’s control explain this</td>
<td>Were there other interventions that could have been made?</td>
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<td>difference, if any?</td>
<td>What are the factors in play that UNFPA has influence over?</td>
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<td>How effective have the different training approaches, namely, training of</td>
<td>What sorts of CD has been undertaken for partners and what has been the level of</td>
<td>Project documentation, evaluations and reviews of training. establishing</td>
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<td>trainers, trainings of beneficiaries, training of health staff, training</td>
<td>activity?</td>
<td>effect of different training approaches</td>
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<td>manuals/tools and trainings conducted by the CO and its partners been in</td>
<td>What has been the quality and the results achieved?</td>
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<td>building capacity of partners, especially the CO’s implementing partners? What</td>
<td>What training approaches have been relatively more effective and how do we know?</td>
<td>Interviews with implementing partners, stakeholders and beneficiaries</td>
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<td>evidence supports this conclusion?</td>
<td>How effectively and to what extent does the training contribute to the programme</td>
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<td>How has UNFPA responded to emergency situations?</td>
<td>results, in particular, to improved knowledge about RH, HIV among the youth and</td>
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<td></td>
<td>Did UNFPA provide a coherent and comprehensive response to identified needs?</td>
<td>among the vulnerable groups and to the increased access to PMTCT services?</td>
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<td>To what extent was the programme developed based on needs assessment and gap</td>
<td>Documented evidence of access to RH services, and effect during emergencies</td>
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<td>analysis? What have been the</td>
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<td>lessons learnt?</td>
<td>What policy advocacy has taken placed under CP2? What policy changes have been made in reproductive health during the programme period? To what extent are these changes attributable to UNFPA’s efforts?</td>
<td>Documentation of policy changes. Documentation of stakeholder opinions on degree of attribution of these to UNFPA’s efforts</td>
<td></td>
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<tr>
<td>5. Programme Efficiency</td>
<td>Did the actual or expected outputs and outcomes justify the cost incurred? Have resources been spent as economically as possible? Did programme activities overlap and duplicate other similar interventions?</td>
<td>To what extent have the programme inputs (human, technical, and financial) been used efficiently? How and where could improvements have been made to improve efficiency without compromising quality? Have the programme inputs (human, technical, and financial) been used efficiently? How effectively were resources mobilized from other sources utilized? Are partnership arrangements organized effectively? Was level of resources to deliver CP2 adequate?</td>
<td>Documentation and analysis of stakeholder, implementing partners and beneficiaries opinions on efficiency of programme inputs. Information on unit costs of services/products Review of adequacy of program resources</td>
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<tr>
<td>Are there more efficient ways of delivering more or better results with available inputs without reducing quality</td>
<td>To what extent was the programme designed to be efficient and cost-effective? What improvements could have been made to improve efficiency and cost-effectiveness without compromising quality?</td>
<td>Documentation and analysis of stakeholder opinions on programme design in regard to efficiency and cost-effectiveness</td>
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<tr>
<td>Were sound financial and equipment management procedures practiced? If not, what could have been done to improve those procedures?</td>
<td>Were sound financial and equipment management procedures practiced? If not, what could have been done to improve those procedures?</td>
<td>Degree of concurrence of financial and equipment management acknowledged best practice.</td>
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<td>6. Programme Impact</td>
<td>What are the overall effects of the programme (intended and unintended, long and short term, positive and negative)? What difference did it make?</td>
<td>What were the major strengths of the programme? What have been its major achievements? What were the shortcomings of the programme? Were there any unintended outcomes – positive and negative?</td>
<td>Documentation of key programme achievements and strengths. Documentation of stakeholder opinions on programme shortcomings and unintended outcomes.</td>
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<tr>
<td>7. Programme Sustainability</td>
<td>Is it likely that programme achievements, especially in areas affected by cyclone Nargis in May 2008 will be sustained after the withdrawal of external support?</td>
<td>What is the current level of partnerships with government agencies and other partners such as WHO, UNICEF and IFRC for the implementation of the programme? What factors, if any, constrain effective partnerships? What factors facilitate effective partnerships? Are involved counterparts willing and able to continue programme activities on their own? To what extent is the programme owned and led at the national level? To what extent are counterparts willing and able to continue programme activities on their own? What would be the timeframe for an exit strategy for UNFPA support to the programme? To what extent have programme activities been integrated into current activities/practices of counterpart institutions? How can integration be enhanced?</td>
<td>Documentation of partnership agreements, MoUs, etc. Documentation and analysis of stakeholder opinions on effectiveness of partnerships Demonstrated level of counterpart commitment, including through budgetary support. Documented evidence of agreed exit strategy Degree to which RH programme is integrated into national planning processes and systems and counterpart work programmes</td>
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<td>Is the return from the investment in equipment tangible (e.g. medical equipment, furniture, ICT equipment, etc.) and how well is maintenance of that equipment managed by owners/institutions?</td>
<td>To what extent is the return from the investment in equipment tangible (e.g. medical equipment, furniture, ICT equipment, etc.)? How well is maintenance of that equipment managed by owners/institutions?</td>
<td>Level of utilization of equipment supported by the programme.</td>
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<td>To what extent has the implementation of the programme components affected, either positively or negatively, the partnership between government and UNFPA? What could be the likely impact of this partnership when it comes to implementation of the next country programme? Any other factors or events affecting the quality of implementation?</td>
<td>To what extent has the implementation of the programme components affected, either positively or negatively, the partnership between government and UNFPA? What could be the likely impact of this partnership when it comes to implementation of the next country programme? Any other factors or events affecting the quality of implementation?</td>
<td>Documentation and analysis of stakeholder opinions on partnership between government and UNFPA and its implications for CP5</td>
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<td>Documentation and analysis of stakeholder opinions on partnership between government and UNFPA and its implications for CP5</td>
<td>Evidence that other factors affected CP2 implementation</td>
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Focus Group Process
(continued)

End of Programme Evaluation
UNFPA’s 2nd Programme of Assistance to Myanmar

Purpose

A small number of focus groups will be used to give special attention to particular program implementation issues where there is value in drawing on a range of perspectives.

The Focus Group

Persons who are (1) beneficiaries of services supported under UNFPA assistance (eg. pregnant mothers); (2) involved as doctors, nurses, BSH, midwives in delivering RH at the local level; (3) working with implementing partners in providing RH, ARH, HIV/AIDS prevention services; or (4) part of a CSG or village health committee services.

Focus Group Process

The focus group process will start with an outline by the facilitator of the EOP evaluation objectives and the focus group process. The group will be told that participation is voluntary as is answering any question asked; then asked if they agree to participate; but assured their views will be kept confidential, with neither their individual or group identity to be disclosed in report-writing.

The facilitator will ensure coverage of major issues identified for discussion and then, with support from a moderator, the process will open up for a general discussion that works through the above four issues. Interventions in the discussion should be kept to around 2 minutes each time. Discussion will go for about 50-70 minutes.

Participants will be thanked for participation

Record of Discussion

A record of the discussion will be made that will include the main views expressed and conclusions reached, but without identifying any particular person.

Issues for Coverage in Focus Group Discussion

(1) Beneficiaries

- Nature of RH services etc provided and whether they met their needs
- Extent of usage of AN care
- Advice/information they had received on RH issues
- Understanding of RH issues
- Understanding of risks of pregnancy
- Wishes in relation to birthing process, including attendance at birth
• Understanding and use of birth spacing
• Support for birthing at home
• Understanding of HIV risks
• Supporting poor people who can’t afford health care costs
• Meeting any costs related to accessing RH services
• Support provided by partner
• Support provided by CSG and village health committee
• Intentions in relation to PN care
• Views about possible hospital referral
• Other issues

(2) *Doctors, Nurses, BHS, Midwives*

• Review of issues arising from local RH profile (MMR, CPR, AN care)
• Local issues impacting on MMR
• Nature of capacity building/training received, including adequacy and any gaps
• Any changes in client group (eg. population level)
• Nature of work undertaken, including staffing levels, turnover, workload and working conditions
• Handling of emergency referrals to hospital
• Support for birthing at home
• Handling of post-abortion cases
• Management of Hospital Stock Outs and implications for care
• Use of birth spacing services and availability of commodities at local level
• Access by young people to RH services
• BCC issues- relationship to CSGs, community awareness of RH/HIV issues
• Supporting poor people who can’t afford health care costs
• Relationship to other RH and birth spacing services at local level
• Outreach services, including nature, value and effect
• Best, and most challenging, part of the work
• Use of IEC materials
• Adequacy of local facilities and equipment- labour and EMoC facilities, drugs, kits
• Other issues

(3) *Implementing partners providing RH, ARH, HIV/AIDS prevention services*

• Local profile issues regarding clients- RH, HIV, ARH- including any recent changes
• Nature of provider support, including staffing levels, turnover, workload
• Understanding of RH, ARH, HIV prevention issues
• Nature of capacity building/training received, including adequacy and any gaps
• Peer education, including nature and quality
• Relationship with and access to public/NGO/private RH/HIV prevention services
• Access to commodities at local level
• Cost issues affecting access to RH, ARH, HIV prevention
• Supporting poor people who can’t afford health care costs
• BCC issues - community awareness of RH/HIV issues
• Supporting clients to make behavioral change
• Gender-related issues, including access to care
• Outreach services, including nature, value and effect
• Evidence of behavioral change
• Best, and most challenging, part of the work
• Other issues

(4) **CSG or village health committee services**

• Local profile issues regarding community- births, RH/birth spacing services
• Understanding of role and various functions to be performed
• Understanding of RH, ARH, HIV prevention issues
• Nature of support they provide, including turnover of members, workload, maintaining commitment
• Interaction and relationship with BHS, local authorities, local health management level
• Any outreach services, including nature, value and effect
• Gender-related issues, including access to care
• Male involvement in RH care
• Nature of capacity building/training received, including adequacy and any gaps
• Role played in referrals - transportation, support on costs for transportation/referral
• Suggestions on transportation issues
• Evidence of behavioral change
• Use of IEC materials
• Best, and most challenging, part of the work
• Other issues
INTERVIEW SCHEDULE

AND LIST OF PARTICIPANTS IN EVALUATION
### A. Interview Schedule Myanmar

<table>
<thead>
<tr>
<th>Date &amp; Day</th>
<th>Time</th>
<th>Meeting</th>
<th>Name</th>
<th>Designation</th>
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<tbody>
<tr>
<td>16/02/2011</td>
<td>10.00-12.00</td>
<td>Meeting with UNFPA Representative, Assistant Representatives and staff</td>
<td>Daw Pansy Tun Thein (chair)</td>
<td>Assistant Representative (RH), UNFPA</td>
</tr>
<tr>
<td>Wednesday</td>
<td>1:00 – 3:00</td>
<td>Meeting with Population Services International (PSI)</td>
<td>Dr. Myint Myint Win</td>
<td>Senior Brand Manager, PSI Myanmar</td>
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<td>Dr. Aung Hein</td>
<td>RH Programme Manager, PSI Myanmar</td>
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<td>3.30 – 5.30</td>
<td>Briefing by individual Program Managers, UNFPA</td>
<td>Daw Pansy Tun Thein (chair)</td>
<td>Assistant Representative (RH), UNFPA</td>
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<tr>
<td></td>
<td>8:30 – 10:15</td>
<td>Meeting with Japanese Organization for International Cooperation in Family Planning (JOICFP)</td>
<td>Dr. Aye Aye Thein</td>
<td>Project Manager, JOICFP Myanmar</td>
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<td>Dr. Nay Min Htun</td>
<td>Project Assistant, JOICFP Myanmar</td>
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<td></td>
<td>1:45 – 3:00</td>
<td>Meeting with Save the Children (SC)</td>
<td>Mr. Daniel Collison</td>
<td>Programme Director (Programme Development and Quality), SC Myanmar</td>
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<td>Dr. Hlaing Min Swe</td>
<td>Child Survival Director, SC Myanmar</td>
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<td>Dr. Myint Thu Lwin</td>
<td>Programme Manager (Health), SC Myanmar</td>
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<tr>
<td>17/02/2011</td>
<td>3:20 – 5:00</td>
<td>Meeting with Myanmar Anti-Narcotics Association (MANA)</td>
<td>U San Thein</td>
<td>President, Myanmar Anti Narcotic Association</td>
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<tr>
<td>Thursday</td>
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<td></td>
<td>Dr. Kyaw Sein</td>
<td>Vice – President, Myanmar Anti Narcotic Association</td>
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<td>Dr. Maung Maung Lwin</td>
<td>Programme Coordinator, Myanmar Anti Narcotic Association</td>
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<td>Dr. Nelly Thein</td>
<td>Programme Manager, Myanmar Anti Narcotic Association</td>
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<td>Dr. Aye Mya San</td>
<td>Project Officer, Myanmar Anti Narcotic Association</td>
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<td>Dr. Ohnmar</td>
<td>Project Trainer, Myanmar Anti Narcotic Association</td>
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<td>Dr. Yi Yi Myint</td>
<td>Project Trainer, Myanmar Anti Narcotic Association</td>
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<td>Dr. Tin Nge Soe</td>
<td>Project Trainer, Myanmar Anti Narcotic Association</td>
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<td>Daw Theingi Haling</td>
<td>Project Trainer, Myanmar Anti Narcotic Association</td>
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<td>Daw Win Mar</td>
<td>Project Facilitator, Myanmar Anti Narcotic Association</td>
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<td>U Phyo Thu Win</td>
<td>Project Facilitator, Myanmar Anti Narcotic Association</td>
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<td>Date</td>
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<tr>
<td>18/02/2011</td>
<td>8:45 – 9:30</td>
<td>Meeting with Aide Medicale Internationale (AMI)</td>
<td>Ms. Delphine Defrade (Country Director, AMI Myanmar)</td>
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<td>Mr. Antoine Renard (Programme Coordinator, AMI Myanmar)</td>
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<tr>
<td></td>
<td>01:30 – 3:00</td>
<td>Meeting with Myanmar Red Cross Society (MRCS)</td>
<td>Dr. Hla Pe (Honorary Secretary, Myanmar Red Cross Society)</td>
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<td>Dr. Saw Ni Tun (Head of Division (Health), Myanmar Red Cross Society)</td>
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<td>Dr. Maung Muang Hla (Deputy Head of Division (Health), Myanmar Red Cross Society)</td>
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<tr>
<td>19/02/2011</td>
<td>9:45 – 3:30</td>
<td>Meeting with Association Francois-Xavier Bagnoud (AFXB) Shwe Pyi Thar</td>
<td>Daw Kathy Shein (Country Director, FXB Myanmar)</td>
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<td>Beneficiaries Women’s Friendly Space, Laputta (21)</td>
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<td>Trainees</td>
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<td>Youth volunteers (9)</td>
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<td>21/02/2011</td>
<td>9:00</td>
<td>Meeting with Central Statistics Organization</td>
<td>U Tun Tun Naing (Director General, Central Statistical Organization)</td>
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<td>10:00</td>
<td>Meeting with Department of Health- (NAP, CHEB)</td>
<td>Dr. Win Myint (Director General, Department of Health, Ministry of Health)</td>
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<td>Dr. Thein Thein Htay (Deputy Director General, Department of Health, Ministry of Health)</td>
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<td>Dr Tin Win Kyaw (Director, Public Health, Department of Health, Ministry of Health)</td>
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<td>Dr. Win Maung (Director (Disease Control), Department of Health, Ministry of Health)</td>
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<td>Dr. Theingi Myint (Deputy Director, Maternal and Child Health Section, Department of Health, Ministry of Health)</td>
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<td>U Sian Za Nang (Deputy Director (Central Health Education Bureau), Department of Health, Ministry of Health)</td>
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<td>Time</td>
<td>Meeting with Department of Health Planning</td>
<td>Dr. Phone Myint</td>
<td>Director General, Department of Health Planning, Ministry of Health</td>
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<tr>
<td>11.00</td>
<td>Meeting with Department of Health Planning</td>
<td>Dr. Theingi Aung</td>
<td>Assistant Director, National AIDS Program, Department of Health, Ministry of Health</td>
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<td>Dr Thet Thet Mu</td>
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<td>Director, Department of Health Planning, Ministry of Health</td>
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<tr>
<td>2.00</td>
<td>Meeting with Department of Health (NAP/ CHEB)</td>
<td>Dr. Win Maung</td>
<td>Director (Disease Control), Department of Health, Ministry of Health</td>
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<td>U Sian Za Nang</td>
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<td>Deputy Director (Central Health Education Bureau), Department of Health, Ministry of Health</td>
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<td></td>
<td>Dr. Ko Ko Naing</td>
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<td>Assistant Director, National AIDS Program, Department of Health, Ministry of Health</td>
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<td></td>
<td>Dr. Theingi Aung</td>
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<td>Assistant Director, National AIDS Program, Department of Health, Ministry of Health</td>
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<td>4.15</td>
<td>Meeting with Maternal and Child Health Section, DoH</td>
<td>Dr. Theingi Myint</td>
<td>Deputy Director, Maternal and Child Health, Department of Health, Ministry of Health</td>
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<td></td>
<td>Dr Su Su Lin</td>
<td></td>
<td>Medical officer, Maternal and Child Health, Department of Health, Ministry of Health</td>
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<td>Dr. Myint Moh Soe</td>
<td></td>
<td>Assistant Director-General, Public Health, Department of Health, Ministry of Health</td>
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<td>Dr Hnin Nnin Lwin</td>
<td></td>
<td>Assistant Director, Maternal and Child Health Division, Department of Health, Ministry of Health</td>
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<td></td>
<td>Dr Khaing New Tin</td>
<td></td>
<td>Medical officer, Maternal and Child Health, Department of Health, Ministry of Health</td>
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| 9:00       | Meeting with *Ministry of Immigration and Population* | U Khin Maung Myint (Deputy Director General, Department of Immigration and National Registration)  
U Aung Chit (Deputy Director General, Department of Population)  
U Nyi Nyi (Deputy Director, Department of Population)  
Daw Khaing Khaing Soe (Deputy Director, Department of Population) |
| 10:30      | Meeting with *Department of Social Welfare*    | U Soe Kyi (Director General, Department of Social Welfare)  
U Aung Tun Khaing (Deputy Director General, Department of Social Welfare)  
Daw Thin Thin Nwe (Deputy Director, Department of Social Welfare) |
| 9:30 – 12:00 | Meeting with *UNFPA*                          | Dr. Khin Aye Myint (National Programme Officer, PMCT, UNFPA)  
Daw Khaing Khaing Saw (National Programme Assistant (HIV), UNFPA)  
Dr. Ni Ni Khaing, |
| 12:30 – 1:30 | Meeting with Office of the UN Resident Coordinator | Kanako Mabuchi (Coordination Officer, UNRC) |
| 3:00 – 4:00 | Meeting with *UNFPA*                          | Dr. Ne Win (Assistant Representative (HIV & Youth), UNFPA)  
Mr. Mohamed Abdel-Ahad (UNFPA Representative for Myanmar)  
Dr. Thwe Thwe Win (National Programme Officer (RH), UNFPA)  
Dr. Ne Win (Assistant Representative (HIV & Youth), UNFPA)  
Win Myint (National Programme Officer (M&E), UNFPA) |
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<th>Date</th>
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<th>Person</th>
<th>Position/Role</th>
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<tr>
<td>24/02/2011</td>
<td>9:00 – 10:00</td>
<td>WHO</td>
<td>Ms. Phavaddy Bollen (HIV)</td>
<td>Technical officer, HIV/AIDS</td>
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<td>10:00 -12:00</td>
<td>UNICEF</td>
<td>Dr. Ohnmar Aung (HIV)</td>
<td>HIV/AIDs Specialist</td>
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<td>Dr Marinus H. Gotink</td>
<td>Chief, Health and Nutrition Section</td>
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<td>2:00 – 3:00</td>
<td>UNAIDS</td>
<td>Markus Buhler</td>
<td>M&amp;E Adviser</td>
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<td>3:00 – 4:00</td>
<td>AusAID</td>
<td>Ms. Shaanti Sekhon</td>
<td>First Secretary, Development Assistance</td>
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<tr>
<td>25/02/2011</td>
<td>9:30 – 12:00</td>
<td>UNFPA</td>
<td>Dr. Win Maung</td>
<td>National RH Coordinator (Emergency Humanitarian Assistance), UNFPA</td>
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<td>Dr. Win Aung</td>
<td>National Programme Officer (German Funded Project), UNFPA</td>
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<td>1:00 – 2:00</td>
<td>3 Disease Fund</td>
<td>Mr. Mikko Lainejoki</td>
<td>Chief Executive Officer</td>
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<td>Dr Nu Nu Aye</td>
<td>National Public Health Officer</td>
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<td>3:30 – 4:30</td>
<td>MRCS</td>
<td>14 MRCS youth volunteers</td>
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<tr>
<td>28/02/2011</td>
<td>1:30 - 4:00</td>
<td>UNFPA on gender-related issues</td>
<td>Dr. Myat Pan Hmone</td>
<td>National Women’s Protection Coordinator, UNFPA</td>
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<td>Daw Khin Zar Naing</td>
<td>National Programme Officer (Gender), UNFPA</td>
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<td>Daw Pansy Tun Thein</td>
<td>Assistant Representative (RH), UNFPA</td>
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<td>U Toe Naing</td>
<td>National Program Associate, UNFPA</td>
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<tr>
<td>1/03/2011</td>
<td>9:30 – 11:00</td>
<td>BHS at Dala Township hospital</td>
<td>Dr. Tin Htoo Hlaing</td>
<td>Township Medical Officer</td>
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<td>Daw Phy Phyu</td>
<td>Township Health Nurse</td>
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<td>Date</td>
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<tr>
<td>2/03/2011</td>
<td>12:30 – 2:30</td>
<td>Meeting with BHS at <strong>Kunchangone</strong> Township hospital</td>
<td>Dr. Saw Kalaya, Dr. Nay Mya Thiha</td>
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<td>Township Medical Officer, Kunchangone Township, Yangon Division</td>
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<td>Township Health Nurse, Kunchangone Township, Yangon Division, Myanmar</td>
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<td>3:00 – 5:00</td>
<td>Meeting with YIC youth volunteers and BHS at <strong>Tawku</strong> sub-centre</td>
<td>Village Health Committee members, BHS</td>
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<td>Community Support Group members</td>
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<td>Youth volunteers</td>
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<td>Tawku RHC, Kunchangone Township, Yangon Division, Myanmar</td>
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<td>Tawku Youth Information Corner, Kunchangone Township, Yangon Division, Myanmar</td>
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<tr>
<td>2/03/2011</td>
<td>9.45 – 10:30</td>
<td>Meeting with <strong>UNDP</strong>, Yangon</td>
<td>David Dallah</td>
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<td>Assistant Representative</td>
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<td>10:30 – 12:00</td>
<td>Meeting with <strong>Gender Theme Group</strong></td>
<td>Myint Myint Sam, Dr. Maung Maung Lim</td>
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<td>UNESCO, Disaster Risk Reduction, WHO, nutrition specialist</td>
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<td>3/03/2011</td>
<td>8:00 – 9:30</td>
<td>Meeting with BHS at <strong>Kawa</strong> Township hospital</td>
<td>Dr. Mya Thet Win, Dr. Nay Mya Thiha</td>
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<td>Township Medical Officer, Kawa Township, Bago (East) Division</td>
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<td>Station Medical Officer, Ohn Hnay, Kawa Township, Bago (East) Division</td>
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| 10:00 – 12:00| Meeting with CSG and BHS at Ohn Hnay sub-centre | Basic Health Staff (Township Medical Department, Kawa Township, Bago (East) Division)  
Village Health Committee members (Ohn Hnay RHC, Kawa Township, Bago (East) Division)  
Community Support Group members (Ohn Hnay RHC, Kawa Township, Bago (East) Division)  
Youth volunteers (Ohn Hnay RHC, Kawa Township, Bago (East) Division) |
| 1:00 – 2:00  | Meeting with DMO at Bago Township hospital    | Dr. Ngwe San (Division Health Director, Bago (East) Division)  
Dr. Kyaw Soe (Acting STD Team Leader, Bago (East) Division)  
Dr. Saw Lwin Naung Soe (Township Medical Officer, Bago Township, Bago (East) Division)  
Daw Tin Tin Kyaing (Township Health Assistant, Bago Township, Bago (East) Division) |
| 2:00 – 3:00  | MMA (Bago branch)                             | Dr. Nay Myo (General Practitioner, Myanmar Medical Association, Bago Branch)  
Dr. Tun Tun (General Practitioner, Myanmar Medical Association, Bago Branch)  
Dr. Htay Aung (General Practitioner, Myanmar Medical Association, Bago Branch)  
Dr. Win Tun (General Practitioner, Myanmar Medical Association, Bago Branch)  
Dr. Thandar Cho (General Practitioner, Myanmar Medical Association, Bago Branch)  
Dr. Myint Myint Than (General Practitioner, Myanmar Medical Association, Bago Branch)  
Youth Volunteers |
| 3:00 – 4:00  | PSI SUN clinic                                | Dr. Naing Win (Medical Officer, PSI SUN Clinic, Bago Township, Bago Division)  
Dr. Khin Hla Win (Medical Officer, PSI SUN Clinic, Bago Township, Bago Division)  
Daw Aye Aye Thant (Centre-in-Charge, PSI TOP Centre, Bago Township, Bago Division) |
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<th>Date</th>
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<th>Participants</th>
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<tr>
<td>4/03/2011</td>
<td>9:00 – 11:00</td>
<td><strong>MMA Youth Development Programme, Yangon</strong></td>
<td>Daw Aye Aye Thet, Supervisor, PSI DIC, Bago Township, Bago Division</td>
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<td></td>
<td>11:00 – 12:00</td>
<td>Meeting with <strong>DFID</strong></td>
<td>Dr. Khin Soe Win, Project Officer, Youth Development Programme, Myanmar Medical Association, Youth Educators</td>
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<td>2:00 – 3:00</td>
<td>Meeting with Japanese Organization for International Cooperation in Family Planning (JOICFP) (International)</td>
<td>Ms. Tomoko Fukuda (Yoshino), Senior Specialist, J-CEU, JOICFP, Japan</td>
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<tr>
<td>5/03/2011</td>
<td>1:30 – 3:30</td>
<td>Meeting with <strong>MMA</strong></td>
<td>Professor Kyaw Myint Naing, President, Myanmar Medical Association</td>
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<td>Professor Myint Thaung, General Secretary, Myanmar Medical Association</td>
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<td>Dr. Soe Aung, Programme Director, Programme Management Unit, Myanmar Medical Association</td>
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<td>Professor U Yu Pa, HR Unit Officer, Programme Management Unit, Myanmar Medical Association</td>
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<td>Dr. Myint Zaw, Project Coordinator, Myanmar Medical Association</td>
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<td>Dr. Khin Thi Dar, Project Officer, RH (General Practitioners) Project, Myanmar Medical Association</td>
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<td>Dr. Phone Mu Hlaing, Project Officer, RH (Work Place) Project, Myanmar Medical Association</td>
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<td>Dr. Aye Aye Than, Project Officer, PMCT Project, Myanmar Medical Association</td>
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<td>Dr. Cho Cho Mar Kyaw, Project Officer, PMCT Project, Myanmar Medical Association</td>
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<td>Dr. Aung Thu, Programme Management Unit, Myanmar Medical Association</td>
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<tr>
<td>Time</td>
<td>Event</td>
<td>Participants</td>
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<tr>
<td>3:30 – 5:00</td>
<td>Meeting with Marie Stopes International (MSI)</td>
<td>Dr. Moe Moe Aung&lt;br&gt;Senior Programme Manager, MSI Myanmar&lt;br&gt;Dr. Myo Yar Zar&lt;br&gt;Assistant Project Manager, MSI Myanmar</td>
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<tr>
<td>7/03/2011</td>
<td>Monday</td>
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<tr>
<td>9:00 – 11:00</td>
<td>Nyaung-U Township hospital</td>
<td>Dr. Tin Maung Htay&lt;br&gt;District Medical Officer, Nyaung-U District, Mandalay Division&lt;br&gt;Dr. Nwe Nee&lt;br&gt;STD Team Leader, Nyaung-U District, Mandalay Division&lt;br&gt;Dr. Kyaw Naing Win&lt;br&gt;Station Medical Officer, Taung Zin Station Health Unit, Nyaung-U District, Mandalay Division&lt;br&gt;Dr. Aye Aye Moe&lt;br&gt;Station Medical Officer, Nga Tha Yauk Station Health Unit, Nyaung-U District, Mandalay Division&lt;br&gt;Basic Health Staff&lt;br&gt;Nyaung-U District, Mandalay Division</td>
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<tr>
<td>1:00 – 2:00</td>
<td>Meeting with TMO and BHS at Chauk Township hospital</td>
<td>Dr. Zar Zar Lwin&lt;br&gt;Acting Township Medical Officer, Chauk Township, Magway Division&lt;br&gt;Daw Win Myint Than&lt;br&gt;Township Health Nurse, Chauk Township, Magway Division</td>
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<tr>
<td>2:30 – 4:00</td>
<td>Meeting at Gabhyu CSG Corner</td>
<td>Daw San San Htay&lt;br&gt;Health Education Officer, Magway Division&lt;br&gt;Daw Tin Tin Htay&lt;br&gt;Health Education Officer, Magway Division&lt;br&gt;Basic Health Staff&lt;br&gt;Gabhyu CSG Corner, Twin Latt RHC, Chauk Township, Magway Division&lt;br&gt;Village Health Committee&lt;br&gt;members</td>
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<tr>
<td>8/03/2011</td>
<td>Community Support Group members</td>
<td>Pokkaku District Hospital</td>
<td>Daw Thinn Thinn Aye</td>
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<td></td>
<td>Community People</td>
<td></td>
<td>Dr. Toe Toe</td>
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<td>Dr. Tin Maung Htwe</td>
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<td>Dr. Kay Thi Aung</td>
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<td>Dr. Su Hlaing Myat</td>
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<td>Daw Tin Tin Khaing</td>
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<td>Basic Health Staff</td>
<td>STD Clininc</td>
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<tr>
<td>11.30</td>
<td>Save the Children, Pokkaku</td>
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<td>Dr. Khin Maung Thant</td>
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<td>Dr. Hnin Pwint Kyaw Maung</td>
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<td>Dr. Khaing Mya Nwe</td>
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<td>Daw Thandar Soe</td>
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<td>Date</td>
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<tr>
<td>9/03/2011</td>
<td>10:00 - 4:00</td>
<td>Meeting with community people, village health committee members, BHS at Pyisongone CSG corner</td>
<td>U Win Myint, U Maung Maung Swe, Village Health Committee members, Local authorities, Community Support Group members, Community people</td>
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<tr>
<td>10/03/2011</td>
<td>9:00 - 10:30</td>
<td>Mandalay STI/STD clinics</td>
<td>Dr. Kyaw Soe, Dr. Nyein Chan, Dr. Su Su Naing, 11 Peer Educators (MSM, SW, IDU), FSW, MSM (3)</td>
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<td></td>
<td>10:30 - 12:00</td>
<td>Chan Aye Tha Zan Township Health Department</td>
<td>Dr. Lin Lin Chit, Dr. Khin War Hlaing, Dr. Chaw Thu Thu, Dr. Nyo Mie Aung, Dr. Sandar Oo</td>
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<td></td>
<td>1:00 - 2:30</td>
<td>MSI clinic &amp; youth, Pyi Gyi</td>
<td>Dr. Kyaw Win Htet</td>
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<tr>
<td>3:00 - 4:30</td>
<td>PSI TOP Centre, Mandalay</td>
<td>Daw Kay Thi Win</td>
<td>Deputy Director, PSI TOP Centre, Mandalay Division</td>
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<td>Dr. Sun Minn Htun</td>
<td>Clinic Medical Officer, PSI TOP Centre, Mandalay Division</td>
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<td>Daw Khin Hlaing San</td>
<td>Programme Officer, PSI TOP Centre, Mandalay Division</td>
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<tr>
<td>6:00</td>
<td>PSI SUN clinic, Mandalay</td>
<td>Dr. Ko Ko Lay</td>
<td>Medical Officer, PSI SUN Clinic, Mandalay Division</td>
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<tr>
<td>9:00</td>
<td>MANA Drop-in Centre, Mandalay</td>
<td>Dr. Tin Aye Kyi</td>
<td>Activity Manager</td>
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<td></td>
<td></td>
<td>Daw Ohmmar Zaw</td>
<td>Counsellor</td>
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<td></td>
<td>Daw Aye Mon Myint</td>
<td>Nurse</td>
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<td>U Nay Myo</td>
<td>Outreach Supervisor</td>
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<td>U Toe Toe Aung</td>
<td>Outreach Worker</td>
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<td>U Tint Htet Aung</td>
<td>Outreach Worker</td>
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<td>Daw Ei Phyu Win</td>
<td>Outreach Worker</td>
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<td></td>
<td>Daw Moe Myint Thu</td>
<td>General Staff/Office Assistant</td>
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<td>Daw Ei The' Seint</td>
<td>General Staff/Financial Clerk</td>
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</table>

Tagon Township, Mandalay Division

Youth volunteers
MSI Kind Hands Youth Centre, Pyi Gyi Tagon Township, Mandalay Division
MSM (5)
1. 14 March 2011- Participants in Dissemination Workshop on Preliminary Findings of End of Programme Evaluation, Naypyitaw

<table>
<thead>
<tr>
<th>No</th>
<th>Participant</th>
<th>Organization</th>
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<tbody>
<tr>
<td>1</td>
<td>Dr. M. M. Gotink</td>
<td>Chief, Health and Nutrition Section, UNICEF</td>
</tr>
<tr>
<td>2</td>
<td>Daw Myat Myat So</td>
<td>Director General, Foreign Economic Relations Department</td>
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<tr>
<td>3</td>
<td>Daw Than Than Lin</td>
<td>Director, Foreign Economic Relations Department</td>
</tr>
<tr>
<td>4</td>
<td>U Aung Htay Win</td>
<td>Director, Department of Labour</td>
</tr>
<tr>
<td>5</td>
<td>Daw Sandar Aye</td>
<td>Staff Officer, Department of Labour</td>
</tr>
<tr>
<td>6</td>
<td>U Aung Tun Khaing</td>
<td>Deputy Director General, Department of Social Welfare</td>
</tr>
<tr>
<td>7</td>
<td>Daw Thin Thin New</td>
<td>Deputy Director, Department of Social Welfare</td>
</tr>
<tr>
<td>8</td>
<td>Dr. May Malar</td>
<td>Myanmar Maternal and Child Welfare Association</td>
</tr>
<tr>
<td>9</td>
<td>U San Myint</td>
<td>Deputy Director General, Central Statistical Organization</td>
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<tr>
<td>10</td>
<td>Dr. Saw Lwin</td>
<td>Deputy Director General, Department of Health</td>
</tr>
<tr>
<td>11</td>
<td>Dr. Tin Win Kyaw</td>
<td>Director (Public Health), Department of Health</td>
</tr>
<tr>
<td>12</td>
<td>Dr. Wynn Mg</td>
<td>Director (Disease Control), Department of Health</td>
</tr>
<tr>
<td>13</td>
<td>Dr. Theingi Myint</td>
<td>Deputy Director, Maternal and Child Health, Department of Health</td>
</tr>
<tr>
<td>14</td>
<td>Dr. Khin Ohnmar San</td>
<td>Deputy Director, National AIDS Programme, Department of Health</td>
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<tr>
<td>15</td>
<td>Dr. Theingi Aung</td>
<td>Assistant Director, National AIDS Programme, Department of Health</td>
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<tr>
<td>16</td>
<td>Dr. Phone Myint</td>
<td>Director General, Department of Health Planning</td>
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<td>17</td>
<td>Dr. Thet Thet Mu</td>
<td>Director, Department of Health Planning</td>
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<tr>
<td>18</td>
<td>Dr. Mar Mar Swe</td>
<td>Director, Department of Health Planning</td>
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<tr>
<td>19</td>
<td>U Aung Chit</td>
<td>Deputy Director General, Department of Population</td>
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<td>20</td>
<td>U Nyi Nyi</td>
<td>Deputy Director, Department of Population</td>
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<td>Daw Khaing Khaing Soe</td>
<td>Deputy Director, Department of Population</td>
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<td>22</td>
<td>Daw Han May Lwin</td>
<td>Health Education Officer, Central Health Education Bureau, Department of Health</td>
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<tr>
<td>23</td>
<td>Dr. S. Kyaw Hla</td>
<td>Vice President, Myanmar Medical Association</td>
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<td>24</td>
<td>Dr. Cho Cho Mar Kyaw</td>
<td>Project Officer, Myanmar Medical Association</td>
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<td>25</td>
<td>Dr. Hla Pe</td>
<td>Honorary Secretary, Myanmar Red Cross Society</td>
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<tr>
<td>26</td>
<td>Daw Ei Hlaing Htet</td>
<td>Project Officer, Myanmar Red Cross Society</td>
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<td>27</td>
<td>U Ye Win</td>
<td>Project Officer, Myanmar Anti Narcotics Association</td>
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<td>28</td>
<td>Daw May Moe Wah</td>
<td>Project officer, Aide Medicale International</td>
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<td>29</td>
<td>Dr. Myo Yarzar</td>
<td>Assistant Project Manager, Marie Stopes International</td>
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<td>Dr. Tin Aung Thant</td>
<td>Assistant Project Manager, Marie Stopes International</td>
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<td>31</td>
<td>Dr. Hnin Pwint Kyaw Maung</td>
<td>Health Programme Manager, Save the Children</td>
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<td>32</td>
<td>Dr. Khin Sabai Khine</td>
<td>Project Officer, Association Francois-Xavier Bagnoud</td>
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<td>33</td>
<td>Dr. Aye Aye Thein</td>
<td>Project Manager, Japanese Organization for Intl Cooperation in Family Planning</td>
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<tr>
<td>1</td>
<td>Mr. Mohamed Abdel-Ahad</td>
<td>UNFPA representative for Myanmar</td>
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<td>2</td>
<td>Ms. Pansy Tun Thein</td>
<td>Assistant Representative (RH)</td>
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<td>3</td>
<td>Dr. Ne Win</td>
<td>Assistant Representative (HIV/Youth)</td>
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<td>4</td>
<td>Dr. Thwe Thwe Win</td>
<td>National Programme Officer (RH)</td>
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<td>Dr. Khin Aye Myint</td>
<td>National Programme Officer (PMCT)</td>
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<td>Dr. Ni Ni Khaing</td>
<td>National Programme Officer (HIV/AIDS &amp; Youth)</td>
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<td>7</td>
<td>U Win Myint</td>
<td>National Programme Officer (M&amp;E)</td>
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<td>Daw Khin Zar Naing</td>
<td>National Programme Officer (Gender)</td>
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<td>9</td>
<td>Dr. Win Maung</td>
<td>National Reproductive Health Coordinator</td>
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<td>10</td>
<td>Dr. Myat Pan Hmone</td>
<td>National Women’s Protection Coordinator</td>
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<td>11</td>
<td>Dr. Win Aung</td>
<td>National Project Coordinator (German Fund Project)</td>
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<tr>
<td>12</td>
<td>Dr. Than Soe</td>
<td>National Programme Associate (IEC/BCC)</td>
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<td>13</td>
<td>Dr. Mya Mya Thet</td>
<td>Training Coordinator (German Fund Project)</td>
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<td>Admin and Finance Associate – Local Procurement</td>
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