



PHOTO CREDIT: HTET NAING ZAW, THE IRRRAWADDY, 2017

FINAL REPORT

USAID HEALTH SECTOR CAPACITY ASSESSMENT OF
INSTITUTIONAL CAPACITY BUILDING THROUGH
IMPLEMENTATION OF THE FIRST MYANMAR DEMOGRAPHIC
AND HEALTH SURVEY

October 2018

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Social Impact, Inc.



USAID
FROM THE AMERICAN PEOPLE

FINAL REPORT

USAID HEALTH SECTOR CAPACITY ASSESSMENT OF INSTITUTIONAL CAPACITY BUILDING THROUGH IMPLEMENTATION OF THE FIRST MYANMAR DEMOGRAPHIC AND HEALTH SURVEY

USAID Program Development Office

AID-486-I-14-00001 (IDIQ) / 720-482-18-F-00003 (Task Order)

October 2018

Dr. Donna Espeut (Team Leader)

Ms. Angela Thaung (Research Specialist)

Social Impact, Inc.

2300 Clarendon Blvd, Suite 1000, Arlington, VA 22201

Telephone: 703.465.1884

DISCLAIMER

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

TABLE OF CONTENTS

ABSTRACT	I
ACKNOWLEDGEMENTS	II
ACRONYMS	III
EXECUTIVE SUMMARY	IV
INTRODUCTION	I
BACKGROUND AND CONTEXT	I
PROGRAM DESCRIPTION	I
ASSESSMENT PURPOSE AND ASSESSMENT QUESTIONS	2
ASSESSMENT PURPOSE	2
ASSESSMENT QUESTIONS	2
ASSESSMENT METHODS AND LIMITATIONS	3
DATA COLLECTION METHODS	3
SAMPLING	3
ETHICAL ISSUES	4
FIELDWORK	4
DATA ANALYSIS	5
LIMITATIONS	5
FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS	7
AQ 1: IN WHAT WAYS AND TO WHAT EXTENT WAS THE MOHS' CAPACITY STRENGTHENED IN THE DPH AND ELSEWHERE THROUGH IMPLEMENTATION OF THE 2015-2016 MYANMAR DHS AND ASSOCIATED TECHNICAL SUPPORT PROVIDED BY USAID AND THE DHS PROGRAM?	7
AQ 2: WHAT SPECIFIC LESSONS CAN BE LEARNED AND APPLIED TO OTHER FUTURE PROGRAMS AND ACTIVITIES IN MYANMAR?	19
ANNEXES	24
ANNEX A. EVALUATION SCOPE OF WORK (OF WHICH THE DHS ASSESSMENT WAS A PART)	24
ANNEX B. EVALUATION DESIGN MATRIX	43
ANNEX C. DOCUMENT REVIEW SOURCES	44
ANNEX D. INTERVIEWEE LIST	46
ANNEX E. DATA COLLECTION TOOLS	48
ANNEX F. EVALUATION TEAM MEMBERS	63
ANNEX G. DISCLOSURE OF CONFLICT OF INTEREST	64

TABLE OF TABLES

TABLE 1. SAMPLE SIZES, ACCORDING TO LOCATION, RESPONDENT TYPE AND DATA COLLECTION METHOD 4

TABLE OF FIGURES

FIGURE 1. LOCATIONS SELECTED FOR FIELDWORK 3

FIGURE 2. GENDER BREAKDOWN OF SAMPLE..... 4

FIGURE 3. PARTICIPANT SCORES FROM FIRST DHS FELLOWS PROGRAM WORKSHOP, MYANMAR, JUNE 2018..... 10

FIGURE 4. SCREENSHOT OF MYANMAR INDICATORS ON THE DHS MOBILE APP 11

FIGURE 5. PHOTO OF WOMEN OF CHANGE RECIPIENTS.....20

ABSTRACT

The United States Agency for International Development (USAID)/Office of Program Development in Myanmar engaged Social Impact to conduct an assessment of the USAID-supported institutional capacity-building activity. The capacity-building partnership centered around the country's implementation of its first ever Myanmar Demographic and Health Survey (MDHS) implemented by ICF in 2015-2016. The MDHS was the cornerstone of USAID support to the Department of Public Health (DPH) within the Ministry of Health and Sports (MOHS). The assessment concluded that the 2015–16 MDHS Activity yielded a high-quality survey. Factors that supported this outcome included: strong local buy-in and commitment by the DPH leadership and ICF's use of their DHS Global Capacity Strengthening Strategy. USAID was pivotal in facilitating consultations and engagement of ethnic minority groups from conflict areas to produce an inclusive national survey. The Activity highlights the importance of the Government of Myanmar investments and commitments and capacity building approaches by implementing partners.

ACKNOWLEDGEMENTS

The assessment team would like to acknowledge the implementing partner of the USAID-supported Activity, ICF. ICF was forthcoming with insights and information that were invaluable to the capacity assessment process.

We would also like to extend gratitude to current and former staff from the Department of Public Health (DPH) within the Ministry of Health and Sports (MOHS). Their well-articulated and honest reflections on what did and did not work with respect to the Activity, as well as their expressed desire to translate donor inputs into meaningful outcomes for the country, were appreciated.

The team also acknowledges current and former USAID staff who met with the assessment team and/or facilitated the assessment team's work to ensure an objective and comprehensive assessment process that yielded insights and recommendations to inform the way forward.

Special appreciation is also extended to stakeholders from Shan State who were frank in their feedback, keen to learn from past program experiences, and resolute in their desire to be active participants in future health-related activities that can benefit all people.

Finally, we appreciate the support of Social Impact headquarters staff, who have been instrumental in all phases of the capacity assessment process.

ACRONYMS

3MDG	The Three Millennium Development Goal Fund	HRMIS	Human Resource Management Information System
AQ	Assessment Question	IP	Implementing Partner
CBO	Community-based Organization	KII	Key Informant Interview
CSO	Civil Society Organization	LOE	Level of Effort
CSS	Capacity Strengthening Strategy	M&E	Monitoring and Evaluation
DG	Director General	MDHS	Myanmar Demographic and Health Survey
DHS	Demographic and Health Survey	MICS	Multiple Indicator Cluster Surveys
DHP	Department of Health Planning	MOHS	Ministry of Health and Sports
DPH	Department of Public Health	MRH	Maternal and Reproductive Health
DMR	Department of Medical Research	PMP	Performance Management Plan
DQA	Data Quality Assurance	SI	Social Impact
EHO	Ethnic Health Organization	TA	Technical Assistance
ERC	Ethics Review Committee	TOT	Training of Trainers
FGD	Focus Group Discussion	UNICEF	United Nations Children's Fund
FRHS	Fertility and Reproductive and Health Surveys	UNOPS	United Nations Office for Project Services
FY	Fiscal Year	USD	United States Dollar
GAD	General Administration Department	USG	United States Government
HMIS	Health Management Information System	USAID	United States Agency for International Development
HR	Human Resources	USAID/W	United States Agency for International Development/Washington

EXECUTIVE SUMMARY

PROGRAM BACKGROUND

USAID invests in many activities that promote institutional strengthening. One such activity was the 2015–2016 Myanmar Demographic and Health Survey (MDHS), implemented by ICF (Sep 2013– Sep 2017).

ASSESSMENT PURPOSE

This report presents findings from a capacity assessment intended to document the achievements, challenges, and lessons learned during the MDHS Activity. The assessment examined the extent to which technical assistance (TA) strengthened the DPH, and identified key factors associated with USAID programming that enabled or impeded capacity strengthening and local ownership. Assessment findings will inform the design of future TA and institutional strengthening activities in Myanmar.

ASSESSMENT DESIGN AND METHODOLOGY

There were two main assessment questions (AQs) for the capacity assessment: (1) In what ways and to what extent was the MOHS' capacity strengthened in the DPH and elsewhere through implementation of the 2015–2016 Myanmar DHS (MDHS) and associated technical support provided by USAID and the DHS Program? -AND- (2) What specific lessons can be learned and applied to other future programs and activities in Myanmar?

Data Collection Methods. The assessment team used a mixed-methods design involving document review, primary qualitative data from key informant interviews (KIs), focus group discussions (FGDs), and secondary quantitative evidence. Key informants were ICF program staff, DPH senior-level staff who worked on the MDHS 2015–16, staff from agencies that were part of the DHS Steering Committee and USAID. The assessment team also interviewed individuals from ethnic health organizations (EHOs) and civil society organizations (CSOs) serving ethnic minorities in Shan State who participated in MDHS consultations or dissemination events, or mobilized local enumerators for the MDHS.

Sampling. There were three selected locations (Yangon, Nay Pyi Taw, and Taunggyi) for field work and 19 KIs and two FGDs.

Data Analysis. In answering the AQs, the assessment team triangulated evidence across stakeholders and qualitative and quantitative data sources. The evaluators used content and comparative analysis of coded KI and FGD interview notes to answer each AQ.

Key Challenges/Limitations. Staff turnover in most respondent groups increased the level of difficulty in reaching some stakeholders targeted for interviews. The assessment team tracked down most targeted respondents and interviewed additional respondents to obtain a comprehensive understanding of experiences and perspectives.

ASSESSMENT FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

AQ 1. IN WHAT WAYS AND TO WHAT EXTENT WAS THE MOHS' CAPACITY STRENGTHENED IN THE DPH AND ELSEWHERE THROUGH IMPLEMENTATION OF THE 2015-2016 MYANMAR DHS AND ASSOCIATED TECHNICAL SUPPORT PROVIDED BY USAID AND THE DHS PROGRAM?

AQ1 FINDINGS AND CONCLUSIONS

The MOHS had a strong foundation in small-scale research, data processing, and data quality assurance. ICF built on these strengths. The MDHS Activity elevated skill levels, introduced new skills (e.g., in further analysis of large datasets) and extended the range of actors involved in MOHS-led data collection.

1A. INTERNAL AND EXTERNAL FACILITATING FACTORS FOR THE SURVEY

Political will and USAID's and ICF's support in fostering inclusion, participation, and representativeness were vital. Timing was also a key factor in the 2015–16 MDHS' success; alternative data sources did not exist, and the first nationwide Census in decades (conducted in 2014) set the stage for a large-scale effort such as the MDHS. Even though the Health Management Information System (HMIS) team within DPH was the focal unit to lead the MDHS (and thus was the primary recipient of ICF's technical support), other structures such as the multi-agency, multi-sectoral DHS Steering Committee and the MOHS Technical Committee leveraged in-country expertise, fostered broad-scale support, and promoted data use.

IB. SPECIFIC MOHS CAPACITIES AND SKILLS THAT WERE STRENGTHENED

Increased ability to implement large-scale surveys within DPH and elsewhere can largely be attributed to the 2015–16 MDHS. With the exception of standard DHS data analysis, ICF cultivated in-house capacity to lead and manage all phases of large-scale survey implementation. However, running data tabulations (to produce the tables and figures included in the survey report) in the US rather than in Myanmar was a missed opportunity for skills transfer during the survey implementation process.

USAID and The Three Millennium Development Goal Fund (3MDG; a co-financer of the MDHS) support for extensive pre-survey consultations with ethnic minority groups contributed to shifts in how the MOHS approached working in conflict areas. Also, through the MDHS Activity, USAID fostered the use of MDHS data, not just by DPH but by other in-country stakeholders. However, there remains a need to promote data use at a sub-national level.

IC. APPLICATION OF DHS GLOBAL CAPACITY-STRENGTHENING STRATEGY

ICF effectively applied its Global Capacity Strengthening Strategy to enhance the ability to implement a large-scale survey and to promote data use. For survey implementation, ICF demonstrated that it is well-equipped to support Myanmar. Post-MDHS, individuals from Myanmar have benefitted from ICF's non-Myanmar-specific capacity-strengthening activities in Asia, attending a number of regional workshops on themes such as sampling and data processing. Capacity building for dissemination was one area where more work needed to be done.

ID. CAPACITY STRENGTHENING OUTCOMES

While deliberate efforts were made to transfer state-of-the-art knowledge and skills from ICF to DPH, the measurement and monitoring of achievements vis-à-vis individual and organizational capacity strengthening were not captured. The diverse set of stakeholders consulted during the capacity assessment expressed that the high-quality, internationally recognized health and demographic data generated by and for the country was the singular outcome of capacity building.

IE. HOW PROJECT DESIGN PROMOTED TO OWNERSHIP/ENGAGEMENT

ICF demonstrated adaptability in its design and implementation of the MDHS Activity. Consultative activities pursued in the design phase of the Activity were not part of ICF's standard DHS approach, nor was the placement of a full-time, in-country survey adviser, but both were critical to fostering country engagement, ownership, and a quality survey. Also, administrative arrangements (e.g., third-party fund management) for the MDHS facilitated survey implementation.

IF. HOW THE DHS AFFECTED MOHS ENGAGEMENT OF ETHNIC GROUPS

From the onset, the 2015–16 MDHS was positioned as an unbiased, inclusive, and neutral tool/mechanism that could be embraced by both Government and ethnic minority groups to improve the health of populations living in conflict areas, and all people of Myanmar. The MDHS approach to engaging ethnic groups was unprecedented and opened dialogue on MOHS' approach to inclusion and representation.

IG. HOW THE MDHS DATA ARE BEING USED AND APPLIED BY STAKEHOLDERS

There has been mixed success with data presentation and use across stakeholders at different levels. The transparency and open access of MDHS data has been an enabling factor for data ownership and use. The

MDHS was regarded as an accurate data source, but difficulties interpreting and using those data in tandem with other data sources (e.g., the HMIS) might limit its full and correct use.

AQ 1 RECOMMENDATIONS

For USAID, in support of MOHS: (1) Based on learning from the 2015–16 MDHS related to the budgetary, IP level of effort and time requirements for meaningful engagement of EHOs, CSOs, and other grassroots stakeholders; and promotion of data use, USAID should increase DHS project budget resources to support the following: (a) iterative consultations led by State Health Directors (and supported by Central MOHS and ICF) to engage EHOs and CSOs in survey planning and anticipated local data use; (b) use of local translators and guides to further extend the reach of MDHS efforts to the hardest-to-reach areas; (c) post-survey re-engagement (above and beyond state-level dissemination workshops) to promote sub-national use of MDHS data; and (c) improved knowledge management related to the MDHS, with a particular emphasis on supporting Government and others with triangulation of DHS data with other evidence available in the country. **(2)** For the next MDHS, and with support from ICF, USAID should conduct a systematic capacity assessment that includes but is not limited to DPH (e.g., covering Medical Research, Maternal and Reproductive Health, National Nutrition Center) to further leverage MOHS internal strengths in survey research and MDHS data use. Use standard ICF capacity assessment tools to establish a valid ‘baseline’ against which changes in capacity can be compared for all phases of survey implementation. **(3)** Using a subset of qualified DHS trainers in MOHS, USAID should support State Health Directors in the engagement of governmental and non-governmental stakeholders in local use of MDHS evidence.

For ICF: (4) ICF should replicate the effective approach for engaging EHOs and CSOs utilized for the 2015–16 MDHS, with even deeper engagement in planning survey activities in their states, not just their orientation on the purpose and scope and/or findings of the MDHS. **(5)** For the next MDHS, ICF should jointly develop and implement a plan with MOHS (centered on mutually agreed handover and capacity milestones for each key phase of DHS implementation) for further strengthening of survey capacity within the MOHS. The plan should be aligned with findings from each round of capacity assessment and/or expressed capacity-strengthening needs from the MOHS, focusing on competencies such as standard DHS analysis/tabulation, sub-national data dissemination, and triangulation of MDHS data with other data.

AQ 2. WHAT SPECIFIC LESSONS CAN BE LEARNED AND APPLIED TO OTHER FUTURE PROGRAMS AND ACTIVITIES IN MYANMAR?

2A. EXPERIENCES, ELEMENTS, OR KEY INPUTS THAT LED TO ACTIVITY SUCCESS

This Activity demonstrated that effective institutional strengthening is predicated on resource commitments from Government counterparts, not just an infusion of TA. Relationship building and trust building between the IP and Government counterparts were also critical success factors in the institutional strengthening of DPH. Staff willingness to learn and their motivation for MOHS’ work to be recognized as being on par with international standards were other enabling factors for institutional strengthening. However, increased capacity of government personnel can contribute to staff attrition and eventual erosion of institutional capacity if measures are not put in place to retain qualified, high-performing individuals. Within MOHS, strong management capacity—not just technical capacity—existed in focal persons/leaders, particularly senior female leaders, who had the vision and ability to manage organizational change.

2B. PRACTICES FOR FUTURE INSTITUTIONAL STRENGTHENING ACTIVITIES

As a complement to institutional strengthening, the Government of Myanmar counterparts provided requisite inputs (e.g., HR, equipment, infrastructure) to support institutional strengthening. A clear strategy for institutional strengthening and handover between ICF and the Government of Myanmar counterpart (e.g., DPH) was in place, serving as a benchmark for activity implementation. At its core,

institutional strengthening must be pursued as a behavior change endeavor, with incentives for change/improved performance and an enabling environment to support and sustain those changes. The above entails addressing issues such as the multiple demands on staff time (e.g., maintaining routine work responsibilities while assuming new tasks or cascading new skills or practices).

2C. PRACTICES FOR FUTURE TA ACTIVITIES

Activity design and administrative arrangements facilitated nimbleness/responsiveness to on-the-ground support needs within a dynamic, ever-changing program context (e.g., changes in the political landscape, issues related to international trade).

AQ 2 RECOMMENDATIONS

For USAID: (1) USAID should consider “phase-gate” provisions to foster mutual accountability between TA providers and Government counterparts. Under this scenario, the project cycle would be divided into distinct phases, each culminating in a specific set of capacity development/handover milestones. At the end of each phase, decisions would be made between USAID, MOHS, and ICF regarding the scale and/or scope of program activities for the subsequent phase. Before initiating Mission-supported activities, develop and apply criteria to establish the state of “readiness” of the counterpart agency/recipient institution for TA and/or capacity-building support. Two such criteria might relate to the existence of a costed workplan/investment plan and the availability of counterpart resources (human, financial, infrastructural) to fully leverage TA and capacity-building inputs from USAID IPs. In the spirit of mutual accountability, USAID should require ICF to report on pre-determined milestones and indicators to monitor handover and risk management over the course of activity implementation. **(2)** USAID should support the implementation of creative HR solutions (e.g., fixed-term secondment of expatriate experts to work in tandem with counterpart staff until agreed milestones are achieved and handover is complete, short-term local contractors to support discrete functions such as data processing/data quality assurance) to (a) minimize the double burden placed on counterpart staff who must manage their routine responsibilities while either deepening their capacities in new areas, or cascading skills/replicating practices within their agency; and (b) retain individuals whose capacity has been strengthened, in order to mitigate capacity erosion within the MOHS.

For ICF: (3) ICF should institute mechanisms and checkpoints over the course of implementation to reassess and, if necessary, reprioritize support needs to ensure timeliness and responsiveness of technical support. For example, this can be achieved through periodic (e.g., quarterly or semi-annual) TA needs assessments within the course of each program/fiscal year to ensure alignment and responsiveness of external, USAID-supported TA provision to local TA needs. **(4)** ICF should maintain continuity of mentors/TA providers (i.e., the same focal person/pool of experts assigned to the country to provide TA and capacity-building support over the life of the program).

INTRODUCTION

BACKGROUND AND CONTEXT

Myanmar ended nearly 50 years of military rule in 2011, and the U.S. Government (USG) has since supported the country's peaceful transition toward democratic governance, national reconciliation, economic integration, and healthy and resilient communities. USAID prioritizes health as one of the key approaches to creating stability and resilience in Myanmar, as its population continues to face some of the highest maternal and child mortality and morbidity rates in the region.

The use of data for decision making is vital to efforts aimed at improving health outcomes. In the past, Myanmar conducted several surveys (e.g., Fertility and Reproductive and Health Surveys (FRHS) in 1991, 1997, 2001, and 2007; Multiple Indicator Cluster Surveys (MICS) in 1995, 2003, and 2009–2010). However, when the USAID Mission re-opened in 2012,¹ there was a paucity of up-to-date, nationally representative health-related data. In response to this need, USAID funded ICF to provide capacity-building support to the Government of Myanmar's Department of Health Planning (DHP), a unit that was later disbanded and absorbed into the Department of Public Health (DPH), for Myanmar's first Demographic and Health Survey (DHS). The "Strengthening DHP's capacity to implement DHS 2015 in Myanmar" Activity included assistance to plan and implement a Myanmar Demographic and Health Survey (MDHS) in 2015–16, as well as disseminate findings and promote data use to address priority health issues and development outcomes in the country.

This report presents assessment findings on the DHS Activity. The assessment was part of a larger USAID Health Sector Capacity-building Evaluation being conducted by Social Impact (SI) in Myanmar ([Annex A](#)).

PROGRAM DESCRIPTION

Box 1 provides summary information on the MDHS Activity in Myanmar. USAID supported the MOHS to implement the first-ever nationally representative DHS covering 16,575 women of reproductive age 15–49 and approximately 8,287 men 15–49 in 12,750 households.² In addition to USAID, the 2015–16 Myanmar DHS (MDHS) was co-financed by The Three Millennium Development Goal Fund (3MDG), which is managed by the United Nations Office for Project Services (UNOPS).³ The USAID -funded DHS Fellows Program

Box 1. Program Description

STRENGTHENING DHP'S CAPACITY TO IMPLEMENT DHS 2015 IN MYANMAR

- **Implementing Partner (IP):** ICF International
- **Type of Assistance:** Contract—Field Support (#: OAA-C-13-00095)
- **Activity Start Date:** 9/8/2013
- **Activity End Date:** 9/6/2018
- **Primary Government Counterpart:** Ministry of Health and Sports (MOHS), with a focus initially on the Department of Health Planning (DHP), which has since been absorbed into the Department of Public Health (DPH)
- **Total Funding Amount:** USD 2.3 million
- **Scope:** Nationwide

¹ United States Agency for International Development (USAID). History: Burma. <https://www.usaid.gov/burma/history>. Accessed on August 9, 2018.

² MOHS and ICF. 2017. Myanmar Demographic and Health Survey 2015–16. Nay Pyi Taw, Myanmar, and Rockville, Maryland USA: Ministry of Health and Sports and ICF.

³ 3MDG. n.d. 3MDG Support to the Myanmar Demographic Household Survey (MDHS) Business Case.

(also implemented by ICF) supported in-country counterparts to conduct and publish secondary analysis of 2015–16 MDHS data.⁴

ASSESSMENT PURPOSE AND ASSESSMENT QUESTIONS

ASSESSMENT PURPOSE

The purpose of this assessment was to document the achievements, challenges, and lessons learned from USAID-funded institutional capacity strengthening through implementation of the MDHS 2015-2016 and associated support to the DPH. The assessment was intended to document the extent to which technical assistance (TA) strengthened this institution and identify key factors associated with USAID programming that enabled and/or impeded capacity strengthening and local ownership. The assessment will be used to inform the design of future technical assistance and institutional strengthening activities in Myanmar.

ASSESSMENT QUESTIONS

There were two main assessment questions (AQs), as noted below.

AQ 1. In what ways and to what extent was the MOHS' capacity strengthened in the DPH and elsewhere through implementation of the 2015-2016 Myanmar DHS and associated technical support provided by USAID and the DHS Program?

AQ 1. Sub-questions:

- a. What factors (internal and external, including enabling environment) facilitated the implementation, analysis, and utilization of the 2015-2016 DHS survey?
- b. What capacities and skills in the MOHS were strengthened through support from the DHS project, USAID, and 3MDG, and to what extent?
- c. How was DHS' global capacity-strengthening strategy applied in the Myanmar context?
- d. Were capacity strengthening outcomes at individual and organizational levels measured for learning and improvement, as well as for accountability?
- e. How did the project's design and implementation approach contribute to country engagement and ownership?
- f. How did the implementation of the DHS, and associated efforts to engage ethnic groups to collect and disseminate data in contested and non-government-controlled areas, build MOHS experience and capacity to engage with ethnic health organizations (EHOs) and other community groups in the future?
- g. To what extent have Myanmar health sector stakeholders been able to use and apply DHS data to influence decision-making around the planning and delivery of health services and reforms?

AQ 2. What specific lessons can be learned and applied to other future programs and activities in Myanmar?

AQ 2. Sub-questions:

- a. What experiences, elements, or key inputs were common for these two cases that led to their success?
- b. What practices should (not) be applied for future institutional strengthening activities?
- c. What practices should (not) be applied for future technical assistance activities (where the primary objective may not be institutional strengthening)?

⁴ ICF. 2017. DHS Updated Workplan 3-30-2017.

ASSESSMENT METHODS AND LIMITATIONS

DATA COLLECTION METHODS

The SI team employed a mixed-methods design that drew upon document review, primary qualitative data collection, and review and analysis of available secondary quantitative data ([Annex B](#)).

DOCUMENT REVIEW

A comprehensive document review provided background knowledge on existing national policies, international standards and best practices, regional programming with similar scope, capacity strengthening initiatives undertaken, and critical information on the status and outcomes of the Activity. A list of all documents consulted for this assessment appears in [Annex C](#). Although the assessment team did not conduct a special desk-based gender assessment, as will be described in subsequent sections of this report, gender and social considerations underlie data collection, analysis, and report preparation for this assessment.

KEY INFORMANT INTERVIEWS

Key Informant Interviews (KIs) were the primary method of qualitative data collection for the assessment. Key informants included ICF program staff, DPH senior-level staff who worked on the MDHS 2015–16, staff from agencies that were part of the DHS Steering Committee, and individuals from ethnic health organizations (EHOs) and civil society organizations (CSOs) serving ethnic minorities in conflict areas (see [Annex D](#) for the list of interviewees). The respondents were asked about learning and accountability, supportive structure, and strengthening capacity for surveys and data-driven decision-making, including for populations in ethnic minority states (see [Annex E](#) for data collection protocols).

FOCUS GROUP DISCUSSIONS

Focus Group Discussion (FGDs) were held separately with female and male respondents in Shan State who participated in pre-survey consultations, attended a DHS dissemination event, and/or were responsible for mobilizing enumerators from his/her organization. Given local gender dynamics, these sex-specific FGDs facilitated female respondents' privacy and confidentiality, allowing their voices to be heard during the assessment.

FGD participants were either ethnic minorities or served in ethnic minority areas as members of ethnic health organizations (EHOs) or civil-society organizations (CSOs). They provided information about the experience of ethnic group representation in the DHS and future considerations for collecting data within ethnic minority populations.

SAMPLING

LOCATIONS/SITES

As depicted in *Figure 1*, three locations were selected for primary data collection: Yangon, Nay Pyi Taw, and Taunggyi (Shan State). These locations were purposively selected based on the specific KI and FGD stakeholder groups targeted (see next section for description of respondents). There were also remote (virtual) KIs with individuals

Figure 1. Locations Selected for Fieldwork



who were not physically available to the team during the designated period of data collection (e.g., due to competing in-country commitments or relocation to another country).

RESPONDENTS

There were 19 total KIIs. The evaluators conducted two FGDs for the DHS Activity, as per the original assessment design. All respondents were purposively selected. TABLE I presents target and actual sample sizes.

The original assessment design called for 1-2 FGDs and up to 6 KIIs. As will be described later in this report (see “Challenges” section), many more DHS KIIs needed to be conducted to enable the assessment team to sufficiently answer the assessment questions. Some KIIs were conducted as individual interviews and some were conducted as two-person interviews.

TABLE I. SAMPLE SIZES, ACCORDING TO LOCATION, RESPONDENT TYPE AND DATA COLLECTION METHOD

LOCATION	RESPONDENT TYPE	DATA COLLECTION METHOD			
		KIIs		FGDs	
		TARGET	ACTUAL	TARGET	ACTUAL
Yangon	ICF International	1-2	1	--	--
	MDHS Steering Committee Members	1-2	3	--	--
	Former DPH Employees involved in DHS	--	2		
	DHS Workshop Attendee (EHO, Shan State)	--	1		
	USAID	--	2		
Nay Pyi Taw	DPH	1-2	2	--	--
	Ministry of Education	--	1	--	--
Shan	DHS Workshop Attendees (Taunggyi)	--	2	1-2	2
Remote	ICF International (USA)	As needed	1	--	--
	DHS Enumerators (CSOs in Shan State)		2	--	--
	Current and Former USAID Staff with knowledge of MDHS		2	--	--
ALL LOCATIONS/ RESPONDENT CATEGORIES		19		2	

Figure 2 provides a gender breakdown of the sample. As shown in the figure, 45% of DHS Activity respondents were female. The evaluators found a preponderance of males among stakeholders from Shan State, accounting for nine of the 12 respondents consulted.

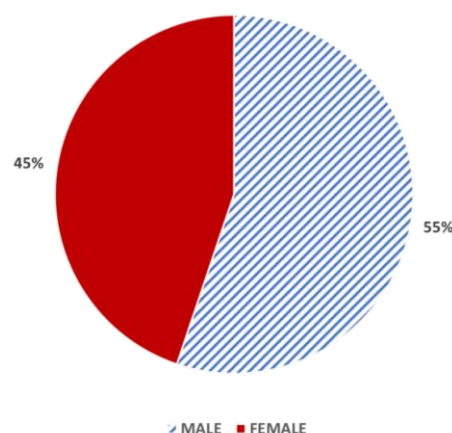
ETHICAL ISSUES

The assessment was conducted in accordance with USAID Ethics Standards in Research Policies and the ethical guidelines and processes of the DPH’S Ethics Review Committee (ERC), including an in-person briefing of the DPH ERC in Nay Pyi Taw in July 2018.

FIELDWORK

During fieldwork, most KIIs and both FGDs were conducted by a two-person SI Team consisting of the Team Leader and the Research Specialist. The M&E Specialist from USAID’s Program Development Office attended and actively participated in one KII conducted with a senior DPH key informant in Nay Pyi Taw.

Figure 2. Gender Breakdown of Sample



Five of the 19 KIIs were conducted remotely, with three of those KIIs being conducted in English. Of the 14 in-person KIIs, three Shan KIIs and the two Shan FGDs were conducted in Myanmar language (facilitated by the Research Specialist, who is a fluent speaker of the language). The remaining KIIs were conducted in English.

DATA ANALYSIS

In answering the AQs, the assessment team triangulated evidence across stakeholders and data sources. The assessment team disaggregated the data by sub-question and used content and comparative analysis, coding interview notes from the KIIs and FGDs to identify recurrent themes and key factors for each AQ. The team analyzed the qualitative data in tandem with the available quantitative data (e.g., in progress reports, workplans, performance management plans (PMPs), and other records shared by the IPs). Data were associated with each assessment question, draft conclusions based on these data, and recommendations developed based on this evidence.

LIMITATIONS

Considerations of gender equality and social inclusion were central to the assessment team's design, data collection, analysis and report writing. However, a gender imbalance in some key respondent categories (e.g., MOHS), as highlighted in the sampling section, sometimes limited gender disaggregation of findings.

- ❖ **Mitigation strategy:** For some quantitative evidence (e.g., number of training participants or workshop participants), the assessment team has presented gender-disaggregated data. As will be described in subsequent sections of this report, there are also some noteworthy gender-related qualitative findings and conclusions. Lastly, although neither was a feature of the original design, the assessment team: (a) pursued sex-specific FGDs in Shan State and (b) deliberately sought out one female and one male former DHS enumerator for KIIs.

Challenges related to accessing EHO respondents to examine the issue of social inclusion (e.g., the engagement and participation of ethnic minorities in DHS efforts), were addressed by going above and beyond the original target sample sizes for Shan state to ensure that the multiplicity of experiences and perspectives of ethnic minorities is adequately reflected in this assessment.

Staff turnover/flux in most respondent groups increased the level of difficulty in either gaining access to originally targeted respondents or capturing the perspectives and/or experiences of particular types of respondent.

- ❖ **Mitigation strategy:** The assessment team was successful in tracking down a number of originally targeted respondents and conducted in-person or virtual interviews with those individuals. For instances when it was not possible to engage the original respondent, the team interviewed additional respondents from the target respondent's organization (e.g., as was the case with DHS Steering Committee members, respondents in Shan State and USAID) who could provide an historical perspective of the situation and/or share insights that could assist the evaluators in acquiring a more-comprehensive understanding vis-à-vis the experiences of the respondent group in question.

There was a high degree of loss to follow-up among DHS workshop participants and enumerators, due to outdated contact information (e.g., mobile phone numbers provided to the evaluators were no longer active), with no additional information available on their current whereabouts known, or relocation of the individual outside of the country. This resulted in great difficulty in (a) mobilizing an adequate number of participants for the female and male FGDs (for which there were ultimately two participants and three participants, respectively) and (b) locating persons from EHOs who were most informed about the DHS in Shan State.

- ❖ **Mitigation strategy:** After an initial interview with originally selected ethnic organization respondents and CSO FGD participants, the team employed “snowball” sampling to get referrals to other persons within the organizations who had some involvement with the 2015–16 MDHS (were MDHS enumerators and/or attended consultations or dissemination events). Those persons were contacted, and the assessment conducted additional KIIs with those individuals.

Recall bias was a very salient issue for DHS respondents, many of whom either had very superficial contact during pre-survey “consultation,” or had not been engaged since completion of the survey a number of years prior.

- ❖ **Mitigation strategy:** SI’s data collection instruments specified the time period being referenced in order to aid respondents with recall. Also, a number of respondents, particularly those from EHOs had retained notes and or documentation from their involvement in the DHS (e.g., hard-copies of workshop handouts, enumerator training and field notes), which were used during their interviews. Lastly, the assessment team triangulated KII and FGD data across multiple types of respondents, as well as triangulated the qualitative data with secondary data and information from the document review.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

AQ 1: IN WHAT WAYS AND TO WHAT EXTENT WAS THE MOHS' CAPACITY STRENGTHENED IN THE DPH AND ELSEWHERE THROUGH IMPLEMENTATION OF THE 2015-2016 MYANMAR DHS AND ASSOCIATED TECHNICAL SUPPORT PROVIDED BY USAID AND THE DHS PROGRAM?

“When you fast forward to the actual data collection then data cleaning, there were very few data errors. There was such pride in this MDHS. There was a culture of ‘We are not going to cut corners. This effort is going to be top quality. We owe it to our country.’”

—A USAID key informant lauding local commitment to producing a quality, first-time DHS for Myanmar

IA. WHAT FACTORS (INTERNAL AND EXTERNAL, INCLUDING ENABLING ENVIRONMENT) FACILITATED THE IMPLEMENTATION, ANALYSIS, AND UTILIZATION OF THE 2015-2016 DHS SURVEY?

FINDINGS

Internal Factors

Management Commitment/Political Will within the MOHS: The most prominent internal factor in support of MOHS capacity building was a strong commitment and will on the part of MOHS leadership (Minister of Health, Deputy Minister, DG, Deputy DGs) to lead and execute a high-quality, nationally representative DHS. Although the

existence of this desire/will was one of the main reasons why ICF/USAID selected the MOHS as the host ministry/implementing agency for the MDHS, this internal factor was further cultivated by USAID and ICF through constant engagement of MOHS, particularly when changes in leadership (Minister) occurred.

Most respondents made explicit references to one particular MOHS official, Dr. Thet Thet Mu (female), for being involved in field activities, not just in high-level management of the MDHS, even travelling to conflict areas for consultations with EHOs and ethnic armed groups. Half of the stakeholders who lauded Dr. Thet Thet Mu's efforts were male.

Staff Commitment: Serving as the focal unit within DPH for all phases of the DHS, an already overburdened and understaffed Health Management Information System (HMIS) Section was further stretched by the demands of the DHS. This issue was raised largely by MOHS and ICF stakeholders. Despite the extra responsibilities added to their existing workload, HMIS staff were self-motivated and were able to ensure a quality process and outcomes from the MDHS, with technical assistance from ICF and leadership and support from Dr. Thet Thet Mu.

Investment in the MDHS did come at a price, however, because HMIS personnel were managing both the MDHS and their routine HMIS responsibilities, in 2014 and 2015, the customary MOHS routine annual statistics report wasn't released until 2017. The 2017 report ended up being a compilation of 2014, 2015 and 2016 reports as a result of the HMIS section's shift in attention to focus on the MDHS. This was corroborated by one former HMIS staff person who was integrally involved in the DHS and was interviewed for the assessment. Notably, 2015–16 MDHS data were also included in the report.⁵

Foundational Skills on which to Build: Multiple respondents mentioned that there were pre-existing research skills (albeit not related to a survey the magnitude of the MDHS) within the MOHS, especially

⁵ Ministry of Health and Sports Department of Public Health. 2017. Public Health Statistics (2014-2016). Nay Pyi Taw. <http://mohs.gov.mm/Main/content/publication/public-health-statistics-report-2014-2016>

the Department of Medical Research. The HMIS team had very strong foundational skills in data processing and data quality assurance (DQA) which provided a foundation to build capacity.

Inclusive and Transparent Survey Process: Initially, people from other ministries and sectors did not appreciate the value of a DHS. The majority of respondents commented that the transparency, inclusion and the high quality of the survey—all of which required investments of time and resources from USAID, 3MDG, MOHS, and ICF—helped stakeholders understand the value and support the process. Some non-health line ministries (e.g., Ministry of Education) were members of the DHS Steering Committee. In addition, the MDHS relied upon a mix of governmental and non-governmental field staff, including persons from conflict areas who were recruited and trained as enumerators, supervisors and field-level data editors. Two former DHS enumerators—one female and one male—from Shan State also highlighted the role of local sensitization and advocacy in promoting buy-in and cooperation during DHS implementation, particularly since the level of engagement and consultation supported by USAID had not previously occurred in conflict areas.

DHS Governance Mechanisms: While not optimal in terms of level of agency participation, the DHS Steering Committee played an important function as a mechanism from high-level approval/decision making/endorsement on the part of Government and its development partners. This point was raised by multiple respondents. Stakeholders also described the important role of the Technical Committee, which was deeply engaged in operational aspects of the survey (e.g., questionnaire design), and consisted solely of MOHS personnel.

External Factors

Paucity of Data: Respondents representing different perspectives and backgrounds underscored that there was a dearth of health outcome data prior to the MDHS. This was perceived to be an enabling factor in the widespread acceptance and use of the 2015–16 MDHS data.

Completion of Census: Stakeholders also noted that the Census that preceded the MDHS in 2014 set the stage and created an appetite within the country for a large-scale household survey like the DHS.

Health Planning Processes: The timing of MDHS dissemination occurred around the same time that the National Health Plan, 2017–2021 was being launched, so the MDHS data were not included in the NHP. However, MDHS data are reflected in the operational plan, as well as in state/regional health plans, as confirmed by one donor respondent and one steering committee respondent.

CONCLUSIONS

‘Political will’ (internal factor), coupled with USAID’s leadership in activities intended to foster inclusion, participation and representativeness (external factor), were vital to the successful implementation, analysis, and use of the 2015–16 MDHS.

Timing was also a key external factor in the 2015–16 MDHS’ success; alternative data sources did not exist, and the first nationwide Census in decades stage for a large-scale effort such as the MDHS.

Even though the HMIS team within DPH was the focal unit to lead the MDHS (and thus was the primary recipient of ICF’s technical support), other structures such as the multi-agency, multi-sectoral DHS Steering Committee and the MOHS Technical Committee leveraged in-country expertise, fostered broad-scale support, and facilitated data use.

1B. WHAT CAPACITIES AND SKILLS IN THE MOHS WERE STRENGTHENED THROUGH SUPPORT FROM THE DHS PROJECT SUPPORTED BY USAID AND 3MDG, AND TO WHAT EXTENT?

FINDINGS

“They [the trainers] taught us so well that we could understand almost all the lessons. We could also discuss and converse with them on the lessons. Through DHS training, we gained lots of health knowledge because the trainers are well-experienced teachers.”

—A former MDHS enumerator (female) from Shan, expressing satisfaction with MOHS master trainers and the MDHS enumerator training, overall.

Large Survey Research: In half of the 19 KIIs, respondents reported that prior to the 2015–16 MDHS, some MOHS Departments and Sections had conducted small-scale research and were skilled in routine health information systems, but that a large, nationally-representative, multi-indicator survey was “new territory” for the MOHS. ICF mentored a core group (12–15 individuals) of master trainers, assembled from DPH and other MOHS departments, equipping them with knowledge, skills and tools related to questionnaire development/adaptation, sampling, field management and data processing, as well as training/teaching skills rooted in adult-learning principles. They also learned about anthropometric and biomarker testing, all of which they taught to DHS field staff during enumerator and supervisor training.

For DHS interviews, it is customary for women to interview women and men to interview men. With far more women to be interviewed for the 2015–16 MDHS, far more female enumerators were therefore required.

In one KII with a USAID respondent and another KII with steering committee members, respondents mentioned that subsequent MOHS survey efforts such as the recently concluded Myanmar Micronutrient and Food Consumption Survey were aided by increased MOHS survey capacity that was honed through the DHS Activity.

Sampling: ICF-led capacity building (see Box 2. For other capacity-strengthening activities) related to sampling was especially impactful for DPH staff. The ICF sampling expert grounded staff in theory and shared sampling templates and tools that can be used for multiple research endeavors. Praise for the sampling support was highlighted by both MOHS and ICF respondents. In addition, two participants from Myanmar, one female and one male, attended the DHS Regional Sampling and Household Listing Workshop, which was conducted by ICF’s sampling team in Bali, Indonesia (August 7–19, 2017).⁶ The workshop aimed to increase participant capacity to design survey samples, to select sample points and households, and to calculate sampling weights for

Box 2. Examples of DHS Capacity Strengthening Activities Pursued for Myanmar

- Report Writing Workshop
 - Funded by 3mDG
- TA for Data Dissemination (national seminar, journalists workshop, topical seminars, TOT for regional seminars)
 - Co-funded by USAID and 3MDG
- Regional Dissemination Seminars (conducted by MOHS staff)
 - Funded by USAID
- Data Processing Procedures Workshops I and II (second workshop led solely by MOHS staff)
 - Co-funded by USAID and other donors
- Sampling and Listing Course - Co-funded by USAID and other donors
- Myanmar Participation in Sub-regional Data Analysis Workshop
 - Co-funded by USAID and other donors

SOURCE: Myanmar Demographic and Health Survey 2015–16: MOHS Capacity Strengthening Plan. Author(s) and date when the document was produced not known.

⁶ ICF. 2017. DHS Program Trip Report No. 5.

any household survey, including the DHS.⁷ The male participant from Myanmar was from the University of Public Health, and the female participant from Myanmar was from MOHS.

Data Processing/Data Management: Prior to the MDHS, the HMIS team had a strong foundation in data processing/data management, as acknowledged by all respondents. ICF further strengthened MOHS capacity related to DQA, data entry, cleaning and editing, with HMIS staff leading on those responsibilities. However, it did not fully engage HMIS staff in tabulations of the MDHS dataset, but rather conducted the analysis in the US. Because the 2015-16 MDHS was the first of its kind in Myanmar, ICF did not make assumptions regarding the extent of in-country capacity to conduct the standard DHS data analysis that produces customary indicator/variable estimates and figures presented in standard DHS reports. As a result, ICF conducted the data tabulations.

Since completion of the MDHS, there have been discrete capacity strengthening activities that were not Myanmar specific but in which persons from Myanmar participated. USAID supported two participants (both female) to attend a Global Data Processing and Procedures Workshop Part II (DPP II), also held in Indonesia from August 7-19, 2017 (ICF Trip Report No. 6). One of the participants was a senior MOHS staff person from the HMIS section (the focal MOHS unit for the DHS).

Data Analysis: ICF was still pursuing a number of activities to deepen local data analysis capacity at the time of this assessment, but this was not being done with an explicit focus on DPH.⁸ All MOHS key informants underscored that in-depth data analysis, tabulation of complex DHS indicators (e.g., related to fertility and family planning), and findings/insights based on DHS further analysis were priority areas for further capacity development within DPH.

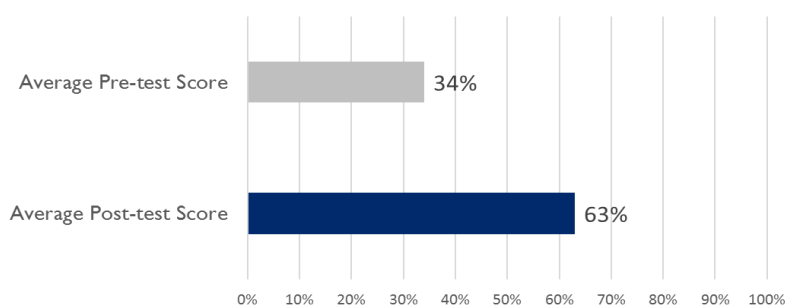
For example, ICF's Myanmar Fellows Program supported by USAID aimed to build the capacity of participants (a total of 21 people: 18 women and 3 men) from Myanmar universities and government agencies to conduct research studies using the Myanmar DHS.⁹ It consisted of two workshops: an analysis workshop (held June 11-22, 2018 in Mandalay) and a writing workshop (held in August 2018 in Yangon). There was a widely publicized call for proposals, which informed participant selection. ICF selected the participants and vetted their selection with the MOHS.

Upon completion of the August workshop, the DHS Program plans to work with authors to produce three DHS further analysis reports on regional health disparities; maternal health services and neonatal death; and urban health and wealth inequities.

For the first workshop of the DHS Fellows Program (June 2018), the average pre-test score among participants was 34%, whereas the average post-test score was 63%, an average improvement of 30 percentage points (Figure 3).¹⁰

General Computing Skills: ICF and Steering Committee respondents, as well as CSO stakeholders in Shan State were

Figure 3. Participant Scores from First DHS Fellows Program Workshop



⁷ Ibid., page 3.

⁸ Also corroborated by DHS Program Trip Report No. 15 (ICF, 2018).

⁹ Ibid.

¹⁰ ICF. 2018. DHS Program Trip Report No. 15

keen to note that Myanmar has only recently opened back up to the larger international development community, so even basic computer literacy was something that had to be built, given a reliance on paper-based systems. This skill was developed within the MOHS as well as among CSO staff that were engaged as MDHS enumerators and field editors (data-entry responsibilities).

Data Dissemination: Whereas ICF played an active role in national-level dissemination for the 2015-16 MDHS, MOHS led state-level dissemination workshops that were conducted in collaboration with each State Health Director, and attended by local government, civil society, implementing partners and ethnic minority groups such as EHOs.

EHO Engagement and Working in Conflict Areas:

Stakeholders from different perspectives and interests mentioned that the DHS Activity provided a neutral, inclusive platform to support the MOHS in unprecedented engagement of EHOs in conflict areas. They also noted that the MOHS was now less reticent to engage/collaborate with EHOs and CSOs in conflict areas.

CONCLUSIONS

Increased large-scale survey implementation capacity within the DPH and elsewhere can largely be attributed to implementation of the 2015-16 MDHS, with females accounting for the majority of personnel who benefitted.

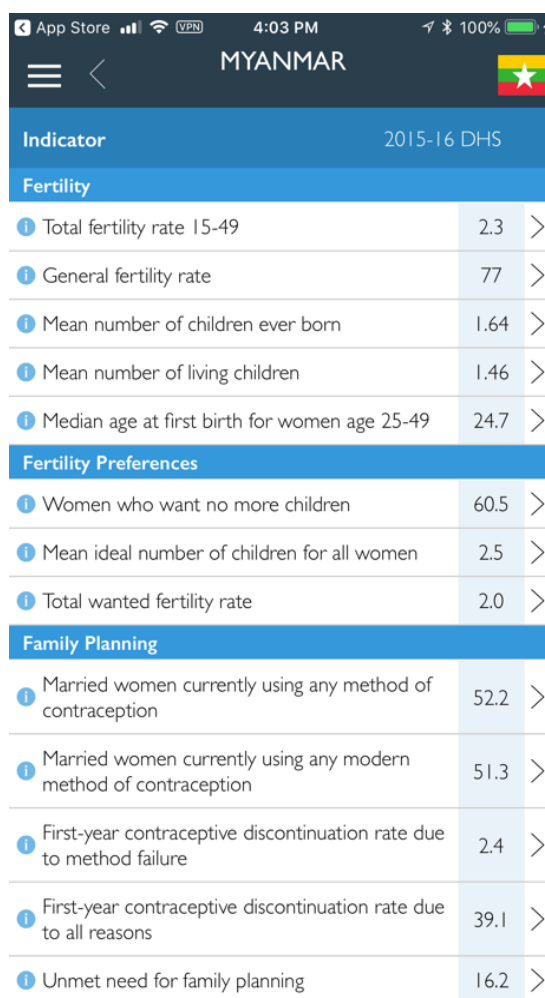
With the exception of standard DHS data analysis, the MOHS, with support from ICF, has cultivated in-house capacity to lead and manage all phases of large-scale survey implementation, building on a solid foundation that already existed within the ministry.

Although part of ICF's standard data protocol involves conducting the DHS analysis in the US rather than in conjunction with HMIS staff in Myanmar, this was a missed opportunity for skills transfer and a deepening of standard DHS tabulation and analytical skills in the MOHS.

Through the DHS Activity, USAID is fostering the use of MDHS data, not just by DPH but by other in-country stakeholders. However, the emphasis has been on data use at a higher level; there is a clear need for the promotion of MDHS data use at a sub-national level.

In addition to building survey technical skills, USAID and 3MDG prioritization and support of pre-survey consultations and sensitization with ethnic minority groups contributed to shifts in how the MOHS approaches working in conflict areas.

Figure 4. Screenshot of Myanmar Indicators on the DHS Mobile App



MYANMAR	
Indicator	2015-16 DHS
Fertility	
Total fertility rate 15-49	2.3
General fertility rate	77
Mean number of children ever born	1.64
Mean number of living children	1.46
Median age at first birth for women age 25-49	24.7
Fertility Preferences	
Women who want no more children	60.5
Mean ideal number of children for all women	2.5
Total wanted fertility rate	2.0
Family Planning	
Married women currently using any method of contraception	52.2
Married women currently using any modern method of contraception	51.3
First-year contraceptive discontinuation rate due to method failure	2.4
First-year contraceptive discontinuation rate due to all reasons	39.1
Unmet need for family planning	16.2

IC. HOW WAS DHS' GLOBAL CAPACITY-STRENGTHENING STRATEGY APPLIED IN THE MYANMAR CONTEXT?

FINDINGS

ICF has a DHS Program Global Capacity Strengthening Strategy (CSS) that “aims to enhance the capacity of DHS host-country partners to plan, implement, analyze, disseminate and use DHS” and other large-scale surveys and assessments.¹¹ DHS leveraged its global strengths and CSS in the following ways:

Local Adaptation of Globally Standardized Tools and Methods: Some stakeholders were able to describe how, in consultation with DPH and other stakeholders (e.g., members of DHS Technical Committee), ICF adapted its global set of tools, as well as its survey methodology for Myanmar.

Sampling: ICF’s sampling training was conducted by an ICF global expert who traveled to Myanmar to provide trainees a theoretical grounding in sampling and DHS’ sampling templates and tools that participants could use for the DHS and beyond. This training was explicitly mentioned by both ICF and MOHS respondents as an ICF global strength/resource that was applied to Myanmar.

Dissemination: One MOHS respondent and one ICF respondent noted that an ICF communications expert traveled to Myanmar to support national dissemination and train central-level staff to conduct national and state/regional dissemination. She also provided support in the development of PowerPoints used for the dissemination workshops but did not participate in any sub-national dissemination activities. However, two other respondents noted that, in the dissemination phase of the MDHS, direct country support was lower than expected, particularly for sub-national dissemination. Although the aim was to target dissemination to different groups of stakeholders, it was beyond the mandate of the DHS Program to ensure total inclusion. The standard arrangement in DHS countries is for the local implementing agency (in the case of Myanmar, the MOHS) to take the lead in ensuring effective sub-national engagement of priority stakeholders. The MOHS did, however, successfully execute state-level dissemination activities during the entire month of May 2017, under the leadership of senior personnel from HMIS/DPH (HMIS Director and Deputy DG, Dr. Thet Thet Mu, Deputy Director of Public Health, Daw Aye Aye Sein and Assistant Director Dr. Lwin Lwin Aung).¹²

DHS Fellows Model and On-going Regional and Global Workshops: Stakeholders lauded ICF’s ‘DHS Fellows Program’ concept, which was replicated in Myanmar. Respondents also mentioned non-Myanmar-specific endeavors by ICF such as regional/global workshops (e.g., on data processing, sampling), to which a total of four Myanmar representatives were sent to participate.

DHS Mobile App: USAID and Steering Committee respondents said that the DHS mobile app—a global resource—was promoted among, and was used by, Myanmar stakeholders to facilitate data access and use (Figure 4). Notably, Shan EHO and CSO stakeholders consulted during the assessment were largely unaware of this resource.

CONCLUSIONS

ICF effectively applied its Global CSS and leveraged its global expertise, rigorous tools and rigorous methodology to enhance survey capacity and data use in the country.

Individuals from Myanmar have benefitted from DHS’ non-Myanmar-specific capacity strengthening endeavors in the Asia region, which aimed to cultivate advanced DHS data analysis skills.

For national survey implementation, ICF demonstrated that it is well-equipped to support Myanmar. However, dissemination was one area for which support and capacity-building did not fully meet expectations of local stakeholders, even though dissemination at the sub-national level was followed as planned, to be cascaded by the implementing agency, which was done well.

¹¹ ICF. n.d. Global Capacity Strengthening Strategy: The Demographic and Health Survey Program, page 3.

¹² DATA SOURCE: Report of State/Region Dissemination of MDHS (2015–16), page 2; *Author(s) and date when the report was produced not known.*

ID. WERE CAPACITY STRENGTHENING OUTCOMES AT INDIVIDUAL AND ORGANIZATIONAL LEVELS MEASURED FOR LEARNING AND IMPROVEMENT, AS WELL AS FOR ACCOUNTABILITY?

FINDINGS

No stakeholders interviewed during the assessment could not identify clear capacity-strengthening outcome indicators at either the individual or organizational level. However, some stakeholders stated that the MDHS dataset itself—one in which ICF identified very few errors when the data were sent from Myanmar to the US for tabulation for the survey final report—was the key outcome of interest. The dataset was evidence of MOHS capacity and commitment to execute a high-quality DHS.

Although ICF applied its standard capacity assessment tools to assess baseline (pre-survey-implementation) capacity in the MOHS, it did not conduct a repeat, post-survey assessment to measure any improvements in individual and/or organizational capacity. ICF did, however, produce a written MOHS capacity strengthening plan that consisted of various workshops (See Box 3 under AQ 2b).¹³ At the time of the MDHS implementation, the DHS Program's Capacity Strengthening Plan was a new tool adopted by ICF to assess the capacity of the implementing agency. Re-administration of the tool, post-MDHS, was not part of the original approach. ICF did, however, pursue activities that addressed some pre-survey capacity gaps.

MOHS and former CSO enumerators interviewed by the assessment team reported that trainings conducted by ICF, and later replicated by the MOHS core team of master trainers, included pre- and post-test assessments, as well as practical applications.

Lastly, although a phenomenon not being systematically tracked by either MOHS or ICF, there has been some 'erosion' of capacity through the departure of staff. Some highly-qualified DPH staff who were trained/mentored by ICF have left the central ministry to pursue other employment opportunities.

CONCLUSIONS

While deliberate efforts were made to transfer state-of-the-art knowledge and skills from ICF to DPH, the measurement and monitoring of achievements vis-à-vis individual and organizational capacity strengthening were not captured.

Stakeholders regard the high-quality, internationally recognized health and demographic data generated by and for the country as the singular outcome of capacity and success.

IE. HOW DID THE PROJECT'S DESIGN AND IMPLEMENTATION APPROACH CONTRIBUTE TO COUNTRY ENGAGEMENT AND OWNERSHIP?

FINDINGS

KIs with a multiplicity of stakeholders indicated that three features of the DHS Activity design and implementation approach that were adapted specifically for Myanmar contributed to country engagement and ownership. Those features related to: (1) staffing decisions for country support, (2) EHO/CSO engagement and (3) financial management.

Staffing Decisions: There was continuity in the TA provider, with the assigned ICF global expert (A. Pradhan) being involved from design through completion of the survey. Multiple respondents explicitly mentioned this as a beneficial aspect of the activity implementation approach. For most aspects of the survey process, ICF experts who came to Myanmar worked alongside DPH, USAID and other stakeholders—an approach that was lauded by numerous individuals interviewed by the assessment team.

¹³ DATA SOURCE: Myanmar Demographic and Health Survey 2015-16: MOHS Capacity Strengthening Plan. Author(s) and date when the document was produced not known.

Respondents specifically mentioned that ICF contracted a full-time, experienced, in-country survey adviser of Myanmar descent to provide in-country oversight and expertise during planning and implementation (not their usual approach). This staffing arrangement was deemed as useful in ensuring sustaining buy-in and effectively responding to on-the-ground needs and issues in close consultation with USAID.

EAO/EHO/CSO Engagement: As mentioned by selected USAID, MOHS, and ICF respondents the extensive consultations with EAOs, EHOs and CSOs was new territory for ICF, and unfolded through a mandated set of activities by USAID to ensure national representativeness, social inclusion, and ownership in the survey and its data. The US Embassy required that appropriate consultative/sensitization work be done before the initiation of any DHS technical activities and, as underscored by one USAID respondent, this was a red-line, non-negotiable requirement instituted by the USG for the Myanmar DHS. USAID provided the necessary funding and on-the-ground leadership and support in engaging EHOs and CSOs in selected states, both for the pre-survey in 2015 and again via state and regional dissemination events in 2017.¹⁴ Working in tandem with the ICF in-country survey adviser, USAID and ICF supported the MOHS in bridging the divide with the EHOs and CSOs in conflict areas.

“[The] DHS was never ever done for us, even by the MOH. The enumerators/girls learned computers, how to input data in computers, they gained knowledge that could help raise their career life. USAID has supported us for the benefit of our community in Shan state.”

—A male FGD participant in Shan State

Financial Management: One donor KII respondent, two MOHS respondents and two IP respondents highlighted that ICF structured cash flow and the management of Activity financial resources through a third-party accounting firm, Baker Tilly, rather than providing direct fund transfer to the MOHS. This was a relatively new approach in Myanmar, and one that was regarded by stakeholders as a general strength of the Activity, enabling more nimbleness in addressing resource needs, particularly during field implementation.

A small number of respondents also mentioned particular standard DHS practices that contributed to country ownership and engagement. According to one ICF respondent, as is ICF’s standard approach, they used the standard DHS report format, but the writing was done by Myanmar technical experts. As confirmed by multiple in-country stakeholders, this arrangement enabled in-country report writers to become very familiar with the DHS findings and could talk about and present the findings with confidence.

In addition to the above, two respondents (one each from USAID and ICF) highlighted that, although the MOHS was selected to lead the DHS effort in Myanmar, the MDHS Activity was structured as a cross-ministry/multi-sectoral activity that required the input/involvement of multiple ministries (e.g., Health, Education, Immigration and Population). Standard DHS “governance” structures such as the DHS Steering Committee and DHS Technical Committee reinforced that approach.

CONCLUSIONS

ICF demonstrated adaptability in its design and implementation of the DHS Activity in Myanmar. Consultative activities pursued during the design phase of the Activity were not part of ICF’s standard DHS Activity design, nor was the placement of an in-country survey adviser, but both were critical to fostering country engagement, ownership and a quality survey.

The administrative arrangements and processes adopted by ICF and USAID for the MDHS facilitated survey implementation, contributing to generally positive perceptions of 2015–16 MDHS implementation.

¹⁴ SOURCE: Reports on DHS consultative workshops held in Kayah, Kachin, Shan, Kayin and Mon, 2015.

IF. HOW DID THE IMPLEMENTATION OF THE DHS, AND ASSOCIATED EFFORTS TO ENGAGE ETHNIC GROUPS TO COLLECT AND DISSEMINATE DATA IN CONTESTED AND NON-GOVERNMENT-CONTROLLED AREAS, BUILD MOHS EXPERIENCE AND CAPACITY TO ENGAGE WITH ETHNIC HEALTH ORGANIZATIONS (EHOs) AND OTHER COMMUNITY GROUPS IN THE FUTURE?

FINDINGS

An Unbiased, Neutral Effort of Mutual Interest to Government and Ethnic Minority Groups:

Prior to the MDHS, the MOHS had a limited/mixed history of engaging EHOs or other groups from non-government-controlled areas, with little to no trust existing between the two parties. Three KII respondents from Shan State mentioned that prior contact between central MOHS and EHOs was limited before the MDHS, but that there was some engagement of EHOs by State Health Departments, and that this practice has continued after the MDHS.

Some central-level respondents mentioned that health is regarded by both the Government and ethnic minority groups as a neutral issue of mutual interest, with the potential to serve as a bridge to peace. The role of health, in general, as a neutral bridge in the peace process was also documented in a June 2018 report produced by a Myanmar DHS co-financer, 3MDG.¹⁵ Multiple respondents mentioned that, through the MDHS, central-level DPH/MOHS learned a different approach to engaging EHOs.

Efforts to engage EHOs and CSOs in conflict areas entailed a series of consultative workshops, both in 2015 (at the outset of the DHS process) and again in 2017 (as part of post-DHS dissemination). Based on documentation from the six pre-survey workshops (two in Shan State (Lashio and Taunggyi), one in Kayah State, one in Kachin State,



**Females made up 40%
(2 out of every 5) participants in DHS state
consultative workshops with EHOs & CSOs.**

one in Kayin State and one in Mon State), there were 109 EHO/CSO participants across the six workshops. Of those 109 EHO/CSO participants, 40% were female.¹⁶ After an initial round of sensitization visits conducted solely by USAID and ICF, MOHS senior leadership accompanied ICF/USAID on subsequent engagement visits with EHOs and leadership in non-government-controlled areas.

As reflected in both FGDs and EHO KIIs, there was a perception on the part of some EHO/CSO stakeholders in Shan State that contacts between their organizations and the DHS team were not entirely consultative or bidirectional. The organizations were oriented on the DHS, and they provided enumerators to support data collection. However, their contextual knowledge was not fully exploited for critical aspects of planning such as sampling (e.g., being able to validate some of the information on which area and household selection decisions were made) or field logistics (e.g., shedding light on feasibility and requirements to travel to particular hard-to-reach areas).

Engagement in DHS Fieldwork: Some individuals from marginalized groups and conflict areas were recruited and trained as MDHS enumerators, field supervisors, and field editors (field-level data quality assurance and data entry). Both male and female FGD respondents in Shan State, as well as multiple KII respondents, reported this was a positive attribute of the MDHS.

However, contextual challenges still arose. The majority of respondents described the tremendous language/dialect diversity that exists within Myanmar, and challenges encountered during MDHS field implementation (e.g., effectively communicating survey questions and responses), even when ‘local persons’ were involved as enumerators. EHOs and CSOs (e.g., literature associations) supported language

¹⁵ 3MDG. 2018. *Experiences and Lessons Learned from the 3MDG Strategy to Operate in Conflict Affected Areas*.

¹⁶ Reports on DHS consultative workshops held in Kayah, Kachin, Shan, Kayin and Mon States, 2015.

translation, both in written and verbal forms. They also liaised with General Administration Department (GAD) administrators and local health workers in DHS enumeration areas to facilitate access to selected households.

Post-survey Engagement: Documentation on the DHS Dissemination Workshops indicated diverse participation from Government, UN agencies, international NGOs, EHOs and CSOs.¹⁷ Four KII respondents noted that during the state dissemination workshops, minority stakeholders provided feedback on the DHS results. During the workshops, there were also group exercises to help EHOs understand how to read the DHS report tables and use the findings in their future work. However, EHO stakeholders consulted in Shan State noted that there was little or no post-survey re-engagement of EHOs, and that they were largely unaware of the DHS findings, or how to use the data.

Some CSO, EHO and Steering Committee respondents gave examples of specific health efforts (e.g., immunization campaigns) that are now being pursued and tailored to conflict areas, with support from Government and development partners such as UNICEF. There are other promising examples of an improved relationship between Government and ethnic minority groups since the time the MDHS was conducted:

- The National League for Democracy's (NLD) National Health Network and the MOHS' National Health Plan (NHP) 2017-2021 make explicit references to alignment and integration with EHOs and civil society in order to achieve universal health coverage.¹⁸
- There is EHO and CSO driven entities and efforts to promote greater integration between health efforts lead by ethnic organizations and those being implemented by the Government. Two such examples are the Health Convergence Core Group and the Health Systems Strengthening Project, both of which consist of EHOs and CBOs/CSOs but not government. Both entities have, however, held meetings/workshops with Central and State-level MOHS representatives.¹⁹

An Unfinished Agenda: The paucity of sustainable communication channels between EHOs and MOHS at state and township levels has been identified as an obstacle to increased engagement between government and EHOs—overall, not just in relation to the DHS.²⁰

Also, despite encouraging, macro-level improvements, some key informants from Shan lamented that there was still difficulty in holding government accountable for agreed actions negotiated under the peace process. Some EHO leaders/decision makers were not directly involved in local MDHS dissemination efforts and stated that they did not know how to access any data that might better equip them to hold the government accountable, although they mentioned that some of their DHS enumerators were invited to attend the state dissemination event.

CONCLUSIONS

The 2015–16 MDHS was positioned as an unbiased, inclusive and neutral tool/mechanism that could be embraced by both Government and ethnic minority groups to improve an issue of mutual interest: the health of populations living in conflict areas.

Both the MDHS level of effort and approach to engaging ethnic groups was unprecedented and opened dialogue on MOHS' approach to inclusion and representation.

¹⁷ Kyu (USAID). 2017. USAID Trip Report for DHS Dissemination, May 2017.

¹⁸ 3MDG. 2018. *Experiences and Lessons Learned from the 3MDG Strategy to Operate in Conflict Affected Areas*, page 7.

¹⁹ *Ibid.*, page 6.

²⁰ *Ibid.*, page 13.

The engagement of EHOs and CSOs was a demonstration of commitment to transparency, inclusion and participation. Engagement was not always as hoped, but it was a start.

There was untapped potential to re-engage EHOs/CSOs post-survey (e.g., dissemination, promotion of MDHS data use) above and beyond what was observed for the MDHS 2015–16.

MOHS strategies and plans developed since the MDHS 2015–16 made explicit references to the engagement of EHOs and universal health coverage for all parts of the country. Although this shift cannot be attributed solely to the MDHS, various types of stakeholders acknowledge that the approach adopted for the DHS in conflict areas has helped to relax a hardline position against formal engagement of EHOs and ethnic minority groups.

IG. TO WHAT EXTENT HAVE MYANMAR HEALTH SECTOR STAKEHOLDERS BEEN ABLE TO USE AND APPLY DHS DATA TO INFLUENCE DECISION-MAKING AROUND THE PLANNING AND DELIVERY OF HEALTH SERVICES AND REFORMS?

FINDINGS

Aspects of the MDHS that Have Facilitated Widespread Use: The MDHS data are open access, and the methods used to generate the data are transparent and highly rigorous, both of which are unprecedented for Myanmar. With the exception of EHO and CSO respondents, multiple stakeholders mentioned that anyone can access MDHS data freely, using multiple means such as the DHS mobile app and website access.

Data Use for Advocacy: The DHS steering committee members shared that MDHS data are being used for advocacy purposes. Two examples were: (1) data were being used by some advocacy groups to shed light on gender roles and women's roles in Myanmar; (2) using MDHS data, UNICEF was advocating with MOHS to take a deeper look at equity issues (e.g., based on differentials, disparities in key MDHS indicators).

Data Use for Planning and Programming: The MDHS was used in preparing the SDG Baseline Report for Myanmar, being cited as a primary data source for multiple health, nutrition and gender equality indicators. Selected MOHS and Steering Committee respondents also cited the above as a positive illustration of MDHS data use.

The timing of MDHS dissemination occurred around the same time that the National Health Plan, 2017-2021 was being launched, so the data were not included in the NHP.²¹ However, MDHS data are reflected in the operational plan, and one respondent whose agency was a member of the DHS Steering Committee member also noted that MDHS data have been used to support development of state and regional health plans.

Various MOHS Departments (e.g., Department of Medical Research) were conducting further analyses of the MDHS and Sections/Centers (National Nutrition Center, Women and Child Health Division, HIV program,) were using the MDHS data based on the relevance of the indicators to their mandate/thematic areas of interest.

Challenges: There were noted challenges with data presentation and/or promotion of data use with some targeted end users. For example, one DHS Steering Committee member described a minor editorial error (misplaced comma, zeros) that elicited confusion on the part of some stakeholders. Two MOHS respondents and one former DHS enumerator (male) shared that, despite efforts to engage media via a data user workshop with journalists, buy-in and interest on the part of the media was suboptimal, at best.

²¹ Ministry of Health and Sports/Republic of Myanmar. 2016. *Myanmar National Health Plan 2017 – 2021*.

http://themimu.info/sites/themimu.info/files/assessment_file_attachments/NHP_2017-2021_ENG_0.pdf

Finally, the issue of data triangulation was broached by respondents in five KIs. More specifically, although MDHS data were regarded as accurate, there was the practice of presenting both MDHS estimates and HMIS estimates simultaneously, with the Government still having a strong preference to use the latter. KI respondents noted challenges/difficulties triangulating data, especially when estimates from different data sources (e.g. MDHS and HMIS) were discrepant (e.g., administrative data sources tend to yield higher estimates for certain indicators, e.g., immunization coverage).

SPOTLIGHT ON GENDER

Gender-related issues are discussed throughout this report. The following are highlights:

- In addition to engaging and training EHO and CSO staff as MDHS enumerators, USAID widely supported efforts to consult EHOs and CSOs from conflict areas in pre-survey and post-survey workshops, with females participating in those consultations. For example, 40% of participants across six pre-survey consultations in conflict areas were female.
- Since completion of the MDHS, both female and male participants from Myanmar have benefitted from ICF's other (non-Myanmar-specific) capacity-building workshops in countries such as Indonesia to deepen skills in sampling and household listing, and in data processing and procedures.
- Increased large-scale survey implementation capacity within DPH and elsewhere can largely be attributed to implementation of the 2015–16 MDHS, with females accounting for the majority of personnel for whom capacity was strengthened.

Stakeholders widely lauded Dr. Thet Thet Mu, Deputy Director General in DPH, for her technical and managerial leadership through all phases of the MDHS 2015-16.

CONCLUSIONS

There has been mixed success with data presentation and use across the full spectrum of health-sector stakeholders at different levels.

Nonetheless, the transparency and open access to the raw MDHS dataset has been a major enabling factor in fostering a sense of data ownership and use.

The MDHS was regarded as an accurate data source, but difficulties interpreting and using that data in tandem with other data sources (e.g., HMIS) might limit its full and correct use.

RECOMMENDATIONS FOR AQ I

For USAID

- I. Based on learning from the 2015–16 MDHS related to the budgetary, IP level of effort (LOE) and time requirements for: (a) meaningful engagement of EHOs, CSOs and other grassroots stakeholders and (b) promotion of data use, USAID should **increase the MDHS Activity budget resources** to support the following:
 - Iterative consultations led by State Health Directors (and supported by Central MOHS and ICF) to engage EHOs and CSOs in survey planning and anticipated local data use
 - Greater engagement of local translators and guides to further extend the reach of MDHS efforts to the hardest-to-reach areas and communities

- Post-survey re-engagement (above and beyond state-level dissemination workshops) to promote sub-national use of MDHS data
 - Improved knowledge management related to the MDHS, with a particular emphasis on supporting Government and other key stakeholders with triangulation of DHS data with other evidence available in the country (e.g., HMIS).
2. For the next DHS, and with support from ICF, USAID should conduct a **systematic capacity assessment that includes but is not limited to DPH** (e.g., covering other teams/units such as DMR, MRH and National Nutrition Center with strengths in survey research and MDHS data use). USAID should use the standard ICF capacity assessment tools to establish a valid 'baseline' against which changes in capacity can be compared for all phases of survey implementation.
 3. Using a subset of qualified DHS trainers within MOHS, USAID should **support State Health Directors in the engagement of governmental and non-governmental stakeholders in local use of MDHS** evidence.

For ICF

4. Leveraging ICF's own institutional capacity that was built through its experience in supporting EHO/CSO engagement, ICF should **replicate the effective approach utilized for the 2015–16 Myanmar DHS, with even deeper engagement of the above entities in planning survey activities in their states**, not just their orientation on the purpose and scope and/or findings of the DHS.
5. For the next MDHS, ICF should jointly develop and implement a plan with MOHS (centered on mutually agreed handover and capacity milestones for each key phase of DHS implementation) for further strengthening of survey capacity within the MOHS. The plan should be aligned with findings from each round of capacity assessment (see Recommendation #7) and/or expressed capacity strengthening needs from the MOHS, focusing on competencies such as the following:
 - Standard DHS analysis/tabulation
 - Sub-national data dissemination
 - Triangulation of DHS evidence with other data

AQ 2: WHAT SPECIFIC LESSONS CAN BE LEARNED AND APPLIED TO OTHER FUTURE PROGRAMS AND ACTIVITIES IN MYANMAR?

2A. WHAT EXPERIENCES, ELEMENTS, OR KEY INPUTS WERE COMMON FOR THESE TWO CASES THAT LED TO THEIR SUCCESS?

FINDINGS

Exemplary Leadership within MOHS: The overwhelming majority of stakeholders lauded the strong leadership from high-ranking officials within MOHS. Dr. Thet That Mu (Deputy DG, DPH) was a central figure in ensuring successful implementation of the MDHS, and she was among the 2018 “Women of Change” award recipients (Figure 5).²² She was described by KII respondents as a manager of organizational

²² US Embassy in Myanmar. Program from US Embassy Yangon Women of Change 2018 Awards Ceremony. <https://mm.usembassy.gov/wp-content/uploads/sites/41/2018-Women-of-Change-Award-Reception-Pamphlet-English.pdf>. Accessed on August 3, 2018.

change, not just an excellent manager of technical implementation of USAID-supported activities within the MOHS.

Extremely High Government Buy-In: Even with turnover in the highest MOHS position (Minister), there was continuous support for the two activities by senior leaders (DGs, Deputy DGs). Various respondents specifically highlighted that MOHS “matched” USAID-funded TA with Government resources (e.g., equipment) and highly motivated and receptive staff. A strong desire on the part of MOHS senior and junior staff for Myanmar’s performance to stand up to international scrutiny (e.g., the rigors of the global DHS program), was frequently mentioned as a driver of success, particularly by MOHS respondents.

Figure 5. Photo of Women of Change Recipients - Dr. Thet Thet Mu, third from right



MOHS personnel are now extremely attractive targets for other employers—particularly those that can offer much-higher-paying jobs (e.g., the private sector).

Trust and Rapport between MOHS and ICF: Respondents identified that maintaining the continuity of TA providers assigned to the country set the stage for trust- and rapport-building between IPs and their government counterpart agencies.

Capacity Erosion through Staff Attrition: Below-market MOHS staff salaries, coupled with increased technical capacity of staff, created a “perfect storm” for increased staff attrition, eroding some institutional strengthening gains. This reality was raised largely by MOHS stakeholders, but also by others (USAID, ICF), who stated that with greater recognition of their capacity and accomplishments, trained

CONCLUSIONS

- Effective institutional strengthening was predicated on demonstrated resource (time and equipment) commitments from counterparts, not just an infusion of TA.
- Relationship building and trust building between the IP and government counterparts were critical success factors in the institutional strengthening of DPH.
- Staff willingness to learn and their motivation for MOHS’ work to be recognized as being on par with international standards were enabling factors for institutional strengthening; however, those were also factors that can contribute to staff attrition and eventual erosion of institutional capacity if mitigating measures are not put in place.
- Within Government counterparts, strong management capacity—not just technical capacity—existed within focal persons/leaders, particularly senior female leaders, who had the vision and ability to manage organizational change.

2B. WHAT PRACTICES SHOULD (NOT) BE APPLIED FOR FUTURE INSTITUTIONAL STRENGTHENING ACTIVITIES?

FINDINGS

Government Mobilization of Resources: Government counterpart mobilization of resources (e.g., financing, HR, equipment, infrastructure) was critical to the successful institutional strengthening outcomes. The need for these resources was mentioned by USAID and ICF staff consulted by the assessment team.

Grassroots Engagement: There was almost universal recognition among respondents that consultation, sensitization, and consensus-building with marginalized or hard-to-reach groups such as

EHOs was a practice that should be replicated in the future, with equal attention paid to central-level and sub-national engagement.

Structured Management of Handover between IP and Government Counterpart: Both ICF and MOHS stakeholders saw having mechanisms for quality monitoring (e.g., via direct observation, virtual monitoring) of counterpart performance, as well as the provision of troubleshooting support as counterparts assume more responsibilities, as part important aspects of handover.

Respondents also mentioned the importance of mechanism(s) for tracking and maintaining engagement of persons who benefitted from skills development/capacity building (e.g., DHS enumerators from CSOs, EHOs, private sector; data-entry personnel), and whose newly-acquired capacity might be a resource that can be tapped by other MOHS units and/or sectors in future endeavors (even if they left the entity/position in which they were originally trained).

Tangible, Internationally-recognized Outcomes, with a Clearly-defined Path toward Achievement of those Outcomes: Identification of ambitious international standards as: (a) a means of keeping counterpart staff motivated and engaged and, (b) the basis for a tangible, common goal between ICF and MOHS was an important aspect of institutional strengthening. In the case of DPH, a high-quality, nationally endorsed but internationally recognized survey was the achievement of focus. Both USAID and ICF regard ICF's tried-and-true models/frameworks as effective means in accomplishing that end.

Cultivating the Skill of Teaching/Skills Transfer: Numerous stakeholders expressed that, in addition to investing in the development of technical capacity within a critical mass of individuals, it was important to dedicate resources and tools to establish/strengthen teaching and training capacity. They also underscored the importance of mechanisms to institutionalize learning and support effective cascading of knowledge and skills; for example, through the use of master trainers who were coached and mentored by ICF.

CONCLUSIONS

- As a complement to institutional strengthening, Government counterparts must increase/provide requisite inputs (e.g., HR, equipment, infrastructure) to fully reap the benefits of external TA and capacity-building support.
- Having a clear strategy for institutional strengthening and handover was an effective element of ICF support.
- At its core, institutional strengthening must be pursued as a behavior change endeavor, with "incentives" for improved performance and an enabling environment to support and sustain change.

2C. WHAT PRACTICES SHOULD (NOT) BE APPLIED FOR FUTURE TECHNICAL ASSISTANCE ACTIVITIES (WHERE THE PRIMARY OBJECTIVE MAY NOT BE INSTITUTIONAL STRENGTHENING)?

FINDINGS

Flexible Administrative Arrangements: While ICF had a set work plan, multiple KII respondents highlighted the need for nimbleness of the TA approach and/or administrative arrangement (e.g., non-bureaucratic yet cost-efficient fund management) to be able to quickly and effectively respond to identified and/or expressed needs on the ground.

Recruitment and Placement of an In-Country Adviser: Both MOHS and ICF stakeholders placed high value on the recruitment and placement of an in-country adviser who was a Myanmar national and could serve as the primary liaison between ICF and the Government of Myanmar counterpart to: (a) maintain open lines of communication and (b) facilitate timeliness of TA provider actions in response to identified and/or expressed TA needs.

Long Lead Time for Consensus-Building and Buy-in for New/Unprecedented Approaches: One lesson learned across all stakeholder types was that, for activities and/or approaches that are novel

or unprecedented in the local context, both sufficient time and resources must be dedicated to extensive, recurrent consensus-building to ensure buy-in and engagement of key decision makers and other stakeholders—both within and external to the counterpart agency.

Open Line of Communication between Donor, Counterpart, and TA Provider: Both USAID and ICF respondents noted that there must be a commitment to fostering a collegial, open, and productive relationship between IP and counterpart agency, as well as ensuring that there is a direct line of communication between the Mission and the Government counterpart agency to ensure that the Mission has a clear understanding of: (a) priority TA needs that might have a major bearing on the achievement of quality outcomes and (b) the importance of timely funding release to support effective TA to address identified support needs.

Creative HR Support to Counterpart: Multiple MOHS key informants also emphasized the need to explore creative HR solutions (e.g., secondment, short-term hires for discrete functions, e.g., data processing, translation) to minimize the burden placed on existing staff, who have competing demands on their time when engaged in TA-supported activities.

CONCLUSIONS

The main conclusion drawn from the above findings was that when the primary objective was not institutional strengthening, activity design and administrative arrangements must facilitate responsiveness to on-the-ground support needs within a dynamic, ever-changing program context.

RECOMMENDATIONS FOR AQ 2

For USAID, in support of MOHS

1. USAID should Consider **“phase-gate” provisions to foster mutual accountability between TA providers and Government counterparts such as DPH**. Under that scenario, the project cycle would be divided into distinct phases, each culminating in a specific set of capacity development/handover milestones. At the end of each phase, decisions would be made between USAID, the Government of Myanmar counterpart and ICF regarding the scale and/or scope of program activities for the subsequent phase. For example, before initiating Mission-supported program activities and interventions, develop and apply criteria to establish the state of “readiness” of the counterpart agency/recipient institution for TA and/or capacity-building support. Two such criteria might relate to the existence of a costed workplan/investment plan and the availability of counterpart resources (human, financial, infrastructural) to fully leverage TA and capacity-building inputs from ICF. In the spirit of mutual accountability, USAID would require IPs to report on pre-determined milestones and indicators to monitor handover and risk management over the course of activity implementation.
2. USAID should support the implementation of creative HR solutions (e.g., fixed-term secondment of expatriate experts to work in tandem with counterpart staff, short-term local contractors to support discrete functions such as data processing/data quality assurance, updating of guidelines or manuals) to (a) minimize the double burden placed on counterpart staff who must manage their routine responsibilities while either deepening their capacities in new areas, or cascading skills/replicating practices within their agency; and (b) retain individuals whose capacity has been strengthened, in order to mitigate capacity erosion within the MOHS.

For ICF

3. ICF should institute mechanisms and checkpoints over the course of implementation to **re-assess and, if necessary, reprioritize support needs to ensure timeliness and responsiveness of technical support**. For example, this can be achieved through periodic (e.g., quarterly or semi-annual) TA needs assessment (e.g., quarterly, semi-annually) within the course of each fiscal year to ensure alignment and responsiveness of external, USAID-supported TA provision to local TA needs.
4. In the interest of fostering rapport and trust with counterparts, ICF should **maintain continuity of mentors/TA providers** (i.e., the same focal person/pool of experts assigned to the country to provide TA and capacity-building support over the life of the program).

ANNEXES

ANNEX A. EVALUATION SCOPE OF WORK (OF WHICH THE DHS ASSESSMENT WAS A PART)

EVALUATION OF HEALTH SECTOR CAPACITY DEVELOPMENT THROUGH USAID PROGRAMMING IN MIDWIFERY, DRUG QUALITY MONITORING, AND SURVEY IMPLEMENTATION

I. PURPOSE OF THE EVALUATION

This evaluation will examine how USAID-supported programming has affected the development of Myanmar national capacity in several areas, looking at key dimensions of human and institutional capacity and commitment. The study is divided into two components with two distinct deliverables, one focused on midwifery and in-service training for health care workers in maternal, neonatal and child health, and the other focused on two specific departments in the Ministry of Health and Sports (MOHS) that have received technical assistance through USAID programs: Department of Food and Drug Administration (DFDA) and the Department of Health Planning (DHP). At the conclusion of the studies, a dissemination event will be organized to share findings with key stakeholders, including implementing partners and the MOHS.

A. Component A: End-line Performance Evaluation of Maternal and Child Survival Program (MCSP)

Contractor will conduct an external endline performance evaluation for the Maternal and Child Survival Program (MCSP), a 3-year, \$8.1 million field support buy-in to the MCSP global mechanism, and support dissemination of findings.

The purpose of this evaluation will be to examine the extent to which MCSP's interventions influenced the country's capacity and systems for in-service training of health workers to improve availability and quality of maternal and newborn care services. The evaluation will analyze the effectiveness of the in-service capacity building approaches supported by MCSP, including the Learning and Performance Improvement Center (L&PIC) model, the roll-out approach for competency based capacity building at the state/regional level and below, the standards-based quality improvement model introduced at selected training sites, and complementary efforts to strengthen institutions such as the Myanmar Nurse and Midwifery Council and Myanmar Nurse and Midwives Association (MNMC and MNMA).

This information will be used to inform approaches for continued strengthening of in-service training at lower levels of the health system under USAID's follow-on Essential Health program, and to generate recommendations for USAID or other development partners on how to optimize support to the MOHS to deliver integrated in-service training interventions and build related country systems through future programs.

B. Component B: Assessment of Institutional Capacity Building of Myanmar Department of Food and Drug Administration (DFDA) and Department of Health Planning (DHP)

This assessment will document the achievements, challenges, and lessons learned from two USAID-funded institutional capacity strengthening activities: 1) Strengthening drug quality monitoring capacity of the Myanmar Department of Food and Drug Administration (DFDA) and 2) Implementation of the Myanmar Demographic and Health Survey (DHS) in 2015-2016 and associated support to the Ministry of Health and Sports, Department of Health Planning. The purpose of this assessment is to better understand and document the extent to which institutional capacity was strengthened in these two institutions, and the key factors associated with USAID's programming approaches that enabled and/or worked against capacity strengthening and local ownership, in order to inform the design of future technical assistance and institutional strengthening activities in Myanmar. The contractor will also support the dissemination of findings.

II.SUMMARY INFORMATION

COMPONENT A	
Strategy/Project/Activity Name	Maternal and Child Survival Program (MCSP)
Implementer	Jhpiego
Cooperative Agreement #	OAA-A-14-00028
Total Estimated Ceiling (TEC) of the Project/Activity to be Assessed	8.1 million
Life of Project	July 2015-June 2018 for Myanmar country program (global award dates are from March 1, 2014 to June 30, 2018)
Active Geographic Regions	Rakhine State (3 townships), Southern Shan State (2 townships), Northern Shan State (3 townships), Ayeyarwaddy Region (3 townships), Kayah, and Magway Region (3 townships)

COMPONENT B				
Activity Name	Implementer	Agreement/Contract #	Budget	Active Geographic Regions
Strengthening drug quality monitoring capacity of DFDA	United States Pharmacopeia	Cooperative Agreement (Field Support)	\$845k	National
Strengthening DHP's capacity to implement DHS 2015 in Myanmar	ICF International	Contract	\$2.3 million	National

Both activities fall under:

Development Objective(s) (DOs)	Activities support the Mission's health Mission Objective (3.2): <i>Improve health of the people of Myanmar through stronger, inclusive health systems.</i>
USAID Office	USAID Burma, Office of Public Health

III. BACKGROUND

A. Component A: End-line Performance Evaluation of Maternal and Child Survival Program (MCSP)

The Maternal and Child Survival Program (MCSP) is a global U.S. Agency for International Development (USAID) cooperative agreement to introduce and support high-impact health interventions in 25 priority countries, in support of the global goal of reducing preventable child and maternal deaths (EPCMD). In Myanmar, MCSP began in 2014 with an initial focus on supporting discrete in-service training and capacity-building interventions partnering with professional associations; the scope of MCSP's program and Mission funding expanded steadily, leading to MCSP serving as the Mission's flagship MCH activity by 2016-2017.

MCSP's program in Myanmar supports the MOHS' strategic priority to strengthen human resources for health by building the capacity of existing health workers to deliver lifesaving maternal, newborn and child health interventions. Health workers often do not receive adequate technical updates, and education and training is heavily classroom-based, theoretical learning. Additionally, systems to ensure health facilities deliver care according to evidence-based technical standards are not in place, meaning that they likely are not suitable to serve as effective training grounds for health care workers.

MCSP is in its fourth and final year in Myanmar, and has had a significant evolution in its SOW since inception in 2014, when the initial focus was on developing a clinical skills training center in Yangon, and following up on national-level technical assistance initiated under MCHIP. In early fall 2015, an opportunity to link with and leverage funds from the Three Millennium Development Goal (3MDG) Fund midwifery strengthening project, led by Jhpiego and focused on midwifery pre-service training institutions, was identified. The workplan of MCSP was updated to add another program year and to shift more explicitly to in-service training and licensing of midwifery, complementing 3MDG support for pre-service training and accreditation of training institutions. Support for strengthening midwifery regulation (licensing and accreditation) is shared between the two programs, and funds are leveraged by both programs for implementation of this comprehensive approach to improving midwifery working with the Myanmar Nurse and Midwife Council (MNNMC).

In the last two quarters of FY16, MCSP prepared and submitted two new work plans in response to additional funding made available by the Mission. The first submission was a President's

Malaria Initiative (PMI) addendum to the ongoing MCSP work plan to respond to guidance from the Mission and the FY15 Malaria Operational Plan, to add activities to strengthen antenatal care (ANC) practices around malaria in pregnancy and support development of an integrated community case management (iCCM) model for Myanmar. The second was a new set of ‘catalytic’ activities written based on guidance from the Mission to respond rapidly to the then new government of Myanmar’s priorities and call to “intensify maternal and child health activities.”

In early 2017, the project integrated all 3 of its work plans (MCH+PMI, PMI addendum, catalytic) to guide implementation through June 2018. All activities in this work plan are an expansion of ideas and activities initiated in these previous work plans, with an expanded focus on systems, and an aim to generate evidence and tools for replication and scale up by the MOHS and/or other actors to improve the health system.

MCSP works with the MOHS to ensure that activities are in line with national priorities of improving health worker capacity to deliver the high-quality life-saving care included in the Essential Package of Health Services (EPHS) and thereby improved health outcomes. MCSP also coordinates with partners to leverage funding and complement efforts wherever possible. MCSP is explicitly linking with and leveraging 3MDG-funded projects for midwifery pre-service education and human resources for health strengthening to work across the continuum of pre-service, regulation, in-service capacity building and continuing professional development to improve the health workforce. MCSP is also coordinating with and leveraging activities led by organizations working in the border areas on activities with Ethnic Health Organization (EHOs) and is complementing activities funded by the World Bank and other partners wherever possible. Some activities, facility based integrated management of newborn and child illness (F-IMNCI) for example, are explicitly complementary to activities already initiated by other partners. MCSP’s investment builds the power of the approach through a larger demonstration. MCSP may possibly receive funding to continue support for the LPICs in Sittwe hospital in Rakhine State, though that extension will be outside the scope of this evaluation.

B. Component B: Assessment of Institutional Capacity Building of Myanmar Department of Food and Drug Administration (DFDA) and Department of Health Planning (DHP)

The USAID Health draft strategy prioritizes addressing key constraints that directly affect health programming – including strengthening the capacity of national institutions, expanding the role of civil society and media, and increasing the quality of life of the people of Myanmar through increased incomes and improved access to health services.

USAID invests in a number of activities where institutional strengthening is either a primary or secondary objective, including capacity strengthening of the Myanmar Department of Food and Drug Administration (DFDA) to monitor drug quality and to achieve International Organization for Standardization (ISO) accreditation. Capacity-building was also a secondary objective in USAID support for Myanmar’s first Demographic and Health Survey, which included assistance to the Government of Myanmar’s Department of Health Planning (DHP)—and later the Department of Public Health (DPH; which absorbed the now-disbanded DHP) to

plan, and implement the survey in 2015 and publish and disseminate the findings in 2016-17

1. Drug quality monitoring

The Myanmar National Strategic Plan (NSP) for malaria aims to address the availability of counterfeit and substandard drugs that not only could have a negative impact on the treatment outcomes for malaria patients but also could be a driver for the development of multi-drug resistance. The DFDA is a key player in fulfilling this objective and takes responsibility in monitoring drug quality as well as upgrading its quality assurance laboratory and building the capacity of inspectors. The DFDA currently has offices in Nay Pyi Taw, Yangon, and Mandalay and plans to establish branch offices in 14 districts and laboratories at 14 more border trade zones over the next few years.

Building the institutional capacity of DFDA towards meeting international standards is one of the main outcomes to date of PMI technical assistance since 2014. In addition to this technical support, PMI has supported the procurement of essential equipment including a dissolution tester, a high-performance liquid chromatography system, and other necessary laboratory and personal safety supplies for use by the DFDA laboratories. In December 2016, the pharmaceutical chemistry laboratory of DFDA in Nay Pyi Taw was assessed by ANSI/ASQ National Accreditation Board (ANAB) from the US and obtained the accreditation of the International Organization for Standardization 17025:2005. With technical assistance provided by USAID/PMI through the Promoting the Quality of Medicines (PQM) Activity and other donors such as the Global Fund for equipment and maintenance, the DFDA was able to achieve ISO accreditation much earlier than anticipated, and became the only laboratory in the SE Asia region with ANAB accreditation. PQM is the key partner DFDA works with to provide technical assistance with regards to capacity building of its human resources and strengthening the existing Quality Assurance (QA)/ Quality Control (QC) systems.

2. Demographic and Health Survey (DHS)

USAID Demographic and Health Surveys (DHS) in various countries globally to measure progress on key population, health, and nutrition statistics. In the past, Myanmar has conducted several population and health surveys: 1) Fertility and Reproductive and Health Surveys (FRHS) were implemented in 1991, 1997, 2001, and 2007 by the Department of Population within the Ministry of Immigration and Population; and 2) Multiple Indicator Cluster Surveys (MICS) were implemented in 1995, 2003, and 2009-2010 by the Department of Planning of the Ministry of Planning and Economic Development, in collaboration with the Department of Health and the Department of Health Planning within the Ministry of Health.

In 2015-2016, USAID with contributions from 3MDG through the DHS7 program, supported the Ministry of Health and Sports (MOHS) to implement the first-ever nationally representative DHS covering 16,575 women of reproductive age 15-49 and approximately 8,287 men 15-49 in 12,750 households. Implemented by the Department of Health Planning with technical assistance provided by ICF International (DHS7 program), the DHS collected data on

demographic rates, particularly of fertility rates, and infant and child mortality rates, at the national level, state/region levels (States: Chin, Kachin, Kayah, Kayin, Mon, Rakhine, and Shan; and Regions: Ayeyarwady, Bago, Magway, Mandalay, Sagaing, Tanintharyi, and Yangon) and Naypyidaw Union Territory, and for the urban and rural strata of the population. This survey succeeded in covering all parts of the country despite many ongoing conflicts. This first-of-its-kind nationwide survey provided valuable baseline data upon which future health policies and programs can be tracked.

To gain country buy-in and government ownership, a Steering Committee, chaired by the Minister of Health and Sports with representatives from the Ministry of Planning and Economic Development, Ministry of Immigration and Population, and other relevant departments and ministries was established. The Steering Committee also included representatives from development partners, including USAID, UNICEF, UNFPA, the World Bank, 3MDG, and other international and bilateral organizations. The MOHS led the entire process from data collection to analysis, and final dissemination by the end of 2016.

Strengthening the capacity of host countries to implement high quality, representative household and facility-based surveys and disseminate and use the results in country is an explicit and critical focus of the DHS Program globally. As a result, DHS developed a Global Capacity Strengthening Strategy (CSS) to help guide, monitor and evaluate the program's capacity strengthening efforts aimed at increasing country ownership and helping to reduce host-country dependence on foreign technical assistance for conducting surveys. The capacity strengthening approach utilizes a whole-systems approach based on USAID's Human and Institutional Capacity Development (HICD) model. Recognizing that individual performance is highly influenced by institutional context, the DHS program provided technical assistance in a holistic manner, while ensuring that the capacities of counterparts are strengthened during survey design, implementation, processing, analysis, dissemination, monitoring, and evaluation. In Myanmar, due to restrictions around provision of funding directly to the host government, the DHS program also established a unique financing mechanism using an intermediary accounting firm to disburse funds to support field implementation, which enabled the MOHS team to exert due leadership and management of the survey. Similar mechanisms are used by the Global Fund (UNOPS) to provide resources for

program implementation under GOM leadership, while upholding restrictions on direct financing to government.

This assessment will document the achievements, challenges, and lessons learned from capacity strengthening in order to understand the common experiences and enabling environment required for sustainable knowledge transfer to inform future institutional strengthening activities in country.

III.

A. Description of the Problem, Development Hypothesis(es), and Theory of Change

1. a. Component A: MCSP's theory of change is:

→ If MCSP builds on past experience to...

- Strengthen and build coordination among the institutions and systems that govern capacity development for health workers;
- Introduce transformative, coordinated and targeted competency-based approaches to provider education (in-service training and continuing professional development), including on-the-job at facilities where quality improvement (QI) efforts, based on standards of quality care are implemented; and at the same time
- Strengthen the regulation of practice to improve the governance and practice of health providers in maternal, newborn and child health;

And if these pilot activities are well documented and shown to be effective,

→ Then they can be scaled up by the government and/or other actors; and as services improve, maternal, newborn and child lives will be saved.

The intermediate results in the approved MCSP work plan for 2017-2018 include working with the MOHS and key partners to achieve the following:

1. Policy environment strengthened for improving quality and equitable access to maternal, newborn and child health services
2. Health workforce strengthened to support effective delivery of MNCH components of the Essential Package of Health Services (EPHS)
3. Quality health service delivery strengthened in targeted technical and geographical areas

1.b. Component A: Summary of MCSP's goal and approaches to be assessed

The activity's stated goal is to respond to the Ministry of Health and Sports' (MOHS) strategic priorities for improving maternal, newborn and child health by demonstrating, documenting and transitioning capacity to counterparts to make sustainable improvements in the health system.

One purpose of the final performance evaluation is to assess MCSP's efforts to build capacity and systems for in-service training, which covers a sub-set of the overall package of interventions supported by the project in Myanmar. Specifically, in-service training approaches have centered

around four key “models” or approaches being introduced by MCSP, and for each, a documentation package intended to support adoption and scale up of these models will be developed by the implementing partner. The project implementation shifted over time from a focus on training to an increased systems strengthening-oriented approach. The assessment should account for the fact that the project emphasis and model shifted between project years.

The four models include:

1. The Learning and Performance Improvement Center (L&PICs) model for in-service capacity building, established in five states & regions and at MNMA, MNMC, and Taw Naw Teaching Hospital in Kayin State (L&PICs were also established to support pre-service training in two Nursing Universities with USAID funding, and in midwifery training schools with 3MDG funding);
2. The roll out approach for competency based capacity building, using the L&PICs combined with complementary support to MOHS counterparts to plan and execute in-service training at the state/regional level and below;
3. A model for strengthening the institutions that the International Confederation of Midwives (ICM) has identified as central to strengthening the midwifery profession (MNMC and MNMA);
4. A standards-based quality improvement model for clinical training sites affiliated with selected L&PICs.

2. a. Component B: If the PQM and DHS strengthen the institutional capacities of the two departments - DFDA and DPH, the performance on drug quality monitoring and health survey implementation will be improved.

2. b. Component B:

(1) Summary of PQM goal and approaches to be evaluated.

PQM is aimed to achieve its strategic objectives by providing technical assistance in three key intermediate result (IR) areas using a systems-based approach tailored to fit the needs of individual countries or regions. Activities include building the capacity of countries’ medicines regulatory authorities (MRAs) to review and approve quality-assured essential medicines and strengthening their ability to protect their own population from poor-quality medicines. PQM works with national and regional MRAs to build sustainable capacity for medicines evaluation, manufacturing inspection, and surveillance. PQM supports national quality control laboratories (NQCLs) through hands-on training and technical assistance to improve laboratory standards and compliance with internationally recognized standards.

(2) Summary of DHS goal and approaches to be evaluated.

The 2015 Myanmar Demographic and Health Survey (MDHS) is aimed at ascertaining nationally representative indicators on fertility, family planning, adult and childhood mortality, maternal and child health, nutrition, knowledge on HIV and AIDS, and women empowerment.

B. Summary of the Monitoring, Evaluation, and Learning (MEL) Plans

1. Maternal and Child Survival Program (MCSP) MEL Plan

MCSP's MEL plan is the tool for managing and documenting the performance of the program during the course of implementation, providing a framework for information to measure progress in project implementation and performance by objectives. The measurement, monitoring, evaluation and action-oriented learning for MCSP rely on program as well as counterpart institution data sources. Specific data sources, and the timing and methods of data collection are detailed in MCSP's FY 17 and 18 MEL Plan. The revised MEL Plan was approved in October 2017, with an expanded set of indicators intended to reflect progress on outputs as well as impact on system functioning (for instance, capturing the utilization of L&PICs by counterpart institutions independent of project resources, and changes in quality measures). A baseline assessment was not conducted overall for this project as it began with a limited work scope that expanded over time. On some measures of quality, a limited baseline assessment was done in 5 clinical sites affiliated with L&PIC: Taunggyi, Lashio, Sittwe, Magway and Patheingyi.

Developing and disseminating high quality, informative program documentation is a central goal for the remaining period of the program to document the models and approaches supported by MCSP. By Dec. 2017, the MCSP project plans to complete documentation of its L&PIC model as well as the roll-out approach, documented in the form of several special studies and reports developed by MCSP. The L&PIC model will include detail on components such as modules that are being implemented, training requirements, roll out process including township selection, and establishment of training teams. A sustainability plan under development will include data on costs of implementation and resources needed, possible sources of funding, and capacity to manage L&PIC.

Program documentation will have several key objectives: describing in detail the processes, systems and models developed/strengthened through MCSP so that they can be used in other contexts; advocating for, and providing the necessary information for, others to take on these approaches, so that they can be scaled up; disseminating key findings that can be used to inform future efforts related to MCSP's approaches.

It will also allow the external assessment team to analyze critical information on how implementation of MCSP's approach in country. The team can compare this information to other data sources on implementation of approaches for systems strengthening for maternity care in Myanmar to understand how the project approach can be improved.

2. PQM MEL Plan

PQM has a robust M&E system that promotes continuous learning, accountability, and informed decision-making across its entire portfolio of programs. PQM monitors its progress against agreed-upon intermediate results and sub-intermediate results by collecting data from sources such as national laboratories, regulatory agencies, manufacturers, WHO, and the Global Drug Facility. Data are captured in Excel-based tracking sheets that help PQM to monitor key achievements related to accreditations/reaccreditation/expanded scopes of accreditation; samples tested and testing results; SOPs, policies, and guidelines developed; presentations, publications, media events and network meetings promoting the quality of medicines; sampling sites of the (Medicine Regulatory Authorities) MRA; turnaround time from sample test to final report, and priority medicines achieving local or global approval for manufacture and sale.

3. **DHS MEL Plan**

N/A (But DHS Work Plan will be provided)

IV. **EVALUATION AND ASSESSMENT QUESTIONS**

A. **Component A: End-line Performance Evaluation of Maternal and Child Survival Program (MCSP)**

Question 1: To what extent did MCSP assistance influence in-service training practices and related systems to improve maternal, neonatal and child health? In answering this question, the contractor must address the following:

- a) To what extent have the MCSP's in-service capacity building activities, including the models outlined in Section B and associated interventions, influenced policies, practices and the enabling environment for in-service training at different levels of the system (regulatory and professional bodies, central MOHS, state/regional level, and township level and below)? To what extent have health system actors been able to apply and replicate interventions introduced by MCSP?
- b) To what extent were MCSP approach and interventions aligned to health system realities in order to address the key barriers for strengthening in-service training at State/Region and Township levels, and;
- c) To what extent were MCSP's interventions and program design aligned to address drivers of maternal and child mortality and morbidity?

In addressing this question, the evaluator is to consider alternative ways of developing health human resource capacity and how the chosen model implemented compares with other alternatives in terms of effectiveness and efficiency in international best practice.

Question 2: How have MCSP's approaches contributed to potential sustainability of project results? In answering this question, the Contractor must address the following:

- a) What interventions will likely be/not be sustained or scaled up by the Government of Myanmar?
- b) What are key factors/evidence that support such conclusion(s)?

Question 3: What are the specific lessons that can be learned to inform future programs that aim to strengthen systems for capacity building related to maternal and child health, particularly at the township level?

- a) Any similar approaches/interventions that should/should not be supported/replicated through future assistance? Why/why not?;
- b) Any challenge(s) in the health system that MCSP did not address which would need to be addressed for future programs to be successful, particularly toward affecting improvements at the township level and below;
- c) Any intervention(s)/support(s) that should be removed or modified to better adjust interventions to health system realities; and
- d) Any necessary modifications to the models and interventions supported by MCSP, including their mode of delivery, if future replication is considered.

B. Component B: Assessment of Institutional Capacity Building of Myanmar Department of Food and Drug Administration (DFDA) and Department of Health Planning (DHP)

Question 1: In what ways and to what extent was the DFDA's institutional capacity strengthened to monitor drug quality as a result of USAID assistance?

- a) What factors (internal and external) contributed to the earlier-than-anticipated attainment of DFDA's ISO accreditation of the Nay Pyi Taw laboratory? (including enabling environment)
- b) How was capacity strengthened from USG-funded assistance?
- c) What factors are/are not in place to ensure that strengthened capacity can/will be sustained?
- d) Are capacity strengthening outcomes at individual and organizational levels measured for learning and improvement, as well as for accountability?
- e) How did the project's design contribute to country engagement and ownership?
- f) How do the DFDA's internal factors (structure, policy or human resource management practice etc.) affect capacity strengthening at individual and institutional levels?

Question 2: In what ways and to what extent was the MOHS's capacity strengthened in the Department of Health Planning and elsewhere through implementation of the 2015-2016

Myanmar DHS and associated technical support provided by USAID and the DHS Program?

- a) What factors (internal and external) facilitated the implementation, analysis, and utilization of the 2015-16 DHS survey? (Including enabling environment)
- b) What capacities and skills in the MOHS were strengthened through support from the DHS project, USAID and 3MDG, and to what extent?
- c) How was DHS' global capacity-strengthening strategy applied in the Myanmar context, and were capacity strengthening outcomes at individual and organizational levels measured for learning and improvement, as well as for accountability?
- d) How did the project's design and implementation approach contribute to country engagement and ownership?
- e) How did the implementation of the DHS, and associated efforts to engage ethnic groups to collect and disseminate data in contested and non-government-controlled areas, build MOHS experience and capacity to engage with ethnic health organizations (EHOs) and other community groups in the future?
- f) To what extent have Myanmar health sector stakeholders been able to use and apply DHS data to influence decision-making around the planning and delivery of health services and reforms?

Question 3: What specific lessons can be learned and applied to other future programs and activities in Myanmar?

- a) What experiences, elements, or key inputs were common for these two cases that led to their success?
- b) What practices should (not) be applied for future institutional strengthening activities?
- c) What practices should (not) be applied for future technical assistance activities (where the primary objective may not be institutional strengthening)?

V. DESIGN AND METHODOLOGY

A. Component A: End-line Performance Evaluation of Maternal and Child Survival Program (MCSP)

Qualitative and quantitative data should be collected and analyzed using case study methodology or other appropriate methods, such as systems analysis and complexity-aware methods that account for the short period of project intervention while helping to understand the suitability and replicability of MCSP-supported models and interventions around in-service training. The evaluation team will propose an appropriate method in consultation with USAID.

There is no overall baseline data that would allow for before-after comparison or with a control group to assess change over time. The project only has limited baseline data on a few quality measures in selected sites available which may allow for some limited secondary analysis to

show the extent or reach of MCSP interventions over time. Availability and comprehensiveness of project-produced data and documentation varies given that the approach for MCSP shifted significantly between workplan years. The existing data include performance statistics from MCSP on program implementation over time and detailed project documentation on project components, cost, and details of the model rollout.

In addition to existing project data, the evaluation team may have to draw on evidence from other donor programs in similar contexts.

To answer the evaluation questions, the evaluation team will have to collect supplementary qualitative (and, as relevant, quantitative) information through key informant interviews, focus group discussions, and survey questionnaires. Questions may focus, for example, on perceived changes due to project activities, project sustainability, and intended and unintended outcomes. Key informants may include project staff, USAID staff, ministry staff at the central level and state health training team members and counterparts at the state and regional level, township medical officers and members of township training teams at the township level and below including midwives, patients, and targeted beneficiaries. Other donors and partners active in the MCH space (including 3MDG technical advisors, UNICEF, WHO, MNMC, MNMA, and MMA-OB/GYN Society), also will likely have valuable perspectives on the role and impact of USAID support for in-service training strengthening in midwifery.

The design matrix and methods below are the illustrative and the contractor may propose other methods as appropriate. The evaluator may also propose alternative wording of evaluation questions if desired:

Questions	Suggested Data Sources (*)	Suggested Data Collection Methods	Data Analysis Methods
<p>Question 1: To what extent did MCSP assistance influence in-service training practices and related systems to improve maternal, neonatal and child health? In answering this questions, the contractor must address the following:</p> <p>a) To what extent have the MCSP's in- service capacity building activities,</p>	<p>MCSP learning agenda documentation (to be completed by Dec 2017), workplans and reports from MCSP project and other MCH projects reports in country, other relevant in country document such as Annual Operational Plan of National</p>	<p>Qualitative (key informant interview and/or focus group discussions etc as relevant), Desk review, secondary analysis</p>	<p>To be determined by the contractor</p>

<p>including the models outlined in Section B and associated interventions, influenced policies, practices and the enabling environment for in-service training at different levels of the system (regulatory and professional bodies, central MOHS, state/regional level, and township level and below)? To what extent have health system actors been able to apply and replicate interventions introduced by MCSP?</p> <p>b) To what extent were MCSP approach and interventions aligned to health system realities in</p> <p>order to address the key barriers for strengthening in-service</p> <p>training at State/Region and Township levels, and;</p> <p>c) To what extent were MCSP's interventions and program design aligned to address drivers of maternal and child mortality and morbidity?</p> <p>In addressing this question, the evaluator is to consider alternative ways of developing health human resource capacity and how the chosen model implemented compares with other alternatives in terms of effectiveness and efficiency in international best practice.</p>	<p>Health Plan (NHP), Yearly NHP implementation report if available, routine facility data, stakeholders & project beneficiaries, finding from the surveys.</p>	<p>as necessary.</p>	
<p>Question 2: How have MCSP's approaches contributed to the potential sustainability of project results?</p> <p>What interventions will likely be/not be sustained or scaled up by the Government of Myanmar?</p> <p>What are key factors/evidence that support such conclusion(s)?</p>	<p>MCSP learning agenda documentation (to be completed by Dec 2017), workplans and reports from MCS'P project and other MCH projects reports in country, other relevant in country document such AOP of NHP, Yearly NHP implementation report if available, routine facility data, stakeholders & project beneficiaries, finding from the surveys.</p>	<p>Qualitative (key informant interview and/or focus group discussions etc as relevant), Desk review, secondary analysis as necessarily.</p>	<p>To be determined by the contractor</p>

<p>What are the specific lessons that can be learned to inform future programs that aim to strengthen systems for capacity building and in-service training related to maternal and child health, particularly at the township level?</p> <p>a. Any similar approaches/interventions that should/should not be supported/replicated through future assistance? Why/why not?;</p> <p>b. Any challenge(s) in the health system that MCSP did not address at Township level which would need to be addressed for future programs to be successful;</p> <p>c. Any intervention(s)/support(s) that should be removed or modified to better adjust interventions to health</p>	<p>MCSP learning agenda documentation (to be completed by Dec 2017), workplans and reports from MCSP project and other MCH projects reports in country, other relevant in country document such AOP of NHP, Yearly NHP implementation report if available, routine facility data, stakeholders & project beneficiaries, finding from the surveys.</p>	<p>Qualitative (key informant interview and/or focus group discussions etc as relevant), Desk review, secondary analysis as necessarily.</p>	<p>To be determined by the contractor</p>
<p>system realities.; and</p> <p>d. Any necessary modifications to the models and interventions supported by MCSP, including their mode of delivery, if future replication is considered.</p>			

B. Component B: Assessment of Institutional Capacity Building of Myanmar Department of Food and Drug Administration (DFDA) and Department of Health Planning (DHP)

To answer all the questions, the assessment team should select/develop a capacity development framework/model that reflects global best understanding. The team should propose an approach to assessing capacity development that draws on the most important available sources, including reports and documents, including Monitoring, Evaluation, and Learning (MEL) plans and indicators, workplans, agreements, quarterly and yearly reports, assessments and special survey reports.

In addition to existing data and reports, the assessment team should collect supplementary qualitative information through key informant interviews, focus group discussions, and stakeholder consultations to understand project context. Questions may focus on perceived changes due to project activities, project sustainability, and intended and unintended outcomes. Key informants may include project staff, USAID staff, ministry officials, and targeted beneficiaries. For FDA, this will include FDA laboratory staff and officials in Nay Pyi Taw. For the DHS, this will include MOHS counterparts in the Dept. of Medical Research, Health Information Systems and selected technical offices, other relevant Ministries responsible for population-based surveys, key partners and stakeholders (3MDG, UNICEF, World Bank, UNFPA, WHO and others), and NGOs, civil society and ethnic group representatives engaged in the survey implementation and dissemination of findings. Qualitative and quantitative data should be analyzed using appropriate methods.

The evaluator will propose an appropriate method in consultation with USAID. The design matrix and methods below are the illustrative and the contractor should propose other methods as appropriate. The evaluator may also propose alternative wording of evaluation questions if desired:

Questions	Suggested Data Sources	Suggested Data Collection Methods	Data Analysis Methods
<p>Question 1: In what ways and to what extent was the DFDA's institutional capacity strengthened to monitor drug quality?</p> <p>a. What factors (internal and external) contributed to the earlier- than- anticipated attainment of DFDA's ISO accreditation of the Nay Pyi Taw laboratory? (including enabling environment)</p> <p>b. How was capacity strengthened from PMI-supported activities? Other project support?</p>	Project quarterly and annual reports, Project MEL plans and indicators, assessment reports and evaluations, capacity strengthening strategies, National Human Resource Development strategy, DFDA's 5-year Strategic Plan, consultancy trip reports	Desk/literature review; key informant interviews, focus group discussions; questionnaires	[To be determined by the contractor] - Disaggregate by gender as applicable.
Questions	Suggested Data Sources	Suggested Data Collection Methods	Data Analysis Methods
c. Are systems in place to ensure that strengthened capacity can/will be sustained?			
d. Are capacity strengthening outcomes at individual and organizational levels measured for learning and improvement, as well as for accountability?			
e. How did the project's design contribute to country engagement and ownership?			
f. How does the DFDA's organizational structure affect capacity strengthening at individual and institutional levels?			
<p>Question 2: In what ways and to what extent was the DHP's capacity strengthened to implement the 2015-2016 Myanmar DHS?</p>	Project work plan and quarterly and annual reports, activity and trip reports from DHS, MOUs and implementation documents developed to support program implementation, consultancy trip reports	Desk/literature review; key informant interviews, focus group discussions; questionnaires	[To be determined by the contractor] - Disaggregate by gender as applicable.

a. What factors (internal and external) facilitated the implementation, analysis, and utilization of the 2015-16 DHS survey? (Including enabling environment)			
b. What capacity and skills were strengthened through the Global DHS project?			
c. Are systems in place to ensure that capacity to implement nationwide, representative surveys can/will be sustained?			
d. Are capacity strengthening outcomes at individual and organizational levels measured for learning and improvement, as well as for accountability?			
e. How did the project's design contribute to country engagement and ownership?			
Question 3: What specific lessons can be learned and applied to other future programs and activities in Myanmar?	Partner project quarterly and annual reports, Project MEL plans and indicators, assessment reports and evaluations, capacity strengthening strategies, national human resource development strategy	Desk/literature review; key informant interviews; focus group discussions; questionnaires	
a. What experiences, elements, or key inputs were common for these two cases that led to their success?			
b. What practices should (not) be applied for future institutional strengthening activities?			
c. What practices should (not) be applied for future technical assistance activities (where the primary objective may not be institutional strengthening)?			

V. FINAL REPORT FORMAT

(THIS SECTION APPLIES TO BOTH COMPONENT A AND B)

The final reports (for each Component) must include an abstract; executive summary; background of the local context and the project being assessed; the evaluation/assessment purposes and main evaluation/ assessment questions; the methodology or methodologies; the limitations to the evaluation/assessment; findings, conclusions, and recommendations. For more detail, see “How- To Note: Preparing Evaluation Reports” (Attachment 2) and [ADS 201mah, USAID Evaluation Report Requirements](#). An optional evaluation report [template](#) is available in the Evaluation Toolkit.

Each executive summary must be 2–5 pages in length and summarize the purpose, background of the project being assessed, main assessment questions, methods, findings, conclusions, and recommendations and lessons learned (if applicable).

The methodology must be explained in the report in detail. Limitations to the assessment/evaluation must be disclosed in the report, with particular attention to the limitations associated with the assessment/evaluation methodology (e.g., selection bias, recall bias, unobservable differences between comparator groups, etc.)

The annexes to each report must include:

- The task order Statement of Work (SOW);
- Any statements of difference regarding significant unresolved differences of opinion by funders, implementers, and/or members of the assessment/evaluation team;
- All data collection and analysis tools used in conducting the evaluation/assessment, such as questionnaires, checklists, and discussion guides;
- All sources of information, properly identified and listed; and
- Signed disclosure of conflict of interest forms for all evaluation/assessment team members, either attesting to a lack of conflicts of interest or describing existing conflicts of interest.
- Summary information about evaluation/assessment team members, including qualifications, experience, and role on the team.

VI. CRITERIA TO ENSURE THE QUALITY OF THE EVALUATION/ASSESSMENT REPORTS

(THIS SECTION APPLIES TO BOTH COMPONENT A AND B)

Per **ADS 201maa, Criteria to Ensure the Quality of the Evaluation Report**, the draft and final reports will be evaluated against the following criteria to ensure the quality.

- The report must represent a thoughtful, well-researched, and well-organized effort to objectively evaluate/assess the project.
- The report must be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summaries of the report must present a concise and accurate statement of the most critical elements of the reports.
- The report must adequately address all questions included in the SOW, or the questions subsequently revised and documented in consultation and agreement with USAID.

- The evaluation/assessment methodology must be explained in detail and sources of information properly identified.
- Limitations to the evaluation/assessment must be adequately disclosed in the reports, with particular attention to the limitations associated with the methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Findings must be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people's opinions.
- Findings and conclusions must be specific, concise, and supported by strong quantitative or qualitative evidence.
- If findings assess person-level outcomes or impact, they should also be separately assessed for both males and females. If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

VII. OTHER REQUIREMENTS

All modifications to the required elements of the SOW of the contract, whether in technical requirements, evaluation/assessment questions, evaluation/assessment team compositions, methodology, or timeline, need to be agreed upon in writing by the Contracting Officer (CO). Any revisions must be updated in the SOW and only the final SOW shall be included as an annex to the Report.

ANNEX B. EVALUATION DESIGN MATRIX

Data Collection and Analysis Matrix, Component B

Evaluation Questions	Data Source	Data Collection Methods	Data Analysis Methods
EQ1: In what ways and to what extent was the DFDA's institutional capacity strengthened to monitor drug quality?	<p><u>Document</u>: Quarterly/annual reports, MEL plans, capacity strengthening strategies, assessment reports/evaluations, trip reports, National Human Resource Development strategy, DFDA's 5-year Strategic Plan,</p> <p><u>Qualitative</u>: KIIs with USAID, MOHS, USP/PQM staff in-country and at headquarters, DFDA, laboratory staff</p>	Desk review, secondary data analysis, KIIs	<ul style="list-style-type: none"> • Content analysis for identifying project successes and challenges • Thematic organization for qualitative analysis • Summary statistics used to assess progress against program indicators • Disaggregate by gender as applicable
AQ 2: In what ways and to what extent was the MOHS's capacity strengthened in the Department of Public Health and elsewhere through implementation of the 2015-2016 Myanmar DHS and associated technical support provided by USAID and the DHS Program?	<p><u>Document</u>: Project work plan and quarterly/annual reports, activity and trip reports from DHS, MOUs and implementation documents developed to support program implementation, consultancy trip reports</p> <p><u>Qualitative</u>: KIIs with USAID, MOHS, Central Statistics Office, ICF International, DHS program staff, Department of Medical Research, DPH / Health Information Division, FGD with workshop attendees.</p>	Desk review, secondary data analysis, KIIs, FGDs	<ul style="list-style-type: none"> • Thematic organization for qualitative analysis
AQ 3: What specific lessons can be learned and applied to other future programs and activities in Myanmar?	<p><u>Document</u>: Quarterly and annual reports, Project MEL plans, assessment reports/ evaluations, capacity strengthening strategies, national strategy documents</p> <p><u>Qualitative</u>: KIIs with ICF International, USP/PQM, DFDA staff, laboratory staff</p>	Desk review, secondary data analysis, KIIs, FGDs	<ul style="list-style-type: none"> • Analysis of key program indicators • Thematic organization for qualitative analysis

ANNEX C. DOCUMENT REVIEW SOURCES

- 3MDG. *Experiences and Lessons Learned from the 3MDG Strategy to Operate in Conflict Affected Areas*. 3MDG, 2018.
- Asian Development Bank, United Nations Development Programme, United Nations Population Fund, and the United Nations Entity for Gender Equality and the Empowerment of Women. 2016. *Gender Equality and Women's Rights in Myanmar: A Situation Analysis*. Asian Development Bank, United Nations Development Programme, United Nations Population Fund, and the United Nations Entity for Gender Equality and the Empowerment of Women. <https://openaccess.adb.org>. Page xvii.
- Barrère, Bernard. *Trip report*. Calverton, M.D.: ICF, 2013. Pp. 1-8.
- Central Statistical Organization and UNDP. 2017. *Measuring Myanmar's starting point for the Sustainable Development Goals: SDG Indicator Baseline Report*.
- DHS. Concept for Inclusive to Sub-National Dissemination of the Myanmar Demographic & Health Survey Draft 4/27/2017 (Author(s) unknown).
- DHS/3MDG. 3MDG Support to the Myanmar Demographic Household Survey (MDHS) Business Case. DHS, 2014.
- Htwe, Ye Min. "NHP 2017-2021: The Way Forward." Nay Pyi Taw, December 2016. PowerPoint presentation.
- ICF. 2018. DHS Program Trip Report No. 15.
- ICF. 2017. DHS Program Trip Report No. 5.
- ICF. 2017. DHS Program Trip Report No. 4.
- ICF. n.d. Global Capacity Strengthening Strategy: The Demographic and Health Survey Program.
- ICF. n.d. DHS Updated Workplan 3-30-2017.pdf
- Kyu MM. 2017. USAID Trip Report for DHS Dissemination, May 2017.
- Marchena, Claudia, Lutwama, Geoffrey & Alibata Handley. *Trip Report*. Rockville, M.D.: ICF DHS, 2017. Pp. 1-7.
- MCSP. Burma Documentation and Dissemination Plan. MCSP, 2018.
- Ministry of Health and Sports Department of Public Health. 2017. *Public Health Statistics (2014-2016)*. Nay Pyi Taw. <http://mohs.gov.mm/Main/content/publication/public-health-statistics-report-2014-2016>
- Ministry of Health and Sports. *Myanmar National Health Plan 2017-2021*. MoHS, 2016.
- Ministry of Health and Sports. National Health Plan 2017-2021: Draft Document for Review. MoHS, 2016. Pp. 2-40.
- Ministry of Health and Sports, Republic of the Union of Myanmar. *National Health Plan 2017-2021 Annual Operational Plan 2017-2018*. MoHS, 2017. Pp. 1-48.
- Ministry of National Planning and Economic Development and Ministry of Health, Myanmar.
- Myanmar Multiple Indicator Cluster Survey 2009 - 2010 Final Report*. Nay Pyi Taw: Ministry of National Planning and Economic Development and Ministry of Health, 2011. Print.
- MoHS, Republic of the Union of Myanmar. Strategic Action Plan for Strengthening Health Information 2017-2021. MoHS, 2017. Pp. 1-72.

MoHS & DHS Program ICF. *Myanmar Demographic and Health Survey 2015-16*. Nay Pyi Taw, Myanmar & Rockville, M.D.: DHS & MoHS, 2017. Pp. 1-453.

Myanmar Demographic and Health Survey. *Workplan and Project Estimated Budget*. MDHS, 2015. Pp. 1-26.

Myanmar Demographic and Health Survey. *Updated Work Plan- March 30th, 2017*. MDHS, 2015-16. Pp. 1-30.

Nybro, Erica. *Trip Report*. Rockville, M.D.: ICF DHS, 2017. Pp. 1-16.

Pradhan, Anjushree. *Trip Report*. Rockville, M.D.: ICF DHS, 2014. 1-10.

Sin Htoo, Thant. "NHP 2017-2021: The Need to Prioritize." Nay Pyi Taw, December 2016. The Three Millennium Development Goal Fund. *Reasons for Optimism*. Yangon: 3MDG, 2016. Pp. 2-15.

Union of Myanmar Ministry of Immigration and Population Department of Population. *Country Report on 2007 Fertility and Reproductive Health Survey*. Nay Pyi Taw: UNFPA, 2009.

USAID DHS. *Consultative meeting in Kachin State*. Myanmar Demographic & Health Survey, 2015.

USAID DHS. Report: Consultative Meetings in Kayah State & Shan State. Myanmar Demographic & Health Survey, 2015.

USAID DHS. Global Capacity Strengthening Strategy: The Demographic and Health Survey Program. Rockville, MD.

USAID DHS. MOHS Capacity Strengthening Plan. DHS Myanmar 2015-16.

USAID DHS. Letter of Project Agreement between MOH, USAID and ICF International. DHS Myanmar, 2015-16. Pp. 2-28.

USAID DHS. *The DHS Program- What We Do*. Website. <<https://dhsprogram.com/what-we-do/>>

USAID. *Evaluation: Learning from Experience*. Washington, D.C.: USAID Evaluation Policy, 2011.

USAID. How-To Note: Preparing Evaluation Reports. Washington, D.C.: USAID, 2012.

USAID. *Evaluation Report Template*. Washington, D.C.: USAID.

USAID. USAID Evaluation Report Requirements: A Mandatory Reference for ADS Chapter 201. Washington, D.C.: USAID, 2016. 2-4.

ANNEX D. INTERVIEWEE LIST

STAKEHOLDER GROUP	RESPONDENT NUMBER	ORGANIZATIONAL AFFILIATION	SEX
DHS			
Government of Myanmar	1.	DPH – Nay Pyi Taw/MOHS	Female
	2.	DPH – Nay Pyi Taw/MOHS	Female
	3.	MOHS – Mawlamyine (Formerly DPH – Nay Pyi Taw/MOHS)	Male
	4.	Jhpiego (Formerly DPH – Nay Pyi Taw/MOHS)	Female
	5.	Department of Education, Research, Planning and Training/Ministry of Education	Female
	6.	Department of Education, Research, Planning and Training/Ministry of Education	Female
Implementing Partner	7.	Resident Advisor for ICF (Myanmar DHS)	Male
	8.	ICF (USA)	Female
DHS Steering Committee	9.	UNICEF Myanmar	Female
	10.	UNICEF Myanmar	Male
	11.	UNICEF Myanmar	Male
	12.	3MDG/UNOPS	Female
	13.	3MDG/UNOPS	Male
DHS Workshop Participants	14.	Min Khun Charity Clinic (CSO)	Female
	15.	Min Khun Charity Clinic (CSO)	Female
	16.	Min Khun Charity Clinic (CSO)	Male
	17.	Danu Literature Association (CSO)	Male
	18.	Parami Development Network (CSO)	Male
	19.	Parami Development Network	Male
	20.	Parami Development Network	Female
	21.	Pa-Oh National Liberation Org. (PNLO) (EAO)	Male
	22.	Pa-Oh Health Office, PNLO (EHO)	Male

	23.	Pa-Oh National Liberation Org. (PNLO) (EAO)	Male
	24.	Restoration Council of Shan State / Shan State Army (RCSS/SSA)	Male
	25.	Restoration Council of Shan State / Shan State Army (RCSS/SSA)	Male
USAID	26.	USAID	Male
	27.	Formerly USAID	Female
	28.	USAID	Female
	29.	USAID	Male

ANNEX E. DATA COLLECTION TOOLS

Component B – Assessment of Institutional Capacity Building of Myanmar Department of Public Health (DPH)

Key Informant Interview:

ICF International (DHS Program)

Former Senior program staff of the MDHS 2015-16

Trainers of the MOHS Capacity Strengthening Workshops – DHS Program

Informed Consent and Confidentiality: Hi, my name is X, and I work for Social Impact, which is an independent research company based in the Washington, DC area. We are collecting data about the *Myanmar Demographic Health Survey (2015-16)* conducted in Myanmar. As you may know, the program was designed to capture national level health information while also increasing the capacity of the DPH in Myanmar to manage, collect, analyze, and report on population-based research. Our evaluation is intended to inform the DPH, MOHS as well as the U.S. Government's design of future technical assistance and institutional strengthening activities in Myanmar.

We selected you and other respondents to interview because we understand that you may have perspective on the *MDHS process* and/or on relevant subject matter. We expect the duration of this interview to be one hour. We plan to ask you about your experience with the MDHS and the Technical Assistance and capacity building provided by ICF International, with funding from USAID. There are no known risks or direct benefits related to your participation; however, your inputs may lead to recommendations that benefit actors engaged in collection and use of large data sets for decision making—and, thereby, the general public.

All information that you share will be kept confidential. We will aggregate and present our findings to USAID in a way that cannot be attributed to any individual or organization. Therefore, please feel free to speak openly and candidly with us. Your participation is voluntary. Please feel free to ask to skip any question that you do not feel comfortable answering, end this interview at any point, or withdraw your responses after the interview.

Do you confirm your consent to participate in this interview? ☐ Yes ☐ No

To guarantee accuracy, we find it useful to keep an audio record of the conversation. If you prefer, however, we will not use recording devices.

Do you confirm your consent for us to record this interview? ☐ Yes ☐ No

Interview Place and Date: _____

Interviewer(s):

Interviewee Name & Title:

Sex: ☐ Female ☐ Male

Introduction:

- a. Tell me about the DHS in Myanmar?
- b. What was your role on the project? (Probes: how involved were you with the program and in what ways were you involved?)

- c. What would you say are the strengths and what are the weaknesses of this program?
- d. What worked well in this project? And what did not work very well?
- e. How does the MDHS compare to other countries' first attempts at a DHS?

AQ2: In what ways, and to what extent, was the MOHS' capacity strengthened in the DPH and elsewhere through implementation of the 2015-16 Myanmar DHS and associated technical support provided by USAID and the DHS Program?

Probes:

- a. What strengths does the DPH have for large scale data collection, analysis and use, that it did not have before starting the MDHS project?
- b. What areas of weakness do you perceive, that it still has?
- c. What went well with the MDHS?
- d. What did not go well with the MDHS?
- e. What role did the Steering Committee serve?
- f. How successful were they in meeting this need?
- g. What went well and what did not go well with the SC?

AQ2a: What factors (internal and external, including enabling environment) facilitated the implementation, analysis, and utilization of the 2015-2016 DHS survey?

Probes:

- a. How was ICF's approach valued by the leadership of the DPH?
- b. How would you judge the level of engagement with the process that ICF put in place to carry out the DHS?
- c. How receptive, in your opinion, was the staff to the trainings, workshops, and Technical Assistance that were carried out by ICF?
- d. How did the skill level of the members of the DPH staff effect, negatively or positively, the quality of the DHS?

AQ2b: What capacities and skills in the MOHS were strengthened through support from the DHS project, USAID, and 3MDG, and to what extent?

Probes:

- a. What aspects of the project were focused on building capacity?
- b. What changes (since the start of the MDHS) have you seen in the DPH with regards to data collection, analysis and use?
- c. What areas of the work did you expect to see change, because of the MDHS project, that did not change?
- d. What would you say are ongoing gaps and needs for the DPH?
- e. Where, from your observations, did you see the most growth? Would you say it was among individual staff? Among job related groupings? Across the organization as a whole? What did you see change, or not change, that makes you believe that?
- f. Which aspects of the "design to use" research process were strengthened the most and why would you say that?
- g. In your opinion, which level improved the most on which research focus? And why would you say that?

Research focus	Different Individuals	Specific job groups	DPH leadership
----------------	-----------------------	---------------------	----------------

Design			
Field Management			
Data analysis			
Data Use			

AQ2c: How was DHS' global capacity-strengthening strategy applied in the Myanmar context?

Probes:

- Please talk about the DHS global capacity-strengthening strategy. What is it and how does it apply to specific countries/Myanmar?

AQ2d: Were capacity strengthening outcomes at individual and organizational levels measured for learning and improvement, as well as for accountability?

Probes:

- Do you measure learning and improvement? If so, how do you do that? What measures do you use and did you apply these to the Myanmar context? If so, what were the findings?
- If you did not measure learning and improvement, what prevented this from happening?
- What could be done in the future to measure institutional capacity strengthened?
- What variables would you measure to see change?

AQ2e: How did the project's design and implementation approach contribute to country engagement and ownership?

Probes:

- How would you describe the level of engagement and commitment to this project by the DPH staff? What information/observations lead you to that conclusion?
- What aspects of the MDHS process effected this level of commitment and why?
- What specifically does ICF build into the process to attempt to ensure the sustainability of the DHS in a country? And what was done in Myanmar?
- How likely, do you believe, the government of Myanmar is likely to continue implementing the DHS in Myanmar? What leads you to believe this?
- What systems does DPH have in place to support another round of the DHS? And what is still missing?
- How did ICF's DHS process contribute to these systems being in place?

AQ2f: How did the implementation of the DHS, and associated efforts to engage ethnic groups to collect and disseminate data in contested and non-government-controlled areas, build MOHS experience and capacity to engage with ethnic health organizations (EHOs) and other community groups in the future?

Probes:

- What specific activities were carried out with EHOs?
- What specific approaches were used to engage with EHOs?
- How receptive were the EHOs to being included in the MDHS?
- Which parts of the research process, design, implementation, analysis, and use, included members of EHOs? What was done to get members of EHOs to engage with the project?

- e. What went well and what did not go very well to ensure that representatives of EHOs were involved in the project?
- f. Which aspects of the DHS project contributed to their engagement/involvement?
- g. What changes, if any, did you notice the DPH making as they related with the EHOs?

AQ2g: To what extent have Myanmar health sector stakeholders been able to use and apply DHS data to influence decision-making around the planning and delivery of health services and reforms?

Probes:

- a. To what extent has the MOHS/DPH used the MDHS data? If they have, what have you seen the DPH do with the data? Policies? Budgeting decisions? Human Resource allocation? Other?
- b. If not, what barriers do you see still existing that prevent the use of the data?
- c. What specifically did ICF do in Myanmar to support 'use of data' by the MOHS/DPH?
- d. What, among these activities, worked well and what did not work well?

AQ3: What specific lessons can be learned and applied to other future programs and activities in Myanmar?

AQ3b: In your experience, what practices should, or should not, be applied for future activities specifically focused on strengthening an organization or institution?

AQ3c: In your experience, what practices should, or should not, be applied for future technical assistance activities where the primary objective may not be institutional strengthening?

Key Informant Interview:

MOHS Department of Public Health (DPH)

Senior level staff who worked on the MDHS 2015-16

Informed Consent and Confidentiality: Hi, my name is X, and I work for Social Impact, which is an independent research company based in the Washington, DC area. We are collecting data about the *Myanmar Demographic Health Survey (2015-16)* conducted in Myanmar. As you may know, the program was designed to capture national level health information while also increasing the capacity of the DPH in Myanmar to manage, collect, analyze, and report on population-based research. Our evaluation is intended to inform the DPH, MOHS as well as the U.S. Government's design of future technical assistance and institutional strengthening activities in Myanmar.

We selected you and other respondents to interview because we understand that you may have perspective on the *MDHS process* and/or on relevant subject matter. We expect the duration of this interview to be one hour. We plan to ask you about your experience with the MDHS and the Technical Assistance and capacity building provided by ICF International, with funding from USAID. There are no known risks or direct benefits related to your participation; however, your inputs may lead to recommendations that benefit actors engaged in collection and use of large data sets for decision making—and, thereby, the general public.

All information that you share will be kept confidential. We will aggregate and present our findings to USAID in a way that cannot be attributed to any individual or organization. Therefore, please feel free to speak openly and candidly with us. Your participation is voluntary. Please feel free to ask to skip any question that you do not feel comfortable answering, end this interview at any point, or withdraw your responses after the interview.

Do you confirm your consent to participate in this interview? ☐ Yes ☐ No

To guarantee accuracy, we find it useful to keep an audio record of the conversation. If you prefer, however, we will not use recording devices.

Do you confirm your consent for us to record this interview? ☐ Yes ☐ No

Interview Place and Date: _____

Interviewer(s):

Interviewee Name & Title:

Sex: ☐ Female ☐ Male

Introduction:

- Tell me about the DHS in Myanmar?
- What was your role on the project? (Probes: how involved were you with the program and in what ways were you involved?)
- What would you say are the strengths and what are the weaknesses of this program?
- What worked well in this project? And what did not work very well?

AQ2: In what ways, and to what extent, was the MOHS' capacity strengthened in the DPH and elsewhere through implementation of the 2015-16 Myanmar DHS and associated technical support provided by USAID and the DHS Program?

Probes:

- a. What strengths does the DPH have for large scale data collection, analysis and use, that it did not have before starting the MDHS project?
- b. What areas of weakness do you perceive, that it still has?
- c. What went well with the MDHS?
- d. What did not go well with the MDHS?

AQ2a: What factors (internal and external, including enabling environment) facilitated the implementation, analysis, and utilization of the 2015-2016 DHS survey?

Probes:

- h. How was ICF's approach valued by the leadership of the DPH?
- i. How would you judge the level of engagement with the process that ICF put in place to carry out the DHS?
- j. How receptive, in your opinion, was the staff to the trainings, workshops, and Technical Assistance that were carried out by ICF?
- k. How did the skill level of the members of the DPH staff effect, negatively or positively, the quality of the DHS?
- l. What role did the Steering Committee serve?
- m. How successful were they in meeting this need?
- n. What went well and what did not go well with the SC?

AQ2b: What capacities and skills in the MOHS were strengthened through support from the DHS project, USAID, and 3MDG, and to what extent?

Probes:

- a. What aspects of the project were focused on building capacity?
- b. What changes (since the start of the MDHS) have you seen in the DPH with regards to data collection, analysis and use?
- c. What areas of the work did you expect to see change, because of the MDHS project, that did not change?
- d. What would you say are ongoing gaps and needs for the DPH?
- e. Where, from your observations, did you see the most growth? Would you say it was among individual staff? Among job related groupings? Across the organization as a whole? What did you see change, or not change, that makes you believe that?
- f. Which aspects of the "design to use" research process were strengthened the most and why would you say that?
- g. In your opinion, which level improved the most on which research focus? And why would you say that?

Research focus	Different Individuals	Specific job groups	DPH leadership
Design			
Field Management			
Data analysis			
Data Use			

AQ2c: How was DHS' global capacity-strengthening strategy applied in the Myanmar context?

Probes:

- a. What is your knowledge and understanding of the DHS global capacity-strengthening strategy? What is it and how does it apply to specific countries/Myanmar?

AQ 2d: Were capacity strengthening outcomes at individual and organizational levels measured for learning and improvement, as well as for accountability?

- b. Did they measure learning and improvement? If so, how did they do that? What measures did they use and did they apply these to the Myanmar context? If so, what were the findings?
- c. If they did not measure learning and improvement, what prevented this from happening?
- d. What could be done in the future to measure institutional capacity strengthened?
- e. What variables would you measure to see change?

AQ2e: How did the project's design and implementation approach contribute to country engagement and ownership?

Probes:

- a. How would you describe the level of engagement and commitment to this project by the DPH staff? What information/observations lead you to that conclusion?
- b. What aspects of the MDHS process effected this level of commitment and why?
- c. What specifically does ICF build into the process to attempt to ensure the sustainability of the DHS in a country? And what was done in Myanmar?
- d. How likely, do you believe, the government of Myanmar is likely to continue implementing the DHS in Myanmar? What leads you to believe this?
- e. What systems does DPH have in place to support another round of the DHS? And what is still missing?
- f. How did ICF's DHS process contribute to these systems being in place?

AQ2f: How did the implementation of the DHS, and associated efforts to engage ethnic groups to collect and disseminate data in contested and non-government-controlled areas, build MOHS experience and capacity to engage with ethnic health organizations (EHOs) and other community groups in the future?

Probes:

- a. What specific activities were carried out with EHOs?
- b. What specific approaches were used to engage with EHOs?
- c. How receptive were the EHOs to being included in the MDHS?
- d. Which parts of the research process, design, implementation, analysis, and use, included members of EHOs? What was done to get members of EHOs to engage with the project?
- e. What went well and what did not go very well to ensure that representatives of EHOs were involved in the project?
- f. Which aspects of the DHS project contributed to their engagement/involvement?
- g. What changes, if any, did you notice the DPH making as they related with the EHOs?

AQ2g: To what extent have Myanmar health sector stakeholders been able to use and apply DHS data to influence decision-making around the planning and delivery of health services and reforms?

Probes:

- a. To what extent has the MOHS/DPH used the MDHS data? If they have, what have you seen the DPH do with the data? Policies? Budgeting decisions? Human Resource allocation? Other?
- b. If not, what barriers do you see still existing that prevent the use of the data?

- c. What specifically did ICF do in Myanmar to support 'use of data' by the MOHS/DPH?
- d. What, among these activities, worked well and what did not work well?

AQ3: What specific lessons can be learned and applied to other future programs and activities in Myanmar?

AQ3b: In your experience, what practices should, or should not, be applied for future activities specifically focused on strengthening an organization or institution?

AQ3c: In your experience, what practices should, or should not, be applied for future technical assistance activities where the primary objective may not be institutional strengthening?

Key Informant Interview:

Steering Committee Members – USAID, UNICEF, UMFP, the World Bank, 3MDG

Informed Consent and Confidentiality: Hi, my name is X, and I work for Social Impact, which is an independent research company based in the Washington, DC area. We are collecting data about the *Myanmar Demographic Health Survey (2015-16)* conducted in Myanmar. As you may know, the program was designed to capture national level health information while also increasing the capacity of the DPH in Myanmar to manage, collect, analyze, and report on population-based research. Our evaluation is intended to inform the DPH, MOHS as well as the U.S. Government's design of future technical assistance and institutional strengthening activities in Myanmar.

We selected you and other respondents to interview because we understand that you may have perspective on the *MDHS process* and/or on relevant subject matter. We expect the duration of this interview to be one hour. We plan to ask you about your experience with the MDHS and the Technical Assistance and capacity building provided by ICF International, with funding from USAID. There are no known risks or direct benefits related to your participation; however, your inputs may lead to recommendations that benefit actors engaged in collection and use of large data sets for decision making—and, thereby, the general public.

All information that you share will be kept confidential. We will aggregate and present our findings to USAID in a way that cannot be attributed to any individual or organization. Therefore, please feel free to speak openly and candidly with us. Your participation is voluntary. Please feel free to ask to skip any question that you do not feel comfortable answering, end this interview at any point, or withdraw your responses after the interview.

Do you confirm your consent to participate in this interview? ☐ Yes ☐ No

To guarantee accuracy, we find it useful to keep an audio record of the conversation. If you prefer, however, we will not use recording devices.

Do you confirm your consent for us to record this interview? ☐ Yes ☐ No

Interview Place and Date: _____

Interviewer(s):

Interviewee Name & Title:

Sex: ☐ Female ☐ Male

Introduction:

- a. Tell me about the DHS in Myanmar?
- b. What was your role on the project? (Probes: how involved were you with the program and in what ways were you involved?)
- c. What would you say are the strengths and what are the weaknesses of this program?
- d. What worked well in this project? And what did not work very well?
- e. How does the MDHS compare to other first attempts in other countries?

AQ2: In what ways, and to what extent, was the MOHS' capacity strengthened in the DPH and elsewhere through implementation of the 2015-16 Myanmar DHS and associated technical support provided by USAID and the DHS Program?

Probes:

- What strengths does the DPH have for large scale data collection, analysis and use, that it did not have before starting the MDHS project?
- What areas of weakness do you perceive, that it still has?
- What went well with the MDHS?
- What did not go well with the MDHS?

AQ2a: What factors (internal and external, including enabling environment) facilitated the implementation, analysis, and utilization of the 2015-2016 DHS survey?

Probes:

- How was ICF's approach valued by the leadership of the DPH?
- How would you judge the level of engagement with the process that ICF put in place to carry out the DHS?
- How receptive, in your opinion, was the staff to the trainings, workshops, and Technical Assistance that were carried out by ICF?
- How did the skill level of the members of the DPH staff effect, negatively or positively, the quality of the DHS?
- What was the purpose of the Steering Committee? What sort of power did the SC have for driving this project?
- In your experience how well did it serve this purpose?
- At what point in the MDHS process is the SC most likely to have the greatest influence? (Design, implementation, analysis, use?) And why do you believe that?
- What went well and what did not go so well?
- What sorts of interactions did the Steering Committee have with ICF Macro?

AQ2b: What capacities and skills in the MOHS were strengthened through support from the DHS project, USAID, and 3MDG, and to what extent?

Probes:

- What aspects of the project were focused on building capacity?
- What changes (since the start of the MDHS) have you seen in the DPH with regards to data collection, analysis and use?
- What areas of the work did you expect to see change, because of the MDHS project, that did not change?
- What would you say are ongoing gaps and needs for the DPH?
- Where, from your observations, did you see the most growth? Would you say it was among individual staff? Among job related groupings? Across the organization as a whole? What did you see change, or not change, that makes you believe that?
- Which aspects of the "design to use" research process were strengthened the most and why would you say that?
- In your opinion, which level improved the most on which research focus? And why would you say that?

Research focus	Different Individuals	Specific job groups	DPH leadership
Design			
Field Management			
Data analysis			
Data Use			

AQ2c: How was DHS' global capacity-strengthening strategy applied in the Myanmar context?

Probes:

- a. Please talk about the DHS global capacity-strengthening strategy? What is it and how does it apply to specific countries/Myanmar?

AQ2d: Were capacity strengthening outcomes at individual and organizational levels measured for learning and improvement, as well as for accountability?

- b. Did they measure learning and improvement? If so, how did they do that? What measures did they use and did they apply these to the Myanmar context? If so, what were the findings?
- c. If they did not measure learning and improvement, what prevented this from happening?
- d. What could be done in the future to measure institutional capacity strengthened?
- e. What variables would you measure to see change?

AQ2e: How did the project's design and implementation approach contribute to country engagement and ownership?

Probes:

- a. How would you describe the level of engagement and commitment to this project by the DPH staff? What information/observations lead you to that conclusion?
- b. What aspects of the MDHS process effected this level of commitment and why?
- c. What specifically does ICF build into the process to attempt to ensure the sustainability of the DHS in a country? And what was done in Myanmar?
- d. How likely, do you believe, the government of Myanmar is likely to continue implementing the DHS in Myanmar? What leads you to believe this?
- e. What systems does DPH have in place to support another round of the DHS? And what is still missing?
- f. How did ICF's DHS process contribute to these systems being in place?

AQ2f: How did the implementation of the DHS, and associated efforts to engage ethnic groups to collect and disseminate data in contested and non-government-controlled areas, build MOHS experience and capacity to engage with ethnic health organizations (EHOs) and other community groups in the future?

Probes:

- a. What specific activities were carried out with EHOs?
- b. What specific approaches were used to engage with EHOs?
- c. How receptive were the EHOs to being included in the MDHS?
- d. Which parts of the research process, design, implementation, analysis, and use, included members of EHOs? What was done to get members of EHOs to engage with the project?
- e. What went well and what did not go very well to ensure that representatives of EHOs were involved in the project?
- f. Which aspects of the DHS project contributed to their engagement/involvement?
- g. What changes, if any, did you notice the DPH making as they related with the EHOs?

AQ2f: To what extent have Myanmar health sector stakeholders been able to use and apply DHS data to influence decision-making around the planning and delivery of health services and reforms?

Probes:

- a. To what extent has the MOHS/DPH used the MDHS data? If they have, what have you seen the DPH do with the data? Policies? Budgeting decisions? Human Resource allocation? Other?
- b. If not, what barriers do you see still existing that prevent the use of the data?
- c. What specifically did ICF do in Myanmar to support 'use of data' by the MOHS/DPH?
- d. What, among these activities, worked well and what did not work well?

AQ3: What specific lessons can be learned and applied to other future programs and activities in Myanmar?

AQ3b: In your experience, what practices should, or should not, be applied for future activities specifically focused on strengthening an organization or institution?

AQ3c: In your experience, what practices should, or should not, be applied for future technical assistance activities where the primary objective may not be institutional strengthening?

Focus Group Discussion:

MOHS DPH

Government employees who attended workshops as part of the DHS' MOHS capacity strengthening plan
Staff who attended regional workshops and acted as peer-to-peer co-trainers

Informed Consent and Confidentiality: Hi, my name is X, and I work for Social Impact, which is an independent research company based in the Washington, DC area. We are collecting data about the *Myanmar Demographic Health Survey (2015-16)* conducted in Myanmar. As you may know, the program was designed to capture national level health information while also increasing the capacity of the DPH in Myanmar to manage, collect, analyze, and report on population-based research. Our evaluation is intended to inform the DPH, MOHS as well as the U.S. Government's design of future technical assistance and institutional strengthening activities in Myanmar.

We selected you all to interview because we understand that you may have perspective on the *MDHS process* and/or on relevant subject matter. We expect the duration of this interview to be one hour. We plan to ask you about your experience with the MDHS and the Technical Assistance, capacity building, and workshops provided by ICF International, with funding from USAID. There are no known risks or direct benefits related to your participation; however, your inputs may lead to recommendations that benefit actors engaged in collection and use of large data sets for decision making—and, thereby, the general public.

All information that you share will be kept confidential. We will aggregate and present our findings to USAID in a way that cannot be attributed to any individual or organization. Therefore, please feel free to speak openly and candidly with us. Your participation is voluntary. Please feel free to ask to skip any question that you do not feel comfortable answering, end this interview at any point, or withdraw your responses after the interview.

Do you confirm your consent to participate in this interview? ☐ Yes ☐ No

To guarantee accuracy, we find it useful to keep an audio record of the conversation. If you prefer, however, we will not use recording devices.

Do you confirm your consent for us to record this interview? ☐ Yes ☐ No

Interview Place and Date: _____

Interviewer(s):

Interviewee Name & Title:

Sex: ☐ Female ☐ Male

Introduction:

- a. Cover logistics and ground rules, for the FGI:
 - 1) Everyone is encouraged to share their ideas, and the FGI is strengthened if everyone participates.
 - 2) There are no wrong answers, and everyone's perspective is equally valued.
 - 3) The ideas shared during the FGI should not be shared outside the FGI with non-participants in order to respect participants' privacy.
 - 4) Disagreements about ideas can be valuable and productive, but personal attacks will not be tolerated.
- b. Tell me about the DHS in Myanmar?

- c. What was your role on the project? (Probes: how involved were you with the program and in what ways were you involved?)
- d. What would you say are the strengths and what are the weaknesses of this program?
- e. What worked well in this project? And what did not work very well?

AQ2: In what ways, and to what extent, was the MOHS' capacity strengthened in the DPH and elsewhere through implementation of the 2015-16 Myanmar DHS and associated technical support provided by USAID and the DHS Program?

Probes:

- a. What strengths does the DPH have for large scale data collection, analysis and use, that it did not have before starting the MDHS project?
- b. What areas of weakness do you perceive, that it still has?
- c. What went well with the MDHS?
- d. What did not go well with the MDHS?

AQ2a: What factors (internal and external, including enabling environment) facilitated the implementation, analysis, and utilization of the 2015-2016 DHS survey?

Probes:

- a. How was ICF's approach valued by the leadership of the DPH?
- b. How would you judge the level of engagement with the process that ICF put in place to carry out the DHS?
- c. How receptive, in your opinion, was the staff to the trainings, workshops, and Technical Assistance that were carried out by ICF?
- d. How did the skill level of the members of the DPH staff effect, negatively or positively, the quality of the DHS?
- e. Please tell me about the different trainings and workshops you participated in, what were they and which ones were effective and which ones were not?
 - 1) Why would you say that?
 - 2) What went well with them?
 - 3) What did not go well?
 - 4) Which ones did you learn the most from?
 - 5) Which ones did not teach you enough?
 - 6) Which ones would you like to see repeated?
 - 7) Which ones do not need to be done again?

AQ2d: How did the project's design and implementation approach contribute to country engagement and ownership?

Probes:

- a. How would you describe the level of engagement and commitment to this project by the DPH staff? What information/observations lead you to that conclusion?
- b. What aspects of the MDHS process effected this level of commitment and why?
- c. What specifically does ICF build into the process to attempt to ensure the sustainability of the DHS in a country? And what was done in Myanmar?
- d. How likely, do you believe, the government of Myanmar is likely to continue implementing the DHS in Myanmar? What leads you to believe this?
- e. What systems does DPH have in place to support another round of the DHS? And what is still missing?
- f. How did ICF's DHS process contribute to these systems being in place?

AQ2f: To what extent have Myanmar health sector stakeholders been able to use and apply DHS data to influence decision-making around the planning and delivery of health services and reforms?

Probes:

- a. To what extent has the MOHS/DPH used the MDHS data? If they have, what have you seen the DPH do with the data? Policies? Budgeting decisions? Human Resource allocation? Other?
- b. If not, what barriers do you see still existing that prevent the use of the data?
- c. What specifically did ICF do in Myanmar to support 'use of data' by the MOHS/DPH?
- d. What, among these activities, worked well and what did not work well?

AQ3: What specific lessons can be learned and applied to other future programs and activities in Myanmar?

AQ3b: In your experience, what practices should, or should not, be applied for future activities specifically focused on strengthening an organization or institution?

AQ3c: In your experience, what practices should, or should not, be applied for future technical assistance activities where the primary objective may not be institutional strengthening?

ANNEX F. EVALUATION TEAM MEMBERS

Overall Team Leader, Principal Investigator/Institutional Capacity Building Specialist, Component B: Dr. Donna A. Espeut is a public health specialist with extensive experience in monitoring and evaluation (M&E), health systems strengthening and maternal and child health. She has over 20 years of experience designing, implementing and evaluating public health programs. Dr. Donna Espeut has served as an evaluation team leader for USAID and other donor-funded evaluations in Africa, Asia and the Caribbean with extensive experience conducting qualitative research and implementing mixed-methods evaluations of large-scale and complex multi-sectoral programs. She is an accomplished implementer and evaluator of Maternal, Newborn, and Child Health (MNCH) programs and demographic and health survey program. Notably, as the Deputy Director at Concern Worldwide US, she provided strategic direction, technical leadership, management and quality assurance for a \$41 million, multi-country MNCH innovation initiative funded by the Bill & Melinda Gates Foundation. In addition, she has conducted analysis of nutritional and health status of young children and mothers in Mozambique for the MEASURE DHS+ Project. Dr. Espeut is deeply familiar with USAID, with experience both implementing and evaluating USAID-funded public health programs. In 2015 and 2016, she has led the meta-evaluation of USAID/Kenya's APHIAplus health program and the baseline assessment of USAID's Nilotde Orphans and Vulnerable Children program in Kenya. Dr. Espeut holds a Ph.D. in Reproductive Health and Family Planning and a Master of Health Science in Maternal and Child Health from Johns Hopkins University, and a B.A. in Human Biology from Stanford University. She is fluent in English and proficient in Spanish.

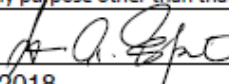
Research Specialist, Component B: Ms. Angela Thaung is a skilled researcher and program coordination specialist with more than two decades of experience monitoring and evaluating capacity building in organizations and interventions. As an Individual Capacity Building Trainer/Consultant with the Myanmar Institute for Gender Studies, she promotes institutional and individual capacity building with the aim of enhancing and building dialogue skills in practice. Most recently as Local DG and Civil Society Specialist on the Mid-term Performance Evaluation of USAID Civil Society and Media Activity, Ms. Thaung evaluated the project's achievements and contributions, especially as it related to gender, ethnic minorities and people with disabilities. As Evaluation Team Member for the Midterm Evaluation Shan State: Peace, Reconciliation, and Development through Community Empowerment project, she assessed project design, measured contribution to the peace process; identified changes that occurred; documented lessons learned, and made recommendations. As a native Burmese, Ms. Thaung, brings extensive knowledge of Myanmar's operating environment. She holds a Master of Public Administration from the Institute of Economics in Yangon, and speaks, reads and writes in Myanmar and English.

ANNEX G. DISCLOSURE OF CONFLICT OF INTEREST

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	DONNA A. ESPEUT, PhD, MHS
Title	Independent Consultant
Organization	Social Impact
Evaluation Position?	<input checked="" type="checkbox"/> Team Leader <input type="checkbox"/> Team member
Evaluation Award Number (contract or other instrument)	
USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	
I have real or potential conflicts of interest to disclose.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes answered above, I disclose the following facts: <i>Real or potential conflicts of interest may include, but are not limited to:</i> <ol style="list-style-type: none"> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. 	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	08 May 2018

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Ms. Angela B. Thaung
Title	Research Specialist
Organization	Social Impact
Evaluation Position?	<input type="checkbox"/> Team Leader <input checked="" type="checkbox"/> Team member
Evaluation Award Number (contract or other instrument)	AID-486-1-14-00001 (IDIQ) / 720-482-18-F-00003 (Task Order)
USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	USAID/Burma Health Sector Evaluation: Assessment of Capacity Building of Myanmar Department of Food and Drug Administration (DFDA) / Promoting the Quality of Medicines (PQM) - US Pharmacopeia Assessment of Capacity Building of Myanmar Department of Health Planning (DHP) / Demographic and Health Survey (DHS) - ICF International
I have real or potential conflicts of interest to disclose.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes answered above, I disclose the following facts: <i>Real or potential conflicts of interest may include, but are not limited to:</i> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	N/A

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	15 August 2018

U.S. Agency for International Development
1300 Pennsylvania Avenue, NW
Washington, DC 20523