joint reviews and planning, and convergence on early childhood care and development (ECCD).

1.3. Theory of Change

Outcome – By 2022, more children under five and women of reproductive age equitably access and utilize evidence-based health, HIV & nutrition interventions, including adoption of key behaviours, especially among vulnerable populations in most deprived states/regions, conflict-affected and peri-urban areas

This outcome embodies the priority issues, bottlenecks and barriers identified in the context of Myanmar, which if achieved, will significantly contribute to gains at the impact level in improving the health and nutritional status of girls and boys in target areas and reducing child mortality and morbidity. UNICEF will deliver on eight key outputs specified below, which are the necessary conditions and changes required during the country program cycle in order to achieve the outcome. These outputs will specifically address bottlenecks in the four key areas of determinants: *enabling environment, supply*, *demand, and quality*. An illustrative diagram of the following theory of change can be found in section 9 of health and nutrition programm outcome (Page number 43).

UNICEF Myanmar's theory of change for health and nutrition states that:

- ***if*** MoHS and other partners at national and sub-national level, including non-state actor areas, have increased capacity and accountability in evidence-based planning & budgeting for scaling up high-impact interventions and monitoring results with equity, and
- ***if*** national systems for harmonized procurement, logistics and supply chain management are strengthened for equitable and quality MNCH, immunization, nutrition and HIV service delivery, and
- ***if*** national and sub national health care institutions and front-line health workers have improved capacity to reach more vulnerable populations with quality immunization and MNCH services (including PPTCT), and
- ***if*** MoHS and other partners at national and sub-national level, including non-state actors, have improved capacity to integrate HIV interventions for young children and key adolescent populations into essential service delivery approaches sustainably at scale, and
- ***if*** caregivers, family members, communities and institutions have increased knowledge and skills to practice appropriate child care, hygiene, feeding, dietary, early stimulation, injury and violence prevention during critical periods of growth and development and to demand quality health and nutrition services, and
- ***if*** government sector plans and legislation for nutrition are evidence-based, adequately resourced, effectively implemented, enforced and monitored at national and sub-national levels, and
- ***if*** multi-sectoral political commitment and approaches are in place to support prioritized, integrated, nutrition sensitive interventions with an equity focus, and
- ***if*** government workers in nutrition related sectors (health and others) have increased capacity to deliver nutrition services according to standards at all times;

Then all children under five and women of reproductive age equitably access and utilize evidence-based health, HIV & nutrition interventions, including adoption of key behaviours, especially among vulnerable populations in most deprived states/regions, conflict-affected and peri-urban areas.

Assumptions, risk analysis and mitigation measures

A series of assumptions must hold true for outputs to lead to the outcome. Assumptions are based on political, structural and social considerations largely beyond the organization's control and thus a risk analysis is conducted to understand the possible dangers if the assumptions prove invalid, as part of prudent programming and to maximize UNICEF's ability to contribute to the outcome. Key ***assumptions*** were identified based on recent consultations with various high level Government officials from different Ministries under the new Government and other stakeholders, as well as trends and lessons learned from recent years. Although many factors pose risks, the most significant are highlighted below. UNICEF's risk mitigation measures are also briefly summarized.

- *Assumption: Government commitments for Universal Health Coverage (UHC) and multi-sector nutrition plan progresses and enabling working conditions within the MoHS, particularly at the local level, are sustained to keep primary health care service delivery functioning; collaboration across sectors will improve nutrition:* Political commitment to address health issues and nutritional status has increased considerably over the past 2 years, signalling the new government's strong commitment to improving maternal and child health and nutrition. This has been instrumental in driving policy change and increased government health expenditure and international development assistance to the sector.
    - *Key risks:* Volatile funding environment of international development assistance, government's bureaucratic processes, and uncertainty in the newly transitioning system may adversely impact programme implementation. Conflicts of interest exist with some stakeholders (i.e. with the private sector and BMS marketing).
    - *Key mitigation measures:* Building capacity in evidence-based policies and investment cases in health and nutrition programmes; documenting lessons from key donor-supported programmes to further advocate both government and donors for replication and sustaining investments in health and nutrition; monitoring of BMS code violation and advocacy for child-friendly business practices.

- *Assumption: Relevant Ministries and sub-national stakeholders are willing and able to collaborate in support of strengthening the health system and nutrition services for the most vulnerable families.*
    - *Key risks:* Pockets of conflict-affected and hard-to-reach areas exist in the country despite the progress in democracy and peace. Escalating conflict between warring parties could divert scarce human and financial resources away from current areas of focus, thus jeopardizing the possibility of delivering on the outcome.
    - *Key mitigation measures:* Strengthen partnerships to expand coverage in non-state, hard-to-reach and disaster affected areas; ensure these stakeholders have adequate capacity in basic health and nutrition services delivery; respond rapidly to efforts to reach vulnerable families with health and nutrition interventions; take

part in climate risk and vulnerability assessment in close collaboration with other UN agencies as part of the UNDAF during the new country programme.

- *Assumption: Front line workers in health and other nutrition-related sectors, and other duty-bearers apply knowledge and skills gained, and use tools available to them:* Successful delivery of health and nutrition services requires considerable human resources from governments and non-governmental partners. Although there has been considerable interest in human resources for health in recent years, this has not resulted in a resolution of all of the capacity constraints especially in rural/hard-to-reach areas, although a collapse does not appear likely.

    - *Key risks:* Resources are not sufficient to fully address capacity constraints. Also, natural disasters may overwhelm/overstretch national capacities to provide quality health and nutrition services in emergencies.
    - *Key mitigation measures:* Strengthen health systems, and front-line worker capacities, to both detect and respond rapidly to emerging issues; build resilience to help communities, families and children cope in the event of a catastrophe. This also entails strengthening linkages between communities and health facilities; improving skills of front-line workers to dialogue with caregivers/parents and community leaders; supporting policy shifts to enable lower cadres of health workers and ethnic health organizations to play more important roles (e.g. through task-shifting).

- *Assumption: Parents and other caregivers are able to hold basic health staff (BHS) accountable, especially in HTR areas. Both women and men apply knowledge gained and are able/empowered to make informed decisions.*
    - *Key Risk:* Underlying and diverse social norms, such as gender inequality and women's lack of decision-making power, are not adequately addressed
    - *Key mitigation measures:* Generating evidence on target populations' knowledge gaps, beliefs, taboos, perceptions, experiences and social norms; identify barriers and bottlenecks related to social norms; develop capacity for human-centred design for demand creation and addressing barriers (especially for women and women's empowerment).

- *Assumption: All families have adequate resources to meet their basic health and nutrition needs (sufficient quantity and quality of food, health care services)*
    - *Key Risk:* The national social protection programme is not rolled out; families do not have adequate resources
    - *Key mitigation measures:* leveraging resources through other programmes, such as livelihood and food security programmes, to ensure roll-out of the national social protection programme

Outputs

The Outputs address bottlenecks in the four areas of determinants, as shown below:

	Output 1	Output 2	Output 3	Output 4	Output 5	Output 6	Output 7	Output 8
Enabling Environment	√					√	√	
Supply		√	√	√			√	√
Demand					√			
Quality		√	√					√

Each Output is described below, including rationale and strategies to deliver. Because certain assumptions must be made about the conditions necessary for UNICEF's actions to lead to the achievement of each output, the most important assumptions, risks, and mitigation measures are also discussed.

Output 1: By 2022, MoHS and other partners at national and sub-national level, including non-state actor areas, have increased capacity and accountability in evidence-based planning & budgeting for scaling up high-impact interventions as well as in monitoring results with equity.

Rationale for focusing on this output

Political commitment has been critical to recent progress in health and nutrition, driving increases in both government and international development assistance investment. However, public health expenditure is still inadequate (1% of GDP) and overseas development assistance for health is slowing (3 of 7 bilateral partners withdrew their overseas development assistance to health in 2016). Challenges remain in translating political commitment at national level into concrete plans and budgets at state/regional and township levels; in finding synergies among the various initiatives (both within the health sector, and between health and other sectors); in ensuring that evidence-based planning and real-time monitoring take place at all levels, with adequate attention to equity and age/sex disaggregated analysis.

Core and important strategies to deliver this output:

The theory of change states that

- ***if*** health personnel at all levels are supported to adequately plan and budget for high impact interventions, and
- ***if*** HMIS data is routinely analyzed and used at national and sub-national levels to inform approaches and interventions at scale, and
- ***if*** technical support is provided for analysis and scenario planning for sustainable RMNCAH investments, and
- ***if*** evidence of good practices is generated and documented, and
- ***if*** government is supported to lead intra- and inter-departmental collaboration and coordination with partners, at national and sub-national levels, including in emergency preparedness and response, and considering gender equity,

then this output would be achieved whereby MoHS and other partners at national and sub-national level, including non-state actor areas, have increased capacity and accountability in evidence-based planning & budgeting for scaling up high-impact interventions as well as monitoring results with equity.

With an equity lens, UNICEF, will provide technical advice on planning, budgeting, monitoring and identification of capacity gaps; help to coordinate stakeholders; and leverage resources of other partners.

Key assumptions, risks and mitigation measures for this output

The major assumption related to this output is that key partners are interested in developing their capacity, particularly in ways that facilitate evidence-based programming and efforts to improve health outcomes among the most disadvantaged girls and boys. Key risks are that in some cases national capacity is overstretched and so partners are unable to take on new issues/roles/functions, and that entrenched interests will oppose attempts to shift the focus to the most disadvantaged populations. Risk mitigation measures include supporting policy shifts for state and regions to play more important roles in decentralized health planning, monitoring, documenting and highlighting the benefits of the approaches employed by UNICEF, so that partners can understand the benefits of evidence for advocacy.

Output 2: By 2022, national systems for harmonized procurement, logistics and supply chain management are strengthened for equitable and quality MNCH, immunization, nutrition and HIV service delivery

Rationale for focusing on this output

In Myanmar, procurement, logistics and supply chain management constraints are major challenges to making progress in health outcomes and nutritional status. Equipment, laboratories and essential medicines including vaccine commodities are insufficient; logistics & supply chain management systems are fragmented; coordinated mechanisms (intra- and inter-departmental and inter-ministerial, DPs, Ethnic and community-based health organisations) to manage supply chains are lacking. Above all, Myanmar's ranking as 134th out of 140 countries in terms of infrastructure quality, poor electricity & road infrastructure complicates logistics and supply chain management systems in health and other sectors.

Core and important strategies to deliver this output

The theory of change states that

- ***if*** government-led coordination and information sharing for logistics and supply chain management is supported, and
- ***if*** technical support is provided to assess and build national and sub-national capacity to forecast, procure, store and distribute essential commodities, including the development of SOPs and guidelines, and
- ***if*** advocacy results in increased government financing for essential commodities and the acceleration of introduction of new and under-utilized vaccines, and
- ***if*** cold chain systems at township and community health facilities are strengthened to improve effective vaccine management; and

- ***if*** systems for establishing real time stock management of essential commodities, including an electronic logistics information management system for disaggregated data, are supported,

then this output would be achieved whereby national systems for harmonized procurement, logistics and supply chain management are strengthened for equitable and quality MNCH, immunization, nutrition and HIV service delivery.

Much of UNICEF's work in this area is around capacity development and technical assistance to ensure integrated/aligned approaches to reduce stock-outs and equitably deliver essential commodities (oral rehydration salts, zinc tablets, essential antibiotics, vaccines and nutrition supplies). Robust and well-functioning vaccine delivery systems are especially critical; as such, central EPI, public health national store and selected states/regional and health offices in 199 townships will be prioritized to strengthen their cold chain and capacity to manage vaccines (including new ones) and other essential medicines which require cold storage. UNICEF support will accelerate the implementation of the effective vaccine management (EVM) improvement plan, and conduct a vaccine management assessment in 2018. Efforts will be made to establish and strengthening electronic logistics information management system for real-time, disaggregated stock management data, supply chain data analysis, and decision making.

Key assumptions, risks and mitigation measures for this output

The most significant assumption underpinning this output is that a minimum level of capacity exists within government and other partners, so that capacity development efforts are not rendered useless by the absence of human resources with whom UNICEF can engage. The major risk to this is in humanitarian situations, where human resources and logistical capacity are sometimes extremely stretched. To mitigate this risk, UNICEF provides training and technical assistance to assess and strengthen the capacity of health personnel at all levels, including the central MoHS staff who manage supply and logistics. In humanitarian situations, UNICEF becomes more directly involved in providing services by partnering with national and international organizations to address human resource and logistical capacity shortfalls.

Output 3: By 2022, national and sub national health care institutions and front-line health workers have improved capacity to reach more vulnerable populations with quality immunization and MNCH services (including PPTCT) in at least four most deprived States/Regions and in conflict, disaster affected[14] and peri-urban areas in Yangon

Rationale for focusing on this output

In Myanmar, the limited capacity of health personnel, shortage of life-saving commodities, inadequately equipped facilities and paucity of timely data, together with vertically oriented programmes are a major challenge to delivery of quality integrated health services to the most vulnerable. A recent health facility assessment of MNCH care services showed that 85% of all hospitals provided basic emergency obstetric and neonatal care (BEmONC) compared to only 7% of rural and sub-rural health centres; and while the performance of health staff was generally good, they lacked practical experience in MNCH-related emergency care. MNCH-

[14] The most deprived states/regions proposed are Chin, Shan, Rakhine, and Ayeyarwaddy based on analysis of composite indicators. Kayin and Kachin and peri-urban areas in Yangon are also proposed because of vulnerabilities identified (conflict, migration and urbanization).

related deaths may be further reduced with improved emergency referral, especially from community to health facility, and effective pre-referral measures. Strengthening the capacity of institutions and front line workers in humanitarian situations is also important, given the country's propensity to natural disasters. This resilience of health systems to better cope with shocks from natural and man-made disasters is a much needed investment. With "low risk women" accounting for 24% of new HIV infections, mother to child transmission remains a concern for which the government has prioritized action and set targets. PPTCT interventions need to be better integrated into MNCH services in very hard-to-reach areas including conflict affected areas.

Core and important strategies to deliver this output

The theory of change states that

- ***if*** government-led mechanisms develop and review key SOPs, implementation guidelines and tools at facility and community level, and
- ***if*** national and selected state/region teams are equipped with knowledge, skills and resources to provide training to improve quality facility and community based care, including in emergencies, and
- ***if*** state/region health personnel are able to identify and address bottlenecks to deliver interventions in hard-to-reach townships of the most deprived states/regions, and
- ***if*** there is strong accountability for quality facility and community-based care, through sustained supportive supervision and monitoring systems, and
- ***if*** referral systems are established for emergency complications and for vulnerable children affected by HIV, violence, developmental delays and disability, and
- ***if*** local partnerships, including Ethnic Health Organizations (EHOs), are strengthened and expanded to address gaps in delivering services and essential commodities to populations in hard to reach, conflict affected and peri-urban areas;

then this output would be achieved whereby national and sub-national health care institutions and front-line health workers have improved capacity to reach more vulnerable populations with quality immunization and MNCH (including PPTCT) services in at least four most deprived S/R and those in conflict, disaster affected, and peri-urban areas in Yangon.

The convergence of interventions fostering the integrated management of childhood illnesses, routine immunization, hygiene, sanitation, nutrition and ECCD interventions is an example of how cross-sectoral linkages are currently being promoted by UNICEF to deliver an integrated package of services for all girls and boys and their families. For outbreak preparedness, surveillance, response and control, UNICEF also employs an integrated strategy involving the different departments within the MoHS as well as regional and state-level officials. UNICEF will also support institutions/hospitals so the full package of BEONC can be accessed by vulnerable populations. Local partnerships will be important to implement strategies in some hard-to-reach or conflict affected settings, with a focus on helping Myanmar attain global targets for disease control, elimination and eradication (e.g. elimination of MTCT and Measles). UNICEF's participation in the Health Cluster will also be instrumental in emergencies. UNICEF field offices will support community mobilization and dialogue with local authorities, community leaders, and CSOs, to address and minimize barriers to access these services.

Key assumptions, risks and mitigation measures for this output

The most significant assumption underpinning this output is that a minimum level of capacity exists within governments and other partners so that capacity development efforts are not rendered useless through the absence of human resources with whom UNICEF can engage. There is also an assumption that government workers apply knowledge and skills gained and use the job aids, tools and supplies available to them. There is a risk that disasters and conflict may disrupt delivery of and services. To mitigate this risk, UNICEF will integrate emergency preparedness and response into routine capacity building of frontline workers and personnel in terms of planning, monitoring, surveillance and coordination. Contingency plans and standby agreements with partners will also be put in place to provide rapid surge capacity where needed. In humanitarian situations, UNICEF becomes more directly involved in providing services in partnership with local and international organizations, including ethnic health organisations, to address acute shortages of health workers.

Output 4: By 2022, MoHS and other partners at national and sub-national level, including non-state actors, have improved capacity to integrate HIV interventions for young children and key adolescent populations into essential service delivery approaches sustainably at scale

Rationale for focusing on this output

HIV prevalence in the general population in Myanmar has declined in recent years, but it is still high among key populations[15], including younger cohorts, and appears to be rising among young MSM. In response, the Government recommended increased accessibility of HIV testing and treatment for children and adolescents, especially those at risk for HIV infection, as well as vulnerable key populations. However, funding constrained decentralised point of care testing, which was started in 2011 with support from UNICEF, WHO, UNFPA and development partners. Sustained support is required to bridge this constraint and scale up point-of-care testing, which could reduce delays in the testing and increase accessibility of ART/ ARV prophylaxis, and to track and follow up care and support for quality, long-life treatment of HIV infected pregnant women, spouses and their children. To ensure sustainability of this support, there is a need to integrate HIV testing and treatment interventions into essential health service delivery approaches.

Core and important strategies to deliver this output

The theory of change states that

- ***if*** data systems and analyses at national and sub-national level are strengthened to identify and track gaps in response and address social determinants of HIV across both young children and key adolescent populations, and
- ***if*** evidence is generated to leverage government and partners to support MOHS to attain better HIV-related outcomes for children, and
- ***if*** national and sub national capacity is strengthened to integrate HIV interventions into health, nutrition and other key social services, and

[15] Targeted young key populations include men who have sex with men; people who use drugs, including injecting drugs; an female sex workers

- ***if*** communities, CSOs and EHOs are engaged to determine the best ways to improve access, coverage and retention in services, including outreach services to marginalized groups and communities and
- ***if*** utilization and scale up of technological and programmatic innovations is promoted to overcome obstacles to accessing HIV treatment and care; and to better track women, children, and adolescents along the HIV continuum of care,

then this output would be achieved whereby MoHS and other implementing partners at national and sub-national level, including non-state actors, have improved capacity to integrate HIV interventions for young children and key adolescent populations into essential service delivery approaches sustainably at scale.

UNICEF will work with the MoHS HMIS unit, National AIDS Programme (NAP), WHO, UNFPA and UNAIDS to strengthen data systems and analyses at national and decentralised levels using DHIS2 platform, to understand the situation, identify gaps in the response, and address social determinants of HIV. To optimize effectiveness and efficiency, UNICEF will work across sectors to better align and integrate HIV services where appropriate. UNICEF will work at the national and subnational levels to impact service integration and improve referral linkages across the Maternal, Neonatal, and Child Health (MNCH) platforms and other service delivery points, such as nutrition, family planning and youth (mainly with UNFPA) HIV, and drug dependency programmes (mainly with UNAIDS). UNICEF will work with National Health Laboratory (NHL) to introduce point of care diagnostics and facilitate decentralization of the use of these technologies to the lowest level of care. At the same time it will actively engage communities, ethnic health organizations, civil society and youth groups to determine the best ways to improve access, coverage and retention in services. Where possible, outreach services which facilitate reaching marginalized groups and communities will be supported through partnership with NGOs. As a UNAIDS Co-sponsor, UNICEF has played a leading role in the national HIV and AIDS response for children, adolescents, and women. UNICEF co-convenes the expanded Technical Working Group on the Prevention of HIV Infection in Pregnant Women, Mothers and their Children (with WHO) and on HIV and Young People (with UNFPA).

Key assumptions, risks and mitigation measures for this output

Critical assumptions to attaining this output will be the meaningful engagement and participation of government, community leaders, UN technical agencies and donors with people living with HIV, including adolescents particularly young people from key populations, in planning, programming, and implementing the response within given national and sub-national contexts. Key government and community based organisations continuously supports more active engagement in: decentralised planning, management, and monitoring processes; service delivery and demand creation; operational and implementation research and national advocacy efforts; as well as efforts to address stigma and discrimination and promote human rights. Current lack of synergies between HIV, Health, Nutrition, Social Welfare and Education sectors pose risks in leveraging better and more equitable results for children and adolescents within the context of HIV and AIDS. Enhancing capacity and building systems to develop more risk-informed programming across sectors to improve access and prevent the discontinuation of services in the wake of crises will be critical. UNICEF will further ensure that care and support interventions for children affected by AIDS are better integrated within social welfare

and protection systems and ensure that these programmes are HIV-sensitive. In order to achieve prevention and treatment outcomes for adolescent girls and boys, effective partnerships will be built across sectors to leverage resources and support for enhanced impact.

Output 5: By 2022, caregivers, family members, communities and institutions, particularly in the four most deprived states/regions[16], have increased knowledge and skills to practice appropriate child care, hygiene, feeding, dietary, early stimulation, and injury and violence prevention during critical periods of growth and development and to demand quality health and nutrition services

Rationale for focusing on this output

Addressing knowledge, behaviour, and sociocultural practices is essential to ensure individual and communal buy-in and demand for health and nutrition services such as immunization (campaigns and routine), maternal and neonatal health services, treatment for pneumonia and diarrhoea, and counselling on infant and young child feeding and care, hygiene and sanitation, early stimulation, and healthy maternal diets. Current social behaviour communication strategies and messages targeting caregivers and families do not specifically target underlying perceptions, taboos and attitudes, which are major barriers towards behaviour change in addition to knowledge gaps. Social norms also exist, where family members and relatives may expect pregnant women and mothers to follow certain dietary restrictions, or other inappropriate behaviours/practices. Gender norms prevent women from having full decision-making power. Furthermore, it has become increasingly important to understand and address the reasons why many women do not deliver in institutions, which appears more complex than simple want of money. Further knowledge is also needed on why some children are missed during routine health care delivery due to refusals, especially in deprived areas like Rakhine, in order to make programme adjustments or develop new strategies to reach all girls and boys. With the expansion of child protection services, including social welfare case management, more children experiencing violence and abuse are being reported with notable gender disparities, physical violence and injuries dominating among boys and sexual abuse among girls. There are missed opportunities to mitigate this vulnerability among affected women and children presenting in the health system. Moreover, the introduction of new vaccines means that children have to receive multiple injections in one visit, which requires improved skills of service provider on risk communication and interpersonal communication (IPC) with caregivers on the importance of continued use of services and to avoid drop-outs. Addressing demand side barriers, paired with community mobilization and engagement, aim to increase the utilization of health and nutrition services.

Core and important strategies to deliver this output

The theory of change states that

- ***if*** technical support is provided to MoHS on C4D strategies, coordination and interventions on immunization, MNCH, nutrition, and HIV for key marginalised communities, and

[16] Most deprived states/regions based on composite of 12 indicators: Ayeyarwaddy, Rakhine, Chin and Shan. Kayin and Kachin states and peri-urban areas in Yangon are also proposed because of specific vulnerabilities identified (conflict, migration and urbanization).

- ***if*** community participation and engagement for demand creation and for addressing barriers to access/utilize services is fostered, and
- ***if*** evidence-based innovative C4D interventions are supported, to empower caretakers/mothers to adopt appropriate preventative and care-seeking practices, and
- ***if*** evidence-based C4D interventions use multi-layer communication channels that address social norms, and
- ***if*** the capacity of frontline workers and local partners is strengthened to deliver appropriate messages through effective C4D approaches, and
- ***if*** scalable early childhood stimulation approaches for young children (aged 0-3) are modelled,

then this output would be achieved whereby caregivers, family members, communities and institutions, particularly in the four most deprived states/regions, have increased knowledge and skills to practice appropriate child care, hygiene, feeding, dietary, early stimulation, and injury and violence prevention during critical periods of growth and development, and to demand quality health and nutrition services.

Capacity development at all levels (government and civil society) is a feature of UNICEF's work on C4D for health and nutrition. Cross-sectoral linkages, particularly between Nutrition-WASH and Nutrition-ECCD, will be ensured to support coherent and consistent messages on nutrition and care to caregivers, families and communities (especially to men as leaders and agents of change, since they are – by social norms – the primary decision makers in families, and the predominant leaders in communities). In hard to reach and vulnerable areas, where nutrition services have low coverage and there are gaps in outreach and community mobilization, UNICEF will work with local partners to support service delivery of C4D and SBCC. Innovative communication tools will also be explored to reach target audiences and monitor changes in knowledge and beliefs.

Key assumptions, risks and mitigation measures for this output

One of the key assumptions in this area is that the communities with which UNICEF is working are open to receiving information, behaviour change messages and other efforts to change sociocultural beliefs and practices that impede health-seeking or support violent behaviours (including gender-based violence). There is also an assumption that people apply knowledge they gain and that mothers are subsequently empowered and able to make decisions – for example, about their diets, care and child feeding. Another assumption that is particularly important, especially for the work on immunization, is that UNICEF and its partners will be able to access communities that have lower uptake rates, and will be able to engage with these communities to understand reasons for low coverage, high drop-out rates and the root causes of refusals to participate in these programmes. There is a risk that underlying social norms may not be adequately addressed or take a long time to change, and another risk that language barriers between researchers/service providers and people in remote communities will limit effective communication. The communication channels and materials employed sometime use language not spoken or easily read by the caregivers in some ethnic areas. To mitigate these risks, UNICEF will ensure that quality formative research and human-centred design inform the development communication strategies, messages and tools. As well, a monitoring system will be established to assess the effectiveness and impact of C4D

strategies on influencing knowledge, social norms, behaviour, and perceptions related to nutrition.

Output 6: By 2022, MOHS and other partners at national and sub-national level, including non-state actors, have increased capacity to legislate, plan and budget effectively for the scaling-up of evidence-based nutrition specific interventions with equity

Rationale for focusing on this output

Although national actions plans and policies for nutrition previously existed, they have not yet been updated to cover the next five year period, within a costed, common results framework, which is critical for the effective scale-up of nutrition interventions (outcome level). Efforts and planning are underway by Government, with technical support from UNICEF and other partners, to update relevant sectors plans for nutrition, particularly nutrition specific interventions, while supporting the development of a high level multi-sectoral plan for food and nutrition which was drafted in 2015. With the new Government and development of relevant new sector plans, such as the National Health Plan (2016-2021) and Agricultural Strategy and Investment Plan, there are opportunities to strengthen the nutrition policy environment, within the Health sector and generally. Legislation for nutrition exists, such as the national order on the Marketing of formulated food for infant and young children, mandatory salt iodization and increased maternity leave, however, they are not currently monitored and enforced. These challenges are due to inadequate resources allocated to nutrition, limited data availability and utilization to inform prioritization and decision-making, lack of monitoring mechanisms and fragmented coordination between some Ministries, departments and between national and sub-national levels.

Core and important strategies to deliver this output

The theory of change states that

- ***if*** high impact nutrition specific interventions are integrated in the essential package of health services, and
- ***if*** a national nutrition costed plan and operational strategy with clear results and M&E framework, and
- ***if*** nutrition legislation is reviewed and strengthened, with monitoring and enforcement mechanisms established, and if MoHS at all levels generates, analyses and utilizes evidence, disaggregated data and information to strengthen monitoring and decision-making for nutrition;

then this output would be achieved whereby MOHS and other partners at national and sub-national level, including non-state actors, have increased capacity to legislate, plan and budget effectively for the scaling up of evidence-based nutrition specific interventions with equity.

Key strategies to be implemented to achieve this output include: fostering partnerships and cross-sectoral linkages, where UNICEF will work closely with relevant MOHS departments and stakeholders to provide technical support to the development or updating of MOHS strategic and operational costed plans to support nutrition, particularly evidence-based nutrition specific interventions, including in the context of emergencies. UNICEF will also help to strengthen the HMIS for nutrition and build local capacity of Government in data management and utilization; support evidence generation through large scale nutrition

surveys and data analysis (including age/sex disaggregated data); and conduct advocacy using these findings.

Key assumptions, risks and mitigation measures for this output

The main assumption is that national and sub-national actors are willing and able to collaborate. The main risk is that the funding environment for nutrition is uncertain or volatile, given recent changes in Government and emergence of other competing national development priorities. To mitigate this risk, UNICEF will continue its high level, evidence-based advocacy work jointly with partners for increased investments for nutrition, emphasizing the gains and contribution that better nutrition can bring, to the socioeconomic development of the country.

Output 7: By 2022, multi-sectoral political commitments and approaches are in place to support prioritized, integrated, nutrition sensitive interventions with an equity focus in four most deprived States/Regions, conflict & disaster affected and peri-urban areas in Yangon

Rationale for focusing on this output

In addition to ensuring objectives, strategies and resources for nutrition are included in sector specific plans, particularly in the Health sector, several country experiences show that multi-sectoral governance and coordination for nutrition across relevant sectors is also required if the effective coverage of both nutrition specific and sensitive interventions is to be increased equitably to reach all children under 5 and women of reproductive age. Past experience in Myanmar, under the National Plan of Action for Food and Nutrition (NPAFN, 2011-2015) demonstrate that effective multi-sectoral coordination and implementation for nutrition is difficult when only one sectoral Ministry is designated as the lead.

Core and important strategies to deliver this output

The theory of change states that

- ***if*** there is coherent joint advocacy, utilizing the SUN multi-stakeholder platform, to support costed multi-sectoral plans and governance mechanisms for nutrition, and
- ***if*** nutrition specific and sensitive strategies and interventions are mainstreamed into relevant sub-national plans, and
- ***if*** multi-sector coordination mechanisms function at national and sub-national level to support nutrition, and
- ***if*** specific, integrated interventions for Nutrition-WASH (including in MNCH and ECD), are defined and reflected in Government work plans, and if good practices for multi-sectoral programming for nutrition are documented, based on local evidence,

then this output would be achieved whereby national and sub-national political commitment and multi-sectoral approaches are in place to support prioritized, integrated, nutrition-sensitive interventions with an equity focus.

Key strategies to be implemented to achieve this output include: partnerships and cross-sectoral linkages to leverage resources for scaling up nutrition sensitive interventions in relevant sectors, where UNICEF will work closely with other sectors, Ministries and SUN multi-

stakeholders on joint advocacy for nutrition, and provide technical support to the development of a costed, multi-sectoral plan for nutrition with a common results and M&E framework. UNICEF will support Government in particular, in the identification of integrated Nutrition-WASH/ECD/MNCH interventions and strategies. It is important to note that a multi-sectoral plan for nutrition and sector specific plans that include nutrition objectives are expected to align with each other. UNICEF, as part of the SUN multi-stakeholder platform and UN network, will support capacity building of sub-national actors in multi-sectoral coordination through its field offices. UNICEF will also contribute to knowledge management and documentation of best practices on multi-sectoral programming for nutrition in the Myanmar context, based on experience accrued during the country program cycle.

Key assumptions, risks and mitigation measures for this output

There is an assumption that Ministries and sub-national actors across different sectors are willing to collaborate with each other, assuming that the development of a multi-sectoral nutrition plan and governance structure would be a high level decision. There is a risk of conflict of interest of some stakeholders, such as different views and priorities among development partners and with the private sector. To mitigate this risk, UNICEF will make all possible efforts to ensure government leadership and ownership throughout the consultation and decision-making processes related to achievement of this output.

Output 8: By 2022, Government workers in nutrition related sectors have increased capacity to deliver nutrition services according to standards at all times in four most deprived States/Regions and in conflict & disaster affected and peri-urban areas in Yangon

Rationale for focusing on this output

Although nutrition specific services are part of the essential health services package, many health personnel and frontline workers are not able to provide quality nutrition services due to lack of knowledge and skills in public health nutrition, supply gaps, lack of effective job aids, poor counselling skills, lack of routine supportive supervision and inadequate data management for planning and monitoring. Nutrition sensitive interventions provided through non-health sectors of government are very limited due to lack of human resources trained or oriented in nutrition in these other sectors, and lack of job aids, tools and messages that are nutrition sensitive.

Core and important strategies to deliver this output

The theory of change states that

- ***if*** nutrition capacity building and training is conducted at national and sub-national levels, and
- ***if*** nutrition job aids for frontline workers in nutrition-related sectors (i.e. health, social welfare, rural development (WASH), etc.) are updated and adapted, and
- ***if*** local partnerships to address gaps in service delivery to populations in hard to reach and peri-urban areas are strengthened and expanded, and
- ***if*** there is supportive supervision and monitoring for nutrition, and
- ***if*** local capacity for risk reduction and mitigation, emergency preparedness and response is strengthened,

then this output would be achieved whereby government workers in nutrition related sectors have increased capacity to deliver nutrition services according to standards at all times, in 4 most deprived S/R and in conflict & disaster affected and per-urban areas in Yangon.

UNICEF will work with other sectors, including through the SUN multi-stakeholder platform, to provide technical support in development of nutrition sensitive job aids (partnerships and cross-sectoral linkages). In the health sector, UNICEF will closely support various aspects of capacity development of personnel and frontline workers at sub-national level to plan, monitor, supervise and deliver nutrition specific services at both facility and community levels according to national guidelines and standards. At the national level, UNICEF will support MoHS capacity development in nutrition supply chain and data management, pre-service training and needs-based training. In hard-to-reach areas and in times of emergency, UNICEF will support Government in addressing gaps in service delivery through local partnerships. Community mobilization and dialogue (including multi-sector advocacy and coordination) will be supported by UNICEF field offices with local authorities, community leaders, and civil society organizations.

Key assumptions, risks and mitigation measures for this output

There is an assumption that Government workers apply knowledge and skills gained and use the job aids, tools and supplies available to them. There is a risk that other sectors will not be interested in nutrition, and that disasters and conflict may disrupt capacities and services. To mitigate this risk, UNICEF will integrate nutrition advocacy, and capacity building in emergency preparedness and response into routine nutrition capacity building of Government frontline workers and personnel in terms of planning, monitoring, surveillance and coordination. Contingency plans and standby agreements with partners will also be put in place to provide rapid surge capacity where needed.

1.4. Programme Results

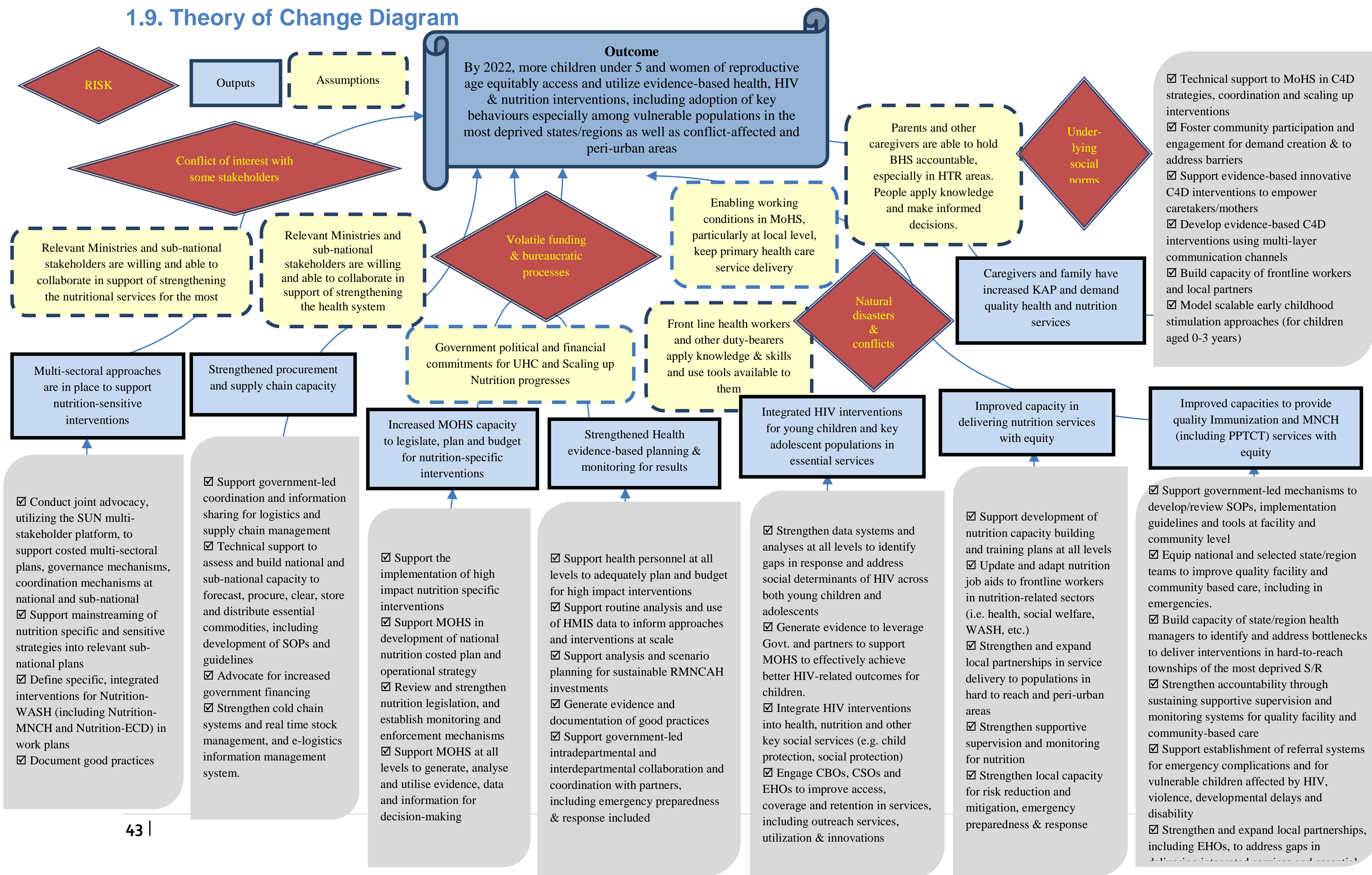
The ToC informed the development of the consolidated H&N programme's results structure and framework, with linkages illustrated. Appropriate standard outcomes and indicators were selected from the globally defined list in RAM, facilitating the aggregation of UNICEF's contribution to results across countries and globally. When the monitoring and evaluation framework of the NHP (2017-2021) is developed, the framework will then be reviewed to ensure appropriate national priorities and related indicators are also duly reflected. Given the protracted and acute humanitarian situations in Myanmar, higher frequency humanitarian performance monitoring of a narrower scope of priority is regularly undertaken based on the Core Commitments to Children in Humanitarian Action. Due attention has also been paid to those indicators with a gender tag, to properly reflect the targeted gender priority/mainstreaming results.

For more details, the results framework with associated indicators, baselines and targets in section 10 of health and nutrition programme outcome on page ## 44.

1.5. Aligning Results, Strategies and Required Resources

Annual planned budgets by Outputs and funding type are summarized in the table below. The programme plans for $16 million in regular resources (RR) and $51million in other resources (OR) over its five-year period. Additionally, depending on evolving humanitarian situation in Myanmar, an additional $8 million of other resources for emergency (ORE) may be mobilised

1.9. Theory of Change Diagram



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Note for the Record

Subject: **Environmental Impact Assessment (EIA)**

As part of the development of the [redacted] and in accordance with recommended practice, the UNICEF Country Office [redacted] has undertaken an initial screening of all proposed activities within each draft programme component to assess their potential impact on the environment.

The Country Office applied the recommended assessment methodology as described in the PPP Manual, Chapter 6, Section 3 (the Manual's 2011 version), namely Checklist 1 "Initial Screening". The completed checklist attached to this note reflects that the Country Office considers that the programme components contemplated in the draft Country Programme Document, submitted to the UNICEF [redacted], should have no impact on the environment.

Sincerely,

Attachment 1 – Checklist 1 *"Initial Screening"*

Checklist 1- Initial Screening

Does the proposed programme or project contain activities that fall under one or more of the following categories? If the answer is **NO,** and EIA is not required, and the process is complete

Category	Answer
• Extraction of water (e.g., groundwater, surface water, and rain water)	NO
• Disposal of solid or liquid wastes (e.g., human faeces, animal wastes, used supplies from a health centre or health campaign)	NO
• Use of chemical (e.g., pesticides, insecticides, paint and water disinfectant)	NO
• Use of energy (e.g., coal, gas, oil, wood and hydro, solar or wind power)	NO
• Exploitation of natural resources (e.g., trees, plants, minerals, rocks, soil)	NO
• Construction work above household level (e.g., hospital or school)	NO
• Changing land use (deforestation, forestation, and developing industrial housing or recreational centres)	NO
• Agricultural production (e.g., growing crops, fish farming)	NO
• Industrial production (e.g., small scale town/village workshops)	NO