Final Evaluation of the Three Diseases Fund
Fund Board Management Response

The Three Diseases Fund (3DF) Board strongly supports the principles of independent evaluation and welcomes the recommendations of this Independent Final Evaluation of 3DF. The evaluation covered the implementation period of the Fund from mid-2007 until the end of 2011, and focussed on 3DF as a whole. The Final Evaluation report represents the views of the Euro Health Group evaluation team.

The Evaluation found that 3DF reflected an impressive donor response in both scale and timing, and was the single largest contributor to all three disease areas in Myanmar during the period 2007-11. Overall, 3DF contributed between about one to two thirds of the total national targets for the three diseases. Without the 3DF, the health needs of thousands of Myanmar people would have gone unmet. These results were achieved with reasonable effectiveness and cost effectiveness assessment suggests the investments represent value for money. The report notes the challenging political and operational context of Myanmar and in particular the important role of the 3DF following the withdrawal of the Global Fund and its efforts to support its return. The Fund Board would like to note the scale of the achievements of the Fund within this challenging context. Up to end 2011 this includes:

- Nearly 60 million condoms and over 13 million needles have been distributed to prevent HIV infection
- 22,000 people with HIV with to access lifesaving anti-retroviral therapy
- 180,000 people diagnosed with smear positive TB
- 1.8 million people diagnosed and treated for malaria

The External Reviews of the National Tuberculosis and Malaria Programme s (2011, and 2012 respectively) acknowledge this tremendous effort in scaling up services from 2006/7 and the significant role played by the 3DF. The achievements of the 3DF were only made possible through the dedication and sustained commitment of the Ministry of Health, the Fund Management Office and implementing partners.

The Final Evaluation made a number of recommendations to improve the impact and effectiveness of future support to Myanmar. The donors to the 3DF propose to address these recommendations through our support to the successor to the 3DF - the Three Millennium Development Goals (3MDG) Fund. Importantly the framework for independent evaluation of the 3MDG Fund will be established at the outset to enable a more thorough assessment of the 3MDG Fund impact. We will also share the findings of the evaluation more broadly to inform other efforts both within Myanmar and in other countries where we operate.

The lessons learnt through our experiences in 3DF can inform efforts to engage in environments with challenging political contexts. The foundation and experiences of the 3DF has allowed us to take further steps in our engagement in the health sector through the 3MDG Fund. This includes working more actively to strengthen the Ministry of Health's stewardship of the sector and the essential role of public health services and systems, working in partnership with a wide variety of development partners including non-government organisations, the private sector, UN and multilateral agencies, and communities.

The findings of the Final Evaluation were presented to the 3DF Annual Review meeting on 26 September 2012. The Fund Board actions in response to the recommendations of the Final Evaluation are outlined below:

Evaluation Recommendation	Response	Action	Responsibility	Deadline
1. Coherent articulation of a Fund's strategy, definitions, and programmatic/M&E logic is essential to enable relevant and effective practice both by the Fund itself, and by IPs (whatever the context of initial Fund implementation).	Agreed	The strategy, definitions and programmatic logic are set out for the 3MDG Fund in the Description of Action. These will be further defined and disseminated to all partners as the 3MDG Fund commences Gender strategy for 3MDG Fund to be developed and monitored, analysis of gender and health issues to be commissioned.	3MDG Fund Manager, with 3MDG Fund Board to review and approve. Input from Independent Evaluation Group.	December 2012
1.1. Once established, Fund-specific strategies, definitions, and overarching programmatic logic should be reviewed regularly and maintained or adapted. Contractual expectations of IPs should be made explicit and should be in direct relation to the defined strategies, definitions and programmatic logic. This would allow for clear recognition of the different strengths and characteristics of LNGOs/CBOs, and a clear articulation of a rationale for funding them.	Agreed	Review the strategies, definitions, and overarching programmatic logic for the 3MDG Fund. Review integration of gender issues into 3MDG Fund programming and implementation.	3MDG Fund Manager, with 3MDG Fund Board to approve. Input from Independent Evaluation Group, as and when relevant.	Annually
		Ensure contractual expectations of IPs, including LNGOs/CBOs, are explicit.	3MDG Fund Manager	Ongoing
2. Use a funding model that enables the Fund to have a more proactive and consistent, positive influence on the operating environment (including the civil society environment) and on provision of effective services to those most in need. A commissioning model would seem most appropriate, given the operating context. Such a model would further reinforce the aforementioned defined Fund strategy, definition and programmatic logic. It would also allow for development of a more coherent M&E system, focused on continual improvement against a clear framework for analysis, learning and adaptation of interventions as a result of data arising.	Agreed	Commissioning model for 3MDG Fund proposed through Description of Action and this is currently being operationalized through programme start up.	3MDG Fund Board and Fund Manager	Ongoing
2.1. Calls for proposals should include	Agreed	Ensure calls for proposals under the 3MDG	3MDG Fund Manager	Ongoing

Evaluation Recommendation	Response	Action	Responsibility	Deadline
requirements for effective M&E, and requirements for clarification of processes to be used to ensure community participation and effective targeting of services.		Fund outline requirements for effective M&E and asks for clarification of processes to be used to ensure community participation and effective targeting of services.		
2.2. Provide direct funding to LNGOs/CBOs for reasons of ownership and sustainability. Set aside resources for ensuring that the specific strengths of LNGOs/ CBOs are identified and best utilised; and that necessary capacity is built for M&E. Mentoring, rather than one-off training, would be the best way forward (both in terms of M&E and in terms of identifying and building on LNGO/CBO strengths).	Agreed	Articulate rationale for direct funding to LNGOs/CBOs as part of articulation of 3MDG Fund strategy and programmatic/M&E logic (response to Rec 1). Component 3 of 3 MDG Fund will support role of civil society in promoting the responsiveness of services. In addition ensure strategy/program outlines ways to capitalise on the strengths of LNGOs/CBOs, and builds their capacity for M&E.	3MDG Fund Manager, with 3MDG Fund Board to review and approve.	First quarter 2013 and ongoing
2.3. Make requirements for an exit strategy part of the contract; thereby building sustainability into the programme from the start.	Agreed	3MDG Fund contracts/ agreements with implementing partners to make this requirement explicit.	3MDG Fund Manager	Ongoing
3. Support the establishment of structures that proactively promote and support on-going learning, innovation and adaptation (rather than on mechanistic accountability).	Agreed	Regular review and reflection of learning from3MDG Fund and other relevant programs to be a regular agenda item of the existing governance structures of the 3MDG Fund, and in the health sector, building on inputs from beneficiary feedback, operational research, partner learning forums, independent evaluation and other sectoral reviews and assessments	3MDG Fund Board, implementing partner forums, TSGs, Senior Consultation Group. 3MDG Fund Manager to facilitate this continual improvement process through regular inputs to these fora and ensure effective knowledge management systems in place	Ongoing
3.1. Set aside a small pool of money (e.g. 1% of the total budget) for operational research (OR) and its dissemination in the health services. Commission qualitative research in order to better understand the socio-cultural dynamics of all three diseases.	Agreed	3MDG Fund strategy and program (Rec 1) to reflect importance of operational research and dissemination.	3MDG Fund Manager, with 3MDG Fund Board to review and approve. Input from Independent Evaluation Group and TSGs on operational research	December 2012

Evaluation Recommendation	Response	Action	Responsibility	Deadline
			priorities.	
		Ensure outcomes of research inform strategies, definitions, and overarching programmatic logic for the 3MDG Fund, and is fed back to TSGs.	Senior Consultation Group, Independent Evaluation Group, Fund Board and 3MDG Fund Manager with regular feedback to TSGs	Ongoing
3.2. Greater learning from communities is needed. Support meaningful participation at all levels and increase asset-based approaches, rather than deficit-based ones.	Agreed	Needs assessments/gap analyses conducted prior to commissioning interventions/delivering programs under 3MDG Fund.	3MDG Fund Manager/ implementing partners	Ongoing
		Ensure programs supported target these expressed needs.	3MDG Fund Manager, for approval by 3MDG Fund Board.	Ongoing
		Modify support in response to learning from communities on the effectiveness of programs.	3MDG Fund Manager, for approval by 3MDG Fund Board.	Ongoing
		Ensure learning from communities is shared more broadly in the health sector.	3MDG Fund Manager and Senior Consultation Group, including through participation in TSGs	Ongoing
3.3. Establish mechanisms and relationships that support transparency in performance as a key principle underlying service delivery with regards to beneficiaries and service quality, effectiveness and efficiency. Set aside resources for regular experience-sharing through annual review meetings, topical workshops, opportunities for joint problem-solving and other focused learning activities.	Agreed	Transparency requirements to be incorporated into contracts/ agreements with implementing partners to 3MDG Fund.	3MDG Fund Manager	Ongoing
		Support to be provided for Government to conduct regular meetings/workshops for sharing of experiences, through TSGs and other fora.	3MDG Fund Manager, MoH/TSGs	Ongoing
3.4. To support continued documentation and application of lessons learnt, invest in appropriate and effective knowledge management mechanisms based on available technologies and global/regional experiences.	Agreed	Effective knowledge management systems in place for Fund Manager and shared through web and other appropriate mechanisms	3MDG Fund Manager	June 2013

Evaluation Recommendation	Response	Action	Responsibility	Deadline
4. Clearly define and support greater FMO involvement in operational decision-making and ensuring service quality and effectiveness. Redefine the role of the FB in implementation-related decisions and consider establishing an independent technical oversight body with detailed technical knowledge of the programme areas including M&E and which can provide maximum responsiveness to the programme needs.	Agreed.	The 3MDG Fund has set out clear roles and responsibilities, building on lessons learned: 3MDG Fund Manager is responsible for operational decision-making and ensuring service quality and effectiveness, 3MDG Fund Board role is to oversee the 3MDG Fund Manager's performance on this and make funding decisions. Technical capacity of Fund Manager to be supplemented through a Technical Support Facility.	3MDG Fund Board	Completed
		Senior Consultation Group to be established to review program implementation and provide advice and recommendations to the 3MDG Fund Board.	3MDG Fund Board	Established
		Independent Evaluation Group to provide independent advice on 3MDG Fund based on an evaluation framework at the outset of the fund.	3MDG Fund Board	October 2012?
5. The FB should take advantage of recent political developments in Myanmar and its unique position as a national trust fund to promote the operationalization of the NSP principles regarding access to services for marginalised populations such as injecting drug users (HIV), prison populations (HIV and TB), and migrant workers (malaria) and others.	Agreed	Gap analysis under 3MDG Fund for the three diseases to consider needs of marginalised populations.	3MDG Fund Manager	September-October 2012
5.1. This includes: advocacy related to NGO access to areas with greatest need; enhanced coordination and cooperation; MoH system-strengthening; and, an enabling environment for service access and social change.	Agreed	Advocacy efforts of donors on NGO access to continue.	3MDG Fund donors, with input from 3MDG Fund Manager on when specific advocacy is needed and on what issue.	Ongoing
		3MDG Fund to support enhanced coordination in the health sector and efforts to improve enabling environment as part of its strategy/program (Rec 1). 3MDG Fund already explicitly addresses MoH system	3MDG Fund Manager, with 3MDG Fund Board to review and approve.	Ongoing

Evaluation Recommendation	Response	Action	Responsibility	Deadline
		strengthening needs.		
6. Provide direct support for strengthening national M&E systems in close coordination and collaboration with other donor-supported programmes as there are shared needs for data, data analysis and data use for more effective strategic and operational planning and increased impact of programmes.	Agreed, subject to MoH agreement	Support for national M&E systems to be explored with MoH during inception phase of 3MDG Fund.	3MDG Fund Manager	December 2012
6.1. This includes continued support for the TSGs with a clearly defined programme of work in terms of: technical oversight for strengthening national M&E systems; funding for specific surveys and special studies as per clearly defined schedules and procedures; support for integrated analyses; and support for evidence-informed strategic planning, resource allocation and programme improvement. TSGs need to be supported with strong and consistent technical assistance.	Agreed	Program of support to TSGs to be developed for implementation under the 3MDG Fund.	3MDG Fund Manager	December 2012
6.2. National M&E system-strengthening should be coordinated and harmonised between all donors under the leadership of the TSGs and relevant data from donor-supported programmes should be shared with the national M&E system.	Agreed	As for Rec 6. Data from 3DF supported programs already shared with the national M&E system, this will continue under the 3MDG Fund.		
7. To sustain the positive effects of 3DF investments, it is paramount that the 3MDG Fund builds on the work carried out, and lessons learnt, from the 3DF.	Agreed	Lessons from 3DF to inform programme inception, including sharing lessons with 3MDG Fund Manager/inception team for programming 3MDG Fund interventions.	3DF Board	September 2012



Myanmar

FINAL EVALUATION OF THE THREE DISEASES FUND

FINAL REPORT

15 October 2012

Submitted to: 3DF Fund Board

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ACRONYMS & ABBREVIATIONS

3DF	Three Diseases Fund
3MDG Fund	Three Millennium Development Goal Fund
ACT	Artemisinin-Based Combination Therapy
AEM	Asia Epidemiological Model
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
CBO	Community-Based Organisation
CCM	Country Coordinating Mechanism
CEA	Cost-Effectiveness Analysis
DALY	Disability Adjusted Life Year
DOTS	Directly Observed Treatment, Short-Course
EOI	Expression of Interest
FHAM	Fund for HIV/AIDS In Myanmar
FB	Fund Board
FFM	Fund Flow Mechanism
FM	Fund Manager
FMO	Fund Management Office
GDP	Gross Domestic Product
Global Fund	The Global Fund To Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
INGO	International Non-Governmental Organisation
IP	Implementing Partner
ITN	Insecticide-Treated Net
JIMNCH	Joint Initiative on Maternal, Neonatal And Child Health
LIFT	Livelihoods and Food Security Trust Fund
LLIN	Long-Lasting Insecticidal Net
M&E	Monitoring and Evaluation
MANA	Myanmar Anti-Narcotics Association
MARC	Myanmar Artemisinin Resistance Containment
MDG	Millennium Development Goal
MMT	Methadone Maintenance Therapy
MoH	Ministry of Health
MoU	Memorandum of Understanding
MSM	Men Who Have Sex With Men
MPG	Myanmar Positive Group
NAP	National AIDS Programme
NGO	Non-Governmental Organisation
NOP	National Operational Plan
NSP	National Strategic Plans
NTP	National Tuberculosis Programme
ODA	Overseas Development Assistance
ODI	Overseas Development Institute
OECD-DAC	Organisation for Economic Cooperation and Development-Development Assistance Cooperation
OI	Opportunistic Infection

RDT	Rapid Diagnostic Test
SHG	Self-Help Group
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TSG	Technical and Strategic Group
UN	United Nations
UNAIDS	Joint United Nations Programme On HIV/AIDS
UNEG	United Nations Evaluation Group
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNOPS	United Nations Operations And Procurement Services
VCCT	Voluntary Confidential Counselling and Testing
VfM	Value for Money
WHO	World Health Organisation

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- Staff from the Ministry of Health of Myanmar for facilitating and supporting all stages of the evaluation and for sharing their expert views with the Evaluation Team. We would like to thank Professor Dr Pe Thet Khin, the Honourable Minister of Health; the Focal Points and staff from the respective National AIDS, Tuberculosis and Malaria Programmes; the State Health Directors of Kayin, Mon, and Northern Shan States and associated State Disease Focal Points and Township Medical Officers; and, Basic Health Staff in Mon State. The Evaluation Team is particularly indebted to Dr Myint Shwe, Assistant Director, National AIDS Control Programme and Dr Aung Thi, Assistant Director, National Malaria Control Programme, who served as our Liaison Officers and who were invaluable in the field data collection phase.

- Members of the Three Diseases Fund Board, former and current staff from the Three Diseases Fund Management Office, and Implementing Partners who took time out of their busy schedules to help facilitate the successful implementation of the evaluation and to contribute their experiences and views to the evaluation findings.

- Beneficiaries and representatives of networks of affected communities who contributed invaluable insight into the experiences, needs and abilities of community members and the interaction between the 3DF and those most in need.

- The local managers of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); the Joint Initiative on Maternal, Neonatal and Child Health; and the Livelihoods and Food Security Trust Fund.

It is our shared hope that this evaluation will contribute to the continued commitment of all stakeholders in striving for excellence in addressing the basic health and development needs of Myanmar people.

[1] The core Evaluation Team consists of: Dr Greet Peersman (Health Promotion and Evaluation Expert, Team Leader and Lead for Key Area 1 and M&E system assessment); Dr Gillian Fletcher (Participation and Cultural Change Expert, Lead for Key Area 2); Anita Alban (Health Economics and Evaluation Expert, Lead for Key Area 3); Dr Phone Saing (Epidemiology and Health Programme Evaluation and Research Specialist); Dr Khynn Than Win (Epidemiology and Communicable Disease Specialist and Researcher).

EXECUTIVE SUMMARY

The US$136 million, multi-donor, Three Diseases Fund (3DF) (2006-2011) was established to reduce the burden of communicable disease mortality and morbidity for HIV/AIDS, Tuberculosis (TB) and malaria in Myanmar, targeted specifically to most in need populations. The Fund had a particular focus on people with limited or no access to public health services due to geographic or security constraints or because of discrimination based on factors such as ethnicity, gender, health or financial status. Up to the end of 2011, the 3DF awarded grants to a total of 34 Implementing Partners (IP) for 58 projects: 29 HIV (US$ 47 million); 15 malaria (US$ 25 million); 11 TB (US$ 16 million); and, 3 integrated projects.

Evaluation purpose and methods
The final evaluation of the 3DF aimed to document lessons learnt to inform future health funding and the evaluation of the Three Millennium Development Goal (3MDG) Fund. The evaluation focused on: What has been the impact of the 3DF, including who has benefitted? What has been the (positive or negative) influence of the 3DF on the operating context? and, Has the 3DF delivered value for money?

The evaluation covered the implementation period of the 3DF programme from mid-2007 until end-2011 and focused on the 3DF as a whole, not on individual IPs or projects. The 3DF was defined as: the management of the 3DF (Fund Board (FB) and the Fund Management Office (FMO)) and the 3DF programme network (IPs; Technical and Strategic Groups (TSGs); 3DF beneficiaries).

The Evaluation Team conducted two 3-week in-country missions in early 2012 and used a range of data collection methods including: desk review; key informant interviews, meetings, and workshops with 3DF FB, FMO, IP staff, beneficiaries, government staff and affected communities.

Key Findings

- **The 3DF reflects an impressive donor response in both scale and timing** considering the difficult local and international circumstances under which it was introduced and sustained. The ability to work with government partners and a wide range of IPs to deliver results was established early on and sustained throughout the 3DF implementation period.

- **After the Global Fund withdrawal from Myanmar, no single donor could have filled the gap in the way 3DF did** in terms of the extent of the scale-up of HIV, malaria and tuberculosis (TB) related services. The donor consortium and pooled fund allowed for shared risk management in the challenging political and operational context of Myanmar.

- **During 2007-2011, the 3DF has represented a large share of the national programmes in all three disease areas based on its funding contributions and its substantial service provision.** Without the 3DF, the health needs of thousands of Myanmar people would have gone unmet. The 3DF was the single largest contributor to all three disease areas in Myanmar during the period 2007-2011(compared to other funding sources). Overall, the 3DF contributed between about one third to two thirds of total national targets for the three diseases. The Fund also raised national awareness of the needs of marginalised populations such as sex workers, men who have sex with men and people who inject drugs.

- **The 3DF achieved its results with reasonable effectiveness.** However, questions arose during the evaluation in relation to the Fund's effectiveness in actual reaching, and engaging, those *most* in need. A deficit approach to programming, focusing on health deficits rather than assets, was common among IPs supported by the 3DF (with a few

mentionable exceptions). The skills, resilience and knowledge of community members were not utilised to the fullest extent possible.

- **3DF effectiveness was hampered by a lack of coherent articulation** of strategy, definitions, and programmatic logic.

- **Overall, the 3DF positively influenced the overall operating environment for the humanitarian response in Myanmar.**
  - The 3DF represented a major vehicle for provision of aid to Myanmar that was profoundly needed, particularly in the context of the Global Fund withdrawal;
  - Use of the pooled fund mechanism enabled donors to share the very real political risks arising from provision of aid to Myanmar;
  - The importance of the existence, survival, and growth of the 3DF within a complex and highly challenging environment cannot be over-estimated; and
  - The effectiveness of the 3DF also significantly contributed to the case for Global Fund return to Myanmar. The 3DF proved that it was possible to deliver aid in Myanmar. In addition, members of the FB and Donor Consortium actively advocated for Global Fund return

The following areas for improvement were found, in relation to the operating context:
  - The 3DF operated on a mainly reactive basis, rather than proactively and consistently seeking to positively influence the operating environment in order to increase effectiveness;
  - The 3DF's use of a competitive grant mechanism (while understandable in the first instance, given the conditions of 3DF initiation) constrained overall effectiveness in terms of coherent impact in areas, and for groups of people, *most* in need;
  - The 3DF did not proactively seek to ensure relevance of Fund-supported work to those most in need; and
  - The 3DF lacked a consistent, clear and widely understood definition between FB and FMO responsibilities in determining the ways in which Fund money is used to support and operationalize National Strategic Plans (NSP), via IPs.

- **Everyone involved acknowledged that the governance structures of the 3DF did not represent an 'ideal' way of doing things** but, rather, were a pragmatic response to challenging internal and external pressures.

- **Cost-effectiveness analyses point to value for money of 3DF interventions.** However, the analyses are limited by important data availability and validity issues and a number of programmatic issues related to the targeting, and implementation of, prevention and treatment programmes.

- **Overall, the 3DF has contributed to enhanced relationship-building and partnership.**
  - The 3DF succeeded in gradually developing relationships of trust with national programme staff inside the Ministry of Health (MoH), despite an initial climate of distrust arising from the Global Fund withdrawal; and
  - The 3DF also contributed to partnership-building within the health development sector in Myanmar through the TSGs. In addition, the partnership engendered between donors through joint involvement in the 3DF has extended into partnerships leading to the Livelihoods and Food Security Trust Fund (LIFT), the Joint Initiative on Maternal, Neonatal and Child Health (JIMNCH), and now the 3MDG Fund.

- **Round 2 represented a significant moment in aid funding for Myanmar.** Throughout the evaluation, participants acknowledged this as the first time in the country that a major

donor focused on providing funds directly to local non-governmental organization (LNGOs)/ community based organizations (CBOs). However, 3DF programming and Monitoring and Evaluation (M&E) did not sufficiently acknowledge, allow for, or build on, the different strengths and characteristics of LNGOs/CBOs compared to international NGOs (INGOs) or international organisations. In addition, there was no systematic follow up on LNGOs/CBOs at the end of the 3DF.

- **3DF M&E focused mostly on reporting for accountability purposes. Insufficient attention was paid to learning and using data for programme improvement** (e.g., best practice application, ensuring reaching those 'left behind').
  - There was no systematic approach to implementing the intent stated in the Description of the Action with regards to operational research and programme evaluation. This has resulted in limited understanding of beneficiaries' needs and experiences, implementation context, and the effectiveness of different programme approaches/components;
  - Experience-sharing between IPs improved over time but was not sufficiently focused on the improvement of the quality of IP services/interventions; and
  - Lack of a 3DF definition or strategy in relation to capacity development means that there is no set point against which the Fund's achievements in relation to capacity development, and impact on the operating environment, can be evaluated.

Recommendations [for the 3MDG Fund & other health/development initiatives]

1. Clear articulation of a Fund's strategy, definitions, and programmatic/M&E logic is essential to enable effective and relevant practice both by the Fund itself, and by IPs (whatever the context of initial Fund implementation).
   1.1 Once established, Fund-specific strategies, definitions, and overarching programmatic logic should be reviewed regularly and maintained or adapted. Contractual expectations of IPs should be made explicit and should be in direct relation to the defined strategies, definitions and programmatic logic. This would allow for clear recognition of the different strengths and characteristics of LNGOs/CBOs, and a clear articulation of a rationale for funding them.

2. Use a funding model that enables the Fund to have a more proactive and consistent, positive influence on the operating environment (including the civil society environment) and on provision of effective services to those most in need. A commissioning model[2] would seem most appropriate, given the operating context. Such a model would further reinforce the aforementioned defined Fund strategy, definition and programmatic logic. It would also allow for development of a more coherent M&E system, focused on continual improvement against a clear framework for analysis, learning and adaptation of interventions as a result of data arising.
   2.1 Calls for proposals should include requirements for effective M&E, and requirements for clarification of processes to be used to ensure community participation and effective targeting of services.
   2.2 Provide direct funding to LNGOs/CBOs for reasons of ownership and sustainability although the rationale for doing so (and the anticipated outcomes) needs to be clearly stated. Resources should be set aside for ensuring that the specific strengths of LNGOs/ CBOs are identified and best utilised; and that necessary capacity is built for M&E. Mentoring, rather than one-off training, would be the best way forward (both in terms of M&E and in terms of identifying and building on LNGO/CBO strengths).
   2.3 Make requirements for an exit strategy part of the contract; thereby building sustainability into the programme from the start.

[2] To buy specified services or other support of credible organisation(s) which has/have an established track record/comparative advantage in addressing the identified need.

3 Support the establishment of structures that proactively promote and support on-going learning, innovation and adaptation (rather than on mechanistic accountability).
   3.1 Set aside a small pool of money (e.g. 1% of the total budget) for operational research (OR) and its dissemination in the health services. Commission qualitative research in order to better understand the socio-cultural dynamics of all three diseases.
   3.2 Greater learning from communities is needed. Support meaningful participation at all levels and increase asset-based approaches, rather than deficit-based ones.
   3.3 Establish mechanisms and relationships that support transparency in performance as a key principle underlying service delivery with regards to beneficiaries and service quality, effectiveness and efficiency. Set aside resources for regular experience-sharing through annual review meetings, topical workshops, opportunities for joint problem-solving and other focused learning activities.
   3.4 To support continued documentation and application of lessons learnt, invest in appropriate and effective knowledge management mechanisms based on available technologies and global/regional experiences.

4 Clearly define and support greater FMO involvement in operational decision-making and ensuring service quality and effectiveness. Redefine the role of the FB in implementation-related decisions and consider establishing an independent technical oversight body with detailed technical knowledge of the programme areas including M&E and which can provide maximum responsiveness to the programme needs.

5 The FB should take advantage of recent political developments in Myanmar and its unique position as a national trust fund to promote the operationalization of the NSP principles regarding access to services for marginalised populations such as injecting drug users (HIV), prison populations (HIV and TB), and migrant workers (malaria) and others.
   5.1 This includes: advocacy related to Non-Governmental Organisation (NGO) access to areas with greatest need; enhanced coordination and cooperation; MoH system-strengthening; and, an enabling environment for service access and social change.

6 Provide direct support for strengthening national M&E systems in close coordination and collaboration with other donor-supported programmes as there are shared needs for data, data analysis and data use for more effective strategic and operational planning and increased impact of programmes.
   6.1 This includes continued support for the TSGs with a clearly defined programme of work in terms of: technical oversight for strengthening national M&E systems; funding for specific surveys and special studies as per clearly defined schedules and procedures; support for integrated analyses; and support for evidence-informed strategic planning, resource allocation and programme improvement. TSGs need to be supported with strong and consistent technical assistance.
   6.2 National M&E system-strengthening should be coordinated and harmonised between all donors under the leadership of the TSGs and relevant data from donor-supported programmes should be shared with the national M&E system.

7 To sustain the positive effects of 3DF investments, it is paramount that the 3MDG Fund builds on the work carried out, and lessons learnt, from the 3DF.

SYNOPSIS

The Three Diseases Fund (3DF) was an US$136 million multi-donor fund (2006-2011), which aimed to resource a programme of activities to reduce transmission and enhance the provision of treatment and care in HIV/AIDS, tuberculosis and malaria for the most in need populations. The final evaluation focused on the 3DF as a whole and investigated the impact of the 3DF and who has benefitted; the influence of the 3DF on the operating context in Myanmar; and, 3DF value for money.

The 3DF has provided a large share of the funding for the national programmes to prevent and control all three diseases. Without the 3DF, the health needs of thousands of Myanmar people would have gone unmet. The 3DF supported substantial service provision including:

- More than 30,000 sex workers, 16,000 men who have sex with men, and 13,000 people who inject drugs were tested and received HIV test results and a large number of condoms and needles was distributed; more than 34,000 sex workers and more than 13,000 men who have sex with men received treatment for sexually transmitted diseases.
- In 2011, about 22,000 persons received AIDS treatment; and, almost 54,000 people received community home-based care. The number of people living with HIV involved in self-help groups increased more than 4-fold over the 3DF period.
- 3DF-supported implementing partners were responsible for identifying about 41,000 new tuberculosis cases each year and treatment success was above 85% each year.
- The distribution of long-lasting insecticidal bed nets increased from about 24,000 in 2007 to more than 400,000 in 2011; and, the number of bed nets re/treated increased from 43,000 in 2007 to more than 370,000 in 2011. In 2010, almost 400,000 households had at least one bed net from 3DF.
- Over 730,000 rapid diagnostic tests for malaria were used by trained village workers, general practitioners and at health facilities in 2011. The number of confirmed and probable malaria cases treated in 3DF project areas increased to more than 600,000 in 2010 and was just over 400,000 in 2011.

The 3DF also contributed to relationship-building and partnerships with the Ministry of Health at all levels and it was the first major donor who provided funding directly to local non-governmental organisations and community-based organisations to help provide HIV, tuberculosis and malaria services.

However, more can be done in terms of:

- Reaching those most vulnerable and most marginalised;
- Using the skills, resilience and knowledge of community members for better services;
- Supporting affected communities for more meaningful participation at all levels;
- Sharing good practices and supporting research to improve service quality;
- Building the capacity of all partners for more effective and efficient service delivery;
- Improving the availability, quality and types of data;
- Influencing the operating environment to ensure service delivery to those most in need.

1 BACKGROUND

Myanmar faces major health challenges. The National Health Plan 2006-2011 prioritized 42 diseases and health conditions among which AIDS, TB and malaria were ranked as the top three. While the disease burdens for malaria and TB are higher, AIDS was ranked as the top priority given its public health importance and political concern, as well as its potential high socio-economic impact (MoH 2006). In addition to extreme underfunding of the health sector, the under-provision of Overseas Development Assistance (ODA) is considered insufficient to make significant impact on the major health problems.

The 3DF was an US$136 million (2006-2011) multi-donor fund supported by a consortium of seven donors (see Technical Paper IV for relative contributions). The 3DF was established in October 2006 with the overall goal to reduce the burden of communicable disease mortality and morbidity of HIV/AIDS, TB and malaria. Support aimed to target those most at risk, with particular focus on people with limited or no access to public health services due to geographic or security constraints or because of discrimination based on factors such as ethnicity, gender, health or financial status.

The 3DF was established as a competitive fund. Since its inception, the 3DF has awarded grants to 34 IPs for 58 projects: 29 HIV; 15 malaria; 11 TB; and, 3 integrated projects. The allocation of 3DF resources was based on the priorities of the national plans and directed at strengthening service delivery by UN agencies, International Non-Governmental Organisations (INGOs), and LNGOs/CBOs.

The intent of Round 1 funding was to ensure continuation after the termination of the Global Fund, carry-over of Fund for HIV/AIDS In Myanmar (FHAM)-supported services, and to expand services, especially for at-risk populations. The intent of Round 2 funding was to include LNGOs and CBOs with the rationale that they would be better able to provide services for hard-to-reach areas/ populations. The intent was also to strengthen their capacity for addressing health issues in their communities. Round 3 funding was aimed at scaling up services taking into consideration programmatic and operational realities and needs.

Myanmar is beset by a complex operating environment that is inevitably affected by shifts in the political environment. Until recently, the delivery of aid to Myanmar met with concerted opposition from groups who argued that such aid supports the military regime. [3] As a result, even donors who focused their support on addressing key challenges of the most vulnerable populations in Myanmar have faced intense scrutiny from lobbyists. The 3DF operated within the confines of the European Union Council Decision on Myanmar[4] and according to the guiding principles for the Provision of Humanitarian Assistance[5] set out by the United Nations (UN) Resident Coordinator. The 3DF cooperated with the MoH through the TSGs and through decentralised cooperation with local civilian administrations, but no direct funding was provided.

In February 2006, prior to 3DF start-up, the Foreign and Economic Relation Department of the Ministry of Planning published formal *Guidelines for UN Agencies, International Organisations and INGOs/NGOs* which require all organisations be registered with the Ministry of Planning. A period of uncertainty followed, in which renewals of INGO

[3] For example: Union Aid Abroad: APHEDA (the overseas humanitarian aid agency of the Australian Council of Trades Unions) stated that 'the Australian Government provides aid to Burma in cooperation with the Burmese military regime' (APHEDA, 2011)
[4] As stated in the Terms of Reference for the 3DF Final Evaluation: Under the EU Council Decision, non-humanitarian aid or development programmes are suspended, apart from exceptions made in the case of projects and programmes in support of "*health and education, poverty alleviation and in particular the provision of basic needs and livelihoods for the poorest and most vulnerable populations*". It is foreseen that "*programmes and projects should be implemented through UN agencies, non-governmental organisations and through decentralised co-operation with local civilian administrations*".
[5] In particular:(i) timely and reliable access for project implementation and monitoring; and, (ii) respect for the international humanitarian principles of humanity, neutrality and impartiality.

Memoranda of Understanding (MoU) were delayed and field work was affected. Throughout the 3DF implementation period, distinct political events (such as public demonstrations, internal conflict, elections) increased public tension and affected trust relationships and work/travel permissions. In the wake of Cyclone Nargis in May 2008, closer collaboration with key development agencies started to develop. With the multiparty elections in November 2010 and the formal transfer of power from military rule to the new government in March 2011, a gradual move towards improved international relationships begun.

External political risks (e.g., relationships between the government of Myanmar and donor governments; pressures from lobby groups) which may have influenced funding levels as well as the very existence of the 3DF were closely monitored and strategies were put in place to pre-empt or counter them. Strategies were also agreed for management of: internal political risk (e.g., government decisions which may constrain 3DF activities); programme development risks (i.e., constraints to a sound programme approach); fund management risks (e.g., capacity of the FMO); and, implementation risks (e.g., flow of resources).

2 EVALUATION FOCUS AND METHODS

The evaluation objectives were:
1. To assess the 3DF for relevance, effectiveness, efficiency, impact and sustainability.
2. To conduct robust in-depth analyses to support the evaluation conclusions:
   - *Key Area 1.* What has been the impact of the 3DF?
   - *Key Area 2.* What has been the influence of the 3DF on the operating context?
   - *Key Area 3.* Has the 3DF delivered value for money?

The evaluation focused on the 3DF as a whole (rather than on individual IPs or individual projects or interventions) including the management of the 3DF (FB, FMO) and the 3DF programme network (IPs, TSGs, 3DF beneficiaries).

The evaluation covered the implementation period of the 3DF programme from mid-2007 until end-2011. The influence of the 3DF (both positive and unintended negative effects) on the operating context was assessed, as well as the influence of the operating context (both facilitating and constraining factors) on the 3DF programme implementation and results.

The Evaluation Team conducted two 3-week in-country missions in early 2012 and used a range of data collection methods including: desk review; and key informant interviews, meetings, and workshops with 3DF FB, FMO, IP staff, beneficiaries; government staff and affected communities.

See the Inception Report and Annex 2 for more details on the evaluation questions and methods to address them.

The following important limitations of the evaluation should be noted:
- The evaluation took place after 3DF funding had ended for most IPs. Certain key staff, volunteers, beneficiaries and field sites were therefore unavailable for the evaluation.
- The 3DF-supported IPs are not the only service providers in the targeted geographic areas. The evaluation did not include a mapping of all providers and services.
- The 3DF-related indicators for progress reporting by IPs underwent changes over time; 2007 baseline data were lacking and data quality issues were noted.
- The 3DF performance framework did not include behavioural outcome indicators.
- The evaluation did not cover an assessment of the mix and quality of services provided by IPs.
- The evaluation did not include an assessment of each IP.

As a result:

- The trend analysis of 3DF indicator data should be interpreted with caution.
- The establishment of a counterfactual and the direct attribution of any observed changes in disease-level indicators to the 3DF programme is not possible; the lack of intermediary behavioural outcome indicators also affects the extent to which 3DF output data can plausibly be linked to disease impact. However, an estimate of the contribution of the 3DF programme to disease impact based on 3DF funding inputs is provided.
- The lack of information about service mix and quality – known factors influencing programme effectiveness, efficiency and impact, hinders the extent to which the findings can be explained and value for money can be determined.
- IP-specific recommendations are not provided.

3 EVALUATION FINDINGS

3.1 Evaluation Findings according to the OECD-DAC Evaluation Criteria

3.1.1 Relevance

Relevance to the national disease control programmes

The 3DF played an important role in supporting the development of TSGs for each of the three diseases, through its support for UNAIDS and WHO. The TSGs, chaired by a representative from the MoH, are responsible for development of disease-specific NSPs, National Operational Plans (NOPs) and budgets. Every disease has a current NSP. HIV has a current NOP, while the malaria and TB NOPs do not appear to have been updated since the 2006-2010 versions. The TSGs are also intended as fora for partner discussion and lesson learning; informants reported that the best practice in relation to discussions and learning occurred within the various Working Groups set up under the HIV TSG. The HIV M&E Working Group is of particular interest in that it is making some headway on issues related to research and the challenges of research ethics clearance processes. Evaluation informants were in agreement that the HIV TSG (with UNAIDS as Secretariat) is the most effective. The malaria TSG (with WHO as Secretariat) is the least effective. WHO also operates as the Secretariat for the TB TSG.

3DF support made evidence-based NSP planning possible, through support for, *for example*, the HIV Sentinel Surveillance Survey, the 2009-2010 national TB Prevalence Survey, and the publication of operational research in the National TB Report. In addition, the Fund supported the development of the Myanmar Artemisinin Resistance Containment (MARC) strategy framework for Myanmar.

One of the key foundational elements of the 3DF, as initially identified in the *Description of the Action* (2006) and as noted during the evaluation by current and former FB members, was alignment with the national programmes for all three diseases. Indeed, Result 1 of the overall Fund as stated in the *Description of the Action* was: ‘Funds allocated in line with FB policies and priorities in response to the three diseases operational plans’. The *Description of the Action* added that there would be ‘consistency of the 3DF resource allocation with the FB priorities and with the National Programme priorities’ (2006: 17).

Activities supported by the 3DF were broadly in line with those proposed in the NSPs: behaviour change communication (BCC) that utilises some form of peer or community-based education (for all three diseases); early diagnosis and provision of treatment and care (for all three diseases); and, disease-specific activities such as distribution of long-lasting insecticidal nets (LLINs), distribution of condoms, needle exchange. Treatment protocols are in place, and the evaluation found that 3DF work was broadly in line with national protocols for diagnosis, treatment and care of the three diseases.

A different picture emerged in relation to prevention. This appeared to be mainly a result of widespread poor practice: commonly used terms such as 'BCC' or 'peer education' are routinely used without any definition of best practice principles or processes (even within HIV prevention work, where BCC and peer education approaches are most widely used). There appears to be an assumption of pre-existing shared understanding, although it is well documented within the HIV prevention field that 'there is a known tendency towards mechanisation of the response - i.e. automatic repetition of programmes without review and evaluation of their effectiveness' (UNAIDS, 2007: 12).

In the NSPs for all three diseases, and throughout 3DF documents, BCC is used as a synonym for different channels of communication (e.g., mass media campaigns, awareness raising through pamphlet distribution, peer education) rather than as an overarching approach to behaviour change that might utilise different channels, in different ways, to influence different groups of people, regarding different behaviours, in different contexts. There is no definition of best practice processes for the development, and delivery, of different messages in relation to the communication channel used. *For example*, 'peer education' is used throughout 3DF materials and the HIV NSP, without attempts to define the key pedagogic processes. This issue will be returned to in the following section. In relation to malaria, the NSP 2010-2015 (MoH: 2010) makes reference to a 'framework for BCC activities' titled *Communication and Social Mobilization for Malaria Prevention and Control in Myanmar,* but this document was not available to the Evaluation Team so could not be assessed.

One area of difference between the NSPs and 3DF implementation relates to identification of most-at-risk populations. 3DF implementation was hampered by the lack of a clear - and consistently repeated - articulation of exactly who are considered the most vulnerable and why. Without this, projects and programmes easily become a set of generic, cut-and-paste activities that are not targeted or relevant to the specific context and need.

The single clearest, overarching articulation of Fund rationale, targeting, and approaches was provided in the 3DF *Description of the Action*. This document was explicit in identifying beneficiaries for 3DF-supported HIV work as '… including sex workers and their clients, migrant workers, intravenous drug users and TB patients'. The list of beneficiaries identified in the NSP at the time was more inclusive:

> … sex workers and their clients, men who have sex with men, drug users, partners and families of people living with HIV, institutionalized populations, mobile populations, uniformed services personnel, young people, individuals in the workplace and, more generally, men and women of reproductive age. (MoH, 2006: 3).[6]

By the time of the Fund's Round 1 Call for Expressions of Interest (EOI -2007), the gap between the Fund's expressed target populations and the NSP had narrowed. For example, specific mention was made of men who have sex with men, men and women who inject drugs and their partners, and men, women and young people in institutions that might limit their access to routine prevention programmes. This specificity on target populations had disappeared in the Round 2 EOI, to be replaced with generic references to 'poor and vulnerable people' and 'populations most at risk of being affected by any of the three diseases, especially those living in remote and inaccessible areas with limited or no access to public health services' (3DF, 2008: 2).[7]

In relation to TB and malaria, neither the Fund's *Description of the Action* nor the 2007 or 2008 EOIs identify specific population groups beyond the generic 'most at risk' or the requirement for work to be undertaken in a 'specific geographical area'. This is despite the clear articulation of specific population groups in the National (and Operational) Plans at the time—an articulation that has continued, and expanded, in the more recent NSPs for both

[6] MoH (2006). *Myanmar National Strategic Plan on HIV and AIDS 2006-2010, DRAFT 21st September 2006.*
[7] 3DF (2008). *Targeted Round 2 For Community-Based Organizations Call for Expressions of Interest (EOI)*.

diseases. The 3DF was not found to have expanded its articulation of the most at risk populations for these diseases.

The *National Operational Plan Prevention and Control of TB in Myanmar (2006-2009)* identified its primary target groups as:

> TB patients living among all population sub-groups in the country including in hard-to-reach townships and in border areas, ethnic minorities who live in these areas, migrants, those with HIV/AIDS, their families and partners, child contacts of HIV and TB adults, prison populations, drug users, partners of people who inject drugs and their families (addressing their needs in order to prevent TB/HIV) and the community at large. (MoH, 2006: 8).[8]

Secondary target groups were also identified:

> … all Basic Health Staff and community volunteers, National Tuberculosis Programme (NTP) and National AIDS Programme (NAP) staff at all levels of the programme, participating public and private sector providers including NGOs, health staff of other ministries and the social security services who will be trained and will participate at all levels in planning, implementing and monitoring the delivery of Directly Observed Treatment (DOTS) services including TB-HIV and DOTS-plus services. (ibid)

The *National Strategic Plan for Malaria (2006-2010)* defined one of the 'guiding principles for malaria prevention and control in Myanmar' as adoption of a 'people-centred public health approach, focused towards the most vulnerable populations', then described the need to 'reach out to populations in remote areas where malaria is highly endemic as well as to other high risk groups such as migrant workers, forest related workers/settlers, pregnant women, young children and the national races in border areas' (MoH, 2006: 10).[9]

The Union of Myanmar Malaria Prevention and Control National Operational Plan Fiscal Years 2006/2007 to 2008/2009 was also explicit in terms of target populations, stating that it would:

> … benefit populations at risk of malaria particularly the high risk groups that include mobile populations in search of economic opportunities (e.g. forest-related workers, miners, workers in development projects, plantation workers), upland subsistence farmers, settlers in the forest or forest fringes, and the national races living in remote endemic areas particularly along the borders' (MoH, 2006: 2).[10]

As far as relative funding levels for each of the three diseases is concerned, the following can be noted: based on the relative disease burdens, HIV was during 2006-2010 by far the area with the highest mortality rates per year. However, this picture changed when the 2009-2010 TB Prevalence Survey was conducted. The study found a much higher (i.e. three times) TB prevalence and mortality rates than previously estimated which brought the TB disease burden to a similar level as HIV. The malaria fatality cases are generally vastly underestimated but still far from the mortality rates for HIV and TB. Direct funding for HIV programmes reflected 53% of the 3DF resources 2007-2011; the second largest proportion was allocated to malaria (not least for distribution of bed nets) while TB received only 18% of the 3DF funding share. Retrospectively, and from a disease burden perspective, more attention and resources to TB could have provided a more optimal mix of resources for the three diseases not least for the area of HIV-TB co-infection, which has the highest mortality rates amongst TB patients.

Relevance to those most in need

The conditions for development of the 3DF were less than ideal. At the time, Myanmar was a restrictive environment for donors, INGOs and LNGOs. Despite the contextual and political

[8] Ministry of Health (2006). *National Operational Plan Prevention and Control of TB in Myanmar (2006-2009).*
[9] MoH (2006). *National Strategic Plan for Malaria (2006-2010, Myanmar)*.
[10] MoH (2006). *The Union of Myanmar Malaria Prevention and Control National Operational Plan Fiscal Years 2006/2007 to 2008/2009.*

pressures, the Fund was explicit in stating that it would serve those most in need, and explicit in describing desired beneficiaries. The *Description of the Action* made specific mention of 'poor and excluded groups (including groups excluded on the basis of religion and sexuality)', 'those from ethnic minority groups (whether living in their home States or elsewhere)', and states that 'Target populations living in remote and inaccessible areas will be prioritised for services, as will high risk behaviour groups' (2006: 6-7).

The *Description of the Action* was also explicit in noting an existing dearth of knowledge in relation to 'the social dimensions of these three diseases' for those most in need populations and intended to enhance its response to those populations by strengthening this knowledge base:

> Under the guidance of the Fund Board, the Fund Manager will: commission work to strengthen the knowledge base - accumulating evidence and understanding of the social components of the three diseases … These research elements will aim to deepen understanding of the social dimensions of the 3 diseases and could include research in the following areas: gender norms on sexuality and power relationships in different communities (ethnic and religious) and their influence on behaviour and ability to protect against HIV-infection; socio-economic factors influencing HIV; malaria and TB vulnerability; socio-economic consequences, and gender differences therein, for people infected and affected by HIV/AIDS, TB and malaria; gender differences in stigma & discrimination of PLHA; and ethnic dimensions of the three diseases. (2006: 11-12).

All of the above indicates a commitment to ensuring that activities supported over the existence of the 3DF be highly relevant to the needs of those most in need in relation to HIV, TB and malaria. The evaluation found several examples of good practice in targeting, and reaching, those most in need, as well as good practice in ensuring that project implementation was relevant to beneficiaries.
For example:

- The 3DF enabled several IPs to begin, or expand, activities in hard-to-reach areas of high need (e.g., Kachin State).
- Community-based DOTS activities were undertaken at the Myanmar-Thailand border, an area of great need; elsewhere, mobile TB detection and treatment teams contributed to expansion of TB programmes into previously un-served areas.
- Sixty percent of all money spent on preventing HIV among people who inject drugs - a key and, previously, largely under-served community - came from the 3DF.
- Some good practice in relation to active beneficiary involvement in projects was found (however these were offset by a larger number of examples of poor practice where the skills, knowledge and expertise of community beneficiaries were over-looked).
- The 3DF dramatically increased the availability of anti-retroviral therapy (ART) for HIV-positive people, including HIV-positive sex workers, men who have sex with men and people who inject drugs (although IP criteria for ART provision are a point of concern, as noted below).
- Round 2 funding is widely acknowledged as ground-breaking, for delivering funds directly to LNGOs/CBOs rather than via INGOs.
- The FMO introduced a Community Feedback Mechanism for CBOs who received grants; there was also an attempt to introduce a Beneficiary Accountability Mechanism for INGOs and LNGOs (however neither of these mechanisms were found to be functioning effectively.

However, the evaluation found the following points of concern in relation to the 3DF's relevance to those most in need:

The FB, and consequently the FMO, did not ensure that technical quality in field work practice was either clearly defined, or *contractually required,* of IPs, and this reduced the overall relevance of 3DF work in relation to those most in need.[11]

For example:

- The final 3DF Stakeholder Satisfaction Survey January-December 2011 (2012) reported that IP respondents felt that 'more efforts could be made to reach the more vulnerable population groups, which would improve the overall disease response' (Focus Point Research Team, 2012: 22), and added a list of suggestions made by IPs for reaching these groups. These suggestions include:
  - 'Better define "Vulnerable Population Groups" (VPGs) with the consensus of all the partners for each disease from the following perspectives: social, financial, disease nature;
  - Identify specific VPGs in each geographical area;
  - Identify appropriate measures for each VPG depending on the local context; and,
  - Improve ownership of VGs. Develop strategies so that at the end of projects VPGs can sustain benefits and improve livelihoods rather than become "dependents" (medium term or long term)' (Focus Point Research, 2012: 23).

  In relation to this last suggestion, one community participant in the Yangon evaluation workshop stated: 'INGOs, LNGOs … don't respect community involvement. In future, peers must be involved in all processes, even the M&E process. So, please set up donor criteria about meaningful peer involvement from the grass-level up to the central level. We are recognised in words but not in reality. For the long run, we get worn out and exhausted'.

- Lack of effective integration and understanding of a gendered analysis at FMO and IP levels and throughout various stages of project design and management including calls for EOIs, EOI assessment, reporting and field work has resulted in the following:
  - Gender is limited to service uptake or provision by men and women (measured by collection of sex-disaggregated data). One programme for people who inject drugs established a 'women's space' without evidence of specific existence of, or needs of, female drug users. Other IP representatives declared that they had no 'gender issue' because the majority of their caregivers are female.
  - Gender appears to be treated as an afterthought, rather than an embedded component to analyse and address gender-based differences in disease burden, treatment-seeking and treatment access, and risk behaviours for *each* of the three diseases. The *3DF Gender Mainstreaming Handbook* (2008) (which is apparently only available in English) was not known at an IP level and has not been operationalized. It is heavily focused on gender equality rather than on exploration of, and responses to, gendered stereotypes and the impact they have on health.
  - Attempts were made to initiate more in-depth responses to gender by partners under Round 2, but these attempts appear only from late 2010 when the FMO commissioned a *Gender Issues Survey* related to the transmission, prevention, care and treatment of the 3 diseases of Round 2 IPs, and developed a concrete follow-up plan for integrating the findings into project design' (GDI, 2010: 2).[12] The report offered a thoughtful analysis of gender issues in relation to the three diseases; for example, in relation to malaria:

    > The study also explored malaria control as a question of the meaning of gender issue as men suffered from malaria more than women while IPs who are working on malaria would like to focus on women more as they understood gender as women concern.

[11] The specific aspects of technical quality most relevant here are: existence of a clear programme logic and evidence base connecting programme activities and operations to the realities faced by target communities in relation to the three diseases; demonstrably delivered to those most in need.

[12] Gender and Development Initiative (2010). *Gender Issues Survey Report*.

> The report concluded with an action plan that included: 'Provide project-contextually designed gender awareness and mainstreaming training to project management team as well as to operational staffs from IPs', and 'Develop appropriate gender integration action plan (GIAP) for and by the IPs' (GDI, 2010: 77).[13] A two-day gender mainstreaming workshop for Round 2 partners was run by GDI in November 2010, but the workshop agenda allocated just over one hour to the development of IP action plans.

The issue of ensuring gender mainstreaming in programming is complex and challenging. Long-term, incremental, reflective learning processes need to be embedded in programmes from the initial problem analysis and design phase, yet the 3DF did not place any such requirements on IPs, beyond requiring IPs to refer to gender in their EoI. A review of the successful EoIs for Round 1 demonstrated that the attention paid to gender was cursory at best and, in some cases (particularly with malaria partners), completely missing. Examples of gender analysis that were found included the following (uncited, to preserve IP confidentiality):

> All male and female participants will benefit equally from the project since the project will include awareness-raising education for equal reproductive rights of both genders. Moreover, during the need assessment process of PLHA through PLA exercises, both male and female should have equal position and have been considered for support activities, thus both genders will be included in the project plan.
>
> According to the case notifications … the proportion of males to females is 2:1 which is in line with the character and epidemiology of the disease with more men developing active disease than women. A large number of Basic Health Staff are indeed women and the majority of DOTS providers and TB outreach workers are drawn from amongst housewives and social workers and less privileged members of the society, both men and women.

The lack of depth of these analyses, combined with the lack of attention paid to gender in relation to malaria (despite it being recognized as an issue in the NSP) lends strong support to the statement made by one participant in the Yangon evaluation workshop: 'I don't think people understand about what we should do about gender'. The intersections between gender and sexuality (especially in relation to sex workers, transgender women and men who have sex with men) remained unexplored and under-utilised in programme approaches.

- IPs make repeated claims of undertaking **'**behaviour change communication' work, yet data shows that this work is, predominantly, basic bio-medical, repetitive, health education, built on a deficit approach to programming. Centuries-old beliefs regarding TB and malaria were simply countered by telling people that their beliefs were wrong, and with regular re-presentation of bio-medical information. In relation to HIV prevention, sex workers, men who have sex with men, people who inject drugs, and people living with HIV (identified as 'in need' under the HIV NSP) are repeatedly given the same information on modes of transmission and means of prevention. Representatives from networks of sex workers, men who have sex with men and people who inject drugs who participated in the evaluation repeatedly stated that their knowledge and skills were both under-estimated and under-utilised). As noted by community representatives in one of the evaluation workshops:

  > 'We get the same kind of health education session about 1,000 times from different organisations and it is boring. They all tell us about condom use, and give a condom demonstration, tell us about HIV and Sexually Transmitted Infections (STIs); how they are transmitted, how they can be prevented.'
  >
  > 'Don't just talk to us or tell us what to do, but start from the community experience and real needs.'

[13] ibid.

A similar point can be made in regards to so-called 'self-help groups' (SHGs), few of which demonstrated evidence of active control by community beneficiaries themselves. The dominant model was one in which the IP controlled the timing, location, and content of SHG meetings and where the focus was, again, one of health education. The one IP among those visited during the evaluation that countered this trend, faced a minimum 50% cut in funding for its work following the end of the 3DF. This IP actively engaged sex workers in genuine BCC based on real-life experiences and discussion-based approaches and the sex workers did have control of SHG finances, decision-making and activities.

- There was no evidence of IPs being *required* to undertake (or to have previously undertaken) local needs assessments/mapping of communities in order to ensure that services were delivered to those most in need.[14] The *National Strategic Plan Malaria Control Myanmar 2010–2015* is unequivocal in its focus on the needs of internal migrants and the gendered nature of malaria infection (with males heavily over-represented, presumably because of work practices). A similar focus was also to be found in the preceding NSP, as previously discussed. Yet the evaluation found that, on the whole, IPs delivered services to officially-registered village households, working via village leaders, and usually during the day time when those present were 'mainly women and old men'. Village leaders do not include internal migrants within household counts, due to lack of local registration. Thus, if the migrants received nets at all, it was *after* the official village households (regardless of the existing bed net ownership within villages). The existence of, and the specific needs of, internal migrants were not given priority, despite the fact that they frequently live in malaria-prone sites, are extremely poor, have limited access to health services, and are likely to contribute to the movement of malaria. In general, resources were not effectively targeted to those most in need.

- In 2009, Myanmar Positive Group (MPG) undertook research that found: 'due to … criteria, some of those people who are in real need do not get [ART] … these criteria do not fulfil the purpose they were written for'. In 2012, criteria used by some 3DF IPs potentially exclude those most in need. *For example*, the English version of one set of criteria contained no less than 12 strongly worded patient requirements including: 'Willing to generate own income', and 'To strictly follow rules and regulations, guidelines set by implementing agency and donor'. The organisation that applied these criteria provided only 16 out of 50 allocated ART regimes in 2011. There was little evidence that IPs had themselves even considered the need to find innovative ways of *responding* to issues that affect ability to adhere for those most in need, such as economic mobility, remoteness, or transportation problems. The FMO could have played a major role in enforcing a review of criteria and supporting development of innovative responses, provided a clear mandate was provided from the Fund Board to this effect.

<u>The Fund as a whole did not succeed in its stated aim to 'deepen understanding of the social dimensions of the 3 diseases'; an aim that, if fulfilled, would have increased the relevance of Fund activities to those most in need.</u> *For example*:

- The evaluation found that 3DF-supported interventions continue to treat HIV, TB and malaria as simple medical conditions that exist outside of socio-cultural and power structures. Sex workers, men who have sex with men and people who inject drugs continue to be treated as if they are homogenous groups whose needs, experiences and existing resilience is already understood. Assumptions are made and opportunities for enhancing the relevance of interventions are lost. Where IPs themselves had undertaken promising small-scale research (e.g. International Organisation for Migration (IOM)'s research into the use of malaria repellents), there was no evidence of the

[14] There were notable exceptions to this. For example, two malaria IPs were explicit in their targeting within villages and sought to ensure that the needs of internal migrants were served. However, there were no clear systems either for the sharing of this good practice with other IPs, or for encouraging (or requiring) other IPs to adopt such approaches.

findings being formally shared or promoted across other IPs by the 3DF. The Evaluation Team acknowledges the issues related to official research ethics clearance.[15] Nonetheless, information *does* get shared in Myanmar and the FB/FMO should have been proactive in promoting the sharing of information that was directly related to increasing the relevance of Fund activities to those most in need. It is a finding of the evaluation that such sharing of information was hampered by the Fund's governance structure, and by the vacuum created in relation to effective, implementation-focused information management and technical knowledge sharing. This would have been in line with the Fund's stated desire to support the NSPs; for example, the *National Strategic Plan Malaria Control Myanmar 2010 – 2015* stated that there is need for operational research into 'innovative vector control methods and strategies to protect migrant and forest-related workers in view of the current low Insecticide-Treated Net (ITN)/LLINs coverage level among this at risk population' (MoH, 2010: 28).

Fund processes were not flexible enough to respond to the rapidly changing situation in conflict areas, resulting in most vulnerable people often being left under-served.
This issue is discussed in the effectiveness section below.

3.1.2 Effectiveness

Evidence for the 3DF Fund's effectiveness includes:

- During the complex and challenging start-up phase, there was an impressive, coordinated, donor response under difficult local and international circumstances after Global Fund withdrawal. This is true for both the scale of the Fund and the speed at which it was established.

- Donor support increased over time, in a large part due to the attractiveness of the sharing of political risk between donors. This established that it was possible to engage with the Myanmar administration, yet avoid formal support to the regime. The success of the pooled 3DF directly contributed to the development of the US$250-300 million 3MDG Fund as well as other pooled fund initiatives outside of health. The effectiveness of the 3DF also significantly contributed to the case for Global Fund return to Myanmar. The 3DF proved that it was possible to deliver aid in Myanmar. In addition, members of the FB and Donor Consortium actively advocated for Global Fund return.

- Overall, practical working relationships with the government and a wide range of IPs were achieved. Given the fraught working environment, especially at the start of the 3DF, the importance of this achievement is not to be underestimated. Several current (and past) FB members, plus FMO staff members, attested to the on-going uncertainty of the early days. Central to the establishment and improvement of these relationships over time was advocacy and personal networking undertaken by both the FB and the FMO.

- Having the Fund Manager in-country helped with understanding local implementation challenges and allowed for good responsiveness from the FMO. Several interviewed IPs mentioned this as a major advantage of 3DF over Global Fund (the Geneva-based Secretariat which is responsible for grant disbursement is far removed from the day-to-day realities). While the FMO was, overall, perceived to be approachable and supportive, IPs also mentioned variation in the quality of the working relationships with the FMO. *For example*, one IP noted in the Client Satisfaction Survey (2012):

  'There are different views. LNGO and INGO should be treated as the same. LNGO staff need be respected. Instead of treating IPs as their employees, they should be accepted as partners who are performing the missions with efforts.'

[15] The Fund Board also noted difficulties in discussing research with the Myanmar government in the early years of the 3DF in relation to sensitive topics such as sexuality and sexual behaviour.

- Overall, the FMO provided good procurement services. Procurement of goods and services via the 3DF FMO has been possible since 2007. The big INGOs and UN organisations had their own procurement facilities, but FMO support for medium-sized NGOs and especially for the less-resourced CBOs included in Round 2, was critical for programme implementation. The FMO Procurement Unit extended its staff with a pharmacist to assist IPs with ordering medical supplies and also provided training on supply chain management. The amount of money allocated for procurement increased over the lifetime of the 3DF from US$268,873 in 2007 to US$2,984,137 in 2011; the average lead time was around 6 months. The proportion of long-term agreements (LTAs) diminished over time due to tendering of large quantities of LLINs and sufficient time available to do so (see Table 1).

Table 1 3DF procurement types and values (US$) 2007-2011

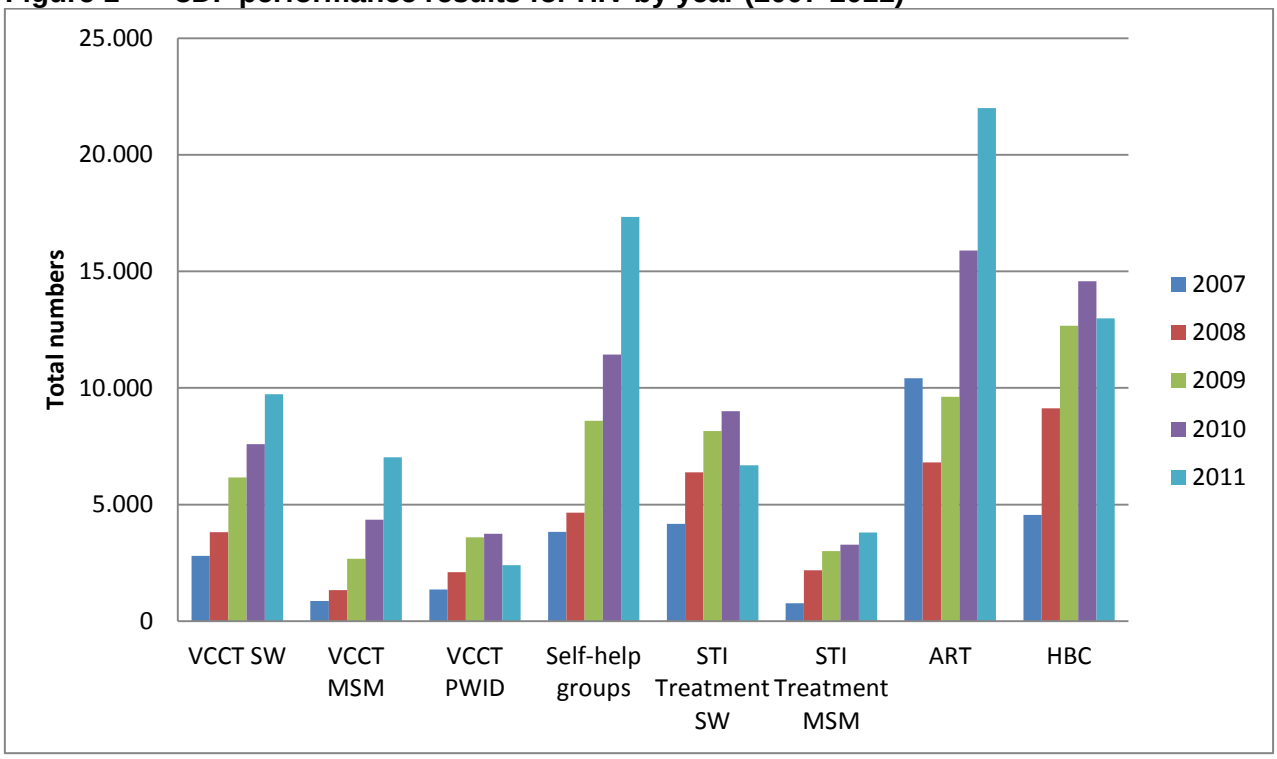
	2007	2008	2009	2010	2011
No of purchase orders	7	34	103	55	58
Value of procurement	268.873	678.285	1.022.572	1.140.516	2.984.137
Average lead time	6.4 Months	6.9 Months	5.5 Months	4.6 Months	5.8 Months
% of order value through LTA	100%	68%	89%	97%	33%
No of partners	1	11	19	18	19

LTA: Long term Agreements

- Overall, 3DF-supported services were significantly scaled up and utilised over time; most programmatic targets were achieved or over-achieved. However, it should be noted that achievements against set targets are difficult to interpret.

- Figure 1 provides the performance indicators for HIV-related services:
  - Over the full 3DF implementation period, more than 30,000 sex workers, more than 16,000 men who have sex with men, and more than 13,000 people who inject drugs were tested and received HIV test results. Performance assessment against set targets indicated over-achievement of targets (except one) for all at-risk population groups for 2009, 2010 and 2011. While the number of sex workers and men who have sex with men treated for an STI increased, targets for these groups were under-achieved;
  - ART treatment was provided to 10,418 persons in 2007 reflecting an impressive number for the first year of the 3DF programme. In 2011, 22,001 persons were receiving ART through 3DF-supported services. All IPs achieved the threshold target of minimum 85% survival rate 12 months after initiation of ART, which reflects good quality ART provision; and,
  - The number of people living with HIV involved in self-help groups increased more than 4-fold since the start of the 3DF.

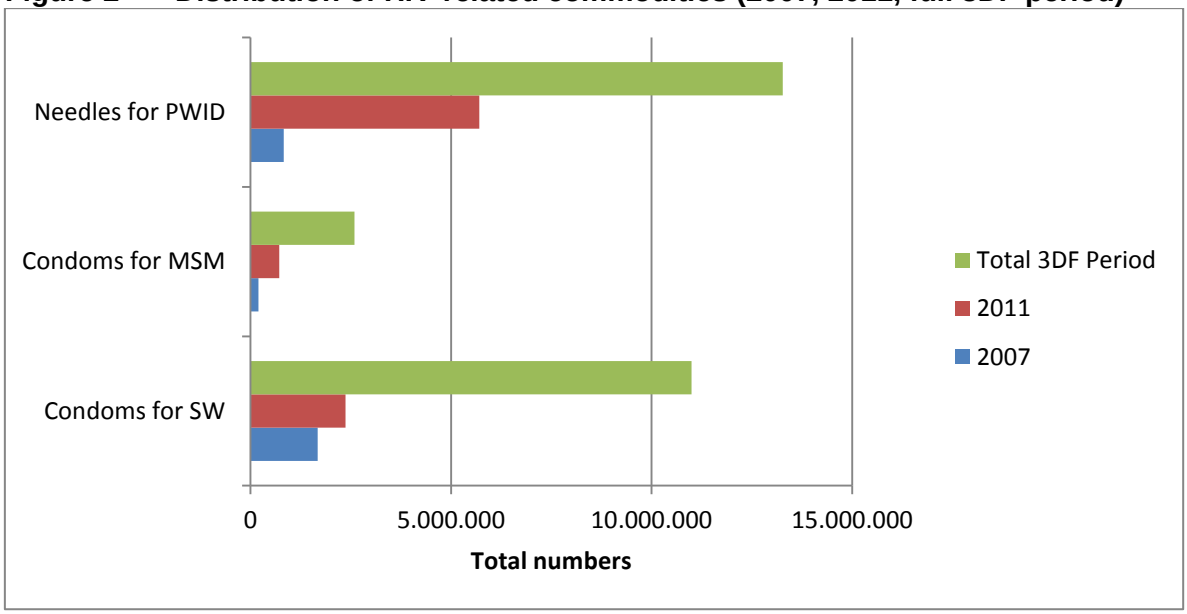
Figure 1 3DF performance results for HIV by year (2007-2011)



Note: 2007 data represent part year data only.

- Figure 2 reflects the performance indicators on the distribution of HIV-related commodities:
  - Numbers of condoms distributed to sex workers over-achieved targets, but condom distribution to men who have sex with men remained below target in 2009 and 2010. Number of needles distributed to people who inject drugs increased almost seven-fold by 2011.

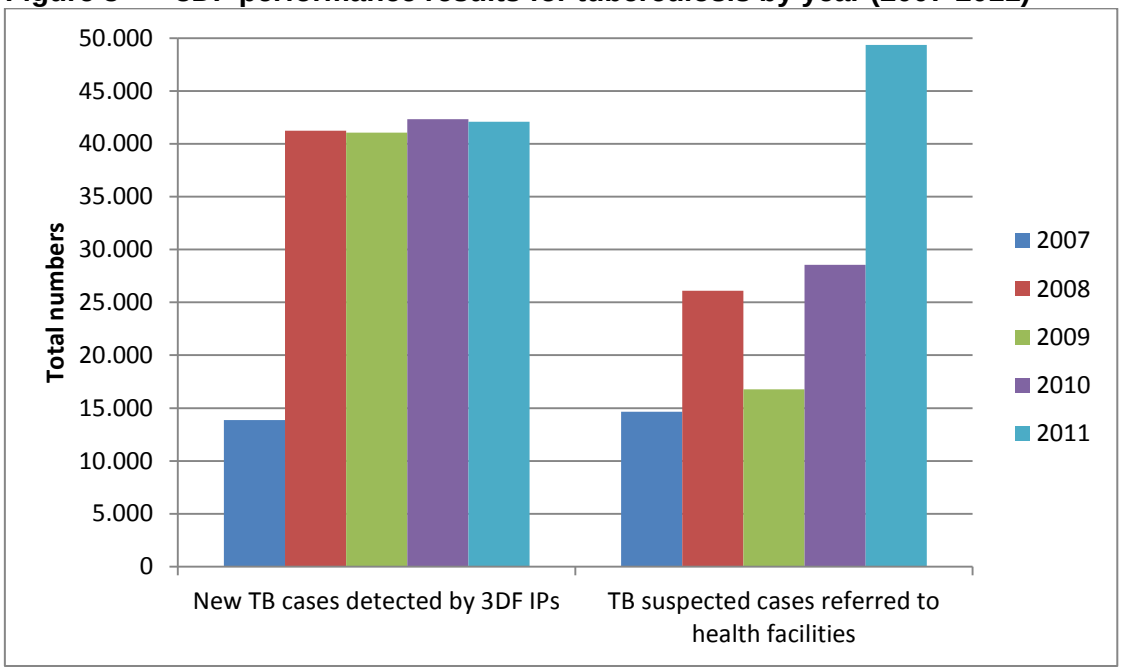
Figure 2 Distribution of HIV-related commodities (2007, 2011, full 3DF period)



Note: 2007 data represent part year data only

- TB performance results (Figure 3) include:
  - The 3DF-supported IPs were responsible for identifying on average 41,681 new TB cases each year;
  - The number of TB suspected cases referred to health facilities were substantial but remained below 80% of the target in 2009 and 2010. IPs noted that TB patients prefer to seek a one-stop service for both diagnosis and treatment from the Township TB centres than receive diagnosis at the decentralized facilities that do not provide treatment. In 2011, the referral targets were over-achieved (123%); and
  - TB case detection rate was good (range 87%-94%) and treatment success was – on average, above 85% (i.e., the global expected minimum target; although success rate for HIV/TB co-infection was lower representing an area of concern) each year.

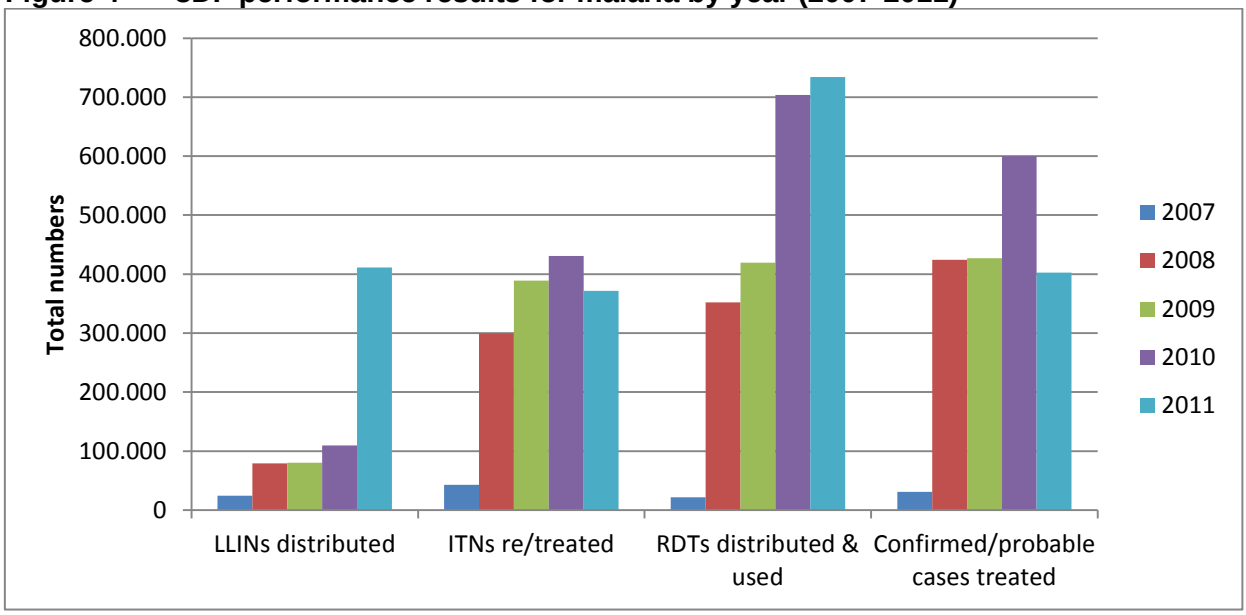
Figure 3 3DF performance results for tuberculosis by year (2007-2011)



Note: 2007 data represent part year data only

- Malaria performance results (Figure 4) include:
  - In 2010, almost 400,000 households had at least one bed net from 3DF in 2010; however, some problems with correct data collection were noted by the 3DF M&E team;
  - There was an impressive scale-up over time of key malaria activities: the number of distributed LLIN reached more than 680,000 over the 3DF period; the number of ITNs re/treated by 3DF increased more than 8 times during the project life; rapid diagnostic tests (RDTs) increased from almost 22,000 in 2007 to more than 730,000 in 2011; and
  - Numbers of confirmed and probable malaria cases treated in project areas in 2011 (reflecting an under-achievement) were much lower than the 2010 numbers (which reflected a 113% achievement).

Figure 4 3DF performance results for malaria by year (2007-2011)



Note: 2007 data represent part year data only

Challenges which may have affected 3DF effectiveness[16] include:

- There was no formal follow-up by the FMO (or other mechanism) on the quality of services (such as BCC, provision of home-based care, self-help groups for people living with HIV) which may directly affect the effectiveness of the 3DF programme. This is also a key issue of concern in the cost-effectiveness analyses of the 3DF programme (see below and Technical Paper IV).

- The issuing of one-year contracts hindered longer-term vision/planning by IPs which affected a strategic, phased approach to programme implementation. Initially, there were too many contract amendments which took both time and effort, but the FMO alleviated some of these constraints through the introduction of yearly budgets. There was the occasional example of perception (and experience) of a lack of flexibility in, and delays resulting from, 3DF systems.
  For example, an IP that was undertaking work in an under-served area of Kachin State faced a situation where the villagers from nearly all of their 3DF-sites became internally displaced due to conflict. Rather than face the time it would take to get a contract amendment to work in 'new' sites to address the higher-than-ever level of need among people with whom they had already worked under 3DF, the IP looked to other funding sources for assistance. As one informant from the IP explained:
  > 'Because we would not get the contract amendment from 3DF in time, we could not use 3DF money. There was no condition that we could use [our budget] in emergency response and with ID persons; we are only meant to work in our target area. We did not think of asking the 3DF … Other donors, we say 'there is this problem, can you help us?' … they say 'prepare the concept note, prepare the budget and submit'. We feel like the 3DF is very strict … we can submit for a revised budget, but it takes so much longer than with other donors.'

  Despite some notable exceptions, flexibility was, overall, acknowledged as a feature of the 3DF:
  > 'The flexibility of 3DF response was acknowledged and recognized by several partners as a real comparative advantage. In debating future support to the sector, it was reaffirmed that this flexibility is seen as necessary to be able to respond to

[16] These challenges may not only affect effectiveness, but also the level of efficiency and ultimately the extent of impact achieved by the 3DF programme.

specific strategic gaps or emerging threats.' (FB Aide Memoire on the Annual IP Review Meeting, December 2010:1).

- Despite overall good procurement practices by the FMO, supply problems still occurred which may be due to lack of appropriate planning and/or lack of ability to mitigate any emerging problems (especially by CBOs). There was, however, impressive problem-solving at the implementation level through regular meetings, informal relationships and 'borrowing' of commodities when supply problems arose, but no systematic approach of the FMO for identifying and following up on implementation problems.
  At the three evaluation workshops, a number of procurement-related issues came up:
  - It took a long time before Standard Operating Procedures (SOPs) were developed;
  - There were delays in procurement through WHO and in delivery through the government system;
  - Fund transfer delays were experienced, which resulted in delays in transportation of essential drugs; as a consequence, some drugs arrived near the end of the 3DF project and could not all be used;
  - Many IPs experienced a gap between 3DF and Global Fund support, especially in procurement of drugs for opportunistic infections (OI) when 3DF ended April 2011. Although these problems cannot be directly ascribed to the FMO, they were perceived by IPs to be a Fund responsibility; and,
  - There have been problems with the capacity of the Central Medical Store.

  Various health programmes including the 3MDG Fund are dependent on an effective procurement and logistical public system. In order for the 3MDG Fund to be effective and efficient, strengthening of procurement systems including medical store management have to be ensured.

- The timeliness of corrective action, where needed, was sometimes hindered by the requirement for approval by the FB and by lack of authority and the restricted mandate of the FMO. There were also delays in funding disbursements which were due to extensive time taken to resolve specific reporting issues also including issues considered non-significant. Other examples were encountered of situations where the Fund's relevance and effectiveness could have been enhanced by making better use of the technical expertise available in the FMO.

- It should be noted that there were several challenges to 3DF programme effectiveness and efficiency due to the specific context of Myanmar, *for example*:
  - The negotiation of MoU for INGOs and the requirement of local-level approval for LNGOs/CBOs to work remained a challenge throughout the 3DF implementation period. It was also noted that obtaining approval at national government level did not automatically translate to local authority approval of work plans or target areas. Throughout the 3DF implementation period, IPs had to face complex and shifting circumstances regarding where they could work. That they continued to work despite these challenging circumstances is a credit to all IPs. Nonetheless, local authority permission is still often withheld in relation to the most remote, conflict-affected and under-served areas (particularly in Kayin and Kachin States);
  - Inaccessibility of certain areas due to conflict. However, there are good examples of innovative responses to the challenges of working in conflict zones; and
  - The Donor Consortium requirement that humanitarian funds may not be provided to the central government or transferred directly to government-owned accounts, referred to as the zero cash flow, necessitated the development of a Flow Fund Mechanism (FFM) in September 2007. The FFM channels funds for interventions implemented in the public sector at the Township level and below. It makes direct payments to intended recipients and the day-to-day management is the responsibility of WHO.

Over the past four years (September 2007 – August 2011), a total of US$3,187,600 has been channelled through the FFM. The financial mechanism works with three modes of resource allocation: (1) direct disbursement that constituted 73% of total resources and included training events, workshops, planning and surveys that are paid at sites by the associated WHO 3DF financial clerks; (2) re-imbursement that constituted 27% of total resources and included supervision, monitoring, drug transportation, data collection, meetings, travel expenses and living allowances; and, (3) advance payments (since 2009 and to a much lesser extent: 0.1% of total allocation). The FFM has, since its start, been "work in progress" towards a robust and cost-effective mode of operation. Especially re-imbursements have been a challenging area.

The FB has, on several occasions, raised questions about the efficiency of the FFM and in 2010 an independent review was carried out (Dalton 2010). One of the key problems of re-imbursements identified by Dalton was the absence of a tracking system for managing claims. The managerial focus was on accuracy and correctness of financial figures and documentation but with little sensitivity to timeliness. The review recommended that process indicators be established for monitoring and reviewing the internal FFM process; the SOP to be implemented and translated into Myanmar; decentralization of field financial clerks; pilot cash advancement system; and establishment of one FFM in the health sector.

Based on the review in 2010, an improvement plan was outlined. The FMO supported improvements by agreeing with WHO to hire two additional staff, one of which dedicated to collecting data for more accurate reporting on indicators. The FMO also financed the international travel cost of one of the Regional Office Staff who conducted the internal assessment of the WHO/3DF office. A workshop in February 2012 showed that many of the recommendations from the 2010 review had been accommodated. These included: implementation of core indicators from Q1 2011; process indicators since end of 2010; dissemination of SOP including sensitization at decentralized levels; and, the implementation of an electronic platform facilitating financial transactions. The decentralization of the field finance clerks showed that 80% of all direct disbursements happened where they were stationed. However, the integrated work plan did not materialize due to work load in connection with co-planning with Global Fund; the pilot projects introducing cash advance payments could not be implemented due to Township resistance based on a perceived increase in administrative work load.

The evaluation workshops in three States showed that the reimbursements amongst public staff still give rise to dissatisfaction with the FFM and underperformance in the health system giving rise to supervision, monitoring and data collection not being carried out because of delayed payments (public staff salaries do not allow for waiting more than a month for US$50-100). In the Lashio workshop, the government participants noted:

> 'There are delays in disbursements which can take from three up to eight months requiring staff to pay out of pocket. The WHO system for reimbursement is very bureaucratic and Basic Health Staff often does not understand the system or do not know how to fill out the required forms and thus, do not apply for reimbursement (and so do not get their money back). As a result, there is reduced motivation and ownership of the programme'. Out-of-pocket figures for supervision meetings were given as between 3-9 lakh per month.

Some of this may also be due to claims not being sent within one month of the activity. According to the newly established indicators for re-imbursements, only 40% of claims were received within a month of the activity; while 68% of claims were

handled within a month by the FMO in the last half of 2011, the FFM is still 32% away from target.

System-strengthening of the FFM remains an issue to be taken into account for the 3MDG Fund. This includes “One Flow Mechanism” as suggested by the review in 2010 (Dalton 2010) under the Country Coordinating Mechanism (CCM) with a Coordinated Health Fund Supervisory Fund. Currently, Global Fund operates with a similar design as 3DF but with its own finance clerks and various IPs in Myanmar have other (more efficient) fund flow systems which the 3MDG Fund could tap into or cooperate with. In the past two years, 3DF disbursed more than US$1 million per year through the FFM – it cannot afford not to try all opportunities to improve FFM services and decrease transfer costs. New possibilities to cooperate with the Myanmar Government might also open in the coming year to assist in fulfilling this agenda.

3.1.3 Efficiency

Cost-effectiveness of interventions

Cost-effectiveness analyses of HIV, TB and malaria interventions supported by 3DF has been used to assess if the US$136 million invested during 2007-11 has been Value for Money (VfM). Although 3DF provided more than US$4 million in 2006, the programme did not take off until 2007 when the first of three rounds of grants became active. Since its inception, the 3DF has awarded grants to 34 IPs for 58 projects (29 HIV; 15 malaria; 11 TB; 3 integrated). The money disbursed to the three diseases have included US$47 million for implementation of HIV activities (approximately half to ART and half to prevention activities for sex workers, men who have sex with men, and people who inject drugs); US$25 million for malaria activities, and US$16 million for TB activities. On average, 50% of all external funding for the three diseases during 2007-2011 has come from 3DF. This is a remarkable achievement in itself for a national-based Trust Fund.

The focus of the cost-effectiveness analyses within the HIV field has been on targeted prevention interventions. Only one cost-effectiveness analysis has been performed for TB and malaria, respectively. Thus, the evaluations of TB and malaria are including a package of prevention/detection and treatment interventions while the analyses of interventions for sex workers, men who have sex with men, and people who inject drugs represent one prevention package including harm reduction. For more details of the individual cost-effectiveness analyses, see Technical Paper IV.

The results of four of the cost-effectiveness analyses (i.e., all HIV-targeted interventions and the malaria interventions) use Disability Adjusted Life Years (DALYs) as the outcome measure and WHO’s thresholds for ‘cost-effective’ and ‘very cost-effective’ interventions. In the case of Myanmar, a DALY should not cost more than the national Gross Domestic Product (GDP) per capita of US$702 (2011) to be ‘very cost-effective’; for interventions to be ‘cost-effective’, they should be within the range of US$702 and 3-times the GDP per capita of US$2,106. The cost-effectiveness analysis of TB interventions used a different outcome measure recommended by WHO: cost per person cured. Cost-Saving (C-S) threshold refers to HIV averted to make the interventions cost-saving even at low ART coverage. The overview of cost-effectiveness results are shown in Table 2.

Table 2 Cost-effectiveness of HIV, TB and malaria interventions

Intervention	Not cost-effective	Cost-effective	Very cost-effective	Cost-saving
FSW			C/DALY 70	
MSM				
IDU		C/DALY 852	C/DALY 371	
TB			USD 138 per cured	
Malaria	?	C/DALY 1256	C/DALY 499	

Notes: FSW=female sex workers; MSM=men who have sex with men; IDU=injecting drug user

Overall all 3DF investments in the selected interventions represent value for money. However, the malaria data are of sub-optimal quality which makes the results highly questionable since they build on assumptions and guestimates.

Both sex worker and men who have sex with men interventions are cost-saving interventions when savings on ART per HIV averted during 2007-11 are considered – despite the fact that only 26% of people living with HIV in need of ART were provided with ART. However, the analysis of interventions for people who inject drugs shows that there is little prospect of these interventions becoming cost-saving even at 80% coverage (and savings) of life-long ART for each HIV averted. The HIV cost-effectiveness analyses (CEA) use primary unit cost data from Myanmar and the results of the Asia Epidemiological Model (AEM) (Brown and Peerapatanapokin 2004) used in Myanmar, which provides incidence data per year (HIV estimates and Projections 2010-2015, AEM Myanmar 2012). The analyses evaluate changes over the period 2007-11.

The results of the CEA of interventions for sex workers show that it costs US$928,000 over 2007-11 to cover an additional number of 18,488 sex workers and the cost per HIV Infection Averted (HIVA) is US$1,444 and measured in DALY is US$70 (at a reduction of 250 HIV infections amongst sex workers). This result only considers the cost-effectiveness ratio amongst sex workers and is in itself within the very cost-effectiveness range for Myanmar. However, in the literature, sex workers (SWs) and their clients are regarded as direct beneficiaries of sex worker interventions and HIVA and DALYs gained from both population groups should therefore count as one outcome. The Myanmar AEM (2011) shows approx. 1,350 HIVA for sex workers and their clients, which makes sex worker intervention cost-saving in the Myanmar context.

The results of the CEA of men who have sex with men show that it costs US$930,142 to cover an additional number of 27,454 men who have sex with men in the period 2007-11 and the cost per HIVA and DALY is cost-saving even at the low ART coverage rate of average 26%. This demonstrates clearly that –assuming that the men who have sex with men interventions reach men who have sex with men at highest risk - they are very good investments in the Myanmar HIV context and a key contributor to the fight against HIV.

The results of the CEA of interventions for people who inject drugs show that it costs US$1,483,825 to cover an additional number of 5,295 people who inject drugs in the period 2007-11 and the cost per HIVA is US$7,622-17,514 and cost per DALY is in the range of US$371-852. The US$371 per DALY is within the very cost-effectiveness range, while the US$852 per DALY is within the cost-effectiveness range. The analysis concludes that scale-up of services is very cost-effective or cost- effective.

The result of the CEA of TB interventions shows that it costs US$138 per cured case/person in 2010 (2012 was the latest available data). The costs of the programme are based on national figures of external and government funding. An estimate of patients' costs has been added to be able to compare the results from Myanmar with results from cost-effectiveness

studies elsewhere in the Asian region. The cost-effectiveness result from 2010 in Myanmar correspond very well with two identified cost-effectiveness studies from India and Pakistan using the same outcome measure. The main data sources used are NTP Reviews, the National TB Prevalence Survey Report (2011), and the yearly WHO Global Report on Tuberculosis Control (WHO 2008, 2009, 2010).

The cost-effectiveness findings on malaria interventions at US$499-1,256 per DALY have a lower validity than the analyses for HIV and TB interventions. The epidemiological data of malaria are assessed to be much more uncertain. The total cost figures have not been confirmed and unit costs for key interventions such as bed net provision and ACT have not been developed in Myanmar. Thus, the cost-effectiveness results of malaria interventions are built on a range of assumptions of mortality and decreases in mortality over 2007-10 converted to DALYs and unit costs from studies in other countries. The data used for the CEA of malaria interventions include the Malaria NSP 2010-2015, the WHO World Malaria Report (2009, 2010) and a recent review of cost and cost-effectiveness of malaria control interventions (White et al. 2011).

The learning from the cost-effectiveness analyses leaves an unfinished agenda for the HIV field on scale-up of interventions for people who inject drugs and a number of suggestions for operational research. The most urgent research gaps identified are: the need to study the effectiveness and efficiency of the clients of sex worker programmes and how to improve the coverage of people who inject drugs including the issue of service provision by IPs in terms of targeting people who inject drugs versus non-injecting drug users.

The TB programme is in transition since the case finding has increased dramatically during 2007-11. An urgent need revealed by the analysis is to improve the HIV-TB treatment effectiveness and efficiency. The malaria response needs to focus on capacity-building support including assistance for systematic collection of data including cost and effectiveness data.

Across the three diseases, individual IPs work with different implementing approaches. Greater attention needs to be paid to assessing the quality of services provided and the effectiveness and efficiency of different approaches to guide the way forward in the fight against HIV, TB and malaria in Myanmar to improve value for money.

If resources for HIV, TB, and malaria are limited in the 3MDG Fund financial portfolio, two priorities are recommended: (1) support operational research on the right mix and scale-up of approaches for people who inject drugs and non-injecting drug user interventions to support best use of external resources (perhaps extra resources are needed for scale up if the next period of the Global Fund Round 9 does not provide sufficient resources to make a difference); and, (2) substantial support to the malaria response to establish an improved routine data collection system supported by operational research in order to identify the most efficient approaches in the Myanmar context. Assessment of the quality of services provided and the quality and use of data collected should be built in as routine practices by IPs.

Other issues that may have affected efficiency

Apart from the administrative issues related to contractual arrangements, procurement and the FFM addressed above, the following issues may have affected programme efficiency:

- An ad-hoc versus holistic approach to addressing the three diseases: Basic Health Staff and IPs involved in community-based work as well as community members identified the disease-specific focus of the 3DF is problematic in terms of time and resource efficiency and effective community engagement.
- The 3DF supported coordination and collaboration (formal and informal) aimed at avoiding unnecessary overlap in services and providing effective referrals to services not available on-site: Community members noted that as a result of the 3DF, they are now invited to national-level meetings (e.g., TSGs). However, there was also a feeling from

some that such involvement was, in effect, little more than lip service as opposed to genuine community participation. Official Township-level coordination and collaboration mechanisms were generally seen as useful in relation to problem-solving; while HIV-related meetings happened regularly, TB and malaria meetings were mainly held in relation to the implementation of a specific TB or malaria campaign.

3.1.4 Impact

Disease-level indicators

- There are positive trends in the HIV epidemic: HIV prevalence has continued to decline over the past number of years in sex workers, men who have sex with men and people who inject drugs. As measurements have improved over time, the decline in absolute terms is not as important as the fact that the downward trend has been consistent. However, it was noted by the 3DF M&E team that the decline in HIV prevalence in men who have sex with men over the period 2009-2011 may be due to sampling bias and that a repeat survey is required.

- The National TB Prevalence Survey 2009-2010 revised the estimated TB burden upward due to improved data collection and TB case detection. The prevalence of TB more than tripled from 169 per 100,000 population in 2008 to 598 and 613 per 100,000 population in 2009 and 2010, respectively. The mortality rate increased from 13 per 100,000 population in 2009 to 41 per 100,000 population in 2010. The revised estimates make a valid trend analysis in terms of the impact of the national TB programme impossible at this stage as data are confounded by measurement effect. No data were available yet for 2011.

- The malaria death rate shows a steady decrease over time. The malaria morbidity rate in 2009 and 2010 was higher than in previous years. These figures are difficult to interpret over the lifespan of the 3DF and without additional information, as data quality is likely to be an issue. Overall, malaria-related mortality and morbidity have been decreasing in Myanmar since the 1990s, but it is widely acknowledged that there is substantial under-reporting[17]. No data were available yet for 2011.

3DF impact on disease burden

- The 3DF has been the dominant contributor to all three disease areas in 2007-11 compared to other funding sources (Table 3).

Table 3 3DF financial contributions (total amounts, relative percentage) to the national disease control programmes for HIV, TB and malaria

Programme Area	3DF contribution	
	Total US$	**as % of total national programme budget** [on average estimate]
Funding for HIV programmes	**46,079,502**	
– Targeted HIV interventions for SW	7,656,850	42%
– Targeted HIV interventions for MSM	5,599,710	49%
– Targeted HIV interventions for PWID	9,783,191	60%
– ART	23,039,751	55%
Funding for TB programmes	**16,491,813**	50%
Funding for malaria programmes	**25,098,475**	71%

Notes: SW=sex workers; MSM=men who have sex with men; PWID=people who inject drugs; ART=antiretroviral therapy

[17]Ministry of Health (2010). *National Strategic Plan for Malaria Prevention and Control*, *Government of the Union of Myanmar, 2010-2015*. Nay Pyi Taw: Government of the Union of Myanmar; WHO (2011). *World report on Malaria 2010.* Geneva: WHO.

- The 3DF contribution to the national malaria programme was estimated to be 71% on average, though this estimate was based on limited financial data.
- Based on the 3DF relative contribution to national output targets of select HIV services, it was found that, overall, the 3DF contribution to achieving the national targets increased over time and constituted at minimum about one third to at maximum about two thirds of the national targets (with the exception of STI treatment for sex workers). This analysis was restricted to certain 3DF indicators as national targets were not always available or were revised over time.

It can be concluded that, during 2007-2011, the 3DF has represented a large share of the national programmes in all three disease areas based on its funding contributions and its substantial service provision. Therefore, it can be concluded that the 3DF has been a dominant contributor to reducing disease impact in Myanmar. Without the 3DF, the health needs of thousands of Myanmar people would have gone unmet. Attention to the needs of marginalised populations such as sex workers, men who have sex with men and people who inject drugs has been particularly impressive. The 3DF has achieved this with reasonable effectiveness. However, it is not possible to judge to what extent the 3DF programme has succeeded in serving those *most* in need populations (see below).

Reaching intended beneficiaries

- Overall, it seems that the right 'generic' risk groups benefited from 3DF services, but the picture on 'those most in need' and, specifically, those 'poor and excluded' groups is far less clear. There were some examples of those most in need being left out altogether due to poor targeting or programme practice (see 'relevance' section). These 'negative' examples may well reflect isolated cases (although we do not know this for a fact) in what seems to be an overall impressive scale up of service delivery and people reached.
- Without additional information – mostly of qualitative nature, it is virtually impossible to make sound judgements about the extent to which intended beneficiaries were reached. Given the limited resources (which do not match the extensive health needs), pro-active identification, targeting and follow-up of intended beneficiaries should have been addressed as an essential component of the 3DF programme. While not reported in the 3DF annual reports, 3DF resources also supported HIV services for young people, men and women of reproductive age and persons in the workplace as part of Strategic Direction 5 to 10 of the NSP for AIDS. It is not clear to what extent, if at all, provision of services for these additional population groups resulted in less services for the key targeted population groups. Target-setting needed to take all of these issues into consideration but it is not clear to what extent this was done, if at all.
- A detailed analysis of 'beneficiaries reached' was hindered by the following challenges:
  - There were no explicit strategic guidelines and/or tools, which operationalized the target population referenced in the *Description of the Action* for identifying the needs of key populations or for appropriately targeting the intended 'most in need' populations with 3DF services (see the 'relevance' in this report);
  - While 3DF reporting guidelines required data to be reported by key population for relevant indicators these groups (and potential sub-groups within them) were not clearly defined. Because of the technical and practical difficulties of determining population size estimates, especially for most-at-risk populations, 3DF core indicators did not require establishing denominators thus coverage is not known
  - Sex disaggregation of 3DF results was not a given from the outset but only introduced after a 2009 M&E consultancy to determine 'whether it is feasible and useful to collate sex disaggregated data from all implementing partners' to be consistent with the 3DF Gender Strategy. The same consultancy was also commissioned to prepare 'recommendations on relevancy of establishing annual and overall target settings for 3DF' (Clary 2009); and,

- Targets were set to reach specified numbers of sex workers, men who have sex with men, and people who inject drugs with HIV-related services in addition to targets by age and sex (where appropriate) for malaria and TB interventions. However, as these targets were pre-dominantly set on the basis of available funding rather than on assessed needs and/or required service scale-up for achieving impact it is not clear how to interpret achievements against them.

Unintended results of the 3DF programme

The assessment of any unintended results (positive, negative) of the 3DF programme in the context of the final evaluation focused on the lives of beneficiaries and the influence of the 3DF on the wider Myanmar context.

- Responses from 3DF beneficiaries and affected communities provided some examples of challenges:
  - Service access and use: fixed quota for Voluntary Confidential Counselling and Testing (VCCT) resulting in some people being turned away; limited access to services (especially ART) in rural/remote areas; persisting discrimination among service providers and limited opportunities for discussions of health and related problems;
  - Appreciation for the opportunity to be involved in national planning processes (through the TSGs) but difficulties with effective participation due to limited technical capacity as well as unfavourable attitudes from some professionals involved;
  - Lack of meaningful community involvement: no real follow-up on community issues; peer educators in INGOs are not always from the community; grassroots-level involvement but not at higher levels such as management level of service providers; and
  - Reporting which does not always reflect the reality of what is happening, such as important gaps in addressing health needs. Worries about providing real feedback for fear that the 3DF programme may be cut.

- As part of the close-out of 3DF projects at the end of 2011, some IPs noted:
  - Some essential equipment (such CD4 count machines) had to be returned to the FMO rather than handed-over to public facilities in order to comply with the strict requirements of the 3D Fund vis-à-vis direct support to the government. This interrupted critical services for people in need[18]; and
  - There were several examples of non-continuation of services, especially at grassroots level, as they had not been moved over to other funding sources (see 'sustainability' in this report).

- Many of the unintended results tended to be in the realm of more intangible effects such as improved trust and more effective working relationships.

Could these unintended results have been foreseen and/or managed? Some of the issues noted above, such as discrimination of service providers towards most-at-risk populations are not a result of the 3DF programme. However, more pro-active identification of implementation challenges may have benefitted the 3DF programme overall. This could have been achieved through (*for example)*:

- FB/FMO providing more explicit requirements from IPs regarding quality of services and implementation and basic M&E for good programme management.

- The FB supporting a more comprehensive M&E approach to identify issues that may affect relevance, effectiveness, efficiency and impact of the 3DF programme.

[18] It should be noted here that the Fund issued a Guidance Note stating that while the ownership of assets could not be transferred to the government, partners could keep both equipment and commodities for use in on-going projects including UN agencies supporting public sector health service providers.

- The FB leveraging improving relationships to help push the envelope regarding the need for more evaluation and research as an example (see below) and for obtaining access to areas/programmes where there were implementation or other IP restrictions.

3DF impact on the operating context

Key findings include:

- The 3DF positively influenced the overall operating environment for the humanitarian response in Myanmar.
  - The 3DF represented a major vehicle for provision of aid to Myanmar that was profoundly needed, particularly in the context of the Global Fund withdrawal;
  - Use of the pooled fund mechanism enabled donors to share the very real political risks arising from provision of aid to Myanmar;
  - The importance of the existence, survival, and growth of the 3DF within a complex and highly challenging environment cannot be over-estimated; and
  - The FB and the Donor Consortium deserve credit for playing a major role in successfully advocating for the return of the Global Fund.

- Round 2 represented a significant moment in aid funding for Myanmar.
  - Throughout the evaluation, participants acknowledged this as the first time in the country that a major donor focused on providing funds directly to LNGOs/CBOs;
  - Inclusion of Round 2 is particularly laudable given the nature of the Fund itself: as has been noted, pooled funds can favour 'larger, "corporate" NGOs'.[19] In addition, the FB persisted with its plans for Round 2 despite stringent Government opposition that included withdrawal of visa for the then FM Chief Executive Officer. (External political pressure represented a 'pull' factor for R2 at the time of implementation); and
  - However 3DF programming and M&E did not sufficiently acknowledge, allow for, or build on, the different strengths and characteristics of LNGOs/CBOs compared to INGOs or international organisations. In addition, there was no systematic follow up on LNGOs/CBOs at the end of the 3DF.

- Overall, the Fund has contributed to enhanced relationship-building and partnership.
  - The 3DF, and in particular senior staff members within the FMO, succeeded in gradually developing relationships of trust with national programme staff inside the MoH, despite an initial climate of distrust and loss of face arising from the Global Fund withdrawal; and
  - The 3DF also contributed to partnership-building within the health development sector in Myanmar through the TSGs. In addition, the partnership engendered between donors through joint involvement in the 3DF has extended into partnerships leading to the LIFT, JIMNCH, and now the 3MDG Fund.

An important question for donors to address is: 'Would the observed changes have happened without 3DF resources?' We conclude that after the Global Fund withdrawal from Myanmar, no single donor could have filled the gap in the way 3DF did in terms of the extent of the scale-up of HIV, TB and malaria-related services. The donor consortium and pooled fund allowed for shared risk management in the challenging political and operational context of Myanmar.

As noted above, there are many challenges in assessing disease impact and the contribution of different stakeholders operating in the national disease control programmes.

[19] Giffen, Janice and Judge, Ruth (2010). *Civil Society Policy and Practice in Donor Agencies: An Overview Report Commissioned by DFID*. INTRAC.

3.1.5 Sustainability

The evaluation found that:

- At the end of the 3DF, the FMO provided a clear rationale and transparent criteria for extending the work of some IPs with the remaining 3DF resources. However, several IP field office staff noted during the evaluation field work (March 2012) that there was limited transparency regarding continued support for currently on-going 3DF activities. They had not yet been informed by their head office or the FMO if their activities were anticipated/ expected to continue after June 2012 when the extended 3DF funding period ends.

- The Risk Management Matrix explicitly mentioned two areas of specific 'sustainability' concern:

  'Does the Global Fund implementation remain on track to meet targets? And Is the successor fund to 3DF on track?

  Both areas were designated as 'high impact' areas and specific activities for risk mitigation included: 'Regular meetings with Global Fund Primary Recipients'; 'Ensure that 3DF projects are in sync with the Global Fund proposals including FMO proposal to provide transition
  costs of essential commodities'; Contingency planning on possible scenarios'; and, 'Regular communications with IP on successor fund'. (Risk Management Matrix 2012: 6)

  However, there was no explicit written exit strategy to ensure service provision is/will be continued under alternative funding sources. While most 3DF-supported activities have been/will be transferred, some critical gaps (e.g., blood safety, HIV surveillance) were noted by MoH staff and some community-based activities were discontinued. The FMO carried out two gap analyses in July-September 2010 including an analysis of 3DF IPs who were and IPs who were not transitioning to Global Fund funding[20]. For the latter, prioritization for allocation of remaining 3DF funding was proposed according to defined criteria. Specific follow-up, such as with LNGOs/CBOs who did not make the cut (or would be cut off from funding after 3DF closure) did not seem to have happened. In addition, it is problematic that on-going service provision and scale-up under Global Fund is based on 2009 levels of services and does not allow for additional scale-up. This has, for example, meant that it is not possible to expand or even maintain services for people who inject drugs to the level reached in 2011 by the 3DF. Such service gaps should be considered for funding under the 3MDG Fund.

- There was no tailored support to ensure sustainability of the still vulnerable CBO activities developed under the 3DF; instead, there were several examples of scaling down/closing services post-3DF support and of the direct negative impact that this scaling down/closure had on people's lives. *For example:*
  - In Lashio, Oasis—a community-established support group for HIV+ drug users—ran on a budget of just 12 million MMK/year (approx.US$15,000). The six volunteers did not receive any salary, but provided hospital- and home-based care for 214 people as well as running a meeting space that attracted weekly gatherings of 50+ people. Oasis succeeded in encouraging and enabling ART for about 190 out of their 214 clients. The group rejected basic health education but focused instead on shared problem-solving (an effective BCC strategy). Oasis Lashio stopped receiving 3DF, as a sub-recipient to UNODC, funding in April 2011 but had no alternate funding source. The volunteers continued to provide care and meet with peers in their own time, but when they met with 3DF evaluators they were depressed and frustrated. Oasis (Muse) closed completely after 3DF money ended.
  - Myanmar Anti-Narcotics Association (MANA) (Naung Mom) had been given a 6-month extension for its basic activities with people who inject drugs, but as of March

[20] Gap analysis for the three diseases. UNOPS, 30 Sept 2010.

2012, no money had been received at the field office. Staff members were working without salary, and the Project Manager had contributed a significant amount of his own money in order to keep activities going. At the time of the evaluation, none of the staff (and none of the drug users who used MANA's services) knew if the service would be able to continue in the future. The centre had been running since 2004 (first funded under FHAM).

- There are examples of good practice in planning for sustainability including:
  - IOM built an exit plan into its project design including income generation by the community to self-sustain activities (already operational during the project); and
  - Burnet had a weekly calendar for their exit strategy from the 3DF including ensuring smooth transition of patients to other treatment facilities and advocacy with the MoH.

  Few of the other IPs seemed to have an explicit strategy for increasing sustainability (and none was required to do so by the FB/FMO).

- Several IPs as well as government staff mentioned the need for addressing shortage of staff in the public sector as a general area of donor support, but also in relation to additional demands placed on government staff due to Fund activities.

- Some IPs expressed concern about the uncertainty of continued investments in order to sustain hard-won achievements such as in harm reduction for people who inject drugs, and the inherent tensions in applying a purely economic model of 'value for money' (i.e., differing perspectives on what is valued and whose values count).

- The FB and the Donor Consortium played a major role in successfully advocating for the return of Global Fund support in Myanmar.

3.2 Evaluation Findings related to the 3DF Monitoring and Evaluation System

The credibility of 3DF data is dependent on the quality of the 3DF M&E system. As the main purpose for conducting M&E is programme improvement, ensuring that the right data are collected, that these data are used for improving services, and that there is sufficient capacity to do so, were key issues assessed:

M&E capacity

- The 3DF management (FB/FMO) under-estimated the time and resources needed to establish a functional M&E system for the 3DF, especially within the context of limited M&E capacity in Myanmar. Corrections were made but early implementation of recognised good practices (regarding M&E budgeting, staffing levels and competencies, partnerships, strategic vision and operational planning, guidelines and tools, staged implementation, capacity-building) may have helped to avoid unnecessary challenges.
- There was effective technical support to the TSG on AIDS (M&E working group) through UNAIDS, this model should be considered for application to M&E in the TB and malaria TSGs.
- The wide range of IPs also represented a wide range of M&E capacity. The restricted mandate of the FMO and its limited M&E staffing hampered M&E capacity-building of IPs and the building of supportive relationships needed for M&E improvement.

Data availability and quality

- The FMO was successful in implementing data quality procedures for the standardised performance indicators in the latter part of the 3DF implementation period; both data quality and data management improved considerably. More can be done in terms of ensuring target-setting is based on actual needs (for improving the performance of individual IPs and the overall 3DF programme) and on integrated analysis (for programme planning and resource allocation).
- Laudable efforts were undertaken by the FMO to implement IP feedback (client

satisfaction survey) and experience-sharing between IPs and other 3DF stakeholders (annual review meetings). While these need further improvements, the 3MDG Fund should consider using and expanding on them. Effective knowledge management to support evidence-based decision-making should be implemented.

Balance of M&E for accountability and M&E for programme improvement

- 3DF M&E had a dominant focus on quantitative measures and reporting for accountability purposes (IPs to FMO; FMO to FB and donor consortium); a framework for accountability to beneficiaries was introduced but remained limited in scope.
- There was no systematic process for implementing the intent stated in the Description of the Action with regards to research. Similarly, there was a lack of attention to programme evaluation. This has resulted in limited understanding of beneficiaries' needs and experiences, implementation context, and the effectiveness of different programme approaches/components, thus constraining the 3DF in maximizing outputs and ultimately, programme impact. While the Myanmar context remains difficult for supporting research, there are examples from the TSG on AIDS and from LIFT that show important opportunities and progress. The FB and the donor consortium should use its relationships and leverage with the government to proactively advocate for needed research and evaluation studies.
- The full potential for M&E (using a range of data collection methods and data sources) as a tool for learning and continued programme improvement was under-valued and under-utilised. This compromised both the assessment of 3DF's relevance and impact and its ability for corrective action and adaptation where needed. There was also limited support for using data for programme improvement (e.g., best practice application, ensuring reaching those 'left behind').

CONCLUSIONS

- **The 3DF reflects an impressive donor response in both scale and timing** considering the difficult local and international circumstances under which it was introduced and sustained. The ability to work with government partners and with a wide range of IPs, and deliver results that mattered was established early on and sustained throughout the 3DF implementation period.

- **After the Global Fund withdrawal from Myanmar, no single donor could have filled the gap in the way 3DF did** in terms of the extent of the scale-up of HIV, TB and malaria-related services. The donor consortium and pooled fund allowed for shared risk management in the challenging political and operational context of Myanmar.

- **During 2007-2011, the 3DF has represented a large share of the national programmes in all three disease areas based on its funding contributions and its substantial service provision.** It can be concluded that the 3DF has been a dominant contributor to reducing disease impact in Myanmar. Without the 3DF, the health needs of thousands of Myanmar people would have gone unmet. Attention to the needs of marginalised populations such as sex workers, men who have sex with men and people who inject drugs has been particularly impressive. However, it is not possible to judge to what extent the 3DF programme has succeeded in serving those *most* in need. The 3DF has achieved its results with reasonable effectiveness.

- **Cost-effectiveness analyses point to value for money of 3DF interventions.** At the same time, the analyses indicate important data availability and quality challenges and a number of programmatic issues related to the targeting, and implementation of, prevention and treatment programmes. In order to sustain the investments made over the past five years, it is key that the 3MDG Fund enhances capacity-building of IPs working in HIV, TB and malaria and invests directly in national M&E system-strengthening.

- **The 3DF has positively influenced the overall operating environment for the humanitarian response in Myanmar.**
  - The 3DF represented a major vehicle for provision of aid to Myanmar that was profoundly needed, particularly in the context of the Global Fund withdrawal;
  - Use of the pooled fund mechanism enabled donors to share the very real political risks arising from provision of aid to Myanmar and set an example from which other pooled funding mechanisms were built;
  - The importance of the existence, survival, and growth of the 3DF within a complex and highly challenging environment cannot be over-estimated; and
  - The FB and the Donor Consortium deserve credit for playing a major role in successfully advocating for the return of the Global Fund.

- **Round 2 represented a significant moment in aid funding for Myanmar.**
  - Evaluation informants acknowledged this as the first time in the country that a major donor focused on providing funds directly to LNGOs/CBOs;
  - Inclusion of Round 2 is particularly laudable given the nature of the Fund itself: as has been noted, pooled funds can favour 'larger, corporate NGOs'. In addition, the FB persisted with its plans for Round 2 despite external political pressures;
  - However, 3DF programming and M&E did not sufficiently acknowledge, allow for, or build on, the different strengths and characteristics of LNGOs/CBOs compared to INGOs or international organisations. In addition, there was no systematic follow up on LNGOs/CBOs at the end of the 3DF.

- **Overall, the Fund has contributed to enhanced relationship-building and partnerships.**
  - The 3DF, and in particular senior staff members within the FMO, succeeded in gradually developing relationships of trust with national programme staff inside the MoH, despite an initial climate of distrust arising from the Global Fund withdrawal; and
  - The 3DF also contributed to partnership-building within the health development sector in Myanmar through the TSGs. In addition, the partnership engendered between donors through joint involvement in the 3DF has extended into partnerships leading to LIFT, JIMNCH, and now, the 3MDG Fund.

- **Despite recent changes in the political landscape in Myanmar, the humanitarian space cannot be taken for granted.**
  Issues related to INGO/NGO registration, and the (I)NGO Guidelines, will continue to present challenges in the foreseeable future.

- **Everyone involved acknowledged that the governance structures of the 3DF did not represent an 'ideal' way of doing things** but, rather, were a pragmatic response to challenging internal and external pressures.

- **3DF M&E focused mostly on reporting for accountability purposes. Insufficient attention was paid to learning and using data for programme improvement** (e.g., best practice application, ensuring reaching those 'left behind'). There was no systematic approach to implementing the intent stated in the Description of the Action with regards to operational research and programme evaluation. This has resulted in limited understanding of beneficiaries' needs and experiences, implementation context, and the effectiveness of different programme approaches/components, thus constraining the 3DF in maximizing outputs and ultimately, programme impact. Experience-sharing between IPs improved over time but was not sufficiently focused on the improvement of the quality of IP services/interventions.

The following areas for improvement were found, in relation to the operating context:

- **The 3DF operated on a mainly reactive basis, rather than proactively and consistently seeking to influence the operating environment positively in order to increase effectiveness[21].**
  - Opportunities for using the Fund's very real financial weight to leverage greater change in the operating context were not taken. At FB-level, the predominant view was that the level of risk management throughout the life of the Fund, while high, was needed (although individual FB members did raise questions of balance of focus between external political risk and internal risks to programme effectiveness). Informants from outside of the FB, however, offered the view that more should have been done to proactively influence the operating environment in order to increase impact. The 'firewall' and FFM were identified as particular Fund features designed for the purposes of external risk management that had a negative impact on implementation and impact. Granted these were put in place to facilitate donor funding in a context of political controversy, there was insufficient follow up by the FB, as the oversight body, on how these measures affected 3DF services and what could be done to overcome challenges;
  - None of this should be read to mean that the 3DF ought to have taken a directly confrontational position but, rather, that greater focus could have been placed on opportunities for innovation and change (at community, IP, Township, State, Division and national level) rather than on 'not rocking the boat';
  - On-going challenges in relation to local access and authority to work were mentioned time and again by evaluation informants, particularly in relation to work with those most in need. This was an area where IPs felt the FB could have worked to leveraged change (for example, through holding State-level advocacy meetings involving all IPs plus Fund senior representatives in order to emphasise the importance of the Fund as a whole and its connections to the national programmes); and
  - From an IP point of view, the relationship with the 3DF was seen by several as less of a partnership and more of a contractual relationship in which the main concern of the Fund (as determined by the FB, and implemented by the FMO) was to ensure IP accountability and procedural adherence. Given the challenging implementation environment in Myanmar, effective partnerships are particularly important to overcome implementation challenges.

- **The 3DF's use of a competitive grant mechanism (while understandable in the first instance, given the conditions of Fund initiation) constrained overall effectiveness in terms of coherent impact in areas, and for groups of people, most in need**.
  - A commissioning model[22] would have enabled the FB/FMO to create a coherent 3DF programme in terms of geographic and target community coverage and in terms of desired ways of working, for instance in relation to capacity development, local community mapping, effectively identifying and addressing gender issues or in rejection of a deficit approach to programming.

- **A deficit approach to programming was common among IPs supported by the 3DF (with a few exceptions). The skills, resilience and knowledge of community members were not utilised.**
  - The 3DF repeatedly supported interventions that were designed around the assumption that community members were ignorant of the facts of disease transmission and treatment, and were thus in need of repeated transmission of basic

[21] The Evaluation Team would like to note that the Fund Board indicated in their feedback to the draft evaluation report that many representations were made through diplomatic channels which may not have been obvious to evaluation respondents.
[22] To buy specified services or other support of credible organisation(s) which has/have an established track record/comparative advantage in addressing the identified need.

biomedical information (regardless of the reality of the specific context). This is not behaviour change communication;
  - The 3DF was in an ideal position to encourage (and even require) the identification, and leverage of, existing community assets by IPs. This would have made a significant contribution to supporting the spirit of the NSPs; and
  - One of the rationales given by a FB member for Round 2 was that LGNOs/CBOs had specific strengths in understanding communities; however, no evidence was found of good LNGO/CBO practice in this respect being specifically identified and encouraged (or required) across other IPs.

- **The 3DF did not proactively seek to ensure relevance of Fund-supported work to those most in need.**
  - The Fund actually lagged behind the NSPs in terms of clear delineation of most vulnerable populations and in terms of requirement of programming that actually addressed the context-specific needs of these most vulnerable populations;
  - While efforts were made to address the challenge of mainstreaming gender into IP programmes, it was a case of too little, too late; and,
  - A clear gap is emerging between INGO views of 'community participation' and the views of community activists. The dangers of merely paying lip-service to participation must be acknowledged and avoided.

- **The Fund lacked a consistent, clear and widely understood definition of where the lines lie between FB and FMO responsibilities in determining the ways in which Fund money is used to support and operationalize NSPs, via IPs.**
  - A variety of different definitions of these boundaries had been given, over the years. The Fund 'firewall' was a particular point of contention. Was it intended to stand between national programmes and the FMO, or between the FMO and what could be called the 3DF programme (as represented by funding decisions, relationships with, implementation by, and monitoring of, IPs)?
  - There remains a strong feeling at FMO level that the FMO/FB relationship needs to be further improved, despite key FB members being of the opinion that any such issues had been resolved post the Mid-Term Evaluation.

- **Lack of a Fund definition or strategy in relation to capacity development means that there is no set point against which the Fund's achievements in relation to capacity development, and impact on the operating environment, can be evaluated.**
  - Basic conceptual issues regarding the 'what, why, when, where, who, how' of the 3DF's definition of and approach to capacity development do not seem to have ever been addressed. As a result, roles and responsibilities for, or expectations of, IPs and specific Fund bodies (e.g., FMO, FB) in relation to capacity building, have not been clearly defined; and
  - The evaluation found a lack of consensus at FB and FMO level in regards to the 'what, why, when, where, who, how' of capacity development, and the 3DF's role in it. Different Fund documents and different individuals (both from the FB and the FMO) offered different views on the meaning, focus, appropriateness, intent of, or methodology for, capacity development under the 3DF.

- **The Fund overall was hampered by a lack of coherent articulation of strategy, definitions, and programmatic logic.**
  - Shared understanding on issues of strategy, definitions, and logic may have existed among those involved in the Fund in 2006 (particularly at FB level) but such shared understanding is easily lost without key supporting documentation that remains 'live' throughout the life of a Fund.

RECOMMENDATIONS

[for the next phase of 3DF and other health/development initiatives]

1. Coherent articulation of a Fund's strategy, definitions, and programmatic/M&E logic is essential to enable relevant and effective practice both by the Fund itself, and by IPs (whatever the context of initial Fund implementation). It is not sufficient to simply refer to 'capacity development', 'gender mainstreaming', targeting of those 'most in need', 'behaviour change communications' or other such development rhetoric.

   1.1 Establish and regularly review, and maintain or adapt Fund-specific strategies, definitions, and overarching programmatic logic. Contractual expectations of IPs should then be made in relation to such concepts (e.g. requirement of community mapping exercises, requirement of active community participation in programme design, requirement of evidence of programme adaptation as a result of learning, etc.). Such articulation would allow for recognition of the different strengths and characteristics of LNGOs/CBOs, clear articulation of a rationale for funding LNGO/CBOs, and recognition of the fact that LNGOs/CBOs require different contractual and reporting arrangements; many LNGOs/CBOs do not wish to become mini-INGOs yet are forced to do so by having to bend to fit donor mechanisms rather than the other way round.

2. Use a funding model that enables the Fund to have a more proactive and consistent positive influence on the operating environment (including the civil society environment) and on provision of effective services to those most in need. A commissioning model[23] would seem most appropriate, given the operating context. Such a model would further reinforce the aforementioned defined Fund strategy, definition and programmatic logic. It would also allow for development of a more coherent M&E system, focused on continual improvement against a clear framework for analysis, learning and adaptation of interventions as a result of data arising. Such a model would also require identification of intersections between Fund activities and the national programmes, and adequately plan for mitigation of any additional demands placed on the national programmes by Fund activities, particularly in the areas of M&E and areas such as laboratory work or Basic Health Staff work.

   2.1 Calls for proposals should include requirements for effective M&E (including average unit costs, output and outcome indicators/targets, data quality assurance procedures, and ensuring service quality and implementation monitoring) and for clarification of processes to be used to ensure community participation and effective targeting of services.

   2.2 Provide direct funding to LNGOs/CBOs for reasons of ownership and sustainability. Set aside resources for ensuring that the specific strengths of LNGOs/ CBOs are identified and best utilised; and that necessary capacity is built for M&E. Mentoring, rather than one-off training, would be the best way forward (both in terms of M&E and in terms of identifying and building on LNGO/CBO strengths).

   2.3 Make requirements for an exit strategy part of the contract to be discussed in more detail with the FMO at least one year before the end of the programme, though building sustainability into the programme from the start is preferred.

3. Support establishment of structures that proactively promote and support learning, innovation and adaptation (rather than on mechanistic accountability). Longer-term

[23] To buy specific services or other support of credible organisation(s) which has/have an established track record/comparative advantage in addressing the identified need.

mentoring should be supported for learning, innovation and adaptation at FMO and IP levels.

3.1 Set aside a small pool of money (e.g., 1% of the total budget) for operational research (OR) and its dissemination in the health services. This can be used to initiate OR in dialogue with the IPs based on critical implementation issues identified. This OR should not be carried out by the IPs themselves but remain independent. Building OR capacity in-country should be a key element of the strategy (in principle, no research should be undertaken by external consultants without effectively building capacity of local staff). Commission qualitative research in order to better understand the socio-cultural dynamics of all three diseases. For example, there is a particular need for qualitative research examining issues of sexuality and gender in relation to HIV. All three disease responses would benefit from research that identifies existing community resilience and coping mechanisms in order that these can be effectively utilised.

3.2 Greater learning from communities is needed. Support meaningful participation at all levels and increasing asset-based, rather than deficit, approaches.

3.3 Establish mechanisms and relationships that support transparency in performance as a key principle underlying service delivery with regards to beneficiaries and service quality, effectiveness and efficiency. Set aside resources for regular experience-sharing between IPs on good practice, monitoring, supervision, exit strategies, game changers and other emerging issues affecting programme implementation. This should include local learning through annual review meetings, topical workshops, opportunities for joint problem-sharing and other focused activities, as well as learning from other countries in the region to widen perspectives.

3.4 To support both continued documentation and application of lessons learnt, it is important to invest in appropriate and effective knowledge management mechanisms based on available technologies and global/regional experiences.

4. Clearly define and support greater FMO involvement in operational decision-making and ensuring service quality and effectiveness (e.g., active use of FMO context-specific knowledge regarding IP funding applications, FMO decision-making on project revisions, based on pre-determined strategies and guidelines, and active FMO involvement in IP knowledge-sharing). Redefine the role of the FB in implementation-related decisions. Consider establishing an independent oversight body with detailed technical knowledge of the programme areas including M&E and which can provide maximum responsiveness to the programme's needs.

5. The FB should take advantage of the new political developments in Myanmar and its unique position as a national trust fund to promote the operationalization of NSP principles regarding access to services for marginalised populations such as people who inject drugs (HIV), prison populations (HIV and TB), and migrant workers (malaria) and others.

   5.1 This includes advocacy related to NGO access to areas with greatest need; enhanced coordination and cooperation; MoH system-strengthening including logistics, procurements, medical stores; and an enabling environment for service access and social change.

6. Provide direct support for strengthening national M&E systems in close coordination and collaboration with other donor-supported programmes as there are shared needs for data, data analysis and data use for more effective strategic and operational planning and increased impact of programmes.

6.1 This includes continued support for the TSGs with a clearly defined programme of work in terms of technical oversight for strengthening national M&E systems; funding for specific surveys and special studies as per clearly defined schedules and procedures; support for integrated analyses; support for evidence-informed strategic planning, resource allocation and programme improvement. Any support provided for M&E capacity-building – whether through formal training or more tailored approaches such as mentoring or task-specific technical assistance needs to be competency-based and committed to technology transfer. The TSGs need to be supported with strong and consistent technical assistance.

6.2 National M&E system-strengthening should be coordinated and harmonised between all donors under the leadership of the TSGs; and relevant data from donor-supported programmes should be shared with the national M&E system.

7. If the positive effects of the 3DF investments are to be sustained, then it is key that the 3MDG Fund builds on the work carried out to date, and the lessons learnt, from the 3DF:

7.1 For *HIV*, it is recommended to sustain gains achieved in sex workers and men who have sex with men by supporting OR that can confirm that the interventions are indeed as effective and efficient as assumed.

In the area of interventions for people who inject drugs the scale of the services is too low to control the epidemic among this very vulnerable group. Further, it is recommended that independent research investigates coverage of effective HIV prevention and ART services including analysis of the appropriate mix of targeting people who inject drugs/non-injecting drug users and Needle Syringe Programme/ Methadone Maintenance Therapy (MMT).

7.2 HIV-TB patients have significantly higher mortality than other TB patients. The 3MDG Fund should support OR and cover gaps in capacity building in the HIV-TB field to ensure increased effectiveness and efficiency of programmes for this population.

7.3 Effective implementation of malaria programmes are hindered by lack of appropriate and accurate data. This is and will remain an important obstacle for efficient implementation and scale-up of the MARC response and the 3MDG Fund phase. It is recommended that 3DF urgently build the necessary capacity in cooperation with the national malaria programme and WHO.

7.4 It is recommended that cost-effectiveness analyses are carried out of different approaches delivered by different IPs including integrated programmes at community level versus disease-specific interventions.

ANNEX 1. REFERENCES & KEY DOCUMENTS CONSULTED

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ANNEX 2. EVALUATION QUESTIONS AND METHODS

Evaluation Focus

The final evaluation of the 3DF aimed to document lessons learnt to inform future health funding and the evaluation of the next phase of the 3DF. The evaluation covered the implementation period of the 3DF programme (mid-2007 to end-2011) and took into consideration the changing operating context over time.

The specific evaluation objectives were:

1. To assess the 3DF against the evaluation criteria endorsed by the Organisation for Economic Cooperation and Development-Development Assistance Cooperation (OECD-DAC) (relevance, effectiveness, efficiency, impact, sustainability).
2. To conduct robust in-depth analyses of three key areas to support the evaluation conclusions:
   - *Key Area 1.* What has been the impact (and effectiveness) of the 3DF, including equity and gender analysis of who has benefitted?
   - *Key Area 2.* What has been the (positive or negative) influence of the 3DF on the operating context?
   - *Key Area 3.* Has the 3DF delivered value for money?

A key evaluation focus was the appropriateness and comprehensiveness of the 3DF M&E approach and system.

The specific evaluation questions for each OECD-DAC domain were:

1. RELEVANCE: The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor.
Was the programme aligned to the national disease control programme? – Were the objectives of the 3DF programme relevant to identified priorities for the three diseases in Myanmar? – Was the 3DF programme aligned with the best practices identified in the NSP? **Was the 3DF programme design technically sound[24]?** – Were the objectives and the design of the 3DF programme relevant to the context and to the needs of the beneficiaries? – Was there a clear logic and locally-relevant evidence base connecting 3DF activities and FB/FMO functions and operations with the realities faced by target communities in relation to the three diseases? Was there a clear rationale provided for the selected 3DF programme activities? – Were the activities and outputs of the 3DF programme consistent with the overall goal and attainment of its objectives? With intended outcomes/impacts? – Did the proportion of funding allocated to each disease area adequately reflect the needs and operating environment? – To what extent was the 3DF programme design based on best practices[25] according to global standards? – Was the 3DF programme design in line with the intent of the Donor Consortium? With individual donor policies? – Were the objectives and mechanisms of the 3DF programme cognisant of the capacity of the different implementing partners (UN, INGO, local NGO/CBO)?

[24] "technically sound" is defined as: (a) has a clear programme logic and evidence base connecting programme activities and operations to the realities faced by target communities in relation to the three diseases; (b) is demonstrably delivered to those most in need; (c) ensures that any medical treatment is in line with national and international guidelines.
[25] Ibid.

Did 3DF policies and programmes adhere to humanitarian considerations? Were they supportive of gender equality and other human rights?
- To what extent has the humanitarian approach influenced the design of the 3DF programme?
- Did the design of 3DF provide local organisations the opportunity to participate equitably in the grant competition?
- Was the 3DF programme designed to provide equal participation and benefits for women and men, boys and girls?
- Did the 3DF programme promote more equal access by women and men to the benefits of the activity, and more broadly to resources, services and skills?
- Did the 3DF programme help to promote women's rights?

Was the 3DF programme adjusted throughout its implementation to align it with emerging priorities/needs and to ensure support for best practice?
- To what extent did the 3DF programme include activities/mechanisms to support effective design, implementation and feedback of the programme?

To what extent were beneficiaries actively involved in these activities/mechanisms? To what extent did 3DF build in downward accountability mechanisms to IPs but also to ultimate beneficiaries?

2. EFFECTIVENESS: The extent to which the aid activity attains its objectives [considering effectiveness in: reaching intended beneficiaries; achieving health and social gains; effectiveness; in avoiding unintended results]

Was the 3DF programme implemented according to plan?
- Was the 3DF programme implemented according to plan? If not, why not and what was done about it?
- To what extent has the humanitarian approach influenced the implementation of the 3DF programme?
- To what extent did contextual factors facilitate or hinder programme implementation?

Was the necessary support for implementation provided?
- What support was provided for programme implementation, by whom and to what effect?
- How were bottlenecks in implementation identified? How were they resolved?
- Did the 3DF programme help to develop capacity of IPs to understand and promote gender equality?

Was timely corrective action taken where needed?
- What were the risks to achieving the 3DF objectives? Were the risks managed appropriately?
- Was additional support identified or provided to overcome implementation challenges? What was it, who provided it and to what effect?
- Has the management of the 3DF programme been responsive to the needs of IPs and beneficiaries?

Were intended results achieved?
- To what extent were the objectives achieved? What were the major factors influencing the achievement or non-achievement of the objectives?
- What were the results of the 3DF programme for women and men, boys and girls?
- What evidence exists for the effectiveness of the 3DF in achieving key results, community participation, and reaching and responding to the realities of those who are most vulnerable and marginalised?

3. EFFICIENCY: The extent to which aid uses the least costly resources possible in order to achieve the desired results [considering sound management and value for money]
Was the 3DF programme implemented in a cost-effective manner? – Did the implementation of the 3DF programme make effective use of time and resources to achieve the results? – Was the 3DF programme designed and/or amended throughout the implementation period for optimal value for money? – To what extent has effective coordination and collaboration with existing programmes and partners been addressed and achieved?

4. IMPACT: The examination of both intended and unintended results including the positive and negative impact of external factors [considering the extent to which the purpose of the 3DF has been achieved as intended and its contribution to the overall goal]
Did the 3DF achieve sufficient scale-up of the programme to improve key health indicators? Did the operating context have any influence on the 3DF programme or vice versa? – Does evidence exist of positive change at the population level in terms of disease prevention or reduction in disease burden? If not, why not? If so, what contributed to this change? – Were there any unintended changes (positive, negative) in the lives of intended beneficiaries and their environment? What were they? Were they directly or indirectly related to the 3DF programme or due to external factors?[26] – What role has the local and national context played in either supporting or hindering change? – Did the 3DF as a donor-driven disease-specific health initiative affect health programming by the government? If so, how? – Did the 3DF have an impact on the broader operating environment for humanitarian work/delivery of aid in Myanmar? If so, what form did this take?

5. SUSTAINABILITY: Determination whether the benefits of an activity are likely to continue after donor funding has been withdrawn [considering funded and non-funded interventions such as policy dialogue, coordination; considering ownership of objectives and achievements, policy support, institutional and technical capacity of IPs, financial and economic sustainability]
Are we achieving results in as sustainable manner? Are we achieving results in adherence to gender equality and other human rights? – To what extent can the benefits of the 3DF programme continue after donor funding has ceased? – Are there any areas of the 3DF programme that are clearly not sustainable? What lessons can be learnt from these? – To what extent do beneficiaries and/or partner country stakeholders have ownership, capacity and resources to maintain the activity results after 3DF funding ceases? – Did the 3DF contribute to capacity building of local organisations to continue to deliver quality disease-specific interventions? If so, what form did this take? – What were major factors which influenced the achievement or non-achievement of sustainability of the 3DF programme? – Did 3DF help to attract additional funding for the three diseases (or beyond) from other donors? From the wider health sector?

[26] Efforts will be made to ensure that as wide a range of intended beneficiaries as possible is accessed in response to this question. To this end, during the Inception Phase, the team met with representatives from Myanmar Positive Group; Sex Worker Network; Network of People Who Inject Drugs; and, Men Who Have Sex With Men Network which are not directly aligned with any one 3DF Implementing Partner but who exist as 'stand alone' organisations with experience of involvement with different 3DF partners.

Monitoring & Evaluation and Learning
– To what extent was the 3DF programme design based on previous learning? – Were M&E guidelines and requirements in line with data needed to allow judgement to be made about meeting 3DF programme objectives? – Were M&E guidelines, procedures and support adequate in ensuring data quality? – Were M&E guidelines, procedures and support adequate in encouraging data use at IP level? – To what extent does valid evidence exist to show that objectives have been achieved? – To what extent was data disaggregated to measure the results of the 3DF programme on the specific population groups targeted? On gender equality? – Were 3DF financial and other reporting requirements acceptable to IPs (was it too time consuming or too complicated)? – To what extent did 3DF M&E activities and/or support go beyond routine monitoring to include programme evaluation, operational research, IP and beneficiary feedback, regular surveillance/surveys? To what extent has appropriate use been made of both quantitative and qualitative methods? – Did 3DF provide feedback mechanisms not only for IPs but also for beneficiaries? – To what extent have M&E data been used to identify strengths/weaknesses of the 3DF programme and lessons learnt? Who has been involved in doing this, how and when? – To what extent was learning from implementation experiences and specific reviews integrated into the 3DF programme? – What lessons from the 3DF programme can be/were applied to the next phase of the programme (i.e., 3MDG Fund) and other health/development initiatives in Myanmar? – What lessons can be learnt from the 3DF M&E that can be applied to the evaluation of the next phase of the programme (i.e., 3MDG Fund)?

The evaluation focused on the 3DF as a whole, rather than on individual IPs, or individual projects or interventions delivered. The 3DF is defined as:

1. The management of the 3DF
   - The FB with responsibility for policy-making and fund-monitoring through oversight of a Fund Manager;
   - The FMO with responsibility for allocating resources through direct and competitive grants.

2. The 3DF programme network
   - The IPs (UN agencies, INGOs, LNGOs and professional associations, the private sector, local civilian administrations) with responsibility for delivering and scaling up provision of health services to reduce transmission of, and morbidity and mortality caused by the three diseases;
   - TSGs (and relevant TSG Working Groups) with responsibility for finalizing the NSPs for each of the three diseases and for leading the development of output-based country-wide Operational Plans incorporating all existing IPs;
   - The beneficiaries of the 3DF programme which reflect those most at risk, with a particular focus on people with limited or no access to public health services due to geographic or security constraints or because of discrimination based on factors such as ethnicity, gender, health or financial status.

The Evaluation focused on the different component groups that make up the 3DF and the interactions between them; with other relevant groups (i.e., the respective National Disease Control Programmes; the State, Regional, Divisional and Township Health Authorities; the CCM); and, with other health strategies/programmes (such as the MARC response, the Global Fund support for AIDS, TB and malaria).

The 3DF was evaluated within the changing political context (i.e., major events occurring during the 3DF implementation period) and in relation to any changes in the knowledge base (i.e., new evidence and emerging needs related to the three diseases which may have affected programme direction and content) during the 3DF implementation period. The influence of the 3DF (both positive and unintended negative effects) on the operating context was assessed, as well as the influence of the operating context (both facilitating and constraining factors) on the 3DF programme implementation and results.

Evaluation Methods

The Evaluation Team conducted two 3-week in-country missions (Jan-Feb 2012; March-April 2012). The evaluation used a range of data collection methods:

- Development and peer review of changes in the political and operating context that took place in Myanmar during the 3DF implementation period.
- Discussions with key informants (past and present) from the development community in Myanmar.
- Desk review of documents related to HIV/AIDS, TB and malaria in Myanmar (including research papers) and the 3DF, as well as relevant published literature (Annex 1).
- Questions added to the annual Client Satisfaction Survey conducted by the FMO.
- Compilation of existing output and impact data from 6-monthly progress reporting by 3DF-supported IPs; cost data of 3DF-supported interventions; additional outcome/impact data for HIV/AIDS, TB and malaria from national reports and surveys.
- Meetings with government staff including: MoH, Focal Points and other staff from the relevant National Disease Control Programmes, State Health Directors (Kayin, Mon, Shan North) and State Disease Focal Points, Township Medical Officers and Basic Health Staff.
- Discussions and in-depth interviews with FB members (current/former) and other Donor Consortium representatives; FMO staff (current/former); and, the current managers of the Global Fund, JIMNCH, and LIFT.
- In-depth interviews with
  - Management staff at 13 IP head offices;
  - Management, programme implementation, and outreach staff at 15 IP field sites;
  - 3DF beneficiaries and networks of affected communities[27] in Lashio, Mowlamyaing, Yangon.
  - Three workshops (Lashio, Mowlamyaing, Yangon) with government staff, IP staff (field and head offices), 3DF beneficiaries, and representatives from networks of affected communities: overall, 73 participants representing 35 different organisations (17 participants

[27] Representatives from Myanmar Positive Group; Sex Worker Network; Network of People Who Inject Drugs; and, Men Who Have Sex With Men Network which are not directly aligned with any one 3DF Implementing Partner but who exist as 'stand alone' organisations with experience of involvement with different 3DF partners.

in Lashio; 21 participants in Mawlamyine; 34 participants in Yangon).

The tools used for the collection of new data were piloted during the Inception Phase and the early stages of the Data Collection Phase; the final versions are provided in the Evaluation Inception Report. Translation support was provided during the Data Collection Period (i.e., all site visits and all workshops) to ensure that participants' views were not excluded simply on the basis of language barriers. The evaluation followed the ethical guidelines of the United Nations Evaluation Group (UNEG).[28]

Limitations of the evaluation

The following important limitations should be noted:

- The evaluation took place after 3DF funding had ended for most IPs. Certain key staff, volunteers, beneficiaries and field sites were therefore unavailable for the evaluation.
- The 3DF-supported IPs are not the only service providers in the targeted geographic areas. The evaluation did not include a mapping of all providers and services.
- The 3DF-related indicators for progress reporting by IPs underwent changes over time; 2007 baseline data were lacking and data quality issues were noted.
- The 3DF performance framework did not include behavioural outcome indicators.
- The evaluation did not cover an assessment of the mix and quality of services provided by IPs.
- The evaluation did not include an assessment of each IP.

As a result:

- The trend analysis of 3DF indicator data should be interpreted with caution.
- The establishment of a counterfactual and the direct attribution of any observed changes in disease-level indicators to the 3DF programme is not possible; the lack of intermediary behavioural outcome indicators also affects the extent to which 3DF output data can plausibly be linked to disease impact. However, an estimate of the contribution of the 3DF programme to disease impact based on 3DF funding inputs is provided.
- The lack of information about service mix and quality – known factors influencing programme effectiveness, efficiency and impact, hinders the extent to which the findings can be explained and value for money can be determined.
- IP-specific recommendations are not provided.

[28] United Nations Evaluation Group (2007). Ethical Guidelines for Evaluation. New York: UNEG.