

Financial Gap Analysis of the national responses to  
HIV/AIDS, Tuberculosis and Malaria in Myanmar.

Prepared for the Three Diseases Fund, Myanmar

Full Study Report  
June 2008

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## **Executive Summary**

### **Study Justification and Objectives**

The Three Diseases Fund in Myanmar (3DF), supported by Australia, the EC, the Netherlands, Norway, Sweden and the UK aims to reduce the burden of communicable disease in Myanmar, by funding a countrywide program of activities to reduce transmission and enhance provision of treatment and care for HIV and AIDS, tuberculosis (TB) and malaria for the populations most in need.

The 3D Fund has commissioned this study to establish the financial needs of the national programs for the three diseases in Myanmar, the financial resources that are available from all sectors and sources to meet this need and through this work to identify the financial gaps in coverage, based upon what is needed to implement the national strategies in their entirety. In addition, the 3DF would benefit from recommendations for the further steps necessary in order to allow evidence based recommendations on resource allocation between diseases and within each of the national responses.

### **Study Methods**

The study was carried out in collaboration with the main stakeholders of the national response for each disease including: the Ministry of Health – Department for Disease Control; the Technical and Strategic Groups (TSG's) for each response; UN agencies (in their capacity as implementing partner and technical agents); international and local NGO's and the 3DF management staff.

The study involved the review of policy documents and materials of the 3DF and the national programs for each response and consultations with the 3DF management staff and the technical agents. A resource tracking survey was designed and data compiled from partner UN agencies, implementing partners and all sources of pertinent data.

### **Findings and Quantitative Analysis**

In general, the study concludes that investment in the national responses to HIV/AIDS, TB and Malaria in Myanmar continues to fall considerably short of what is required to implement the levels of service necessary to impact the spread of the epidemics.

Resource availability increased marginally from 2006 to 2008, however pledged funds for impending years decline sharply against continued growth in planned activities to support the responses to the three diseases.

Investment in AIDS, TB and Malaria in Myanmar comes from a variety of donor sources and modalities. Cumulatively, for the period 2006 to 2010, multi-donor approaches (notably the 3DF and EC) account for approximately half of resources available. Core or head-quarter funding (both UN and private/International NGOs) contributes thirty-five percent of available funding. Bilateral aid constitutes twelve percent, while private donations contribute four percent, of all available funding.

Of the three diseases, the response to HIV/AIDS in Myanmar attracts the most funding, almost two thirds of all available, almost 25% of all investment is allocated to TB and the remaining 16% goes to the malaria response. This is roughly in line with overall GFATM distribution statistics ,which reflect the proportionate burden of disease and financial resources required for intervention from a global perspective. More comprehensive analysis is required to allow resource allocation decisions to be made which more accurately reflect the proportionate burden of disease in the Myanmar context.

For all three disease responses, the majority of expenditure and funding is focused on service delivery components, which generally accounts for 90% of the budget for each disease.

### **Required next steps**

In the current environment of scarce resources, the 3D Fund Board needs to ensure a high degree of prioritization in the allocation the funds they manage.

Evidence based recommendations on resource allocation between diseases and within each national strategic program should be supported by cost-effectiveness analysis (CEA), which compares the costs and outcomes of two or more courses of action. This requires

- outcome based disease and cost information;
- an adequate financial management system to provide cost data and trends;
- a system for monitoring and evaluation to ensure resources are in fact put to their intended use.

The planning and budgeting capacity of the TSGs needs to be stimulated to operate on a more dynamic basis. Standard costing methodologies and budgeting tools should be encouraged for establishing unit costs of interventions. The planning and budgeting function, supported by strong information systems, will be capable of re-examining service delivery targets and activity levels required to address the national strategies. Operational plans and supporting budgets developed can thus present an accurate assessment of financial need.

The 3DF Board will be able to rely on the assessment of need presented in three year rolling plans and together with the analysis of the costs of specific interventions and impact on disease develop an approach to resource allocation which is evidence based, transparent and delivers stability to prioritized strategies.

## **1. Introduction**

The Three diseases fund in Myanmar (3DF) is supported by a donor consortium representing Australia, the EC, the Netherlands, Norway, Sweden and the UK. It was established to ensure that activities to reduce transmission and enhance provision of treatment and care for HIV/AIDS, TB and malaria are effectively resourced. The 3DF superseded the Fund for HIV/AIDS in Myanmar (FHAM), which effectively ceased in 2007, and aimed to compensate for the shortfall of funds for the three diseases created by the termination of the Global Fund to Fight AIDS, TB and Malaria (GFATM) in 2005. In this way the 3DF aimed to ensure the successful continuation of public health programs in respect of the three diseases.

The 3DF supports activities which target vulnerable and underserved population groups. In particular, populations living in remote and inaccessible areas are considered priority target groups for service delivery.

At the formulation of the 3DF, a requirement was made for detailed implementation plans and annual budgets, which specified the programs that would be supported. This coincided with the formation, by the Ministry of Health (MoH), of Technical and Strategic Groups (TSGs) for each of the three diseases. These TSGs, chaired by the Ministry of Health (MoH), with technical support from U.N. agencies and with members drawn from the major stakeholders, would be responsible for the development of disease specific national strategies and operational plans. Based upon these, annual rolling plans and budgets would become the basis for the support from the 3D Fund.

## **2. Background**

### **2.1 Planning and Budgeting**

Executive working groups (EWGs), or 'core groups', were nominated from the ranks of the TSG membership and with consultant led technical support, three year national operational plans, incorporating all existing implementing partners, were developed. The operational plans for each disease for the years 2006-2009 complement the national strategies, reflect the participatory process upon which they were developed, are outcome focused, and provide detailed information on interventions and service delivery targets for tackling the three diseases in Myanmar.

The national operational plans were further developed to include budgets to support the annual plans. The costing and budgetary processes employed varied between the three responses.

For the HIV/AIDS response UNAIDS guidelines were followed, whereby unit costs were developed for packages of prevention and support activities for thirteen strategic directions, which were adopted to meet the stated objectives of the Myanmar Strategic Plan on HIV and AIDS (2006 – 2010). The operational plan was costed and a budget developed using the strategic directions as a basis.

The budgets for the national responses to TB and malaria were developed through a collaborative process involving the national programs, the TSGs and implementing partners, whereby each of the partners directly costed the activities involved in the

prescribed outcomes and targets of their particular element of implementation, employing a mix of prevailing local and international costs.

## **2.2 Implementation**

The implementing environment for the three diseases in Myanmar involves relatively few known and authorised partners. These have been identified by the national programs and by the Secretariats of the TSGs and are referred to in the national operational plans. It is reasonable to assume that implementation of any funded program in respect of the three diseases involves these known players. For the purpose of the study this presented a comprehensive picture of funding sources.

## **3. Study justification and objectives**

Myanmar has a low income economy, but conversely, it is one of the lowest recipients of development aid compared to its regional neighbours, with similar burdens of disease.

In Myanmar there is notable absence of some of the larger actors in financial support such as the World Bank and the Asian Development Bank. This situation is exacerbated by relatively low levels of domestic contribution creating lost opportunity for investment particularly in the public health system and funding growth.

The 3D Fund's pledged budget of \$100m over 5 years, though significant, is considered nominal from a multilateral perspective.

In such a climate of scarce financial resources, policy-makers need to know which interventions represent value for money and target resources accordingly.

Therefore, the Board of the 3D Fund would benefit from a thorough understanding of the financial need for implementation of the national strategies for HIV/AIDS, TB and Malaria and the gaps which exist, in both funding and coverage. Further analysis to determine the financial and disease data required for informing the 3D Fund's decision-making capacity in targeting resources, will ensure equity in the allocation of resources which reflects variation in need across the three diseases and (keeping in mind 3DF policy to target marginalized populations) across geographical area.

The objectives of the study are therefore:

- To establish a clear understanding of the total financial need for full implementation of the national strategies for each of the three diseases in Myanmar, as outlined in the national operational plans.
- To acquire a comprehensive overview of all financial resources available in respect of the three diseases in Myanmar, from all sources and sectors.
- To identify the financial gaps in coverage in respect of the three diseases in Myanmar.
- To assess the quality of information available in respect of the three diseases and identify the gaps.
- Based on this study, make recommendations to the 3D Fund Board, on the next steps required to create further evidence for resource allocation of 3DF funds.

The terms of reference for the consultancy are attached in Annex A.

#### **4. Study approach**

In financial/economic terms the gap is the difference between the total financial needs for full implementation of each of the national plans and the projection of funding available. In order to establish the current financial gaps in coverage for the three diseases, therefore, requires a presentation of up-to-date budgets and level of funds available. This involves:

- A review of the budgetary processes and revision of the budgets of the operational plans to ensure that they accurately represent current financial need based upon updated operational plans. i.e. that the budgets depict updated targets on service delivery based upon relevant, informed planning models.
- An assessment of all funding sources and modalities in existence in Myanmar in respect of HIV/AIDS, TB and Malaria, along with a compilation of the levels of finance available for investment in the disease responses.

A recent mapping study of investments in the national response to AIDS in Myanmar was carried out by UNAIDS, acting as the Secretariat of the TSG on AIDS. Data was collected and compiled from stakeholders in relation to sources of funding and allocation against strategic directions. This data will be utilised for the purpose of the current analysis.

All implementing partners identified in the operational plans, and by the secretariats of the TSGs, were targeted as the primary source of data on available funding in relation to TB and malaria.

Templates were designed, with accompanying instructions, to survey the partners. Detailed Information was requested on funding available from all sources and allocation of funding against the outputs of the national operational plans, for prior years (2006 and 2007), for current commitments (2008) and pledged funding for 2009 and 2010. A copy of the survey is attached in Annex B.

In an effort to ensure participation in the survey, the consultant held meetings with senior personnel of all the implementing partners, to explain the rationale and requirements of the survey and to enable partners to express any difficulties likely to be encountered in filling up the survey.

Thirteen organisations were surveyed in respect of the TB response and fifteen for Malaria. There were eleven respondents for TB and ten respondent organisations for the Malaria response, the deadline for response was extended to capture enough data for pragmatic analysis. For the non-respondents it was possible to include data in respect of 3DF funding from the 3DF Managers office. Annex C lists the organisations represented in the analysis presented in this report.

The analysis presented in the report provides a snap-shot of the current funding scenario. It should be interpreted in the context of the data supplied, which detail actual expenditures and committed pledges for the period 2006 – 2008, but for the period 2009

to 2010 the data is based upon current *known* pledges and therefore may be understated.

## **5. Study constraints**

Some limiting factors were encountered during the study which raised concern not only for their impact on the analytical potential of this report, but in a wider context on the 3DF Board in terms of its resource allocation capacity.

At the formulation of the 3DF it was established that annual rolling plans and budgets would be the basis for the support from the 3D Fund. It was assumed at this stage that capacity had been established to enable a dynamic process of operational planning and budgeting. Although three year plans were developed in 2006, for each disease response, rolling forward of these plans has been limited. Some planning has been undertaken for HIV/AIDS, within the “core groups” for each of the strategic directions and service delivery targets and some unit costs have been revised and rolled forward to 2009 and 2010.

No such action has been undertaken for TB and malaria budgets remain unchanged. In effect, this means that the targets and costs of service delivery established in 2006 continue to be the basis for current implementation. For the purpose of this study, in meeting the objective of establishing *current* financial gaps, the budgets incorporated in the national operational plans for TB and malaria provide an inadequate assessment of current financial need.

## 6. Quantitative findings and analysis

### 6.1 Overall Funding Gap for HIV/AIDS, TB and Malaria in Myanmar

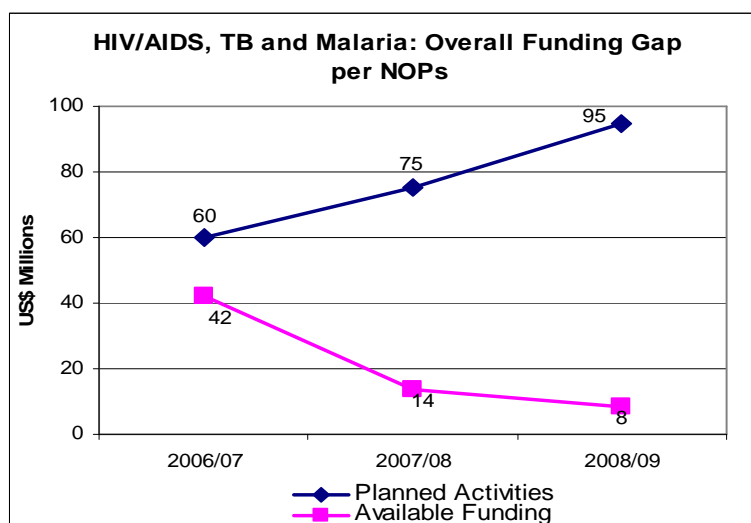
The three-year operational plans developed for each disease response in Myanmar, 2006-2009, along with their corresponding budgets, forecast the levels of funding required for full implementation of each of the national plans and detailed the resources available, based upon *known* commitments at that time. Available funding estimations, take into account the withdrawal of the GFATM in August 2005 and the termination of FHAM in 2007. Implicit in the identification of the funding gaps was the assumption that the 3DF would meet the shortfalls.

**Table 1: Total funding gap for HIV/AIDS, TB and Malaria (2006 - 2009) per National Operational Plans.**

	2006/07	2007/08	2008/09
<b>Operational Budget</b>			
HIV/AIDS	34,016,689	41,703,753	62,328,898
Tuberculosis	13,467,871	18,809,752	18,477,025
Malaria	12,504,148	14,678,328	13,860,365
<b>Total</b>	<b>59,988,708</b>	<b>75,191,833</b>	<b>94,666,288</b>
<b>Available Funding</b>			
HIV/AIDS	30,817,381	7,297,810	6,430,950
Tuberculosis	6,917,120	5,140,011	953,311
Malaria	4,268,149	1,200,424	1,022,610
<b>Total</b>	<b>42,002,650</b>	<b>13,638,245</b>	<b>8,406,871</b>
<b>Overall Funding Gap</b>	<b>17,986,058</b>	<b>61,553,588</b>	<b>86,259,417</b>

Each response envisaged ambitious expansion in service activities, to meet their strategic objectives. This scale-up of key interventions was based upon known capacity in the public and private sectors and also built upon the recent experience in the implementation of the GFATM grant.

**Chart 1**



Estimates for investment in the three diseases fell considerably short of requirements for the planned scale-up of services and as a result the operational plans forecast an escalating funding gap for the three diseases in Myanmar rising to US\$86 million by 2008/09, mapped in Chart 1.

The resource tracking survey carried out with the implementing partners, solicited detailed information on sources and levels of funding made available for implementation of the three year operational plan, as well as known pledges or commitments up to 2010.

The survey response allows a more accurate picture of the funding trends and gaps to be compiled. Table 2 summarises the *actual* funding gap for the three diseases for the period of the operational plans (2006–2009) and estimates of the funding gap up to 2010, based upon known commitments.

**Table 2: Overall funding gap for HIV/AIDS, TB and Malaria (2006 - 2009)**

	2006	2007	2008	2009	2010	Cumulative Total
<b>Operational Budget</b>						
HIV/AIDS	30,346,972	43,470,970	51,983,506	62,581,609	74,644,928	<b>263,027,985</b>
Tuberculosis	13,467,871	18,809,749	18,477,025	18,477,025	18,477,025	<b>87,708,695</b>
Malaria	12,504,148	14,678,328	13,860,365	13,193,077	13,193,077	<b>67,428,995</b>
<b>Total</b>	<b>56,318,991</b>	<b>76,959,047</b>	<b>84,320,896</b>	<b>94,251,711</b>	<b>106,315,030</b>	<b>418,165,675</b>
<b>Available Funding</b>						
HIV/AIDS	26,979,076	30,860,121	38,280,146	23,755,598	15,661,263	<b>135,536,206</b>
Tuberculosis	3,599,811	4,882,590	8,163,328	3,327,675	1,646,510	<b>21,619,915</b>
Malaria	2,765,937	4,971,026	6,847,118	4,760,278	4,517,126	<b>23,861,485</b>
<b>Total</b>	<b>33,344,824</b>	<b>40,713,738</b>	<b>53,290,592</b>	<b>31,843,552</b>	<b>21,824,900</b>	<b>181,017,605</b>
<b>Overall Funding Gap</b>	<b>22,974,167</b>	<b>36,245,309</b>	<b>31,030,305</b>	<b>62,408,159</b>	<b>84,490,130</b>	<b>237,148,069</b>

**Chart 2**

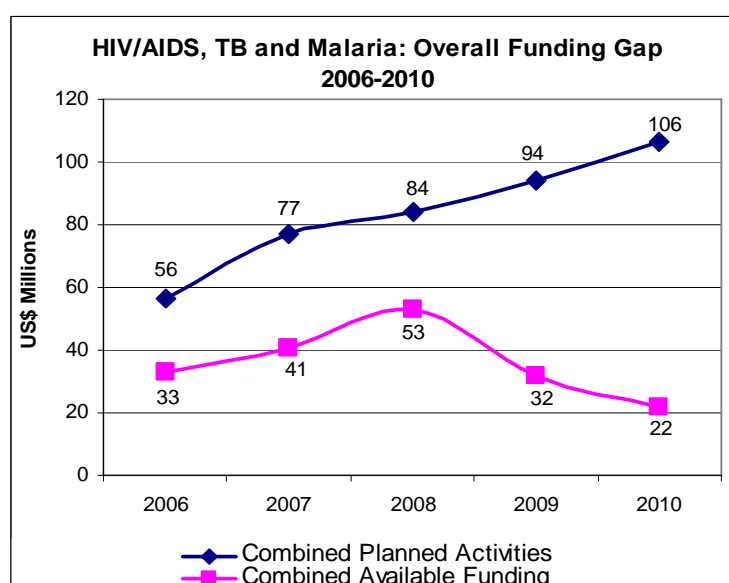


Chart 2 maps the combined planned activities and investment in the national responses to HIV/AIDS, TB and Malaria in Myanmar. It indicates the considerable and widening

gap in the amounts required to implement the levels of service necessary to impact the spread of the epidemics.

In general terms, resource availability has shown some increase, from 2006 to 2008, albeit at a slow pace and maintaining a consistent funding gap. Pledged funding falls sharply again for 2009 and 2010, widening an already substantial gap to US\$84 million by 2010, which equates to 80% of total financial requirement. This corresponds with acute gaps in coverage for activities and service delivery for the population of Myanmar affected by the HIV/AIDS, TB and Malaria.

**Chart 3**

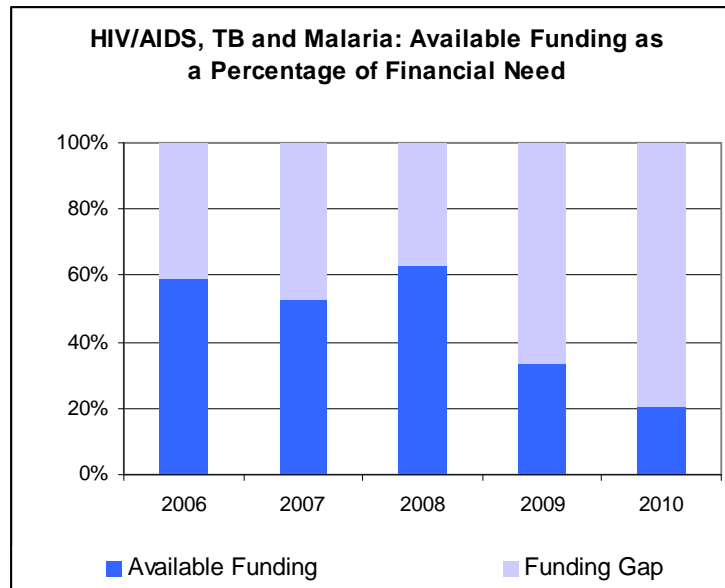


Chart 3 illustrates the proportion of the planned activities that are realizable based upon resource availability and clearly demonstrates the widening gap between available funding and financial need.

### 6.2.1 Distribution of Investment by Donor

The response to the resource tracking survey, carried out with the implementing partners, identifies a variety of donor sources and modalities in investment in AIDS, TB and Malaria in Myanmar. These can be summarised as multi-donor approaches (notably the 3DF and EC), core or head-quarter funding from both UN and NGOs, bilateral funding and funding from private sources.

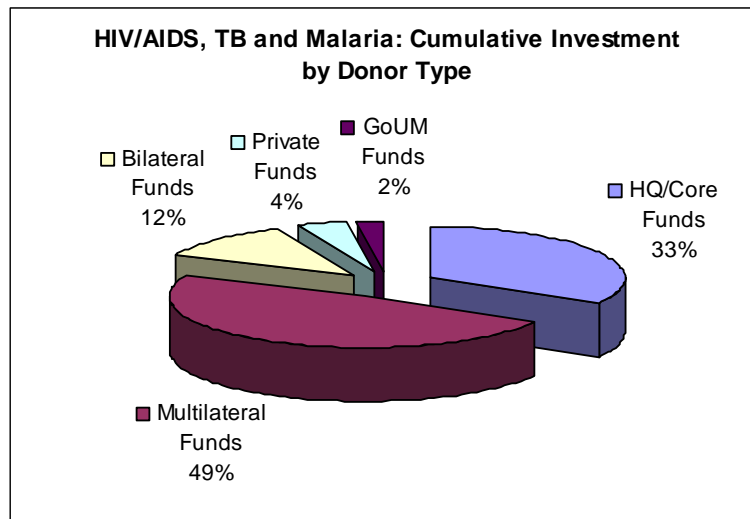
The national programs for each of the disease responses were surveyed as part of the resource tracking exercise<sup>1</sup>. The National TB Program disclosed contributions from the Government of the Union of Myanmar (GoUM) and these are reflected within the analysis of available funding. The National Malaria Control Program did not respond to the survey, however estimations of contributions were made during interviews with program personnel, and are included in the analysis. The National Aids Program did not

<sup>1</sup> The National Aids Program was surveyed as part of the UNAIDS resource tracking exercise.

disclose GoUM contribution in their survey response, but approximations were included in the analysis based on figures disclosed in the operational plan for HIV/AIDS.

Cumulatively, for the period 2006-2010, multilateral funding accounts for almost half of all available resources, core funding contributes one third of all available funding (of this, UN funding accounts for approximately half). Bilateral aid constitutes 12%, private donations contribute 4% and GoUM contributes 2% of all investment (chart 4).

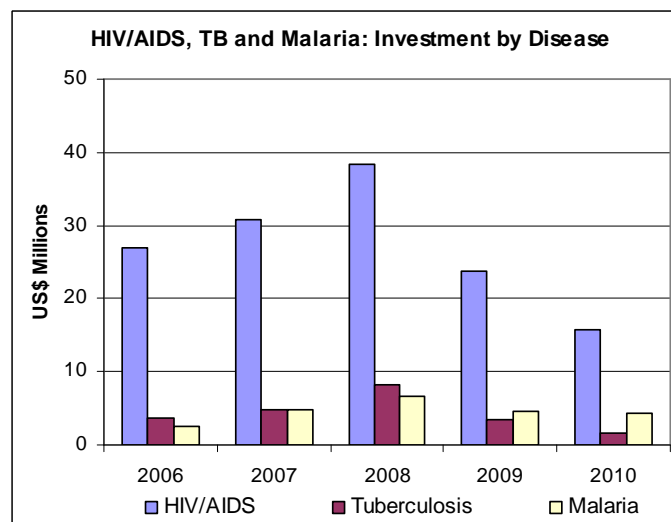
**Chart 4**



### 6.3 Distribution of investment in HIV/AIDS, TB and Malaria

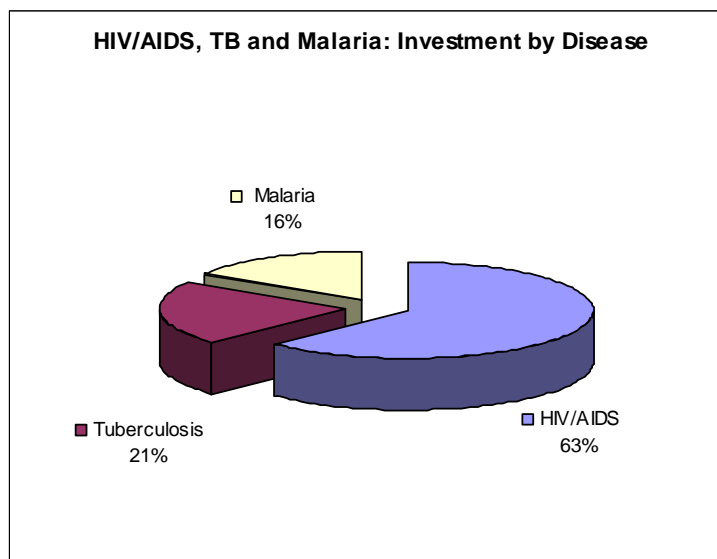
The resource tracking survey requested responses separately for each disease response, which allows an analysis of how funding is distributed between the three diseases. This is illustrated on a year by year basis in Chart 5.

**Chart 5**



In general, HIV/AIDS attracts considerably higher levels of investment, than TB and malaria each year. For each disease response overall investment has shown steady increase, followed by sharp decline for 2009 and 2010, although this needs to be considered in the context of the survey response which identified current *known* pledges.

**Chart 6**



The proportionate distribution of funding based upon cumulative data for each disease is illustrated in Chart 6. The national response to AIDS in Myanmar, accounts for almost two-thirds of investment in the three diseases, tuberculosis prevention and control attracts twenty one percent of total investment, and Malaria prevention and control account for sixteen percent.

#### **6.4 The national response to HIV/AIDS in Myanmar 2006 – 2010.**

The three year National Operational Plan for HIV and AIDS, 2006-2009, was developed and costed, based upon 13 Strategic Directions which were adopted in response to the three stated objectives of the National Strategic Plan on HIV and AIDS:

- Reduction of HIV transmission and vulnerability, particularly among people at highest risk;
- Improvement of the quality and length of life of people living with HIV through treatment, care and support; and
- Mitigation of the social, cultural and economic impacts of the epidemic.

The operational plan forecast the resources required for the national response to HIV/AIDS over the three years allowing for ambitious, but realistic, expansion in services. Further planning activities have been carried out within the strategic direction core groups for HIV/AIDS, resulting in revised service delivery targets for 2008 and rolling forward of targets for 2009 and 2010. Some adjustment of unit cost has also been achieved through the same process.

**Chart 7**

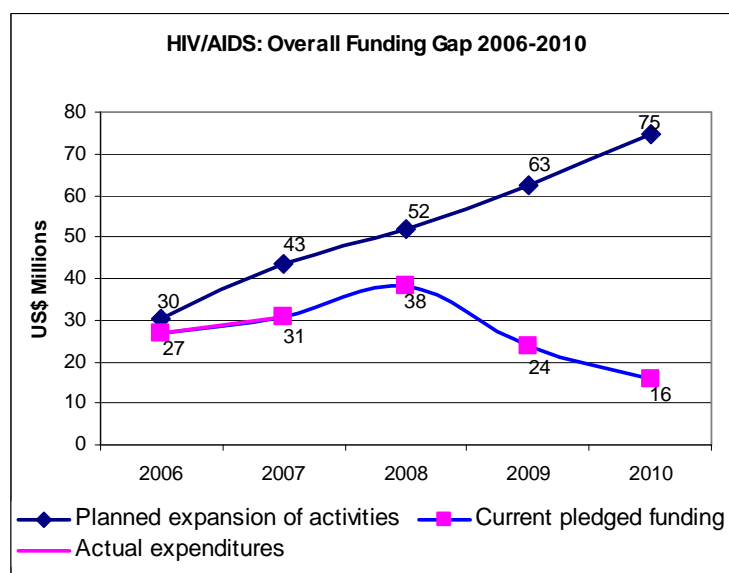


Chart 7 maps the total costs of service expansion and resource availability for the period 2006 to 2010. Costs are based upon the three year national operational plan for HIV/AIDS in Myanmar for 2006 to 2007 and the revised plans for 2008 to 2010. Resource availability data is summarised from responses to the resource tracking survey for HIV/AIDS and includes actual expenditures to date (2006 – 2007), current pledges (2008) and anticipated funding (2009-2010) for the national response

There has been some growth in investment between 2006 and 2008, however current pledges forecast a reduction in investment from US\$38 million in 2008 to US\$15.5 million by 2010. At these levels, available funding will increasingly fail to meet the requirement for the planned scale-up of services, with the funding gap widening to US\$59 million by 2010.

#### **6.4.1 Distribution of investment in the HIV/AIDS response in Myanmar**

The four major activity areas identified in the HIV/AIDS national operational plan are:

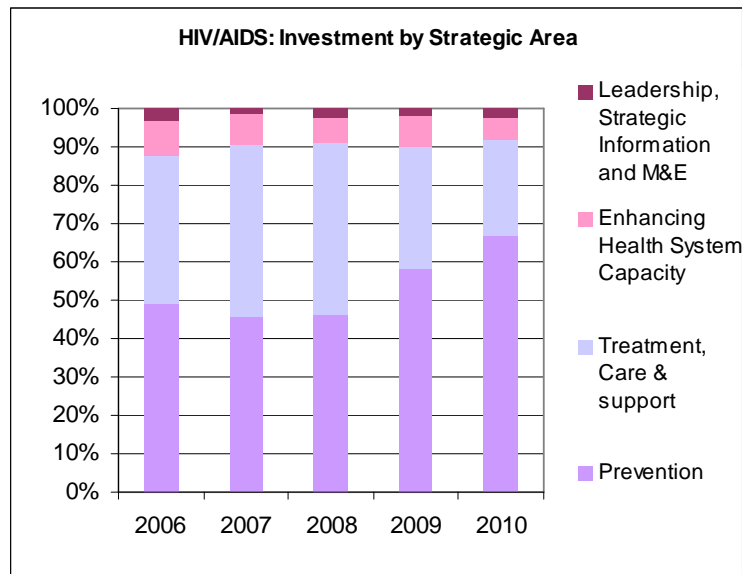
- prevention;
- treatment, care and support;
- enhancing the capacity of the health system;
- leadership, strategic information, Monitoring and Evaluation (M&E).

Overall, the prevention activities receive the highest proportion of investment and together with treatment, care and support activities account for approximately 90% of total investment in the response to HIV/AIDS in Myanmar.

In general, the relative share of investment in prevention shows a decrease from 2006 to 2008, while the proportion available for treatment, care and support shows a steady

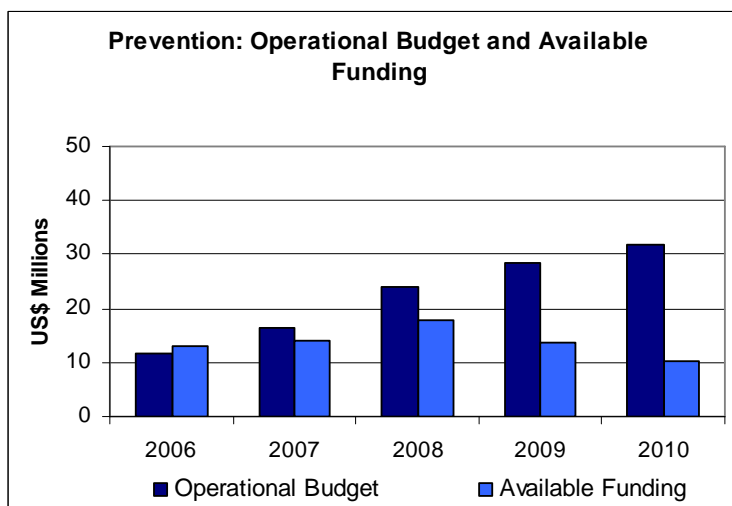
increase (chart 8). This trend appears in reverse for 2009 to 2010, but should be interpreted within the context of current *known* pledges.

**Chart 8**



Prevention activities account for approximately 40% of the annual AIDS operational budget. Investment shows a steady increase from 2006 to 2008, followed by substantial decreases for impending years (chart 9), it is clear that funding is inconsistent with the continued expansion of prevention activities with a funding gap which extends to over US\$21 million forecast by 2010, which equates to a gap of two thirds of planned activity.

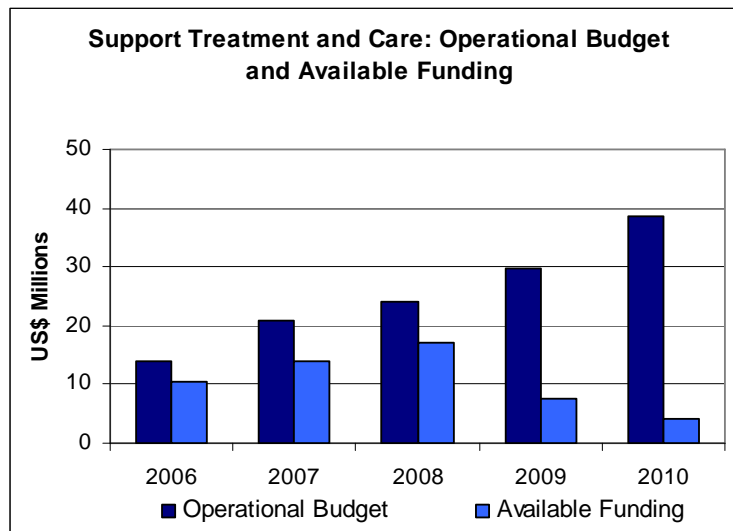
**Chart 9**



Support, treatment and care activities account for 50% of the annual AIDS operational budget. Despite significant growth of investment in this area from 2006 to 2008, the funding gaps are consistently higher than for prevention activities (chart 10). Current *known* pledges of funding, for 2009 and 2010, for treatment, care and support forecast

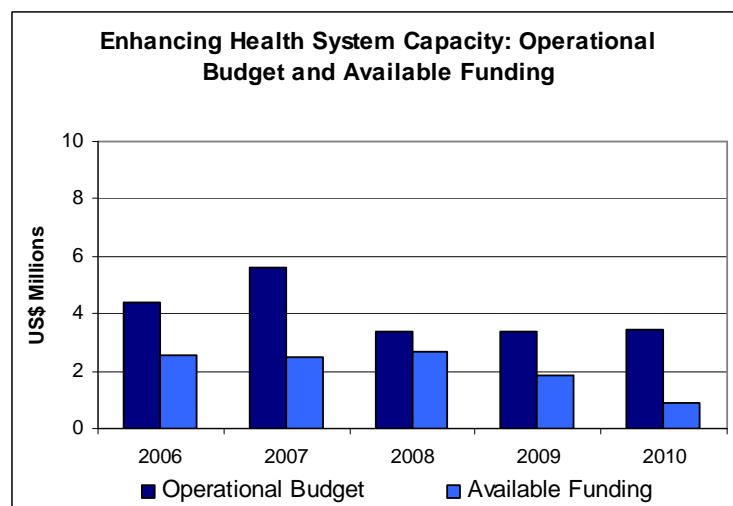
the gap between expansion of need and resource availability to increase considerably, reaching US\$34 million, this translates to 90% of planned activities unfunded.

**Chart 10**



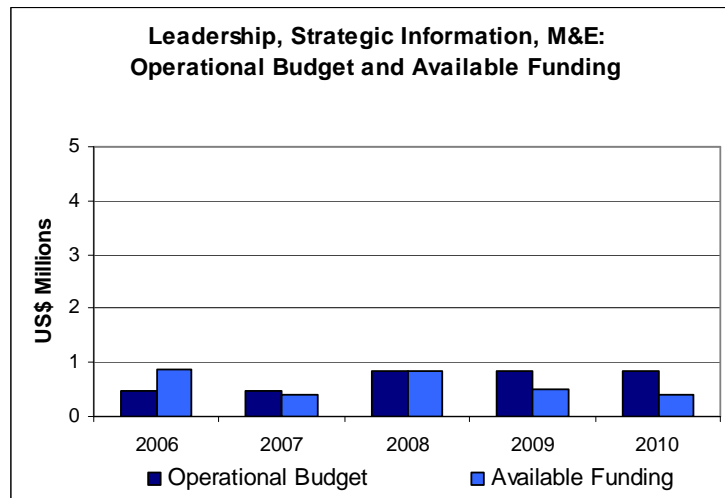
Enhancing health system capacity activities account for approximately 9% of the annual AIDS operational budget. Investment has shown no real growth from 2006 and a steady decline from 2008 onwards, based upon current known pledges. By 2010 a funding gap of US\$2.5 million will exist, equating to 75% of activities unfunded.

**Chart 11**



Provision of leadership, strategic information and M&E accounts for just 1% of the annual AIDS operational budget. Sufficient investment has been experienced in this area up to 2008. However, a funding gap appears, reaching 50% by 2010 (chart 12).

**Chart 12**



#### **6.4.2 Investment in the response to HIV/AIDS by donor**

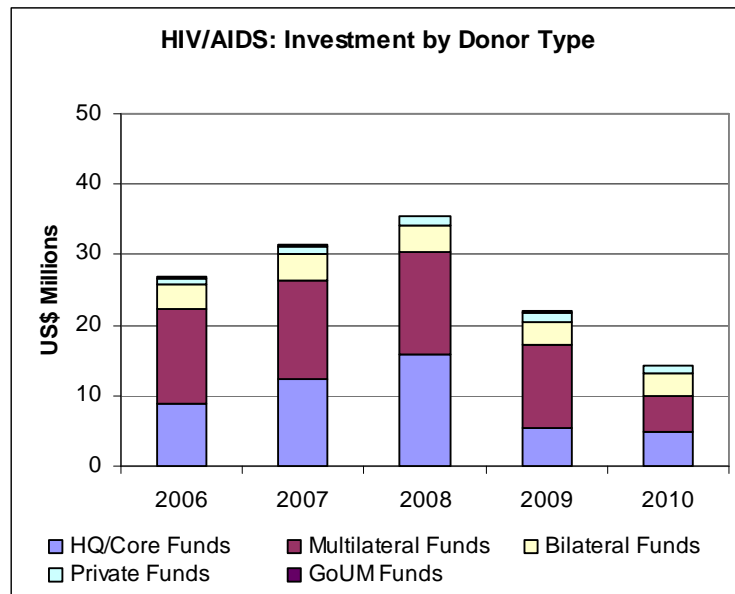
Funding for HIV/AIDS response in Myanmar comes from a variety of sources. A list of donors involved in the HIV/AIDS response in Myanmar is attached in Annex D.

Multi-donor funds (which include GFATM and FHAM in 2006 and 3DF funds from mid 2007), account for the largest share of investment in HIV/AIDS, though this shows steady decrease by 2010. There is more overall growth in funding from core funds which come from headquarters (of both UN agencies and NGOs). Implementing partners identified direct funding from thirteen bilateral donors, though contributions are relatively low but consistent at around US\$ 3.5 million annually. Private funding sources (from large NGOs outside Myanmar, foundations and associations) contribute less than US\$ 1 million per year of total funding (chart 13). The contribution of GoUM to the national response to HIV/AIDS is estimated at approximately US\$ 0.2M per year<sup>2</sup>.

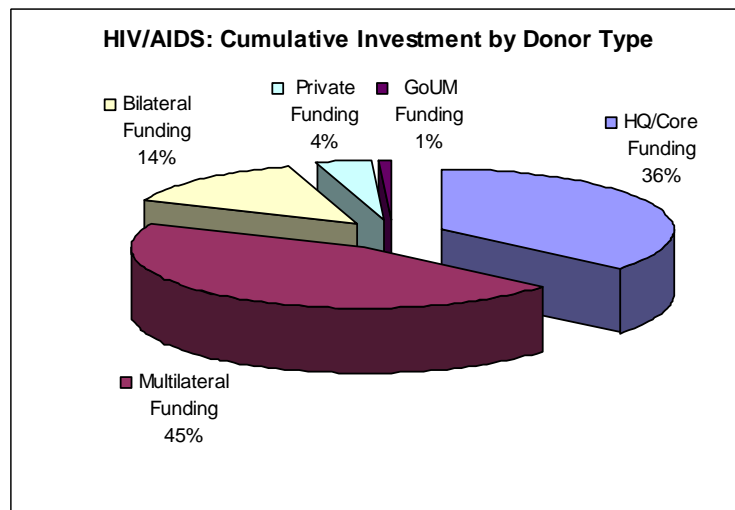
The cumulative investment by donor category for the period 2006–2010 is presented proportionately in Chart 14. Multilateral funding constitutes almost half of all investment (expended and pledged), while core of headquarter funding contributes over one third. Bilateral funding accounts for 14% of cumulative investment and private sources provide 4% of overall available funds. GoUM funding accounts for 1% of total cumulative funding.

<sup>2</sup> From National Operational Plan for HIV/AIDS 2006-2010

**Chart 13**



**Chart 14**



## 6.5 The national response to the prevention and control of Tuberculosis in Myanmar

The National Operational Plan for Prevention and Control of Tuberculosis in Myanmar, 2006-2009, developed collaboratively by the TSG for TB, describes four main outputs which are in line with the four objectives of the National Strategic Plan for TB, Myanmar 2006-2010:

- To Sustain and improve the quality of DOTS services to reach all TB patients
- To improve the treatment success rate among all detected TB patients, including those with TB/HIV and multi-drug resistant (MDR) forms of TB

- To maintain the case detection rate of the estimated new smear positive TB cases above 70%
- To measure both progress with program implementation and the impact of interventions towards more accurately determining progress towards the Millennium Development Goals (MDGs)

The operational plan along with the corresponding budgets, details activities by proposed implementing partner and outlines the resources required for the national response to TB, allowing for rapid scale up of activities and services throughout the country in order to reach more than 90% of the population by year 2009.

No planning or budgeting has taken place for TB since 2006, which inhibits prediction of funding gaps beyond 2008. For the purpose of analysis, activity levels have been projected forward at the same levels as 2009.

**Chart 15**

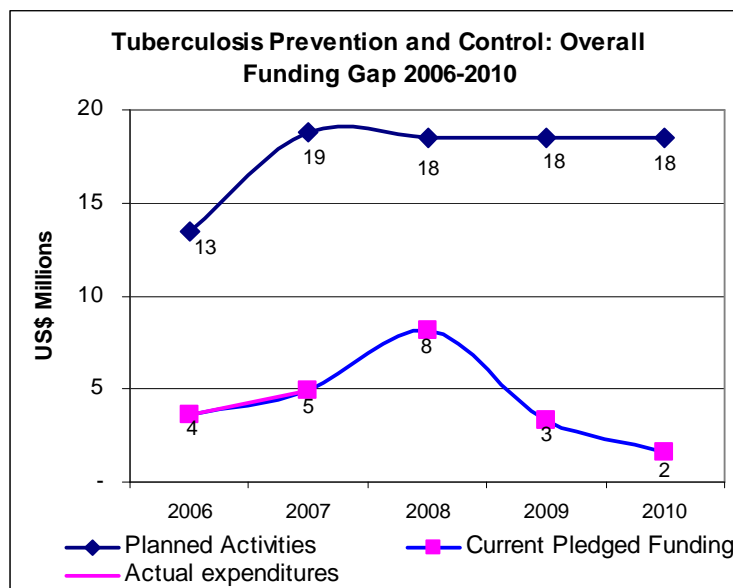


Chart 15 maps the total costs of the scaled-up activities and resource availability for the period 2006 to 2010. Resource availability data is summarised from responses to the resource tracking survey for TB and includes actual expenditures to date (2006 – 2007), current pledges (2008) and anticipated funding (2009-2010) for the national response. Rapid scale-up of activities was planned from 2006, with levels of service delivery maintained beyond 2007.

Some growth in investment has been experienced between 2006 and 2008, but this has not been adequate to bridge the escalating gap. Furthermore, current pledges depict a sharp decline in available resources for coming years, forecasting a funding gap reaching approximately US\$16 million.

### 6.5.1 Distribution of investment in the TB response in Myanmar

The four major output areas identified in the national operational plan for the prevention and control of TB are:

- Quality DOTS services provided to more than 90% of the total population including remote and hard to reach areas.
- Treatment success rate among all TB patients at or above 80% (anticipating a lower treatment success rate among HIV/TB co-infected and MDR-TB patients).
- Case detection rate at or above 70% in all States/ Divisions.
- Progress towards TB-related Millennium Development Goals measured through TB prevalence survey, Drug resistance survey and TB/HIV surveillance.

Overall, the provision of quality DOTS services receives the highest proportion of investment and together with treatment and support activities account for approximately ninety percent of total investment in the TB response in Myanmar.

**Chart 16**

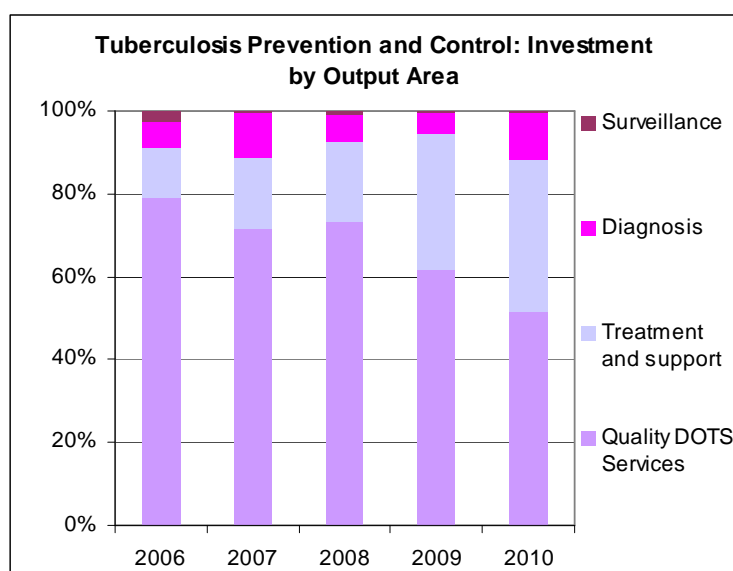
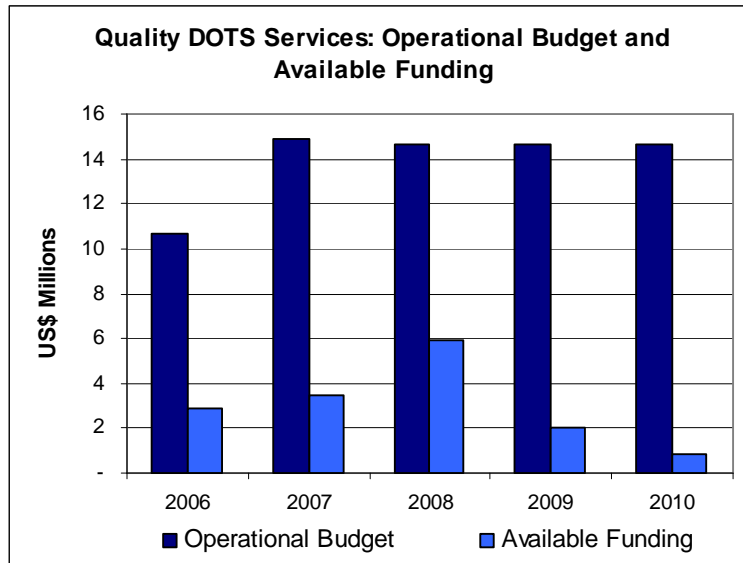


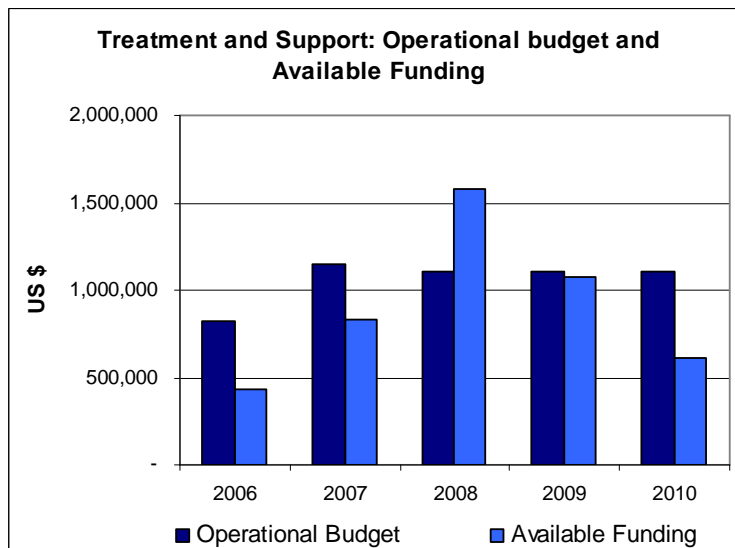
Chart 16 shows the proportion of investment in the four output areas from 2006 to 2010. In general, the relative share of investment in provision of quality DOTS services shows a steady decline from 2006 to 2010, while the proportion available for treatment and support shows a steady increase. The proportion of investment in both diagnosis and surveillance activity is relatively low and shows little growth for the same period.

**Chart 17**



The provision of quality DOTS services accounts for 80% of the total TB operational budget and investment in activities has shown a steady increase from 2006 to 2008, followed by substantial decreases. However, greater growth was planned, which results in a funding gap of US\$10 million in 2008 which equates to 45% of planned activities being achieved. Based upon anticipated funding, and extending current levels of activity, this shortfall will extend to US\$16 million by 2010, equating to a 90% funding gap.

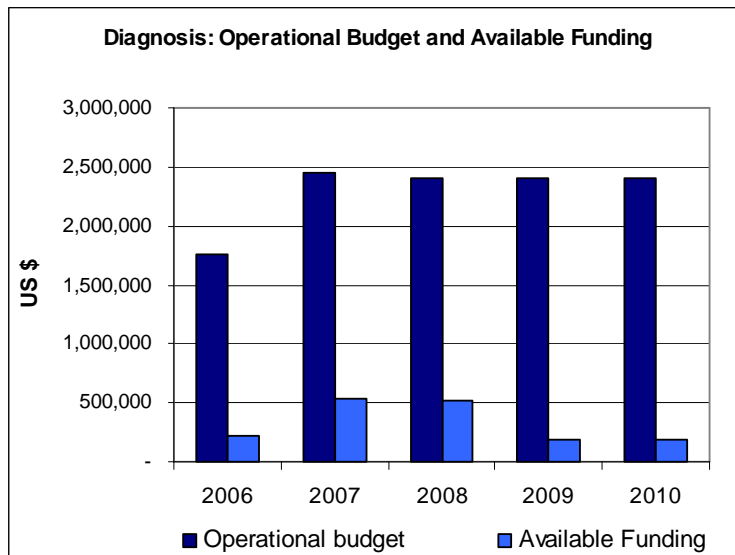
**Chart 18**



Activities for treatment and support account for 6% of the total TB operational budget. In material terms, the funding gaps which exist are considerably lower than for prevention. The data shows a surplus of funding over budget for 2008 (chart 18). Based upon anticipated funding and no change in planned levels of activity, investment in treatment

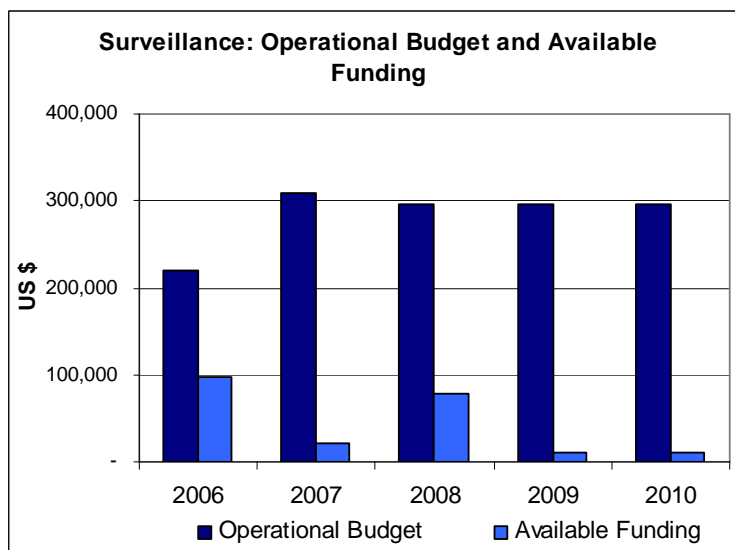
and support, forecasts a nominal gap for 2009 which increases to US\$0.5 million by 2010, which equates to funding for 45% of planned activities.

**Chart 19**



Planned activities for TB diagnosis account for 13% of the total TB operational budget. Investment in this area is consistently below 20% of budget (chart 19). Based upon anticipated funding and no change in planned level of activity this gap widens to over US\$2 million by 2010, which will result in realization of just 8% of planned activities.

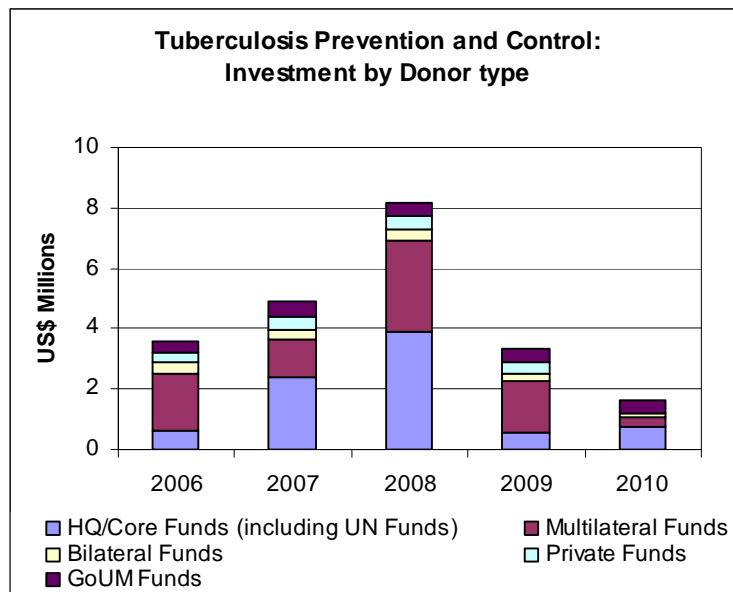
**Chart 20**



Planned activities in the area of surveillance account for just 1% of the total TB operational budget and receive a less than significant relative share of overall investment (chart 20). A funding gap of US\$0.2 million is forecast by 2010, based upon anticipated funding and continued levels of activity, this equates to 96% of surveillance activities remaining unfunded.

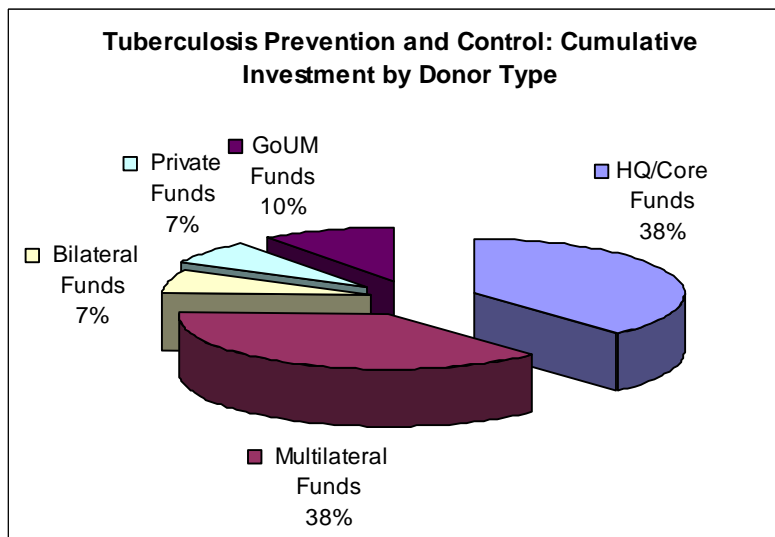
## 6.5.2 Investment in the prevention and control of TB by donor

Chart 21



Investment in the prevention and control of TB in Myanmar comes from a variety of sources. The trends depicted in chart 21 show most growth has been experienced in core funds or funds from headquarters (of both UN agencies and NGOs). Multilateral funding is the next largest contributor, the trend reflects the withdrawal of GFATM funding in 2006 and the injection of 3DF funds from mid 2007. Bilateral and private funding together account for less than US\$1 million annually. The contribution of GoUM was disclosed by both the National TB Program and WHO in the survey response, it is estimated at approximately US\$ 0.4M per year.

Chart 22



The cumulative investment in TB by each donor category for the period 2006 – 2010 is presented proportionately in Chart 22. Core or headquarter funding and multilateral funding contribute 38% each of total funding. GoUM contributes 10% while bilateral and private sources account for 7% each of cumulative funding.

## 6.6 The national response to the prevention and control of malaria in Myanmar

The National Operational Plan on Prevention and Control of Malaria in Myanmar, 2006-2009, was developed through consensus among all partners involved in malaria control in Myanmar. It reflects the objectives of the National Strategic Plan for Malaria Prevention and Control in Myanmar, which are:

- Majority of populations at risk is protected against malaria using appropriate preventive measures by 2010.
- Majority of malaria cases received quality diagnosis and appropriate treatment in accordance with national malaria treatment guidelines by 2010.
- Communities at risk of malaria and the village and township health committees actively participate in malaria prevention and control by 2010.
- Management, technical and other supportive services for malaria prevention and control, including epidemic preparedness and response, are further strengthened by year 2010.

The National operational plan envisages massive and rapid scale-up of key interventions in areas with a moderate or high risk of malaria.

No planning or budgeting has taken place for TB since 2006, which inhibits prediction of funding gaps beyond 2008. For the purpose of analysis, activity levels have been projected forward at the same levels as 2009.

**Chart 23**

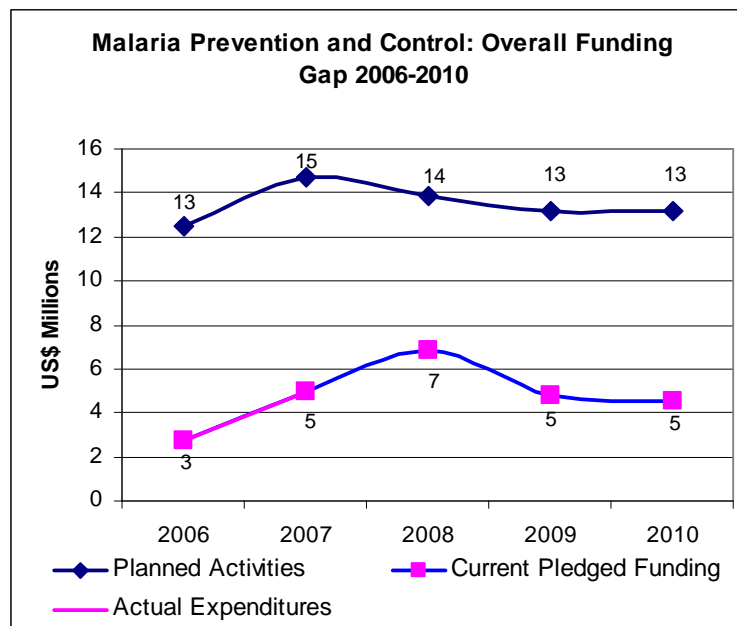


Chart 23 maps the total costs of the scaled-up activities and resource availability for the period 2006 to 2010. Resource availability data is summarised from responses to the resource tracking survey for malaria and includes actual expenditures to date (2006 – 2007), current pledges (2008) and anticipated funding (2009-2010) for the national response. Rapid scale-up of activities was planned from 2006, with levels of service delivery more or less maintained beyond 2007.

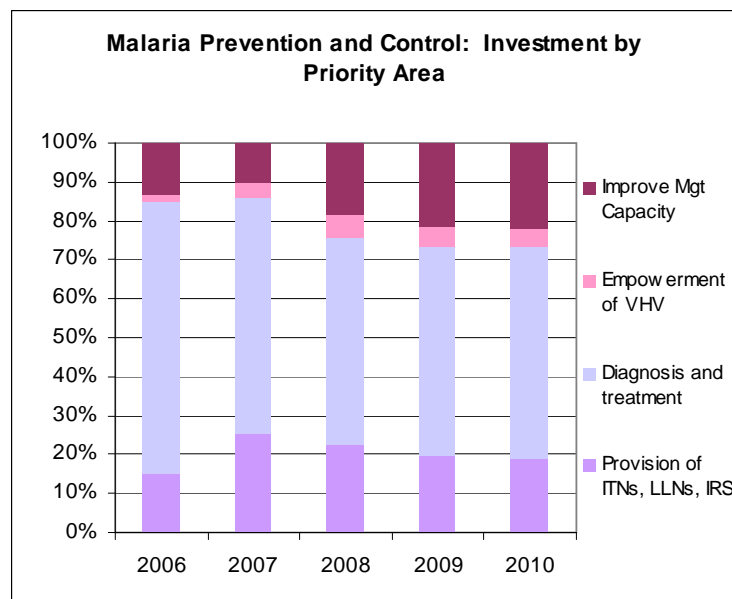
### 6.6.1 Distribution of investment in the malaria response in Myanmar

The four major output areas identified in the national operational plan for the prevention and control of malaria are:

- **(Prevention)** Populations at risk of malaria are protected with insecticide-treated mosquito nets, long lasting insecticidal nets or indoor residual spraying.
- **(Diagnosis and appropriate treatment)** Malaria cases (probable and confirmed) are treated according to national malaria treatment guidelines.
- **(Empowerment)** Empowered village health workers deliver malaria control services in malaria endemic communities.
- Improved managerial and technical capacities on malaria control, including epidemic preparedness and response.

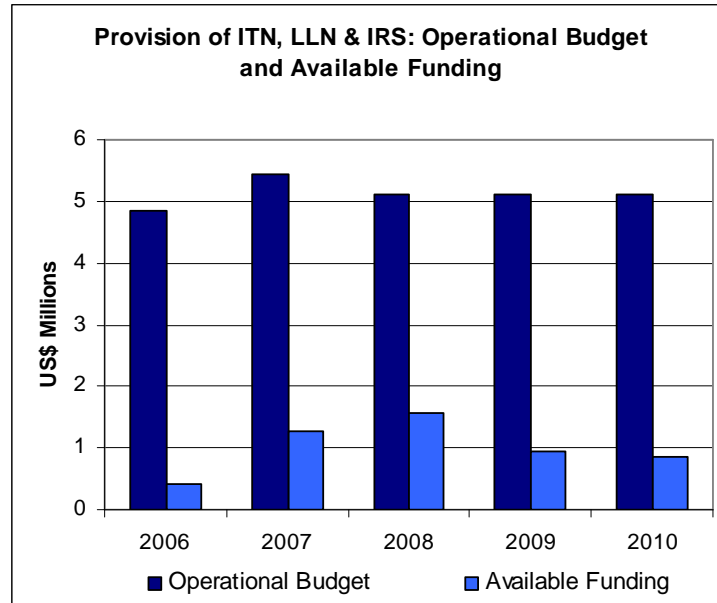
Overall, diagnosis and treatment activities receive the highest proportion of investment and along with the prevention activities associated with provision of bed nets account for more than 75% percent of total investment in the prevention and control of malaria in Myanmar (chart 24)

**Chart 24**



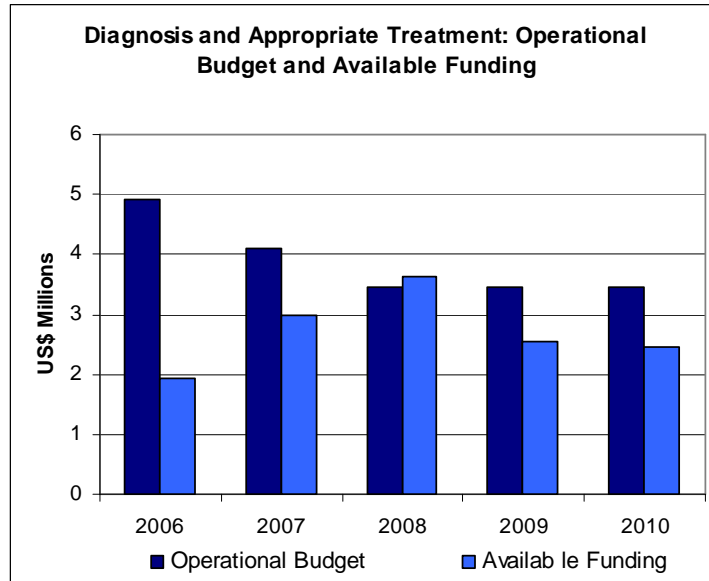
In general, the relative share of investment in provision of quality diagnosis and appropriate treatment services shows a steady decline from 2006 to 2010, while the proportion available for provision of bed nets shows a steady increase. It is worth noting that the proportion of funding available to improve management capacity shows consistent increases, while investment in empowerment shows relatively little growth beyond 2007.

**Chart 25**



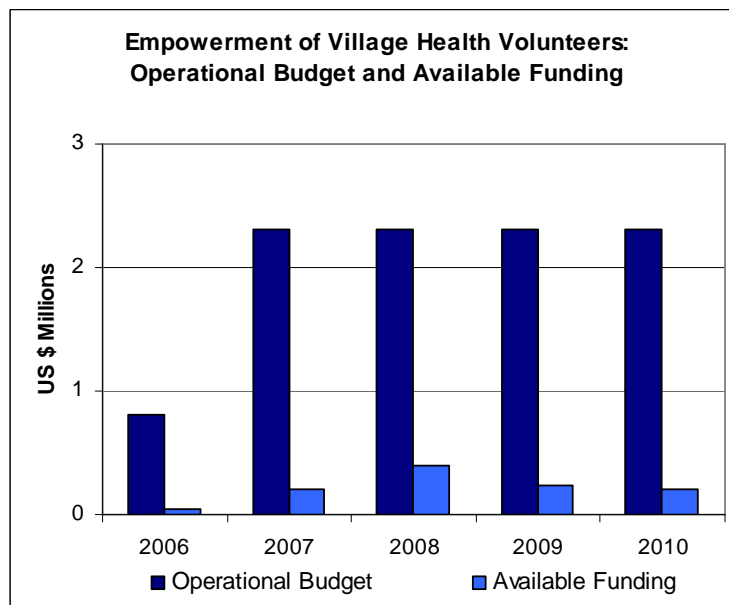
The prevention activities associated with provision of bed nets accounts for approximately one third of the total malaria operational budget and investment in activities has shown an increase between 2006 and 2008 (chart 25). However, investment is significantly less than financial requirements in this area, creating a funding gap of about US\$4 million annually. Based upon anticipated funding and extending current levels of activity, this shortfall will extend to 90% by 2010.

**Chart 26**



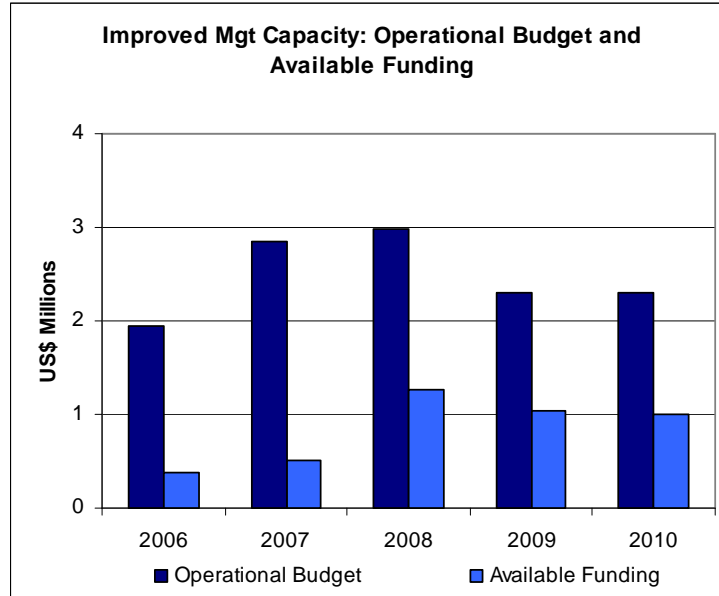
Planned diagnosis and appropriate treatment activities account for approximately 25% of the total malaria operational budget and increases in investment in this area have resulted in a small surplus by 2008 (chart 26). Based upon anticipated funding and no change in planned levels of activity, investment diagnosis activities show decreases for the impending years, creating gaps of over US\$1 million annually equating to 30% of budgeted activity.

**Chart 27**



Although empowerment activities account for around 15% of the total malaria operational budget, investment remains insubstantial in this area, at approximately US\$0.2 million annually from 2007 which results in 90% of empowerment activities remaining unfunded.

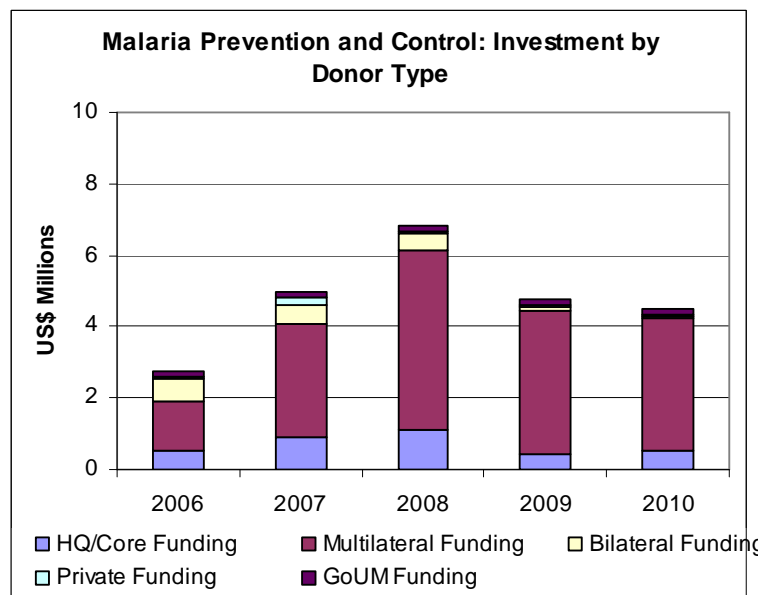
**Chart 28**



Planned improvement in management capacity accounts for approximately 20% of the total malaria operational budget. Investment in this area has shown year on year increase by 2008 and a diminishing funding gap. Based upon anticipated funding and no change in planned levels of activity, investment (and subsequently the funding gap) in this output area remains consistent at 50% of budgeted activity for 2009 and 2010.

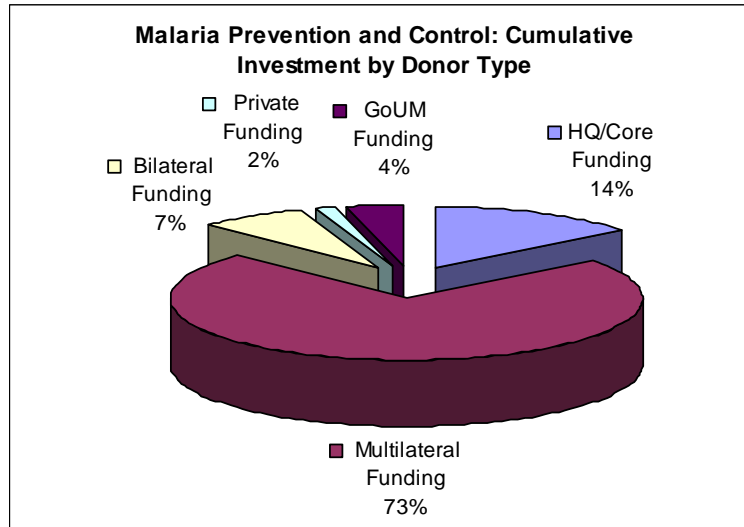
**6.6.2 Investment in prevention and control of malaria by donor**

**Chart 29**



A distinct majority of investment in the prevention and control of malaria in Myanmar comes from multi-donor sources (including 3DF) each year. Core funds or funds from headquarters (of both UN agencies and NGOs) have shown some growth between 2006 and 2008 but constitute significantly less in relative terms. Bilateral aid and private funding together account for less than US\$1 million annually. The contribution of GoUM is estimated at approximately US\$ 0.2Million per year, as indicated informally during interviews with national program personnel.

**Chart 30**



The cumulative investment in malaria by each donor category for the period 2006 – 2010 is presented proportionately in Chart 29. Multilateral funding contributes three quarters of overall funding, core or headquarter funding constitutes approximately 14%. Bilateral aid provides 8% of all funding, GoUM contributes 4% and private sources account for just 2%.

## 6.7 Other funding sources

### 6.7.1 The wider funding scenario

Some implementing partners are involved in the delivery of integrated programmes or mainstream primary health care programmes which identify communicable diseases as priority but where delivery cannot be measured against the operational focus of the national response.

To quantify the amount of funding allocated to a specific disease would require a deeper study of expenditure tracking. It should, however, be acknowledged as supplementing the direct funding of service delivery outputs, and when consolidated may have impact on the overall funding picture.

Other integrated approaches, for example, community based initiatives, also present difficulties in apportioning or quantifying the resources allocated to specific diseases and

within diseases to specific output areas. In the survey response some implementing partners have provided best estimates. Again a wider, in-depth, expenditure tracking exercise would be required to accurately quantify levels of funding allocated to the three diseases from integrated budgets.

### **6.7.2 User Fees**

The operation of user fees or private payments for services by the patient exists in the public health system in Myanmar through a cost recovery programme for some services and/or drug provision. This should be acknowledged as a resource, however, the consultant was unable to access any detailed information of the operation of the programme or its usage. To quantify user fees for inclusion in the analysis of funding available would require accurate data on expenditure, from government accounts which were not accessible for this study.

## **7. Information gap analysis**

This study required further analysis to be undertaken to determine the quality of available information for the three disease responses in order to recommend any next steps to be taken in order to better inform the 3D Fund's decision-making capacity in targeting resources to ensure the proportionate distribution of funds to priorities identified in the national strategies.

### **1.1 Financial Information gap**

Customarily, it is the national accounts that generate financial information on total national disease expenditure, expenditure per capita, and distribution of expenditure to particular strategies or economic categories. This type of information is necessary in establishing the total costs of health programs and of particular health interventions for the purpose economic analysis as well as for costing purposes for planning and budgeting.

National accounts can also highlight the interaction of public and private funding, as well as the roles of external donors and lenders, to establish the level of resources made available for health programs and interventions.

In the Myanmar context, donor funding is not channelled through government, therefore does not appear on the national accounts as either revenue or expenditure..

Within the national response for each disease there exist various modes of financial information flow:

- implementing partners report financial activity, of 3DF funds only, to the 3DF Fund Manager, in line with the fund requirements;
- implementing partners also report financial activity to head-quarters and often to their various donor sources, in line with specified reporting requirements;
- the national programs (and some implementing partners) report financial activity to Department of Health

In terms of administration and disbursement of funds there are again various practices in operation:

- 3DF funds are managed locally by the 3DF Fund Manager and disbursed to the national programmes by WHO;
- INGOs disburse and administer funds in line with headquarters or donor requirements.

This results in separate, parallel and often duplication of financial reports being generated to meet various reporting requirements. Financial information is fragmented in terms of economic categorisation and currency used. Although the reporting requirements of various stakeholders are being met, a fundamental gap exists in that there is no comprehensive system of financial information available which consolidates the overall financial activities involved in the implementation of the disease responses and from which the 3DF can draw the financial information required for decision making in resource allocation.

A strong, comprehensive system of financial management is required to deliver accurate, evidence based financial information that is necessary for economic cost analysis purposes.

## **7.2 Disease Information gap**

Within the public sector, the Department of Health Planning operates a Health Management Information System (HMIS). Information is collated from health units at township, district and divisional level on a bi-annual or quarterly basis. The information compiled in terms of HIV/AIDS, TB and malaria is generally case finding based, epidemiology data. This information is compiled in an annual report published on each disease response.

National information on the burden of each disease is flawed for various reasons. For Malaria, information from the national surveillance system reflects hospital based data on aggregated malaria cases in Myanmar, presented by age, gender and sub-national level. The data is often in conflict with information from community based programmes, which is not captured in the national statistics and suggests under-reporting of malaria prevalence. For TB, estimates of burden are based upon prevalence surveys carried out up to 1994 and incidence rate is assumed to be constant in the absence of information to the contrary. Data on the burden of disease for HIV/AIDS is based upon methods of estimation of “most-at-risk” populations.

The implementing partners for each disease response report to their own headquarters on a regular basis as well as to national programs on a quarterly or annual basis. Reporting is against the monitoring and evaluation (M&E) frameworks established for the national operational plans and are generally focused on the technical aspects of implementation and on case findings and management.

During the execution of the study the consultant was not aware of the existence of any available information on the impact of the various interventions within each disease response, in either financial or physical terms. Performance data is not generally included in any current reporting requirements.

The consolidation of outcome based information and accurate financial information enables cost analysis to be carried out for better targeting of resources.

## **8. Required next steps**

In the current environment of scarce resources, the 3D Fund Board needs to ensure a high degree of prioritization in the allocation the funds they manage. This can be achieved through evidence based recommendations on resource allocation between diseases and within each national strategic program, whilst considering the most cost-effective interventions in order to maximise impact on the three diseases.

Resource allocation is the process of distributing available resources against interventions competing for the same budget, whilst achieving a specific goal, in the case of the 3D Fund this goal is to reduce the mortality and morbidity for TB, malaria and HIV/AIDS.

There are many different approaches which can be applied in decision making for resource allocation.

The simplest models are based upon equity criteria. In the context of the three diseases in Myanmar this would represent allocation proportional to the burden of each disease and within diseases proportional to the number of cases of disease in different target groups (e.g. the different risk groups identified in the HIV/AIDS response).

Economic analysis tools can help set priorities and enable allocation of resources to interventions in the order of cost-effectiveness ratios until the budget is depleted.

A number of approaches can be adopted. This table provides an overview of different types of economic analysis

### Advantages and Disadvantages of Various Approaches to Economic Analysis

Approach	Measure	Pros	Cons
Cost Benefit Analysis	Rate of return (%)	Enables comparisons to be made with interventions outside d	Problems in putting a financial value on (quality of) life
Cost Effectiveness Analysis	Cost per Unit e.g. life saved, couple year of protection, death averted	Enables comparisons between interventions with <i>similar</i> outputs	Does not allow comparisons between services with different outputs
Cost minimisation	Cost	Enables comparisons to be made between interventions with <i>identical</i> outputs	Rarely applicable
Cost Utility Analysis	Cost per DALY or QALY	Enables comparisons between all interventions with a health impact.	Does not allow comparisons with non health interventions

**Cost Benefit Analysis (CBA):** a compares benefits and costs, discounted at suitable rates, in money terms. This is a broad form of analysis and represents the ideal approach as it allows interventions to be compared within each response and with other responses. This would allow the 3DF Fund, for example, to make informed decisions as to which uses of funds represent the best value for money. Unfortunately, the problem of measuring health outcomes, and then valuing them in monetary terms, usually means that this approach has been little used within health sectors.

**Cost Effectiveness Analysis (CEA):** compares the costs of an intervention with a natural unit of health output which has no money value attached e.g. cost per life saved. The major deficiency of this approach is that it can only deal in outputs which are one-dimensional. So, although CEA can identify the best way of doing something, and changes in resource use can be analysed, it does not tell us whether it was worth doing in the first place. In practice, the outputs of disease interventions are often multi-dimensional and can change not just quantity or quality of life but both, this approach is of limited usefulness.

**Cost Utility Analysis (CUA):** comparison of costs with a multidimensional measure of health benefit or impact. Disability Adjusted Life Year (DALY), Quality Adjusted Life Year (QALY) are measures which take account of effects on both quantity and quality of life. This is a step on from cost-effectiveness analysis, allowing the comparison of interventions through the development of a composite health indicator – covering both life expectancy and health related quality of life. This approach is useful for interventions which produce reductions in morbidity as well as mortality. A key point to note is that the health outcome has to be measured subjectively.

**Cost minimisation** – in a very small number of cases where the outputs are identical it is possible to simply identify which intervention has the lowest cost.

Economists have traditionally used *cost benefit analysis* as their gold standard. In simple terms it requires identifying costs and benefits and placing a monetary value on both. This allows for comparison of the return on investment across various activities and selecting those which offer the highest returns. The problem is that in health, whilst we can put a value on costs, it is much harder to put a value on health benefits and lives saved. Resource allocation decisions in relation to the three diseases in Myanmar are also influenced by social, ethical and other factors which are impossible to quantify.

The method of choice in the health sector is usually *cost utility analysis* (most often referred to cost-effectiveness analysis). This involves creating a composite measure of health (such as QALYs or DALYs) which captures the effects of intervention on both the *quantity* of life (life expectancy) but also, crucially, on the *quality* of life. This allows comparisons to be made across different interventions.

The Board of the 3DF would benefit from employing cost-effectiveness analysis to establish formulae for resource allocation which reflect as precisely as possible the variation in need across the three diseases and across geographical area.

Economic analysis relies on accurate information (or evidence) on

- the total costs of interventions, including both direct and indirect costs;
- the impact of various interventions, identified as natural units, e.g. no. of disease cases identified, no. of disease cases avoided/[prevented, no. of life years saved.

This in turn relies upon:

- an adequate financial management system to provide cost data and trends;
- reliable, up-to-date data on disease burden and impact of interventions on disease;
- a system for monitoring and evaluation to ensure resources are in fact put to their intended use.

A further consultancy would provide the technical assistance required for the development of appropriate systems of financial and disease information and should consist of:

- a disease specific public health specialist with the clinical expertise required to determine the evidence required to assess the impact of interventions on disease, and the methods required to retrieve and interpret the data required;

- A health financial systems specialist to develop a financial management system to capture pertinent cost data and financial flows;
- A monitoring and evaluation specialist to ensure that the M&E systems reflect resources are meeting their intended use.

The ownership of the information systems and the responsibility for the collection and management of information would initially rest with the 3DF, as development of systems will meet the decision-making needs of the fund's Board, but will require the support of the TSG's, the UN secretariats and the national programs for successful operation.

Some pre-conditions are also necessary within the national responses before such systems of information can be fully developed:

- The planning and budgeting capacity of the TSGs needs to be re-stimulated to operate on a more dynamic basis to produce three year rolling plans which consider plans for the coming year in detail with indicative data for subsequent years.
- The use of standard costing methodologies and budgeting tools should be encouraged for establishing unit costs of interventions. Unit costs are average costs and generally include assumptions of coverage, but for financial need estimation and resource allocation they are easy to compute, accurate and provide a basis for comparison.
- The planning and budgeting function, supported by strong information systems, will be capable of re-examining service delivery targets and activity levels required to address the national strategies. Operational plans and supporting budgets developed can thus present an accurate assessment of financial need.

As a result of the further efforts in establishing evidence based financial and disease information, and strengthening the systems of planning and budgeting recommended here, the 3DF Board will be able to rely on the assessment of need presented in three year rolling plans and, together with the economic analysis of the costs of specific interventions and impact on disease, develop an approach to resource allocation which is evidence based, transparent and delivers stability to prioritized strategies.

## Annex A

### Terms of Reference

#### **HEALTH ECONOMICS CONSULTANCY FOR 3D FUND TO CONDUCT A COMPLEX GAP ANALYSIS FOR POLICY FORMULATION AND STRATEGIC DECISION MAKING**

##### **1. Introduction**

The overall objective of the Three Diseases Fund (3D Fund) is to reduce the burden of communicable disease in Myanmar, i.e. to reduce the mortality and morbidity for TB, malaria and HIV/AIDS. Its purpose is to resource a countrywide program of activities to reduce transmission and enhance provision of treatment and care for HIV and AIDS, tuberculosis (TB) and malaria for the populations most in need.

Supported by Australia, EC, the Netherlands, Norway, Sweden and the UK, the pooled funds are managed by the 3D Fund Manager (UNOPS) according to priorities set by the 3D Fund Board. Activities will primarily be derived from National Strategies and Operational Plans that are in line with 3D Fund priorities described in the Guidelines for the Allocation of 3D Fund Resources. This will be done by funding Implementing Partners (IPs) drawn from UN Agencies and INGOs to work with local NGOs and professional associations, the private sector and local civilian administrations at township level to deliver and scale up provision of health services to address the three diseases. There is a clear distinction between management of the 3D Fund and the activities being funded.

The actions financed by the Fund target those most at risk of being affected by each of the three diseases, with a particular focus on those who have limited or no access to public health services due to geographical or security considerations, or for reasons of ethnicity, gender, stigmatization or financial status.

On the Program side, national Technical and Strategic Groups (TSG) – one per disease – are chaired by the Ministry of Health (MoH) with UN technical support and with members drawn from a wide range of stakeholders. The TSGs are responsible for finalization of the National Strategic Plans (NSP) and for leading the development of the outcome-based country wide Operational Plans (NOP) incorporating all existing Implementing Partners (IPs). Based on the Operational Plans, the Board seeks technical advice from the Fund Manager before deciding on Fund priorities and on funding allocations. The Fund Manager implements the decisions of the Board, negotiates as necessary with potential implementing partners and monitors implementation.

A set of Operational Guidelines have been developed for use by Implementing Partners and by staff of the Fund Manager's Office from 1 April 2007. They will be updated as implementation proceeds and as the need arises.

##### **2. Justification of the Consultancy**

The 3D Fund would benefit from a thorough understanding of financial and geographical gaps currently present in these three diseases and from a system/situation analysis in order to identify financial gaps in coverage.

*Operational objective:* The purpose of the consultancy is to inform 3DF on the financial needs of the national programs by providing support to the TSGs to prepare/finalise the costing of the

National Strategies, operational plans of the national programs and budgets for the three diseases linking these to any established budget processes.

Establish a clear understanding of financial needs for the implementation of the National Strategic Plans (NSP) and collate the available funds for the three diseases in Myanmar from all sectors and resources.

Through this work, identify the gaps in available information and data and in addition recommend further steps needed to be taken in order to make evidence based recommendations on resource allocation between diseases and within each national strategic program.

### **3. Methodology**

The consultancy will be carried out through a combination of study and review of available materials and documentations and policy papers of the 3DF, NSPs, NOPS, consultations with 3DF FM staff, and data compilation collected by the consultant from and together with the TSGs, partner UN agencies and 3DF Implementing Partners through interviews/consultations with all stakeholders and holders of valuable data. The involvement and collaboration with TSGs is a core element of the work to be carried out:

- a. Technical and Strategic Groups/ National Programs (HIV/AIDS, TB, and Malaria);
- b. UN Agencies involved in HIV/AIDS, TB, and Malaria programs;
- c. International Non-Governmental Organizations (INGOs);
- d. Staff of the Fund Manager's office in Yangon;
- e. Other donors in Myanmar

### **4. Outputs**

For the Operational Objective:

Verify and re-calculate the budgets of the National Operational Plans and compile a comprehensive analysis of presently available funds for the three diseases from all sectors and sources, including national budgets, donors and user fees. Analyse the quality of information available and make recommendations on the further steps, its modalities and approaches necessary to make evidence based allocations between disease and with the different interventions within each disease's national program:

- Identify the financial needs for the implementation of national programs (including all works in support of the NSP)
- Re-calculate, with the assistance of relevant stakeholders in collaboration with TSGs, the budgets of the NOPS. Pricing/costing should be updated and verified. Consolidated budget tables presented.
- Acquire and compile a comprehensive overview of all available funds for the three diseases in Myanmar from all sectors and sources.
- Identify financial gaps in coverage. The general analysis should be based on what is needed to implement the national strategies in their entirety.
- Analyse the quality of available disease and financial information and data on the three diseases taking into account possible under- or over-reporting of prevalence and incidence of disease data and quality as well as quantitative gaps of the information available in the NSPs and NOPS.
- Make recommendations on the necessary further steps and the approach and modalities on what is deemed necessary to create further evidence for resource allocation of 3DF funds between diseases and between the different interventions within the disease specific operational plans.

- Present the first interim report and its findings at the 3DF Fund Board meeting on 31 March 2008 and this interim report's presentation at the 3DF Annual Review meeting on 1 April 2008 if the latter is required by FB.

The consultant will provide a comprehensive report with data sets where financial needs are listed in detail for the implementation of the national programmes, budgets of NOPS re-calculated, designed and presented and costs are listed. In addition the consultant will gather the necessary data from stakeholders and compile all available funds in Myanmar for the three diseases in all sectors and from all sources and the report will include a full analysis of these findings – a financial gap analyses. The report will in addition include an analysis of the quality of data and information available for each disease and a list of recommendations on the necessary steps and further study/analysis and its modalities necessary to create evidence for allocation of funds between and within the diseases for best utilisation of resources.

An interim report/presentation should include the financial gap analysis as per the Operational Objective available before the 31 March 2008 and be presented at the 3DF Fund Board meeting.

## **5. Qualifications and responsibilities of the consultant**

The review will be carried out by an international consultant who has relevant Masters level academic background and who has hands-on experience in the design, management, and evaluation of public health operations in resource-constrained settings, and has a demonstrated capacity for strategic thinking. The consultant should have a good knowledge of health economics, public health aspects of the three diseases, public financing, data management, as well as humanitarian aid interventions, and preferably have prior experience and exposure to the special circumstances governing humanitarian assistance to Myanmar.

## **6. Implementation Arrangement**

- The Consultant will be briefed by Fund Manager's office prior commencing the work;
- The FM's office will work closely with the consultant: the FM's office will provide logistical and administrative support to the consultant as needed; the FM's office will ensure that all relevant background material and documentation are made available to the consultant, either before or during the review;

## **7. Timing and Duration**

The total duration of the assignment should not exceed **35 working days**. The first interim report/presentation to fulfil the Operational Objective should be available latest **31 March 2008**.

The consultant will complete and finalise the full report responding to the Operational Objective and submit it to the CEO, Fund Manager within one week after receipt of comments from Fund Manager's office to the complete draft report. FM will provide feedback 2 weeks after receiving the drafts.

## **8. Contract Management**

The Consultant will be contracted by UNOPS who will be responsible for the management of the contract.

## Annex B

### Myanmar - Funding sources for Malaria Prevention and Control

#### Organisation:

Please provide the amount for each donor contributing to the program; in the case that contributions are not per calendar year, calculate pro rata

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Source of funding / name of donor	2006 Funding Expended	2007 Funding Expended	2008 Committed Funding	2009 Indicative Funding	2010 Indicative Funding
Core funds / HQ allocation					
Donor 1 (name)					
Donor 2 (name)					
Donor 3 (name)					
Donor 4 (name)					
Donor 5 (name)					
...					
...					
Total	-	-	-	-	-

**Annex B**

**Myanmar - Resource availability for Malaria Prevention and Control**

**Organisation:**

Column 1		Column 2	Column 3	Column 4	Column 5	Column 6
Outputs		2006 budget allocation US\$	2007 budget allocation US\$	2008 expected budget US\$	2009 expected budget US\$	2010 expected budget US\$
<b>1. Population at risk of malaria are protected with either insecticide-treated mosquito nets, long lasting insecticidal nets or indoor residual spraying</b>						
1.1	Annual mass treatment of mosquito nets with insecticide					
1.2	Provision of long-lasting insecticidal nets (LLINs) to marginalised populations in high risk of malaria					
1.3	Behaviour change communication for appropriate use of ITNs/LLINs					
1.4	Indoor residual spraying in selected areas					
	Other (specify):					
<b>Sub-total Output 1</b>		-	-	-	-	-
<b>2. Malaria cases are confirmed either by microscopy or RDTs and treated according to national malaria treatment guidelines</b>						
2.1	Establishing/maintaining quality assured malaria microscopy services at different levels of health care facilities					
2.2	Diagnosis of malaria using rapid diagnostic tests					
2.3	Quality assurance of malaria rapid diagnostic tests					
2.4	Training/re-training of malaria rapid diagnostic tests					
2.5	Social franchising of private medical practitioners					
2.6	Operating mobile and fixed malaria clinics in remote strategic areas					
2.7	Treatment of malaria cases in accordance with national malaria treatment guidelines					

2.8	Behaviour change communication to improve care seeking practices and adherence to treatment					
	Other (specify):					
	<b>Sub-total Output 2</b>	-	-	-	-	-
<b>3. Empowered village health volunteers deliver malaria control services in hard to reach highly endemic communities</b>						
3.1	Development and production of advocacy materials, training kits and job aids for village health volunteers					
3.2	Advocacy, community mobilization and recruitment, training and supportive supervision of village health workers in hard to reach malaria endemic villages					
	Other (specify):					
	<b>Sub-total Output 3</b>	-	-	-	-	-
<b>4. Improved managerial and technical capacities on malaria control, including epidemic preparedness and response.</b>						
4.1	Training of concerned health staff on different aspects of malaria control program, program management, field entomology and vector control, community mobilization, basic malariology, etc					
4.2	Improving information systems for decision making at all levels particularly at township					
4.3	micro-stratification of areas for better targeting of interventions					
4.4	Improving evidence base for policy development (operational research, studies on drug efficacy, quality of malaria drugs, insecticide susceptibility, vector behaviour, etc)					
4.5	Improving supply chain management					
4.6	surveillance and epidemic preparedness and response					
4.7	Technical support to NMCP and TSG by WHO					
4.8	Planning, supportive supervision, monitoring and evaluation					
4.9	Others					
	<b>Sub-total Output 4</b>	-	-	-	-	-
	<b>TOTALS</b>	-	-	-	-	-

## Myanmar - Resource availability for Tuberculosis Prevention and Control

Organisation:

	Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
	OUTPUTS	2006 budget allocation US\$	2007 budget allocation US\$	2008 expected budget US\$	2009 expected budget US\$	2010 expected budget US\$
<b>Objective # 1: To sustain and improve the quality of DOTS services to reach all TB patients</b>						
<b>Output # 1: Quality DOTS services provided to more than 90% of the total population including remote and hard to reach areas.</b>						
# 1.1	To strengthen the Human Resources to ensure adequate technical and managerial capacity at all levels within the program, including among TB providers in other sectors and community ( <b>Human Resource Development</b> ).					
# 1.2	To build the infrastructure required to implement the program including laboratory and radiology infrastructure and transport facilities, storage and telecommunications network ( <b>Infrastructure Development</b> ).					
# 1.3	To ensure uninterrupted supplies of quality first and second line anti-TB drugs, laboratory supplies and commodities ( <b>Procurement and Supply Management</b> ).					
# 1.4	To enhance regular <b>Supervision, Monitoring and Evaluation</b> to enable the program to measure and achieve its targets.					
# 1.5	To strengthen <b>Advocacy and Partnerships</b> with other sectors, ministries, development and technical agencies and related programs such as HIV/ AIDS					
# 1.6	To conduct <b>Operational Research</b> to improve the accessibility and delivery of TB services.					
	<b>Subtotal Output 1</b>	-	-	-	-	-
<b>Objective # 2: To improve the treatment success rate among all detected TB patients</b>						

<b>including those with TB-HIV and multi-drug resistant forms of TB.</b>						
<b>Out put # 2: Treatment success rate among all TB patients at or above 80% (anticipating a lower treatment success rate among HIV/TB co-infected and MDR-TB patients).</b>						
<b># 2.1</b>	To ensure the timely detection and the quality treatment of all TB cases, including children, through strengthened <b>Case Management</b>					
<b># 2.2</b>	To establish mechanisms for better patient support during treatment including direct observation of treatment, improved counselling, patient transport and greater social support ( <b>Supporting TB Patients</b> )					
<b># 2.3</b>	To implement DOTS-Plus pilot projects for the detection and treatment of <b>MDR-TB</b> through Green Light Committee mechanism					
<b># 2.4</b>	To strengthen and expand <b>TB-HIV collaboration and intervention</b> with National Aids Program and partners					
	<b>Subtotal Output 2</b>	-	-	-	-	-
<b>Objective # 3: To maintain the case detection rate of the estimated new smear positive TB cases at or above 70%.</b>						
<b>Output # 3: Case detection rate of estimated new smear positive TB cases at or above 70%.</b>						
<b># 3.1</b>	To ensure earlier <b>identification of infectious patients</b> through improving access to microscopy services.					
<b># 3.2</b>	To engage and empower the TB patients and their communities through <b>Community Based Outreach Activities</b>					
<b># 3.3</b>	To develop and implement <b>Behaviour Change Communication</b> strategies down to the grass root level to enhance utilization of TB services					
	<b>Subtotal output 3</b>	-	-	-	-	-

<b>Objective # 4: To establish the baselines and objectively measure reductions in the prevalence of TB including HIV-TB and MDR-TB and TB deaths, towards more accurately determining progress towards the Millennium Development Goals.</b>						
<b>Out put # 4: Progress towards TB-related Millennium Development Goals measured through TB prevalence survey, Drug resistance survey and TB/HIV surveillance.</b>						
<b># 4.1</b>	To measure progress towards TB-related MDGs and to assess TB, TB/HIV and MDR-TB epidemiology ( <b>Surveillance and Epidemiology</b> ).					
	<b>subtotal Output 4</b>	-	-	-	-	-
	<b>Total</b>	-	-	-	-	-

## **Annex C**

### **List of implementing partners participating in the resource tracking survey for the response to HIV/AIDS in Myanmar**

ADRA  
Asian Harm Reduction Network  
ALLIANCE  
AMI  
ARHP  
AZG (Medecins Sans Frontieres – Holland)  
Burnet Institute  
CARE  
Danish Red Cross  
FXB  
United Nations International Organisation on Migration (IOM)  
JACA  
Malteser International  
Myanmar Anti Narcotics Association  
MBCA  
MDM  
MHAA  
Myanmar Medical Association  
MNA  
Myanmar Red Cross Society  
Medecins Sans Frontieres, Suisse  
MSI  
National Aids Program  
PACT Myanmar  
PARTNERS  
Progetto Continenti  
PGK  
Population Services International (PSI) Myanmar  
Save the Children  
UNAIDS  
UNDP  
UNFPA  
UNICEF  
UNION  
UNODC  
World Food Programme  
World Health Organisation  
World Vision

### **List of implementing partners participating in the resource tracking survey for prevention and control of TB in Myanmar**

Asian Harm Reduction Network  
AZG (Medecins Sans Frontieres – Holland)  
CARE Myanmar

Japanese International Cooperation Agency (JICA)  
Malteser International  
Myanmar Medical Association  
National TB Program  
PACT Myanmar  
Population Services International (PSI) Myanmar  
World Health Organisation  
World Vision

**List of implementing partners participating in the resource tracking survey for prevention and control of Malaria in Myanmar**

AZG (Medecins Sans Frontieres - Holland)  
CARE Myanmar  
CESVI  
United Nations International Organisation on Migration (IOM)  
Japanese International Cooperation Agency (JICA)  
PACT Myanmar  
Population Services International (PSI) Myanmar  
World Health Organisation  
World Concern  
World Vision

## Annex D

### List of donor organisations identified as sources of funding in the resource tracking surveys

Source of Funding/Donor Organisation	Category	HIV/AIDS	TB	Malaria
3DF	Multilateral	√	√	√
AusAID	Bilateral	√	√	√
Australia Nat Com UNICEF	UN	√		
CARITAS	Private	√		
Chevron	Private		√	√√
CIDA	Bilateral	√		
Daewoo	Private	√		
DFID	Bilateral	√	√	√
EC	Multilateral	√	√	√
ECHO	Multilateral	√		√
Episcopal Council	Private	√		
FHAM	Multilateral	√		
Germany	Bilateral	√		√
Global Drug Facility	Multilateral		√	
Government of the Union of Myanmar	Bilateral	√	√	√
GFATM	Multilateral	√	√	√
Japan	Bilateral	√	√	√
Jap Nat Com UNICEF	UN	√		
Italy	Bilateral	√		
Netherlands	Bilateral	√		
Denmark	Bilateral	√	√	√
Mekong Malaria Program	Private			√
Norway	Bilateral	√	√	√
NRMFA	Bilateral		√	√
NOVIB	Private	√		
New Zealand NZAID	Bilateral	√		√
PAF	Bilateral	√		
Switzerland SDC	Bilateral	√	√	√
Sweden SIDA	Bilateral	√		
Swiss Foundation	Bilateral	√		
UK Nat Com UNICEF	UN	√		
UN organization Core/HQ	UN	√	√	√
UIATLD	Private		√	
USAID	Bilateral	√		
Total – Yadana	Private	√		