

Final: 04 July 2009

Three Diseases Fund

**Monitoring and Evaluation Framework for Prevention and Control of
HIV, TB and Malaria**

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List of Abbreviations and Acronyms

3DF	Three Diseases Fund
AIDS	Acquired Immune Deficiency Syndrome (Also seen as: Acquired Immunodeficiency Syndrome)
ANC	Antenatal Care
ACT	Artemisinin-based Combination Therapy
ART	Antiretroviral Therapy
ARVs	Anti-retroviral drugs
BCC	Behavior Change Communication
BHS	Basic Health Staff
BSS	Behavioral Surveillance Survey
DALY	Disability-Adjusted Life Years
DOTS	Directly Observed Treatment - Short course
EOP	Effective Operations Policy
FB	Fund Board
FM	Fund Manager
GP	General Practitioner
HF	Health Facility
HIV	Human Immunodeficiency Virus
HSS	HIV Sero-Surveillance
HYLG	Healthy Years of Life Gained
IDU	Injecting Drug User
IEC	Information, Education and Communication
INGO	International Non Governmental Organization
IP	Implementing Partner
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Net
LLIN	Long Lasting Insecticidal Net
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MDR	Multi-Drug Resistance
MOA	Memorandum of Agreement
MOH	Ministry of Health
MIS	Management Information System
MSM	Men who have Sex with Men
NMCP	National Malaria Control Programme
NOP	National Operation Plan
OG	Operational Guideline
OHW	Outreach Health Workers
OI	Opportunistic Infection
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PPM	Public-Private or Public-Public Mix
PTB	Pulmonary tuberculosis
RDT	Rapid Diagnostic Test
SDP	Service Delivery Point
SOP	Standard Operating Procedure
ss+	Sputum smear positive
STI	Sexually Transmitted Infection

SW	Sex Worker
TB	Tuberculosis
TSG	Technical and Strategic Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNOPS	United Nations Office for Project Services
UNICEF	United Nations Children's Fund
VBDC	Vector-borne Disease Control
VCCT	Voluntary Confidential Counseling and Testing
VHW	Village Health Worker
WHO	World Health Organization

Glossary of Terms

1. Capacity development is a process to improve the ability of a system to meet objectives and improve performance.
2. Coverage is the extent to which a programme reaches its intended target population, institution, or geographic area.
2. Target population refers to the group of people who are in need of an intervention. The target population can be the total population or a smaller, specific group such as young people.
3. Evaluation is the systematic and objective assessment of an on-going or completed project, programme or policy, its design, implementation and results. Evaluation also refers to the process of determining the value or worth of a particular project, program, or policy.
4. An indicator is a specific measure of program performance or impact that is tracked over time by the M&E system. Indicators provide the quantitative and qualitative detail to a set of goals, objectives and targets of a policy or program.
5. Monitoring is the routine tracking of key elements of a programme or project and its intended outcomes. It usually includes information from records and surveys and can be both population and client-based.
6. Prevalence is the measure of a condition in a population at a given point in time, (numerator, number of people with a given condition at a certain time; denominator, population at the same time).
7. Surveillance is the routine tracking of disease status or behaviour over time via a single data collection system. Surveillance is not necessarily in relation to any specific program or intervention.
8. Triangulation refers to the analysis and use of data from multiple sources which have been obtained using different methods. Findings are cross-referenced enabling the weakness (or bias) of any one method or data source to be compensated for by the strengths of another. Therefore the validity and reliability of the results is increased.
9. A marginalized population is a group that experiences systemic discrimination or unequal access to power and resources in society.

1. Introduction

1.1 Context of Establishing 3DF

The Government of the Union of Myanmar identified health sector as one of its priority areas for development (UNOPS, 2006). Despite the government plan for combating the main public health challenges, the scope of providing health services was constrained by the budgetary limitations for health sector spending (UNOPS, 2007a). According to official figure, per capita expenditure for health care in Myanmar was only 428 Kyats (US\$ 0.35) in 2006 (MoH, 2007). Moreover, the services are concentrated primarily in the urban areas and the access to quality health services has largely been unavailable to the vulnerable communities, especially those in border and conflict areas (UNOPS, 2006).

Due to high morbidity and mortality, Myanmar national health policy had special focus on the prevention and control of HIV/AIDS, tuberculosis and malaria. The Global Fund initiated to provide supports for these diseases in Myanmar. However, the prospects for an adequate response to these health crises were bleak after the withdrawal of the Global Fund in August 2005.

Responding to the shortfall of funds due to their withdrawal, a group of concerned donors initiated to create the Three Diseases Fund (3DF) to be managed by UNOPS (UNOPS, 2006). The donor countries were Australia, the European Commission, the Netherlands, Norway, Sweden and the United Kingdom. By establishing a pooled funding mechanism, the 3DF was expected to support projects - designed and implemented by a group of implementing partners including selected UN agencies, international Non-Governmental Organisations (INGOs), local NGOs and professional associations, private sector and, where appropriate, local civilian administrations (UNOPS, 2007b). The priorities were given to serve those communities and populations most at risk of being affected and had limited or no access to services due to ethnicity, gender, stigmatisation, financial status or geographical considerations (UNOPS, 2007b).

The core mandate of 3DF is to serve as a Fund Manager and not a technical agency. It raises money, allocates funds to implementing partners and monitors how the funds help fight three diseases in Myanmar. Although officially established on October 2006, 3DF became operational in April 2007 (UNOPS, 2007b).

1.2 Need of Monitoring and Evaluation System

The national strategic plans for HIV/AIDS, TB and Malaria have been developed by the Ministry of Health with the technical assistance from UNAIDS and WHO (MoH, 2005; MoH, 2006a; MoH, 2006b). Each of the national strategic plans has the provision of having a monitoring and evaluation system for each of the three diseases. The national systems have the capacity not only to track programme management activities but also to measure inputs, outputs, outcome as well as impact of programme interventions. The relevant departments of the Ministry of Health (MoH) are responsible for routine monitoring of national response to the three diseases. However, the national M&E systems for the three diseases are not linked together or with the information system for other health services. Thus, the use of national M&E data has remained very limited as it cannot capture information on multiple diseases at different levels (WHO et al., 2006).

The 3DF, on the other hand, monitors the performance of its own activities and routine activities of its implementing partners by developing a common, comprehensive and uniform M&E system consistent with national monitoring systems. It measures the progress of implementing 3DF operations policy, shares performance, helps identify the gaps and challenges, provides information to take actions to fill those gaps,

ensures accountability of the use of resources and supports the evidence based policy development processes. It takes a holistic and inclusive approach to monitor the services provided to marginalized, women and poor communities living in the remote geographic areas along with general population (UNOPS, 2007c). In addition, it monitors social and programmatic dimensions of three diseases such as gender and equity, transparency and accountability, coordination and collaboration, and risk assessment and mitigation processes.

The 3DF and national M&E systems are proposed to be strategically linked together at both systems and operational levels (UNOPS, 2007b). The 3DF M&E system is designed to be consistent with the national M&E systems as it follows national guidelines, and its indicators are taken from the national strategic and operational plans. The system takes a coordinated approach and maintains continuous dialogues with the national programmes and TSG M&E working groups. On the other hand, the Fund Board and Fund Manager share the performance, achievements and challenges of the 3DF funded projects with the Coordinating Body, Ministry of Health, national programmes and TSGs. The Implementing Partners at the local level share relevant data to Township Health Departments as required. In addition, the 3DF M&E framework proposes to conduct policy studies to identify future strategies for 3DF and shares reports with relevant departments of the MoH.

Thus, 3DF has not proposed to develop a parallel system to existing national data collection activities (UNOPS, 2006). Although covers sub-national level only, data generated by 3DF M&E system using the same indicators, is likely to be complementary to the national M&E systems. If efficiently implemented by ensuring quality, 3DF data can be an important asset in preparing reports for advocacy, resource mobilization, guiding policy discussions, validating results at higher levels and understanding better indication of trends (WHO et al., 2006).

1.3 Structure and Functions

The system aims to harmonize the existing M&E systems of the implementing partners (IPs) into one coherent system to monitor and evaluate the performance of 3DF. It generates data from two levels: i) Implementing Partners (IP) and ii) Fund Manager.

1.3.1 Implementing Partners

Each implementing partner (IP) has its own M&E system to monitor and evaluate their own activities for three diseases using indicators derived from the national strategies for each disease along with indicators developed by 3DF itself. They develop plan, monitor and ensure quality of M&E activities and routinely report to 3DF. The relevant IP staff at the project/area level is responsible for collecting information from the grassroots health workers, mobile and fixed health facilities, laboratories and other service delivery points. They process, collate, compile, manage and report data to the IP offices in Yangon. Data from various project sites are compiled following the agreed principles and formats developed by 3DF.

Implementing Partners are proposed to share their consolidated reports focussing on their achievements and gaps to the national programmes in NPT through formal reports. They are also expected to routinely share raw data with Township Health Departments using the national reporting formats. To avoid double counting at the Township Health Offices, the IPs at the local level are expected to share only relevant information required by the Township Offices. Relevant information are those which the Township Health

Department cannot gather from alternative sources but has to depend on all providers working in the township.

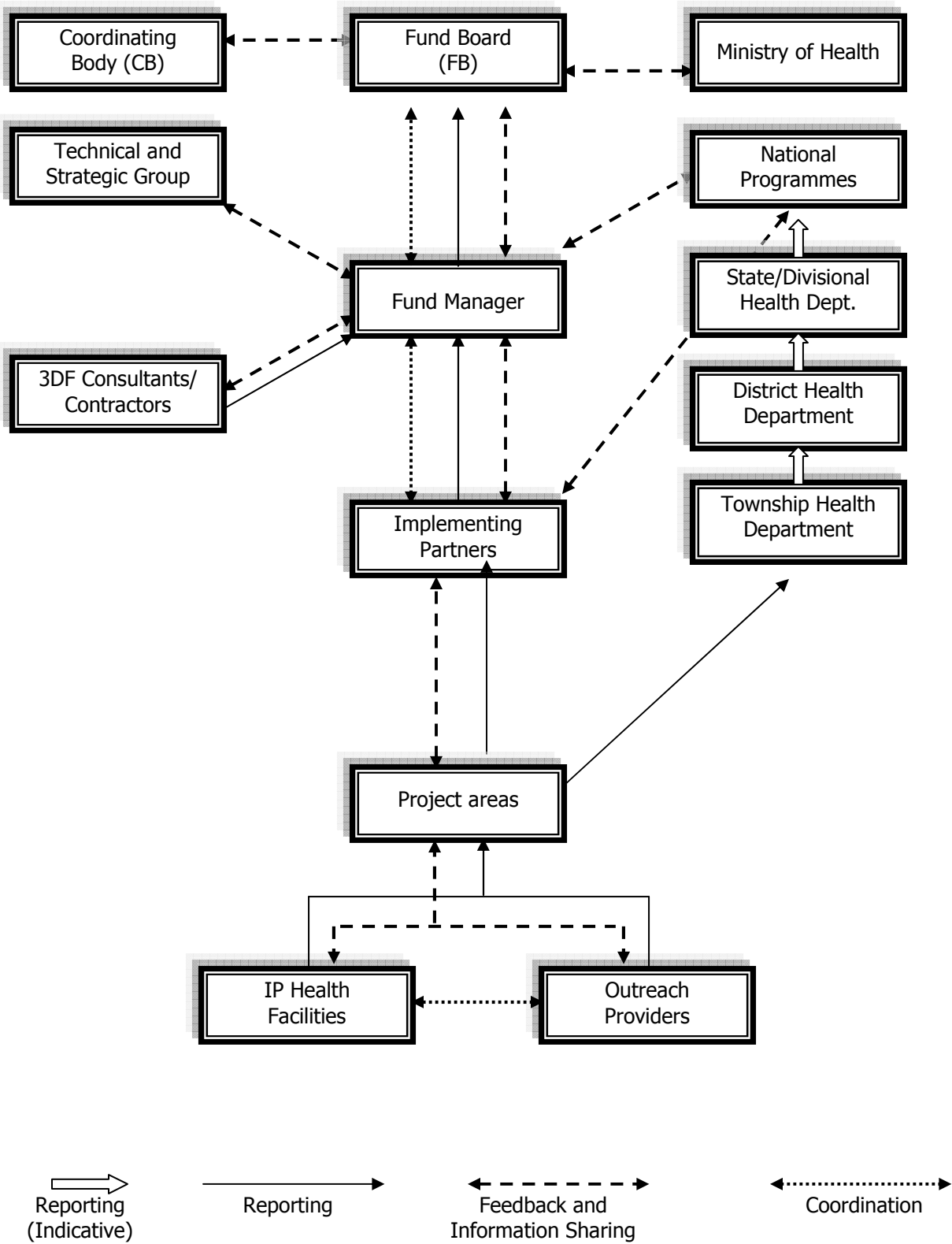
The M&E unit (or person) in each IP provides technical guidance, supervision and support for its own data collection, analysis and reporting. They are responsible to maintain the quality of data of their own M&E system. The implementing partners prepare technical and financial reports, and send the reports to Fund Manager on a regular basis.

1.3.2 Fund Manager

Fund Manager plans, develops and manages the 3DF M&E system. It coordinates with the M&E units of all implementing partners in collecting and analyzing M&E data, ensuring quality and preparing reports. Fund Manager shares the performance of its own and implementing partners to support the national responses for three diseases with the Fund Board, donor consortium, the government and other stakeholders. Fund Manager is also responsible for facilitating mid-term review and final evaluation, and conducting a series of special studies on 3DF programme activities.

For an overview of the structure of M&E system of 3DF, see Figure 1. The Fund Board shares performance and gaps of 3DF funded projects, and 3DF policy issues with the highest level of the Ministry of Health through formal meetings. The Fund Manager manages all M&E activities, facilitated to conduct special studies and reports back to the Fund Board. It shares key findings of the 3DF performance with the national programmes and Technical and Strategic Groups (TSGs) through formal meetings or sending electronic or printed reports.

Figure 1. Structure of M&E Framework for 3DF



1.4 Capacity Building

Developing capacity of the implementing partners, particularly for the CBOs and local NGOs, is considered a pre-requisite for proper monitoring and evaluation of activities (UNOPS, 2007a). With a focus on scaling up access and coverage, promotion of gender and equity, inclusion of poor and hard-to-reach communities, the proposed M&E system will create an opportunities for the implementing partners, specially local NGOs and CBOs, to strengthen health information systems at community level. This should ultimately lead to improved planning and decision-making by project beneficiaries.

Activities to develop and run an effective M&E system by the CBOs and local NGOs may begin by conducting a needs assessment study to identify the specific areas for support. This may be followed up by convening a half-day workshop with their Chief Executives to understand the current status and point out their specific M&E needs. Such a workshop would help sensitize and aware them about the need and benefits of having an M&E system in their organizations. Based on the findings of needs assessment and workshop, training workshops may be planned and carried out with at least one staff from each organization.

The agenda of the proposed workshops will include basic concepts of the M&E system, designing tailor-made input-output templates and worksheets, and field testing in their own communities for modification and finalization of the system. The workshops should be carried out in Burmese language as most of the participants are not likely to be able to communicate in English. Fund Manager should explore and identify potential training workshop providers for this task. 3DF has the provision of providing such support where required.

2. Designing and Managing M&E System

2.1 Elements of M&E System

The strength of 3DF M&E system is to *routine* tracking of key indicators of programme performance through record-keeping, facility observation and progress reports as well as *episodic* assessment of changes in targeted results related to the programme interventions. The system provides a visual conceptualization of how key activities of Fund Manager and implementing partners fit together, which inputs are necessary to run the programme, what outputs are expected and what outcomes will ultimately result.

Designing 3DF M&E system begins by assessing the requirements of Fund Manager, implementing partners and other stakeholders. The system is kept very simple and easy to be used by staff not exposed to and familiar with M&E activities. It includes a standardized core set of tools to collect and analyze data. A system of internal self-assessment and external verification is proposed to verify the completeness and accuracy of the data. Data is expected to be widely disseminated and placed in the public domain.

One widely-accepted organizing framework to assess whether an M&E system can be considered “functional” is to examine the M&E system along twelve separate components. This method, originally developed for HIV M&E systems, has been adopted and/or adapted for numerous other M&E systems as well and could, likewise, be used for assessing M&E systems in Myanmar at all levels. The twelve components, in brief, are: 1) organizational structures with M&E systems; 2) human capacity for M&E; 3) M&E partnerships; 4) M&E framework; 5) costed M&E work plan; 6) advocacy, communications and culture for M&E; 7) routine programme monitoring; 8) surveys and surveillance; 9) information systems; 10) learning and research; 11) supervision and data auditing; and, 12) data use. While it is not expected that all twelve components would already be functional, the framework does provide a starting point for assessing future capacity building needs.

2.2 Collection and Use of Data

2.2.1 Sources and contents

The flow of data is presented in Figure 2. 3DF M&E data comes from several sources.

Technical and Financial Reports

Six-monthly *Technical Progress Reports* and Quarterly *Financial Reports* from Implementing Partners (IP) provide information on programme operations and management, and a specific set of key prevention, care and support. The required data for these reports come from the routine M&E system and Management information System (MIS) of the Implementing Partners. Both quantitative and qualitative data are collected and reported in the technical progress reports.

Given that it is difficult to collect disease prevalence data and their socioeconomic correlates, the reports contain basically programme outputs and are not expected to provide information on the programme coverage except in few cases. One important feature of the reports is the analysis of the social and programmatic dimensions of diseases such as gender, equity, transparency and accountability, participation, coordination and collaboration, capacity, effectiveness and efficiency. Fund Manager and the Implementing Partners jointly develop, test and finalize the formats of the Technical Progress Report.

Special Studies and Trip Reports

To address the key cross-cutting issues and assess the performance of projects, the Fund Manager facilitated to conduct a series of *Special studies*. The studies cover two broad aspects:

- Strategy development for the 3DF and
- Performance monitoring of 3DF funded projects

Studies on strategy development are likely to provide more in-depth understanding of priority issues such as inclusion of gender approach and minority populations, increasing access and geographical coverage, risk assessment and management, effectiveness of programme interventions, and assessment of funds allocation, etc. Most of these assignments are need-based and their timeframes are finalized jointly with the Fund Board. Performance monitoring studies, on the other hand, may be conducted to understand the changes primarily at the beneficiary level such as access to and the utilization of services, equity and affordability, health seeking behaviour, etc.

Outside agencies or consultants are recruited by Fund Manager to carry out these tasks to address specific questions. All logistic, financial and other support to carry out such assignments are provided by the Fund Manager where required. Information for these studies is shared with all stakeholders including the Fund Board. The final reports, along with all data, are stored in 3DF database for further analysis.

The Fund Manager routinely monitors project activities and prepares trip reports for internal use. Commodity tracking and use of drugs, quality of care, constraints and challenges in implementation, etc. are better understood by monitoring at the field sites than using other approaches.

Mid-term and Final Evaluation

Information will be generated from mid-term evaluation and final evaluation of the Fund's performance.

- *Mid-Term Evaluation* is likely to provide an understanding of whether 3DF interventions have made a difference, what changes in outcome and impact indicators have been observed and what do they mean, whether the observed changes in outcome and impact indicators should be attributed to programme outputs or whether the collective efforts are large enough to impact the course of the epidemic in Myanmar.

The Mid-Term Evaluation will also assess the appropriateness and effectiveness of the institutional arrangements of the Three Diseases Fund, the direction and shape the funded programmes have taken during the first two and half years.

- *Final Evaluation* is designed to assess the end results of the programme as a whole.

Both these tasks will be carried out by external reviewers appointed by the Fund Board. While Mid-term Evaluation will be undertaken in early 2009, the Final Evaluation will be carried out towards the end of the 5th year of the current cycle of the project in 2011. Both tasks are likely to be very comprehensive and will require extensive field visits, consultations with different stakeholders including the beneficiaries, implementing partners, health service providers, civil society organizations in Myanmar and abroad, and the

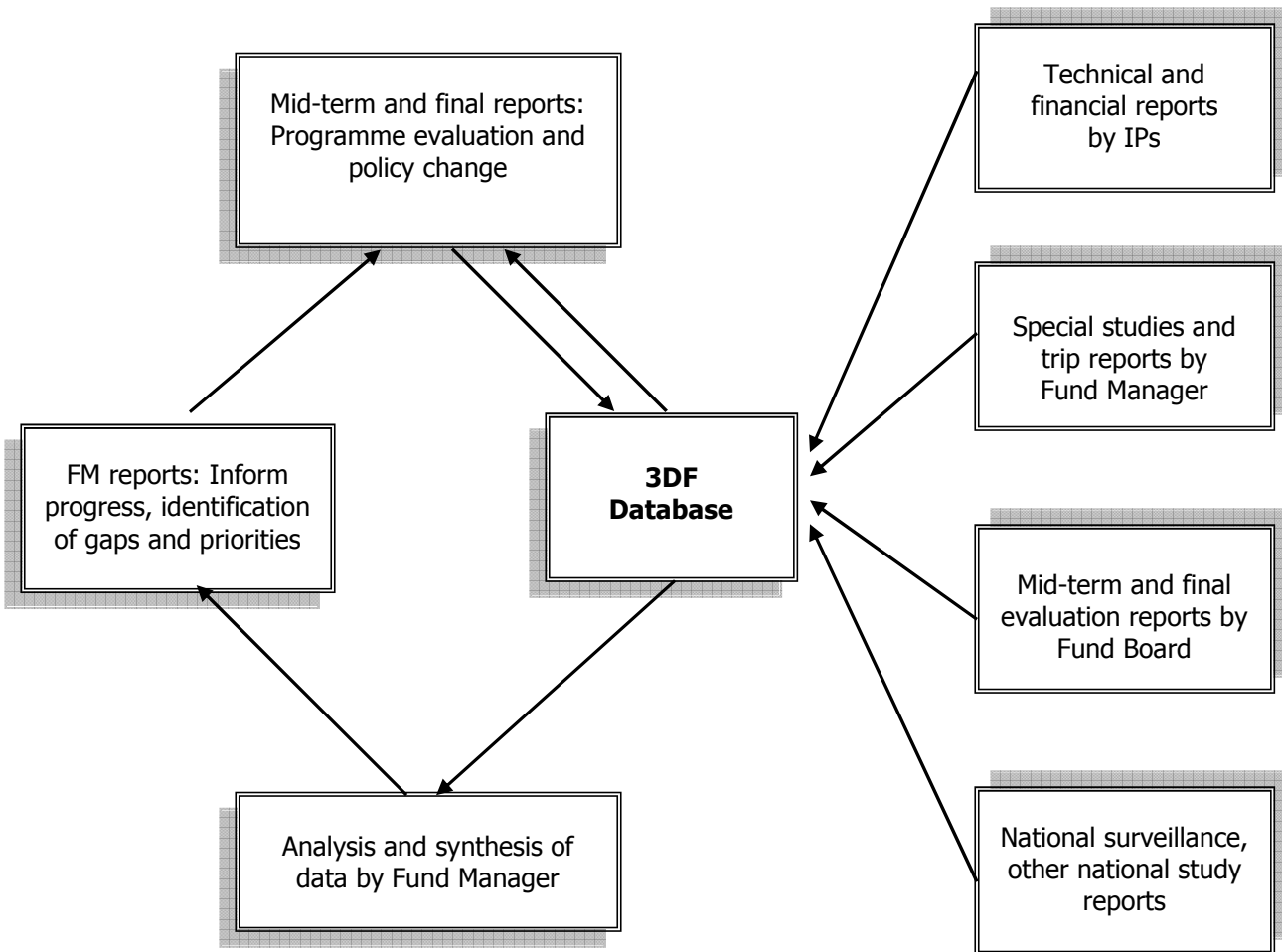
public officials. Fund Manager will arrange all logistics supports, and financial and human resources needed to carry out the tasks. Findings of the mid-term review will be shared with the Fund Manager, Fund Board and limited number of stakeholders including donors and implementing partners. The results of the Final Evaluation, on the other hand, will be widely disseminated. The Mid-term and Final Evaluation studies are two of the key activities within the 3DF's M&E system.

National Database and Studies

Another important source for 3DF M&E is the national database such as sentinel surveillance reports, national study reports, behavioural surveillance survey reports and other studies conducted by the government.

National AIDS programme has been routinely carried out Behavioural Surveillance Surveys (BSS) to monitor changes of behaviour of population at risk of having HIV and AIDS. In addition, it has sentinel surveillance system in place that provides trends and prevalence of HIV in Myanmar. WHO and UNAIDS have been providing technical assistance in running BSS and sentinel-surveillance system ([UNGASS, 2004](#)). National malaria control programme (NMCP) has also been providing data on malaria morbidity and mortality every year. Data on progress on national TB control programme (NTP) include coverage of DOTS by population and township along with case detection, cure and treatment success rates by year. Surveillance data, although collected infrequently, may provide a valuable source to assess disease epidemics and monitor changes in behaviours that affect the epidemic. The studies are not necessarily carried out in areas where 3DF is funding and, therefore, cannot be claimed as the performance of Fund Manager for the outcome. However, the findings do provide an overall trend or change of the situation that help explain the performance of activities of 3DF in general. Findings of other studies on the three diseases, although cover limited project areas, provide unique information and valuable to understand specific problems in detail.

Figure 2. Data Management Process



2.2.2 Analysis and synthesis of data

The Implementing Partners (IP) analyze their own data not only for reporting to the Fund Manager but also for immediate use to help their programme improvement. Using an agreed format, IPs send data and reports to Fund Manager on regular intervals. 3DF database consists of information from four major sources including routine reports from IPs, special studies conducted by Fund Manager and FM trip reports, mid-term assessment and final evaluation by external reviewers, and national database and other studies. FM is responsible to manage and use the database to prepare reports for the Fund Board, donors and other stakeholders in addition to its own use.

The routine reporting system from the IPs provides essentially *quantitative* data although provisions have been made for narratives (on Most Significant Changes or success stories of the projects) for validation and a richer understanding of the quantitative findings. Special studies are likely to address contextual responses to behaviour change and explain the conditions of the poor and vulnerable populations. A synthesis of both qualitative and quantitative approach would contribute to a more substantial understanding of the data.

M&E data are used primarily for self-assessment of the performance of Fund Manager, and to assess whether the projects implemented by IPs are on the right track, identify gaps, problems and priorities of the programme, identify the key areas for interventions, measure the effectiveness of specific interventions and measure programme coverage. In addition, M&E data are also used in programme development, advocacy, and allocation of resources and in modifying programme design where needed after consulting with the Fund Board. At the end of the first 5-year cycle of 3DF, M&E system is expected to provide a wealth of information to the donors, Fund Board and other policy makers for a comprehensive evaluation of 3DF and to develop evidence-based new strategies for the prevention and treatment of three diseases in Myanmar.

2.2.3 Quality assurance measures

The M&E units of all Implementing Partners (IP) along with Fund Manager regularly monitor data collection and reporting processes to ensure the quality of data. The reporting staff needs to follow the standard data collection protocol and ensure that the system covers the target populations. Triangulations of data collected from various sources should be carried out to assess the quality of data. It is suggested to periodically review the strengths and weaknesses of the M&E system to ensure that the system provides accurate information.

2.2.4 Outputs and time frame

Dissemination of information is an important component of M&E system. Results and recommendations are presented to relevant stakeholders in a timely and effective manner. Expected outputs from the M&E system are of different types. These are:

- Two six-monthly *Technical Progress Reports* from the Implementing Partners. The reporting periods are January – June and July – December. The deadlines to submit the reports to Fund Manager are end of July and January respectively.

- The reporting periods of *Quarterly Financial Reports* are: January – March, April – June, July – September and October – December. The deadlines are end of April, July, Oct and January respectively.
- Fund Manager should prepare two six-monthly *Progress Reports* by 30 April and 31 October each year.
- Mid-term Evaluation should be undertaken in early 2009 by an external review team selected by the Fund Board.
- Special studies should be conducted by the Fund Manager if and when necessary throughout the project period.
- Final evaluation should be conducted at the end of 3DF project by an external evaluation team selected by the Fund Board.

Product	Responsible organization	Date of submission
Technical Progress Report	Implementing Partners	Within 31 July and 31 January each year to FM
Quarterly Financial Report	Implementing Partners	Within 30 April, 31 July, 30 Oct and 31 January each year to FM
Progress Report	Fund Manager	Within 31 March and 30 September each year to FB
Special Study Reports on: <ul style="list-style-type: none"> ○ Strategy development and ○ Performance monitoring 	Fund Manager	Based on needs
Mid-term Evaluation Report	Fund Board/Donors	Mid – 2009 to Fund Board
Final Evaluation Report	Fund Board/Donors	End of 2010 to Fund Board

2.2.5 Dissemination of information

Fund Manager disseminates information to a diverse group of audience using various media. Six-monthly Progress Reports is intended to the Fund Board and for public scrutiny through the web site. Depending on the nature of the topic, findings of the special studies are disseminated to selected groups of audience. Mid-term review report and end of the project evaluation report are expected to reach all stakeholders. All reports are published on the 3DF website.

3. Purposes and Indicators

The M&E framework follows the principles laid out in the 3DF proposal and is consistent with monitoring and evaluation framework of the National Operational Plans for each disease developed by the Government of Myanmar. Categories for organizing the M&E system and subsequent indicators were chosen to reflect the most important programme activities of the 3DF. Indicators are chosen to reflect the basic and most important programme activities of 3DF and are selected from the national frameworks. Emphasis is given to ensure that the indicators are linked to the objectives and able to measure change over the programme time period, standard indicators are used to the extent possible for comparability over time or between groups, cost and feasibility of data collection are considered, and the number of indicators are kept minimum needed. These are complemented by 3DF specific indicators developed to monitor Fund Management and Effective Operations Policy. The key activities are grouped into three sub-categories as shown below:

Category	Components
Fund Management	Fund allocation and disbursement
	Procurement and supplies
Effective Operations Policy	Humanitarian approach
	Strategic development
	Public information
Disease-specific Activities	HIV and AIDS
	Tuberculosis
	Malaria

In the following sections, detailed information of indicators and their purposes for each of the selected components are presented.

3.1 Fund Management

As fund manager, 3DF provides resources to selected implementing partners to carry out projects for the population most at risk of being affected who have limited or no access to health services. Three broad issues under Fund Management are proposed to monitor. These are fund allocation and disbursement, procurement and supplies, and feedback mechanism.

3.1.1 Fund allocation and disbursement

To monitor fund allocation and disbursement, several key issues are considered such as whether the Fund Manager (FM) adopts the national strategies and prioritised the policy of the Fund Board, whether the FM maintains a balance in contracting projects with IPs and whether funds are disbursed efficiently and accounted for in a transparent manner.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To assess whether funds are allocated following the policies and priorities of Fund Board	Percentage of programmatic activities considered by the FB to either not be in line with FB policies or not adhering to national plans	Every 2-3 years	Annual Review Meetings, and progress reports	Process, Output
2	To assess whether a balance of IPs have been contracted by 3DF to implement projects	Percentage of 3DF IPs which are either local NGOs, CBOs, or civil society organizations.	Yearly	Annual Review Meetings, programme documents	Output
3	To assess whether funds are disbursed efficiently as planned	Days required for disbursement of fund to IPs after receiving acceptable payment request	Yearly	Feedback from partners, 3DF records, Annual audit reports	Process
4	To assess performance of IPs for the contract extensions	Performance assessment framework available and fully utilised for consecutive annual contract extensions	Yearly	Progress Reports, Performance assessment reports	Output
5	To assess whether the IP activities are in line with MOUs	Number of IPs whose activities are in line with MOUs	Yearly	Rapid assessment, Project proposals	
6	To assess performance of financial management of IPs	Number of IP's audit reports received on time	Yearly	Certified audit reports	
7	To assess grant management capacity of partners	Number of (both FM and IP) audit areas rated as unsatisfactory	Yearly	Annual audit reports, Certified financial	Process

				reports, Interim Financial reports	
8	To assess performance of Fund Manager in disbursing funds to IPs	Percentage of IPs “satisfied” with the grant allocation process	Yearly	Client satisfaction assessment report	Process, Output
9	To assess whether IPs perform according to the 3DF performance guidelines	Number of IPs effectively delivered proposed project activities according to 3DF performance guidelines	Mid-term and end of the project	Fund MTR report	
10	To assess the utilization of disbursed funds by IPs	Percent of disbursed funds utilised in each quarter by IPs (Implementation Rate)	6-monthly	Interim Financial reports, Fund Manager’s records	Process, Output

3.1.2 Procurement and supplies

The purposes of monitoring commodity procurement and supplies are to assess whether the FM developed and implemented *Standard Operating Procedures (SOP)* for procurement and commodity tracking to ensure timely and efficient procurement, whether the commodities are supplied from approved agents and manufacturing sites, whether IPs timely receive required amount of drugs and supplies, whether the supplies are either expired or damaged and whether there is any case of leakages in the supply chain.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To assess performance of 3DF supply chain systems in supplying drugs and commodities	Percent of procurement actions completed within 5 months from order up to final delivery	6-monthly	Procurement data and records	Outcome
2	To assess extent to which commodity tracking is monitored by grant holders	Percentage of those IPs engaged in providing commodities which undergo an annual commodity system review	6-monthly	External reports on commodity tracking system	Process

3.2 Effective Operations Policy

The 3DF operations policy is designed to reflect international best practices and has endorsed principles for the provision of humanitarian assistance (UNOPS, 2007c). It is essential, therefore, to monitor the extent of supportive operating environment created and maintained to ensure providing the greatest possible benefits to people at risk when needed. The best practices and principles are presented below in three categories.

Category	Issues
Humanitarian approach	Access to services
	Equity and gender
Strategic development	Participation and interaction
	Operating environment
	Evidence-based approach
Public information	Inform stakeholders about 3DF policies

3.2.1 Humanitarian approach

The 3DF uses the internationally agreed humanitarian principles as the basis for programme design, monitoring and evaluation. Several issues such as access, coverage, equity and gender are considered. In the following sections, key purposes and indicators are presented.

3.2.1.1 Access to services

The performance of implementing partners in raising access to and coverage of services for the minorities may be understood by assessing whether the IEC materials developed and used are appropriate for them, the proportion of poor people covered with sustained inputs and compensations, and the total number of population covered by 3DF funded projects.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To assess progress in reaching different ethnic populations	Number of BCC materials specifically developed or translated for different ethnic groups	6-monthly	Progress report	Process
2	To assess increase of access to services by the populations at risk	Number of beneficiaries reached by 3DF funded projects in high risk townships by disease	Yearly	Progress report	Output

3.2.1.2 Equity and gender

The key purposes of monitoring the equity and gender issues are to understand the kind of problems the implementing partners generally face and their responses, whether the IP reaches all project communities it proposed, the inclusion of gender in the project design phase and whether gender and equity gaps in accessing and using health services are declining.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To promote gender in 3DF supported projects	Number of IPs conducted gender analysis at design, annual planning and assessment	Yearly	Progress report	Process, Outcome
2	To assess gender mainstreaming in 3DF supported projects	Percentage of proposals which identify the potential range of issues in implementing activities for both genders and include options for mitigating those challenges	Yearly	Project proposal	Outcome
3	To assess differences in access/uptake of services at SDPs	Percentage of relevant indicators received from IPs that are disaggregated by sex and by given deadline	6-monthly	Progress report	Process, Outcome

3.2.2 Strategic development

3.2.2.1 Participation and interaction

Several indicators are proposed to monitor and evaluate the participation of beneficiaries, implementing partners and other stakeholders in 3DF programme activities. To have a clear understanding of interaction among them, special studies may need to be conducted while other issues may be monitors on a regular basis.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To assess progress towards acceptance of participatory development approach	Number of IPs involved beneficiaries in design, implementation and monitoring of project activities	Yearly	Progress report	Process
2	To assess the progress of the scope of expanding service provision at the local level	Number of ethnic minority staff and service providers employed by IPs at the local level	6-monthly	Progress report	Process

3.2.2.2 Operating environment

A supportive operating environment is essential to ensure that 3DF provides the greatest possible benefits to people at highest risk and vulnerability and with the greatest needs. Several indicators are proposed to assess the operational obstacles that either inhibited expansion or at least slowed implementation of the project activities.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To assess extent to which the international staff are able to access project sites	Percentage of actual monitoring visits which occurred of those planned	6-monthly	Progress report, FM checklist	Outcome
2	To assess length of time to renew MOUs	Number of months required to get MOU renewed	Yearly	Progress report	Process, Outcome

3.2.2.3 Evidence-based approach

The 3DF requires that the Fund Manager should monitor project activities, encourages innovations and proposes to design and continuously improve its programmes based on empirical evidence and research.

Three indicators are proposed to monitor the process of gathering information from the grassroots, programme performance and attempt to improve on-going programme activities.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To assess routine monitoring of 3DF funded projects	Percent of 3DF supported projects by diseases monitored by FM	On-going	Progress reports and Trip reports	Process
2	To promote the use of M&E and LF among IPs	Percentage of IPs with at least 5% of grant resources dedicated to M&E	Yearly	EoI, Project proposal	Outcome
3	To assess performance of FM in terms of providing policy advice to the Fund	Number of FB actions recommended based upon FM reports and other advice	Yearly	Special study reports, FB meeting minutes	Outcome
4	To modify current approach and identify new programme components to achieve the targets of FM	Number of new approaches or interventions arising from research	Yearly	Special studies, 3DF web site	Outcome
5	To assess performance of FM in sharing findings with stakeholders	Number of dissemination workshops held on 3DF findings	Yearly	Minutes of TSG meetings	Outcome
6	To assess compliance of IPs in responding to FM's recommendations	Percent of IPs taking actions following 3DF's recommendations after field visits	Yearly	Progress reports and Trip reports	Outcome

3.2.3 Public Information

Designing and implementing an effective communication strategy are important responsibilities of 3DF to promote better understanding of the fund policies and achievements, and ensure fund visibility among stakeholders. Several indicators are proposed to monitor whether the Fund Manager publishes its strategy and policies, and implementation procedures and operational guidelines on its website. Other indicators include whether the Fund Manager conducts public consultation meetings with a wide range of stakeholders and routinely communicate with the Technical and Strategic Groups (TSG).

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To assess the extent to which the public has access to information on 3DF activities	Percent of the Fund's progress reports published on 3DF's website	6-monthly	3DF website	Output
2	To assess the provision regular access to 3DF information	Percent of the Fund's non-sensitive documents, including those of the IPs, published on 3DF's website	Yearly	3DF website	Output

3.3 Disease-specific Activities

This section presents an overview of the key questions and indicators, and the purpose of using indicators to answer the key questions for HIV/AIDS, TB, and malaria. These indicators are extracted from 3DF LogFrames and National Operational Plans that have been discussed and agreed upon by a wide range of stakeholders including Fund Board, Implementing Partners and Technical and Strategic Groups (TSG). Some of these indicators may need to be revised over time as programme matures. Efforts are given to minimize the number of indicators and to harmonize with the national and international M&E frameworks.

Category	Issues
HIV and AIDS	Reduction of HIV-related risks, vulnerability and impact
	Providing comprehensive care, support and treatment
	Enhancing the capacity of health system
Tuberculosis	Promotion of DOTS
	Treatment and support
	Case detection of TB
	Managing MDR TB
Malaria	Prevention of malaria
	Providing care and treatment
	Empower communities at risk
	Quality assured case detection
	Measuring programme impact

3.3.1 HIV and AIDS

Given that it is difficult to determine the populations or denominators while monitoring HIV programme, focus has given on the numerators or the subset of the population that received the benefits from the programme (WHO et al., 2006). Denominators are included where possible.

The sources of data for HIV/AIDS are health facility-based statistics, surveillance studies, population-based sample surveys such as BSS and specially designed surveys of specific groups (e.g., most-at-risk populations). Other monitoring resources, including trip reports by FM, programme reviews of the health facilities and other specific information should also supplement the system.

3.3.1.1 Core indicators

It has been agreed among all partners implementing HIV projects that they must include all core indicators in the M&E system and routinely report to 3DF.

Strategic Direction 1 to 10: Reduction of risk among target populations

The priority to reduce HIV related risks and vulnerability is given to reach the populations with high risk with appropriate HIV preventive services. Sex workers, clients of sex workers, men who have sex with men (MSM), drug users and families of people living with HIV have been identified in the National Strategic and Operational plan as highest priority. Other groups such as , institutionalized, mobile populations, uniformed service personal, young people, persons in workplace and persons of reproductive age are identified also as priority for the national response. One feature of HIV programme indicators is the lack of accurate denominator of the beneficiaries that limits measuring programme effects and impact.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To assess progress in providing HIV preventive services among populations-at-risk	1 A Number of persons who have been reached at least once by any type of prevention programme including: 1) sex workers; 2) clients of sex workers; 3) men who have sex with men; and, 4) injecting drug users	6-monthly	Progress report	Output
		1 B Number of persons who have been reached at least once by any type of prevention programme including: 1) prisoners; 2) mobile/migrant populations; 3) police and military; 4) youth (15-24); 5) persons in the workplace; and, 6) adults (15-49) of reproductive age	6 monthly	Progress Report	Output
2	To assess progress of providing STI treatment	Number of persons who have been treated for an STI including: 1) sex workers; 2) clients of sex workers; and, 3) men who have sex with	6 monthly	Progress Report	Output

		men.			
3	To assess the utilization of VCCT services	3 A Number (and percentage) of persons at high risk accessing voluntary confidential counselling and testing (VCCT) including: 1) sex workers; 2) clients of sex workers; 3) men who have sex with men; and, 4) injecting drug users.	6-monthly	Progress report	Outcome
		3 B Number of persons accessing voluntary confidential counselling and testing (VCCT) including: 1) prisoners; 2) migrant/mobile populations; 3) police and military; and, 4) youth (15-24).	6-monthly	Progress report	Outcome
4	To assess progress in preventing exposure to HIV among populations-at-risk	4 A Number of condoms distributed (including those sold) to: 1) sex workers; 2) clients of sex workers; 3) men who have sex with men; and, 4) injecting drug users.	6-monthly	Progress report	Output
		4 B Number of condoms distributed (including those sold) to: 1) prisoners; 2) mobile/migrant populations; 3) police and military; and, 4) youth (15-24).	6-monthly	Progress report	Output
5	To assess availability of harm reduction services for injecting drug users	Number of needles distributed (including those sold) to injecting drug users.	6-monthly	Progress report	Output

Strategic Direction 11: Care, Support and Treatment

In this section, several indicators are proposed to monitor the accessibility for people living with HIV to access treatment, care and support as well as to monitor the progress of HIV prevention from parents to children

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
6	To assess the progress of providing clinical management to all people with advanced HIV infection	6 A Number of people with HIV infection received treatment for opportunistic infections	6-monthly	Progress report	Outcome
		6 B Number of persons with advanced HIV infection receiving ART, by sex	6-monthly	Progress report	Outcome
7	To assess progress towards providing care and support to people living with HIV	7 A Number of people receiving community home-based package of support (without ARV) <u>in project areas</u> , by sex.	6-monthly	Progress report	Output
		7 B Number of people living with HIV involved in self help groups <u>in project areas</u> , by sex	6-monthly	Progress report	Output
8	To assess progress in preventing mother-to-child HIV transmission	8 A Number of pregnant women accessed HIV testing and counseling service for HIV and received their test results	6-monthly	Progress report	Outcome
		8 B Number of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission (cumulative figure as of the end of the reporting period)	6-monthly	Progress report	Outcome

Strategic Direction 12: Enhancing the capacity of health system

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
9	To assess progress of the capacity development of health facilities in providing blood transfusion	Percent of transfused blood units screened for HIV	6-monthly	Progress report	Outcome

3.3.2 Tuberculosis

3DF has also planned to track inputs (especially in the early stages of a grant) and outputs to outcomes, and ultimately to impact as suggested by others (WHO et al., 2006). One important step in designing M&E for TB programme is the selection of indicators along with clearly defined purposes, frequency and sources. Major source is routine data recorded by the health staff at the facility or microscopy units while they provide services daily. The data include service statistics, such as the number of cases registered by category and type of TB, the number of deaths, and the number cured, etc.

3.3.2.1 Core indicators

Promotion of DOTS

Only two indicators are proposed to monitor the capacity development of health staff at different levels and training of laboratory technicians for sputum microscopy.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To monitor progress of capacity development to prevent and treat TB	Number of private medical doctors (GPs), Basic Health Staff (BHS), Community Health Workers/ Village Health Workers/Outreach Health Workers, trained on management of TB at health facility (HF) level and/or trained for case detection, collection of sputum specimen and provision of DOT	6-monthly	Progress report	Output
2	To assess progress of training laboratory technicians	Number of laboratory technicians trained for sputum microscopy	6-monthly	Progress report	Output

Treatment and support

In this section, the indicators have focused to measure the progress of treating TB, identified the proportion of defaulters, treatment failure, expansion of DOTS services and the extent of support provided to the patients.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
3	To assess progress of treating TB at the communities	TB treatment success rate by sex	6-monthly	Progress report	Outcome
4	To assess performance of community based providers	Number and percent of (new sputum smear positive) defaulters by sex	6-monthly	Progress report	Process, Output
5	To assess continuity of support from the community health workers	Number and percent of (new sputum smear positive) treatment failures by sex	6-monthly	Progress report	Output
6	To assess expansion of TB DOTS services in the communities	Number of sputum collection centres/points established	6-monthly	Progress report	Output
7	To assess the coverage of financial supports provided for transport and/or food	Number of TB patients/families receiving allowance for transport or for diagnosis and treatment services at health centres and/or food/nutritional support	6-monthly	Progress report	Process, Output

Case detection of TB

This section comprises with three indicators only to monitor early case identification of infectious patients to treat TB, assess accessibility of microscopy services and improvement of promotional activities.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
8	To assess early case identification of infectious patients to treat TB at the communities	Number of new PTB ss+ cases detected by sex	6-monthly	Progress report	Process, Output
9	To assess accessibility of microscopy services at	Number of TB suspected cases	6-monthly	Progress report	Output

	the community level	referred to Health Facility by sex			
10	To assess improvement of promotional activities at the community level	Number of people reached through BCC services	6-monthly	Progress report	Input, Output
11	To assess total case notification	Number of new TB patients (all forms) registered for treatment by sex	6-monthly	Progress report	Input, Output

3.3.2.2 Additional indicators

Provision of other services

Five additional indicators are proposed to monitor the capacity in managing MDR TB patients, HIV-TB collaboration and to cover stock-outs of drugs,

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To assess progress of capacity development in managing MDR-TB	Number of HF's trained in the management of MDR-TB care	6-monthly	Progress report	Output
2	To assess supply chain management	Number of townships reporting no stock-outs of drugs, laboratory equipment and supplies	6-monthly	Progress report	Output
3	To assess progress in treating drug-resistant forms of TB	Number of laboratory confirmed MDR-TB patients enrolled in the MDR-TB treatment programme (DOTS Plus) (by sex)	6-monthly	Project internal HIS Township/NTP HIS	Output
4	To assess progress in treating drug-resistant forms of TB	Number (and percent) of MDR TB cases successfully treated (by sex)	Annually	Project internal HIS Township/NTP HIS	
5	To assess progress in TB-HIV collaboration	No. of people living with HIV referred to TB services for TB screening	Annually	National M&E Report	Output
6	To assess progress in TB-HIV collaboration	Number of TB patients tested for HIV (by sex)	6-monthly	National M&E Report	Output

3.3.3 Malaria

Given that the burden of record keeping and reporting is unacceptable in many health care settings, WHO recommended that data collection should be kept to a minimum and the principal monitoring and evaluation system be based on a small number of core indicators that are likely to be reliable and useful for decision-making (WHO, 2000).

3DF M&E framework for malaria identifies four “critical areas” for monitoring the progress and evaluating the outcomes (UNOPS, 2007a). These include prevention with appropriate measures, ensure universal access, quality diagnosis and care, enabling community participation in the programme, and strengthening support services for prevention and control. M&E system is based on a small number of core indicators representing each of the critical areas. The potential sources of data for these indicators are facility-based statistics, baseline and end-line surveys, programme reviews, trip reports by FM, etc.

The public health sector runs a national monitoring and evaluation system. Monitoring of drug resistance is in place in 6 sentinel sites while insecticide efficacy is monitored in one site (WHO, 2006). Aggregated national data on malaria cases are submitted to WHO. Due to incompleteness of the reporting system, actual malaria burden is difficult to estimate but may be useful for understanding trends of the burden of malaria.

3.3.3.1 Core indicators

Prevention: Protecting at risk population with appropriate measures

Only two indicators are proposed to monitor the programme activities that protect population at risk. These are focused on mosquito-nets, indoor residual spraying and the population protected.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
1	To assess mass treatment of mosquito nets and the distribution of LLINs and/or IRS in high endemic area of malaria	Number of ITNs/bednets re/treated and/or number of LLINs distributed (separate indicators for distribution and bednet treatment)	6-monthly	Progress report	Output
2	To assess progress of protecting people through ITN/LLINs by age and sex	Percentage of households (HH) with at least one LLINs in the project area	Yearly	Special studies	Outcome

Care: Providing standardized treatment and empowering communities

In this section, indicators are selected to monitor malaria cases treated through fixed, mobile and franchised clinics and health workers, type of treatments administered, use of RDTs, promotion of staff and volunteers through training, and population served by trained providers.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
3	To assess change of provision of treatment courses	Number of confirmed and probable malaria cases (by age and sex) treated in accordance with national malaria treatment guidelines by project clinics, and/or private franchised clinics, and/or health workers (community or village) <u>in project areas.</u>	6-monthly	Progress report	Output
4	To assess improvement of diagnosis by RDT among volunteers	Number of RDTs distributed and used by trained VHWs/GPs and health facilities	6-monthly	Progress report	Outcome
5	To assess improvement of services by trained providers	Number of trained CHWs/VHWs/GPs providing malaria prevention services and case management	6-monthly	Progress report	Process, Output

Quality assured case detection and morbidity

Both outcome and impact indicators are proposed to assess improvement of malaria cases detection, change of health seeking behaviour and malaria morbidity.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
6	To assess reduction of malaria morbidity	Malaria morbidity rate for the project area.	Yearly	NMCP annual report	Impact
7	To assess improvement in treatment seeking behaviour	Percentage of patients who receive treatment from trained providers within 24 hours of onset of fever in the reporting period (by sex)	Yearly	NMCP annual report	Outcome

3.3.3.2 Measuring programme impact

Only two indicators are proposed as optional indicators to assess the programme impact focusing on the knowledge to assess improvement of knowledge, the progress of behaviour change in receiving treatment and impact of programme in reducing malaria mortality.

#	Purpose	Indicators	Frequency	Means of verification	Type of indicators
8	To assess the impact of programme in reducing malaria mortality	Malaria death rate	Every year	Progress report of national programme	Impact

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