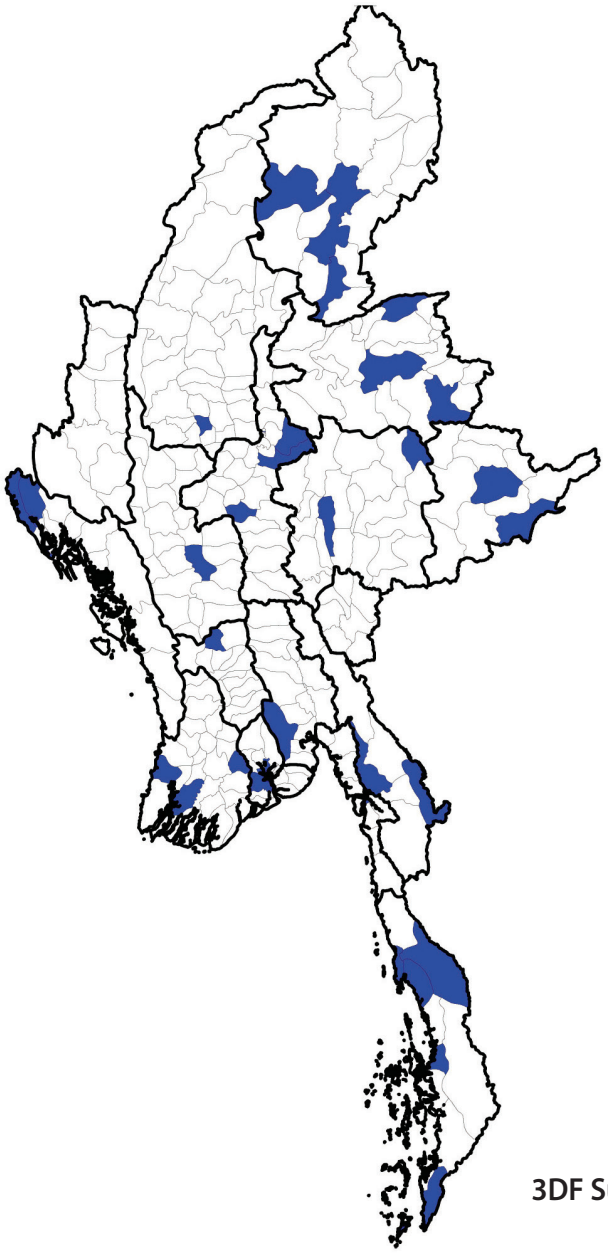
Three Diseases Fund Annual Report 2009

A pooled fund in Myanmar supported by Australia, Denmark, the European Commission, the Netherlands, Norway, Sweden and the United Kingdom



3DF Supported ART Sites (2009)

ABBREVIATIONS AND ACRONYMS

3DF	Three Diseases Fund
ACT	Artemisinin-based Combination Therapy
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASG	AIDS Support Group
BHS	Basic Health Staff
CBO	Community-Based Organisation
CCM	Country Coordinating Mechanism
CDR	Case Detection Rate
CESVI	Cooperazione e Sviluppo (INGO)
CHW	Community Health Worker
DFID	United Kingdom Department for International Development
DOTS	Directly Observed Treatment Short-course
EC	European Commission
EU	European Union
FB	Fund Board, Three Diseases Fund
FM	Fund Manager, Three Diseases Fund
FMO	Fund Management Office, Three Diseases Fund
HH	Household
HIV	Human Immunodeficiency Virus
IP	Implementing Partner
ITN	Insecticide-Treated Net
JATA	Japan Anti-Tuberculosis Association
JICA	Japan International Cooperation Agency
KAP	Knowledge, Attitudes and Practices
LIFT	Livelihoods and Food Security Trust Fund
LLIN	Long-Lasting Insecticidal Net
LTA	Long-Term Agreement
M&E	Monitoring and Evaluation
MDR-TB	Multi Drug Resistant Tuberculosis
MHAA	Myanmar Health Assistant Association
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSC	Most Significant Change
MSF-H	Médecins Sans Frontières-Holland
MTE	Mid-Term Evaluation
NGO	Non-Governmental Organisation
NMCP	National Malaria Control Programme
NTP	National Tuberculosis Programme
PMCT	Prevention of Mother-to-Child Transmission of HIV
PSI	Population Services International
RDT	Rapid Diagnostic Test
SIDA	Swedish International Development Cooperation Agency
SS+	Sputum smear positive
TB	Tuberculosis
TSG	Technical and Strategic Group
TSR	Treatment Success Rate

ABBREVIATIONS AND ACRONYMS

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNITAID	International drug purchase facility through solidarity levy on air tickets
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
VCCT	Voluntary, Confidential HIV Testing and Counselling
WHO	World Health Organization

This report is based on a set of data from 42 projects funded by the 3DF in 2009.

CONTENTS

INTRODUCTION

The Three Diseases Fund (3DF) allocates grants to programmes targeting populations most at risk of HIV, Tuberculosis and Malaria in Myanmar, to provide them with access to essential medicines and related services.

Pooled funds of US$ 100 million have been pledged over five years until October 2011 by six donors: Australia, the European Commission, the Netherlands, Norway, Sweden and the United Kingdom. The Fund gained donor confidence with Denmark joining the consortium in 2009, and additional sums were raised to reach a total of US$ 125 million pledged to date. The United Nations Office for Project Services (UNOPS) is the Fund Manager on behalf of the Donor Consortium.

Relief of suffering is guided by the needs and priorities of the most urgent cases of distress, and the principles of humanity, neutrality and impartiality under the European Union Common Position on assistance to Myanmar[i] and the Guiding Principles for the Provision of Humanitarian Assistance set out by the United Nations Resident Coordinator.

No funds are channelled through the government. Support to the National Programmes for disease control, surveillance and monitoring is provided through WHO, UNAIDS and UNFPA. A fund flow mechanism managed by WHO facilitates disbursement and reimbursement of funds to support the costs of training and service provision at township level and below at an annual rate of approximately US$ 500,000 - 600,000.

In three years, over three funding rounds, the Fund has signed grant agreements worth over US$ 90 million, making it the biggest single contributor to the fight against the three diseases in Myanmar.

It has achieved broad geographic coverage, reaching remote communities through diverse independent organisations, including international and local non-governmental organisations and community based organisations, as well as five United Nations entities.

[i]Common Position 96/635/CFSP. (Australia shares the concern to address the humanitarian needs of the population.)

1. EXECUTIVE SUMMARY

2009 was the second full year of implementation of the Three Diseases Fund (3DF). A total of US$22.87 million was disbursed to 31 implementing partners (IPs), supporting 42 projects across all of Myanmar's States and Divisions. Donor support increased in 2009. We welcomed Denmark as a new donor, bringing the donor membership to seven. Additional funding was committed and a further US$23 million were made available to the end of 2011, which allowed the launch of Round III and an extension of all current projects by one year to a full four years of implementation.

The year witnessed the start of Round II implementation and expansion of support involving community-based organisations (CBOs) and local non-governmental organisations (NGOs). Round III was launched to upscale the Fund's contribution to the national response with an additional US$ 16 million. Monitoring and evaluation (M&E) systems were refined with a view to improving data quality. The Fund Board acted quickly to implement key recommendations from the Mid-Term Evaluation (MTE).

Reliability of data to map the three epidemics and services provided remains a challenge in Myanmar. The Fund took dedicated measures to address these problems together with implementing partners (IPs), the National Programmes and Technical Strategic Groups (TSGs). Throughout 2009 a sustained effort was undertaken to improve the quality of data and the way it was reported to the 3DF. Indicator dictionaries were developed and reporting templates were refined. Data quality has now significantly improved and, through the implementation of a Data Quality Assurance system in 2010, ongoing improvements are expected enabling the Fund to measure performance and impact with greater confidence and reliability.

> As a result of these efforts, it became clear that some previously reported results had been overstated. To allow meaningful trends to be observed across years, consistent methodologies to record and report data have been put in place. Figures that were recorded through different interpretations in earlier years have been cleared and adjusted to reflect such changes in data reporting practices. This year's Annual Report presents targets and results for 2009 and includes trend data across the key sectors in which we are involved.

Notwithstanding the adjustments described above, we can discern a steady increase in the delivery of key services with 3DF resources. In 2009, 427,000 malaria cases were treated with 3DF support; 80,000 long-lasting insecticidal nets (LLINs) were distributed and 389,000 bed nets were (re)treated with insecticides. 41,000 new sputum smear-positive TB cases were detected and registered, and the treatment success rate reached the targeted 85%. The number of people living with HIV involved in self-help groups nearly doubled to reach 8,600. 12,400 people from high risk groups – namely men who have sex with men, sex workers and people who inject drugs – received Voluntary, Confidential HIV Counselling and Testing (or VCCT) services. 15.8 million condoms were distributed mostly to high risk groups and 2.4 million needles to people who inject drugs. Continual care, including treatment with life saving antiretroviral drugs (or ART), was provided for 9,600 people, representing nearly half of those receiving ART in Myanmar.

The Mid-Term Evaluation of the 3DF, undertaken in mid 2009, confirmed the Fund's impact and performance. In addition to crediting the Fund's contribution towards containing the three diseases, the independent evaluation confirmed what many know: that humanitarian health services can

be effectively delivered throughout Myanmar. The Fund confirmed donor confidence and secured additional funding. The initiative of regular meetings between the Fund Management Office (FMO) and Ministry of Health (MOH) in Nay Pyi Taw led to better understanding, heightened cooperation and an extension of the Fund's reach into previously uncovered parts of the country through Round II funded CBOs, and scaling up through the launch of Round III. The Fund has contributed towards securing the availability of first-line anti-TB drugs, the National TB Prevalence Survey, and thus a better comprehension of the national disease burden. Importantly, evidence of the 3DF's performance within Myanmar's complex operating environment provided leverage for the return of the Global Fund and paved the way for future humanitarian interventions such as the Livelihoods and Food Security Trust Fund (LIFT).

2 PROGRAMMATIC ACHIEVEMENTS

2.1 MONITORING AND EVALUATION

During 2009, the 3DF continued to work with its partners to monitor and evaluate the programme. However, challenges remain particularly around how we can measure the extent to which the 3DF's inputs and outputs contribute to national level outcomes and impact. There are some practical issues regarding data availability and quality. Intensive efforts with stakeholders have seen significant improvement on all of these fronts. Partnership with 3DF implementers has provided both the necessary knowledge base and a platform to address issues of data quality and reporting requirements. There were intensified individual consultations and interactive workshops with all partners. As a result of this collaboration, the 3DF has refined its M&E system, its own Logical Framework matrix, set targets based on information provided by IPs, provided guidance to IPs to refine individual Logical Framework matrices, and adjusted its reporting requirements and templates to facilitate improved reporting. The FMO has also focused on assessing IPs' M&E systems and databases during field visits and provided feedback on reporting and data quality to partners. Through this collaborative effort the FMO refined the core indicators used to measure progress in the disease control efforts. In order to provide detailed explanation of core indicators and their use, the Fund developed dictionaries and presented them to the disease-specific Technical and Strategic Groups (TSGs) for consultation, with a view to eventually adopting these core indicators for national use.

The Fund remains committed to ensuring that robust, good quality data are available in order to assess progress and as part of this commitment will introduce the 3DF's Data Quality Assurance System in 2010. The Fund is also committed to one national M&E system and to strengthening national M&E capacities. This commitment will continue in 2010 through the 3DF's contribution to national level Monitoring and Evaluation System Strengthening efforts. The importance of this has been underscored by the forthcoming return of Global Fund financing to Myanmar.

The Fund Manager has continued to monitor progress of the 3DF programme through IPs' six-monthly progress reports (both financial and technical) and field visits to project sites. In 2009, 45 monitoring trips were carried out to 96 townships and to all implementing partners including national programmes. Following the recommendations of the MTE, the FMO reviewed its Performance Assessment Framework that measured five aspects of project progress and adopted a simplified methodology whereby results are measured against targets in each IP's project implementation using the refined Logical Frameworks introduced in 2009. Report certifications and clearance by the FMO and consequent disbursement to IPs are based on analysis of results achieved against targets, and presented funding needs for planned activities against budgets.

2.1 RESULTS

The Results Matrix table below is based on the 3DF Logical Framework

COMPONENT & INDICATORS	Target 2009	Actual 2009	Percentage achieved 2009
GOAL: Reduce the burden of communicable disease in Myanmar.			
1 **HIV Prevalence**	Not set nationally for 2009	0.61% (UNGASS 2009)	2009 National Annual Reports for each disease are the source of data for these indicators – those will be available in the second half of 2010 only and thus will be included in the next progress report.
2 Percentage of **sex workers that are HIV infected**	15.60%	Not yet available	
3 Percentage of **men who have sex with men who are HIV infected**	27.00%	Not yet available	
4 Percentage of **people who inject drugs that are HIV infected**	27.00%	Not yet available	
5 **TB prevalence**	Not set nationally for 2009	Not yet available	
6 **TB mortality** rate	Not set nationally for 2009	Not yet available	
7 **Malaria death** rate	Not set nationally for 2009	Not yet available	
8 **Malaria morbidity** rate	Not set nationally for 2009	Not yet available	
PURPOSE: To resource a programme of activities to reduce transmission and enhance provision of treatment and care for HIV/AIDS, TB and malaria for the most in need populations			
1 **Budget (by disease) contributed to the national response** by 3DF	28.57 M (budgeted)	22.87M (disbursed)	80%
HIV	15.93 M	14.06 M	88%
TB	6.84 M	5.01 M	73%
Malaria	5.80 M	3.80 M	65%
2 Number of **persons at high risk accessing voluntary counselling and testing (VCCT):**	9,412	12,444	132%
Sex workers	4,703	6,168	131%
Men who have sex with men	2,414	2,683	111%
People who inject drugs	2,295	3,593	157%
3 Number of people living with HIV in need **receiving ART (including package of support)** by 3DF	10,619	9,623	91%
4 Percent of adults and children known to be **alive and on treatment 12 months after initiation of antiretroviral therapy**	87.00%	87.00% (relates to MSF-H data as the only reporting partner)	100%
5 Percentage of known **HIV-infected pregnant women who received antiretrovirals** to reduce the risk of mother-to-child transmission in Myanmar	Not set nationally for 2009	55.4% (UNGASS 2009 Report)	55%
6 **TB case detection rate** by sex	At least 75%	94%	125%
7 **TB treatment success rate** by sex	At least 85%	85%	100%
8 Percentage (and number) of **households** in project area that **have at least one bed net** (funded by 3DF)	7.36% (229,506)	7.14% (230,423) (No. of baseline HH increased)	0.4% above targeted HH

COMPONENT & INDICATORS	Target 2009	Actual 2009	Percentage achieved 2009
OUTPUT 1: Sufficient commodities are resourced and distributed for the three diseases through 3DF activities			
1 Total number of **condoms distributed** (including those sold), of which:	15,373,000	15,790,925	103%
Sex workers received at least	1,157,680	2,412,014	208%
Men who have sex with men received at least	861,947	662,687	77%
2 Number of needles distributed (including those sold) to people who inject drugs by 3DF	1,744,891	2,377,939	136%
3 Number of **LLINs distributed** during the reporting period by 3DF	84,850	80,159	94%
4 Number of **ITNs/bednets re/treated** per reporting period by 3DF	367,535	388,887	106%
5 Number of **rapid diagnostic tests (RDTs) distributed and used** by trained village health workers/GPs and health facilities	598,545	419,334	70%
OUTPUT 2: Services are sufficient to address the needs of those most affected by HIV, TB and Malaria			
1 Number of people living with HIV **involved in self-help groups** in project areas, by sex	4,535	8,594 (M: 3,743; F:4,851)	190%
2 Number of persons receiving **treatment for sexually transmitted infection** in project areas	15,827	11,159	71%
Sex workers	10,758	8,157	76%
Men who have sex with men	5,069	3,002	59%
3 Number of people receiving **community home-based package of support (without ART)** in project areas, by sex	9,225	12,669 (M:6,152; F:6,517)	137%
4 Number of **HIV-infected pregnant women who received antiretrovirals** to reduce the risk of mother-to-child transmission (by 3DF)	627	479	76%
5 Number of **new pulmonary TB smear positive cases detected,** by sex, by 3DF IPs	43,645 (estimated total)	41,065	94%
6 Number of **TB suspected cases referred** to health facilities, by sex	22,035	16,761	76%
7 Number of **confirmed and probable malaria cases (by age and sex) treated** in project areas	582,415	427,020	73%
8 Number of **high risk/priority townships** with 3DF supported activities*	TB: 325 of 325 Malaria: 118 of 180 HIV: 55 of 76	TB: 325 of 325 Malaria: 118 of 180 HIV: 62 of 76	TB: 100% Malaria: 100% HIV: 112%

*The National Tuberculosis Programme offers DOTS support in all 325 townships. However, regular reporting is established in 313 townships in 2009.

COMPONENT & INDICATORS	Target 2009	Actual 2009	Percentage achieved 2009
OUTPUT 3: Funds are allocated in line with Fund Board policies and in response to national plans, and are accounted for in a transparent manner			
1 Percentage of **FB recommendations implemented** by the FM within given deadline	100%	89%	89%
2 Percentage of **3DF IPs** which are either **local NGOs, CBOs or civil society organisations**	No target set- will report exact figures	11 (35%)	N/A
3 Percentage (and number) of **audit areas** (both FM and IPs) rated as **"high priority"** by auditors	0 for all parties	1 for FM 22 for 18 IPs	N/A
4 Percent of **IPs "satisfied" with the grant allocation process**	80%	79%	99%
5 Percent of IPs with **at least 5% of grant resources dedicated to M&E**	80%	2009 budgets disallow such calculation	N/A
OUTPUT 4: Fund flow and IP performance are monitored and evaluated			
1 Percentage of IPs for whom 3DF successfully completes the **Performance Assessment Framework** per given deadline	100%	N/A	N/A
2 Percentage of **relevant indicators** received from IPs that are disaggregated **by sex and by given deadline**	100%	42%	42%
3 Percentage of **actual monitoring visits which occurred** of those planned	100%	92% (no travel authorisations were refused)	92%
OUTPUT 5: Results from 3DF are used to inform program development both internally and externally			
1 Number of **presentations at TSGs and CCM meetings about 3DF programmes**	4	7	175%

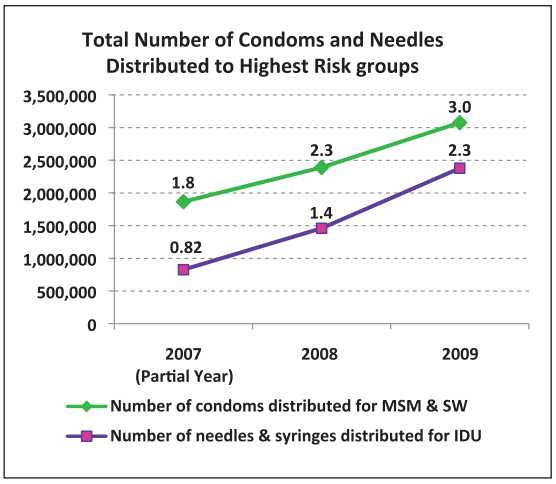
2.3 HIV/AIDS

The Fund has continued to play a key role in the national response to HIV in both public health facility and community settings. In 2009, US$ 15.93 million were committed to support the HIV activities of 26 implementing partners – 21 from Round I and five CBOs from Round II. Similarly to 2008, 53% of the total HIV grant was utilised for prevention activities and 47% for delivering treatment, care and support services for people living with HIV. In 2009, 23 IPs delivered services in community-based settings and three international organisations – WHO, UNFPA and UNAIDS – supported the National AIDS Programme, including assistance for public health facilities at township level.

With the increased number of implementing partners from Round II, 3DF-funded HIV interventions expanded into 19 additional townships to reach 158 townships in 2009, of which 62 are among the 76 high priority townships defined in the National Strategic Plan on HIV/AIDS.

The 3DF doubled its grant to the National Blood Safety programme in 2009, in order to fill the funding gap after JICA completed its support. As a result, the 3DF is now the main donor to the National Blood Safety programme. In 2009, 190,000 units of blood were screened for HIV with 3DF support.

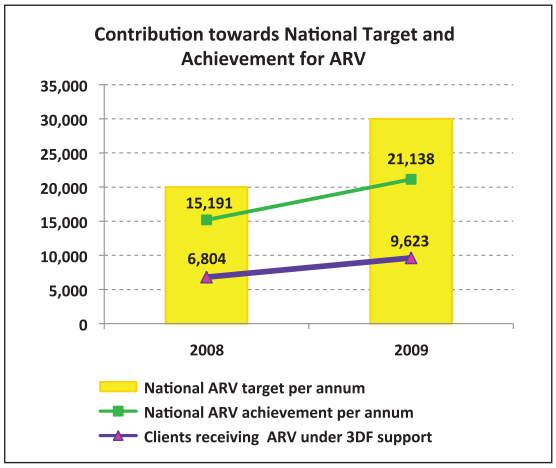
Partners provided a wide range of prevention, treatment, care and support services, with interventions aimed at behaviour change among key populations at higher risk of infection, and targeted service provision. During the reporting period, 161,144 beneficiaries from among highest risk groups (men who have sex with men, sex workers and their clients and people who inject drugs) were reached through HIV prevention services, of whom 20% received treatment for sexually transmitted infections, yet only 12.5% undertook VCCT. These ratios may indicate the need to intensify the efficacy of prevention activities and to increase VCCT uptake. An almost equal proportion of male and female clients received care and support services. However, prevention interventions reached more male (61%) than female beneficiaries. This is largely a reflection of the inherent gender bias within the population groups targeted: men who have sex with men, clients of sex workers, people who inject drugs and mobile and migrant populations.



In addition to behaviour change communication, condoms and needles were provided for highest risk groups, with the numbers distributed almost doubling during this year. Some partners reported that client acceptance of condoms had improved and that condom use was increasing, both in groups with higher-risk behaviour and the wider community. Altogether 15.8 million condoms were provided for all target groups by free distribution and at subsidised prices through social marketing. This represents 38% of the national target of 42 million condoms distributed.

In order to reduce injection-related HIV risk and improve quality of life, the 3DF has supported methadone maintenance therapy since 2007 and by the end of 2009, 1,200 beneficiaries had been enrolled. Due to the mobile nature of clients and the limited number and locations of fixed service delivery points, only 771 people who inject drugs were retained in the programme by the end of 2009. Two additional sites providing methadone maintenance therapy will open in 2010.

The number of beneficiaries receiving care and support services increased during 2009, when 23,721 beneficiaries from high risk groups received treatment for opportunistic infections and 12,669 received community home-based care services, representing increases of 12% and 39% respectively from 2008.



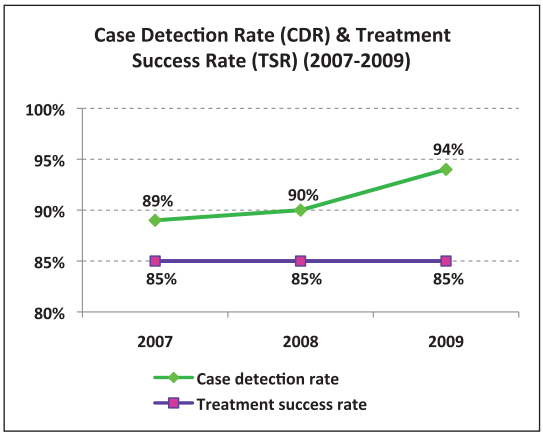
In 2009, 9,623 people living with HIV received ART, 41% more than in 2008, and equivalent to 45% of all people on ART in Myanmar. Twenty percent of ART patients received treatment at public health facilities and 80% through NGO services. Ongoing prevention of mother-to-child transmission of HIV (PMCT) services included couple counselling and testing and 40,122 pregnant women accessed counselling and testing services in both community and public health facility settings. In township hospitals where 3DF support is targeted, 479 HIV-infected pregnant women received a complete course of antiretrovirals to reduce the risk of mother-to-child transmission of HIV. This represents 20% of the national total, but was 25% below target as a result of overestimation of needs in one location.

Through WHO, the 3DF has supported national annual HIV Sentinel Sero-Surveillance and Behavioural Sentinel Surveillance studies since 2007. In 2009 a Mapping Survey of highest risk groups was conducted to assess geographical distribution and characteristics of high-risk behaviour in each area. Results of the Mapping Survey will be disseminated in 2010. The 3DF has also continued to provide support for trainings, coaching and operational support to strengthen procurement and supply management systems nationally. The 3DF has supported the procurement and transportation of all drugs and diagnostic laboratory supplies in the public sector nationwide.

2.4 Tuberculosis

With the nationwide availability of first-line TB drugs in Myanmar secured until early 2011 with 3DF support, the National Tuberculosis Programme (NTP) and its partners were able to maintain momentum in TB control with increased attention to strengthening treatment adherence and outreach activities. Altogether seven implementing partners – six from Round I and one CBO from Round II – provided TB prevention, treatment, care and support activities in all townships during 2009, when approximately 122,400 patients (all clinical forms of TB) received treatment with the provided TB drugs.

Although there was no significant geographical expansion of community-based programmes during this reporting period, 41,065 new sputum positive (SS+) TB cases were detected through outreach activities. However, data were available from only 313 of the 325 townships at the time of reporting. Although the number of new cases detected in 2009 was similar to in 2008, the denominators used by the NTP to calculate Case Detection Rate (CDR) were adjusted to better reflect true population and incidence figures in 2009. Preliminary data from NTP showed a 4% increase in CDR to 94% in 2009 from 90% in 2008. Treatment Success Rate (TSR) was maintained at 85%, the same as in 2008. CDR and TSR have been steady at above and on the global targets (70% and 85%



respectively) during the last five years. Results of the 2009 prevalence survey in Yangon found incidence rates 2.3 times above present estimates, and indicated that the true national TB burden might also be significantly higher, requiring the baselines to be adjusted accordingly. Consequently, the CDR might be reviewed downwards once the National TB Prevalence Survey is completed, suggesting the need to further intensify TB control. It is essential that the TSR is maintained at the global target of 85% through good quality Directly Observed Treatment Short-course (DOTS) provision to avoid the emergence and spread of Multi Drug Resistant TB (MDR-TB) especially if increasing numbers of new SS+ patients are detected as a result of intensified efforts.

Some community-based projects have already reached full DOTS coverage in their catchment areas. Two projects were closed at the end of 2008 resulting in fewer referrals to the NTP's service centres compared with previous years.

Nine new TB laboratory/diagnostic centres were established, seven in the private sector and two in remote station hospitals, improving access to diagnostic facilities in the community. Altogether 412 laboratories in both the public and private sectors participated in the external quality control system, implemented by the NTP in collaboration with the National Health Laboratories. The 3DF provided supplies and commodities nationwide for the diagnosis of TB as well as for transportation and accommodation costs for all laboratory monitoring and supervisory visits.

The Fund has continued to provide resources for trainings and monitoring visits to all levels within the NTP, as well as for all in-country transportation of TB drugs. However, shortage of manpower in the NTP and the demands of the National TB Prevalence Survey on technical staff's time led to lower than expected coverage in trainings and monitoring and supervision visits, with only 75% of such planned activities carried out.

TB-HIV integrated activities started to receive 3DF support in this period. Under the integrated TB-HIV pilot project in 11 townships, NTP provided VCCT to all TB patients and referred people with positive HIV test results to the National AIDS Programme with a view to ART provision. Some NGO partners referred TB patients to other partners who provide VCCT services, whereas others were able to provide VCCT for TB patients within their own integrated package of TB/HIV services. To date, 555 TB patients were tested for HIV within community-based TB programmes. Isoniazid Preventive Treatment started in this period in nine townships and reached 333 people living with HIV. TB-HIV sentinel surveillance had been expanded from 10 sites in 2008 to 15 in 2009 with 3DF support. HIV prevalence among TB patients was found to be 11.1%.

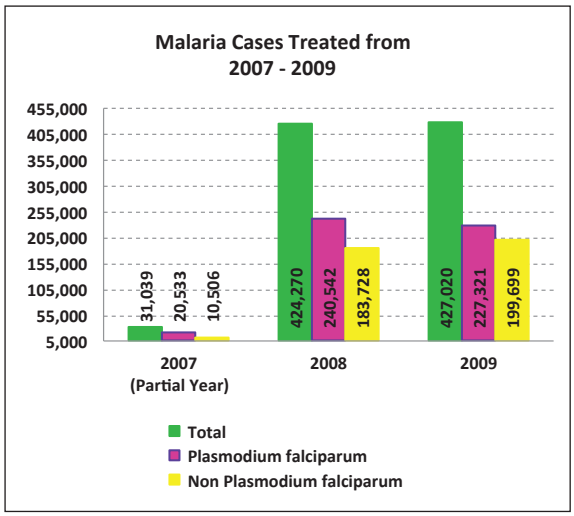
The MDR-TB pilot project started in July 2009. The late start was due to non-availability of second-line TB drugs in the global market and late arrival of drugs in-country. By the end of 2009, 64 MDR-TB patients (of a target of 275) had been enrolled in the programme and received treatment as well as nutritional support during hospitalisation. Treatment outcomes for these MDR-TB cases will not be known until 2011. The NTP is working together with WHO and MSF-Holland, while the 3DF is funding the entire project's operational costs and drugs are provided with support from UNITAID.

2.5 Malaria

Ten implementing partners, six from Round I and four CBOs from Round II, continued to work in malaria control during this reporting period, in 137 of the 284 endemic townships. Of these, 118 are among the 180 townships identified as high priority. Direct provision of malaria care services in community-based programmes was expanded and 32 fixed and 16 mobile clinics were functioning in 17 malaria-endemic townships. In addition, a network of 1,569 community volunteers in 38 townships provided malaria care services in the communities with 3DF support.

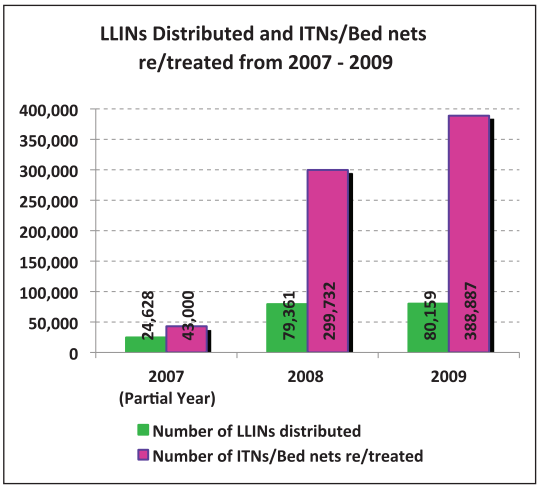
WHO continued its technical assistance to the National Malaria Control Programme (NMCP) through supportive field monitoring, training township medical officers and basic health staff in malaria control and management skills, and provided anti-malarial drugs, rapid diagnostic tests (RDTs), LLINs and insecticide tablets including support for in-country transport and supply chain management. This year, WHO piloted a computerised data management system and carbonless recording at township level in all 100 townships receiving 3DF support through the WHO. The system will eventually be rolled out to all townships to improve programme and logistics management, M&E and reporting. Partners reported that supportive monitoring and supervision visits were conducted throughout the year with a focus on strengthening M&E systems and improving quality of data. WHO and NMCP reviewed and updated M&E checklists at different levels.

All partners reported commodity supply improvements and FMO monitoring visits confirmed sufficient stocks of drugs and RDTs in all townships visited. This pattern has been seen since mid 2008 and there is reason to believe that the timely availability of Artemisinin-based Combination Therapy (ACTs) and RDTs in the public sector will result in an increasing number of cases treated in public health facilities. A similar impact was experienced for TB where the steady supply of TB drugs over the last eight years has resulted in most TB cases being treated within the NTP system. The availability of good quality and affordable drugs within the public sector at township and rural health centre levels is slowly becoming public knowledge in most communities.



During 2009, 427,020 cases of malaria were treated with 3DF support, either with ACTs or other standard malaria treatments. Unfortunately, disaggregation of data by sex is not yet common practice. For the past few years, the NMCP has reported around 5-600,000 malaria cases treated per year within the public health facilities, suggesting that a large proportion are treated through 3DF support. However, the true malaria burden is estimated at 4.2 million cases per year (WHO estimate), with most cases occurring in the communities and in people who do not access public health facilities. Therefore, it is essential that availability of good quality affordable drugs be maintained in the public sector.

In all, 80,159 LLINs and 388,887 net treatment tablets were distributed in 2009. However, LLIN distribution was lower than planned, mainly due to delayed arrival of commodities, in particular for NMCP townships. The number of households that own at least one insecticide treated bednet with 3DF support was reported to be 230,000. No data are currently available on nationwide bednet coverage, but surveys are planned for 2011. However it is reasonable to assume that the needs



are significantly higher, given that approximately 8 million households are in endemic areas.

A number of surveys were supported in this period. Facility-based malariometric and Knowledge, Attitudes and Practices (KAP) surveys were carried out by WHO and NMCP in July and August in townships of Kachin, Kayin, and eastern Shan States, and Magway and Tanintharyi Divisions. NMCP also conducted a community-based survey in 21 villages of Rakhine and eastern Shan States and Tanintharyi Division. Survey data will be available in 2010. CESVI conducted two field surveys: a quality assessment of RDT usage in the field, and status and effectiveness of ITNs. Both studies showed good results confirming the validity of a community-based approach to malaria control. CESVI also conducted a routine malariometric school survey in 2009.

The 3DF provided malaria commodities (drugs, RDTs and bednets, worth US$ 35,000) directly to eight Township Medical Officers to implement malaria control activities at township level where a community-based project was closed in 2008 and NGO staff were transferred to cyclone affected areas to focus on emergency relief work. These commodities have been closely monitored by FMO to ensure appropriate use. The FMO visited all eight townships at least once since May 2009 and no major difficulties were reported.

2.6 Experience of Round II for inclusion of CBOs among 3DF partners

The first year of the 3DF directly funding and working with CBOs has brought with it an experience rich in lessons learned for both the partners and the Fund itself. While the CBOs themselves have learned the ropes in directly receiving funds from a multi-donor fund and what that entails in terms of contractual compliance and accountability mechanisms, the FMO itself has learned more about the comparative strengths and needs of CBOs and the ways of effective engagement with civil society organisations for their active contributions in controlling the three diseases in Myanmar.

Eight CBOs signed contracts with the 3DF to implement Round II community-based HIV/TB/malaria projects in January 2009 to the collective value of US$ 529,000 per year. The selected CBOs represent diverse geographical, ethnic, socio-economic groups/backgrounds and bring a wide range of experience and expertise in implementing community-based projects.

An Orientation Workshop was conducted at the beginning of the contract to introduce the 3DF and its strategic priorities. The 3DF ensured that technical support for CBOs was available both on the ground and at the Fund Manager's Office. The FMO field support team has visited all CBOs in the field and provided technical support for project planning, implementation, reporting and documentation processes.

A mid-year project review meeting was held to promote collective learning and strengthen knowledge and skills for effective implementation, and to build stronger networking among CBOs as well as with the FMO. A capacity strengthening plan for partner CBOs was also developed, based on

observations from field visits, review of reports and discussions with the CBO partners. The FMO has also worked with the CBOs to enable them to develop and refine project plans for years two and three based on their experiences during the first year of implementation.

A number of significant developments were noted. Firstly, with active participation of the communities, CBOs have been able to deliver much needed services to the most vulnerable people in rural and underserved areas. Self-help initiatives among most-at-risk populations and within the community itself have been mobilised and strengthened. Communities, through their experience with CBO partners' projects have increased the demand for and access to improved health services. Greater opportunities for expansion have been identified along the way. Linkages and coordination with the public health system have been established and CBOs are recognised as providing complementary services to national disease control programmes. Finally, exposure to and compliance with contractual requirements, while cumbersome and resource consuming for small organisations, have in fact enhanced capacities of staff, and improved management and accountability systems in their organisations.

During 2009, local CBO partners introduced a system to enable communities to provide direct or indirect feedback to the project in order to ensure transparency, accountability and active participation of community members, and improve impact. The 3DF organised workshops and provided continuing technical support to pilot the scheme. Pilot projects were well received by the communities and the local leadership, and considered as a useful and empowering tool to provide feedback to service providers and donors. Informed by ongoing experiences and lessons learned from these pilots, the scheme will be rolled out in all CBO partners for the remaining two years of the present cycle (until the end of 2011). The FMO is currently looking into ways to facilitate a beneficiary accountability scheme to include all 3DF IPs from 2010.

3. OTHER NOTABLE ACHIEVEMENTS

3.1 Additional funds for scaling up – Round III

The Fund's initiative of regular bilateral meetings between the FMO and Ministry of Health in Nay Pyi Taw, joint monitoring visits in the field and constructive communication between the Fund Board and MOH led to better understanding, trust and heightened cooperation. Donors welcomed the improved operational environment and intensified national programming through TSGs and consequently an extension of the Fund's reach was possible through awarding additional grants of US$ 16 million for Round III, thereby scaling up the 3DF programme.

Round III was launched through a Call for Proposals to scale up the 3DF contribution to the national response in all three diseases. The priorities for this funding round were determined through a national collective programming exercise with the MOH and all three TSGs in collaboration with the Fund. Priorities were decided to enable a rapid scale-up of services, with equal weight given to each of the three diseases as well as to prevention and treatment within disease-specific interventions. Thirty one eligible proposals were evaluated by an independent review panel and, taking account of its recommendations, the Fund Board awarded four direct grants (US$ 6.6 million) to WHO to support the National Programmes, and 12 additional grants through a competitive selection process to 11 local and international NGOs, of which two were new IPs to the 3DF. The split of funds between diseases was 40-31-29% for HIV, TB and malaria respectively, representing a shift towards a more balanced resourcing across diseases. The FMO issued the

contracts for direct grants in July and to NGOs at the end of 2009, for implementation commencing 1 January 2010 and operational closure on 31 December 2011.

3.2 Mid-Term Evaluation

In June-July 2009, the Fund Board commissioned an independent evaluation of the 3DF to reflect on whether the structure, management and interventions of the Fund have responded effectively to the three diseases in Myanmar and to document lessons learned. Overall, the evaluation team confirmed that the 3DF governance structure was still appropriate to the context, that its programme made direct impact in the containment of the three diseases in Myanmar and that the Fund performed well. Indirectly, the Fund evidenced the ability to provide services to vulnerable groups and better understanding of disease trends through funding surveys and operational research. It also appraised the congruency of the Fund's interventions in general with National Strategies and complementarities to public health. However, coverage was considered to be low, leading to limited impact. An improvement to M&E systems was recommended due to the disparate and disconnected roles and functions and strategic use of information, together with more impact assessment to get strategic oversight. A fully satisfactory finding was provided regarding fiduciary and operational arrangements of the FMO.

An action plan to address the MTE team's recommendations was drawn up, with Fund Board's responses, in order to operationalise all agreed recommendations.

3.3 Annual Review

The 3DF Second Annual Review Meeting was held on 14 October 2009 and attended by some 160 participants representing the Ministry of Health, donors, United Nations agencies, international and local NGOs, CBOs, Fund Board and the Fund Manager. Achievements were presented together with lessons learned, challenges and issues that still need to be addressed. A 'Market Place' exhibition by 31 implementing partners closed the event. The Fund Board reflected on the collaboration, trust and clear progress in partnership among all actors involved in the 3DF. The MOH remarked that the 3DF represented "an innovative partnership with all key players". Issues highlighted during the review meeting included the importance of consistent quality standards across projects, joint work on monitoring and evaluation, and better synergy between similar modalities or disease programmes.

3.4 Communications

The Fund Board's Communications Strategy and the Fund Manager's Strategic Communications Plan define how information is disseminated to national and international stakeholders, and this remained constant in 2009.

The Fund Manager used the website http://3dfund.org/ as a main platform to publish key documents in 2008. In 2009, however, a malfunction of the United Kingdom-based web host necessitated migration of the site to a Singapore-based company. The move prompted a two-stage redesign of the website to facilitate access to key information and results. This is continuing in 2010.

In 2009, the FMO interviewed various stakeholders in the field, prepared press releases, key messages and talking points to respond to parliamentary questions and media queries. Printed materials produced included the annual glossy report compendium and progress report, and a newsletter (also in Burmese language). The Fund Manager facilitated a donor field trip to strategic areas of Mandalay Division and northern Shan State in March 2009.

The Round III call for proposals was widely advertised in local news releases as well as through direct mail to known stakeholders in Myanmar, and internationally through websites.

In March 2009 and for the second consecutive year, the Fund Manager provided MOH senior officials with CD-ROMs containing information on projects, progress reports, policies and operational guidelines.

3.5 Gender

Gender is a key cross-cutting issue integral to the Fund's operational policy. Building on the momentum created in April 2008 through a study commissioned to develop the 3DF Gender Strategy and a Gender Mainstreaming Handbook, and subsequent formulation of the 3DF Gender Task Force with interested implementing partners in October 2008, the FMO provided training on 'Integrating Gender in 3DF projects/programmes' for FMO staff and IPs in May-June 2009. Subsequently, a gender checklist was provided to 3DF partners. The 3DF Gender Task Force met during January, February, May and December 2009 to operationalise the Gender Strategy and to coordinate and share information with existing gender initiatives in the country and on activities implemented by the 3DF's partners. These efforts were a catalyst and complementary to national initiatives on gender by the TSG Gender Working Group and United Nations Gender Theme Group.

3.6 Contracting

Additional donor contributions to the Fund allowed the extension of all existing grants to a fourth year of implementation, one year beyond the Fund's initial commitment. The Fund has introduced a new contracting modality, which was applied at the time extensions were agreed, to cover the entire remaining two years until 2011. This differs from the previous practice whereby grants were extended on a year-by-year basis. This multi-year contracting modality has been perceived by partners to bring a greater degree of financial security, and to enable more flexible programming and planning. The new modality commits all funds for the entire project period and thus disallows the previous practice of releasing unspent funds at the end of each project year for additional activities.

A number of improvements to the contracting process were also introduced. Firstly, the financial reporting and technical reporting periods were harmonised from quarterly to semi-annually. There is no longer accounting for interest earnings, and a 'Miscellaneous' budget line has been introduced to cover some unforeseen direct costs related to project implementation, while clarification on indirect costs was provided. Finally, budgeting for M&E is now included as a separate output, in order to gain a clearer view of the amount of effort and resources allocated for this purpose. The revised indirect costs allocation generated savings of at least US$ 867,000 in 2009.

3.7 Financial Status

The Three Diseases Fund portfolio grew in 2009. DFID pledged an additional GBP 10 million (approximately US$ 15.5 million), the Netherlands increased its contribution by EUR 1.0 million (approximately US$ 1.48 million) and Sweden by SEK 10 million (or approximately US$ 1,280,000). In late 2009, Denmark joined the Fund's donor consortium and committed DKK 30 million (approximately US$ 5.87 million) bringing the total pledges for the Three Diseases Fund until 2012 to approximately US$ 125 million. In terms of contributions received since 2006, the breakdown is as follows:

	2006	2007	2008	2009	Total
AusAid	786,600	2,146,550	2,678,600	1,707,317	7,319,067
DFID	2,661,540	8,985,990	8,518,050	15,029,375	35,194,955
EC		7,067,555	5,471,295	6,344,625	18,883,475
The Netherlands		1,362,400	1,314,600	2,993,000	5,670,000
Norway	754,152	1,735,898	1,972,355	1,545,563	6,007,968
SIDA		5,738,187	6,883,625	3,699,790	16,321,602
Danida				1,950,116	1,950,116
Total US$	4,202,292	27,036,580	26,838,525	33,269,786	91,347,183

The grants awarded to IPs since October 2006 represent the following disease allocation: HIV 55.91%, TB 18.11%, malaria 18.40% and integrated projects 7.58%.

The combined implementation rate for the Round II partners (CBOs) was 92.56% for their first year of operation (i.e. 16 January to 31 December 2009). For Round I IPs, the indicative implementation rate increased from 85.7% in year 1 to 88.23% at the end of the second project year (i.e. 30 April 2009 and 31 August 2009), corresponding to a utilisation of US$ 19,942,300 of the total approved budget of US$ 22,601,629.

3.8 Financial Audit of Fund Manager

For the 2006 financial audit of the Fund Manager, one recommendation remained open until mid 2009. The issue of the basis of calculation of the administrative fee was closed in July 2009 with UNOPS offer of a revised pricing scheme to the Fund Board. Of the 26 recommendations from the 2007 audit, only two items remain open: the need to arrange for comprehensive insurance of all valuable assets, and to strengthen the finance unit to perform monthly reconciliation and review of account charges.

The 2008 internal audit of the Fund Manager was planned for October 2009 but was postponed to February 2010.

3.9 Financial Audit of Implementing Partners

The 2008 financial audit covered the areas of Programme/Project Management, Financial Management and Reporting, Procurement, Staffing and Human Resources Management and Asset Management.

The audit of 18 non-United Nations partners reported 13 Satisfactory and five Partially Satisfactory audits, demonstrating good adherence by partners to the Fund's principles and operational guidelines. The auditors made a total of 215 observations and recommendations with a view to further strengthening financial management, the application of which will be regularly reported to the Fund Board. In terms of priority, these recommendations were rated as High (22 items), Medium (147 items) and Low (46 items). As of reporting date, 87 recommendations had been closed after IPs took appropriate action, whereas 128 recommendations remained open. Most common issues were related to eligibility of expenditures, applied exchange rates in accounting, availability of detailed records and written applicable procedures, insurance of valuable assets and expired MOUs with the Government.

3.10 Procurement

In 2009, 103 orders were placed on the part of 19 implementing partners for a total value of US$ 1,022,571, up from US$ 658,087 in 2008. Of all orders, 89.4% were made utilising Long Term Agreements (LTAs) established either by UNOPS or other United Nations agencies. Although using LTAs reduces the time required for tendering, it increases the number of purchase orders issued since not all required items can be obtained under a single LTA.

TOTALS	2007 (half year)	2008	2009
Number of orders	6	33	103
Total order value	US$ 258,886	US$ 658,087	US$ 1,022,571
% under LTAs	100.00%	92.79%	89.40%

In 2009, the average lead time from requisition to full delivery was 21 weeks (in 2008 this was 19 weeks) and 77% of all ordered commodities had been delivered within six months (81% in 2008). Delays occurred in 2009 due to expiration of some LTAs, which took around one month to renew.

The FMO provided assistance and acted as consignee for partners' health commodities shipments needed for project implementation, as in their approved workplans. This resulted in time savings for partners, who would otherwise have had to obtain import licenses. In addition, the FMO provided customs clearance assistance in 114 instances, of which 25 were related to procurement undertaken by partners and 89 to procurement undertaken by the FMO.

The FMO provided special support to Round II partner CBOs by managing their supply chain process requirements from order placing through customs clearance to in-country transport for all procured commodities.

The FMO designed and implemented a new tracking system to improve procurement process management. The tracking system identifies delays in the procurement process, hence allowing more timely actions to avoid potential delays and minimise their impact. UNOPS internal auditors recommended introduction of the system organisation-wide as a good practice.

3.11 Commodity Tracking

The FMO engaged in a commodity tracking review with 14 IPs (15 projects), which exceeded the set target of 30% of partners to be reviewed during 2009. The overall results of the review verified that partners have satisfactory supply chain systems in place and that losses are kept to a minimum. The review broke down the supply chain into 22 different components, which were scored. The results of the review are in the table below:

Score categories	IPs in 2008	IPs in 2009
Exceeds expectations	0	0
Satisfactory	8	11
Needs development	1	4
Fully unsatisfactory	0	0

The most common issues raised were related to the absence of written inventory management guidelines and non-registration of batch numbers, necessary to trace pharmaceuticals throughout the supply chain.

4. SUPPORT/LINKAGES TO THE NATIONAL PROGRAMMES

4.1 Collaboration with MOH

The FMO continued regular bilateral meetings with MOH throughout 2009. Such close working collaboration with MOH enabled rapid resolution of pending issues and clearing of potential misunderstandings related to the functioning of the Fund. The regular exchange of information fostered not only the resolution of programmatic and administrative issues, but establishment of a culture of transparency, trust and collaboration. Through these meetings it was decided that the FMO would conduct joint monitoring visits with MOH staff and MOH regularly delegated relevant high-level technical staff to join field visits. Starting in 2010, every second such bilateral meeting is foreseen to include WHO participation, in order to address practical issues around the implementation of 3DF support to the National Programmes.

The collaboration led to the MOH playing an active role in the development of technical policy content for Round III and was instrumental in arranging the aforementioned collective programming exercise through mobilisation of the TSGs. This culminated in a joint TSG meeting with participation of the Fund Board, where all stakeholders in the three diseases presented their views on priorities, which were considered in the finalisation of the Round III Call for Proposals.

4.2 Direct grants to WHO to support the National Tuberculosis Programme

The Fund awarded two direct grants to WHO to support NTP in 2009 to finance the provision of first-line anti-TB drugs for one whole year of 2010 and to contribute to the implementation of the National TB Prevalence Survey. Total grant values are US$ 3,000,000 and US$ 270,000 respectively starting from July 2009. The grants will cover the entire TB drug needs in Myanmar for 140,000 new TB cases in 2010 and approximately 30% of the budget for the National TB Prevalence Survey.

A National TB Prevalence Survey was designed in NTP with multi-donor support (3DF, Bill and Melinda Gates Foundation, WHO, JICA, JATA and USAID) and implementation commenced from June 2009. The 3DF mainly funded procurement of commodities, equipment and field operation costs. The FMO visited one field location jointly with WHO, PSI and NTP to monitor progress. The quality of field work and the efforts put in by the survey team were impressive in the face of operational difficulties.

According to the workplan, NTP initially planned to complete data collection in 70 field clusters under this survey by December 2010. However, NTP subsequently indicated that all field survey clusters would be completed in early April 2010 and most of the supplies procured with 3DF support had been used in remote clusters.

4.3 Coordination for CBO project development

While developing the project proposals, the CBOs, particularly those with project sites in remote areas, have consulted the National Programmes to identify the gaps and opportunities for service delivery. Sharing of resources – commodities as well as human resources – between the National Programmes and CBOs is also encouraged and practised at the field level.

One CBO in eastern Shan State (AIDS Support Group, or ASG) works in collaboration with the National AIDS Programme in delivering treatment, care and support to people living with HIV through a weekly clinic. ASG provides medicines for opportunistic infections and nutritional support to patients and manpower to help the clinic run smoothly. Another CBO Round II partner in Rakhine state (Myanmar Health Assistant Association, or MHAA) received anti-malaria drugs on loan to fill the gap during procurement lead times, and technical expertise from the NMCP. In turn, MHAA contributed to malaria control in the project villages through collaboration with the Basic Health Staff for campaign activities and through collecting data for malaria research by the NMCP.

4.4 Fund Flow to implementation in the public sector

Fund Flow Mechanism is the modality to transfer funds from the central level to townships to support cash-based activities implemented by the National Programmes. The modality has two components. Disbursement refers to a decentralised payment at the time and at the venue of the activity. It is conducted by WHO Finance Clerk, who attends the event, makes direct payments to the recipients and produces the required financial records. Reimbursement refers to a decentralised claim that is made after the activity. The recipient is required to submit a claim and report of the activity to WHO to be authorised, verified and paid. Reimbursement is used as a modality when activities cannot be serviced by a WHO Finance Clerk.

Expenditure summary	Year 1	Year 2
Disbursements	395,519	411,865
Reimbursements	196,184	151,367
Total US$	**591,703**	**563,232**
FFM costs	329,196	369,607
Cost/Spend ratio	**0.557**	**0.656**

Following the introduction of the multi-year contract modality to provide continued support to the National Programmes, the Fund Flow Mechanism grant to WHO was extended in 2009 for an additional 25 months. This brings the committed cost for this decentralised disbursement system to US$ 2,149,275 for the period September 2007 to September 2011.

In response to feedback and concerns on the efficacy of the modality by which the Fund Flow Mechanism is being implemented in the field, a brainstorming session was undertaken in April 2009 with participation from the Department of Health, National Programmes, selected Township Medical Officers, WHO and FMO. During this meeting key stakeholders provided concrete inputs on how best to channel fund flows through the local civilian administration, and measures were proposed on how to improve the existing WHO-3DF fund flow. In keeping with the recommendations of the MTE, implementation of the proposed modality was deferred. The MTE team recommended to wait for the result of the strategic review of the Fund Flow Mechanism which WHO proposed to undertake during the Country Coordination Meeting held in January 2009. The review is scheduled for the first half of 2010.

In 2009, WHO focused on minimising the use of the reimbursement modality in order to reduce delays in payments, hampering programme implementation.

5. IMPLEMENTATION CHALLENGES

Some challenges were encountered in relation to delivering services to communities in remote and underserved areas. In these areas, there is limited potential for referral and network development, and IPs working there are sometimes the only organisations providing health services in the area. This can lead to community expectations and demand for health services beyond the scope of the project, and which the IP is unable to provide. While there are needs and demands from the community for expansion of services, CBOs and NGOs face several hindrances to scale-up, such as staffing, capacity, geographical restrictions, limited mandate, legal and administrative restrictions and funding constraints. Services in the communities often operate in parallel to the public health services and are relatively costly to provide and limited in scope. Supporting and working through public sector service providers offers opportunities to scale up service levels at lower cost and that can have a wider reach.

Mobility and turnover of project staff continues to be identified as a challenge. This includes availability and retention of community-based peer workers as most peer approaches are on a volunteer basis. Peers educators themselves can be as mobile as the beneficiaries they serve, and lack of incentives also contributes to high turnover.

Reaching mobile populations also has its own particular set of challenges. Community volunteers do not always have the necessary social network within migrant worker communities and, as such, have limited ability to reach into this vulnerable group. Low coverage of LLINs in these communities is one factor that contributes to high malaria incidence.

Coordination between health professionals at township level is key to achieving good public health outcomes. However, Township Medical Officers are not always able to take the lead and assume the

important coordinative role. Collaboration between public service providers and some partners for community-based projects was reported as a challenge in some areas.

Some partners reported that delayed approval of travel authorisation for international staff to field project sites led to complications in project planning, monitoring and implementation. In some locations, international staff are only allowed to visit for short periods and permanent placement of staff has not been possible.

The illegal nature of sex work and drug use in particular means that from time to time local law-enforcement authorities clamp down on sex workers and drug users in some areas. This can affect the ability to reach these high-risk groups with services, especially during such periods. Despite continual advocacy efforts, it can be difficult to convince local authorities and community members of the acceptability of harm reduction as an approach to address public health needs.

Some challenges persist around availability, timeliness and quality of data, and these are faced by NGOs, CBOs and National Programmes alike. The lack of efficient communications and established M&E systems affects the timely availability of data, needed for reporting and planning requirements. For National Programmes in particular, timely data collection from remote townships is a challenge. Needs for capacity building in M&E have been identified in some agencies.

Support for procurement and supply management faced specific challenges. Long Term Agreements (LTAs) are essential to ensure that delivery lead times remain within an acceptable range. However, since the LTAs used by the 3DF mostly belong to other United Nations agencies, access to these LTAs is neither guaranteed nor can timely extension be ensured by the Fund Manager alone. In terms of advance planning, not all partners have sufficient experience with planning six months ahead for their medical commodity requirements. As a result, there were a number of requests for urgent procurement during 2009.

Fund Flow to the public sector has been identified as a significant challenge to implementation for the National Programmes, and has proved to be much more complex and demanding than anticipated due to its scale and scope. Delays in payments for the public sector resulted in aspects of the programme being delayed or not executed at all.

6. STORIES OF MOST SIGNIFICANT CHANGE

Three Diseases Fund introduced Most Significant Change (MSC) methodology in 2008 to enable implementing partners to gather and report complementary, qualitative information on how services provided have affected people's quality of life. The Fund provided training to all IPs on this participatory methodology through a two-day workshop. In 2009, 18 IPs included MSC stories as one element of their technical progress report, with some providing as many as five stories within a six-month period. The majority were from HIV projects where people still face significant stigma and discrimination. Personal development and behaviour change were frequent themes and there were also stories on the evolution of CBO projects.

The following MSC story tells of change at many levels; of coping with discrimination and creating a place in the community for people living with HIV and men who have sex with men:

"When I first joined the support group they knew I was HIV positive but I didn't tell them I am a man who has sex with men. This was because of the stigma, not only in the community but in my family. There are many levels of discrimination; I suffered and was afraid - which is normal, of course. But when I started learning more within the group, I thought, what am I afraid of? As the group grew larger, I didn't care anymore about discrimination.

"I went to Pyapon town for a World Aids Day event and acted as a facilitator. On that stage, I told 700 people that I am HIV positive and advised how to live well with HIV. Because of my speech, others felt safe to 'come out'. Now there is an HIV support group in Pyapon, and I've also helped open groups in Bogalay, Kyaiklat, Dedaye and in Mandalay.

"I motivate many people through the groups – they see I'm healthy and unafraid. Most importantly, I want the next generation to be safe. It's my right to be able to do this, and they have the right to be protected. When people first come to us, many don't admit they have HIV. Some have no hope and cover their faces with a towel. But then they listen. I'm 53 years old and I will do this until my last breath."

A story from a TB clinic in the Yangon satellite town of Hlaing Thaya resonates in other stories from around the country:

He worried about his frequent sickness - hard coughing with severe chest pain. With meagre income from repairing car tyres, he dared not consult a doctor. He had a family of five to support, including three school children. Over time, he became so weak that he had to stop work. Soon he could not pay the rent on their one roomed home and moved to a nearby slum, in a small reed hut walled with bamboo mats. ''At that time, I totally gave up on my life. I had no idea what was wrong with me and was ready to die," he says.

Concerned neighbours brought a community health volunteer. He learned he had tuberculosis and was relieved to hear that there is a specialised TB project in the township. He received immediate support including medication and nutritional supplements and, as standard procedure, medical checkups were conducted on his family. Two of his daughters had also contracted TB. While they recovered, he could not work. To his surprise, the TB project provided them with rice and cooking oil.

Within six months, the family was free from TB. He returned to work and the children re-started school. On a visit to his home village, he saw that his cousin's wife showed the same symptoms of illness he once had. He immediately took her for a medical check up at the village health centre. "I've heard that she, too, is better now," he smiles.

A Community Health Worker relates a story about the dramatic impact of malaria education and treatment in a remote village:

> *"Our village is called Dawn. It is on the Myanmar/Indian border in Chin State. The nearest health centre is 16 miles away, and we are not able to get health care from the nearest Indian town. With no health education, there was misery caused by malaria, acute respiratory infections, diarrhoea and other communicable diseases. Maybe five to six people died every year from these diseases. A few years ago, 27 people died within a year due to severe malaria. At that time, people from nearby villages were afraid to come here. Nobody knew that it was malaria. They believed that devils bewitched our village.*
>
> *"Today, we have increased health awareness not only about malaria but also about the other diseases. From 2007 onward, there's been a major reduction in disease mortality in our village. Moreover, pregnant women are now well aware of danger and they are changing their behaviour. Both diagnostic materials and drugs have been very effective."*

7. LESSONS LEARNED

It has proved essential to review and monitor partners M&E systems and implement a Data Quality Assurance System in order to ensure the availability of robust data. Clarity on indicators and reporting requirements needs to be provided regularly. After each reporting period, a lessons learned forum helps to summarise findings, practices and methods applied and to foster discussion among partners. While maintaining high standards, the Fund has learned to have realistic expectations on data reliability and quality.

Coordination, collaboration and the operational environment at the township level can be improved through open communication and introduction of an information sharing/reporting system (without compromising client confidentiality) that involves local officials and other stakeholders. Partners have worked through Township Steering Committees or through direct contact with local authorities where no coordination committee has been set up.

A longer-term view towards capacity strengthening of CBOs is essential to sustain their active involvement in the response to the three diseases. As most local organisations are relatively young, they still require support and time for organisational and systems development. Therefore it is important to take a long-term view in order to strengthen the capacity of local organisations, rather than reacting to short-term opportunities or needs. For the Round II CBO partners, 2009 brought the first experience of partnership with a multi-donor trust fund, and as such the FMO provided significant inputs for orientation, guidance and introduction of international best practices. In addition, significant monitoring inputs proved necessary to reduce fiduciary risk.

Experience has shown that in places where a space is created by the public health system and international NGOs, CBOs have been able to contribute to the provision of comprehensive continuum

of care, in particular in relation to HIV. At the same time, there is a need to recognise that CBOs play a unique role in the response to the three diseases, which is not necessarily to provide services at scale, but to mobilise segments of community usually less heard or reached by larger organisations and the public health system. An opportunity also exists to look at the approaches being used by CBOs to mobilise and reach out to their own communities and document various models with a view to their application elsewhere.

Given the evolving operating context, the Communications Strategic Plan needs revisiting to ensure clear designation of risk management roles within the Fund Board and FMO. Emphasis needs to be placed on relaying key results with beneficiary stories at this stage. Opportunities should be taken to build on the goodwill shown towards the Fund by various stakeholders, to consolidate relationships with partners and uphold the 3DF culture of transparency.

Procurement and supply management practices have had to be tailored to needs. Although consolidation of requirements is considered good practice and was applied to 3DF procurement in 2008, IPs planning proved suboptimal, and procuring through consolidating needs across projects did not achieve the desired goals of reducing costs and reasonable lead times. Instead the 3DF opted for an LTA-based strategy which allows more frequent order placing by IPs. However, when non-standard commodities are procured it is essential that sufficient time be allocated for establishing specifications and procurement action.

Moving the gender mainstreaming objective from a conceptual phase into programmatic application requires deeper understanding of context, dedicated capacities and resources and buy in from all stakeholders.

Regarding contract management, the FMO learned that it is necessary to further strengthen partners awareness of and compliance with contractual obligations, in order to ensure accountability, transparency and adherence to international good practices.

The multifaceted nature of Fund operations put considerable pressure on the FMO both in terms of the volume of issues arising and the complexity of domains to be managed. In response to observations from the MTE, the FMO intensified self-assessment in respect of required skills and capacity. Immediate actions included reinstating the international M&E Officer position, ensuring extra support to the finance function and further improvement to the website platform.

8. CONCLUSIONS

There is well-evidenced goodwill and trust around the work of the 3DF as reflected throughout its operations and by all stakeholders. The Mid-Term Evaluation as well as the Annual Review confirmed that the 3DF has laid solid foundations to prove that it is an innovative partnership that demonstrated the possibility to deliver humanitarian aid effectively in Myanmar. It has gained the trust and collaboration of all stakeholders and delivered substantial contributions to the national response to the three epidemics. As a successful, large-sized health trust-fund, it paved the way for other donor initiatives in Myanmar to complement efforts already in motion. The model is there to be used and replicated and for gathering lessons for all concerned.

There is still a lot to learn and improve, both in the scope and the quality of the work to be carried out. A fruitful partnership has been established in-country to address issues around good programming, measuring results and impact in the long run. Efforts must continue to respond to new challenges resulting from the 3DF generating demand for health care in the communities that are currently beyond its ability to serve. It is becoming increasingly clear that a vertical health fund generates demand in all areas of health care wherever gaps are and that it cannot meet all expectations. However, there is a need to start looking into ways how such gaps in covering several other pressing needs in Myanmar could be better addressed, based on the experience gathered. The donors are looking into options for the future of the Fund and contemplating ways to expand its coverage both in scope and reach. Such policy work is foreseen for 2010, commissioned by the 3DF's donors.

The 3DF has chosen to work mostly through a competitive tendering process for awarding grants. This modality resulted in the composition of a portfolio of projects in the 3DF programme that is not necessarily always targeting the most in need or achieving best quality and value for money or fulfilling completely the Fund Board's intended policies, due to a shortage of providers to select from. The MTE also suggested that it might be desirable for the Fund to look into ways to review its model of fund allocation in the future and consider adopting a more commissioning type allocation modality. Under such a modality, evidence-informed prescriptive results are expected from best-suited service providers, directly contracted to deliver in areas of highest priorities.

The arrival of the Global Fund will necessitate an ever closer collaboration between stakeholders to secure a smooth operational environment that will enable better results. It is paramount to ensure that no major gaps are left uncovered and the complementarity of the two major Funds leads to a scaling up and a more comprehensive approach. Such a coordinative framework is to be set up during 2010 with all stakeholders.

The MTE mapped out several areas where the Fund will need to examine how to evolve further. An ever increasing challenge is to measure results with good evidence generated which needs additional focus on M&E systems both in the 3DF and its partners as well as nationally. In 2010 a Data Quality Assurance System will be put in place and it is expected that increased attention to reporting and data quality will improve available information. Generating robust data and evidence in the three epidemics is necessary to define the exact areas where the gaps are the largest, especially if the Fund will aim at commissioning work against evidence-based service delivery plans. Such work can be carried out only in collaboration with all stakeholders and it is necessary to generate further momentum at a national level to improve available information.

The MTE has also emphasised the importance of separating roles of the Fund Board (policy and oversight) and Fund Management (implementation and monitoring) that is in line with the established governance structure to be maintained in the remaining time of the present phase of the Fund. Current best practices will need to be well recorded and reflected and accountability and transparency in the Fund's operations maintained through continuing rigorous audits and maintaining international standards in contract management.

The fund flow to the public sector remains a challenge and to address its shortcomings it is urgent to secure good programmatic achievements in health services of the public sector and to further

improve the operational environment. Addressing the efficacy of the fund flow scheme is a priority for 2010 and a review of existing schemes to gather lessons in designing a potentially harmonised approach across the stakeholders working through the public sector will commence in 2010. Such work is essential if the Fund is to consider scaling up its coverage and achieve best value for money, which would necessitate intensified efforts to mobilise both public and private sector health service providers.

Finally, responsiveness of the Fund and its accountability to beneficiaries will need to be improved by increasing community involvement both in design and delivery. The initial experiences gathered in 2009 through the present Community Feedback Mechanisms piloted by a limited number of CBO partners will be used to review best practices and expand a beneficiary accountability scheme among all 3DF implementing partners from 2010 onwards.