Myanmar
Independent Evaluation Services
of the 3MDG Fund

Final Inception Report

24 April 2014

Submitted to: UNOPS Myanmar
Submitted by: Euro Health Group A/S

In consortium with: ITAD, UK
In collaboration with: The Department of Medical Research – Lower Myanmar
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ABBREVIATIONS AND ACRONYMS

3MDG Three Millennium Development Goal
3 MDG Fund Three Millennium Development Goal Fund
3DF Three Diseases Fund
AIDS Acquired Immune Deficiency Syndrome
AEM Asian Epidemiology Model
AusAID Australian Agency for International Development
AMW Auxiliary Mid Wife
CB Capacity Building
CCM Country Coordinating Mechanism (Global Fund)
DAC Development Assistance Committee
DD Deputy Director
DFID Department for International Development
DMR-LM Department of Medical Research – Lower Myanmar
EAC Evaluation Advisory Committee
EHG Euro Health Group
EU European Union
FB Fund Board
FM Fund Manager
FMO Fund Management Office
GAVI Global Alliance for Vaccines and Immunisation
Global Fund Global Fund to fight HIV/AIDS, TB and Malaria (Global Fund)
HIV Human Immunodeficiency Virus
HMIS Health Management Information System
HSS Health Systems Strengthening
IE Impact Evaluation
IEG Independent Evaluation Group
IOM International Organization for Migration
IP Implementing Partner
KAP Knowledge Attitude and Practice
LiST Lives Saved Tool
M-CCM Myanmar Country Coordinating Committee
M-HSCC Myanmar Health Sector Coordinating Committee
M&E Monitoring and Evaluation
MDG Millennium Development Goal
MNCH Maternal, Newborn and Child Health
MoH Ministry of Health
NGO Non-Governmental Organisation
PD Project Director
QA Quality Assurance
RH Reproductive Health
TB Tuberculosis
TBE Theory Based Evaluation
TL Team Leader
ToC Theory of Change
ToA Theory of Action
ToR Terms of Reference
TSG Technical and Strategy Group
UFE Utilisation Focused Evaluation
UN United Nations
UNAIDS Joint United Nations Programme on HIV/AIDS
UNDP United Nations Development Programme
UNICEF United Nations Children’s Fund
UNOPS United Nations Operations and Procurement Services
US$ United States Dollars
VfM Value for Money
WHO World Health Organisation
WP Workplan
EXECUTIVE SUMMARY

The Three Millennium Development Goal Fund (3MDG Fund) is a five-year, $300 million fund that aims to improve Maternal, Newborn and Child Health (MNCH) and reduce the burden of communicable diseases in selected targeted areas in Myanmar. The 3MDG Fund programme has three components: Component 1: Supporting MNCH; Component 2: Supporting HIV, TB and malaria interventions and Component 3: Health systems strengthening.

Eight international development agencies support this Fund and are represented on the Fund Board (FB), which provides the Fund’s oversight. UNOPS Myanmar, through a Fund management Office (FMO), manages the Fund by providing funding and support to, and working in collaboration with, the Ministry of Health (MoH) and Implementing Partners. The Independent Evaluation Group (IEG), a consortium led by the Euro Health Group (EHG) in partnership with ITAD and the Department of Medical Research-Lower Myanmar, has been engaged to ensure high quality evaluation processes that will encourage learning and improvement and provide empirical data that will support the 3MDG Fund to achieve success. Between 2013 and 2017, the IEG will conduct the following tasks:

Ensure Credible and Useful Programme Data. The IEG will conduct several tasks to ensure useful and credible programme data. First, the IEG will provide feedback on the FMOs six-monthly reports, reviewing it against criteria set by the FB. The thematic areas include: Clarity and consistency, usefulness in understanding progress made and potential gaps, and achievements against plans. The IEG will then provide recommendations that aim to strengthen the report. Second, the IEG, while not conducting a full external data quality audit, will conduct an external data quality assessment of programme data based on the FMO’s review and provide recommendations. Third, the IEG will provide technical inputs into the Fund’s baseline methodology, a study that aims to provide data on the population that are intended to receive services under Component 1, though this population may also benefit from other components. The IEG aims to ensure that: (1) baseline protocol and methodology are in line with best practices, (2) processes are in place for data quality assurance, (3) contextual considerations are included in the design, and (4) resulting data provide sufficient information to address evaluation questions. Further, the IEG will work with the baseline service provider regarding assessing the differential impact of interventions on marginalised groups, while the FB undertakes to define vulnerable groups.

Conduct Three Evaluations. The IEG will conduct three evaluations: (1) implementation evaluation (2) outcome evaluation and (3) impact evaluation. The evaluation methodologies will be guided by two key approaches, Utilization Focused Evaluation (UFE) and Theory Based Evaluation (TBE). UFE is based on the principle that an evaluation should to be useful to its primary intended users. TBE focuses on the assumptions made about what makes the programme successful. This approach identifies how activities are expected to contribute to the outcomes and impacts which help guide what and how data are collected and analysed. The evaluation method decisions will be further guided by four conditional considerations - the context, range of implementing partners and variation in implementation, process and timing of implementation and the quantity and quality of secondary data. Evaluation questions will be heavily informed by the OECD DAC criteria and influenced by the primary stakeholders data needs.

Given the complexities of the 3MDG programme, and the IEG’s aim to ensure that data are useful to intended users, the IEG will further focus on and refine the evaluation approach prior to implementing each evaluation.

Mid-term Evaluation – Implementation Evaluation. This evaluation has three key focus areas. First, it aims to identify if the programme is on track to achieve its intended impacts and provides in-depth information about the quality of service delivery and unintended results. The primary users are the
FMO and FB and secondary users include key stakeholders. With these users in mind, the evaluation will provide data that will: (1) document implementation, (2) allow comparison of actual implementation to planned implementation, including financial information, and (3) provide data to improve implementation. Additionally, it will have an organisational focus and explore the implementation of the Fund. Third, it will inform decisions on how to value the impact findings. The evaluation will use mixed methods and draw on secondary and primary data collection.

**Final Evaluation – Outcome Evaluation.** The final evaluation will identify programme results (anticipated and unanticipated), explore the extent of coverage, determine enabling and hindering factors for achieving or not achieving those results and coverage and assess those findings against the OECD DAC criteria and 3MDG targets. This evaluation will also determine the programme’s value for money and incorporate recognised modelling approaches for MNCH as well as malaria. The primary users include the FMO, FB and MoH, and secondary users include key stakeholders. This evaluation will use mixed methods and draw on primary and secondary data. The fuller analysis of causality and net impact will be part of the impact evaluation.

**Impact Evaluation.** The impact evaluation will assess the extent to which the 3MDG Fund has contributed to intended, sustainable, health impacts in MNCH and the extent that these impacts reached targeted, marginalised populations. The focus will be on the outcome and impact levels and assessment of the cause-effect relationship – what led to the changes, how they occurred and under what circumstances.

The IEG suggests two potential approaches, (1) a quasi-experimental quantitative approach with a Theory of Change (ToC) and 2) a theory-based mixed method evaluation (with baseline). The quasi-experimental model is more focused on identifying and quantifying impact while the theory-based evaluation model focuses on assessing causality and contribution in a more qualitative sense. The final design for the impact evaluation will be developed when there is clarity on the baseline design and its timing, a further refined ToC and clarity on available and reliable credible secondary data. The primary user of the impact evaluation is FB, FMO and MoH; and secondary users include other key stakeholders.

**Additional Studies.** The IEG will conduct studies to supplement the evaluations. In the first year, the IEG proposes to conduct two studies: 1) a stakeholder satisfaction survey that will be repeated annually and 2) a comprehensive desk review of existing research relevant to the 3MDG Fund that will be updated quarterly. The IEG will propose additional studies as they are identified.

**Risk Management, Quality Assurance and Capacity Building.** The IEG has considered and identified actions to mitigate various internal and external risks and, using EHG’s Quality Assurance Management System, aim to ensure the quality products. The IEG will provide capacity building to the FMO Performance Unit based on need, either through technical assistance or mentoring.

**Dissemination and Learning Strategy.** The IEG will promote learning and sharing through facilitated discussions with the FB and FMO, conducting workshops, and supporting the sharing of the evaluation processes through a presentation at a prominent Myanmar conference with a specific symposium on evaluation. IEG deliverables will be submitted to the FB via the FMO. Further dissemination to IPs, MoH and other stakeholders is the responsibility of the FMO.
1 OVERVIEW

1.1 Background

The Three Millennium Development Goal Fund (3MDG Fund) became a reality in June 2012 and builds on the success of the Three Diseases Fund (3DF). The 3MDG Fund Board (FB) comprised of donor representatives and independent experts is responsible for the 3MDG Fund oversight, including of the Fund Manager (FM) - the United Nations Office of Project Services (UNOPS), with an established Fund Management Office (FMO) in Yangon. The five-year, US$300 million 3MDG programme is funded by the following donors:

- Australia (AusAID)
- Denmark (Danida)
- The European Union (EU)
- Norway (NORAD)
- Sweden (Sida)
- Swizz Development Cooperation (SDC)
- The United Kingdom (DFID)
- The United States (USAID)

The primary goals of the 3MDG Fund are to facilitate improvements in maternal and child health and to reduce the burden presented by communicable diseases in targeted areas. The 3MDG Fund provides multi-donor support to address the basic health needs of Myanmar’s poorest and most vulnerable citizens. This includes providing access to vital maternal, newborn, and child health services; providing support and access to interventions for HIV/AIDS, Tuberculosis (TB), and malaria for populations not supported by the Global Fund; and providing responsive, affordable, and equitable health services that support long-term sustainability.

The 3MDG Fund is guided by the aid effectiveness principles presented in the Paris Declaration, which are: Ownership, alignment, harmonization, managing for development results, and mutual accountability. These principles promote coordinated policy and management processes, which are critical to ensure the long-term sustainability the 3MDG Fund’s outcomes.

The 3MDG Fund has three components, which are described next.

Component 1

Component 1 represents approximately 74% of the overall indicative financial envelope based around a funding envelope of $250 - $300 million over five years, which is expected to be attracted for the 3MDG Fund.

Component 1 will adopt a continuum of care through a range of service providers at township level that is aligned with national strategies for reproductive and child health. This component will prioritise high impact, low cost interventions and integrated delivery of services as close to the beneficiaries as possible, at primary and community level. This will ensure provision of a package of essential health services that will address the main causes of maternal, newborn and child death and illness for poor and vulnerable populations in Myanmar/Burma. The 3MDG Fund will support training of Basic Health Staff, in particular of midwives for skilled attendance at birth, Community Health Workers (CHWs) and Auxiliary Midwives (AMWs), essential Maternal, Newborn and Child Health (MNCH) medicines, equipment and commodities, referrall for and provision of emergency obstetric and neonatal care, and minor refurbishment of health facilities. It will also support demand-side financing to reduce financial and other barriers to use of health services. Activities at township level will be implemented under the auspices of the coordinated township health plan.
Component 2
Component 2 will support priority gaps in the national responses for HIV, TB and malaria that are not readily funded by the Global Fund. Priority will be given to vulnerable and marginalised populations, to hard-to-reach areas and to emerging health threats. Complementing and adding value to Global Fund and other donor programmes will be a key guiding principle. This component will also provide technical support for future Global Fund applications.

Component 3
Component 3 will support complementary health systems strengthening at central and decentralised levels of the health system, to help develop a more effective and a more responsive health system. It aims to support the longer-term sustainability of investment in the MNCH services and communicable disease control components of the 3MDG Fund and to complement existing health systems strengthening initiatives. Systems strengthening will also include measures to strengthen voice and accountability and to build related capacity.

1.2 Oversight and management of the 3MDG Fund

The 3MDG Fund operates under the oversight of the FB, which includes representatives of seven donors and three independent experts. The FB promotes transparency and accountability at the national, regional, and local levels. The FB’s responsibilities also include making decisions about the 3MDG Fund; reviewing and approving operating policies, national strategies, work plans, and budgets, communicating with Ministry of Health (MoH) and other key stakeholders; commissioning independent external evaluations; and contracting and supervising the operations of the FMO.

The FMO carries out the management of the 3MDG Fund in collaboration with the MoH and with Implementing Partners (IPs) that include local and international Non-Governmental Organisations (NGOs), Community Based Organisations (CBOs), UN agencies, public sector health services, research institutions, private sector partners, and township health authorities in the target communities.

The FB uses a variety of vehicles to engage with the FMO. These include subcommittees in Monitoring and Evaluation (M&E) and risk management and specific task teams that focus on fund flow, finance, budget, and performance, and one for each of the three 3MDG Fund components.

A Senior Consultation Group acts as a formal advisory group to the FB. As well as conducting regular meetings with the FB, the Senior Consultation Group consults with the IPs Forum, the MoH and other stakeholders. In addition, the Senior Consultation Group monitors the 3MDG Fund with regard to gender, human rights, and accountability.

The Myanmar Country Coordinating Mechanism (M-CCM) was re-established in 2008. The M-CCM has a mandate to oversee the responses to HIV/AIDS, TB and malaria, and since 2012, also for MNCH and Health System Strengthening. In November 2012 the M-CCM broadened into the Myanmar Health Sector Coordinating Committee (MHSCC) reflecting its multi-sectoral nature with broad participation, including representatives of different government ministries, UN agencies, international organizations, donors, international and local NGOs, private sector and people living with HIV – all of them selected by their own constituencies. The Myanmar HSCC also supports coordination among IPs on specific health issues such as HIV, TB and malaria, health system strengthening, maternal, child and reproductive health and disaster preparedness via technical and strategic groups.¹

¹ Draft National Strategic Plan for Reproductive health
The MoH is the major provider of comprehensive health care in Myanmar. It is structured across three levels of government—national, state/regional, and township—and delivers health services through both public and private providers. The MoH’s primary objectives are to enable all citizens to enjoy healthy, disease-free lives and achieve their full life expectancy. To realize these goals, the MoH employs the following strategies: 1) widespread dissemination of information and education related to health; 2) improvements to disease prevention strategies; and 3) providing effective treatment of prevalent diseases.

**Figure 1: Oversight and management of the 3MDG Fund**
1.3 Role of the Independent Evaluation Group (IEG)

The IEG is a consortium led by Euro Health Group (EHG) in partnership with ITAD and working in collaboration with Department of Medical Research – Lower Myanmar (DMR-LM). The IEG is comprised of a core team of four key experts, a pool of short term experts and an advisory board. The aim of the IEG is to ensure high quality evaluations and evaluation processes that will encourage learning and programme improvement, and help to ensure the 3MDG Fund’s success. The IEG will provide judgement through an impact evaluation, by gathering empirical data that will assess the 3MDG Fund’s achievement of success. The IEG will also serve in an advisory and capacity building role, and through this encourage a culture of evaluative thinking. Further the IEG will help to ensure that conflict sensitivity is integrated into the evaluation framework, drawing heavily on the OECD Development Assistance Committee (DAC) guidance for evaluations in conflict areas (Evaluating Peace building Activities in Settings of Conflict and Fragility Improving Learning for Results).

The IEG does not conduct routine M&E or conduct the baseline assessment.

The IEG will:

1. Establish an evaluation framework which includes: a Theory of Change (ToC) for the 3MDG Fund in support of the logframe; key questions and methodologies for the different evaluations; options for a rigorous impact evaluation
2. Assess the 3MDG Programme data collection systems and proposed data collection tools and methods (particularly with regards to the baseline survey) to ensure that data supports required information critical for evaluating implementation, progress and impact
3. Conduct a Midterm Evaluation that focuses on the extent of programme implementation, and includes a review of programme, financial and management issues
4. Conduct a Final Evaluation, that explores outcomes and includes assessment of programme, financial and management issues
5. Conduct an Impact Evaluation
6. Conduct special studies addressing key questions identified in, and in support of, the evaluation framework at the outset, requested by the FB or arising from the midterm evaluation.

2 REVIEW OF FMO PROGRESS REPORTS

The IEG is responsible for providing a critical analysis of the FMO six-monthly reports, and to assess progress against the proposed work plan. The review will provide feedback on the clarity and consistency of the reports based on criteria and a checklist to be provided by the 3MDG FB. This review will aim to ensure that the information presented is credible and useful, to the extent possible, in understanding progress made and potential gaps in the programme.

External Data Quality Assurance (DQA)

Each year, the IEG will also carry out critical analysis of the FMO Data Quality Assurance reports, produced together with the Annual Progress Reports, from the perspective of whether or not data are being collected that respond to 3MDG Fund’s data needs. The IEG will also review how data are collected by the FMO, how they are stored, and how they are analysed. Based on this the IEG will provide concrete feedback, as needed, to the FMO. While this is not a full data quality audit, this will help to ensure data quality. As part of the external DQA role the IEG will join 2-3 FMO Routine DQA field visits, and carry out annual external DQAs including field visit, and share critical information with the FMO and the FB.

DMR-LM is the sole local collaborating partner of the IEG. The MoH has granted DMR-LM permission to work with this consortium. If DMR-LM requires DMR-Upper Myanmar support they will contact them and make the appropriate arrangements.
3 REVIEW OF BASELINE SURVEY PROTOCOL

A service provider, who will work in partnership with the DMR- LM and MoH, will conduct a baseline survey in 42 townships – and a Service accessibility and Readiness Assessment (SARA) in 102 townships - that determines the current access and provision of MCNH services and health status in the townships where the 3MDG Fund will be operating. The Baseline Team will collaborate with DMR-LM in designing, planning and conducting the baseline survey, analysing data, and drafting the report and disseminating the findings.

Concrete uses for the baseline data will be to identify appropriate targets for 3MDG Fund indicators, identify opportunities for sustainability and scalability of project activities within Myanmar, and provide necessary data for the impact evaluation.

At this point we understand the specific objectives of the baseline survey to be to:

- Establish the prevailing health status and issues affecting mothers, infants and children under the age of five within each of the targeted townships, excluding mortality measures
- Determine current levels of knowledge, attitudes and practice towards MNCH issues and access to MNCH services
- Determine the capacity of the township health systems (including public, private and community-based health systems) to provide MNCH services. This includes the availability and accessibility of health facilities and services offered for mothers, new born and children under the age of five, in terms of distances, cultural acceptability, affordability, availability and appropriateness (client-friendly, inclusive, responsive, hygienic)

The baseline data heavily influence future evaluations, in particular the impact evaluation. Therefore it is essential that the IEG work in partnership with the selected baseline service provider to develop the baseline study. Specifically we will aim to:

- Ensure the protocol and methodology are in line with best practices and the evaluation requirements of the 3MDG Fund
- Provide technical inputs into the robust methodological approaches to address the evaluation questions
- Ensure that processes are in place for quality assurance of data collection and analysis
- Determine if the baseline methodology will be able to assess the differential impact of interventions on marginalised groups, as defined by the FB
- Ensure that the FB and the baseline team consider how the issue of conflict affected areas and populations influence the study design

When the baseline team is in place, the IEG will engage with them through face-to-face meetings, Skype, and email as early in the process as possible³.

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³ The review of the baseline protocol will need to consider both coverage in relation to impact indicators, and coverage with regards to households included, so as to establish viable control and comparison groups. As randomization has not been part of the 3MDG programme approach, this will have to be done through matching. Thus, trade-offs may be encountered and this is best discussed in relation to the winning proposal (see annex on impact evaluation for further elaboration).
4 SPECIAL STUDIES TO BE CARRIED OUT IN YEAR 1

The IEG has been asked to suggest potential studies to take place in Year 1 that support the IEG’s evaluation process. These suggestions do not cover the full range of studies to be supported by the 3MDG Fund. The IEG proposes two special studies for Year 1.

- A stakeholder satisfaction survey
  - The IEG submitted a technical proposal on 19 March 2014

- A review of current research and studies that are relevant to the 3MDG work
  - A brief description is included in Annex 11

5 EVALUATIONS

The IEG will conduct three evaluation processes that will result in three distinct evaluation products. These are the (1) midterm, (2) final and (3) impact. This section provides an illustrative approach to each. With a programme such as 3MDG, and its complicated context, we need to have a realistic and fully informed understanding prior to each evaluation to develop a final and appropriate approach. Our Utilisation Focused Evaluation (UFE) approach prioritises the usefulness of the evaluation processes and products to the FB and FMO and their key stakeholders.

The three evaluations processes and their products

The midterm evaluation will explore the ways in which the 3MDG programme has been implemented against the intended ToC, and examine its processes, related outputs, and the key stakeholder perceptions. This information will then inform the final evaluation, which will mainly focus on identifying outcomes, or “causal” pathways of change. Most outcomes are also preconditions: they are necessary before outcomes farther up the results chain can be achieved. These data will inform how we design and focus the impact evaluation that will measure impact, and at the same time be drawn on to explain impact level findings (or lack thereof).

Each evaluation will examine the programme at different stages, and while some questions will be repeated, they will be used to explore different levels of depth, with different perspectives, and at different time periods. To the extent possible, each evaluation will explore issues that surround efficiency and equity. The synthesis of these data will present a holistic interpretation and provide insight into the value and implications of the 3MDG Fund.

Assumptions

We assume that an end-line/follow-up survey will be conducted by another service provider. With restrictions in access and sensitivity around research and data collection, it is unlikely that the IEG will collect quantitative data independently. Therefore in developing the evaluation framework the group will identify, to the extent possible, routine quantitative information that will generate data for the planned evaluations.

Figure 2 provides an overview of the three evaluation processes (midterm, final and impact evaluation) and how they interact. Annex 6 provides a matrix that shows how each evaluation process then addresses the OECD-DAC criteria.
The next sections discuss the purpose and potential approaches for each evaluation process.

5.1 Overall guiding approaches

Two specific methodological approaches will inform our final evaluation approach, underpinned by conditional considerations. First we explain the key concepts of Utilisation Focused Evaluation (UFE) and then we provide an overview Theory Based Evaluation (TBE). We then highlight key conditional considerations.

**Utilisation Focused Evaluation (UFE)**

Utilisation Focused Evaluation is an approach based on the principle that an evaluation should be judged on its usefulness to its intended users. Therefore evaluations should be planned and conducted in ways that enhance the likely utilization of both the findings and of the process itself to inform decisions and improve performance.

Utilisation Focused Evaluation has two essential elements. First, the primary intended users of the evaluation must be clearly identified and personally engaged at the beginning of the evaluation process to ensure that their primary intended uses can be identified. We have three evaluations, and their primary users shift slightly with the evaluation purpose. While there are multiple secondary users, we have identified the following Primary Users for each evaluation:

- **Midterm Evaluation**: The primary user for the midterm evaluations are the FMO and the FB
- **Final Evaluation**: The primary users are the same as the midterm, however the MoH now becomes a primary user
- **Impact Evaluation**: The primary users are the same as the final evaluation. An additional potential secondary user for the impact evaluation includes other donors and adding to the body of knowledge in this field
Secondly, evaluators must ensure that these intended uses guide all other decisions that are made about the evaluation process. We will maintain a focus on utility by engaging with intended users of the evaluation early and throughout the evaluation. This will help to ensure that the (1) evaluation processes are useful to appropriate stakeholders, and (2) evaluation findings are relevant, credible, and accessible to key stakeholders. For example, being clear on who is the primary user will inform the questions we ask, the processes and methods we use, and how we write and disseminate the report. For example, decisions about the baseline will have strong implications for measuring the impact. Therefore primary users of the evaluation reports need to be consulted and aware of implications at each key decision point in the evaluation process.

While we will apply a very detailed 17 step framework (Annex 2), in this report we focus on five key steps that provide the general key steps in the evaluation process.

- **Step 1. Identify primary intended users.** This step has been implemented. This process began with several face-to-face meetings with the FB and FMO (initial meetings have already taken place and were used to focus this inception report). For example, during an initial visit to Myanmar, we identified key stakeholders, including the MoH and the FMO. While we clarified the key purpose for the three evaluations, which are further explained in each of their sections of this Inception Report, we will encourage further feedback from the FMO, FB, and MoH, as appropriate.

- **Step 2. Gain commitment to Utilisation Focused Evaluation and focus the evaluation.** From the outset, it was clear that key stakeholders were committed to using the midterm evaluation to improve implementation of the 3MDGs Fund, the final evaluation to ascertain if progress in health outcomes had been made in targeted areas, and for the impact evaluation to establish changes in health indicators in targeted areas for mothers and children brought about as a result of the 3MDG Fund interventions. However, we will refine and clarify these purposes prior to implementing each evaluation.

- **Step 3. Decide on evaluation design.** Early interactions with 3MDG FMO and FB resulted in a second field visit for the IEG Team where we suggested an approach for the midterm and final evaluation, and several options for the impact evaluation. These are presented in this Inception Report, and will be further refined as the processes move forward.

- **Step 4. Conduct the evaluations, analyse and interpret findings and reach conclusions.** At the end of each data gathering process, for each evaluation, we will conduct a debriefing session with the FMO, and FB as appropriate. For each evaluation, we will share the draft reports with the FMO and the FB, and invite one round of feedback provided in one concise holistic document. We will then address these comments and questions to the best of our ability.

- **Step 5. Disseminate evaluation findings.** For each evaluation, we will engage with stakeholders at a workshop or use another appropriate approach, to discuss key evaluation findings. We anticipate that the impact evaluation will be posted on the 3MDG website. We will draft and submit, as appropriate, presentations and/or articles for sharing in Myanmar. It has been agreed that the IEG will present the Evaluation Framework at a Symposium on “Evaluation Methodology” at the annual Myanmar Health Research Congress organised by DMR-LM in January 2015.
Theory based evaluation (TBE)

Theory Based Evaluation is an approach that focuses on the assumptions people make about what it takes to have a successful programme. In simple terms we could think about how people learn or how they change their behaviour. What conditions need to be in place for that to happen? This approach identifies how activities are understood to contribute to a series of outcomes and impacts. These can help guide data collection, analysis and reporting. This is beneficial for assessing all three components, and critical for evaluating the impact of Component 1.

Theory Based Evaluation involves identifying the key components and expected programme outcomes and impacts, and understanding the underlying assumptions about how these components will lead to the desired impacts. These components, outcomes, and impacts, and the hypothesized links between them are the basis for developing a programme model or theory. This programme theory then becomes the framework to guide the development, implementation, and interpretation of the evaluation. The rationale for such an undertaking is relatively simple: Projects may fail either because of problems related to their implementation (e.g. lack of money) or because the logic on which they were built was wrong in some way (e.g. inadequate focus, unrealistic assumptions). Programme theory evaluation focuses on this latter set of problems and opens up the “black box” of implementation. While we have explored 3MDG’s ToC prior to the midterm evaluation, continuing to explore and check the theory and its causal pathways (through empirical data) is an integral and continuing part of the entire evaluation framework and forms a vital part of the midterm, final and impact evaluation.

While Theory Based Evaluation allows an in-depth understanding of the workings of a programme or activity, it need not assume a simple linear cause-and-effect relationship. For example, the success of the 3MDG programme to reduce child mortality, improve maternal health and combat HIV/AIDS, TB and malaria will depend on a number of factors outside of 3MDG programme’s control. These include, among others, availability of working infrastructure, the acceptance of services by intended beneficiaries, or the political climate. By mapping out the determining or causal factors judged important for success, and how they might interact, it can then be decided which steps should be monitored as the programme develops, to see how well they are in fact borne out. This allows the critical success factors to be identified and assessed in the midterm and final evaluations. For
example, where the data show these factors have not been achieved, a reasonable conclusion is that the programme is less likely to be successful in achieving its objectives.

There are **four key Theory Based Evaluation questions** that guide this approach, and we will engage with the FB, FMO, and baseline team, and to a certain extent the IPs, to obtain clarity. The responses will then inform methodological decisions for the baseline, midterm, final and impact evaluations. These are:

1. **Who will be impacted?** The simple answer is those marginalised groups that receive services from IPs. However the IEG needs more specific information regarding how the FB defines marginalised population and special considerations (if any) for conflict affected population groups. This group may vary by state or province, potentially by component.
2. **How many will change?** How many people in the defined marginalised population does the 3MDG Fund intend to affect? This may also vary by component.
3. **How much will it change?** How much change does the FB expect in the marginalised population in order for us to judge the programme as a ‘success’? Will a small change on the established health indicators (established in the baseline) be good enough? We need to establish with the FB the threshold that the 3MDG Fund needs to cross in order to proclaim success on the particular indicator.
4. **When will it change?** When does the FB realistically anticipate that change will take place? We assume this will likely vary by state and potentially township given the differing contexts. This is the timeline that will determine when to look for success by collecting data on the indicator. This is a very important task because long timelines on early or intermediate outcomes will have implications for how soon the impact can be reached.

**Conditional considerations**

There are **four conditional considerations** that will also guide this approach, and for which we will also engage with the FB, FMO, baseline team and the IPs to obtain clarity. The responses will then also inform methodological decisions for the midterm, final and impact evaluations. These are:

1. **Context.** First, we are aware that the context varies amongst the townships and it cannot be anticipated that the same evaluation approach will provide the same evaluation data. Related to this, we may need to use different methods in different townships to identify and explore changes, or lack thereof. **Second,** we are aware of heterogeneity of both process and results. Capturing results for the relevant specific target groups will be important. Analysing data across the whole population will obscure variation. Data analysed at the state level will miss changes in marginalised groups (assuming the entire population of the state is not the marginalised population).

2. **IPs and variation of the implementation.** Range of IPs that bring their own approaches, experience and length of time in the target area, and their own strengths and weaknesses. They will also likely bring varying levels of data quality, on which we are reliant.

3. **Process and related timing of the interventions.** The implementation process will vary by IP and likely by township. For example the timing of the implementation will differ so that IPs will be expected to initiate interventions at different points in time.

4. **Quantity and quality of data.** We have concerns around existing data quality, quantity, and accessibility. As can be expected in a challenging context like Myanmar, where uncertainty exists with regards to the data that will be collected throughout the period, and for the data that will be collected we are unsure of the quality. This hugely influences our evaluations decisions (not just the impact, but the midterm and final evaluations) as we are heavily
reliant on secondary data. We will attempt to use quality data where possible, for example most UN agencies appear to rely on the Health Management Information System (HMIS) data. Further, at this point we have a void regarding how the baseline data will be implemented.

Figure 4: Theory Based Evaluation and context: Role in informing the evaluation design

The next sections provide illustrative evaluation approaches for the midterm, final and impact evaluation that will be further refined prior to each evaluation, and informed by the processes described above. Annex 6 provides illustrative evaluation questions based on OECD-DAC criteria.

5.2 Midterm Evaluation

Purpose
Implementation evaluation is an essential part of effective programme management. Ongoing performance monitoring can provide some information about implementation and intended outputs, but implementation evaluation provides more in-depth and comprehensive information about the quality of service delivery, unintended results, and identifies if the programme is on track to achieve its intended impacts.

While an impact evaluation can provide information about whether or not a programme is having intended results, it needs to include an implementation evaluation that can provide an understanding about how those results were achieved.

Focus
The implementation evaluation will provide data that will: (1) document implementation, (2) allow comparison of actual implementation to planned implementation, including financial information, and (3) provide data to improve implementation. It is both an evaluation of the 3MDG Fund organisation as well as its IPs. The midterm evaluation will also identify how to value the eventual impact findings.
Methods
We will use qualitative and quantitative methods, as appropriate, which include but may not be limited to: (1) desk review that includes examining 3MDG programme monitoring data, internal reports, and other empirical data sources, which includes both qualitative and quantitative data, and (2) semi structured interviews and/or group interviews with IPs, key stakeholders and staff, as appropriate. We will use purposive sampling to select interviews and sites, as needed, and our data analysis most likely will include thematic and content analysis. We will check the consistency of our findings by using at least two different data sources (data triangulation).

Illustrative steps
1. **Assess 3MDG indicators. This will be a desk review.** Using the 3MDG M&E framework, we will identify what current 3MDG programme indicators, and their resulting data, are likely to provide data that addresses the DAC evaluation and current management questions. *This will then be used to identify indicators for the evaluations (Annex 6).* In anticipation of using the LiST modelling approach (further described in the Final Evaluation section), we will also determine if all necessary output data are being collected that are needed for this modelling approach. While this initial step will take place in 2014, we will use data provided by these indicators to answer evaluation questions, as part of the desk review.

   Anticipated start date: March 2014

2. **Clarify how IPs are implementing and reporting.** This process has several objectives. First, we will identify which IPs are doing what, where, their start dates, and agreed upon indicator reporting. *This will be a desk review.* We will then clarify how each IP is implementing 3MDG’s ToC, also called a Theory of Action (ToA) and address the four Theory Based Evaluation questions raised in the ToC section. We will then re-confirm which IPs are reporting on what indicators and confirm that the ToA and indicator reporting are consistent (i.e. is the IP reporting what they are actually doing?). *This will be a workshop* that also fulfils our capacity building role. We will be up-skilling the FMO to assist in implementing the training, and capacitating the IPs to develop or refine their ToA (and where necessary their individual ToC), and linking that with their reporting requirements.

   Anticipated start date: March 2014

3. **Clarify Values (“What would success look like?”).** This is further explained in Step One of the Impact Evaluation. It is critical for the development of the baseline and valuing of the impact results. Some key questions for this step include clarifying: How does the FB value covering the first 20% of the marginalised population against covering the last 20% - which has a higher value? How do they define equity? Where will the FB spend money over the next several years?

   While implemented as part of the midterm evaluation, these data need to be gathered in time to inform the baseline study. This has already been substantially clarified for a range of indicators, where targets have been set. However, even here issues around expected impact trajectories and possible heterogeneity of results may still be useful to investigate. Further, there may be additional results areas where it will be relevant to identify values and perspectives on achievement. *This will be informal and formal interviews, and a desk review.*

   Anticipated start date: March 2014

4. **Refine evaluation questions and methodology.** The refining of the questions and the methodology will ensure that the evaluation responds to current management information needs, and uses the appropriate methods. This will be done through using open-ended
qualitative questions with the FB and FMO, and drawing on the results of earlier informal engagements and processes (e.g. review of progress reports).

Anticipated start date: January 2015 (NB: Year)

5. Develop report outline and organise logistics. We will develop a detailed report outline that includes evaluation questions and methodology, and request approval from the FB and FMO. During this step we will also inform potential interviewees (key stakeholders, staff, etc.) of potential dates for field interviews, and organise the logistics.

Anticipated start date: February 2015

6. Analyse secondary data. This will be a desk review. These data will: (a) inform what questions need to be addressed with primary data gathering and the focusing of that (sampling), and at the same time, (b) provide data for answering the evaluation questions. This includes reviewing the township level assessment documents provided by the IPs and understanding what data they provide, and having a revised and updated document (from Step 2) that shows which IPs are implementing what interventions, in what places, and reporting against what indicators. The review of the secondary data will also identify any data gaps that exist and need to be filled to respond to evaluation questions.

Anticipated start date: February 2015

7. Develop evaluation data collection tools and data analysis processes for primary data collection. This will take place at the same time as step 5. The need for primary data will be informed by what additional information is needed to answer evaluation questions.

Anticipated start date: March 2015

8. Gather and analyse primary data. These are qualitative methods and are described in the methods section.

Anticipated start date: March 2015

9. Reanalyse, triangulate data and write report. We will provide a draft report to FB and FM based on the approved outline, for comments. We will then receive one comprehensive and non-conflicting set of comments, address them, and write the final report.

Anticipated start date: April 2015

10. Dissemination. Provide key report findings to key stakeholders, as agreed. Please see Section 9: Dissemination and Learning Strategy.

Anticipated date: June 2015
5.3 Final Evaluation

Purpose
The purpose of the final evaluation is to identify and assess the achievements of the 3MDG programme (anticipated and unanticipated) against the OECD-DAC criteria, the extent of coverage, and the Value for Money (VfM). It will also identify enabling and hindering factors and explanatory data (e.g. how did the 3MDG programme achieve results along the pathway towards impact?). The fuller analysis of causality and net impact will be part of the impact evaluation, and is addressed in that section.

We assume that an ‘end-line’ study (repeat of the baseline survey) will be implemented that compares the baseline to the actual outcomes, at the household level. At this point we assume that the end-line data collection will take place after the final evaluation as a first step of the impact evaluation. Therefore our quantitative data will be drawn from 3MDG’s programme (FMO M&E Unit) monitoring data, and other secondary project and as needed, country level, sources.

Focus
The focus will be on identifying the 3MDG programme’s successes and identifying reasons for achievements (or lack thereof). The final evaluation’s methodology will be heavily guided by: (1) ToC approach that explores causal pathways and their related indicators, and (2) follow up on the results identified in the midterm evaluation. The questions and approach may vary among different townships depending on their baseline and emerging data. For example, some areas may achieve outputs rather quickly if they have already been working in the area and the necessary infrastructure exists, while other areas may need longer time frames to reach intended outcomes, or be hampered by conflict.

In sum, the final evaluation will not focus on the 3MDG FMO, or the 3MDG Fund organisation, unless the midterm evaluation or key stakeholders indicate a need for this. Rather a strong focus will be on the extent that the IPs have implemented the ToC, and with what results.

Methods
The methods suggested below will provide the IEG with data with which to map the 3MDG programme implementation and causal result paths, and also provide necessary explanatory and contextual data. This will enable analysis using theory-based assessment of influential factors. The IEG will use 3MDG Fund’s VFM approach to inform how VfM will be assessed.

Specifically, the FMO will provide to the IEG data that derives from two models: Lives Saved Tool (LiST) and the Asian Epidemic Model (AEM). We will also use best available modelling approaches data to explore the effectiveness of 3MDG programme interventions on malaria.

We will use mixed methods, which include but may not be limited to: (1) a desk review that includes examining 3MDG programme monitoring data, internal reports, and other empirical data sources, all of which likely have qualitative and quantitative data, (2) semi structured interviews and/or group interviews with key stakeholders and staff, as appropriate, and (3) potentially surveys (quantitative data) or questionnaires (qualitative data) should the evaluation questions and need for information

4 LiST (The Lives Saved Tool), provides a structured format to combine the best scientific information about effectiveness of interventions for maternal, neonatal and child health with information about cause of death and current coverage of interventions to inform their planning and decision-making, to help prioritize investments and evaluate existing programs. The AEM (Asian Epidemic Model) is a process model for exploring HIV policy and programme alternatives in Asia. Projections are closely tied to the epidemiological and behavioural data in the country.
We deem this appropriate. We will use appropriate data analysis. This will most likely include thematic analysis for qualitative data. For the quantitative data it will depend on the research questions and, for example, the variables we need to measure, whether we are interested in differences between groups, or correlations between variables. Most likely we will use a form of purposive sampling (of which 16 different types exist) to appropriately focus and select people and sites, and this decision will be informed by the midterm evaluation. We will check the consistency of our findings by using at least two different data sources (data triangulation).

**Illustrative Steps**

1. **Clarify current management evaluation needs.** Using primary data gathering methods, we will interview FMO and FB. This is in line with our Utilisation Focused Evaluation approach. These data will (a) inform the evaluation questions and sampling approach, and (b) provide data for answering the evaluation questions. We may need to interview several people multiple times at different points in the final evaluation.

   **Anticipated start date:** December 2016

2. **Refine questions, methodology, and methods.** We will re-visit and question the assumptions made in the ToC (and use data from Step 1), to further guide refinement of our evaluation questions for primary data collection. Once final evaluation questions are refined, we will then determine the most appropriate methods to gather and analyse that data.

   **Anticipated start date:** December 2016

3. **Develop report outline and organise logistics.** We will develop a detailed report outline that includes evaluation questions and methodology, and request approval from the FB and FMO. During this step we will also inform potential interviewees (key stakeholders, staff, etc.) of potential dates for field interviews, and organise the logistics.

   **Anticipated start date:** December 2016

4. **Gather and analyse secondary data.** This includes 3MDG reports, monitoring data, and other relevant documents. These may be either quantitative or qualitative data, and likely both.

   **Anticipated start date:** January 2017

5. **Gather and analyse primary data.** These will be qualitative data.

   **Anticipated start date:** February 2017

6. **Reanalyse, triangulate data and write report.** We will provide a draft report to FB and FM based on the approved outline, for comments. We will then receive one comprehensive and non-conflicting set of comments, address them, and write the final report.

   **Anticipated start date:** April 2017

7. **Dissemination.** Provide key report findings to key stakeholders, as agreed.

   **Anticipated delivery date:** June 2017
5.4 Impact Evaluation

Purpose
The purpose of the impact evaluation is to assess the extent to which the 3MDG Fund has contributed to intended, sustainable, health impacts in maternal and child health, in targeted areas in Myanmar, and the extent that these impacts reached marginalised populations. The impact evaluation focuses on the population reached by Component 1, a population that may also be reached by the other components. The decision to focus on the Component 1 population is based on two facts: (1) a significant percentage of 3MDG funds focus on this population, and (2) the baseline data only assesses this population.

Although the definition of what constitutes an impact evaluation is contested, two core features distinguish it from implementation evaluation. First, the focus is on the outcome and impact levels – a consequential change that occurs beyond what the project or intervention is able to deliver. And secondly, an impact evaluation assesses the cause-effect relationship – what led to the changes, how they occurred, and under what circumstances. The definition we use for this evaluation is:\footnote{This draws on the OECD definition of impact, but goes further by highlighting the importance of assessing the relationship between cause and effects. It is however not as narrow as definitions that restrict evaluations to only one form of causal inference (the counterfactual), or one particular type of evaluation design and method (the experimental).}

Impact evaluations are evaluations that assess the contribution of an intervention towards some outcome or goal. The contribution may be intended or unintended, positive or negative, long-term or short-term. Impact evaluations attempt to identify a clear link between causes and effects, and explain how the intervention worked and for whom.”

Focus
The impact evaluation will focus on the extent that the 3MDG programme brought about (caused) sustainable change in health outcomes, in targeted sites, with targeted populations, in Myanmar. Specifically, the impact evaluation aims to identify and understand these causal relationships with a focus on the population served by Component 1. We are focusing on this population for two reasons: (1) the baseline study will only gather data on the population that receives the 3MDG MNCH interventions in the 42 (48) townships and (2) Component 1 receives the significant amount of 3MDG funds. The impact evaluation will explore various reasons for any identified change, which, for example may also be attributable to activities carried out under other components.

If significant funds are spent on other components (e.g. HIV) we also suggest measuring this impact through existing data.

Key Discussion Points
Thus understanding the approach to causal inference is at the core of the impact evaluation. There are a range of approaches to causal inference that connect cause and effect in different ways and draw on different theories of causation. There are also multiple ways of categorising impact evaluations (i.e. according to method of analysis or approach to establishing causal links).

Before we explain the methods and approaches being considered, there are a few key points that lay the foundation for that discussion. First, because there was no randomisation in selecting the groups that receive the interventions, we have ruled out any approach that requires randomisation. Second, some of the approaches being considered demand high a quality and quantity of data, and even the best planning will not always provide the answers to the degree hoped for. Third, different approaches can deliver different types of answers, and therefore we will not rely on one method. A combination of methods as well as maintaining a degree of flexibility in planning is important.
will help to ensure that we are able to provide relevant answers with the highest degree of analytical quality possible.

**Five steps and their associated methods**

Regardless of the methods or combination of methods that we implement (e.g. LiSt, described on page 20), difference-in- difference, there are five different steps that need to be considered to develop a solid impact evaluation. Some of these steps below we will cover in the midterm and final evaluations and we will draw the information from these previous evaluations. However we may need to revisit these steps during the impact evaluation process to gain further needed clarity or to reconfirm the midterm and final evaluation’s findings.

The five steps are: (1) Clarifying values – conducted as part of the midterm evaluation (2) Developing a ToC – conducted prior to the midterm evaluation and refined in the midterm and final evaluations (3) Answering descriptive questions- covered in the midterm and final evaluation (4) Answering causal questions and (5) Summarising evidence into an overall judgement. These five steps are discussed here.

**Step 1: Clarifying Values (“What would success look like?”)**

This step will be part of the midterm evaluation. We will continue to revisit this step as necessary. The impact evaluation will draw conclusions about the degree of success (or failure) of the 3MDG Fund, so it is important to clarify what success looks like in terms of:

- Achieving desirable impacts and avoiding (or at least minimizing) negative impacts
- Achieving a desirable distribution of benefits

While we will use the formal stated goals and organizational policies provided to us by the FMO and FB to begin to clarify the values, this may not be sufficient and we will need further clarification from the FB and the FMO. For example, one of the stated goals of the 3MDG Fund may be to reduce child mortality but it might also produce benefits for others who access the same clinics. Is this considered important? If so, we need to measure this. An impact evaluation also needs to take into account any negative outcomes. We also need to consider the distribution of the benefits – for example, did the improvements in access to clinics only benefit literate women who could afford to pay transport costs or women within a certain ethnic group?

The MoH and the 3MDG Fund may have different views about which values should be used in an evaluation and additional methods will be needed to negotiate amongst them. This must also be considered when establishing the baseline, as this will influence what can be assessed in the impact evaluation.

- **Timing of this step**

This step informs decisions for the overall evaluation framework and the baseline (i.e. it influences all three evaluation processes) and we have already begun to identify these values. For management purposes, we have linked the step with the midterm evaluation. This begins in March 2014.

**Step 2: Developing a Theory of Change**

A ToC, or programme theory, describes how the intended results will be achieved – how programme activities are understood to contribute to a series of intermediate outcomes that will lead to the final intended impacts. Developed prior to the midterm evaluation, the focus will be on validating critical assumptions and on testing the causal logic in ToC pathways (i.e. has x led to y). The ToC will be developed at the beginning of the assignment (as described above) and explored in the midterm, final, and IE, and if necessary, amended, as the ToC may change over time.
• **Timing of this step**

In October 2013 the IEG began the process of understanding the 3MDG’s ToC, specifically for the MNCH component, and less intensively to define the overall 3MDG programme ToC. We anticipate further work on these during February-June 2014, and revisiting them throughout the evaluation process.

We anticipate working with the contracted IPs in March 2014 to develop or refine their ToC and ToA.

**Step 3  Answering Descriptive Questions**

Impact evaluations need to answer descriptive questions—what has implementation been like (what activities have been undertaken and what has been the quality of implementation?), what changes have occurred (and for whom?), and what has been the context in which the 3MDG programme has been implemented? Many of these questions will be addressed in the midterm and final evaluations. However the IE may also need to focus on answering these questions.

• **Timing of this step**

Most of these methods will be implemented during the midterm and/or final evaluation. Some will be repeated, as necessary, in the impact evaluation. This will depend on the evaluation questions and the data gaps.

**Step 4  Answering Causal Questions**

In addition to describing what changes have occurred, an impact evaluation must explain whether the intervention contributed to producing these observed impacts. It is rare that a programme is the only cause of identified change. Further, in a programme targeting a diverse range of geographical areas and situations, it is expected that differences in progress and achievements will be found.

While it is hoped that monitoring data together with baseline and endline data will deliver an overall picture of observed change, the impact evaluation must “dig deeper” in order to establish the degree to which the programme has caused the observed changes, and the role of enabling and hindering factors in explaining results (or lack thereof). In this context, ‘causal attribution’ does not refer to total attribution, but partial attribution or analysing the programme’s contribution, contingent on the analysis that the available data, especially the baseline–end line data sets, allows.

There are multiple ways to assess causal attribution. As indicated above, we can use “counterfactual models”. These models (of which there are several options) aim to measure/estimate net change by comparing results with a counterfactual\(^6\). These data isolate the effect that can be attributed to the 3MDG programme. Other models attempt to assess whether the intervention can be credited with the observed change. We discuss several potential approaches below that will be considered for use on their own, or in combination with other approaches. The final design will depend on: (1) available credible data, (2) evaluation questions, (3) information provided by other sources, (3) the baseline methodology and indicators, and (5) budget and time frame.

**Step 5  Synthesis**

Finally, impact evaluations synthesize information and provide an overall evaluative judgement. For example, if the 3MDG programme has been effective for some but not all participants, or if it has produced positive and negative outcomes, these varying results need to be weighed in some way to produce an overall result. We will use information that we obtain in Step 1 of the Impact Section to

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\(^6\) The “statistically valid control groups” noted in Table 5 are expected to be based on matching, in the absence of randomization. We recognise that there will be challenges and trade-offs in this approach.
make these evaluative judgements. In order to do this, we anticipate using a rubric that is created based on the midterm and final evaluation that has detailed descriptions rather than numbers, and provides a way to value the findings.

**Final key points**

We have not provided a final impact design for several reasons. First, the lack of certainty around baseline methodology, and the data emanating from that study. Second, the need to refine the ToC in order to identify determinants of change (i.e. causal pathways). Three, the four Theory Based Evaluation questions and the various contextual factors raised in the Theory Based Evaluation section require clarity.

Having said that, the chart below illustrates two potential approaches that we believe are the most likely options that we will base the impact evaluation design upon.

**Figure 5: Two potential approaches**

<table>
<thead>
<tr>
<th>Evaluation design</th>
<th>Option 1: Quasi-experimental (impact) evaluation, with a ToC</th>
<th>Option 2: Theory-based mixed method evaluation (with baseline)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of causal analysis</strong></td>
<td>Counterfactual frameworks that depend on the difference between two otherwise identical cases (i.e. the causal effect of X on Y).</td>
<td>This design relies on the detailed articulation of the ToC, against which evidence is compiled to test the plausible contribution that a combination of factors led to particular changes along the theory. In order to avoid bias, the design requires assessing whether and how other factors may have influenced the observed outcomes. (Rogers 2012; Scriven 2008; White and Philips, 2012). Where primary evidence is collected, it may be possible to construct a counterfactual, to further bolster analysis. Generative causation depends on identifying the causal links and ‘mechanisms’ that explain effects in a particular context. Generative causation, investigate the patterns of association between cause(s) and effects (e.g. frequency, strength).</td>
</tr>
<tr>
<td><strong>Strengths</strong></td>
<td>This approach is considered by many to provide a rigorous assessment of impact. The primary data collection can provide generalisable evidence of beneficiary-level effects and impacts; which may not be obtainable through routine and other secondary data collection.</td>
<td>This approach provides an in-depth understanding of how an intervention works and under what conditions and in what context. It is also effective in identifying the contribution of an intervention as part of a package of causal factors. Because of the in-depth analysis of causal processes this design is arguably more suited to answering the question of ‘impact for whom?’ (Stern et al 2012).</td>
</tr>
<tr>
<td><strong>Weaknesses</strong></td>
<td>The approach is resource intensive, and may not provide an accurate measure of impact over a relatively short period of time; particularly where process changes are expected, and there are likely to be multiple causal and contextual factors (low external validity). Trade-offs and difficulties may be encountered, i.e. that viable control or comparison groups can only be established for some intervention areas, or that there will be limits to the ability to assess relevant subgroups and overall average net change may not be sufficiently informative in light of possible heterogeneity. Thus, this approach may not in be sufficient to establish a holistic impact assessment.</td>
<td>The approach is weaker on quantifying effects and extent of impacts of an intervention. That said, while it may not be possible to place an exact numerical estimate of the effect produced by an intervention, it is possible to interpret evidence in terms of scale of magnitude and necessity and sufficiency (White and Phillips 2012).</td>
</tr>
<tr>
<td><strong>Key issues of bias</strong></td>
<td>Elimination of selection bias hinges on valid selection of the treatment and control samples, which is expected to be challenging under the circumstances</td>
<td>Seeking out evidence that supports the ToC entails risk of confirmation bias, unless appropriate attention is given to other possible influences/explanations</td>
</tr>
</tbody>
</table>
There is no such thing as a perfect evaluation design – there is however such a thing as a credible and useful evaluation. We need to make appropriate and informed method choices that will lead to a credible, and useful, impact evaluation. We have outlined potential approaches that will be used in combination, as appropriate; developing the impact evaluation requires flexibility.

**Approaches that will not be used for the impact evaluation**

The following approaches cannot be used for the impact evaluation and have been ruled out as potential methods.

- *Randomised control trial (RCT).* RCTs can be appropriate when it is possible to randomise people or sites, to ensure compliance with randomisation and avoid attrition of the control group over time. This approach cannot be used because it requires randomisation. The 3MDG programme interventions have not chosen states, townships or participants using a randomised approach.
- *Step wedge design.* The lack of random assignment amongst the selected townships and need for time series data does not allow us to use this approach. Further, the need to coordinate data collection with the actual roll out of the 3MDG programme interventions does not appear feasible.

6 **RISK MANAGEMENT PLAN**

In the following Risk Matrix we set out the key risks that we anticipate for this assignment. We present these risks in terms of **internal risks** (risks within the assignment which may affect our delivery) and **external risks** (those beyond our control, but for which we can still set out our mitigation measures). The first two columns describe the nature and the level of the risk. The third column sets out our mitigation measures. The last column estimates the ‘residual risk’, which is the risk level after we have undertaken our mitigation efforts.

Our assessment of risk uses a high, medium, low scale. It is a composite assessment that covers two elements: potential impact and likelihood of occurrence. This risk table will be monitored on a regular basis and will be updated in the reports that are provided to the FB. If critical risks arise, these will be flagged to the client as soon as they occur.

**Table 1: Risk Matrix**

<table>
<thead>
<tr>
<th>Most significant risks</th>
<th>Analysis</th>
<th>Mitigation measures that we will undertake</th>
<th>Residual risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERNAL RISKS AND MITIGATION MEASURES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to collect data due to lack of security/field security reasons</td>
<td>• This lack of security may affect the ability of the evaluation team to go to certain areas of Myanmar at certain times.</td>
<td>• We will monitor security in various areas of the country, providing real time information to the IEG. Particular attention will be paid to Rakhine state.&lt;br&gt;• If security does affect the ability of the IEG to visit certain areas of Myanmar at certain times then we will: a) revise timings in consultation with the client; b) look for alternative data collection methods, or c) use existing secondary data.</td>
<td>LOW RISK</td>
</tr>
<tr>
<td>Staff turnover (e.g. the loss of key staff members)</td>
<td>• The 5-year timeframe for this assignment implies the possibility of staff turnover during the period, with associated problems of loss</td>
<td>• We will minimize staff turnover through the provision of clear individual objectives and staff development.&lt;br&gt;• We will maintain a knowledge management system to aid institutional memory.</td>
<td>LOW RISK</td>
</tr>
</tbody>
</table>
of institutional memory, capacity and credibility.  

- In exceptional circumstances, we will replace staff who leave with like-for-like capacity (in consultation with the client). To achieve this, we are able to draw on the extensive networks of our three partner organisations.

### Difficulty in reaching marginalized groups  
**MEDIUM RISK**

- In some cases there may be social obstacles to reaching marginalized groups; in others they may just be physically hard to reach.
- This evaluation includes gender analysis and a social impact assessment. As we develop the evaluation framework, we will include a sampling methodology that engages with this within the boundaries of what is possible.

### Lack of uptake of evaluation findings  
**MEDIUM RISK**

- It is possible that the intended audiences for the evaluation may not find the evaluation findings useful and hence are not used to inform future decisions of the 3MDG Fund.
- We have built in our design, based on a UFE approach, careful steps to ensure use of evaluation data. This includes but is not limited to a dissemination and learning strategy, which includes the goal and benefits of different knowledge products and a plan for dissemination of the products for the three evaluations.
- We will communicate closely with the FB throughout all stages of the evaluation, in order to ensure that the findings are useful for all intended audiences.

### External Risks and Mitigation Measures

#### Delays in the contracting of consultants to produce baseline and/ or end-line survey  
**HIGH RISK**

- There will be severe delays to the collection of the baseline data, since this assignment has recently been retendered.
- It is possible that there may also be delays in receiving the data from the end-line survey.
- We will liaise with both the FB, FMO and appointed baseline data collection consultants about this issue, in order to make use of the data as soon as it becomes available.
- If the IEG does not receive the baseline or end-line data in time, it impacts on design choices, and potentially on the robustness of findings. It does not mean that credible findings cannot be produced.

#### Lack of high quality and verified data from the baseline and/ or endline survey  
**LOW RISK**

- Large sample sizes are needed to get sufficient power of analysis for “smaller” changes to come across as significant, and to explore changes among subgroups.
- Once the baseline data has been generated, there is a danger that the data produced is of insufficient quality or standard.
- UNOPS is undertaking a formal contracting process in order to select the best offer for this assignment. Once appointed, we will liaise with the consultants in order to discuss both our and their requirements.
- We will engage closely with the baseline team to ensure that it is of sufficient quality and standard for 3MDG Fund’s data needs.

#### External change in comparison townships may limit the statistical use of the impact assessment  
**HIGH RISK**

- The treatment group and comparison group are est. at an “overall” level and cannot address the low prevalence of certain impact indicators. This may potentially lead to looking at an average effect leading to the conclusion of “absence of evidence for
- We will work closely with the FB, FMO and baseline team to discuss ways in which to mitigate this challenge.
- The IE will use several methods that will aim to mitigate this risk, including qualitative and quantitative methods that recognise these changes. However, being aware of these changes, and understanding how they may impact the evaluation results.
In connection with the services offered by the IEG, EHG’s Quality Assurance Management System has been adapted to the particular conditions of this assignment. EHG is an ISO 9001:2008 certified company and consequently complies with standard ISO 9001:2008 requirements with regard to quality management.

7.1 The Quality Plan
A specific Quality Assurance (QA) Plan has been designed, based on mechanisms and processes both internal and external to the team, in order to ensure that:

- The services provided by the IEG fulfil the requirements of the FB and FM and are in full conformity with the scope of services as described in this inception report as well as the deliverables outlined in the contract signed between EHG and UNOPS
- The evaluation services provided are based on learning exercise for all involved
- Findings and recommendations of all evaluations are based on evidence and high quality analysis
- Deliverables have been quality controlled before submission
- Key stakeholders are involved and benefit from every step of the evaluation process
- The IEG is fully committed during the implementation to continuously monitor, evaluate and act to improve the services provided in full cooperation with the FM and the FB
EHG’s QA System is based on a well-defined organization and complies with standard requirements of DS/EN/ISO 9001. The system for this assignment will be based on the following dimensions:

- Management of information
- Management of contract
- Management of the quality of products

7.2 Management of information
The Team Leader (TL) is responsible for the organization and management of the team and for all contents of the assignment.

The IEG consortium members, led by EHG, support the TL in the management of information, on a daily basis, so that the TL and team members can focus attention on "content". To that extent a web-based storage space has been set up on EHG’s web servers where all relevant information related to the assignment are stored (major communication, documents, reports), can be up- and downloaded by the team members and all other key personnel (protected by user name and password) which will be made accessible also to all interested parties. A standard structure has been developed and put in place for this purpose.

7.3 Quality Management, Monitoring and Auditing Team
The following team have been designated as the Quality Management, Monitoring and Auditing team:

- Michele Gross, (CEO- EHG) will act as the Project Director (PD)/QA. She will support and monitor the evaluation team through all phases of the evaluation. She will monitor the implementation of the Quality Plan and ensure adherence to the EHG Business Integrity System.
- Sam McPherson, (ITAD) will act as the Deputy Project Director (PDD)/Quality Manager (QM). He will ensure quality of all deliverables and presentations. He will provide advice on methodology and research processes, review intermediate results.

Between them, the two represent extensive up-to-date knowledge on evaluation methods and best practices, and experience with large scale health research programmes and evaluations in additional to the technical areas of MNCH, HIV/AIDS, TB and malaria along with health systems strengthening. The Quality Management Team is available to support the core evaluation team throughout the evaluation process via telephone and conference calls, advice and feedback by email and face-to-face working together in EHG headquarters. They will provide advice on best practice regarding methodology for the midterm, final and impact evaluations in addition to interim reporting requirements. They will advise on data collection and analysis as well as review and validate key findings and recommendations from all evaluations.

An Evaluation Advisory Committee (EAC) will assist in devising the final methodology for the impact evaluation along with providing critical input into the overall evaluation framework. They also serve the role of QA and Peer Review of all deliverables produced under the assignment. The EAC, which includes the Project Director and the Project Deputy-Director (DD)/QA Manager, will also assist with annual work planning.
The following people form part of the EAC:

- Michele Gross (CEO, EHG)
- Sam McPherson (ITAD)
- Eva Broegaard (Evaluation Specialist) – newly proposed member
- Kalipso Chalkidou (Global Health Expert)
- Juan Pablo Gutierrez (Impact Evaluation Specialist)
- Henry Luca (Health Evaluation Specialist)

EHG headquarters has assigned an experienced Project Coordinator, Ms Anette Cramer. She will provide back-stopping support to the IEG team and have financial and contractual management support from Allan Bo Petersen, CFO EHG.

7.4 Management of contract

Contract management encompasses all activities necessary to ensure correct flow of finances between the parties involved. For the assignment these activities comprise:

1. Communication with the client on contractual issues, drafting and follow-up of invoices (advance payment, quarterly progress payments, and final payment, reimbursable invoices), and with EHG's bank in relation to advance payment security;
2. Communication with the consultants on contractual issues, follow-up of invoices and payments to them, based on terms agreed upon.

7.5 Management of quality of products

IEG uses eight quality criteria that will be applied to all evaluation processes and outputs. Our understanding of these criteria related quality benchmarks are summarized in the table below.

7.6 Quality Criteria and the respective benchmarks

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Our understanding</th>
<th>Quality Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criterion 1:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Meeting needs</td>
<td>The evaluation reports adequately address the information needs of the client. They answer all questions included in the RFP in a way that reflects their stated level of priority with full consideration of data availability and analysis. As far as possible, they satisfy incidental information needs that have arisen during implementation of evaluation services.</td>
<td>According to the contract and specification by UNOPS/FM and the FB; quality assessed by them along the criteria set out in this inception report.</td>
</tr>
<tr>
<td><strong>Criterion 2:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Relevant scope</td>
<td>The reports describe the rationale mid-term and final evaluations of the entire portfolio of the 3MDG Fund and for the impact evaluation with a focus on Component 1.</td>
<td>According to the contract and specifications by UNOPS and the FB; quality assessed by them.</td>
</tr>
<tr>
<td>Criteria</td>
<td>Our understanding</td>
<td>Quality Benchmarks</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Criterion 3:</strong></td>
<td>The evaluation methods are clearly described and are appropriate and adequate to</td>
<td>The rationales behind the methodological choices are clearly explained, together with data requirements, data collection and data constraints. Each set of methodological questions and respective conclusions is subject to methodological and analytical reflection, leading to:</td>
</tr>
</tbody>
</table>
| **Defendable**   | answer the key evaluation questions. Methodological limitations are explicitly stated. | • Indication of methodological or data limitations as relevant to the conclusion  
• Indication of limitations with regards to external validity as relevant to the conclusion. |
| **design**        |                                                                                   |                                                                                                                                                   |
| **Criterion 4:** | Primary and secondary data are sufficiently reliable with respect to their use.  | When relevant, each of the main conclusions builds upon data which originate:  
• From a multitude of sources that have been cross-checked. |
| **Reliable data**| This criterion does not assess the quality of pre-existing information but how the evaluation team has managed to retrieve and/or to produce information during the life of the assignment. |                                                                                                                                                   |
| **Criterion 5:** | Information is appropriately and systematically analysed or interpreted. Underlying assumptions are made explicit. Critical exogenous factors are identified and taken into account. | When relevant, each of the main conclusions builds upon a sound cause-and-effect analysis including:  
• The evaluation team’s understanding of the main chain of causes and effects which is connected to the conclusion  
• Assessment of the role of exogenous factors, so as to avoid “strategy/project bias” |
| **Sound analysis**|                                                                                   |                                                                                                                                                   |
| **Criterion 6:** | The reports provide stakeholders with a substantial amount of fresh knowledge (findings). Findings follow logically from evidence, analyses and interpretations. | Each of the main conclusions is written in several paragraphs, of which at least one is devoted to findings. This paragraph explains the extent to which the conclusion builds upon fresh knowledge stemming from the evaluations, in comparison to previous expert knowledge. This paragraph refers to the methodological explanations quoted in criterion 3. |
| **Robust findings**|                                                                                   |                                                                                                                                                   |
| **Criterion 7:** | Recommendations derive from conclusions. They are detailed enough and feasible.  | • Linkages between conclusions and recommendation are clear  
• The quality of the recommendations is such that they are feasible by stakeholders supposed to implement them  
• They provide sufficient detail to be used  
• They are sufficient specific to target/address the various actors/organisations/institutions to whom they particularly apply, when relevant as general guidance by the relevant stakeholders |
| **Useful recommen-** |                                                                                   |                                                                                                                                                   |
| **dation**        |                                                                                   |                                                                                                                                                   |
7.7 Quality of reporting

Quality implies that evaluation reports, are in conformity with the contract, are adequately presented, and are delivered on time. The TL will ensure the overall quality of work provided by the team accordingly and has the overall responsibility for drafting the first version of all reports. The quality assessment is then organized according to the sequencing presented below.

Particular attention will be paid to the clarity and the linguistic qualities of the reports. This point is part of quality management.

7.8 Quality assurance process for the assignment

The IEG has a pool of quality managers with the adequate skills including: having been evaluation Tls, having carried quality assessments of evaluation reports, and being trained in the nine quality criteria.

The following major quality assessments are undertaken at the key steps of the evaluation process:

Figure 6: Importance of quality criteria in assessing core outputs of assignment

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Inception Report</th>
<th>Draft Reports of Findings and Recommendations from evaluations</th>
<th>Draft Final Evaluation Reports</th>
<th>Executive Summaries</th>
<th>Final Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Meeting needs</td>
<td>■■■</td>
<td>■■■</td>
<td>■■■</td>
<td>■■■</td>
<td>■■■</td>
</tr>
<tr>
<td>2: Relevant scope</td>
<td>■■■</td>
<td>■■■</td>
<td>■■■</td>
<td>■■■</td>
<td>■■■</td>
</tr>
<tr>
<td>3: Defendable design</td>
<td>■■</td>
<td>■■</td>
<td>■■</td>
<td>■■</td>
<td>■■</td>
</tr>
<tr>
<td>4: Reliable data</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>5: Sound analysis</td>
<td>■■</td>
<td>■■</td>
<td>■■</td>
<td>■■</td>
<td>■■</td>
</tr>
<tr>
<td>6: Robust findings</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>7: Useful recommendations</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>8: Clear report</td>
<td>■■■</td>
<td>■■■</td>
<td>■■■</td>
<td>■■■</td>
<td>■■■</td>
</tr>
</tbody>
</table>

Each quality assessment is conducted as follows:

- The TL finalizes a first version of all reports
- The Project Director and DD/QM along with the EAC reads the reports carefully; they insert comments in the assessed report and rate the relevant quality criteria in the grid
- The TL (referring if necessary to her team members) responds to all major comments from the PD & PDD/QM and EAC and produces the next version of the document
- The PD and PDD/QM immediately check whether comments have been properly integrated, then update the rating of quality criteria and edit the grid in order to highlight the main points which have been addressed through the quality assessment process
- Then, the re-edited version of the grid is attached to the document, which is delivered to the FM

The following illustrates this procedure in a graphical way (simplified).
8 CAPACITY BUILDING PLAN

Capacity Building (CB), also referred to as capacity development, is a conceptual approach to development that focuses on understanding the obstacles that inhibit people, governments, international organizations and NGOs from realising their developmental goals while enhancing the abilities that will allow them to achieve measurable and sustainable results. As such, the IEG endeavours, as part of our Utilisation Focused Evaluation approach, to provide CB primarily to the FMO Evaluation Unit using formal and informal approaches.

Because the CB is reactive, as opposed to a set plan, the CB will emerge over the course of the contract. We will identify CB needs in three ways (1) asking the FMO how we can support them, (2) identifying gaps and challenges in the M&E and associated FMO reporting that suggests a need for support, and (3) responding to the FB’s requests. We will address feasible needs that fall within our scope of work, budget and time frame.

CB will take place as a formal workshop, ad hoc training, emails or leading the FMO to informative documents, lectures, and online courses that will support learning in a timely and cost effective
manner. An example of an already planned workshop includes a ToC workshop for IPs and the FMO, and an example of an ad hoc training is one that took place in October 2013 on ToC for Evaluation, which was provided at two separate sessions.

9 DISSEMINATION AND LEARNING STRATEGY

Focus and mode of dissemination
The IEG provides information to the 3MDG Fund management, so that they can make informed decisions. The IEG will also promote learning and sharing through facilitated meetings, structured workshops, and conferences. Therefore our main purpose is to ensure that the FB and the FBO receive credible and useful information for their planning, decision making and sharing with stakeholders.

Semi-annual reports on IEG activities and 3MDG Fund special studies reports as well as midterm, final and impact evaluation reports will be produced. The IEG reports will be submitted electronically and in English only; the decision which key documents or executive summaries of key documents to translate to Burmese rests with the FB. The IEG submits all deliverables to the FB via the FM. Further dissemination to IPs, MoH and other stakeholders is the responsibility of the FMO and can only take place after final endorsement of the FB.

It is expected that study and evaluation reports will be made available to the larger public by the FM on the 3MDG Fund website. Key audiences in Myanmar include the MoH, IPs, township and community level stakeholders as well as other donors.

As part of the dissemination and learning strategy, the IEG will support a presentation on evaluation methodologies during the Myanmar Health Research Congress in January 2015. A paper will be prepared and submitted in December 2014 for the presentation. DMR-LM is the overall organiser of the Congress and a separate Symposium will be organised on the topic “evaluation”. The IEG will be one among several presenters at this symposium.

Focus of the learning strategy
As part of the learning strategy, we will conduct one or more workshops, as necessary, that engage relevant stakeholders with the key findings identified in the midterm, final and impact evaluation reports. This is more than a dissemination of information, which would only provide key findings. Rather the learning strategy provides a structured format to ensure engagement and learning with empirical findings. The IEG’s local collaborating partner, DMR-LM, is well placed to host learning conferences (in Burmese if preferred) to share findings and engage with the MoH and other relevant ministries. These workshops will focus on the topics and pieces of information key stakeholders are interested in for their own learning.

Collection of information for the planned evaluations is the responsibility of the M&E Unit of the FMO as is on-going monitoring and production of semi-annual progress reports on 3MDG programme implementation. The IEG has been tasked with critically reviewing the 3MDG programme progress reports against approved work plans and carries out annual data quality assurance. This feedback process is considered a critical part of the learning strategy. As noted above, the IEG will submit its own Semi-annual and Annual Progress reports of 5-6 pages each to the FB. The IEG’s Annual Progress report will include a section on the external DQA of the 3MDG programme data as captured by the FMO.
## 10 AGREEMENTS ON REPORTING REQUIREMENTS WITH THE FUND BOARD

Table 2: Overview of reporting schedule based on the contract signed between UNOPS and EHG

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Key performance indicator</th>
<th>Target date</th>
<th>Proposed new target date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Approval of Sounding Board and endorsement by the FB</td>
<td>6 February 2014</td>
<td>28 April 2014</td>
</tr>
<tr>
<td></td>
<td>Evaluation strategy and methodology paper submitted for publication</td>
<td>23 July 2014</td>
<td>30 September 2014</td>
</tr>
<tr>
<td></td>
<td>Review of baseline protocol</td>
<td>30 November 2013</td>
<td>One month after receiving protocol from FM</td>
</tr>
<tr>
<td>Deliverable 2: Progress reports at six months intervals</td>
<td>2013 Annual &amp; Data Quality Assurance Report</td>
<td>15 June 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2014 Progress Report</td>
<td>15 November 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2014 Annual &amp; DQA Report</td>
<td>15 June 2015</td>
<td></td>
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<tr>
<td></td>
<td>2015 Progress Report</td>
<td>15 November 2015</td>
<td></td>
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<td></td>
<td>2016 Progress Report</td>
<td>15 November 2026</td>
<td></td>
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<tr>
<td></td>
<td>2016 Annual &amp; DQA Report</td>
<td>16 June 2017</td>
<td></td>
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<tr>
<td></td>
<td>2017 Progress Report</td>
<td>15 November 2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approval of Sounding Board and endorsement by the FB</td>
<td>14 July 2015</td>
<td></td>
</tr>
<tr>
<td>Deliverable 4: Final Evaluation</td>
<td>Final Evaluation report</td>
<td>30 June 2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approval of Sounding Board and endorsement by the FB</td>
<td>14 July 2017</td>
<td></td>
</tr>
</tbody>
</table>
## 11 Work Plan

<table>
<thead>
<tr>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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</thead>
<tbody>
<tr>
<td>3.</td>
<td>Inception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Development of Draft Evaluation Framework</td>
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</tr>
<tr>
<td>3.1.1</td>
<td>Initiate Utilization Focused Evaluation (UFE) Process</td>
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<tr>
<td>3.1.2</td>
<td>Stakeholder consensus meetings</td>
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<tr>
<td>3.1.3</td>
<td>Development and refinement of Theory of Change</td>
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<tr>
<td>3.1.4</td>
<td>Draft Methodology for the overall evaluation methodology and framework</td>
<td></td>
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<tr>
<td>3.1.5</td>
<td>Mapping of secondary data against ICS criteria, UST and other relevant framework</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1.6</td>
<td>Evaluate framework finalised</td>
<td></td>
<td></td>
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<tr>
<td>3.1.7</td>
<td>Review of SMDG MNCI Indicators</td>
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<tr>
<td>3.1.8</td>
<td>Review of SMDG Logframe Indicators</td>
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<tr>
<td>3.2</td>
<td>Mid Term Evaluation</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3.2.1</td>
<td>Inception - Refine method and approach</td>
<td></td>
<td></td>
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<tr>
<td>3.2.2</td>
<td>Implementation</td>
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<td></td>
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<tr>
<td>3.2.3</td>
<td>Data Analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2.4</td>
<td>Report write-up</td>
<td></td>
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<tr>
<td>4.</td>
<td>Final Evaluation</td>
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</tr>
<tr>
<td>4.1</td>
<td>Inception - Refine method and approach</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4.2</td>
<td>Implementation</td>
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<tr>
<td>4.3</td>
<td>Data Analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.4</td>
<td>Report write-up</td>
<td></td>
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<tr>
<td>5.</td>
<td>Impact Evaluation</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5.1</td>
<td>Inception - Refine method and approach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>Implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Data Analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>Report write-up</td>
<td></td>
<td></td>
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<tr>
<td>6.</td>
<td>Special Studies Supporting ICS Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>Define and propose ICS special studies (TDC Study Protocols)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2</td>
<td>Conduct proposed ICS Special Studies 1-4</td>
<td></td>
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<tr>
<td>7.</td>
<td>Review of FMO Semi-Annual Progress, Reports, and annual QA reports</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7.1</td>
<td>Critical review of FMO semi-annual progress reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.2</td>
<td>Critical review of FMO annual reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.3</td>
<td>Critical review of external data quality audit of FMO DQA reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.4</td>
<td>Attend FMO routine DQA field visits</td>
<td></td>
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<td>8.</td>
<td>Stakeholder Meetings and Dissemination and Communication</td>
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<td>8.1</td>
<td>Framework and Theory of Change (FSC-P)</td>
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<td>8.2</td>
<td>Submission of evaluation strategy/method for Myanmar Health Research Conference</td>
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<td>8.3</td>
<td>Presentation at Myanmar Health Research Conference</td>
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<td>8.4</td>
<td>Mid-Term Evaluation</td>
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<td>8.5</td>
<td>Final Evaluation</td>
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<td>8.6</td>
<td>Impact Evaluation</td>
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<td>9.</td>
<td>On-going IEG Support to FMO and FBB</td>
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<tr>
<td>9.1</td>
<td>Attendance and presentation at FBB/FMO request at MoH/other meetings</td>
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<tr>
<td>9.2</td>
<td>Attendance at FBB, stakeholder etc. meetings on request of the FBB/FMO</td>
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<tr>
<td>9.3</td>
<td>Review and provide feedback on TDCs and IPR/Research study protocols</td>
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<tr>
<td>10.</td>
<td>Management</td>
<td></td>
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<tr>
<td>10.1</td>
<td>IEG Semi-annual and Annual progress reporting</td>
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<tr>
<td>10.2</td>
<td>Evaluation close-out</td>
<td></td>
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</tr>
</tbody>
</table>
ANNEXES

Annex 1: Documents reviewed to date

**3MDG Organisational docs**
3MDG Fund. (September 2013). Implementing partners contact list. Myanmar.

**3MDG Programming docs**
Uhrig, J. (September 2012). Analysis of gaps related to the national response to HIV and recommendations to the 3MDG Fund. Myanmar: 3MDG Fund.
Presentations on the gap analysis for TB and malaria. PowerPoint presentations.

**Township profiles**
MIMU, N.D. Map of Labutta township.
Ministry of Health, N.D. Matupi township: List of health facilities, map of health facilities and map of village tracts.
Ministry of Health, N.D. Mindat township: List of health facilities, map of health facilities and map of village tracts.
Ministry of Health, N.D. Magway region: List of health facilities and map of health facilities in all townships in Magway region.

**3MDG Fund Board docs**
3MDG Fund. (September 2012). 3MDG Fund Board meeting minutes, 6 September 2012. Myanmar.
3MDG Fund. (December 2012). 3MDG Fund Board meeting minutes, 4 December 2012. Myanmar.
3MDG Fund. (December 2012). 3MDG Fund Board meeting minutes, 1 March 2013. Myanmar.
3MDG Fund. (June 2013). 3MDG Fund Board meeting minutes, 7 June 2013. Myanmar.
3MDG Fund. (June 2013). 3MDG Fund Board meeting supporting documentation, 7 June 2013. Myanmar.
DFID. (N.D.). 3MDG Fund Business Case and Intervention Summary.

**3MDG strategy docs**

**3MDG M&E Docs**
New funding model GFATM (N.D.). Discussion and consensus on TB indicators. Myanmar.

**3DF Evaluation docs**
**Ministry of Health docs**


Reproductive health interventions implemented by stakeholders 2007-2012.

Reproductive health, WCHD, CSG, MCHP, STD, GAVI, PMCT townships.

**Myanmar health background docs**


Pilot Township Based Health Protection Scheme


UNICEF. (March 2013). Minutes of the consultation meeting on health care financing modalities in Myanmar and sharing of Township Based Micro-Health Protection Scheme.


Joint Initiative for Maternal and Child Health


Various planning documents for JIMNCH.

Conducting Township Health Assessment. PowerPoint presentation. (describes tools and methods for conducting townships health assessments)

Integrated Household Living Conditions Survey in Myanmar


Post-Nargis Response
Tripartite Core Group. (January 2010). Post-Nargis Periodic Review I. Myanmar. (Report in English and Myanmar and all data collection and supporting documents)
Tripartite Core Group. (July 2010). Post-Nargis Periodic Review I. Myanmar. (Report in English and all data collection and supporting documents)

Myanmar Multiple Indicator Cluster Survey

Thai border programs and organisations
MIMU. (July 2012). 3W Southeast Myanmar, Border and country based organisations by township.
Maps of health and livelihood. Myanmar.


Others
Joint UN MNCH Programme Document. (November 2011). Myanmar. (programme proposal)

Research
3MDG Fund. (September 2012). Public health research and ethical review in Myanmar: Dilemmas for 3DF and 3MDG. For internal use only. Myanmar.
Baseline survey

EHG evaluation docs
Deliverables and timing from the IEG contract (2014).

Other resource materials
Annex 2: 17 Steps Utilisation-Focused Framework

Utilization Focused Evaluation Graphic
## Annex 3: Delineation of tasks between FMO and IEG

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>FMO for 3MDG FUND</th>
<th>IEG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale and Background of Tasks of 3MDG FMO and IEG</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Accelerating progress towards the health MDGs</td>
<td>The FMO will deliver the components of the 3MDG Fund program to achieve this goal.</td>
</tr>
<tr>
<td>2</td>
<td>Building on lessons learned</td>
<td>The 3MDG Fund was designed using the lessons learned through the 3DF and the JIMNCH, and other donor-funded programs.</td>
</tr>
<tr>
<td>3</td>
<td>Strengthening aid effectiveness</td>
<td>The FMO will implement 3MDG in line with aid effectiveness principles including ensuring harmonization and alignment with the initiatives of other donors such as Global Fund and GAVI.</td>
</tr>
</tbody>
</table>

## Objective, M&E Focus and Deliverables

| 4 | Objective | The overarching objective of the 3MDG Fund is to contribute towards national progress towards the health Millennium Development Goals using a human rights-based approach to health. | The IEG Fund will evaluate the extent of impacts of the 3MDG Fund including specific evaluations of different components as well as of the Fund as a whole. |
| 6 | Monitoring and Evaluation | The FMO will carry out routine monitoring and evaluation of all components and activities and present their analysis of progress towards results. The FMO will identify who and how the data will be collected and analysed. | The IEG will review proposed programme evaluations and data collection methods to ensure that routine information supports data requirements for learning and management of the 3MDG Fund. |

## 10 Expected beneficiaries and key stakeholders

| 8 | Beneficiaries | The main beneficiaries of Component 1 will be mothers, newborns, and children under five in identified townships. The main beneficiaries of Component 2 will be people with HIV, TB and malaria in the selected areas or populations. Efforts to address emerging threats under this component will have significant social and health benefits. The main beneficiaries under Component 3, the strengthening of health systems, are expected to be wide reaching as the purpose is to contribute to long-term sustainability of health services. | Beneficiaries of the evaluations include the FB, FMO, and government counterparts. The 3MDG FMO will also benefit through capacity development efforts. |
| 9 | Key stakeholders | For the 3MDG Fund, the key stakeholders include the FB and their donors, FMO, MoH, health providers in target townships, and IPs. | The key stakeholders for IEG are the FB and the FMO. |

## Cross-cutting issues

| 10 | Human rights and | To support human rights, the 3MDG Fund will ensure that human rights | As part of its evaluation methodology, particularly for the midterm evaluation |
### CATEGORY: overall Accountability, Equity and Inclusion (AEI)

**FMO for 3MDG FUND**

- Principles are applied. This includes the assumption that access to health is a right and, as such, all individuals are entitled to basic health services without discrimination. Human rights, gender equity and social inclusion will be addressed through AEI (Accountability, Equity and Inclusion Strategy developed by FMO and agreed by Fund Board. AEI has 4 key aspects:
  1. Enabling environment;
  2. Platforms for systems of mutual accountability that are participatory, equitable & accountable;
  3. Empowered citizens and civil society; and
  4. Health accountability & equity systems supporting interaction of community, health facilities & government.

**IEG**

- and final evaluation, the IEG will devise a method to measure the effectiveness of the 4 strategies which are being put in place as part of the Accountability, Equity and Inclusion (AEI) Strategy. The 4 aspects to be evaluated will be:
  1. Was an enabling environment developed?
  2. Were participatory, equitable and accountable platforms for systems developed?
  3. Are citizens and civil society empowered? and
  4. Do health accountability and equity systems support interaction among community, health facilities and government?
Annex 4: Myanmar Health Sector Coordinating Committee (M-HSCC)

The M-HSCC has a total of 35 members, including the Chair and Vice-Chair and a Secretary who facilitates implementation of committee decisions with the Executive Working Group and assists the Chair and Vice-Chair. Members of the M-HSCC serve for a term of two years and include the following constituencies: Government (10 members), Parliament representative (1 member), UN agencies (4 members), Development partners (2 members), International Financing Institutions (1 member), National NGO and Professional groups (4 members), Community-based and Faith-based organizations (3 members), International NGOs (4 members), Private sector (1 member), People living with diseases/disabilities (4 members), and Academic constituency (1 member).
Annex 5: Structure of the MoH and Accountability Linkages in Health Service Delivery
### Annex 6: Illustrative Evaluation Questions

**Note:** Midterm explores processes - Final provides judgement - Impact demonstrates impact

Indicators and methods are often a part of these matrices. As thoroughly explained in Section 5: Evaluation, of this paper, identifying appropriate indicators is an intensive first step of the midterm evaluation process, and will also be heavily influenced by the baseline team and their approach.

<table>
<thead>
<tr>
<th>Illustrative Evaluation Questions</th>
<th>Midterm</th>
<th>Final</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RELEVANCE:</strong> The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor. This section would review the overall objective and overall design.</td>
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<tr>
<td>Did 3MDG fill its intended niche?</td>
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<tr>
<td><strong>Was the 3MDG programme design technically sound?</strong></td>
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<tr>
<td>• Were the objectives and the design of the 3MDG programme relevant to the context and to the needs of the beneficiaries?</td>
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<tr>
<td>• Was there a clear rationale provided for the selected 3MDGF programme activities? Were the activities and outputs of the 3MDG programme consistent with the overall goal and attainment of its objectives? With intended outcomes/impacts?</td>
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<tr>
<td>• Was the 3MDG programme design in line with the intent of the Donor Consortium? With individual donor policies/national policies?</td>
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<tr>
<td>• Were the objectives and mechanisms of the 3MDG programme cognisant of the capacity of the different implementing partners (UN, INGO, local NGO/CBO)?</td>
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<tr>
<td><strong>To what extent did the township targeting meet relevant MNCH needs? HIV, Malaria and TB needs?</strong></td>
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<tr>
<td><strong>Was the targeted population covered (reached?)</strong></td>
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<tr>
<td>Were the 3MDG policies and programmes supportive of gender equality and other human rights?</td>
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<tr>
<td>• Was the 3MDG programme designed to provide equal participation and benefits for women and men, boys and girls, as appropriate?</td>
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<tr>
<td>• Did the 3MDG programme promote more equal access by women and men to the benefits of the activity, and more broadly to resources, services and skills?</td>
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<tr>
<td>• Did the 3MDG programme help to promote women’s rights?</td>
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<tr>
<td><strong>Was the 3MDG programme adjusted throughout its implementation to align it with emerging priorities/needs and to ensure support for best practice?</strong></td>
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<tr>
<td>• To what extent did the 3MDG programme include activities/mechanisms to support effective design, implementation and feedback of the programme?</td>
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<tr>
<td>• To what extent were beneficiaries actively involved in these activities/mechanisms? To what extent did 3MDG build in</td>
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</table>
### Illustrative Evaluation Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Midterm</th>
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<tr>
<td><strong>downward accountability mechanisms to IPs but also to ultimate beneficiaries?</strong></td>
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<tr>
<td>• Was the 3MDG programme planned and implemented in a conflict sensitive manner</td>
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<tr>
<td><strong>EFFICIENCY: The extent to which aid uses the least costly resources possible in order to achieve the desired results [considering sound management and value for money]</strong></td>
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<tr>
<td>Was the 3MDG programme implemented in a cost-effective manner?</td>
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<tr>
<td>• Did the implementation of the 3MDG programme make effective use of time and resources to achieve the results?</td>
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<tr>
<td>• (IP getting contracting/on board/implementation)</td>
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<tr>
<td>• Was the 3MDG programme designed and/or amended throughout the implementation period for optimal value for money?</td>
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<tr>
<td>• To what extent has effective coordination and collaboration with existing programmes and partners been</td>
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<tr>
<td>• Was it necessary to change any strategies after the MT Evaluation?</td>
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<tr>
<td>• Did the 3MDG programme achieve results as expected in light of resources spent?</td>
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<tr>
<td><strong>EFFECTIVENESS: The extent to which the aid activity attains its objectives [considering effectiveness in: reaching intended beneficiaries; achieving health and social gains; effectiveness; in avoiding unintended results]</strong></td>
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<tr>
<td>Was the 3MDG programme implemented according to plan?</td>
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<tr>
<td>• Was the 3MDG programme implemented according to plan? If not, why not and what was done about it?</td>
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<tr>
<td>• To what extent did contextual factors facilitate or hinder programme implementation?</td>
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<tr>
<td>Was the necessary support for implementation provided?</td>
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<tr>
<td>• What support was provided for programme implementation, by whom and to what effect?</td>
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<tr>
<td>• How were bottlenecks in implementation identified? How were they resolved?</td>
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<tr>
<td>• Did the 3MDG programme help to develop capacity of IPs to understand and promote gender equality?</td>
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<tr>
<td>To what extent did component 1, 2 and 3 achieve their intended results?</td>
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<td>To what extent are updated financial systems in place?</td>
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<td><strong>Was timely corrective action taken where needed?</strong></td>
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<tr>
<td>• What were the risks to achieving the 3MDG objectives? Were the risks managed appropriately?</td>
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<tr>
<td>• Was additional support identified or provided to overcome implementation challenges? What was it, who provided it and to what effect?</td>
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<tr>
<td>• Has the management of the 3MDG programme been responsive to the needs of IPs and beneficiaries?</td>
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<tr>
<td>To what extent has system strengthening taken place? (not financial)</td>
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<tr>
<td>• Did 3MDG identify and address bottlenecks that prevented implementation?</td>
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<tr>
<td>Did 3MDG shift the key health indicators amongst the target population? If so why did this happen?</td>
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<tr>
<td>• Did 3MDG facilitate health changes in the targeted population?</td>
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(MNCH only)
### Illustrative Evaluation Questions

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<th>Midterm</th>
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<tbody>
<tr>
<td>To what extent did changes take place in HIV indicators for the target population</td>
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<tr>
<td>What factors hindered or enabled the achievement of impact?</td>
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<tr>
<td>Were intended results achieved?</td>
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<tr>
<td>To what extent were the objectives achieved? What were the major factors influencing the achievement or non-achievement of the objectives?</td>
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<tr>
<td>What were the results of the 3MDG programme for women and men, boys and girls?</td>
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<tr>
<td>What evidence exists for the effectiveness of the 3MDG in achieving key results, community participation, and reaching and responding to the realities of those who are most vulnerable and marginalised?</td>
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<tr>
<td><strong>IMPACT:</strong> The examination of both intended and unintended results including the positive and negative impact of external factors [considering the extent to which the purpose of the 3MDG has been achieved as intended and its contribution to the overall goal]</td>
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<tr>
<td>Did the 3MDG achieve sufficient scale-up of the programme to improve key health indicators? Did the operating context have any influence on the 3MDG programme or vice versa?</td>
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<tr>
<td>Does evidence exist of positive change at the population level in terms of disease prevention or reduction in disease burden? For MNCH? If not, why not? If so, what contributed to this change?</td>
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<tr>
<td>Were there any unintended changes (positive, negative) in the lives of intended beneficiaries and their environment? What were they? Were they directly or indirectly related to the 3MDG programme or due to external factors?</td>
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<tr>
<td>What role has the local and national context played in either supporting or hindering change?</td>
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<tr>
<td>Did the 3MDG as a donor-driven disease-specific health initiative affect health programming by the government? If so, how?</td>
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<tr>
<td><strong>SUSTAINABILITY:</strong> Determination whether the benefits of an activity are likely to continue after donor funding has been withdrawn [considering funded and non-funded interventions such as policy dialogue, coordination; considering ownership of objectives and achievements, policy support, institutional and technical capacity of IPs, financial and economic sustainability]</td>
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<tr>
<td>Are we achieving results in as sustainable manner? Are we achieving results in adherence to gender equality and other human rights?</td>
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<tr>
<td>To what extent can the benefits of the 3MDG programme continue after donor funding has ceased?</td>
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<tr>
<td>Are there any areas of the 3MDG programme that are clearly not sustainable? What lessons can be learnt from these?</td>
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<tr>
<td>To what extent do beneficiaries and/or partner country stakeholders have ownership, capacity and resources to maintain the activity results after 3DF funding ceases?</td>
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7 How has 3MDG defined these populations? On which sub-group are they focusing? The IEG team, and the baseline team, need clarity on this to ensure data capture of the correct groups.
### Illustrative Evaluation Questions

<table>
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<tr>
<th>Question</th>
<th>Midterm</th>
<th>Final</th>
<th>Impact</th>
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<tbody>
<tr>
<td>Did the 3MDG contribute to capacity building of local organisations to continue to deliver quality disease-specific interventions? If so, what form did this take?</td>
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<tr>
<td>What were major factors which influenced the achievement or non-achievement of sustainability of the 3MDG programme?</td>
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<tr>
<td>Did 3MDG help to attract additional funding for the MNCH? From other donors? From the wider health sector?</td>
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<tr>
<td>Did 3MDG lead to improved co-ordination between NGOs and local authorities?</td>
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<tr>
<td>Was the support to CBOs from township, district and regional/state levels timely and adequate?</td>
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### Monitoring & Evaluation and Learning

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<th>Question</th>
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<tr>
<td>Were M&amp;E guidelines and requirements in line with data needed to allow judgement to be made about meeting 3MDG programme objectives?</td>
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<tr>
<td>Were M&amp;E guidelines, procedures and support adequate in ensuring data quality?</td>
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<tr>
<td>Were M&amp;E guidelines, procedures and support adequate in encouraging data use at IP level?</td>
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<tr>
<td>To what extent was data disaggregated to measure the results of the 3MDG programme on the specific population groups targeted? On gender equality?</td>
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<tr>
<td>To what extent have M&amp;E data been used to identify strengths/weaknesses of the 3MDG programme and lessons learnt? Who has been involved in doing this, how and when?</td>
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</table>

To what extent did 3MDG M&E activities and/or support go beyond routine monitoring to include programme evaluation, operational research, IP and beneficiary feedback, regular surveillance/surveys? To what extent has appropriate use been made of both quantitative and qualitative methods?

<table>
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<tr>
<th>Question</th>
<th>Midterm</th>
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<tbody>
<tr>
<td>Did 3MDG provide feedback mechanisms not only for IPs but also for beneficiaries?</td>
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To what extent was learning from implementation experiences and specific reviews integrated into the 3MDG programme?

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<tr>
<th>Question</th>
<th>Midterm</th>
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<tr>
<td>What lessons can be learnt from the 3MDG M&amp;E that can be applied to the evaluation of the next phase of the programme?</td>
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<tr>
<td>What lessons from the 3MDG programme can be/were applied to the next phase of the programme and other health/development initiatives in Myanmar?</td>
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<td>How useful was the 3MDG data for national level data systems?</td>
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Were 3MDG financial and other reporting requirements acceptable to IPs (was it too time consuming or too complicated)?

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<th>Question</th>
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Annex 7: 3MDG overall Theory of Change

- **Improved maternal, new-born and child health and a reduction in communicable disease burden HIV, TB, malaria in areas and populations supported by the 3MDG Fund**
  - Accountability, equity, and inclusiveness at all levels

- **Increased access to essential maternal and child health services for the poorest and most vulnerable in areas supported by the 3MDG Fund**

- **Increased availability of essential maternal and child health services for the poorest and most vulnerable in areas supported by the 3MDG Fund and HIV**

- **Increased access for HIV, TB and malaria interventions for populations and areas not readily covered by the Global Fund**

- **Increased availability of HIV, TB, and malaria interventions for populations and areas not readily covered by the Global Fund**

- **Strengthened delivery of essential maternal and child health services for targeted groups**

- **Strengthened systems for essential maternal and child health services for targeted groups**

- **Prioritised HIV, TB and malaria interventions not readily covered by the Global Fund provided to targeted populations or areas**

- **Enhanced health Services accountability and responsiveness through capacity development of target communities, CSO, and the public sector**

Implementing Partners (Needs to be unpacked)
Annex 8: MCNH Theory of Change

- **Improved MNCH**
  - in areas supported by the 3MDG Fund
  - Who is the targeted population, sub-groups?
  - Differentiated impact, baseline

- **Increased utilisation of services by targeted population**

- **Changed MNCH Practices**

- **Increased awareness for MNCH services**

- **Improved quality of MNCH services**

- **Increased access of essential MNCH services**

- **Increased availability of essential MNCH services**

- Accountability, equity, and inclusiveness at all levels

- Coordination, commodities and supplies, capacity strengthening, support for emergency referrals and awareness raising for community
Annex 9: Research carried out by various organisations

<table>
<thead>
<tr>
<th>No</th>
<th>Organisation</th>
<th>Disease</th>
<th>Title of Research</th>
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<tbody>
<tr>
<td>1</td>
<td>DMR (UM); DOH</td>
<td>MAL</td>
<td>A randomized trial on artemether-lumefantrine versus dihydroartemisinin-piperaquine phosphate for treatment of uncomplicated falciparum malaria</td>
<td>MHRC Programme and Abstract 2008; pp. 9</td>
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<tr>
<td>2</td>
<td>DMR (LM); DOH</td>
<td>MAL</td>
<td>Efficacy and safety of Artesunate-Amodiaquine versus Artemether-Lumefantrine for the treatment of uncomplicated P. falciparum malaria in 4 sentinel sites (Rakhine, Kayin, Mon, and Kachin States) in Myanmar</td>
<td>MHRC Programme and Abstract 2008; pp.10-11</td>
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<tr>
<td>3</td>
<td>University of Medicine (1), Yangon; DMR (LM)</td>
<td>MAL</td>
<td>Red cell deformability and nitric oxide concentration in confirmed un-complicated falciparum malaria patients</td>
<td>MHRC Programme and Abstract 2008; pp.11-12</td>
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<td>4</td>
<td>DMR (LM); WHO</td>
<td>MAL</td>
<td>Efficacy and safety of artesunate-amodiaquine vs. artemether-lumefantrine for the treatment of uncomplicated falciparum malaria at Sinthay Rural Health Sub-Centre, Ponnagyun Township, Rakhine State from July, 2007 to October, 2007</td>
<td>16th Myanmar MMC Programme and Abstract 2008, No.1: pp. 1</td>
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<td>5</td>
<td>DMR</td>
<td>MAL</td>
<td>A study on the clinical patterns and changes in blood glucose levels in adult severe falciparum malaria patients</td>
<td>16th Myanmar MMC, Programme and Abstract 2008, No. 3: pp. 1</td>
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<td>6</td>
<td>DMR</td>
<td>MAL</td>
<td>A study on impact of some hepatic co-infections and co-morbidities on severity and outcome of malaria hepatitis</td>
<td>16th Myanmar MMC Programme and Abstract 2008, No. 4: pp. 2</td>
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<td>7</td>
<td>DMR (LM) &amp; Military hospitals</td>
<td>MAL</td>
<td>A study on clinical profile of falciparum malaria in children admitted to paediatric ward of No (1) Defence Services Obstetrics, Gynaecology and Children Hospital (300-bedded) and No (2) Military Hospital (500 bedded)</td>
<td>16th Myanmar MMC Programme and Abstract, 2008; No. 24: pp. 12</td>
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<td>8</td>
<td>DMR(LM); International Institutions</td>
<td>MAL</td>
<td>The relationship between age and the manifestations of and mortality associated with severe malaria</td>
<td>Clinical Infectious Diseases 2008; 47:151–7</td>
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<td>9</td>
<td>DMR (LM); DOH</td>
<td>MAL</td>
<td>Efficacy and safety of artemether-lumefantrine versus dihydroartemisinin-piperaquine for the treatment of uncomplicated</td>
<td>MHRC Programme and Abstract 2009; pp. 10</td>
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<td>10</td>
<td>DMR (LM) &amp; Military hospitals</td>
<td>MAL</td>
<td>The efficacy of artemisinin-naphthoquine (ARCO) in adult uncomplicated falciparum malaria</td>
<td>MHRC Programme and Abstract 2009; pp. 13</td>
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<td>11</td>
<td>DMR(LM); DOH</td>
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<td>The association between ‘ABO’ blood group distribution and HIV seropositivity among falciparum malaria patients in NOGH (2007-2008)</td>
<td>55th Myanmar Medical Conference Programme and Abstract 2009, pp. 56</td>
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<td>12</td>
<td>Kaung Myat Khaing</td>
<td>MAL</td>
<td>A study on ocular manifestations of falciparum malaria</td>
<td>17th Myanmar MMC Programme and Abstract 2009; No. 3: pp. 2</td>
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<td>13</td>
<td>Clinical Research Unit (Malaria), DSGH, Mingaladon; DMR (LM)</td>
<td>MAL</td>
<td>Efficacy and safety of artemisinin-piperaquine (Artequick) compared to dihydroartemisinin-piperaquine (Artekin) in uncomplicated falciparum malaria in adults</td>
<td>The MHSRJ 2009; 21(2): pp. 78</td>
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<td>14</td>
<td>DMR (LM); DOH; Yuzana Palm Oil Project</td>
<td>MAL</td>
<td>Evaluation of efficacy and safety of artemether-lumefantrine for the treatment of uncomplicated P. falciparum malaria and chloroquine for the treatment of Plasmodium vivax in a sentinel site (Tanintharyi Division) in Myanmar</td>
<td>MHRC Programme and Abstract 2010; pp. 11</td>
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<td>15</td>
<td>DMR (LM)</td>
<td>MAL</td>
<td>Glucose-6-Phosphate Dehydrogenase enzyme deficiency in Kayah and Rakhine States</td>
<td>MHRC Programme and Abstract 2010; pp. 36</td>
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<td>16</td>
<td>DMR (LM) &amp; Military hospitals</td>
<td>MAL</td>
<td>Clinical study on efficacy and safety of piperamisin (dihydroartemisinin-piperaquine) in uncomplicated falciparum malaria in adults</td>
<td>MHRC Programme and Abstract 2010; pp. 43</td>
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<tr>
<td>17</td>
<td>Yangon Children Hospital, National Health Laboratory, DSMA</td>
<td>MAL</td>
<td>Hypothetical approach of natural protective role of haemoglobinopathies in Myanmar malaria patients</td>
<td>56th Myanmar Medical Conference, Programme and Abstract, 2010; No. 17: pp. 62</td>
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<tr>
<td>18</td>
<td>Biochemistry Research Division; Parasitology Research Division; DMR (LM)</td>
<td>MAL</td>
<td>Glucose-6-Phosphate Dehydrogenase (G6PD) enzyme deficiency in Chin State</td>
<td>The MHSRJ 2010; 22(3): pp. 159-163</td>
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<tr>
<td>19</td>
<td>DMR(LM); International Institutions</td>
<td>MAL</td>
<td>A simple score to predict the outcome of severe malaria in adults</td>
<td>Clinical Infectious Diseases 2010; 50:679–685</td>
</tr>
<tr>
<td>20</td>
<td>Ohnmar Myint Thein</td>
<td>MAL</td>
<td>Study of red cell deformability, nitric oxide and haematological parameters in confirmed uncomplicated falciparum malaria patients</td>
<td>Thesis Ph.D. (Physiology), UM (1), 2010</td>
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<td>21</td>
<td>Ministry of Defence</td>
<td>MAL</td>
<td>Clinical study on efficacy and safety of Duocotexin (dihydroartemisinin-piperaquine) in uncomplicated falciparum malaria in adults</td>
<td>MHRC Programme and Abstract 2011; pp. 36</td>
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<td>22</td>
<td>DMR (LM); DOH</td>
<td>MAL</td>
<td>Evaluation of efficacy and safety of dihydroartemisin-piperaquine 42 days trial for the treatment of uncomplicated P. falciparum malaria in Kawthaung, Taninthary Region, Myanmar</td>
<td>MHRC Programme and Abstract 2011; pp. 36-37</td>
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<td>23</td>
<td>University of Pharmacy, Yangon; DMR (LM)</td>
<td>MAL</td>
<td>Piperaquine concentrations in red blood cells and plasma of Myanmar healthy volunteers and uncomplicated falciparum malaria patients</td>
<td>MHRC Programme and Abstract 2011; pp. 40</td>
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<tr>
<td>24</td>
<td>DMR (LM); Myanmar Medical Association</td>
<td>MAL</td>
<td>Malaria antibody: Is it an alternative tool for estimation of local malaria transmission in malaria micro-stratified areas</td>
<td>MHRC Programme and Abstract 2011; pp. 40-41</td>
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<td>25</td>
<td>DMR (LM); Thanbyuzayat Hospital, Mon State</td>
<td>MAL</td>
<td>Association between the use of Insecticide-Treated Nets (ITNs) and parasitaemia and presence of malaria antibody in Thanbyuzayat Township, Mon State</td>
<td>The MHSRJ 2011; 23(1): pp. 44-50</td>
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<td>27</td>
<td>DMR (LM) &amp; Military hospitals</td>
<td>MAL</td>
<td>Clinical study on efficacy and safety of artemether-lumefantrine in uncomplicated falciparum malaria in adults in Loikaw</td>
<td>MHRC Programme and Abstract 2014; pp. 29</td>
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<td>28</td>
<td>DMR (LM); DOH</td>
<td>MAL</td>
<td>The role of merozoite surface protein (MSP) malaria antibody in treatment response of uncomplicated malaria in Myanmar</td>
<td>MHRC Programme and Abstract 2014; pp. 29</td>
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<tr>
<td>29</td>
<td>DMR (LM)</td>
<td>MAL</td>
<td>Study on protective effects of malaria antibody among the community in malaria endemic areas</td>
<td>MHRC Programme and Abstract 2014; pp. 34</td>
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**DIAGNOSTICS: DRUG RESISTANCE AND MOLECULAR STUDIES**

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<td>1</td>
<td>Yee Htwe</td>
<td>MAL</td>
<td>Parasitological indices of malaria infection in some villages of Thaton Township, Mon State</td>
<td>Thesis Ph.D. (Chemistry), University of Yangon, 2008</td>
</tr>
<tr>
<td>2</td>
<td>Khin Myo Aye</td>
<td>MAL</td>
<td>Sensitivity and specificity of Parasite Lactate Dehydrogenase (pLDH)-Based Rapid Diagnostic Test (SD Bioline Malaria Antigen Test) in comparison with parasite density</td>
<td>Thesis M.Med.Sc. (Microbiology), UM (1), 2008</td>
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<td>3</td>
<td>DMR (LM)</td>
<td>MAL</td>
<td>PfcrT76 and Pfmdr1 Y86 mutations and their relation to in vitro sensitivity Of Mefloquine</td>
<td>MHRC Programme and Abstract 2008; pp. 4</td>
</tr>
<tr>
<td>4</td>
<td>Win Thandar Shwe, UM (2)</td>
<td>MAL</td>
<td>A study on usefulness of Rapid Diagnostic Test (Paracheck PI) for malaria diagnosis in children</td>
<td>MHRC Programme and Abstract 2008; pp. 8</td>
</tr>
<tr>
<td>5</td>
<td>DMR (LM); UM (1), Thanbyuzayat Hospital, DOH</td>
<td>MAL</td>
<td>Sensitivity and specificity of Parasite Lactate Dehydrogenase (pLDH)-Based Rapid Diagnostic Test</td>
<td>MHRC Programme and Abstract 2008; pp. 11</td>
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<td>6</td>
<td>DMR (LM); UM (1)</td>
<td>MAL</td>
<td>Molecular assay and in vitro susceptibility test for monitoring chloroquine resistant falciparum malaria in the era of artemisinin-based combination therapy</td>
<td>MHRC Programme and Abstract 2008; pp. 12</td>
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<td>7</td>
<td>DMR (LM)</td>
<td>MAL</td>
<td>Pfmdr1 N86 alleles and in-vitro dihydroartemisinin sensitivity status of P. falciparum in Kawthaung and Butheedaung</td>
<td>MHRC Programme and Abstract 2009; pp. 11</td>
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<td>9</td>
<td>DMR (LM)</td>
<td>MAL</td>
<td>Early screening of G6PD deficiency among the healthy children living in malaria area Bogalay Township, Ayeyawady Division</td>
<td>MHRC Programme and Abstract 2009; pp. 71</td>
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<tr>
<td>11</td>
<td>DMR (LM)</td>
<td>MAL</td>
<td>Association of Pvmdr1 Y976f mutation and in vitro chloroquine sensitivity of Plasmodium vivax in Kawthaung</td>
<td>The MHSRJ 2010; 22(3), pp. 131-136</td>
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<td>14</td>
<td>DMR (LM); DOH &amp; International Institutions</td>
<td>MAL</td>
<td>Genetic polymorphism of merozoite surface protein-1 and merozoite surface protein-2 in Plasmodium falciparum field isolates from Myanmar</td>
<td>Malaria Journal 2010, 9:131 <a href="http://www.malariajournal.com/content/9/1/131">http://www.malariajournal.com/content/9/1/131</a></td>
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<td>16</td>
<td>Myat Htut Nyunt</td>
<td>MAL</td>
<td>Role of HRP2 and Pan pLDH Based Immunochromatographic Assay in therapeutic monitoring of uncomplicated falciparum malaria in Myanmar</td>
<td>Thesis M.Med.Sc (Microbiology), UM 1, 2010</td>
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<td>17</td>
<td>DMR (LM); UM (1); Myawaddy District Health Department, DOH</td>
<td>MAL</td>
<td>Field evaluation of HRP2 and Pan pLDH based Immunochromatographic Assay in therapeutic monitoring of uncomplicated falciparum malaria</td>
<td>M HRC, Programme and Abstract, 2011; pp. 39</td>
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<td>18</td>
<td>DMR (LM)</td>
<td>MAL</td>
<td>Study on malaria antibody prevalence to P. falciparum and Plasmodium vivax infections in endemic areas of Mandalay Region</td>
<td>MHRC Programme and Abstract 2011; pp. 3-4</td>
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<td>19</td>
<td>DMR (LM)</td>
<td>MAL</td>
<td>In vitro susceptibility status of P. falciparum to antimalarial drugs and prevalence of its Pfmdr1 86 polymorphism in Kawthaung</td>
<td>MHRC Programme and Abstract 2011; pp. 42-43</td>
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<td>DMR (LM); Kangwon University, ROK</td>
<td>MAL</td>
<td>Molecular Epidemiology of drug resistant Plasmodium vivax and therapeutic efficacy of chloroquine against Plasmodium vivax in Shwe Kyin, Myanmar</td>
<td>MHRC Programme and Abstract 2014; pp. 32</td>
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<tr>
<td>2</td>
<td>UOP, Yangon; DMR (LM); Loikaw General Hospital, Kayah State</td>
<td>MAL</td>
<td>Pharmacokinetics of piperaquine and clinical outcome of acute, uncomplicated falciparum malaria patients after administration of Piperaquine, a locally manufactured ACT in Myanmar</td>
<td>MHRC Programme and Abstract 2010; pp. 53</td>
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<tr>
<td>3</td>
<td>Khine Kyi Han</td>
<td>MAL</td>
<td>Determination of piperaquine concentration in red blood cells and plasma of Myanmar healthy volunteers and uncomplicated falciparum malaria patients</td>
<td>Thesis Master of Pharmacy, UOP, 2010</td>
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<td>4</td>
<td>Marlar Myint</td>
<td>MAL</td>
<td>Pharmacokinetics of piperaquine in Myanmar healthy volunteers and acute, uncomplicated falciparum malaria patients after oral administration of dihydroartemisinin-piperaquine co-formulation</td>
<td>Thesis Ph.D. (Pharmacology), UM (2), 2010</td>
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<td>5</td>
<td>Thet Thet Mar</td>
<td>MAL</td>
<td>Antimalarial activities and chemical investigation of Nyctanthes Arbortristis Linn.(Seikphaleu) leaves and Garcinia Pedunculata Roxb (Metlinchin) Bark</td>
<td>Thesis PhD (Chemistry), YU, 2010</td>
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<td>6</td>
<td>Khin Ohnmar Kyaing</td>
<td>MAL</td>
<td>Anti-malarial activity and identification of active principle of Dichroa Febrifuga growth in Pyin Oo Lwin area</td>
<td>Thesis PhD (Pharmacology), IM (1) 2010</td>
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<td>7</td>
<td>DMR(LM); DOH</td>
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<td>Evaluation of artesinin resistant falciparum malaria in Shwe Kyin, Myanmar</td>
<td>MHRC Programme and Abstract 2014; pp. 33</td>
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<td>1</td>
<td>DMR(LM); DOH</td>
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<td>Knowledge, attitude and practice study on malaria in 4 different malaria endemic areas in Myanmar</td>
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<td>2</td>
<td>MMA</td>
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<td>Assessment of counselling services of general practitioners from 21 selected townships of Myanmar for 3 Diseases: Malaria, Tuberculosis, and HIV/AIDS in 2008</td>
<td>MHRC Programme and Abstract 2008; pp. 21</td>
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<td>DMR(LM); DOH</td>
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<td>Long lasting insecticidal nets (LLINs): a simple effective personal protective measure for malaria prevention</td>
<td>MHRC Programme and Abstract 2008; pp. 58</td>
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<td>4</td>
<td>DMR (CM), Township Health Department, Pyinmana Township</td>
<td>MAL</td>
<td>Study of utilization of rapid diagnostic tests by community health workers and acceptance of the served community of the diagnostic tests in remote malaria endemic areas</td>
<td>The MHSRJ 2008; 20(2): pp. 75</td>
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<td>5</td>
<td>DMR(LM)</td>
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<td>Socio-behavioural study on malaria prevention and control among forest related workers in hard to reach areas</td>
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<td>Technical Working Group, MMA, Malaria Project</td>
<td>MAL</td>
<td>Prevalence and Knowledge, Attitude and Practice (KAP) of malaria and insecticide treated bed net (ITN) in Mingone Village, Yangon Division</td>
<td>55th Myanmar Medical Conference, Programme and Abstract, 200; pp. 70</td>
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<td>7</td>
<td>Technical Working Group, MMA, Malaria Project</td>
<td>MAL</td>
<td>Qualitative research of knowledge and practice of malaria and insecticide treated net (ITN) in Mingone Village, Yangon Division</td>
<td>55th Myanmar Medical Conference, Programme and Abstract, 2009, pp. 71</td>
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<td>8</td>
<td>DMR (UM), DOH</td>
<td>MAL</td>
<td>Utilization of basic health staff by rural community in disease management of malaria</td>
<td>The MHSRJ 2009; 21(2): pp. 88-92</td>
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<td>9</td>
<td>DMR(LM); International Institutions</td>
<td>MAL</td>
<td>The effect of insecticide-treated bed-nets on the incidence and prevalence of malaria in an area of unstable transmission in western Myanmar</td>
<td>Treating and preventing malaria in Myanmar, Medicine sans Frontieres-Holland 2009; pp. 73</td>
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<td>MSF Holland</td>
<td>MAL</td>
<td>The development and results of a large-scale malaria project in Rakhine State, Myanmar</td>
<td>Treating and preventing malaria in Myanmar, Medicine sans Frontieres-Holland 2009; pp.107</td>
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<td>12</td>
<td>DMR (LM); NMCP, DOH</td>
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<td>Effects of insecticide-treated nets (ITN) on malaria in pregnancy in Thaton District</td>
<td>MHRC Programme and Abstract 2010; pp. 3</td>
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<td>DMR (UM); VBDC, DOH</td>
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<td>Validation of malaria diagnosis and treatment made by basic health staff in sub-centres</td>
<td>MHRC Programme and Abstract 2010; pp. 9-10</td>
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<td>DMR (LM); DOH</td>
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<td>Malaria in Myeik District: Feasibility of health and health related community networks in mobilizing early diagnosis and prompt treatment</td>
<td>MHRC Programme and Abstract 2010; pp. 60</td>
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<td>MMA</td>
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<td>Treatment seeking behaviour of malaria patients admitted to Loikaw State Hospital</td>
<td>56th Myanmar Medical Conference, Programme and Abstract 2010; pp. 49</td>
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<td>16</td>
<td>DMR (LM); NMCP, DOH</td>
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<td>Social burden of malaria on family in Hlegu Township, malaria endemic area</td>
<td>The MHSRJ 2010; 22(1): pp. 58-61</td>
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<td>17</td>
<td>DMR (CM), Taungnyo Station Hospital</td>
<td>MAL</td>
<td>Sociocultural and behavioural determinants of malaria and its appropriate control measures in forested areas of Central Myanmar</td>
<td>The MHSRJ 2010; 22(2): pp. 83-88</td>
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<td>18</td>
<td>DMR (UM), DOH</td>
<td>MAL</td>
<td>Patients' perspectives on choosing either public or private sector for malaria treatment in Upper Myanmar</td>
<td>The MHSRJ 2010; 22(2): pp. 123-128</td>
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<td>19</td>
<td>Military Institute of Nursing and Paramedical Sciences, DMR (LM)</td>
<td>MAL</td>
<td>Cost analysis of severe and complicated malaria cases admitted to Medical Intensive Care Unit, No.1 Defence Services General Hospital (1000 Bedded)</td>
<td>The MHSRJ 2010; 22(2): pp. 95-100</td>
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<td>20</td>
<td>Tun Myint</td>
<td>MAL</td>
<td>Knowledge, attitude and practice on malaria and insecticide treated bed nets (ITN) in Salin Township</td>
<td>56th Myanmar Medical Conference, 20-26 January, 2010; No. 5: pp. 50</td>
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<td>21</td>
<td>Khaing Nwe Tin</td>
<td>MAL</td>
<td>Risk factors of malaria among the migrant populations</td>
<td>10th Medical Specialities Conference, Programme and Abstract, 2010; pp. 35</td>
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<td>22</td>
<td>Aung Khant and Tin Oo</td>
<td>MAL</td>
<td>Malaria related risk behaviours among rubber plantation workers near Pann-Ta-Pwint hill, Hmawbi Township in 2008</td>
<td>18th Myanmar MMC Programme and Abstract, 2010; No. 18: pp. 16</td>
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<td>23</td>
<td>DMR (UM)</td>
<td>MAL</td>
<td>How community health workers participated in malaria control and prevention at Madaya Township</td>
<td>MHRC Programme and Abstract 2011; pp. 37</td>
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<tr>
<td>24</td>
<td>DMR (LM); VBDC Team, Bago Division, DOH; NMCP, DOH</td>
<td>MAL</td>
<td>Cluster randomized trial on the use of community volunteers to improve early diagnosis and treatment of malaria in Bago Region, Myanmar</td>
<td>MHRC Programme and Abstract 2011; pp. 38-39</td>
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<td>25</td>
<td>DMR (LM)</td>
<td>MAL</td>
<td>Scaling up mechanisms for early diagnosis and prompt treatment of malaria in rural areas prior to Myanmar Artemisinin Resistance Containment</td>
<td>MHRC Programme and Abstract 2011; pp. 42</td>
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<td>26</td>
<td>VBDC, Mon State, DOH; DMR (LM)</td>
<td>MAL</td>
<td>Epidemiological significance of malaria in Mon State, Myanmar</td>
<td>MHRC Programme and Abstract, Poster, 2011; pp. 57</td>
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<td>27</td>
<td>DMR (LM); Township Health Department, Thanbyuzayat Township, Mon State</td>
<td>MAL</td>
<td>The effect of innovative personal protection on malaria among temporary migrant workers in rubber plantation, Mon State, Myanmar</td>
<td>MHRC Programme and Abstract 2011; pp. 67</td>
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<td>28</td>
<td>DMR(LM)</td>
<td>MAL</td>
<td>Access to a blood test and anti-malarials after introducing rapid diagnostic tests in rural Myanmar: Initial experience in a malaria endemic area</td>
<td>J. Int Health 2010, 10.1016/j.inhe.2010.09.008</td>
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<td>29</td>
<td>DMR (UM), DOH</td>
<td>MAL</td>
<td>Community acceptance on insecticide treated bed nets in selected rural communities</td>
<td>The MHSRJ 2011; 23(2): pp. 116-122</td>
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<td>31</td>
<td>Myo Min</td>
<td>MAL</td>
<td>Knowledge, perception and utilization of insecticide treated nets (ITNs) for malaria prevention and control in Indaw Township</td>
<td>Thesis M.Med.Sc. (Disease Prevention and Control), DSMA, 2011</td>
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<td>32</td>
<td>DMR(LM)</td>
<td>MAL</td>
<td>Effects of malaria volunteer training on coverage and timeliness and diagnosis; a cluster randomised controlled trial in Myanmar</td>
<td>Malaria Journal 2012, 11:309 <a href="http://www.malarialjournal.com/content/11/1/309">http://www.malarialjournal.com/content/11/1/309</a></td>
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<td>33</td>
<td>DMR(LM), IM II</td>
<td>MAL</td>
<td>Renal involvement in severe malaria (Insein General Hospital 2012-2013)</td>
<td>MHRC Programme and Abstract 2014; pp. 34-35</td>
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<td>34</td>
<td>DMR(LM); DOH</td>
<td>MAL</td>
<td>Challenges in Universal coverage and utilization of insecticide treated bed nets among the Migrant Plantation Workers in Myanmar</td>
<td>MHRC Programme and Abstract 2014; pp. 28-30</td>
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**MALARIA VECTOR STUDIES**

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<tr>
<td>1</td>
<td>DMR (UM); VBDC Team, Mandalay Division, DOH</td>
<td>MAL</td>
<td>Seasonal prevalence and biting patterns of malaria vectors in a hard to reach area</td>
<td>MHRC Programme and Abstract 2009; pp. 12</td>
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<td>3</td>
<td>DMR(LM); International Institutions</td>
<td>MAL</td>
<td>Relationship of anopholes vector abundance and behaviour to the efficacy of insecticide treated bed nets in preventing malaria in western Myanmar</td>
<td>Treating and preventing malaria in Myanmar, Medicine sans Frontieres-Holland 2009; pp. 91</td>
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<td>4</td>
<td>DMR (UM); Unit of Medical Entomology, Institute for Medical Research (Malaysia)</td>
<td>MAL</td>
<td>Detection of insecticide resistance in anopheles mosquitoes in selected areas of Selangor, Malaysia</td>
<td>MHRC Programme and Abstract 2010; pp. 12</td>
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<td>5</td>
<td>DMR (LM); VBDC Team, Bago Region, DOH</td>
<td>MAL</td>
<td>Understanding malaria transmission and vector bionomics at a forest fringe hilly rural area incorporating Geographical Information System (GIS) application</td>
<td>MHRC Programme and Abstract 2011; pp. 41</td>
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<td>6</td>
<td>UNICEF</td>
<td>MAL</td>
<td>Assessment of Ownership and Usage of Insecticide Treated Nets in Malaria Endemic Townships in Myanmar</td>
<td>UNICEF 2012 report</td>
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<td>7</td>
<td>DMR(LM)</td>
<td>MAL</td>
<td>Access to a blood test and anti-malarials after introducing RDTs in rural Myanmar; initial experience in malaria endemic area</td>
<td>DMR Congress 2012 poster</td>
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<td>8</td>
<td>DMR(LM)</td>
<td>MAL</td>
<td>The effectiveness of migrant mapping tool on formulating strategies to support malaria interventions for temporary mobile/migrant workers in Taninthary Region</td>
<td>Malaria on the move 2012</td>
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<td>9</td>
<td>IOM</td>
<td>MAL</td>
<td>Mapping of population and malaria in the South-East region of Myanmar</td>
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<td>11</td>
<td>DMR(LM)&amp; Khon Kaen University, Thailand</td>
<td>MAL</td>
<td>Availability and dispensing practices of anti-malarial drugs in private drug outlets of Myanmar</td>
<td>MHRC Programme and Abstract 2014; pp. 31</td>
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<td>12</td>
<td>DMR(LM); DOH</td>
<td>MAL</td>
<td>Human behavioural practices of malaria in Mudon Township, Mon State</td>
<td>MHRC Programme and Abstract 2014; pp. 32-33</td>
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**MNCH**

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**HIV/AIDS**

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Annex 10: Supporting discussion and theory for evaluation approaches

Midterm evaluation
The following paragraphs provide a more in-depth explanation of our approach to the midterm evaluation.

Documenting Implementation: What is happening?
This focus is on documenting the details of how the programme is being implemented. In addition to producing a detailed description of programme implementation, and the programme, we will answer the following types of questions:

- Can the implementation of the programme be described in terms of a clear Theory of Change (ToC)? Are there variations of implementation (ToA) at different sites or by different service deliverers?
- What factors have influenced and shaped the intervention in response to particular contextual factors that might not be present in other sites? (e.g. conflict affected areas, different initial conditions)
- What planned results have been achieved? What are the unintended results?
- What have been the start-up and/or continuing costs of implementation?
- What are the challenges faced by the FMO that influence implementation?

Comparing Implementation: Is it being implemented as planned?
Here we will focus on whether the 3MDG programme is being implemented as expected. It is particularly important for: (1) quality control and improvement and (2) to complement an impact evaluation. Many programmes experience problems with the quality of implementation – such as delays and gaps in staffing, non-delivery of materials, service delivery processes that do not follow agreed procedures, and security concerns that may limit access. While some of these problems will be evident from ongoing performance monitoring, others will only be visible through a more comprehensive implementation evaluation.

Implementation evaluation is also useful for interpreting the results of impact evaluation, thereby enhancing their usefulness. If an impact evaluation finds that a programme has not achieved its intended impacts, it will be essential to know whether or not it has been implemented properly. For example, if one township, or state, does not produce improved maternal and child health outcomes, is it because the programme doesn’t work – or because it was not implemented properly? If an impact evaluation finds that the 3MDG programme has been effective, this implementation evaluation can produce a description of the activities of the programme so it can be replicated or scaled up.

This form of implementation evaluation answers the following questions:

- Is the programme being implemented as planned? In what ways is it being done differently?
- Are these differences due to a deliberate decision to implement the programme differently? Are they an improvement on the original plan?
- What are the indicators of bottlenecks to implementation?

Improving Implementation: How can implementation improve?
The third focus will be on improving implementation and it involves identifying what is and is not working.

The evaluation questions at this level are expected to include, but not necessarily be limited to:
• What are the strengths and weaknesses of the programme? (from the point of view of staff, clients, experts) Are there particularly successful IPs or sites (“bright spots”) that are using better practices?
• How might the programme be implemented differently? How could others learn from more successful sites? How could these changes be made?

Final evaluation
The following paragraphs provide a more in-depth explanation of our approach to the final evaluation.

Quantitative counterfactual analysis
A well-established approach to IE is quantitative counterfactual analysis. Here the impact attributable to the intervention is identified by measuring the observed change in impact indicators and comparing it to the observed change for a control or comparison group. This process establishes how large the net change in indicators is, and whether it is statistically significant. This approach has clear strengths, in that it at the same time delivers an estimate of the size of the impact as well as a clear assessment of the certainty with which the change can be attributed to the intervention (White and Phillips, 2012).

Quantitative counterfactual analysis is extremely demanding with regards to both data and identification of viable control or comparison groups, that certain humility with regards to applicability is required. While it may be possible to obtain solid analytical results for certain areas or beneficiary groups, it may not be possible for all. For example, the contextual heterogeneity and varied IP approaches can create a situation where use of a statistical counterfactual analysis may be of more limited analytical value than hoped for (see White, 2012, et al).

Further, in the case of non-conclusive findings from statistical analysis based on counterfactual, the important distinction of absence of evidence and evidence of absence (of impacts) counterfactual analysis must be kept in mind. Finally, counterfactual analysis does not shed light on the important impact questions of explaining how the intervention worked and for whom. Here, other approaches are required.

Theory Based Evaluation
Thus, in addition to including counterfactual analysis to the degree possible, we will also use a different approach to investigate the issue of the causal link between the intervention and the observed changes. We will draw on Theory Based Evaluation approaches for impact evaluation, where causation and contribution is assessed in a “method-neutral” way, open to the use of both quantitative and qualitative data, thereby allowing for integration of all available data sources. As pointed out by White & Phillips, these approaches build on a specification of a theory of change for the intervention, where analysis is undertaken “with the goal of rigorously evidencing the links in the actual causal chain” (White and Phillips, 2012). It must be stressed that in order to establish causation beyond a reasonable doubt, it is not just a matter of following the chain of events as seen from a programme perspective. Other possible influences and explanations for the observed changes must also be considered.

“Common core involves the specification of a theory of change together with a number of further alternative causal hypotheses. Causation is established beyond reasonable doubt be collecting evidence to validate, invalidate or revise the hypothesised explanations, with the goal of rigorously evidencing the links in the actual causal chain. We argue, that properly applied, approaches that undertake these steps, can be used to address attribution of cause and effect.” (White and Philips, 2012).
Here, the objective is to assess whether the intervention has worked as expected, and whether and how enabling and hindering factors outside the programme played a role. This means considering the role of contextual factors and the possibility that other actors and/or interventions could contribute to changes. By assessing if and to what degree this has been the case, a credible contribution story can be developed. Rather than measuring the net change in impact indicators through a comparative counterfactual analysis, these approaches assess the degree to which the interventions have contributed to and by implication can take credit for observed change. Further, by focusing on the actual causal chain as well as contextual factors, it allows for a more thorough exploration of the questions of how the intervention has worked, and for whom.

Prominent scholars and practitioners note that there are several different ways of investigating the causal links between interventions and effect that may be applied depending on the specific circumstances (see White and Phillips, 2012, and Stern et al. (2012). For instance, the fact that a parallel range of 3MDG interventions are implemented in a number of distinct settings creates an opportunity for comparing the interplay between intervention, context and results, so as better to be able to identify patterns of causation and effect, even in a situation where an actual counterfactual is not available (for example see further below on dosage-response design).

Finally, it should be noted that the approaches complement each other: As control groups cannot be established through random assignment, a thorough understanding of the theory of change and the factors that may influence the outcomes is important for identifying appropriate comparison groups. Thus, the foundation for the Theory Based Evaluation assessment of causation and contribution also helps create the groundwork for the counterfactual analysis. And even a limited, but solid counterfactual impact estimate provides important information to help underpin and bolster the accuracy and validity of the theory based assessment.

Impact evaluation
The following paragraphs provide a more in-depth explanation of our approach to the impact evaluation.

Step 1: Clarifying Values (“What would success look like?”)

- Methods for Clarifying Values
  We will review formal documents, such as policies and project plans, to identify the stated values. We will also interview the FB, FMO and IPs to attempt to identify unstated values. The valuing stage is important because it moves the process from research (e.g. % of reduced child mortality) to evaluation by placing a value on that finding.

Step 2: Developing a Theory of Change
A ToC will unpack causal pathways and identify/operationalise what impacts are likely to be achieved during the timeline of an evaluation, how, and what else should be examined in the evaluation – activities, context, and intermediate outcomes. It can then be used to analyse the evaluation results. If the 3MDG interventions have not worked, the ToC can help to identify whether this is due to failures in implementation or because the theory of change does not work. If the 3MDG programme has worked, the ToC can help to identify what is needed to repeat this success at another time or another site.

- Methods for Developing and Representing a Theory of Change
  We have taken the first step to develop 3MDG’s ToC through a combination of a desk review of existing documentation, a literature review of research and evaluations of similar programmes, observing the 3MDG programme, and talking with the FB and FMO. While the overall ToC for 3MDG
is very similar to the DFID ToC (Annex 8), we also developed a ToC more specific to the MNCH programme (Annex 9) for which we will conduct impact evaluation. We anticipate a continued iterative, participatory process between January 2014 and June 2014 with the FMO and IPs and other relevant stakeholders that provide additional clarity and more depth to these ToC, and also provide theories of action. This includes working directly with IPs to understand their Theory of Action (ToA) with respect to 3MDG’s ToC. We will use this to inform an evaluative discussion and also to begin to identify values. For example, do the IPs ToC and ToA look reasonable to achieve the 3MDG’s intended impacts? If not, why not? What are the gaps? How do IPs perceive differences in context? Do they foresee any implications for implementation and progress? Do the IPs have different goals (values) of what they hope to achieve? These and other outputs from the ToC workshops and other discussion are highly valuable to the overall evaluation approach.

Step 3 Answering Descriptive Questions

- **Methods for Answering Descriptive Questions**

It is likely that a combination of qualitative and quantitative data will be needed to answer these questions well. Examples of potentially useful methods are provided. For example, we will likely re-analyse existing statistical data. In many cases, existing data are relevant and can be used if it is of adequate quality. This can include: programme performance information (e.g. performance measures for strategic objectives published in annual performance plans), management information systems (e.g. District Health Information System), programme monitoring and evaluation data, operational data, financial data, and data on social and economic indicators. These data may come from government sources or from external organisations.

We anticipate that an end line survey will be conducted that will collect quantitative and qualitative data from households. Surveys usually consist of mostly closed-ended questions, but may contain a limited number of open ended questions where the answers are not predefined, which will then later be coded. We anticipate that this will be a repeat of the baseline survey, with potentially a few additional questions, as needed.

**Interviews** will gather participants’ perceptions in their own words, capturing rich, and detailed accounts of their experiences or perceptions. There are three basic approaches that we anticipate using: (1) the informal conversational interview (no predetermined questions), (2) the interview guide, (topics and issues are outlined) and (3) the standardised open-ended interview (exact wording and sequence of questions determined in advance). These are not mutually exclusive and can be combined as needed.

**Focus groups** combine elements of both interviewing and participant observation in a single method. A focus group involves a small group of individuals selected to discuss, based on personal experience, their perceptions, opinions, beliefs, and attitudes about a specific topic. We will use group dynamics to generate data that would have not likely occurred without group interaction, and where we have one or two specific questions.

Finally we anticipate drawing data from township assessments, implemented by the IPs which will provide community and clinic level descriptive data.

*This section provides methods that we have not ruled out, and will be chosen based on answers to these 5 items. Methods that we have decided not to use are described later in this section.*

**Quantitative counterfactual analysis – potential approaches**

A comparison group can be identified during the baseline study. A comparison group is a group who are like the people who received a programme in all ways except for not receiving the programme.
• **Comparison group**

In quasi-experimental designs, a comparison group is created which attempts to be equivalent to the treatment group, but without using randomisation. In matched comparisons, participants (individuals, organizations or communities) are each matched with a nonparticipant on variables that are thought to be relevant, in an attempt to create equivalent groups without randomisation.

Matching can only be done on observable variables with available data (for example, age and gender) so it can be difficult to match on all the important variables for example, motivation. This is an example of where the people implementing the baseline and the identified health experts (e.g. IEG experts, DMR-LM) need to work together.

We need to establish which factors are contributing factors (determinate factors). The challenge is that in order to use a quantitative approach based on matching a solid understanding of the relevant determinants in across programme contexts is required as the basis for the matching, so that the treatment and comparison group are appropriate for comparison, as well as a sufficiently large number of treatment and comparison group households, to have a sample size that will allow for assessing impact. Here, it should be noted that the required size of the sample will also depend on the need to assess subgroups (e.g. a specific marginalised group), and prevalence of the impact indicator (i.e. is the health issue being assessed rare or common in the population surveyed).

In some states/regions (and perhaps all) we recognise that comparison communities may not be identified. In this case we may be able to use qualitative data to allow for collection of data that shows comparison and allows for differences to be identified. However, it should be stressed that both in terms of ability to identify relevant comparison groups, and in terms of feasible sample size, it should not be expected that all MNCH target areas can be covered by matched difference-in-difference approach. A difference-in-difference design compares the before-and after difference for the group receiving the intervention and is compared to the before-after difference for those who did not. This is an example of when the baseline forms an integral part of the design, and where the timing critical. By implication, the specific design is dependent on decisions with regards to the baseline approach, coverage, and other related factors mentioned above.

**Propensity score matching** provides an option for establishing an appropriate comparison group. This is a particular approach to creating matched comparisons based on an analysis of the factors that influenced people’s (inclination) to participate in the programme and establishing sufficient similarities between treatment and comparison groups in the absence of randomization. Recent methodological research has showed that when used in combination with a sampling frame that is based on a thorough understanding of the programme participation process, it is possible to overcome the issue of otherwise “unobserved” important variables, so that difference-in-difference analysis based on matching can deliver highly robust and credible impact estimates (Hansen et al, 2013). A practical aspect of this is to consider area or group-based similarities (e.g. social, area-based) that may be of importance to programme results as part of a qualitative sampling frame, to form the basis for the statistical sampling and matching. This combination could be highly relevant in the present context, where the programme interventions target distinct and different areas, and where there is a need to consider heterogeneity also within the various target areas.

**Non counterfactual approaches**

• **Theory Based Evaluation model - Checking results match tightly the theory that the programme produced them**

As described in the beginning of this section, we will use this approach in combination with other appropriate approaches. This approach allows for critically examining how tightly the theory and results relate, and explores the key assumptions and context. For example, we will carefully consider the timing of the evaluation—did the impacts occur at a time consistent with the ToC? We will also check whether all cases that achieved the final impacts achieved the intermediate outcomes. This can be done by following patterns, or modelling from outputs. We can also address the same type of
question using qualitative data. For example, did key informants (who might include participants) believe the intervention had made a difference, and could they provide a plausible explanation of why this was the case?

- **Dosage-response design**
  If the monitoring delivers data of sufficient detail, quantity, and quality, we can explore the differences across the units and look at the comparison with secondary data resources. This would attempt to see the “dose-response pattern” by examining the link between dose and response as part of determining whether the programme caused the outcome. It should be noted that this does not in itself deliver an impact estimate based on counterfactual analysis, but rather helps establish whether observed change in impact indicators is caused by the programme interventions. A strength of this approach is that it does not require identifying comparison groups external to the programme, as it uses heterogeneity within the different target areas as the basis for comparative analysis. However, if both IP implementation and context varies to too high a degree, it will not likely be feasible to identify a pattern with sufficient clarity.

- **LiST**
  We cannot rely on measuring indicators only at the impact level, as impact level changes may not have taken place at the time of the impact evaluation. For example data may show a change in behaviour (outcome) that does not yet translate into a change in health (impact); and if we only measure (and value) the change in impact level health indicators, we may miss these and other significant findings. We anticipate using Lives Saved Tool (LiST), a modelling approach that would use behaviour, treatment and other output and outcome level data to demonstrate potential and likely change at the impact level, in the health indicators.

This software tool, LiST (formerly IMPACT), is used to estimate the impact (in lives saved) and cost of scaling up various interventions. The tool is designed so that a user can load in country-specific information on coverage of over 40 interventions and the causes of deaths by age for the country, along with other relevant background information about the particular country. The user can then build scenarios of different packages of expanded health coverage. For each of these packages the model produces estimates of deaths averted and will produce estimates of costs. In anticipation of using this approach, we have built in the initial necessary processes as part of the Midterm Evaluation.

- **Qualitative model - General elimination method (GEM)**
  This approach would likely supplement other approaches, and attempts to identify and rule out alternative explanations. Key informants can be useful to identify possible alternative explanations and then specific data collected to investigate whether these might plausibly be the explanation. If more programmes are working in an area, or if other significant events take place that change the context, then it may be possible that the process appears to match the expected chain – but that outside events have had a (positive or negative) influence on achievements. Thus, in order to establish contribution as credibly as possible, considering the role of external factors and alternative explanations is important.

1 EHG will work with DMR-LM as our local collaborating partner. The Ministry of Health has granted DMR-LM has permission to work with this consortium. DMR-UPPER Myanmar does not have this permission. If DMR-LM require DMR-Upper Myanmar support they will contact them and make the appropriate arrangements. EHG’s sole local collaborating partner is DMR-LM.
Annex 11: Brief description of Special Study “Overview of Relevant Research”

Title of Study: Desk Review of Relevant Research: Data to Support IEG Evaluations

Purpose of Study: The primary purpose is to identify useful and credible information that will support the three evaluations to be implemented by the IEG. Secondly, the updated overview of relevant research will be accessible to stakeholders, including MoH, donors, UN organisations, INGOs etc., to inform planning and implementation of projects, studies and research.

IEG Researchers: Key researcher Khynn Than Win, IEG Epidemiologist, with support from Choo Phuah, IEG Operations Manager, as required. QA and back-stopping to be provided by the IEG team leader Donna Podems.

Duration of Study: An initial 30 days to establish an overview of existing research, anticipated start date May 2014. The desk review will then be repeated/updated quarterly, with approximately 7 days input every quarter, for the duration of the 3 MDG Programme.

PURPOSE
The IEG is heavily reliant on information provided by secondary resources. Therefore we need to identify (1) useful and relevant research that focuses on each component of 3MDG: MNCH, Malaria and TB, and Health Systems Strengthening, and at the same time (2) broad gaps in the research in relation to the 3MDG programme. The research approach to identifying useful and relevant research will use a systematic method of identifying and selecting research that will support or provide answers to key evaluation questions. It is systematic because the process will be broken up into clear steps that lead to the identification of relevant and credible research.

We will identify research that provides:

- **Substance to arguments**
  Often people have firm beliefs about particular issues, but when they have to argue their case they lack reliable information to back up their beliefs. Research helps to clarify and strengthen beliefs especially in the face of opposition and doubt from others. Research can confirm or disconfirm views, and our team will remain open-minded and impartial.

- **New, empirical information**
  Research should strengthen, or change, arguments and beliefs. These facts make it easier to plan programmes and ensure that interventions are effective.

- **What is most likely to address the key issues successfully**
  Research may provide key information that will enable you to develop clear strategies.

- **Anecdotes and examples**
  In addition to providing statistics, research provides real life experiences that are often more convincing than statistics organised into graphs and tables. For example, parts of a research report on poverty in a rural community can deal with actual case studies that will have a great impact on the 3MDG programme.

- **Information to inform cost-benefit arguments**
**KEY STEPS**

We will do this by conducting a broad and far reaching review of any reports that are published and accessible to the IEG and then reviewing that data against set criteria.

**Step 1: Identify research studies**

The IEG will identify research in two simultaneous ways. They will conduct focused search within newspaper archives, government sources (e.g. MoH), DMR-LM and UM, university libraries, websites, and INGOs and CBOs.

The key researcher, who has a strong network within health research in Myanmar, will personally approach senior level people in all relevant organisations and institutions to interview key persons and request information on pertinent research.

**Step 2: Test feasibility and usefulness of research criteria.**

The IEG will sample four to five studies and have two of its researchers apply the criteria to them. The researches will then assess the criteria’s feasibility and usefulness and make any necessary changes before reviewing the remaining research.

**Step 3: Sort research according to set criteria and establish list**

The IEG will then use selected criteria (please see below) to determine the usefulness of each piece of research, and only list those that are deemed appropriate to the research purpose.

The information will be recorded in an Excel database allowing simple sorting such as by each listed criteria.

**Step 4: Identify gaps in research and make recommendations**

Based on the list of research, the IEG will identify recognisable gaps and make recommendations for further research with which to fill those gaps.

**Step 5: Reporting and dissemination**

The IEG will include in the six-monthly progress reports to the FB/FMO an annex with the updated overview of relevant research. The FMO will have access to the Excel database and be able to share the information widely; the FB and FMO might consider uploading the overview of research on the 3MDG website.

The table below provides the summary table that will be presented to the 3MDG FB and FMO and used by the IEG, with a paragraph following to explain each category. There will be four tables, each containing research focused on one of the three component areas, and one table with additional research that the IEG thinks may potentially be of overall value to the evaluations.

1. **Research title:** Title of the research and key question answered.

2. **Component addressed:** This will note which component the research focuses on, which may be one or several.

3. **Year published:** Year published, also to include month and day if available.

4. **Year of data in report:** This will note, where feasible, the data that are used in the report. Often the report is published months if not years after the data are available.
5. **Author and/or publisher:** Often times this is the same person/group. If not we will list both. We will mention who funded the research, if possible as well as national or international partners.

6. **Geographical location of research:** National; state/region and if possible township(s).

7. **Population:** Clarify group studied. This criteria will be refined as the study is implemented and thematic areas are identified. The population studies may ‘tick’ more than one box. (E.g. displaced persons, pregnant mothers, youth).

8. **Location of research document:** This is the site or place that we can locate the research. For example, we may not download all accessible web data, just note its location, while some reports may be hard copies, and others soft copies located on our own server.

9. **Report available in English/Myanmar language:** Note language of report. If only a summary is available in one of the languages, this will be noted.

10. **Relevance:** This means that the data are likely to provide useful information to address the evaluation questions or explain contextual contexts. If it is relevant (or looks relevant by its title or source) we will then review it for accessibility.

11. **Accessible:** This refers to the document being available to our research team, and also notes if updated data will be available at the ‘right’ time. For example, the researcher will note if the study is to be repeated, and the date of those data being available.

12. **Credible:** This refers to “face” credibility. On the surface of it, is the report believable? Are the data reasonable? Do the results connect to how people understand the world?\(^8\)

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The table below provides the summary table that will be presented to the 3MDG FB and FMO and used by the IEG.

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