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MID-TERM REVIEW OF THE UK MALARIA AND RMNH FRAMEWORKS FOR RESULTS

19 December 2013

Acknowledgements

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The team is grateful to the DFID Internal Management Team and Monitoring and Evaluation Reference Group for comments and advice on earlier drafts of this report for facilitating access to information. The team is also grateful to many DFID staff and other key informants for information supplied.

The responsibility for the analysis presented and for the conclusions drawn is solely that of the consultants.

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Executive Summary

In December 2010, the UK government published two Frameworks for Results setting out its commitment to accelerate progress on addressing the international challenges of malaria and Reproductive Maternal and Newborn Health (RMNH). This report presents the findings of the Mid-Term Review (MTR) of the Frameworks.

Overview of the Frameworks

The Frameworks reflected a shift in UK development policy under the Coalition Government elected in May 2010 to a greater focus on results, seeking to direct DFID and other resources to support interventions that have strong international evidence of their effectiveness.

The Frameworks are innovative as statements of strategy for DFID in combining a thorough process of evidence review and consultation with the setting of outcome targets directly related to DFID's activities:

- The Malaria Framework has the goal of contributing to at least halving deaths in at least ten high-burden countries by 2015 and to sustain and expand gains into the future, through: (1) improving the quality of services to address malaria; (2) increasing access and building demand for these services; (3) supporting innovation and the supply of global public goods; and (4) focusing on impact and results. It is the first complete statement of a UK policy toward malaria, and is closely aligned with the Global Malaria Action Plan (GMAP) agreed in 2008 and most recently revised in 2011, which provides a comprehensive international framework for malaria control.
- The RMNH Framework aims to save the lives of at least 50,000 women during pregnancy and childbirth and 250,000 newborns by 2015, through (1) empowering women and girls to make reproductive choices; (2) removing barriers that prevent access to services, particularly for the poorest and most at risk; (3) expanding the supply of quality services; and (4) enhancing accountability for results at all levels. It builds on DFID's earlier strategies to address maternal deaths and promote sexual and reproductive health (SRH).

The development and implementation of the Frameworks has taken place in parallel with other measures to strengthen the focus on results for UK aid and to ensure the achievement of value for money (VfM) and accountability in the use of public funds. These measures included the Bilateral and Multilateral Aid Reviews (BAR and MAR) that took place during 2010, the introduction of the requirement for business cases for all DFID spending, the establishment of the Independent Commission for Aid Impact (ICAI), and the establishment of DFID's Departmental Results Framework (DRF).

The Mid-Term Review

This MTR takes stock of progress in the implementation of the Frameworks to assess if DFID is on track to achieve the results intended, and to provide advice on any actions required. Specifically, the MTR has addressed the following headline questions for each Framework:

- Has the Framework provided an effective strategic instrument to achieve UK government objectives?
- Have adequate resources been used and appropriately applied to achieve these objectives?
- Has the Framework and DFID's programmes under it been effectively managed in order to achieve UK government objectives?

- Are activities and outputs under the Framework on track to meet its objectives?
- Are outcomes on track to meet the objectives of the Framework?
- To what extent is it possible to measure the impact of the Framework and of DFID's activities, and how can the measurement of impact be improved?

The audience for this MTR encompasses DFID and other UK government departments and a wider range of stakeholders including DFID's multilateral and bilateral donor partners and partner governments and civil society in the countries in which DFID is providing assistance under the Frameworks.

The approach of the MTR involved four main analytical steps, based on an overarching conceptual model and outline Theories of Change developed for each Framework:

- Setting out the global context for each Framework in terms of trends in international actions, in resources and in key health indicators;
- A compilation and analysis of information on what DFID has done over the Framework period, in terms of spending and evidence on results achieved, in relation to multilateral and bilateral programmes and other DFID activities (such as support to research);
- A more detailed focus on selected bilateral programmes (including country case studies of Ethiopia, India and Nigeria) and the multilateral programme, including case studies of engagement with specific multilateral organisations. These studies sought to review evidence where available along the whole results chain and to examine what DFID has done, and the influence of the Frameworks on what DFID has done, within an understanding of the global and national contexts; and
- Reviewing evidence on the process by which the Frameworks were formulated and developed.

Data collection involved document reviews, key informant interviews (KIIs), quantitative data analysis (of data on global outcomes and aid activities and from DFID monitoring and reporting systems), and an online survey of DFID country programmes.

Headline MTR findings for the Malaria Framework

The global context for malaria

The past decade has seen an increased global commitment to malaria control and transmission reduction, with an emphasis on engaging both the public and private sectors to increase access to malaria services. Global goals were most recently revised in the GMAP in 2011, and there have been international initiatives since 2010 to develop global plans to address artemisinin and insecticide resistance. The main routes for aid funding for malaria services have been through the Global Fund and the President's Malaria Initiative (PMI). Aggregate donor support has fallen from a peak in 2010. There have however been increases in global research funding for malaria.

Has the Malaria Framework provided an effective strategic instrument to achieve UK government objectives?

The Malaria Framework has provided important strategic guidance to help achieve government objectives and has contributed to increasing DFID's profile and international influence by providing DFID's first comprehensive policy statement on malaria. The evidence base presented in the Framework is sound and the strategy closely aligned with the global agenda. However, the BAR

and MAR were considered by DFID key informants to be more significant factors influencing programme decisions than was the Framework itself. The Framework identifies a range of possible interventions but given DFID's decentralised planning and resource allocation process based on country context, DFID's comparative advantage and an analysis of partner activities, it did not provide guidance on the relative allocation of resources across pillars or types of activity. Consideration should be given as to the benefits of providing more guidance on resource allocation at the sub-programme level in future resource allocation rounds.

Have adequate resources been used and appropriately applied to achieve the Malaria Framework objectives?

DFID's malaria spend is expected to reach £500 million per year by 2014/15, in line with the commitment made to spend up to this level. This will be achieved through increased commitments to the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) as well as increases in DFID's bilateral programmes. The bilateral programme has accounted for 83% of total spending, of which 64% was direct support to countries. Out of this 64%, 39% was direct country-specific malaria spend, while the remainder represented an attribution from health systems strengthening (HSS) and RMNH spend.

Generally, the allocation of funding between countries under the bilateral programme is judged to be broadly appropriate as is the allocation across multilaterals. However, there are no explicit criteria to determine the appropriate allocation between bilateral and core multilateral channels. It is not possible to assess whether outcome and impact targets will be achieved based on this level of spending.

Have the Malaria Framework and DFID's programmes under it been effectively managed in order to achieve UK government objectives?

The management and implementation of the Framework lacked appropriate DFID-wide organisational processes and mechanisms for delivery and monitoring of the Framework. Top level results are tracked in the DRF. The development of a Malaria Results Tracker to collate a wider set of output and outcome statistics has also been valuable, although at present it has some limitations, particularly in linking project codes and hence financial spend with outputs and outcomes. Other than at these levels, there was no consistent use of malaria indicators in Operational Plans (OPs). Indicators were reported against in project documentation but there was no systematic way to collate this information for monitoring or evaluation purposes.

Systems for risk management are being strengthened. Actions have been taken by DFID to increase focus on VfM and cost-effectiveness in programmes, although conceptual and data quality issues remain in the use of indicators.

Are activities and outputs under the Malaria Framework on track to meet its objectives?

Activities under the Malaria Framework are resulting in substantial, measurable progress in the delivery of relevant outputs, both directly through DFID's bilateral programmes and through DFID's multilateral contributions and influencing. These include the delivery of commodities to high-burden countries, enhancing the availability of low-cost quality-assured treatment and diagnostics, and wider health system strengthening. Between 2009/10 and 2012/13 DFID distributed over 33 million bednets, protected over 10.9 million people with indoor residual spraying (IRS), provided malaria prevention support to over 11.6 million pregnant women, and procured over 19.4 million

artemisinin-based combination therapies (ACTs) and 14.4 million rapid diagnostic tests (RDTs). Support for product development, market dynamics and tracking artemisinin resistance is critical to the sustainability of the interventions. There are no specific output targets defined in the Framework against which to measure progress, however guidance on suggested output indicators was provided to country health advisers separately. DFID has also made substantial investments in research to support new tools, in particular through product development partnerships, which the evidence suggests represent good VfM.

Are outcomes on track to meet the objectives of the Malaria Framework?

Trends in outcome indicators for malaria show substantial progress but it is too early to be certain that the Framework objectives will be met. There have been substantial increases in the coverage of bednets, but so far only six of the seventeen high-burden countries in which DFID has programmes have more than 90% coverage. Although the provision of treatment (in the form of ACTs) to children with fever has significantly increased, the proportion reached remains very variable between countries (only 11% in Nigeria for instance). Strengthened health systems, together with increased government efforts and commitment of resources, will be required to sustain the gains and accelerate progress in the high-burden countries, along with the continuation of DFID's multilateral and bilateral malaria and health systems support.

To what extent is it possible to measure the impact of the Malaria Framework and of DFID's activities, and how can the measurement of impact be improved?

Modelled estimates of overall trends in high-burden countries undertaken for the MTR using WHO methodology suggest that five countries were by 2011 close to achieving a 50% reduction in malaria burden since 2005 and another four are on track to achieve this reduction by 2015. In addition, all-cause under-five mortality has dropped more than 30% in seven of the high-burden countries over a similar period. However further empirical validation of assumptions about model parameters is required to enable measurement of the impact of DFID activities.

Headline MTR findings for the RMNH Framework

The global context for RMNH

Since 2008, there have been a series of international initiatives focused on addressing concerns that Millennium Development Goals (MDGs) 4 and 5 are off track. These include the Global Consensus on Maternal, Newborn and Child Health (MNCH) agreed in 2009, the UN Secretary General's 'Every Woman, Every Child' Global Strategy and the G8 Muskoka Declaration, both of which were launched during 2010, and the Family Planning (FP) Summit in 2012. DFID has been an influential participant in these processes, and the RMNH Framework and funding commitments have signalled the priority the UK has placed on these objectives, as well as DFID's special focus on the high-impact but relatively neglected areas of reproductive and neonatal health.

These initiatives have been accompanied by significant additional international funding commitments including to meet the US$ 30 billion financing needed to achieve MDGs 4 and 5. Aid for Reproductive, Maternal, Neonatal and Child Health (RMNCH), having peaked in 2010, decreased slightly in 2011, although the share of funding for reproductive health and FP increased. RMNCH government expenditures in low- and middle-income countries continue to grow on average but with large disparities between countries.

Has the RMNH Framework provided an effective strategic instrument to achieve UK government objectives?

The RMNH Framework has provided an effective strategic instrument to articulate and communicate DFID's priorities and approach. As with malaria, the BAR and MAR had more direct influence on programme decisions than the Framework. The RMNH Framework contributed to ensuring coherence with HIV/AIDS and gender strategies, although the review processes for these strategies have not so far been linked.

Have adequate resources been used and appropriately applied to achieve the RMNH Framework objectives?

DFID met its financial commitments under the Muskoka agreement on Maternal and Child Health, to which spending on the RMNH Framework contributes, spending a total of £2.7 billion on maternal and child health from 2010-13. The Framework objectives have not been fully specified or costed and so it is not possible to judge whether this level of spending is sufficient to achieve the objectives. Around two-thirds of spending has been through the bilateral programme and a third through the multilateral programme. This is judged to be broadly appropriate given the evidence from the MAR on the strong performance of the multilateral agencies supported. There has been some change in the pattern of spending toward new priorities, including FP.

Have the RMNH Framework and DFID's programmes under it been effectively managed to achieve UK government objectives?

The Framework had no implementation plan and had the role of communicating priorities rather than directing activities. In that it has been broadly effective. There are however significant weaknesses in the monitoring systems at the country level and for multilateral programmes, which make the assessment of progress difficult.

The Framework has avoided potential risks related to its results-focused orientation such as an excessive focus on short-term activities, largely because of DFID's continuing commitment to partnership working and support to health systems, as well as its decentralised structure and the weak incentives within the organisation linked to the targets. As with malaria, although actions have been taken by DFID to increase focus on VfM and cost-effectiveness in programmes, conceptual and data quality issues remain in the use of VfM indicators.

Are activities and outputs under the RMNH Framework on track to meet its objectives?

DFID activities under the RMNH Framework appeared to be generally relevant, effective and efficient. However, except for outputs that are related to headline targets reported in the DRF, the information available from DFID's monitoring systems does not permit an aggregation of the outputs from DFID's activities. Hence it is not possible for the MTR to make a complete assessment of whether DFID is on course to meet the objectives of the Framework. The country case studies and key informant interviews found that DFID targets poor and disadvantaged states and groups, but there is no disaggregated analysis of activities to support a judgement about whether priority groups (young people, the poorest, those affected by conflict and natural disaster areas) are in fact reached.

Are outcomes on track to meet the objectives of the RMNH Framework?

DFID is on track to meet its target of supporting at least 2 million safe deliveries, with a cumulative total of 1.63 million reported by 2012/13. It is not clear whether that is the case for the target of enabling 10 million more women to use modern FP methods, with 48% achievement by 2012/13.

To what extent is it possible to measure the impact of the RMNH Framework and of DFID's activities, and how can the measurement of impact be improved?

Reports by DFID on maternal and neonatal lives saved based on aggregation of estimates from specific programmes suggest that DFID is off track to achieve its target of saving 50,000 maternal and 250,000 neonatal lives by 2015. However, the information is incomplete and potentially misleading as it risks both under- and over-estimation. Modelling approaches suggest DFID may be on track to achieve both targets but the validity of these estimates depends on the quality and completeness of data and assumptions made about key parameters. Final results are not yet available as the model is being refined.

Conclusions of the MTR: Lessons learned

The overall conclusions from the MTR draw on and develop the findings from the review of each Framework that are summarised above, identifying both general lessons and specific lessons for each Framework.

Lessons on policy and strategy

The Frameworks have served an important and generally effective role in signalling both internally and externally DFID's policy and results focus and commitments on RMNH and malaria. The Frameworks also provided explicit targets for results which have been incorporated in DFID's corporate DRF for 2015. These are well aligned with global targets.

The evidence review that was part of the Framework preparation process had an additional independent value in providing an authoritative assessment of the evidence on effective interventions. The MTR found both to be of high quality, although there is now a need to update them to take on new evidence.

The Frameworks are generally consistent with other DFID policies, and for RMNH built on a number of previous policies. There is also strong coherence between the RMNH Framework and other strategic DFID documents, such as the Strategic Vision for Girls and Women (SVGW) and the HIV Position Paper. In the longer term, linkages across DFID's health programmes as a whole, and cross-sectoral linkages (for instance with gender strategies), may be better served by developing policies and reporting results for malaria and RMNH within a broader sectoral Framework, such as that provided by the recent Health Policy Position Paper.

The Framework documents identified an appropriate set of evidence-based interventions for working towards the targets. However, the relationship between spend and final outcome targets was not based on any clearly defined costing. They also did not provide guidance on how resources should be allocated across the pillars or across different channels, and the intended focus on selected countries has not been followed through systematically.

The Frameworks (both the documents and the process by which they were developed) have strengthened DFID's role and influence in international forums and contributed to sustaining or

reinforcing international attention on reproductive, maternal and newborn health and on malaria control.

The Frameworks have substantially influenced aspects of the bilateral programme in some countries, contributing to the redesign of some programmes and the design of business cases for new ones. However, the main process that shaped DFID's bilateral programmes was the BAR rather than the Frameworks as such.

Despite the commitment to measureable results, there has been insufficient development of monitoring and information systems to provide adequate management information and accountability and to enable lesson learning.

While the specification of a target of 'lives saved' had a clear political rationale, there are risks related to such a target-driven approach, including the challenges it raises for measurement since it depends on modelling of impact. It may draw attention away from intermediate issues that have more direct significance for ensuring effective management, such as tracking programme outputs and assessing on a routine basis their relevance, efficiency, effectiveness and equity.

The overall lesson on the Frameworks as strategy documents is that they provided a clear articulation of ambitious overall priorities and a sound evidence base. However, they appeared to assume that practical mechanisms for implementing and monitoring them would be developed that pose challenges given DFID's decentralised structure.

Lessons on implementing the Frameworks

Programming and expenditure allocation

DFID's bilateral and multilateral programmes have been driven by bottom-up business plans that bid for resources. While the BAR and MAR provided a basis for decision-making within the bilateral and multilateral programmes in relation to the Frameworks, there is no objective basis for judging whether the allocation between bilateral and multilateral programmes is appropriate in the absence of any explicit guidance or criteria in the Frameworks. The split seems broadly appropriate, but a more explicit analysis of this issue in the Framework documents would have been warranted, and should be provided in the future.

In general, there is a reasonably strong relationship between measures of need and the levels of bilateral spend by country. However, for both RMNH and malaria some large population, high-burden countries are relatively 'underfunded'. In principle, there is scope to increase impact by increasing the resources allocated to these countries. That said, some are countries in which political instability and conflict are major barriers to success, such as the Democratic Republic of Congo (DRC), and increased spend would need to be conditional on mechanisms for ensuring effectiveness.

For malaria, it is important to consider the likely effectiveness of interventions that will determine whether the planned impact is achievable in deciding geographical priorities. This requires a mapping of the epidemiological characteristics of the country and of the capacity of the wider health system. Given the potential for malaria's resurgence if resources are sharply reduced in malaria endemic countries, careful consideration must be given if resources are sharply reduced in countries in which DFID currently has a large commitment but which have already achieved substantial reductions in disease burden.

The assessment of the balance of effort across different pillars and intervention areas has been limited by a lack of information. Comprehensive information on programme and activity relevance, effectiveness, efficiency and equity was not available. However:

- For malaria, there has been most progress in extending the coverage of bednets, although gaps between distribution and use are significant in some countries. Progress in IRS in countries where DFID provides support has been limited. There was appreciable progress in increasing the coverage of appropriate treatment, but overall levels of access remain low. Wider strengthening of health systems and health services will remain essential, as well as country-specific operational research to identify specific gaps.

- For RMNH, self-reported effectiveness is highest for activities on improving supply and access. Further work on developing clear metrics for empowerment and accountability is needed. Global trends, though encouraging in some areas, highlight the need for continued support to all three areas of reproductive, maternal and newborn care. Uptake is low in many of the DFID focus countries, and all three should continue to receive high priority. The strengthening of services for adolescent girls was identified as an area for improvement in the case study countries.

Supporting preventive services and strengthening primary-level care is generally pro-poor. Equity issues have been further addressed by targeting resources at areas that are poorer and substantially disadvantaged on a number of key health indicators, for example towards poorer states in Nigeria. There is however often limited recent disaggregated information by target group for many of the key indicators in both RMNH and malaria. Continued attention to strategies to reach the marginalised will be key to meeting global and DFID targets.

In terms of influencing global policy and programming:

- For malaria, DFID has become an influential global actor over the period of the Framework having previously played a more limited international role.
- For RMNH, DFID performed an important and effective international influencing role over the period since the Framework, building on earlier initiatives. Its work with both multilateral agencies and on specific events led to significant resource increases in priority health areas such as FP as well as to improvements in VfM in the operations of some international partners. DFID is perceived as being able to address some important (and sensitive) issues that other donors do not.

There has been substantial investment by DFID in global public goods:

- For malaria, investments have been made by DFID in supporting innovative models to enhance the availability of low-cost quality-assured treatment and diagnostics, some elements of which have been declared by independent evaluations to be effective.
- For RMNH, DFID invested substantially in market-shaping activities in relation to improving access to safe, effective and affordable health commodities, particularly for reproductive health. While it was too early to evaluate the effectiveness of these activities, large price savings, better quality products and greater supply security are anticipated.

DFID's total spend on health research between 2010/11 and 2012/13 was £212.6 million. While it is too early as yet to evaluate the effectiveness of these investments as a whole, some earlier investments are already yielding significant results, for instance through the Medicines for Malaria Venture.

Systems and practices

The MTR has identified significant weaknesses in DFID's monitoring systems that work against both lesson learning and the effective communication of the achievements of DFID's programmes under the Frameworks. There is a lack of a strategic perspective across the various projects and programmes, particularly in terms of linking performance in high-burden countries of critical importance to the achievement of Framework objectives.

Apart from the DRF, DFID does not have adequate mechanisms in place - especially for RMNH and to a lesser extent for malaria - to track the activities and performance of projects that are contributing to top-level results. As a result it has been difficult to aggregate information on outputs and to assess to what extent DFID is on track to achieve targets. There are also significant challenges in achieving adequate reporting against disaggregated targets, including for the prioritised groups, which were a central part of the strategies. Logframes are currently not integrated into the project management system.

The project coding system does not allow an accurate assessment to be made of how much DFID is investing in different programme areas. While DFID's investments in influencing activities with multilateral organisations appear to have been successful, they are not currently explicitly measured or reported.

There is also a lack of available recent project or programme evaluation material, although a programme of relevant evaluations is planned.

While there is a strong focus on improving systems for measuring VfM at the corporate level, this has not yet been effectively translated to the project level to ensure that explicit VfM indicators are included in project logframes. Reporting on progress against budget targets in project logframes would contribute to improving the monitoring of VfM.

The RMNH Framework has encouraged greater dialogue between health and social development staff in particular, recognising the important role of social factors in determining health outcomes. How much this happens in practice, however, depends to some extent on individual relationships rather than being a systematic process.

MTR recommendations

The following recommendations are proposed to address lessons that have been identified for each area in the MTR.

Recommendations on policy and strategy

Recommendation 1: Undertake strategic reviews of the prospects of achieving Framework objectives in selected high-burden countries

Issue to address: Prospects for achieving the global targets set for both Frameworks depend critically on outcomes in a small number of high-burden countries in which DFID is active through its bilateral programmes. At the moment, DFID does not have a completely integrated strategic view across the projects relevant to each Framework in these countries, although for malaria there is an annually updated programme spreadsheet which could be expanded to provide a strategic view of activities and results at the sub-pillar level.

Action required: A practical process for undertaking Framework strategic reviews in selected countries needs to be agreed. They should take place during the first half of 2014 in order to identify both short-term measures that could be implemented by the end of 2015 and longer-term issues for future engagement beyond the current Frameworks. Central and regional policy resources should be made available to support country teams.

Recommendation 2: Strengthen linkages between RMNH programmes and other non-health interventions

Issue to address: The MTR found that linkages between non-health focused interventions aimed at empowering women and girls, strengthening accountabliity and the achievement of objectives relating to reproductive choices are currently weak.

Action required: In the short term, a core set of indicators and ways of measuring and tracking them should be agreed for monitoring pillars 1 and 4 of the RMNH Framework, so as to take account of linkages with the empowerment of women and girls. In the medium term, the development of the successors to the Frameworks should address empowerment issues through reference to DFID's other relevant policies. For the longer term, research should be supported on understanding and modelling how interventions such as girls' education contribute to better RMNH.

Recommendation 3: Strengthen operational research for malaria

Issue to address: DFID has played an important role in promoting operational research to reduce the gap between the efficacy and effectiveness of malaria interventions. However, gaps in the availability, coverage and utilisation of the key vector and treatment strategies remain a major barrier to achieving the goals set out in the Framework and in the wider global agenda.

Action required: DFID should invest further in operational research to understand better the barriers to achieving high coverage of malaria interventions in the high-burden countries in which they are focused. National malaria control programmes (NMCPs) should be involved in the identification and implementation of these studies.

Recommendation 4: Update the review of evidence for RMNH

Issue to address: There is scope for conducting further evidence reviews and research to cover new or challenging areas. Least progress has been made in relation to improving accountability for RMNH results and this is an area where DFID country health teams require further guidance.

Action required: An evidence review and further research should be conducted on the role and potential of strengthening accountability as a means to improve RMNH, to obtain a better understanding of what types of intervention work and how to measure progress. Additional areas include: (i) interventions for scaling up more effective neonatal care/saving of lives; (ii) improving access to SRH services (especially family planning) for hard-to-reach groups; and (iii) addressing quality of care gaps in RMNH.

Recommendations on programming

Recommendation 5: Assess and strengthen relevant national data systems

Issue to address: The MTR highlighted problems with a lack of data and inconsistency between different sources at the country level. This hampers the assessment of national trends and of DFID's support.

Action required: DFID should enhance its support to data-strengthening activities at the country level, including routine data collection and use, surveillance activities and periodic surveys. This should begin with data-quality assessments, which could help to improve the value of data and the understanding of trends for both recipient governments and DFID. Reviews should identify where further support is required. Strengthening routine information systems will take time, so DFID county offices should have an active engagement with the next rounds of Demographic and Health Surveys (DHS) and Malaria Indicator Surveys, as well as US-PMI supported malaria impact assessments.

Recommendation 6: Strengthen support to country programmes

Issue to address: It is sometimes difficult for country programmes to identify and exploit opportunities for making progress under the Frameworks outside the scope of existing projects and the particular skills of staff in post. While support is provided through existing central and regional teams, there is a case for expanding this.

Action required: Central or regional teams should provide enhanced support to offices in high-burden countries, including around the proposed strategic review process. Some financial as well as technical advisory resources should be earmarked at regional level to help country teams take advantage of opportunities or identify and address constraints, such as specific bottlenecks which prevent programme effectiveness.

Recommendation 7: Build on success and innovation in RMNH programmes

Issue to address: DFID has demonstrated a strong comparative advantage in addressing 'difficult' topics in SRH which tend to be neglected by other donors. These include unsafe abortion, gender-based violence, early marriage and teenage sexuality.

Action required: Innovative programmes should be reviewed for evidence of effectiveness and then extended, based on the lessons learned. Progress in saving neonatal lives and addressing high stillbirth rates is lagging and deserves additional attention. Family planning, improving quality of care and access to care for marginalised groups should remain core concerns.

Recommendation 8: Regular review of the epidemiological situation of malaria and support provided by country

Issue to address: The MTR has noted the debate around how malaria spending should be allocated across countries. Appropriate allocation requires consideration of the likely effectiveness of interventions, based on a mapping of epidemiological characteristics and the capacity of the health system. The potential for malaria resurgence in countries where resources are reduced must also be considered.

Action required: We recommend that in 2014 additional mapping of intervention needs and potential impact is undertaken in a subset of the high-burden countries, following the approach that DFID has recently completed in Tanzania. This should form the basis for assessing the current focus of domestic, bilateral and multilateral investments in multiple countries. This would allow both the benefits and risks of any changes to be considered, including the potential for malaria resurgence.

Recommendations on systems and practices

Recommendation 9: Undertake an annual internal review of the Frameworks

Issue to address: Exclusive dependence on a process of periodic external review is not sufficient as a means to assess progress and identify challenges, opportunities and lessons. It needs to be supplemented by strengthened regular monitoring and internal reflection on progress and on the lessons emerging.

Action required: DFID should establish a formal (though light) process of annual review of performance against Framework targets. This should be undertaken globally and in selected high-burden countries.

Recommendation 10: Strengthen the Malaria Results Tracker

Issue to address: The existence of the Malaria Results Tracker has made it possible to provide an aggregated report on outputs produced. However, further strengthening of this system is required for it to provide robust data for results analysis and reporting.

Actions required: The limitations of the Malaria Results Tracker should be addressed (in the short term, over the remaining period of the Framework) through clearer processes for data specification, checking and control. The elements of the tracker that monitor DFID progress should be incorporated in the DRF system.

Recommendation 11: Establish a RMNH Results Tracker

Issue to address: There is currently no aggregated report on outputs for RMNH. The weakness of available information on outputs prevented the MTR making a full and evidenced assessment of how far DFID was on track to achieve the targets of the RMNH Framework.

Actions required: The feasibility and value of implementing a RMNH Results Tracker should be investigated, building on the existing datasheets populated for the Lives Saved Tool (LiST). This should encompass results achieved through both DFID's multilateral and bilateral programmes.

Recommendation 12: Incorporate logframes into DFID's project management system

Issue to be addressed: Logframes are the building blocks of DFID's result reporting system but are currently held in separate spreadsheets and are not integrated into the project management system.

Action required: DFID should incorporate logframes into its project management system and develop a set of 'standard indicators' in addition to the indicators in the DRF. These could include some malaria and RMNH indicators from the Frameworks. They should not be mandatory, but country offices should be able either to select from a list of standard indicators or, where appropriate and justified, to include their own.

Recommendation 13: Strengthen the analysis and monitoring of VfM

Issue to address: The focus on improving systems for measuring VfM at the corporate level needs to be better translated to the project level so that there are more explicit VfM indicators included in project logframes.

Actions required: VfM indicators should, where appropriate, be included in project logframes, and the approach by which VfM will be assessed at each project milestone should be explicitly outlined in business cases. A guidance note on VfM in RMNH and malaria should be developed. DFID should continue to improve the rigour with which VfM is assessed and managed.

Recommendation 14: Improve reporting on influencing and multilateral engagement

Issue to address: DFID has increased its human resources focused on influencing multilaterals and other partners. The potential benefits are significant but currently they are not explicitly measured and reported.

Actions required: Key departments in the international and policy divisions should consider investing more in collating information on the achievements of influencing as it takes place.

Recommendation 15: Revise the coding and expenditure classification

Issue to address: The MTR encountered significant difficulties in using the current project coding system when seeking to put together a more accurate picture of how much DFID is investing in different programme areas, particularly against the Framework pillars.

Action required: DFID should revise its coding structures to improve ways of identifying malaria and RMNH expenditures and outputs, and also review the accuracy of its coding.

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List of figures, tables and boxes

Abbreviations

ACT	Artemisinin-based Combination Therapy
AMFm	Affordable Medicines Facility – Malaria
ANC	Ante-Natal Care
ART	Antiretroviral Therapy
BAR	Bilateral Aid Review
BBSRC	Biotechnology and Biological Sciences Research Council
BCC	Behaviour Change Communication
BMGF	Bill & Melinda Gates Foundation
CDC	Centers for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CSO	Civil Society Organisation
DAC	Development Assistance Committee
DALY	Disability-Adjusted Life Year
DFID	Department for International Development (UK)
DH	Department of Health (UK)
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
DRF	Departmental Results Framework
EmOC	Emergency Obstetric Care
EQ	Evaluation Questions
FIND	Foundation for Innovative New Diagnostics
FP	Family Planning
GMAP	Global Malaria Action Plan
GMP	Global Malaria Programme
GPRHCS	Global Programme on Reproductive Health Commodity Security
HRH	Human Resources for Health
HRITF	Health Results Innovation Trust Fund
HSS	Health Systems Strengthening
ICAI	Independent Commission on Aid Impact
IPPF	International Planned Parenthood Federation
IPTi	Intermittent Preventive Treatment of Malaria for Infants
IPTp	Intermittent Preventive Treatment of Malaria for Pregnant Women
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Bednet
IVCC	Integrated Vector Control Consortium
JHU	Johns Hopkins University
KII	Key Informant Interview
LiST	Lives Saved Tool
LLIN	Long-Lasting Insecticide-Treated Nets
M&E	Monitoring and Evaluation
MAR	Multilateral Aid Review

MCH	Maternal and Child Health
MDG	Millennium Development Goal
MERG	Monitoring and Evaluation Reference Group
MMR	Maternal Mortality Ratio
MMV	Medicines for Malaria Venture
MNCH	Maternal, Newborn and Child Health
MPAC	Malaria Policy Advisory Committee
MRC	Medical Research Council
MSI	Marie Stopes International
MTR	Mid-Term Review
NAO	National Audit Office
NGO	Non-Government Organisation
NMCP	National Malaria Control Programme
NORAD	Norwegian Agency for Development Cooperation
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
OP	Operational Plan
PDP	Product Development Partnerships
PMNCH	Partnership for Maternal, Newborn and Child Health
PMTCT	Prevention of Mother to Child Transmission
PMI	President's Malaria Initiative
PSI	Population Services International
QuRHM	Quality of Reproductive Health Medicines
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
RED	Research and Evidence Department (DFID)
RMNCH	Reproductive, Maternal, Neonatal and Child Health
RMNH	Reproductive, Maternal and Newborn Health
SMC	Seasonal Malaria Chemoprevention
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
SuNMap	Support to National Malaria Project
SVGW	Strategic Vision for Girls and Women
ToR	Terms of Reference
TRAC	Tracking Resistance to Artemisinin Collaboration
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
UNSG	United Nations Secretary General
USAID	US Agency for International Development
VfM	Value for Money
WHO	World Health Organisation
WMR	World Malaria Report

1 Introduction

1 In December 2010, the UK government published two Frameworks for Results setting out its political commitment and ambition to accelerate progress on addressing the international challenges of malaria (DFID 2010a) and Reproductive, Maternal and Newborn Health (RMNH) (DFID 2010b). The Frameworks reflected a shift in UK development policy under the Coalition Government elected in May 2010 toward a greater focus on results, as well as consolidating earlier initiatives and commitments. The Frameworks set out strategic priorities and specific quantitative targets to be achieved by 2015, as well as detailing proposed actions to achieve these objectives.

2 The e-Pact consortium was commissioned by DFID to undertake an evaluation of the Frameworks. The evaluation involves three phases:

- An Inception Phase during which an Evaluability Assessment and an Approach Paper for the MTR were prepared;
- The present MTR; and
- A Final Evaluation, due in 2016.

3 This report presents the findings of the MTR. The Terms of Reference (ToR) for the assignment (Annex A) state that the MTR will:

> *Take stock of progress in implementation of the Frameworks and set out recommendations for changes that need to be made in order to achieve DFID's results. It will provide advice on how DFID can better monitor progress in priority countries against the Framework indicators, including on cost and impacts, in order to inform decision making.*

4 This MTR report addresses the ToR (the specific MTR questions are set out in Chapter 3), and also provides recommendations for the Final Evaluation. The audience for the MTR encompasses both DFID and other UK government staff and a wider range of stakeholders. These include DFID's multilateral and bilateral donor partners, as well as partner governments and civil society in the countries in which DFID is providing development assistance under the Frameworks. The process of conducting the MTR provided opportunities for obtaining the views of a wide range of stakeholders, through interviews with DFID and other international agency staff and key informants, and in the countries (Ethiopia, India and Nigeria) for which case study visits were made. A list of interviewees is provided in Annex B. All information was collected on the understanding that while such a list would be provided, confidentiality of information and views provided would be assured by not presenting any of this information in a way that enables it to be attributed to particular individuals. The MTR team was able to work freely and without interference in undertaking the MTR.

5 This report is organised as follows. Chapter 2 provides a summary and overview of the two Frameworks, as well as an assessment of the process by which they were prepared. Chapter 3 explains the approach and methods used for the MTR. It also discusses the limitations of the evidence available and the implications of these limitations for interpreting the MTR findings. Chapter 4 presents the findings of the MTR of the Malaria Framework and Chapter 5 the findings of the MTR of the RMNH Framework. Chapter 6 discusses the overall MTR conclusions, while Chapter 7 provides recommendations for action. Annex A contains the evaluation ToR, Annex B gives a list of KIIs, Annex C provides the list of references, Annex D presents an outline of the Theories of Change for the Frameworks, and Annex E gives a summary analysis of risks associated with the use of targets.

6 Background and supporting material has been produced as a series of Working Papers. Working Papers I and II analyse the main features of the global context over the period since 2010 for RMNH and malaria respectively. Working Paper III presents the DFID multilateral engagement and influencing analysis. Working Paper IV provides the analysis of DFID expenditures and activities. Working Paper V contains the results of the Survey of DFID Country Programmes. Working Paper VI presents an analysis of Value for Money (VfM) measurement and reporting and Working Paper VII the cost-effectiveness analysis. The country case studies are contained in Working Paper VIII, and a review of results reporting in Working Paper IX.

2 The Purpose and Content of the Frameworks

7 This chapter sets out the purpose of the Frameworks in relation to UK government objectives, describes how the Frameworks were developed and summarises the substantive content of each Framework.

2.1 Purpose of the Frameworks

8 The initiative to establish the two Frameworks reflected two priorities for the Coalition Government elected in 2010.[1] These priorities were strongly articulated by the Secretary of State for International Development and his ministerial team from their first day in office.

9 First, the Frameworks articulated and sought to communicate targets and strategies for UK development assistance (and wider international action) to achieve priority goals related to maternal and newborn health and reducing the impact of malaria. The general areas of focus for development assistance for health were set out in the Coalition Agreement (HM Government 2010) (p. 17):

> *We will support actions to achieve the Millennium Development Goals. In particular we will prioritise aid spending on programmes to ensure that everyone has access to clean water, sanitation, healthcare and education; to reduce maternal and infant mortality; and to restrict the spread of major diseases like HIV/AIDS, TB and malaria. We will recognise the vital role of women in development, promote, gender equality and focus on the rights of women, children and disabled people to access services.*
>
> *We will push hard in 2010 to make greater progress in tackling maternal and infant mortality.*

10 The Malaria Framework was the first complete statement of a UK government policy toward malaria, closely aligned with the Global Malaria Action Plan (GMAP), focusing on reducing deaths in high-burden countries.[2] The Malaria Framework had a particular purpose of marking DFID's increased policy and financial commitment to addressing malaria at a time when global funding was stagnating.

11 There are significant common features between the RMNH Framework and the DFID strategy for reducing maternal deaths and the position paper on Sexual and Reproductive Health (SRH) and Rights, both of which had been published in 2004. Each emphasised increasing access to evidence-based interventions, multi-sectoral approaches and national ownership. The RMNH Framework provided more detail on specific strategies and quantified indicators, and had an emphasis on cost-effectiveness and results that was absent in the 2004 strategies. The RMNH Framework also placed relatively more emphasis on empowerment and accountability compared to the earlier strategies.

12 Second, the Frameworks were part of a broader process of strengthening the focus on results in UK development assistance (and UK government spending more broadly), in order to

[1] These were based on policy proposals and approaches developed in Opposition by the Conservative Party International Development Team (Conservative Party 2009).

[2] This reflected a particularly strong emphasis on malaria in the Conservative Party's manifesto for the 2010 election, which included a commitment to spend at least £500 million per year on tackling malaria. However, there has been a high degree of political consensus across the major UK parties on the priority to be accorded to RMNH and fighting malaria. The 2010 Labour Party Manifesto similarly included a commitment to 'deliver at least 30 million additional anti-malarial bednets over the next three years.'

achieve VfM and to strengthen accountability in the use of public funds for development purposes. This focus reflected a view that in a period of general fiscal austerity, the political viability of the continuing UK government commitment to increasing international development spending depended on demonstrating a clear and credible link between this expenditure and the achievement of tangible development results, particularly in areas that were likely to attract popular political support. The Frameworks were envisaged as contributing to this process by setting out measurable medium-term targets for the results to be achieved, and by providing a summary of the evidence base that could be drawn on in the design of specific interventions.

13 To this end, the Frameworks are intended to provide a clear statement of the linkage between the strategic priorities, outcome targets to be achieved, and areas of action, while providing an assessment of the evidence base underlying the strategy presented.[3] They have a common structure which seeks to provide this:

- An overarching 'Vision and Rationale' with two strategic priorities identified for each Framework.
- 'Results by 2015' defined as specific quantitative targets for the reduction in the number of deaths (from malaria), and for saving the lives of women during pregnancy and childbirth and newborn babies, increasing the access of women to FP and preventing unintended pregnancies, and supporting safe deliveries.
- A 'Framework for Results' defining in each case four pillars of action based on analysis of the key drivers of the relevant health outcomes, evidence on effective interventions, and an assessment of where the UK could add most value.
- A listing of planned actions for 'Achieving Results.'
- 'Core Indicators for Tracking Progress', together with an outline of the monitoring and evaluation (M&E) systems by which progress would be measured.

14 Parallel processes to the development of the Frameworks that were also directed at this objective included the BAR and MAR that took place during 2010, the introduction of the requirement that 'all proposals for DFID funding must be accompanied by a business case which sets out the need, justification and affordability of the intervention – making a sound case for the commitment of public funds' (DFID 2011c) and various initiatives to strengthen the focus on evaluation and results reporting within DFID, including the establishment of the ICAI. It also included the establishment of the DRF, which sought to move beyond an approach based on monitoring and reporting progress against global development outcomes (in particular the MDGs) to strengthen the measurement of DFID's specific contribution.[4] This was done through two features of the DRF (DFID 2013h para. 12):

> *Firstly, by identifying a core subset of results which DFID will seek to influence directly over the next four years* [i.e. to 2015]*, and secondly by identifying a range of key performance indicators that provide closer to real time data on DFID's operational effectiveness and organisational efficiency.*

15 The initiative to develop the Frameworks was innovative in combining a thorough process of evidence review and consultation and the articulation of outcome targets related to DFID's

[3] The two Frameworks appear to be the only DFID strategy documents to precisely follow this structure, although other strategies, such as the DFID Position Paper on HIV in the Developing World (published in May 2011), broadly contain the same elements. The Frameworks are significantly longer and more detailed documents than other strategies. The Malaria Framework is 63 pages long and the RMNH Framework is 55 pages long, compared to the HIV Position Paper which is 22 pages long.

[4] High level indicators for the two Frameworks were included in the DRF.

selected activities. In doing so, the Frameworks sought to communicate with and to influence several distinct stakeholder groups, including addressing the political imperatives for making the case for aid expenditure in a period of fiscal consolidation and setting out the focus for DFID's engagement with partners – although no explicit communication strategies for the Frameworks were developed. These groups included:

- The UK government as a whole – in order to demonstrate that the financial resources provided through the ring-fencing of development assistance were being used to achieve tangible results.
- The wider public – similarly, in order to provide assurance to the public as taxpayers and voters that aid resources were being used effectively, in a context of falling public support for high levels of aid expenditure and scepticism about the effectiveness of the aid provided.[5]
- DFID staff – to communicate corporately the priorities for UK policy and to provide a summary of evidence that could be used to inform the business case for proposed interventions.
- The international community (including other multilateral and bilateral agencies and international non-government organisations (NGOs) and civil society) – to articulate the UK's view of global priorities and the UK's specific role in taking these forward, including a potential leadership role in specific initiatives and in presenting an overarching diagnosis and prescription for action.
- Partner countries – to set out the UK's priorities in light of the process of reviewing DFID's bilateral programmes, and the assessment of the evidence on effective interventions that would inform the design of the DFID programme and the types of intervention that DFID would advocate.

16 The Frameworks were not developed within an articulated overall strategy for DFID's engagement in the health sector, but both Frameworks were strongly rooted in a commitment to HSS as a necessary condition for the sustainable achievement of results. Subsequently, DFID published a Health Position Paper (DFID 2013h) in July 2013. This sets out DFID's overall public health approach[6] to improving health outcomes in developing countries, which is emphasised (p. 2) as combining 'investments that achieve targeted results with investments that strengthen broader health systems.' The key principles guiding DFID support are defined as the following (p. 3):

- 'Evidence-based decision-making: decisions are based on the best available evidence of effectiveness;
- Value for money: the UK is committed to maximise the value achieved with tax payers' money;
- Delivering more effective aid: helping countries deliver high-quality health services accessible to the poorest and most marginalised people, and delivering sustainable results; and

[5] Henson & Lindstrom 2010 reported, based on a public opinion survey in June to August 2010, that 63% of respondents considered that aid to developing countries should be reduced and only 8% that it should be increased. 54% considered that much development aid was wasted. The percentage considering that aid should be reduced had increased to 71% by November 2010 (Lindstrom & Henson 2011), although in the longer term support for aid and concern about global poverty was higher. Earlier surveys (with a not directly comparable methodology) found that support for increased UK government spending on aid had fallen from 55% in September 2007 to 40% in February 2010.

[6] In addition to the Frameworks and the HIV Position Paper, this document also refers to two other documents as setting out the commitments and activities on health that DFID has already articulated: DFID's SVGW and the summary document following the BAR and MAR that set out DFID's overall strategy and results ('UK Aid: Changing Lives, Delivering Results) in March 2011.

- Putting girls and women at the heart of DFID's work and not shying away from addressing sensitive issues such as unsafe abortion.'

17 These principles also reflect the underlying approaches embodied in the Frameworks.

2.2 The process of Framework development

2.2.1 Main steps in developing the Frameworks

18 The two Frameworks were developed in parallel between May and December 2010. The key elements of this process of development were:

- Preparation of an initial ministerial submission for each Framework (in June and July 2010), which included papers on strategic options, a draft business plan for RMNH and a draft logframe for malaria, a summary evidence paper on malaria, and a paper on the cost-effectiveness of RMNH interventions. The initial submissions and the process of discussion around them defined the key elements of each Framework in the form of a draft business plan;
- A process of evidence review that culminated in the publication of two evidence papers in December 2010, intended to accompany the Frameworks;
- A public consultation process, culminating in each case in the production of a Consultation Report; and
- An iterative process of development of the Frameworks from the initial draft business plans, culminating in final publication of both Frameworks in December 2010.

19 The development of the Frameworks took place in parallel with the BAR and MAR, which were the principal instruments for reviewing and reorienting DFID's ongoing programmes. The BAR was launched in May 2010, and during July to September 2010 DFID's bilateral programmes prepared 'results offers' setting out the results that they believed could be realistically achieved in their country/region over the four years from April 2011–March 2015, what this would cost, and what delivering these results would represent in terms of VfM (DFID 2011b). These offers were reviewed and aggregated, and decisions made at ministerial level on the take up of the results offers and indicative budgets in December 2010. At this point Operational Plans (OPs) were commissioned from country and regional teams. The MAR process also began in May 2010 and involved assessments of 43 multilateral agencies against a common framework emphasising measurements of organisational effectiveness and relevance to the UK's development objectives. The results of the MAR were published in March 2011 (DFID 2011f).

2.2.2 Consultation on the Frameworks

20 The public consultation process on the Frameworks involved the following elements:

- A short online survey which received responses from academics, civil society organisations (CSOs), health professionals and the public (attracting 483 responses for malaria and over 2,000 on RMNH). In the case of the RMNH Framework there was also a more detailed Technical Consultation;
- The collection of more detailed views through an online discussion forum and response template;
- The receipt of email submissions and comments; and

- Consultation meetings in the UK and in Kenya (for both Frameworks) and also in India and South Africa on RMNH, involving NGOs, health professionals, academics, international organisations and the private sector.

The findings of the consultation process were published as stand-alone consultation reports (DFID 2010c) (DFID 2010d). For the malaria consultation, the findings were explicitly stated to have been analysed independently of the process of development of the business plan, so as to ensure objectivity. The Consultation Report sets out the findings and how they informed the development of the Malaria Framework.

2.2.3 Evidence review

21 As part of the development of the Malaria Framework, an evidence paper was produced that aimed to synthesise current evidence on malaria, focusing on areas with direct applicability to policy and decision-making (DFID 2010e). This comprised a structured review of the relevant literature, considering:

- **Epidemiology and burden:** this explores geographic distribution in terms of deaths and disease burden, the burden of different species, populations at risk, and emerging issues for control;
- **Interventions and delivery:** evidence for IRS, insecticide-treated bednets (ITNs) and long-lasting insecticide-treated nets (LLINs) and their delivery mechanisms is presented, as well as non-insecticide approaches to larva control;
- **Case management (diagnosis and treatment):** use of Rapid Diagnostic Tests (RDTs) and drugs, including implications of resistance, delivery mechanisms, and need for staff training, are discussed. There is also consideration of the needs of high-risk groups and the potential for a malaria vaccine;
- **Health system approaches:** the key point in this section is that Health Systems Strengthening (HSS) will help to ensure that evidence-based, proven effective interventions reach the people who need them; and
- **Eradication and elimination:** discussion of considerations and feasibility.

22 For the RMNH Framework, an initial source of information on evidence was a study that had been already commissioned (jointly with NORAD) in February 2010 which assessed progress towards MDG 5. Three additional evidence papers were produced, which were published in parallel with the Framework in December 2010. These comprised:

- A structured review of evidence covering **fertility levels and preferences**, unmet needs for **family planning**, **maternal and newborn health**, **distal determinants** of RMNH (for instance associations with poverty, education and employment), **barriers to access** to RMNH services, and the importance of functioning **health systems**;
- A structured review of evidence on **reducing the burden of unintended pregnancies**, focusing on family planning and safe abortion; and
- A study on **private sector engagement**, published as a systematic review of peer-reviewed literature supplemented with case studies, anecdotes and project reviews.

23 Additional RMNH evidence papers had been planned but were not produced. The overview papers on maternal death and unintended pregnancy published in December 2010 were prepared by DFID staff, drawing on externally commissioned studies.

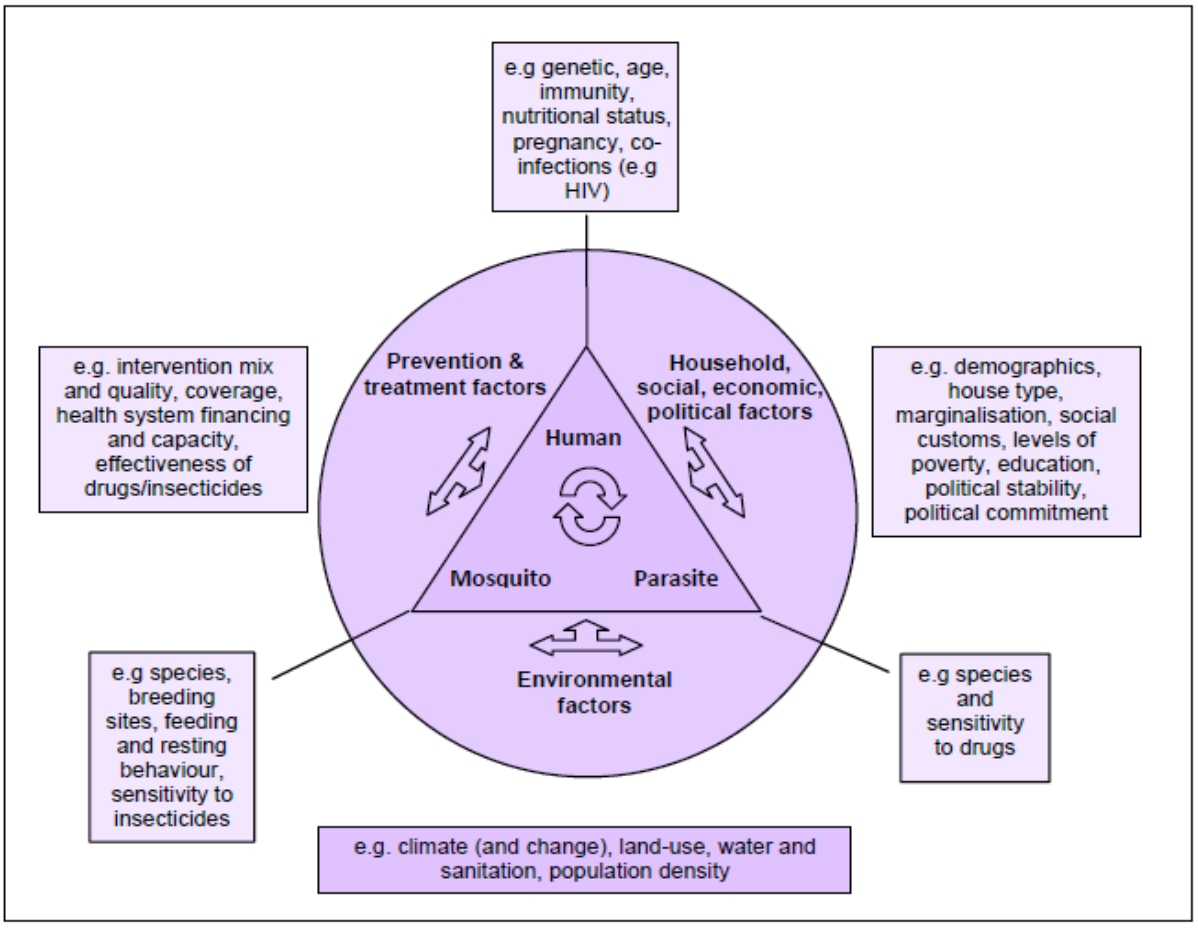
2.3 The Malaria Framework

24 The Malaria Framework document sets out a vision 'that illness and death from malaria are dramatically reduced and controlled over the long term in the countries most affected' (p. 3) and two strategic priorities to realise the vision: (i) to reduce the burden of illness and death; and (ii) to sustain and expand gains into the future. It provides a rationale for this focus based on the global significance of malaria as a cause of mortality and morbidity, its close association with poverty, and the cost-effectiveness of established interventions when appropriately delivered. It notes the increasing global political commitment to address malaria reflected in the GMAP but also states that 'while progress in many countries shows what is achievable, most high burden countries in Africa are lagging behind' (p. 14).

25 The Framework is emphasised as being 'based on an understanding that malaria outcomes are driven by a wide range of interdependent factors, many of which fall outside of the focus of health services' (p. 20), as represented in a simplified form in Figure 1 below. The guiding principles for the UK government's approach are defined as the following (p. 19):

- Focus on poor and vulnerable populations in high-burden countries;
- Achieve results by supporting National Malaria Control Programmes (NMCPs) that are embedded in health sector plans and use country-appropriate funding methods;
- Seek opportunities to link malaria with other health and non-health programmes to increase benefits and VfM;
- Improve the quality and availability of data on malaria so that results are measurable, transparent and strengthen accountability to communities and the UK public;
- Base investment on evidence of what works and innovate where needed; and
- Work with international partners to ensure that global efforts support countries to tackle malaria as efficiently as possible.

Figure 1 Determinants of malaria epidemiology and health outcomes



26 This interdependence of the factors determining outcomes, and in particular mortality and morbidity outcomes, underlies the range of areas of action that are identified as necessary for an effective strategy to achieve the strategic priorities. This is encapsulated in the Malaria Framework, which is summarised in Table 1. It is based on areas of action defined under four pillars: (1) Improve quality of services; (2) Increase access and build demand for services; (3) Support innovation and global public goods; and (4) Focus on impact and results. The text of the Framework document provides a summary of the evidence base underlying the pillars and the action areas proposed.

Table 1 UK government Framework for Results (Malaria)

Goal: Contribute to at least halving deaths in at least ten high burden countries			
Reduce burden of illness and death		Sustain and expand gains into the future	
Improve quality of services	**Increase access and build demand for services**	**Support innovation and global public goods**	**Focus on impact and results**
• identify and scale up context appropriate, high quality and cost effective malaria interventions, including diagnosis and appropriate treatment • support more effective financing, management capacity, human resources, commodity supply and use of information to deliver and monitor equitable results • link malaria with other health and non-health services to maximise value for money and ensure sustainability	• support increased reach of services, particularly to marginalised populations, through public and non-state providers as appropriate • remove financial and other barriers to accessing services to support equitable outcomes • improve choice and responsiveness of services, including through results based funding approaches • reduce the financial impact of malaria on households • increase community knowledge and participation	• support evidence based global norms and policies • contain resistance to drugs and insecticides • work with partners to improve the performance of global commodity markets for the poor • support new product and new tool development • support an operational and policy research agenda to improve malaria and broader health outcomes now and in the future	• work with national governments, donors and other agencies to support better data and information systems to drive and measure results & impact • actively monitor and evaluate results in all DFID funded programmes • make information on performance transparent and increase accountability at all levels • work with country and international partners to improve the effectiveness of the global response

Source: Malaria Framework, Table 2, p. 18

27 Within this assessment of the appropriate global strategic approach, the Framework document (p. 4) identifies the following areas of action, stating that the UK government will:

- Invest up to £500 million each year by 2014/15, where results can be delivered and VfM demonstrated.
- Work through its country programmes, using appropriate funding approaches in each case, to support countries and communities to achieve malaria and broader health goals. Based on the BAR, UK bilateral support for malaria efforts was to be concentrated in sixteen countries in Africa and two in Asia. The Framework document notes that it would not be appropriate to set out detailed country-by-country plans and targets, although summary Operational Plans (Ops) for bilateral country programmes were to be produced. It was also highlighted that eleven of the countries were considered fragile and conflict-affected, and that using a variety of funding channels and state and non-state partners was appropriate in these contexts. It was also emphasised that a flexible range of funding approaches would be used and that, in addition to malaria-specific interventions, DFID's general health and broader development projects and programmes also supported malaria control, and that the contribution these make to malaria control would be estimated and added to the total malaria funds provided specifically by DFID.

- Improve the effectiveness and efficiency of the global response through international institutions, partnerships and global civil society. The Framework emphasised that the UK government's engagement with multilateral agencies and partnerships[7] would be based on 'an ambitious reform agenda that would be taken forward through positions held on governing boards, funding-related performance Frameworks, and financial technical and policy work' with a view to improving focus on 'areas of comparative advantage, performance, cost-effectiveness, transparency and coordination' and that specific priorities would be informed by the MAR (p. 44).

- Invest in global public goods including tackling resistance, building and sharing evidence and supporting market efficiencies. This was to be undertaken through direct funding for research and development on new antimalarial interventions, and operational and implementation research to improve intervention effectiveness.

- Harness UK expertise through better partnerships with academics, civil society, professional bodies and partnerships with other UK government departments.

28 A set of key indicators to track progress was defined (Table 2) and the methodology by which malaria-attributable spending was calculated was set out, providing a baseline for 2008/9 of £138.5 million (of which £117.8 million was bilateral and £20.7 million multilateral).

Table 2 Malaria Framework indicators

Impact indicators
(1) All-cause under-five mortality rate (the number of children who die by the age of five, per thousand live births)
(2) Malaria-specific deaths per 1,000 persons per year
Outcome indicators
a) Percentage of children under five who slept under an ITN the previous night
b) Percentage of children under five who received appropriate antimalarial treatment – including ACTs – within 24 hours of onset of fever in the last two weeks
c) Percentage of children under five with fever in the last two weeks receiving finger/heel stick diagnostic test for malaria
d) Percentage of women who received at least two doses of Intermittent Preventive Treatment (IPTp) during Antenatal Care (ANC) visits during their last pregnancy (in settings where IPTp is recommended)
e) Number of health workers per 10,000 population disaggregated by rural and urban settings and by cadre
f) Average availability of 14 selected essential medicines in public and private health facilities, plus a first-line ACT for treatment of uncomplicated malaria
g) Average unit price (Free Carrier) of highest volume LLINs procured by (or on behalf of) a country

[7] The Framework document identified the WHO (including the Global Malaria Programme), the Roll Back Malaria Partnership, the Global Fund, UNITAID, UNICEF, the World Bank, the European Union, the PMI, and the BMGF.

2.4 The RMNH Framework

29 The vision set out in the RMNH Framework is of 'a developing world where all women are able to exercise choice over the size and timing of their families, where no woman dies giving birth and where all newborns survive and thrive' (p. 2). The strategic priorities to realise this vision are to: (i) prevent unintended pregnancies by enabling women and adolescent girls to choose whether, when and how many children they have; and (ii) ensure pregnancy and childbirth are safe for mothers and babies. The rationale presented is based on need (the maternal mortality MDG being the most off track, and global figures of 215 million women with unmet FP needs, more than a third of a million annual deaths of mothers in childbirth, and 3.6 million deaths of newborns), the extent of the benefits that could be achieved (through improving the status of women, saving lives, intergenerational benefits, reduced unwanted fertility and slower population growth), and the VfM provided by interventions where effectiveness has been empirically established.

30 The guiding principles for implementation of the Frameworks are listed (on p. 19) as:

- Demonstrate results, VfM, accountability and transparency.
- Achieve objectives by reaching those not currently benefiting from progress.
- Ensure action is context specific.
- Respond to national priorities.
- Use appropriate and effective aid instruments for the context.
- Work to ensure reproductive, maternal and newborn health outcomes are delivered by efficient, effective, sustainable and accountable health services.
- Support action to overcome a range of demand-side and supply-side barriers to health care, addressing high-impact, neglected issues that other donors will not or cannot address.
- Take a multi-sectoral approach to create an enabling environment for RMNH.

31 Areas of action are defined under four pillars:

1) Empower women and girls to make healthy reproductive choices.

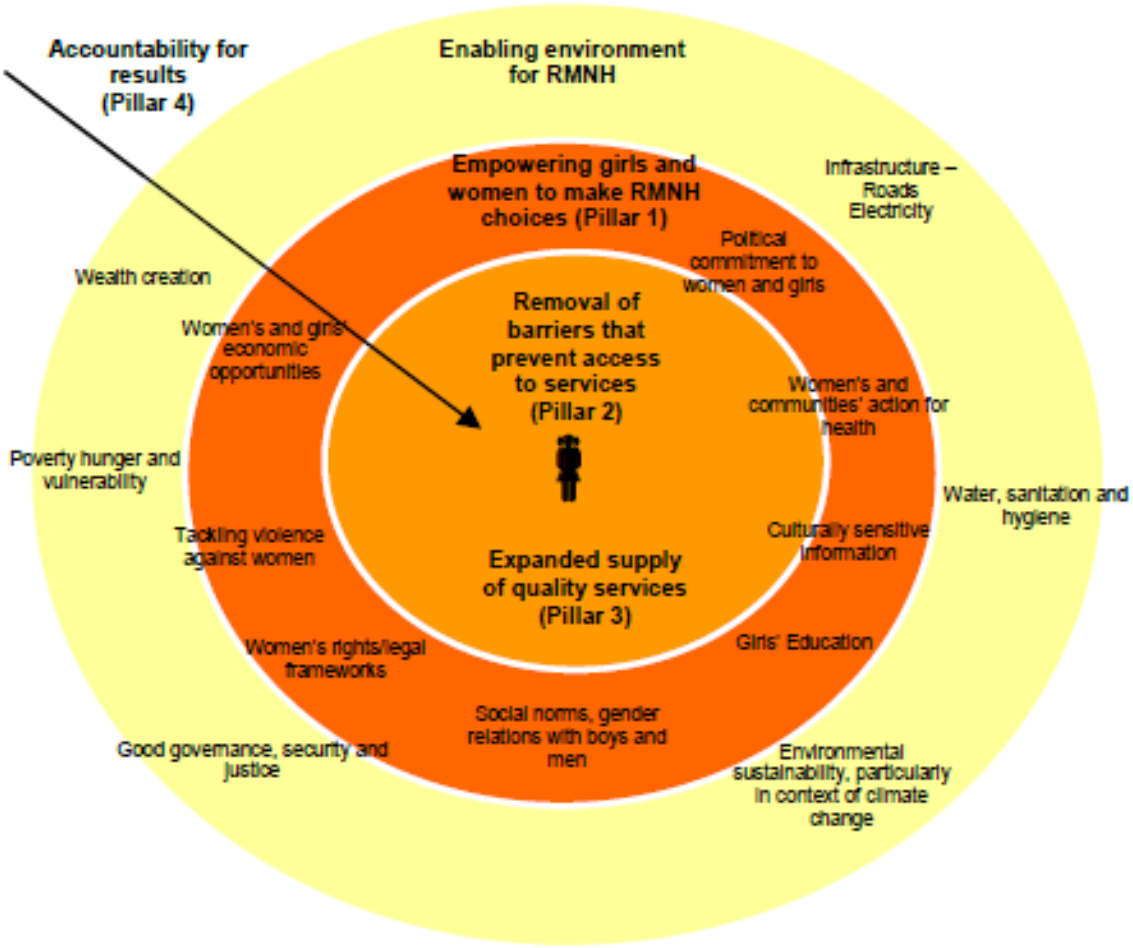
2) Remove barriers that prevent access to services, particularly for the poorest and most at risk.

3) Expand the supply of quality services.

4) Enhance accountability at all levels.

The relationship of the four pillars to the broader context is illustrated in Figure 2 and the detailed areas of action under each pillar are set out in Table 5. The Framework document contains a review of the evidence related to the actions under the pillars and the priorities that are implied.

Figure 2 The RMNH Framework in the context of multi-sectoral response



32 The RMNH Framework states that DFID will double its efforts for women's and children's health to:

- Save the lives of at least 50,000 women during pregnancy and childbirth and 250,000 newborn babies by 2015;
- Enable at least 10 million more women to use modern methods of family planning by 2015, contributing to a wider global goal of 100 million new users;
- Prevent more than 5 million unintended pregnancies;
- Support at least 2 million safe deliveries, ensuring long lasting improvements in quality maternity services, particularly for the poorest 40%.

33 In terms of spending commitments, the Framework document notes (p. 36) that:

> "In September 2010, the UK committed to double its annual support for women and children's health by 2012 and sustain that level to 2015. The UK will provide an annual average of £740 million from 2010-2015, totaling £4.4 billion, meaning that over this period

the UK will spend an additional £2.1bn on women and children's health. This commitment added to the one made at the Muskoka G8 Summit in July 2010. Reproductive, Maternal and Newborn Health is a subset of this commitment. Child health investments, including some malaria spend, and some investments in wider women's health account for the rest."

Table 3 Core results/indicators attributed to UK support

	Preventing unintended pregnancies	Safe pregnancy and childbirth
Indicators for all RMNH programmes (minimal set)	**Lives saved: women during pregnancy and childbirth** and **newborns**[13] (modelled from: *maternal mortality ratio*; *neonatal mortality rate*)	
	Numbers of women using modern methods of family planning calculated from *Contraceptive Prevalence Rate* (CPR) – for all women, the poorest 40% of women and for young women aged 15-19 **Number of unintended pregnancies prevented*** **–** modelled from *couple years of protection* (CYP) of family planning	**Number and percentage of births attended by a skilled birth attendant*** **–** for all women, for the poorest 40% of women

34 Indicators for the Framework were defined in the RMNH Framework document (Annex on Monitoring and Evaluation), distinguishing between a set of core indicators that should be tracked across all RMNH programmes (Table 3), and a set of recommended additional indicators (Table 4).

35 Spending under the Framework was to be tracked using the MCH methodology agreed at the G8 Muskoka Summit. [8]

[8] It should be noted that some DFID spending is attributed to both Malaria and to Maternal and Child Health (the latter calculated based on the Muskoka methodology), so it would not be appropriate to aggregate spending across the two Frameworks.

Table 4 Recommended additional indicators

Strongly recommended wherever possible	Percentage of women receiving at least 4 antenatal care contacts during pregnancy. Number of health workers per 10,000 population by cadre (by rural/urban) – includes midwives and others with midwifery skills, community health workers. Number of functioning health facilities with emergency obstetric and newborn care (EmONC) per 500,000 population (WHO target is 5 facilities per 500,000 with at least 1 offering comprehensive EmONC) Where possible: Average availability of 14 selected essential medicines in public and private health facilities (plus some from WHO additional list for family planning methods & maternal health supplies).	
Recommended	Unit cost of marker contraceptives to major procurers Percentage of women who have an unmet need for modern contraception Percentage and number of live births to girls and adolescent women (aged 19 and under) In high undernutrition settings: percentage of non-pregnant women aged 15-49 with a Body Mass Index outside normal range	Percentage live births delivered by Caesarean section (WHO target is 5-15%) Percentage of infants exclusively breastfed for up to 6 months In high HIV and AIDS settings: percentage of HIV positive pregnant women who received anti-retrovirals to reduce the risk of mother to child transmission In high malaria prevalence settings: % of women who received at least two doses of IPTp during ANC visits during their last pregnancy
Indicators for development (and then use in projects and studies where possible)	Percentage of first births to mothers under age 18 (measured among women aged 18-24 at the time of the survey) Indicator for empowerment	Percentage of mothers or newborns receiving at least one post natal contact [within two days] of birth Indicator for quality: Percentage of women reporting at least a satisfactory experience of services Indicator for clean birth including functioning water and sanitation infrastructure plus soap and hygiene in facilities

Table 5 RMNH Framework

Preventing unintended pregnancies		Safe pregnancy and childbirth	
Women and newborn lives saved [target at least 50,000 women during pregnancy and childbirth and 250,000 newborns by 2015]			
Numbers of women/couples using modern methods of family planning calculated from Contraceptive Prevalence Rate – for all, poorest 40% of women, those aged 15-19; **Number of unintended pregnancies prevented –** modelled from Couple Years of Protection of family planning		**Number and percentage of births attended by a skilled birth attendant** - for all women and the poorest 40%	
Target groups: Those at greatest risk, especially growing numbers of young people, the poorest, those affected by conflict and natural disaster. **Programme focus:** Based on comparative advantage, where short, medium and long term impact can be delivered, on budget, with demonstrable results and value for money			
Framework for results			
Pillar 1 **Empower women and girls to make healthy reproductive choices**	**Pillar 2** **Remove barriers that prevent access to services**, particularly for the poorest and most at risk.	**Pillar 3** **Expand the supply of quality services**	**Pillar 4** **Enhance accountability for results at all levels**
Political commitment to girls and women and their health at all levels **Legal frameworks** for girls' and women's rights and protection	**Financial barriers to services removed**, increasing purchasing power, choice and incentives where appropriate through services free at point of use, cash transfers, vouchers, cash incentives, social health insurance *(see para 55 for important considerations)*.. Including for family planning.	**Increased coverage and integration of health services that provide high impact, cost effective interventions** for family planning, safe abortion, antenatal care, safe birth, emergency obstetric care, postnatal care, newborn care, with PMTCT, HIV prevention, nutrition, malaria, water, sanitation and hygiene	**Data and information systems** for registering births/deaths, better planning and tracking of results
Girls' education, including to lower secondary level			**Enhanced accountability and transparency** between citizens, communities, civil society and providers
Economic opportunities including employment, income, assets, financial education and savings	**Innovative approaches to referrals and transport** (to emergency obstetric care)	**Health workers** –especially midwives/equivalent and community health workers – trained, deployed, motivated, managed and supervised	**Accountability for better performance** in RMNH services
Locally-led social change of norms that constrain women's choice, control over resources and body (eg early marriage, FGM/C, violence, cultural preferences for sons); working with men and boys	**Tackling discrimination** and treatment of women in services. **Services that are appropriate for adolescents,** including married and unmarried girls at risk.	**Commodities** – product innovation (eg for long acting and reversible methods of family planning), getting supplies in the right place at the right time, making them affordable and available, social marketing	**International agencies** more accountable for better reproductive, maternal and newborn health outcomes
Girls', womens' and wider communities' action for RMNH	**Action for those affected by conflict and natural disaster** to improve reproductive, maternal and newborn health	**More efficient and effective delivery of quality services by public or private providers** through quality assurance, management, regulation, performance based funding	
Culturally sensitive information especially about family planning, to meet unmet need and stimulate demand	*(Note: action to remove many social and cultural barriers is covered in Pillar 1)*	**Delivery through a range of non state providers (private and NGOs) whenever appropriate,** cost effective and pro-poor - through social marketing, accreditation, innovation.	

3 Approach and methods

3.1 Overview

36 The ToR identify the following questions for the MTR to answer:

- Are the planned activities likely to achieve the Framework outputs? If not, what should be done differently or in addition between 2013 and 2015?
- If all the outputs are achieved, will they achieve the purposes of the Frameworks? If not, at this mid-term point, are extra outputs or altered outputs required?
- Are the assumptions in the Frameworks correct? If not, do these require revision? Have any assumptions been overlooked?
- Are the risks being managed successfully? If not, what measures are needed to mitigate them?
- What lessons are being learned for wider interest?
- Are relevant evaluation questions properly embedded in DFID's routine project and programme monitoring processes?

37 A general conceptual model for the evaluation of the Frameworks is set out in section 3.2.1 along with a discussion of the theory of change for the Frameworks in section 3.2.2. This model was used to inform the formulation of the headline questions for the MTR, which incorporate the questions from the ToR within a more systematic conceptual structure. These are presented in section 3.3. The detailed methodology for the MTR is set out in section 3.4. Section 3.5 discusses constraints on the MTR and the evidence base.

3.2 Conceptual model and theory of change

3.2.1 Conceptual model

38 A general conceptual model for evaluation of the Frameworks is presented in Figure 3 below. The columns provide a generalised representation of the results chain – from inputs and design through processes, outputs, and outcomes to impacts – identifying also how the columns in the results chain and the links between them relate to the Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) evaluation criteria. Evaluating the Frameworks requires identifying what has happened at each stage of the results chain, and making an assessment of the causal factors that explain what has been observed.

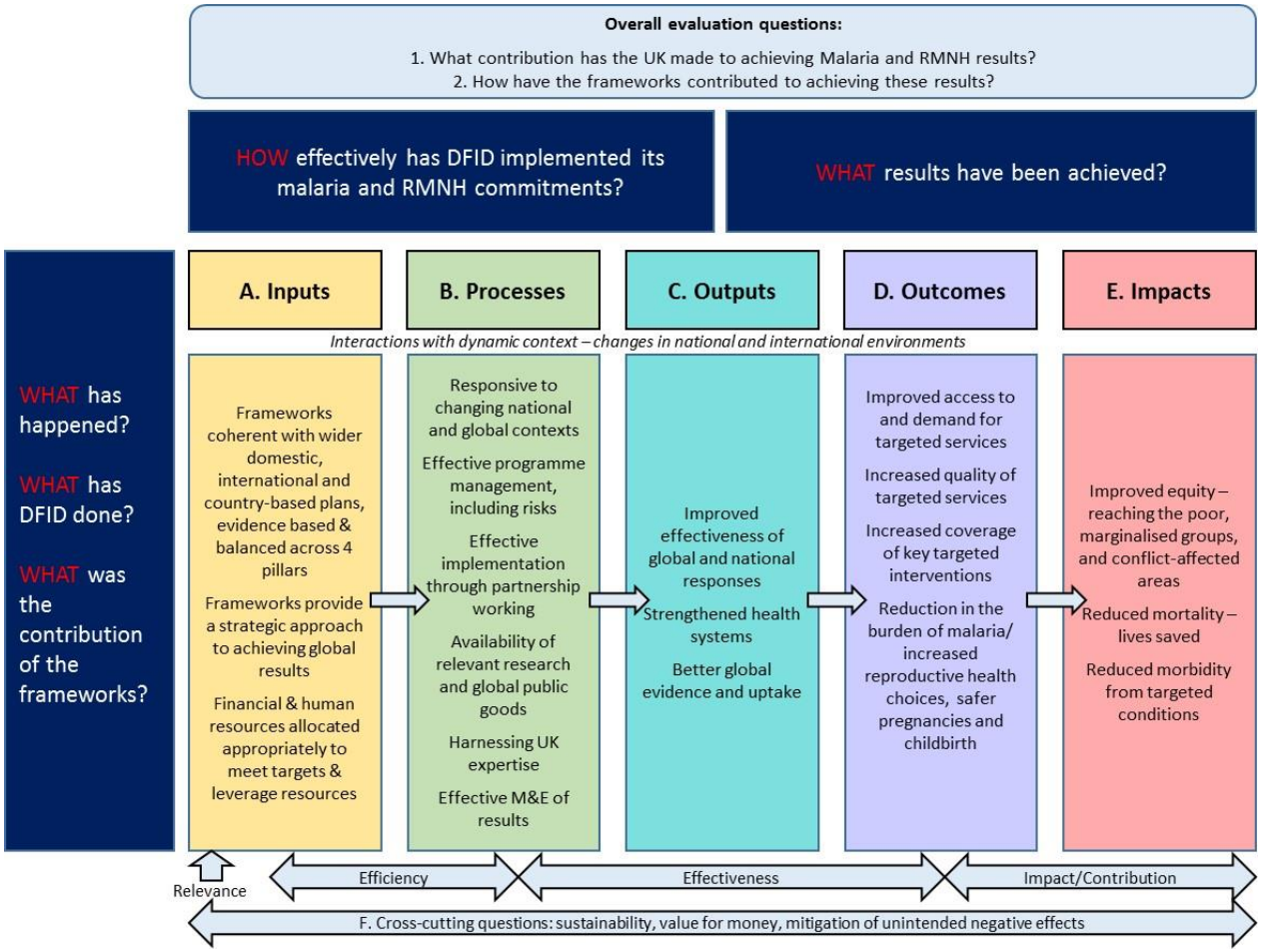
39 A further element of the conceptual model is the distinction between the three levels at which the results chain can be analysed:

- **Level 1** relates to the results chain globally, or in specific countries of interest – i.e. what inputs have been provided (in aggregate), what processes have affected how these inputs have been used, what outputs have been produced, and to what outcomes and impacts these have led.

- **Level 2** focuses on what DFID has done, in terms of inputs (in the most general sense of resources provided or actions taken), and the contributions to processes, outputs, outcomes and impacts that may be attributed to what DFID has done.

- **Level 3** concentrates on the specific role of the Frameworks, and how these have influenced what DFID has done (Level 2), as well as how they might contribute to what has happened globally or nationally (Level 1).

Figure 3 Levels and the results chain: the conceptual model



40 The purpose of distinguishing the three levels of the results chain is to allow a clear distinction to be made between the effects of DFID's activities (including bilateral and multilateral programmes) and the effects of the Frameworks (viewed as strategic instruments).

41 The conceptual model highlights that it is possible in principle for DFID's activities to have had a significant impact at the global or national level but for the Frameworks themselves to have had a relatively limited role in shaping the activities that have occurred.

3.2.2 Theories of change and counterfactuals

42 The Frameworks provided a means of articulating an overall strategic approach and linking objectives to actions. They went beyond earlier statements of DFID strategy in defining outcome-focused targets and attempting to provide a comprehensive overview of the approaches and evidence base for these approaches that would guide DFID's actions. As documents, they went beyond other comparable DFID strategy statements (such as the HIV/AIDS Position Paper) in the depth and detail of the discussion of actions and evidence. While the Frameworks were not explicitly formulated as presenting a Theory of Change, they set out a narrative and diagrammatic representation of the causal relationships judged critical to achieving the results intended, and the four pillars of each Framework are based on detailed

assessments of the evidence relating to particular types of intervention and the relationships between them.

43 It is useful to distinguish three aspects of a Theory of Change for the Frameworks and for DFID's programmes to implement them:

- First, the Framework for Results tables shown in Chapter 2 present an outline, based on the evidence reviewed that is reported in the Framework documents, of the appropriate strategies and actions to address malaria and to improve RMNH, in terms of the broadly appropriate actions to be taken globally or in specific countries. The key assumptions at this level relate to the validity of the evidence used in developing the strategies (including the definition of the four pillars of each Framework), and its appropriate interpretation.

- Second, within this broader assessment of effective and appropriate strategies, the Frameworks present a specific view about the appropriate role and focus for DFID's activities. One assumption related to this is that the Frameworks were in fact able to exert influence on DFID's bilateral programmes, within DFID's relatively decentralised management structure for bilateral programmes (which emphasises the importance of national ownership and alignment with nationally articulated policy priorities). A further assumption relates to the extent to which complementary actions are undertaken by partners, with a particular focus on high-burden countries.

- Third, DFID's expectation was that the business case for each activity under the Frameworks would set out a Theory of Change tailored to the specific activity and context, and in this sense the Frameworks provided a compendium of evidence and resources that could be drawn on to develop or support a business case for activities appropriate in different contexts.

44 Schematic representations of general Theories of Change for the Frameworks are set out in Annex D. These have been used to identify critical (and largely implicit) causal assumptions to complement those explicitly presented in the Framework documents, which relate to the validity of the evidence base for the specific types of intervention that are proposed. These assumptions are discussed in the next section in the context of the headline MTR questions.

45 Two types of counterfactual are relevant in providing a basis for comparison and for the assessment of DFID's contribution. The first type of counterfactual (Level 3) compares the Frameworks as results-focused strategic instruments with the alternative of less innovative forms of strategic statement used by DFID such as position papers. As noted above, the Frameworks differed from these approaches in two main ways – by presenting results targets that sought to identify a specific DFID contribution and by providing a much fuller discussion and review of the evidence base. In addition, a specific additional comparison for the RMNH Framework is with an approach based on a focus on maternal and child health rather than emphasising reproductive and newborn health.

46 The second type of counterfactual (Level 2) is appropriate for assessing the contribution of DFID's programmes. This would involve comparing the results (globally and in specific countries) with what would have happened in the absence of DFID's programmes and expenditures.

47 Two main approaches can in principle be used for making this comparison. The first is based on applying modelling approaches linking DFID spending to the achievement of results. The modelling work on impact which has been done for each Framework is reviewed in Chapters 4

and 5. The second approach would be based on the aggregation of evaluations of individual DFID programmes that themselves make use of clearly defined counterfactuals. As is discussed in section 3.5 below, very little evaluation information on programmes under the Frameworks is as yet available, so this approach could not be applied in the MTR. Evaluations of DFID country programmes in high-burden countries are likely to be the most informative way of making this assessment.

3.3 MTR questions

48 The conceptual model set out above has been used to expand and restructure the MTR questions defined in the ToR. This has involved linking questions to stages of the results chain and to levels of action, and then identifying the critical assumptions related to each question. This section sets out the headline MTR questions (to be applied to each Framework), elaborates sub-questions relevant to answering the headline questions, and discusses the criteria for assessment and the main assumptions. The subsequent section (3.4) presents the methods for answering these questions.

3.3.1 Design: Has the Framework provided an effective strategic instrument to achieve UK government objectives?

49 As strategic instruments, the Frameworks are assessed by considering: 1) the relevance and appropriateness of the specific targets and methods set out to achieve them, both in terms of their internal logic and coherence and their relation to available evidence; and 2) how effectively the Frameworks communicated key messages to stakeholders (particularly those whose actions had significant influence over the achievement of the objectives), and how far the behaviour of these stakeholders was influenced by these messages. Within DFID, this includes facilitating a process of harmonising priorities across the organisation. This question relates to Level 3 in the conceptual model.

50 The critical assumptions for the Frameworks to provide an effective strategic instrument are that:

- The review and the interpretation of the evidence base, and the selection of specific areas of action identified in the Frameworks that is based on it, are valid and robust;
- The approach articulated in the Frameworks and specific targets identified are coherent with wider international and country-based plans and targets;
- The Frameworks identify an appropriate role for DFID in line with its comparative advantage; and
- The Frameworks are able to drive (and change) the plans and actions of DFID country offices and other business units. This may pose a particular challenge since DFID country strategies and programmes are developed in a decentralised way so as to ensure strong partner country ownership and alignment of partner country objectives.

3.3.2 Inputs: Have adequate resources been used and appropriately applied to achieve the Framework objectives?

51 Answering this question requires identifying the financial and other resources that have been allocated by DFID to achieving the Framework objectives (Level 2 in the conceptual model), and assessing whether this has been in line with what was planned and whether this level has been appropriate to achieve the Framework targets.

52 In addition to the level of resources provided by DFID, it is also necessary in principle to assess the extent to which complementary resources have been provided by partners, both nationally and internationally (Level 1 in the conceptual model).

53 The critical assumption is that both DFID and partner resources are appropriately mobilised, allocated and used.

3.3.3 Process: Have the Framework and DFID's programmes under it been effectively managed to achieve UK government objectives?

54 The extent to which the Frameworks can achieve their purposes depends on how effectively they are being managed and implemented, as well as on the validity and appropriateness of their design. This includes whether the risks are being managed successfully and whether the M&E arrangements are appropriate. A further dimension of effective management is the extent to which DFID has ensured cost-effectiveness and VfM for DFID resources used.

55 The literature on results frameworks and development assistance highlights a number of possible risks associated with strategies that are articulated around very precisely defined quantitative targets (see, for example, Barder 2012, Eyben 2013 and Whitty 2013). The most significant risks involve an excessive focus on actions that can lead to short-term, measurable and directly attributable results at the cost of an emphasis on the longer term, sustainability, joint action, and system-wide improvements. The potential advantages of results-based approaches that are cited in the literature include: increasing the focus on analytical thinking and the link between activities and outcomes, rather than focusing just on activities; making it easier to measure progress toward and achievement of strategic objectives and to define and articulate success; encouraging greater engagement and ownership among stakeholders including among agency staff and partner country stakeholders, and facilitating agreement with other donors, cross-government and partner country stakeholders; and reducing the cost of evaluations. The MTR has therefore assessed to what extent these potential benefits are being realised and whether the risks are being effectively managed.

56 A further dimension of the effectiveness of the Frameworks as a strategic instrument is the extent to which they contributed to developing effective cross-sectoral approaches in DFID programmes, and whether there were effective linkages between the Frameworks and between the Frameworks and other DFID strategies.

57 Critical assumptions for effective management are the following:

- DFID country programmes are able and incentivised to respond to Framework recommendations and other initiatives consistent with them; Government, DFID and multilateral monitoring and reporting systems enable the tracking of progress, responsive management and increased accountability;
- Programmes and projects are designed appropriately for the country circumstances and are managed effectively;
-
- Partners are willing to engage in improving global M&E and accountability systems; and
- UK expertise is relevant and available.

3.3.4 Outputs: Are activities and outputs under the Framework on track to meet its objectives?

58 A starting point for answering this question is accurate and complete information on the outputs that have been produced so far under the Frameworks through DFID programmes and to what extent this is in line with the activities identified in them. On the basis of this information (complemented by information on the relevance, effectiveness and efficiency of these activities), an assessment can in principle be made of whether the activities that have been carried out and that are planned are likely to achieve the planned outputs by 2015, and if not whether changes need to be made.

59 The critical assumptions for the achievement of planned outputs include the following:

- Government and other organisations in partner countries are able and willing to respond to increases in resources, new knowledge and new technologies;
- Multilateral programmes are able to improve the supply of and demand for services at country level;
- Partner coordination is effective; and
- Expansion of support to health systems can be undertaken reasonably cost-effectively.

3.3.5 Outcomes: Are outcomes on track to meet the objectives of the Framework?

60 This requires an assessment of evidence on the outcomes that have been achieved so far, whether the achievement of the outputs planned will achieve the purpose of the Frameworks, and if not what extra or altered outputs may be required. It was recognised that only partial information on outcomes is likely to be available for the MTR, but that both national evidence on progress made and evidence on the effectiveness of DFID's programmes was potentially relevant to assessing the extent to which outcomes are on track.

61 Critical general assumptions for the achievement of outcomes are that:

- Services are of sufficient technical quality and are provided as an appropriate mix;
- Increased supply from a range of providers is able to meet increased demand;
- Services are accessible and acceptable to populations (physically, financially and culturally); and
- The improvements to services can be sustained over time.

3.3.6 Impact: To what extent is it possible to measure the impact of the Frameworks and of DFID's activities, and how can the measurement of impact be improved?

62 DFID has commissioned studies to model the impact of DFID's activities under the Frameworks. The validity of modelling approaches depends both on the robustness of the empirical models and on the availability of sufficient data. The MTR has involved an assessment of these modelling approaches, and the quality of the data available. A critical assumption for achieving the overall Framework impact targets is that resources and progress made are concentrated in high-burden countries.

3.4 Methodology for the MTR

3.4.1 Overview

63 The approach for data collection and analysis in the MTR involved a series of studies focused on distinct elements of the results chain and on the three levels of action, with the aim being to provide evidence to answer the MTR questions. The overall structure of the analytical approach involved the following elements:

- Setting out the global context for each Framework in terms of evidence on global and national outcomes and the main features of international action and how this has developed over the period of the Frameworks (Level 1).
- A compilation and analysis of information on what DFID has done over the Framework period, in terms of spending and evidence on results achieved, in relation to both multilateral and bilateral programmes as well as a review of other DFID activities such as support to research (Level 2).
- A more detailed focus on selected bilateral programmes and the multilateral programme, including case studies on the engagements with specific multilateral organisations. These studies sought to review evidence where available along the whole results chain and to examine what DFID has done, as well as the influence of the Frameworks on what DFID has done, within an understanding of the global and national contexts (Levels 1, 2 and 3).
- Reviewing the evidence on the process by which the Frameworks were formulated and developed (Level 3).

64 Four main types of data collection and analysis were carried out for the MTR:

- Document reviews: An initial identification of relevant documentation was undertaken. This was reviewed in each of the studies to identify the evidence relevant to each question. In general, document reviews were undertaken as a first step for each study, and KIIs were used as a way to triangulate the information provided in the documentation.
- Key Informant Interviews (KIIs): A list of key informants was developed through (a) discussion with DFID staff to identify key partners and current and former DFID staff involved in decision-making and implementation of the Frameworks; and (b) supplementing this list by identifying additional key informants including prominent researchers and the staff of other development agencies and CSOs. A similar approach was used to identify key informants for case studies. Question lists were used to guide interviews and to record the information collected. This information was collated and summarised to identify conclusions in each question area of the MTR. The understanding with key informants was that the names of interviewees would be included in the report but that no information would be presented in a way that permitted identification of the source.
- Quantitative data analysis: Quantitative data from two main types of source were used for the MTR: first, data on global outcomes and aid activities; and second, data from DFID monitoring and reporting systems. Analysis of global data focused on the identification of trends and developments in the period since the establishment of the Frameworks. Quantitative analysis was undertaken of DFID data on spending and results reporting.
- Questionnaire responses: Information was collected through an online survey of DFID country programmes (more details are provided below) using a questionnaire. This information was also collected on the understanding that it would not be presented in a form that would allow identification of the source.

65 The use of a variety of sources to address each MTR question (Table 7) has allowed some degree of triangulation of the findings to take place. In particular, where evidence has been based on interviews with DFID staff or on data from DFID systems, attempts were made where feasible (for instance in the country case studies) to cross-check with external key informants.

3.4.2 Summary of data collection and analysis undertaken for the MTR

66 This section summarises the studies undertaken to provide evidence as part of the MTR against each of the three levels. Table 7 shows which of the MTR questions are addressed by each study.

Level 1: Global context

67 The **Global Analysis** compiled evidence on the global aid architecture and response to malaria and RMNH over the evaluation period in order to provide a context for understanding DFID's contributions. It included an assessment of the available evidence on outcomes, outputs, and global processes (Level 1). It was based on a review of international data sources, documentation, and KIIs. Details are presented in Working Papers I (RMNH) and II (malaria) and the main findings are summarised in sections 4.1 and 5.1.

Level 2: What DFID has done

68 The review of **DFID's results reports and reporting procedures** assessed the availability of evidence on results through DFID's reporting systems. This included reporting against the DRF and OPs. Full details are provided in Working Paper IX.

69 The **analysis of DFID's expenditures and project activities** was based on a review of expenditure information and on a sample of DFID project documentation for each Framework. Details of the data sources and the selection of projects are set out in Table 6 below.

70 Source materials included financial data, project documentation and KIIs. Relevant projects to be included under each Framework were identified in consultation with DFID, and data were collected through a combination of sources, starting with publicly available sources where possible (such as the DFID projects database, the list of DFID evaluations, DFID OPs and annual reports).

71 Three categories of project were defined for sampling: (i) those projects comprising 75% of expenditure under each Framework; (ii) a sample selected from projects outside the top 75% of expenditure that had 75% or more of their budgets allocated to relevant codes; and (iii) projects identified as of special strategic significance. The analyses were completed using different approaches: financial data were analysed for overall trends in bilateral and multilateral expenditure and a comparison of expenditure and numbers of deaths. Project-level data were analysed against the Framework pillars, against Framework indicators, and for implementation performance. Linkages between the identified projects and specific thematic issues such as HIV/AIDS and HSS were also analysed. These project analyses were based on a process of coding project documentation.

72 Coding was completed by a small team (three people) to promote consistency in interpreting documentation and applying codes. Full details are provided in Working Paper IV.

Table 6 Linking issue areas to the components of the DFID Activity Analysis

Issue area	Components in the DFID analysis	Subset of projects
Funding	1. Overall trends (bilateral and multilateral) 2. Mapping country-level expenditure onto estimates of malaria and maternal deaths	Data for components 1 and 2 were sourced directly from DFID, drawing on the systems that they have put in place to report against the financial commitments in each Framework. World Health Organisation (WHO) and Countdown 2015 data were used for mortality estimates.
Activities and performance	3. Projects by principal project sector code 4. Activities by pillar 5. Projects use of indicators from the Frameworks for Results 6. Implementation performance 7. Trends in start dates for projects	Component 3 drew on the complete list of identified projects (284 RMNH and 194 malaria). Components 4–6 drew principally (as at 7 October 2013) on the projects accounting for 75% of spending. The list of 16 strategic projects highlighted by DFID also informed this. Component 7 drew on the complete list of identified projects (284 RMNH and 194 malaria).
Civil society	8. Overview of DFID support to CSOs	Civil society projects were also reviewed, using routine project reporting.
Research	9. Overview of relevant research activities	Twelve projects, drawn from a mapping provided by DFID's Research and Evidence Department (RED).
UK expertise	10. Information on activities to harness UK expertise	One project, plus evidence (on an ad hoc basis) of other examples where projects have harnessed UK expertise.

73 The **cost-effectiveness analysis** (Working Paper VII) examined evidence related to cost-effectiveness based on current DFID information systems. It reviewed the modelling approaches that are being used by DFID as a tool for estimating outcomes, as well as the methodological issues involved in establishing a baseline for assessing elements of cost-effectiveness.

74 The **VfM analysis** (Working Paper VI) was undertaken based on a review of project documentation sourced from a sample of projects for each Framework. As a first step in the analysis, the team assessed existing project logframes to examine the prevalence and typology of VfM indicators. This was complemented by consideration of the qualitative statements on VfM that have been made in project planning and review documents.

Levels 1, 2 and 3: DFID's multilateral and bilateral programmes

75 The **Influencing and Multilateral Engagement Analysis** (Working Paper III) examined DFID's approach to influencing the activities of multilateral agencies and international processes and the results that this has achieved. It was based on a review of DFID documentation (a wide range of internal submissions, briefing note and meeting records) and KIIs, and included case studies of DFID's engagement with the United Nations Population Fund (UNFPA) (under the RMNH Framework) and with Roll Back Malaria (RBM).

76 **Country case studies** of DFID's activities and results achieved under each of the Frameworks (within an analysis of the wider national context and progress) were carried out in Ethiopia, India and Nigeria. These are provided in Working Paper VIII. The country case studies examined: design and inputs; development and implementation processes; outputs; outcomes and impact; and cross-cutting issues. The choice of countries was based primarily on a

consideration of disease burden and the nature of DFID support. Two African (Ethiopia and Nigeria) and one South Asian (India) countries were selected. Data collection was based on a review of documentation and a one-week visit by one international consultant for each Framework, involving meetings with key informants at DFID and other stakeholders including the programme personnel, government representatives, other bilateral and multilateral agencies and CSOs. All three country visits took place in September 2013.

77 The **online survey** was carried out of DFID's country programmes under each of the Frameworks (Working Paper V) and was completed in most cases by DFID health advisers. It was targeted toward 20 out of 27 DFID priority countries where an initial judgement was made in discussion with DFID that significant activities were being undertaken against the Frameworks. The survey asked for assessments to be made of country progress,[9] and of the relevance and effectiveness of DFID's activities, against each of the Framework pillars. It also asked for comments on the role and contribution of the Frameworks. Responses were received for 16 countries for the Malaria Framework survey and 19 for the RMNH survey. The countries which were unable to complete the survey were those which either did not have significant activities over the period or staff in post with information about activities. The findings from the online survey could be cross-checked and triangulated with other respondents in the countries that were visited for the case studies, but not in other cases.

Level 3: Development of the Frameworks

78 A study was undertaken on the origins and objectives of the Frameworks and the process by which they were developed, based on a review of documentation produced during the development of the Frameworks and KIIs with DFID staff involved in the process of developing and implementing the Frameworks. This study provided the basis for the description of the Frameworks and their development process, which is set out in Chapter 2 above, and for the findings reported for each Framework in chapters 4 and 5.

[9] Findings from the survey of DFID country programmes in relation to their assessments of national progress were judged by respondents to be potentially sensitive and so could not be included in this report, although the results have been used to inform the conclusions.

Table 7 MTR headline questions and MTR components

MTR headline question	Global analysis	DFID results and reporting	DFID expenditures and project activities	Cost-effectiveness and VfM	Influencing and multilateral engagement	Country case studies	Online survey of DFID country programmes	Frameworks analysis
Design: Has the Framework provided an effective strategic instrument to achieve UK government objectives?	International policies, targets, and coordination arrangements (DR, KII, QDA)				Influence of Frameworks on engagement with multilaterals (DR, KII)	Influence of Frameworks on country programmes (DR, KII)	Influence of Frameworks on country programmes (QR)	Objectives and process of Framework development (DR, KII)
Inputs: Have adequate resources been used and appropriately applied to achieve the Framework objectives?	Data and trends in global spending (DR, QDA)		Classification of DFID spending by country and purpose (QDA)	Modelling approaches and spending allocation (QDA)		Inputs provided (DR, KII)		
Process: Have the Framework and DFID's programmes under it been effectively managed to achieve UK government objectives?		DFID reporting and M&E arrangements (DR)		Incorporation and use of VfM indicators in project logframes (DR)		Management issues (DR, KII)	Management issues (QR)	Influence of Frameworks on DFID programme decisions (KII)
Outputs: Are activities and outputs under the Framework on track to meet its objectives?	Data and trends in global outputs (DR, QDA)	DRF and other DFID reporting on outputs (DR)	Classification by Sector Code and Framework Pillar (QDA) Outputs from project reports (DR)			Outputs produced and effectiveness of DFID programmes (DR, KII)	Effectiveness of DFID programmes (QR)	
Outcomes: Are outcomes on track to meet the objectives of the Framework?	Data and trends in global outcomes (DR, QDA)	DRF and other DFID reporting on outcomes (DR)				National progress on outcomes (DR, KII, QDA)	National progress on outcomes (QR)	
Impact: What progress has been made against the targets set by the Framework?		DFID reporting and M&E arrangements (DR)				National evidence on impact (DR, KII)		

DR: Document review; KII: Key Informant Interviews; QDA: Quantitative Data Analysis; QR: Questionnaire Response

3.5 Constraints and assessment of the evidence base for the MTR

3.5.1 Constraints

79 One set of constraints on the ability of the MTR to answer the questions related to information that was not readily available through existing DFID systems:

- Although DFID is planning a large number of evaluations that will be relevant for assessing progress and lessons from current and innovative activities within each Framework, there was almost no recently published relevant evaluation material (particularly covering the period since the start of the Frameworks). This may be in part explained by the fact that the evidence review process for each Framework was regarded as identifying and summarising all relevant lessons, and that new or innovative programmes under the Frameworks are too early in implementation to be fully evaluated.
- DFID's project coding is not well suited to identifying projects as falling under the Frameworks or to enabling estimates of the level of spending related to each pillar to be made. It proved to be a time-consuming process to prepare an agreed list of projects falling under each Framework, and it was not always the case that objective indicators could be used to make this classification.
- In addition, difficulties were encountered in locating and obtaining access to project documentation (such as annual reviews) that were expected to be readily available from DFID systems.
- The lack of comprehensive monitoring and reporting for each Framework at the country level (i.e. between the project level and DRF reporting) made it challenging to obtain a comprehensive national picture of DFID's activities and progress in relation to Framework objectives in the case study countries.
- For RMNH, the absence of an output tracker system similar to the Malaria Results Tracker made it impossible to provide any aggregated assessment of the outputs produced by activities under the Framework. The existence of the Malaria Results Tracker did allow aggregated estimates to be made for outputs under this Framework, although the tracker remains to be developed further. These issues are discussed further in chapters 4 and 5.

80 A second set of constraints related to the timing of the MTR and resources available:

- The tight timetable for preparing the MTR, and the fact that most of the data collection process (July to September) took place over the summer, meant that it was not possible to complete all the KIIs originally planned.
- The short time available in country for the country case studies limited the range of respondents and sources of information that could be reviewed. In some countries, difficulty was also encountered in sourcing complete documentation on DFID programmes.
- Unexpected difficulties in finalising the sample of DFID projects for more detailed review and locating and analysing relevant documentation meant that it was not possible to complete the review of the full range of DFID projects that had been intended and the analysis focused on the projects that made up 75% of spend.

3.5.2 Assessment of the evidence base

81 DFID's recently produced Framework for Evidence Assessment (DFID 2013i) highlights the importance of the quality of the body evidence (particularly whether it has been based on

experimental design that allows a valid assessment of causality, or on the application of systematic review methods), the size of this body of evidence, and its consistency and relevance to the question to be addressed. Evidence can be categorised from 'Very Strong' (with a large body of high-quality, relevant and consistent evidence) allowing a high degree of confidence in the conclusions drawn, to 'Limited' where only a small number of moderate or low-quality studies are relevant and available and findings may lack consistency.

82 Judged against these criteria, there are important limitations affecting the evidence base available to answer the MTR questions. These relate in part to the fact that most DFID activities under the Frameworks involve significant delays before it is plausible to expect firm evidence of results achieved, so assessments of progress depend heavily on DFID's progress reporting and on the perceptions of the relatively small number of stakeholders (outside the case study countries) that it has been possible to interview during the MTR. Making fully evidenced judgements of the effectiveness of the Frameworks as strategic instruments, or of the extent to which DFID is on track to meet Framework targets, requires at a minimum reasonably complete information on the outputs from DFID's activities. Moreover, this information would not in itself provide a guarantee that outcomes and impact would be achieved, since this depends on additional assumptions. With the level of information we had access to on major programmes, strong judgements of attribution (of observed outcomes to DFID programmes or to the Frameworks) could not be made, although plausible assessment of contribution could be made through a combination of modelling approaches (where these have been determined to be valid and sufficient data is available) and evidence from DFID reporting triangulated by independent assessments.

83 As a result, it is not possible to rate the overall evidence base for answering any of the headline MTR questions as stronger than 'Medium', implying moderate confidence in the findings and an expectation that, while they are likely to be robust to additional evidence, some doubt remains.

4 The Malaria Framework: MTR findings

4.1 Global progress in malaria control and elimination

4.1.1 Changes in the global aid architecture and policy

84 Over the past decade, there has been an increased global commitment to malaria control and transmission reduction. The inclusion of a specific goal for malaria as part of the MDGs (to 'have halted by 2015 and begun to reverse the incidence of malaria') gave malaria a prominent position within the wider global health agenda (United Nations 2000). Meeting these goals requires the political commitment of governments. For the Africa region, in which most high-burden countries reside, the Abuja Summit goals were set in 2000, focusing on a reduction in malaria mortality (Roll Back Malaria Partnership 2003).

85 Global goals were revised first in 2005, 2008 and most recently in 2011 as the GMAP by the RBM Partnership (Roll Back Malaria 2008). In 2005, the World Health Assembly passed a resolution to support WHO technical recommendations to "ensure a reduction in the burden of malaria of at least 50% by 2010 and 75% by 2015". More recent goals from the GMAP are to 'reduce global malaria deaths to near zero by end 2015, reduce global malaria cases by 75% by end 2015 (from 2000 levels), and to eliminate malaria by end 2015 in 10 new countries (since 2008) and in the WHO Europe Region' (Roll Back Malaria Partnership 2008, 2011). The first two goals were present in the 2008 GMAP while the third was added in 2011, after the Framework was published. The GMAP was formally endorsed by the 64th World Health Assembly at its meeting in May 2011 (WHO 2011a).

86 The GMAP provides a Framework to coordinate the range of public and private stakeholders' efforts at all levels to tackle malaria through a three-part global strategy: 'control malaria to reduce the current burden', 'eliminate malaria over time, country by country', and 'research new tools and approaches to support global control and elimination efforts' (Roll Back Malaria 2008).

87 A number of multilateral and bilateral agencies and NGOs work both at the international level and in country to support implementation of malaria control and elimination activities. The largest is the Global Fund which, through its network of partners, has supported malaria programmes in 97 countries. A focus of its work has been the distribution of LLINs, with Global Fund support having distributed 360 million LLINs since its inception (The Global Fund 2013). The Global Fund also provides support for malaria diagnostics and treatment as well as wider support to strengthen health systems.

88 The PMI works in 19 focus countries in Africa and also has a programme in the Greater Mekong Sub-Region. Its goal is to 'halve the burden of malaria (morbidity and mortality) in 70% of at-risk populations in sub-Saharan Africa (approximately 450 million people)' (USAID 2010). Alongside this central objective, the PMI also aims to limit the spread of antimalarial drug resistance in Southeast Asia and the Americas, achieve strategic integration of malaria prevention and treatment with other health initiatives, strengthen health systems and national capacity, work with host countries to develop appropriate policy, and ensure a 'woman-centred' approach.

89 The World Bank has had a long-term commitment to malaria control through its Global Strategy and Booster Programme launched in 2005 (The World Bank 2005). The overall aim of the programme is to enable countries to achieve and sustain impact in malaria control by

supporting them to ‘ i) cost-effectively reduce morbidity, productivity losses in multiple sectors, and mortality due to malaria, particularly among the poor and vulnerable groups such as children and pregnant women; and ii) address the challenges of regional and global public goods’. Since 2005, the World Bank has invested in 22 projects across 20 countries in sub-Saharan Africa, including procurement and distribution of bednets, strengthening of drug supply chains, investments in information systems for M&E and investment in human resource management.

90 In October 2007 the BMGF shifted the focus of the world malaria community with their challenge to embrace ‘an audacious goal—to reach a day when no human being has malaria, and no mosquito on earth is carrying it’ (Gates 2007). This has had a noticeable impact on global policy, such as the shift from focusing bednet distribution on children under five years of age to a policy of ‘universal coverage’ (Roll Back Malaria 2008). It is also noticeable in the GMAP inclusion of elimination as one of the three core goals.

91 A major threat to sustaining the gains that have been made over the last decade is the emergence of resistance to both drugs and insecticides. The scientific evidence for these developments was present at the time the Framework was developed and was included in the evidence review. However, since 2010, coordinated action has been aided by two ‘calls for action’ published by the WHO Global Malaria Programme (GMP). The Global Plan for Artemisinin Resistance Containment was published in 2011 (WHO 2011b) while the Global Plan for Insecticide Resistance Management was published by WHO in 2012 (WHO 2012a). Significant progress has also been made in the development of synthetic artemisinin compounds to counter this threat (see Box 3).

92 Even in the absence of resistance, historical data highlight the risk of resurgence due to failure to maintain the interventions (Cohen et al. 2012). Thus, the importance of strengthening broader health systems, and in particular monitoring and surveillance systems, to ensure that emerging cases are rapidly identified and treated is increasingly being recognised in the global agenda. Coordination and M&E of national and international efforts is critical to ensuring both the longer-term success of the programmes and VfM. The RBM partnership is the global coordinating mechanism for stakeholders and NMCPs while the WHO GMP has a complementary coordinating role at the global and regional levels with a focus on technical support. The Malaria Policy Advisory Committee (MPAC) was established in GMP in 2011 to provide independent advice to the WHO.

93 A number of new policy recommendations have been made by the WHO-GMP since the publication of the Framework. The ‘Test, Treat, Track (T3)’ initiative was launched in 2011 to support countries in their efforts to achieve universal coverage with diagnostic testing and antimalarial treatment alongside strengthening their surveillance system (WHO 2013c). This was supported by the publication of a number of operational manuals, including updated treatment guidelines, an operational manual to support diagnostic testing and two manuals to strengthen surveillance during the control and elimination phases respectively. For vector control, a number of new recommendations have been made regarding net packaging and procurement, testing for insecticide resistance and use of DDT.

94 Since 2010 there have been some significant advances in malaria research. Most prominent is the first malaria vaccine – RTS,S/AS01 – which is nearing completion of Phase III trials in 13 sites in Africa. If licensed, this could be used in malaria-endemic countries from 2017 onwards (Agnandji et. al. 2011; Agnandji et al. 2012). Another advance is Seasonal Malaria Chemoprevention (SMC) which was recommended as an additional tool in parts of the Sahel region of Africa based on positive results from multiple clinical trials (WHO 2012b).

95 A range of other multilaterals and NGOs also carry out coordinating and monitoring activities. The African Leaders Malaria Alliance (ALMA) is an alliance of African heads of state and government formed in 2010 which acts as an advocacy union to keep malaria high on the political and policy agenda. In terms of monitoring, ALMA produces a scorecard tracking each country's progress on a range of policy, financial, and output indicators. A similar alliance in Asia – the Asia-Pacific Malaria Leaders Alliance – was established in October 2013. Its aim is to reduce malaria cases and deaths in the region by 75% by 2015 and to contain the spread of drug resistance.

96 The investment in new vaccines, drugs, diagnostics and vector control tools has been boosted by the formation of four product development partnerships (PDPs) – the Malaria Vaccine Initiative, Medicines for Malaria Venture (MMV), Foundation for Innovative New Diagnostics (FIND) and Integrated Vector Control Consortium (IVCC). Established between 1999 and 2008, these PDPs are not-for profit organisations committed to the development of new products to reduce the burden and transmission of malaria.

97 There is also growing recognition of the need to engage both the public and private healthcare sectors in order to increase access to malaria services. This has led to a number of new initiatives to improve market engagement. The most prominent of these is the Affordable Medicines Facility – malaria (AMFm), which was launched in April 2009 to 'enable countries to increase the provision of affordable ACTs through the public, private and NGO sectors' and 'reduce the use of artemisinin as a single treatment or monotherapy' to limit the risk of resistance (The Global Fund to Fight AIDS, Tuberculosis and Malaria 2012). The aim was to achieve these goals through price reductions, buyer subsidy and supporting interventions to promote appropriate use of ACT.

4.1.2 Financing malaria interventions

98 The World Malaria Report produced annually by the WHO Global Malaria Program provides figures on global financing of malaria interventions. The most recent data were presented in the 2013 report published in December 2013. The figures here are based on the previous year's report and hence cover the period up to the end of 2011.

99 There are three main sources of funding for tackling malaria: household expenditure, national expenditure and external donor assistance. In relation to donor assistance, The Global Fund is by far the largest financing organisation, providing 58% of the overall donor support between 2008 and 2011 (Working Paper II, Section II.4). This is followed by PMI/USAID which provided 36% with DFID's direct contributions and the World Bank[10] contributing the remainder in almost equal proportions (approximately 3–4%) (Figure 4). Approximately 95% of the Global Fund's contributions come directly from donor countries[11] with the remaining 5% contributed by the BMGF, Debt2Health and other NGOs (Working Paper II, Section II.4). Overall the total donor support appears to be well aligned with need[12] (Working Paper II, Section II.4).

100 There has been a levelling-off in overall donor support for malaria from 2010 onwards. This was mostly due to the lower levels of disbursements from the Global Fund over this period. Note that 2011 figures for the World Bank were not available and hence are not included in Figure 4.

[10] In the 16th replenishment round of the World Bank (in 2011), the four largest donor country contributors were: the UK (12.08%), the US (11.36%), Japan (10.41%) and Germany (6.01%).
[11] Based on 2012 pledges to the Global Fund, the US contribution is 35%, France 13.7%, UK 11.7% and Japan 9.9%.
[12] Need is defined on the basis of WHO burden estimates (Working Paper II, Section II.5.1).

Figure 4 International donors' contribution to bilateral funding to malaria-endemic countries between 2008 and 2011. Figures are given in USD[13]

101 The World Malaria Report (WMR) 2012 (WHO 2012c) estimated total domestic spending (not including household expenditures or costs associated with healthcare) at US$ 625 million in 2011, representing approximately 25% of all malaria financing. The European Region reports the greatest expenditure per capita in the period 2006–2010 while Africa has by far the highest ratio of external to domestic expenditure. The small proportion of domestic financing has issues for the sustainability of the programmes given their dependence on external donor funds. This issue was raised in the recent National Audit Office report of DFID's malaria programme (National Audit Office 2013).

102 Funding for malaria research has increased over the past five years from US$ 468 million in 2007 to US$ 559 million in 2011(Working Paper II, Section II.4). Twelve funders contributed 92% of all research funds to malaria over this five-year period. Of these, the BMGF and US National Institutes of Health contributed nearly half.

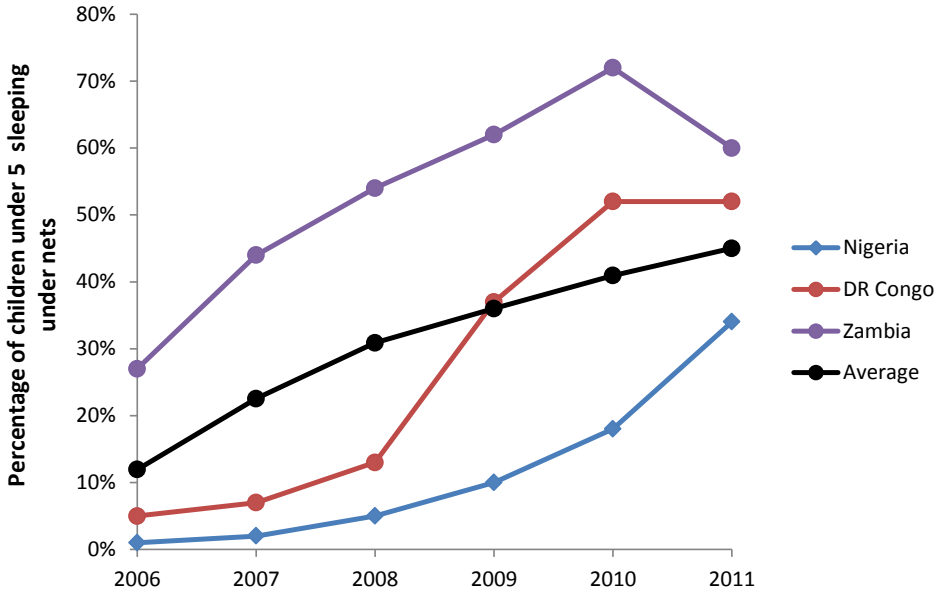
4.1.3 Global trends in intervention scale-up

103 Coverage with vector control has increased substantially over the last decade. Between 2006 and 2011 the estimated number of children aged under five sleeping under a bednet the previous night averaged across the top 20 high-burden countries[14] increased from 12% to 45% (Figure 5) (Working Paper II, Section II.3). IRS is less frequently used but is at high levels in some countries and there is no clear trend in its use (WHO 2012c).

[13] Data were obtained from the World Malaria Report 2012, Annex 3. Figures for DFID for 2011 were calculated from the OECD database using the WMR methodology. 2011 figures for the World Bank were not available.

[14] See Working Paper II for the definition of high-burden countries.

Figure 5 Estimated number of children under five who slept under a bednet on the previous night[15]



104 Access to treatment with effective antimalarials has increased substantially but there remain major gaps in provision of appropriate, high-quality ACTs, particularly in the private sector. The ACTWatch study (PSI 2013) reported an increase in the proportion of children under five treated with an ACT between 2009 and 2011/12 in four high-burden African countries,[16] although overall levels remain low (11%–44%). Correct diagnosis of fever[17] remains very low in all four countries. Of all outlets surveyed, between 8% and 28% had an antimalarial in stock on the day of the survey and between 4% and 16% had an ACT in stock.

105 The proportion of at-risk pregnancies protected by chemoprevention (i.e. IPTp)[18] has recently been estimated in a meta-analysis of survey data from 2009 to 2011. Trends between 2007 and 2010 were available for six[19] of the top 20 high-burden countries. Five out of the six countries showed a significant increase in the estimated number of malaria-exposed births protected by IPTp, with an overall increase from 1.7 million in 2007 to 2.8 million in 2010.

4.1.4 Global trends in outcomes and impact

106 The 2013 World Malaria Report demonstrates the substantial progress that has been made towards the MDG targets. Between 2000 and 2012, malaria mortality is estimated to have decreased by 45% across all age groups and by 51% in children under the age of 5. This translates to an estimated 3.3 million deaths averted over this period, with 69% of these lives saved in the 10 highest burden countries.

107 The analysis presented in the following paragraphs was undertaken prior to the publication of the 2013 World Malaria Report. It therefore uses statistics up to the end of 2011 unless otherwise stated.

[15] Data are shown for three high-burden countries and for the average across the top 20 high-burden countries.
[16] These are Nigeria, DRC, Uganda and Zambia.
[17] The proportion of children under five reporting fever in the last two weeks who had a blood stick from the heel or finger.
[18] Defined as receiving two or more doses of an appropriate antimalarial.
[19] These six are Nigeria, DRC, Uganda, Zambia, Tanzania and Kenya.

108 In 2006, the WHO estimated there to be 247 million cases of malaria worldwide (WHO 2008). 206 million of these (83% of the total burden) were estimated to occur in the top 20 burden countries (Table 8 from WHO 2008). This dropped to an estimated 190 million cases in 2009 and 184 million cases in 2010 (WHO 2012c) in these top 20 burden countries, representing an 11% reduction between 2006 and 2010.

Table 8 Top 20 high-burden countries for malaria[20]

Country	Estimated cases in 2006 (millions)	Cumulative proportion of global burden	DFID priority country?
Nigeria	57.5	23.3%	Yes
DRC	23.6	32.9%	Yes
Ethiopia	12.4	37.9%	Yes
Tanzania	11.5	42.6%	Yes
Kenya	11.3	47.1%	Yes
India	10.6	51.5%	Yes
Uganda	10.6	55.8%	Yes
Mozambique	7.4	58.8%	Yes
Ghana	7.3	61.7%	Yes
Cote d'Ivoire	7.0	64.6%	No
Burkina Faso	6.2	67.1%	No
Niger	5.8	69.4%	No
Cameroon	5.1	71.5%	No
Sudan	5.0	73.5%	Yes
Malawi	4.5	75.4%	Yes
Mali	4.3	77.1%	No
Burma	4.2	78.8%	Yes
Chad	4.2	80.5%	No
Guinea	3.8	82.0%	No
Zambia	3.7	83.5%	Yes

109 In 2006, the WHO estimated there to be 754,000 deaths in the top 20 high-burden countries (WHO 2008). This was estimated to have decreased to 393,000 in 2010 (WHO 2012c), representing a 48% reduction in malaria-associated mortality.

110 All-cause under-five mortality dropped from 5.7 million deaths in 2000 to 4.5 million deaths in 2011 in the 20 high-burden countries, representing a 21% reduction (WHO 2013).

111 Since 2000, four countries have achieved malaria elimination and thus been formally declared 'malaria-free' by the WHO Director-General: United Arab Emirates (2007), Morocco (2010), Turkmenistan (2010) and Armenia (2011) (WHO 2012c).

112 Health reporting systems in many malaria-endemic countries are insufficient to capture the true burden of malaria disease. Equally, the lack of vital registration data also means that absolute population numbers, deaths and causes of death are unreliable in many countries. In 2012, the WHO MPAC convened an Evidence Review Group to consider the best way forward in producing malaria burden estimates as well as to describe how to improve future data for input into those estimates. An update from this group was provided to the March 2013 MPAC meeting (WHO Malaria Policy Advisory Committee and Secretariat 2013). The limitations in

[20] The ranking is based on estimates of clinical cases for 2006 reported by the WMR 2008 (WHO 2008). Updated estimates by country for 2010 were published in the WMR 2012 (WHO 2012c). Two countries in this table are no longer in the top 20 high-burden countries based on the 2010 estimates – Burma and Zambia. In 2010 India had the second highest number of estimated cases (24.2 million).

estimating deaths in the high-burden countries will make it difficult for the global community to report against the GMAP goals by 2015.

113 Table 9 summarises the findings in relation to the assessment of overall country progress from the DFID survey. A quarter of DFID country offices (25.0%) considered that progress in the country since 2010 has been strong in terms of both improving the quality of malaria services (Pillar 1) and increasing access and building demand for malaria services (Pillar 2). In contrast, a third of country offices (33.3%) rate progress as having been limited in supporting innovation and global public goods for malaria (e.g. at the country level, by supporting a research agenda). Country offices are less positive about the evidence base for assessing progress. The best evidence appears to be available for progress against Pillar 1, with 25.0% rating it as strong. On the other hand, only 6.7% rate progress against Pillar 3 as strong, but this may be because most DFID programmes working on Pillar 3 are supported centrally rather than through country programmes. Country offices tend to rate the effectiveness of donor support as stronger for improving the quality of malaria services (Pillar 1) and increasing access and building demand for malaria services (Pillar 2) than the other two pillars.

Table 9 Survey findings on assessment of country performance on Malaria

	Strong	Medium	Limited	None	Don't Know
Pillar 1: Improving the quality of malaria services					
Progress since 2010	25.0%	62.5%	6.3%	0.0%	6.3%
Evidence base to assess progress	25.0%	31.3%	37.5%	0.0%	6.3%
Effectiveness of donor support	26.7%	46.7%	20.0%	0.0%	6.7%
Pillar 2: Increasing access and building demand for malaria services					
Progress since 2010	25.0%	56.3%	12.5%	0.0%	6.3%
Evidence base to assess progress	18.8%	25.0%	50.0%	0.0%	6.3%
Effectiveness of donor support	18.8%	56.3%	18.8%	0.0%	6.3%
Pillar 3: Supporting innovation and global public goods for malaria					
Progress since 2010	6.7%	53.3%	33.3%	0.0%	6.7%
Evidence base to assess progress	6.7%	40.0%	46.7%	0.0%	6.7%
Effectiveness of donor support	14.3%	42.9%	35.7%	0.0%	7.1%
Pillar 4: Focusing on malaria impact and results					
Progress since 2010	18.8%	50.0%	25.0%	0.0%	6.3%
Evidence base to assess progress	18.8%	31.3%	43.8%	0.0%	6.3%
Effectiveness of donor support	25.0%	31.3%	31.3%	0.0%	12.5%

4.2 DFID's contribution to malaria control and elimination

4.2.1 Resource allocation

114 DFID has invested a total of £812 million in malaria in the last three financial years, of which £263 million was spent in 2010/2011, £250 million in 2011/2012 and an estimated £299 million in 2012/2013[21] (Working Paper VII, Section V.3). Coupled with a levelling off and decline

[21] Note that this is given in current prices.

in real terms in the contributions made from other countries, the proportionate role of UK contributions has increased from 2.7% in 2008 to 11.7% in 2012, making it currently the third largest global contributor.

115 Table 10 summarises these expenditures by the route of delivery. Overall, 80% of the estimated malaria spend was via bilateral aid and 20% via multilateral aid. This breakdown between the bilateral and multilateral routes has remained constant for the last three financial years.

Table 10 DFID expenditure on malaria (£ millions, current prices)[22]

Category	2010/2011	2011/2012	2012/2013*
BILATERAL AID	**213.4**	**203.8**	**254.0**
25 countries in which DFID provides bilateral malaria aid	**113.7**	**143.9**	**169.6**
-Direct malaria spend, incl. research	44.9	70.0	68.1
-RMNH	13.2	20.3	19.4
-Health systems and services	55.2	53.6	82.0
Bilateral spend, non-country specific	**99.7**	**59.9**	**84.4**
-AMFm	91.1	52.8	72.9
-Regional spend, Africa	2.6	1.8	4.9
-Regional spend, Asia	0.0	0.1	0.5
-Water and Sanitation	6.0	5.2	6.1
MULTILATERAL AID	**49.3**	**46.2**	**45.0**
Global Fund	36.4	33.3	33.3
World Bank	3.6	4.8	3.7
UNICEF	1.0	1.8	1.8
EC	0.4	0.4	0.3
Water and Sanitation	7.9	5.9	5.9
TOTAL	**262.7**	**250.0**	**299.0**

116 DFID's multilateral spend on malaria is predominantly through the Global Fund (Table 10). Other multilateral contributions include the World Bank and UNICEF, both of which spent far less on malaria than either the Global Fund or the UK bilateral programme (Working Paper III, Section III.4). The Global Fund is the largest multilateral supporter of malaria. The UK's overall contribution to the Global Fund[23] (including funds for HIV and TB as well as malaria) has increased steadily from US$ 79 million (~£39 million) in 2008 to US$ 405 million (~£250 million) in 2012, making it now the third largest contributor (Working Paper II, Section II.4.2).

117 DFID's direct spend on malaria control in countries to which it provides bilateral aid[24] amounted to 7.7% of the total direct bilateral contributions in 2010.[25] DFID's share of the total contribution to individual countries varied substantially (Table 11). There is a significant correlation between the estimated bilateral contributions by DFID to individual countries and need based on past burden (Figure 6). There are some apparent outliers where the funding contributions are higher than might be expected based on burden alone. For example, in Cambodia there is substantial investment due to the emergence of artemisinin resistance. In

[22] DFID's contribution to the Global Fund in 2010/2011 is an adjusted estimate to account for uneven front- and back-loading of Global Fund contributions. See Working Paper II, Section II.4.2.
[23] Calculated as annual pledges to the overall fund plus the contributions to AMFm (Working Paper II, Section II.4.2).
[24] Based on analysis of 'direct' expenditures on malaria control (i.e. excluding indirect expenditures such as health system support).
[25] Note that global expenditure estimates are by calendar year, whereas available DFID expenditures are by UK financial year, which starts in April. In this report, DFID expenditures for financial years are unadjusted; thus, for example, DFID spend in 2010/11 is matched to global spend for 2010.

Ghana, the investment also appears high relative to the burden, but a more complete analysis of the role of other funding sources would be required to make a definitive assessment. However, overall the balance across countries appears to be broadly appropriate.

Table 11 DFID expenditure on malaria as proportion of total spend: direct expenditures only[26]

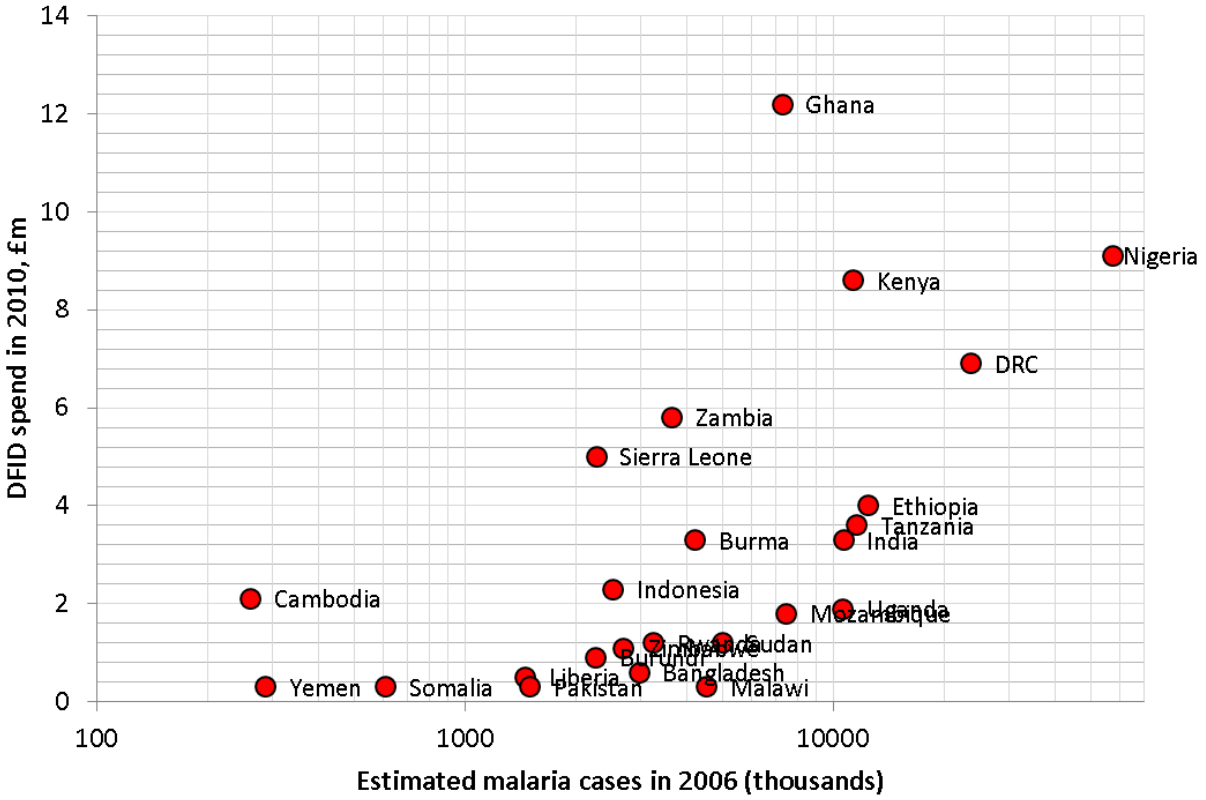
Country / Area	'Direct' malaria expenditure, 2010		
	Total (£m)	DFID (£m)	DFID (%)
25 DFID-supported countries	**860.3**	**77.0**	**9.0%**
Top 20 malaria burden countries with direct DFID bilateral spend	**685.8**	**59.0**	**8.6%**
DRC	58.2	6.9	11.8%
Ethiopia	48.4	4.0	8.3%
Ghana	56.4	12.2	21.6%
India	77.5	3.3	4.2%
Kenya	65.9	8.6	13.1%
Malawi	27.2	0.3	1.2%
Mozambique	40.6	1.8	4.4%
Nigeria	91.4	9.1	9.9%
South Sudan	8.2	0.5	5.6%
Sudan	23.0	1.2	5.1%
Tanzania	114.4	3.6	3.1%
Uganda	45.6	1.9	4.1%
Zambia	29.0	5.8	19.9%
Other countries with direct DFID bilateral spend on malaria	**174.5**	**18.0**	**10.3%**
Bangladesh	7.5	0.6	8.2%
Burundi	16.3	0.9	5.7%
Cambodia	24.7	2.1	8.5%
Indonesia	30.8	2.3	7.3%
Kyrgyz Republic	0.9	0.2	18.8%
Liberia	16.2	0.5	3.0%
Burma	16.2	3.3	20.6%
Pakistan	4.7	0.3	6.4%
Rwanda	25.3	1.2	4.8%
Sierra Leone	6.5	5.0	75.8%
Somalia	3.4	0.3	9.1%
Yemen	7.4	0.3	3.5%
Zimbabwe	14.6	1.1	7.5%
Other low- and middle-income countries	**1362.5**	**8.9**	**0.7%**
Seven other high-burden countries[27]	749.8	8.9	1.2%
62 other countries in WMR	612.7	0.0	0.0%
AMFm[28]	**(91.1)**	**91.1**	**(100.0%)**
TOTAL	**2313.9**	**177.0**	**7.7%**

[26] DFID total contribution to each multilateral (Global Fund, World Bank and UNICEF) is attributed across the 25 countries with DFID malaria expenditure and seven other countries with a high malaria burden. For the Global Fund, total DFID support in 2010 of £36.4 million is therefore split at 9.2% of Global Fund in-country spend (excluding AMFm) across 32 countries. Corresponding figures for the World Bank are a total DFID support of £3.6 million, split at 8.7% of World Bank in-country spend across 32 countries.

[27] These are Burkina Faso, Cameroon, Chad, Cote d'Ivoire, Guinea, Mali and Niger.

[28] UK contributions only. Contributions to country have not been calculated as this period included the pilot phase.

Figure 6 Comparison of DFID's spend by country on malaria compared to the estimated burden of disease in 2006



118 Contributions to malaria research spend from the UK government[29] totalled US$ 159.8 million (in 2007 USD, ~£80 million) over the period 2007-11, representing 6% of the estimated global contribution (Working Paper II, Section II.4.5).

119 Fifty-five projects with at least 75% of funding falling under malaria-specific contributions were further analysed (Working Paper IV, Section IV.3.2). From this sample there is evidence of action under each of the four pillars of the Framework. While investment through multilaterals contributes to activities under all four pillars of the Framework, there is a particular focus on activities under Pillar 1 (Working Paper III, Section III.4.1).

4.2.2 Building capacity and working with partners

120 Inter-agency cooperation at an international level is aided by the coordinating role provided by RBM. DFID holds a seat as an RBM board member as a result of the substantial contribution that the UK makes to international malaria control (Working Paper III, Section III.6.2). DFID is also represented on the M&E working group of RBM. Furthermore, DFID additionally provides funding to RBM and WHO/GMP (see Box 1 and Working Paper III, Section III.6.2).

121 DFID engages closely with the Global Fund. It is an active participant on the board, has country health advisers involved in commenting on board papers, and holds frequent informal technical meetings with staff from the Global Fund in relation to the malaria programme. It

[29] The Medical Research Council (MRC), DFID, the Biotechnology and Biological Sciences Research Council (BBSRC) and the Department of Health.

leads a Global Fund group on performance indicators and also had close links with the establishment of AMFm (see Box 2) (Working Paper III, Section III.5.1).

122 One of DFID's strengths is its clear ability to engage with a wide range of organisations strategically over the long term. Since 2010 DFID has significantly expanded its human resource capacity for malaria, with an increase in the number of health advisers appointed since 2010 and new posts in New York and Geneva, focused on individual agencies, to supplement staff in London and East Kilbride (Working Paper III, Section III.5).

123 DFID plays a key role in the coordination of, and support for, malaria activities within the countries in which it works. For example, a key informant from DFID noted that the 'DFID and PMI staff speak regularly. Although overlap continues, the two organisations have a good relationship on the ground'. This is further evidenced in the recent PMI annual report in which coordination with DFID country programmes is cited (USAID et al. 2013).

124 Significant coordination activities were also noted at the regional level. Within Africa, for example, DFID's regional programme was noted by an external key informant as having aided the development of plans to implement SMC in Nigeria. The key informant also noted that 'the DFID programme appeared to be more flexible at a regional level than at country level. Country programmes have an allocated envelope and the flexibility to respond to new intiatives is lost'.

125 Specific examples of DFID's leadership and coordinating roles at country level were noted in the country case studies. For example, in Nigeria DFID plays a leading role in donor coordination that was recognised by all the stakeholders interviewed (Working Paper VIII). This is aided by the integration of DFID's key health programmes within the national programme. In Ethiopia, DFID is the co-chair of the Health Development Partners Group on the Joint Core Coordinating Committee, the technical arm of a joint forum for dialogue on overall health sector policy and reform issues between the Government of Ethiopia, development partners, NGOs and other stakeholders (Working Paper VIII). However, the lack of a specific malaria programme was identified by the review team as a barrier to the engagement of the DFID Ethiopia office in malaria-specific discussions.

Box 1 Example of working with partners

Case Study – Roll Back Malaria

RBM was established in 1998 by the WHO, UNICEF, UNDP and the World Bank, in an effort to provide a coordinated global response to malaria. By 2010 it had over 500 partners, grouped into eight constituencies. All the key partners for malaria are members of this partnership and thus it has a major influence globally. RBM published the 2008 GMAP, which lays out global and national targets to reduce the burden of malaria and to move towards elimination and eventual eradication of the parasite.

The UK was a partner within RBM from early on, providing small amounts of core funding. At the beginning of the Framework period in early 2011, DFID developed a business case on 'Improving the effectiveness of the global response to malaria' which reviewed a number of options to best achieve this. Under this business case, RBM was jointly funded with the WHO GMP alongside a third tranche called the 'Enhancing Performance and Value for Money Project'. This last element was designed to be managed directly by DFID using innovation to reach the most vulnerable, engaging with private providers, market management for malaria commodities and other aspects vital to malaria control that may be best taken forward by DFID.

4.2.3 Programme outputs

126 In total, there were 200 active DFID projects with at least 25% of funds coded as being used for malaria-related activities funded from June 2010 onwards, with a total malaria-attributable budget over the lifetime of the projects of approximately £3,185 million (Working Paper IV). Some 33 projects accounted for 75% of this spend, although a large proportion of this is via general health sector support.[30]

127 Of the top 194 projects contributing to the overall malaria spend counted against the Malaria Framework, 23 (12%) were specifically malaria-related while approximately one-third (37%) were general health sector support. The remainder were basic nutrition programmes (11%) and health research (9%); there was a range of other codes applied to a small number of projects (e.g. emergency food aid, rural development, urban development and management). Within this, large contributions were also made to multilateral agencies (i.e. the Global Fund, UNITAID and UNICEF).

128 The Malaria Results Tracker is a tool developed by DFID to monitor the outputs procured and distributed by DFID country programmes as well as to track outputs in those countries from all of the major donors and from domestic financing. Seventeen countries are included in the tracker – Burma, the DRC, Ethiopia, Ghana, India, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Sierra Leone, Somalia, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe.

129 Table 12 summarises the outputs procured and delivered by DFID over the last four financial years. In total, over these four years DFID has procured and distributed 33.2 million bednets, protected 10.9 million people from malaria using IRS, protected 11.6 million women during pregnancy, procured 19.5 million courses of ACT and procured 14.4 million RDTs. These figures mostly show a substantial upward trend over time although year-on-year variation is to be expected since bednet distribution (which can also influence the figure for the number of pregnant women receiving prevention) often occurs in mass campaigns that only need repeating in a three-year cycle. The decrease in IRS in 2012/13 is due to the data field only being completed in one country and hence it is not possible to infer whether the programmes in the other countries have ceased or if the data are not yet entered.

Table 12 DFID's global malaria outputs

Category	2009/2010	2010/2011	2011/2012	2012/13	Total
Bednets procured and distributed[31]	5,293,041	4,798,322	11,933,367	11,184,960	33,209,690
Number of people protected by IRS	1,050,025	1,370,961	7,973,084	530,000	10,924,070
Number of pregnant women receiving prevention	1,822,232	3,632,138	5,202,471	980,301	11,637,142
Number of ACTs procured	10395	8,858	4,886,790	14,568,278	19,474,321
Number of RDTs procured	176,120	295,471	2,467,837	11,481,707	14,421,135

130 Comparative data on total outputs from all donor sources were not available for all indicators in these countries and, where reported, are available in calendar years rather than financial years, therefore complicating direct comparison. In 2011/2012, DFID procured and

[30] These calculations made use of some approximations to estimate spend. These are outlined in Working Paper IV.
[31] Includes only nets procured and delivered by DFID and not those procured by others but delivered with DFID support. The latter were reported from Nigeria, Tanzania and Uganda. However, as this was a new field in the database, it was unclear whether the lack of reports from other countries reflected a true absence or a delay in data entry.

distributed 11.9 million bednets (Table 12) and distributed 12.2 million bed nets in total compared to a total global output of 82 million in 2011 (WHO 2012c), representing a 15% contribution. This figure excludes the substantial additional contribution made through DFID's contribution to the Global Fund.

Table 13 Outputs of vector control in the 17 high-burden countries with a DFID malaria programme over the three-year period (2009/10, 2010/11, 2011/12)[32]

	High burden[33]	DFID procured and distributed bednets	Total bednets	% DFID	DFID funded IRS	Total IRS	%DFID
Burma	Y	0	3,720,346	0%	0	22,216	0%
DRC	Y	927,593	22,161,583	4%	0	289,114	0%
Ethiopia	Y	754,266	19,953,007	4%	2,701,116	76,268,645	4%
Ghana	Y	2,350,000	5,663,329	41%	0	2,484,422	0%
India	Y	121,700	18,385,000	1%	0	173,592,360	0%
Kenya	Y	7,531,140	13,510,914	56%	894,484	4,790,038	19%
Malawi	Y	0	6,504,070	0%	0	2,647,309	0%
Mozambique	Y	2,353,446	6,062,302	39%	5,841,896	24,525,525	24%
Nigeria	Y	3,455,283	53,357,589	6%	0	707,235	0%
Rwanda	N	908,572	6,377,317	14%	0	4,803,770	0%
Sierra Leone	N	1,000,000	3,751,757	27%	0	1,159,209	0%
Somalia	N	0	814,779	0%	956,574	454,875	210%[34]
South Sudan	Y	12,458	6,068,616	0%	0	0	
Tanzania	Y	1,300,000	50,815,748	3%	0	25,686,767	0%
Uganda	Y	0	8,985,054	0%	0	6,876,725	0%
Zambia	Y	1,000,000	6,092,899	16%	0	19,132,351	0%
Zimbabwe	N	0	1,859,866	0%	0	8,964,463	0%
TOTAL		**21,714,458**	**234,084,176**	**9%**	**10,394,070**	**352,405,023**	**3%**

131 Table 13 shows the total nets distributed between 2009 and 2011 (2009/10 and 2011/12 for DFID) in the seventeen high-burden countries. The total across all countries for the three year period was 27.3 million nets procured and distributed.[35]

132 Sample projects were reviewed for indicators of HSS. In total, 24 of 29 projects (83%) included at least one indicator that was relevant to HSS. The use of HSS indicators has not changed significantly since the publication of the Framework (6/18, 82% prior to 2011 versus 7/22, 86% from 2011) (Working Paper IV, Section IV.3.2).

133 The country case studies provide examples of the types of initiatives that general HSS projects involve. For example, in India DFID support has been used to strengthen the sentinel laboratory sites for malaria and dengue testing. It also enabled procurement of rapid diagnostic test kits and essential antimalarials to take place when government procurement was delayed. In Nigeria, the PATHS-2 project funded by DFID works with the federal, state and local

[32] Total outputs from the comparable three-year period (2009–2011) are from the WMR 2012.
[33] In the top 20 countries contributing to the global burden of malaria in 2006.
[34] The discrepancy may be due to a mismatch between calendar and financial years.
[35] This figure is from DFID Annual Reports based on data from DFID's Finance and Corporate Performance Division.

governments to strengthen the health systems and therefore improve the quality of general primary care services.

134 DFID programmes also invest substantially in capacity building to improve the quality of services. For example, in Nigeria, DFID funds the Support to National Malaria Programme (SuNMaP), a five-year £50 million project started in 2009 to support the NMCPs. In addition to supporting prevention, diagnosis and treatment activities, 20% of the costs in year 4 of the programme were associated with capacity building. This includes increasing the capacity of the NMCPs, as well as increasing capacity in state and local governments. It also works to increase capacity in the commercial and private sectors to support malaria prevention and treatment (Working Paper VIII).

135 DFID is leading the development of innovative models to engage with the private sector to increase access to high-quality services. One of the most visible of these initiatives is its support for the AMFm (see Box 2). A second major investment of up to £35 million was made in 2012 to the Clinton Health Access Initiative to support 'market-shaping' (innovative methods for engaging with the private sector to increase supply and demand) for access to health commodities. This project includes antimalarials and diagnostics for malaria alongside support for HIV- and TB-related interventions. The overall aim is to stimulate markets to lower prices for these key health commodities through intervening in both the supply and demand side in addition to complementary interventions to strengthen the health system for intervention delivery.

Box 2 Example of market dynamics work

Affordable Medicines Facility – Malaria (AMFm)

One of the major challenges in scaling up access to treatment has been the lack of availability of quality-controlled ACTs. The AMFm was launched in April 2009 to 'enable countries to increase the provision of affordable ACTs through the public, private and NGO sectors' and 'reduce the use of artemisinin as a single treatment or monotherapy' to limit the risk of resistance (The Global Fund to Fight AIDS Tuberculosis and Malaria 2012). The aim was to achieve these goals through three broad activities: price reductions, buyer subsidy and supporting interventions to promote appropriate use of ACT. Phase 1 consisted of pilot interventions in eight countries. An independent evaluation undertaken in 2012 was broadly positive (AMFm Independent Evaluation Team 2012), with AMFm Phase 1 demonstrating that it could represent 'an effective mechanism to rapidly improve the availability, price and market share of QAACTs' (Tougher et al. 2012).However, PMI and Oxfam have expressed doubts over the results achieved through AMFm at the outcome and impact level (The President's Malaria Initiative 2012; Oxfam 2012) although PMI ultimately supported the GFATM decision. In November 2012, the Global Fund Board took the decision to integrate the AMFm funding stream into the general funding model.

136 The overall UK contribution to malaria research includes both UK government funding and support from foundations. Just under half of UK funding was from the Wellcome Trust, 34% from the UK MRC and 15% from DFID. Other small contributors included BBSRC, the Department of Health, the Royal Society and the Leverhulme Trust.

137 Analysis of the research funded by UK government other than DFID was outside the scope of this review. However, the largest research project assigned malaria funding was the support to the joint MRC, DFID and the Wellcome Trust funded Global Health Clinical Trials Initiative.

This scheme funds research to generate new knowledge about trials that will contribute to the improvement in health in low- and middle-income countries, with a focus on late-stage clinical and intervention trials to measure efficacy and effectiveness (Medicial Research Council 2013). Other substantial research investments include those made to PDPs, including to the MMV (Box 3), FIND and the IVCC.

138 DFID has also recently invested in a major research-based project to track the spread of artemisinin resistance – the Tracking Resistance to Artemisinin Collaboration (TRAC). The programme, led by the Mahidol-Oxford Research Unit in Bangkok in collaboration with the Liverpool School of Tropical Medicine, London School of Hygiene and Tropical Medicine and WHO GMP, includes monitoring the spread of artemisinin-resistant parasites at fifteen sites (including two in Africa alongside thirteen in Asia), new research on the vector profile and potential novel vector control strategies in the areas affected by artemisinin resistance, research into the health systems, counterfeit and substandard drugs and socioeconomic factors impacting control strategies in areas with emerging resistance, and improved coordination of activities to curb the spread of resistance.

Box 3 Example of results delivered through the research portfolio

Medicines for Malaria Venture

The MMV was established in 1999 in Switzerland with funding from the Government of Switzerland, DFID, the Government of the Netherlands, the World Bank and the Rockefeller Foundation. Its mission is to reduce the burden of malaria in endemic countries by discovering, developing and facilitating delivery of new, effective and affordable antimalarial drugs. It is one of four not-for-profit PDPs in malaria research. DFID is currently MMV's second largest donor.

There has been a huge uptake of MMV's first product, Coartem D, with 72 million courses being delivered in 35 countries since the product's launch in 2009. In the last year, MMV have helped gain WHO approval for injectable artesunate and are now working in partnership to produce this in quantity at US$ 1 per vial. They are on track to gain European Medicines Agency approval for two further combination drugs (Eurartesim and Pyramax) this year. MMV have also made good progress on the development of non-artemisinin drugs (vital to combat artemisinin resistance) – with OZ439 offering the additional benefit of a single dose cure. They have also advanced drugs to combat malaria in pregnancy and to tackle relapsing forms of *Plasmodium vivax* (a form of malaria common outside Africa that has a significant associated burden of disease (Gething et al. 2012)), as well as developing paediatric formulations of drugs undergoing approval.

Moreover, MMV have an impressive discovery pipeline. They have built the world's largest portfolio of new and innovative antimalarial medicines and are on target to bring three new compounds from discovery into pre-clinical development in 2011. Technological advances in recent years have allowed for high throughput screening methods that are yielding significant results – 6 million compounds from a number of drug company libraries have been screened with the identification of 25,000 active compounds.

139 DFID has worked with its international partners, and in particular through the RBM partnership, to improve the M&E of malaria interventions in high-burden countries (see Box 1). DFID has additionally directly supported several projects to strengthen monitoring and information systems in high-burden countries. For example, in India this includes support for the Odisha State Malaria Information System, a web-based application to acquire, analyse and report on five key malaria surveillance indicators, including the numbers of cases and deaths. In Nigeria, the SuNMaP project includes funding to establish methods to track changes in malaria burden, provide evidence on how malaria control interventions have worked, provide

information on trends in knowledge, attitudes and practice related to malaria control and to promote links between the research community and policy makers. In Tanzania, DFID provides direct support to the Ifakara Health Institute, a leading institution for malaria research in the region, to collaborate with the NMCPs in assessing the current epidemiological situation and impact of interventions to provide the evidence to support federal resource allocation.

4.3 Findings of the Mid-Term Review

140 This section addresses the MTR questions outlined in Chapter 3. It covers the effectiveness of the Framework as a strategic instrument; resource mobilisation; management; activities and outputs; outcomes and impact; and the cross-cutting issues that were identified.

4.3.2 Has the Malaria Framework provided an effective strategic instrument to achieve UK government objectives?

141 Evidence from the Framework analysis and KIIs suggests there were two parallel motivations for the development of the Framework. The first was as a strategic document to bring together the broad malaria portfolio (delivered via the bilateral and multilateral programmes) into a more coherent whole to enable the different types of support to have greater impact. The second was a broader agenda to strengthen the results focus and accountability of UK development assistance (see Section 2.1).

142 A number of key assumptions underpin the Frameworks, as were outlined in Chapter 3. They are that the evidence base is solid; that it effectively identifies DFID's specific role and comparative advantage; that other partners will undertake complementary actions, particularly through wider processes of health systems development; and that the Frameworks are able to drive processes within the organisation, including DFID country-level programming.

143 The Framework development phase included an extensive evidence review that directly informed the identification and structure of the pillars. External key informants rated the evidence review as extremely strong. They also positively noted the strong involvement of the internal DFID team in developing the evidence base, commenting that this had a parallel benefit in 'increasing the internal knowledge of malaria'. DFID staff noted the importance of developing a strong evidence base to support accountability and monitoring.

144 The malaria elimination agenda is discussed in the evidence paper supporting the development of the Framework, although it is was explicitly not a focus of the Framework. The focus of the Framework was clearly defined as being the dramatic reduction of illness and death from malaria over the long-term in the countries currently most affected. At the time of the Framework development, elimination in the high-burden countries in which DFID is engaged was not expected to be a near-term goal. This has changed recently with a number of high-burden countries introducing elimination targets into their national strategic plans. This discrepancy was noted by several external key informants. This is unlikely to have an impact on the activities that DFID is engaged in up to 2015 given the longer-term nature of any elimination goals. However, elimination will be important to consider in the post-2015 agenda.

145 The comprehensive evidence review provided an implicit theory of change linking investment across pillars 1 (improve the quality of services) and 2 (increase access and build demand for services) to measurable impacts on morbidity and mortality. The implicit theory of change underpinning Pillar 3 was also provided by the evidence review, demonstrating the need to sustain tools to prevent the risk of resurgence. The focus of Pillar 4, to strengthen

M&E, while not explicitly linked in the evidence review to impact on morbidity and mortality, is clearly recognised in the wider international community (e.g. through the RBM M&E Reference Group (Roll Back Malaria 2013)) as being essential to strengthening results-based reporting.

146 In relation to DFID's proposed focus, KIIs supported the view that DFID's main strengths were in health systems support (falling under pillars 1 and 2) but that DFID did not have an established comparative advantage under pillars 3 and 4. However, DFID has developed an important niche of expertise under Pillar 3 by combining its general health sector support expertise with innovative market dynamics. Investment in new products is being undertaken through support for the PDPs which are funded by multiple donors. This is an area in which some external key informants felt DFID had less comparative advantage, although conversely DFID key informants noted their long-term experience in this area with ventures such as the International AIDS Vaccine Initiative. Nevertheless, the PDP route was praised by external key informants as providing the combined collaborative expertise that is needed.

147 Evidence from key informant interviews demonstrated a comprehensive, informal consultation both within DFID and with external partners. On the whole, this increased engagement and buy-in in regard to the Framework. However, it was noted by external key informants that the consultation process appeared to have occurred after the Framework structure was determined, and that the Framework was therefore not responsive to the views of those consulted.

148 It was also noted by external key informants that, since the publication of the Framework, there had not been much further communication of the strategy or of the results. This was in contrast to other organisations, particularly the USAID PMI, which was cited as having very clear reporting aided by annual reports to Congress (USAID et al. 2013). In contrast, DFID was viewed by multiple external key informants as lacking transparency. A common complaint was: 'we don't know what DFID are actually spending their £500 million on'.

149 The Framework was viewed positively by external key informants as being closely aligned with the international agenda (in particular with the USAID PMI). While the focus on morbidity and mortality was viewed by some as 'a safe bet for a short-term political commitment', others felt that this focus was appropriate for an agency with a strong footprint in wider health systems support. DFID was more generally viewed as being a 'strategic funder' – 'sticking to their principles rather than following trends'[36] – although this view was not clearly linked to the existence of the Framework.

150 The goals of the Framework closely match those set for the wider international community through the GMAP (Roll Back Malaria 2008). This was cited by DFID staff and external key informants as a strength of the Framework, in particular aiding results-based reporting.

151 DFID has a substantial and often influential engagement with a range of global actors in malaria (Section 4.2.2). However, DFID managers of multilateral relationships generally cited the MAR as their guiding strategic document rather than the Malaria Framework (Working Paper III, Section III.4.1)

152 The Framework did not provide any guidance on how resources should be allocated across the pillars, or any indicators with which to monitor this. There is currently no formal mapping process for projects against the pillars, although this is informally monitored by the Policy

[36] This was stated in reference to new interventions and did not reflect a perception that DFID was not adapting to change.

Division. Our analysis of the DFID project portfolio (Working Paper IV, Section IV.3.2) suggests that the Framework has had limited impact to date in determining the allocation of projects across pillars. Of the 55 malaria projects reviewed, there was activity under all four pillars with the balance remaining constant over time. This in part reflects the fact that many projects began prior to its publication. However, DFID staff noted that there was no expectation to have a balanced portfolio across all four pillars.

153 At country level, knowledge and application of the Framework was variable. For example, in Ethiopia, where there is no direct malaria programme, the Framework had had no direct effect on project funding allocations (Working Paper VIII). In Nigeria, a country in which there is substantial direct bilateral malaria funding, knowledge of the Framework was greater (Working Paper VIII). One health adviser stated that 'the Frameworks are useful. They provide useful strategic direction. Not as a Bible, but as a guide'. Here there was agreement among the DFID health and results advisers that the Framework helped the country office to prioritise actions and align them with DFID's global vision, as well as to support business cases. The design of a successor malaria programme had been directly influenced by the priorities in the Framework.

154 A similar pattern emerged from the survey of country offices (Working Paper V). For example, some country offices found that it helped them to prioritise malaria (particularly within the scope of the BAR), to focus their existing programme, to support business cases, as an evidence base and as a communication tool. However, in other countries the impact was more limited – with reasons cited including the lack of large-scale malaria programmes and the Framework appearing after the programmes had already begun. One programme noted 'The Framework really just articulates sensible public health/disease control parameters, and so I think we would probably be doing exactly the same whether or not we had it'.

Summary: Key findings

The Framework is assessed to have provided important strategic guidance to help the UK government objectives to be met. The evidence base is sound and the strategy is closely aligned with the global agenda, although consideration will need to be given to the post-2015 agenda, particularly given the global shift to encompass the malaria elimination agenda. DFID has, to varying degrees, a comparative advantage in the areas identified in the Framework.

DFID has developed influential relationships with a range of global actors and the Framework has contributed to raising DFID's international profile on malaria. However, the MAR was considered to be a more important influence on multilateral funding decisions than the Malaria Framework itself. The use of the Framework in informing DFID funding allocations at the country level is variable, with some countries reporting substantial use while in others it has not influenced programming. There was evidence of activity under all four pillars of the Framework. However, the Framework does not provide guidance on the allocation of resources across the pillars.

Overall assessment: The Malaria Framework has provided important strategic guidance to help achieve government objectives and has helped to raise DFID's international profile on malaria. However, its effectiveness in influencing country-level programmes has been partial.

4.3.3 Have adequate resources been used and appropriately applied to achieve these objectives?

155 The high-level objective of the Framework was to 'contribute to reducing deaths by at least 50% in at least 10 high-burden countries'. While there is a clear implicit theory of change within the Framework for achieving these aims, it is not possible to assess whether sufficient resources have been committed as the objective is contingent on the inputs from other international donors and from domestic funding in the high-burden countries. Nevertheless, the fact that DFID is now the third largest contributor to international malaria funding demonstrates substantial commitment to achieving the high-level objective.

156 As noted above, the yearly spend is estimated to be approximately £300 million over the past three financial years. This is substantially lower than the high-level target of '*up to £500 million each year by 2014/15*' set out in the Framework. A projected significant increase in the funding pipeline will, if followed through, increase the annual spend in the next two financial years, with a DFID estimate of £494 million in 2014/15 (National Audit Office 2013, p 20). This rises with recent increased commitments to the Global Fund (DFID 2013a). DFID is therefore on target to reach the annual spending level set out in the Framework by the end of the period.

157 Of the total spend on malaria in the last three financial years approximately 17% is channelled through multilateral agencies (Table 8). By far the largest proportionate contribution (13% of total spend) is to the Global Fund, which has a strong footprint in malaria control in high-burden countries (Table 8).

158 Bilateral spend accounted for an average of 83% of all spend in the past three financial years, split between direct support to countries (64% of the 83%) and non-country-specific support (including AMFm, regional programmes and water and sanitation). Of the total calculated direct bilateral spend in 2010/11 of £113.7 million (Table 10), £44.9 million (39%) was direct country-specific malaria spend. The remaining 61% was attributed as a proportion of wider HSS (49%) and a proportion of reproductive, maternal and neonatal health spending (12%).

159 The method for assigning these contributions was published in the Framework and appears to be appropriate. However, there remains a discrepancy between the amount reported by DFID and that reported in the WMR (Working Paper II, Section II.4.2). DFID should continue to work with the WHO to ensure that in future years consistent figures are reported.

160 The AMFm project (recently integrated into the Global Fund) accounts for a significant proportion of the overall malaria spend (on average 27% over the past three financial years) (Table 10). The project maps closely to Pillar 2 of the Framework. A recent independent evaluation of AMFm (Arnold et al. 2012) showed success against benchmarks in the majority of countries, demonstrating the overall effectiveness of the programme.

161 Including both the direct bilateral aid and the indirect contributions through the multilateral route (including the Global Fund, UNICEF and the World Bank), we estimated a total malaria spend of £177 million in 2010 in malaria-endemic countries (Table 9). £159 million (90%) of this spend was in the top 20 high-burden countries. The majority of total malaria resources in high-burden countries are provided by external donors. Thus, the resources are currently well matched to achieve the commitment to reduce deaths in at least ten high-burden countries.

162 Considering the bilateral and multilateral routes combined, the resources are largely concentrated in the high-burden countries on which the Framework objectives are focused.

Some high-burden countries, however, have relatively proportionately low resources allocated (Figure 6). While it may be possible in principle to achieve greater impact by increasing focus on a smaller number of countries with particularly high burden, these are also countries in which political instability and conflict are major barriers to success, such as DRC. Assurance would be needed that spend will be effective in these countries when considering future programming allocations across high-burden countries.

163 There is no obvious way to assess whether the current split in resources between the bilateral and multilateral routes is appropriate. Investing via bilateral programmes increases the input that DFID has into country-level programming and thus allows better strategic alignment with the Framework. However, investment via the multilateral route allows a greater global footprint and hence impact. Both routes have associated risks. Thus, our assessment is that balancing investments via both routes, as is currently planned, is appropriate in balancing the potential gains and risks.

164 In general, DFID's strong focus on strengthening health systems and services more widely is appropriate. Calculating malaria spend using a proportion of wider health sector support spend reflects the fact that sector-wide improvements should contribute to improving malaria services.

Summary: Key findings

Our assessment, based on the inputs to date and commitments for 2013 to 2015, is that DFID is currently on track to reach the annual spending level set out in the Framework by 2014/15. It is not possible to say whether this will be sufficient to achieve the overall targets since this will also depend on resources from other sources.

The geographical focus of bilateral aid appears to be broadly appropriate in relation to need. However, the Framework does not establish clear criteria or guidance on the balance of funding between multilateral and bilateral channels.

Overall assessment: Spend is expected to reach the target levels by 2014/15 and this represents a major contribution to combatting malaria. The allocation is broadly appropriate, although it is not possible to determine if the impact targets will be achieved on the basis of this information.

4.3.4 Has the Framework and DFID's programmes under it been effectively managed to achieve UK government objectives?

165 This section assesses mechanisms for implementing the Framework activities, including M&E systems and the management of risk. It also assesses whether mechanisms for financing global public goods and harnessing UK expertise have been put in place.

166 Informal coordination of the malaria programme occurs through quarterly meetings involving health advisers from endemic countries, staff from the research and global funds departments, the Policy Division team, regional advisers and others (e.g. the communications team) where relevant. The focus of these meetings is on technical issues rather than process or monitoring.

167 Project documentation potentially provides the most detailed source of data for monitoring. While informal monitoring of the allocation of projects against pillars is undertaken, there is no systematic way of collating this information for regular monitoring or evaluation purposes,

although reviews and evaluation of individual projects are undertaken under the wider guidelines set out in the DRF.

168 DFID has a strongly decentralised system of programming at the country level. This is a considerable strength in many respects and allows programmes to respond to local circumstances. However, it means that there is no direct mechanism for the Framework to determine country programming. The extent to which the country programmes reflect Framework priorities is discussed in section 4.3.5. The analysis here focuses on the mechanisms to link DFID strategic priorities to country-level programming.

169 The BAR which was undertaken at the time of the Framework publication introduced new mechanisms for project appraisal, including the use of business cases. The BAR process had a much more direct effect on country-level programming than did the Framework, although interviews with DFID staff, the in-depth country reviews and the country office survey noted that the Framework had been useful during the BAR process and more generally in developing new business cases.

170 The top-level commitments in the Framework are tracked through the DRF. Monitoring information against these indicators is collected through a centrally coordinated process every six months, with results published in the DFID Annual Report in June each year. DFID departments and country offices are expected to report against all DRF indicators where they have relevant activity, and where their reporting meets standards set out in methodology notes for each DRF indicator (DFID 2013k). Monitoring information is not necessarily available for each indicator.

171 There are two level 1 indicators related to the Malaria Framework – namely, incidence and death rates associated with malaria under MDG6. In addition, under level 2 (DFID bilateral indicators) the number of ITNs distributed with DFID support and the number of malaria-specific deaths per 1,000 persons per year is reported. The number of ITNs distributed by the Global Fund is also included under the multilateral indicators. As a measure of efficiency, the weighted average unit cost of an ITN is also reported.

172 In parallel, each DFID department reports against its OP. Also updated twice a year and published annually, OPs set out the strategic priorities for DFID departments based around eight indicators [37] As at 30 June 2013, relatively few of the OPs reported against either the number of ITNs distributed with DFID support (6/31) or the number of malaria-specific deaths per 1,000 persons per year (1/30) (Working Paper IV, Section IV.3.2).

173 Following the publication of the Framework, DFID health advisers and country offices were provided with a recommended core list of standard input and output indicators. These indicators, plus additional locally relevant data, are collated at country level each year in the Malaria Results Tracker. This provides a coherent set of indicators that in principle could be used to assess trends between countries and over time. However, further strengthening of this system is required for it to provide robust evidence. In particular, the system does not currently link project codes, financial commitments and outputs, making it impossible to systematically evaluate effectiveness or VfM across all projects. In addition, in interviews with DFID staff, a lack of ownership of the data at country level was noted that potentially limits its quality, with one informant noting that the country office ‘needs malaria results to keep HQ happy’.

[37] See Annex B in DFID’s Operational Plan for Ethiopia (DFID 2013l) .

174 DFID's investment in strengthening country reporting systems is improving the quality of country-level data as well as increasing the uptake of evidence for national strategic planning. For example, in Tanzania DFID supported a collaboration between the Tanzanian NMCPs, the Ifakara Health Institute and the KEMRI-Wellcome Trust programme in Kenya to assemble epidemiological and intervention coverage data. The work has assisted the national programme to better understand what is required to achieve universal access and to prioritise future funding needs, as well as to provide inputs into the new malaria strategic plan. In India, DFID has invested in several projects to strengthen monitoring and information systems (Working Paper VII).The Framework provides a mandate to develop global public goods under Pillar 3. There is strong evidence of substantial activity in this area through a number of projects. One major route is the support that DFID provides alongside other international donors (notably the BMGF) to the PDPs to increase the product pipeline for drugs, diagnostics and, more recently, vector control. The effectiveness and VfM of MMV, one of these PDPs, was praised in its first evaluation (Fairlamb et al. 2005). DFID has also promoted the PDP model to other donors, most recently helping to support a funding application from one PDP to another international donor (source: key informant interview).

175 Under Pillar 3 of the Framework, DFID directly supports the TRAC project to track the spread of artemisinin resistance at sites in Asia and Africa. This multi-partner project, which includes WHO-GMP, was initiated in 2011 and is studying clinical, molecular, pharmacokinetic and socioeconomic aspects of artemisinin resistance at 15 sites in Asia and Africa (WWARN 2013). Early results from the project have enabled mapping of the emergence of delayed parasite clearance in South East Asia, allowed an assessment of the characteristics of the populations at highest risk, and have demonstrated an improvement over time in drug quality. Several external key informants noted the need for longer-term commitment in this area

176 There was relatively little evidence to support any systematic focus on UK expertise in the project funding database. One external key informant noted that much of DFID's visible work is at the deployment level, and hence it tends to harness UK expertise at the operational level. One example of this is their support for the Malaria Consortium, a UK-based NGO providing operational support in a number of malaria-endemic countries. However, at the same time, such support was also sought from international organisations (e.g. CHAI).

Are risks being appropriately managed?

177 The Framework has been developed and implemented in a period of rising DFID budget, falling administrative resources,[38] and sharp reductions in the budgets of most other UK government departments. In this context, it is particularly important that DFID identifies and manages the risks associated with delivering the results in the Frameworks. The main potential risks that have been identified in relation to the Framework in the MTR are the following:

- There is a risk that DFID cannot demonstrate **VfM** for the increased resources that are linked to the Framework. The VfM analysis that has been completed for this MTR highlights concerns in regard to the use of VfM indicators. The MTR has also noted limitations in DFID's management capacity, particularly from the country case studies. These have also been referred to in the latest DIFD Annual Report, which notes that 'there are some weaknesses in programme management at country office level, including lack of robust due diligence and weak oversight' (DFID 2013c p. 148).

[3838] In 2011, the NAO reported that 'over the next four years, [DFID's] programme budget will grow by £3.7 billion (35% in real terms). At the same time, its administration budget will reduce by one third' (National Audit Office 2011).

- There is a risk, which has been highlighted by others including the ICAI,[39] that **DFID resources may be mismanaged**. The 2012/13 DFID Annual Report and accounts note that a particular focus of 2012/13 has been on strengthening results Frameworks, managing risk and developing new M&E approaches, and it sets out a number of ways in which DFID is responding to the recommendations of the ICAI (DFID 2013c), including by publishing country-specific strategies to safeguard DFID spending and contribute to reducing the impact of corruption. Risk mitigation for resources provided through multilateral agencies may be provided by the MAR process, which involves regular assessments of the performance of agencies that DFID funds.

- There is an inherent risk in the substantial fraction of M&E data being **self-reported by recipients of funds** (contractors, governments) and of review processes being managed by the country offices themselves. While there have been improvements in the risk and VfM focus of project documentation and review processes (in particular of business cases and annual reviews since 2011), DFID's Annual Report notes that annual review processes could be strengthened and that the quality of reviews is variable (DFID 2013c p. 147). The results agenda is an important contribution to mitigating this risk, but it is important that the systems to tell a robust and compelling results story are in place. DFID may consider the introduction of 'technical and data audits' or similar processes in selected annual reviews.

- The **sustainability** of the projected results is at risk if the countries to which DFID is providing support under the Frameworks lack the fiscal resources or the technical and management capacity to sustain the investments made – or if there is a lack of political commitment to take forward Framework goals. These risks may be assessed at the country level by reviewing indicators of national commitment, such as trends in public expenditure on malaria programmes or wider HSS, and the evidence of effective investments and reform.

- The wider development management literature has identified a series of **potential risks associated with adopting a results focus** – specifically that too much attention may be given to short-term, directly attributable outputs at the expense of investment in systems and capacity that should generate sustainable outcomes but for which results are harder to demonstrate (particularly in the short term) (see Annex E for further details). The main conclusion of this assessment was that the strong focus on HSS in DFID militated against an excessively short-term focus, and the emphasis on partnership and joint results militated against an excessive focus on actions with directly attributable results.

178 The MTR has not attempted comprehensively to assess DFID's structures and processes for managing these risks. However, it is clear from the material presented above, and in the course of conducting the review, that the existing structures in place to manage risk have been subject to recent strengthening. External assessments of these (for example, by the National Audit Office (NAO) (National Audit Office 2013) and ICAI (DFID 2013j)) suggest that these systems are improving, but that there is room for further improvement. DFID has sets out guidance for the corporate, OP and intervention levels in a document on managing risk (DFID 2011d), which highlights annexes and templates for different parts of the organisation to use in managing risk, and proposes ToR to clarify responsibilities for managing risk. The MTR has not looked in detail at any of the OPs or project plans for managing risk, but has noted that:

[39] The ICAI has produced around 20 reports scrutinising development assistance spending (DFID 2013j).

- There is a clear focus on risk assessment in the business case, which has sharpened in recent iterations of the business case template;
- That annual reviews and project completion reports explicitly focus on risk management. The most recent templates for annual reviews include a risk rating for each output; and
- Corporate-level performance against annual reviews is reported in DFID's Annual Report (DFID 2013c p. 40).

What has DFID done to ensure cost-effectiveness and VfM?

179 The Framework has promoted interventions that are highly cost-effective and therefore offer VfM provided the services and intervention are well implemented and the beneficiaries access and utilise them.

180 There is no universally agreed method to assess VfM. We therefore sought to review the project documentation to assess the extent to which projects incorporated VfM indicators covering the 'four Es' – economy, efficiency, effectiveness and equity (Working Paper VI, Section VI.1.1). Of the 25 malaria projects assessed, only six included any VfM indicator in their logframes. Of these, two projects included indicators of economy, four included indicators of efficiency, two projects included indicators of effectiveness and three projects included indicators of equity. However, it should be noted that many of these projects started before DFID identified its VfM strategy.

181 A small proportion of the total number of indicators being used to evaluate projects related to VfM and even fewer measured cost-effectiveness (such as cost per lives saved or cost per Disability-Adjusted Life Year (DALY)) (Working Paper VI, Section VI.1.2). Of the malaria project logframes that were analysed (25), there were only 17 indicators that provided explicit measures of economy and cost-efficiency and only one that explicitly measured cost-effectiveness (which was the number of lives and DALYs saved).

182 The project business case had a greater focus and reference to VfM. However, the coverage of high-quality appraisals of VfM was still variable. While VfM was referenced more explicitly in the business cases and in the annual reviews, many of the statements were generic (e.g. 'there are grounds to believe that overall the programme has represented VfM'). In particular, equity was not considered in terms of VfM in the documents reviewed.

183 These findings are consistent with those of the recent NAO report, which noted that 'Deeper analysis of cost-effectiveness at country level, such as approaches being developed by the Department's team in Nigeria, would help direct resources to where they should have most benefit' (National Audit Office 2013). We therefore recommend, in line with the NAO report, that cost-effectiveness and VfM statements are strengthened in business cases and annual reviews and that a minimal core set of VfM and cost-effectiveness indicators are included in logframes.

Summary: Key findings

While the decentralised programming undertaken by DFID country offices is in many ways a strength, it means that there is a disconnect between the high-level commitments at policy level and the country programmes. This limits the extent to which high-level commitments can be reliably implemented through the bilateral programmes.

There is effective work on developing global public goods, although the emerging

problem of artemisinin resistance will require long-term commitment.

Monitoring of results is clearly articulated in the top-level Results Framework. Recent development of a Malaria Results Tracker to collate a wider set of output and outcome statistics is a positive addition, although at present it has some limitations, particularly in linking project codes and hence financial spend with outputs and outcomes. Other than at these levels, there was no consistent use of malaria indicators in OPs. Indicators were reported against in project documentation but there was no systematic way to collate this information for monitoring or evaluation purposes. There was also a lack of wider evaluation of the portfolio as a whole. These weaknesses in the monitoring systems mean that data for evaluation are not readily available.

Systems for risk management are being strengthened across the organisation. Specific risks relating to the results orientation of the Framework were assessed and found not to be realised, largely because of a continuing commitment to partnership working and support to health systems.

Overall assessment: There is no systematic mechanism for ensuring that high-level commitments are implemented through the bilateral programme. The Malaria Results Tracker provides a practical mechanism to track country-level progress, but the monitoring system as a whole is disjointed and does not allow information from different levels to be properly integrated and analysed.

4.3.5 Are activities and outputs under the Framework on track to meet its objectives?

184 This section assesses which activities are being undertaken, the outputs produced and how the Frameworks have contributed to these; whether the planned activities are likely to achieve the Framework outputs; and whether they are relevant, effective, efficient, and equitable.

Achieving targeted outputs

185 Since the publication of the Framework in 2010 there has been a rapid increase in the output of commodities to high-burden countries (Section 4.2.3). The UK provided a substantial proportion of the global procurement and distribution of bednets in 2011 and additionally made significant contributions to IRS, procurement and distribution of drugs and diagnostics, and protection for pregnant women. As such, the UK contribution represents an increasing share of the global supply. A recent systematic review of the cost-effectiveness of current malaria interventions – including bednets, IRS, treatment, IPTi, SMC and IPTp – demonstrated that all are highly cost-effective compared to the international threshold of <US$150 per DALY gained (White et al. 2011). However, further systematic studies are needed to better understand variation in cost-effectiveness between different settings. Efficiencies in delivery are not possible to evaluate in summary indicators but were covered in more detail in the recent NAO report (National Audit Office 2013). They noted gaps between ownership and usage of bednets and lack of availability of RDTs as challenges to achieving high coverage.

186 Between 2006 and 2009 there was an increase in the number of DFID malaria projects initiated, which plateaued in 2010/11 (Working Paper IV, Section IV.3.2). Fewer malaria projects began in 2012/2013 than in previous years, although this excludes some large projects that began towards the end of 2013. Of the top 100 projects contributing to the overall malaria spend counted against the Framework, approximately one-third were general health sector support. The country case studies found that the majority of the health system strengthening

programmes were delivering the expected outputs or above according to the project reviews (Working Paper VIII). Some of this support is also malaria specific. In India, for example, funding has been used to train community health workers (ASHAs) who test and treat malaria at the village level (Working Paper VIII). To capture the outputs of this proportionally large investment area, additional indicators on health system strengthening need to be included in the Malaria Results Tracker.

187 DFID programmes also invest substantially in capacity building to improve the quality of services. It is difficult to quantify the outputs and outcomes associated with such support but it was widely recognised by the external key informants that DFID plays an important role in this domain.

188 Equity in access to the outputs delivered through DFID investments is difficult to assess as the indicators are not disaggregated by gender or socioeconomic status. However, given that malaria is a disease of poverty external key informants felt that malaria programmes by definition were improving equity in health. The support to AMFm to improve access to treatment by engaging the private sector was cited by external key informants as one model for improving equity.

189 Overall, DFID country offices perceived progress against pillars 1 and 2 to be good, with only one of the sixteen reporting poor progress in improving the quality of malaria services and two reporting poor progress in increasing access and building demand for services (Working Paper V). However, overall just under half of the countries surveyed rated the evidence for assessing progress to be 'limited'[40] – comments included 'there is a lack of accurate data' and 'limited tools assessing quality'. The effectiveness of donor support for both pillars was generally felt to be good, although in one country 'the donor coordination is weak'. Progress and donor support for Pillar 3 (supporting innovation and global public goods for malaria) and for Pillar 4 (focusing on malaria impact and results) at the country level were similarly perceived to be good, though again the evidence for assessing progress was reported to be limited.

190 The majority of country offices reported DFID's role in outputs under pillars 1, 2 and 4 to be effective ('strong' or 'medium') but a larger proportion rated it to be 'limited' under Pillar 3 (supporting innovation and global public goods for malaria), reflecting the fact that most activities under this pillar were taken forward under multilateral or centrally managed programmes (Working Paper V). This reflects the more focused nature of Pillar 3, with global activities and some countries reporting important contributions (for example, in evaluating integrated community case management, in supporting approaches to reduce the spread of artemisinin resistance and in piloting innovative drug supply models).

Multilateral programme activities and influencing

191 DFID has a strong influence on the global malaria agenda, primarily through its role in RBM but also via its seats on the Global Fund and UNITAID boards, its promotion of AMFm and through its financing of the World Bank. As stated by external key informants: 'DFID has a great deal of influence – their commitment is quite a bit of money and 'money talks''; 'DFID are well respected because of their quality in the field and their commitment to achieving results. They have highly effective partners.' 'In general there is a high degree of respect for what DFID do. They are listened to.'

[40] Country programmes were asked to rate this as 'Strong', 'Medium', 'Limited' or 'None'.

192 DFID's RBM board seat allows it to work closely with partners and beneficiaries, especially with other major financiers. External key informants noted that it allowed DFID to have a clear technical vision as well as making a statement of the degree of political priority accorded to malaria. This has helped in implementation, allowing coordination and complementarity with other donors in individual countries. For example, DFID co-funds with the BMGF research in Burma while coordinating with partners like the USAID PMI in high-burden African countries including Nigeria and Zambia.

193 A specific output of the Framework which is of direct influence on the wider global agenda has been the funding of Support to the Global Response to Malaria. This provides direct support to the WHO GMP and RBM to provide normative guidance and implementation support respectively (Working Paper III, Section III.6.2). In addition, a third tranche of funding – 'Enhancing Performance and Value for Money' – was allocated to provide flexible support to engage with private providers and market management.

Global public goods

194 Substantial investments have been made by DFID in supporting innovative models to enhance the availability of low-cost quality-assured treatment and diagnostics. The highest profile of these is its support, in partnership with UNITAID, for the AMFm. More recently, additional investments have been made to evaluate alternative models for improving availability. For example, in India, DFID is supporting the CHAI to improve supply by working with private manufacturers on pricing, production processes and market information (Working Paper VIII). While these models remain controversial (Oxfam Briefing Paper 2013), the effectiveness of AMFm has been established through an independent evaluation (ICF & LSHTM 2012).

195 DFID's support for the AMFm project, and market dynamics more broadly, was frequently cited by external key informants as being one of DFID's strongest areas. They noted that DFID had a broad portfolio in this area, supporting multiple partners to achieve synergies in their programme. Importantly, it was noted by an external key informant that DFID 'seeks out models for sustainable support'.

Research and evidence

196 DFID is committed to spend £249 million on health research between 2011/12 and 2014/15 (DFID 2013m). This includes investment in new drugs, diagnostics and vaccines for diseases affecting poor people (including malaria) and includes research organisations, PDPs, consortia and research councils as mechanisms for delivery of the results. According to figures provided by DFID, total DFID spend on commissioned health research between 2010/11 and 2012/13 was £212.6 million. Malaria research spend over this period was £47.6 million and made up 22% of the total.

197 It is too early as yet to evaluate the effectiveness of these research investments as a whole. However, earlier investments in the MMV are already resulting in substantial returns with a large increase in the uptake of MMV's first product, Coartem D, since its launch in 2009 and a substantial increase in the pipeline of new compounds and drugs at each stage of the development process. DFID's 2012 annual review of this project confirms the high level of effectiveness and efficiency of this programme.

198 DFID has made substantial investments in improving the global evidence base and its uptake in multiple countries. For example, in India DFID has supported the development of

national and state malaria information systems that allow reporting on a range of malaria-specific indicators (Working Paper VIII). It additionally supports more general health management systems in India, including a drug inventory, blood bank, referral monitoring unit and mobile health unit tracking system. Other than through specific project reviews, there is no systematic way to monitor the effectiveness or efficiency of these investments across all projects.

Summary: Key findings

There has been a rapid increase since the Framework was published in the delivery of commodities to high-burden countries. Independent evidence demonstrates the cost-effectiveness of these interventions provided utilisation is high. Recent investments in innovative models to enhance the availability of low-cost quality-assured treatment and diagnostics have proved to be effective and should continue to be monitored. A large fraction of the outputs related to malaria spend are in wider HSS. The annual project reviews showed these to be delivering their expected outputs.

While the Malaria Results Tracker tracks a number of health systems indicators it does not capture the breadth of DFID-wide health systems investments that would have malaria impact. Substantial investments are also being made in supporting country-level information systems, but their impact is not being systematically monitored.

The Framework has had a positive effect on the wider global agenda, through DFID's bilateral work with partners, multilateral contributions and strategic influence. Their recent increased support for product development, market dynamics and tracking artemisinin resistance is critical to the sustainability of the interventions.

DFID has made substantial investments in research to support new tools, in particular through PDPs. Evaluations of these initiatives undertaken to date show high levels of efficiency and effectiveness and hence represent good VfM.

Overall assessment: The activities under the Framework are resulting in substantial, measurable progress in the activities identified under all four pillars and in the delivery of relevant outputs. There are, however, no specific output targets defined in the Framework against which to assess progress.

4.3.6 Are outcomes on track to meet the objectives of the Framework?

199 The MTR was not expected to review outcomes comprehensively. Instead it sought to address three main issues: if there was evidence on outcomes achieved so far; whether the purpose of the Framework will be achieved if all outputs are achieved; and, if not, what extra or altered outputs are required.

200 It is not possible to directly link DFID's outputs to overall outcomes or impact at a country level as DFID malaria programmes operate alongside multiple other donors and implementers with variation between countries in their relative contribution. There are no quantitative targets defined for these outcome indicators in the Framework. Thus, our preliminary assessment is focused on the overall trends in a selection of the outcome indicators in the countries in which DFID provides support.

201 Much of the data cover up to the end of 2011 and so it is not possible to reach conclusions on more recent trends. New estimates for 2012 will be published in the 2013 WMR very shortly and the analyses here can be updated after publication.

202 There has been a substantial increase in bednet coverage in the 17 high-burden countries where DFID has a bilateral programme. The average proportion of the population protected by a delivered net[41] in these 17 countries rose from 49% in 2010 to 59% in 2011. Six countries reported >90% of the population protected in 2011 – including Ghana and Sierra Leone, countries in which the DFID contributions were substantial (41% and 27% of the total nets distributed respectively).

203 However, there remains sub-optimal bednet coverage in a number of countries. In particular, bednet coverage in Burma, Somalia and Uganda is very low (approximately 22%, 15% and 50% respectively in 2011). These are countries in which DFID did not procure and distribute bednets. In Nigeria and Mozambique, despite substantial contributions from DFID, the number of nets distributed remains much lower than the population at risk. There is therefore the opportunity to increase coverage, and hence have substantial impact, in these five countries.

204 There remain gaps between coverage based on distribution and utilisation (both in ownership and in using the net) in many countries, although there is substantial variation in these trends. For example, coverage in Nigeria in 2011 is estimated to be 62% based on distribution statistics (WHO 2012c) but in the most recent Multiple Indicator Cluster Survey undertaken in 2011, 40% of households had at least one net while only 16% of children under five and 17% of pregnant women were reported to have slept under a net the previous night (Working Paper VIII). In contrast, in Ethiopia coverage through distribution was estimated to be 63% in 2011 (WHO 2012c) and this closely matched the estimate of 64.5% of children under five reporting sleeping under a net the previous night in the 2011 Malaria Indicator Survey (Working Paper VIII). There are many possible reasons for these discrepancies, including bottlenecks in distribution channels and seasonal and geographic variation in usage. Continued investment in country programmes and further operational research is needed to understand and reduce remaining gaps between coverage and use. Similar recommendations were made in the recent NAO report (National Audit Office 2013).

205 The average proportion of the population covered by IRS has remained level in these 17 countries (16% in 2010 versus 17% in 2011). This average figure masks wide variation in both levels and trends. For example, in Ethiopia, in which DFID has invested substantially in IRS over the past three years, IRS coverage is estimated to have dropped from 49% in 2010 to 37% in 2011. In Mozambique, in which DFID also invested substantially in IRS (representing 24% of the total houses sprayed; Table 11), the estimated coverage level has remained reasonably static (32% in 2010 versus 36% in 2011). It is impossible to know whether these levels would have dropped further without DFID support. However, there remain potential gaps in coverage that require further investigation.

206 DFID programmes distributed ACTs for first-line treatment directly in six countries – Burma, Kenya, Nigeria, Somalia, Uganda and Zambia. DFID also contributed to supporting wider access to ACTs through its support of AMFm (see Box 2). Systematic data on changes in access to first-line treatment are available in three high-burden countries.[42] Between 2009 and 2011/12 the proportion of children under five with fever in the last two weeks who received an ACT rose from 4% to 11% in Nigeria, from 20% to 44% in Uganda and from 21% to 35% in Zambia. Similar increases were also observed in prompt access to care (within 48 hours of fever onset) (Working Paper II, Section II.3.3). These increases are significant and can be

[41] This is calculated assuming one net for every two people and is based on distribution statistics reported by national malaria control programmes assuming an average three-year life for each net.
[42] Database available at (ACTwatch 2013).

expected to have a substantial impact on morbidity and mortality. However, the overall levels of access remain low. This again highlights the need for the wider strengthening of health systems and health services to improve overall access as well as country-specific operational research to identify specific gaps.

207 Through its bilateral programmes, DFID has additionally supported the use of RDTs in a number of countries including Burma, Kenya, Nigeria, Rwanda, Zambia and Zimbabwe. Data from Nigeria show a low overall uptake of diagnostic testing and little change between 2009 and 2012 (Working Paper II, Section II.3.3). These mirror global trends (WHO 2012c), with low levels of diagnostic testing in the public sector and very low levels in the private sector. However, increasing the availability of RDTs alone is not predicted to improve case management outcomes given that there are a range of bottlenecks to receiving prompt care (Rao et al. 2013). Increasing prompt access to health facilities, improving drug stock management, and health care worker training to improve compliance with diagnostic test results will additionally be required to improve case management outcomes.

How sustainable are DFID's investments under the Framework? What has DFID done to ensure sustainability of its investments?

208 The sustainability of DFID's bilateral malaria programme remains an issue since it is focused in high-burden countries, many of which do not currently have the capacity to increase domestic support. In general, domestic funding for malaria control remains a small proportion of overall support in these countries. Thus, for example, in Nigeria our assessment was that the NMCPs relied heavily on donor assistance and thus are unlikely to be self-sustaining in the near future (Working Paper VIII). Similarly, in the DRC, domestic contributions to malaria control dropped in 2010 and 2011. However, in contrast, in Ghana, in which DFID has invested substantially in malaria programmes (Table 9), domestic contributions increased from less than US$ 3 million in 2008 to approximately US$ 6 million in 2009, 2010 and 2011 (WHO 2012c). Similarly, India increased its domestic contributions from US$ 60 million in 2009 to US$ 92 million and US$ 100 million in 2010 and 2011 respectively. Nevertheless, it is likely that continued support will be required for many years before these programmes become sustainable without international donor assistance.

209 The gaps identified in the outcomes section between delivery and uptake of interventions highlight potential barriers to sustained effectiveness and impact. To maintain and increase the gains in malaria reduction that have been achieved to date, there is a need to invest in building local capacity to address these issues, strengthen health systems and improve programme management. DFID has invested in all of these areas. However, this investment will need to be maintained beyond 2015 in order to ensure sustainability.

210 In contrast, the investments that DFID is making in product development, and in testing models for market engagement in supply and delivery of interventions, have the potential to generate self-sustaining models for intervention supply. The Framework has clearly guided investment in these areas. However, it is currently too early to evaluate this potential.

Summary: Key findings

Based on the available data, the trends in outcome indicators show substantial progress but it is too early to be certain whether the Framework objectives will be met.

There have been substantial increases in coverage of bednets, but so far only six of the 17 countries have achieved coverage levels greater than 90%. The relationship between the level of support by DFID and bednet coverage is variable and the gap between distribution and usage needs to be closed to ensure that the intervention remains cost-effective.

There have been improvements in levels of appropriate treatment of children with fever in many countries, but overall levels remain low. More extensive improvements in wider health services and systems will be needed to address this. Use of IRS is more variable and hence its impact is difficult to evaluate. SMC has the potential to further reduce burden and mortality in the areas in which it is recommended and hence accelerate progress towards the Framework goals.

Increased effort and finance, improved effectiveness and sustained political support will all be required to sustain these gains as well as to accelerate progress in the other high-burden countries.

Overall assessment: The trends in outcome indicators show substantial progress but it is too early to definitively state whether the Framework objectives will be met. Strengthened health systems, together with increased effort and finance and sustained political support will be required to sustain the gains and to accelerate progress.

4.3.7 Impact: To what extent is it possible to measure the impact of the Framework and of DFID's activities, and how can the measurement of impact be improved?

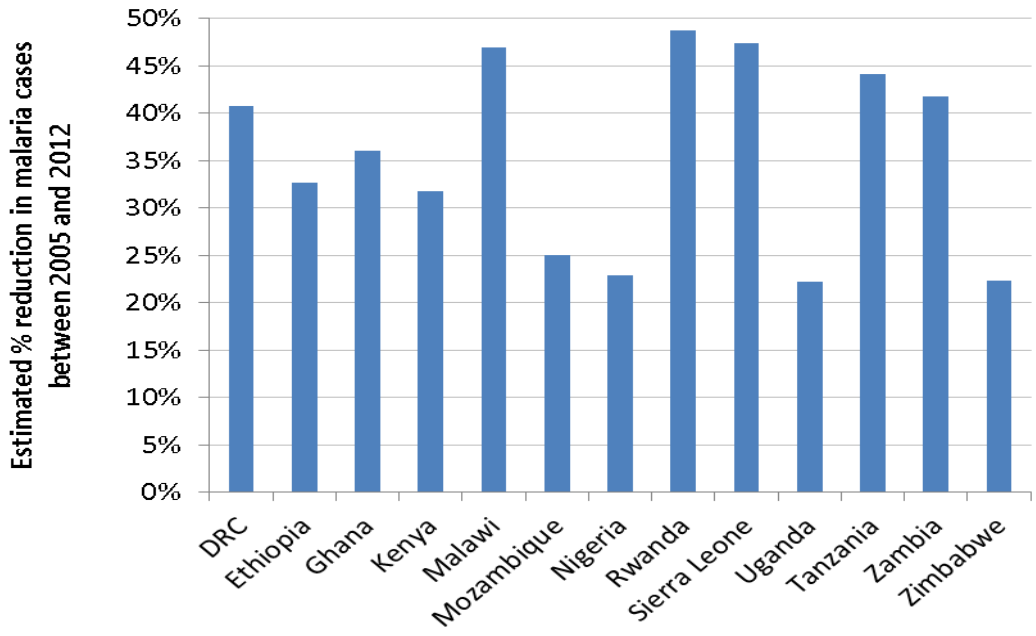
211 Estimates of malaria-specific mortality are only currently available for 2006 and 2010 at country level and hence it is too early to assess the impact of the DFID malaria programme on this outcome. However, using the methodology employed by WHO/GMP to estimate cases (Cibulskis et al. 2011), we estimated the percentage reduction in malaria cases between 2005[43] and 2012 in the 13 high-burden countries in which a risk-based methodology is currently employed. The maximum reduction achievable under this methodology is 50% as it relies on trends in bed net coverage. Furthermore, improvements in access to care can substantially reduce mortality while having lesser impact on case incidence. Using this methodology, five countries are close to achieving the maximum reduction – Malawi, Rwanda, Sierra Leone, Tanzania and Zambia (The 2013 World Malaria Report provides additional estimates of trends in malaria case incidence based on malaria admission rates. Of the 17 high burden countries with DFID country programmes, Rwanda is estimated to be on track to achieve reductions in malaria admission rates of 75% or more, whilst Ethiopia and Zambia are projected to achieve reductions of 50-75% by 2015.Data from the other 14 countries were considered insufficiently consistent to assess trends.

[43] We compared changes since 2005 as this is when scale-up of bednets began in most countries. The Framework is not specific about the time period over which a 50% reduction in deaths should be measured but the baseline year is likely to be later than 2005, which would imply a proportionately smaller reduction in cases.

212 Figure 7). A further four are on track provided outputs are sustained (DRC, Ethiopia, Ghana and Kenya). Four countries remain substantially off track (Mozambique, Nigeria, Uganda and Zimbabwe).

213 The 2013 World Malaria Report provides additional estimates of trends in malaria case incidence based on malaria admission rates. Of the 17 high burden countries with DFID country programmes, Rwanda is estimated to be on track to achieve reductions in malaria admission rates of 75% or more, whilst Ethiopia and Zambia are projected to achieve reductions of 50-75% by 2015.Data from the other 14 countries were considered insufficiently consistent to assess trends.

Figure 7 Estimated percentage reduction in malaria cases between 2005 and 2012 in 13 of the 17 high-burden countries with DFID country programmes[44]

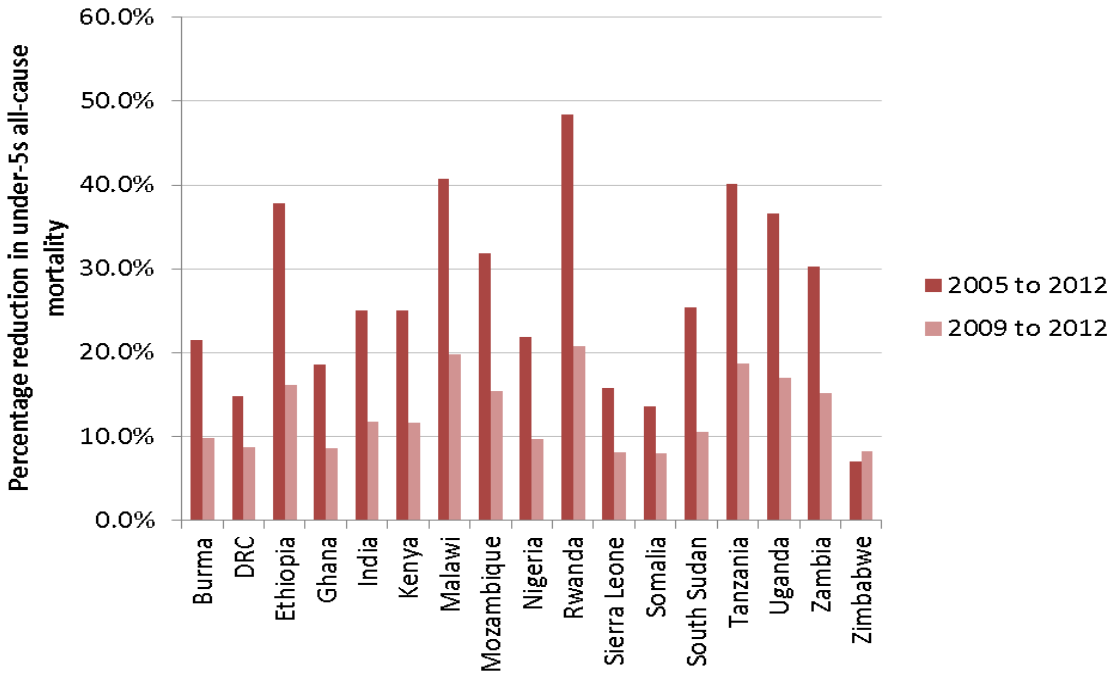


214 There are many limitations in the modelling approach to estimating impact. First, the method only takes into account one intervention (bed nets) and thus progress in countries in which IRS is used extensively (Zambia and Zimbabwe; Table 11) or in which treatment access is high will be under-estimated. Second, the method does not fully account for variations in the intrinsic potential for transmission which mean that impact in intrinsically high transmission settings such as DRC may be overestimated. New methods for estimating cases based on extensive parasite prevalence surveys are being considered by an Evidence Review Group of the MPAC (WHO Malaria Policy Advisory Committee and Secretariat 2013); these new estimates should be used going forward in order to monitor trends in the 17 high-burden countries in which DFID works.

[44] Estimates were obtained by applying the risk-based method used by Cibulskis et al. (2011) using coverage of LLINs based on LLIN distribution data as reported by NMCPs. These coverage data do not account for the difference between ownership and usage, nor loss of efficacy of nets over time, and hence will likely over-estimate their impact.

215 In the 17 high-burden countries in which DFID has a malaria programme, all-cause mortality in children under five decreased by an average of 26.7% between 2005 and 2012 and 12.8% between 2009 and 2012. There was substantial variation in this statistic between the countries (Figure 8), with the largest declines reported in Ethiopia, Malawi, Rwanda, Tanzania and Uganda. Three of these countries – Malawi, Rwanda and Tanzania – had large drops in malaria case estimates. Least progress was made in DRC, Sierra Leone, Somalia and Zimbabwe (although the mortality rate in Zimbabwe is substantially lower than in many of the other countries).

Figure 8 Estimated percentage reduction in all-cause under-five mortality 2005–12 and 2009–12 in the 17 high-burden countries with DFID country programmes[45]



216 Empirical data on trends in deaths from malaria were not available for the MTR. However, new estimates of the number of cases at the country level should be available for the Final Evaluation. Modelling approaches may therefore be used to make estimates of trends in malaria mortality and to estimate the impact of DFID interventions, provided an empirically validated model is available that links outputs to outcomes and impact, along with sufficient data on the outputs produced and on mortality and case incidence.

[45] Data were obtained from the World Bank Development Indicators database.

Summary: Key findings

Using WHO methods for estimating disease burden, five out of thirteen of the high-burden countries to which this method could be applied are estimated to be close to achieving a 50% reduction in burden in 2011 compared to 2005. A further four are on track provided outputs are sustained. Impact on deaths is likely to be greater than impact on cases since prompt access to effective treatment dramatically improves survival rates. All-cause under-five mortality has dropped significantly (more than 30% in seven years) in seven of the 17 high-burden countries and five out of seven of those countries also experienced substantial declines in malaria cases.

Subject to the availability of data and the validation of the modelling approach, it should be possible to make some plausible assessments of impact, although the limitations to the approach must be acknowledged.

Overall assessment: There is evidence based on modelled estimates of significant progress in the reduction in the malaria burden in most high-burden countries. Further development of the approach and strengthening of data on outputs and outcomes is required to enable measurement of the impact of DFID activities.

5 The RMNH Framework: MTR findings

217 This chapter presents the findings of the MTR in relation to the RMNH Framework for Results and the interventions which fall under it. It begins with an overview of the global context and how it has developed over the period of implementation of the Framework. It then summarises the findings on what DFID has undertaken. The chapter then presents answers to the MTR questions, signposting more detailed evidence providing the basis of these answers in the working papers.

5.1 Global progress in improving RMNH[46]

5.1.1 Changes in the global aid architecture and policy

218 The development of the RMNH Framework coincided with a series of international initiatives, prompted in particular by the recognition that targets for MDGs 4 and 5, which cover child and maternal health respectively, were seriously off track, and that Reproductive, Maternal, Neonatal and Child Health (RMNCH) had received less attention and fewer resources from donors than some disease-oriented programmes.

219 Recognising this challenge, and building on existing platforms for action, such as the Partnership for Maternal, Newborn and Child Health (PMNCH) that had been launched in 2005, the Global Consensus for Maternal, Newborn and Child Health was agreed in 2009 (WHO 2009) between international development agencies and world leaders. Effective implementation of the Global Consensus in 49 aid-receiving countries during 2009 to 2015 was expected to save the lives of up to 1 million women, 4.5 million newborn babies and 6.5 million under-five children, as well as to prevent 1.5 million stillbirths. It envisaged a significant decrease in unwanted births and unsafe abortions, and ensuring all needs for FP services were met. The High Level Task Force for Innovative International Financing for Health Systems estimated the total additional programme costs of achieving the proposed targets as US$ 30 billion[47] for the period 2009–2015, with annual costs rising from US$ 2.5 billion in 2009 to US$ 5.5 billion in 2015 (Taskforce on International Financing for Health Systems 2009).

220 Following this, several other major initiatives were launched in 2010, culminating in the launch of the UN Secretary General's (UNSG) Every Woman, Every Child Strategy (United Nations 2010) in September 2010, which aimed to give momentum and cohesion to global investments in maternal and child health. Two bodies were subsequently established to oversee its implementation: the Commission on Information and Accountability, which reports annually to the UNSG on progress with establishing mechanisms for results and accountability at country level (focused around 11 core indicators), and the Commission on Life Saving Commodities, which reports on commodities for women's and children's health. In addition, the independent Expert Review Group was established to focus on tracking actual results and resources for RMNCH.

[46] This section summarises a more detailed analysis in Working Paper I.
[47] A challenge for the comparison of information on international financial commitments and spending to expenditure that is covered by the UK's RMNH Framework is that these may also cover child health (so relating to MDGs 4 and 5) but omit other aspects of reproductive and sexual health. Figures are therefore quoted as covering MNCH or RMNCH for different sources. It has not been possible to identify global spending on RMNH specifically.

221 Earlier in 2010, at the G8 Summit in Muskoka in Canada, G8 countries agreed to build on cost-effective, evidence-based interventions, focusing on countries with the greatest need while continuing to support those making greater progress. The agreed approach involved supporting national, locally developed and owned health policies, improving coordination of development efforts, improving accountability and strengthening monitoring, reporting and evaluation. The G8 Muskoka Declaration (Government of Canada 2010) strove for a 'continuum of care', including ANC, post-partum care, FP (including contraception), reproductive health, treatment and prevention of diseases, prevention of mother to child transmission of HIV (PMTCT), immunisation and nutrition.

222 Between 2008 and 2013, the international community also paid greater attention to women's development and health more broadly. For example, at the institutional level, the launch of UNWomen in 2010 aimed to provide a stronger and more harmonised approach to promoting gender equality and the empowerment of women.

223 While enhancing access to key RMNCH services was at the core of these initiatives, the international community also recognised areas of particular neglect, including failures to address and improve the health of newborns and the need to address difficult areas, such as gender-based violence. Important international events over 2010 to 2013 include: the FP Summit of July 2012 (Family Planning 2020, 2013), which catalysed additional funding and momentum for FP; the 2013 annual meeting of the Commission on the Status of Women, which called for greater attention to ending violence against women (UN Women 2013); and a campaign to end sexual violence during conflict, which was launched in 2013 (The Preventing Sexual Violence Initiative 2013). Furthermore, in June 2013 a Global Nutrition for Growth Compact was signed, signalling the recognition of the need for global action to improve nutrition for mothers and children and in March 2014 the launch of the Newborn Action Plan will also contribute to a greater focus on saving newborn lives (Every Newborn 2013).

224 In addition to these initiatives, greater attention has also been paid to the need for effective investments in HSS as an integral part of an effective strategy to achieve RMNCH objectives. Moreover, Global Human Resources for Health (HRH) forums were set up in 2008, aiming to improve the distribution of human resources, especially in rural areas, which has also led to an increase in interest on an expanded role for mid-level providers (Global Health Workforce Alliance 2013). On financing of health services, the 2010 World Health Report on Universal Coverage set out how the international community could address financial barriers to accessing services, including for RMNH (WHO 2010).

5.1.2 Financing RMNH interventions

225 In response to the identification of a financing need of US$ 30 billion to achieve MDGs 4 and 5, the UNSG's Global Strategy sought to harmonise global efforts to track financial commitments to maternal and child health (MCH) and addressed fragmentation of funding mechanisms. The G8 Muskoka Declaration also aimed to address the significant gaps by committing to provide financial assistance to FP for an additional 12 million couples.

226 According to the PMNCH 2013 report (WHO 2013a), of the US$ 40–45 billion in total commitments made to the UNSG's Global Strategy (that could be expressed in explicitly financial terms), at least US$ 18–22 billion could be considered as confirmed new and additional funding. Of this amount, an estimated US$ 12–17 billion was targeted at the 49 Global Strategy countries.

227 There is evidence that the committed funding is indeed being disbursed. An estimated US$ 25 billion was disbursed between the launch of the Global Strategy in September 2010 and June 2013, more than double the US $12 billion disbursements reported as at September 2012.

228 However, Official Development Assistance (ODA) for RMNCH to the 49 Global Strategy countries and the 75 countries tracked by the Countdown collaboration (Countdown to 2015 2013) peaked in 2010, decreasing slightly in 2011 as a result of the financial crisis that affected major aid donors.

229 For the past two years, FP has received the largest number of commitments, and commitments have increased since the 2012 PMNCH report, mainly driven by commitments made at the London Summit on FP (FP2020) in July 2012 (UKaid & BMGF 2013). Interventions critical to improving women's and children's health that are receiving relatively less attention include postnatal care for mothers and newborns, antibiotics for pneumonia, and adequate sanitation facilities.

230 The profile of donors changed after 2009, with global health initiatives and private foundations playing a bigger part, although bilaterals remained dominant. The UK remained an important donor in most areas of RMNH funding, second only to the US, including in terms of FP and reproductive commodities. However, despite an increased global effort, the bulk of funding for RMNH services continued to come from domestic sources, and indeed from service users themselves. In Asia and the Pacific and Africa, direct 'out-of-pocket' expenditure on RMNH care accounted for 71% and 51% respectively of total contributions.

5.1.3 Global trends in intervention scale-up

231 There are many interventions that make up the full 'continuum of care' for women and girls throughout their reproductive lives. In addition, access to and effectiveness of RMNH services is heavily dependent on the overall performance of the health system as well as wider social factors, in particular the status of women and their education. The discussion below summarises evidence on recent trends in access to RMNH services and related interventions. However, only limited information is available on trends over the Framework period since 2010, and in general there are major weaknesses in the available data. The 2012 report of the independent Expert Review Group (World Health Organization 2012a) states that, of the 75 countries that accounted for over 95% of maternal and child deaths, only 11 had recent data on all eight indicators recommended for monitoring key health interventions. This indicates the continuing challenges in monitoring and hence in accountability.

232 In developing regions, the proportion of deliveries attended by skilled personnel rose from 55% in 1990 to 66% in 2011 (United Nations 2013). Nevertheless, in about 46 million of the 135 million live births in 2011, women delivered alone or with inadequate care. Wide disparities were found among regions in the level of trained attendance at birth, ranging from nearly universal attendance in East Asia, the Caucasus and Central Asia (100% and 97%, respectively) to a low of about 50% in Southern Asia and sub-Saharan Africa, the regions with the highest levels of maternal mortality. Rural/urban differences remained significant, and supervised delivery remained the intervention with the greatest discrepancies between rich and poor (Gwatkin et al. 2007).

233 Unmet need for contraception fell in all regions during 2000 to 2011, although this has stalled in recent years (UNFPA 2011). In many settings, contraceptive use was much lower

among the poorest, least educated women. Adolescent girls had the lowest level of contraceptive use and the highest level of unmet need for FP. The highest birth rate among adolescent girls aged 15 to 19 is in sub-Saharan Africa (118 births per 1,000 girls). This region has also made the least progress since 1990, both in relative terms and absolute numbers. The substantial decline in the global abortion rate observed in earlier years has stalled, and the proportion of all abortions that are unsafe has increased from 44% in 1995 to 49% in 2008 (Sedgh et al. 2012). An estimated 13% of maternal deaths are attributed to abortion (Save the Children 2013).

234 Coverage of other key maternal health interventions, such as ANC and postnatal care, rose globally but remained low in some regions and with continued significant inequalities across social groups. For example, in 2011 only 36% of pregnant women in Southern Asia and 49% in sub-Saharan Africa received at least four ANC visits during their latest pregnancy (United Nations 2013) and the quality of these interventions was still poorly documented. Coverage of HIV PMTCT and antiretroviral treatment (ART) for HIV-positive pregnant women varied considerably by country, and pregnant women and children were less likely to receive ART treatment than other adults (UNAIDS 2013), while primary prevention of HIV made slow progress (UNICEF 2013).

235 There is a lack of comprehensive global data on quality of care indicators, such as commodity availability and emergency obstetric care (EmOC). Caesarean section rates, which are a proxy for met need for EmOC, were below 1% in 18 of the Countdown countries (reported in 2012), including DFID priority countries such as Ethiopia (WHO & UNICEF 2012). Disparities across socioeconomic groups and rural/urban areas remain significant.

236 Although there has been increased international attention to the need to extend risk pooling and reduce catastrophic health care costs for essential health care (of which women and newborns are core users), Countdown data from 2012 showed that in all but five of the 75 Countdown countries, out-of-pocket expenditure for health services accounted for 15% or more of health spend. Similarly, although a tracking study of HRH in 2011 found a wide range of policies being pursued to improve health worker availability in countries facing shortages (Witter et al. 2013), 53 of the 75 priority Countdown countries continued to experience a severe shortage of health workers according to the 2012 report (WHO & UNICEF 2012).

237 MDGs 4 and 5 set overall targets and did not incorporate a distributional focus. Analysis of many indicators shows the need to pay attention to particular vulnerable groups (in particular the poor and young mothers). Data to track equity are not well developed, however, especially in terms of age disaggregation and conflict-affected areas. The Countdown 2012 report showed that progress toward equitable quality health care was slow, in particular for services such as skilled attendance at birth, which relied on a strong health system. MDG5b commits governments to provide universal access to reproductive health but has no specific targets attached to it, either in aggregate or with a particular equity focus.

238 On wider contributing factors, the World Economic Forum Gender Gap report in 2012 suggested that global progress has been made in closing the gap in health and educational outcomes between women and men since 2006 (Hausmann et al. 2012). The gender gap in educational attainment at primary level fell in all regions from 1990 to 2011 but nevertheless increased in some countries and remained greater in all regions for secondary education. The gap between women and men on economic and political participation (which may be seen as a proxy for female empowerment) remained wide. The 2013 MDG progress report

(United Nations 2013) showed a 25% difference between men and women in the employment-to-population ratio in 2012. The gap was most acute in Northern Africa, Southern Asia and Western Asia. The issue of violence against women has acquired higher profile, with a global study finding that more than one-third of the world's women report having suffered physical or sexual violence (a figure which reaches nearly 47% for Africa) (WHO 2013b).

239 The overall global picture that emerges for RMNH service provision, while noting the severe data problems particularly in the poorest countries that are of most significance for achieving global objectives, is one of progress that is however patchy and uneven, with inequalities in access persistent. Although there has been greater emphasis on developing country-level accountability and data systems, these remain weak, while demand-side barriers of different types persist (WHO and UNICEF 2013).

Table 14 Findings from DFID survey on assessment of country performance on RMNH

	Strong	Medium	Limited	None	Don't Know or Not Applicable
Pillar 1: Empowering women and girls to make healthy reproductive choices					
Progress since 2010	10.5%	52.6%	31.6%	0.0%	5.3%
Evidence base to assess progress	10.5%	42.1%	36.8%	5.3%	5.3%
Effectiveness of donor support	21.1%	57.9%	21.1%	0.0%	0.0%
Pillar 2: Removing barriers that prevent access to quality RMNH services					
Progress since 2010	10.5%	42.1%	42.1%	0.0%	5.3%
Evidence base to assess progress	15.8%	42.1%	36.8%	0.0%	5.3%
Effectiveness of donor support	16.7%	55.6%	27.8%	0.0%	0.0%
Pillar 3: Expanding the supply of quality RMNH services					
Progress since 2010	26.3%	42.1%	31.6%	0.0%	0.0%
Evidence base to assess progress	16.7%	50.0%	33.3%	0.0%	0.0%
Effectiveness of donor support	33.3%	38.9%	27.8%	0.0%	0.0%
Pillar 4: Enhancing accountability for RMNH results at all levels					
Progress since 2010	5.3%	31.6%	57.9%	0.0%	5.3%
Evidence base to assess progress	15.8%	15.8%	57.9%	0.0%	10.5%
Effectiveness of donor support	10.5%	36.8%	52.6%	0.0%	0.0%

240 The survey of DFID country programmes (Working Paper V) provided an assessment by DFID advisers of the extent of progress made by each country against the pillars in DFID's priority countries (Table 12). This confirms a general picture of moderate and uneven progress. DFID country offices rated progress since 2010 the strongest for expanding the supply of quality services (Pillar 3) and the weakest for enhancing accountability for results at all levels (Pillar 4).[48]

[48] The survey gathered the perceptions of 18 DFID health advisers on progress at country level, as well as of DFID's contribution (which is reported later). The responses need to be interpreted in that light: health advisers may be less well informed on pillars 1 and 4, compared to other members of the DFID team. It is also noted that perception on the evidence base and effectiveness of donor support are generally correlated with perceptions of country progress.

5.1.4 Global trends in outcomes and impact

241 According to UN maternal mortality estimates, the global maternal mortality ratio (MMR) almost halved during the last two decades, from 400 in 1990 to 210 in 2010 (WHO 2012e). Although there was significant progress in all developing regions, the average annual decline in global MMR was 3%, short of the MDG target of 6%. Two regions – sub-Saharan Africa and South Asia – accounted for 85% of global maternal deaths. Sub-Saharan Africa suffers from the highest MMR at 500 maternal deaths per 100,000 live births (an estimated 162,000 maternal deaths), followed by South Asia, with an MMR of 220 (83,000 maternal deaths). It is not possible, on the basis of the data available, to obtain an overview of trends in maternal morbidity.

Table 15 Top 20 countries by number of maternal deaths (2010)

Country or territory	Number of maternal deaths (2010)	% of total burden	Cumulative total	DFID priority country?
India	56,000	20%	20%	Yes
Nigeria	40,000	14%	33%	Yes
DRC	15,000	5%	39%	Yes
Sudan	10,000	3%	42%	Yes
Pakistan	12,000	4%	46%	Yes
Indonesia	9,600	3%	50%	No
Ethiopia	9,000	3%	53%	Yes
Tanzania	8,500	3%	56%	Yes
Bangladesh	7,200	3%	58%	Yes
Afghanistan	6,400	2%	61%	Yes
China	6,000	2%	63%	No
Kenya	5,500	2%	65%	Yes
Chad	5,300	2%	66%	No
Cameroon	4,900	2%	68%	No
Uganda	4,700	2%	70%	Yes
Niger	4,500	2%	71%	No
Mozambique	4,300	1%	73%	Yes
Somalia	4,200	1%	74%	Yes
Mali	3,800	1%	76%	No
Angola	3,600	1%	77%	No

Source: Joint UN estimates (WHO 2012e)

242 Table 13 shows that a small number of countries are responsible for an extremely large proportion of the global burden. The top six (India, Nigeria, DRC, Sudan, Pakistan and Indonesia), five of which are DFID priority countries, account for half of global maternal deaths, with India and Nigeria alone accounting for a third.

243 A growing proportion of child deaths is now occurring at or around the time of birth, highlighting the importance of a concentration on newborn health. Over the past two decades,

mortality in children under five has declined by 3% a year, compared to the much slower rate of 2% a year for newborns in their first month (United Nations 2013). Additionally, an estimated 2.6 million babies are stillborn annually (Cousens et al. 2011).

5.2 DFID's contribution to improving RMNH

5.2.1 Resource allocation

244 During 2010 to 2013, the UK reported funding for the Framework according to categories agreed through the G8 at Muskoka in 2010 that cover RMNCH (rather than RMNH), thus complicating efforts to identify an accurate figure for spend under the Framework. Estimating DFID's exact contributions to the multilateral system also needs to take account of the OECD classification of discretionary resources hosted by multilateral agencies as bilateral 'non-country specific.' Table 14 shows DFID expenditures by route of delivery (from Working Paper VII).

Table 16 DFID expenditure on RMNCH (£ millions, current prices)

Category	2010/2011	2011/2012	2012/2013*
BILATERAL AID	**514.5**	**649.1**	**686.6**
34 DFID-supported countries/areas	**342.2**	**430.7**	**432.5**
-Direct spend (reproductive, maternal)	122.1	198.1	183.9
-Indirect spend (child including newborn, and other spending under Muskoka methodology	220.1	232.6	248.6
Bilateral spend, non-country specific	**172.3**	**218.4**	**254.1**
Regional and small island states	11.8	16.0	38.7
GPEI	15.0	65.0	40.0
UNFPA GPRHCS	25.0	65.0	62.0
PMNCH	1.2	3.0	0.8
World Bank – Health Results Innovation Trust Fund (HRITF)	6-7	0	12-13
Other	112.8	69.4	100.1
MULTILATERAL AID	**257.9**	**258.7**	**336.1**
GAVI	39.1	93.9	182.6
Global Fund	136.4	58.9	58.8
AfDB	4.5	6.1	5.8
ADB	0.9	0.7	0.7
IDB Special Fund	0.0	0.0	0.0
UNFPA	13.4	13.4	13.4
UNICEF	13.0	22.0	22.0
World Bank	46.3	51.9	46.5
World Food Programme	4.3	4.1	0.8
WHO	0.0	7.7	5.5
TOTAL	**772.4**	**907.8**	**1022.7**

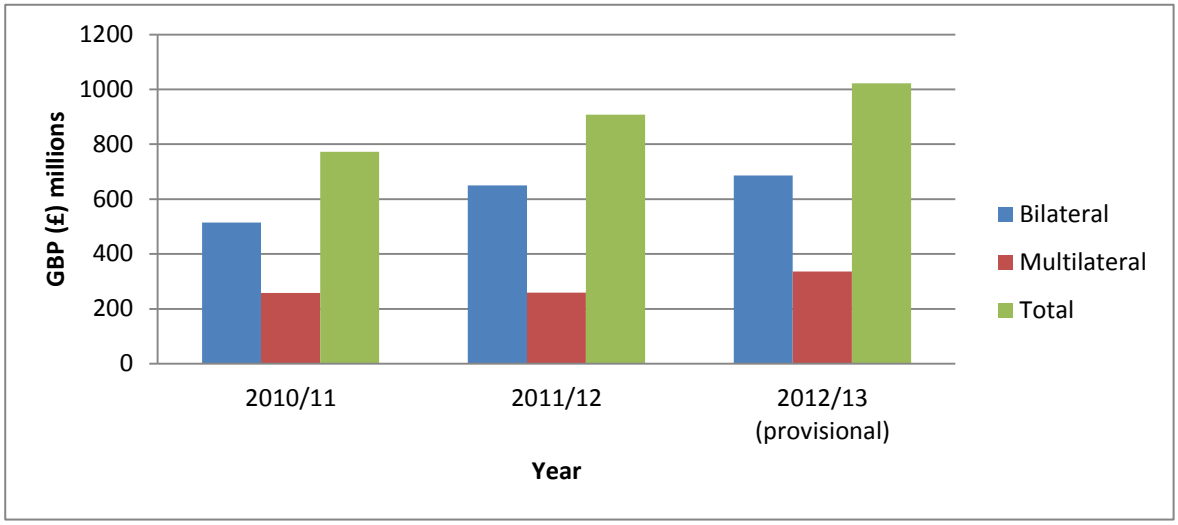
Source: DFID Human Development Department

245 In 2013, DFID was on track to meet its RMNCH spending targets, to double annual support for women and children's health by 2012 and sustain that level to 2015 with an annual average of £740 million from 2010 to 2015. Provisional estimates for 2012/13 showed that DFID spent over £1 billion on RMNCH during this financial year with a year-on-year increase in expenditure from £772.4 million in 2010/11 (Working Paper IV). No figures on pre-2010 spend were available for comparison.

246 The split between multilateral and bilateral expenditure is broadly consistent over a three-year period, with the bilateral programme (including non-country-specific expenditures)

making up approximately two-thirds of the total programme (Figure 9; see Working Paper IV).

Figure 9 Multilateral and bilateral RMNCH spend (Muskoka methodology)



Source: DFID Human Development Department

247 Over the period 2010 to 2013, funding to country programmes was spread across 37 countries, of which 20 were in Africa and 12 in Asia. Of the 28 focus countries that DFID prioritised in its 2011/12 Annual Report, 27 received RMNCH funding. A quarter of funding was coded as non-specific country, including regional programmes and resources channelled through international organisations and multilateral agencies. Additional details are provided in Working Paper IV.

248 According to a Lancet study, in 2010 DFID's bilateral resources for RMNCH across 27 countries constituted 15% of total donor contributions (Table 15 – see Working Paper VI for more details). However, there was wide variation in this proportion with no obvious benchmark for determining whether these contributions were 'appropriate'.

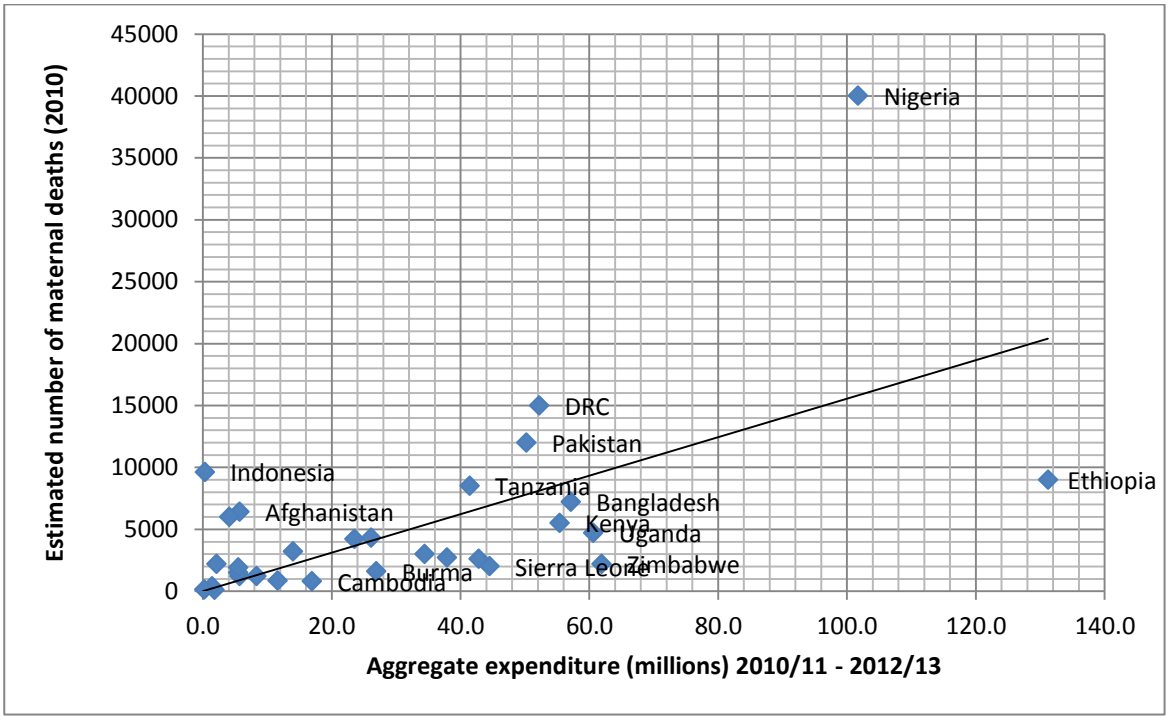
Table 17 DFID bilateral expenditure on RMNCH as proportion of total ODA [49]

Country / Area	RMNCH expenditure, 2010		
	Total (£m)	DFID (£m)	DFID (%)
Countries in Lancet study	**2155.0**	**323.4**	**15.0%**
Afghanistan	138.7	0.1	0.1%
Bangladesh	124.1	6.0	4.8%
DRC	154.9	13.4	8.7%
Ethiopia	139.3	22.4	16.1%
Ghana	75.0	17.2	22.9%
India	231.4	99.1	42.8%
Kenya	130.4	16.9	13.0%
Kyrgyz Republic	9.8	0.7	7.1%
Liberia	33.3	1.7	5.1%
Malawi	55.8	12.8	23.0%
Mozambique	95.2	9.5	10.0%
Myanmar	17.4	7.8	44.8%
Nepal	49.0	1.9	3.9%
Nigeria	139.5	22.2	15.9%

[49] These expenditures only include DFID bilateral expenditures.

Country / Area	RMNCH expenditure, 2010		
	Total (£m)	DFID (£m)	DFID (%)
Pakistan	195.8	9.0	4.6%
Rwanda	44.7	3.0	6.7%
Sierra Leone	27.4	18.6	68.0%
Somalia	29.0	1.5	5.2%
South Africa	10.0	2.4	24.1%
South Sudan	-	-	-
Sudan	110.4	2.8	2.5%
Tajikistan	14.4	0.1	0.7%
Tanzania	144.8	13.3	9.2%
Uganda	71.4	12.8	17.9%
Yemen	28.1	1.4	5.0%
Zambia	40.2	9.6	23.9%
Zimbabwe	45.2	17.2	38.0%

Figure 10 Bilateral RMNCH expenditure by country vs. maternal deaths [50]



249 RMNCH country-level expenditure is mapped against maternal deaths in Figure 10, noting that India is omitted from the figure as an extreme outlier. This shows that in general more money was invested in countries with higher numbers of maternal deaths. However, some large population, high-burden countries, such as Nigeria and DRC, were relatively 'underfunded' on this indicator. For example, in 2011/12 Ethiopia received more DFID RMNCH funding[51] than Nigeria, although it had only 23% of Nigeria's maternal deaths, and half the funding received by India, with 16% of India's maternal deaths.

250 Analysis of DFID's RMNH spend against newborn deaths (Working Paper IV) supports the conclusion that funding is broadly correlated with need, although again with outliers that

[50] Note that, for clarity of presentation, India (as a far outlier in relation to maternal deaths) is omitted from this figure.
[51] Ethiopia received a total of £131 million over the period 2010/11 to 2012/13, compared with Nigeria which received £102 million over the same period.

overlap to some extent with those identified for maternal deaths. There are however differences. Ethiopia, which was relatively overfunded in relation to maternal deaths, is relatively underfunded in relation to newborn deaths, for example.

5.2.2 Building capacity and working with partners

251 At the global level, DFID has worked with multiple partners to adopt a broad approach to improving RMNH through measures that also addressed social and systemic constraints. From 2007 to 2010, DFID had already been involved in several important MCH and RMNH initiatives, including: the launch of the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) in 2007; the launch of the Maternal Health Thematic Fund in 2008; the launch of the HRITF in 2007; and the creation of the Health Systems Financing Platform in 2009 (Working Paper III). Neglected areas of RMNH were integral to DFID's work and DFID was also already a leader in demanding that responses to MCH and RMNH were embedded within HSS efforts.

252 DFID has continued to play a leading role in international processes for RMNH during 2010 to 2013, including in a number of the major international initiatives highlighted above, and the UK was able to take well-informed and influential positions at international meetings, boards and other events (Working Paper III). In some cases, DFID contributed to driving the international agenda forward to demand greater resource commitments to key policy areas.

253 Internal and external interviewees gave many examples of DFID's work with multilaterals contributing to policy or funding changes, although attribution was inhibited by a highly complex political environment. DFID's work led to both incremental improvements in organisational performance as well as major step changes in policy. Examples of incremental change included DFID's work to improve the UNFPA Results Framework and procurement efficiency and results reporting for the GPRHCS. Examples of larger step changes in policy included DFID's leadership with the BMGF of the FP Summit that generated a new momentum and an additional £2.6 billion of resource commitments for FP to 2020.

Box 4 Example of working with partners

Case Study: UNFPA GPRHCS

The UNFPA GPRHCS was established by DFID in 2008 to improve the global supply of contraceptives and DFID committed £177 million over five years. DFID's work on the GPRHCS focused on two areas of aid effectiveness: improving UNFPA's efficiency in procuring contraceptives on behalf of countries; and improving the results framework. Influencing took place through many forms – regular formal and informal meetings, consultants' input to the results framework and procurement function, and political meetings and speeches.

Both procurement efficiency and results reporting were found to have improved significantly. DFID focused relentlessly on improving UNFPA's results framework and the impact of this focus permeated through to the main UNFPA results reporting as well as the GPRHCS. UNFPA improved its results tracking globally and at country level, with investments in understanding stock positions, national health budgets for family planning and contraceptive uptake, as confirmed in a mid-term review.

254 During 2010 to 2012, DFID invested in increased human resources by establishing posts in London, New York and Geneva to engage more regularly with multilateral health agencies

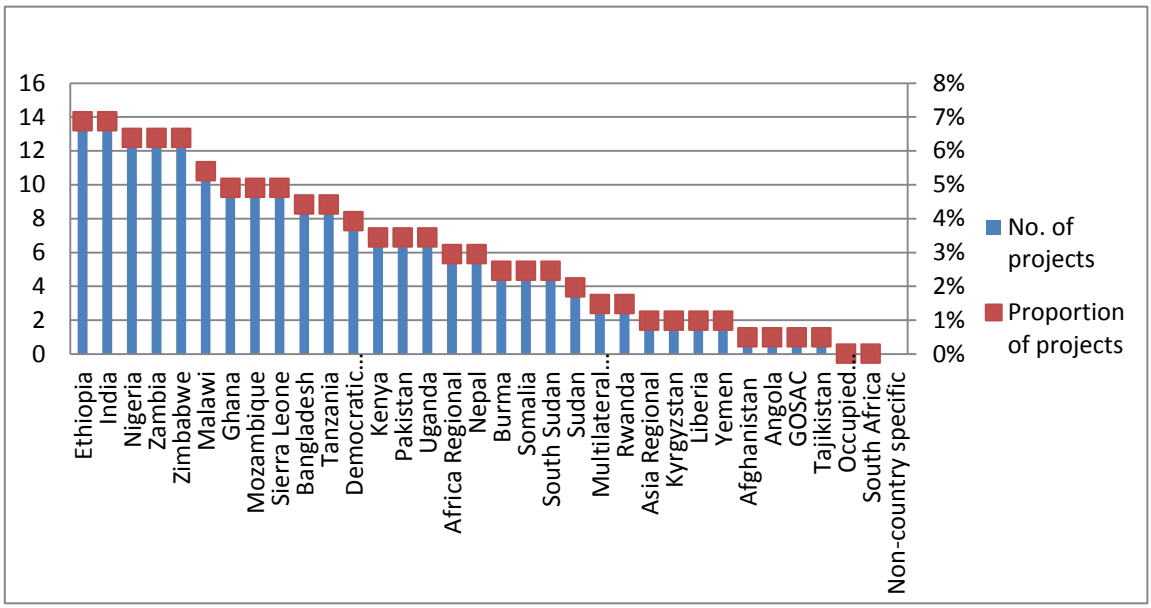
(Working Paper III). According to both internal and external interviewees, these posts helped provide greater consistency and continuity of engagement. DFID also carried out a wide range of influencing activities in relation to both multilateral agencies and the wider policy arena. They included: use of evidence and advice (for example providing £114 million to the World Bank's HRITF to generate evidence on results-based financing from 2010 to 2014); public campaigns and advocacy (for example, the Prime Minister chaired the FP Summit in 2012); and lobbying and negotiation (for example, promoting the donor consensus on the continuum of care at the UN General Assembly (UNGA)).

255 At the global level, programme agreements are an important way of working with civil society. Within reproductive health, for example, there are programme agreements with the International Planned Parenthood Federation (IPPF) and Marie Stopes International (MSI), which are important global players.

5.2.3 Programme outputs

256 In total, 284 projects with at least a 25% contribution to RMNH[52] were active from June 2010 onwards. These projects were implemented in 29 countries, of which 19 were in Africa and eight in Asia. The countries with the largest number of projects were Ethiopia, India, Nigeria, Zambia and Zimbabwe (Figure 11).

Figure 11 RMNH projects by country (number and proportion of projects)



257 Analysed across some of the principal spending codes, some areas within RMNH have benefited from increased bilateral spending over the years, while others have diminished (Table 16). FP in particular has more than trebled in volume, and more than doubled in relative proportion of DFID's bilateral health spend. The majority of this increase (176%) happened between 2010/11 and 2011/12. The proportion of FP expenditure through bilateral channels (including the GPRHCS) increased from 87% in 2010/11 to 96% in 2012/13. The volume and proportion of multilateral funding fell between 2010/11 and 2011/12, but was constant through to 2012/13. Bilateral reproductive health spend has increased absolutely but remained constant

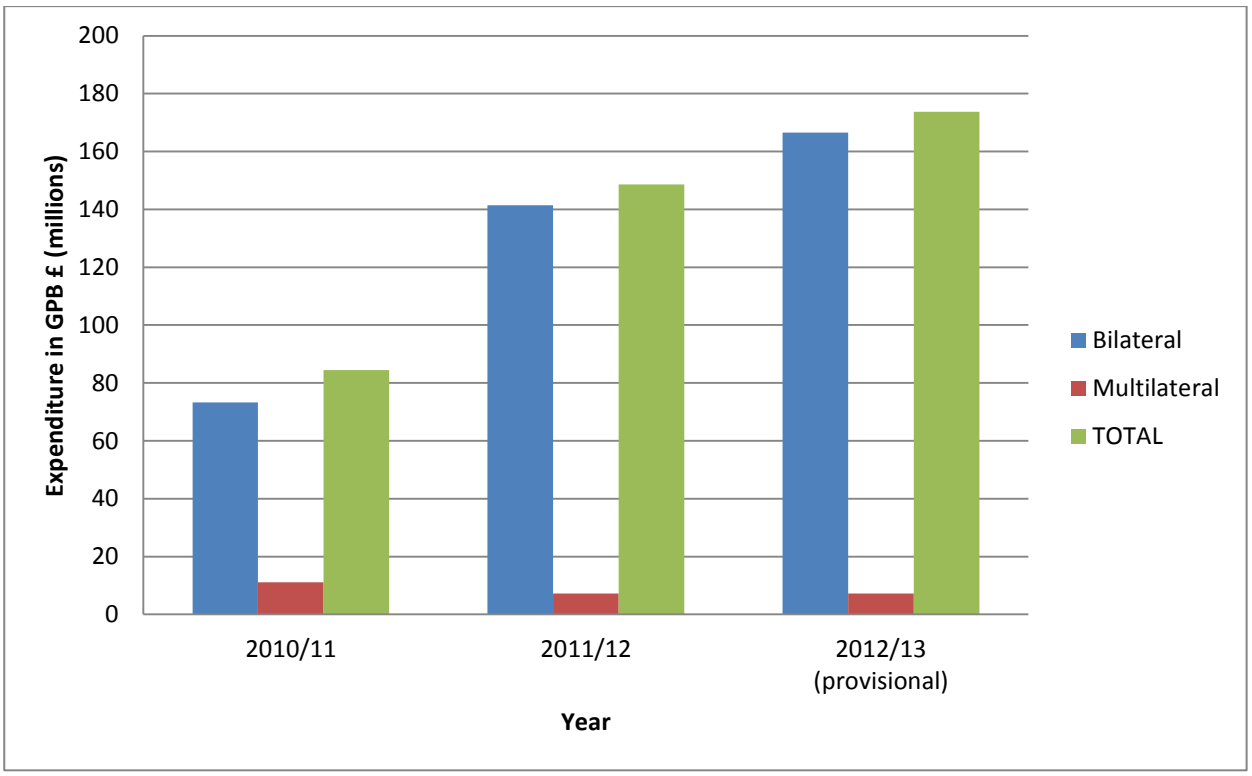
[52] Using the G8 Muskoka methodology.

as a proportion, while funding for sexually transmitted diseases (STDs) including HIV has reduced absolutely and relatively.

Table 18 Changes to DFID bilateral spend across some RMNH areas, 2010–2012

	2010/11	%	2011/12	%	2012/13 (provisional)	%
Reproductive health (including DAC codes 13021 and 13022)	121.7	24%	186.1	29%	174.0	25%
FP (DAC code 13030)	32.3	6%	92.9	14%	112.8	16%
STDs, including HIV (DAC codes 13041 and 13042)	85.4	17%	42.1	6%	37.6	5%
TOTAL BILATERAL health spend DFID	514.5		649.4		686.6	

Figure 12 DFID expenditure on Family Planning, 2010–2012



258 DFID was also making important interventions through alternative channels to country and multilateral programmes. Notable examples include investment in research and global public goods, support to civil society, and efforts to harness UK expertise.

259 Between 2008 and 2013, DFID provided £177 million to the UNFPA GPRHCS. This is discussed as a case study in Working Paper III, providing evidence that procurement efficiency had improved significantly during this period, through improved results tracking and investments in improving information on national stock positions.

260 DFID's total spend on commissioned health research between 2010/11 and 2012/13 was £212.6 million. Five research and evaluation projects were fully focused on RMNH, supporting clinical trials or operational research. Most of these started after 2010, and so have few results to report. All that were internally reviewed by DFID to date had met or exceeded expectations, with notable progress in building local research capacity (see Working Paper IV for further details).

261 DFID invested substantially in market-shaping activities to improve access to safe, effective and affordable health commodities. Funds were provided to selected specialist agencies, most notably the CHAI. Starting in July 2012, funds were set up to implement a portfolio of supply- and demand-side market-shaping activities and DFID had spent £11 million of an expected budget of £29 million. The project's focus was on engaging with pharmaceutical industries from China, India and South Africa to produce high-quality, affordable health commodities for developing countries. For RMNH, these commodities were long-acting, reversible contraceptives and childhood vaccines. Since 2011, DFID has funded the Reproductive Health Supplies Coalition to undertake the Quality of Reproductive Health Medicines (QuRHM) programme, which focuses on shaping generic hormonal product markets for reproductive health commodities (Concept Foundation 2013).

262 DFID provided substantial support to CSOs to implement activities of direct relevance to the Frameworks. Four main channels for CSO support existed: Programme Partnership Agreements (DFID 2013e), the Governance and Transparency Fund (DFID 2013g), the Civil Society Challenge Fund (CSCF) (DFID 2013b), and the Global Poverty Action Fund (DFID 2013f). Together, these funding streams allocated over £600 million of funding to CSOs across all sectors, but it was not possible to separately identify RMNH activities.

263 In terms of UK expertise, the Health Partnership Scheme (Tropical Health & Education Trust 2013) was established in 2008 and in May 2012 26 grants were announced across 16 countries in Africa and Asia. Ten of these are directly relevant to the RMNH Framework (Working Paper IV). Other relevant programmes included the collaboration with NICE International[53] to scope out and respond to requests coming from national governments and the 'Making it Happen' programme at the Liverpool School of Tropical Medicine (Liverpool School of Tropical Medicine n.d.).

5.3 Findings of the MTR

264 This section addresses the MTR questions outlined in Chapter 3. It covers the effectiveness of the Framework as a strategic instrument; resource mobilisation; management; activities and outputs; outcomes; and the cross-cutting issues that were identified.

5.3.1 Has the RMNH Framework provided an effective strategic instrument to achieve UK government objectives?

265 The RMNH Framework was driven by two objectives: first, to define specific policy priorities for improving health outcomes and, second, to contribute to a broader agenda for strengthening the results focus and accountability of UK development assistance.

266 The publication of the Framework was a clear organisational and political statement of priority and served to consolidate and build on DFID's earlier policy documents, including the

[53] Limited information on support to NICE is available in (DFID 2013n).

DFID Strategy for Reducing Maternal Deaths and the Position Paper on SRH and Rights, both of which were published in 2004. It was also coherent with later policy documents within DFID, such as the SVGW and the HIV/AIDS Position Paper, both of which contained overlapping intervention areas and related targets. Furthermore, it encapsulated the UK's 2010 UNGA and G8 Muskoka MCH spending commitments.

267 The Framework was innovative in its broad framing of RMNH and health care, including HIV, within the wider social and health system context, and in its specific focus on newborn health (rather than child health more generally). It provided for a clear strategic direction within a field in which DFID had long been active and a clear statement on the continuum of care. The focus on FP stemmed from recognition of its relative neglect, its high cost-effectiveness and potential cost savings (for instance, in reducing unwanted pregnancies and averting obstetric complications). The judgement of key informants, both internal and external, was that this helped DFID to focus on areas where they could add value and achieve impact. Global indicators in relation to continued high unmet need for contraception and slow progress on neonatal mortality rates suggest that the focus on RMNH (rather than, say, child health) was an appropriate one. DFID supports child health through other channels, including its investments in GAVI, the Global Fund, the Malaria Framework and nutrition.

268 The second objective of strengthening results focus and accountability, particularly through defining high-level measurable commitments, was innovative, although not without risks. In combination with other DFID management and strategic measures, such as the BAR and MAR in 2010, and the associated development of business plans, as well as initiatives to strengthen evaluation and results reporting within DFID, interviewees reported that the Framework contributed to a strengthening of the results focus within DFID's programmes.

269 As discussed in Chapter 3, three aspects of the Theory of Change for the Framework and the activities under it can be identified: first, the assessment of effective interventions to improve RMNH (represented in the Framework for Results table and the actions identified under the four pillars of the Framework); second, the assessment of DFID's appropriate role and comparative advantage within this broad view of effective interventions; and third, the Theories of Change supporting specific interventions through DFID programmes in particular contexts (as articulated in business cases), within the areas of action identified by the Framework.

270 The overall implicit Theory of Change (with the key assumptions relating to the evidence base reviewed) was that the combination of evidence and targets would lead to better informed and more effective programming in general, and that by focusing on a set of empowerment, access, quality service and accountability interventions (specifically designed for each context), DFID could contribute to the intended impact of maternal and newborn lives saved. The Framework did not provide a complete basis for prioritisation between the types of activities to be supported, and so did not provide a complete guide to resource allocation between types of activities identified under the pillars, although it did provide a basis for prioritisation of DFID resources to high-burden countries where these were relatively underfunded (in relation to other donor efforts) and for a specific focus on 'difficult' areas like safe abortion, where there was also evidence of underfunding.

271 Some key assumptions have been elaborated by the MTR team for the theory of change underlying the Framework (Annex D). These are examined by the MTR as a whole. A key assumption for DFID's activities to achieve impact (particularly at country level) has been that adequate complementary resources are provided, particularly through wider processes of health systems development. The MTR found that DFID had managed this risk by a continued

focus on health systems within its portfolio. Another important assumption is that the Framework is able to drive processes within the organisation. This is less clear as there are limited internal rewards and sanctions attached to reaching the Framework targets, and it is unclear what direct levers were available to implement it.

272 The process of preparation of the Frameworks was judged by participants and informed observers to have been a useful and inclusive one in articulating and communicating DFID's objectives and the implications of the changes in approach for UK development assistance. In general, the consultations appear to have been used to support and develop the strategy set out in the Frameworks, rather than shaping the main elements of the Frameworks, since these did not undergo significant changes through the process of drafting, comparing the drafts produced at the start of the process with the final published versions.

273 The preparation of the Frameworks took place in parallel with the BAR and MAR processes, and (as is shown from the country case studies; Working Paper VIII) the main decisions about priorities and changes to DFID programmes at country level took place through the BAR rather than being determined by the Frameworks. However, the fact that discussion of the Framework and the process of evidence preparation was going on at the same time did allow some influence from the Framework preparation process on DFID country programmes.

274 Beyond the Framework itself, the evidence papers that fed into it were independently reported as useful by internal and external stakeholders, as was the process of developing them (for those involved within DFID). Moreover, the evidence review is regarded as authoritative. As one internal KI commented: 'The review of evidence was pretty comprehensive. Since then more evidence has come out, for example, stronger evidence on the economic impacts of maternal health, but this just strengthens their case. Similarly, there is more knowledge now about cost-effective interventions for newborns, which were not in the Frameworks but are consistent with its goals'. There is a case for additional investment in evidence reviews in some areas where the availability of evidence has progressed since the evidence review was published (for example, better knowledge on scaling up life-saving strategies for newborns) and where gaps in evidence had been identified (for example, on effective strategies for reaching young people with FP). Although the fundamental purpose of the Framework involved effective communication to multiple stakeholders, including within DFID, the wider UK government, the general public, partner organisations and governments, there was no explicit communication strategy to accompany the Framework. The levels of awareness and knowledge of the Framework and its contents among sector stakeholders (including DFID health advisers in the field) were found to be mixed.

275 While the specification of a target of 'lives saved' had a clear political rationale at the time the Frameworks were developed, there are concerns about such a target-driven approach. One is that it risks instrumentalising investments below the impact level, as if they are only valued in relation to their contribution to saving lives. This ignores their intrinsic, independent value and also raises the difficulty of modelling their impact on maternal or newborn lives saved (discussed in section 5.3.3). By focusing on these desired final impacts and setting up systems to report on them, DFID risks being distracted from intermediate issues that have more direct significance to management – such as tracking programme outputs and assessing on a routine basis their relevance, efficiency, effectiveness and equity.

To what extent did the Framework contribute to effective cross-sectoral approaches in DFID programmes? Can linkages between the Frameworks, and between the Framework and other DFID strategies, be improved?

276 The RMNH Framework had strong linkages with a number of other strategic priority areas in DFID, including the SVGW (DFID 2011a) and the HIV Position Paper (DFID 2011e). The first pillar of the SVGW equates to pillars 2 and 3 of the RMNH Framework, while SVGW pillars 2–4 map to Pillar 1 of the RMNH Framework. They were therefore mutually reinforcing. However, the M&E mechanisms were not harmonised to prevent duplication: for example, the annual process for reviewing the SVGW provided a potential model for the Framework, as well as generating analysis and data that can also be used to assess progress against the Framework target.

277 HIV is integrated within SRH and so there are also strong links with the HIV Position Paper. DFID's focus within the HIV field was firmly on basic programme activities, as well as critical social and structural enablers, such as access barriers, gender inequality and violence against women, poverty, weak health systems, and stigma and discrimination. These barriers could not be addressed with HIV programmes only, as recognised in the UNAIDS investment Framework of 2011. DFID's HIV portfolio hinged around three axes that map closely to goals within pillars 2 and 3 of the RMNH Framework:

- Reduced number of new HIV infections, particularly among women and key populations;
- Scaled up access to diagnosis, treatment, care and support; and
- Reduced stigma and discrimination.

278 According to a draft review of the HIV Position Paper (OPM, 2013), DFID funding to HIV declined during 2011 to 2013, while focus also shifted to integration with health programming and targeting vulnerable groups, including women and children. DFID supported a wide range of HIV prevention initiatives focused on women and girls, including among those that are especially vulnerable to HIV infection. In addition, DFID has supported initiatives to promote the meaningful involvement of women living with HIV in all issues that affect them, as well as initiatives to address women's sexual and reproductive rights, including some focused specifically on women living with HIV. These actions also tied in closely with the gender strategy.

279 At the global level, DFID has engaged in policy discussions to try to define and measure integration in relation to HIV and SRH (OPM, 2013). HIV and SRH integration was part of the agenda of the FP2020 summit. Through its membership of the International Agency Task Team on HIV and SRH linkages, DFID supported a process to identify high-quality indicators to measure linkages. In a number of countries in sub-Saharan Africa, DFID also pursued country-level service integration between HIV, SRH and MNCH, through social marketing programmes, voucher schemes, integrated service agreements and clinics. DFID-funded research on HIV drivers contributed to cross-cutting issues, such as how to reduce transactional sex among adolescent girls. There were few aspects of the HIV portfolio which lacked relevance for the RMNH Framework.

280 Analysing RMNH projects looking for evidence of HIV/AIDS indicators, a total of nine of 47 reviewed projects included at least one indicator relevant to HIV/AIDS. When comparing pre- and post-publication of the Framework, the proportion of RMNH projects that tracked HIV/AIDS indicators rose from 17% to 22%.

Summary: Key findings

The Framework objectives are clear and well set out. The strategy outlined by the Framework was based on robust and comprehensive evidence. There is now some scope for updating the evidence review in areas where gaps were previously identified. The Framework objectives are coherent with wider UK and international commitments and have provided effective strategic guidance for bilateral and multilateral programmes across DFID.

The broad theory of change underlying the RMNH Framework's assessment of effective actions was based on sound assumptions related to evidence, and the identification of DFID's specific role and comparative advantage was also judged to be appropriate, although the achievement of specific objectives depends on assumptions about complementary activities by partners.

There was no explicit communication strategy for the Framework and knowledge of the document and its content varied both within DFID and externally. There is no comprehensive mechanism for communicating results or impact on a regular basis.

There was strong coherence between the Framework and related HIV and gender documents and some evidence of learning across the policies. The RMNH Framework contributed to this cross-sectoral approach as it pre-dated the other two strategic documents and emphasised both gender and service integration. The processes of annual monitoring of the RMNH Framework, the SVGW and the HIV Position Paper were all separate, although much of the analysis of data could be shared.

Overall assessment: The RMNH Framework for Results provided an effective strategic instrument to articulate and communicate DFID's priorities and approach.

5.3.2 Have adequate resources been used to and appropriately applied to achieve these objectives?

281 The Framework contained a re-statement of the UK government's commitment, made in September 2010 at the UNGA, to:

> *Double its annual support for women and children's health by 2012 and sustain that level to 2015. The UK will provide an annual average of £740 million from 2010–2015, totalling £4.4 billion, meaning that over this period the UK will spend an additional £2.1bn on women and children's health.*

282 The MTR found that DFID is on track to reach these commitments (Working Paper IV): provisional estimates for 2012/13 showed that DFID had spent just over £1 billion on RMNCH during this financial year, and a total of £2.7 billion for the period 2010–2013.

283 It is difficult to assess whether DFID resources were adequate for the achievement of the Framework objectives. Global MCH targets have been costed and DFID's commitments were made in relation to these estimates. However, there is no specific analysis in the Framework of what financial, human and other resources would be required to meet their own top-level targets, and it has not been possible to undertake a full analysis of the cost-effectiveness of DFID interventions under the Framework.

284 On spend by country, there was no ex ante allocation of RMNH resources to particular countries as DFID operated a bottom-up planning system through the BAR and country business cases. Focus countries were prioritised in the Framework but actual spend has been determined by a number of factors, including needs, capacity and interest, other partners'

investments and overall budget constraints. In general, DFID spending has been focused on countries with higher numbers of maternal deaths. However, some large population, high-burden countries appear to be relatively 'underfunded'. In principle, there is scope to increase impact by increasing resources allocated to these countries although increased spend would need to be conditional on mechanisms for ensuring effectiveness. There is evidence of effective programmes in a number of such countries that shows that this can be done, but in some cases a potential trade-off between short-term results, poverty orientation and longer-term sustainability should be acknowledged.

Summary: Key findings

DFID's expenditure has met its financial commitment targets as re-expressed in the Framework. The allocation of resources between bilateral and multilateral programmes was not determined by the Framework but has been based on bottom-up planning processes. The result was that around two-thirds of the RMNCH spend was through the bilateral programme and one-third multilateral. Given the strong performance of health multilaterals in the MAR, this was judged appropriate. Across pillars, Pillar 3 received the most resources while the others received a similar amount each. There is evidence of some areas within the RMNH field receiving increased resources over the period, linked to changing priorities – funding for FP, for example, grew, and this is likely to be connected to the momentum around the international summit of 2012 and growing focus on this area within DFID, including as a result of the Framework.

Overall assessment: DFID met its commitment targets during 2010 to 2013, spending a total of £2.7 billion on RMNCH in this period. The Framework objectives and targets have not been fully specified or costed, however, and it was not possible to judge whether these resources were sufficient to achieve the goals.

5.3.3 Have the Frameworks and DFID's programmes under them been effectively managed to achieve UK government objectives?

285 Decisions on DFID bilateral programming are decentralised and so have responded to country contexts as much as to corporate strategies. According to the country case studies, the BAR played the most important role in signalling a shift in approach in 2010, including the introduction of business cases for programme appraisal. The main use of the Framework was to emphasise the political priority accorded to RMNH and to inform the design of programmes and their business cases. The associated evidence papers were used as a source of information on RMNH interventions, and as a communication tool with both internal and external stakeholders at country level.

286 Both external and internal informants (at central and country levels) referred to a disconnect between central policy initiatives (like the Frameworks) and the process by which decision-making was made within country programmes. According to one informant: 'It is a Policy Division Framework but no-one is accountable to the Policy Division for it. So it is hard to know whether it has been translated to bilateral programmes. Some country plans have additional users of contraception and others do not. Influencing 28 countries is not easy! It depends on strong relationships, including with the regional advisers. I think we were pretty successful, but not 100%'. High-level commitments were made but there were no direct mechanisms for implementing them, given the bottom-up planning systems in place. Some country offices reported that the Framework had some importance in influencing the BAR process, in the design of new programmes and in the redesign of existing programmes (Working Paper VIII,

RMNH Country Case Studies). However, subsequent management and reporting was generally focused at the programme level, through the sector or country OPs, where the Framework was less relevant.

287 The Framework encouraged cross-sectoral approaches and communication within DFID, particularly between health and social development staff, although there was room for this to improve, both at country office and headquarters levels. Interviews suggested that these linkages depended on individual relationships rather than being systematic. The practical links between empowerment work and health sector work were often quite limited at the country level, although there were examples of close cooperation around particular programmes of joint interest (Working Paper VIII, RMNH Country Case Studies). The breadth of the Framework created challenges in establishing effective linkages between teams working on such varied areas as girls' education, violence against women, economic opportunities, health services, HIV and accountability.

288 Opportunities for reviewing programming and ensuring it is maximising effectiveness have been developed, but this could be done more systematically. For example, one internal informant reported that 'the LiST is useful for getting countries to look at what they are doing and whether it is likely to meet the outcomes goals. In 2013, three regional workshops were held with 20 high-burden countries to do bottleneck analysis. People realised that some areas of big investment were unlikely to contribute much to the goals (e.g. big deworming programmes, or vaccination where coverage was already high). They might have other benefits but they weren't addressing the targets. Conversely, they were encouraged to focus on areas with potential benefits ... there is a lot more that can be done'.

Results monitoring, evaluation and reporting

289 In 2011, DFID published an outline of the proposed M&E approach for the Frameworks including identifying core indicators and a plan to focus M&E on eight to 12 focal countries. However, instead of following this more focussed approach, a modelling of high-level results was commissioned for 19 countries. In addition, internal corporate reporting against RMNH indicators took place through three separate processes: the DFID DRF; against OPs; and through project-level reviews and evaluations.

290 The DRF tracks the Framework top-level outcome and impact commitments achieved by DFID. DFID departments and country offices report six monthly against all DRF indicators where they have relevant activity, and where their reporting meets standards set out in methodology notes for each DRF indicator (DFID 2013k). From 2010 to 2013, the results of this process were published in the DFID Annual Report.

291 Reporting of results through multilaterals was found to pose particular challenges compared to reporting on the bilateral programme. The DRF did not capture sufficient information from most multilaterals and contained few indicators for RMNH. The problem was compounded by the time lag on national data availability, variation between organisational goals and a lack of fit between inputs and outputs.

292 Results against OPs were reviewed by directors and used as the basis for accountability of spending departments, including through quarterly meetings between directors and DFID's Finance and Corporate Performance Department. OPs therefore potentially offered additional reporting opportunities for DFID departments on their RMNH activities. However, between 2010 and 2013 most departments did not include RMNH activities in their OP reports (14 out of 46 reported numbers of births delivered with the help of nurses, midwives or doctors through

DFID support; eight reported number of additional women using modern methods of FP through DFID support; and four and two respectively reported maternal lives saved and neonatal lives saved).

293 Project documentation offered a broad, comprehensive set of results data. Specific programmes do not report against the Framework but instead against their logframes. Furthermore, during 2010 to 2013 there was no central source of results information on DFID's RMNH projects and no clear mechanism for DFID staff or evaluators to aggregate results across projects. Programme-level indicators rightly reflected the specific objectives of the projects and local circumstances. As a result, it was often difficult to link programme data and reviews to the reporting of higher-level targets.

294 There was no systematic reporting even of the 'strongly recommended' RMNH indicators and the use of Framework indicators by RMNH projects varied. Twelve out of 42 projects, or 29%, included no Framework indicators (Working Paper IV). The proportion of projects using four or five Framework indicators was consistently around 20–25%, although in three years (2007, 2009 and 2013) no projects used this many Framework indicators (Working Paper IV). In four out of eight years, half the projects used no Framework indicators, including two years (2011 and 2012) after the publication of the Frameworks, which covered 16 projects.

295 The only Framework indicator that was reported by all three country programmes reviewed was the number of DFID-attributed attended deliveries for the whole population (rather than the bottom 40% or any other priority sub-group). FP indicators were not reported in the OP reports for these countries. DFID staff members at country level were not always clear about how indicators were defined and measured (e.g. 'new FP user') and others could not be measured on the basis of the information available nationally (for instance, age- or socioeconomically disaggregated indicators).

296 Greater clarity was also requested about the conceptualisation and measurement of accountability (one DFID respondent commented: 'we don't have agreement on what accountability means – do we?', while an external reported that 'better metrics to measure both quality and accountability for RMNH services are needed'). This reflected a number of factors, including the quality and availability of data.

297 The limitations identified above in DFID routine monitoring systems imply restrictions on the extent to which they can be used to inform evaluations. Evaluations could consider four different generic levels: the overall global programme, support to multilateral organisations, bilateral country programmes and individual programmes. There is generally a richer data set to monitor progress and assess effectiveness at the programme level. They have a more specific set of actions and indicators against which to evaluate impact, as well as expenditure data linked to them. Individual programme reviews, including mid-term and final reviews, can be scoped to request teams to make some assessment along these dimensions or more formal programme evaluations can be commissioned.

298 The challenges are more substantial at higher levels, and particularly for overall country programmes and the Framework as a whole, where the problems of aggregation across projects and attribution are significant. This will affect, particularly, aggregate assessments of effectiveness and impact because the indicators used often differ between projects and are not additive. A number of recommendations made in this report should help to address some of these problems in advance of the Final Evaluation, although a number are intrinsic.

299 The MTR found a paucity of recent project or programme evaluation material. No project or thematic evaluations of direct relevance to the Frameworks were published during the last three years. This may reflect a hiatus in the commissioning of evaluations while DFID's overall approach to and management arrangements for evaluation were revised and reorganised.

Management of risk

300 Issues of the management of risk are common across both Frameworks and are discussed in Section 4.3.4.

What has DFID done to ensure cost-effectiveness and VfM for DFID resource inputs?

301 The VfM analysis found that the majority of the VfM indicators in project logframes covered economy and efficiency measures (Working Paper VI). There were few cost-effectiveness indicators and a paucity of VfM indicators in the logframes for the RMNH Framework. Business cases contained a broader consideration of issues around VfM. A significant proportion of the VfM statements in business cases were generic and not specific enough to allow for future measurement. A preliminary review of annual reviews and project completion reports showed that the quality of VfM assessment was variable.

302 It was therefore hard to be conclusive about the extent to which investments under the Framework offer VfM, although the influencing analysis does highlight some areas where VfM appears to be generated, for example in improving the procurement functions at UNFPA and the GPRHCS (Working Paper III). Both the Netherlands and UNFPA itself confirmed that, as a result of longer-term more predictable funding for contraceptives, progress had been made in renegotiating contracts at more competitive prices that could be passed onto national programmes. Increased VfM had been accompanied by a rise in spend on contraceptive procurement. UNFPA reported that 40% of their resources now go to contraceptives, compared to 25% previously. However, most interviewees recognised that there had been variable improvement across countries, depending on government interest and the capacity of the local UNFPA office. There are also some early examples of increased VfM derived from market-shaping investments, such as an increased number of generic hormonal reproductive health products now pre-qualified with WHO under the QuRHM programme (Concept Foundation 2013).

303 The cost-effectiveness analysis concluded that, while it was possible to estimate DFID's spending under each Framework, including at country level, some issues needed to be addressed about appropriate classification (Working Paper VII). While broad estimates of contribution could be made (where adequate information was available for modelling), it was not possible to draw more nuanced conclusions (for instance, comparative estimates of the cost-effectiveness of different types of intervention) on the basis of these data.

304 Work on multilateral aid effectiveness was not directly addressed in the Framework but the timing of its publication so close to the MAR meant that aid effectiveness work was integral to multilateral engagement for RMNH. Through the MAR, DFID could be confident that, as a group, health multilaterals offered adequate to very good VfM. Subsequent MAR updates confirmed progress in areas identified as weak. However, much of the DFID money that flowed through non-country-specific bilateral spend to multilateral trust funds and global partnerships was not captured under the MAR. Information on these agencies was therefore less easily reported.

305 There was no evidence that trends toward increased attention to VfM and cost-effectiveness had been driven by the Framework, though the Framework itself was part of the drive towards evidence-based programming. Trends instead evolved through the BAR and the MAR, which encapsulated a greater emphasis on results and VfM throughout the organisation.

Summary: Key findings

While there was a significant expansion in RMNH programmes from 2010 in the bilateral, multilateral and research areas of DFID's work (see below), the Framework itself had no implementation or business plan. It was a guiding document, which communicated priorities to country and multinational programmes, rather than directing their activities. There were no direct mechanisms or incentives for ensuring that the top-level targets were realised through bilateral or multilateral programming.

Processes were in place for reporting some top-level results through the DRF but there was no systematic reporting of progress against the Framework in country or multilateral programmes. It was not possible to understand the contribution of specific programmes to desired outcomes or to report against disaggregated targets. Multilateral reporting emphasised aid effectiveness and organisational performance and little information on the impact of these efforts on RMNH outcomes was available.

Systems for risk management are being strengthened across the organisation. Specific risks relating to the result orientation of the Framework were assessed and found not to be realised, largely because of a continuing commitment to partnership working and support to health systems and the weak incentives (highlighted above).

Through the MAR and the BAR, DFID is increasingly focused on the VfM and cost-effectiveness of its programmes. Business cases for projects after 2010 are required to have VfM indicators and assessment processes. However, conceptual and data quality issues remain and it was not possible at this point to undertake any systematic assessment of progress or trends in VfM among DFID bilateral or multilateral programmes. Some examples of driving better VfM emerge from influencing case studies and from recent investments in global public goods.

Overall assessment: There was no direct mechanism to translate the RMNH Framework vision and targets into programming, though it has been effective, as noted above, in communicating priorities. There are significant weaknesses in the monitoring system that make it difficult to assess the progress achieved.

5.3.4 Are activities and outputs under the Framework on track to meet its objectives?

Bilateral activities

306 There was some evidence of an increased number of projects launched after the Framework publication compared with pre-publication: in both 2009 and 2010 there were 39 new RMNH projects, while 58 started in 2011 (Working Paper IV). Although the Framework discussed specific interventions that DFID would support in some detail, analysis of spend by intervention area was difficult and limited to patterns revealed by principal sector codes. Across all RMNH projects, there were two dominant codes (reproductive health and STD control, which includes HIV) that together made up 37% of projects. The third most used code was

health policy and administration management (11%). Over the period, funding to FP increased and funding to HIV decreased, which reflects, in the judgement of the team, the changing international priority areas, as well as changing priorities within DFID.

307 Analysis of spend by pillar across the 55 projects that included 75% of DFID bilateral resources found evidence of action under each of the four pillars. Pillar 3 (expanding the supply of quality services) was the subject of most focus, and the remaining three pillars appeared to be given broadly similar priority. There were no obvious trends over time in activities under each pillar, and no benchmark for assessing the appropriateness of these allocations.

308 Some staff within DFID felt that the Framework had provided a 'strong storyline' for developing programmes in innovative areas, such as female genital mutilation, an area DFID had not engaged with before: 'DFID now has a new programme on this; it has high priority in the organisation; DFID is one of the biggest donors. That is a really important story – it was not the case a few years ago. The same with violence against women – DFID now takes a lead role here and is committed'. Other innovative projects that may reflect a change of focus within the organisation, linked to the pillars, is the Evidence for Action programme, which aims to improve maternal and newborn survival in six sub-Saharan African countries through a combination of evidence, advocacy and accountability (Evidence for Action 2013). Projects outside the health sector also contributed to results, particularly for pillars 1 and 4, but were not included in this analysis.

309 Analysis of selected projects (Working Paper IV) found that in total 44 of 55 projects (80% of projects across both Frameworks) included at least one indicator that was relevant to HSS. While there is a mixed trend, there is some suggestion that the use of HSS-related indicators has increased in recent years, for example comparing pre- and post-publication of the Frameworks.

Multilateral programme activities and influencing

310 In the multilateral programme, no new funding initiatives were launched after the Framework, although additional resources were provided to existing programmes, such as the GPRHCS.

311 Influencing took place through many forms – regular formal and informal meetings, consultants' input into the results Framework and procurement function, and political meetings and speeches. There was, however, little evidence that the Framework itself had been the driving force behind influencing activities. Much of DFID's agency-specific work and wider political engagement was ongoing prior to the Framework publication. The Framework was cited by internal interviewees as having set out a comprehensive approach, not necessarily different from before, but within which to prioritise next steps. The RMNH Framework was described in an interview as the 'platform whereby DFID and the new Government could progress these core agendas across the continuum of care'. It also hardwired high-level commitments into DFID's operational Frameworks with some multilaterals in a way that had been difficult to make happen previously.

312 In relation to broader influencing, DFID was an influential player in global forums and international policy discussion and the Framework played some role in consolidating and extending this influence. External key informants highlighted continuing challenges of newborn care, unsafe abortion, unintended pregnancies, teenage pregnancies, still births, violence against women, and the lack of use of ANC, and noted that DFID was playing an active role in

addressing these issues.[54] As one external key informant expressed it: 'DFID has been a steady voice, continuing to push the field in SRH. For example, it has been influential in including induced abortion in the debate... It has been an important voice in seeing the issues comprehensively and unique in coming from that angle and having the resources to push the agenda.'

Research and evidence

313 DFID's RED played a central role in the development of the evidence papers for the Framework. Subsequently, guided by the Framework, in 2011 RED conducted a mapping of the existing research portfolio to identify gaps and strategic priorities for commissioning future research. This led to the identification of a number of new research projects. According to figures provided by DFID, research expenditures related to RMNH were projected at £69.4 million over the period 2010 to 2016. However, in 2010/11 alone expenditure was £57.7 million. It is unclear whether spending in subsequent years, and projections up to 2015 are set to remain at this level. (Note that this amount excludes further research spending on results-based finance – discussed further below.)

314 The range of research topics covered within the RMNH research portfolio is wide and includes basic research and operations research on a number of relevant issues. Informants identified additional topics of importance for future research, including on quality of care, newborn care and increasing uptake of contraception. As one external key informant explained: 'On the demand side, there is a need to understand better the reasons for non-use of contraception. The reasons which come to the fore at the moment are perceptions of needs and side effects, partner attitudes, rather than cost and access, but those may lie behind the primary reasons given. We also need to work on new contraceptive products. We don't know much beyond the DHS data – we need more nuanced analysis'.

Global public goods

315 In terms of global public goods, DFID invested substantially in market-shaping activities in relation to improving access to safe, effective and affordable health commodities. During 2012/13, DFID spent £10.5 million of an expected budget of £28.6 million under the Framework. The focus was on engaging with pharmaceutical suppliers in China, India and South Africa to produce high-quality, affordable health commodities for developing countries, such as long-acting, reversible contraceptives and childhood vaccines. While it was too early in the project to evaluate its effectiveness, large price savings were anticipated, alongside better quality products and greater supply security. For RMNH, DFID's support to the CHAI expected to contribute to a 35% decline in the prices of long-acting, reversible contraceptives (Working Paper IV). According to an internal key informant: 'In terms of public goods, DFID has always been strong on this and has been allowed to be stronger. We have had a greater focus on price and quality – negotiating reductions in prices of contraception, for example'. According to others, there is a need to focus not just on commodities but also on in-country distribution systems – an internal interviewee commented that, 'commodities are not the only important element but they are important and a good place to start discussion about how they are distributed and by whom'.

[54] DFID has started a number of innovative projects relating to some of these areas, such as the 'Reducing maternal mortality through supporting in-country initiatives to tackle unsafe abortion and improve access to services' project, which started in 2013, the 'Adolescent Girls Empowerment Programme', which has been operating in Zambia since 2011, the Ethiopia 'End Child Marriage Programme', which started in 2011, and the 'Toward Ending Female Genital Mutilation/Cutting in Africa and Beyond' programme, which started in 2012.

316 Two other investments in RMNH global public goods were managed by the DFID Policy Division: support to the PMNCH to deliver enhanced technical advice, coordination and lobbying on RMNH issues; and support to a research programme at the World Bank looking at the impact of results-based financing on maternal health outcomes, to which DFID contributed £114 million over three years. Both predated the Framework but have been significantly extended during 2010 to 2013.

Achieving targeted outputs

317 DFID has no mechanism for aggregating information about outputs from RMNH activities that are supported through bilateral and multilateral programmes. A sample of projects was analysed for evidence of how activities relate to the pillars of each Framework, for evidence of use of the Framework indicators in project logframes, and for evidence of performance. These projects were selected because they made up 75% of the total spending of the 284 projects. Focusing on outputs, there were no clear central guidelines on the indicators that projects should use, with the result that, across these projects, there were over 1,000 indicators. There were significant challenges to analysing these and generating useful aggregations and comparison across the portfolio.

318 Further assessment of the programmes' relevance and effectiveness was made through country case studies, the survey of DFID staff, reviews of annual reports and the influencing analysis. DFID country programmes adopted a wide range of approaches to achieving RMNH results, with an emphasis in many countries on aligning with national government objectives and strengthening government capacity to deliver critical interventions (particularly through harmonised sector support arrangements) (Working Paper V).

319 Partner government representatives generally appreciated DFID's flexibility in programming and in some cases DFID led in introducing wider changes in aid modalities. For example, in Ethiopia, DFID had previously led the creation of health pooled funds which became an increasingly important channel for donor support in the sector, strengthening coordination and national systems (Working Paper VIII, Ethiopia RMNH Country Case Studies).

320 Some 59% of DFID survey respondents reported that the Framework had influenced the design and implementation of new activities in the country. They also ranked the effectiveness of DFID RMNH programmes highest for removing barriers to access to quality RMNH services and for expanding the supply of quality RMNH services.

321 DFID country programmes supported a wide range of activities and outputs that were relevant to all four Framework pillars (Working Paper VIII, RMNH Country Case Studies). In the case study countries, these included:

- Significant programmes related to women's empowerment (Pillar 1), such as improving girls' education, in all three countries. In Orissa, India, scholarships were used to encourage girls to stay in school and delay marriage; women were being informed of their reproductive choices; women's groups had been established; and work was undertaken to combat violence against women.
- Substantial support to reducing barriers to access (Pillar 2). This included: providing transport for EmOC and implementing free primary care packages in some areas; and support to increasing access for marginalised groups (such as in India).
- The largest investments were in expanding the supply of quality services (Pillar 3). This included: support to RMNH services, including the supply of FP commodities, improving EmOC and abortion and post-abortion care. Much of the support went toward strengthening

health services and the health sector as a whole, through sector support in Ethiopia and large, state-level health sector strengthening programmes in Nigeria and India. In Ethiopia, for example, reviews of DFID-supported pooled funds indicated substantial improvements in health infrastructure and expansion in the numbers of community health workers and midwives.

- Enhancing accountability for results (Pillar 4) through strengthening Health Management Information Systems and undertaking household surveys. In some cases, DFID programmes also worked with central and local governments and civil society to strengthen the use of information for management and accountability, although this remained a significant challenge. There were also widespread concerns about data quality.

322 DFID project reviews for the country case studies found that most projects were delivering their outputs at least as expected (Working Paper VIII, RMNH Country Case Studies). These reviews assessed the progress of projects against their objectives as specified in logframes and work plans. Of the five most relevant projects in each country, most projects scored either A or A+, meaning that they were delivering their outputs either to or above target. Self-reporting against targets called for some caution in interpreting these findings but they still suggested that programmes were effectively delivering these outputs and substantially strengthening the health systems and services they were supporting.

323 The integration of FP services into routine care was sometimes weak and the strengthening of services for adolescent girls was identified as an area for improvement in two countries (Nigeria and India). The review teams also identified wider gender mainstreaming and further strengthening the use of data for management and accountability as important gaps.

324 DFID's work with multilateral agencies was heavily focused on improving performance and effectiveness, and was reported as being successful in achieving many of these objectives. Most logframe indicators focused on progress toward highly targeted and specific performance indicators generated under the MAR, rather than on identifying the outputs produced.

325 Evidence from the DFID survey found a higher self-estimate of DFID effectiveness relating to pillars 2 and 3 than for 1 and 4 (39% of respondents rated the effectiveness of DFID activities related to Pillar 2 as strong, compared to 33% for Pillar 3, 17% for Pillar 1 and only 6% for Pillar 4). Across all RMNH pillars, DFID activities were more likely to be rated by insiders as strong in terms of relevance rather than effectiveness.

326 The Framework incorporates an equity perspective, with its emphasis on adolescent girls (for contraceptive uptake), poor households (the bottom 40% for contraceptive uptake and skilled attendance) and conflict- and disaster-affected areas. Data to track equity are less developed, however, especially in terms of age disaggregation and conflict-affected areas. However, key informants welcomed DFID's continued focus on this area: 'We welcome the reduction in maternal deaths but we need the political voice of DFID to focus on poorer women and poorer countries where there is still great need. There is a risk that the emphasis is lost in response to positive overall trends'.

327 Within case study countries, it was noted that supporting preventive services and primary-level care, including RMNH, is generally pro-poor. Equity issues have been further addressed through the targeting of resources at areas (states) that are poorer and substantially disadvantaged on a number of key health indicators. In India, some programmes also target scheduled castes.

328 In relation to conflict-affected areas, DFID's wider focus is shifting increasingly toward working in fragile and conflict-affected countries, with 21 of its 28 priority countries now classified as such (DFID 2012). This indicates that the emphasis on RMNH programming for conflict-affected areas is very likely to be fulfilled, although there is no evidence of disaggregated monitoring in relation to this focus area.

Summary: Key findings

In the bilateral programme there was evidence of a growth in the number of projects after 2010 and that the Framework had encouraged cross-sectoral approaches. The Framework's pillars approach did not have a measureable impact on project design. However, the results focus has in some cases been used to review programming and whether it is likely to maximise gains. There is potential to do this more systematically in future.

In the multilateral programme, DFID was acknowledged to be a leader in the RMNH field across the international architecture. Much of this work started prior to the Framework, including work on multilateral organisation effectiveness and wider influencing and market-shaping investments. Gaps in international attention and research remain however (for example, to newborns and quality of care, though DFID has been active in these areas).

Analysis of spend found evidence of action under each of the four pillars of the Framework. There are no obvious trends over time in activities under each pillar and no benchmark for assessing the appropriateness of these allocations. Some areas, such as FP, received more focus and funding during the period. New attention was paid to some important but sensitive areas, such as female genital.

DFID country programmes were implementing an expanding range of activities across all pillars in the Framework. The three country case studies found projects to be relevant across the pillars and effective at delivering outputs. DFID's multilateral programme was focused on improving performance and effectiveness among international agencies, and could demonstrate success against these indicators. There was no evidence that the Framework itself had contributed to them.

There was no central mechanism for tracking bilateral or multilateral programme activities in order to assess how they contributed to outputs. In the bilateral programme, there were over 1,000 project indicators across the 52 projects analysed. Although guidance exists for tracking core indictors for attended deliveries, in practice these can be interpreted in a variety of ways, leading to inconsistencies across countries.

The country case studies found that DFID effectively targets poor states and groups, and the choice of priority states indicates an organisational commitment to supporting conflict-affected and fragile areas. However, there is a lack of disaggregated analysis to support any judgement about whether priority groups were really reached. Comprehensive information on programme and activity relevance, effectiveness, efficiency and equity was not available.

Overall assessment: The DFID activities reviewed appeared generally to be relevant, effective, and efficient. However, except for outputs that are related to headline targets reported in the DRF, it is not possible to aggregate the outputs of DFID's activities. Hence it is not possible to make a complete assessment, on the basis of measured outputs, as to whether DFID is on course to meet the overall objectives of the Framework.

5.3.5 Are outcomes on track to meet the objectives of the Framework?

329 In the MTR conceptual model, the outcome domain focused on assessing access to services, quality of care, reproductive choices, morbidity indicators and coverage of key interventions (including equity). However, the MTR found that up-to-date national data were only available for key interventions, so a full assessment of progress in relation to other outcomes cannot be made.

330 According to the DRF, there was good progress toward the Framework target of supporting at least two million safe deliveries, with a cumulative total of 1,630,000 reported in 2012/13 by DFID programmes, or 82% of the 2015 target (Working Paper IV). Progress was steady against the target to enable at least 10 million more women to use modern methods of FP by 2015. DFID reported 4,810,000 (48% of target) in 2012/13, up from 3,250,000 in 2011/12. However, given that there were just two years remaining to achieve more than a doubling of the current performance, it was not clear that DFID is on track to meet this target. The target on modern methods of FP explicitly counted multilateral results but using a different method to that used for bilateral funding. DFID is revising the methodology on this indicator.

331 The three case study countries reported a total of DFID-attributed increases in attended deliveries of 550,000 to 2013. In Ethiopia, the 2012 Annual Review showed DFID was behind its target to increase the number of assisted deliveries, while the Nigeria office reported being ahead of target (Working Paper VIII, Country Case Study Reports, RMNH).

332 The estimation of the number of safe deliveries attributed to DFID faces substantial challenges. The methods proposed in the DFID guidance note allow scope for a wide variation in results depending on the assumptions made, particularly in what is taken to be the 'business as usual' scenario (DFID 2013d) The methods that have been used to report it in practice vary between country case studies. In some cases, the current figures are essentially projections rather than being based on empirical data. In other cases, the estimates use data from different sources that may not be comparable to analyse trends in the number of attended deliveries (see Working Paper VIII, India and Nigeria Case Study Reports, RMNH). The country offices have made pragmatic decisions on how to calculate and report these numbers, given the challenges involved, but it is important that their limitations are recognised and that results are validated using future household surveys when they become available.

333 In Ethiopia, the 2012 annual review showed DFID was behind its target to increase the number of assisted deliveries, while the Nigeria office reported being ahead of target. The three case study countries reported a total of DFID-attributed increases in attended deliveries of 550,000 to 2013. These were difficult numbers to estimate and the methods proposed in the indicator notes allowed scope for a wide variation in results depending on the assumptions made. The country offices made further pragmatic decisions in these regards, given the requirement for six monthly updating.

334 There was evidence from case study countries that some programmes managed to increase the uptake of priority services and improve outcome measures in the geographical areas that they operate in (Working Paper VIII, RMNH Country Case Studies). In Nigeria, DFID health system support programmes demonstrated substantial improvements in the uptake of key services including the proportion of births with a skilled attendant. The total population covered by these interventions is, however a relatively modest fraction of the national population, given DFID's approach of working with priority states rather than nationally.

335 One area identified from KIIs as meriting more focus to reach outcome goals is quality of care, which in the case of skilled attendance is a critical link that will lead to improved outcomes (or not). While many countries are reporting increased facility deliveries, for example, maternal mortality and neonatal mortality rates remain stubbornly high in some cases. In order to ensure that outcomes are met, the stakeholders interviewed emphasised that country staff need to be supported to diagnose critical bottlenecks in the health system which, if addressed, could increase the effectiveness of care. For newborns, for example, there are a few key evidence-based interventions that require specific items to be present in facilities (such as antenatal corticosteroids, which can reduce the risk of newborn death by more than 50% in facilities where ventilation support technologies are not available). By working with government to ensure these are available, especially in countries with large burdens of disease like India, DFID can increase its effectiveness. This requires all staff to be up to date with the latest evidence. Similarly, the need to understand better what strategies are effective in reaching adolescent girls with unmet contraceptive needs was raised by some stakeholders, along with strategies to reduce stillbirths.

How sustainable are DFID's investments under the Framework?

336 The MTR found that, in general, the strong health systems focus in DFID's bilateral programming has helped to encourage the development of sustainable technical capacity. Health programmes usually address overall health system strengthening, often including human resource development. Reviews of these programme commonly found that they were delivering on most of the expected outputs (Working Paper VIII, RMNH country case studies). In Ethiopia, for example, the support to sector pooled funds is helping to develop sustainable capacity in government systems. While government capacity is also being developed in Nigeria, this is more dependent on external service providers and the gains are less likely to be sustainable in the short term without continued support.

337 DFID priority countries are likely to be dependent on fiscal support for their health systems for years to come, and this is an appropriate use of aid. Ideally this expenditure will be used to 'leverage in' additional government resources to RMNH – DFID should expect at least that the assistance supplements, rather than substitutes, expenditure by recipient governments in these areas. Government spend on health in Ethiopia increased substantially up until 2008, but appears to have stagnated at about 8.5% of the government budget more recently. Obtaining accurate information on public expenditure on health in Nigeria across the three levels of government is difficult and no recent data were obtained by the MTR (Working Paper VIII, RMNH country case studies). DFID should expect transparency and a commitment to maintain or increase relevant spend from partner governments as part of the process of negotiating support programmes; however, this does not happen consistently.

338 DFID has made a decision to end direct support to India (the country that has the largest number of maternal deaths) after 2015. Central government spend per capita on health is low in India but has been increasing in recent years (Working Paper VIII, India country case study, RMNH). Given the decision to end direct aid, the sustainability of DFID's investments in RMNH in India is particularly dependent on a rapid increase in national spending to improve RMNH and a strengthening of capacity, especially in the states in which maternal and neonatal mortality is most concentrated.

339 The investments that DFID is making in market-shaping activities to improve the accessibility and quality of health commodities have the potential to generate long-term, self-sustaining benefits without incurring ongoing costs. However, it is currently too early to evaluate how far this has been realised.

340 Influencing of multilateral organisations has focused on strengthening international organisations' effectiveness (Working Paper III), which ultimately strengthens sustainability. DFID also clearly aims to contribute to the sustainability of health systems through wider influencing on aid architecture and macroeconomic debates, although these fall outside the scope of the MTR.

341 RMNH investments are estimated to generate US$ 20 for every US$ 1 spent,[55] such that they should be more than self-sustaining in principle over the longer term. However, in the short term, DFID is expected to continue to be a major player in most areas of RMNH funding, including FP and reproductive commodities (Working Paper I).

Summary: Key findings

DFID is on track to meet its targets for skilled attendance at delivery. It was less clear whether it was on track in terms of new users of modern FP methods, though this may in part be related to how this output is tracked.

The strong health systems focus in DFID's bilateral programming has helped to encourage the development of sustainable technical capacity, although this varies between countries. While priority countries are likely to be dependent on fiscal support for a number of years, DFID should expect transparency and increased relevant spend from partner governments. This does not happen consistently. DFID also contributes to sustainability at a global level through its influencing (in the broadest sense) and investment in strengthening multilateral organisations.

Overall assessment: **Comprehensive and up-to-date national data on RMNH outcomes are not available in the high-burden countries that are of most interest to DFID. This limits the extent to which outcomes can be assessed to be on track to meet the objectives of the Framework. DFID is on track to meet targets for skilled attendance at birth.**

5.3.6 Impact: To what extent is it possible to measure the impact of the Framework and of DFID's activities, and how can the measurement of impact be improved?

342 The 2012/13 DFID Annual Report stated that DFID saved 6,000 maternal lives and 16,000 neonatal lives in 2011/12. These represented 12% of the five-year target of 50,000 maternal lives and 6% of the target of 250,000 neonatal lives saved. They therefore implied that DFID was off track on its top-line indicators. However, they were derived from data for only nine out of 19 countries that reported and for just one year of activity. No information was available on the contribution of multilateral activities. Results reporting in the 2013/14 DFID Annual Report may provide more comprehensive figures for 2011/12 as well as preliminary results for 2012/13, thus facilitating a more accurate assessment of whether DFID was on track against these targets.

343 DFID has commissioned external independent advisers to model lives saved and other results, based on intervention inputs and coverage data. Maternal and newborn lives saved

[55] See: http://www.ministerialleadershipinhealth.org/wp-content/uploads/sites/19/2013/03/KS24-Economic-case-26_03_2013-low.pdf

were modelled by researchers from Johns Hopkins University using the Lives Saved Tool (LiST). Progress towards the commitment to reach the poorest 40% with quality maternity services was estimated by the Guttmacher Institute for DFID's 28 countries using population-based data. The DFID contribution was estimated by DFID staff on the basis of its proportion of contribution to OECD-DAC ODA. Unintended pregnancies prevented are estimated based on number of additional users reached over five years. Final results were not available to the MTR but are scheduled to be made public in time for the Final Evaluation.

344 Preliminary results generated by Johns Hopkins University (JHU) conclude that if all targets are reached for maternal and child health programming in these countries, the target of 250,000 neonatal deaths averted between 2011 and 2015 can be achieved (see Working Paper VII; note these results are currently being revised). However, they conclude that planned activities are only sufficient to achieve the maternal target of 50,000 deaths if lives saved through avoiding pregnancy are included. Although the top line DFID target is 'lives saved during pregnancy' (i.e. technically would exclude lives saved through avoiding unintended pregnancy), it is generally accepted that the maternal lives saved goal includes both family planning and maternal/newborn health interventions.

345 The modelling approaches are technically sound but, as with all models, validity depends on the quality of the available data as well as the validity of the model assumptions. In generating results for any one year, the LiST used a mix of actual and projected data. Forward estimates were based on the assumption that DFID would implement its programmes as planned in the logframes. Built into the model are estimates of effectiveness of coverage with key interventions that may or may not reflect real conditions on the ground. The LiST may both under-estimate projected lives saved, in that it does not attempt to model gains from some cross-cutting support areas such as training, and over-estimate lives saved, where intervention quality and effectiveness (e.g. availability of critical commodities in facilities) rates may be overestimated in some contexts. It is also not clear how robust the counterfactual is: it appears to be based on no change to coverage rates for key RMNH interventions, which is not necessarily realistic. It may be that increases in coverage rates based on historical trends would be more appropriate.

346 The attribution of changes in outcome and impact indicators to DFID spend is difficult. Where attribution is done on a proportion of total spend then perverse results can be obtained. For example, if DFID spend displaces government or private sector funding and this is not properly accounted for then its overall impact is overestimated. Analytical approaches that adjust for this can be used, but the results will often depend on a number of the assumptions made and the imprecision of estimates must be recognised (Working Paper VII).

347 The Final Evaluation should look to cross-check some of the modelling results. It should review the quality of input data used and robustness of its assumptions and look for evidence of changes on the ground in line with the theory of change.

Key Findings

Reports by DFID on maternal and neonatal lives saved suggest that DFID is off track on its top-line indicators. However, information available is incomplete and potentially misleading as it risks both under- and over-estimation. The methodology is being improved based on previous rounds of data collection and is broadly appropriate. Further analysis will be needed to determine whether planned impacts will be achieved.

Preliminary results using modelling approaches suggest that DFID may be on course to achieve the maternal and newborn lives saved targets if all activities planned are successfully delivered. However further work is required to strengthen the underlying data and to test further the validity of assumptions about key parameters. Final results are not yet available as the model is being refined.

Overall Assessment: The scope for estimating lives saved by DFID programmes by aggregating estimated programme results is limited by the availability of data. Modelling approaches suggest DFID may be on course to achieve targets, but these estimates depend on the quality and completeness of data and the validity of assumptions made about key parameters.

6 Conclusions

6.1 Summary of answers to the MTR questions

348 This section presents the overall conclusions of the MTR for the two Frameworks, beginning with a summary of the answers to the MTR questions. The MTR has reached broadly positive conclusions about the role and guidance that the Frameworks have provided, and about the effectiveness of DFID's activities under the Frameworks, while also identifying some weaknesses, particularly in relation to monitoring systems. The following sections discuss in more detail specific conclusions and lessons in relation to policy, strategy and implementation, distinguishing between programming and expenditure and systems and practices.

6.1.1 Design: Has the Framework provided an effective strategic instrument to achieve UK government objectives?

349 The Malaria Framework has provided important strategic guidance to help achieve government objectives and has contributed to increasing DFID's profile and international influence by providing DFID's first comprehensive policy statement on malaria. However, the BAR and MAR were considered by DFID key informants to be more significant factors influencing programme decisions than the Framework itself.

350 The RMNH Framework has provided an effective strategic instrument to articulate and communicate DFID's priorities and approach. As with malaria, the BAR and MAR were considered to have had more direct influence on programme decisions than the Framework. The RMNH Framework contributed to ensuring coherence with HIV/AIDS and gender strategies, although the review processes for these strategies have not so far been linked.

6.1.2 Inputs: Have adequate resources been used and appropriately applied to achieve the Framework objectives?

351 Malaria spend is expected to reach the target levels by 2014/15, which represents a major contribution to combatting malaria. However, it is not possible to determine if outcome and impact targets will be achieved based on this level of spending.

352 DFID has also met its financial commitments under the RMNH Framework during 2010 to 2013, spending a total of £2.7 billion on MCH during this period. The Framework objectives have not been fully specified or costed and so it is not possible to judge whether these resources are sufficient to achieve the objectives.

6.1.3 Process: Have the Framework and DFID's programmes under it been effectively managed to achieve UK government objectives?

353 Apart from through the DRF there is no systematic mechanism for ensuring that high-level commitments are implemented through DFID's bilateral programmes, reflecting DFID's highly decentralised programming mechanisms. These are a strength in general, but represent a challenge in delivering on central policy commitments.

354 In terms of monitoring, the Malaria Results Tracker provides a practical mechanism to track country-level progress, but DFID's monitoring system as a whole does not allow results information to be properly integrated and analysed.

355 Monitoring in aggregate against the RMNH Framework suffers from similar weaknesses, and the lack of an equivalent to the Malaria Results Tracker makes it more difficult to assess the overall progress achieved.

356 DFID has generally avoided the risk that a results and attribution-based focus could encourage a narrowing of activities onto the immediately measurable, particularly through the strong commitment to a health systems approach. Some other risks – including around fiscal probity, VfM, and the robustness of programme-level monitoring systems – are significant, but mechanisms to manage them are being strengthened.

6.1.4 Outputs: Are activities and outputs under the Framework on track to meet its objectives?

357 Activities under the Malaria Framework are resulting in substantial, measurable progress in the delivery of relevant outputs. These include the delivery of commodities to high-burden countries; enhancing the availability of low-cost quality-assured treatment and diagnostics; and wider health system strengthening. Support for product development, market dynamics and tracking artemisinin resistance is critical to the sustainability of the interventions. There are no specific output targets defined in the Framework against which to measure progress.

358 DFID activities under the RMNH Framework appeared to be generally relevant, effective and efficient. However, except for outputs that are related to the headline targets reported in the DRF, it is not possible to aggregate the outputs from DFID's activities. Hence it is not possible to make a complete assessment of whether DFID is on course to meet the overall objectives of the Framework. There is also a lack of disaggregated data to assess how far priority groups (young people, the poorest, those affected by conflict and natural disaster areas) are in fact reached.

6.1.5 Outcomes: Are outcomes on track to meet the objectives of the Framework?

359 Trends in outcome indicators for malaria show substantial progress but it is too early to be certain that Framework objectives will be met. Strengthened health systems, together with increased government efforts and commitment of resources, will be required to sustain the gains and accelerate progress in the high-burden countries.

360 For RMNH, DFID is on track to meet its targets for skilled attendance at delivery, but it is not clear whether that is the case for use of modern FP methods. The strong health systems focus in DFID's bilateral programming has helped to encourage the development of sustainable capacity. While priority countries are likely to be dependent on fiscal support for a number of years, DFID should expect transparency and protected or increased relevant spend from partner governments. This does not happen consistently. DFID contributes to sustainability at a global level through its influencing, investment in market-shaping and strengthening of multilateral organisations.

6.1.6 Impact: To what extent is it possible to measure the impact of the Frameworks and of DFID's activities, and how can the measurement of impact be improved?

361 For malaria, modelled estimates of overall trends in high-burden countries undertaken for the MTR using WHO methodology suggest that five countries were by 2011 close to achieving a 50% reduction in malaria burden since 2005 and another four are on track to achieve this reduction by 2015. In addition, all-cause under-five mortality has dropped more than 30% in seven of the high-burden countries over a similar period. However further empirical validation of assumptions about model parameters is required to enable measurement of the impact of DFID activities.

362 For RMNH, reports by DFID on maternal and neonatal lives saved based on aggregation of estimates from specific programmes suggest that DFID is off track on its top-line indicators. However, the information is incomplete and potentially misleading as it risks both under- and over-estimation. Modelling approaches suggest DFID may be on track but, as with malaria modelling, the validity of these estimates depends on the quality of data and completeness of data and assumptions made about key parameters. Final results are not yet available as the model is being refined.

6.2 Lessons on policy and strategy

363 The Frameworks have served an important and generally effective role in signalling both internally and externally DFID's policy focus and commitments on RMNH and malaria. The Frameworks, together with the BAR and MAR and other related processes, signalled a need for a more systematic focus on results and the articulation of the rationale linking specific activities to expected impacts. The Frameworks also provided explicit targets for results that have been incorporated in DFID's corporate DRF for 2015. These are well aligned with global targets.

364 The evidence review that was part of the Framework preparation process had an additional independent value in providing an authoritative assessment of evidence on effective interventions. The MTR found both to be of high quality, although there is now a need to update them to incorporate new evidence.

365 The Frameworks are generally consistent with other DFID policies, and for RMNH built on a number of previous policies. There is also strong coherence between the RMNH Framework and other strategic DFID documents, such as the SVGW and the HIV position paper. In the longer term, linkages across DFID's health programmes as a whole and cross-sectoral linkages (for instance with gender strategies) may be better served by developing policies and reporting results for malaria and RMNH within a broader sectoral Framework, such as that provided by the recent Health Policy Position Paper.

366 The Frameworks have both identified an appropriate set of evidence-based interventions for working towards the targets. However, the relationship between spend and final outcome targets was not based on any clearly defined costing. They also did not provide guidance on how resources should be allocated across the pillars or across different channels, and the intended focus on selected countries has not been followed through systematically.

367 The Frameworks (both the documents and the process by which they were developed) have strengthened DFID's role and influence in international forums and contributed to

sustaining or reinforcing international attention on maternal and newborn health and on malaria control.

368 The Frameworks have had only a partial influence on DFID country-level programmes, reflecting decentralised planning and management arrangements that permit country offices to respond to local priorities and circumstances. The Frameworks have substantially influenced aspects of the bilateral programme in some countries, contributing to the redesign of some programmes and the design of business cases for new ones. However, the main process that shaped DFID's bilateral programmes was the BAR rather than the Frameworks as such.

369 Despite the commitment to measureable results, there has been insufficient development of monitoring and information systems to provide adequate management information and accountability against the Frameworks, and to enable lesson learning.

370 While the specification of a target of 'lives saved' had a clear political rationale, there are concerns about such a target-driven approach. It risks instrumentalising investments below the impact level and ignoring their intrinsic value. It raises challenges in measuring trends and modelling impact. It also risks distracting attention from intermediate issues that have more direct significance to management – these include tracking programme outputs and assessing on a routine basis their relevance, efficiency, effectiveness and equity.

371 The overall lesson on the Frameworks as strategy documents is that they provided a clear articulation of ambitious overall priorities and sound evidence base, but they assumed practical mechanisms for implementing and monitoring them would be developed that have as yet remained incomplete.

6.3 Lessons on implementing the Frameworks

6.3.1 Programming and expenditure allocation

372 Both DFID's bilateral and multilateral programmes have been driven by bottom-up business plans that bid for resources. While the BAR and MAR provided a basis for decision-making within the bilateral and multilateral programmes in relation to the Frameworks, there is no objective basis for judging whether the allocation between bilateral and multilateral programmes is appropriate in the absence of any explicit guidance or criteria in the Frameworks. A more explicit analysis of this issue in the Framework documents would have been warranted, and should be provided in the future.

373 In general, there is a reasonably strong relationship between measures of need and the levels of bilateral spend by country. However, for both RMNH and malaria some large population, high-burden countries are relatively 'underfunded'. In principle, there is scope to increase impact by increasing the resources allocated to these countries. However, some are countries in which political instability and conflict are major barriers to success, such as the DRC, and increased spend would need to be conditional on mechanisms for ensuring effectiveness, although there is evidence that shows this can be done.

374 For malaria, it is important to note that the distribution of burden between countries is driven in part by the large populations in some countries and that equal or greater impact in terms of reductions in incidence and mortality rates are also possible in smaller high transmission countries. In deciding geographical priorities, it is important to consider the likely effectiveness of interventions that will determine whether the planned impact is achievable. This requires a

mapping of the epidemiological characteristics of the country alongside a consideration of the ability of the health system and wider infrastructure to deliver the intervention. It is also important before making any significant changes in allocation across countries to consider carefully the potential for malaria resurgence if resources are sharply reduced in countries in which DFID currently has a large commitment but which have already achieved substantial reductions in disease burden.

375 The assessment of the balance of effort across different pillars and intervention areas has been limited by a lack of information. Comprehensive information on programme and activity relevance, effectiveness, efficiency and equity was not available. However:

- For RMNH, self-reported effectiveness is highest for activities on improving supply and access; further work on developing clear metrics for empowerment and accountability is needed. Global trends, though encouraging in some areas, highlight the need for continued support to all three areas of reproductive, maternal and newborn care. Uptake is low in many of the DFID focus countries, and all three should continue to receive high priority. The strengthening of services for adolescent girls was identified as an area for improvement in case study countries.

- For malaria, there has been most progress in extending the coverage of bednets, although gaps between distribution and use are significant in some countries. Progress in IRS in countries where DFID provides support has been limited. There was appreciable progress in increasing the coverage of appropriate treatment, but overall levels of access remain low. Wider strengthening of health systems and health services will remain essential, as well as country-specific operational research to identify specific gaps.

376 Supporting preventive services and strengthening primary-level care is generally pro-poor. Equity issues have been further addressed through targeting resources at areas that are poorer and substantially disadvantaged on a number of key health indicators, for example towards poorer states in Nigeria. There is however often limited recent disaggregated information by target group for many of the key indicators in both RMNH and malaria. Continued attention to strategies to reach the marginalised will be key to meeting global and DFID targets.

377 In terms of influencing global policy and programming, DFID has an influential relationship with a range of global actors in both malaria and RMNH:

- For malaria, DFID has become an influential global actor over the period of the Framework, having previously played a more limited international role.
- For RMNH, DFID performed an important and effective international influencing role over the period since the Framework, building on earlier initiatives. Its work with both multilateral agencies and on specific events led to significant resource increases in priority health areas such as FP, as well as to improvements in VfM within some of the international partners. DFID is perceived as being able to address some important (and sensitive) issues that other donors do not.

378 For malaria, DFID has developed over the period of the Framework a strong influence on the global malaria agenda through relations with key actors. While the Frameworks helped to raise DFID's profile in both areas, the MAR was often cited as a more important influence than the Frameworks themselves:

- For malaria, a specific element of the Framework of direct influence to the wider global agenda has been the funding of support to the WHO GMP and RBM to enhance and rationalise their respective roles. However, reporting of results through multilaterals was found to pose particular challenges.
- DFID's work with multilateral agencies in RMNH has focused heavily on improving performance and effectiveness. It could demonstrate successes in this regard, although there was no evidence that the Framework itself had contributed to them.

379 There has been substantial investment by DFID in global public goods:

- For malaria, investments have been made by DFID in supporting innovative models to enhance the availability of low-cost quality-assured treatment and diagnostics, some elements of which have been declared by independent evaluations to be effective.
- For RMNH, DFID invested substantially in market-shaping activities in relation to improving access to safe, effective and affordable health commodities, particularly for reproductive health. While it was too early to evaluate the effectiveness of these activities, large price savings, better quality products and greater supply security are anticipated.

380 DFID's total spend on health research between 2010/11 and 2012/13 was £212.6 million. While it is too early as yet to evaluate the effectiveness of these investments as a whole, some earlier investments are already resulting in substantial returns.

6.3.2 Systems and practices

381 The MTR has identified significant weaknesses in DFID's monitoring systems that work against both lesson learning and the effective communication of the achievements of DFID's programmes under the Frameworks. There is a lack of a strategic perspective across the various projects and programmes, particularly to link performance in high-burden countries of critical importance to the achievement of Framework objectives.

382 Apart from the DRF, DFID does not have in place adequate mechanisms to track activities and the performance of projects that are contributing to top-level results. As a result, it has been difficult to aggregate information on outputs and to assess to what extent DFID is on track to achieve its targets. There are also significant challenges in achieving adequate reporting against disaggregated targets, including for conflict affected populations, the lowest income groups and young women, which were a central part of the strategies.

383 The project coding system does not allow an accurate assessment to be made of how much DFID is investing in different programme areas. For example, while DFID's investments in influencing activities with multilateral organisations appear to have been successful, they are not currently explicitly measured or reported.

384 There is also a lack of available recent project or programme evaluation material, although a programme of relevant evaluations is planned.

385 Logframes are currently not integrated into the project management system. The MTR has identified changes to DFID's overall project management systems and practices that could strengthen reporting, particularly in relation to cost-effectiveness.

386 While there is a strong focus on improving systems for measuring VfM at the corporate level, this has not yet been effectively translated to the project level to ensure that explicit VfM

indicators are included in project logframes. Reporting on progress against budget targets in project logframes would contribute to improving monitoring of VfM.

387 The RMNH Framework has encouraged greater dialogue between health and social development staff in particular, recognising the important role of these determinants. How much this happens in practice, however, depends to some extent on individual relationships.

7 Recommendations

388 This section identifies the main recommendations of the MTR. It includes some that are common to both Frameworks and others specific to a particular Framework.

7.1 Recommendations on policy and strategy

7.1.1 Recommendation 1: Undertake strategic reviews of the prospects of achieving Framework objectives in selected high-burden countries

389 **Issue to address**: The prospects for achieving the global targets set for both Frameworks depend critically on outcomes in a small number of high-burden countries in which DFID is active through its bilateral programmes. At the moment, DFID does not have an integrated strategic view across the projects relevant to each Framework or an explicit strategy for achieving its objectives in each country. The country case studies undertaken for the MTR were useful in identifying some emerging issues but could not be comprehensive. In addition, a strategic review process needs stronger engagement from DFID country teams and country partners, as well as support from regional and central policy teams.

390 A relatively light process of strategic review in some key countries would have the potential to determine the prospects for achieving the results envisaged and identifying the main constraints on progress, as well as to identify gaps and priority actions beyond DFID's current projects where targeted actions (beyond existing project activities) should take place. Some additional resources could be made available to support priority actions to achieve results that are not included within current bilateral expenditure plans.

391 **Action required**: A practical process for undertaking Framework strategic reviews in selected countries needs to be agreed, and ToR need to be developed. The reviews should take place during the first half of 2014 in order to identify both short-term measures that could be implemented by the end of 2015, and longer-term issues for future engagement beyond the current Frameworks. Central and regional policy resources should be made available to support country teams. The country strategic review should be undertaken jointly with partners and should build on existing national review processes. It would involve the following elements:

- Identification of all projects contributing to the goal (including multilateral ones).
- Mapping of activities by partners.
- Review of research and information sources providing evidence on progress and constraints.
- Review of expenditures, outputs and outcomes from DFID and partner programmes.
- Review available data on outcomes and system performance, and identify gaps and weaknesses.
- Undertake selective assessments of effectiveness or cost-effectiveness, and barriers to these.
- Identify levels of recipient government support to relevant programmes and opportunities to leverage additional resources. In contexts where public health systems are particularly weak and it may take a long time to strengthen these systems, review the opportunities for and implications of making use of non-government systems.
- For RMNH, review linkages with HIV/AIDS and gender strategies.

- For malaria, review barriers in the efficacy-to-effectiveness pathway and management/coordination issues.
- Identify gaps or weaknesses in the programme and risks to not achieving the goal.
- Identify clear short-term actions that need to be undertaken to address gaps, together with strategies for longer-term engagement beyond the period of the Frameworks.

7.1.2 Recommendation 2: Strengthen linkages between RMNH programmes and other non-health interventions

392 **Issue to address**: The MTR found that linkages between non-health focused interventions aimed at empowering women and girls and strengthening accountability and the achievement of objectives relating to reproductive choices are currently weak. There is no systematic way of tracking relevant projects beyond the health sector.

393 **Action required**: Actions can be identified over the short, medium and long terms:

- In the short term, a core set of indicators, and ways of measuring and tracking them, should be agreed for monitoring pillars 1 and 4 of the RMNH Framework. These should take account of specific linkages between the broader process of empowering women and girls, increasing accountability and RMNH.

- In the medium term, the development of the successors to the Frameworks should address empowerment issues through reference to DFID's other relevant policies rather than seeking to incorporate them as an explicit programming area within the policy itself. This will require consistency on policy, programming and reporting of programmes and indicators, but should seek to avoid potential duplication. Close cooperation and joint working at the programme level should be strengthened where there are gaps, but this should be within a Framework that recognises where primary accountability for results in each area is situated within DFID.

- For the longer term, research should be supported on understanding and modelling how interventions such as girls' education feed through into better RMNH and the different time scales on which they would be expected to act.

7.1.3 Recommendation 3: Strengthen operational research for malaria

394 **Issue to address**: DFID has played an important role in promoting operational research to reduce the gap between the efficacy and the effectiveness of malaria interventions. However, gaps in the availability, coverage and utilisation of the key vector and treatment strategies remain a major barrier to achieving the goals set out in the Framework. These issues require further investigation with localised operational research to identify the underlying causes and hence to develop appropriate locally tailored solutions. DFID is well placed to explore these issues. This should be done in coordination with NMCPs.

395 **Action required:** DFID should invest further in operational research to better understand the barriers to achieving high coverage of malaria interventions in the high-burden countries in which they are focused. NMCPs should be involved in the identification and implementation of these studies. For vector control, this could include not just issues in the supply chain and utilisation of bednets but some consideration of alternative vector control tools, including those currently in late-stage development through their partnership with IVCC. For treatment, this would include further developing and testing methods to engage the private sector in improving

not just access to high-quality ACTs but also to improve more general prescribing for fever management by increasing access to diagnostics and drugs for the range of causes of non-malarial febrile illness rather than simply a diagnostic and drug for malaria. In this latter area there are opportunities for cross-linkages to wider objectives to improve child health and reduce infant mortality.

7.1.4 Recommendation 4: Update the review of evidence for RMNH

396 **Issue to address**: There is scope for conducting further evidence reviews to cover new or challenging areas. Least progress has been made in relation to improving accountability for RMNH results and this is an area where DFID country health teams require further guidance.

397 **Action required**: Further research should be conducted on the role and potential of strengthening accountability as a means to improve RMNH, so as to obtain a better understanding of what types of intervention work and how to measure progress. This would include clarification on definitions and guidance on measurement, as well as a review of evidence on effective interventions to strengthen accountability and achieve results, including the scope for modelling the impact of measures to improve accountability. Indicators for empowerment should be aligned to the indicators developed by UNWomen under the Evidence and Data for Gender Equality programme.

398 Further areas where additional evidence review for RMNH would be useful include: (i) interventions for scaling up more effective neonatal care/saving of lives; (ii) effective ways to provide SRH services (especially family planning) to hard-to-reach groups, especially FP; and (iii) addressing quality of care gaps in RMNH.

7.2 Recommendations on programming

7.2.1 Recommendation 5: Assess and strengthen relevant national data systems

399 **Issue to address**: DFID works to strengthen national routine data systems and surveys in many countries. Nevertheless, the MTR highlighted problems with a lack of data and inconsistency between different sources at the country level. This hampers the assessment of national trends and of DFID's support.

400 **Action required:** DFID should enhance its support to data-strengthening activities at the country level, including routine data collection and use, surveillance activities and periodic surveys. This should begin with data-quality assessments in key areas, undertaken together with partners. These could utilise existing data-quality assessment tools and could also be charged with examining areas of particular concern – for example, to examine the reasons for inconsistencies between different sources of data on trends in key indicators. These reviews would have value for national governments and for DFID's reporting systems. They could help to improve the quality of data and the understanding of trends in the data reported through the Malaria Results Tracker and other channels. Reviews should identify where further support is required.

401 Strengthening routine information systems will take time so DFID country offices should have an active engagement with the next rounds of DHS and Malaria Indicator Surveys, as well as US-PMI supported malaria impact assessments. Such household surveys are one of the key sources of information on indicators disaggregated by household socioeconomic status, such as income/wealth quintile.

402 DFID should enhance its support to data strengthening activities at the country level,, including routine date collection and use, surveillance activities and periodic surveys . This should begin with data quality assessments, which could help to improve the quality of data and the understanding of trends for both recipient governments and DFID. Reviews should identify where further support is required. Strengthening routine information systems will take time so DFID country offices should have an active engagement with the next rounds of Demographic and Health Surveys and Malaria Indicator Surveys and well as US-PMI supported malaria impact assessments.

7.2.2 Recommendation 6: Strengthen support to country programmes

403 **Issue to address**: The Frameworks cover between them a wide field of knowledge that is continually advancing, and country offices are expected to manage an increasing spend with lower overheads. It is sometimes difficult for country programmes to identify and exploit opportunities to make progress under the Frameworks outside the scope of existing projects. While support is provided through existing central and regional teams, there is a case for expanding this.

404 **Action required**: Central or regional teams should provide enhanced support to offices in high-burden countries, including around the proposed strategic review process. Some financial as well as technical advisory resources should be earmarked at regional level for each Framework to help country teams take advantage of opportunities or to identify and address constraints that are identified, such as specific bottlenecks that prevent programmes being effective.

7.2.3 Recommendation 7: Build on success and innovation in RMNH programmes

405 **Issue to address:** In recent years, DFID has demonstrated a strong comparative advantage in addressing 'difficult' topics in SRH that have tended to be neglected by other donors. These include unsafe abortion, gender-based violence, early marriage and teenage sexuality. This programming should be built on and extended in the next phase of the Framework.

406 **Action required:** Innovative programmes in SRH should now be reviewed for evidence of effectiveness and then extended, based on the lessons learned. FP has been demonstrated to provide extremely good VfM and provision remains very low in many of DFID's priority countries, so this should continue to be a focus area. Progress in saving neonatal lives and addressing high stillbirth rates is lagging and deserves additional attention. Improving quality of care and access to care for marginalised groups, including HIV-positive women, should remain a core focus. DFID should continue to focus its programmes and engagement in these areas, where there is a demonstrated need, evidence on effective interventions and limited support from other development partners.

7.2.4 Recommendation 8: Regular review of the epidemiological situation of malaria and support provided by country

407 **Issue to address**: The MTR has outlined debate around how malaria spending should be allocated across countries. In deciding geographical priorities, it is important to consider the likely effectiveness of interventions that will determine whether the planned impact is achievable. This requires a mapping of the epidemiological characteristics of the country alongside a consideration of the ability of the health system and wider infrastructure to deliver

the intervention. It is also important before making any significant changes to consider carefully the potential for malaria resurgence if resources are sharply reduced in countries in which DFID currently has a large commitment but which have already achieved substantial reductions in disease burden.

408 **Action required:** There is a need for DFID to take a more focused view, in particular for planning beyond the Framework period, about what interventions to fund in different countries and in different areas within a country. We recommend that in 2014 additional mapping of intervention needs and potential impact is undertaken in a subset of the high-burden countries, following the approach that DFID has recently used in Tanzania. This can then form the basis for an assessment of changing the current focus of domestic, bilateral and multilateral investments in multiple countries. This would allow both the benefits and risks of any changes to be considered, including amongst others the potential risk of resurgence. It would provide the evidence base for any changes from the current approach.

7.3 Recommendations on systems and practices

7.3.1 Recommendation 9: Undertake an annual internal review of the Frameworks

409 **Issue to address**: Exclusive dependence on a process of periodic external review (through the MTR and Final Evaluation) is not sufficient as a means to assess progress and identify challenges, opportunities and lessons. This external process therefore needs to be supplemented by strengthened regular monitoring and internal reflection on progress and lessons emerging.

410 **Action required**: DFID should establish a formal (but light) process of annual review of performance against Framework targets. This should be undertaken globally and in selected high-burden countries, with a strong focus on the small number of countries where achieving results is most critical in relation to achieving overall quantitative targets (i.e. those for which strategic reviews are proposed). This review process could include expert support to bring in to discussions the latest evidence on interventions which can achieve impact. Furthermore, the findings and conclusions should be made publicly available.

411 Improving the communication, consolidation and use of project annual reviews by regional and central policy teams could also allow additional information to be tracked, such as mapping projects to the Framework pillars, tracking the extent and use of indicators, and tracking the timing and outcomes of project performance assessments (annual reviews, project completion reports, evaluations, etc.). It could form part of strengthening the interaction between these teams and the country offices during and beyond the Frameworks' remaining period of operation.

412 In priority high-burden countries, this annual review process should include an assessment of progress against the country Framework strategies, including identifying blockages and constraints to progress. This process should ideally be coordinated with a review of other related DFID strategies, including the SVGW and the HIV Position Paper. It should ideally involve members of regional and central policy teams.

413 To support this process it would be useful to establish a voluntary network of interested individuals working on areas falling under all of the pillars. This could contribute by: enabling an ongoing conversation on progress toward targets; enabling learning between DFID country programmes through the identification of issues that could be addressed by other parts of the

organisation (i.e. on aid effectiveness related to other partners); providing a mechanism for collaboration with non-health programmes (particularly for RMNH); and supporting effective policy and programmatic decisions and results. Similar mechanisms have previously been implemented in tracking the HIV/AIDS programmes and commitments, and lessons could be drawn from these experiences.

7.3.2 Recommendation 10: Strengthen the Malaria Results Tracker

414 **Issue to address**: The existence of the Malaria Results Tracker has made it possible to provide an aggregated report on the outputs produced. However, further strengthening of this system is required for it to provide robust data for results analysis and reporting evidence. In particular, the system does not currently link project codes, financial commitments and outputs, making it impossible to systematically evaluate effectiveness or VfM across all projects. Also, there was evidence of a lack of ownership of country-level data among DFID staff.

415 **Actions required**: The limitations highlighted on the Malaria Results Tracker should be addressed (in the short term, over the remaining period of the Framework) through clearer processes for data specification, checking and control. This could involve developing the Malaria Results Tracker into a stand-alone database that is of use both as a central monitoring resource and to individual country programmes to track progress, and including additional indicators in the Malaria Results Tracker so as to enable evaluation of investments in general health sector support. Work can be undertaken with WHO and the RBM M&E Reference Group (MERG) to collate more consistent and comparable data on outcomes in the Malaria Results Tracker. The elements of the Malaria Results Tracker that monitor DFID progress should be incorporated in the DRF system.

7.3.3 Recommendation 11: Establish a RMNH Results Tracker

416 **Issue to address**: There is currently no aggregated report on outputs for RMNH. The weakness of available information on outputs prevented the MTR making a full and evidenced assessment of how far DFID was on track to achieve the targets of the RMNH Framework.

417 **Actions required**: The feasibility and value of implementing a RMNH Results Tracker should be investigated, building on the existing datasheets populated for the LiST. This should encompass results achieved through both DFID's multilateral and bilateral programmes. Given the breadth of the Framework, however, the challenge is to agree on a minimum core of indicators. External support might be needed to develop this tracker. It should facilitate the collation of national and disaggregated data on trends in output and outcome indicators, with an assessment of the consistency and quality of the data. The elements of the RMNH tracker that monitor DFID progress should be incorporated in the DRF system. Specific concerns raised by DFID offices about the interpretation and measurability of some indicators (e.g. definition of 'new FP users', difficulty of obtaining disaggregated indicators from national sources, etc.) should be addressed through the process of reviewing indicators and producing guides for their measurement for the trackers.

7.3.4 Recommendation 12: Incorporate logframes into DFID's project management system

418 **Issue to be addressed:** Malaria and RMNH trackers provide a short-term solution to the immediate needs of monitoring against the Frameworks. However, logframes are the building blocks of DFID's result reporting system – yet they are currently held in separate spreadsheets

and are not integrated into the project management system. Bringing them into the project management system would allow information on progress to be accessed at the centre without the need for a separate results collection system.

419 **Action required:** In the medium term, DFID should incorporate logframes into its project management system. In order to aggregate the information from individual programmes, DFID should also develop a limited set of 'standard indicators' (in addition to the indicators in the DRF) into the new logframe system, together with relevant supplementary data such as the population represented by the indicator (e.g. national). They should be based wherever possible on international standards. These could include some malaria and RMNH indicators from the Frameworks for Results. These indicators should not be mandatory, but country offices should be able either to select from a list of standard indicators (improving consistency and the ability to aggregate), or where appropriate and justified to include their own.

7.3.5 Recommendation 13: Strengthen the analysis and monitoring of VfM

420 **Issue to address**: The focus on improving systems for measuring VfM at the corporate level needs to be better translated into the *project level* so that, for example, there are more explicit VfM indicators included in project logframes, where this is appropriate and meaningful. These indicators need to be assessed regularly as part of project management and monitoring.

421 **Actions required:** VfM indicators should, where appropriate, be included in project logframes, and the approach by which VfM will be assessed at each project milestone (using quantitative and/or qualitative information) should be explicitly outlined in business cases.

422 A guidance note on VfM in RMNH and Malaria should be developed which explicitly looks at strengthening VfM at project level, as well as improving the robustness of the indicators used (e.g. increasing use of benchmarked and quantifiable indicators, where appropriate). This note would usefully include examples of 'good' VfM indicators for staff to refer to, along with benchmarking data across countries.

423 DFID should improve the rigour with which VfM is assessed and managed through annual reviews. Annual reviews should be required to demonstrate that the programme is delivering within appropriate budgets and at levels of economy and efficiency that are consistent with identified relevant marker programmes. The annual review should include an assessment of whether or not the programme is spending in line with the planned project budget, and whether it is delivering outputs in line with the project logframe.

7.3.6 Recommendation 14: Improve reporting on influencing and multilateral engagement

424 **Issue to address**: DFID has increased its human resources focused on influencing multilaterals and other partners. The role that they perform is central to its business model and explicitly tries to leverage improvements in the wider aid envelope beyond DFID's own resources. The potential benefits are significant but currently they are not explicitly measured and reported.

425 **Actions required:** DFID should consider using the MAR update processes to document these activities and report against the Frameworks, in order to understand the impact of its influencing. Key departments in the international and policy divisions should consider investing more in collating information on the achievements of influencing as it takes place. A more systematic approach to documenting influencing activities across both agencies and special

issues and events would build institutional memory and capacity, rather than relying solely on individuals and their networks. Modest investments in collating and analysing influencing outcomes as they occur would have major pay-offs for improving subsequent evaluability and for lesson learning.

7.3.7 Recommendation 15: Revise coding and expenditure classification

426 **Issue to address:** The MTR encountered significant difficulties in using the current project coding system to analyse spend by programme areas, particularly against the Framework pillars. Project expenditures also need to be more explicitly linked to the outputs and outcomes identified in the Frameworks. In relation to multilaterals, linking results to inputs is currently impossible. This issue has two aspects: first, the appropriateness of the coding system used (which is constrained by the need to ensure international comparability within OECD-DAC guidelines) and, second, how accurately this coding system is implemented.

427 **Action required**: DFID should revise its coding structures to improve ways of identifying malaria and RMNH expenditures and outputs, and also review the accuracy of its coding. For both Frameworks, it should be possible to provide a more systematic mapping of projects against the Framework pillars. DFID should publish estimates of spend under each heading to improve transparency.

Annex A Evaluation ToR

- Breaking the Cycle: Saving Lives and Protecting the Future: The UK's Framework for Results for Malaria in the developing world

- Choices for women: planned pregnancies, safe births and healthy newborns: The UK's Framework for Results for improving Reproductive, Maternal and Newborn health in the developing world

Introduction

1. In 2010 the Department for International Development (DFID), of the UK Government, produced two Frameworks for results to save, and to improve the quality of, the lives of people living in the developing world. The Frameworks for Results for Malaria and for Reproductive, Maternal and Newborn Health (RMNH) set out how DFID will deliver on its commitments to:

- help halve deaths from malaria in at least ten high burden countries by 2015
- save the lives of at least 50,000 women during pregnancy and childbirth and 250,000 newborn babies by 2015

2. DFID's approach to achieve these commitments is summarised as such:

- Work through its country programmes, using appropriate funding approaches in each case, to support countries and communities to achieve their health goals;
- Improve the effectiveness and efficiency of the global response through international institutions, partnerships and global civil society;
- Invest in global public goods including tackling resistance, building and sharing evidence and supporting market efficiencies;
- Harness UK expertise through better partnerships with academics, civil society, and professional bodies and with other UK government departments.

Objective

3. DFID is seeking to procure the services of an independent Evaluation Provider (Provider) to undertake the following for the two Frameworks:
- An Evaluability Assessment, and Evaluation Framework;
- Design and implementation of a Mid-Term Review (MTR)
- Design and implementation of a final Evaluation

Recipient

4. The recipient of this work is DFID**.**

Scope

5. The MTR and Evaluation will assess the effectiveness of DFID's work on Malaria and RMNH as articulated in the Frameworks; specifically to better understand what was done and whether and how the impact and outcomes were achieved. The Evaluation will assess both:

- The results achieved; and

- The effectiveness of the Frameworks as a modality.

6. The Provider will prepare separate MTR and final Evaluation reports for each Framework, and will also undertake a third stream of work to identify and report on themes that are common to both Frameworks.

7. The Evaluability Assessment will consider the technical possibility of evaluating the Frameworks to inform the MTR and final Evaluation, and will require:

- A thorough examination of the logic and coherence of the Frameworks from an evaluation perspective;
- Assessment of the complexity of the evaluation and identification of any evaluability concerns;
- Development of an Evaluation Framework, articulating evaluation questions, and including risks and risk management;
- Assessment of available data sources, such as data generated by existing monitoring and evaluation systems and Frameworks, including at country level;
- Recommendation on the MTR and Evaluation's composition and proposed methodological approaches, including the feasibility of identifying and reporting on themes that are common to both Frameworks;
- Detailed design for the MTR and Evaluation, including appropriate timeframes, and milestones; and
- Identification of areas in which new evaluations or other sources of information may need to be commissioned.

To complete the evaluability assessment, the Evaluation Provider will draw on secondary data synthesis and mapping, and document reviews.

8. The MTR will take stock of progress in implementation of the Frameworks and set out recommendations for changes that need to be made in order to achieve DFID's results. It will provide advice on how DFID can better monitor progress in priority countries against the Framework indicators, including on cost and impacts, in order to inform decision making.

9. The final Evaluation will be a comprehensive assessment of the success of the Frameworks drawing on the five DAC evaluation criteria of relevance, efficiency, effectiveness, sustainability and impact. In particular:

a. Relevance and level of attainment of the strategic goals;
b. Impact of the interventions and across the different pillars of action;
c. Impact of DFID's bilateral and multilateral related investments, including the cost-effectiveness of DFID's influencing work;
d. Value for Money (VFM) and cost-benefit of the Frameworks.

10. DFID uses the definition of evaluation agreed by the OECD's Development Assistance Committee (DAC):"The systematic and objective assessment of an on-going or completed project, programme or policy, its design, implementation, and results in relation to specified evaluation criteria." The proposed Evaluation Framework will be in line with OECD DAC guidance, including relating to partnership and transparency. The final Evaluation will be published and is intended to contribute to the global evidence base to help understand what works and what does not work in achieving malaria and reproductive, maternal and newborn health outcomes.

11. It is anticipated that the initial evaluability assessment, development of an evaluation Framework, and MTR will draw principally on secondary data sources. For the Evaluation the Provider is likely to need to complement secondary data with primary data collection, including from beneficiaries, in a selected number of DFID priority countries. For the evaluation it is anticipated that the provider will visit around 6 countries where DFID has significant bilateral programmes. These are likely to include 5 countries in sub-Saharan Africa (including two fragile, high population countries), and 1 country in South Asia. The provider is expected to budget for these visits in their bids, although final selection of countries will be made after the evaluability assessment findings, aiming to ensure a comprehensive assessment against all variables'

Secondary data sources will include:

- Routine programme monitoring: including DFID's monitoring and corporate reporting processes;
- Routine project and programme level evaluation;
- Relevant National Audit Office (NAO) and Independent Commission for Aid Impact (ICAI) reviews;
- Other on-going and planned evaluations;
- Global and partner monitoring and evaluation processes;
- Country level data sources such as Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and routine health service data.

12. The Provider should consider not just the measurable results or outcomes, but the process, choices and strategy employed by DFID and other partners to achieve these results and how these could be improved. The evaluation should enable DFID to understand the indirect and long term effects emerging from work through the Frameworks, and any unintended outcomes and consequences. For example, work to improve environmental risk factors or distribute insecticide treated nets to improve malaria control may also contribute to neglected tropical disease outcomes. Health systems support to improve access and quality of care for reproductive health care or malaria prevention or treatment could also result in better treatment and prevention for other common causes of illness or death.

13. In carrying out the MTR and final Evaluation the Provider will take into account DFID's focus on: the poorest 40%; women and young women; those affected by conflict, and other vulnerable groups, such as those at risk of and living with HIV. The Evaluation Framework will include the degree to which issues around HIV and its interaction with RMNH issues in particularly can be evaluated.

Requirements

14. The first key output will be an Evaluability Assessment report, which will clearly set out the monitoring and evaluation approach. This report will include:

a. Evaluation questions and sub-questions;
b. Data availability mapping, assessing whether the data generated will meet final Evaluation needs; with advice on what additional data will be needed to enable comparison, generalisation and analysis of the overall impact and propose how to build this into the evaluation design;
c. Timeframes: Set out the timeframe for key steps of the evaluation with key milestones for reporting;
d. Budget: Propose an indicative budget for the evaluation approach, broken down by financial year;

e. An Evaluation Framework which will propose what is to be measured and how measurement should be carried out in an easy reference matrix format. The Framework will link the evaluation questions to evaluation activities to make clear how different parts of the evaluation work will allow a complete assessment of the Frameworks, including identifying and reporting on themes that are common to both Frameworks, to be made. The evaluation Framework will set out:
    - The overarching hypotheses of the Frameworks.
    - The evaluation questions to be considered, including sub-questions, if necessary.
    - The way each evaluation question should be addressed (identifying relevant primary, secondary and monitoring data and areas in which evaluations will need to be commissioned or questions incorporated at the country level).
    - The analysis that should be undertaken of this data.
    - Detailed design steps for the MTR and the final evaluation.

15. The second key output will be the MTR, covering the Framework related activities up to mid-2013. Separate reports should be produced for each Framework, and a third synthesis report covering issues common to both Frameworks. The MTR will answer the following questions:

- Are the planned activities likely to achieve the Framework outputs? If not, what should be done differently or in addition between 2013 and 2015?
- If all the outputs are achieved will they achieve the purposes of the Frameworks? If not, at this mid-term point, are extra outputs or altered outputs required?
- Are the assumptions in the Frameworks correct? If not, do these require revision? Have any assumptions been overlooked?
- Are the risks being managed successfully? If not what measures are needed to mitigate them?
- What lessons are being learnt for wider interest?
- Are relevant evaluation questions properly embedded in DFID's routine project and programme monitoring processes?

16. The third key output will be an approach paper setting out the approach to the final Evaluation, including a:

a. risk management plan;
b. quality assurance plan;
c. finalised evaluation approach and method;
d. strategy for stakeholder and partner engagement;
e. communication and dissemination strategy;
f. timetable

17. The fourth key output will be the final Evaluation itself. The approach to the evaluation will be guided by the findings of the evaluability assessment and should be informed by the 'Synthesis Study of DFID's Strategic Evaluations (2005 – 2010)', commissioned by the Independent Commission for Aid Impact.[56] As well as an assessment and synthesis of secondary data, it is anticipated that the Evaluation will involve some limited and focused primary research, including but not limited to, the following approaches:

- Experimental, non-experimental, quantitative, qualitative and mixed research methods;

[56] ICAI (2011), Synthesis Study of DFID's Strategic Evaluations 2005 –2010, http://icai.independent.gov.uk/publications/

- In-depth case studies;
- Participatory evaluation methods; and
- Value for Money assessments.

18. Separate evaluation reports should be produced for each Framework, and a third synthesis report covering issues common to both Frameworks. Additionally it is anticipated that there will be several short papers on key lessons learned. These may include the identified focus areas and will be based on the information ascertained from the evaluation process.

Reporting

19. The Provider will submit all reports in a written format to the DFID project officer, who will also provide day-to-day oversight and monitor operational and financial progress on an on-going basis.

20. A Monitoring and Evaluation Reference Group (MERG) will be established to provide leadership and cross-DFID coherence. The Provider will attend MERG meetings and/or prepare briefing papers for MERG as the need arises. It is anticipated that the Provider will submit progress reports written and / or orally to the MERG on a monthly basis while the evaluability assessment is on-going and on a quarterly basis thereafter.

Timeframe

21. It is anticipated that the consultancy will commence in March 2013. With the following indicative time-frame for the outputs:

- May 2013 – Evaluability Assessment with Evaluation Framework
- October 2013 – First Draft MTR; covering the Frameworks implementation period 2010 to mid-2013; to be fully finalised end-2013
- June 2016 – Publication of the final evaluation which will cover the Frameworks implementation period 2010 to end-2015.

The time-frame (including other milestones) will be set out again in the Evaluation Framework and adjustments may occur during implementation of this contract in consultation and agreement with the MERG.

DFID Coordination

22. The first point of contact for the Provider will be the DFID project officer, who will also be the focal contact person to manage relationships between the Provider and DFID stakeholders including country offices and the MERG. It is anticipated that the contractor will take a proactive approach to notifying DFID of any matters which may require immediate attention.

Background

23. The UK government is committed to reduce poverty in poorer countries, in particular through achieving the Millennium Development Goals (MDGs), including MDG 4 (Reduce child mortality), MDG 5 (Improve maternal health) and MDG 6 (Combat HIV/AIDS, malaria and other diseases). While progress is being made towards attainment of the MDGs, the rate of progress is insufficient to attain the MDG targets in some countries, with particular challenges in reaching the poorest and most disadvantaged

24. To support attainment of the MDGs, in 2010 DFID produced two Frameworks for action to save and improve the quality of the lives of children and women worldwide: by preventing, treating and controlling malaria; and giving women the chance of a planned pregnancy, safe birth and healthy newborn baby.

25. The Frameworks for Results (Frameworks) for malaria and for RMNH in the developing world set out Frameworks for delivering on UK Government commitments to:

- help halve deaths from malaria in at least ten high burden countries by 2015;
- provide access to modern methods of family planning for 10m additional women, including 1m young women aged 15 – 19 by 2015;
- prevent more than 5m unintended pregnancies by 2015;
- ensure at least 2m safe deliveries, particularly for the poorest 40% by 2015;
- save the lives of at least 50,000 women during pregnancy and childbirth and 250,000 newborn babies by 2015

26. Further detail is contained within the 2 Frameworks which are annexed.

Evaluation Criteria

27. This is covered more fully in Volume 1. The Provider should have the requisite competence and experience to undertake an evaluability assessment, MTR and final evaluation. This will include evidence (i.e. previous work) of conducting:

- Large multi-country evaluations
- Evaluations of complex Frameworks / programmes of large organisations
- Evaluations using OECD-DAC criteria
- Evaluations demonstrating up-to-date knowledge of Value For Money criteria and beneficiary monitoring
- Work that demonstrates knowledge of the epidemiology, and policy agenda of malaria and RMNH
- Innovative or game-changing evaluations and similar pieces of work

28. The provider is expected to propose a team of sufficient size to undertake the evaluability assessment within the required timeframes. Bids should include CVs for each team member.

Annex B List of Key Informant Interviews

Name	Role	Organisation
Jo Abbotts	Health Adviser, AIDS and Reproductive Health (ARH) Team	DFID
Michael Anderson	Chief Executive Officer Formerly Director-General, DFID	Children's Investment Fund Foundation
Ebere Anyachukwu	Health Adviser (Malaria), DFID Nigeria	DFID
Angela Baschieri	Health Adviser, ARH Team	DFID
Alison Beattie	Health Services Team Leader, Policy Division	DFID
David Brandling-Bennett	Deputy Director, Malaria	BMGF
Leo Bryant	Chair, SRH Network	MSI and SRH Network
Nichola Cadge	Senior Health Adviser, Malaria Team	DFID
Peter Colenso	Formerly Head of Human Development Group, DFID	DFID
Jacqui Darroch	Senior Fellow and one of the leaders of the 'Adding It Up' project	Guttmacher Institute
Benedict David	Principal Health Adviser	AUSAID
Chris Drakeley	Director of the Malaria Centre	LSHTM
Nel Druce	Senior Health Adviser, RH, HST	DFID
Ruth Duebbert	Head of policy and advocacy	Women and Children First
Eric Dupont	Chief, Procurement Support	UNFPA
Jane Edmondson	Head of Human Development	DFID
Susan Elden	Health Adviser (RMNH), DFID Nigeria	DFID
Carlton Evans	Programme Manager, Global Fund, UNITAID,	DFID

	AMFm, GFD	
Scott Fuller	Senior Technical Adviser	Global Fund
Andrew Glynn	Programme Manager, UNFPA, UNCD	DFID
Wendy Graham	Former maternal health adviser	DFID/Immpact (University of Aberdeen)
Richard Gregory	Regional Results Adviser, Africa	DFID
Philippe Guerin	Director of the Worldwide Antimalarial Resistance Network (WWARN)	University of Oxford
Anna Henttinen	Evaluation Adviser, Health Nutrition, Water and Sanitation (IMG)	DFID
Lindi Hlanze	Economic Adviser, Policy Division. Pillar lead: Assets to girls and women	DFID
Jane Hobson	Social Development Adviser, ARH Team	DFID
Silas Holland	AMFm	Global Fund
Penny Innes	Deputy Head of Human Development Department	DFID
Mette Kjaerby	Parliamentary and Policy Adviser	PDRH
George Jagoe		MMV
Iain Jones	Health Economist/Statistics Adviser, Health Services Team	DFID
Jason Lane	Senior Health Adviser, GFD	DFID
Joy Lawn	Newborn health adviser	DFID/LSHTM
Ruth Lawson	Senior Health Adviser, MNH, ARH Team	DFID
Matthew Lindley	Head of Fundraising	IPPF
Matt Lynch	Director of Global Program on Malaria	Center for Communications Programs, Johns Hopkins University
Sandra MacDonagh	Health Adviser, ARHT	DFID
Gillian Mann	Acting team leader, Health services	DFID
Sylvia Meek	Technical Director	Malaria Consortium

Jane Miller	Senior Regional Health Adviser, Africa	DFID
Andrew Mitchell	Formerly Secretary of State for International Development	Member of Parliament
Bruno Moonen	Director, Malaria	CHAI
Jo Mulligan	Health Adviser, RED	DFID
Fatoumata Nafo-Traore	Executive Director	RBM
Line Neilsen	Programme Manager, UNICEF, UKDel	DFID
Rob Newman	Head, GMP	WHO
David Reddy	Chief Executive Officer	MMV
Alastair Robb	Senior Health Adviser, ARHT	DFID
Anna Seymour	HIV Adviser	DFID
Lizzie Smith	Senior Regional Health Adviser, Asia	DFID
Vincent Snijders	Policy Coordinating Officer, Sexual & Reproductive Health and Rights	Netherlands Ministry of Foreign Affairs
John Stuppel	Programme Manager, WHO, UNCD	DFID
Thomas Teuscher	Former Executive Director	RBM
Jagdish Upadhay	Chief, Commodity Support	UNFPA
Saul Walker	Senior Health Adviser, Mozambique	DFID
Sally Waples	Programme Manager, IFID	DFID
Julia Watson	Senior Health and Economics Adviser, HST	DFID
Jonathan Wittenburg	Vice President for Institutional Development	Guttmacher Institute

Ethiopia country case study

Name	Role	Organisation
Angela Spilsbury	Human Development Team Leader	DFID Ethiopia
Kassa Mohammed	Health Adviser	DFID Ethiopia

Moltotal Mekuria	Social Development Programme Officer	DFID Ethiopia
Mieraf Mergia	Social Development Adviser	DFID Ethiopia
Metsehate Ayenekulu	Programme Officer, Girls HUB Project	DFID Ethiopia
Kenny Osborne	Results Adviser	DFID Ethiopia
Andrew Pillar	Director	DKT Ethiopia
Nils Gade	Director	Marie Stops International, Ethiopia
Tewodrso Bekele	Director; Maternal, Child and Newborn Health	Ministry of Health
Abdissa Kurkie Kabeto	Director, Directorate of Disease Prevention and Control	Federal Ministry of Health
Luwei Peterson	Chief, Health Section	UNICEF Ethiopia
Sabine Beckman	Programme Coordinator, Sexual Reproductive Health and HIV/AIDS	UNFPA Ethiopia
Mieraf Taddesse	Public Health Specialist, Health MDG Programme for Result	World Bank Ethiopia
Gune Dissanayne	Malaria Adviser	USAID/PMI
Sheleme Chibsa	Malaria Adviser	USAID/PMI
Worku Bekele	National Professional Officer/ Malaria	WHO
Dereje Muluneh	Health Specialist	UNICEF
Aster Bedane	President	Ethiopian Midwives Association
Yemiserach Belayneh	Country Adviser, Population and Reproductive Health Programme	Packard Foundation
Dejene/Mekonon	M&E Programme Officer	Consortium of Reproductive Health Association
Saba Kidanemariam	Country Director	IPAS Ethiopia
Bethlehem Tenker & Yitbarek Yohannes	Acting Directors	Network of Ethiopian Women's Association
Bogale Worku	President	Ethiopian Paediatrics Society
Haylay Desta	Programme Officer	Centre for National Health Development in Ethiopia
Agonafir Tekalegne	Country Coordinator	Malaria Consortium
Zerihune Tadesse	Director of Programmes	The Carter Centre
Adugna Woyessa	Malaria Focal Person	Ethiopian Health and Nutrition Research Institute

Aklilu Getnet	Vice-Director	Ethiopia Anti-Malaria Association

Nigeria: country case study

Name	Role	Organisation
Ruth Lawson	Health Adviser	DFID Nigeria
Esther Forgan	Evaluation and Results Adviser	DFID Nigeria
Ebere Anyachukwu	Health Adviser	DFID Nigeria
Sarah White	Team Leader, Human Development	DFID Nigeria
Sajil Liaqat	Health Adviser	DFID Nigeria
Susan Elden	Former Health Adviser	DFID Nigeria
Omokhudu Idogho	Programme Director	Enhancing Nigeria's Response to HIV & AIDS Programme
Solomon Mengiste	Deputy National Programme Director	Partnership for the Revival of Routine Immunisation in Northern Nigeria & Maternal Newborn Child Health Programme
Folake Olayinka	Programme Director	SuNMaP
Ebenezer Baba	Programme Technical Director	SuNMaP
Bridget Brown	Northern Regional Programme Manager	SuNMaP
Mike Egboh	Chief of Party	Partnership for Supporting Health Systems 2 (PATHS-2)
Amina Dorayi	Director, Service Delivery	PATHS-2
Azeez Aderemi	Head of Research and Statistics	Federal Ministry of Health Director of Planning, Research and Statistics
Ogbe Oritseweyimi	Technical Adviser	National Primary Health Care Development Agency
S. U. Ozodinma	Head of Product and Supply Chain	NMCP
Wole Odutolu	Senior Health Specialist	World Bank Nigeria
Olanike Adedeji	National Programme Officer, Access to FP Commodities	UNFPA Nigeria
Celeste Carr	Health Officer	USAID Nigeria
Eileen Petit-Mshana	Health Systems Adviser	WHO Nigeria

Taiwo Oyelade	National Professional Officer	WHO Nigeria
Muhammed Lecky	Executive Secretary	Health Reform Foundation of Nigeria
Abba Zakari Umar	Chief of Party	Malaria Action Programme for States (MAPS), Nigeria
Oluwole Adeusi	Implementation Director	MAPS, Nigeria
Bolatito Aiyenigba	M&E Adviser	MAPS, Nigeria
Wale Adedeji	Chief Operating Officer	Society for Family Health
Ernest Nwokolo	Director, Malaria	Society for Family Health
Ayo Ipinmoye	National Programme Coordinator	Civil Society On Malaria Immunization And Nutrition ACOMIN

India: country case study

Name	Role	Organisation
Sam Sharpe	Head of Office	DFID India
Ian Shapiro	Head Global and Nutrition team	DFID India
Billy Stewart	Senior Health Adviser (transferred now to Burma)	DFID India
Rashmi Kukreja	Acting Senior Health Adviser (Madhya Pradesh, Reproductive Health)	DFID India
Sudipta Mondal	Results Framework Adviser	DFID India
Manjula Singh	Health Adviser (Odisha, Nutrition)	DFID India
Sabina Bindra-Barnes	Health adviser (Global, Infectious Disease)	DFID India
Anita Anasuya	Sector Lead	Health Technical and Management Support Team
Basavaraj	Managing Director,	MSG Consulting (National RCH support)
Anupama Joshi	Director	Deloitte Touche Tohmatsu India Pvt. Ltd. (National RCH support)
Amit Bhanot	Team Leader	Future's Group (Bihar and Odisha)
Bulbul Sood	Country Director	Jhpiego (Bihar)
Carol Squires	Country Director	MSI (MP – PMDUP)
Preeti Anand	Consultant	MSI (MP – PMDUP)

B Swain	Team Lead	State Human Resource Health Management Unit (Odisha)
Sunderaraman	Executive Director	National Health Systems Resource Centre
Himanshu Bhushan	Deputy Commissioner, Maternal Health Division	Ministry of Health and Family Welfare (MOHFW)
Pushkar Kumar	Consultant (Maternal Health)	MOHFW
Viipin Garg	Consultant	MOHFW
Sikdar	Deputy Commissioner, FP Division	MOHFW
A Pradhan	State Programme Manager	National Rural Health Mission, Odisha
D Behera	Director Nursing	State Government, Odisha
RK Das Gupta	Joint Director, National Vector-Borne Disease Control Programme	Government of India
M M Pradhan	Deputy Director, National Vector-Borne Disease Control Programme	Government of Odisha
Priyanka Kar	M&E consultant, National Vector-Borne Disease Control Programme	Government of Odisha
Aparajita Gogoi	Executive Director	Centre for Development and Population Activities
Rajesh Singh	Team Leader	MCCHIP/USAID grantee for National RMNCH+A strategy
Ashis Sen	Health Specialist	UNICEF India
Francois Daniel	Senior Coordinator – Health Programmes	
Saurabh Jain	National Professional Officer, Vector-Borne Diseases	WHO India
S. K. Mohanty	Senior Public Health and M&E Consultant	Price Waterhouse (LFA-GF)
M. S. Malhotra	Scientist and Household Survey coordinator	National Institute of Malaria Research

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Annex D Theories of change

Figure 13 Schematic theory of change: Malaria Framework

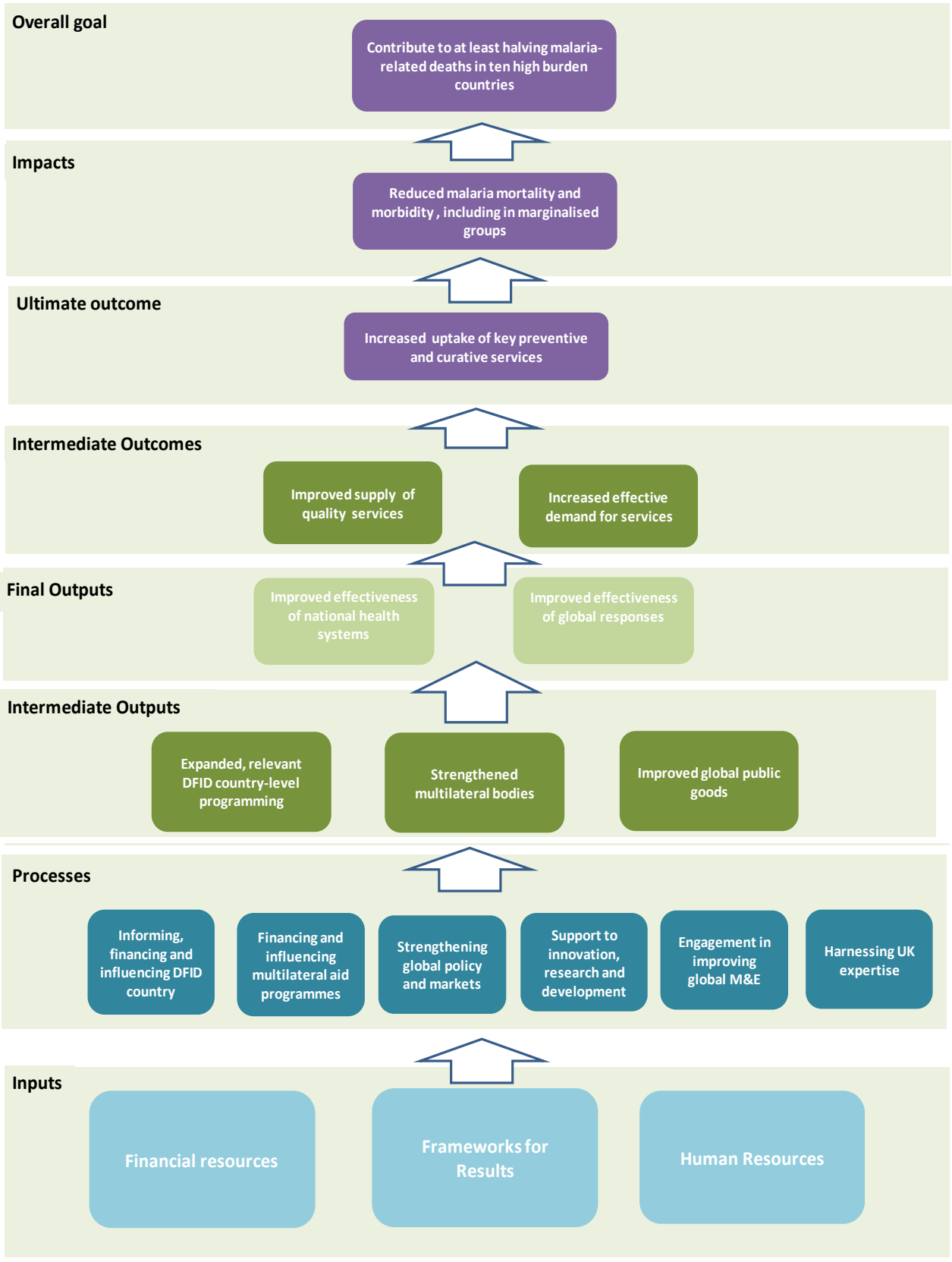

Table 19 Table of questions and assumptions for Malaria Framework theory of change

Impact: To what extent is it possible to measure the impact of the Framework and of DFID's activities, and how can the measurement of impact be improved?
Assumptions:
- resources and progress are concentrated in the high-burden countries
Outcomes: Are outcomes on track to meet the objectives of the Framework?
Assumptions:
- Services are of sufficient technical quality and appropriate mix
- Increased supply from a range of providers is able to meet increased demand
- Services are accessible to population (physically, financially, culturally)
- Improvements to services can be sustained over time
Outputs: Are activities and outputs under the Framework on track to meet its objectives?
Assumptions:
- Government and other organisations in partner countries able and willing to respond to increase in resources, new knowledge and new technologies
- Ability of multilateral programmes to improve supply of and demand for services at country level
- Government, DFID and multilateral monitoring and reporting systems enable tracking of progress, responsive management and increased accountability
- Programmes and projects are designed appropriately to country circumstances and managed effectively
- Partner coordination is effective
- Expansion of support to health systems can be achieved reasonably cost-effectively
Processes: Have the Frameworks and DFID's programmes under them been effectively managed to achieve UK government objectives?
Assumptions:
- Country programmes are able and incentivised to respond to Framework recommendations, and other initiatives are consistent with them
- Multilateral organisations are able and incentivised to respond to DFID influencing and additional resources
- Global policy and markets amenable to change
- Research and development outputs are appropriate and are translated into policy and programmatic change
- Partners are willing to engage in improving global M&E and accountability systems
- UK expertise is relevant and available
Inputs and Design: Has the Malaria Framework provided an effective strategic instrument to achieve UK government objectives? Have adequate resources been used and appropriately applied to achieve these objectives?
Assumptions:
- The evidence base, and the selection of the specific areas of action, are valid and robust
- Frameworks and targets are coherent with wider domestic, international and country-based plans
- Frameworks identify appropriate role for DFID in line with its comparative advantage
- Financial and human resources allocated appropriately to meet targets and leverage resources
- Frameworks are coherent with and support other DFID policies, planning and management processes
- Frameworks are able to drive plans and actions of DFID country offices and other business units

Figure 14 Schematic theory of change: RMNH Framework

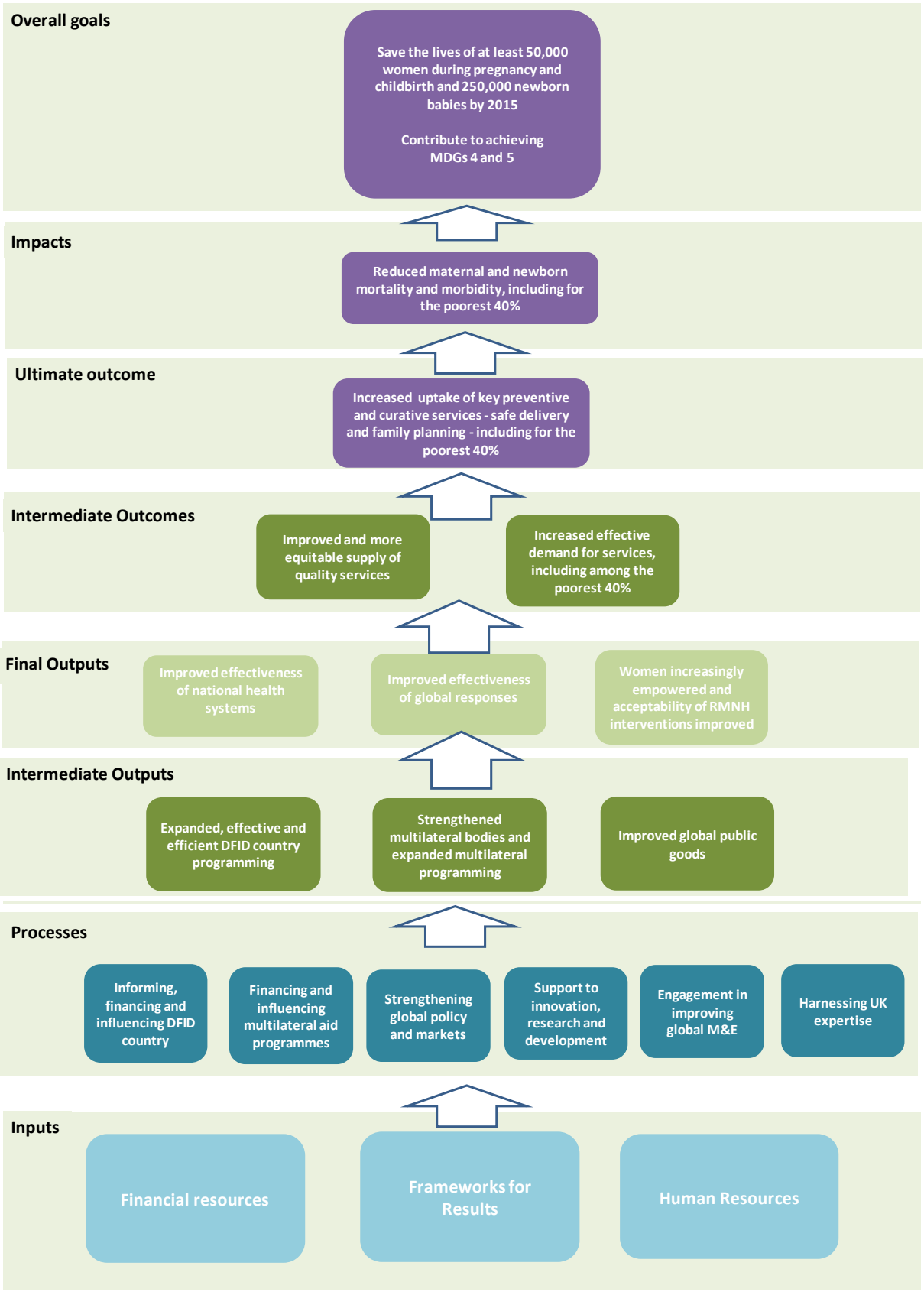

Table 20 Table of questions and assumptions for RMNH Framework theory of change

Impact: To what extent is it possible to measure the impact of the Framework and of DFID's activities, and how can the measurement of impact be improved?
Assumptions:
- resources and progress are concentrated in the high-burden countries
Outcomes: Are outcomes on track to meet the objectives of the Framework?
Assumptions:
- Services are of sufficient technical quality and appropriate mix
- Increased supply from a range of providers is able to meet increased demand
- Services are accessible to population (physically, financially, culturally)
- Improvements to services can be sustained over time
Outputs: Are activities and outputs under the Framework on track to meet its objectives?
Assumptions:
- Government and other organisations in partner countries are able and willing to respond to increase in resources, new knowledge and new technologies
- Ability of multilateral programmes to improve supply of and demand for services at country level
- Government, DFID and multilateral monitoring and reporting systems enable tracking of progress, responsive management and increased accountability
- Cultural and economic shifts can be encouraged by external engagement
- Programmes and projects are designed appropriately to country circumstances and managed effectively
- Partner coordination is effective
- Expansion of support to health systems can be undertaken reasonably cost-effectively
Processes: Have the Frameworks and DFID's programmes under them been effectively managed to achieve UK government objectives?
Assumptions:
- Country programmes are able and incentivised to respond to Framework recommendations, and other initiatives are consistent with them
- Multilateral organisations are able and incentivised to respond to DFID influencing and additional resources
- Global policy and markets amenable to change
- Research and development outputs are appropriate and are translated into policy and programmatic change
- Partners are willing to engage in improving global M&E and accountability systems
- UK expertise is relevant and available
Inputs and Design: Has the RMNH Framework provided an effective strategic instrument to achieve UK government objectives? Have adequate resources been used and appropriately applied to achieve these objectives?
Assumptions:
- The evidence base, and the selection of the specific areas of action, are valid and robust
- Frameworks and targets are coherent with wider domestic, international and country-based plans
- Frameworks identify appropriate role for DFID in line with its comparative advantage
- Financial and human resources allocated appropriately to meet targets and leverage resources
- Frameworks are coherent with and support other DFID policies, planning and management processes
- Frameworks are able to drive plans and actions of DFID country offices and other business units

Annex E Analysis of risks associated with targets

This annex considers the set of risks identified with target setting outlined in Chapter 3, and the extent to which these risks have been realised for each of the Frameworks, as presented in the table below.

Table 21 Assessment of risk of adverse impact of Framework on programming

Risk	RMNH assessment	Malaria assessment
Donors are incentivised to focus on interventions that produce easily measurable, short-term outcomes rather than interventions that may have more significant and/or longer-term benefits.	Analysis of selected projects found that in 36 of 47 RMNH projects, at least one indicator that was relevant to HSS was included. While there was a mixed trend, there was some suggestion that the use of HSS-related indicators had increased after the Framework: for example, 72% of projects that started before its publication included HSS indicators, compared with 83% for those projects that started after its publication. The implementation of the Frameworks largely avoided the risk of encouraging an overemphasis on actions leading to short-term and directly measurable and attributable results. This was reflected in the strong continuing commitment to a health systems approach which had informed earlier DFID health strategies and was reinforced in DFID's recent Health Position Paper.	Malaria programme overall remains strongly aligned with HSS, suggesting no evidence of a shift towards short-term outcomes.
Results reporting adds to bureaucratic overload in a system that is already overburdened with forms and procedures. Results reporting has been tacked on to all the other reporting requirements rather than simplifying the procedures.	This was not found to be a major problem.	The limitations of the results reporting system as outlined suggest that reporting has been tacked on to other requirements. Although countries did not report this to be a burden (Working Paper VIII), better ownership of the data at country level could help to alleviate any future adverse impact.
The results focus undermines country ownership and leadership. It makes donors less flexible to get behind partner country government priorities as they are focused on reaching their own set of narrowly defined results.	Our findings in the case study countries were that DFID maintained a strong focus on working within country priorities and systems.	We found no evidence of this in the country office surveys (Working Paper V)) or in the in-depth country studies (Working Paper VIII). There was clear evidence that DFID continued to work well with partners in country (Section 2.2).
Donors are only incentivised to achieve the	An equity focus was built into the output targets in	We found no evidence of this. In particular,

numerical targets rather than reaching those who are in the most need, as they are likely to be the hardest and most expensive to reach.	the Framework, to mitigate this risk and to maintain DFID's pro-poor focus. In practice, it was hard to assess to what degree the equity targets were met. However, there was a strong awareness among DFID staff of the need to design programmes to meet the needs of marginalised groups in particular.	DFID's programme continues to focus considerable resources in the two high-burden countries (Nigeria and DRC) that are at greatest need and include some of the hardest-to-reach populations.
Targets always create perverse incentives, for example when the quality of a service suffers even though access has improved.	It was not possible to assess this risk, given the absence of data within country systems (and globally) on quality of care. However, this risk was low for the Framework as a whole as the results-based incentives are weak at levels of the system where the focus on volume over quality might occur. The risk of low quality of care was there but independent of the results-based approach.	We had no evidence to assess this.
Donors are incentivised to demonstrate the impact of their particular contribution as an aid programme, which means they are less likely to work jointly with other donors or through the multilateral system.	There was no evidence of this occurring within DFID's partnerships and work with multilateral organisations. There is a desire to demonstrate impact but this has not dominated DFID's relationships with other agencies.	We found no evidence of this occurring. DFID continue to work well with other donors.
If donors are working toward different results using different indicators they will be less able to work in partnership with other donors or through multilateral systems.	DFID targets were intentionally based on standard, globally agreed indicators, such as coverage with skilled attendants. They were therefore harmonised with country systems and other donors.	The harmonisation of DFID's goals with those of the RBM GMAP eliminates the potential for this.
It is too difficult to prevent results being double counted by different agencies as there is no common Framework for determining attribution.	This issue presented real difficulties for attribution to DFID but did not generate a wider risk to the health system or services.	This remains a risk but is being mitigated by the collaborative international approach to M&E coordinated through WHO/GMP and RBM, in which DFID are active partners.
The data, particularly in fragile and conflict-affected settings, are not reliable and timely enough to support the results Framework approach.	This was a substantial problem for tracking of results but again did not drive perverse effects.	This remains a potential risk in some of the countries in which DFID is working.
Donors are incentivised to cover up failures and not be innovative in their approaches. There is no longer space for the incubation of small-scale local solutions.	Although the MTR team was not able to investigate individual projects in detail, it was clear that there were a number of small-scale innovative projects in operation which sought to address the more sensitive issues in the	We found no evidence of this occurring. A good counter-example is the work DFID is funding on innovative approaches to market dynamics.

	Framework, and that these had been given support and space to innovate. This was attributed in part to the broad focus of the Framework, which focused attention on demand-side, cultural and community factors in addition to a more traditional supply-side focus, and to the focus on specific target groups, such as adolescents.	
Donors are incentivised not to use country systems because it prevents attribution of results.	There was no evidence of DFID setting up parallel reporting systems.	There is strong evidence to the contrary. The Malaria Results Tracker relies heavily on country systems including local surveys. Standardisation is aided by the international support provided by RBM. DFID has also invested in support to develop information systems in endemic countries.
The focus on measuring results detracts from understanding how and why a result has/has not been achieved and using that for future learning. Focusing on quantitative data may not capture certain types of successes and progress.	There was no evidence that quality of implementation had changed over the course of implementing the Framework.	We found no evidence that the quality of understanding has changed since the introduction of the Framework. An annual review in focus high-burden countries could include further assessment of the barriers to achieving high coverage that would be more widely useful for future learning.
Focusing on results as the sole basis for policy and programming decisions overlooks the importance of politics and political judgement.	This was not seen as a real risk for this Framework: policy and programming decisions were taken with partners operating within political contexts, which clearly played a role.	There was no evidence of this occurring. DFID retains a clear political agenda (Working Paper III).
The considerable costs of collecting and verifying the data outweigh the benefits of the approach.	See above – there were no new data collection costs, as data were collected from country systems and partners. There were some limited additional costs to aggregating and analysing them.	Much of the cost of data collection and verification is borne by others (e.g. through national surveys) so there is no evidence of this being an issue for DFID.
The inclusion of programme staff in generating data is questionable as they are incentivised to present positive results.	This was not applicable as the data were largely generated through surveys and routine data collection processes that were independent of service delivery staff (for whom there are limited direct incentives in most cases anyway).	Programme staff do not generate the data and hence this is not expected to be a substantial risk.