Independent Evaluation of the Fleming Fund Grants Programme: Executive Summary of the Summative Report (accessible version)

Introduction

The O’Neill report[[1]](#endnote-2) estimated that by 2050, drug-resistant infections or antimicrobial resistance (AMR) could kill 10 million people per year at a potential cost of US$100 trillion in global economic output. In 2019, estimates suggested that globally 4.95 million deaths were associated with bacterial AMR, including the 1.27 million deaths directly attributable to such resistance.

The Fleming Fund was established in 2015 by the UK Government’s Department of Health and Social Care (DHSC) using Official Development Assistance (ODA) funding to tackle the threat of AMR in low and middle-income countries (LMICs) through a One Health[[2]](#endnote-3) approach. The initial phase, for £265 million, ran over a five-year period (2016–2021) and was extended to March 2023. With its focus on improving laboratory capacity and diagnosis as well as data and surveillance of AMR, it contributes directly to one of the five pillars in the 2015 Global Action Plan (GAP) on AMR. Significant impact to address AMR requires progress across all five pillars of the GAP and while the Fleming Fund’s contribution is necessary, it is not expected to be sufficient on its own. Ultimately, achieving the Fleming Fund’s intended impact relies on other actors too. At the country level, this depends on how well One Health AMR National Action Plans (NAPs) are implemented.

In 2016, the DHSC commissioned Itad to provide an independent evaluation function for the Fleming Fund grants programme. This is the executive summary of the summative report[[3]](#endnote-4) on what the Fleming Fund has achieved during its first phase, based on data collected up to July 2022. More detail on the methodology is included at the end of this executive summary.

How has the Fleming Fund been designed and what are the implications for the evaluation?

The Fleming Fund is delivered through grants to a range of partners across four workstreams.[[4]](#endnote-5) Two workstreams aim to (a) focus international attention on the need for AMR surveillance; (b) develop and implement guidance and protocols for the standardised collection of data so it can be shared nationally and internationally; and c) support the development of One Health AMR NAPs. Much of this work has been delivered by The Food and Agriculture Organization of the United Nations (FAO), the World Organisation for Animal Health (WOAH) and the World Health Organization (WHO).

The other two workstreams aim to support the generation and analysis of data in a range of LMICs. For these workstreams, the DHSC contracted Mott MacDonald as the Fleming Fund Management Agent (MA)*.* The MA designed a range of grants, based on detailed country needs assessments, to support country priorities for AMR and antimicrobial consumption/use (AMC/U) surveillance as set out in the AMR NAPs. The delivery of these grants was tendered by the MA using a competitive process. As of late 2022, grant support had been delivered in 23 focus countries.[[5]](#endnote-6) Across these focus countries, 81 grants delivered relevant outputs.

Key findings by evaluation question

**Even in a challenging context, the Fleming Fund has delivered significant outputs to develop** **laboratory capacity and enhance surveillance systems across the 23 countries. These outputs have contributed to stronger laboratories and workforces to a varying degree across all of our focus countries. This first phase of Fleming Fund support aimed to build the foundations for AMR surveillance, which is an incremental process and takes time. Achieving strategic outcomes, such as significant use of AMR data and analysis to drive or inform anticipated policy, regulatory and behavioural change was expected to be the focus of subsequent phases of support.**

We present below headline findings for each of our evaluation questions (EQs). These focus on the outcomes to which the Fleming Fund-supported capacity contributed, in terms of changes in quantity, quality and use of AMR surveillance data. When assessing results across these 23 countries, the following things are important to note:

* There was substantial variation in the status of the laboratories that the Fleming Fund was due to support. For example, sites in some countries did not have reliable water and electricity supplies, which are fundamental for AMR testing whereas in some others, laboratories were much more sophisticated.
* Grant start dates were staggered across countries so that the duration and level of overall support from the Fleming Fund varied across countries.
* The pace of implementing many grants was affected by COVID-19 restrictions.
* The process of building a surveillance system is incremental and results, in terms of data generation, were not expected before 36 months’ support. By the end of June 2022, 16 of the 23 countries had received 36 or more months’ support, with another seven receiving between 24 and 36 months’ support.
* This first phase of Fleming Fund support was mainly intended to build the foundations for AMR surveillance. Achievement of the Fleming Fund’s strategic outcomes, such as significant use of AMR data and analysis to drive or inform anticipated policy, regulatory and behavioural change was expected to be the focus of subsequent phases of support.

(EQ1) What has been the increase in the quantity and/or quality of data on AMR at country level and to what extent has the Fleming Fund contributed to this increase?

**The MA achieved the stated aims for data generation as set out in the implementation plan, albeit the targets were neither ambitious nor sector specific.** By mid-2022, there was evidence of increases in the quantity of human health (HH) AMR surveillance data in 11 out of 16 (69%) of our focus countries, although the extent of change varied; and of increases in quantity of other types of HH data beyond AMR.[[6]](#endnote-7) There was evidence of increases in the quantity of animal health (AH) AMR surveillance data in 12 out of 16 countries (75%), in which the extent of change also varied.

**Improvements in internal systems ensuring the quality of AMR testing were seen in HH and AH in a majority of countries, but progress was mixed.** However, quality improvements have varied on a site-by-site basis, and it is not clear whether the MA’s aims have been consistently achieved (given the limited delineation of quality goals at the start of phase 1).

Major drivers of increases in quantity and quality were identified as: renovation of sites and provision of equipment, training of the laboratory workforce, supporting laboratory quality management systems, and AMR governance. Overall, **the Fleming Fund has made a vital or important[[7]](#endnote-8) contribution to most key drivers of increased quantity and quality in both HH and AH AMR data, albeit to variable extents.**

(EQ5) What has been the increase in quality of data shared and reported internationally and has the Fleming Fund contributed to this?

**There is evidence of sharing at the international level, and emergent examples of use at the facility level.** At the *international level*, for HH more AMR data has been made available, with the majority of evaluation focus countries (13 out of 16) sharing data to the Global Antimicrobial Resistance Surveillance System (GLASS) since 2018 (of which seven had not previously done so) and a further four across other Fleming Fund countries. In the AH sector, more data on AMC/U has been reported to WOAH; by May 2022, 14 out of 16 of the evaluation focus countries (88%) reported to WOAH, with a reduction in the number reporting the most basic level of data and an increase in the number providing more sophisticated data.

(EQ4) Has, or is it likely that, the increase in AMR data influenced: (a) changes in national policies/regulations? and/or (b) changes in practice and attitudes in-country?

**There are initial indications that data from AMR surveillance systems are starting to be collated and shared at the *national level*, but AMR data is not prominent in decisions on AMR action.** Progress on the use of data has been slower and more difficult than anticipated in the MA’s implementation plan, especially at national level. *At the national level*, data sharing with relevant committees is happening in six out of 16 focus countries.[[8]](#endnote-9) Even where AMR/C/U data is not yet being shared with relevant committees on a routine basis, some progress towards this goal has been realised in most countries. Despite progress on sharing, AMR surveillance data collated from laboratory antimicrobial susceptibility testing (AST) is yet to play a prominent role in relevant decision-making about action on AMR. Over half of the focus countries have nevertheless initiated significant policy and regulatory action on AMR *at the national level* since 2018.

**At the local/facility level, there is emergent evidence that Fleming Fund interventions are stimulating positive changes to practices and attitudes** as clinicians and other stakeholders start to interact differently with improved laboratories. However, these are not yet representative of wider system changes within countries.

**The Fleming Fund has made very substantial contributions to the main drivers of *data sharing* at the national level.** So far this has been primarily through Country Grants (CGs). It remains to be seen to what extent policy fellowships and other interventions focused on data use will contribute to the intended outcome-level results. The Fleming Fund has also contributed strongly to the drivers of data sharing at the international level, especially sharing with GLASS.

(EQ3) How likely are the Fleming Fund’s country-level results to be sustained?

**Based on action to date and current country-level conditions, there are limited prospects for sustaining Fleming Fund results at present.** This is linked to a lack of progress in establishing key conditions (resources, capacity, motivation, planning) as identified in published literature. The MA has been clear that prospects for achieving sustainability during phase 1 were limited given the starting points in most countries and limited implementation time of some grants (and this is backed up by broader evidence which underlines that sustainability is hard to achieve and takes time). The MA’s approach to sustainability has focused on (a) hardwiring sustainability prospects in grant design; (b) delivering success in Fleming Fund 1; and (c) increasing focus on sustainability in second CGs. The MA’s sustainability assessments indicate what will be ‘left behind’ but do not set out an explicit strategy or plan for achieving this. Overall, this has limited the extent to which realistic expectations and plans have been established with DHSC or key country counterparts (although lack of clarity on future Fleming Fund funding hindered dialogue on sustainability). Sustainability is a shared responsibility between the DHSC, MA team and recipient governments.

(EQ2) To what extent have the Fleming Fund’s investments been aligned and coherent with other relevant investments at country level?

**The model has created challenges in terms of delivering internal coherence between CGs, RGs and Fellowships,** compounded by several design, management and contextual factors. Over the years, efforts have been made by the DHSC and the MA to increase coherence and coordination among the various partners and funding streams. However, the bases for true coordination and collaboration are still missing. This has likely led to some missed opportunities (in terms of linkages to other relevant agendas) and synergies, and increased transaction costs for country stakeholders.

**The MA-managed Fleming Fund investments have generally been well aligned with national priorities.** On some occasions, however, alignment with government systems and long-term needs could have been stronger. External coherence between all Fleming Fund grants and other delivery partners’ (DPs) interventions was found to be strong in a majority of the focus countries. External coherence and coordination is difficult to achieve, depending on many factors outside of the control of one programme and ultimately the responsibility of a strong Antimicrobial Resistance Coordinating Committee (AMRCC), although experience suggests this is not always a realistic assumption[[9]](#endnote-10).

(EQ6) Did the Fleming Fund’s investments at country level offer value for money?

**The Fleming Fund’s experience in delivering value for money (VfM) generally aligns with the Foreign, Commonwealth and Development Office (FCDO) and the Independent Commission for Aid Impact (ICAI) guidance. Overall, there are strong systems in place to manage economy and efficiency. However, the Fleming Fund has been weaker at establishing systems to manage for effectiveness.** In spite of some existing and planned adaptations to strengthen this area (and the Fleming Fund experience is not uncommon compared with other equivalent programmes), this is a key strategic requirement for phase 2.

**In narrow terms (economy, efficiency) there is evidence of VfM having been delivered. But in terms of effectiveness (as defined by the Organisation for Economic Co-operation and Development (OECD)) the case is less clear.** There is evidence of significant cost savings (economy) delivered by the MA, underpinned by strong systems to manage budgets and expenditures; performance is comparable to similar programmes. There is some evidence that the value of leveraged resources is reasonably significant in some grants (>5% of grant value in Timor-Leste and Laos People’s Democratic Republic). However, this indicator has not been reported or consistently tracked across all grants. The alignment between Fleming Fund expenditure, contribution and progress in generating quality AMR data is likely to be high, suggesting one positive outcome in terms of VfM.

Conclusions

The focus of phase 1 of the Fleming Fund was mainly to build the foundations for AMR surveillance. Achievement of the Fleming Fund’s strategic outcomes, such as significant use of AMR data and analysis to drive or inform anticipated policy, regulatory and behavioural change was expected to be the focus of subsequent phases of support. Our conclusions therefore significantly focus on the strengths and weaknesses of phase 1 in terms of maximising the contribution to the outcomes and what needs to change in phase 2.

Strengths and weaknesses of the current programme design in terms of supporting LMICs to develop and sustain national programmes for surveillance of AMR and AMU

Progress towards strategic goals

**Conclusion 1: During phase 1, the Fleming Fund has made significant progress in supporting countries to develop foundations for national AMR and AMU surveillance programmes.** Laboratory functions have been strengthened compared to international norms, the capacities of key members of the laboratory workforce have been increased, and surveillance functions have been established in some countries. Broadly, within this narrow focus on building foundations, phase 1 has achieved what was agreed upon between the MA and the DHSC.

**Conclusion 2: Building on these necessary foundations, it is reasonable to expect that the Fleming Fund will be able to make progress towards achieving its higher-level goals for phase 2 (in terms of the use of data for clinical improvement, policy and behaviour change), providing there is a stronger focus on understanding the needs and priorities of decision-makers.** However, processes to achieve these goals are inherently political, complex, unpredictable and will take time to work through. In phase 1, the AMR NAPs developed by country governments neither identified prioritised outcomes nor provided a strong framework within which the Fleming Fund could easily engage with key national stakeholders. It cannot be assumed that this will change without support to strengthen NAPs and AMRCCs.

Observations on programme design

**Conclusion 3: The programme has operated within a challenging context, which will continue into phase 2. However, the Fleming Fund has proven flexible enough to respond effectively, even though some features of the programme design made responding more challenging.** Looking forward, the political and economic impacts of COVID-19 and other global factors are still emerging. These include economic disruption (global recession and inflation), supply chain issues, high LMIC indebtedness, high-income country budgetary issues, the impacts of climate and environment change, and the introduction of new technologies. A recent analysis by the World Bank[[10]](#endnote-11) suggests that per capita government health spending will decline annually in many LMICs, remaining lower than 2019 expenditures each year to 2027. The social environment for vaccines is also problematic, with the emergence of strong anti-vaccination movements (vaccines being a comparatively low-cost but effective response to AMR). All will generate significant headwinds for governments seeking to make rapid progress against AMR. The Fleming Fund made a range of changes in response to COVID-19, such as refocusing and extending grants. However, having key MA management and delivery capacity located in regional hubs rather than at the country level meant that it was not possible to implement important activities as originally planned.

**Conclusion 4: The MA has successfully operationalised strong and effective procedures to manage economy and efficiency at the activity level. With further use of the laboratory capacity established during phase 1, the overall VfM of the programme will be enhanced.** Delivering efficiently in this context has been challenging, and the operational model that has been chosen affects VfM in terms of internal and external coherence, as well as management overheads. It has also been challenging to track efficiency given the focus on reporting implementation rates and the lack of a link between financial reporting and outputs; this seems to be driven by systems and culture within the DHSC. Notwithstanding these challenges, the evidence suggests the delivery of efficiency and economy. The fact that laboratory functions have been strengthened compared to international norms, and the capacities of key members of the laboratory workforce have been built up means that effectiveness has also been delivered, albeit limited to lower-level or intermediate outcomes at this stage. The effectiveness of outputs delivered under phase 1 will be highly contingent on the success of phase 2 when the priority shifts to the use of AMR evidence.

Conclusion 5: Experience from phase 1 suggests some specific areas in which the Fleming Fund can strengthen its approach through further reflection; in terms of using a stronger and prioritised sustainability lens from the start in deciding what support to provide to laboratories, working at the organisational level to sustain capacity-building results, focusing on other data types as well as AMR, and differentiating more strongly between support provided to AH and HH. Specific areas include:

* *Laboratory infrastructure enhancement*. Specific choices about the nature of support provided and rationale for this, for example in terms of the sustainability implications of automating laboratory processes through the supply of sophisticated and expensive equipment, and the supply of consumables and reagents.
* *Human resource strengthening and workforce reforms*. Working at the organisational/ institutional (rather than individual) level to strengthen the sustainability of capacity building (health workforce training) efforts.
* *Focus on AMC/U and other types of data.* A central assumption of the Fleming Fund is that toensure AMR is prioritised, key national and local stakeholders need to have evidence of both the trends of resistance and the impact that this is having on the health of their populations*.* However*,* since 2018, over half the focus countries have initiated important policy and regulatory action on AMR at the national level without using significant analysis from Fleming Fund investments. This experience suggests that change at country level can have other drivers and, if identified, presents a wider range of opportunities for the Fleming Fund to contribute to its higher-level objectives.
* *Give greater priority to sustainability from the start***.** While phase 2 appears set to address some of the challenges noted in the summative report[[11]](#endnote-12), the detail on how this will happen remains unclear to the evaluation team. Sustainability is a shared responsibility between the DHSC, the MA team and recipient governments. During phase 1, developing an approach to sustainability that might be effective has been constrained by a lack of consensus on what needs to be sustained. At the surveillance system level, the extent to which it is feasible and realistic to expect governments to allocate scarce domestic resources to AMR surveillance functions, particularly where the investment case is not clear, needs to be carefully considered, alongside the question of whether some aspects need to be funded as a global public good. Developing plans and strategies for sustainability should be done based on detailed, context-specific, politically informed analysis[[12]](#endnote-13).
* *Differentiation* could be strengthened by giving more thought to the A–D categorisation[[13]](#endnote-14) that the MA presented in phase 1 but which has not been central to targeting change.

**Conclusion 6: The Fleming Fund deserves recognition for prioritising One Health and for convening cross-sectoral dialogues. The lack of models[[14]](#endnote-15) on how this can be operationalised at a national scale has impacted the design of the Fleming Fund’s One Health approach. Experience from the joint research aspects of the Fellowship programme, which echoes wider experience in One Health, may help identify informal mechanisms to replicate during phase 2.** When the Fleming Fund started, it relied on limited practical guidance around how to successfully operationalise One Health in different country contexts. This is something that the international agencies have only now started to address, as demonstrated in the objectives of the recent World Health Assembly resolution on One Health[[15]](#endnote-16) and with the development of a more structured approach to implementing One Health.[[16]](#endnote-17) However, there are few examples of effective One Health approach implementation on a national scale. During this evaluation, we found that One Health partnerships can assume different forms across different countries, including varying levels of formality, and that formal and informal modes of partnerships often work together. Working with different degrees of formality/informality in One Health structures across Fleming Fund-supported countries is likely to be key during phase 2, and there is potential to draw on the Fleming Fellows’ joint research projects to learn lessons about supporting multisector collaboration.

Observations on programme management and implementation

**Conclusion 7: During phase 1, planning by both the MA and DHSC was over-optimistic in terms of the time taken for design and approval and then delivery. It is not clear whether this has been fully addressed for phase 2.** Implementation has not met expectations due to a range of factors (some of which were outside MA and the DHSC control) including: two civil service purdahs;[[17]](#endnote-18) delays in contracting the MA and sign-off on the MA’s implementation plan (which was extended from eight to 17 months); country positioning and competitive tendering taking longer than expected (including the approval of key documentation by DHSC) due to COVID-19, and due to the challenges of working in specific country contexts. The competitive tender process required by His Majesty’s Government (HMG) procurement rules was of limited relevance in the context of a highly technical intervention where the pool of qualified suppliers is small. CG implementation, therefore, began two years after the start of the programme, and the Fleming Fund has been catching up since. While these issues are well known by the MA and the DHSC, there is an understandable risk that ambition and realism are not well balanced in setting expectations for what can be delivered in phase 2.

**Conclusion 8: The complexity of the programme, with multiple Fund grantees operating at the country level, has made it challenging to deliver coherence across the Fleming Fund’s investments. This has been exacerbated by the DHSC’s decision to expand the number of grantees. The challenge was recognised, and progress was made but focused mainly on avoiding duplication. Less progress has been made in enhancing synergy and greater overall effectiveness. Evidence of external coherence with external partners is strong within limits but reflects the lack of working formal government coordination mechanisms: ultimately, external coherence should be the remit of AMRCCs but these are not always fully functional and do not always include all relevant non-government stakeholders.** Nevertheless, the basic mechanisms to deliver internal coordination are now in place, but their remit remains focused on information sharing. Therefore, widening their remit presents an opportunity to enhance internal coherence. While external coherence between all Fleming Fund grants and other DPs’ interventions was found to be strong in a majority of the focus countries, this does not focus on linkages to wider (non-surveillance) aspects of the AMR response. Progress on addressing external coherence may be key given the aspirations in phase 2 but the experience of phase 1 suggests that several of the contextual conditions that would have facilitated achieving external coherence (in terms of effective AMRCCs) are missing and a feasible solution has not been identified. The assumption is that AMR NAPs identify prioritised actions through a functional multisectoral coordinating mechanism (AMRCC) with clear terms of reference (ToR), a budget, and an accountability framework. The phase 1 experience is that AMR NAPs and AMRCCs have limitations in providing, organising, and driving the framework for action and external coordination. This links to the challenge of ensuring external coherence with other donors that our key informant interviews (KIIs) suggest are investing in the HH AMR sphere. Evidence suggests that, in the absence of prioritisation through AMRCCs, this coordination is happening to some degree in some countries, but ad hoc and based on existing relationships of grantees at the country level.

Strengths and weaknesses of the current programme design in terms of contributing to the overall longer-term objectives of the Fleming Fund as articulated in the Business Case for phase 2.

The previous conclusions include a number of strengths in the phase 1 approach that the Fleming Fund should build upon. Below we highlight a key conclusion that is critical for the Fleming Fund to address, given the evolving context and focus on contributing to the ultimate objectives of the Fleming Fund.

**Conclusion 9: The Fleming Fund approach to managing for effectiveness could be strengthened at the country and portfolio levels. There has been progress in this regard during phase 1, in terms of developing a portfolio-level theory of change (ToC) and a core set of indicators; and the challenges observed reflect factors common in many aid programmes. But some are particular to the Fleming Fund and addressing these will be of increasing importance in phase 2.** The 2015 ICAI review of the UK’s former Department for International Development (DFID) approach to delivering impact[[18]](#endnote-19) notes that ‘*…Getting the balance right between direct impact and policy and institutional change emerges as a critical factor for successful impact. It calls for clear, long-term goals, combined with considerable flexibility as to the steps required to achieve them*’. This is true for the Fleming Fund which also faces programme delivery challenges.[[19]](#endnote-20) Managing for effectiveness requires both clarity of where the balance is to be struck, between impact at the individual facility level and the policy/ regulatory level, and flexibility through adaptive management that can achieve effectiveness.

The Fleming Fund did not start with clear and realistic goals on what could be achieved during phase 1. This is a common challenge.The lack of clarity on expected results may have been due to the innovative nature of the programme, or to the uncertainty of the purpose of the Fleming Fund at the outset. Either way, it has undermined the clarity of strategic focus and effectiveness of implementation in terms of higher-level outcomes during phase 1. As discussed above, fundamental questions about the purpose of the Fleming Fund should have been addressed upfront – such as whether national policy, regulatory and/or behaviour change (and of which target audiences) were the priority and how AMR surveillance was expected to contribute to that. We note that in the original ToR that the MA responded to, the DHSC prioritised generating additional data.[[20]](#endnote-21) Establishing clear, long-term goals and mechanisms to track and adapt the steps required to achieve them is standard practice in developing programmatic interventions of this kind, although not routinely implemented. There has been progress in this regard during phase 1, in terms of developing a portfolio-level ToC and a core set of indicators. Note the following, related to establishing clear expectations:

* Establishing goals at a strategic level will help manage the risk of rigidly maintaining focus on operational plans at the cost of strategic adaptation. The extent to which DHSC systems and culture allow for this kind of adaptation needs careful consideration during phase 2.
* Establishing expectations needs to be done with country counterparts. The country investment strategy process provides a good opportunity to do this. However, given expectations for how phase 2 will shift, there is a risk that country investment strategy processes are overloaded. In this scenario ‘delivering’ key strategic shifts will be more challenging and so the importance of establishing clear, shared expectations cannot be overstated.
* Defining success for phase 2 in ambitious but realistic terms. This will be essential because phase 2 is short, and tackling AMR requires a long-term response. Experience from phase 1 provides a clear basis for calibrating ambition appropriately.

Recommendations

The recommendations presented below follow the findings and conclusions of the evaluation team[[21]](#endnote-22). More detailed recommendations on their operationalisation can be found in the summative report[[22]](#endnote-23). They are of equal priority and should be implemented as a package for the best results.

Five recommendations:

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| 1. **The DHSC and the MA should ensure that clear, ambitious, realistic goals for phase 2 are in place from the outset, with targets to track progress. These should be established at the country and portfolio levels, based on understanding the current status of AMR surveillance systems and their use, as developed during phase 1.** |
| 1. **The DHSC and MA should ensure systems and processes for establishing expectations and tracking progress are proportionate, timely, and sufficiently flexible to deal with uncertainty and the need for strategic adaptation. These must strike the right balance between strategic reflection and accountability, and avoid focusing too heavily on tracking the implementation of inputs and activities.** |
| 1. **The process of establishing goals at the country level should be focused on understanding the priorities and needs of key decision-makers on AMR, recognising inter alia that: (a) AMR action will take place through multiple policy processes and that differentiation between HH and AH is of fundamental importance; (b) that achieving higher-level goals requires action by other actors and therefore effective collaboration with key stakeholder groups.** |
| 1. **The Fleming Fund should make adaptations to, or emphasise specific aspects of, its technical approach for phase 2, that are supported by experience from phase 1. These should include focusing on AMU and other data sources, identifying informal approaches to One Health multisector collaboration, and maximising the prospects for sustaining laboratory functions.** |
| 1. **The Fleming Fund should place greater emphasis on internal and external coherence and coordination from the outset of phase 2, including strengthening AMRCCs and NAPs to play this role and their linkages to institutional homes.** |

About the evaluation scope and methodology

As noted above, the DHSC commissioned Itad in 2016 to provide an independent evaluation function for the Fleming Fund grants programme – focusing on workstreams 3 (portfolio of One Health country and regional projects) and 4 (Fleming Fellows).[[23]](#endnote-24) The evaluation has been undertaken by a multidisciplinary team[[24]](#endnote-25). As agreed, we have not evaluated the performance of individual grants within these two workstreams. Rather, the focus of the evaluation has been on how far the outputs of the grants developed and managed through the MA have, or are likely to have, contributed to the outcomes and impact identified by the DHSC.

Previous evaluation outputs were focused on and timed to ensure the utility of evaluation processes, e.g., through supporting adaptation by the Fleming Fund based on emerging evidence from implementation[[25]](#endnote-26). The purpose of this report is to provide an independent summative judgement of the Fleming Fund’s results for accountability purposes using six EQs[[26]](#endnote-27) that reflect DHSC’s priorities. Our focus is on the country- as opposed to regional- or global-level results across the human, animal, and environment sectors. Our primary target audience is senior management within DHSC and His Majesty’s Treasury (HMT), as well as the MA and other donors and DPs.

The timing of the evaluation was set at the request of the DHSC, to maximise utility through feeding into detailed planning of the second phase of the Fleming Fund, starting in April 2023. One consequence was having a July 2022 data collection cut-off point, which was nine months before the end of phase 1 implementation. We recognise that further implementation and progress, not reflected in this report but in the MA’s reporting, is likely to have occurred following the completion of our data collection.

To address the EQs we have collected data in 16 case study countries, resulting in the review of more than 1,900 documents and the completion of more than 400 KIIs over the period September 2021 to July 2022. Grants included in our assessment as operating in our 16 sample countries are listed in the summative report[[27]](#endnote-28). We do not believe that evidence from the remaining seven countries would significantly alter our conclusions and recommendations. A range of analytical methods including contribution analysis, benchmarking against broader evidence and experience, and triangulation was used in analysing the evidence and developing our conclusions.

1. [Link to O'Neill, J. (2016). Tackling drug-resistant infections globally: final report and recommendations [PDF].](https://amr-review.org/sites/default/files/160525_Final%20paper_with%20cover.pdf) [↑](#endnote-ref-2)
2. One Health is a multiple disciplinary effort to attain optimal health for people, animals and the environment. [Link to the American Veterinary Medical Association webpage on One Health](https://www.avma.org/resources-tools/one-health). [↑](#endnote-ref-3)
3. [Link to the Knowledge and Resources section of the Fleming Fund website](https://www.flemingfund.org/knowledge-resources/) where the summative report (volumes 1 and 2) can be accessed. [↑](#endnote-ref-4)
4. Surveillance protocol and platform; Grants to multilaterals WHO, FAO, OIE; Portfolio of One Health country and regional projects; Fleming Fellows. [Link to the Programme Design section of the Fleming Fund website](https://www.flemingfund.org/our-approach/programme-design/). [↑](#endnote-ref-5)
5. The Fleming Fund started in 23 countries, but subsequently pulled out of Sri Lanka and Myanmar. [↑](#endnote-ref-6)
6. E.g. data on AMC/U also increased in some countries. [↑](#endnote-ref-7)
7. Contribution to drivers was rated against the following scale: vital / important / some / limited / none / negative. Annex 3 section 1.3.1 of the summative report has more details on the methodology applied and Annex 22 includes a visual summary of the results. [↑](#endnote-ref-8)
8. This assessment differs from MA reporting on data sharing because it is undertaken on a different basis. [↑](#endnote-ref-9)
9. As discussed in section 3.1.1. of the summative report. [↑](#endnote-ref-10)
10. Kurowski, Christoph; Evans, David B; Tandon, Ajay; Eozenou, Patrick Hoang-Vu; Schmidt, Martin; Irwin, Alec; Salcedo Cain, Jewelwayne; Pambudi, Eko Setyo; Postolovska, Iryna. 2021. From Double Shock to Double Recovery: Implications and Options for Health Financing in the Time of COVID-19. Health, Nutrition and Population Discussion Paper; © World Bank, Washington, DC. [Link to access the publication](https://openknowledge.worldbank.org/entities/publication/d964eff2-d6b8-5aea-96d5-c0a628a13706). [↑](#endnote-ref-11)
11. See section 2.3 of the summative report. [↑](#endnote-ref-12)
12. Similar to that outlined in section 2.2 of the summative report. [↑](#endnote-ref-13)
13. See Annex 15, Table 47 of the summative report. [↑](#endnote-ref-14)
14. We note the Tricycle protocol could potentially play a role in providing a tried and tested model; however, it was published in 2021, so not available for Fleming Fund use for the majority of phase 1.[Link to the Tricycle protocol](https://apps.who.int/iris/handle/10665/340079) [↑](#endnote-ref-15)
15. [Link to Strengthening WHO preparedness for and response to health emergencies - Strengthening collaboration on One Health [PDF]](https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_19-en.pdf) [↑](#endnote-ref-16)
16. [Link to the Tripartite Zoonoses Guide](https://www.who.int/initiatives/tripartite-zoonosis-guide). [↑](#endnote-ref-17)
17. Purdah is a period of pre-election sensitivity when Government departments and councils will normally observe discretion about making new announcements or decisions that could influence voters. [Link to briefing on House of Commons Library website](https://commonslibrary.parliament.uk/research-briefings/sn05262/). [↑](#endnote-ref-18)
18. [Link to ICAI report 45, June 2015 [PDF]](https://icai.independent.gov.uk/wp-content/uploads/ICAI-report-DFIDs-approach-to-Delivering-Impact.pdf) [↑](#endnote-ref-19)
19. ICAI’s 2018 review ofDFID’s approach to VfM in programme and portfolio management finds the same problem, as does a 2019 review of experiences with results-based management across development organisations. [↑](#endnote-ref-20)
20. DHSC Terms of Reference: Management Agent for The Fleming Fund – para 2.4 and 2.5, which lists eight indicative focus areas for the grants portfolio, only one of which mentions ‘Policy and advocacy work with national governments, using AMR data and analysis collected to make the case for evidence-based public health interventions’. [↑](#endnote-ref-21)
21. As set out in Annex 21 of the summative report. [↑](#endnote-ref-22)
22. See section 4 of the summative report. [↑](#endnote-ref-23)
23. Workstreams 1 and 2 were outside the evaluation scope. [↑](#endnote-ref-24)
24. As described in Vol. II, Annex 14 of the summative report (Figure 26 and Table 46) [↑](#endnote-ref-25)
25. See Vol. II, Annex 23 of the summative report, for summary examples of where this has happened. [↑](#endnote-ref-26)
26. (EQ1) What has been the increase in the quantity and/or quality of data on AMR at country level and to what extent has the Fleming Fund contributed to this increase? (EQ2) To what extent have the Fleming Fund’s investments been aligned and coherent with other relevant investments at country level? (EQ3) How likely are the Fleming Fund’s country-level results to be sustained? (EQ4) Has, or is it likely that, the increase in AMR data influenced: (a) changes in national policies/regulations? and/or (b) changes in practice and attitudes in-country? (EQ5) What has been the increase in quality of data shared and reported internationally and has the Fleming Fund contributed to this? (EQ6) Did the Fleming Fund’s investments at country level offer value for money? [↑](#endnote-ref-27)
27. See Vol. II, Annex 25 of the summative report. [↑](#endnote-ref-28)