Myanmar Country Coordinating Mechanism for AIDS, Tuberculosis and Malaria

Meeting Minutes

10th M-CCM Meeting

10:00-13:50, 21 June 2011

Conference Room, Ministry of Health, Nay Pyi Taw

(1) Announcement of reaching quorum

Dr Saw Lwin announced at the start of the meeting that quorum is reached for today's meeting with 28 out of 29 members/alternate members attending. According to the M-CCM Governance Manual, quorum is reached when there are at least 7 participants from government sector and 7 participants from NGO sector. There were 9 members from government sector and 14 member/alternate members attended from INGO, LNGO, CBO/FBO, Private sector and People living with/affected by the Disease Sectors.

(2) Opening remarks by the Chair (H.E. Prof Pe Thet Khin)

H.E. Prof Pe Thet Khin welcomed the participants along with the Global Fund Mission led by Dr Elmar Vinh-Thomas. He shared with the M-CCM meeting that the Global Fund delegation met with him prior to the M-CCM meeting and the issue of visa and MoU approvals was raised. The Minister provided information that he had met with relevant ministries and confirmed that some improvements in the approval process have been made.

H.E. Prof Pe Thet Khin stressed that as the Global Fund support is performance-based, all partners involved in Round 9 implementation must continue to work hard and have commitment to carry-out activities to the best effort possible. He emphasized the important oversight function of the M-CCM and mentioned the challenges the PRs face regarding procurement of supplies and commodities and he requested the Global Fund mission to address this issue and recommend steps to accelerate the resolution of the situation. The Minister underlined that the government takes the three diseases (AIDS, TB and Malaria) programmes very seriously and appreciates the funding support to fight the diseases. He recognized that this meeting will also discuss Myanmar's application status and eligibility criteria for Global Fund Grant Round 11. He stressed his appreciation for the support of all stakeholders and wished the participants a successful meeting.

(3) Endorsement of the 10th M-CCM meeting agenda and endorsement of the minutes of the 9th M-CCM meeting (Dr Saw Lwin)

Dr Saw Lwin presented the M-CCM meeting agenda for endorsement. The agenda was endorsed without comments. He also requested the M-CCM participants to state whether anyone had any conflict of interest they had to declare prior to discussing any of the agenda items. There were no statements of conflict of interest from the M-CCM participants. Dr Saw Lwin summarized the main discussion points from the 9th M-CCM meeting minutes. There were no comments from the M-CCM participants. The Chair of the M-CCM endorsed the 9th M-CCM meeting minutes.

(4) CCM review of the Global Fund first quarter reports

Briefing by PR Save the Children

Ms Barbara Greenwood, PR STC presented the program progress. The main points from the presentation (attached) are highlighted below:

STC TB performance:

- Percentage of patients receiving incentives in the form of transport costs for diagnosis and or treatment reached 81%.
- Percentage of all registered TB patients 15 years and above who are tested for HIV reached 67%
- Percentage of smear-positive TB patients registered for treatment in PPM DOTS clinics (scheme 3 includes both diagnosis and treatment by the private providers) reached 107%
- (There was no procurement from Global Fund but with the support of 3DF and other donors the target surpassed 100%)
- Percentage of Community Health Workers (CHW) trained and actively involved in TB case finding and/or treatment activities at the community level during the reporting period reached 57%.
- Other findings:
    - Inconsistent payment/incentive to volunteers among implementing agencies
    - The number of staff at formal health facilities is insufficient to handle large number of patients
    - Limited access for TB patients to VCCT (lack of services, staff skills etc)
    - Procurement of microscopes delayed

STC HIV performance:

- Percentage of condoms distributed free of charge to most at risk populations (MSMs, Sex Workers and IDUs) reached 60%
- Percentage of Sex Workers reached by package of prevention services including BCC and STI prevention/treatment is 103%
- Percentage of Men who have Sex with Men reached with package of prevention services including BCC and STI prevention/treatment is 119%
- Percentage of injecting drug users reached with harm reduction programme in drop-in centres is 81%
- Percentage of people currently on methadone maintenance therapy is 81%
- Percentage of adults and children with advanced HIV infection currently receiving antiretroviral therapy is 138%
- Percentage of people receiving community home-based care is 91%
- In general, the targets have been reached with funding from other donors, mainly 3DF
- Potential delays in achieving Q3/Q4 targets due to delays in procurement
    - 2,521 patients on ARTs at risk of treatment disruption (August to Dec 11) (ARVs covered by 3DF until Dec 11)
    - 122 IDUs on Methadone at risk of treatment disruption (August to Dec 11) UNODC/WHO will fill the gap
    - SRs will encounter gaps in OIs

STC malaria performance:

- Number of LLINs distributed free of charge to people at risk is achieved 69%
- Number of blood slides taken and examined is achieved 60%
- Number of rapid diagnostic tests done and read is achieved 34%

- Number of people with confirmed malaria treated with recommended ACT (disaggregated by age group and sex) is achieved 17%
- Number of people with malaria (probable and confirmed) treated with chloroquine (disaggregated by age group and sex) is achieved 41%
- Number of village health volunteers trained and supported for malaria prevention and control is achieved 104%
- Number of health staff trained/retrained is achieved 196%
- Main findings in monitoring to and report analysis of SRs are as follows:
  - Budget under spent in Q1
  - Decreased in malaria cases as compared to proposal targets set 2 years ago
  - Overlapping areas among STC SRs and NMCP has delayed start up
  - Procurement delay impacts quality of services and underachievement of targets
- The situation of procurement and supply chain are as follows:
  - Chloroquine and LLiN arrived in country May 2011
  - ACT tender one is cancelled and UNOPS revised and retendered discussion on current BER
  - RDT will be arrived in July 2011. RDT
  - LFA is to evaluate STC capacity to procure basic health products locally (not pharmaceuticals)
  - STC is hoping to delegate procurement of these products on SRs with experience.
  - STC is researching possible pre-approved for year 2 procurement and STC is comparing percentage of supply needs that can be met and also costing.

Main findings across all programs
- Lower $ exchange rate (25%) and inflation (~20%) affects program operations (salaries, rent, running costs)
- Delayed procurement affecting program implementation
- Budget under spent in Q1
- SRs MoU and visa status affecting program implementation (13 visas and at least 3 MoUs)

Procurement and supply chain
- LFA to evaluate STC capacity to procure basic health products locally (not pharmaceuticals)
- STC researching possible procurement agent for Year 2 procurement (GF pre-qualified).
- Next steps: tender for procurement for PA for Year 2 in Q3
- Negotiate with MoH on process for importing pharmaceuticals
- In Q5, six training plans will be submitted by mid-August 2011
- UNOPS and STC will update PF year 1 targets to reflect contribution of other donors in untied indicators from Q3
- Plan variance analysis and reallocation of budget for quarter 3 and quarter 4
- STC will make forecasting for year 2 procurement order with PA

Barbara also added that from the previous M-CCM meeting, STC was requested to formally confirm that the Wa Region is no longer included in its GF project area; she briefed the M-CCM that STC's partner Malteser is waiting for MoU to be approved in order to move into the alternative areas.

Briefing by PR UNOPS and updates on procurement issues

Dr Attila Molnar, PR UNOPS presented the first PUDR. The main points from the presentation (attached) are highlighted below:

- Reports are received timely from SRs but some of the required supporting documents are missing.

- LFA in their initial feedback meeting has appreciated the completeness of reports and the level of efforts by the PR and SRs in completing the Update.
- The financial section is cash mostly based and has not ample provision to add commitments in the expenditure statements, which jeopardizes the total payments in the subsequent quarters. PR to provide feedback to GF on the need to adjust the new PUDR template.

Summary of the progress update:

- UNOPS had good achievement in untied indicators, in a few even overshooting targets as a result of additional donor funding in Q1 but there were modest achievement in tied indicators for quarter 1 as a result of late start of GF disbursements.
- Training workshops with all the SRs are on-going and opportunity used to feedback on the PUDR.
- The two pending issues (TB quality reviews and PSM trainings) are now cleared and the training plans are fully approved
- Approval of the Compliance Manual/Plan (CP-1) was granted – all CPs are resolved
- Direct Disbursement under the fund flow mechanism is working to its capacity fully unrolling in June
- Reprogramming for UNFPA amount is in process – discussions with NAP and the Joint UN Platform suggested the use of US$228,000 as: HSS and BSS in 2012, 1-3 additional TA S/M to be employed by WHO for supporting TCP in the field and additional TCP activities in NAP.

Update on procurement issues:

LFA Assessment of PR's Procurement Capacity:
- LFA assessment was conducted between 23 and 27 May 2011.
- Initial feedback received from GF – detailed discussions are to follow
- GF is of the view that UNOPS Myanmar needs more time to fully develop capacities for procuring pharmaceuticals directly
- Procurement of pharmaceuticals in Year 2 will be through Procurement Agents
- A second assessment will follow once UNOPS declares its preparedness, incorporating all lessons learnt during this assessment – most likely towards the end of the year
- UNOPS will request GF to agree to the recruitment of the outstanding additional QA expert
- Capacity building is continuing in UNOPS towards building full capacities in PSM
- The way to conduct procurement of non-pharmaceuticals is under discussion with GF
- Renovation and Constructions
    - Renovation: For central warehouse, selected consultant has provided the drawings and BOQ for tender for selection of the contractor. Renovation work for Yangon warehouses expected to be completed by Aug 2011. Renovation plan, drawings and bill of quantities submitted to GF and NAP & VBDC. GF approval received.
    - State /Region Level plans will be taken up in the later part of the year.
- Challenges in procurement of lab and surgical items:
    - Very large number of low value items (maximum in the range of USD 20-100).
    - Volume is not attractive for foreign manufacturers and suppliers. IPO is still trying to decide the correct procurement strategy for such items.
    - Local suppliers are not used to submission of bids with complex requirement of qualifying documents.
    - Many items available locally with retailers/ wholesale dealers but complex procurement process makes it difficult for the local suppliers to bid correctly.
- Challenges in PSM:

- Low supplier compliance with different delivery schedules and packaging of ARVs, OI drugs and test kits
- Different description and unit prices of the same item from different SRs.
- IPO unable to decide how to procure Lab and surgical items
- Detailed specifications of different products not provided/ time consumed in clarifications

Discussions:

Mr Jason Eligh, UNODC, commented that it appears that there are currently two organizations procuring methadone for the same period given the PR's report that it expects methadone to be delivered by October and that UNODC is in the process of procuring methadone for the period September to December 2011. Jason sought clarification from UNOPS on (1) how long the current methadone supply is available until? and (2) is there need for UNODC to procure methadone?

Dr Attila Molnar, PR-UNOPS, stated that the methadone supply will most likely arrive by October 2011.

Dr Herbert Tennakoon, WHO, clarified that the procurement WHO is handling will be only for 3 months and cover the period up to early September 2011.

Mr Paul Sender, Merlin, said that it doesn't seem to be the right time to cancel any processes that are now in place (referring to the methadone issue), at the very least there will end up being buffer stock. He asked UNOPS what they needed to deal with bureaucratic issues to expedite procurement and also how they can accelerate the delivery of drugs.

Dr Attila Molnar clarified that there has been delays due to a variety of factors including the situation that procurement is done through their India Procurement Office, delays are a result of mistakes, errors that were made by all involved in the review and due to additional controls by the LFA. Regarding shipment, shipping by air would give an additional 2 weeks window, unfortunately budget is so tight after the 10% reduction and the exchange rate loss that this is not possible. What UNOPS is trying to do to make these issues go smoother in the future is to build capacity of their team in Myanmar to control fully the processes. The standards of public sector procurement particularly in the health sector of drugs are rather complicated and demanding and standards are a result of basic policies of good quality procurement and value for money as stipulatyed inGlobal Fund PSM policies. In Year 2, UNOPS should be in a better position in-country based on lessons learned, to make things go smoother.

Dr Julia Kemp, DFID, highlighted two main issues that the M-CCM should address: (1) what is the potential gap in some of the essential drugs and commodities in the second half of this year and the need to seek practical solutions with partners and 3DF including a clear analysis of stock levels; and (2) in light of the findings of the assessment, see that an alternative procurement agent be put in place quickly to commence procurement of year 2 drugs and commodities. She added that if recommended by the PRs, could the GFATM consider permitting different procurement agents for each PR to help mitigate risks of gaps in supply of essential drugs and equipment in future. She also welcomed the review by STC looking at procurement agencies that have been pre-qualified by the GF.

Dr Saw Lwin commented on the many challenges faced in the R9 start-up phase, including no release of funds pending satisfactory completion of Conditions Precedent, SoPs and fund flow mechanism; funding delays resulted in NAP not being able to carry-out planned activities, mainly in areas of training and advocacy. He also raised a concern that now that training has started but supplies and drugs are not yet available. If there is a big gap between the training and the service provision period, training knowledge or skills may be lost. Concerning procurement challenges, Dr Saw Lwin asked about the financial

implication whether additional budget can be made available to cover the cost of hiring a new procurement agency since this was not included in the plan of action. Since this is the first time the M-CCM is experiencing this issue he requested the Global Fund mission delegation to provide some recommendations how to resolve the procurement issue. He added that there are other issues that need to be clarified for all members of the M-CCM to have better understanding of grant oversight such as definition of "tied" and "untied" indicators.

Mr Mohammad Abdel-Ahad, UNFPA, reiterated UNFPA's commitment to provide continuing technical assistance to the national programmes according to the UN division of labour even though UNFPA and PR-UNOPS could not reach an agreement due to legal issues which prevented UNFPA from becoming one of the Sub-Recipients of Round 9.

Dr Sun Gang, UNAIDS, noted that for Q1, while untied indicators have been achieved, however, the procurement issues still need to be resolved urgently to prevent stock out for ARV, OI and ACT drugs. He requested the M-CCM to encourage implementing partners to work with PRs to update drug stock levels and timeline for expected delivery of drugs to identify solutions to prevent stock-outs. He expressed his concern that since the 3DF is at the end of its programme, unlike previous times, the further procurement assistance from the 3DF to meet the gaps will not be available.

Dr Julia Kemp suggested to carry-out an assessment of what the procurement needs are and share this information with the 3DF to explore possibility of filling immediate gaps.

Regarding tied and untied targets, Julia explained that the Three Diseases Fund was set up in response to the withdrawal of the Global Fund in 2005 and that the Round 9 Global Fund activities will continue to scale up some of the activities funded under the Three Diseases Fund. She provided information that the Global Fund and 3DF donors in-country agreed that in Year 1 (2011), all targets would be untied i.e. the results achieved by the 3DF programmes would count towards the achievement of the Year 1 Global Fund targets. This ensures a smooth transition of the programme; mitigating the risk that partners would end agreements early with 3DF and allowed Global Fund to secure budget reductions. The 3DF has continued to provide full support to the early start up of the Global Fund. However, she noted with concern that the first quarter report states that some targets have been 'tied' to the Global Fund.

(5) Dashboard presentation (Dr Saw Lwin)

Dr Saw Lwin presented the Dashboard tool to the M-CCM. Participants were provided with a hardcopy of the Dashboard reports before the meeting. He stressed that the Dashboard is one of the CCM tool that members can use to oversee grant implementation. He added that M-CCM members should use the Dashboard tool to provide comments, recommendations and actions to be taken on the grants; Dr Saw Lwin then presented an example from the PR-UNOPS HIV component.

Financial indicators:

F1: In Q1, more than 5 million dollars already disbursed
F2: Cumulative budget breakdown by objectives (untied activities with support of other donors) there is actually no SR expenditures
F3: Disbursement figures (PR can't disburse budget to SR)
F4: Latest PR reporting (red colour – warning,) need to discuss with PR the reasons for delays and how to improve

Management indicators

M1: Status of conditions precedent (all 6 TBA fulfilled; out of 4 CPs, 3 fulfilled on time)
M2: Key PR management positions (all planned 7 positions already filled)

M3: Contractual arrangements for SRs (6 identified, signed 5, with UNFPA opt-out)
M4: 3 SRs not reporting on time (which SRs and reason? Need to improve timely reporting)
M5: Budget and procurement more than US$ 2 million approved, but no disbursement made. We now know that this is due to procurement delays
M6: Danger of stock-out (which drugs should be selected for monitoring which are the key drugs) Request TSG to identify key drugs to monitor and prevent stock-out.

Programmatic indicators

P1: Number of condoms distributed free of charge (overshoot of target, untied target). We should put this information about tied and untied in the indicators
P2: Number of sex workers reached (tied target, no funds to SR, no achievement)
P3: Number of MSM (tied target, no funds to SR, no achievement)

Dr Saw Lwin also suggested that the colour of targets not included in the reporting period should be white, not red which means that targets are not achieved.

(6) Updates of new developments from national programmes (Dr Win Maung)

Dr Win Maung provided updates of new developments from each disease programme. For AIDS, he referred to the new National Strategic Plan that was disseminated early June in a multi-sectoral event presided by the Minister of Health and Dr Nafis Sadik, UNSG Special Envoy for AIDS and the new national ART guidelines recommending treatment for those with CD4 count less than 350. For TB he highlighted the TB prevalence survey results and the summary of the TSG meeting on 4 June at which they discussed R11. The focus for Rd 11 application should be on acceleration of TB case findings especially in new townships; treatment and care; and expansion to new geographic area for MDRT. For Malaria, the TSG will meet soon. The intent could be developing concept note for GF R11 to include new area of LLIN and geographic areas. Please see presentation attached.

(7) Updates from 3DFs and its future directions (Mr Pietro and Dr Julia Kemp)

Dr Julia Kemp started this session by sharing the appreciation, on behalf of the Chair of the 3DF, for having this opportunity to discuss new development of 3DF, as the M-CCM ToR covers national programmes as well as Global Fund.

Mr Pietro summarized the achievements of the 3DF. Please see presentation attached. Julia then informed the M-CCM of the forth coming final evaluation of the 3DF. She stressed that the final evaluation will focus on the 3DF as a whole, and not on evaluating individual projects. The evaluation will look at impact and the role of 3DF in operating context and value for money. She indicated that the next phase of the fund will address the three health MDGs covering three main areas: Component 1: Increased availability and accessibility of essential health services focused on maternal, newborn and child health; Component 2: Flexible and strategic support to prioritized HIV, TB and malaria interventions for hard to reach populations and areas; and Component 3: complementary HSS (Complementary health systems strengthening to support long term sustainability of programmes funded under components 1 and 2, in line with international best practice.). The rights-based approach and focus on the basic health needs of the most vulnerable populations were highlighted. She added that the common document “Description of Action” will be shared as soon as the Headquarters of the seven donors cleared the document. She mentioned that the CCM/TSG model has set a good example on how the work of different partners can be coordinated. She also informed the M-CCM that remaining funds in 3DF cannot be transferred to the next phase of the 3DF. Fund balance will have to be returned to Ministry of Finance of donor countries.

Discussion:

Dr. Thein Thein Htay, Deputy Director General Public Health requested to CCM to support for forming a technical strategic group on maternal child health under the umbrella of the CCM. She also said that this is the high time to have a forum and all stakeholders and partners who are working with the reproductive health and the maternal and child health activities can work together and share knowledge. The aim is to have better collaboration through a functional partnership forum and to have more transparency on the important discussions in the major policy and technical issues.

Mr Mohammad Abdel-Ahad, UNFPA, thanked Julia for the clear presentation and welcomed the initiative of establishing a TSG-MCH which is very much needed at time when many countries face challenge in achieving health MDGs. He mentioned that the UN Secretary-General launched an initiative on maternal child health and Myanmar government committed to the UN SG strategy. He is pleased to hear mention of rights-based approach and focus on vulnerable populations. He suggested that there should be alignment on new 3MDG fund and commitment from Myanmar government. Support from all partners UN and INGO are needed to map out inputs from around the country and see how gaps can be filled. He commented that it would also be useful to get feedback on outcome of the design mission of the 2nd phase of the 3DF that was conducted earlier this year.

Dr Julia Kemp welcomed suggestion by DDG Public Health to establish an overarching TSG for MCH under CCM to support more effective coordination of programmes and funding to health from different donors. She request a concept note on the structure and the changes to Governance Manual at the next CCM.

(8) Status of the GF Round 11 application (Dr Saw Lwin)

Dr Saw Lwin reminded the M-CCM that at its last meeting, the M-CCM decided to apply for R11. However, there are new eligibility criteria that the M-CCM need to be familiar with. He provided an overview of the eligibility criteria (please see presentation).

Dr Saw Lwin also informed the M-CCM that the Myanmar Government has committed to provide 5% contribution to the national programme (based on discussion during the meeting of the GF mission with the Minister of Health). However, M-CCM is ineligible since according to the recent funding history requirement the M-CCM has less than 12 months from the time of R9 grant start date (1 January 2011) to the time of R11 proposal submission (15 December 2011). Dr Saw Lwin presented recommended actions to M-CCM to address this issue:

1) Clarify to Global Fund that grant start date of 1 January was chosen to harmonize reporting cycle with national programmes in line with aid effectiveness practice;

2) Submit Proposal Concept (that is strategic and focused)by 22 July to qualify for exception containing the following justifications:

   - Geographic areas different from the recent proposal
   - New technical guidelines
   - Unmet need cannot be addressed through re-programming of existing funds
   - Adequate absorptive capacity and ability to roll out proposed new interventions

(presentation is attached).

Dr Julia Kemp clarified that the grant start date was set for 1 January 2011, following international best practice to harmonize reporting cycles between all partners in the country. She added that during discussions with the Global Fund, the Global Fund did not allow alignment on quarterly basis, leading to

the start date being set for 1 January. She commented that it is unfortunate that the M-CCM is only 16 days short of the 12 months duration required.

Mr Paul Sender supported the statement made by Julia.

(9) Discussion and suggestion by the Global Fund Mission including feedback from field visit (Mr Elmar Vinh-Thomas and Dr Enkhjin Bavuu)

Mr Elmar Vinh-Thomas made the following general points:

(1) M-CCM has done an excellent job in submitting proposals (high technical proposal). While there were long negotiations it is not unusual. It is good to hear that R9 activities are complementing other donor funding and scaling up programmes.

(2) One of the main functions of the CCM is its oversight function – in some countries this is not particularly a strength of the CCM. In Myanmar, he is encouraged to see Dr Saw Lwin's presentation of the Dashboard. He urged the CCM Executive Committee to look at the issue of oversight and be aware of red flags that might come up. He mentioned that the GF has made available a small amount of funding (around US$40,000) to support the M-CCM Secretariat. He made one caveat on the dashboard that it is only as good as the data that populates the system. He cautioned that the only data that the GF accepts is data that is verified by the LFA. He suggested that the M-CCM ensures that the data used in the Dashboard can be updated with those verified by LFA (in order to have the most recent figure that is approved by GF).

(3) Tension between principle of performance-based funding and principle of trying to get money out as fast as possible. He stressed that the Global Fund take performance-based funding very seriously (this principle goes hand in hand with fiduciary controls) and that the GF have to be accountable for tax payers' money.

(4) Need to have access to areas where the grants are implemented to verify that results reported are accurate and that funds reach beneficiaries. He stressed that the LFA has to be able to conduct the site visit. He also pointed out the need for balance between implementation, access and funding support.

Please see presentation attached.

Regarding the issue of procurement, Mr Elmar Vinh-Thomas confirmed the importance of procurement: 40% of GF money goes to procurement. He shared that the PSM assessment showed weaknesses in UNOPS Myanmar procurement processes (although assessment may have been too soon since capacity building has not yet been completed). He recommended that a procurement agent be urgently selected for Year 2. He added that there will be another LFA assessment towards the end of the year and hoped that UNOPS will then be able to procure their own supplies. He also requested UNOPS to develop a detailed plan for procurement of health and non-health products for approval by GF.

Concerns about storage facilities, Dr Enkhjin Bavuu expressed the appreciation to the government of Japan for their contribution in strengthening the storage facilities and wished the support will continue..

Dr Enkhjin Bavuu, Fund Portfolio Manager, summarized the highlights from the site visit that was carried out by the GF mission. He thanked the authorities and PR, implementation partners for their support of making this field visit happening. He raised special thanks to Dr Myint Shwe, the liaison officer for this mission from NAP for his support. He hoped that the next field visit can be planned for some more difficult-to-reach areas (presentation attached).

Mr Elmar Vinh-Thomas addressed other issues raised by the PRs and M-CCM during the Global Fund mission visit:

(1) Depreciation of US$: Myanmar is not the only country that is affected, other countries in the region. The best solution is to use savings to mitigate loss. Another option that may be considered is to accelerate implementation and run the programme in 4 years instead of 5 years and make an early submission of request for continued funding.

(2) Tied versus untied targets: GF should be complementary – part of national disease program including health system strengthening. GF can accept untied targets as long as it can be distinguished how GF funds are used. He recognized that first quarter fund has not been disbursed and hoped to see the tied targets doing better in the next quarter.

(3) Eligibility – this is a complex discussion. As the GF Board policy stands now, Myanmar is not eligible because it doesn't meet the recent funding criteria. All grants should align with national policies, according to GF board. He suggested that if the M-CCM wished to appeal the Board's decision, then the M-CCM can make the request through the Asia Representative to the GF Board. If there is adequate support from other constituencies, through a regional process, there is better chance the Board may review its decision.

However, if the M-CCM will choose to proceed with the concept paper submission, he expressed his belief that both exceptions may be used by Myanmar effectively. He reminded the M-CCM that the decision will be taken by the TRP, not the Global Fund Secretariat. He stated that the two exceptions are straightforward (1) geographic area different from previous grant or (2) if new round implement new technical guidelines, (e.g. Myanmar has new HIV strategy which has new technical guidelines which require significant investment); TB and Malaria, can also justify according to these two exceptions.

Mr Paul Sender requested the M-CCM to decide on the way forward: appealing the board decision on eligibility criteria or submission of concept paper?

Dr Saw Lwin advised that the most important thing is the how to apply with the strong justification with the focus and strategically, as the Global Fund has a strong policy.

H.E. Prof Pe Thet Khin suggested that we proceed with submission of a concept paper as we can justify the exceptions. He also raised a question whether there were any suggestions for a procurement agent?

Ms Barbara Greenwood shared information that STC has already contacted IDA and UNICEF Copenhagen. However, she requested the M-CCM to wait until there is more solid information in order to identify the best procurement agent to do the job.

Dr Attila Molnar stated that UNOPS is also currently exploring potential partners for procurement. It is not necessarily best option to procure each and every item by the same procurement agent and UNOPS is planning to select PA based on value for money for each item.

<u>(10) Any other business</u>

M-CCM Governance Manual

Dr Saw Lwin informed the M-CCM that since the last meeting, the revised Governance Manual has already been distributed electronically for comments but to date, there are no comments received. He highlighted the differences between the previous Governance Manual (May 2010) and the new one:

- Added elements of conflict of interest of the oversight function
- Updated ToR of TSG and its working Groups
- Updated CCM member list

Dr Saw Lwin suggested that comments on the Governance Manual be sent to the Secretariat as soon as possible and that by the next CCM meeting, the new Governance Manual should be endorsed.

Mr Paul Sender inquired about the process for establishing a TSG for MCH.

Ms Anne Lancelot pointed out that there are more than three pending MoU and 13 visas as what had been presented was only for STC. She offered INGOs support in any process that would make these approval processes quicker and smoother.

H.E. Prof Pe Thet Khin clarified that visa approval for people seeking business or short term entry can now be obtained through the Myanmar Embassy at the country of origin. However, those who are applying for long-term stay visa, and they already stayed in country for a long time, a MoU is required. He added that the MoU approval process in general is faster now. Previously delays were due to the transition period from old to new government.

Dr Julia Kemp welcomed the request from the Minister of Health to other government departments to look into the delays in visas, and in particular the renewal of MOUs. And she also requested to have feedback at next M-CCM meeting.

Dr Julia Kemp also welcomed suggestion by Deputy Director General Public Health to establish an overarching TSG for MCH under CCM to support more effective coordination of programmes and funding to health from different donors. She also suggested for making the changes to a concept note on the structure and to the Governance Manual at the next M-CCM meeting.

H.E. Prof Pe Thet Khin supported the idea of establishing the TSG-MCH in general. He also highlighted the focus of which should be on rural areas.

Dr Enkhjin Bavuu shared ideas from meeting last week with private sector and MBCA. He stated that the private sector had keen interest to be part of the national responses for the three diseases. They expressed willingness to provide workforce and contributions from companies. This can also be incorporated into the next proposal (could gain value for money). CCM could support this issue and invite interested businessment to participate in proposal development.

Dr Khin Aye Aye, MBCA, shared that business sector can also give support and they can be called as the partners for local authorities. She also said that business sector can contribute a lot in three diseases area and they can access mainly to workers and families and there are a lot of things which business sector can contribute towards national health issues and national health strengthening plans, i.e. malaria prevention in plantation sector; She emphasized the need to promote private-public mix in wider areas, i.e. advocacy, logistic support, improving access and coverage of services.

H.E. Prof Pe Thet Khin commented that businessmen often accompany government leaders' visit to country side, he expressed his optimism that in the future there will be more collaboration with the private sector. He mentioned that the Ministry of Health has always welcome the contribution of private sector.

Dr. Soe Aung, MMA made the following points:

(1) for Global Fund round 11, HSS should focus on township level and below to strengthen services for remote areas

(2) Regarding technical working group, propose one on procurement, supply management (this can help to resolve the problem) can be linked with the M&E working group (can highlight areas that require quick response)

(3) Procurement options: if we can have more than 1 procurement agency, perhaps we can pick up some local private sector entities to procure

(4) MDGs 4, 5, 6, Malaria mortality is coming down; have to keep in mind, coming years there need changes in case definition in HIV and TB (need trend analysis for coming years) definition changed according to revised guidelines;

(5) 3DF external evaluation mission coming, report will be vital and can be good resource mobilization tool for the coming period.

Dr Saw Lwin identified key action points from today's meeting as follow:

1) **The TSGs of the three diseases need to identify key drugs to monitor to ensure stock safety, including the key drugs for M6 of the dashboard.**

2) **UNODC is requested not to cancel purchase order for methadone**

3) **Need to identify a procurement agent for Year 2 as soon as possible (ExWG need to discuss procurement issue). For remaining part of Year 1, partners need to look at stock balance and take action to prevent stockout.**

4) **Each disease TSGs to prepare proposal concept for R11**

5) **Form an MCH TSG under CCM (need to be reflected in the CCM Governance Manual)**

Dr Saw Lwin also expressed appreciation to 3DF and its new phase to have continued support to the three diseases.

<u>(11) Closing remarks by the M-CCM Chair (H.E. Prof Pe Thet Khin)</u>

H.E. Prof Pe Thet Khin expressed his appreciation for all the efforts and kind suggestions of the M-CCM participatns. He confirmed that the M-CCM will deliver value for money as requested by 3DF and GF with help of friends and partners. He also urged the M-CCM members not to be discouraged by ineligibility of R11 as there is a lot of needs for support and partners and supporting the application efforts. He mentioned that while the health budget in terms of proportion of GDP may not be increasing but overall GDP is increasing. This means that the actual amount received for health sector is increasing compared to last year. He commented on the positive signs from leaders that more contributions will be provided for health such as alternative health financing to respond to the poor and needy. He also said the need to reallocate more budget on rural people as 70 percent of the people are living in rural areas. The Minister again expressed his appreciation for everyone's attention and time and his belief that with help and support of all partners, the M-CCM can achieve the MDGs and health of Myanmar people.

The meeting was adjourned at 13:50.