Country Coordinating Mechanism for AIDS, Tuberculosis and Malaria

Meeting Minutes

7th Myanmar Country Coordinating Mechanism (M-CCM) Meeting

10:30 – 12:40, 26 March 2010 – Ministry of Health, Nay Pyi Taw, Myanmar

Opening remarks: Chairperson, M-CCM – HE Professor Dr Kyaw Myint, Minister of Health

His Excellency Professor Dr Kyaw Myint, Chairperson and Minister for Health, welcomed the M-CCM members and everyone for coming. He mentioned that this meeting is an important milestone in the response to the TRP and IBR. The M-CCM and its members need to ensure that the response is satisfactory to the TRP. He also called for a good coordination between the GF and the 3DF.

1. Approval of the Minutes of minutes of the last M-CCM meeting (1 December 2009)

Dr Saw Lwin, Deputy Director General Department of Health, presented an overview of meeting minutes from the 6th M-CCM meeting held 1 December 2009. As suggested by the last CCM meeting, GAVI (Dr Nilar Tin, Director of Planning from Department of Health) and 3DF (Mr Mikko Lainejoki) are invited to today's meeting. There were no comments received and the Chair requested the minutes to be endorsed.

2. Updates on the new developments after last M-CCM Meeting

Dr. Saw Lwin presented an update since last meeting:

- ***Swiss Centre for International Health (SCIH)*** was selected as LFA; it still needs to set up office;
- GF Secretariat visited and met with stakeholders;
- ***Independent Budget Review (IBR)*** was received and work has been undertaken to respond;
- SR assessment carried out.

The next steps to be undertaken were presented:

- HIV TRP comments to be sent by 29 March; deadline for completion of the TRP clarification process is 20 April 2010;
- TB and Malaria have more time and comments will be sent by 2nd week of April; deadline for initial response is 20 April (Malaria) and 22 April (TB);
- Review additional saving;
- PR and SR assessment by LFA;
- **Monitoring & Evaluation Systems Strengthening (MESS)** workshop – Malaria 29-30 April / HIV 3-5 May / TB 6-7 May.
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3. Presentation and approval of response to TRP comments

a) HIV component

Dr. Khin Ohnmar San presented the TRP recommendations of the HIV component. The TRP required responses to 2 minor weaknesses.

- ***Minor Weakness 1*** – A list of common townships for GAVI and the GF was developed; the differences in target areas (remote areas for GAVI and more urban settings for HIV) was highlighted; the inclusion of HIV in township health plans will be encouraged;
- ***Minor Weakness 2*** – It is explained that vehicles are not purchased upon specific request by the M-CCM since the M-CCM feared that the additional safeguards would render the procurement of vehicles impossible; vehicles will be rented from private companies and individuals; furthermore the present cumbersome import system could cause delays to the implementation of activities; the M-CCM will assess the situation prior to requesting Phase 2.

The IBR requested clarifications on a number of budget items. The PR was requested to submit a revised budget showing how overlaps between the 3 disease component will be avoided. The SRs and PRs met for a full day to address the detailed comments.

Consolidated staffing structures of each PR were developed so that there will be no overlapping of staff cost from PRs.

In line with the IBR request, the SRs submitted a training schedule to the PR in order for the PR to develop a single combined training schedule.

At this point, no major savings have been identified from SRs for HIV component. The saving from 2 PRs are approximately $4.66 million. This corresponds to 3% of the grant amount for HIV.

b) TB component

Dr. Thandar Lwin, Director of National TB Programme, presented the response to the TRP of the TB component.
The TB component had to respond to 1 major weakness and 6 minor weaknesses.

- ***Major Weakness 1*** – The TRP noted that the MDR scale-up does not continue in the years 3-5:
  The TP component responds that the procurement of 1st line drugs is the priority; the MDR enrollment is in line with the targets of the National Strategic Plan; the present human and infrastructure capacity is limited and fully utilized with the present planned MDR provision.
- ***Minor Weakness 1*** - The capacity development plan for staffing the new laboratories in not well described:
  A plan has been developed.
- ***Minor Weakness 2*** - Not clear the strategy for detecting tuberculosis in HIV infected patients.
  The strategy has been clarified.
- ***Minor Weakness 3*** - Expansion of the incentive and enablers program is proposed as being dependent upon a successful evaluation of the pilot, but no evaluation is budgeted:
  Budget for the evaluation will be taken from other funding sources.
- ***Minor Weakness 4*** – It is no clear whether there is a formal MDR surveillance system in place:

Drug resistance surveys are planned every 3 years and the next one will take place in 2011. Formal MDR surveillance will be established in line with the NSP.

- ***Minor Weakness 5*** - The smooth transition of drug procurement from GDF to UNOPS is not well described. It is not clear whether UNOPS has an internal drug procurement capacity:
  UNOPS has experience in large scale procurement. There is no plan to integrate TB drug procurement with the other programme procurements.
- ***Minor Weakness 6*** - The target for HIV testing in tuberculosis patients is inconsistent in the text and in the performance monitoring plan (80% target of the total population versus 80% in 26 townships):
  The target for HIV testing is 75,630 TB patients for 5 years in page 30 which represent 80% of TB patients being tested in the 26 townships over the same period of time by NTP.
  In Annex A the target for HIV testing is 88,470 TB patients, which include other partners' projects.

The IBR requested clarifications on PR and other budget issues:
The PR revised a budget that takes into account that all three components have been approved. A 33.2% (or 4.68 million $) and 31.9% (or 1.19 million $) saved respectively from UNOPS and STC PR budgets.

- The PR developed a staffing plan that shows the 3 components have no overlaps.
- The NTP and partners have corrected calculation errors in the budget. Detailed calculations are provided for the items that the IBR singled out. The costs for common items were agreed on and changed in the SR budget.

The TB proposal had a total saving of $6.8 million which corresponds to 8.05%.

c) Malaria component

Dr. Ni Ni Aye, National Programme Manager VBDC, presented the response of the Malaria component. The TRP identified 4 major weaknesses and 1 minor weakness.

- ***Major weakness 1:*** The portion of the budget that is allocated for program management cost is deemed excessive:
  Response: The PR/ SR management costs reviewed. A reduction of 9.27% is made, which translates to saving of 3.06 US$ million.

- ***Major weakness 2:*** Although the problems facing the health service are clearly described, the actual structure of the health service is not clearly defined:
  The MOH is the main organization responsible for raising the health status of the people in Myanmar and accomplishes this through provision of promotive, preventive, curative and rehabilitative measures.
  The health system is based on the principles of primary health care up to the community level.
  A pluralistic mix of public and private system both in financing and commodity and service provision is encouraged.

- ***Major weakness 3:*** Cross border collaboration on artemisinin resistance:
  Initiative of Mekong Malaria Program in Greater Mekong Sub-region including Myanmar. Establishment of network on monitoring therapeutic efficacy of anti-malaria drugs (in Sep 2007). The MOH hosted the meeting in Myanmar to review and plan on therapeutic efficacy studies to monitor the resistance to

anti-malaria drugs (Sep 2009). Border health collaboration between Myanmar and Thailand on malaria (monitoring drug resistance, quality of drugs and information sharing

Participation in cross-border meetings/ workshops in other neighbour countries

- ***Major weakness 4:*** Indicators on quality of services are needed:
  The following indicators defined (approved by TSG):
  (1) % of health care providers who provide anti-malaria treatment in accordance with the national malaria treatment guideline.
  (2) Sensitivity, specificity and accuracy of malaria microscopy diagnosis by laboratory technicians/ malaria microscopists

- ***Minor weakness 1:*** Although the work of the NGOs in terms of geographical location and in terms of service delivery areas and/or activities is described in the text, the proposal would benefit from a table or map illustrating this:
  The SDA wise and SR wise geographic coverage defined.

The PR provided the same clarifications as under the other components.

The total savings amount to $2.97 million savings.

4. <u>Updates from PRs on the response to IBR comments and grant negotiation timelines</u>

Sanjay Mathur, UNOPS, assured that the budgets presented by the PR have no duplication. He also informed that the LFA assessments will be starting soon.
Robert Bennoun, UNOPS consultant, reported that the PR self-assessment is nearly finished and the assessments of the SRs are well underway. Other grant documents are scheduled to be finished for early April.
UNOPS has achieved about 22% total savings in their budget. This corresponds to about 9.5 million.

Grant	Original submission in USD	Revised budget in USD	Variance in USD	Variance in %
HIV	**15,963,711**	**12,752,726**	**3,210,985**	**20%**
Malaria	**13,006,885**	**11,406,654**	**1,600,231**	**12 %**
TB	**14,100,405**	**9,418,242**	**4,682,163**	**33 %**
Total	**43,071,001**	**33,577,622**	**9,493,379**	**22 %**

At the moment the PR operates with temporary staff and a number of these consultants require visas.
The long term staffs have either been appointed or deadlines for recruitment have been set.
There are some continuing challenges with regard to the timeliness of the responses from the GF Secretariat. The timelines are tight. The support of the UN to the National Programmes has not yet been entirely clarified. One of the biggest concern

is the standard of the storage facilities for HIV and Malaria. There is no budget allocation for those, but they will not pass assessment as they are. An additional concern is that the distribution system is based on the public transport system. The 10% efficiency gains are not yet achieved and the LFA will likey be instructed to identify more savings.

Naida Pasion, Save the Children US, presented an update of their work. STC finalises the self-assessment and SR assessment by the end of March. SR documents are being prepared for submission to the GF Secretariat. Grant documents are to be finished by 9 April.

SCI achieved a 20% reduction of the budgets.

Grant	Description	Original submission in USD	Revised budget in USD	Variance in USD	Variance in %
HIV/AIDS	**PR Budget**	**9 094 145**	**7 643 944**	**1 450 201**	**16 %**
Malaria	**PR Budget**	**4 379 832**	**3 549 594**	**830 238**	**19 %**
TB	**PR Budget**	**3 737 913**	**2 543 051**	**1 194 862**	**32 %**
Total	**PR Budget**	**17 211 889**	**13 736 589**	**3 475 300**	**20 %**

Save the Children functions with consultants at this moment. Two full time employees are being recruited. STC also faces tight timelines to collect and combine all the necessary documents.

Discussion:

Dr. Saw Lwin, MoH, summarised some of the points and suggest the way forward for the submission to the GF. He pointed out that the budget savings have not reached 10%. The SRs mention that the services provided are tightly costed even from proposal development time and that a reduction in budget would not allow them to provide these services at the level indicated. An additional area of concern is that even identified savings have been crossed out by increases in other areas, notably unexpected increases in drug costs(i.e. 2nd line TB drugs).
He pointed out some easy savings. For example some malaria programmes want to provide training abroad. This does not seem necessary. All training should be in-country. He also mentioned to reduce the days of training workshop to be more cost effective.
He suggest the following proceedings: **To form an ad-hoc group of M-CCM members.**
The group will be responsible for the review of the IBR response and to identify cost savings.

Paul Sender, Merlin, thought that a strong case could be made concerning the savings made since the start of the proposal development. He also thought that a further review of the budgets are a good idea.

Bishow Parajuli, UN Resident Coordinator, supported Dr Saw Lwin and called for a clear distribution of tasks among the members.

Anne Lancelot, MDM, thought that the Executive Working Group could be used for the review of budgets.

Dr. Sun Gang, UNAIDS, supported a further review of the SR budgets. In the case that overall 10% efficient saving cannot be achieved, he suggested that the M-CCM could write to the GF Sec to justify the case. He also raised the need for visas for the LFA to be issued as soon as possible. He thanked the MOH and notably HE the Minister for the assistance provided during the last few months, but nevertheless there is a great need to set up LFA quickly to ensure a smooth and timely assessments made by LFA.

Dr. Ko Ko Naing gave an update on the visa requests. He explained that the MOH receives a large number of visa requests and they are presented to FAPC on a weekly basis. Due to the number of visa request, priorities have to be made which ones are presented first.

In response to concerns about the supply management of HIV and malaria commodities, Professor Kyaw Wyint clarified that the MOH will make a building available at Gyoe Kone in Insein township which will have sufficient space for centre storage.

Dr. Leonard Ortega, WHO, reported that he had a conversation with the Portfolio Manager of the GF who had confirmed that a strong justification is needed if 10% are not reached. He also informed that WHO plans to host the Monitoring and Evaluation Systems Strengthening (MESS) Workshop on malaria and TB in Yangon.

Andrew Kirkwood, Save the Children International, supported Dr. Saw Lwin's call for review, but thought that timelines are very tight. He suggested the ad hoc team could be built based on the Executive Working Group of the CCM.

Paul Sender, Merlin, mentioned that the MDR scale-up response to TRP comments should also include that in-country capacity is not sufficient.

5. Proposed starting date of Myanmar GF grants

Dr. Win Maung, Director Disease Control, summarised the discussion on the starting dates of the grant implementation. He showed a number of advantages and disadvantages for the two options under discussion.

	Pros	Cons

1st Oct 2010	• Procurement can start earlier. • People might get services earlier	• 1st quarter monitoring unlikely see designed targets reached. • Reporting cycle not harmonized with national planning and reporting • Most ppartners have not planned to conduct additional work in last quarter of 2010
1st Jan 2011	• .Harmonized with national planning and reporting cycle. • Sufficient preparation for a full scale implementation. • More time for grant negotiation.	• Procured modilities are likely to reach the field late (? co-financed by 3DF for start up) • PRs need to budget additional resource to maintain the good team

He proposed a start on 1 Jan 2011.

Naida Paison, Save the Children US, noted that a 1 Jan 2011 will imply more pre-funding for the PRs. Sanjay Mathur confirmed that the same would be the case for UNOPS.

Other M-CCM member supports the 1 Jan 2011 for management reason, alignment of funding and reporting cycles.

H.E. Professor Kyaw Myint emphasized that sufficient time need to be given for Government of Myanmar review of the key grant documents. Bishow Parajuli raised a point that there is a historic event being held in Myanmar, general election, this needs to be factored in the planning - therefore sooner we get the global funds signed the better.

Therefore M-CCM supported a start date of 1 January 2011.

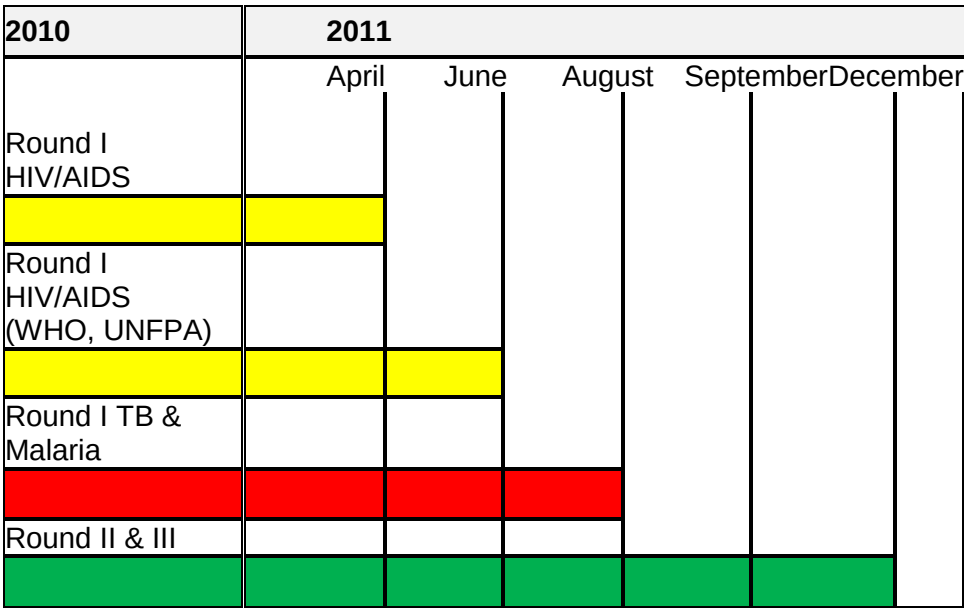
6. Coordination between Global Fund grants and Three Diseases Fund

Shaanti Sekhon, AusAID, spoke on behalf of the 3DF Board. She welcome Global Fund decision to untied the targets for 2011. This will allow implementing partners to ensure a smooth transition of programmes. She encourage all implementing partners to use the opportunity of this flexibility to see if more services can be delivered and encouraged all SRs to plan for the hand over in meeting with 3DF FM and PRs together. The 3DF Board has signaled its full support to close coordination on M&E systems and the MESST workshop on M&E and is currently considering its policy on the disposal of assets (equipment & drug stocks) at the end of projects, and hopes to agree a position shortly to assist partners in their planning and budgeting. .

Mr. Mikko Lainejoki, CEO 3DF, talked about the procurement of commodities and the pipeline as it is known. In his view, the procurement of TB drugs is not very urgent as the supply is ensured well into 2011. However, ARV and other drugs are a different

matter and careful planning will be required to ensure continuity of supplies. It needs to be kept in mind that procurement lead time is 6-9 months.

He showed the closing of 3DF supported projects which will be used to plan for the phase in of GF. The 3DF contracts stop in 4 batches. The agreement with the GF that targets and achievements for the 3DF and GF can be reported together should assist in planning and reporting for this transition period. IPs are encouraged to discuss the transitions with 3DF along with relevant PR.



Bishow Parajuli congratulated the minister for his effort to increase government contributions to the health sector. He also appealed MOH to continue increased funding from the government. He called for a continuation of the 3DF to support the health sector and the 3 diseases to meet the MDG targets in Myanmar. Dr. Sun Gang supported this call and expressed the hope that the 3DF will provide continuing support in the areas of three diseases, while other areas with burning public health concerns deserves more additional support. There is a particular need to ensure that no patients are left without support of life saving treatment.

Professor Dr Kyaw Myint added that during a recent meeting with the Chair of the Fund Board he raised this issues and expressed his wish that 3DF continues and complements the GF.

HE Professor Dr Mya Oo, Deputy Minister, stated that in order to reach the MDG there is a need for additional funding. The 3DF should continue its support to ensure that this remains on track. The 3DF can compliment the GF. The overall ODA continues to be very low.

7. AOB

- **UNGASS**

The UNGASS Report is now finalized and ready to be submitted. Dr. Sun Gang thanked all stakeholders who have contributed to the successful development of the report. He reported that there were stakeholder meetings with civil society stakeholders which led notably to the establishment of the NCPI Part B as well as

an extended TSG which presented the draft data and report for discussion. The narrative report will be shared with CCM members after its submission.

- **CCM Regional Workshop**

The GF invites for a regional workshop on CCM governance in Bangkok from 11 to 13 May 2010. CCM took a note that the constituency listed in the GF letter does not correlate constituencies in Myanmar CCM well. The M-CCM decided after discussion to send the following representatives:

1. MOH/ Secretariat (Dr. Saw Lwin)
2. Private sector/MBCA
3. Local NGO/MMA
4. CBO/FBO/Pyi Gyi Kin
5. UN and donor/UNAIDS
6. Person living with HIV

Shaanti Sekhon added that if donor community can send in participant, DFID can represent. She also raised a point on the CCM Secretariat Support Fund, for which it is agreed that the M-CCM will need to apply.

- **Aretesimin and Round 10**

Dr. Ortega mentioned that artiseminin drug resistance is a growing concern in the greater Mekong sub-region, including Myanmar. However, there is no funding in the present programmes. It should be considered to apply for GF Round 10 for this, or should be considered as one of the priorities for 3DF support. Dr. Sid Naing, MSI, supported this since there never was discussion of the 3DF closing down.

Dr. Saw Lwin pointed out that the August submission deadline for Round 10 would make this a great challenge. Dr. Sid Naing thought that this could certainly be addressed with additional support by the UN and others. Dr Ortega expressed the possibility that support from WHO SEARO office can be available for the proposal development.

Closing remarks

H.E. Professor Dr Kyaw Myint again thanked all the members. He ensured the members that the MOH will undertake all possible to assist with the progress of the grant negotiations. He also thanked the members who brought up the issue of Round 10 and assured that consideration will be given whether to apply.