Executive Working Group Meeting
9:00 to 12:00 – 24th of September 2018
TB Office, Latha, Yangon, Ministry of Health and Sports
Meeting Minutes

1) Endorsement of the meeting agenda

As 9 out of 12 members were present, the Chair noted that the MHSCC ExWG was at quorum. With regard to potential conflict of interests (COIs) related to the meeting agenda items, it was noted that Dr. Thandar Lwin, Deputy Director General of Disease Control, Dr. Stephen Jost from WHO, Daw Nwe Zin Win of Pyi Gyi Khin, and Dr. Sid Naing from MSI represent organisations that are Sub-recipients of Global Fund grants. The meeting agenda was adopted.

The chair delivered the opening remarks and provided some information and updates on the NCD TSG, about access to Health Fund and the upcoming meeting of the South-East Asia Constituency Meeting to be held in Yangon 30 and 31 October.

2) Oversight Report Follow-up

Mr. Oussama Tawil, UNAIDS Country Director, presented on the follow-up to the ExWG Oversight Visit. As part of the M-HSCC's oversight mandate, a visit was organized on 17-22 July 2018 by the MHSCC Secretariat to assess status of health services and programme implementation in the States of Mon and Kayin. Over the span of six days, the M-HSCC ExWG visited different health services in Paung, Mawlamyine, Thanbyuzayat and Kyaikmayaw in Mon State, and Hpa-an, Kawkareik and Myawaddy in Kayin State.

ExWG representatives from the Ministry of Health and Sports (MoHS), donors, United Nations, Non-Governmental Organizations (NGOs) and Community-Based Organizations (CBOs) were divided into two field teams to assess selected health services, identify health system issues as well as their specific contributions to specific programmes including on HIV/AIDS, Tuberculosis and Malaria (ATM), Maternal and Child Health (MCH). Observations were also made on other health issues when sufficient information was provided, such as on Sexual and Reproductive Health (SRH), Health Promotion, Human Resources in health.

The general finds were:

- Most public-sector facilities were well kept and operational. However, there are still Human Resources issues such as filling in of sanctioned posts, benefits for staff such as proper housing.
- Non-Governmental Organizations (NGO) activities are well managed and results-oriented. Timely referral to public sector is noted in many cases. However, supervision, coordination and information-sharing still needs to be strengthened.
- EHOs and specific NGOs provide much needed health care to hard-to-reach populations, though closer and more regular collaboration with public sector is desirable.
- In some areas, a rise in Low Birth Weight and U5 malnutrition rates are of concern.

- National policy and guidelines on community health volunteers essential in provision of health care and referral.
- Adherence and implementation of national guidelines in various program areas and reporting system to be adhered to.
- Financial management in public health sector facilities to be strengthened, as well as ensuring medical store management capacities.

The many detailed recommendations can be found in the full presentation here:

https://drive.google.com/file/d/1dVmZKky4nF8GPZmaZg01f6n2_iLNvaxk/view?usp=sharing

Discussion Points

- Mr Oussama Tawil suggested that each MoHS unit at central level and at state level units should consider the recommendations when reviewing their annual workplans and during mid-term reviews. Hence MoHS should ensure recommendations are widely circulated and followed up on at relevant units at central level and at state level.
- **Dr Thandar Lwin encouraged the donors to pass** the recommendations to the attention of the INGOs implementing programmes as MoHS are not always in a position to do so. She pointed to up-coming Access to Health Fund and encourage that the soon to be design implementation plans take the ExWG recommendations into consideration.
- Ms Karen Cavanaugh suggested that to help with coordination of monitoring, implementation and follow-up to recommendations, the future oversight visits should include participants from donors that are responsible for larger programmes such as the World Bank, 3MDG and Access to Health Fund. This suggestion was endorsed by the Chair and Dr Stephan Jost.
- The ExWG encouraged stronger engagement of the 3MDG/Access to Health and GAVI in the MHSCC and the ExWG and not just in the oversight visits. The shape and form of such stronger engagement would need further discussion on all sides and would need to be agreed at MHSCC level.
- Dr Stephan Jost also emphasized the importance of getting the recommendations implemented at the level of state and region and gave the new state level operational plans on HIV as well as state level activities on NCDs as examples. He also asked that the HSS TSG take the system level recommendations into considerations. This recommendation was agreed by the Chair.

3) LFA presentation on ART Transfer and MMT

Mr Patrick Bergman, team leader of the GFATLM LFA started his presentation by explaining a bit about the work of the LFA including the four annual spot-checks of service delivery they do of the GFATM funded programmes. He moved on to explain about the recent two spot-check done on ART transition and Methadone Maintenance Therapy (MMT).

The objectives of the ART transition spot-check were to review the following:

- The ART transition process of 2017 and identify enabling factors, issues, bottlenecks, and challenges.
- The user perspectives on ART transition.

- The effect of ART transition on treatment compliance.
- The ART stock transfer process: adequate quantity, appropriate documentation for the patient and stock, timeliness of stock transfer
- Stock ordering and monitoring processes at NAP sites that have received transferred patients.
- Inventory records and storage of transferred stock at NAP central warehouse.
- Storage capacity, storage conditions and stock levels at 1 or 2 state warehouses
- Capacity of the sites (infrastructure and human resources) to receive additional patients in future.

The objectives of the MMT spot-check were to:

- Assess the Methadone Maintenance Therapy (MMT) program implementation, including compliance with the recommended global guidelines as well as the national guidelines;
- Assess service quality, including: capacity for further expansion; reasons for low maintenance of clients and drop out; client satisfaction; etc.
- Assess the quality of data and planned transition from paper-based to electronic data system within OST program;
- Assess the extent to which one-stop-shop model of Methadone clinic provide services to PWID and user perspective on the model
- Assess the service provision and reporting system of satellite model MMT sites,
- Assess the key service linkages from outreach services provided by NGOs, as well as referrals to services such as HIV testing, ART, diagnosis and treatment of tuberculosis, diagnosis and vaccination for viral hepatitis and other prevention services

A number of issues were identified and **recommendations** were made including:

- ART transition process is not systematic and there is **limited assessment of ART centers** and ART DC sites on their readiness for ART Transition. It is recommended that NAP and partners jointly conduct assessment of health facilities that are receiving significant number of transferred in cases as well as additional number of new ART patients as per the projected ARV targets. The assessment should cover infrastructure, human resources, effect on the supply chain and availability of access to laboratory capacity. The output of the assessment are: 1) costed work plan for: renovating and where possible expanding the infrastructure, 2) sustainable human resources support plan, and 3) plan for systematic linkages with laboratories.
- **Eligibility criteria for the ART** client to go through ART transition varied for different organization. It was hence recommended to streamline the eligibility criteria amongst the ART providers to ensure Government health facilities in the receiving end have clear idea on what to expect when a new transferred-in ART case arrives to their facility. The following aspects should be considered in the updated eligibility criteria: - controlled NCD, VL result, and absence of adherence problem.
- **Limited infrastructure and renovation budget.** Four out of ten Government ART facilities visited have very limited physical space compared to the case-load. In addition, all ART Centers and ART DC sites have an annual maintenance budget of MMK 500,000 per health facility only. Hence, renovation of ART facilities to accommodate increasing number of cases and stock levels is challenging unless other implementing partners (such

as MSF-H and MSF-CH) provide assistance. Hence, based on the ART facility assessment results, NAP should ensure that renovation of ART facilities is prioritized to those ART centers and ART DC sites receiving majority of transferred in ART cases and those with the potential of receiving and managing increased numbers of patients.

- **Minimum staffing level in relation to the client load is not available.** Current National Methadone Guidelines does not provide minimum staffing level required to operate a MMT site. Also there appeared to be limited involvement of psychiatrist, general physician and government medical staff in the MMT sites in general hospitals / district – township hospitals respectively. MOHS- NDAPCP should ensure that in the new revision of National Methadone Guidelines, minimum staffing level for a MMT site and MMT Satellite site should be clearly defined. Client load should also be taken into consideration in mobilizing human resources
- **Not all ten core services are available on-site in one-stop-shop site**. Diagnosis and treatment for tuberculosis are not available in some of the one-stop-shop MMT sites. This was due to the fact that some hospitals were highly specialized (i.e. mental health hospital and drug treatment hospital) and they did not have tuberculosis services. MOHS-NDAPCP to ensure that One-stop-shop sites provide all ten core services in one place. Township, district, or general hospitals are the candidates for one-stop-shop model.
- **Minimum package of services to be provided in Satellite sites is not well defined**. In the MMT sites, it is generally agreed that integrated comprehensive services are to be provided on-site or through referrals. However, in the MMT Satellite sites, there is no standard list of services to be available on-site and/or through referral. Current availability of on-site services varies from one satellite to the next. For instance, some sites do not provide testing for HIV, HBV, and HCV. MOHS- NDAPCP to ensure that the minimum package of services to be provided in a MMT Satellite site is well defined. Then, ensure MMT Satellite site staff are trained and equipped to provide these services.
- **Poor storage conditions and practices**. Temperature and humidity regulation, monitoring and recording was not being conducted in majority of the sites. At Inndaw DTC, site staff reported that the storeroom gets flooded during the monsoon season; the ceiling also had a hole; stock was placed directly on the floor at three different sites. DDTRU to advocate for minimal upgrade of the storage facilities e.g. provision of thermohydrometers, repairs of faulty air conditioners, repair of ceiling at the Inndaw DTC etc. MMT sites to ensure that stock is stored according to good storage practices.

For more information kindly see the full presentations here:

https://drive.google.com/file/d/1F8hAyuTKZJ90QbTcDs8mcCBfrPOve21N/view?usp=sharing

and

https://drive.google.com/file/d/16G2OXLS-KwUnB5SRjzY50p_bEoUFyWdW/view?usp=sharing

Mr Patrick Bergman mentioned that the LFA is happy to present the results of future spot-checks at the MHSCC or ExWG and/or invite representatives of the MHSCC to the debriefings the LFA does with the PRs and SRs after the spot-checks.

Discussion Points

- Mr. Oussama Tawil mentioned that several issues identified by the LFA were very similar to the findings from the oversight visit including on storage, stock management, procurement and M&E. Hence the solutions and their implementation should not be focused only on the HIV sector, but be spread out much broader to the general health system.

4) Updates on Multi-country Funding Request on TB among Migrants in the Greater Mekong Sub-region

Dr Sithu Aung, Director of Disease Control, presented an update on the Multi-country Funding Request on TB among Migrants in the Greater Mekong Sub-region. The goal of this 3-year grant is to reduce the burden of TB among the migrant populations of the Greater Mekong Sub-region – particularly aiming at the missing cases and thereby reduce TB transmission, incidence and mortality in each of the participating countries.

Myanmar was allocated around **USD 1,318,000** (SMRU: **USD 800,000**; NTP and IPs USD **300,000** and HR support to NTP through WHO: **USD 217,737**). 1,6M was earmarked for Myanmar in above allocation (50% of requested amount). 1.3M was allocated for regional activities including the Regional Coordination Mechanism.

Apart from regional activities and bilateral activities (twin city meetings by NTP/IPs and Bilateral project by SMRU) the project activities in Myanmar will be:

- Central level activities (NTP, WHO): Coordination and Advocacy, IEC material development with IPs.
- Ground level activities (NTP and IPs): ACD and CBTBC in priority sites: Muse at China border and Tachilek, Myawaddy, Dawei, Kawthaung at Thai border; Pre-departure screening and IEC (NTP): Yangon; IEC for Prevention and Referral: other sites.

The TB TSG has recommended the following to be SRs: NTP, WHO (HR support to NTP), SMRU, World Vision and American Refugee Committee (ARC). Dr Sithu Aung outlined the main activities of each recommended implementing partner.

For more information kindly see the full presentation here:

https://drive.google.com/file/d/1lQXrYjbcWIXE_LWMCF1362Tr5PYhi2-n/view?usp=sharing

Discussion Points:

- Dr Thandar Lwin emphasized that the proposal has a regional component with five packages. Based on the experience from the RAI regional component, she mentioned the importance of avoiding splitting the approval of the 5 packages up. The regional packages should all be handled and approved at the same time.
- The ExWG noted that the GFATM had allocated a larger amount of funds to SMRU than was asked for in the concept note and that their targets remained the same while already being comparatively low. The ExWG also noted that the GFATM managed process for this regional grant was highly inefficient and not a good use of partners time

given the level of funding and the cumbersome process. It was finally noted that certain SRs were pre-selected by the GFATM overriding the autonomy of the country CCM – i.e. the MHSCC and the ExWG.

- The ExWG endorsed on behalf of the MHSCC the TB TSG suggested SRs for this proposal as well as the split of funding and targets.

5) GFATM grant implementation for 2018 (2 PRs presentation)

Mr. Albert Concepcion of UNOPS PR presented on behalf of UNOPS PR. The financial performance for 2013-2017 period is good with 87% budget absorption rate overall (HIV 87%, TB 83%, Malaria 88%, RAI-Myanmar 96% and ICC-Myanmar 95%). The summary grant rating between 2011-2017 is also good. The 2017 performance for HIV, TB and Malaria is averaging at A2 level. However, the final rating for 2017 was B1 due to low performance in Isoniazid Prevention Therapy (IPT) that is at less than 60%, which affects both HIV and TB grant performance. The Malaria grant performance is downgraded to B1 due to stock-out indicators (health facilities with no stock-out in key commodities was at 56%).

The total GF grant managed by UNOPS PR for 2018-2020 for ATM is around **USD 252 million,** not including the regional grant for malaria of **USD 9 million**. Total grant absorption for January to June 2018 is 46% (HIV 38%, TB 40 % and Malaria 62%).

The highlights under HIV programmatic performance (Jan-June 2018) are that most of the target indicators are on track to be achieved except in areas such as Isoniazid Prevention Therapy (25.4%) and TB-HIV ART (58%). Also the FSW reached is just below 80% of the target due to the mobile nature of FSW and the for strengthening the peer network formation. The IPT performance will hopefully increase as WHO and NAP are conducting training to Medical Officers. The number of PLHIV on ART is being scaled up dramatically, but NAP needs to address supply chain concerns on additional storage space. ART transition is ongoing as planned and LFA programmatic spot check was recently conducted. National forecasting and quantification of drugs and commodities for 2019 was done and government will provide co-financing of 14M USD. Support to NAP with the existing seconded HR support needs to continue until a long-term sustainable HR plan is adopted by the government. Savings under the HIV grant will be channeled to MANA and PGK to achieve the 10,500 missing PWID target.

For the TB programmatic performance (Jan-June 2018), the majority of key indicators are on track. However, under-5-years Isoniazid Prevention Therapy (IPT) was only offered to 197 children (<60%), which needs a specific strategy for improvement. Improvement in MDR TB notified cases (65%) was noted due to the expanded use of GeneXpert and more patients enrolled in treatment. It was noted that first-line anti-tuberculosis drugs for 2018 were procured with government resources. The nationwide TB prevalence survey is progressing well with 99 survey clusters (out of the 138) completed by the end of June 2018. Eligibility criteria for shorter treatment regimen (STR) for MDR-TB have been relaxed; therefore, increase in the number of MDR-TB patients put on STR is expected. National forecasting and quantification of drugs and commodities for 2019 was conducted with the involvement of all stakeholders. This includes USD 2M of co-financing from government. USD 1.6 million was shifted from NTP to 4 SRs for nutrition cash support for MDR-TB patients. The burn rate for TB for January till June 2018 was 40%.

For Malaria programmatic performance (Jan-June 2018), there are a few challenges. LLIN distribution is below 40% due to challenges such as mobile nature of the target population and geographical and seasonal constraints. Foci investigation and classification is a new indicator shows low performance (20%). On some other indicators the situation is better such as treatment in the community and in the private sector at 97 and 96% of the target respectively. The current National Strategic Plan and ongoing elimination activities were reevaluated and plans to shift from a phased approach to the continuum approach (for malaria elimination) were discussed in the TSG in July 2018. Recently, an outbreak investigation was conducted in Tanintharyi Region where increased P. vivax caseloads were observed in Thayetchaung and Palauk. NMCP, WHO and UNOPS PR were involved in the mission. It was also noted that SMRU requires more anti-malaria commodities due to relatively high malaria cases in the project areas in Kayin State and discussions are ongoing between the local VBDC team and SMRU for this situation. The burn rate for the Malaria grant in Myanmar for January till June 2018 was 38%.

UNOPS also presented a summary of the procurement of the HIV, TB and Malaria health products, reinvestment plans for the 2018 savings and progress of the regional TB grant.

Draft projected savings including procurement and non-procurement saving is **USD 2.6 M** for HIV, **2.6 M** for TB and **USD 600,000** for Malaria. The final endorsed SR reinvestment plans will be discussed at TSG level and be submitted to GF for approval in early November 2018 and implementation of approved activities will be done in November-December 2018.

For the full presentation, please see the following link:

https://drive.google.com/file/d/1mrRxhSuzGyu18IMpR-LYaLmf2fEJDCnH/view?usp=sharing

Discussion points:

- The Chair of the ExWG commented that the endorsement of MHSCC is needed for activities like shifting of saving under the HIV grant (**USD 1.4 million**) to MANA and PGK and under the TB grant **(USD 1.6 million**) from NTP to 4 SRs for nutrition cash support for MDR-TB patients. Therefore, in future, similar issues cannot be done by National Programs and PRs alone, which needs endorsement from MHSCC or must be at least endorsed by the Executive Working Group.
- Mr. Albert explained that shifting of saving under the HIV grant (**USD 1.4 million**; calculated unit costs based on 10,500 PWIDs) to MANA and PGK is still under discussion. Shifting of **USD 1.6 million** of the TB grant from NTP to 4 SRs for nutrition cash support for MDR-TB patients was already recommended by the TB TSG. The HIV grant saving is included in the new reimbursement plan. For TB, it was already shifted and not included in the additional and newly identified saving.
- The Chair also guided that the mandatory report of TB cases from private sector to NTP will be started soon following the guidance of MoHS. An additional 10,000 more cases must be found. Additionally, as there is more focus on migrant health, there were recent discussion on Myanmar-Thai border collaboration and the development of an MoU and thus, there is a need to develop bilingual IEC materials. Therefore, savings should be used for those activities as we do not have other funding.

- Mrs. Karen Cavanaugh asked how the 2 SRs (MANA and PGK) were selected for added PWID activities and if there is any assumption why they are the most competent to do the planned activities.
- Mr. Albert replied that MANA and PGK are current SRs that conduct harm reduction activities under the UNOPS managed grant. The process is still ongoing. Mr Albert also mentioned that there is no open proposal or tender for this selection process, but that since they are already SRs under UNOPS PR this is a much smoother process.
- The Chair commented that it should be an open process as there are other SRs who are also implementing harm reduction activities like AHRN under SC PR and which might want to compete for this activity.
- Dr. Myo Sett Aung suggested that as Access to Health Fund from 3MDG will start soon, the shift to target 10,500 PWIDs from MMT centers to partners, should be coordinated with regard to geographical coverage.
- Mr. Oussama from UNAIDS and the ExWG Chair agreed that it would be a good idea to conduct a meeting to discuss with Access to Health Fund coordination on PWID.

Dr. Myo Sett Aung from Save the Children International (SCI) presented the updates on the SCI program achievements. The burning rate for 2013-2017 is 92% for HIV, 80% for TB and 93% for Malaria. The overall grant rating for HIV is A1, for TB A2 and for Malaria A1 for 2017. The slightly lower TB grant performance of A2 is due to decline in case finding and case notification from the private sector.

Grant absorption for Jan-June 2018 is 77% for HIV, 91% for TB and 81% for Malaria and overall absorption rate is 81%. The somewhat lower HIV performance at 77% is due to a few SRs having been phased out from GF support. It was noted that in 2018, SCI is changing reimbursement system with quarterly cash projection from SRs.

The anticipated unspent amount for 2018 from the 3 programs (HIV, TB and Malaria) is around **USD 3.7 million** (the currency exchange gains is around **USD 1,260,000** which must be reported back to GF) while the expected reprogrammable amount is a bit less than **USD 2,470,000**. SRs were notified to propose reprograming activities in August. Prioritization of reprograming activities will be done by PR in Mid-October and will be proposed to TSGs for recommendations around late October. Finalized packages will be submitted to GFATM around end November for approval and the amendment and signing is expected to be conducted in the 3rd week of December 2018.

For the HIV performance (Jan-June 2018), PWID indicators showed good achievements and IPT indicators had improvements as a result of the Enhanced Outreach Strategy in delivering prevention services. ART transfer is ongoing as planned (approximately 3,000 patients) and increase in HIV testing EQAS sites supported by NHL (45 out of 55) were seen in 2018. Armed conflicts were still a challenge for harm reduction activities in Kachin State.

The TB performance is good although case contribution by private sectors is weak (76%) and thus, expansion of PPM services in Ayeyawaddy Region (High TB burden Region) and Kayin State was under discussion with PSI. ACF mobile activities in 3 States and Regions are conducted in hard to reach areas and the active finding of cases did not reflected expected targets as hard to reach areas do not translate into more cases. Therefore, TB case notification mapping is necessary for conducting ACF activities in potential areas.

The Malaria grant performance is good, but lesser finding of positive cases leads to less motivation of provider interest especially in the private sectors such as GPs. ICMV training and implementation have been rolled out and coordination meeting was done for support in Malaria elimination surveillance (case investigation).

On PSM updates, 2 incinerators (1 in Kachin and 1 in Yangon) were handed over to Ministry of Health and Sports.

For the full presentation, kindly see the following link:

https://drive.google.com/file/d/1d-pJXABKCR8WCbRIbKuKDwNjTcmnTn_I/view?usp=sharing

Discussion Points:

- The Chair commented that TB mapping exercise should be done in collaboration with NTP. As community volunteers are important for malaria elimination, 3MDG has been working on ICMV (also known as Village-based Community Volunteer) policy guideline for 8 months and the first draft will be issued next month. As Access to Health Fund will use a different kind of volunteers, MoHS need to have guidelines for policy guidance and control. The Chair also requested PRs to share PR's procurement plan with PSM focal points from the national programmes (Dr. Win Naing and Dr. Mar Lar Soe).
- Mr. Oussama suggested that coordination meeting with the government, private, NGOs and INGOs sector for PWID additional target (10,500) is essential as police crackdown, turnover rate of drug users and civil unrest affects the target setting of programs.
- The Chair concluded that as the reinvestment planning is underway lead by the two PRs, there will be no endorsement in this meeting for reprograming activities.

6) Discussion on Next MHSCC meeting agenda

The ExWG decided to plan for two MHSCC meetings with the following suggested agenda items:

Meeting 1

1. Update on Access to Health Fund
2. Injuries and Injury Surveillance
3. Implementation of health-related recommendations of the Rakhine Commission
4. Second tranche of World Bank funding
5. Report from the parliament incl. on health financing
6. Update on MOHS HR plan and MOHS structure

Meeting 2

1. NCDs and Health Literacy
2. Follow-up on JEE recommendations
3. AIMS
4. ICC and Health Cluster link to the MHSCC
5. Follow-up on ExWG oversight recommendations
6. New MHSCC meeting preparation guidelines and governance manual update
7. Updates from ExWG and TSGs

7) SEA Constituency meeting info sharing

Mr. Ole Hansen of WHO presented on the upcoming meeting of the South-East Asia (SEA) Constituency of the Global Fund Board. The SEA constituency has been organizing regular

regional meetings prior to the Global Fund Board Meetings where representatives of countries from the region can discuss issues relevant to regional cooperation and agree on points to be shared at the Board Meetings. The regional meeting also discusses issues relevant to regional cooperation and communication.

Traditionally, the SEA Constituency meeting is hosted rotationally by member countries, which are requested on a voluntary basis to host. At the last meeting, the Myanmar Ministry of Health and Sports agreed to host the next SEA meeting in Myanmar prior to the next Global Fund Board meeting in November 2018. The meeting is therefore planned to be held in the Summit Parkview Hotel with preparatory meetings planned for 28 October and subsequent meetings planned for 29-31 October. An estimated 40 representatives will participate from the 11 country CCMs as well as WHO, UNAIDS, PATH, and the Global Fund.

The main objectives of the constituency meeting are:

- To discuss issues relevant to the agenda of the 40th GF Board Meeting.
- To produce position paper from SEA constituency
- To share information and lesson learned among the member countries
- To follow up and finalize recommendation or decision points of the previous constituency
- meeting.
- For countries to get updates on Board Affairs
- For countries to get updates on the multi country funding request/Concept note and the establishing of a Multi Country CCM Secretariat in New Delhi
- For countries to get updates on the New CCM Policy of the Global Fund

The MHSCC Vice Chair and the Secretary of the MHSCC will attend the meeting.

8) Closing

The Chair made the closing remarks and closed the meeting at 12:30 p.m.