The Global Fund
To Fight AIDS, Tuberculosis and Malaria

# HIV & TB

# CONCEPT NOTE

## MYANMAR

## Investing for impact against tuberculosis and HIV

Countries with overlapping high burden of tuberculosis (TB) and HIV must submit a single concept note that presents each specific program in addition to any integrated and joint programming for the two diseases.

In requiring that the funding requests be presented together in a single concept note, the Global Fund aims at maximizing the impact of its investments to make an even greater contribution towards the vision of a world free of the burden of TB and HIV. Enhanced joint HIV and TB programming will allow to better target resources, to scale-up services and to increase their effectiveness and efficiency, quality and sustainability.

All concept notes should articulate an ambitious, strategically focused and technically sound investment, informed by the national health strategy and the national disease strategic plans (NSPs).

The concept note for TB and HIV is divided into the following sections:

**Section 1:** The description of the country's epidemiological and health systems context including barriers to access, the national response to date, country processes for reviewing and revising the response, and plans for further alignment of the NSPs, policies and interventions for both diseases.

**Section 2:** Information on the national funding landscape, additionality and sustainability

**Section 3:** The funding request to the Global Fund, including a programmatic gap analysis, rationale and description of the funding request, as presented in the modular template.

**Section 4:** Implementation arrangements and risk assessment.

***IMPORTANT NOTE:*** **Applicants should refer to the TB and HIV Concept Note Instructions to complete this template.**

| Applicant Information | | | |
|---|---|---|---|
| **Country** | **Myanmar** | | |
| **Funding Request Start Date** | **1 January 2017** | **Funding Request End Date** | **31 December 2020** |
| **Principle Recipient(s)** | **UNOPS; Save the Children** | | |
| ***If the programs are to be managed as separate grants:*** | | | |
| **Funding Request Start Date for HIV** | **1 January 2017** | **Funding Request End Date for HIV** | **31 December 2020** |
| **Principal Recipient(s) for HIV** | **UNOPS; Save the Children** | | |
| **Funding Request Start Date for TB** | **1 January 2017** | **Funding Request End Date for TB** | **31 December 2020** |
| **Principal Recipient(s) for TB** | **UNOPS; Save the Children** | | |

## FUNDING REQUEST SUMMARY TABLE

A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

## SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including descriptions of the TB and HIV disease epidemiology and their overlaps, the health systems and community systems setting, and the human rights situation.

### 1.1 Country Disease, Health Systems and Community Systems Context

With reference to the latest available epidemiological information for TB and HIV, and in addition to the portfolio analysis provided by the Global Fund, highlight:

a. The current and evolving epidemiology of the two diseases, including trends and any significant geographic variations in incidence or prevalence of TB and HIV. Include information on the prevalence of HIV among TB patients and TB incidence among people living with HIV/AIDS.

b. Key populations that may have disproportionately low access to prevention, treatment, care and support services, and the contributing factors to this inequity.

c. Key human rights barriers and gender inequalities that may impede access to health services.

d. The health systems and community systems context in the country, including any constraints relevant to effective implementation of the national TB and HIV programs including joint areas of both programs.

### 1.1 Country Disease, Health Systems and Community Systems Context

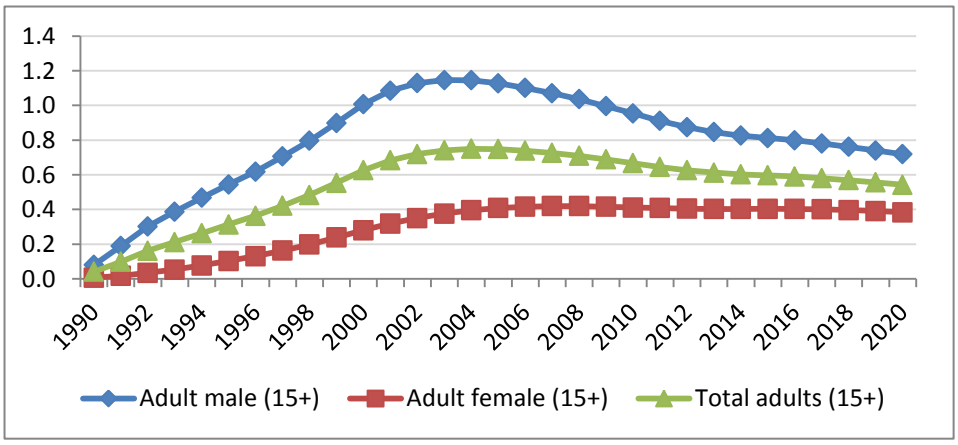
**a) Epidemiology of HIV and TB and their overlap**

According to the 2014 population census results, Myanmar's population is 51.4 million.

**HIV**

As a Fast Track Priority country, Myanmar is one of the 35 countries that account for 90% of new HIV infections globally (UNAIDS Fast Track Update on Investments, 2015). Myanmar has an estimated 224,794[1] people living with HIV in 2015. Figure 1.1.1 shows the HIV epidemic in Myanmar was at its height in 2005, when HIV prevalence reached 0.73% of the general population. In 2015, HIV prevalence declined to 0.60%. The HIV epidemic in Myanmar remains concentrated among key populations with HIV transmission primarily occurring among people who inject drugs; MSM and transgender people; and sex workers (and their clients). The table below presents latest population size estimates of key populations, based on results of the integrated bio-behavioural survey conducted using respondent driven sampling.

**Figure 1.1.1 HIV prevalence by gender (15 years and above)**[2]




[1] AEM Spectrum, April 2016
[2] Draft Myanmar HIV Estimates and Projections Report, 2015

**Table 1.1.1 Population Size Estimates of Key Populations**

| Key Population | Population size estimate | Prevalence |
|---|---|---|
| People who inject drugs | 83,000 (IBBS 2014) | 28.5% (IBBS 2014) |
| Female sex workers | 66,000 (draft IBBS 2015) | 14.6% (draft IBBS 2015) |
| Men who have sex with men | 253,000[3] (draft IBBS 2015) | 11.6% (draft IBBS 2015) |

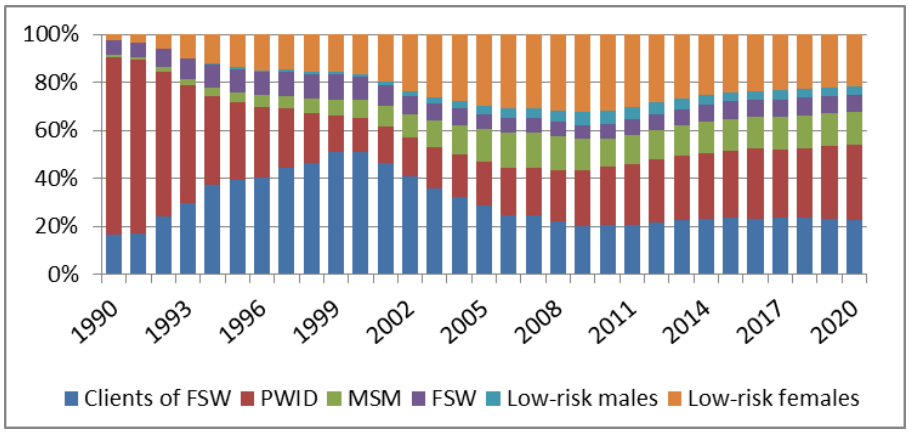
HIV prevalence rates among key populations are much higher than that of the general population. As such, the HIV epidemic disproportionately affects the key populations and their intimate partners. Most up-to-date surveillance data shows national HIV prevalence at **28.5%** (2014 PWID IBBS) among people who inject drugs; **14.6%** (2015 FSW IBBS draft) among female sex workers[4]; and **11.6%** (2015 MSM IBBS draft) among MSM. Prevalence varies geographically: for example in the north and north-eastern parts of Myanmar, just only a couple of hours plane ride from Yangon, in Muse (Northern Shan State), Waingmaw and Bamaw (Kachin State) nearly one in two people who inject drugs who participated in the IBBS survey in 2014 tested HIV-positive (5th highest HIV prevalence level in Asia/Pacific among PWID). Similarly, HIV prevalence among MSM was 27% in Yangon and 22% in Mandalay (second largest city after Yangon). HIV prevalence among MSM in Yangon is also the highest in a specific geographical site in the Asia region.[5]

In 2015, HIV infections among PWID represented 28% of new infections - followed by female partners of key populations (24%); clients of FSW (23%), MSM (13%), FSW (7%), and low risk male (4%). It is projected that given the current level of resources and response, by 2020, PWID will continue to represent the largest share of new infections (31%). Figure 1.1.2 shows the trend of new infection by population group over time. From the national trend data, it appears that HIV prevalence is stabilizing; there are still unknowns in different parts of the country where services do not reach (conflict and remote areas). For instance, data is needed to know more about risks and vulnerability of other priority populations such as people in prisons and other closed settings such as camps for internally displaced people and migrants. Estimates from the 2014 census indicate that over 11 million Myanmar residents have migrated internally and externally; but no comprehensive information is available on HIV prevalence or risk behaviours in migrants and mobile populations in Myanmar. Limited programme data does indicate that HIV is an issue among particular migrant groups. Save the Children reported under the category of "other vulnerable populations" 7% of the 47,885 migrants, and mobile populations such as fishermen, truck drivers clients/partners and undisclosed MSM/FSW who underwent HTC were found to be HIV positive in 2015. In 2014, the positive rate among this group was 11%[6]. Another priority population in the new NSP refers to people in closed settings. The total prison population is estimated at 60,000 in Myanmar. 48% of detainees are in prison for drug-related offences[7]. Prisons in Myanmar are often overpopulated[8], understaffed and under resourced, and lack adequate health facilities to address the basic health care and targeted HIV and TB care. There are no health promotion and HIV prevention interventions (in terms of information, preventive commodities or other support) in the prisons which heightens HIV, TB and other infectious diseases risks and vulnerabilities. According to the authorities there are 1397 PLHIV in prisons, 124 HIV+TB co-infected and 912 prisoners with TB (December 2015).

With the rapid socio-economic and political transitions and the opening up of Myanmar that started a few years ago, Myanmar will have to keep up the efforts to address drivers of the HIV epidemic in order to maintain the fragile gains that the national HIV response has achieved.

[3] The National M&E framework uses 126,000 as higher risk MSM to be reached with HIV services.
[4] National estimated HIV prevalence among FSW based on HSS and IBBS input to AEM is 14.6% (ranging from 12.3% among FSW who seek work through internet or phone to 16.2% among street and brothel-based FSW)
[5] AIDS Data Hub for Asia/Pacific Men who have Sex with Men, Dec 2015
[6] Save the Children program data
[7] Director General of Prison Department, in presentation on March 22 2016
[8] The Insein prison in Yangon, the biggest prison in the country and built during British rule of the country, has a capacity of 5000 prisoners, but is is currently hosting 8000 prisoners. Source: Prison Department

**Figure 1.1.2. New HIV infections by population groups in percentage (15 years and above)**[9]




## TB

Myanmar is among the 30 highest TB burden countries worldwide. Among adults 15-49, TB is the leading cause of death, accounting for more than 9% of all deaths. In 2015, 140,700 cases of drug sensitive TB were notified. In addition, 2793 cases of MDR-TB were notified and 2207 were initiated on treatment.

A prevalence survey carried out in 2009-2010 estimated the prevalence rate of all forms of TB cases to be 598/100,000 population. WHO estimates that the country met the MDGs for reduced TB prevalence and mortality in 2015. Myanmar experienced a consistent decline in the prevalence, incidence and TB death rates from 1990 through 2014, as illustrated below. A follow-on prevalence survey is planned for 2017 which will allow for the validation of the epidemiological trends.

**Table 1.1.2: Tuberculosis indicators trends in Myanmar 1990-2014**[10]

| TB indicator | 1990 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|
| TB prevalence rate (per 100,000) per year | 922 | 525 | 506 | 489 | 473 | 457 |
| TB death rate (per 100,000) per year | 133 | 51 | 49 | 48 | 49 | 53 |
| TB incidence rate (per 100,000) per year | 404 | 384 | 381 | 377 | 373 | 369 |

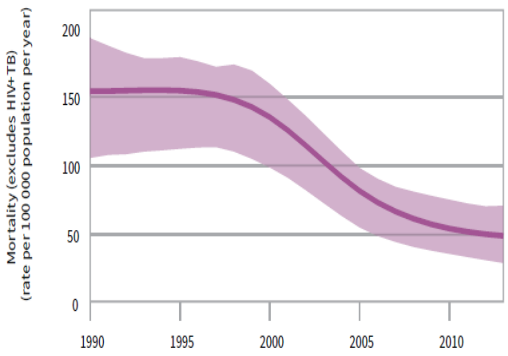



**Figure 1.1.3: Mortality rate/100,000 (no HIV+TB)**

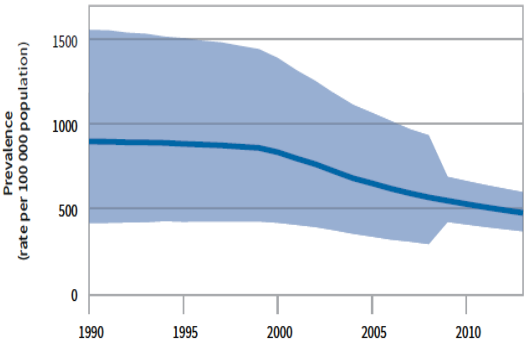



**Figure 1.1.4: Prevalence rate/100,000**

[9] Draft Myanmar HIV Estimates and Projections Report, 2015
[10] Source: Global TB Report 2015 *Estimated

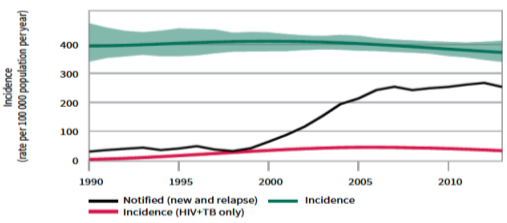



**Figure 1.1.5: Incidence Rate per 100,000 per year**

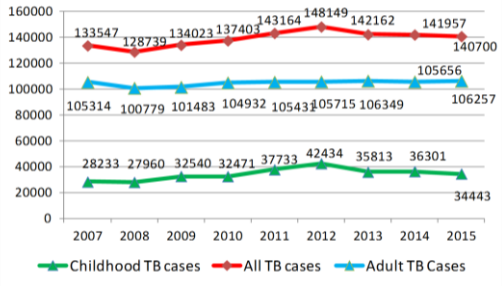
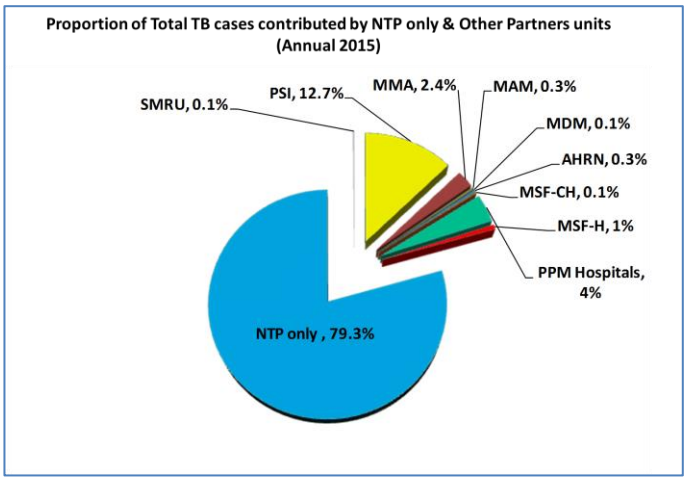



**Figure1.1.6: Trend of Child and Adult TB Cases**

The 2009 national TB prevalence survey found that males were more likely than females to have TB, people in states more likely than those in the regions, the elderly (over 55) more likely than younger people and urban dwellers more likely than those from rural areas.




The survey suggested that among confirmed TB cases with symptomatic cough (n=759), 20% had not sought care, 26% self-medicated, 16% sought care from traditional healers, 9% visited pharmacies, 12% went to public health centers, 8% to private GPs, 4% to public hospitals, 1% to specialists, and <1% to private hospitals. These patterns of health seeking behavior have likely shifted somewhat since the introduction of free essential medicines and the rise in overall care seeking. However, the informal and delayed care seeking preferences suggest barriers to diagnosing patients in a timely manner. The TB NSP responds to the varied and commonly informal care seeking patterns of TB patients by engaging all partners, from communities to private providers. The NTP has long been acknowledged for its innovation and successful engagement of all types of care providers including the private sector. Public hospitals engaged in PPM have increased from nine in 2011 to 24 in 2014. In 2015, the PPM hospitals notified 4% of new TB cases. In addition, they also referred TB cases for registration and notification in their townships.

New childhood TB case notifications (all forms) in 2015 comprised 25% of total notifications (all ages), totaling 34,443 cases, a considerably higher percentage compared to the expected range (5-15% of all TB cases are expected to be in children). Of these, 60% were 5-14 years of age. There is strong evidence of over-diagnosis of primary complex disease among the 5-14 years of age group. Concurrently, there is likely an under-diagnosis of children under 5 years of age.

Myanmar is one of 30 highest MDR-TB burden countries in the world. WHO estimated that approximately 9,000 cases of MDR-TB occurred in the country in 2014. Based on the most recent drug-resistance survey, however, the NTP estimated that the number was 5500. Three national drug-resistance prevalence surveys show increasing prevalence of MDR-TB among new cases, currently estimated to be 5%, and among retreatment cases, currently estimated to be 27.1%. In 2015, 2793 MDR-TB patients were notified and 2207 initiated on treatment.

**Table 1.1.3: Summary of National Drug Resistance Surveys**

| Survey years | MDR-TB among new cases | MDR-TB among retreatment cases |
|---|---|---|
| 2002-2003 | **4.0% (95% CI: 2.7- 5.7%)** | **15.5% (95% CI: 9.5- 23.4%)** |
| 2007-2008 | **4.2% (95% CI: 3.1- 5.6%)** | **10.0% (95% CI: 6.9- 14%)** |
| 2012-2013 | **5.0% (95% CI: 3.1- 5.6%)** | **27.1% (95% CI: 15.0- 39.2%)** |

Cases of extensively drug resistant TB (XDR-TB) have been identified in Myanmar since 2008. The NTP estimates that 1% of drug resistant cases are XDR. A drug regimen for XDR-TB has been established and 7 patients were started on treatment in 2015. Under the UNITAID-funded program (EndTB), MSF-

Holland and the NTP are considering adding some of the newly WHO endorsed drugs to enable the treatment of 10 XDR-TB patients per year for 4 years.

**TB/HIV**

Myanmar is one of 30 highest burden TB/HIV countries in the world. In 2015, approximately 60% of TB patients were tested for HIV and 9% were HIV positive. This is an improvement over 2014, when only 40% of TB patients had a known HIV status. The HIV positivity rate among TB patients ranged between 6% Yangon, 13% in Nay Pyi Taw and up to 25% in Phakant and Myitkyina (Kachin State) in 2014. The proportion of HIV positive TB patients receiving ART remained low, at 37% in townships where the national TB and AIDS programmes implement collaborative TB/HIV activities. Overall, an estimated 19,000 people living with HIV developed tuberculosis in Myanmar in 2014, although only about 34% of them were detected and notified in that year. 7,918 confirmed cases of TB/HIV were reported in 2015. Since 2010, estimates derived from sentinel surveys have shown a consistent decrease in the prevalence of HIV among TB patients.

## 1.1 Country Disease, Health Systems and Community Systems Context

**b) Key populations that may have disproportionately low access to prevention, treatment, care and support services (and the contributing factor to this inequity)**

Overall context of human rights and underserved populations: Since the 2011 national elections, wide ranging reforms have brought fundamental changes to Myanmar. During that time, thousands of political prisoners were released, numerous laws were adopted or reformed, and significant steps were taken towards allowing greater media freedom and government transparency. National elections held in November 2015 saw the National League for Democracy win an absolute majority. The new Government now faces formidable human rights challenges. The transition period following the elections has been smooth and peaceful, but also one of great uncertainty. The new Government plans to further recent reforms initiated by the outgoing Government and create an environment in which communities, civil society actors and human rights defenders may speak out and protest peacefully without fear of reprisal. The international community remains engaged and is supporting Myanmar in furthering reforms and in fulfilling its international human rights obligations.

Ethnic and conflict-affected populations: Within the country, there are 135 recognized ethnic groups, speaking over 100 languages and dialects. The ethnic minorities live primarily in the States and in autonomous regions.

Access to basic healthcare services is historically low in areas of the country where there has been a history of conflict and consequent population dislocation. In areas with long standing conflict situations there has been very limited availability of health facilities and services. In Myanmar this impacts most upon populations in parts of Kachin, Kayah, Kayin, Mon, Shan, and Rakhine States. During the decades of active conflict in the ethnic states, official government health facilities and services were unavailable or inaccessible for the majority of ethnic populations in non-government controlled areas as a result of lack of provision of services as well as security factors, geographical access factors, and lack of freedom of movement/displacement.

As a result, many ethnic groups established their own community-based primary health care service provision structures. Their service delivery models include a 'package' of medical services comprising treatment of common diseases, war casualty management, reproductive and child health services, community health education, and water and sanitation programs provided through a mix of mobile medical teams and stationary clinics. Many of these services however, have not previously been able to be covered by or linked with national (HIV/TB/Malaria) programs and instead have relied on funding, technical, operational and material support from external partners and cross-border backing, primarily based in Thailand. However for HIV, with Global Fund support, the NAP has been progressively scaling up ART treatment and has covered nation-wide needs where such information is available.

**Table 1.1.4: Number of PLHIV on ART by the end of 2015 by Service Providers in Ethnic and Conflict-Affected Areas**

| State | PLHIV on ART | Service Providers |
|---|---|---|
| Chin | 79 | NAP |
| Kachin | 15,221 | NAP, MSF-H, MDM, MAM (under NAP) |
| Mon | 3115 | NAP, Alliance, IOM, AFXB, Consortium |
| Rakhine | 1108 | NAP |

The Ministry of Health and Sports and Sports, and the National Disease Programs for HIV, TB and

Malaria have articulated the intention to increasingly work with Ethnic Health Organizations and expand coverage to previously uncovered populations. Ethnic health organizations have recently become more involved in national level health discussions including representatives being invited to and attending Technical and Strategy Group (TSG) meetings in 2016**.** In May 2016 consultations concerning health services, the NSPs for HIV & AIDS, TB and Malaria, and draft Global Fund Concept Notes for the 3 diseases were conducted with representatives of Ethnic Health Organizations, Ministry of Health and Sports, MHSCC, and civil society partners in the east – Hpa-An in Kayin State and northeast – Lashio in Northern Shan State. Issues discussed included the need to strengthen coordination; improve access to service delivery; expand surveillance and disease monitoring and continued partnerships with third party organizations (NGOs). Moving forward, the meeting participants agreed to explore further collaboration. This will need to be done with conflict-sensitive approaches, particularly as local and national peace agreements are being negotiated, that respect the cultural, linguistic and self-determination aspirations of non-state service providers.

The Ministry of Health and Sports and Sports, through the National Disease Programmes for HIV & AIDS, TB and Malaria is committed to ensure that comprehensive prevention, care and treatment services reach all those in need. Health systems strengthening, particularly effective coordinating and monitoring and evaluation will be critical components for these areas. 3MDG, the Global Fund and USAID are already working with new partners (ethnic health organizations and local NGOs) in Kayah, Kayin, and Mon states, principally malaria. In accordance with the National Health Policy, which aims for 'Health for All' within the National Health Plan, as well as the "Myanmar Health Vision 2030", which promotes quality health care and access for all patients, the 'Protection Sector' and 'Health Cluster' are now developing indicators and a monitoring framework in order to enable comprehensive monitoring of access to health in all States and Regions from early 2016.

Inequitable access to healthcare in Rakhine State: Rakhine State is identified by the World Bank as the poorest in Myanmar and the 2009-10 Integrated Household Living Condition Survey ranks Rakhine State in second worst position in terms of overall poverty (43.5 per cent compared to the national average of 25.6 per cent)[2]. It is characterized by low income, poverty and weak infrastructure, compounded by high vulnerability to natural disasters with a densely populated coastal area and an eastern hilly forest region that is sparsely populated and has prolonged displacement as a result of inter-communal violence.

Access to basic services is historically low for all people in Rakhine. In recent years, access has further diminished in central Rakhine with some populations facing a number of barriers in accessing health care, while historically it has been low in Northern Rakhine. The provision of health throughout the state is complex and multifaceted resulting in services being provided in an inconsistent patchwork. In some locations, primary health care access is availed, while in other locations secondary health care is offered. Although the referral pathway has improved, there are inconsistencies in the way that medical authorities apply established protocols which contributes to inequitable access and services. With the humanitarian response in central Rakhine State, some Internally Displaced Persons may have comparably better access to health care than some non-displaced populations also affected by communal violence. Generally, non-displaced populations are not covered by humanitarian agencies and access to health care provided by government or humanitarian agencies is inadequate.

Health services to IDP camp populations in Kachin and Rakhine: Some IDP camp populations in Kachin and Rakhine have access to health care (delivered by National Disease Programs coordinated mobile teams and other I/NGO services funded by the Global Fund and 3MDG as well Ethnic Health Organisations and local health authorities). Existing health services provided to IDPs include testing and treatment of TB and Malaria; MNCH, and water and sanitation supplies and commodities. While data suggests that HIV prevalence is low in Rakhine, there is concern about limited access to prevention and care services. To ensure that these populations are not excluded from community-based health initiatives, village health volunteers are recruited and trained from among these populations to encourage trust in the provider and increase utilization of services.

Screening and accessing treatment services in Kachin State: After the conflict, access problems challenged the detection and treatment follow-up of patients from areas outside Laiza town. However, the KSR2 Health Department has set up camp hospitals and clinics and assigned health staff after the IDP camps were established. Health Poverty Action (HPA) has re-established the microscopy network in the IDP camps. This health workforce can be engaged for TB case finding and treatment follow-up. The KSR2 Health Department issued a written request to MSF-Holland and HPA to collaborate with them to detect and treat TB patients, especially in the camps. 3MDG has funded to HPA to implement integrated health care services in 2 special regions; Wa SR2 and Shan SR4 since 2015 until end of 2017. They train local health staff and providing technical assistance. They will work closely with regional TB team to find cases in remote areas and referral and case holding for routine PCF community based activities. MSF-Holland operates an ART clinic in Laiza town, the headquarter of KSR2, providing treatment for HIV and HIV-TB co-infection. MSF-Holland also built a TB ward in Laiza hospital, treating TB patients with the in collaboration with the KSR2 Health Department. A GeneXpert machine has been established in Laiza

hospital by MSF-H in 2015.

People living with and affected by HIV: All HIV key populations in Myanmar (people who inject drugs; sex workers; men who have sex with men; their partners; and prisoners) have disproportionately low access to health services including low access to prevention, testing, treatment, care and support services. Findings from the 2014 National Legal Review concluded that HIV key populations often face difficulty with the law as the legal environment in Myanmar presents a criminalized approach towards sex workers, people who use drugs and men who have sex with men. Subsequent reports (situational analyses of people who inject drugs, men who have sex with men and sex workers, 2015-2016) also identified specific issues and challenges that the key population groups face in accessing HIV services. Exacerbated by social stigmatization and discrimination, the key populations often fear to disclose their behaviour and avoid public health services. Police crackdowns and arrests as well as community resistance to HIV and harm reduction programmes often disrupts access to HIV prevention outreach programmes and results in lower numbers of key population accessing prevention, testing, treatment, care and support services.

The people who inject drugs IBBS shows that in the majority of sites more than 20% of people who inject drugs had a history of arrest. Stigma and discrimination are also highly prevalent in Myanmar – key populations do not enjoy equal rights to education, health care and livelihoods. Men who have sex with men and transgender people gets harassed and detained by police under the Rangoon Police Act (for loitering or suspicious activity) and under Section 377 (penalises "unnatural sex acts" with imprisonment for up to ten years) of the Penal Code.[11] It is estimated that less than half of men who have sex with men are accessing HIV prevention, testing and treatment in Myanmar as they fear judgemental attitudes, harassment and arrests. Men who have sex with men in Myanmar are not a homogeneous group and current service delivery models which rely on traditional outreach approaches do not adequately meet the needs of all, especially those not willing to disclose their same-sex behaviour.

Many health care workers display prejudicial attitudes and behaviours towards key populations.[12] Sex work is illegal in Myanmar and sex workers face harassment even from law enforcement personnel. There is limited legal protection and services to mitigate this situation. Female sex workers who seek abortion or post-abortion care also face stigma and discrimination as abortion is illegal in Myanmar. Currently few NGOs are providing counselling support - this is a critical gap area that has been raised by sex workers. The low level of HTC among key populations is a critical issue that will be addressed as part of the new NSP. In the new national strategic plan, Myanmar places high importance of human rights and strengthening an enabling environment for key populations to be able to increasingly access prevention, treatment, care, and support services. A law protecting the rights of people affected by HIV has been drafted and it is expected to be submitted to Parliament within this year. There is high expectation that the new government will support efforts to improve the legal framework and ensure a more enabling environment for scaling up HIV prevention, testing and treatment programmes.

People with TB and their families: It was estimated that about 26% of TB cases remained undiagnosed in 2015. Efforts are underway to better understand where these "missing" cases are, and high-risk populations have been identified through operational research. Concurrently, the NTP is collaborating with CBOs, NGOs and the private sector to ensure reporting or referral of all patients, and to conduct active case finding among marginalized populations. In Myanmar, there exist sub-sets of the population who are at higher risk for TB given their occupational or socio-economic conditions. In addition, there are sub-populations who are particularly difficult to reach with services, due to geographical or social reasons. There is significant overlap between populations vulnerable to and with TB and HIV key populations, especially people who inject drugs; sex workers; men who have sex with men; their partners; and prisoners.

There are several sub-populations that face legal and/or societal barriers to TB care. For each, innovative approaches to serve the special needs of these populations have shown success and are sustained by partners who are trusted by and work closely with the populations. These include:

**Ethnic groups:** The 2009-2010 prevalence survey showed that, compared to 1994, the level of smear positive cases with chronic cough in the community had fallen significantly. The fall in the States, though, was much less than in the Regions, suggesting some disparities among ethnic lines.

**Migrants:** Migration is an important phenomenon in Myanmar, with government estimates indicating that as many as 14 per 100 people move internally. The 2015 census data suggest that at least 2 million former Myanmar residents now live overseas, mostly in Thailand. Specific information on tuberculosis in migrants in Myanmar is limited but evidence from a 2006 study suggests that nearly 58%

[11] National HIV Legal Review Report (2014)
[12] Ibid.

of migrants delay care-seeking.

**People who use drugs:** There were estimated 350,000 people who use drugs in Myanmar in 2015, of which 83,000 are people who inject drugs. TB/HIV co-infection rates are known to be high among this population. Given the illegality of injecting drug use, reaching this sub-population is challenging. Some successful models have been implemented, including a comprehensive programme for people who use drugs implemented by AHRN which integrates HIV and TB services in Kachin and supports around 2,000 clients with harm reduction services. In close cooperation with the township hospital, this project provides substitution therapy with methadone, HIV and TB testing, and good reporting to NTP. During three quarters of 2014, the programme detected 174 cases among their clients, 78 of whom had HIV infection as well.

**Urban poor:** The urban poor may reside in unofficial shanty towns with limited access to adequate health care, education, or employment. This community is one of the high risk populations for TB, given the crowded living conditions and poor socio-economic status. According to the 2009-2010 National TB Prevalence Survey, TB prevalence in urban areas was higher than rural areas. With 3MDG support, TB mobile clinics go to urban poor and hard-to-reach areas. During the first two quarters of 2015, 26 mobile clinics were carried out in urban poor areas. From that, 612 TB cases were notified and started on treatment. The percent of all forms of TB among presumptive TB cases in urban poor areas was 5.6%. The Joint Monitoring Mission noted that income was in fact a determinant of healthcare seeking with 67% of the poorest and 87% of the wealthiest doing so. The 2009-2010 prevalence survey results showed that the utilization of the public sector was different between urban and rural populations. While 62-77% of TB-symptomatic participants chose the public sector in rural areas, only 15-36% of those in urban areas visited the public sector.

## 1.1 Country Disease, Health Systems and Community Systems Context

**c) Key human rights barriers and gender inequalities that may impede access to health services**

Human rights barriers and gender inequalities add to the above contributing factors and impede access to health services particularly for HIV key populations in Myanmar as mentioned in point b).

Based on the 2009-2010 TB prevalence survey, 71.5% of sputum smear positive TB patients were male and 28.5% were female. The proportion of male to female notified TB patients was 2:1 in 2015, which is in line with the character and epidemiology of the disease. However, some studies have found that women have less access to TB treatment and prevention services than men and are less likely to undergo sputum smear examination. Social factors may account for gender differences in use of TB services. For example, women in some contexts have difficultly accessing TB services because male family members are unwilling to pay for these services, women's health may not be considered as important as that of male family members, or because TB in women is more stigmatized than in men. Gender-insensitive health care infrastructure also has an impact on women's access to services. Although women are less likely to delay seeking care, once they do access TB services, women generally wait longer than men for diagnosis and treatment. Women who attend TB services have also complained about a lack of privacy in health centres when receiving directly observed treatment short-course (DOTS), and women with children may not be able to attend TB services regularly due to a lack of child-care facilities.

Networks of people living with HIV and key populations report instances of dismissal from employment if found to be HIV or TB positive. As mentioned above, the National HIV Legal Review Report (2014) and the Gender Assessment of the HIV National Strategic Plan (2014), found that Myanmar's legal instruments relating to HIV key populations are punitive and there are no protective policy or legislation that prohibit stigma and discrimination against MSM, transgender people, sex workers, PLHIV, and people who inject drugs. There are no protective laws for women and girls against domestic violence or spousal rape. Representative of Myanmar Positive Women's Group raised concerns that in some areas, HIV positive pregnant women pay higher delivery fees compared to HIV-negative women. Women living with HIV also report stigma and discrimination by midwives, nurses and other health care providers – making them stay away from health services. Gender and cultural norms contribute to women having inequitable access to knowledge and skills that would protect them and reinforce good health-seeking behaviours. However, even when young women dare to purchase condoms, they are refused by shopkeepers and they need parental permission to access health care services including reproductive health and ART.

However, it must also be noted that in the past two years quite a few gains have been made with support from Global Fund and 3MDG Fund: (1) Review of the 1993 Drug Law that proposes reduced sentences for minor drug offence and promotion of voluntary drug treatment; (2) Amendment of the Excise Act which now allows non-health personnel to handle needles/syringes; (3) Development of Draft Elimination of Violence Against Women Law (4) Draft Law to protect PLHIV and key populations from stigma and discrimination and ensure access to services as well as (5) Substantive inputs and comments to ensure

Myanmar continues to access full TRIPS flexibilities accepted by government to the existing draft IP Law that Myanmar plans to pass in the near future. A Joint Parliament and Community Network Committee on HIV and Human Rights was formed in 2015 which provided key opportunities for advocacy through the Parliament. An HIV Human Rights and Gender sub-working group under the HIV TSG also functions as a forum for members to raise concerns and advocate for scaling up rights-based and gender sensitive programmes (the group meets on a quarterly basis and is one of the most active working group of the HIV TSG). The HIV Human Rights and Gender Sub-Working Group has finalized a rights-based law for people living with HIV and key population, called the "Law on the Rights of People Affected by HIV" to encourage key populations to come forward for testing and treatment, ensuring people affected by HIV are not unreasonably discriminated against at work or in the services they receive including health care.

## 1.1 Country Disease, Health Systems and Community Systems Context

**d) Health systems and community systems context and any constraints**

Myanmar, with a population of around 51.4 million, has the lowest GDP per capita and one of the highest poverty rates in Southeast Asia. The poverty headcount rate is officially estimated at 37.5%. Approximately 70% of Myanmar's population live in rural areas. Within the country, there are 135 recognized ethnic groups. Access to services is variable across the country. There are serious constraints to accessing health care for populations living in remote townships, due to the climatic conditions, terrain, security concerns and limited transport facilities.

**HEALTH SYSTEMS**

Key indicators for health in Myanmar show significant improvements over the past decades. In 2011, the previous Government initiated a series of far-reaching health reforms. The Ministry of Health and Sports began moving towards Universal Health Coverage. The Government began providing free essential drugs and x-rays beginning in 2014. Overall life expectancy at birth has increased since the 1990s and progress has also been made on health-related MDGs. Child survival has improved over the past decade with the greatest reduction in all-cause mortality rate for females aged 1-4 years. Maternal mortality ratio has declined steadily and the proportion of births attended by skilled health personnel has increased gradually. Progress is also seen in HIV in decline in prevalence; TB incidence rate has declined since 1995 and the target of halving TB mortality compared with 1990 levels was met in 2010; similarly the goal of 50% reduction in malaria morbidity and mortality was achieved in 2007. However, the health systems require considerable strengthening after decades of limited support. Nearly 68% of health care expenditure in Myanmar is out-of-pocket constituting a disproportionately large share of total health spending and reinforcing inequities in health outcomes between income groups; states/ regions and rural/ urban areas. Health personnel ratios and number of health facilities remain inadequate for the needs of the people. All elements of health systems (health workforce; health care financing; information & research; medical products and technologies; service delivery and leadership and governance) in Myanmar require dedicated and scaled-up support.

A holistic approach to strengthen the health systems and community systems will be needed in order to improve service delivery for people in need. Efforts to integrate HIV and TB into the essential health services package under Myanmar's Universal Health Coverage vision must be intensified.

Myanmar has officially committed to Universal Health Coverage by 2030, where everyone has access to health care they need without suffering financial hardship. World Bank, GAVI, the UN health agencies, 3MDG Fund are supporting the UHC vision. At the time of this Concept Note submission, a new government was within its first 100 days in office. As such, the Ministry of Health and Sports and Sports and health sector are in a period of transition.

World Bank has mobilized International Development Assistance (IDA) financing, global knowledge and learning and analytical work to support strengthening of Myanmar's health system, namely in the area of health financing. With IDA of US$ 100 million from 2015-2019, the Essential Health Services Access Project (EHSAP) aims to increase access to essential services of adequate quality, in particular to improve maternal, newborn and child health outcomes – providing funds to facilities at township level and below, including township and station hospitals, urban and rural health centres, maternal and child health clinics and school health programs. The EHSAP has already identified public financial management constrains that need to be tackled to improve service delivery. In spite of challenges however, the project also highlights that front line units of service delivery are able to spend money efficiently and transparently. Myanmar health sector today faces a challenge of having several parallel financing and implementation arrangements with different modalities of procurement, financial management, human resources, and reporting that are often significantly different from those of the MoHS.

GAVI also supports health system strengthening in Myanmar to address bottlenecks and achieve better immunisation outcomes (health workforce, supply, distribution, maintenance) and organization and management (US$ 29 million). An additional HSS support for 3 years (2017-2019), scheduled to start in January 2017 will cover 199 (out of 330) townships contributing US$ 52 million focusing on strengthening

demand for immunization services; implementing cold chain expansion and improvement plan; strengthening leadership management capacity and coordination; improve equitable access to service delivery; strengthen EPI data management, M&E system; and program management. MoHS is responsible for implementation, human resource, social mobilisation and UNICEF for procurement and strengthening supply chain, cold chain, etc. WHO provides technical support, trainings, strategic information, surveillance, and data management activities.

The 3MDG Fund provides sector wide support across a broad range of areas, especially initiatives to strengthen the institutions and systems of the Ministry of Health and Sports to deliver quality health services. Major areas of work covering US$ 45 million have included support to develop the country's health financing policy; strengthen the supply chain that will make medicines available at all levels of the health system; improve health workforce training; build and renovate health facilities to boost primary health care. In addition, the 3MDG Fund which also provides funding for TB and HIV prevention particularly harm reduction for people who inject drugs. The 3MDG Fund will end in 2017 and it is as yet unclear whether there will be a replacement and how much funding for health, TB and HIV might be available.

**HSS requirements:**

**(i) Procurement and Supply Management:** An important cross-cutting issue for all three diseases is the system for procurement and supply management. A review conducted by SCMS in 2014 (National Supply Chain Baseline and Procurement Options Analysis Study) found that the supply chain system was performing below the required standard to satisfy the health sector needs. Currently the national procurement system is in its infancy, lacking national legislative framework or national body to oversee procurement. Priority interventions to strengthen the PSM system in line with the National Health Supply Chain Strategy for Medicines, Medical Supplies, and Equipment (2015-2020) are proposed within this Concept Note.

One of the three key priority areas identified in Myanmar's *National Health Supply Chain Strategy for Medicines, Medical Supplies, and Equipment 2015-2020* is the integration of the fragmented supply chains that currently exist across the country. As documented in a number of reviews over the past few years, the supply chains for health commodities in Myanmar are fragmented along government and other donor program funding lines, leading to significant duplication and inefficiency. The primary funder of commodities under the National AIDS Program (NAP), the National Tuberculosis Program (NTP) and the National Malaria Control Program (NMCP) is the Global Fund to Fight AIDS, Tuberculosis, and Malaria (The Global Fund). Save the Children International (SCI), Médecins Sans Frontières (MSF) and the United Nations Office for Project Services (UNOPS) do the majority of the commodity procurement under these grants, operating separate and distinct supply chains by program area. Further complicating the dynamic is the numerous of Sub-Recipients under each of the PRs. SCI, for example, has 17 SRs managing their own distribution of multi-donors program implementation. Within the three disease programs, there are over 100 documented distinct storage locations across the country; additionally, there are instances where multiple programs (i.e., NTP, NAP and NMCP,) maintain separate warehouse stores within the same building rather than sharing locations. A similar dynamic exists with transportation and distribution of goods, which is managed in parallel and results in many lower level sites receiving multiple shipments of goods each month.

Forecasting: The three disease programs managed by the Ministry of Health and Sports and Sports (MoHSS) have organized simultaneous week of annual forecasting meetings This week involves a series of meetings between PR, regional and central program managers to review input assumptions (i.e., treatment regimens, program changes, new drugs being introduced, review of products list), data on consumption and/or morbidity patterns, and any other relevant factors. Over the past several years, efforts have been made to standardize the forecasting methodologies across the disease programs and across the Principal Recipients. The NAP has called for all program partners to utilize a common forecasting methodology at the national level. In both 2014 and 2015 a national level annual forecast for Rapid Test Kits, ARVs and PMTCT drugs combining all UNOPS Sub-Recipients was conducted using a methodology introduced by the USAID-funded Supply Chain Management System (SCMS) project. SCI developed a forecasting tool based on consumption data and uses the Clinton Health Access Initiative's (CHAI) tool for the quantification of ARVs. The breadth of SCI SRs providing HIV/AIDS services and the diversity of their treatment modalities increases the complexity of forecasting for HIV program, as does the need to procure for small-scale treatment regimens. For the TB programs, NTP conducts a national forecast annually for the entire needs of TB drugs and for other health and pharmaceutical products required for the implementation of their programs; each of the GF TB PRs conducts their own forecasts on an annual basis.

Procurement: NTP, NAP and NMCP are Sub-Recipients under UNOPS for the Global Fund grant; procurement for these programs is managed by UNOPS for all health commodities. UNOPS also procures commodities for other SRs. SCI procures most health and pharmaceutical commodities

required for the HIV and TB program implementation of their SRs, with the exception of TB drugs that are centrally forecasted and procured by NTP and UNOPS. SCI has indicated that they will begin utilizing the Pooled Procurement Mechanism (PPM) for its key items purchasing later this year.

Warehouse and distribution: Most NTP partners and treatment sites receive drugs from the state and regional TB stores on a quarterly basis. UNOPS arranges for shipment of commodities to the NTP Central Store in Yangon, and from there then NTP makes quarterly distributions to the Upper NTP (Mandalay) and Lower NTP (Yangon), and from there to state and regional stores. Distribution to the various partner sites is done through a variety of means; in some cases trucks dispatch from the stores, while in other cases recipient sites pick up their commodities from stores or arrange their own transportation.

For NAP commodities, UNOPS arranges for shipment of commodities to the NAP Central Store in Yangon. From there NAP operates its distribution in a pull fashion similar to TB, with quarterly requests being made from various levels and quarterly distributions to lower levels (central to sub-depots and transit camps and on to townships and treatment sites). The exception under UNOPS is for condoms, because of high volume, which are done in a 'push modality' direct from the port to township levels across the country.

SCI manages all in-bound shipments of the TB and HIV commodities that they procure, including customs clearance with the support of CMSD, and re-dispatch of shipments using third-party logistics service providers. SCI, as PR, does not have its own warehouses and shipments are directly sent to each of the SRs, which then manage the distribution up to the dispensing sites. 65% of SCI's SRs maintain separate central warehouses in Yangon while others have transit warehouses and/or warehouses in the Regions where they are implementing activities funded by donors. Generally from central or transit SR warehouses, commodities are distributed directly to township level to limit cost of storage and risks related to handling and transport.

Logistics management information system: Each of the PRs, the three MoHSS disease programs and many of the SRs maintain their own distinct logistics management information systems (LMIS). It is largely paper-based reporting system and they note many challenges in getting accurate and timely consumption data from dispensing levels. SCI, in collaboration with their SRs, developed a tool for tracking, reporting and monitoring key performance indicators (KPIs) related to stock management (i.e.: risk of shortage, risk of overstock, risk of expiry, risk related to storage condition) ensuring timely oversea shipment and In-country stock reallocation between partners if needed.

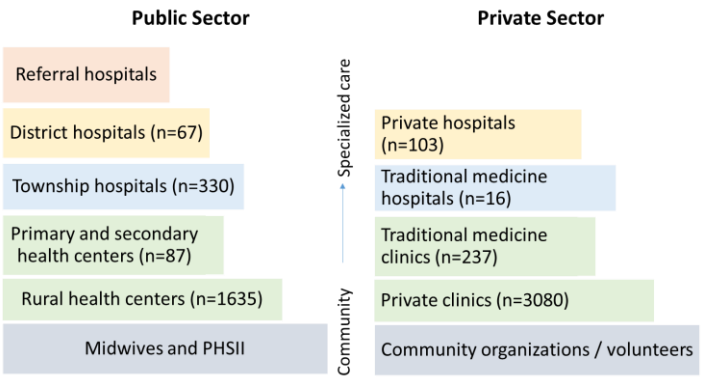
The Clinton Health Access Initiative (CHAI) has been working with the NAP and NTP to rollout an electronic inventory management system (mSupply) at all central and regional/state level program warehouse locations. It is anticipated that most of these NTP (25) and NAP (~15) sites will be utilizing mSupply for stock monitoring by the end of 2016. The USAID-funded Systems to Improve Access to Pharmaceuticals and Services (SIAPS) project supported the NTP with the implementation and training in the use of QuanTB in 2015, a quantification and forecasting software. QuanTB has been implemented at central and regional TB stores. SCMS continues to work with all three disease programs at the national level to harmonize logistics data standards and move toward integrating data systems (particularly mSupply) to provide a more comprehensive picture of stock on hand and consumption patterns for key program commodities.

Supply chain management challenges: The Principal Recipients in Myanmar have identified three key challenges to the work that they are currently doing. The first challenge is the absence of an approved drug disposal/waste management program, particularly for health and pharmaceutical waste (expired and damage products), which must be handled effectively in order to not produce toxic waste. There are no incinerators currently available in Myanmar that comply with international standards for the appropriate incineration of such wastes. This situation has led MSF-Holland to rent warehouse space in order to safely store unusable waste rather than disposing of it in an unsafe manner. The second challenge identified by the PRs in Myanmar is the customs clearance process. The process for clearance at Myanmar ports takes an extended period of time for many shipments, delaying distribution timetables and resulting in the holding of commodities in conditions that do not meet their required storage standards. Most areas in the customs clearance storage facilities cannot be effectively temperature controlled, which is a major problem for most of pharmaceutical products and in particular for those commodities requiring cold chain conditions. The third challenge noted was the absence of generic specifications for the purchase of equipment. While proposals have been made to funding agencies and the MoHSS, no resources have yet been provided to establish a central repository of technical specifications that can be referenced when undertaking a procurement activity for equipment.

**(ii) Human resources:** Inadequate human resources is a major barrier to increasing services for HIV, TB and Malaria – including inadequate numbers, high turn-over and limited capacity of medical and non-medical staff. To address critical human resource shortages for HIV, TB and Malaria in the public sector,

the Ministry of Health and Sports Department of Public Health recently announced a major increase in the number of approved positions. For example, the number of positions which includes HIV in the terms of reference increased from 300 to more than 1500 across the country. Further addressing the human resource challenge will also require substantial support to recruit and quickly build capacity of individuals and the broader health structure in the townships. Priority activities will include development of modules and tools, job aids, roll out standardized training, development of specific job descriptions including for task-shifting, development of site and township and individual work plans, and engagement of with township, district, regional and central to absorb the positions.

Within the 330 townships, 11-member disease control teams are being established to provide more consistent human resource capacities and to enable integrated service delivery. These integrated teams will replace the disease-specific teams that exist in some places, but will carry responsibility for implementing disease-specific agendas. Within the integrated teams, one member will be designated as the point person for TB/HIV collaborative activities.




Strengthening the community based health work force is crucial for ensuring equity and access to basic health care services up to grass- root level. In Myanmar, Basic Health Staff are the major community based health workforce responsible for providing comprehensive health care services. Within each Rural Health Center (RHC), one Health Assistant (HA), one Lady Health Visitor (LHV), five Midwives (MWs) and five Public Health Supervisors Grade II (PHS 2) are included in the team. The main duties of PHS 2 are disease control activities, including TB and HIV care, and environmental sanitation but due to the shortage of PHS 2, all health care activities especially in rural area are carried out by midwives. Therefore, midwives have to take responsibility for maternal and child health care as well as immunization, nutrition promotion and disease control activities. In order to reduce the work load of midwives, deployment of PHS 2 in all vacant posts is mandatory. In January 2014, a total of 2,986 new PHS2 were posted at the vacant posts in all States and Regions.

The private sector is expanding particularly in cities and towns, with limited existence of village-level private providers. The private, for-profit sector mostly provides ambulatory care with some institutionalized care in large cities. The Myanmar Medical Association and its branches provide a link between the numerous private providers and counterparts in public sector. Private non-profit facilities, run by Community Based Organizations (CBOs) and Faith based Organizations, are also providing ambulatory care. International and local NGOs deliver services, largely supported by development partners. Moreover, organizations serving ethnic minorities provide health services in many conflict and post-conflict areas in the States.

It is estimated that 58% of medical doctors were employed in the private sector in 2013-14. In 2010 there were 103 private hospitals, 192 special clinics and 2891 general clinics. A national law passed in 2007 and revised in 2013 governs the engagement of the private sector. The law recognizes the important role of the private sector and was enacted to enable private health care services to be integrated in the national health care system, with provision for cost containment and quality assurance. A central regulatory committee and supervisory committees at the state and region, district and township levels monitor the activity of the private sector.

The Health Workforce Strategic Plan, 2012-2017, guides the development of human resources for health (HRH). The Department of Health has increased the number of sanctioned posts for Public Health Supervisor (level II) (PHS-II) from 2080 in 2011 to 10 228 in 2013 and plans to produce 8000 PHSs-II within three years. Persistent challenges for healthcare service delivery in Myanmar include the high number of vacant positions throughout the government network, low salaries paid to government health workers, insufficient allowances for staff in remote or hardship areas, and lack of suitable arrangements for accommodation of staff and their families in such areas.

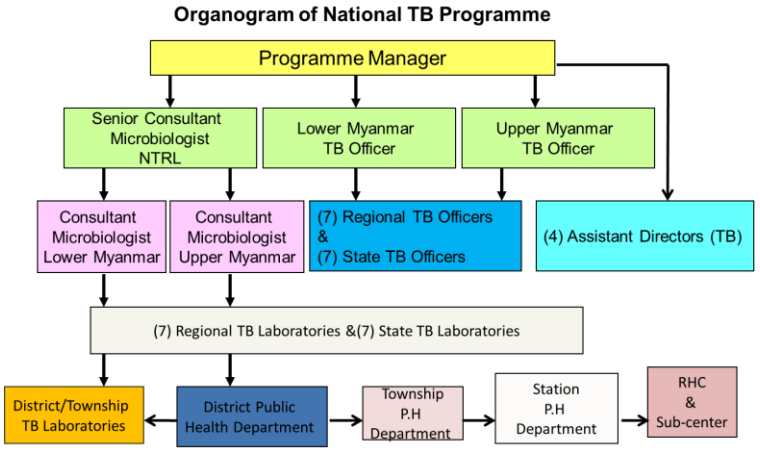
**(ii.a) HIV:** ART, HIV testing and counseling, and even basic HIV information and awareness raising programmes should shift to the public sector in order for the national response to be sustainable. For HIV response to shift from NGO and private sector to the public sector, the health system in Myanmar must be well prepared to absorb the responsibility. However, given the current human resource shortage, sub-optimal information management system and limited skills and knowledge to manage and coordinate a comprehensive HIV response, a complete transition is not possible in the next five years.

There is also the need to address the issue of stigma and discrimination presented in Section 1.1 (b) and (c) and bring public sector up to speed with rights-based approaches. Current success with partnership models between Government, NGOs and community self-help groups collaboratively implementing treatment and treatment adherence programmes encourage the expansion of this model – also as a way of complementing human resource where needed.

At a Consultation on Expansion of HIV Services in Public Sector on 18 May 2016, participants stressed the need to ensure adequate transitional support to health facilities which should include infrastructure support (space for TB/HIV, MMT and infection control) and human resource and capacity strengthening support for basic health service staff. Other important elements include clear criteria for the ART transition process, with expansion to take place in phased approach. Coordination mechanisms between Medical Service Department and Public Health Department must also be strengthened in order to successfully implement the transition and decentralization of services. Training aiming at reducing stigma and discrimination of key populations in health facilities will also be prioritized as this has been identified as weakness in public sector service delivery as compared to the INGOs. Success of the program depends on greater engagement of PLHA networks and CBOs including increased use of community peers and volunteers in the high burden townships in order to reach and follow key populations in communities and in partnership with medical staff in ART facilities. Development of training materials and providing training through the CBOs will be important to ensure the program is sustained over the long run.

**(ii.b) TB:** The NTP operates in Nay Pyi Taw Union Territory and the 14 regions and states with TB centers headed by state/regional TB officers. each district public health department is composed of 89 staff. Among them one district team leader Medical Officer ( TB and Leprosy) is responsible for TB and leprosy control. This team is composed of one nurse, one clerk, one office assistant and one general worker.

At every township, township public health department has 65 staff. It is headed by Township Public Health Officer. Under this, 3 deputy township public health Officers are posted. One Officer is responsible for Disease Control. Under this, there will be 2 team leaders and one team leader is responsible for VBDC,TB, AIDS, Leprosy and Trachoma. Each team has 17 staff and among them nurse, lab tech and statistician are TB focal persons. TB prevention, diagnosis and care will be integrated into the responsibilities of the disease-control teams at township level as these are established. There are a total of 1028 sanctioned posts and 82 additional TB posts created to strengthen the TB control activities at central, regional/state and district level.




At the Rural Health Center level, TB control activities are implemented by Basic Health Staff. At the peripheral level, midwives and PHS-II's provide health education, identify and refer presumptive TB cases, conduct contact investigation through home visits, and provide treatment support for TB patients. In 2013-14, there were 4,998 of PHS2 equivalents at local levels. At community level, government sponsored health cadres (community health workers (CHW) and auxiliary midwives (AMWs)), together with other community volunteers from national NGOs, are involved in TB activities.

**(iii) Laboratory:** There is nearly one microscopy laboratory for every 100,000 populations and three culture-capable laboratories nationally. However, some rural areas still face geographic and cost barriers to diagnostic facilities. At the end of 2015, there were 48 sites in 17 Sates/ Regions performing Xpert®MTB/RIF tests. Nearly 42,000 patients underwent Xpert screening in 2015, nearly tripling the number screened annually since 2013. Treatment success among the 2014 cohort of new drug-sensitive patients was 85%, with 71% cured. Among the 2013 cohort of MDR-TB patients, treatment success for those on regimens including PAS was 75%, while it was 85% among those on non-PAS regimens. Eleven cases of XDR-TB were identified in 2015.

The National Policy for Health Laboratories in Myanmar and National Strategic Plan for Laboratories developed in 2015 highlight weaknesses in the existing laboratory system and identified 8 priorities activity areas for the next 5 years, including address human resource constraints, improving quality and safety, including strengthening procurement, maintenance and supply chain, and improving coordination between various departments in the Ministry of Health and Sports. In order to achieve targets for HIV

prevention, ART and virus suppression in the next four, laboratory systems in the public and NGO sector will need to be strengthened to meet the needs for increased HIV testing and viral load. Under leadership of the National Health Laboratory and National AIDS Program, capacity for HIV testing consistent with the revised national strategy for HCT (reference) will be enhanced. Training materials and training programs will be adapted to include new settings and testers, such as community volunteers, midwives, and community settings. With support from JICA, NHL currently implements annual external quality control for HIV testing; 380 laboratories and blood banks, including 69 NGO laboratories. With technical support from WHO, JICA and US CDC, EQAS for community settings will be developed and EQAS expanded to cover all HIV testing sites and testers during the next 4 years.

Early Infant Diagnosis (EID) and targeted scale-up of HIV viral load was initiated in 2014, however progress has been limited except recently in the NGO sector by MSF. The limited progress has been due to a number of constraints, including infrastructure and human resource limitations, limited availability of equipment and reagent suppliers, and lack of a national coordinated scale up plan. Development of the national viral load plan for routine monitoring will be a priority activity in 2016 in order to inform future procurement and scale up. According to initial assessment, equipment already or planned to be procured is sufficient to VL needs when used at full capacity, therefore emphasis will be placed on addressing constraints, including building capacity of laboratory technologists, improving quality control, developing sustainable specimen transport and reporting systems, and appropriate forecasting, timely commodity procurement, and maintenance of rather than procurement of new equipment. Once VL scale-up is assured, routine CD4 monitoring will be discontinued (initially in MSF and in a phased manner nationally). Laboratories performing VL will be enrolled in CDC or NRL external quality control programs.

**(iv) M&E, Health Information System and eHealth:** The HIV National M&E system was assessed during the NSP II review end 2015. While improvements were noted the following significant challenges were highlighted:

- Insufficient human and financial resources to carry out data collection and analysis in a systematic and efficient manner; data collected and reported via a cumbersome paper-based system (multiples registers, folders, patients booklets) and double recording;
- Complete, timely and quality data and reports are difficult to obtain due to a host of factors, which include the absence of a unique identification code (UIC), a non-functional HIV case reporting system and incipient national data quality assurance;
- Standardization and disaggregation of M&E indicators and reports needs to be further improved; subnational data are scares. In particular PSEs for key populations and people living with HIV are not available. There are knowledge gaps on HIV and co-infections, as well as HIV and co-morbidity. Data and strategic information is not used in an optimal way for planning, programing and policy-making.

The following recommendations were made to address information gaps in the national HIV situation and response:

- Prioritize M&E/surveillance/research as a main strategic area of next NSP with a sustainable human resources and financial plan;
- Establish a Unique Identifier and a Case-Based Reporting system and to roll out an Electronic Reporting System integrated to the MOHS Health Management Information System DHIS2 web based platform.
- Integrate HIV, TB and Malaria data into the DHIS2 platform while envisioning the future incorporation of the Department of Medical Services data in the same electronic application.
- Implement a detailed five-year surveillance and research plan including programmatic mapping and subnational PSEs to provide subnational data and to continue strengthening the use of data at all levels.
- Standardize and streamline indicators and reports with a Data Quality Assurance Plan as well as linkages between the Community-based data systems for outreach activities with subnational and national systems.

The Health Information System (HIS) in Myanmar includes disease surveillance and outbreak notification, data generated by household surveys, vital events and census, administration and resources management, data collection on patients and services records and reporting, program specific monitoring and evaluation. The HIS Strategic plan (2011-2015) will be assessed and a new five-year plan will be developed in 2016. The current HIS Strategic Plan promotes data sharing encompassing IT development. In 2014, MoHS began using DHIS2 (a Web based application, free and open source software for HIS) for processing its data at the national level. Through 2015, DHIS2 has begun expansion to the township level. This township-level roll-out is expected to be mostly completed by the end of 2016.

The Health Management Information System (HMIS) includes public health programs information, among others information from the HIV, Malaria and TB National Programs which are hosted under the

Department of Disease Control. National Programs operate their data collection systems in parallel and there is no platform that enables efficient data sharing between programs even at central level. DHIS 2 platform was suggested as the core platform for aggregate data collection, reporting and analysis. This allows one Monitoring and Evaluation system (M&E), supporting long term sustainability and communication between programs with secured sharing of data and statistics to inform decisions.

MoHS and development partners are collaboratively working on the HIV, TB and Malaria E-Health Investment Plan (2016 – 2020). In May 2016, an integrated E-Health plan for HIV/AIDS, TB and malaria case-based surveillance and aggregate reporting systems was formulated and agreed to by the three national programs. A software was chosen to develop the Master Patient Index (MPI) for effective longitudinal patient monitoring across care and aggregate DHIS2 reporting form development has been prioritized for 2016. Overall HIS strengthening will be financed in future years by GAVI, the WB and MA4Health among others.

**COMMUNITY SYSTEMS**

Community volunteers are increasingly involved in TB care provision through NGOs. In 2015, 83,126 presumptive TB cases in 179 townships were referred by volunteers who were trained by four local NGOs (Myanmar Maternal and Child Welfare Association (MMCWA), Myanmar Red Cross Society (MRCS), Myanmar Health Assistant Association (MHAA) and the Myanmar Women's Affairs Federation (MWAF). In addition, Save the Children Global Fund SRs (International Organization for Migration, Malteser International, Word Vision International, and CESVI) identified 4675 cases (3% of total national case notification in 2015).

In 2015, UNAIDS supported a rapid needs assessment of all the national networks of PLHIV[13]. Findings show that networks are not well resourced to strengthen their work and the long-term sustainability of their organizations. Dependence on time-bound, fragmented or unpredictable project-based and *ad hoc* funding keeps them at the margins of a community system, rather than at the centre of one. Rights-based advocacy, particularly monitoring to ensure equitable, quality service delivery; protection and promotion of human rights, and community mobilization remain unmet needs and underfunded areas that community networks themselves have identified as requiring strengthening to leverage both change and impact. Furthermore, findings show that the support needed to ensure good governance and strong leadership of networks is low and capacity is weak. The lack of support could impact on the credibility of the networks to mobilize communities and act as spokespeople for their respective constituencies.

Among the national community networks, more support is needed for an inclusive and transparent community-led mechanism that can enable stronger constituency coordination and representation by key populations in national HIV/AIDS planning and decision-making processes. In addition, continued investment in human resources was found to be critical to addressing major capacity gaps of networks. A lack of human resource capacity among staff and volunteers is a major barrier to achieving the objectives of the networks. Networks do not have the capacity to continuously recruit, train, and sustain skilled volunteers at all levels on an on-going basis; and are facing obstacles such as poor motivation and a high turn-over of people. Findings of the needs assessment show that networks have insufficient knowledge, systems, policies and procedures on how to address these obstacles; and lack sufficient support to increase the skills among their members to manage and implement HIV/AIDS activities.

While GF, USAID and 3MDG currently provides support to strengthen community systems there is still a need for external funding to cover remaining gaps for all the nine national networks representing people living with HIV and key population groups: Myanmar Interfaith Network on AIDS (MINA), Myanmar Positive Group (MPG), Myanmar Positive Women Network (MPWN), Myanmar MSM Network (MMN), Myanmar Youth Stars (MYS), National Drug User Network Myanmar (NDNM), National NGO Network (HIV/AIDS) (NNN), the Sex Workers in Myanmar Network (SWiM) and Aye Myanmar Associations (AMA).

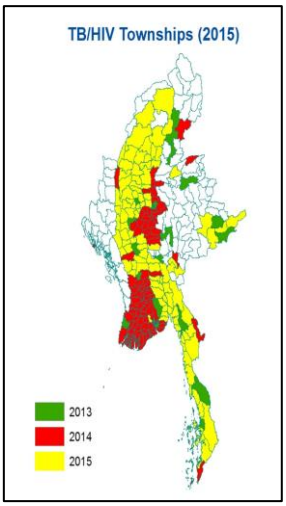
Strengthening community networks to engage and collaborate in service delivery, advocacy and monitoring and evaluation will be needed to fill the human resource gap and build an enabling environment for scaling up HIV services to reach the 90-90-90 Fast Track targets. The concept note includes interventions that engage CBOs and networks in ART treatment/ adherence support; prevention outreach; and raising demand for HTC along with request for strengthening community systems and addressing legal barriers for key population groups to access HIV services.

[13] Rapid Needs Assessment of Networks of PLHIV, UNAIDS, 2015

## Health and Community Systems for TB/HIV

The above issues apply to TB&HIV. By the end of 2015, TB/HIV collaborative activities had expanded to 236 townships. Expansion into all 330 townships is expected by the end of 2016. Both the NTP and NAP have dedicated teams (TB and STD/HIV, respectively) in 46 townships, although the teams do not overlap in all townships. In townships where there are both TB and HIV teams, collaborative activities are better supported and more successful. The move to fully integrated disease control teams in each township, with the designation of a TB/HIV focal point within each team, will facilitate collaborative activities nationwide.

Co-location of TB and HIV services has not yet been realized in many townships. TB patients and PLHIV must transfer between health facilities and providers to receive testing and care for dual infection. The NSPs and this CN reflect plans to ensure more seamless care for people living with TB and HIV. In high TB/HIV priority townships (n=85), co-location of services will be pursued. In medium and lower priority townships, funding has been allocated to support patient referral between TB and HIV diagnostic and treatment sites.



## 1.2 National Disease Strategic Plans

With clear references to the **current** TB and HIV national disease strategic plan(s) and supporting documentation (including the name of the annexed documents and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas under each of the TB and HIV programs including those that address joint areas.

b. Implementation to date, including the main outcomes and impact achieved under the HIV and TB programs. In your response, also include the current implementation of TB/HIV collaborative activities under the national programs.

c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints and barriers described in question 1.1 are currently being addressed.

d. The main areas of linkage with the national health strategy, including how implementation of this strategy impacts the relevant disease outcomes.

e. Country processes for reviewing and revising the national disease strategic plan(s). Explain the process and timeline for the development of a new plan and describe how key populations will be meaningfully engaged.

## 1.2 National Disease Strategic Plan: HIV

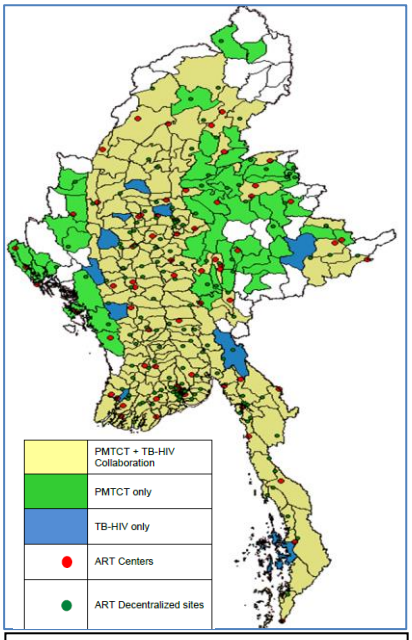



Figure 1.2.1: HIV public sector services in Myanmar

**a) The key goals, objectives and priority program areas**

The Myanmar National Strategic Plan on HIV and AIDS (2016-2020) aims to end HIV as a public health threat in Myanmar by 2030 through fast-tracking access to a continuum of integrated and high quality services that protect and promote human rights for all. To achieve its goal to reduce HIV transmission and HIV-related morbidity, mortality, disability and social and economic impact, it defined **five Strategic Milestones**

**(1) 90% of SWs, MSM, PWID, prisoners and migrants have access to combination prevention services;**

**(2) 90% of PLHIV know their status;**

**(3) 90% of PLHIV who know their status receive treatment;**

**(4) 90% of people on treatment have achieved viral suppression;**

**(5) 90% of people living with, at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings**.

Strategic directions and priority intervention areas are defined around broad areas of reducing new HIV infections; improving health outcomes for all PLHIV; strengthening integration of community and health systems; promoting human rights-based approach; strengthening strategic information and research to enhance the response; promoting accountable leadership for the delivery of results and financing of a sustainable response. The map in Figure 3, presents an overview of expansion of public sector services for ART, PMTCT and TB&HIV.

**Table 1.2.1: Township categorization**

| | City | High | Medium | Low | Grand Total |
|---|---|---|---|---|---|
| Mon | | 2 | 8 | | 10 |
| Ayarwaddy | | 4 | 15 | 7 | 26 |
| Bago | | 3 | 20 | 5 | 28 |
| Chin | | 1 | 2 | 6 | 9 |
| Kachin | | 6 | 6 | 6 | 18 |
| Kayah | | 1 | 1 | 5 | 7 |
| Kayin | | 2 | 3 | 2 | 7 |
| Magway | | 4 | 11 | 10 | 25 |
| Mandalay | 1 (7) | 13 | 14 | 1 | 28 |
| Naypyitaw | | 5 | 3 | 0 | 8 |
| Rakhine | | 3 | 5 | 9 | 17 |
| Sagaing | | 7 | 13 | 17 | 37 |
| Shan (N) | | 6 | 11 | 7 | 24 |
| Shan (S) | | 2 | 9 | 10 | 21 |
| Shan E | | 3 | 3 | 4 | 10 |
| Thanintharyi | | 3 | 5 | 2 | 10 |
| Yangon | 1 (17) | 20 | 22 | 3 | 45 |
| Grand Total | 2(24)* | 85 | 151 | 94 | 330 |
| * 24 high priority townships are within Yangon and Mandalay | | | | | |

**Figure 1.2.2 Map of Township Categorization**

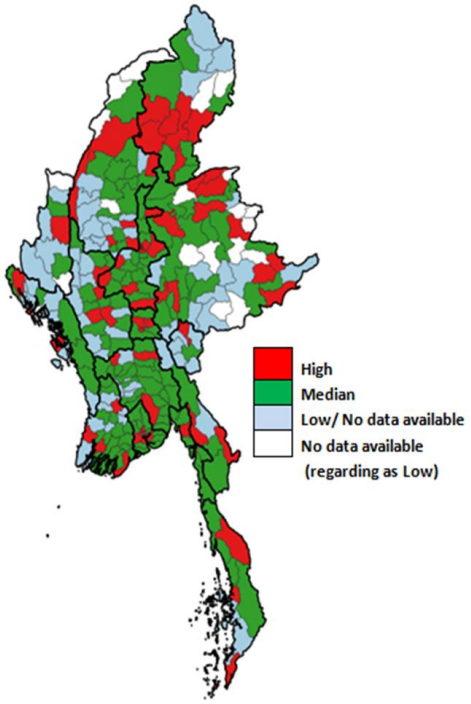



**Table 1.2.2 Key Populations by Geographical Categorization**

| | Total population (Census 2014) | | FSW | | MSM | | PWID | |
|---|---|---|---|---|---|---|---|---|
| High | 19,089,190 | 38% | 51,161 | 77% | 159,792 | 63% | 54,011 | 65% |
| Medium | 22,833,375 | 45% | 13,018 | 20% | 78,007 | 31% | 25,279 | 30% |
| Low | 8,357,335 | 17% | 1,877 | 3% | 15,411 | 6% | 4,048 | 5% |
| Total | 50,279,900 | 100% | 66,056 | 100% | 253,210 | 100% | 83,338 | 100% |

| | Adult PLHIV | | Adult new infection | | Adult on ART (by reporting site) | | Adult on ART (by residence) | |
|---|---|---|---|---|---|---|---|---|
| High | 165,503 | 76% | 8,250 | 76% | 94,838 | 95% | 77,422 | 78% |
| Medium | 44,264 | 21% | 2,234 | 21% | 4,544 | 5% | 19,218 | 19% |
| Low | 6,924 | 3% | 355 | 3% | 22 | 0% | 2,764 | 3% |
| Total | 216,692 | 100% | 10,839 | 100% | 99,404 | 100% | 99,404 | 100% |

In the new NSP, a geographic and population categorization approach is proposed to optimize the combination of
services for the right locations and the right people. Furthermore, Myanmar has managed to significantly reduce HIV programme costs by streamlining human resource, training, transport costs (to name a few) thereby securing savings for programme interventions. Myanmar's unit costs for prevention and treatment are in the low scale compared with other countries in Asia and the Pacific.

Optimizing the response to HIV in Myanmar required an analysis of the geographical distribution of needs and risks of new infections. Townships were prioritized at a national level through a process of triangulating population size estimates of priority populations, known HIV prevalence, HIV positive and TB/HIV positive reported data, number of PLHIV on ART and PMTCT/HIV positive reported data. This analysis resulted in the classification of 85 high priority/burden townships; 151 medium priority townships; and 94 low burden townships. In terms of need, between 63% and 77% of key populations are found in high priority townships; 76% of the adult PLHIV and 78% of adults on ART reside in high priority townships. Between 19% and 31% of key populations and adults on ART are found in medium priority townships and only up to 6% of priority populations are found within low priority townships.

Myanmar has undertaken additional analysis to provide scientific evidence to determine the most optimal combination of interventions. This series of "optimization analysis" has been achieved through the AIDS Epidemic Model (AEM)[14] and Optima[15] Modelling Software Tools – which resulted in recommendations to scale up prevention interventions and treatment as close to the 90-90-90 Fast Track targets as possible (within different levels of resource availability). It also shows that current level of available resources is far from sufficient to achieve the recommended scenario.

**b) Implementation to date, including the main outcomes and impact achieved under the HIV programs**

**Table 1.2.3: Summary of Progress To Date**

| Programmes | Progress | |
|---|---|---|
| General prevention reach of FSW, MSM, PWID | Expanded to more townships |  |
| Needle Syringe Programme | Increased by more than 25% |  |
| MMT | Increased by 80% from 2013 |  |
| Prisoners, young people, people in workplace setting | Decreased |  |
| Mobile and migrant population and uniformed service personnel | Stayed at same level as 2013 |  |
| Condom distribution (social marketing) | Decreased by 5 million |  |
| Condom distribution (free) | Stayed at same level as 2013 |  |
| People received STI treatment | Increased by 23% |  |
| People received HCT | Doubled that of 2013 (in 2014)[16] |  |
| People receiving ART | 85,626 end of 2014; 106,000 end of 2015[17] |  |
| PMTCT program | # of pregnant women received HCT exceeded the NSP II targets (184%) |  |
| Pregnant women received ART | 24% increase from 2013 |  |
| PLHIV received community home-based care | Decrease |  |
| Orphans and vulnerable children affected by HIV received package of support | Decrease |  |

Overall, the HIV response in Myanmar has continued to be expanded to reach more townships. Prevention programmes tailored to relevant key population groups are being scaled up as needed with additional implementing partners for harm reduction to address previously identified gaps. Despite good programmatic reach and coverage, HIV testing among key populations remains lower than optimal. Data from the National Progress Report shows testing coverage at between 20% and 34% of the total number of key populations reached.

For ART treatment, Myanmar has followed global guidance and adjusted the national SoPs and guidelines prioritizing test and treat all for key populations. ART coverage among all PLHIV doubled from 24% to almost 50% within three years (2012-2015). Part of this impressive achievement includes the shift of

[14] AIDS Epidemic Model – HIV epidemiological modeling and projections including optimization of interventions to inform resource allocation and programme planning (East-West Centre)
[15] Optima – utilizes optimization function to determine most optimal scenario of interventions for HIV response (World Bank, University of New South Wales & University of Bern)
[16] Considerable increases were recorded for each key population, in particular for PWID with almost four-fold increase.
[17] 54.5% of PLHIV in need of ART covered

patients from private sector to the public sector – Government now manages nearly 56% of ART programme[18].

Myanmar has also achieved progress in addressing violations of human rights particularly in completing national legal review and gender assessment of the HIV response in 2014. Priority action areas have been identified to eliminate HIV-related discrimination; implement supportive policy on the ground for harm reduction and prevention and treatment programmes for PLHIV and key populations; amendment of the 100 years old Excise Act that criminalized possession of needles and syringes by non-medical personnel; ensure universal ARV access for PLHIV and key population groups; ensure reproductive rights of HIV-positive women and ensure Patents Bill includes maximum flexibilities and safeguards for Myanmar to continue to access affordable generic medicines. Currently, there is a draft protective law for PLHIV and key populations (to ensure rights to treatment and HIV-related services; prevention from discrimination and penalties for those who discriminate on basis of HIV sero-status).

Achievements in M&E area included Integrated Bio-behavioral Survey (IBBS) with Population size estimation (PSE) for PWID, MSM and Sex Workers; National AIDS Spending Assessment (NASA) for tracking HIV expenditure with a costing study for planning apart from usual national and international reports and HIV projections. MoHS and development partners are collaboratively working on the HIV, TB and Malaria E-Health Investment Plan (2016 – 2020). A software was chosen to develop the Master Patient Index (MPI) for effective longitudinal patient monitoring across care and in May 2016, an integrated E-Health plan for HIV/AIDS, TB and malaria case-based surveillance and aggregate reporting systems was formulated and agreed to by the three national programs.

**c) Limitations to implementation and any lessons learned that will inform future implementation**

Key challenges for prevention

Section 1.1 b provided some insights into barriers and constraints faced by key populations around stigma and discrimination and legal framework. However there are also programmatic issues around implementation. For prevention, fragmentation among programmes, and limited coherent local planning and key population mapping and ad hoc coordination arrangements lead to reduced scale and access to essential services. The current model of Drop-In-Centre and outreach has limited network penetration - many people who can be seen at DICs are those who are already HIV positive and peer outreach workers may have tendency to conduct outreach in same location over time. Testing uptake among key populations reached remains relatively low. The new NSP prioritizes new approaches designed to further penetrate these social networks, reaching those who are at high risk and do not know their status. This will increase uptake of HTC among key populations not currently reached.

Key challenges for HTC

The majority of ART initiation sites in public hospitals do not offer HIV confirmation testing systematically to walk-in patients and those who are found positive with screening test at NGO sites. Voluntary HIV counselling is not widely available in hospital settings. As a result, patients are referred to multiple locations before ART can be initiated, which leads to increased risk of loss to follow up. Quality assurance for HIV rapid testing remains limited to health facility level and does not extend to outreach or mobile testing sites.

Key challenges for treatment

In scaling up ART treatment and transitioning public sector management, there are also limitations to implementation: mainly insufficient qualified health personnel to rapidly expand and decentralized ART treatment. Technical assistance interventions including training must be scaled-up to improve and increase the number of health staff in HIV service delivery. Another challenge for treatment is the sub-optimal monitoring system and the loss to follow up between HIV diagnosis and treatment. As flagged in the TB&HIV section, a priority area is also to increase the number of TB patients who are HIV positive receiving ART treatment. In the PMTCT programme, there is low coverage of early infant diagnosis. The percentage of infants born to HIV-positive women receiving a virological test for HIV within two months of birth was at 17% in 2015 and mother to child transmission rate was 13% in 2015 from PMTCT meeting presentation[19].

Strategic Information and M&E

Starting in 2014, UNAIDS, WHO, and implementing partners under the leadership of the National AIDS Programme have completed surveys, reviews, and situational analyses that provide much needed data to inform programme implementation. The IBBS for all three key population is now available for reference providing updates population size estimates for sex workers, MSM and people who inject drugs. However, information gaps remain: review of prevention programme effectiveness; establishing unique identifier to track number of people reached with HIV services; trends of behaviour of young key population; and HIV risks and vulnerability of migrants/mobile populations. The NSP and this concept note

[18] This includes human resource support from INGOs such as Union, in selected Government sites (2015)
[19] Spectrum 5.4, PMTCT review 2016

emphasize the implementation of the national HIV research agenda and strengthening the national M&E system.

Other limitations
Other HSS issues have been addressed in Section 1.1 (d).

Apart from the limitations stated above, there are a number of different factors that limit scaling up HIV programmes for PLHIV and key population groups. Stigma and discrimination remains one of the most serious issues that impede HIV response scale-up. Surveys and consultations with community representatives, key population groups, and PLHIV (Stigma Index; Do No Harm Asia Catalyst; Legal Review and Community Consultations) report discrimination in health-, employment- and education-settings. Community sentiments against drug production and lack of programmes for drug cessation have also negatively impacted on HIV and PWID harm reduction programmes. In Kachin State, peer educators have been harassed, arrested and jailed for doing their work. Outreach services for sex workers have also been limited due to crack-downs by law enforcement authorities. Together with the National AIDS Programmes, UNAIDS, civil society, networks of key population and media groups are conducting human rights sensitization workshops at local levels to address these issues. 3MDG, USAID are funding programmes to strengthen community capacity to conduct advocacy and champion HIV issues for their communities. The Concept Note addresses these issues in the modules for Legal Barrier and Community System Strengthening.

**d) The main areas of linkage with the national health strategy, including how the implementation of this strategy impacts the relevant disease outcomes.**

The right to health is enshrined in Myanmar's constitution: Article 367 "Every citizen shall, in accord with the health policy laid down by the Union, have the right to health care." The 1993 National Health Policy placed Health for All as a prime objective using Primary Health Care approach. Under the Policy, the National Comprehensive Development Plan for Health Sector from 2010-11 to 2030-31 includes the National AIDS and Sexually Transmitted Disease Control Programme under the Disease Control Section. The National Health Plan covers HIV and AIDS under "Controlling Communicable Diseases".

Full implementation of the new National Strategic Plan on HIV and AIDS will avert 55,537 AIDS-related deaths and 64,637 new HIV infections, bringing Myanmar close to the aim to end HIV as a public health threat by 2030.

**e) Country processes for reviewing and revising the national disease strategic plan(s)**

The evaluation of the previous NSP (2011-2016) took place in 2015 from June to September. The HIV Technical and Strategy Group (TSG) convened thematic working groups to review each of the strategic directions of the NSP (prevention, treatment, impact mitigation, and cross-cutting). Each working group identified key achievements as well as areas for improvement and priority issues that must be addressed in the new NSP. A final list of recommendations was incorporated into the final report. As for all aspects of the HIV response, community representatives, networks of people living with HIV (all nine networks) together with implementing partners, UN and development partners work together with the National AIDS Programme and Ministry of Health and Sports. Representatives of networks of PWID, MSM, SW, and PLHIV actively participated in working group meetings and national consultations to review and endorse recommendations.

From October of December 2015, the TSG followed a similar process to develop the new National Strategic Plan. Numerous consultations and thematic reviews and workshops were held building on the work that was initiated for the NSP Evaluation earlier. Working Group members focused on how they can do things differently in the new NSP and were also guided by the TSG to be aware that Myanmar will most likely face significantly resource reductions in the years to come. A core team (NAP, UNAIDS, WHO, US-CDC, ICAP) was established to guide and coordinate the inputs from the various working groups. A team of consultants was brought in to help look at new service delivery models and approaches to adapt to the Myanmar context and developing a focused, cost efficient NSP. The core team also conducted an analysis of different levels HIV burden and key populations in different geographic areas and proposed a geographic prioritization approach assigning High, Medium and Low Priority for different township. The final NSP will be submitted to the Ministry of Health and Sports for approval in June 2016.

## 1.2 National Disease Strategic Plan: TB

**a) The key goals, objectives and priority program areas**

The National Tuberculosis Program has recently completed its National Strategic Plan 2016-2020. The plan's goal is to end the TB epidemic in Myanmar, indicated by fewer than 10 cases per 100,000 population by 2035. The NSP is fully aligned with the WHO End TB Strategy and is organized according to 3 Strategic Priorities, highlighted below. It also embraces the 4 key principles: i) government stewardship and accountability, with M&E; ii) Strong coalition with civil society organizations and communities, iii) protection and promotion of human rights, ethics and equity; and iv) adaptation of the strategy and targets at

decentralized levels, with NTP coordination.

**Strategic Direction I: Integrated, patient-centered care and prevention**

Under this strategic priority, the NSP sustains the current strengths of the program while tackling key challenges. Most notable among these is the high rate of drug resistance among new and retreatment cases. A third national drug-resistance survey completed in 2013 found 5.0% (CI: 3.1% - 6.8%) multi-drug resistance (MDR) among new TB cases and 27.1% (CI: 15% - 39.2%) among retreatment cases. The roll-out of Xpert has begun, enabling the detection of more MDR-TB patients. The NSP plans for further scale-up of Xpert, bringing access to the entire population and optimizing the use of Xpert based on lessons learned from the introductory phase. While the numbers being enrolled on treatment have doubled over the past year, treatment scale-up has not kept pace with diagnosis. MDR-TB treatment commensurate with diagnostic scale-up is reflected in the NSP. By 2020, all MDR-TB patients will be enrolled on treatment within 2 weeks of their diagnosis.

With ambitious plans to expand service coverage to the entire population, all care providers and communities must be engaged. The NSP presents evidence-based interventions to improve the quality of care provided by non-MoHS providers and seeks to engage non-health sectors in TB control through schools, workplaces, prisons, housing, etc. Evidence regarding knowledge, attitudes and care-seeking practices of the population provide the foundation for an advocacy, communications and community-engagement strategy as an integral component of the NSP.

The NSP take into account the special needs of high-risk populations as it seeks to intensify case finding and successful treatment among these groups. Evidence drawn from years of pilot projects seeking to address these populations has been harnessed and the scale-up of successful models is planned. Targeted interventions are proposed, tailored to the socio-economic and epidemiological determinants related to increased risk of TB among the health workers, miners, migrants, prisoners, the urban poor, and drug users.

Little is currently known about the provider practices that have led to over a quarter of all notified cases being among children < 15 years of age. Epidemiological evidence suggests that pediatric TB is likely being over-diagnosed, especially among children 5-14, and under-diagnosed among children < 5. Plans to better understand the situation and build an evidence-base for a systematic response are included among the operational research priorities. Innovative strategies to improve the quality of pediatric diagnosis, such as the creation of an external quality-assurance system for x-ray, will be employed. Concurrently, expanded use of Xpert for increasing the proportion of child TB cases that are bacteriologically confirmed is planned. Prevention of TB in children, primarily through enhanced contact tracing and implementation of isoniazid preventive therapy, is envisaged.

This NSP reflects a patient-centered approach to care, both in the planned devolution of capacity to ensure quality services where patients live and in the management of the “whole” person. The NTP will, in particular, collaborate with other programs of the Ministry to ensure comprehensive management of TB concomitant with HIV and diabetes.

**Strategic Direction II: Bold policies and supportive systems**

The NSP will be implemented in the context of a devolving health system and national progress toward Universal Health Coverage. As such, the NSP both builds upon and aims to strengthen several core aspects of the health system. Vital to successful case detection and treatment will be the availability of uninterrupted, quality-assured laboratory commodities and anti-TB drugs. The NSP acknowledges the needs to strengthen supply chain management systems, optimally based on demand as expressed through an electronic case-based recording and reporting system with links between laboratories and healthcare providers. The NSP prioritizes the filling of vacant posts and expansion of partner implementation sites to best cover populations that remain under-served. It simultaneously proposes innovative models for building human resource capacity through the mentorship and exchange of staff to / from well-performing sites and townships.

Finally, this NSP is a roadmap for the country, not only the Ministry of Health and Sports. It acknowledges the important role of partners, non-health sectors, and communities. It offers a framework for efficient coordination and consistently high standards to be employed by all in the fight against TB in Myanmar.

**Strategic Direction III: Intensified research and innovation**

The NSP recognizes that a robust and responsive surveillance, monitoring and evaluation (M&E) system is important for ensuring evidence-based planning, implementation of quality TB control activities and tracking progress towards achieving NTP goals. To address specific knowledge gaps, the NSP builds on Myanmar’s rich history of employing operations research. Implementation of a prioritized research agenda is envisaged, led by the Department of Medical Research (DMR) and the universities of medicine and university of public health For the period of this NSP, the NTP will focus on a shift to electronic data capture and management systems, including the use of GIS technologies, integration of TB into the emerging DHIS and LMIS systems, strengthening of vital registration for more consistent recording of TB-related deaths, decentralization of data analysis skills, and enhanced evidence base for future policy and practice through operations research.

**b) Implementation to date, including the main outcomes and impact achieved under the TB programs**

Since the newly developed NSP 2016-2020 has yet to be implemented, the program implementation status needs to be assessed on the basis of the previous NSP, covering the period 2011-2015. The most recent comprehensive assessment of program performance was completed during the joint monitoring mission (JMM) 2014. The full report is annexed. Among the key findings were:

- The JMM noted that Myanmar has already met the 2015 target for reducing incidence and mortality, and is on track for the prevalence target. The JMM was concerned, however, by the slow increase and even stagnation of case detection since 2007. There was some evidence that there was a deliberate (and appropriate) reduction in pediatric notifications due to an increase in the stringency of the diagnostic criteria for primary complex, especially in the 5-14 years age group.
- Disappointingly, the introduction of new technology, specifically Xpert, was not resulting in an increase in notifications. However, in both the Union's PICTS project and in Ayeyarwaddy Region the proportion of total cases that was bacteriologically confirmed increased in 2013, and this was attributable to the deployment of Xpert® MTB/RIF.
- The JMM also observed an increase in public hospitals engaged in PPM from 9 to 24 between 2011 and 2014. TB care provision by NGOs has contributed to an increased involvement of and referrals by community volunteers.
- There was a significant increase in detection of MDR-TB cases, from 778 in 2012 to 1984 in 2013. Since this is attributable in large part to greater use of Xpert® MTB/RIF, it is likely that the diagnosis is made earlier, but there had been no formal evaluation.
- There was a significant increase in HIV-TB service provision, compared to 2011. However, only 12% of TB patients knew their HIV status in 2013.
- The Asian Harm Reduction Network (AHRN) is screening and diagnosing drug users for TB (2000 registered in 2014) and referring them to the Waing Maw Township Hospital (Kachin State) for methadone and TB treatment.
- In 2013, through all ACF methods, approximately 45 000 people were screened for TB (nearly 4300 TB cases (all forms) including 899 smear-positive TB cases were detected; 4 298/142 162 or 3% contribution to case detection).
- Community volunteers are increasingly involved in TB care provision by NGOs. In 2013, 8692 presumptive TB cases in 166 townships were referred by volunteers

Since the conclusion of the JMM, there has been a flurry of activity in response to the recommendations. A series of technical assistance visits have been made to guide the technical direction of the NTP (all reports are annexed) and have informed the NSP. Various national guidelines have been updated, and capacity building activities rolling out. Some examples include:

- NSP: Completion of the National Strategic Plan for TB 2016-2020 through a consultative process
- PMDT scale-up: A recent GLC mission noted that much progress had been made since the 2014 monitoring mission. The "Guidelines for the management of MDR−TB" have been revised. Updates include: revision of the diagnostic algorithms, including removal of the requirement for confirmatory testing for cases diagnosed by Xpert; widened eligibility criteria for DST, including testing all registered TB cases in the Yangon Region; PAS not included in the MDR−TB treatment regimen for all MDR−TB cases; treatment duration now 20 months; and an XDR−TB regimen has been agreed upon. Testing and treatment initiation has scaled up.
- Laboratory strengthening: a national Annual TB Laboratory Evaluation was completed and recommendations incorporated into the NSP. Xpert capacity has been expanded.
- Infection control: a national assessment of infection control practices and capabilities was completed and recommendations incorporated into the NSP
- Childhood TB: Training development and roll-out has been initiated at Regional and State level
- Chest x-ray: Training on CXR interpretation has been initiated for township medical officers and partners.
- Intensified case finding activities have rolled out, yielding important contributions national case notification.

**Table 1.2.4 Intensified Case Finding (20% of all cases) in 2015**

| Activities | Number of TB Patients |
|---|---|
| Community-based TB care | 16465 |
| Initial home visit & contact tracing | 1387 |
| Sputum Collection Centre | 191 |
| Mobile Team | 4277 |
| TB screening in PPM hospital (OPD) | 950 |
| TB screening in Pregnant and lactating mother | 149 |
| TB screening in under 5 children | 4997 |
| Total | 28416 |

**c) Limitations to implementation and any lessons learned that will inform future implementation**

The following main limitations to implementation and lessons learned from previous activities were identified by the JMM team:

- There are gaps in the numbers and capacity of staff working on TB, particularly in basic health services and the fields of monitoring and evaluation, laboratory, and programme management at central and state/regional levels.
- Capacity at district and township levels is still insufficient for the programme expansion that is needed and the additional demands created by adding new fields such as childhood TB, MDR-TB, budgeting/planning etc.
- The current health sector reform and the proposed split of medical care and public health are already changing the health environment. It is not clear how TB will be mainstreamed within emerging structures.
- Current case detection is missing around 30% of the estimated TB cases, especially those in vulnerable groups, including the elderly and children under five years.
- Only a minority of TB and HIV co-infected patients currently accesses appropriate services, especially antiretroviral treatment (ART).
- There are insufficient drugs, and capacity, to treat all the MDR-TB cases in Myanmar, in spite of recent increases in availability due to additional funding from the Three Millennium Development Goals Fund (3MDG) and the Global Fund.
- Future expansion of MDR-TB diagnosis and treatment may place too heavy a burden on peripheral health services.
- The rapid expansion of the private health care sector and the multiplicity of partners and nongovernmental organizations (NGOs) in Myanmar emphasize the need for NTP to exercise leadership and for all the partners to collaborate and coordinate with each other

The newly developed NSP 2016-2020 effectively addresses the previously identified limitations to implementation and builds on lessons learned from previous activities. As a result, the NSP sustains the current strengths of the program while tackling key challenges. The NSP 2016-2020 plans for further scale-up of Xpert, bringing access to the entire population and optimizing the use of Xpert based on lessons learned from the introductory phase. MDR-TB treatment commensurate with diagnostic scale-up is reflected in the NSP. The NSP envisions that by 2020, all MDR-TB patients will be enrolled on treatment within 2 weeks of their diagnosis.

The NSP presents evidence-based interventions to improve the quality of care provided by non-MoHS providers and seeks to engage non-health sectors in TB control through schools, workplaces, prisons, housing, etc. Evidence regarding knowledge, attitudes and care-seeking practices of the population provide the foundation for an advocacy, communications and community-engagement strategy as an integral component of the NSP.

The NSP take into account the special needs of high-risk populations as it seeks to intensify case finding and successful treatment among these groups. Evidence drawn from years of pilot projects seeking to address these populations has been harnessed and the scale-up of successful models is planned. Targeted interventions are proposed, tailored to the socio-economic and epidemiological determinants related to increased risk of TB among the health workers, miners, migrants, prisoners, the urban poor, and drug users. Plans to better understand the childhood-TB situation and build an evidence-base for a systematic response are included among the operational research priorities. Innovative strategies to improve the quality of pediatric diagnosis, such as the creation of an external quality-assurance system for x-ray, will be employed. Concurrently, expanded use of Xpert for increasing the proportion of child TB cases that are bacteriologically confirmed is planned. Prevention of TB in children, primarily through enhanced contact tracing and implementation of isoniazid preventive therapy, is envisaged. The NSP reflects a patient-centered approach to care, both in the planned devolution of capacity to ensure quality services where patients live and in the management of the "whole" person. The NTP will, in particular, collaborate with other programs of the Ministry to ensure comprehensive management of TB concomitant with HIV and diabetes.

**d) The main areas of linkage with the national health strategy, including how the implementation of this strategy impacts the relevant disease outcomes.**

The latest version of Myanmar's national health strategy is available through the MOHS publication "Health in Myanmar 2014". Both the TB and HIV NSP's are clearly aligned with the national MOHS policy. The chapter on "Controlling Communicable Diseases" of the MOHS policy identifies the following priorities, which are all reflected in the NSPs:

"Communicable diseases prevention and control is one of the priority tasks of Ministry of Health and Sports in achieving its objectives of enabling every citizen to attain full life expectancy and enjoy longevity of life and ensuring that every citizen is free from diseases. The objective of the Communicable Disease Control Programme is to reduce morbidity and mortality from communicable diseases so as to eliminate them from

arising as public health problems and to mitigate subsequent social and economic problems. As emphasis has been given for control of communicable diseases, plans have been developed systematically for preventing and controlling diseases like malaria, tuberculosis, leprosy, filariasis, dengue haemorrhagic fever, water borne epidemic diseases, diarrhoea, dysentery, viral hepatitis, and other preventable diseases.

As in many other countries, AIDS, TB and Malaria primarily affect the working age. These three diseases are considered as a national concern and treated as a priority. The ministry has determined to tackle these diseases with the main objectives of reducing the morbidity and mortality related to them, of being no longer a public health problem, and of meeting the Millennium Development Goals. Other communicable diseases and emerging communicable diseases that have regional importance are also tackled through activities encompassing surveillance and control. Under the Disease Control Division and with the support of Central Epidemiological Unit, supervision, monitoring and technical support are provided by disease control teams at central level and state/regional levels."

**e) Country processes for reviewing and revising the national disease strategic plan(s)**

The NSP development process started with the completion of an Epidemiological Assessment in November 2014, by WHO and the Research Institute of Tuberculosis (RIT), Japan. This served as a critical background document for 5th Joint Monitoring Mission, which took place during December 2014. These two assessments were reviewed and considered during an initial stakeholder meeting for the NSP development in May 2015. The stakeholder meeting was convened immediately following the Annual Laboratory Review and Annual TB Evaluation 2014. As such, participants benefitted from an up-to-date review of progress, plans and challenges across the country. The first NSP stakeholder meeting involved central level staff of various departments of the Ministry of Health and Sports, and nearly 100 representatives from Regional and State Health Departments, Physicians from general and specialist Hospitals, civil society and non-governmental organizations, donors and other partners. Priorities for the coming 5-years were discussed and consensus reached on the impact and outcome targets, and strategic objectives for the NSP.

A writing team for each thematic area was derived from the participants of these initial stakeholder meetings and the strategic priorities for each technical component of the NSP were prepared. Based on these inputs, a preliminary draft of the NSP was developed, shared and discussed with the TB Technical and Strategic Group in August 2015. Revisions were incorporated and a second stakeholder meeting was convened in August 2015, to seek wide inputs to the draft NSP. Comments were taken into account by the writing teams and a second draft was prepared. Finalization of the technical sections occurred through thematic writing groups, in consultation with the TSG and NTP, during September – December 2015. A financial costing, operational plan and monitoring and evaluation plan were developed at the conclusion of the drafting process. The final draft was shared virtually with all interested parties and comments considered by the National TB Program.

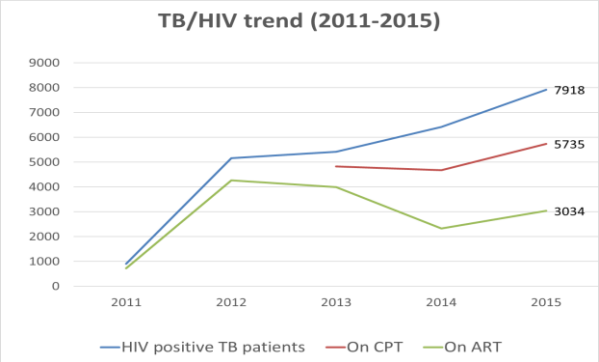
## 1.2 National Disease Strategic Plan: TB&HIV

**a) The key goals, objectives and priority program areas**

Both National Strategic Plans of TB and HIV prioritize scale-up of TB/HIV collaborative activities to cover the entire country. Targeted operational research is also planned to further inform scale-up and address barriers to uptake of collaborative approaches, such as IPT. Essential TB/HIV services to be implemented nationwide and at all levels of the health system include:

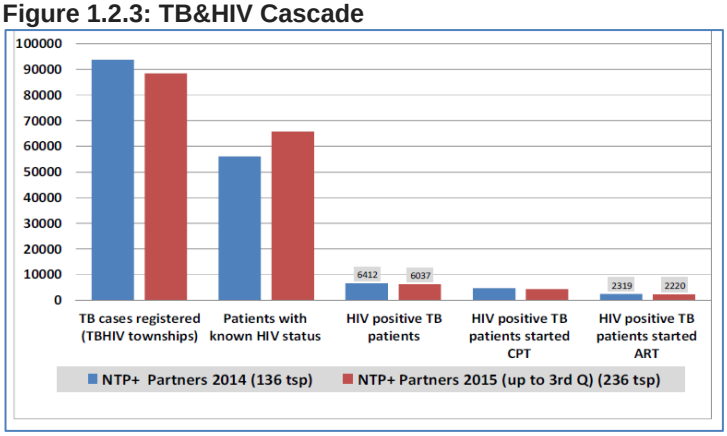
- Improve coordination between programs by establishing functional TB/HIV coordinating bodies at national, state and region, district, township, and in all hospitals caring for both TB and HIV patients.
- Ensure human resource capacity for TB/HIV collaborative activities with regular training of new staff at all levels, quarterly supportive supervision and annual refresher training of existing staff, nationwide dissemination of guidelines and development of supportive, on-the-job tools.
- Designate a TB/HIV focal point within each integrated disease control team at township level.
- Conduct TB symptom screening during the initial and follow up visits of PLHIV, as an integral part of care
- Provide HIV counselling, testing, and prevention services to all patients with presumptive and diagnosed TB
- Initiate early ART for all TB patients with HIV infection
- Provide TB treatment for all PLHIV with active TB disease
- Provide isoniazid preventive therapy to all PLHIV who do not have active TB disease
- Provide co-trimoxazole preventive therapy for TB patients living with HIV
- Link data systems to enable monitoring of care and treatment for patients with TB and HIV.
- Coordinated and enhanced procurement and supply management systems (across TB, HIV and malaria)

**b) Implementation to date, including the main outcomes and impact achieved under the HIV and TB programs**




TB/HIV collaborative activities began in seven townships in 2005. By 2014 and 2015, they had expanded to 136 and 236 townships respectively with full national coverage expected by the end of 2016. Tools and trainings modules have been developed to enable the health care personals to conduct TB symptom screening in HIV clinics and HIV testing in TB clinics. The cross referral system has been established in all TB/HIV townships. Sixty-three (63%) of registered TB patients in TB/HIV townships had known HIV status in 2014, an increase from only 12% in 2013. During 2015, 236 townships reported on TB/HIV indicators. Of the 7918 HIV-positive TB patients notified in 2015, over 72% were given CPT and 38% initiated ART. A total of 10,345 PLHIV were enrolled under the care of the NAP in these townships, out of which, 85% (8781/10345) of patients received TB screening and 17% (1,515/8781) of PLHIV were given IPT. States and Regional level TB/HIV workshops were conducted in 2015 to strengthen the existing TB/HIV activities including recording and reporting of TB/HIV data. However, the table below shows low number of HIV positive TB patients started ART, which will be addressed in this Concept Note.

**Figure 1.2.3: TB&HIV Cascade**




A joint TB/HIV assessment mission was supported by UNAIDS and WHO (with financial support from USAID) in 2016. The mission offered recommendations to strengthen each of the NSPs, which were taken into account by the respective programmes and their partners. The full report is annexed.

**c) Limitations to implementation and any lessons learned that will inform future implementation**

Given the high rate of TB/HIV co-infection, TB and HIV collaborative activities, including appropriate case management for co-infected patients, will mitigate deaths and disability. While HIV testing among TB patients has been scaling up rapidly, slower progress has been made with the introduction of TB screening among PLHIV. It was estimated that approximately 85% of people with known HIV were screened for TB in 2015.

Access to ART remains limited. Around 38% of HIV-infected TB patients accessed ART in 2015. Several key interventions for TB/HIV, such as infection control and isoniazid preventive therapy have not yet been introduced on a wide scale. Provision of isoniazid preventive therapy (IPT) remains low primarily due to provider unwillingness to give IPT to their patients.

There is wide variability between regions and states with regard to their experience and success with the implementation of TB/HIV collaborative activities. For example, the Mandalay region has conducted TB/HIV activities for 10 years, while Chin state has not yet started. Contributing to the geographic variance in the prevalence of TB/HIV is the variable distribution of HIV itself, and its high rates among some hard-to-reach populations. By the end of 2016, all townships should be implementing TB/HIV collaborative activities.

**1.3 Joint planning and alignment of TB and HIV Strategies, Policies and Interventions**

In order to understand the **future** plans for joint TB and HIV planning and programming, briefly describe:

a. Plans for further alignment of the TB and HIV strategies, policies and interventions at different levels of the health systems and community systems. This should include a description of i) steps for the improvement of coverage and quality of services, ii) opportunities for joint implementation of cross-cutting activities, and iii) expected efficiencies that will result from this joint implementation.

b. The barriers that need to be addressed in this alignment process.

A joint TB/HIV assessment mission conducted in 2016 was supported by WHO, UNAIDS, USAID and implementing partners (full report annexed). This was a first joint review mission for TB&HIV. The assessment teams reviewed the TB and HIV NSP's, conducted sites visits and offered recommendations for strengthening TB/HIV collaborative activities within each of the plans. These were taken into account by the respective programs by the joint TB&HIV Working Group.

As such, full implementation of the NSPs will yield improved collaboration and a comprehensive package of services for patients. Efficiencies will be gained through joint supervisory missions and capacity building activities, coordinated TB/HIV focal points within disease control teams.

The pharmaceutical and supply management system needs to be strengthened to ensure uninterrupted and smooth flow of HIV test kits and drugs, as well as TB medicines and diagnostic commodities – irrespective of administrative arrangements. M&E systems need to be enhanced upgrading to electronic data systems such as DHIS2 and adopting common indicators to harmonize reporting. More research is needed to identify trends and issues that must be addressed to improve programme implementation. For the joint Concept Note – TB will cover all TB costs for PLHIV (TB tests for PLHIV) and HIV will cover all HIV costs for TB patients (ART treatment and IPT). Cross-cutting components such as coordination, training, referrals of patients for services will be shared between the two programmes. TB will cover training for both TB and HIV programmes as it has been agreed by the two programmes to combine training efforts to reduce costs and increase efficiencies. As described in section 1.2 above, a comprehensive package of activities has been defined, including:

1. Co-location of TB and HIV services, where possible, and funded referral of patients where not
2. Improved coordination between programs through TB/HIV coordinating bodies at national, state and region, district, township, and in all hospitals caring for both TB and HIV patients.
3. Ensure human resource capacity for TB/HIV collaborative activities with regular training of new staff at all levels, quarterly supportive supervision and annual refresher training of existing staff, nationwide dissemination of guidelines and development of supportive, on-the-job tools.
4. Designate a TB/HIV focal point within each integrated disease control team at township level.
5. Conduct TB symptom screening during the initial and follow up visits of PLHIV, as an integral part of care
6. Provide HIV counselling, testing, and prevention services to all patients with presumptive and diagnosed TB
7. Initiate early ART for all TB patients with HIV infection
8. Provide TB treatment for all PLHIV with active TB disease
9. Provide isoniazid preventive therapy to all PLHIV who do not have active TB disease
10. Provide co-trimoxazole preventive therapy for TB patients living with HIV
11. Link data systems to enable monitoring of care and treatment for patients with TB and HIV
12. Coordinated and enhanced procurement and supply management systems (across TB, HIV and malaria)

## SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources that are insufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

### 2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the TB and HIV national programs and how this funding request fits within these, briefly describe:

a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).

b. How the proposed Global Fund investment has leveraged other donor resources.

c. For program areas that have significant funding gaps, planned actions to address these gaps.

### 2.1 Overall Funding Landscape for Upcoming Implementation Period

Overview: Public spending on health increased from $1 per capita in 2009/2010 to $11 in 2013/14. Still, Myanmar's national expenditures on health, at 3.38% of its gross domestic product in 2014/15, are the lowest among the ASEAN countries. Recent policy made essential drugs available free of charge through public facilities contributing to a reduction of the weight of OOP payments from 90% of health spending to 60% today. However, approximately 20% of people face catastrophic costs when seeking care. Since 2011, external partners to the health sector including GF have committed over US$ 1 billion for health. These investments have resulted in progress for improving health systems, however, further investment will still be required to address remaining gaps including for communicable diseases.

**HIV**

**a. Availability of Funds and Funding Sources**

Based on the new National Strategic Plan on HIV and AIDS (2016-2020), the total funding need is estimated at US$ 450 million, an 18% decrease from the total funding need of the previous NSP (2011-2016) at US$ 550 million. The decrease in the new NSP is attributable to newly adjusted service delivery models and streamlined costs that will enable an effective and efficient strategic scale-up of priority programme components and strengthening of cross-cutting components. The geographic and population prioritization approach following levels of HIV burden in the new NSP also contributes to cost savings as comprehensive packages of services are only implemented at highest intensity for those in the highest priority areas (85 out of the 330 townships), and not nation-wide.

Domestic funding for the national HIV response is channelled through the budget of the National AIDS Programme and shared health systems. Public sector spending increased from US$ 3.6 million in 2014 (5% of total HIV spending) to US$ 10.4 million in 2015 (12% of total HIV spending). Results from the recent National AIDS Spending Assessment (NASA) in Myanmar for 2014-2015 indicated that public sector direct spending on HIV in 2015 was primarily focused on treatment and care programmes, harm reduction (MMT), and policy and coordination.

Through shared health systems, MoHS funding for HIV also includes maternal and child health, infrastructure costs for public health facilities that provide HIV programmes, and general health care staff, among other components. Other Ministries also provide modest contributions to the national HIV response through their respective budgets, including the Ministry of Social Welfare and Ministry of Home Affairs. Planned direct Government contributions to implement NSP activities in 2016 are estimated to increase to **US$ 9 million** for HIV medicines and OST alone, which does not include shared health systems costs (i.e. total Government contributions will be greater than US$ 9 million). Although the country remains dependent on external resources, the growing share of public sector spending indicates the commitment and ownership of the Government to transition a domestically financed national HIV response. Refer to **Table 2.1.1** for a summary of expected contribution by the Government and external sources.

The single largest external financing source of the HIV response is the Global Fund, accounting for 50% in 2015. Other limited external financing sources include the 3MDG Fund (a multi-donor trust fund that pools the contributions of seven bilateral donors), PEPFAR/USAID, ADB, and international and local NGOs. Between 2012-2017, out of US$ 271 million total funds available from the 3MDG Fund, US$ 13.5 million was allocated for HIV.

There is a decreasing trend in external funding for HIV in Myanmar. The Government of Australia in 2015 withdrew health sector support. The 3MDG Fund will close out at the end of 2017 significantly decreasing resources for HIV prevention in Myanmar, particularly in the area of harm reduction for people who inject drugs. As yet, there is no official commitment from 3MDG Fund Board for HIV after 2017. US Government has increased HIV prevention and TA funding through PEPFAR, but this is a modest amount at around US$ 10 million a year. ADB's investments are largely infrastructure-focused and HIV funding (US$ 10 million over three years ending at the end of 2017) towards national capacity strengthening, limited to the economic corridor in Kayin and Mon state. No other donors have pledged significant funds for HIV response in Myanmar for the NSP period (2016-2020). Table 2.1.1 provides an overview of non-GF resources available from 2017-2020 at around US$ 98.6 million.

**Table 2.1.1. Resources available for HIV NSP III implementation (excluding GF)**

| Funding Source | 2017 | 2018 | 2019 | 2020 | Total |
|---|---|---|---|---|---|
| Public | 13,243,600 | 13,370,908 | 13,502,035 | 13,637,096 | 53,753,639 |
| Intl bilateral | 7,949,000 | 7,549,000 | 7,549,000 | 7,549,000 | 30,596,000 |
| Intl multilateral | 14,076,750 | 200,000 | - | - | 14,276,750 |
| Private | - | - | - | - | - |
| **TOTAL** | **35,269,350** | **21,119,908** | **21,051,035** | **21,186,096** | **98,626,389** |

* Resource availability survey results; no estimates available from certain organisations beyond the current year

### b. Leverage of Other Donor Resources Through GF Support

Global Fund funding has enabled the leveraging of other donor support in the national HIV response to have greater depth and wider coverage within the main priority areas of prevention, testing, and treatment, care and support. Other (non-GF) donor support, such as from PEPFAR/USAID and ADB, covers multiple areas of the national response, supplementing or complementing GF-funded HIV programmes, including community systems strengthening, institutional capacity building, harm reduction, and other focus areas. However, given that funding allocation decisions on external resources are managed outside of the national context, there are limits to the extent with which other donor resources can be leveraged. As such, as part of the development of the new NSP and the Concept Note, the need for more efficient and effective coordination and collaboration on programme implementation, including service delivery and technical assistance, among partners has been emphasised and used as a guiding point to prioritise interventions and optimise resources for the national response.

### c. Funding Gaps and Planned Actions

Total HIV funding needs, as per the new NSP, is US$ 450 million for 2016-2020. The NSP funding needs for 2017-2020 is US$ 372 million. Current and anticipated resources from Government and donors from the same four-year period, excluding GF funding, at US$ 98.6 million are insufficient to meet these funding needs. **Table 2.1.2** highlights the estimated funding gap as required to fully implement the NSP for each major programme component.

**Table 2.1.2: Estimated NSP Funding Gap by Programme Area and Planned Actions (2017-2020)**

| Programme Area | Planned Actions |
|---|---|
| **PREVENTION**<br>Resource Need<br>$95.7 million<br><br>Anticipated Resources*<br>$31.5 million | • Transition to integrated DIC model in areas with large priority populations, providing combination prevention interventions, with linkages to care and treatment. Will reduce management costs and realise efficiency gains from economies of scale through greater utilisation.<br>• To optimise resources and ensure value-added use of facilities, non-integrated DICs and DICs with low utilisation will be phased-out, as appropriate depending on the area context.<br>• In conjunction, transition to a community-based approach to bring services closer to those in need with outreach units. Cost savings on management and |

| | |
|---|---|
| Funding Gap<br>$64.2 million | not having physical structures with low utilisation will be achieved.<br>• Use of social media, mobile applications, and social networks to expand outreach to hard-to-reach and non-disclosed priority populations. Will maximise coverage, reduce missed opportunities, and provide efficiency gains. |
| **TESTING**<br>Resource needs for KP HCT are included as part of Prevention. | • Integration of HCT in DICs and (mobile) outreach units, with links to treatment will provide efficiency gains and cost savings.<br>• Co-location of decentralised HCT and ART sites to ensure linkage, reduce loss to follow-up, and realise related efficiency gains.<br>• Greater implementation of community-based screening, with linkages to confirmation and treatment, will be cost-effective to increase coverage.<br>• HCT will be made available to prisoners through integrated HIV/TB services, which will prevent new infections and ensure initiation on ART if needed. |
| **TREATMENT**<br>Resource Need<br>$213 million<br>Anticipated Resources*<br>$152 million<br>Funding Gap<br>$61 million | • Transition of PLHIV on ART from the private (I/NGO) sector to the public sector to increase cost efficiency and ensure sustainability. Transition support provided by I/NGOs will help to strengthen public sector capacity to provide quality care<br>• Scale-up' test and early treatment' approach (e.g. establish HCT confirmation at ART initiation sites) to maximise retention<br>• Scale-up viral load testing, which will provide cost savings through lower disease progression / transmission, and earlier detection of potential drug resistance<br>• Standardise adherence support for PLHIV on ART to reduce loss to follow-up; improved support and earlier initiation on ART will result in less patients needing assistance over time |

* Includes both anticipated Global Fund allocation and Government contribution

As indicated earlier, Myanmar has undertaken additional analysis to provide scientific evidence to determine the most optimal combination of interventions. These series of "optimization analyses" were achieved through the AIDS Epidemic Model (AEM)[20] and Optima[21] Modelling Software Tools – which resulted in recommendations to scale up prevention interventions and treatment as close to the 90-90-90 Fast Track targets as possible (within different levels of resource availability).

**Table 2.1.3: Funding Scenarios and Projected Impact[22]**

| Next Four Years Funding: 2017-2020 | | Epidemic Projection Period: 2017-2030 | |
|---|---|---|---|
| Scenarios | GF resource level in US$ | Cumulative New Infections | Cumulative Deaths |
| 1) Scale Down | 175,205,903 | 186,681 | 173,569 |
| 2) Maintenance | 229,619,329 | 76,637 | 127,287 |
| 3) Optimized | 257,554,348 | 54,316 | 121,195 |
| 4) Fast Track | 318,589,806 | 52,135 | 111,380 |

**Scale Down Scenario**

Myanmar requires US$ 120 million as part of the GF allocation over the next four years to maintain the current ART cohort. However, given the GF allocation of US$ 175 million, only US$ 27.5 million will be available for prevention in the same period. As a result, prevention interventions will be scaled down, resulting in exponentially high numbers of new infections - the highest being among PWID, followed by clients of female sex workers and low risk females (female partners of key populations). By 2020, prevention programme coverage will be less than 30% for each key population. By the end of 2020, treatment coverage will be stagnant at 47% for key populations. The resulting new HIV infections will directly increase the number of people needing ART and requiring more resources. After the first year, remaining resources will be inadequate to maintain prevention, other cross-cutting components (HSS, CSS and removing legal barriers) as well as essential programme management support. The detailed proposed budget distribution is presented in Table 2.1.4.

[20] AIDS Epidemic Model – HIV epidemiological modeling and projections including optimization of interventions to inform resource allocation and programme planning (East-West Centre)

[21] Optima – utilizes optimization function to determine most optimal scenario of interventions for HIV response (World Bank, University of New South Wales & University of Bern)

[22] AEM Optimization Analysis and Impact Projections, May 2016

**Table 2.1.4: Budget Distribution of the Scale Down Scenario over Four Years**

| Module name | Year 1 | Year 2 | Year 3 | Year 4 | Total |
|---|---|---|---|---|---|
| Prevention programs for MSM and TGs | 2,188,477 | 1,049,993 | 1,100,072 | 1,088,926 | 5,427,468 |
| Prevention programs for sex workers and their clients | 2,941,787 | 1,346,121 | 1,351,233 | 1,335,223 | 6,974,364 |
| Prevention programs for people who inject drugs (PWID) and | 6,791,736 | 2,608,268 | 2,488,764 | 2,496,922 | 14,385,691 |
| Prevention programs for other vulnerable populations (please | 899,046 | 903,136 | 780,010 | 776,842 | 3,359,033 |
| PMTCT | 2,395,911 | 2,395,911 | 2,395,911 | 2,395,911 | 9,583,644 |
| Treatment, care and support | 29,147,544 | 27,735,229 | 26,395,198 | 25,157,903 | 108,435,873 |
| TB/HIV | 222,310 | 249,441 | 279,056 | 310,167 | 1,060,974 |
| HSS - Procurement supply chain management (PSCM) | 245,313 | 10,523 | 9,796 | 9,808 | 275,439 |
| HSS - Health information systems and M&E | 1,705,058 | 307,637 | 299,111 | 267,644 | 2,579,451 |
| HSS - Service delivery | 490,626 | 105,227 | 97,955 | 98,078 | 791,888 |
| Removing legal barriers to access | 215,876 | 46,300 | 43,100 | 43,154 | 348,431 |
| Community systems strengthening | 667,252 | 143,109 | 133,219 | 133,386 | 1,076,967 |
| Program management | 9,473,290 | 3,465,003 | 3,851,149 | 4,117,240 | 20,906,682 |
| | | | | | |
| **Total** | **57,384,226** | **40,365,898** | **39,224,575** | **38,231,204** | **175,205,903** |

**Maintenance Scenario**

The "Maintenance" scenario is based on a continuation of 2016 expenditure level (burn rate) of approximately US$ 57 million and will require US$ 229 million over the next four years. As a result of identifying efficiency gains, this funding amount is adequate to maintain the current treatment cohort, absorb some newly detected infections, and sustain current prevention interventions. However, significant scale-up will not be possible. The "Maintenance" scenario will result in 76,637 cumulative new infections and 127,287 new deaths by 2030, still far from the level needed to be on track to end the AIDS epidemic by 2030.

**Optimized Scenario**

Myanmar is requesting the Global Fund to consider funding the HIV response above a maintenance level at the most optimal level in terms of epidemiological impact, the "Optimized" scenario at US$ 257 million for four years. With additional funding from Global Fund of around US$ 20 million a year, Myanmar will be able to reach the 90-90-90 targets among key populations resulting in similar impact level as the Fast Track Scenario for all. By 2030 this scenario will limit the number of cumulative new infections and deaths at 54,316 and 121,195, respectively.

**Fast Track Scenario**

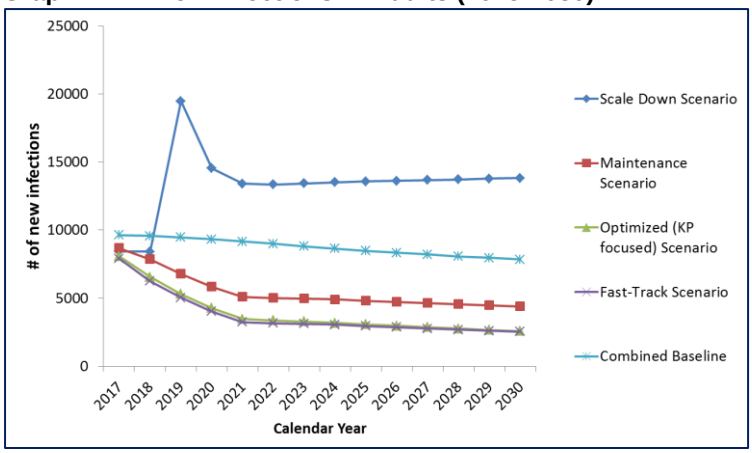
The "Fast Track" scenario requires US$ 319 million and reflects Myanmar's full expression of demand. This scenario will result in the lowest number of cumulative new infections and deaths by 2030, at 52,135 and 111,380, respectively.

**Domestic funding**

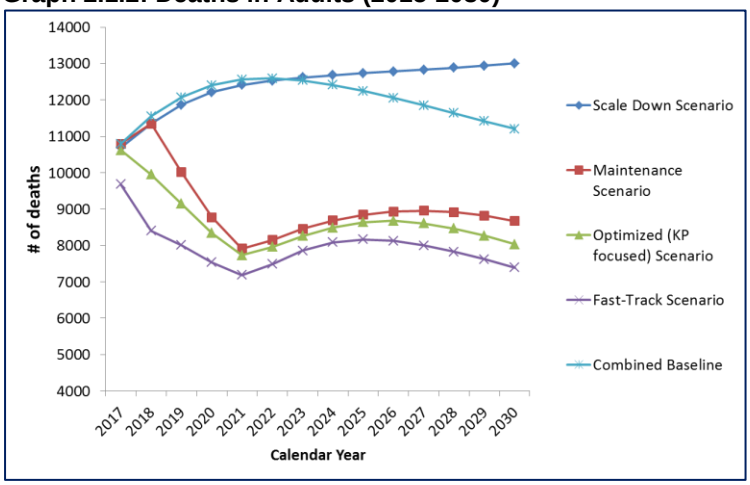
It must be noted that for all scenarios presented here, Government of Myanmar has already committed 100% increased contribution for treatment, from US$ 4 million to US$ 8 million per year and for methadone at US$ 1 million per year, totalling US$ 36 million for four years. While on-going advocacy efforts are being undertaken for Government to increase resources for health and HIV, the new Government can only confirm any possible additional increases later in the year in 2016.

See graphs below illustrating impact of number of new infections and number of deaths among adults between 2015 and 2030. The recommended scenario for Myanmar is "Optimized Scenario" which as stated above gives the highest epidemiological impact with the least resource requirement.

**Graph 2.1.1: New Infections in Adults (2015-2030)**[23]




**Graph 2.1.2: Deaths in Adults (2015-2030)**[24]




The tables below from AEM Optimization Analysis and Impact Projections presents an overview of the different scenarios summarizing new infections and deaths per key populations as well as different coverage levels in the next four years as well as up to 2030.

**Table 2.1.5: Summary of Impact**

| | Cum New HIV (2017-2030) | New HIV in 2030 | Cum Death 2017-2030 | Deaths in 2030 |
|---|---|---|---|---|
| Scale Down | 186,681 | 10,732 | 173,569 | 11,721 |
| Maintenance | 76,637 | 4,382 | 127,287 | 8,673 |
| Optimized | 54,316 | 2,569 | 121,195 | 8,032 |
| Fast Track | 52,135 | 2,530 | 111,380 | 7,395 |

[23] AEM Optimization Analysis and Impact Projections, May 2016
[24] Ibid

**Table 2.1.6: Breakdown of Budget by Programme Components**

| Resource in US$ | Treatment | % | Prevention | % | Other | % | Management | % | Total |
|---|---|---|---|---|---|---|---|---|---|
| Scale Down | 120,654,449 | 69 | 27,511,623 | 16 | 6,133,149 | 4 | 20,906,682 | 12 | 175,205,903 |
| Maintenance | 125,308,190 | 55 | 52,611,139 | 23 | 11,700,000 | 5 | 40,000,000 | 17 | 229,619,329 |
| Optimized | 132,742,518 | 51 | 69,007,831 | 27 | 12,000,000 | 5 | 43,804,000 | 17 | 257,554,348 |
| Fast Track | 178,393,335 | 56 | 72,196,471 | 23 | 14,000,000 | 4 | 52,000,000 | 17 | 318,589,806 |

**Table 2.1.7: Prevention Coverage by 2020**

| | PWID | MMT | FSW | MSM |
|---|---|---|---|---|
| Scale Down | 20% | 7% | 26% | 17% |
| Maintenance | 58% | 15% | 85% | 29% |
| Optimized | 90% | 20% | 90% | 90% |
| Fast Track | 90% | 25% | 90% | 90% |

**Table 2.1.8: New Infections Averted by 2030**

| | Clients | FSW | PWID | MSM | LR_Male | LR_Female | Total |
|---|---|---|---|---|---|---|---|
| Scale Down | -13,488 | -5,121 | -32,182 | -4,195 | -395 | -8,876 | -64,258 |
| Maintenance | 18,080 | 5,876 | 13,614 | 2,492 | 631 | 5,093 | 45,786 |
| Optimized | 19,007 | 6,196 | 26,810 | 8,482 | 659 | 6,955 | 68,108 |
| Fast Track | 19,156 | 6,419 | 26,812 | 8,484 | 1,201 | 8,215 | 70,288 |

**Table 2.1.9: Treatment Coverage by 2020**

| | Key Populations (Test & Treat) | General Population |
|---|---|---|
| Scale Down | 42% | 62% among CD4<500 |
| Maintenance | 60-70% | 81% among CD4<500 |
| Optimized | 81% | 81% among CD4<500 |
| Fast Track (Treat All) | 81% | 81% |

**Table 2.1.10: Number of Deaths Averted by 2030**

| | Clients | FSW | PWID | MSM | LR_Male | LR_Female | Total |
|---|---|---|---|---|---|---|---|
| Scale Down | 3,586 | 189 | -6,181 | 189 | -2,877 | -1,036 | -6,213 |
| Maintenance | 14,130 | 3,937 | 3,362 | 3,937 | 11,569 | 6,452 | 40,069 |
| Optimized | 14,742 | 6,375 | 5,376 | 6,375 | 12,169 | 6,348 | 46,161 |
| Fast Track | 17,344 | 6,375 | 5,380 | 6,375 | 15,219 | 10,513 | 55,976 |

## 2.1 Overall Funding Landscape for Upcoming Implementation Period

**TB**

**a. Availability of Funds and Funding Sources**

Government spending for TB increased dramatically between 2011 and 2012, and has been slowly increasing each year since then. The project-based funding for TB activities primarily comes from larger funds of the Global Fund and 3MDG, which support a number of implementing agencies, alongside a moderate investment from USAID, and smaller investments from partners such as MSF, the Union, PSI and others.

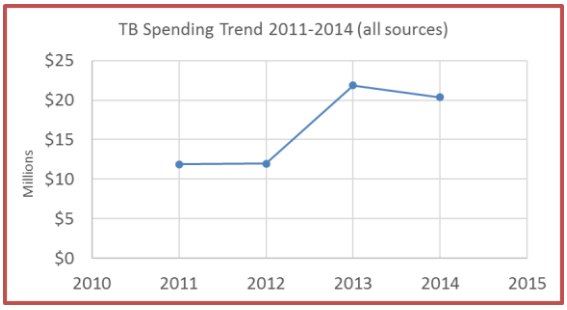



**Table 2.1.11: Past contributions to TB 2011-2014**

| Financing Sources | Year | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 2011 | % | 2012 | % | 2013 | % | 2014 | % |
| Domestic Public | $ 953,308 | 8% | $ 1,331,304 | 11% | $ 1,324,257 | 6% | $ 1,418,417 | 7% |
| Bilateral Government | $ 2,635,753 | 22% | $ 827,458 | 7% | $ 832,375 | 4% | $ 3,594,632 | 18% |
| Japan (JICA) | $ 164,513 | | $ 191,238 | | $ 130,802 | | $ 178,600 | |
| USA (USAID) | $ 568,420 | | $ 439,978 | | $ 440,000 | | $ 689,677 | |
| 3DF / 3MDG | $ 1,902,820 | | $ 196,242 | | $ 261,573 | | $ 2,726,355 | |
| Multilateral | $ 7,219,790 | 61% | $ 8,900,270 | 74% | $ 19,697,106 | 90% | $ 15,331,822 | 75% |
| GDF | $ - | | $ - | | $ 935,000 | | $ - | |
| GFATM | $ 6,238,566 | | $ 7,929,047 | | $ 15,735,193 | | $ 13,991,571 | |
| UNITAID | $ 834,224 | | $ 834,223 | | $ 2,889,913 | | $ 1,294,233 | |
| WHO | $ 147,000 | | $ 137,000 | | $ 137,000 | | $ 46,018 | |
| International NGO | $ 1,100,000 | 9% | $ 900,000 | 8% | $ - | 0% | $ - | 0% |
| FIND | $ 900,000 | | $ 900,000 | | $ - | | $ - | |
| UNION | $ 200,000 | | $ - | | $ - | | $ - | |
| ***Grand Total*** | ***$11,908,851*** | ***100%*** | ***$11,959,032*** | ***100%*** | ***$21,853,738*** | ***100%*** | ***$20,344,871*** | ***100%*** |

Each of the partners financing TB offers funding that complements Government resources, and strategically addresses a particular programmatic need. The comparative advantage(s) of the major donors to TB, other than Global Fund, as well as expectations about their future funding are summarized below:

**USAID**

The U.S. Agency for International Development receives annual funding allocations from the U.S. Congress and can therefore not commit to future funding levels. However, stable annual funding levels from USAID are assumed for the purposes of this concept note, given the recent history of USAID funding in Myanmar. USAID funding for TB in Myanmar increased five-fold between FY2014 and FY2015, and then increased again, more modestly, between FY2015 and FY 2016. USAID funding for TB is channelled through two mechanisms, namely the Challenge TB project managed by FHI360 in Myanmar, and the Pharmaceuticals and Supply Management project managed by Chemonics. Under Challenge TB, FHI360 supports technical assistance to the NTP and partners, and funds the development and dissemination of normative tools and guidelines. USAID is deeply committed to serving vulnerable populations, including populations in non-state areas and ethnic minorities. As such, Challenge TB also funds active case finding and other targeted activities to serve hard-to-reach populations. The PSM project is supporting improvements to the supply management system for TB, HIV and malaria. USAID has expressed its willingness to further explore how its funding can best be applied to fill gaps as other funding ends; i.e. 3MDG Fund, or shortages persist.

**3MDG Fund**

By pooling the contributions of seven bilateral donors - Australia, Denmark, the European Union, Sweden, Switzerland, the United Kingdom and the United States of America, 3MDG promotes the efficient and effective use of development funds. With commitments totalling more than $271 million for the period July 2012 to December 2017, it is currently the largest development fund in Myanmar. It is managed by the United Nations Office for Project Services (UNOPS). Between 2012-2017, 12% of all funding disbursed and planned by the 3MDG Fund (US $32.5 million) was designated for TB, while 5% (US$ 13.5) was for HIV. Related to TB, the 3MDG fund has focused its investments on active TB case finding among vulnerable populations in 100 townships and programmatic management of MDR-TB. For HIV, it has invested primarily in harm reduction programs. The 3MDG Fund will end in 2017.

In May 2016, donors to the 3MDG Fund engaged consultant support to explore options for external financing to the health sector that would best support the Government's goal of Universal Health Coverage. The consultant will develop an options paper that will summarise discussions with development partners and identify options emerging for possible successor instrument(s) to the 3MDG Fund. Options will consider the possible scope and focus of future funding; relationships between different instruments for external funding for ensuring broader coordination among all partners supporting the sector; recommendations to improve coordination; and outline next steps for taking things forward in coming months along a calendar, taking into consideration key events from other Development Partners. As such, the concept note does not reflect an expectation for TB or HIV-specific funding from the 3MDG Fund beyond 2017.

**MSF**

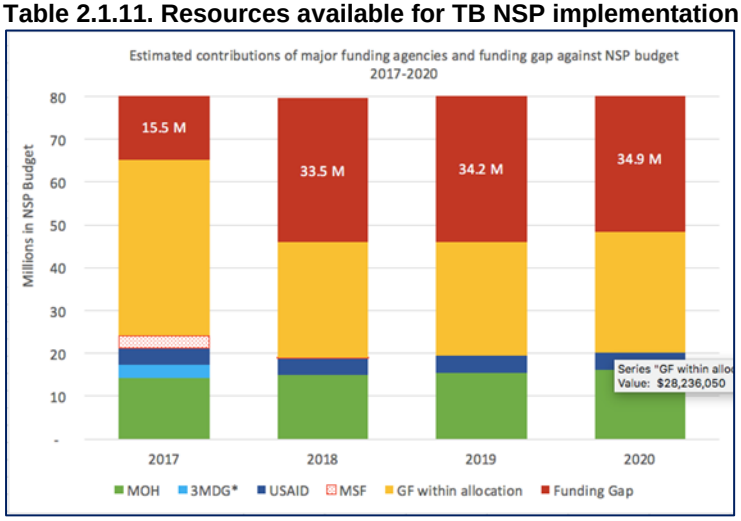
MSF-Holland has been working in Myanmar since 1992 and is currently providing healthcare in Kachin, Rakhine and Shan states, as well as Yangon and Tanintharyi regions. Over 1,200 international and national staff work closely together to provide high-quality care and treatment through a network of health centres, health posts and mobile clinics. To address the challenges of TB and HIV co-infection, MSF provides TB treatment as part of its HIV programmes and is currently giving free diagnosis, treatment and counselling to more than 900 co-infected HIV patients in Shan and Kachin states, the Tanintharyi region, and in Yangon. In 2009, MSF launched a drug-resistant TB (DR-TB) pilot project in partnership with the Ministry of Health and Sports in Yangon aimed at integrating DR-TB care into the country's existing healthcare system. This pilot project has since evolved into a national programme. MSF continues to treat co-infected HIV patients and had more than 100 HIV-DR-TB co-infected patients on treatment by the end of 2015. MSF continues working closely with the Ministry of Health and Sports to try to address this alarming national health crisis and DR-TB remains a key priority for the organization in the coming years. In 2016, MSF together with the National TB Programme (NTP) started introducing two new drugs to treat people suffering from drug-resistant tuberculosis (DR-TB) in Myanmar. In other contexts, the new drugs bedaquiline and delamanid have proven highly effective especially for patients with severe forms of drug-resistance, including extensively drug-resistant TB (XDR-TB), and thus offer new hope to successfully treat patients in Myanmar.

**Other**

The TB program receives smaller levels of financial support from several other donor agencies including DFAT, DFID, and JICA. In 2017, these partners will contribute approximately US$ 170,000 combined. The funding levels from these partners are not known beyond 2017.

The summary graph and table below reflect the expected sources of financing toward the costed NSP and its total budget requirement of nearly US$308 million. The contribution expected from the Government is shown as the MoHS financing, assuming a 5% annual increase for 2018-2020. The 3MDG fund concludes at the end of 2017, as noted above. USAID funding allocations are estimated to remain flat across the years of the grant. MSF contributions will decrease substantially after 2017. The Global Fund allocation reduces the funding gap to US$ 100.5 million.

**Table 2.1.11. Resources available for TB NSP implementation (excluding GF)**



| Year | NSP | MOHS | 3MDG | USAID | MSF | Unfunded | Within allocation | Funding gap |
|---|---|---|---|---|---|---|---|---|
| 2017 | 77,264,773 | 14,344,054 | 2,874,501 | 4,000,000 | 2,830,727 | 56,538,498 | 40,978,417 | 15,560,081 |
| 2018 | 75,643,197 | 14,894,725 | - | 4,000,000 | 130,200 | 60,518,602 | 27,010,621 | 33,507,981 |
| 2019 | 76,302,736 | 15,453,074 | - | 4,000,000 | 100,000 | 60,738,918 | 26,541,235 | 34,197,683 |
| 2020 | 79,271,843 | 16,062,035 | - | 4,000,000 | - | 63,183,961 | 28,236,050 | 34,947,911 |
| TOTAL | 308,482,549 | 60,753,888 | 2,874,501 | 16,000,000 | 3,060,927 | 240,979,979 | 122,766,323 | 118,213,656 |

**b. Leverage of Other Donor Resources Through GF Support**

Across TB and HIV programming, Global Fund resources are used strategically to provide essential services that are not supported by Government or partners. Global Fund investments have provided an important foundation of health systems and disease program strengthening that have enabled other donor funding to be optimized.

**c. Funding Gaps and Planned Actions**

As illustrated by the programmatic gap tables for both TB and HIV, there are significant funding gaps for both programs. The dramatic decline in Global Fund investments in TB, HIV and TB/HIV will most certainly negatively affect the coverage of services. To address gaps, the programmes will explore additional funding through Government and new donors. As the new Government settles in, government investments in health can be further explored. For TB, the NTP and partners may apply for project-based additional funding through TB REACH but this is not expected to yield large investments. Without additional funding, however, the programmes will have to reduce the scope of planned activities to respond to the highest priority essential services defined within the allocation amounts in this concept note.

Concurrent with the decline in Global Fund allocations, all 3MDG funding for TB and HIV will conclude at the end of 2017. Other donors have been consulted to try and ensure that support for TB, especially to non-state areas and ethnic minorities, will continue. Until it is known if there will be a follow-on grant, and the design of that grant, the TB and HIV programmes cannot know how programming will need to be adjusted. USAID has expressed a willingness to re-program funds to ensure the continued support to these populations should 3MDG funding for TB not be continued.

**TB/HIV**

The U.S. government, through PEPFAR, is expected to provide US$ 300,000 for TB/HIV collaborative activities in their fiscal year 2016 (implementation during 2017). They will support:

a) Development and implementation of a Standard Operating Procedure (SOP) for HIV/TB collaborative activities, particularly with the aim of increasing ART initiation including completed referral to ART sites;
b) Intensified case finding of co-infected HIV/TB individuals;
c) Improve and expand PITC for presumptive and diagnosed TB patients in the focus areas;
d) Increase ART treatment access, including through decentralized sites, and monitor ART provision to HIV-positive TB patients on a quarterly basis;
e) Expand access to TB services for key populations; and,
f) Implement more widely the Policy Guidelines for TB/HIV collaborative activities for PWID.

In developing the budget for joint TB/HIV interventions, budget optimisation for cross-cutting issues was ensured. Activities included in the separate TB and HIV programme budgets were taken into account to determine whether those activities (and related budget amounts) were adequate to ensure prevention, testing, and treatment coverage of people with TB/HIV co-infection. As well, activities under the HSS Module (e.g. PSM, HMIS etc.) were not duplicated in the joint TB/HIV budget. For both epidemics, this Concept Note proposes a clear focus on key priority populations, both independently for each disease and on a joint basis. In doing so, both national programmes aim to maximise the impact of the limited resources available.

## 2.2 Counterpart Financing Requirements

**Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1).** The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

a. For TB and HIV, indicate below whether the counterpart financing requirements have been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

| Counterpart Financing Requirements | Compliant? | If not, provide a brief justification and planned actions |
|---|---|---|
| i. Availability of reliable data to assess compliance | ☒Yes ☐ No | |
| ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%) | ☒Yes ☐ No | Note that in the Financial Gap Table for HIV, Government contribution is shown to account for 17% of existing GF funding and anticipated country allocation, which is less than the minimum threshold of 20% for a lower lower-middle income country. However, the counterpart financing requirement will be met during implementation, as shared health systems costs are expected to be higher than what is currently estimated, especially with the ART transition to the public sector. As well, the NAP is working to secure additional domestic funding commitments for treatment. |
| iii. Increasing government contribution to disease program | ☒Yes ☐ No | |

b. Compared to previous years, what additional government investments are committed to the national programs in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

**Additional GOM Investments**

**HIV**

Direct contributions to the national HIV response are expected to increase due to the Government commitment to scale-up HCT and ART, including transitioning more patients on ART from the private (I/NGO sector) to the public sector. As well, the Government remains committed to MMT for PWID and is exploring additional service delivery options for MMT and other harm reduction interventions. As well, the Government (MOHS/NAP) continues to pay for HIV-related staff at the central, state/region, and township levels. In addition, costs for the increased use of general health infrastructure for HIV programming will

be borne by the MOHS.

**TB**

Government spending for TB control dramatically increased in 2012 (see section 2 above), largely for second-line drugs, infrastructure and human resources. The MOHS currently pays for only a small fraction of first-line TB drugs, restricted to single drugs used for patients with suspected allergies to 4FDCs. The new government made a commitment to substantially increase the government spending for health. The implications of this spending increase were discussed with the directors of the finance section of the MOHS during the preparation period of this Concept Note. The magnitude of this increase has not yet been determined. For the purposes of this concept note, an annual increase of 5% has been conservatively assumed. The Government contribution to direct costs of implementation will therefore increase from $4 million in 2017 to $4.6 million in 2020. The Government has also committed resources for staff and infrastructure that will contribute to the effective implementation of TB and TB/HIV activities. The total contribution from Government, for direct and indirect costs, will increase from US$14.3 million in 2017 to US$16.0 million in 2020.

**Assessment of the Completeness and Reliability of Financial Data Reported**

**HIV**

All external funding coming into the country is required to be recorded in the National Health Sector Budget, under the financial management of the MOHS. Within the MOHS, technical units at all levels are responsible for monitoring and evaluation of programmes, including data collection. Financial units at all levels are responsible for disbursement and financial management, including financial reports. Assessments of all plans and projects are carried out every 2–3 years, in addition to the mid-term and annual reviews. Internal and independent external reviews are also carried out to study and monitor progress and assess performance and impact of the interventions. Auditing mechanisms, both internal and external, are also in place. Overall, the current system allows for financial data completeness, reliability, transparency, and accountability.

**TB**

There is a system of both financial and management audit in place to ensure the monitoring of MOHS expenses on TB control through the MOHS's annual operational plan and budget. As expenditures under the operational plan are regularly audited, this system can be assessed as complete and reliable. The available MOHS data allows for the monitoring of expenditures for both infrastructure investments and recurrent costs, and separate information is available for expenditures at the central and peripheral levels.

## SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and outlines how the investment is strategically targeted to achieve greater impact on the diseases and health systems. While the investments for both the HIV and TB programs should be described, the applicant should also provide information on the expected impact and efficiencies achieved from planned joint programming for the two diseases including cross-cutting health systems strengthening as relevant.

### 3.1 Programmatic Gap Analysis

**A programmatic gap analysis should be conducted for the six to twelve priority modules within the applicant's funding request. These modules should appropriately reflect the two separate disease programs in addition to cross-cutting modules for both programs such as Health System and Community Systems Strengthening.**

Complete a programmatic gap table (Table 2) for the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps in the narrative section below.

### 3.1 Programmatic Gap Analysis

Programmatic Gap Table (Table 2) for quantifiable priority modules is completed and attached along with the submission of the TB&HIV Concept Note. It is consistent with coverage targets in section D of the modular template (Modular Table also attached).

**HIV Modules difficult to quantify**

HSS PSM

Allocation funds are requested to support the operationalization of procurement and supply chain systems. Key activities included under this heading include: the establishment of a PR transition unit; establishment of a centralized procurement unit; investments in the national Logistics Management Information System; standardization of forecasting and reporting methods; and improved distribution monitoring systems. Resources are also requested maintenance and operation of incinerators to dispose of medical waste (including expired or damaged drugs and commodities). The request also includes support for warehousing infrastructure and storage conditions improvements as well as for the harmonization of commodity distribution. These costs have been distributed evenly across the three disease components in the current concept notes.

Above allocation funding is requested to further invest in the support the improvement of warehousing infrastructure and storage conditions and harmonization of commodity distribution.

HSS HIS and M&E

Allocation funding is requested to support the roll out of the National HIV M&E Plan (2016 – 2020). Key activities include routine reporting (scale up of systems, associated training and coaching, national program reviews); analysis, review and transparency (routine data analysis, programming mapping); surveillance priorities (including IBBS, STI surveillance, HSS, yearly ART drug resistance surveillance, etc.); and strategic investments in human resources for M&E (WHO M&E assistant). In the area of eHealth, in 2016 UNAIDS and Global Fund are supporting the customization of DHIS2 and the development of a master patient index (MPI). WHO, 3MDG Fund, ICAP, UNICEF, CHAI, and other partners will all contribute to this effort. Allocation funding is requested from 2017 through 2020 to support initial investments on E-Health applications through deployment of systems nationwide, starting in areas heavily burdened with HIV, TB and malaria diseases. This funding will support the development of case-based reporting formats, establishing standards and interoperability for efficient data sharing, and sustaining a robust E-Health environment for HIS.

Above allocation funding will support micro-planning at township level, additional review meetings at

local level, human resources to support the data-hub functionality, National AIDS Spending Assessment (NASA), additional IBBS and PSE sites, national annual HIV estimation and projection, HIV prevalence studies in special regions and among special populations, early initiator surveys, and market segmentation studies.

Removing legal barriers to access

Currently, the Global Fund, 3MDG Fund, and USAID (just starting with new Country Programme) are supporting limited programmes to strengthen capacity of community members and key population representatives to know their rights and create change. Much more needs to be done to improve the situation, including awareness raising among communities, Members of Parliament, key government sectors, and media. *Pro Bono* legal aid or partnership with paralegals that can help with key population arrest and negotiation with law enforcement needs to be expanded and accessible to sex workers, men who have sex with men, transgender and people who inject drugs and peer workers. The programmes listed in the Concept Note are not covered by other funding.

Allocation funding is requested to support critical activities to strengthen human rights and gender equality and reduce stigma and discrimination. Key activities include awareness raising among key populations and stakeholders at community-level. Advocacy events targeting Members of Parliament, key government sectors, and media to support legal reform. The allocation request also includes funding to expand *Pro Bono* legal aid/partnerships with paralegals to support key populations in confrontation with legal authorities. The requested support with complement the USAID and 3MDG funding commitments for organizational strengthening and community advocacy.

The available funding is only sufficient to implement these activities at a reasonable scale in 2017. For years 2018 – 2020, above allocation funding is requested to maintain these critical activities.

Community systems strengthening

While there has been substantive increase in number of events and forums with active engagement of people living with HIV and key population groups as well as partnership models between community based organizations and public sector (i.e. community self-help groups providing treatment/adherence support to PLHIV at public sector ART sties) there is much more room for improvement and expansion.

Allocation resources are requested to support organizational development and capacity strengthening for all networks of people living with HIV and key populations. These activities will support active engagement of people living with HIV and key population groups as well as partnership models between community-based organizations and public sector (i.e. community self-help groups providing treatment/adherence support to PLHIV at public sector ART sties).

The available funding is only sufficient to implement these activities at a reasonable scale in 2017. For years 2018 – 2020, above allocation funding is requested to maintain these critical activities.

Programme management

While cost savings and efficiency gains have been identified for both Principal Recipients and Sub-Recipients – the management requirements of the Global Fund grant are still numerous. Efforts to shift to public sector management and reducing the number of international sub-recipients can only occur in phased approach hence management and operational costs still need to remain at minimum level of 20% of the grant. Resources will be required to fund finance, program, M&E and PSM staff at PR level; annual audit and other compliance requirements; program management and Yangon-based costs at SR level; routine monitoring of SRs by the PRs. The resources under the within allocation (US$ 175 for 4 years) are not adequate to maintain high quality management and will pose challenges in Years 2, 3, and 4.

**TB Modules difficult to quantify**

The NSP 2016-2020 describes the main challenges and gaps in programming, by technical area. It also proposes the strategic approaches and activities to be undertaken, should funding be available.

As shown in the programmatic gap table, the decrease in the Global Fund allocation for the years 2018-2020 will result in declines in several of the coverage indicators. The increase achieved by the above-allocation request is small, relative to the budget requested, but it must be recognized that many of the additional gains will be made among some of the hardest-to-reach populations, such as the ethnic minorities. The targeted interventions to serve these populations are more expensive but still represent value-for-money for their impact on the TB epidemic for the most vulnerable.

## 3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request for TB and HIV, including both the proposed investment of the allocation amount and the request above this amount. Include the specific elements related to joint programming such as health systems and community systems strengthening. Describe how the request addresses the gaps and constraints described in sections 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

## 3.2 Applicant Funding Request

**HIV**

**Strategic overview of funding request for HIV**

In line with Myanmar's new NSP, the funding request encompasses the following key strategies:

1) **Geographic and population prioritization** – all 330 townships are categorized into High, Medium and Low townships based on varying levels of disease burden, estimated number of people living with HIV, estimated number of key populations by each population group (PWID, MSM, FSW, migrants/mobile population, TB patients), number of people on ART, number of service providers (public and NGO) for HIV services. Depending on the category, each township will then implement differentiated service delivery approaches.

**Figure 3.2.1: Service Delivery Approaches Based on Township Classification**

| | High burden | Medium burden | Low burden |
|---|---|---|---|
| Prevention | NGO (& Public)<br>DIC/ Outreach | Public (& NGO)<br>Outreach | Public<br>Facility/ IEC |
| Testing | ANC, TB-HIV<br>AIDS/STD Team VCT<br>Hosp ART Center VCT<br>Tsp VCT<br>HTC/DIC/ Outreach | ANC, TB-HIV<br>Tsp VCT<br>HTC/ Outreach | ANC, TB-HIV<br>Tsp VCT<br>HTC |
| Treatment | Full ART Incl. complex<br>Up to sub-TSP<br>Integrated care<br>Case Monitoring | ART initiation<br>and/or maintain<br>At TSP | Referral |

By varying service delivery approaches by townships classification, Myanmar will focus resources to implementing the right programmes in the right areas and for the right people. This approach will maximize impact and return on investment.

In high priority townships, Government and NGO partners will jointly scale-up programmes that are relevant to the needs of the key population through the Key Population Service Centre approach which includes drop-in-centre; mobile outreach units; peer educators; internet and smart phone-based applications. Medium and low priority townships will receive basic programme package, mainly IEC, condom distribution, prevention and HIV testing information, and HIV awareness raising and World AIDS Day campaigns – at significantly lower costs. ART initiation will be available in high priority townships. In medium and low priority townships, ART will be accessible by referral. PMTCT services will be available throughout the country.

2) **Service integration:** To the extent possible, services for TB&HIV and other co-infections will be integrated at public sector and INGO service delivery sites. While Hep C treatment is not requested under this Concept Note due to funding constraints, HIV programme will ensure linkages to the National Hepatitis Strategy. Other examples of integration include screening and referral for sexually transmitted infections during all prevention contacts.

3) **Public sector transition**: Over the next several years, the ART programme will increasingly transition to public sector management. Investments in capacity building and partnership models will enable be essential to maintain quality and standards. Over time, this will result in significant cost savings as the public treatment unit cost is lower than the NGO sector.

4) **Cost efficiency:** All programmes under the new NSP and the interventions proposed within this Concept Note have undergone intensive review to ensure cost savings and efficiency gains to the extent possible. Unit costs used for budgeting take into account actual expenditure as well as additional areas of reduction.

5) **Modelling for optimization:** Facing considerable resource constraints, Myanmar HIV Technical and Strategy Group utilized the AIDS Epidemic Model to run scenarios to determine the most optimal mix of interventions and select choices that will yield maximum impact. The proposed combination of

interventions and balance between prevention and treatment and other cost categories have been analysed and the most optimal epidemiological choice identified for each resource ceiling.

**Prevention**

The allocation request for prevention services includes the Myanmar Prevention Package (behavioural change; condoms; HIV testing and counselling; diagnosis and treatment of STIs) for MSM, Sex Workers, PWID, and other vulnerable populations. In addition, it includes needle/syringe programmes and OST (for PWID) and screening and immunization for hepatitis B. These prevention interventions will be supported with other activities intended to improve legal framework and strengthen CSS and improve the enabling environment. In the within allocation amount (referred to above as the "Scale Down" scenario), these prevention interventions represent 15% of the allocation amount at US$ 27,511,623. This amount is far from the global guidance of 25% and will require a significantly scale down in prevention programme coverage. Given this funding constraint, it is expected that prevention programme coverage for key populations by 2020 will be 20% for PWID; methadone will be 7% due to higher unit costs and limited information on programme effectiveness and impact of reduction of HIV infection given scale of programme; for sex workers 26% and MSM 17%.

To address the remaining challenges described earlier (which were also been raised by the GF TRP[25]) , the Concept Note proposes the introduction of regular, periodic local mapping of key populations including more robust local planning and coordination mechanism in order to respond rapidly to needs of key populations. The new NSP focuses on reaching the higher risk key populations and those who do not currently know their HIV status. Implementers must expand outreach effort in order to expand to new geographic areas in order to find the "right" people. New approaches for condom promotion will be explored to find evidence-informed market segmentation of "free" versus social marketing or commercial products which will ultimately reduce the number of "free" condoms needed. Outreach service will use real time mapping data to identify locations with clusters of new HIV positive cases and further penetrate key population networks and will facilitate HTC as close to key populations as possible – including approaches such as community test with confirmatory test at public sector. A combination of in-person and mobile phone-based follow up approaches will be employed for highly mobile populations to ensure effective timely referral to treatment as needed. Using the latest IBBS data and applying an adjustment for mobility, the NSP has identified revised targets for key populations to be reached with the new case management prevention approach.

For the prevention indicators, Myanmar is defining the coverage as those reached with the full package of prevention or "effective coverage". Effective coverage refers to those key populations who have been reached with Myanmar Prevention Package and enrolled in case support/management system that will ensure support from prevention to testing to diagnosis to treatment or to continued prevention.

**Unit costs**

Detailed descriptions of Prevention and Treatment Unit Costs are available in attachments.

The prevention unit costs have also undergone intense scrutiny and cost reductions where possible, while refocusing and maintaining quality of services. As mentioned in the description of the new NSP in Section 1 earlier, the strategies to reach key populations takes into account barriers and constraints and utilizes prioritization approach to intensify the right set of programmes in the right places for the right people. The interventions within this allocation will be focused in the high priority townships (85 out of 330) where there is highest HIV burden, existing infrastructure and highest need. Government and NGO partners will jointly scale-up programmes that are relevant to the needs of the key population through the Key Population Service Centre approach which includes drop-in-centre; mobile outreach units; peer educators; internet and smart phone-based applications. Medium and low priority townships will receive basic programme package, mainly IEC, condom distribution, prevention and HIV testing information, and HIV awareness raising and World AIDS Day campaigns – at significantly lower costs. However, the GF will note that the unit cost is higher than in the previous programme as more resources will be required to transition to a more intensive, case-management approach: training for peer educators on case management approach; more resources for outreach; and support for clients throughout the full continuum. While the actual unit cost increased, it is expected that the programme will be able to provide higher quality support and yield more results – i.e. more of the higher risk key populations receiving HTC and knowing their results and timely initiation of ART where needed.

[25] Applicant to consider consolidating services in single sites that offer service integration, e.g. one-stop shops. Where possible applicant should work with local governments to secure free space for the use of existing clinics. Indicators for adequate prevention coverage require better specification. Need improved population size estimates. SoP for outreach and training packages for prevention.

## Treatment

Treatment and care comprises (i) Pre-ART care; (ii) provision of ART; (iii) treatment monitoring; (iv) treatment adherence; (v) prevention, diagnosis and treatment of OIs; (vi) counselling and psycho-social support (vii) in-patient care; (viii) transition TA support for public sector; (ix) paediatric ART treatment. The total treatment component for four years under the "Scale Down" scenario represents 70% of the allocation amount at US$ 120,654,449 (US$ 30 million a year). *For the previous grant, the Myanmar 2016 treatment budget already reached US$ 29.5 million.* This current request, the Scale Down scenario will only be able to maintain ART treatment for 104,536 adults each year and 6,247 children by 2020.

**Table 3.2.2: Treatment Targets for Adults and Children reaching 44.6% and 90%, respectively**

| Total targets | Year 1 | | | Year 2 | | | Year 3 | | | Year 4 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N # | N # / D # | % | N # | N # / D # | % | N # | N # / D # | % | N # | N # / D # | % |
| Allocation + other sources | 40,769 | 104,536 | 47.2% | 38,678 | 104,536 | 46.4% | 33,452 | 104,536 | 45.5% | 30,316 | 104,536 | 44.6% |
| | 63,767 | | | 65,858 | | | 71,085 | | | 74,221 | | |
| | | 221,542 | | | 225,453 | | | 229,734 | | | 234,324 | |
| Allocation + other sources | 3,449 | 7,086 | 82.1% | 3,560 | 7,315 | 90.0% | 3,311 | 6,803 | 90.0% | 3,040 | 6,247 | 90.0% |
| | 3,637 | | | 3,755 | | | 3,492 | | | 3,207 | | |
| | | 8,634 | | | 8,128 | | | 7,559 | | | 6,941 | |

At the end of 2015, there were 99,404 adults and 7,086 children on ART. In the new NSP and the priority of the Concept Note, individual case monitoring system will be introduced to better track patients in order to minimize loss to follow-up across the care continuum particularly from HIV diagnosis to treatment which is currently sub-optimal. In addition, a supportive and essential intervention is the engagement of key populations and networks of people living with HIV in providing treatment and adherence support. This is currently operating well in the partnership model between public sector and NGOs. The Concept Note prioritizes this programme to support the transition from NGO to public sector. It also serves to increase community involvement in the HIV response and supports community systems strengthening. Providing familiarity and interactions with communities and key populations also serves to increase understanding and compassion of public sector health care providers towards PLHIV and key populations. Other focus areas include building infrastructure and capacity for viral load monitoring and testing in order to achieve viral suppression of ART patients; improving and speeding up treatment of TB patients who need ART; and addressing problems identified around high MTCT rate.

## Unit costs

In calculating the unit cost of ARV treatment per person per year, the NSP III development working group has considered numerous efficiency and cost reductions such as reducing the number of clinic visits by stable patients; streamlining and harmonizing appropriate personnel structure for ARV treatment sites; identifying cost savings from phasing out CD4 and reducing the number of tests prior to ARV initiation and projecting cost savings from new ARV prices. Most of all, the plan to transition from NGO to Government and public sector managed ART programme will significantly reduce costs. The table below presents a summary of the transition plan from 2017-2020 aiming to reach up to 45% of ART to be managed by the public sector alone by 2020. The resulting average unit cost taking into consideration all these factors, is US$ 322 - one of the lowest in the region.

However, it must be noted that for the transition plan to succeed, technical assistance to strengthen public sector capacity must be fully funded and implemented quickly. Hence, technical assistance for transition is built into the ART unit cost (i.e. budget amounts for training, upgrading of health facilities etc. are included). ART treatment is a high priority for the HIV Concept Note as Myanmar has only reached 46% of the treatment target by the end of 2015, many more people need to be put on treatment to move towards the 90-90-90 Fast Track targets which will avert 55,976 deaths between 2017 and 2030.

Government contribution for ARV treatment has increased from US$ 4,000,000 in 2015 to US$ 8,000,000 in 2016, and will further increase to US$ 9,000,000 over the grant period. This contribution is to procure ARV drugs for new patients – additional to those currently on ARV treatment.

**Table 3.2.3 Transition Plan to shift management from non-government to public sector**

| Transition Mix | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| MOH non-complex (DC) | 8% | 9% | 11% | 12% | 14% |
| MOH non-complex (AIDS/STD) | 5% | 5% | 6% | 6% | 6% |
| MOH complex | 21% | 22% | 23% | 24% | 25% |
| Satellite Sites (NAP+I/NGO) | 2% | 3% | 3% | 4% | 4% |
| MOH+NGO (non-complex) | 4% | 5% | 5% | 6% | 6% |
| MOH+NGO (complex) | 16% | 17% | 18% | 19% | 20% |
| INGO model (non-complex) | 8% | 7% | 6% | 5% | 4% |
| INGO model (complex) | 37% | 33% | 29% | 25% | 21% |

**Table 3.2.4 Current ART Service Delivery Models**

| Non-Complex ART Management | Definition |
|---|---|
| MOHS (ART maintenance) | Public facilities that maintain ART for stable PLHIV who do not have complex clinical conditions (e.g. township hospitals, sub-township level facilities, AIDS/STD teams) |
| MOHS (ART Initiation & maintenance) | Public facilities that initiate and maintain ART for PLHIV who do not have complex clinical conditions (e.g. AIDS/STD teams) |
| MOHS+NGO model | Public facilities that maintain ART for stable PLHIV who do not have complex clinical conditions with HR and other support from NGO/INGOs (e.g., township hospitals with HR support from UNION) |
| Satellite Sites (NAP + INGO/GP) | NGOs/INGOs sites that maintain ART for stable PLHIV who do not have complex clinical conditions, receiving ARV drugs from NAP. This includes GPs that are supported and supervised by NGOs/INGOs (e.g., MAM, PSI-TOP centres, PSI-GP, Alliance-GP). |
| INGO alone (ART initiation & maintenance) | INGO run clinics that maintain ART for stable PLHIV who do not have complex clinical conditions (e.g. Ratana Myitta, Consortium) |
| **Complex ART Management** | **Definition** |
| MOHS Complex | Public hospitals that initiate and maintain ART for PLHIV including those who have complex clinical conditions (e.g. Specialized hospitals, general hospitals) |
| MOHS+NGO model | Public facilities that initiate and maintain ART for PLHIV including those who have complex clinical conditions (e.g. general hospitals with HR and other support from UNION) |
| INGO model | INGO run clinics that initiate and maintain ART for PLHIV who have complex clinical conditions (e.g. clinics run by MSF-H, MSF-CH, MDM) |

## 3.2 Applicant Funding Request

**TB**

Like that of HIV, the Global Fund allocations for TB in 2017 represent a continuation of the 2016 funding level. However, for the years 2018, 2019 and 2020, they represent a dramatic decrease in annual funding. For TB, the 2018-2020 allocation represents a 25% decrease compared to 2016-2017 levels. As such, the funding requests reflect strict prioritization of only the most essential services and even then, are often unable to achieve national coverage.

The total grant allocation amount for 2017 is USD 40,978,503. The total allocation amount for the three-year period 2018-2020 is anticipated to be USD 81,799,429.

The total funding gap over the grant implementation period 2017 to 2020 (US$ 267 million) significantly exceeds the funding available under the allocation amount (US$122.8 Million). It was therefore necessary to prioritize NSP interventions to be included in the funding request. The prioritization of activities followed the principle of seeking to fully fund the most essential of interventions to save lives; i.e. drugs, diagnostic capacity, quality assurance of service delivery, and human resource capacity. Prioritization was conducted through a three-step process. In the first step, all partners involved in TB control activities in Myanmar were asked to rank all NSP activities using a priority score of 1 to 3. Partners were instructed to give the highest priority only to those interventions that have been demonstrated to increase case detection or improve treatment success rates. In the second step, small working groups with representatives of all partner organizations were formed to discuss individual sections of the NSP and determine those interventions most essential to sustaining the gains made in the programme to date. As the allocation levels were finalized, it became clear that a hyper-prioritization of the most essential services was required. As a third step, the TB Technical and Strategy Group reviewed and endorsed the prioritization presented in this Concept Note.

The above allocation request reflects prioritized activities to sustain the gains made over the past grant, and to achieve modest scale-up of MDR-TB activities. The remaining funding gap of approximately US$10 million per year represents the full expression of demand to fulfil the objectives of the NSP. The requests are in-line with the operational plans and detailed costings of the NSP. The TB and HIV programmes have collaboratively agreed that the prioritized above-allocation requests are critical to sustain the gains made to date.

**Within allocation**

During 2017, funding levels will remain as per 2016 and a robust program is planned. A slight overage in the TB drug supply from 2016 resulted in some savings for the 2017 budget as it reduced the expenditures on drugs in 2017 compared to 2016, and offered room for other programmatic investments. In anticipation of funding reductions from both the Global Fund and 3MDG fund at the end of 2017, additional investments are planned in 2017 to build the diagnostic infrastructure, communication materials especially for ethnic minorities, and systems for M&E. These foundational components will support efficient implementation in the more budget-constrained years. Table 3.2.9 summarizes the planned investments.

**Table 3.2.9 Planned Investments**

| | 2017 Allocation | 2018 Allocation | 2019 Allocation | 2020 Allocation |
|---|---|---|---|---|
| ⊟ Bold Policies and Supportive Systme | $ 14.412.430 | $ 9.583.085 | $ 8.762.049 | $ 10.097.001 |
| ⊞ Ensure a stable supply of mdicine, diagnostics and other commodities | $ 169.000 | $ 17.395 | $ 17.395 | $ 17.395 |
| ⊟ Human Resources for Health | $ 1.509.077 | $ 339.916 | $ 328.578 | $ 337.214 |
| ⊞ In Country Training | $ 1.483.897 | $ 339.916 | $ 328.578 | $ 337.214 |
| ⊞ International Training | $ 25.180 | $ - | $ - | $ - |
| ⊞ Promote a coordinated and Multi-sectoral Response and Policy Development | $ 72.352 | $ 49.952 | $ 49.952 | $ 49.952 |
| ⊟ Secure Financial Resources for implementation of NSP | $ 12.662.001 | $ 9.175.821 | $ 8.366.124 | $ 9.692.440 |
| ⊞ HRD Staff | $ 8.421.296 | $ 7.462.963 | $ 7.137.002 | $ 7.746.314 |
| ⊞ Support for management and Supervision | $ 4.240.705 | $ 1.712.859 | $ 1.229.122 | $ 1.946.125 |
| ⊟ Integrated, patient-centered care and prevention | $ 22.403.500 | $ 15.973.757 | $ 16.324.521 | $ 16.683.499 |
| ⊞ Accelarate the appropriate diagnosis of TB | $ 4.774.869 | $ 2.360.097 | $ 2.636.361 | $ 2.694.635 |
| ⊞ Engage all care providers, including NGOs and the private sector, in appropriate TB diagnosis and care | $ 344.937 | $ 344.930 | $ 344.619 | $ 344.971 |
| ⊞ Identify and treat all forms of TB, among all ages and including drug-resistant and drug-sensitive | $ 13.455.380 | $ 9.464.507 | $ 9.038.235 | $ 9.186.741 |
| ⊞ Implement a robust communication strategy, extending from policy makers to patient education | $ 488.653 | $ 221.080 | $ 221.080 | $ 221.080 |
| ⊞ Intensify Targeted action to reach marginalised and at-risk populations | $ 1.971.120 | $ 1.819.611 | $ 1.910.027 | $ 2.004.643 |
| ⊞ Joint TB and HIV programming to enable decentralized and integrated services for TB and HIV | $ 673.171 | $ 650.175 | $ 687.226 | $ 723.456 |
| ⊞ Prevention transmission and the emergence of active TB | $ 94.000 | $ 348.656 | $ 701.272 | $ 701.272 |
| ⊞ Promote and Strengthen community engagement | $ 601.370 | $ 764.700 | $ 785.700 | $ 806.700 |
| ⊟ Intensified research and Innovation | $ 4.162.388 | $ 1.452.359 | $ 1.453.115 | $ 1.453.871 |
| ⊞ Enhanced Evidence-based program Monitoring and Implementation | $ 2.360.403 | $ 1.452.359 | $ 1.453.115 | $ 1.453.871 |
| ⊞ Prioritized research agenda | $ 1.801.985 | $ - | $ - | $ - |
| TOTAL | $ 40.978.318 | $ 27.009.201 | $ 26.539.685 | $ 28.234.371 |

i. Human resource capacity building, supportive supervision and monitoring

Significant reforms in the health sector will build the availability of human resources for health. The reforms have the potential to strengthen the ability of system to deliver quality TB and TB/HIV services in future. However, TB- and TB/HIV-specific knowledge and skills need to be built within the emerging system. There are 3 major shifts that are concurrently driving the need for an intensive training and human resource development focus. The first is active recruiting of health staff by the Government to fill previously vacant posts at all levels of the system. Critical cadres, such a health technologists (laboratory) and physicians need up-to-date post-service training. Secondly, task-shifting will gradually shift responsibility for community-based referral of presumptive TB cases and DOT support from midwives to PHS2 staff. Thousands of new PHS2 will be deployed across the country and will play a critical role in connecting rural populations to care. With explicit responsibilities for TB, PHS2 staff will require training. Finally, within each township, 11-person integrated disease control teams will be established. TB and TB/HIV point people within each of the 330 townships will need to be identified and trained.

Training budgets for the new primary care staff are only included in the within allocation request for 2017. There are insufficient funds in 2018-2020 to sustain on-going training. As such, the 2017 budget also includes considerable investment in the development on-the-job training tools, and supervision-based checklists and on-site training tools that can be used to sustain capacity during 2018-2020 should above-allocation funding not be available. The 2018-2020 budgets include only essential training activities to build capacity in laboratories, for x-ray and the use of new data systems.

In addition to training, the budget reflects the continuation of important staff positions. These positions are largely based with NGO and CBO partners and have direct service-delivery responsibilities. The majority of the positions are based within and serve extremely marginalized populations. The positions fill gaps in government service availability. Their continued salary support and ongoing professional development is central to sustaining the gains made in reaching rural, ethnic minority and otherwise marginalized communities. Given the essential nature of these positions, they are included in all 4 years of the grant.

Patient self-help groups have proven successful in improving adherence to medicine regimens among both TB and HIV patients. Such groups will be enabled in the 85 highest HIV-prevalence townships.

ii. Laboratory strengthening

The planned diagnostic network and diagnostic algorithms are described in the NSP. Current gaps in the diagnostic network inhibit access to a timely and appropriate diagnosis for many parts of the country.

Basic smear microscopy is still lacking in many geographically remote areas and specimen transport systems are nascent. Nationally, there is nearly 1 microscopy lab per 100,000 population. However, some districts are still underserved based on the population size, while others need laboratories to enable geographic access. The 2017 within-allocation budget includes funding for the establishment of 50 new microscopy laboratories, to be positioned in underserved areas. In addition, the 2017 budget includes the addition of x-ray capacity in all townships, and for the establishment of a quality-assurance system for x-ray interpretations. The continued expansion of the diagnostic network is included in the above-allocation for years 2018, 2019 and 2020.

A comprehensive laboratory assessment was conducted in 2015, with support from USAID. The report is annexed. Recommendations were made to expand the geographic coverage of culture and DST capacity. Existing culture and DST laboratories in Yangon and Mandalay cover the lower Myanmar and upper Myanmar parts of the country, as well as serving the largest urban populations. The 2017 allocation request includes the establishment of 2 additional culture and DST sites, in Taunggyi to cover three parts of Shan state and Kayah state, and Mawlamyaing to cover the southern part of Myanmar. The 2018-2020 allocation requests support maintenance, supplies, and quality assurance for all 4 laboratories.

Xpert coverage has expanded and the NSP reflects the country's aims to have Xpert capacity in each of the districts. The NSP calls for more ambitious use of Xpert as an early diagnostic tool for selected presumptive cases, such as PLHIV and children, and screening of all retreatment cases was described. Additional Xpert machines will be procured with Government resources.

The budget includes activities to achieve the following:

a) Expand the diagnostic network to include x-ray in all townships, fluorescent microscopy in all station health units, Xpert in all districts, and first-line drug sensitivity testing and culture in 6 states and regions.
b) Introduce district-designed sputum transport systems to cover all remote populations.
c) Ensure sufficient and qualified human resource capacity within the expanded diagnostic network.
d) Accelerate the communication of results between diagnostic and treatment sites, enhancing the recording and reporting system(s) for laboratories and x-ray to align with the treatment monitoring systems, including for PMDT facilities, and introducing electronic systems.
e) Design and introduce an EQA system for x-ray interpretation, while expanding access to digital x-ray nationwide.
f) Ensure biosafety and infection prevention control measures in all TB laboratories and sputum collection sites.
g) Guarantee a regular supply of lab commodities, including centralized supply procurement.
h) Update and disseminate guidelines and Standard Operating Procedures (SOPs).

**Above allocation:** There is no new equipment in the 2018-2020 budgets. However, in above-allocation request, a further 50 new microscopy centres per year are planned in 2018-2020.

i. Engagement of all providers; public-private mix (PPM)

Given the important role of the private sector for care provision in Myanmar, their engagement in TB detection and care has been prioritized in the concept note. Private providers are linked to the NTP, most commonly through PSI and MMA, using innovative models such as the SUN franchise managed by PSI. In 2015, private providers notified over 15% of cases. PPM hospitals contributed a further 4% of new TB cases in 2015. Nearly 1000 patients were identified through active screening in the out-patient departments in several PPM hospitals. The number of public hospitals engaged in PPM increased from nine in 2011 to 24 in 2014. One private hospital was recently linked up with the NTP. Given the important contributions of the PPM network to case finding and quality care provision, a flat-lined budget was maintained within the allocation amount for each year to ensure continued engagement. The budget provides small incentives to the private providers for each case successfully managed, as has been the standard practice in Myanmar for many years. Funds for supervision of the PPM sites are included in the general supervision budget of partners and the NTP.

ii. Advocacy, Communication and Social Mobilization: adopt culturally appropriate communication

Given budget limitations, the concept note includes robust funding for ACSM within the allocation level in 2017 only. In 2017, emphasis will be given to the development of key tools that can be used at various levels of the system to raise awareness about TB and to education patients. Particular priority will be given to developing patient and provider education materials for use in special regions and among different ethnic groups. Only World TB Day activities are included in the 2018-2020 within-allocation budgets.

The provision of health information and TB treatment education materials in relevant ethnic languages is

essential to ensure information is understood. Where communities have oral traditions, health information using pictorial material may be relevant alongside other means of transmitting health messages, such as drama and songs.

**Above allocation:** A more robust ACSM plan, consistent with the NSP, is budgeted in the above-allocation request.

i. Commodities (first-line for adults and children)

Essential to the functioning of a national TB program is the availability of a secure, quality-assured drug supply. The health reforms are streamlining the procurement, storage and distribution of all essential drugs in the country. A USAID-funded project is supporting the TB, HIV and malaria programs to enhance the efficiency of the procurement and supply chain systems. Therefore, the Global Fund request does not include funding for supply systems strengthening.

All first-line drugs for children and adults are included in the request to the Global Fund. The government is unable to cover the costs of these drugs at the current time. Procurement, storage and distribution costs are also included in the allocation budgets for 2017-2020. The government will contribute first-line, single drugs needed for some patients.

ii. MDR-TB

The Government has committed to funding some of the required second-line drugs, but cannot meet the expanded demand that will be generated by enhanced testing for drug-resistance. Within the allocation, a budget for second-line drugs and the nationally standardized patient support package (see NSP) is included for 9,596 patients. Combined, it is estimated that the Global Fund, Government and MSF funds for PMDT will cover 100% of the need in 2017 but only 54%, 62% and 64% in years 2018, 2019 and 2020, respectively. A budget to cover the remaining MDR-TB patients is included in the above allocation request.

Myanmar is decentralizing the care of MDR-TB. Additional training of the staff newly taking on PMDT responsibilities is included in the budget. In addition, the NTP has found that providers must be incentivized to willingly take on the added burden of managing these complex cases. In addition, MDR-TB patients are among some of the most vulnerable to catastrophic costs and food insecurities. As such, a patient support package that includes funds for transport and nutritional support was agreed upon by all partners and is included in the budget. The within allocation budget for patient support will cover the same number of patients for which the allocation will provide drugs. The additional patients are covered, for both drugs and the patient support package, in the above-allocation amount.

Based on the recommendations of a GLC monitoring mission (report attached) and the subsequent country consultation, Myanmar will not immediately shift to the WHO-endorsed shorter regimens for management of MDR-TB. However, it will test the feasibility of the shorter regimen for future consideration of a policy shift. The budget for this feasibility study is front-loaded in the 2017 allocation, although the study will only conclude in 2018.

iii. Targeted approaches to reach the hard-to-reach

Community-based organizations in 179 townships have been linked, with NGO support, to the NTP. Their collective contribution to case finding in 2015 was 10%. In 2015, they referred nearly 15,000 presumptive TB patients and financially enabled their transport to diagnostic centers or sputum collection centers. A budget for sustaining their work with communities accounts for <2% of the total allocation in each year. As such, their continued support is considered high value-for-money.

As mentioned in section 1 above, the allocation request includes salaries for key staff who work in direct support of hard-to-reach populations. In addition, the budget includes incentives and travel funds for volunteers and other local staff to support patient care. Thee staff, as well as those working community based organizations (described below), conduct in-home visits and active contact tracing among hard-to-reach and marginalized populations. In 2015, contact tracing activities contributed 1% of cases notified nationally.

In remote areas with constrained access to diagnostic facilities, sustained funding for sputum collection centers is proposed. In 2015, the existing sputum collection centers screened nearly 13,000 presumptive TB patients and contributed 4% of all bacteriologically confirmed cases notified.

For the most remote and hardest-to-reach populations, mobile teams have been deployed over the past several years. While the cost-per-case detected (approximately US$300) is higher than those identified through routine service visits, this approach has enabled case detection among populations that the health system does not yet reach. In 2015, nearly 95,000 presumptive cases were screened by the mobile teams, accounting for approximately 3% of cases notified. Expansion to add another mobile team

is envisaged in 2017, while costs to sustain their operations are budgeted in 2018-2020.

Ethnic minorities have been identified as key populations in the National Strategic Plan and efforts have been made to engage with Ethnic Health Organizations in national level planning, including for the development of this concept note. A limited number of community based, patient centred approaches are budgeted within the allocation amount to cover underserved areas in collaboration with Ethnic Health Organizations and implementing partners in non-state actor areas. For this, the CN proposes to support SRs who serve known migrant and internally displaced populations to establish a network of sputum collection, diagnostic and treatment services. The SRs will build the capacities of BHS and voluntary health workers to implement "migrant friendly" outreach and care. Where active case finding using mobile clinics has demonstrated success in identifying patient, it will be sustained, particularly in TB hot spots populated by the internally displaced, migrants and ethnic minorities. Note that the budget for SRs is found under "Secure financial resources for implementation of NSP" in the modular template.

TB diagnosis and treatment requires harmonised collaboration between community volunteers, and primary and secondary health care providers. Past Global Fund grants have supported malaria control programs in the special regions, resulting in a basic health provider network with microscopists working in the 85 primary health facilities of special regions and involving 400 village volunteers, all of whom are from the local communities. This concept note proposes to integrate TB case finding and care into the existing malaria platform at community and primary care level. This approach avoids competition for the scarce health human resources in the special regions. Given the reduced malaria incidence in this regions, the staff believe it's feasible to incorporate TB responsibilities.

Specifically, activities described in this concept note will be targeted to reach these vulnerable populations and efforts made to collaborate with and integrate existing EHO systems, service providers, commodity distribution and data systems into National Malaria Control Program efforts.

Key to the design and implementation of the approaches outlined as part of this concept note is improved and greater coordination, collaboration and inclusion of Ethnic Health Organizations, CSOs and other implementing partners (both government where appropriate and non-government) to expand reach and coverage of these vulnerable groups and geographically/socially underserved populations.

iv. Monitoring and evaluation

The NSPs for malaria, tuberculosis and HIV all call for a more efficient and integrated data management system that will facilitate patient management. Each component program has therefore included a budget request for a cross-cutting investment in a DHIS system; i.e. e-Health. As part of the investments in updating the monitoring & evaluation system, the recording and reporting system will be adapted to capture migrant status. A comprehensive proposal for this system is annexed.

The last TB prevalence survey was conducted in 2009. The estimation of prevalence, mortality and incidence are difficult to derive accurately from this outdated, and insufficiently well designed, survey. A follow-on prevalence survey is budgeted in 2017. The equipment to conduct the survey is being purchased from the 2016 Global Fund budget, allowing for a smaller investment in 2017 to conduct the survey.

Routine supervision is budgeted for all years of the concept note. This supportive supervision is essential for sustaining the quality of the program. It operates through a cascade with increasing periodicity of monitoring taking place the closer to patients the facility; e.g. monthly for all rural health centers and township hospitals.

v. Infection Prevention and Control (IPC)

A national IPC assessment (report annexed) highlighted numerous gaps in the current infrastructure and practices related to IPC. The recommendations were taken into account in the NSP. The CN further prioritizes key activities needed to strengthen IPC and divides them, by priority level, across the within- and above-allocation requests, depending on priority. Among the priorities are: active TB screening of all health workers engaged in TB service provision, facility remodelling for IPC, addition of laboratory biosafety equipment, training on IPC, patient education materials for IPC, and N95 masks for health workers supporting MDR-TB patients.

vi. Technical assistance

It is important to note that most technical assistance and guideline development / dissemination will be supported through WHO and by USAID through FHI360. One medical officer position within WHO is included in the concept note to ensure sustained WHO technical support to the country. A technical assistance plan is annexed.

vii. Research and innovation

In 2014, a prioritized national research agenda for TB was developed by the NTP, in collaboration with academic and implementing partners. Studies proposed for funding both within and above-allocation are taken directly from the national research agenda. The NTP is the lead organization for all TB-related research in the country, coordinating partner involvement and provide technical leadership and oversight. As described in the section on MDR-TB above, a feasibility study to test the WHO-endorsed shorter MDR-TB regimen(s) is included in 2017.

### Above allocation

**Table 3.2.10 Summary of Above Allocation Investments**

| | 2017 above allocation | 2018 above allocation | 2019 above allocation | 2020 above allocation |
|---|---|---|---|---|
| ⊟ Bold Policies and Supportive Systme | $ 1.508.466 | $ 5.000.911 | $ 3.416.710 | $ 5.120.333 |
| ⊞ Ensure a stable supply of mdicine, diagnostics and other commodities | $ 51.368 | $ 251.368 | $ 51.368 | $ 249.928 |
| ⊟ Human Resources for Health | $ 1.389.230 | $ 4.455.653 | $ 3.198.952 | $ 4.567.515 |
| ⊞ In Country Training | $ 1.389.230 | $ 4.455.653 | $ 3.198.952 | $ 4.567.515 |
| ⊞ Promote a coordinated and Multi-sectoral Response and Policy Development | $ 18.368 | $ 18.368 | $ 18.368 | $ 18.368 |
| ⊟ Secure Financial Resources for implementation of NSP | $ 49.500 | $ 275.522 | $ 148.022 | $ 284.522 |
| ⊞ HRD Staff | $ 49.500 | $ 54.000 | $ 58.500 | $ 63.000 |
| ⊞ Support for management and Supervision | $ - | $ 221.522 | $ 89.522 | $ 221.522 |
| ⊟ Integrated, patient-centered care and prevention | $ 2.053.889 | $ 13.842.450 | $ 14.524.269 | $ 14.333.118 |
| ⊞ Accelarate the appropriate diagnosis of TB | $ 99.351 | $ 2.668.858 | $ 2.869.252 | $ 2.278.938 |
| ⊞ Engage all care providers, including NGOs and the private sector, in appropriate TB diagnosis and care | $ - | $ 41.417 | $ 66.222 | $ 90.675 |
| ⊞ Identify and treat all forms of TB, among all ages and including drug-resistant and drug-sensitive | $ 423.695 | $ 8.893.912 | $ 9.318.248 | $ 9.675.825 |
| ⊞ Implement a robust communication strategy, extending from policy makers to patient education | $ 676.682 | $ 1.070.720 | $ 1.070.720 | $ 1.070.720 |
| ⊞ Intensify Targeted action to reach marginalised and at-risk populations | $ 630.000 | $ 1.014.393 | $ 1.036.977 | $ 1.059.561 |
| ⊞ Joint TB and HIV programming to enable decentralized and integrated services for TB and HIV | $ 144.160 | $ 73.150 | $ 82.850 | $ 77.400 |
| ⊞ Promote and Strengthen community engagement | $ 80.000 | $ 80.000 | $ 80.000 | $ 80.000 |
| ⊟ Intensified research and Innovation | $ 353.243 | $ 561.721 | $ 728.345 | $ 600.219 |
| ⊞ Enhanced Evidence-based program Monitoring and Implementation | $ 353.243 | $ 561.721 | $ 698.345 | $ 580.219 |
| ⊞ Prioritized research agenda | $ - | $ - | $ 30.000 | $ 20.000 |
| TOTAL | $ 3.915.598 | $ 19.405.082 | $ 18.669.324 | $ 20.053.670 |

An above-allocation request is being made to ensure that Myanmar can both sustain the current strengths of the program supported under the previous grant. The Global Fund allocation for TB in 2018-2020 is sufficient only for the most essential activities required to keep the programme operational nationwide and to sustain targeted support to hard-to-reach populations. As described above, all first-line drugs and diagnostic commodities are budgeted, as are essential human resource functions such as supervision, quality assurance and sustained capacity.

It proposes scale-up of PMDT and active case finding among marginalized populations, only. Otherwise, the above-allocation request simply enables sustained levels of activity, compared to 2016 and 2017. Without above-allocation funding, there will be a reduction in the coverage of programmatic management of drug-resistant TB, and extreme (up to 50%) cuts to community-based and NGO organizations that serve the hard-to-reach, as well as for private sector engagement.

To increase the detection of MDR-TB cases, the roll-out of Xpert has begun under the previous grant, and the 2017 allocation includes plans for minimal scale-up of Xpert. While the numbers being enrolled on treatment have doubled over the past year, treatment scale-up has not kept pace with diagnosis. MDR-TB treatment commensurate with diagnostic scale-up is reflected in the above-allocation request for MDR-TB. The above-allocation request includes funding for second-line drugs and patients support packages for 4,170 patients. This would bring the coverage of PMDT covered by the Global Fund and government to 65% of the estimated need.

Many community-engagement and activities targeting hard-to-reach populations at funded at reduced levels under the allocation; e.g. up to 50% reduction as compared to 2017. The 3MDG fund has historically supported activities that reach the most marginalized population. Noting that the 3MDG fund will end in 2017 some of their activities have been absorbed into the within-allocations amounts in 2018-2020. Where the 2018-2020 levels are insufficient to replace 3MDG funding to key partners, the above-allocation request includes bridge funding for sustaining the activities currently provided by 3MDG partners. The above-allocation funding requests will allow these activities to be sustained, although not scaled-up.

Activities to improve service in 2 special autonomous regions have been added to the above-allocation request. In KSR1, Kokant, Wa and SR4, government township hospitals will be strengthened in terms of both human resources (doctors and lab technicians) and infrastructure (x-ray and lab facilities). In KSR2, where the government township hospitals are not accessible, the special region hospital will be supported with Global Fund resources as MSF-H funds diminish. Community-based support will be provided to link the existing community service networks with formal services to improve the utilization of services among the ethnic communities.

The training roll-out initiated in the 2017 allocation can only be sustained in 2018-2020 with the addition of above-allocation funding. This will be essential to ensure that TB diagnostic and treatment capacity will be integrated into the newly posted health staff.

A robust advocacy, communication and social mobilization strategy, consistent with the plans described

in the NSP are included in the above-allocation request. In summary, the activities include:

1. **Build political will and mobilize resources at township and district level**
    a. Develop and implement township-specific advocacy and communications plans that take into account the local challenges and opportunities
    b. Establish township-level STOP TB Partnerships to coordinate communication and advocacy efforts
2. **Build political will and mobilize resources at national government level:** Enhance communications and advocacy across the central government, broadening ownership of the NTP and integrating TB and MDR-TB issues into plans for universal health coverage, social protection schemes and other health and non-health sector development
3. **Build political will and mobilize resources at donor level**
    a. Nurture existing donor partnerships with regular programmatic updates
    b. National and township-level Stop TB Partnerships will be supported to engage new donors from the private and other non-state sectors, including businesses
4. **Accelerate case detection and increase treatment success through all health providers:** Ensure health providers have all relevant technical information; a) disseminate existing tools; b) develop new communication and advocacy materials targeting the specific needs of private sector GPs, hospitals, community-based organizations, and other NGOs, e.g. tools for adherence counseling and health education, fact sheets on IPT and contact tracing.
5. **Reduce stigma, accelerate care seeking, and enhance case holding through communities:** Target community-specific communications, including print, radio and mobile-phone based (depending on the local context) information
6. **Increase awareness of symptoms and expectations during treatment by patients:** Former and current TB patients, especially youth, will be engaged in crafting patient-centered messages and promoting the best communications platforms

## 3.2 Applicant Funding Request

**TB&HIV**

TB and HIV collaborative activities were prioritized within the allocation amount. Coverage of the activities are nationwide, with two important exceptions. First, there is insufficient budget for ART for all PLHIV. However, ART will be provided to TB patients at the same coverage levels as other high-risk populations (see programmatic gap table). This means that in 2017, it is anticipated that 40% of TB patients will have access to ART, while 30% will have access in 2018, 2019, and 2020, respectively. Secondly, Xpert testing as the initial tool for TB diagnosis will only be available in the 85 high HIV priority townships. An essential of package of TB/HIV collaborative activities has been defined and budgeted within the respective TB and HIV allocations. In summary, the within allocation request will support:

| Interventions budgeted within allocations | TB budget | HIV budget | Notes |
|---|---|---|---|
| Human resources | | | |
| Capacity building: workshop based training of all TB/HIV focal points at township level, PHS2's and other TB and HIV program staff | ✓ | | Capacity building programmed under TB includes TB/HIV training in 2017 |
| Capacity building: on-the-job tools | ✓ | | Development and dissemination of tools for TB/HIV collaborative activities |
| Supervision and coordination | | | |
| Supervision and monitoring visits | ✓ | ✓ | Joint supervision planned and budgeted under both programs; monthly |
| TB/HIV co-ordination meetings | ✓ | | Quarterly meetings at various levels of the health system; budgeted by TB but will include TB and HIV staff |
| Engagement of private sector | ✓ | ✓ | Private sector engagement in TB/HIV activities included under the PPM activities in the TB budget; HIV participation is enabled under the M&E budget for travel and per diems |
| Patient care | | | |
| TB symptom screening among all PLHIV | ✓ | ✓ | Development of checklists and capacity building included across both budgets |
| Xpert testing of all PLHIV | ✓ | | In 85 highest HIV priority townships |
| Rapid HIV testing among all TB patients | ✓ | | Given the funding shortfalls in HIV, additional HIV rapid test kits are included in TB budget for 928,391 TB patients and presumptive TB patients |

| | | | |
|---|---|---|---|
| Transport for TB patients to reach HIV testing sites | ✓ | | |
| IPT for HIV+, TB- patients | | ✓ | National coverage |
| TB treatment for all PLHIV | ✓ | | National coverage |
| ART initiation / provision for HIV+ TB patients | | ✓ | ART coverage of TB patients commensurate with ART coverage overall |
| Co-trimoxazole for TB/HIV | | ✓ | For all estimated TB patients with HIV |
| Infection control | ✓ | ✓ | Budgets limited to masks and gloves |
| TB/HIV in prisons | ✓ | ✓ | Co-ordination meetings and mobile teams to provide integrated services in 2 prisons (TB budget); training in HIV budget |
| Patient self-help groups | | ✓ | To be implemented by partners in 85 high-burden townships |
| Patient adherence support | | ✓ | To be implemented by CHWs; includes funds for transport |
| Supportive systems: IEC and M&E | | | |
| Workshop to design joint communication strategy; advocacy and IEC materials | ✓ | | Tools development and dissemination within allocation during 2017; above-allocation request for 2018-2020 |
| DHIS2 module for integrated TB/HIV case-based reporting | ✓ | ✓ | Cross-cutting activity budgeted across TB, HIV and malaria |
| Link existing TB and HIV data systems for case management | ✓ | ✓ | Cross-cutting activity budgeted across TB, HIV and malaria |

## 3.3 Modular Template

Complete the **modular template (Table 3)**. Note that the template allows access to modules that are specifically relevant to TB and HIV components, in addition to modules that are cross-cutting for both diseases.

To accompany the modular template, for both the allocation amount and the request above this amount, explain:

a. The rationale for the selection and prioritization of modules and interventions for TB and HIV, including those that are cross-cutting for both diseases.

b. The expected impact and outcomes of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

The modular template has been completed for TB and HIV components as well as for those that are cross-cutting for both diseases.

**a) Rationale for the selection and prioritization of modules and interventions for TB and HIV, including those that are cross-cutting for both diseases**

**HIV**

Prioritization process for HIV

Through the Concept Note Working Group and Sub-Working Groups, the HIV Technical and Strategy Group (TSG) requested all implementing partners to review programme achievements and challenges and identify priority interventions to address weaknesses and have highest impact in the next four years. The priorities identified by HIV partners were then integrated into the draft Concept Note. However, due to resource constraint, it was necessary to further prioritize among all the different interventions for each key population and among different geographic areas. This additional step was the AEM Optimization Analysis and Impact Projection, which presented the TSG with a number of funding scenarios with expected targets to achieve and resulting impact of reductions of new infections and deaths. These funding scenarios introduced in Section 2, are the following: Scale-Down, Maintenance, Optimized and Fast Track which have been endorsed by the HIV TSG. Throughout the process, consultations with PLHIV, networks of key populations and ethnic health organizations have been held.

All 14 modules selected for the HIV component have been prioritized by the thematic working groups assigned by the HIV TSG for Global Fund Concept Note development. Following the evaluation of the NSP (2011-2015) last year, and the process to develop the new NSP – the working groups have identified challenges and priority interventions to be undertaken in the next four years to bring about desired change and impact in the Myanmar's HIV response. All priority interventions through intensified outreach component will improve penetration of key population networks reaching those that have not been reached and those that may have been underserved such as women and young girls who are either partners of key populations or are themselves the key populations.

As described in the previous section, treatment represents the highest percentage of the funding request as it has the highest priority to reduce the number of people dying from HIV related illnesses. While ART has expanded to more than double in the last three years from just over 40,000 people receiving ARV in 2012 to over 99,000 people by the end of 2015. This still represents only 46% of PLHIV who need treatment. Treatment remains one of the central pillars of the NSP both as an objective and strategic milestone. Following the previous GF allocation and the success in scaling up treatment in such a short timeframe, without a choice, ARV treatment continues to be high priority for this Concept Note. It should be noted that while other programmes such as TB or Malaria may have options for stopping or reducing treatment components, ARV treatment programme is life-long and once a PLHIV is put on treatment, termination of treatment will have fatal consequences. Doing less than what is presented in this proposal would mean that as we find new people who are HIV positive we would not be able to put people on treatment. Another important consideration is the transition plan to shift patient initiation and management from non-government and private sector to the public sector, as much as possible. Historically ARV has been mostly managed by INGO with external funding. If within the next four years, public sector can manage up to 45% of ART by themselves using mixed domestic and external funding, it would lay a strong foundation for full absorption of ART programme by the Government under the UHC vision.

With regards to HIV prevention – the working groups have agreed unanimously that more effort must be placed to reach the right people, in the right places with the right set of interventions in order to achieve greater impact. In Myanmar, the number of new infections among key populations has not declined

despite downward trend of HIV prevalence. Given the low levels of HIV testing among key population groups, it is imperative that focused and tailored outreach to create demand of HIV testing and accessing HIV services is accomplished. The focus of the prevention interventions is to address weaknesses in previous performance areas and aim to expand ***effective*** coverage. The priority for prevention interventions for all key populations includes promoting intensified and frequent outreach in high priority townships, with improved referral to services and case management approach using internet technology and mobile applications – aiming to get people into care and treatment services more quickly. For PWID, it is critical to significantly scale-up coverage of combination prevention services: innovative models for needle/syringe distribution particularly in difficult to reach areas, expansion of methadone services, overdose prevention, linkages to TB diagnosis and treatment and prison-based combination prevention and treatment programmes will ensure consistent access to services. Similarly, MSM and sex workers also required tailored interventions based on their needs. One example is to focus on increasing uptake of HTC services through community-based and mobile services, integration of services and same day testing and results. Prioritization analyses were also carried out between the interventions for the different key populations: sex workers, PWID and MSM. The AEM and Optima models analysed the most optimal mix of prevention programmes and recommended focus on all key populations but highest among sex workers (due to large client and partners size estimates) followed by PWID and MSM. For a successful HIV programme and in order to end the AIDS epidemic, it is also not an option to further reduce prevention efforts – effective prevention interventions in the next four years can avert up to 12,720 new infections translating to at least 12,720 less people needing to be put on ART. On the other hand, if the prevention effort is inadequate the number of people needing ART will continue to grow ceaselessly.

Other priority areas identified by the working groups include the need to continue to implement programmes to strengthen community systems and improve human rights, gender equality to ensure an enabling environment where rights-based HIV services can be scaled up. As pointed out in Section 1.2 (c), stigma and discrimination and the legal barriers in Myanmar present serious constraints to scaling up services. The previous GF grant provided support in these areas and this request aims to build on the achievements from the previous grant. This is relevant to both TB and HIV and for joint TB&HIV interventions. Proposed interventions include scaling-up training about human rights and gender among key stakeholders in Myanmar, including the public sector; and strengthening and increasing capacity of local NGOs to provide legal aid to key population groups.

**a) Rationale for the selection and prioritization of modules and interventions for TB and HIV, including those that are cross-cutting for both diseases**

**TB**

The interventions under the 6 modules selected for the TB component were prioritized through a three-step process. In the first step, all partners involved in TB control activities in Myanmar were asked to rank all NSP activities using a priority score of 1 to 3. Partners were instructed to give the highest priority only to those interventions that have been demonstrated to increase case detection or improve treatment success rates. In the second step, small working groups with representatives of all partner organizations were formed to discuss individual sections of the NSP and determine those interventions most essential to sustaining the gains made in the programme to date. As the allocation levels were finalized, it became clear that a hyper-prioritization of the most essential services was required for activities to be included in the allocation funding request. As a third step, the TB Technical and Strategy Group reviewed and endorsed the prioritization presented in this Concept Note. The prioritization of activities followed the principle of first seeking to fully fund the most essential of interventions to save lives; i.e. drugs, diagnostic capacity, quality assurance of service delivery, and human resource capacity. After choosing modules and interventions that will ensure the provision of these essential services, interventions that have been demonstrated to result in highest impacts for increasing case detection or improving treatment success rates were selected. Key interventions to increase case detection focus on the strengthening of diagnostic services, targeted case-finding activities in hard-to-reach populations, and the engagement of all providers through public-private mix (PPM) activities.

**b) The expected impact and outcomes of the interventions being proposed**

**HIV**

**Table 3.3.1: Summary of Scenarios and their Expected Impact**

| Scenarios | GF contribution (in millions) | Summary Impact | Prevention | | | Treatment |
|---|---|---|---|---|---|---|
| | | | MSM | PWID | SW | |
| Within Allocation - Scale Down | 175 | ↓ ↓ ↓ | ↓ 15% | ↓ 20% | ↓ 26% | ↔ 45% |
| Above 1- Maintenance | 229 | ↔ | ↓ 29% | ↑ 58% | ↑ 85% | ↔ 48% |
| Above 2 - Optimized | 257 | ↑ ↑ ↑ | ↑ 89% | ↑ 78% | ↑ 90% | ↑ 62% |
| Above 3 - Fast Track | 319 | ↑ ↑ ↑ | ↑ 89% | ↑ 78% | ↑ 90% | ↑ 80% |

*All scenarios of GF contribution will be matched with US$ 36 million contribution from Government
** Among CD4 < 500

For HIV, Global Fund funding up to 2016 is the **allocation amount** (US$ 175 million for four years). As has been presented in this Concept Note, this level of resources will result in significant scale down of programmes. While treatment programmes remain fixed, it results in fast-rising new infections as prevention resources will be too low for scaling up and some programmes will have to close down.

In the Above Allocation 1 (Maintenance Scenario), the next resource level higher at US$229 million, Myanmar will have additional funds to basically maintain current levels of achievements. While there is scale up for sex workers and ART for general population (prioritizing those with CD4 less than 500), the overall impact with this scenario still leaves much to be desired as new infections will continue to rise among PWID and particularly among MSM with only 29% coverage.

**Myanmar therefore strongly urges the Global Fund to consider funding its HIV response at the most optimal level: the Optimised Scenario, US$ 257,554,348 for four years from 2017 to 2020.** If Myanmar receives funding for the **Optimized Scenario from above allocation,** AEM projections indicate that Myanmar will be very close the reaching the 90-90-90 targets with only 21,485 new infections and 33,612 deaths in the next four years or 5,371 new infections and 8,403 deaths per year well on track to ending the AIDS epidemic by 2030.

HIV Modules and Interventions

For HIV, the application for funding covers activities grouped under 14 modules and around 56 interventions – the summary targets and budgets are presented in the tables below for each funding scenario.

**Table 3.2.5 Within Allocation "Scale-Down" Scenario US$ 175,205,903**

| | | | Targets | | | | Budget |
|---|---|---|---|---|---|---|---|
| Module | Coverage/Output Indicator | Baseline (2015) N# D# % | 2017 N# D# % | 2018 N# D# % | 2019 N# D# % | 2020 N# D# % | Total |
| PWID (NSP) | Percentage of PWID reached with HIV prevention programs | 32,370 83,000 39% | 35,864 83,000 43% | 16,666 83,000 20% | 16,666 83,000 20% | 16,666 83,000 20% | 12,505,950 |
| PWID (OST) | Percentage of individuals receiving Opioid Substitution Therapy who | 10,290 83,000 12% | 12,000 83,000 14% | 3,058 83,000 4% | 3,003 83,000 4% | 2,979 83,000 4% | 1,879,740 |
| SW | Percentage of sex workers reached with HIV prevention programs | 33,466 66,000 51% | 37,340 66,000 57% | 17,352 66,000 26% | 17,352 66,000 26% | 17,352 66,000 26% | 6,974,364 |
| MSM | Percentage of MSM reached with HIV prevention programs | 37,994 126,000 30% | 41,556 126,000 33% | 19,311 126,000 15% | 19,311 126,000 15% | 19,311 126,000 15% | 5,427,468 |
| Prevention Awareness Raising | | | | | | | 724,101 |
| Treatment (Adults) | Percentage of adults currently receiving antiretroviral therapy | 99,404 215,312 46% | 104,536 214,786 49% | 104,536 211,830 49% | 104,536 219,441 48% | 104,536 221,759 47% | 102,574,262 |
| Treatment (Children) | among all adults and children living with HIV | 7,086 9,483 75% | 7,086 8,634 82% | 7,315 8,128 90% | 6,803 7,559 90% | 6,247 6,941 90% | 5,861,611 |
| PMTCT | Percentage of HIV+ pregnant women who received ARVs for | 4,365 5,074 86% | 4,094 5,117 80% | 4,105 5,131 80% | 4,106 5,133 80% | 4,103 5,129 80% | 9,583,644 |
| Other HCT (non-KP) | Percentage of others reached with HIV prevention programs | 93,264 1,340,632 7% | 120,394 1,357,734 9% | 120,235 1,360,911 9% | 119,849 1,362,492 9% | 119,326 1,362,902 9% | 2,634,932 |
| TB/HIV | Percentage of HIV+ registered TB patients given ART during TB | 3,034 7,918 38% | 3,480 8,792 40% | 2,726 8,955 30% | 2,809 9,318 30% | 2,820 9,656 29% | 1,060,974 |
| HSS, Legal Barriers, CSS | | | | | | | 5,072,175 |
| PR Programme Management | | | | | | | 20,906,682 |
| TOTAL (within allocation) | | | | | | | 175,205,903 |

## Table 3.2.6 Above Allocation 1 "Maintenance" Scenario US$ 229,619,329

| | | | Targets | | | | Budget |
|---|---|---|---|---|---|---|---|
| Module | Coverage/Output Indicator | Baseline (2015) | 2017 | 2018 | 2019 | 2020 | Total |
| | | N # % D # | N # % D # | N # % D # | N # % D # | N # % D # | |
| PWID (NSP) | Percentage of PWID reached with HIV prevention programs | 32,370 39% 83,000 | 38,145 46% 83,000 | 41,583 50% 83,000 | 45,020 54% 83,000 | 48,458 58% 83,000 | 23,749,707 |
| PWID (OST) | Percentage of individuals receiving Opioid Substitution Therapy who | 10,290 12% 83,000 | 12,000 14% 83,000 | 12,000 14% 83,000 | 12,000 14% 83,000 | 12,000 14% 83,000 | 5,561,854 |
| SW | Percentage of sex workers reached with HIV prevention programs | 33,466 51% 66,000 | 41,937 64% 66,000 | 46,627 71% 66,000 | 51,317 78% 66,000 | 56,007 85% 66,000 | 14,572,502 |
| MSM | Percentage of MSM reached with HIV prevention programs | 37,994 30% 126,000 | 36,529 29% 126,000 | 36,678 29% 126,000 | 36,826 29% 126,000 | 36,974 29% 126,000 | 8,002,976 |
| Prevention Awareness Raising | | | | | | | 724,101 |
| Treatment (Adults) | Percentage of adults currently receiving antiretroviral therapy | 99,404 46% 215,312 | 104,536 49% 214,832 | 106,857 51% 211,331 | 109,179 52% 208,094 | 111,500 54% 205,153 | 106,909,890 |
| Treatment (Children) | among all adults and children living with HIV | 7,086 75% 9,483 | 7,339 85% 8,634 | 7,315 90% 8,128 | 7,181 95% 7,559 | 6,941 100% 6,941 | 5,861,611 |
| PMTCT | Percentage of HIV+ pregnant women who received ARVs for | 4,365 86% 5,074 | 4,483 88% 5,117 | 4,536 88% 5,131 | 4,579 89% 5,133 | 4,616 90% 5,129 | 9,583,644 |
| Other HCT (non-KP) | Percentage of others reached with HIV prevention programs | 93,264 7% 1,340,632 | 120,394 9% 1,357,734 | 120,235 9% 1,360,911 | 119,849 9% 1,362,492 | 119,326 9% 1,362,902 | 2,953,045 |
| TB/HIV | Percentage of HIV+ registered TB patients given ART during TB | 3,034 38% 7,918 | 4,308 49% 8,792 | 4,701 52% 8,955 | 5,218 56% 9,318 | 5,745 59% 9,656 | 1,060,974 |
| HSS, Legal Barriers, CSS | | | | | | | 10,639,026 |
| PR Programme Management | | | | | | | 40,000,000 |
| TOTAL (above allocation) | | | | | | | 229,619,329 |

## Table 3.2.7 Above Allocation 2 "Optimized" Scenario US$ 257,554,348

| | | | Targets | | | | Budget |
|---|---|---|---|---|---|---|---|
| Module | Coverage/Output Indicator | Baseline (2015) | 2017 | 2018 | 2019 | 2020 | Total |
| | | N # % D # | N # % D # | N # % D # | N # % D # | N # % D # | |
| PWID (NSP) | Percentage of PWID reached with HIV prevention programs | 32,370 39% 83,000 | 44,700 54% 83,000 | 51,415 62% 83,000 | 58,130 70% 83,000 | 64,846 78% 83,000 | 29,896,218 |
| PWID (OST) | Percentage of individuals receiving Opioid Substitution Therapy who | 10,290 12% 83,000 | 12,625 15% 83,000 | 13,250 16% 83,000 | 13,875 17% 83,000 | 14,500 17% 83,000 | 6,734,904 |
| SW | Percentage of sex workers reached with HIV prevention programs | 33,466 51% 66,000 | 43,314 66% 66,000 | 48,693 74% 66,000 | 54,072 82% 66,000 | 59,450 90% 66,000 | 14,963,982 |
| MSM | Percentage of MSM reached with HIV prevention programs | 37,994 30% 126,000 | 67,013 53% 126,000 | 82,403 65% 126,000 | 97,793 78% 126,000 | 113,184 90% 126,000 | 16,688,625 |
| Prevention Awareness Raising | | | | | | | 724,101 |
| Treatment (Adults) | Percentage of adults currently receiving antiretroviral therapy | 99,404 46% 215,312 | 104,536 49% 214,411 | 111,357 53% 211,016 | 118,179 57% 207,172 | 125,000 62% 203,095 | 115,314,962 |
| Treatment (Children) | among all adults and children living with HIV | 7,086 75% 9,483 | 7,339 85% 8,634 | 7,315 90% 8,128 | 7,181 95% 7,559 | 6,941 100% 6,941 | 5,861,611 |
| PMTCT | Percentage of HIV+ pregnant women who received ARVs for | 4,365 86% 5,074 | 4,483 88% 5,117 | 4,536 88% 5,131 | 4,579 89% 5,133 | 4,616 90% 5,129 | 8,612,900 |
| Other HCT (non-KP) | Percentage of others reached with HIV prevention programs | 93,264 7% 1,340,632 | 120,394 9% 1,357,734 | 120,235 9% 1,360,911 | 119,849 9% 1,362,492 | 119,326 9% 1,362,902 | 2,953,045 |
| TB/HIV | Percentage of HIV+ registered TB patients given ART during TB | 3,034 38% 7,918 | 6,154 70% 8,792 | 6,716 75% 8,955 | 7,454 80% 9,318 | 8,208 85% 9,656 | 1,060,974 |
| HSS, Legal Barriers, CSS | | | | | | | 10,939,026 |
| PR Programme Management | | | | | | | 43,804,000 |
| TOTAL (above allocation) | | | | | | | 257,554,348 |

## Table 3.2.8 Full Expression of Demand "Fast Track" Scenario US$ 318,589,806

| | | | Targets | | | | Budget |
|---|---|---|---|---|---|---|---|
| Module | Coverage/Output Indicator | Baseline (2015) | 2017 | 2018 | 2019 | 2020 | Total |
| | | N # % D # | N # % D # | N # % D # | N # % D # | N # % D # | |
| PWID (NSP) | Percentage of PWID reached with HIV prevention programs | 32,370 39% 83,000 | 44,700 54% 83,000 | 51,415 62% 83,000 | 58,130 70% 83,000 | 64,846 78% 83,000 | 29,896,218 |
| PWID (OST) | Percentage of individuals receiving Opioid Substitution Therapy who | 10,290 12% 83,000 | 14,474 17% 83,000 | 16,566 20% 83,000 | 18,658 22% 83,000 | 20,750 25% 83,000 | 9,923,544 |
| SW | Percentage of sex workers reached with HIV prevention programs | 33,466 51% 66,000 | 43,314 66% 66,000 | 48,693 74% 66,000 | 54,072 82% 66,000 | 59,450 90% 66,000 | 14,963,982 |
| MSM | Percentage of MSM reached with HIV prevention programs | 37,994 30% 126,000 | 67,013 53% 126,000 | 82,403 65% 126,000 | 97,793 78% 126,000 | 113,184 90% 126,000 | 16,688,625 |
| Prevention Awareness Raising | | | | | | | 724,101 |
| Treatment (Adults) | Percentage of adults currently receiving antiretroviral therapy | 99,404 46% 215,312 | 134,421 62% 215,175 | 145,411 68% 213,017 | 156,077 74% 210,037 | 165,725 80% 206,517 | 160,965,779 |
| Treatment (Children) | among all adults and children living with HIV | 7,086 75% 9,483 | 7,339 85% 8,634 | 7,315 90% 8,128 | 7,181 95% 7,559 | 6,941 100% 6,941 | 5,861,611 |
| PMTCT | Percentage of HIV+ pregnant women who received ARVs for | 4,365 86% 5,074 | 4,483 88% 5,117 | 4,536 88% 5,131 | 4,579 89% 5,133 | 4,616 90% 5,129 | 8,612,900 |
| Other HCT (non-KP) | Percentage of others reached with HIV prevention programs | 93,264 7% 1,340,632 | 120,394 9% 1,357,734 | 120,235 9% 1,360,911 | 119,849 9% 1,362,492 | 119,326 9% 1,362,902 | 2,953,045 |
| TB/HIV | Percentage of HIV+ registered TB patients given ART during TB | 3,034 38% 7,918 | 6,154 70% 8,792 | 6,716 75% 8,955 | 7,454 80% 9,318 | 8,208 85% 9,656 | 1,060,974 |
| HSS, Legal Barriers, CSS | | | | | | | 12,939,026 |
| PR Programme Management | | | | | | | 54,000,000 |
| TOTAL (above allocation) | | | | | | | 318,589,806 |

**b) The expected impact and outcomes of the interventions being proposed**

**TB**

The prioritized interventions will result in increased case detection leading to a decline of TB prevalence and incidence. The expected impacts (annual reduction of prevalence by 5%, annual reduction of incidence by 3%, annual reduction of mortality by 7% and annual reduction of MDR-TB prevalence by 4%) are closely aligned to the global targets described in WHO's End-TB-Strategy. Over the four-year grant implementation period 587,898 TB patients would be detected by the program and receive adequate treatment under the allocation funding request. Additional investments in line with the above-allocation funding request would result in the detection and treatment of an additional 30,942 patients. The number of cases detected in key affected populations and high-risk groups would total 76,388 under the allocation funding request and increase by an additional 32,738 cases under the above allocation funding request. Due to the substantial reduction of available funding during 2018-2020, and the relatively high costs of detecting and treating MDR-TB cases, the differences in the expected program outcomes related to MDR-TB are substantial: an expected 9,596 MDR-TB cases are expected to be treated under the allocation funding request, while additional investments under the above-allocation request would result in the treatment of an additional 4,171 MDR-TB cases.

## 3.4 Focus on Key Populations and/or Highest Impact Interventions

**This question is <u>not</u> applicable for Low Income Countries.**

For TB and HIV, describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:

a. If the applicant is a lower-middle income country, describe how the funding request focuses at least 50% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

b. If the applicant is an upper-middle income country, describe how the funding request focuses 100% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

a) The funding request focuses at least 50% of the budget on underserved and most-at-risk populations and/or highest-impact interventions

**HIV**

This funding request follows the new NSP strategy of categorizing townships into different priority levels according to the disease burden. Out of the 330 township, 85 are High Priority (high HIV burden); 151 are Medium Priority (medium HIV burden) and 94 are Low Priority (low HIV burden). In terms of need, between 63% and 77% of key populations are found in high priority townships. 76% of the adult PLHIVs are found in the High Priority townships and 78% of adults on ART reside in High Priority townships. Between 19-31% of key populations and adults on ART are found in Medium Priority townships and only 3-6% of priority populations are found within low priority townships. It is also important to note that while 95% of adults on ART are found in high priority townships a proportion of those people reside in Medium Priority townships, suggesting the need to continue to decentralize ART distribution efforts closer to PLHIV homes.

More than 80% of the funding request budget (service delivery areas) focuses on the most-at-risk populations in the 85 High Priority townships.

**TB**

TB is strongly linked to poverty. In Myanmar, evidence suggests that TB is also impoverishing. A recent study found that 65% of TB patients experienced catastrophic costs when seeking care. Up to 64% of TB-affected households had to sell assets or take a loan to manage the indirect and direct costs. Among the poorest quintile, nearly 75% of households had to take loans or sell assets to seek and sustain care.

While the provision nearly all TB diagnosis and care services benefit the most underserved and most at-risk populations, this concept note has prioritized activities that will reach the hard-to-reach.

## SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

This section requests information regarding the proposed implementation arrangements for this funding request. Defining the implementation arrangements for the program including the nominated Principle Recipients (PRs) and other key implementers is essential to ensure the success of the programs and service delivery. For the concept note for TB and HIV, the Country Coordinating Mechanism (CCM) can nominate one or more PRs, as appropriate given the country context**.**

### 4.1 Overview of Implementation Arrangements

For TB and HIV (including HSS if relevant), provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector PRs).

b. If more than one PR is nominated, how co-ordination will occur between PR(s) for the same disease and across the two diseases and cross-cutting HSS as relevant.

c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipient(s) have been identified.

d. How coordination will occur between each nominated PR and its respective sub-recipient(s).

e. How representatives of women's organizations, people living with the two diseases and other key populations will actively participate in the implementation of this funding request.

**a. Dual-track financing arrangement**

Not applicable. The proposed implementation arrangement does involve a dual-track financing arrangement (i.e. both government and non-government sector PRs)

**b. Coordination between Principal Recipients**

More than one PR is nominated (same PRs as in Round 9 and NFM: UNOPS and SCF). Regular meetings are conducted to share programmatic achievements and lessons learned. PRs and M-HSCC share PSM, M&E and programmatic challenges and best practices on a quarterly basis during M-HSCC meetings. Technical meetings are also run between PRs and with SRs as needed. UNOPS manages grants for local NGOs, WHO and the NAP, NTP and NMCP; SCF manages the grants for international and local NGOs.

**c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified**

SRs for this proposed grant have not yet been identified. A transparent SR selection will be carried over during the grant making, under the supervision of the M-HSCC. The selection will take into account TRP comments as well as the final funding levels approved by the Global Fund for the Myanmar 2017-2020 NFM. More emphasis however will be placed on maximizing cost effectiveness by avoiding the administrative and logistical duplication and coordination related issues that arise from having multiple SRs implementing similar activities in the same state and regions. For HIV, Myanmar is looking at the need to streamline the number of SRs in the context where there is limited and decreasing funds in Years 2, 3 and 4.

Sub-recipient management arrangements (split between PRs) will remain as they are at present. These are well established and considered effective by GF and the country.

**d. Coordination between each nominated Principal Recipient and its respective sub-recipients.**

PRs regularly conduct meetings in addition to day-to-day communication, to review programmatic achievements, issues and lessons learned. Annual procurement plan meetings and fund flow

management workshops are also carried out to brief SRs regarding latest issues. Workshops to review Standard Operating Procedures in various technical and management areas are also conducted together with the NAP, NTP and NMCP and SRs to seek inputs and validate policy guidance.

**e. How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request**

The funding request was made through a consultative and transparent process of Core and Expanded HIV and TB TSGs and M-HSCC meetings, as well as sub-working groups on the areas of Prevention, Testing, Treatment and Care, Enabling Environment, Strategic Information, and Management. In these meetings, NAP, PRs, SRs and other implementing partners who have exposure to field and communities are present. Civil society, key populations networks, community based organisations, faith-based organisation, and others who are also present in these meetings review and discuss policies and practices related to HIV interventions, barriers to access to treatment and prevention such as stigma and discrimination, punitive laws etc. They ensure that women, migrant population and ethnic people are not neglected or omitted from the national response. Consultations were held in Hpa An and Lashio with ethnic health organization representatives who expressed interest in working with HIV and TB programmes.

## 4.2 Ensuring Implementation Efficiencies

**Complete this question only if the CCM is overseeing other Global Fund grants.**

From a program management perspective, describe how the funding requested links to any existing Global Fund grants, or other funding requests being submitted by the CCM at a different time. In particular, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

The NFM grant will come to a close in December 2016 and the new NFM grant is expected to start in January 2017. There is therefore no chance of overlap or duplication of effort between these two grants..

## 4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery

**For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.**

| **PR 1 Name** | **UNOPS** | **Sector** | **HIV&TB** |
|---|---|---|---|
| Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)? | | Yes | |

| **Minimum Standards** | **CCM assessment** |
|---|---|
| **1.** The Principal Recipient demonstrates effective management structures and planning | Meets minimum standards. PR fulfils GF staffing requirements including professionals competitive at international level (e.g. Programme Director, Head of Programmes, Finance Officer, M&E Officer, Procurement specialist, Logistics Officer, Quality Assurance Officer). Regarding procurement, PR conducts the procurement for both pharmaceuticals and other health products as approved by GF based on the PSM capacity assessment carried out in August 2012. A procurement and logistics-monitoring sheet is being shared with M-HSCC, all the stakeholders and partners every Monday. LMIS manual/system had been developed and 2,000 people were trained in the MOHS on logistics management. |

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| **2.** The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients) | Meets minimum standards. Financial and programmatic oversight plans for SRs had been approved. Semi-annual reports of findings are submitted to GF including measures to address identified issues. PR provides status updates of capacity building of SRs in the area of financial management and other LNGO capacity building workshops, summary reports on desk reviews and field visits to identify and address weaknesses. Regarding required SR M&E responsibilities, PR embarked on RDQAs, on-site data validation with submission of periodic reports, programme review meetings etc. that support indicator and target revision. PR monitors SR compliance with set agreements on eligibility of expenses. |
| **3.** The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud | Meets minimum standards. The internal control system is considered effective to detect misuse and fraud. This system is implemented through such mechanisms as: A code of conduct to which all personnel subscribe; clear delegations of authority which limit an individual from processing incompatible transactions; regular reports and reconciliations to UNOPS Regional Office; financial declarations for identified personnel; robust recruitment systems which require a thorough background check; a financial management information system (one UNOPS) with embedded strong and proven controls, and periodic reviews and audits by HQ for PR operations and PR compliance reviews for SRs operations. |
| **4.** The financial management system of the Principal Recipient is effective and accurate | Meets minimum requirements. The financial management system of the PR is considered effective and accurate. The system can handle large budgets and can easily produce accurate income and expenditure reports in the format desired by most donors. |
| **5.** Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products | Meets minimum requirements. Renovation work of central NAP and VBDC warehouses was completed and highly appreciated during the inaugurated by H.E. the Minister of Health and the General manager of the GF on 17 August 2012. The renovation work of the 3 TB warehouses of NTP Central, Lower Myanmar and National TB Reference Lab was also completed in December 2012. Besides the above, Latha warehouse originally used as Central NAP has also been renovated for NAP. 41 warehouses, ART clinics and TB/HIV sites of all three National Programmes in the state and regions were renovated in 2013. Six new warehouses were built with financial and administrative support of the Embassy of Japan. The renovated warehouses now have enough capacity, appropriate storing conditions and access control environment.<br><br>Trainings on LMIS including TOTs were successfully conducted twice, once in 2012 and then in 2014, covering around 2000 Staff from all over the country. Third round of LMIS training is planned for 2016. |
| **6.** The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions | Meets minimum requirements. In order to ensure adequate and quality supplies and avoid over/under estimation of supplies, the two PRs works close consultation with the DOP, technical partners to generate annual forecasts and quantification considering stock in hand, pipeline supplies and expected consumption until arrival of the next orders. There are plans to further strengthen the PSM including automating the systems and interface it with the HIS. This will allow the use of consumption data in the forecasting and quantification. Additional investment in the PSM system strengthening is needed. The National Programmes had started using M-supply for the stock management and this has improved the quality of the stock management and reporting.<br><br>UNOPS LMIS and the related SOPs have been very effective in proper management of the supply chain. SOPs have been translated into local language and distributed all over the country.<br><br>With the implementation of the LMIS, and introduction of M-supply the storage and distribution system and reporting has much improved. |

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| **7.** Data-collection capacity and tools are in place to monitor program performance | Meets minimum standards. The PR uses the national system to avoid creating parallel and sustainably system. The routine HIV and TB reporting and recording systems are functioning well. However, the PR documented several concerns: (1) risk related data security as there is weak back up system, (2) the data management system is continue to be paper-based at state/region and below, (3) minimal data management trainings for township level.<br><br>Despite difficulties to collect and submit documentation of a high volume of activities with vast coverage, PR provides aggregated training reports from States and Regions along with PUDR as supporting documents.<br><br>In May 2016, an integrated e-Health plan for HIV, TB and Malaria case-based surveillance and aggregate reporting system was formulated and agreed to by the three national programmes. A softward was chosen to develop the Master Patient Index for effective longitudinal patient monitoring across care and aggregate DHIS2 reporting form development has been prioritized for 2016.<br><br>In 2016, CHAI – funded by 3MDG - is working with NTP on establishing a national electronic MDR-TB patient case management system and enrollment system. CHAI finished the development of Prototypes 1 and 2 and will share and train NTP data assistants to test run with Yangon patient data. CHAI is also supporting NAP to pilot the ART openMRS database.<br><br>The PR conducts routine monitoring activities including onsite verification of implementation, data and service quality assurances, period reviews and coordination meetings. Feedbacks are provided to DOP at highest level, to the MHSCC and to all implementing and technical partners. |
| **8.** A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately | Meets minimum standards. As mentioned above, there good and functional paper-based reporting system. The automation of the data management systems with the strengthened supervision and monitoring at all level shall address the aforementioned gaps and concerns. The rollout of these electronic data systems (eHealth) shall further improve the quality of the data including timely reporting.<br><br>The PR, conducts RDQAs, on-site data validation, program reviews and monitoring visit for the SRs.. Each Quarter a review is held with all SRs to share lessons and review results and M&E related matters.<br><br>Quarterly stock reports are received from NAP. These reports are analysed to check for the near to expiry products, over stocked products and necessary decisions are taken, if required, to relocate the stocks or expedite the orders. |
| **9.** Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain | Meets minimum standards. Appropriate systems/procedures are being put in place to ensure compliance with the requirement to conduct random sampling and quality control testing of health products throughout the supply chain (WHO pre-qualifications or ISO17025 standards for laboratories). An in-country quality monitoring team chaired by the DG FDA was formed in November 2011 and TOR established, for in-country quality monitoring of pharmaceuticals. The team meets periodically and prepares sampling plan for a year. The sampling is carried out as per the established QC workplan by the FDA inspectors. Samples of different key and sensitive pharmaceuticals are withdrawn from different locations in the supply chain and sent to TUV SUD Singapore a WHO prequalified laboratory for test/analysis |

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| **4.3 Minimum Standards for Principal Recipient (PR) and Program Delivery** | | | |
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| **For both TB and HIV complete the table below for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.** | | | |
| **PR 2 Name** | **SCF** | **Sector** | **HIV&TB** |
| Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)? | | Yes | |

| **Minimum Standards** | **CCM assessment** |
|---|---|
| **1.** The Principal Recipient demonstrates effective management structures and planning | Meets minimum standards. The PR demonstrated effective management structures and planning in regard to management letters sent by GF. A team of 40 international and national staff are employed to work exclusively in the management of the GFATM grants to ensure that activities are technically sound and are implemented following national and global quality standards. This includes providing support on financial and program management to SRs, procuring pharmaceutical and health products, and reporting on program performance to both the Global Fund and the Myanmar Health Sector Coordinating Committee. Annual planning processes, such as the submission of training plans and annual budgets and work plans are routinely implemented according to deadlines. The latest GF ratings for the PR (as of November 2015) are A2 for the Tuberculosis, Malaria and HIV grants. |
| **2.** The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients) | Meets minimum standards. The PR has effectively managed both the Round 9 and the NFM (2013 – 2016) grants. Under the NFM (2013 – 2016), the PR supports 18 sub-recipients (SRs) across the three grants with a total budget of $132.1 million. The PR is organized in four units: program implementation; monitoring and evaluation; procurement and supply chain management; and grants and compliance. Each unit conducts routine monitoring visits to SR and sub-SR (SSR) to ensure that interventions are implemented according to agreed standards, reporting systems are robust and accurate, health and non-health products are stored and managed as per best practice, and that resources are used and managed according to agreed compliance standards. These units routinely meet to triangulate information, e.g., that expenditure trends match program implementation and stock consumption. |
| **3.** The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud | Meets minimum standards. The PR is operating under the set standard policies and procedures of Save the Children International. The internal control system is the main key performance indicator for the team, which will be maintained by the Country Office operations, monitored by the Regional and HQ level, and verified by the Global Assurance Unit (serves as internal audit function). In addition, the business workflow and control are highly effective to detect misuse and fraud. The fraud protection training is compulsory for all staff members and also applicable to the partner organizations receiving funds from Save the Children. |
| **4.** The financial management system of the Principal Recipient is effective and accurate | Meets minimum requirements. The financial management system of the PR is effective and accurate. Save the Children uses a grant accounting system to segregate accounting books for each donor funding. This system enables analysis of the portfolio throughout program implementation. Accurate donor reports are generated and available for further verification and audit by an independent agent or auditor. The financial system supports analysis of implementing |

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| | partner expenditure as required by the donor. |
| **5.** Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products | Meets minimum requirement. Warehouses have been strengthened since SRs began implementation in Round 9 and the NFM (2013 – 2016) grants. Annual turnover of goods is higher than USD 10 million through the current network and distribution system. The PR conducts regular monitoring visits to ensure that SRs maintain adequate storage conditions. In collaboration with Myanmar FDA, samples are collected each year at SCI's SR warehouse level, up to dispensing sites. All QC testing to date has resulted in a "PASS" rating, demonstrating that SR's warehousing network / distribution system can maintain quality of products along the supply chain. |
| **6.** The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions | Meets minimum requirements. Supply is well regulated and scheduled from one to three shipments / year according items shelf life and volume. This approach is taken in order to limit the risk of expiry, damage, and overstock in-country, as well as to ensure adequate flow of goods. SC-PR does not have a central warehouse. Items procured by SC-PR PSM team are directly transported either from port to SRs central warehouses, or, in the case of high volume items, to township level. This decreases the storage and transport costs of such products. Each SRs has a well-established distribution system based on programs and activities. Moreover, the PR has a monitoring system, which identifies items at risk of shortage/overstock and reallocates stock in urgent need or to limit risk of expiry. The current distribution system has been proven highly efficient: there has been no shortage of key items among SC-PR SR during the past five years of program implementation. |
| **7.** Data-collection capacity and tools are in place to monitor program performance | Meets minimum standards. Data collection mechanism has been in place since beginning of phase I and is functioning well. The latest OSDV have consistently indicated "Overall Good Data Quality" for malaria, TB and HIV grants. The PR has also conducted periodic training and capacity building activities so that all SRs observe the key aspects of data quality: completeness, validity, consistency, timeliness and accuracy. The M&E system ensures the ability to report according to both Global Fund and national M&E reporting requirements. |
| **8.** A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately | Meets minimum standards. Routine reporting (based on MOHS data collection forms) is in place to report performance in time and accurately as confirmed by management letters sent for the previous reporting periods. The latest OSDV have consistently indicated "Overall Good Data Quality" for malaria, TB and HIV grants. The PR routinely meets PU-DR reporting deadlines and tracks SR submissions in terms of timeliness and completeness of information. Results are verified through Routine Data Quality Assessments (RDQA) carried out by the PR's M&E team. By the end of 2016, the PR will have supported the roll out of DHIS2 at SR level to expand reporting coverage and streamline SR-level reporting systems. |
| **9.** Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain | Meets minimum standards. Save the Children coordinates QA/QC of key pharmaceuticals with the Food and Drug Administration (FDA) in order to avoid duplication of QA/QC systems. SC- PR PSM staff conduct regular monitoring visit to ensure that adequate storage conditions are maintained. Temperature monitoring devices recording T° have been installed at each of the SRs' warehouse levels. This system has improved management of the supply chain and significantly decreased risks. Moreover, SC-PR is member of the in-country Quality Monitoring Team chaired by Myanmar FDA. In collaboration with Myanmar FDA, samples are collected regularly at SC-PR SRs' warehouse level, up to dispensing sites. All QC testing to date has resulted in a "PASS" rating, demonstrating that SRs' warehousing network / distribution system can maintain quality of products along the supply chain. |

## 4.4 Current or Anticipated Risks to Program Delivery and PR(s) Performance

a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, PR(s) and key implementers' capacity, past and current performance issues.

b. Describe the proposed risk mitigation measures (including technical assistance) included in the funding request.

**a. Major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions**

Key anticipated risks to the implementation environment are listed below with proposed mitigation measures.

1. **Security issues.** Although very significant progress has been made in resolving security issues in recent years, the situation in some ethnic states where armed groups operate remains volatile. There is currently an on-going conflict in the north of Shan State and in Kachin State, and there remains the possibility of violent clashes in other ethnic states. Programme development and programme implementation in areas such as these is often problematic, slow[26] and somewhat haphazard. Total cessation of services may be necessary periodically. Proposed mitigation: The programme cannot significantly improve the security situation. Implementers will follow security related protocols and take precautions as advised by security officials.

2. **Natural disasters.** Cyclones, flash and floods and earthquakes occur frequently in Myanmar and these may jeopardize implementation of planned activities both in directly affected areas and in other parts of the country due to diversion of efforts and supplies to affected areas. Proposed mitigation: Buffer stocks have been incorporated into the procurement of all key programme commodities (ARV, IPT, methadone drugs, condoms, needles and relevant health products). Realignment/Reprogramming of GF-budgets and work plans to cover the immediate needs is another option to mitigate the losses and resume essential services

3. **Reduced support from other funding partners**. Untied indicators linked to GF projects represent a risk for the performance framework. The 2 PRs and its SRs have no control over non-GF donor commitments to SRs. If contributions decrease or are cancelled, GF performance targets could be missed. This risk is becoming an issue in the termination of 3MDG Fund at the end of 2017. Proposed mitigation. As far as possible, any significant financial gaps left by the withdrawal of funds by other funding partners will be addressed through periodic reprogramming of GF funds. The government will also be requested to increase its contributions to cover any such crucial gaps.

4. **Financial issues**. Fluctuations in exchange rates have negatively affected the purchasing power of the budget in the past. While the exchange rate appears now to be becoming more stable, inflation remains an issue and commodity prices are on the rise. Proposed mitigation: Where necessary, shortfalls will be addressed during periodic reprogramming of GF funds.

5. **Imports.** Timely clearance for import license and tax exemption of pharmaceutical and health products (under Save the Children) cannot be achieved without increased government commitment to support abstention of import permits. Proposed mitigation: High level commitment and support is needed to resolve the issue.

6. **Access**. The extreme remoteness of some areas is often compounded by poor physical infrastructure making access limited, particularly during the rainy season. Proposed mitigation: The timing of visits to remote areas will be planned taking seasonal constraints into consideration. Additional funds for accessing hard to reach target communities have been incorporated into the budget. Special travel rates are paid to the health staff and volunteers in these areas. Special price and brand is approved for vehicles and motorcycles to be used in these areas. Mobile activities are organised to reach such areas for their basic medical and malaria needs.

[26] MOU agreements are required for each new geographical area to be covered by the programme and their preparation can be very time consuming.

7. **Health system weaknesses.** Inherent weaknesses in the health systems often limit the quality of services. Proposed mitigation: HIV and TB-related health system strengthening activities have been incorporated into this application (e.g. PSM, HMIS and M&E). Extensive use of volunteer networks to provide HIV and TB-related services in less accessible communities solves some of the issues associated with access and at the same time reduces the burden on overstretched health workers, particularly in the periphery. GF is also supporting the implementation of e-Health system that will improve recording and reporting for all the three diseases. LMIS is also improving and supply chain is being strengthened progressively. National Programmes through Managed Cash Flow of UNOPS has been capacitated throughout the country in terms of bottom up budgeting, planning, implementation, controls and reporting. Financial Management and Procurement is still a challenge for the national structures.

8. **Global Fund support fails to continue at existing levels**. Proposed mitigation: Advocate for increasing financial commitment from Government and other donors including USAID, EU, successor to 3MDG Fund, and the private sector. However, with the new Government only recently in place (since April 2016), many donors are still taking a "wait and see" approach before pledging to commit more resources to this new democracy.

These risks will be monitored in partnership with members of the MHSCC including international development partners, donors and implementing partners during grant implementation and reported on by the PRs, regularly reviewed by the LFA, the Oversight Board of the MHSCC, and assessed by GF during periodic grant appraisal sessions.

## CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

| | |
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| ☐ | Table 1: Financial Gap Analysis and Counterpart Financing Table |
| ☐ | Table 2: Programmatic Gap Table(s) |
| ☐ | Table 3: Modular Template |
| ☐ | Table 4: List of Abbreviations and Attachments |
| ☐ | CCM Eligibility Requirements |
| ☐ | CCM Endorsement of Concept Note |