Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Concept Note for Early Applicants

Myanmar - HIV

This concept note template is to be completed by early applicants invited to request funding from the Global Fund in 2013 during the transition to the new funding model. For more information on how to complete the concept note, please refer to the Concept Note Instructions.

The concept note details the applicant's request for Global Fund resources in a disease area (and/or health and community systems strengthening) for the next three year period. The concept note should articulate an ambitious and technically sound response, drawing from the Health Sector Strategic Plan, National Strategic Plans and other appropriate documentation. It should include a prioritized full expression of demand to maximize impact against the disease(s).

There are five different sections of the concept note:

Section 1: How the application development process complies with CCM Eligibility Requirements.

Section 2: An explanation of the country's epidemiological situation and the current legal and policy environment, and how the National Strategic Plan responds to the country disease context.

Section 3: How existing and anticipated programmatic gaps of the National Strategic Plan have been identified.

Section 4: How the funds requested will be strategically invested to maximize the impact of the response.

Section 5: How the program will be implemented.

This concept note is specifically designed for early applicants and does not represent the final template to be used for the full roll-out of the new funding model. The concept note template will be revised to reflect feedback received during the transition phase.

OVERVIEW: Summary Information			
Applicant Information			
Country	**Myanmar**		
Applicant Type	**CCM**	**Component**	**HIV**
Funding Request Start Date	**2013**	**Funding Request End Date**	**2016**

Funding Request Summary			Currency of Funding Request		USD
Component:			AIDS		
[Inset dates for annual period covered]	A= Existing (Global Fund grants)	B= Incremental Funding Request (Indicative)	C= Funding Request (above Indicative)	A+B= Existing and total Incremental Indicative Funding Request	A+B+C= Full Request
Insert Year 1	28,500,000		5,624,930		34,124,930
Insert Year 2	31,700,000		18,539,649		50,239,649
Insert Year 3	31,500,000		25,774,282		57,274,282
[Additional Yr]		39,500,000	30,147,975		69,647,975
Years 1-4 Totals:		131,200,000	80,086,836		211,286,836

Note: In the above table, Incremental Funding Request figure includes Round 9 Phase II grants.

Confirmation of Program Split for Indicative Funding		
This question is only relevant for early applicants invited to submit funding requests for more than one disease.		
During country dialogue, the applicant will decide how best to distribute indicative funding across relevant disease programs and HCSS. Please provide the original indicative program split as communicated by the Global Fund and if relevant, the split approved by the Global Fund following country dialogue.		
Program	**Original Indicative Program Split Amount (USD)**	**Approved Program Split Amount (USD)**
HIV	39.5 million	
Malaria	26 million	
Tuberculosis	26.3 million	
HCSS		
Total Indicative Funding	91.8 million	

SECTION 1: CCM Eligibility Requirements and Dual Track Financing

Two of the six CCM Eligibility Requirements relate to application development and Principal Recipient (PR) selection processes and will be assessed as part of the concept note:

a. **Requirement 1** – Application development process
b. **Requirement 2** - The Principal Recipient(s) selection process.

For each Requirement, applicants must provide evidence of compliance and attach relevant supporting documentation. Please also fill in and attach the **CCM Endorsement** (Attachment 1).

1.1 Application Development Process (Requirement 1)

Please describe:

a. The **documented and transparent process** undertaken by the CCM to **engage** a broad range of stakeholders, including non-CCM members, in the application development process.

b. The efforts made to engage **key population groups**[1], including most-at-risk populations[2], as active participants in the country dialogue and application development process.

a) The Myanmar CCM (M-CCM) engaged a broad range of stakeholders, including non-CCM members in the application development process. The M-CCM follows as established procedure in developing applications: the M-CCM Secretariat together with relevant Technical Strategy Groups of the M-CCM organizes information briefings, consultations, workshops, and proposal writing working group meetings to produce draft proposals or concept notes for review and endorsement by the M-CCM. (Annex 1: M-CCM Performance Assessment Tool). For the development of this current Concept Note, the TSG-HIV conducted a series of meetings in 2012 and 2013 (Annex 2: TSG meeting minutes, 1 October 2012 and Annex 3: TSG meeting minutes, 6 March 2013). The Expanded TSG for HIV includes government sector, international non-government and local non-government sector, community organizations, networks of key affected populations (including HIV, sex workers, people who inject drugs, women living with HIV, Kachin Women Peace Network and MSM), UN agencies and representatives of bilateral/donor agencies (total of more than 50 members).

Information briefing was provided to all TSG Chairs on 25 September 2012 and to the core TSG of 1 October 2012 and expanded TSG on 6 March 2013. Discussions on priorities and programmatic gaps concluded with three areas of intervention: treatment, testing and

[1] **Key population groups** include: women and girls, men who have sex with men, transgender persons, people who inject drugs, male and female and transgender sex workers and their clients, prisoners, refugees and migrants, people living with HIV, adolescents and young people, vulnerable children and orphans, and populations of humanitarian concern. In addition to these groups: internally displaced persons, indigenous persons, people living with TB and malaria and people working settings that facilitate TB transmissions should also be considered as key affected populations.

[2] For the purpose of the transition to the new funding model (GF/B28/DP5), most-at-risk populations will be defined as subpopulations, applying to HIV, malaria and tuberculosis, within a defined and recognized epidemiological context:

1) That have significantly higher levels of risk, mortality and/or morbidity;
2) Whose access to or uptake of relevant services is significantly lower than the rest of the population; and
3) Who are culturally and/or politically disenfranchised and therefore face barriers to gaining access to services.

prevention. At this meeting, programme implementers cautioned against scaling up too rapidly especially in the area of harm reduction for people who inject drugs due to a number of reasons, including limited access to project sites and limited capacity on the ground to expand harm reduction activities to reach more beneficiaries. After the priorities were agreed upon, a sub-group of the TSG (volunteers, PRs and lead UN technical agency for the three areas) was formed to write up the draft concept note. The Sub-Group also consulted with key implementing partners for each priority area and a number of meetings were held to confirm activities, target groups and target size. The TSG then reviewed the final draft prior to submission to the M-CCM for endorsement. The M-CCM had a meeting on 18 October 2012, at which endorsement for submission of Concept Notes for all three diseases was obtained. The Concept Note was submitted to the Global Fund on 23 October 2012.

The process was transparent and inclusive of a broad range of stakeholders (civil society, PLHIV, local NGO, international NGO, bilateral partners, UN agencies, and government). The M-CCM and TSG are multi-sector forums (Annex 4: TSG member list).

The Concept Note was reviewed by the Global Fund Phase II Renewal Panel in February 2013. M-CCM/ Chair received an invitation letter from the Global Fund on 1 March 2013 to become an early applicant in the New Funding Model.

Information briefing to the TSG Chairs and Convenors and expanded TSG on 6 March 2013. Meeting of the Sub-Group of the TSG to prepare for Concept Note writing on 7 March and 20 March 2013. Sub group started preparing draft Concept Note on 8 March 2013.

Work in collaboration with the Global Fund country team (14-15 March Modules Workshop; 18-19 March Multi-stakeholders Workshop) to finalize the Concept Note

Submit draft Concept Note to M-CCM for endorsement (end of March 2013).

b) Network members representing key populations of MSM, IDU and sex workers participated in the expanded TSG meetings at which priorities and programmatic gaps were confirmed. Key population groups are also directly consulted regularly to ascertain their priority needs. The M-CCM secretariat together with UNAIDS Country Office routinely organizes meetings with network members representing key populations and PLHIV and influential visitors such as Executive Director of UNAIDS, USG PEPFAR representative, and Global Fund General Manager, Deputy General Manager and other senior GF representatives. At these meetings, representatives of key population and PLHIV raise policy, technical and socio-economic constraints they are facing and request for concrete support to community systems strengthening. PLHIV and key population are also key participants in all aspects of development, dissemination and review of the National Strategic Plan (2011-2015) which is the main guiding document and resource allocation reference for the national AIDS response.

1.2 Principal Recipient (PR) Nomination and Selection Process (Requirement 2)

Please describe:

a. The documented and transparent **process and criteria** used to nominate any new or continuing PR(s).

b. How any **potential conflict of interest** that may have affected the PR(s) nomination process was **managed**.

1 PAGE MAXIMUM

The PRs nominated for the Concept Note are the same ones from the previous GF grants for HIV, TB and Malaria: UNOPS and Save the Children. There is no new PR.

For a summary of the documented and transparent process and criteria used to nominate

PRs for Round 9, (Annex 5: 4th M-CCM meeting minutes).

1.3 Dual-track Financing

Dual-track financing refers to a proposed implementation arrangement that involves both government and non-government sector PRs. If this funding request does not reflect dual-track financing, please explain why. If your funding request includes dual-track financing, please leave this section blank.

This funding request does not reflect dual-track financing as Myanmar does not have a government sector PR. UNOPS acts as a PR on behalf of government. However, it is anticipated that given the current changes in Myanmar, a transition to government sector PR is being considered. Technical assistance will be provided to the National AIDS Programme and government sector to enable the transition to take place.

SECTION 2: Country Context

2.1 Country Disease Context

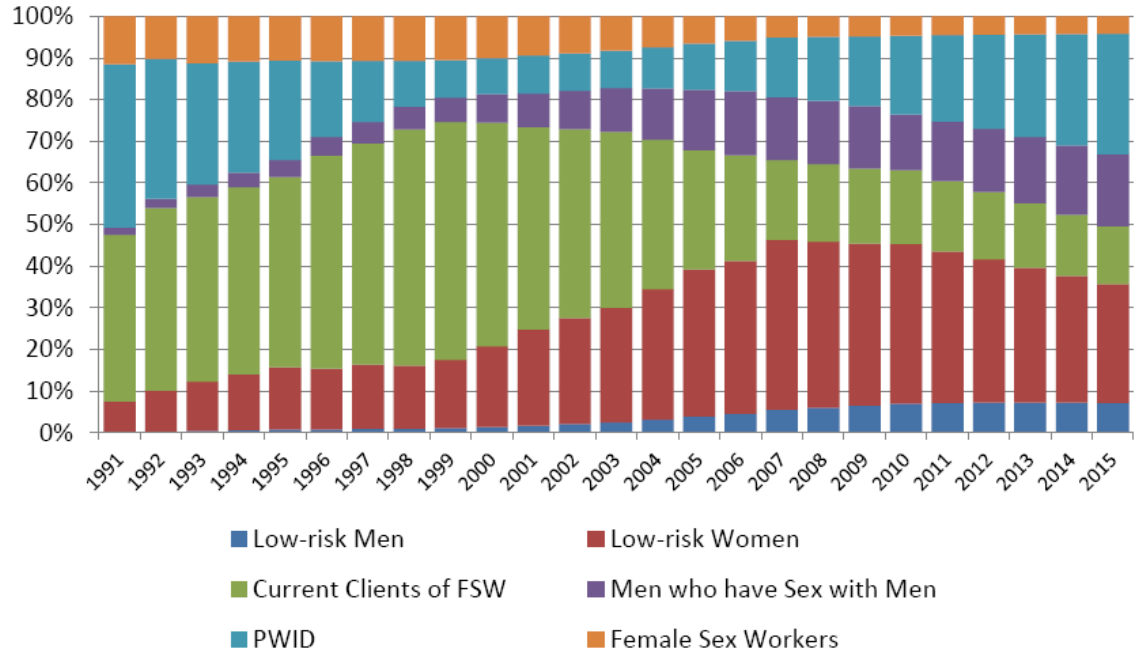
Explain the current and evolving epidemiological situation of the disease in your country. Refer as appropriate to the Performance and Impact Profile provided by the Global Fund, as well as other recent program reviews or relevant sources. Highlight the concentration of burden among specific population groups and/or geographic regions and any recent disease pattern changes (incidence or prevalence).

In your response, describe:

a. **Key affected populations** that are epidemiologically important and may have disproportionately low access to prevention and treatment (and for HIV and TB, care and support services).
b. Factors that may cause **inequity in access to services** for treatment and prevention, such as gender norms and practices, legal and policy barriers, stigma and discrimination, poverty, geography, conflict and natural disasters.
c. **System-related constraints** at the national, sub-national and community levels in reducing the burden of the disease.

Whilst the country welcomes the additional funding over a four-year period, the reality is that the level of funding will only barely cover maintenance of existing programme activities and will not allow for expansion to geographic areas not included in Phase II (border areas with high disease burden) nor additional scale-up as originally planned and presented in this concept note. The planned additional scale-up activities include key prevention activities such as harm reduction and methadone reaching 40% of PWID (80% of the NSP targets) and up to 85% of the NSP targets for ARV treatment and securing ART coverage for the 40,000 people currently receiving treatment. Stavudine-based regimens will be replaced by Tenofovir, HIV positive TB patients and HIV positive pregnant women will receive immediate access to ARVs under the additional funding scenario.

a) The HIV epidemic in Myanmar is concentrated, with HIV transmission primarily occurring among KAPs, including sex workers (and their clients), MSMs and the sexual partners of these sub-populations. There is a high level of HIV transmission among PWIDs through use of contaminated injecting equipment, with transmission to sexual partners. Latest modelling estimated the HIV prevalence in adult population (15-49 years) at 0.53% in 2011 (216,000 people). The UN population estimate for Myanmar as of 2011 is 47.8 million. KAP surveillance data from 2011 showed HIV prevalence at 9.6% in female sex workers, 7.8% in MSMs, and 21% in male PWIDs. All sentinel groups have shown a decrease in prevalence over the last years.



Estimated % distribution of new infectons among key affected population in Myanmar – 1995-2020 (Ref: GAPR 2012)

The AEM also suggests that the distribution of injections among the sub-populations included in the model has changed and will continue to change. As of 2011, over 60% of the new infections occurred among female sex workers, their clients, people who use drugs and men who sex with men. By 2015, these groups will constitute over 70% of new infections. In the 2011, the largest proportion of new infections occurred among low-risk women, i.e. partners of men with high risk behaviour. By 2015, people who inject drugs will contribute the largest part of new infections.

It is estimated that there were around 216,000 PLWHAs in Myanmar in 2011, of which 36% were female. In the same year, 18,000 people died of AIDS-related illness. Incidence was estimated at well above 8,000 new infections in 2011. As of end of 2011, 40,128 people received ARV (10,303 people started treatment in 2011).

Access to ethnic minorities in Kachin, Northern Shan and Rakhine is unpredictable due to intermittent conflicts. In Kachin and Northern Shan PWIDs have HIV prevalence of around 30%.

b) With the recent reforms, the central government has been successful is signing ceasefires with several ethnic minority groups. However, there is on-going conflict in the Kachin State and communal tensions in the Rakhine State which have displaced a large number of people and for which immediate humanitarian response is needed. There are 1.2 million stateless people/IDPs in Myanmar.

The Round 9 proposals did not include the areas in which access was restricted for security reasons. Presently, all partners are working with Government as well as non-state actors to explore ways to operate programmes in the restricted areas. This concept note if fully funded, will allow for expansion of programmes to these hard to reach areas.

Stigma and discrimination: The general impression is that stigma continues to exist, confirmed by PLHIV from all over the country (including PWID, MSM, FSW, etc) who attended conference on HIV (15-16 September 2012) in Yangon. A survey on stigma and discrimination focused on at-high-risk people living with HIV group reports prevalence of discrimination (People living with HIV Stigma index, 2009). A repeat survey is being considered in 2013.

Policy environment: Drug use, homosexuality and sex work activities are illegal in Myanmar. Implementers have been able to implement activities though informal trusting relationships with local officials. National level policy changes and written policies are much needed, and if immediately implemented, may increase the speed with which programme reach can be expanded. However, these changes are almost certain to be slow and depend on forces largely outside the influence of official development assistance.

c) **Systems related constraints**:

Myanmar is classified as a "low income" country by the World Bank and a "least developed country" by the United Nations, with a Gross National Income per capita in 2009 of USD 379.60. The health sector in Myanmar has long been underfunded, with public spending at levels under 1 percent of GDP. Total spending on health stands at 1.3 percent (2011) of GDP, or US$ 2 per person per year. Out-of-pocket payments constitute about 85 percent of total spending on health, followed by public spending (around 10 percent) and external development assistance (around 5 percent). Overall development assistance is the second lowest per capita amongst low-income countries. The total financial resources available for both prevention and care in the country over the last eight years averaged less than USD 30 million a year. About the same amount is spent in Cambodia with a less severe epidemic, little injecting drug use, and a population one fourth that of Myanmar. USD 100 million a year is spent in Viet Nam though HIV prevalence is much lower there. Together with the internal conflict that caused extensive damage, these limited resources have translated to very low levels of basic services.

There are problems with storage and distribution of supplies, especially to facilities at township level and below. The health information has many weaknesses and there are gaps in data from the community level and from hard-to-reach areas. Analysis and use of data at township level is limited. There are significant gaps in knowledge, and not much is known about health-seeking behavior. Human resource training, ensuring adequate number of skilled health personnel at local level (state, region, district and township) and health infrastructure can benefit from strengthening efforts from development partners. With the current reform processes, World Bank, ADB, US government and development partners who are focusing on health systems strengthening are coordinating technical assistance to the health sector through the Myanmar-Health Sector Coordinating Committee (formerly Myanmar Country Coordinating Mechanism).

2.2 National Strategic Plan

Briefly describe your National Strategic Plan and how it addresses the country disease context described in 2.1.

In your response, please describe:

a. The **goals, objectives and priority interventions** of the National Strategic Plan, placing emphasis on their **on-going relevance** and any planned or needed revisions over the lifetime of the Funding Request.

b. The **current stage of implementation** of the National Strategic Plan and the country processes for reviewing the Plan. If you are in the last 18 months of the period covered by the National Strategic Plan, please explain the process and timeline for the development of a new plan.

c. The **main findings of, and response to,** any recent assessments and/or program reviews.

4 PAGES MAXIMUM

The Global Fund Round 9 programs and programmes proposed in this Concept Note are fully aligned with the National Strategic Plan. Since 2006 the national response has been aligned to the National Strategic Plan (NSP) on HIV and AIDS, 2006-2010. In 2010 the second NSP, covering 2011-2015 was developed. The NSP provides the strategies for

reaching universal access. It is costed and includes yearly targets for a set of agreed indicators. The NSP identifies three strategic priorities to address the most pressing needs of the populations at higher risk of HIV infection, namely: (1) Prevention of the transmission through unsafe behavior in sexual contacts and use of contaminated needles; (2) Comprehensive Continuum of Care for people living with HIV/AIDS (PLWHAs); and (3) Mitigation of the impact of HIV on PLWHAs and their families. The strategic priorities identified in the NSP remain relevant.

In May 2013, Myanmar is undertaking a Mid Term Review of progress against the Ten Targets of the 2011 Political Declaration and in the second half of 2013, a Mid Term Review of the National AIDS Response (based on the NSP). A key aspect of this review will be to extend the NSP by one year to cover 2016. The extension is proposed by the Ministry of Health so that they can take into account the implications of the MDG review and the post-2015 agenda when developing the next NSP.

The MTR of the National AIDs Response will specifically focus on the following areas:

1. Prevention of sexual transmission
2. Prevention among injecting drug users
3. Prevention of mother-to-child transmission
4. Treatment, care and support
5. Strategic information and M&E

Overall the review will provide insights and recommendations with regard to the following questions:

- To what extent are the NSP II and the Operational Plan and other strategic guidance documents still suitable in their current form to guide the National AIDS Programme?
- Are there any objectives, strategies, activities or targets that require revisions?
- Are interventions and services that are provided in different areas of the national response relevant, effective, efficient, adequately targeted, scalable and sustainable in the longer term?
- Have the different strategies and activities achieved the targets and delivered the intended results in terms of quantity and quality?
- Are the intervention models and institutional arrangements still relevant, cost-effective and do they allow for effective participation, coordination and alignment?
- What information is available that helps answer these review questions and what are the information gaps that will need to be filled to improve monitoring, planning and targeting?

The report of the reviews will inform programme implementation and adjustments to the national AIDS programmes (including those funded through 3MDG fund and GF) may be made as required.

As of end of 2011 (Progress Report 2011) , the current achievement of the NSP against the key programmatic areas are as follow:

Number of people receiving ARV: 40,128

Number of people who received HIV counseling and testing: 71,342 (this includes sex workers, clients, MSM, PWID and partners)

Number of PWID reached with prevention intervention through outreach: 15,297

Number of PWID reached with prevention intervention through DIC:14,956

Number of drug users receiving methadone maintenance therapy: 1,637

Number of MSM reached with prevention intervention: 64,740

Number of female sex workers reached with prevention intervention: 62,420

Number of TB patients tested positive for HIV and have started ART: 5,735

Number of HIV-positive pregnant women who received ARV to reduce risk of mother-to-child transmission: 3,132

The Progress Report 2012 will be available in June 2013.

2.3 Implementation of the National Strategic Plan

Please describe the **implementation progress** of your National Strategic Plan, referring as appropriate to the Performance and Impact Profile provided by the Global Fund as well as any recent evidence from program reviews, evaluations and relevant surveillance surveys.

In your response, include:

a. The **priority interventions** that are currently being implemented.

b. The **outcome and impact** achieved to date by these priority interventions.

c. The **key stakeholders** involved in the implementation.

d. Any **limitations** of the response to date and the **lessons learned** informing the design of future interventions.

e. Any **limitations** in **national data systems** to measure and demonstrate impact.

a) NSP priority interventions that are currently being implemented:

- ART
- TB/HIV
- Community home-based care, health facility-based care and referral
- Prevention key affected populations (sex workers, clients, MSM, their partners, people who inject drugs)
- Prevention among prison or rehabilitation facility population
- Prevention among mobile and migrant populations and communities affected by population movement
- Condom distribution
- HIV counselling and testing for key affected populations
- Treatment of sexually transmitted infections
- Prevention of mother-to-child transmission of HIV
- Mitigation of the impact of HIV on PLHIV and their families

The data show that the national response is highly targeted and in line with National Strategic Plan and Operational Plan on HIV and AIDS 2011-2015, which highlights the importance of reaching KAPs at higher risk of infection. In 2011, 80% of the expenditures for prevention were spent on programmes for sex workers, their clients, MSMs and PWIDs. The geographical coverage for sex workers is considered relatively extensive and most cities where a majority of sex workers are located have prevention services. The coverage for MSMs is more limited due to the hidden nature of same sex behavior in most places, but more so in rural and semi-rural environments.

b) Outcome and impact achieved by these priority interventions:

The indicative amount of US$ 39.5 million provided on top of Round 9 Phase II will maintain the existing programme activities as presented in the Phase II Request for Renewal for an additional year, in 2016. Only with additional funding above this indicative amount as presented in this concept note will the expansion of programme activities to reach hard-to-reach areas and scale-up of ARV and prevention interventions be possible.

Should the additional funding be provided, there is potential for universal access to treatment and reduced hospital deaths and adult mortality (aged 15-49) by 2015. Myanmar HIV programme has made progress towards proposal goals over the first implementation period. Routine HIV sentinel surveillance system indicated that HIV prevalence decreased from 30.4% in 2007 to 20.3% in 2011 among PWIDs, 15.8% in 2007 to 8.3% in 2011

among FSWs, from 35% in 2007 to 9% in 2011 in Mandalay and from 23.5% in 2007 to 6.5% in 2011 in Yangon among MSMs, while HIV prevalence among new TB patients remained stable around 10% from 2007 to 2011. Modeled HIV prevalence among adults decreased since 2000. Modeled HIV incidence remained unchanged since 2000. HIV prevalence among younger age group FSW, MSM and PWID (15 to 24 years old) decreased from 13.5% in 2007 to 9.1% in 2011, from 15.5% in 2007 to 5.7% in 2011 and from 28% in 2007 to 13.7% in 2011 respectively. There are no reported AIDS mortality data. For patients enrolled in ART program, the case fatality was about 4% after 12 months. Modeled AIDS mortality decreased since 2005. High treatment adherence of 92% survival and 87% not lost to follow up among MSF cohort.

c) Key stakeholders involved in implementation:

Implementing partners International and local NGOs, CSOs and National AIDS Programme.

d) Limitations of the response to date and lessons learned:

See above section describing upcoming Mid-Term Review of the national AIDS programme.

A major limitation for expanding service provision for PWIDs is the lack of access to some areas in northern Myanmar due to security reasons. The fact that drug use is prevalent in some remote rural areas hampers the establishment of cost-effective services in those areas. As addressed previously, partners are collaborating to expand access to those areas. The additional funding requested in the Concept Note will allow for new partners to become SRs and assist to reach more PWIDs as well as operate in remote areas that are high-disease burden.

Currently (2012 partners report to NAP), around 43,000 people out of the 125,000 people who are eligible for treatment with CD4 below 350 are accessing ARVs. The limited availability of anti-retroviral drugs has long been a major block for access to HIV treatment and care. This limitation has restricted service providers to initiate ART to all those who need it, regardless of CD4 count. At present, the waiting list for ART is long (at least 7,000 people eligible for treatment with CD4 below 350 are confirmed to be on the waiting list) and with additional funding many more people can be put on treatment. Those who can receive treatment are in poor clinical condition, requiring more OI treatment and home-based care. Limited provision of HIV testing amongst key populations was also a factor that contributed to late detection of HIV infection (CD4 already below 150). The concept note proposes to have adequate testing and thereafter ensure availability of ARVs that could be given to all PLHIV who would be eligible and this would include PWIDs. With the full funding request, it is proposed to scale up the ART services. This Concept Note aims to reach up to 85% of the ARV treatment target by the end of 2016.

About 44% of the adult ARV patients are women. Women represent less than 40% of the total HIV case load. Therefore, access to treatment appears to be equal for either gender. Children represent about 8% of the total ARV patients in 2011. The geographical coverage is still limited, but the major hubs in the country are covered. However, implementers report that people tend to travel to Mandalay and Yangon to access treatment. Often this appears to be the preferred option, since it guarantees confidentiality. For PMTCT, the country is planning to move to option B+ if additional funds are available. To address cost-effectiveness issue, PMTCT will be implemented through the existing maternal and child health and reproductive health systems and is part of the ANC package.

The use of methadone for maintenance started in Myanmar as pilot in 2006, since then it has gradually been increasing. At the start of the MMT programme, the dosage was low, but as experience gained the mean dosages given to patients increased. The National guidelines have been revised in 2012 and it advocates for higher methadone maintenance dose. The Concept Note proposes a scale-up of provision of MMT.

e) Any limitations in national data systems:

The health information has many weaknesses and there are gaps in data from the community level and from hard-to-reach areas. There has been no national survey of

maternal and under-five mortality since 2002. Data is reported up through the system, but there is little feedback. Analysis and use of data at township level is limited.

For HIV, behavior data for key populations (PWID, MSM and Sex workers) are limited and out of date. The most recent BSS among FSW and PWID was done in 2008 and among MSM in 2009. Lacking mapping tools, Myanmar does not have geographic prioritization of "hot spots" for key interventions. The current proposal covers request for behavioural surveillance among the 3 key population groups while continuing the HIV Sentinel Surveillance. The need to identify gaps under the current protocol, improve coverage with higher number of sites, and the strength of the current sample sizes are recognized by the country. The current size estimates for the key population groups were derived through consensus among all technical and implementing partners in Myanmar. The geographical coverage for sex workers is considered relatively extensive and most cities where a majority of sex workers are located have prevention services. The coverage for MSMs is more limited due to the hidden nature of same sex behavior in most places, but more so in rural and semi-rural environments.

As partners recognize the limitations, a review of HIV surveillance system and size estimation methodology has been planned by the national programme jointly with WHO and UNAIDS. The findings from this review is expected to provide further insights on expansion, methodology, and surveillance questionnaires as well as articulation with routine programme data. These findings will be incorporated into subsequent rounds of surveillance. Plans for new size estimates and switching to integrated bio-behavioural surveillance where needed are part of the follow-up proposed actions. This concept note includes these proposed activities in the full funding request.

2.4 Enhancing TB/HIV Collaborative Activities

If you are submitting a **TB and/or HIV concept note(s)**, you must describe the scope and status of on-going TB/HIV collaborative activities.

a. How the funding requests will strengthen TB/HIV collaborative activities.
b. The linkages between the respective national TB and HIV programs in your country.

The country has established a sentinel surveillance system which annually assesses (among others) the burden of HIV in TB. The number of sites has increased from 4 in 2005 to 25 in 2012. Subsequent rounds show a positivity rate around 10%. There are, however, more wide variations between sites with one site reporting a co-infection rate of 19%. The TB prevalence among people living with HIV is believed to be over 30%. The mortality amongst the TB/HIV co-infected persons is also higher: 24% compared to 5.5% in TB patients with unknown HIV status. This could be due to a relatively late diagnosis as well as delayed initiation of antiretroviral treatment.

The National AIDS Programme in collaboration with the National Tuberculosis Programme plans to promote enhanced collaboration between TB and HIV programmes. In Round 9, Phase I, NAP and NTP have expanded TB/HIV collaborative activities with HIV screening among TB patients and ART for HIV infected TB patients and their spouses and the provision of isoniazide preventive therapy for people living with HIV to 21 townships. It is envisaged that TB/HIV townships will be increased from 21 in 2012 to 42 in 2015. As of June 2012, up to 2,105 co-infected patients were started on ART. For 2015, target is to reach 3000 people (Round 9 Phase II). With the full funding request, all TB-HIV co-infected patients will receive ARVs.

In 2012, a TB/HIV treatment strategy has been finalized. The joint strategy includes intensified case finding for TB among PLHIV, HIV counseling and testing services for TB patients, improved TB/HIV awareness and health education, co-trimoxazole prophylaxis, and referral to HIV care and treatment including ART.

The current TB/HIV activities include screening of PLHIV for TB during each visit (this is done using a clinical algorithm focusing on detecting TB among symptomatic patients); provider-initiated HIV testing for TB patients; and infection control measures. These activities are planned to be strengthened and expanded under the current request through the concept notes from TB and HIV programs. The provision of IPT was piloted at 12 sites in Myanmar in 2011 and planned for scale up.

In the TB Concept Note, it is proposed to offer HIV testing to all diagnosed adult TB patients across the country. Through the joint efforts of two programs, by the end of 2015 it is expected that 90% of adult TB patients should be offered HIV testing through PICT and an expected uptake of 60-70% is expected. It is also envisaged that once detected to be HIV positive, patients will be linked to the care and treatment services for HIV under NAP so that they could be offered cotrimoxazole prohylaxis and immediate access to appropriate ARVs as per the National guidelines.

SECTION 3: Programmatic Gap

Please complete the **Programmatic Gap Table** in Attachment 2 by identifying the gaps in coverage for three to six priority program areas consistent with the National Strategic Plan, and which will be addressed through the applicant's funding request.

All numbers in this table should relate to the size of the population groups targeted by the priority program areas, and not the financial need for the program areas.

3.1 In accordance with the **Programmatic Gap Table** in Attachment 2, describe the **assumptions, methodology and sources** used in estimating the programmatic gaps.

The Phase 2 request for renewal submitted by M-CCM was based on the TRP-approved ceiling for Phase. The current concept note incorporates (and extends) Phase 2 and includes a significant request for scaling up beyond Phase 2. While undertaking the programmatic gap analysis in the attachment 2, the country targets were taken from those already set in the National Strategic plan for HIV (2011-2015). Programmatic achievements are reported annually and data from progress report for 2011 have been included here as the current coverage. The programmatic gaps are then determined based on what has already been achieved and what remains according to the targets. Also considered is the need that will be addressed by current Global Fund grant (Round 9 Phase II) and the total gap is therefore, the target to be achieved with the new funding request plus the Round 9 Phase II. The programmatic gap table covers the period from 2013-2016.

The Programmatic Gap Table (Attachment 2) identifies the gaps in coverage for programme areas to be addressed through the funding request.

The targets set is based on the Round 9 target and achievements and the concept note for additional funding submitted in October 2012. The new targets being proposed in this Concept Note now exceed the original targets set in the NSP. In the mid-term review of the NSP, this issue will be addressed and the targets of the NSP will be adjusted accordingly along with an extension of the NSP period to cover 2016.

The concept note envisages a scale up in care, treatment and support services (including HIV/TB), HIV testing for the key population as well as prevention of new HIV infections in vulnerable groups. The harm reduction activities focuses on the reduction in incidence while the counseling and testing for key populations will lead to an early diagnosis and referral to ARV treatment and care services. The treatment scale-up would therefore, rely on the expansion of the testing facilities. It is also assumed that the testing of TB patients shall be made available through the TB program while the NAP would facilitate the

provision of screening of TB in PLHIV and ART to TB/HIV co-infected

The HIV sentinel surveillence reports, the Global AIDS progress report, the 2011 annual progress report from NAP as well as the National strategic plan for HIV have been used for programme gap analysis. In projecting and planning targets for the future, the latest report on implementation has also been used (reports from implementing partners to the National AIDS Programme), to determine programme performance and absorptive capacity. Hence all proposed targets are considered achievable granted the full funding request is approved.

As mentioned in Section 2.3, under limitation in national data systems, the population size estimates given for female sex workers, men who have sex with men and people who inject drugs were estimates that have been reached through formulas and consensus on the estimates have been reached through the TSG which comprises of technical and programme implementation partners. It is recognized that there needs to be more effort to provide up-to-date and more accurate estimates including information on the geographic distribution of key affected populations. Mapping exercises and identification of hotspots will be needed as Myanmar moves forward to scale-up the prevention interventions. Presently, programmes are distributed across the country, focusing mainly on urban centres with some rural sites as determined by information on drivers of the epidemic such as border areas where there is drug use and high population mobility and migration. Expansion into hard to reach and border areas (ex-conflict areas) will bring opportunity to conduct mapping exercise to determine size estimates in those geographic locations, particularly for people who inject drugs.

SECTION 4: Funding Request to the Global Fund

Please complete the questions below together with the **Modular Template** in Attachment 3.

4.1 Funding Request within the Indicative Funding Amount

Please describe how indicative funding requested and any existing Global Fund financing will be invested (or reprogrammed) during the funding request period to maximize impact. In your response, include:

a. The **objectives and expected outcomes** of the funding request, and how the outcomes have been estimated and will contribute to achieving greater impact. Please refer to available local evidence of effectiveness of the programs being proposed.
b. The **proposed modules and interventions** of the funding request in order of priority, in addition to the rationale for their **selection** and **prioritization**.
c. For **consolidated funding requests**, explain how current interventions will be adapted, discontinued or extended to maximize impact.

HIV is requesting full funding request, beyond the Indicative Funding amount.

4.2 Funding Request above the Indicative Funding Amount

Building on the applicant's funding request in 4.1, please describe and prioritize the funding request above the indicative amount, including:

a. The **additional gains, objectives** and **outcomes** that could be realized to achieve specific national goals or objectives.

b. What the **additional proposed modules and interventions** are in order of priority. Explain the rationale for this prioritization.

a) The objective of the funding request is to scale-up the national AIDS response, particularly to expand service coverage for ARV treatment, HIV counseling and testing and prevention service package for key populations (sex workers, MSM and people who inject drugs). Data on programme progress is collected yearly and presented as the Progress Report of National Strategic Plan implementation. HIV prevalence is measured for each key population.

For HIV, the M-CCM is requesting funding request above indicative funding amount, in order to expand services to reach more beneficiaries. Only with additional funding will Myanmar be able to reach higher targets than those already set for Phase II of Round 9. For ART, the scale-up can reach 85% by end of 2016. For harm reduction programmes for people who inject drugs, the additional funding will allow up to 40% of people who inject drugs to be reached by HIV prevention programmes. This represents 80% of the NSP targets. This is a significant increase from the baseline situation (Progress Report 2011) where only 20% of PWID received outreach or services through DIC. All other prevention activities for sex workers and MSM will also be scaled up accordingly. These gains will not be achieved if the level of funding remains at level proposed in the Round 9 Phase II plus indicative amount of around 30 million per year.

b) Proposed modules and interventions (as selected in the modular template)

- Treatment, care and support
  - ART
  - Community systems strengthening for specific HIV interventions
  - Counseling and psychosocial support
  - Human Rights
  - Pre and post-exposure prophylaxis
  - Pre-ART Care
  - Prevention, diagnosis and treatment of opportunistic infections
  - TB/HIV collaborative interventions
  - Treatment adherence
  - Treatment monitoring
- PMCT
  - Community systems strengthening for specific HIV interventions
  - Prong 3: Preventing vertical HIV transmission
  - Prong 4: Treatment, care and support to mothers living with HIV and their children and families
- Prevention General Population
  - HIV testing and Counseling (this is for bridge populations such as clients of sex workers, partners of key affected population)
- Prevention Key Population- PWID

  With the full funding request, the targets to reach PWID with comprehensive harm reduction services will increase significantly from 20% to 40% of the 75,000 estimated number of people who inject drugs, thus representing 80% of the NSP target. The scale-up will be possible with additional funding but also with the support of efforts by partners and government to ensure that the policy environment and security concerns are addressed to allow for expansion of harm reduction interventions into border areas where there is high prevalence of injecting drug use and HIV.
  - Behaviour Change Programmes
  - Condoms
  - Community systems strengthening for specific HIV interventions
  - HIV testing and counseling
  - Diagnosis and treatment of STIs
  - Needle and syringe programmes
  - Opiod substitution therapy and other drug dependence treatment (new methadone centres will be opened and MMT will be scaled up across the

country. This includes plans for mobile clinics to reach out to PWID in remote locations.)
    - Vaccination, diagnosis and treatment of viral hepatitis
- Prevention Key Population-MSM
    - Behaviour Change Programmes
    - Condoms
    - HIV testing and counseling
    - Diagnosis and treatment of STIs
    - Community systems strengthening for specific HIV interventions
    - Vaccination diagnosis and treatment of viral hepatitis
- Prevention Key Population-SW
    - Behaviour Change Programmes
    - Condoms: For condoms, it needs to be highlighted that the 2.3 million free condoms that were distributed constitute only a small proportion of the total need as the majority of the requirement was met through social marketing not funded by Global Fund. Regarding the estimate of client numbers per month, in 2010, a nation-wide mapping of estimates of FSW was carried out (findings disseminated in 2011). Findings suggested sex workers can be classified into two types: high frequency (average 2 clients per day) and low frequency (1 per day), representing 88 and 12 per cent respectively. The average working days are 5.4 per week.
    - HIV testing and counseling
    - Diagnosis and treatment of STIs
    - Community systems strengthening for specific HIV interventions

HIV counseling and testing will be scaled-up in point of care NGO service sites as well as government settings, with accelerated provider initiated testing and counseling in clinical settings including STI clinics of townships level; multi-channel communication initiative, including targeted campaigns, social engagement, and action that will result in behavior change leading to increased testing and reduced stigma and discrimination.) The success of scaling up testing will directly contribute to the success of a scaled-up ARV treatment programme.

Prioritization:

In the TSG consultations, representatives of people living with HIV had confirmed that their priority request is to achieve universal coverage for ARV treatment. The M-CCM confirms that the number one priority is treatment and ensuring zero-AIDS related deaths. However, it is also critical to address the main driver of the epidemic: HIV transmission through sharing of contaminated needles/syringes. Prevention services for PWID have been underfunded and targeting this key affected population will undoubtedly yield high impact. If the full funding request is not granted, the M-CCM will re-visit the priorities presented in the Concept Note and ensure that the treatment scale-up and necessary testing efforts will be covered and strategic interventions to expand harm reduction programmes for PWID to border areas where there is high prevalence of drug use and HIV. However, if there are inadequate resources to cover programmes beyond treatment and testing, the priority will be to secure the scale-up of ARV treatment programme.

4.3 Commitment to Sustainability and Additionality

Financial sustainability is important to ensure continuity of impact. In particular, implementing country governments must fulfill their obligations to sustain and increase contributions to the national response. The counterpart financing requirements of the Global Fund are set forth in the Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization (ECFP).

Please complete the **Financial Gap Analysis and Counterpart Financing Table** in

Attachment 4.

a. Indicate whether the **counterpart financing requirement** has been met. If not, provide a justification that includes actions planned during implementation to reach compliance.

b. Describe whether and how this funding request to the Global Fund will be complemented by **additional funding commitments from the Government.**

c. Describe how this funding request to the Global Fund can leverage **other donor resources**.

Minimum threshold government contribution to disease program

The CCM assumes that 2011 level of government spending will be, at the minimum, maintained in subsequent years. Applying the same assumption, the Country Team used government spending data published by UNAIDS and the Ministry of Health to calculate the counterpart financing share. Based on current levels of government spending, the counterpart financing share is 10% and meets the minimum threshold of 5% for low income countries.

Stable or increasing government contribution to disease program

Available data on HIV program spending indicate that government spending on the HIV program has significantly increased over time. Myanmar is classified by UNAIDS among countries that has increased government spending by more than 100% between 2006 and 2011. Given the significant increase in allocation of government resources to the health sector, it is expected that the increasing trend will be sustained in the next implementation phase. However, according to the calculation in the financial gap analysis file (Attachment 4), using the total funding request, HIV counterpart financing threshold is not met (3% instead of 5%). The HIV figures are only estimates and will be verified when the Government budget is announced. The Minister for Health has indicated at many forums that the health budget will increase (HIV has also been targeted for increase). The M-CCM continues to encourage increasing government contribution to the health sector and all disease programmes. It is important to note that the M-CCM is now transformed into a broader entity, called the Myanmar Health Sector Coordinating Committee for coordinating all efforts of the health sector. The M-HSCC will be in a good position to advocate for increasing government spending on health as well as implementing resource tracking system to accurately record public expenditure on health.

Stable or increasing government contribution to health sector

In an effort to address the funding crisis, the government has quadrupled the health budget for 2012-2013 from 92 billion kyat to 368 billion kyat.[3] Out of pocket expenditure is the primary source of funds for health spending in Myanmar, accounting for 81% of the total health expenditure in 2010. External resources contributed to 9% of total health expenditure in 2010 (Global Health Expenditure Database, WHO). Despite significant increases over time, till recently government spending was around 10% of the total health expenditure. Total health expenditure has been about 2% of GDP, one of the lowest in the world. As part of the planned health sector reforms, the country is aiming to attain universal coverage by increasing total health expenditure to around 4% -5% of the GDP through tax based financing and social health insurance and bringing down out-of-pocket expenditure to 30-40% of total health expenditure (Ministry of Health, Health in Myanmar, 2012). In 2012-13 fiscal year, government has made a four-fold increase in budget allocation to health sector in line with the government's reform agenda. Share of health in government budget, which was historically about 1%, has now increased to around 3%. Given that the economy is projected to grow at over 6% (World Economic Outlook, IMF, 2012), resources are likely to be available for moving ahead with planned reforms of the health sector.

[3] Source: The Lancet, Volume 379, Issue 9834, Page 2313, 23 June 2012, doi:10.1016/S0140-6736(12)60998-2

In the Financial Gap Analysis file (Attachment 4), the figure for HIV government funding is US$ 1,450,000 (2013); US$ 1,522,500 (2014); US$ 1,598,625 (2015) based on assumption of estimate 5% increase per year. In response to the Global Fund observation that the HIV government contribution reported to Global Fund is significantly lower than figures reported to UNAIDS (GAPR and UNGASS reports), this is due to limited data at the time of data collection. The situation has improved on data recently but in the past due to inadequate financial management systems, the data on expenditures were not easy to compile. The figures reported included those of direct NAP costs, PMTCT hospital infrastructure, health care workers, ARVs and lab costs. The total was then projected for each year, using assumptions that there would be higher percentage increase per year of government contribution (30% increase from 2008 to 2009 and 50% increase from 2010 to 2011). However, due to budgetary constraints, no funding increases materialized in that period. Only recently did the government announce a fourfold funding increase to the health budget and also allocated dedicated budget for ARV and lab costs. Moving forward it is necessary to use a consistent methodology for estimating government spending. As part of the reform process, government with support from the UN, donors and the World Bank are reviewing the health system and have identified the financial systems as one of the components that require strengthening. The Ministry of Health is working to establish a National Health Account and work on that should provide accurate financial information on government contribution for health programmes including HIV, TB and Malaria.

As highlighted above, the Government is increasing domestic budget on health (increase already occurred for 2012-2013 fiscal year). The Minister of Health has stated that the health budget will continue to increase. The annual progress reports will use standardized criteria to report and confirm these amounts. These are prepared by key partners and then confirmed by the TSG/M-CCM.

Currently the Global Fund remains the main source of external funding for HIV. Other donors, like AusAID (through 3MDG fund) and USG are still exploring their funding support including geographic and technical scope. It is clear, however, that there will be no duplication with Global Fund support. 3MDG fund and USG are planning contribute towards covering the remaining programmatic gaps (i.e., prevention interventions and procurement and supply management and monitoring and evaluation).

4.4 Focus of Proposal

This question is **not** applicable for Low Income Countries.

If the applicant is a **Middle Income Country,** describe how this request meets the Focus of Proposals requirement according to the threshold based on the income classification for the country.

NOT Applicable

SECTION 5: Implementation Arrangements			
5.1 Principal Recipient Information			
Complete this section for each nominated Principal Recipient. For more information on Minimum Standards refer to the Concept NoteInstructions.			
PR 1 Name	UNOPS	**Sector**	**HIV**
Does this PR currently manage a Global Fund grant(s) in this disease/HCSS area?		☒Yes	☐No
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		Meets minimum standards Overall evaluation PR programmatic performance showed that, the HIV grant has met or, in many cases exceeded its targets for 9 output indicators. PR fulfills GF staffing requirements including professionals competitive at international level (e.g. Programme Coordinator, 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 CCM and among all the stakeholders and partners every Monday. The LMIS submitted by the PR to the GF has now been approved. PR conducted a workshop to review Phase II Performance Framework and discussed programmatic challenges and lesson learnt during phase I implementation. Latest quantitative indicator rating by GF for HIV/AIDS grant equaled A1 (P7/2012).	
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 FPPM and PMPM submitted and approved financial and programmatic oversight plans for SRs. It also analyzed individual SR level performance assessment with budget absorption capacity and data quality assurance. Quarterly reports of findings are submitted to GF including measures to	

	address identified issues. Management capacity building to NAP is enhanced through regular bi-monthly workshops, and on-the-job support through WHO hired staff, UNOPS-Programme associates and Finance officer placed in Disease Control office and in the States and Regions. The PR developed automated database for ART and IDU data for use by the relevant SR. The PR plans to continue providing this kind of technical assistance in data management processes and procedures and continue with its current practice of data validation and continuous DQA and support visits to the SRs linked to perceived risks to data management practices. For LNGOs, capacity building activities include quarterly review and work plan meetings, field visits, and on-the-job support to SR offices by the PR's Finance and Programme Capacity Building Officers. PR activities proved to be beneficial and the outcome has been the achievement of A ratings. PR further provides status updates of its capacity building activities for SRs. Summary reports on desk reviews and field visits to identify and address weaknesses. PR monitors SR compliance with set agreements on eligibility of expenses.
3. There is no conflict-of-interest for the selection of the Principal Recipient(s) and Sub-Recipients	Meets minimum standards No conflict of interest has been reported by the parties concerned in terms of PR and SR selections by the CCM. A MoU has been developed between the two PRs describing how they would co-ordinate and determining the roles and responsibilities of each party in January 2011.
4. The program-implementation plan provided in the concept note is sound	Meets minimum standards The plan of implementation provided in the concept note is aligned to the National Strategic Plan and is supported by all the stakeholders including the NAP

	and WHO.
5. The internal controlsystem 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 mechanisms including the following: 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 (Atlas) with embedded strong and proven controls, and periodic reviews and audits by HQ for PR operations and PR compliance reviews for SRs operations.
6. The financial-management system of the Principal Recipient is effective and accurate	Meets minimum standards The financial-management system of the PR is considered as 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.
7. The central warehouse and the warehouses for key regions have capacity, appropriate conditions and security to store health products, and to maintain their quality	Meets minimum standards Renovation work of central NAP and VBDC warehouses was completed and highly appreciated during the inauguration by HE the Minister 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. Regarding a total number of 41 warehouses, ART clinics and TB/HIV sites of all three National Programme in the States/Regions, completion of renovation works is expected by June 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. Overall 21 trainings on LMIS including TOTs were successfully completed by December 2012 for HIV staff and TMOs in all the States and Regions.
8. The distributionprocess can handle the requisition of supplies to avoid treatment / program disruptions	Meets minimum standards Meets minimum requirements. In order to avoid over/under estimation of supplies in 2012, PR forecasted the requirement considering stock in hand, pipeline supplies and expected consumption until arrival of the next orders. PR tries to minimise the stock out by encouraging effective exchange of drugs between all SRs. Exchange mechanisms must not take place without the prior approval of the PR and borrowed supplies need to comply with the GF QA policy. Despite delays in approval of the procurement plan for Health products and equipment and Pharmaceutical products for Year 2 that has slowed down implementation, there were stock outs caused and no physical stock out reported by SRs due to exchange of drugs. Stock Management Software has been developed and now being pilot tested by National TB Programme and PyiGyiKhin to improve maintenance of stocks and timely reports. The PR is also working on the preparation of the distribution plan in consultation with the National Programmes, other SRs and WHO. With the implementation of the LMIS, the storage and distribution system and reporting is expected to improve. Inventory management has already improved a lot even in States/Regions and the information is being correctly filled in the stock cards/ledger.
9. Data-collection capacity and tools are in place to monitor program performance	Meets minimum standards Updates on progress in using the HIV

	M&E tool have been provided to GF in January 2012. The PR uses the national system to avoid creating parallel and sustainably system. The routine HIV reporting and recording system is 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 staff and high staff turnover. 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. FFAs directly monitor activities during disbursement visits. Attendance sheets can be viewed by LFA for specific trainings at the locality.
10. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	Meets minimum standards The PR, through its Programme and M&E Unit (Performance Management Unit) also conducted RDQAs, on-site data validation, program reviews and monitoring visit for the SRs. A Database Management workshop was held in May 2012 involving WHO, NAP and UNOPS. NAP's automation of ART database is ongoing. Further, NAP has completed M&E tools, such as ART monthly reporting format and referral forms. SRs M&E, data management and reporting capacity was also strengthened through WHO technical and managerial support. A total of 186 trips to the field reaching a total of 220 townships were executed. Each Quarter a review is held with all SRs to share lessons and review results and M&E related matters. In June 2012, Phase II preparation workshop was conducted with all SRs to draft the Phase II PF with revised indicators and targets. During Phase I, remarkable improvement in timely and accurate submission of programmatic

	reports have been achieved by all SRs while reporting from security compromised states/regions has been a challenge.
11. The CCM actively oversees the implementation of the grant, and intervenes where appropriate	Meets minimum standards Meets minimum standards. CCM is informed in due time of the implementation of the grant through its Technical Support Group and regular CCM meeting. Moreover, M-CCM organizes in a bi-annual basis field visit to project sites to identify best practices and bottle necks regarding GFATM implementation. CCM also has a dash board and a website to monitor and report the progress of the grants.
12. A quality-assurance plan is in place 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 ISO 17025 standards for laboratories). A team headed by one representative of the FDA was formed in November 2011 and TOR established for in-country quality monitoring of pharmaceuticals. The team finalized the SOPs and first sampling plan for testing of selected pharmaceuticals during the first meeting in June 2012. Samples of different key and sensitive pharmaceuticals were withdrawn from Yangon and Sagaing state and sent to TUV SUD Singapore a WHO prequalified laboratory for test/analysis. The TUV SUD declared all the drugs samples are of standard quality. The PR is in the process of establishing a LTA with a qualified Lab.

SECTION 5: Implementation Arrangements			
5.1 Principal Recipient Information			
Complete this section for each nominated Principal Recipient. For more information on Minimum Standards refer to the Concept Note Instructions.			
PR 1 Name	Save the Children	**Sector**	**HIV**
Does this PR currently manage a Global Fund grant(s) in this disease/HCSS area?		☒Yes	☐No
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		Meets minimum standards Yes, the PR demonstrated effective management structures and planning in regard to management letters sent by GFATM. Save the Children has a team of 30 international and national staff fully dedicated to the management of GFATM grants in Myanmar. The GFATM rating of periodic review for the STC has been A1, A2 and A2 for the Tuberculosis, Malaria and HIV grants respectively.	
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 Yes, the PR has the capacity and system for effective management of SRs as demonstrated during the first two years of the grant	
3. There is no conflict-of-interest for the selection of the Principal Recipient(s) and Sub-Recipients		Meets minimum standards. No conflict of interest has been reported so far by the concerned committed for selection of PR and SR	
4. The program-implementation plan provided in the concept note is sound		Meets minimum standards The plan provided in the concept note was developed in coordination with the other PR, UNOPS and all stakeholders, and is considered to be sound	
5. 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	
6. The financial-management system of the Principal Recipient is effective and accurate		Meets minimum standards The financial-management system of the PR is considered as effective and accurate	
7. The central warehouse and the warehouses for key regions have capacity, appropriate conditions		The warehouse network for GF project was assessed during the first six months	

and security to store health products, and to maintain their quality	of 2011 and recommendations for improvement where put in place during the last six month of 2011. Moreover, Save the Children PR regularly monitors, through filed visits, warehousing and storage capacity of SRs at central and township level.
8. The distribution process can handle the requisition of supplies to avoid treatment / program disruptions	A good distribution system is in place. No disruption of key medicines has taken place during the period 2011-13. Moreover, the PR has put in place a supply chain system that identifies over stock of supplies that can be redirected to other SRs in urgent need or pharmaceuticals.
9. 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 it is well functioning
10. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	Meets minimum standards Routine reporting is in place to report performance in time and accurately as confirmed by management letters sent for the previous reporting periods
11. The CCM actively oversees the implementation of the grant, and intervenes where appropriate	Meets minimum standards CCM is informed in due time of the implementation of the grant through its Technical Support Group and regular CCM meeting. Moreover, M-CCM organizes in a bi-annual basis filed visit to project sites to identify best practices and bottle necks regarding GFATM implementation
12. A quality-assurance plan is in place to monitor product quality throughout the in-country supply chain	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. It is expected that GFATM QA/QC plans will be presented to FDA and subsequently approved.

5.2 Current or Anticipated Risks to Program and PR(s) Performance

In reference to the Minimum Standards above and risk assessments conducted (if applicable), describe current or anticipated risks to the program and nominated PR(s) performance, as well as the proposed mitigation measures (including technical assistance) included in your funding request.

- Timely clearance for import license and tax exemption of pharmaceutical and health products
- Procurement challenges due to delays in arrival of commodities and medical supplies
- Lack of clearly defined minimum outreach packages for MSM, sex workers and people who inject drugs (consensus needs to be reached by June 2013)
- Identification of new implementing partners to scale-up harm reduction
- Unpredictable accessibility to certain parts of country (post-conflict areas, weather conditions including floods)
- Scale-up needs to be staggered: time needed for procurement and funding to set up programme expansions
- Communication challenges (internet connectivity, GSM networks etc.) in many areas causing delayed or incomplete report submission.

Proposed mitigation measures:

There is increased government commitment to support programme implementation and continuing improvement in unblocking bottlenecks such as more timely clearance of import license and commitment to expand harm reduction interventions. M-CCM will play lead role in coordinating increased collaboration among existing and new implementing partners to facilitate treatment absorption by NAP, to scale up harm reduction and to expand to areas previously inaccessible.

It is anticipated that increased resources from GF, donors and government will enable the national AIDS response to be scaled up to reach targets set by the National Strategic Plan. Other donors are also planning to cover gaps. The US government will provide US$ 3 million for procurement and supply management enhancement to the central government.

With the exception of harm reduction where more efforts will be needed to improve policy environment, a limited expansion service provision to those in need in hard to reach areas will be possible through the additional funding.

With regards to the minimum standard and risk assessment review, the M-CCM is confident the both PR meets minimum standard in all necessary areas and where there has been weaknesses, improvements have been made. As of the latest progress report (last 18 months), the HIV grant of both PRs received A rating (UNOPS A1 and STC A2)

A transition plan is being developed by UNOPS in response to the request from the Minister for Health for supporting the government to become PR by the end of 2016.

5.3 Overview of Implementation Arrangements

Please provide an overview of the proposed implementation arrangements for the funding request. In your response, please describe as appropriate:

a. If more than one PR is nominated, how co-ordination will occur between PR(s).
b. Whether Sub-Recipients (SRs) have been identified and the type of management arrangements likely to be put into place.
c. How coordination will occur between each nominated PR and its respective SR(s).

a. More than 1 PR is nominated (same as PRs in Round 9: UNOPS and Save the Children). Regular meetings are conducted to share programmatic achievements and lessons learned. The PRs also conducts M&E meetings and workshops for harmonising understanding of indicators and introducing qualitative indicators. UNOPS will continue to manage the grant for local NGOs and the National Malaria Control Programme, Department of Health whereas Save the Children continues managing the grant for international NGOs.

b. Sub-Recipients have previously been identified during Round 9. They will remain to be implementing the Programme for the new funding mechanism. New SRs will be required and subsequently recruited in order to ensure expansion of coverage, notably in harm reduction services for people who inject drugs. In accordance with Round 9, the process for new SR selection is open and transparent.

c. PRs regularly conduct review meetings in, addition to day-to-day communication, for programmatic achievements and lessons learned. Annual procurement plan meetings and fund flow management workshops are also carried out to brief SRs on latest issues. Workshops to review Standard Operating Procedures in various technical and management areas are conducted together with the National AIDS Programmes and SRs to seek inputs and validate policy guidance. During P9, PR has continued SR visits for strengthening SRs' capacity regarding budgeting for GF funds.

5.4 Addressing Links to other Concept Notes and/or Existing Grants

If you are requesting funds for more than one component (including stand-alone HCSS) during the transition or have an on-going Global Fund grant (for another component), describe how the interventions being requested link to existing Global Fund grants or other concept notes being submitted, in particular as they relate to human resources, staffing, training, monitoring and evaluation and supervision activities.

The full funding request includes Round 9 Phase II grant. Human resources, staffing, training, monitoring and evaluation and supervision activities for Round 9 will continue to be carried out with additional activities to scale-up programmes should the full funding amount be approved.

UNOPS' (PR1) costs for human resources, staffing, training, monitoring and evaluation and supervision activities are tentatively distributed between the three diseases as follow: HIV 41%; TB 35% and Malaria 24%, and are subject to change once the final approval from TRP is known. STC's (PR2) costs for human resources, staffing, training, monitoring and evaluation and supervision activities are tentatively distributed between the three diseases as follow: HIV 50%; TB 20% and Malaria 30%, and are subject to change once the final approval from TRP is known. STC based this estimation on the distribution for the current Round 9 grants.

5.5 Women, Communities and other Key Affected Populations

Please describe how representatives of women's organizations, people living with the three diseases and other key affected populations will actively participate in the implementation of this funding request, including in interventions that will address legal or policy barriers to service access.

The full funding request includes CSS interventions on ART and stigma and discrimination: (1) a community feedback mechanism led by civil society that will ensure monitoring of access to scaled-up ART and (2) civil society, MoH, MPs, technical experts in law and Ministry of Social Welfare will review law and policies related to HIV; barriers to access to treatment and prevention such as stigma and discrimination. They will make recommendations to policy and law reform. These CSS interventions will be implemented by community-based organizations and networks of key populations. This will ensure the active participation and engagement of key affected populations including representatives of women organizations in the implementation of this funding request.

The indicative amount alone, without additional funding as requested in this Concept Note will not accommodate the CSS and human rights activities as funding will be limited solely to ensuring existing Round 9 targets are met for four years from 2013 to 2016.

5.6 Major External Risks

Please describe any major external risks (beyond the control of those managing the implementation of the program) that might negatively affect the implementation and performance of the proposed interventions.

1 PAGE MAXIMUM

While the average exchange rate is becoming more stable. Inflation remains an issue and commodity prices are on the rise. There are social unrest and on-going conflicts, humanitarian crises and possibility of natural disasters. Poor physical infrastructure requires dedicated support. Inherent weaknesses in the health systems often limit the quality of services. General Elections scheduled for 2015.

ATTACHMENT 1

CCM Endorsement of Concept Note

Please attach the CCM Membership Form Attachment with signatures of all the members

endorsing the concept note submitted.

ATTACHMENT 2

Programmatic Gap

The Programmatic Gap Table is a required attachment to be completed as an Excel template.

ATTACHMENT 3

Modular Template

The Modular Template replaces the performance framework, detailed budget and logical framework previously requested for Global Fund grants. Further guidance on completing the Template is available in the Concept Note Instructions.

ATTACHMENT 4

Financial Gap Analysis and Counterpart Financing Table

The Financial Gap Analysis and Counterpart Financing Table is a required attachment to be completed as an Excel template.