Access to Health Fund Call for Proposals

Q&As

Reflecting all questions received by 23rd July 2018

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1. Geographic areas

Questions received by 11th July

1.1. Some townships that we would like to work in are not listed in the Annex. Does that mean they are not eligible to be included in the proposal?
All Townships (in Rakhine, Chin, Kachin, Shan, Kayin, Kayah, Mon and Yangon) are eligible for mentioned interventions. Proposals are invited to cover as many townships as possible.

1.2. Are there priority or selected townships in each geographic groups?
There are no priority Townships, but for MNCH, we encourage applicants to cover all current 3MDG townships (see Guidelines, section 2 point [6]).

1.3. How many townships should a proposal cover at minimum in a geographic group?
There is no minimum.

1.4. Will there be a permit process for a geographic region the consortium hasn’t worked in before or will the consortium work under the fund’s authority?
Organizations and consortia are welcome to apply for (i) geographic areas for which they are already working and (ii) geographic areas in which they are not working yet. If organizations are selected for geographic areas in which they are not working yet, they will be invited to ensure (after the selection) that they can carry out the work.

1.5. If we have 2 EHO partners (e.g. Kayin, Kayah), should we submit one proposal?
You should submit one Proposal only, unless the two programs (one in Kayin, one in Kayah) are so different from each other, that you feel they need to be presented separately.

1.6. If there is a consortium under one geographical grouping, but we want to work with two different partners in two different States (e.g. Kachin and Shan), what do we do?
If the two programs (one with the partner in Kachin, and one with the partner in Shan) are so different from each other that you feel they need to be presented separately, you should submit two proposals. Otherwise, you are welcome to submit one proposal only.

1.7. What is the administrative requirement for working in 2 townships to cover X and Y activities?
You are welcome to submit a proposal for two Townships, covering any type of eligible activities.

1.8. Does IP need to submit a proposal covering all thematic areas for a geographical region?
No – Implementing Partners should only apply for the thematic areas they want to cover in their program.

1.9. Under the headings of indicative budget (pg. 9 of the guidance note), it is written:

| Chin | MNCH + Nutrition + TB + malaria + SRHR | 11.40 |
Thematic areas are not divided with separate lines like other States. So if IP submits a proposal for Chin, does IP need to cover all thematic areas? Can IP submit a proposal covering individual or combined thematic sectors? Are there any plans to provide individual budgets for each thematic area?

The Access to Health Fund will aim at building integrated programs which cover MNCH, Nutrition, TB, malaria, and SRHR. However, Implementing Partners should apply for the thematic areas they want to cover in their program, under the overall envelope for Chin.

1.10. For MNCH, the townships of Rakhine State are divided into two parts: 7 townships and 3 townships. Can we apply for all 10 Townships? Should there be two separate proposals?

Applicants are welcome to apply for all ten townships in one (not two) Proposal. Applicants should indicate which Townships they are applying for, and funding will come from the relevant envelope.

1.11. For TB and malaria, Paletwa (a township of Chin State) is grouped with Rakhine. Can Paletwa still be included in Chin Proposals for TB and malaria?

Partners are encouraged to include Paletwa in proposals for TB and Malaria for Rakhine. But Paletwa can also be included in integrated proposals for Chin.

1.12. In Paletwa, is it possible to do more than TB and malaria?

Yes.

1.13. Will the allocation of Shan be equally divided for 3 regions (North, East and South)?

No. The budget for Shan will be allocated based on needs and proposed interventions.

1.14. Can IPs submit one proposal mixing the townships of Northern and Southern Shan State or Northern Shan State and Kachin State?

Yes.

1.15. If we want to apply for other states together with the Yangon Region, how many proposals do we need to submit? One proposal or separate?

The Yangon proposal should be separate.

1.16. Submission is by geographical grouping. If we submit a proposal for Kayin and Mon for SRHR, do we need to submit separately apply for SRHR proposal in Yangon?

Yes. Two proposals are required because Kayin and Mon are in one geographical grouping, while Yangon is in a different geographical grouping.

Questions received by 16th July

1.17. In Annex 8 of the guidance note, it mentions that applicants are encouraged to include in their proposals all the Townships currently covered under the 3MDG Fund. In the Q&A session, it was stated that it is flexible and there is no obligation to apply for all townships?

There is no requirement to cover all townships currently covered under the 3MDG Fund, but we encourage applicants to do so, particularly in MNCH, as this will lead to efficiency gains and better coordination with the State Health Department.
Questions received by 23rd July

1.18 My organization operates in Kayin state and only has an MOU to operate there, however we could get our partners to operate the project in Kayah and Mon states. Would such an arrangement be acceptable for this funding scheme?
Yes. If organizations are selected for geographic areas in which they are not working yet, they will be invited to ensure (after the selection) that they can carry out the work.

1.19 Please can you confirm the size (in US$) of the envelope for “Group 3” - Kayah, Kayin and Mon states?
Please refer to page 10 of the Guidance Note for the envelopes for each thematic area within each geographic area.

2. What can/cannot be included in Proposals?

Questions received by 11th July

2.1. Are there restrictions to programming?
There are no specific restrictions. Proposed programs should be in line with the Access to Health Fund’s overall mission and mandate (see Guidance Note).

2.2. Is Sexual Reproductive Health included in the potential Yangon programming?
Yes. An update has been posted on the website on 9 July 2018 to indicate that SRHR in Yangon will be supported. The indicative budget for SRHR in Yangon is USD 2 million which is in addition to the 5 million already allocated for TB and MDR-TB in Yangon.

2.3. Are projects focused on Accountability, Equity and Inclusion (AEI) included under cross-cutting approaches? If yes, please provide the ceiling of grant allocation.
AEI programs are expected to be integrated in service-delivery grants. As such, they do not have their own ceiling grant-allocation, but are rather part of the overall ceiling for each region/thematic area.

2.4. Is this call also focusing on Non communicable diseases (NCDs) under health system strengthening?
NCDs are not a focus area of this Call. While the Fund does not expect to provide significant funding to NCDs, interventions could be considered if they represent a small portion of the overall program (with the bulk of the program under the Fund’s priority thematic areas) and would increase efficiency and reach of the program (see pages 11-15 of the guidelines)

2.5. Could cash transfers in the programming be considered?
Yes, if relevant (and as part of a broader program).

2.6. Could capacity building for GPs be considered?
Yes, if relevant (and as part of a broader program).

2.7. Is it possible to apply for strengthening surveillances systems under the disease control department of MOHS?
Yes, if relevant (and as part of a broader program).

2.8. Can our proposal address both development and humanitarian needs? If so, is there any coordination mechanism between the Access to Health Fund and humanitarian organizations?
The Access to Health Fund is not a humanitarian fund, and its Donors have other mechanisms to cover humanitarian needs. As such, the Fund will not look at dedicating important resources to humanitarian work. However, working on health in conflict-affected areas will often touch on humanitarian issues, and applicants are welcome to make these links in their proposals.

2.9. What if the work is shut down because of conflict situations?
The Access to Health Fund will be working alongside Implementing Partners to deal with situations of conflict flare-ups and humanitarian crises.

2.10. Would you consider Implementation Research or Operational Research activities if relevant?
Yes.

2.11. For Implementation Research or Operational Research activities, should we apply under the service-delivery grants in States, Regions and Townships (p14 guidance note)?
Operational research can be included under service-delivery grants or under National Health Systems Strengthening grants – as relevant.

2.12. Can I apply for policy research under National HSS?
Yes, if relevant.

2.13. Our organization focuses on policy guidance and building community capacity. Should we apply under national HSS or for a specific geographic location?
Both options are available, and the answer will depend on the content of your proposal.

2.14. Our organization focuses on policy and legislation work that goes beyond MOHS. Should we apply under thematic area or HSS?
Both options are available, and the answer will depend on the content of your proposal.

2.15. Would CSO network activities and capacity building of CSOs for UHC movement be considered? Where would they fit?
Yes, they would be considered. These activities could fit under service-delivery grants or national Health Systems Strengthening, depending on the proposed approach.

2.16. What type of interventions is the Access to Health Fund expecting in conflict affected areas?
Please refer to the guidance note, which summarizes the Fund’s expectations for service-delivery grants.

2.17. Our organization focuses on physical rehabilitation work in Kayin state, should we apply under thematic area or HSS?
It is difficult to respond without details on the content of your proposal – but it sounds like service-delivery grants may be more appropriate. We encourage to link with main thematic areas of service delivery.

2.18. On page 15 of the guidance note, for ‘financial protection’ under cross cutting headings, could one of the examples for local intervention be referral?
Yes.
2.19. What if I have an idea but it doesn’t quite fit the categories set in the Guidance note?
The Guidance Note defines the Fund’s focus areas and calls for flexibility. You are welcome to explore ways to submit the Proposal, possibly within a larger program (consortium submission).

Questions received by 16th July

2.20. Will the Access to Health Fund consider proposals related to anti-microbial resistance?
Anti-microbial resistance is not a focus area of this Call. While the Fund does not expect to provide significant funding to anti-microbial resistance, interventions could be considered if they represent a small portion of the overall program (with the bulk of the program under the Fund’s priority thematic areas) and would increase efficiency and reach of the program (see pages 11-15 of the guidance note).

Questions received by 19th July

2.21. Can UNOPS please provide the full list of "supporting documents" that are referenced throughout the guidelines as required to be submitted within each Proposal?
Supporting documents may be submitted if deemed necessary to strengthen the proposal. However, the following three documents are essential:
- Short document clarifying the consortium’s structure (if applying together with other organizations) (p1, section 1 narrative template)
- Organogram (p6, section 9.1 narrative template)
- Organization’s code of conduct (p7, section 10.2 narrative template)

Other attachment if relevant are:
- 4.2: Needs assessment or evaluations (p3 narrative template)
- 7.2: Relevant documents (if deemed necessary) supporting how proposed program will ensure that service-providers are being held accountable by communities (p5 narrative template)
- 7.3 Relevant documents (if deemed necessary) supporting how proposed program will ensure sensitivity to gender, social inclusion and disability (p6 narrative template).

2.22. Could Infrastructure development be funded under this grant?
If what you mean for infrastructure is “Construction of Buildings”, that will not be prioritized area under the Access to Health Fund.

Questions received by 23rd July

2.23. Will the fund support construction or upgrading of health facility infrastructure (i.e water or energy supply)?
“Construction of Buildings” is not a priority area under the Access to Health Fund. However, upgrading could be considered if they represent a small portion of the overall program (with the bulk of the program under the Fund’s priority thematic areas) and would increase efficiency and reach of the program.

2.24. Can a portion of the grant be used for strategically improving the functionality of certain health facilities, as a prerequisite for service delivery?
Yes, interventions that would increase efficiency and reach of the program can be considered

3. Working as a consortium

Questions received by 11th July
3.1. If I cannot find a consortium/group, is it possible for me to apply only from my individual organization?
Yes.

3.2. Is it possible for one organization to participate in more than one consortium?
Yes.

3.3. Is there a limit to the number of consortium members?
No.

3.4. When one IP submits for all the townships in one state mentioned in the CfP and other IPs submit with other townships not listed in CfP within the same state, will FMO make these two organizations partner? Will FMO allow separate grants if both win the bid?
We expect to receive many proposals for each State, covering different combinations of Townships. In reviewing Proposals, the Fund could accept parts of a Proposal and/or, in close consultation with applicants, build a program composed of several proposals (or parts of these proposals) put together.

3.5. Can the Consortium be an INGO partnering with an LNGO?
Yes.

3.6. Can a group of organizations be a consortium if they are working together technically, but one of them receives and manages funds without any need of a financial flow among them?
Yes.

3.7. Is it possible to submit a separate budget under a consortium/joint proposal?
Each Proposal should have its own budget, and only one budget. In the budget template, each partner budget can be mentioned under the “sub-contractor” column of the entry sheet.

3.8. Would it be possible to apply as a Consortium with CSO & INGO in respective geographical areas?
Yes.

3.9. Is it possible to coordinate with the Global Fund for MDR TB in Yangon? How?
Coordination is encouraged.

3.10. Can two organizations apply together in one combined proposal?
Yes.

3.11. What do you mean by linked submissions?
Applicants are encouraged to show how their proposal links to other programs (existing and upcoming) in the selected area. If two organizations submit in the same area, applicants are encouraged to ‘link’ their proposals by showing how they complement each other.

3.12. Can a consortium include governmental departments?
A program can and should strive to work very closely with relevant government departments, who will be major partners for implementation. They are not, however, part of the consortium.
3.13. Please clarify p.18 footnote 6 on private companies (businesses co-financing interventions) in the guidance note?
It is expected that a private company, who is seeking a grant from the Access to Health Fund, will also contribute funds to the program. No specific percentage is prescribed.

3.14. Which kind of private companies would you recommend forming a consortium with? E.g. gold mine, insurance company?
Proposals – and proposed implementing organizations – will need to make sense in context, based on the details of the program and the approach.

3.15. Can one EHO be linked with more than one consortia and have applied to this grant with more than one proposal, but within the same geographical groups, and different thematic areas?
Yes.

3.16. Will the grant consider to support other nearby geographical areas which are outside of project targeted geographical groups, but which are linked with one EHO within the same territory and under the same health service system of the EHO?
While it may sometimes be appropriate for Access to Health project activities to reach out to populations across state/regional borders (e.g. when there exists a continuum of populations and health situations), it is expected that the overwhelming majority of proposed interventions under each Proposal will focus on the areas defined in the Guidance Note.

Questions received by 16th July
3.17. Footnote 6 on page 18 implies that private businesses will ‘co-finance’ interventions. Does this also apply to consulting firms?
No.

Questions received by 19th July
3.18. In the ‘consortium’ approach, is there any expected roles of the Lead Organization from UNOPS side in terms of financial and programmatic management? Or does it totally depend on the agreement reached by the partner organizations in the consortium?
The lead organization will be expected to play a leading role in managing funds and reporting back to the Fund on behalf of the consortium. The grant agreement and legal contract will be signed with the lead organization.

Questions received by 23rd July
3.19 The format suggests a preference for joint proposals – with the lead partner to receive funds and manage disbursements. Is this correct?
This CfP encourages applicants to apply in a consortium (group) approach with an identified lead organization who will be in charge of managing funds and reporting back to the Access to Health Fund. ‘Linked’ proposals are also encouraged, but are different from consortium applications. For linked proposals, no lead organization is required (see note 3.11 Q&As).

3.20 Please note that transfer arrangements between entities could potentially be quite cumbersome, with possible inefficiencies in implementation. Accordingly, we would like to
Propose technical coordination be considered as well i.e. using a common technical approach to reinforce activities across proposals, clearly referenced in respective proposals. Technical coordination is encouraged. Rather than a consortium, this would be considered a ‘linked’ application (see note 3.11 Q&As)

3.21 Can the international body of an INGO be the applicant and the national chapter of the same organization be the implementing partner in the country? Is this considered a consortium?
If the international body (e.g. head quarter) and in country implementing partner are under the umbrella of the same organization, it cannot be regarded as consortium.

3.22. Looking at the guidelines for bidders/grant applicants for the above opportunity, I note that there is an expectation for private businesses to co-finance proposed interventions. Could you please confirm whether this is a case where a private business joins an NGO-led consortium as a sub-contractor?
Yes, however, grant support through UNOPS funding cannot be used to produce a direct financial profit for the grantee or a sub-grantee.

4. Who can apply?

Questions received by 11th July

4.1. How would you prefer to allocate funding: 100% Private or joint venture of Private and NGO?
The Access to Health Fund will select proposals based on their relevance, approach, Value for Money, and other objective considerations.

4.2. Will you allow applications from organizations who are already under the SR of Global Fund?
Yes.

4.3. Do we need a prior MOU for implementation?
The Access to Health Fund accepts proposals from organizations who have the ability and authority to work in Myanmar. Organizations and consortia are welcome to apply for (i) geographic areas for which they are already working and (ii) geographic areas in which they are not working yet. If organizations are selected for geographic areas in which they are not working yet, they will be invited to ensure (after the selection) that they can carry out the work.

4.4. Can you clarify what is meant by “prior experience in activities?”
Implementing Partners are expected to have implementing experience in the Proposal’s thematic areas (this implementing experience does not necessarily need to be with the 3MDG Fund). If an organization, for example, applies for funding for an MNCH program, the Proposal should make it clear that the applicant has experience in MNCH.

4.5. From Section 7, ‘Who can apply’ (p.18 guidance note), please clarify “authority to receive funding.”
The Access to Health Fund wants to keep this Call for Proposals as open as possible. Therefore, if an organization feels it has the “authority to receive funding” for the implementation of health programs in Myanmar, it is welcome to submit a proposal under the Call.
Questions received by 16th July

4.6. Are private sector (profit making) consulting firms allowed to participate in this call for proposals?
Yes. Please refer to answer 3.14.

Questions received by 23rd July

4.7 We are from one faith based association. In our organization we have a community health care training program and child protection program. We can apply or not?
Please review the thematic areas and the funding envelopes available for each geographic area. You can apply if you think majority of your project activities are in line with the prioritized thematic and geographic areas of the Access to Health Fund and can propose additional activities if it makes sense.

5. Working with EHOs

Questions received by 11th July

5.1. How do you define EHOs? Are these health organizations/departments formed under ethnic armed forces?
By Ethnic Health Organizations, we refer widely to organizations who, in conflict and post-conflict areas, are providing essential health services to populations that public sector providers do not reach.

5.2. For Ethnic Health Organizations, how would it work with documents such as signing MOU with the government and registration if they did not previously have them?
The Access to Health Fund will aim to select Implementing Partners who are best positioned to deliver health services in given geographies. Once the selection is done, we will work with selected partners and the MOHS to ensure program implementation can proceed.

5.3. Are you aware of any legal restrictions for some INGOs sub-granting funds to specific EHOs?
We will be looking at these types of restrictions (when relevant) as part of the selection process.

5.4. Where does funding come from for the capacity building of EHOs?
Funding for capacity building of EHOs comes from Health Systems Strengthening, under ‘National Health Systems Strengthening’ (see pgs. 10 and 13-14 of the guidance note).

5.5. Are there any stipulations on financial management with EHOs?
They are the same as for any other applicant.

5.6. Can EHOs apply for the Fund directly and alone, or lead an application in a consortia/group?
Yes – they can do either.

Questions received by 16th July
5.7. For working with EHOs in South-East, will the Access to Health Fund consider cross-border office related costs as some EHOs do not have office in Myanmar? Proposals should include all costs that are essential to the successful implementation of proposed programs/activities. Funding decisions will be made on a case-by-case basis.

5.8. For working with EHOs, does the Access to Health Fund have any plan to get drugs faster rather than international procurement by UNOPS? Procurement of medical supplies will still be done by UNOPS. In the transition from 3MDG to Access to Health, UNOPS will procure in advance for some key essential drugs minimize stock-out.

5.9. Can EHOs propose a new thematic area in the proposal eg. primary health care services? Yes.

**Questions received by 23rd July**

5.10 Will the Access to Health Fund allow for the payment of salaries, a portion of salaries, remuneration or incentives for EHO health service providers working in health facilities in conflict affected areas? If the answer is no to all or any parts of the first question, would the answer change to the affirmative if the proposal includes a strong transition plan? Yes, this can be allowed. However applicants should show how they will promote sustainability and move away from donor reliance together with a strong transition plan.

6. **Integration of services**

**Questions received by 11th July**

6.1. Are integrated services compulsory for the proposal (e.g. TB must be integrated with malaria) or are standalone interventions acceptable? Integrated services are encouraged when they are feasible and make sense. They are not an obligation.

6.2. Do we need to cover all thematic areas mentioned in the CfP? No.

6.3. What do you mean by integrated services for SRHR, e.g. services within SRHR; SRHR together with MNCH and ATM (HIV, TB, malaria) services? The Fund is asking for integrated services to make sure that every dollar invested results in as much health service-provision as possible for vulnerable populations in conflict-affected areas. We encourage programs to deliver several SRHR services instead of one, when possible. We also encourage programs to deliver other health services alongside SRHR (e.g. TB, HIV, malaria) when possible.

7. **Timeframe: funding extension past 2020**
Questions received by 11th July

7.1. Can my organization submit a proposal this year to start implementation in January 2021?
No. Applications are currently being received for two years starting January 2019 or soon thereafter.

7.2. Should we write the proposal for 2 or 5 years? If 2 years what should we write for a transition plan (2 years is a short time to have a full transition plan)?
The proposal should be for five years, but only the two first years will be funded. A review will take place in 2020 for continuation of programs for another three years. The transition should be built within the (two or five-year) program.

7.3. Can my organization apply for less than 5 years, or is it 5 years only? E.g. can we apply for 2-3 years (e.g. 2019-2020 or 2020-2023?)
Yes.

7.4. Will you accept new partners at a later point?
Possibly as part of the 2020 review.
Also, a second Call for Proposals for Health Systems Strengthening will take place in a few months.

7.5. On what criteria is the award decision about the remaining 3 years based on?
The decision will be based on (i) contextual changes and continued program relevance, (ii) performance, and (iii) availability of funding.

7.6. What will the evaluation in 2020 look like, e.g. consultant, outside evaluator, internal process?
The review will build on the ongoing bi-annual reviews on partners’ performance. The modalities (external consultant, Fund-managed) have not been decided yet.

Questions received by 19th July

7.7. Given that programs under this proposal are to be funded for the first two years, should activities proposed be for only that two year period, or may they extend beyond that funding period?
Please see response 7.2. The proposal should be for five years, but only the two first years will be funded. A review will take place in 2020 for continuation of programs for another three years. The transition should be built within the (two or five-year) programme.

Questions received by 23rd July

7.8 Given that the Access to Health Find will fund only the first two years, do you expect to see a strategy on how the organization intends to cover the expenses of the remaining three years in case the funding will not be renewed during 2020?
Applicants are requested to submit projects for up to five years (2019-2023). It is not necessary to provide mentioned strategy in your question.

7.9 What is your definition of an international organization, in the context of transition plans to local organizations? Are private corporations incorporated in Myanmar but with international presence considered an international organization?
Regardless of types of organization (either non-profit or private), we encourage partners to include transition plans in the proposal. For example, the number of international staff should be reduced year by year and the unit cost of service delivery should move towards local costs over time.

8. **Health Systems Strengthening (HSS)**

**Questions received by 11th July**

8.1. Can my organization apply to do HSS only?
Yes.
If the question pertains to the national HSS grants, the answer is squarely yes.
If the question pertains to Health Systems Strengthening under service grants, the answer is still yes – but you are highly encouraged to apply as part of a consortium in order to ensure a clear linkage between service-delivery and systems strengthening.

8.2. For the HSS CfP- what is the funding envelope, how it will be different, what will the modality be?
This is still work in progress – all details have not yet been decided, which is why we will be issuing this call at a later stage.

8.3. Can National level HSS be a separate proposal? Can a single organization apply for one thematic area of HSS and not as a consortium?
Yes (to both questions).

8.4. If IP adds HSS activities related to the six HSS programmatic areas supported at central level (see pg. 13 of the guidance note) into their MNCH grant activities, but not all topics and not cross cutting HSS activities, does the IP need to prepare a separate proposal?
No. Health Systems Strengthening aspects can (and should) be included in service-delivery proposals. They should be added as relevant, and there is certainly no expectation that all six areas be part of a service-delivery proposal.

8.5. Please provide more explanation on how to propose HSS work in this CfP and the next CfP (2019)?
There are three different ways to receive funding for HSS work under the Access to Health Fund:
1) National HSS: applications under one or more of the six themes currently in this Call for Proposals;
2) Service-delivery grants: it is expected that all service-delivery grants in all States (and Yangon) will also contribute to strengthening Health Systems;
3) Another HSS-specific Call, for approximately USD10 million, will take place at the beginning of next year (scope still to be defined).

8.6. In addressing HRH work related to the building capacity of EHOs, should the proposed work be at the national or local level?
Both can be submitted.

**Questions received by 23rd July**

8.7 If we are addressing more than 1 of the 6 programmatic areas of the National HSS, do we have to put up more than 1 proposal, or can they be all classified under one proposal for National HSS?
If you think applying more than one programmatic areas of the National HSS in one proposal set would bring efficiency gain and make more sense, please do it. Otherwise, please apply its own proposal and links between the areas in the proposals.

8.8 Is there a specific geographic scope of coverage required if we want to address any of the programmatic areas under National HSS?
No. The focus of National HSS is to support central-level policy and national strategic and operational plans.

8.9 For the National HSS opportunities, do activities still need to be broken down by region, or should we just put ‘Central’ for all? What about activities, workshops etc. that happen in regions that aren’t Access to Health regions?
Please try to choose the States/Regions where your proposed activities will be happening as much as you can. In the budget template, you can still choose regions that are not the prioritized areas of the Access to Health Fund. Please refer to step 4 and step 5 of instruction sheet for budget template for more clarifications.

8.10 We have a question regarding the national HSS grant number 1. SRHR- policy, implementation and coordination. In the illustrative activities it mentions Supporting the RMNCAH strategic plan, which is broader than the scope of SRHR. Does this mean that the grant is for the supporting the SRHR part or is it for the full RMNCAH?
We do not limit supporting SRHR policy development only and partners can include supporting RMNCAH strategic plan in the proposal.

9. Government/MoHS related

Note: in response to several questions, we wish to reiterate that this Call for Proposals is only for Implementing Partners; the Fund is in separate discussions with the MOHS regarding grants to the Ministry.

Questions received by 11th July

9.1. Will the government provide and authorize access to conflict areas or black zones (eg. Rakhine, Kachin etc.)?
Geographic areas of the Access to Health Fund have been determined in close consultation with the government. Specific access questions will need to be looked at jointly (applicants, other partners, Access to Health Fund, MOHS) on a case-by-case basis.

9.2. Will the funding to MoHS be used in the same target areas and activities as the counterpart fund?
Grants to the Ministry will be supporting the Ministry’s work at central level (policy) and across the country.

9.3. How do IPs complement MoHS activities? How can we find out MoHS activities so as not to overlap? If IP win the bid with overlapped activities, will FMO allow adjustment of the activities?
Applicants should strive to ensure they have a good overview of ongoing programs in proposed areas, and avoid overlaps. The Access to Health Fund will show flexibility in adjusting activities accordingly.
Questions received by 23rd July

9.4 To what extent are we expected to collaborate with MOHS?
Collaboration with MOHS is essential as the core principle of the Access to Health Fund is to complement the National Health Plan. So, we suggest the partners to coordinate and collaborate closely with MoHS at all levels as much as possible.

10. Procurement

Questions received by 11th July

10.1. Will the procurement of medical supplies still be done by the FMO? Or will the IP be expected to be in charge under Access to Health? If procurement is still done by UNOPS, when will it start to provide continuation of supplies (to avoid stock-out)?
Procurement of medical supplies will still be done by UNOPS. In the transition from 3MDG to Access to Health, UNOPS will procure in advance for some key essential drugs to minimize stock-out.

10.2. Is there any reference procurement related documents to calculate/estimate the budget for medical supplies?
Applicants are suggested to use the 3MDG requisition form (which can be downloaded from the 3MDG website) in which standardized drug lists and unit costs are available.

Questions received by 23rd July

10.3 In the case of unique commercial solutions and competencies, do these still need to follow UNOPS public tender processes?
Partners can apply their own internal procurement regulations if available. In case, if there are no documented guidelines issued by the organization regarding procurement procedures, 3MDG/UNOPS guidelines shall prevail.

10.4 Are there limitations on the extent to which specific solutions and competencies of commercial vendors can be detailed in the proposals due to considerations of fairness of procurement tenders?
No. But, it is suggested to discuss with UNOPS when you have to actually do the process.

10.5 For family planning commodities, does the fund expect linkage with existing supplies or should the project include procurement and distribution of family planning/contraceptive supplies?
It can be both scenarios. But, the partners should apply the most efficient and reliable way.

10.6 We see in the CFP that the program design/thematic area is not focused on community needs for primary healthcare services. Can we also for the procurement/receiving of medicine and medical supplies, for long term existing primary health care provided by EHOS and ECBHOs in their targeted areas?
We can allow/procure medicine and medical supplies for primary health care if partners can demonstrate the needs and effective interventions. Please use 3MDG requisition form to calculate the medicine and medical supplies expenses. It can be download here:
11. Scoring/selection criteria

Questions received by 11th July

11.1 Can you provide more information about the final scoring system for assessing the proposals?
The scoring matrix was made available on the 3MDG website on the 12th of July.

Questions received by 19th July

11.2. In the CfP, there are multiple mentions of the need to have prior experience in implementing activities similar to those proposed for funding. For INGOS, does previous experience in other countries count, or is it limited to experience with proposed activities specifically within Myanmar?
Yes, previous experience in other countries is certainly valid. However, the applicant should demonstrate how they will apply this experience to the Myanmar context. If appropriate, forming a consortium with other organization(s) who have such knowledge/experience may be optimal.

12. Filling in required documents

Questions received by 11th July

12.1. What does number 4 ‘letter submission’ in the narrative template refer to? Does this mean the cover note?
Partners need to include a signed letter of submission with organizational letterhead and cover note giving an overview of the proposal(s) submitted. If you submit more than one proposal, please mention in the cover-letter what proposals are being submitted and how they relate to each other.

12.2. How many times do we need to fill out the logframe and budget templates if we have different proposals?
There should be one budget and one logframe for each proposal. So the answer is: as many times as there are proposals.

12.3. Should detailed activities be described in the narrative template (e.g 4.2), or is it fine to give activity details in the budget only? By ‘details’ I mean e.g., ‘how many volunteers are to be trained,’ ‘on what topics’ etc.
The narrative template will be at a higher level, but with enough detail to fully understand the program. The budget template will include all details.

Questions received by 16th July
12.4 Budget Template: Can the Access to Health Fund please provide an additional free Excel sheet in the budget template?
“Detailed Calculation Sheet” is free excel sheet and partners are invited to use that sheet for calculation.

Questions received by 19th July

12.5. For the electronic submission, what format would UNOPS like the documents to be submitted in (Word or PDF)?
Please submit by Microsoft Word document.

12.6. For the hard copy submission, what size paper would UNOPS like the documents to be in (A4 or letter - 8.5” x 11”)?
A4.

12.7 For the cost proposal(s), how are costs that are shared across locations (Kachin and Shan, for example, not across geographic groupings), and across technical areas supposed to be reflected in the budget? For example, for staff who work across the whole project, or rent of office space in a central location. The budget template itself has drop down menus that require selection of specific geographic and technical areas. Would we leave those blank or would we split the costs across multiple lines?
Partners cannot leave blank for Region/State, Thematic Area, Activity and Sub Activity column in budget template as linked with formula to come out summary budget. Please see Step 4 and Step 5 of Instruction Sheet for Budget Template for more clarification.

12.8. If our proposed intervention is cross cutting across the key thematic areas, what guidance would you provide for allocating activities and costs across these areas?
Please see Step 5 (Thematic Area) in Instruction Sheet of Budget Template.

12.9. If our proposal is national in scope but cross cutting across states, how should we attribute costs to each state?
If your activities are happening in States, please choose respective State in budget template and prepare your costs and budgets. We need budget for each State. Please see Step 4 (Region/State) in Instruction Sheet of Budget Template.

a. Logframe (indicators)

Questions received by 11th July

12.1.1 Is the list of indicators final?
No. The list of indicators is indicative and assists in the review/comparison of proposals; the final list of indicators will be negotiated with partners as the portfolio is finalized.

12.1.2. The indicators listed do not include the one(s) we would like to propose?
You have the opportunity to propose other indicators. Please do not hesitate to submit a specific question if needed.

12.1.3. Does FMO plan to combine the additional indicators submitted by each IP and develop standard ones? If FMO has a plan, when will the indicator/ M&E guideline be out?
This will be addressed as part of grant negotiations, when we are clearer about proposed programs and indicators.

12.1.4. For additional indicators allowed to be proposed, why are nutrition and MNCH targets lumped together?
You are welcome to propose five additional indicators for MNCH and five for nutrition.

12.1.5. The proposed indicators can be picked by applicants but are not required?
Correct.

12.1.6. The percentage indicator can be interpreted in 2 different ways - through prevalence survey, or through organizational information on those reached/screened?
Please refer to HMIS indicator guidelines – or let us know if you would require a more specific response to your question.

12.1.7. Should the indicators be completed for State or Township level?
If you are planning to work in 3 townships of a State, the targets of indicators should represent the combination/average of 3 townships. You can mention detailed calculations/assumptions of each township in the assumption column. We expect the indicators to be at the most relevant level given the scope and scale of the proposed program. Indicators should, when possible, reflect the achievements of the proposed program.

12.1.8. What about Shan State - will it divided into North, South, East?
For Shan, it is likely that indicators, to be relevant, should be addressing the North, the South, and the East separately.

12.1.9. A percentage indicator is challenging to set as a partner may only cover 10% of villages in a township?
Please include the most relevant indicator/target given the scale of the proposed program; we will refine this during grant negotiations.

12.1.10. If our organization is working in SRHR, MNHC, ATM and nutrition, do we need to come up with indicators for all the indicators?
Yes.

12.1.11. In SRHR or other areas of work where no baseline exists, can we propose to conduct a baseline?
If there is no baseline, you can leave the field in the template blank. If you think there is great need for a baseline, you may propose conducting one with sound rationale.

12.1.12. Should we give each indicator, for each township, for each year of TB work?
We expect the indicators to be at the most relevant level given the scope and scale of the proposed program. Indicators should, when possible, reflect the achievements of the proposed program.

12.1.13. Long lasting insecticide nets (LLINs) are not included in malaria indicators - does that mean they are not supported?
GFATM is supporting LLINs for the whole country. Partners are encouraged to coordinate with NMCP for LLINs distribution if required.
12.1.14. There are no HSS indicators?
We invite you to suggest up to 10 indicators here.

Questions received by 19th July

12.1.15. Adolescent SRH: Can you provide more clarity on the difference between SRHR indicators numbers 2.1 and 2.3? I believe you need to describe and quantify both “SRH awareness information” and “competent basic knowledge of SRH.” Indicator 2.3 (competent basic knowledge of SRH) asks for a percentage — is this meant to reflect the success rate of the awareness/training efforts of 2.1 and/or 2.2? Or is 2.3 meant to reflect a different training effort altogether, such as the % of those completing a comprehensive sexuality education curriculum (CSE), who demonstrate competent basic knowledge as a result?

Number 2.1 asks for total number of young people who received SRH information through interpersonal communication (e.g. awareness session, peer education) by the program.

Number 2.3 does not mean to reflect the success rate of Number 2.1. But it can include Number 2.2, and other type of Youth SRH trainings. It measures how much % of trainee participants (young people) become competent in basic knowledge after SRHR training by the program (which can be assessed through Post-test after training). For example, if partners planned to give training to 500 young people (SRH peer educator trainings in Number 2.2, plus other SRH youth trainings, etc.) in year 1, the target can be set 95% which means 475 young people have shown competent basic knowledge of SRH in the Post-test. Please provide the assumption of setting the target (detail numbers) in the Logframe.

12.1.16. Post-Abortion Care: Indicators 3.1 and 3.2 specifically state “public health facilities” — is A2H not interested in expanding PAC beyond public health facilities? Please clarify if these indicators are, or can be, meant for all facilities and all eligible doctors (only Ob/Gyns?). Indicator 3.3 does not explicitly state public health facility — please confirm/clarify. Also, I assume by “appropriate technology” you mean vacuum aspiration and misoprostol, and exclude D&C?

Post-Abortion Care indicators (3.1, 3.2 and 3.3) in the Logframe, asks for Public Health Facilities/practitioners so the targets requested are from public sector (Ref: Post-Abortion Care Reference Manual, MoHS 2015). But it can be beyond public health facilities/practitioners, depending on the programmatic approach of IP under consultation with MoHS (IP can clearly explain and state the number of non-public health facilities/practitioners that will be covered, in the assumptions column of template to complement the public sector targets). The appropriate technology means manual vacuum aspiration and misoprostol (Ref: Post-Abortion Care Reference Manual, MoHS 2015).

Questions received by 23rd July

12.1.17 In the logframe, should health system strengthening indicators for service delivery grants be incorporated under sector indicator tab i.e MNCH or on the HSS specific tab?
Yes. If it is service delivery grant covering HSS indicators, they should be put in the additional indicators under the relevant thematic area (e.g. additional indicators in MNCH and Nutrition).

12.1.18 Are we required to use all the proposed list of indicators when responding to the logframe? For example, if our proposal addresses MNCH issues, do we have to show our targets of all 7 indicators stated in the list, or can we select only the relevant ones which speaks to our proposal, plus add our own indicators in the optional field?
Yes, you need to set all proposed list of indicators under (i) MNCH and Nutrition, (ii) TB and Malaria, and (iii) Drug use and consequences (except Indicator 1.3 which is not a mandatory requirement for some applicants) thematic areas. For example, a partner who wishes to apply for MNCH must set all proposed list of indicators under MNCH and Nutrition. But in SRHR, you can select the relevant thematic area that you wish to cover (e.g. Family Planning and/or Adolescent Sexual and Reproductive Health Awareness Raising), and set the targets under this area.

However, in some circumstances, if a partner is planning to provide integrated health services (for instance, adding of some MNCH interventions into TB and Malaria volunteers), partners can choose relevant indicators only in MNCH tab. Similar scenario for integration of SRHR intervention into harm reduction projects, applicants for harm reduction can choose relevant indicators in SRHR tab.

b. Narrative template

Questions received by 11th July

12.2.1. Is the “Lesson Learned” section 8.2 is meant only for M&E, or the overall project approach?
This is focused mainly on M&E systems and limited to half a page.

12.2.2. What are the roles of Monitoring and Evaluation in a proposal? And the extent?
In the narrative template section 8.1, please describe the monitoring system used to gather, manage and report data, and how data will be analyzed and used as evidence in decision making. Please describe how the program will be evaluated.

12.2.3. Section 8.1 of the narrative template states: ‘Please describe the monitoring system used to gather, manage and report data, and how data will be analyzed and used as evidence in decision making. Please describe how the program will be evaluated.’ Should baseline and endline assessments be included under this section?
Yes, if relevant.

Questions received by 23rd July

12.2.4 If not applying for National HSS funding, can we remove the related tables and sections in the template?
Please do not delete HSS related tables. You can leave as blank.

12.2.5 Page 1 – lead organization. Is there also a lead organization with a linked proposal?
No. Lead organizations refer to consortiums in which the lead organization will be in charge of managing funds and reporting back to the Access to Health Fund on behalf of the consortium. Linked proposals may be from organizations applying separately but showing how their activities complement each other and/or technically collaborating. Linked applications do not require a lead organization.

12.2.6 Where should the applicant put technical experiences and previous program results? (If in section 10.1 the word limit is 250, which is quite a limited amount of space)
You can also use section 10.5 to outline any other important information about your organization, application, or any other relevant fact.

12.2.7 Section 10.3 - Transition plan, including handover to local organizations. When a national NGO applies for funding, there is no need for handover by 2023?
Correct.

12.2.8 Can you please indicate what reviewers are hoping to see from section 10.5 “Please use the space below to outline any other important information about your organization, application, or any other relevant fact”? There are no specific guidelines for this section. Applicants can emphasize parts of their application or organization that they find most relevant.

12.2.9 Where do we find the principles of “Do No Harm and Conflict Sensitivity” to address your narrative template pt. 7.1? As the prioritized geographic areas of The Access to Health Fund are in conflict-affected areas, it is essential for partners to have appropriate “Do No Harm and Conflict Sensitivity” approaches in designing, planning and implementation of the project. You can find some resources related with conflict sensitivity on 3MDG website:


12.2.10 In a consortium scenario, how the Sections 7, 8 and 10 (mostly related to the past experiences of the organization) are supposed to be filled in? Should we include the experiences of all organizations in the consortium? Or only the lead organization? While it is important to highlight mostly about the lead organization in section 7, 8 and 10, you should also include experiences of all organizations in the consortium as long as relevant. Besides, you can elaborate more in “2 pages consortium’s structure” which is additional and "section 10.5 2 pages any other important information".

12.2.11 We are applying for a national HSS grant as a consortium. For questions in the proposal template that ask about “your organization” or your organization(s),” do we answer the question from the perspective of the lead organization only or from the perspective of all the organizations in the consortium? We are wondering about this distinction for questions 4.5, 7.1, 10.1, and 10.2 specifically. Please refer to previous answer.

12.2.12 In Section 9 staffing, which levels of key positions you expect to be filled in here? Presumably, the interpretation of ‘key positions’ could vary quite much without any specific instruction. Generally, “key positions” refer to senior level positions (i.e. officer level and above) of the organization in both central level and field level. Partners also need to submit an organogram that shows the full set up of the project.

12.2.13 The fund flow diagram seems very oriented towards the service delivery grants, rather than the National HSS grants. Is a fund flow diagram still required for the national HSS grants? Would ‘beneficiaries’ in this case be defined as the health system itself? If you are submitting HSS grants by consortium approach, the fund flow diagram is still needed to visualize how lead organization will ensure smooth fund flow among partners up to beneficiaries (in the case of HSS, this can be number of documents/policies/SOPs developed or number of staff trained or others). Depending on project designs of HSS grants, what we defined as beneficiaries can be changed.

c. **Budget**

**Questions received by 11th July**
12.3.1. You ask for budget by “region” – do you mean State?
Yes.

12.3.2. Some staff members’ level of input differs and they may work on different areas - how do we calculate this?
Please choose a category (or categories) that best reflect the work.

12.3.3. What kind of costs should be included when budgeting for emergency referrals?
Mostly transportation costs. We are looking at an Emergency Referral model in which the government covers hospital costs, as discussed with the Ministry over the last year.

12.3.4. To what extent is there flexibility to move across budget lines during implementation?
There is full flexibility when these changes make sense. Significant changes require the Fund’s prior approval.

12.3.5. Is the variation across budget lines also determined by a set amount, or only by percentage?
This is a question for the implementation phase – it will be addressed in the Operational Guidelines.

12.3.6. Where in the budget table can we budget working with EHOs?
Partners can enter EHO names and respective budget under “Sub Contractor” column of budget entry.

12.3.7. How will FMO calculate unit cost?
In general, total budget will be divided by target of key indicators to come out draft unit cost. This ratio between program budget and administrative budget may be one of the factors used to determine a project’s value for money.

12.3.8. ‘Value for money’ cannot be determined only by unit cost when working in conflict affected areas?
The Value for Money considerations will of course take into account the conflict settings.

12.3.9. The budget template says 6% overhead - please confirm this proportion and also if that applies to sub-grants?
UNOPS is bound by rules to not exceed 7% in overall indirect costs. When the FMO acts as a ‘pass-through’, it retains 1%, while 6% are passed on to Implementing Partners. The 6% cover both IPs and sub-IPs, meaning that they must be shared among the consortium partners or sub-grantees in whatever way the consortium decides.

12.3.10. How should we to interpret Section 6, point J on value for money (90/10)?
The point is not about Value for Money but about budget-execution. The text reads, “Applicants should design realistic budgets that reflect actual needs and execution-capacity under the program. Access to Health will expect budget-execution averages above 90 percent (unless unforeseen circumstances arise).” In other words, to the extent possible, please develop solid and realistic budgets which you are confident can be executed in full or at least at 90%.

12.3.11. Is there a set proportion for the management and operational budgets?
The Fund expects efficient, economical and lean proposals – and will review proposals accordingly. There is no set percentage for management vs. operational budgets.
12.3.12. Should proposals aim to apply for 40% or 50% of the total funding within a single geography? The guidelines give both percentages (pg 4 of the guidance note).
An application could cover up to 50%.

12.3.13. Will there be a focal person to address issues related to budget, e.g. allowable per diem rates etc.?
Yes. For now, questions can be submitted via the same address and will be addressed on the website. During grant negotiations, UNOPS staff will be available to answer questions.

12.3.14. What is the flexibility of fund allocation between direct implementation approach and indirect implementation approach (eg. community mobilization, training)
There is no set allocation.

12.3.15. On pg. 5 of the guidance note it is written ‘applicants should indicate how proposed activities will be complemented by support from other sources of funding’ What does this mean?
If activities are planned to be co-funded (i.e. funded partly from the Access to Health Fund and partly from another source), please mention that here.

12.3.16. Partners’ creativity is limited by prescriptive geographic areas, themes and working in consortiums stipulated in the Guidance Note. Are the percentages set in the overall program budget table, or will there be flexibility?
The document reflects discussions within the Fund and with Donors. The portfolio will be built flexibly.

12.3.17. Is FMO planning to provide individual budget envelope for North, East and South Shan?
No.

12.3.18. If an IP submits two proposals for two different States sharing the management and operation Cost (50% from each region) but only one is selected, can the IP revise the budget 50% to 100% for Management cost?
These questions will be addressed during grant-negotiations, and required flexibility applied.

12.3.19. You mentioned in the Q&A session that operational guidelines will be out soon. Will they be the same as the previous 3MDG one?
We are currently preparing operational guidelines for the Access to Health Fund based on current 3MDG experiences and lesson learned. We will upload this on the website once it is finalized.

12.3.20. Particularly with regard to carrying over the budget - in the previous 3MDG budget, the budget cannot be carried even from one quarter to next if IP does not first gain prior approval. Whenever new funding is started, IPs can face challenges (e.g. with setting up an office and financial flow) and for new IPs which are not familiar with 3MDG fund. Can FMO be flexible for this, especially in 2019?
While there cannot be any carry-over from 3MDG budgets into Access budgets, the FMO will explore the requested flexibilities (in the Access to Health Fund) with selected Implementing Partners.

12.3.21. In the budget, do we need to calculate office equipment like laptops and tables for current existing townships (some are not in good condition due to long usage) as IP has to donate all asset and inventory items to THD and CSO according to 3MDG office closure guidelines?
All budget lines (including equipment) which are necessary for the implementation of the proposed program should be included. We will consider transfer of assets from current 3MDG grantees to successor grantees of the Access to Health Fund.

Questions received by 16th July

12.3.22. It looks like there are 2 issues confused in the following Q&A from 11 July:
Q: Should proposals aim to apply for 40% or 50% of the total funding within a single geography?
The guidelines give both percentages (pg 4 of the guidance note).
A: An application could cover up to 50%.
The guidance note 12 is talking about 40-50% of the budget for the first 2 year time period, and not for a geographic area. The Q&A response seems to be talking strictly about geographic area. Is this a new and separate guideline, that any one IP should not apply for more than 50% of the total funding envelope in any given geographic area?

1. The table in the guidance note on pages 9-10 shows the maximum 5-year funding envelope per geography and key thematic area (for example: if applying for SRHR in Shan, the maximum envelope is USD 13.25m).
2. Applications are expected to cover five years, and the Access to Health Fund will consider funding the two first years – which should represent 40 to 50% of the total 5-year budget.

12.3.23. Do IPs need to include budget for incentives of TB and malaria volunteers if they intend to integrate TB and malaria in MNCH program?
Yes.

Questions received by 23rd July

12.3.24 For the National HSS opportunities, how detailed does the budget for sub-contractors need to be; is it the same level of detail as the overall budget or can we provide a simplified budget?
If possible, the budget for sub-contractors should be the same level of detail as the budget of the lead organization. If the budget is too simplified (for example, mentioning lump sum amount only), it would be difficult to evaluate.

12.3.25 We assume that the unit cost doesn’t apply to the National HSS opportunity, as it doesn’t fit with activities under that thematic area – it just applies for service delivery?
Correct.

12.3.26 How should national HSS type activities e.g. national level policy briefs be codified in the budget template, as they don’t fit under the other activity headings? Should all and anything that doesn’t fit the pre-determined list of activities go under ‘other’? However, ‘other’, as activity 19, is under operation and administration budget, not program budget. How would this be resolved?
To develop “National level policy briefs” as you mentioned, meetings, trainings, hiring consultants and project staff, etc. will be needed. Then, you can choose from relevant “Activity” and “Sub-Activity” of budget template. Just adding lump sum amount of budget for “Development of national level policy briefs” would not be adequate. We understand that the nature of HSS grants will need more “Operation and Administration Budget” than “Program Budget”.

12.3.27 Do we need to cover Central level to State/township monitoring and supervision costs?
If “Central level” here referred to central level staff of the organization, it is important to do “central level to field level” monitoring and supervision. You can budget in Activity “12. Travel” category in budget template.
If “Central level” here referred to central level staff of MoHS, it will depend on your project design. But, we encourage coordination with MoHS in different levels. For this case, you can budget the supervision and monitoring of central MoHS level to state/regional and township level under “02. Supervision and monitoring” activity in the budget template.

12.3.28 Do all partners need to submit the Detailed Calculation sheet of the budget template? We note that it was recently added.
This is free excel sheet that can be used to calculate for meetings, trainings, supervisions etc. if needed. It is good to include detailed calculation, then, FMO staff can check the breakdown if needed. Please also review “Step 9 (Unit Cost)” in Instruction Sheet of budget template to know more on the usefulness of “Detailed Calculation Sheet”.

13. Miscellaneous

Questions received by 11th July

13.1. Will grants to NGOs be issued under the current Grant Support Agreement & General Conditions for GSAs (Version 1.2, available on 3MDG website) or will these templates be updated? The GSA template will be updated for the Access to Health Fund.

13.2. Considering that USAID is one of the donors to the fund, would all grants be subject to the PLGHA (Protecting Life in Global Health Assistance) policy? The Fund is a pooled funding mechanism managed under UNOPS rules.

Questions received by 16th July

13.3. Will organizations be excluded from subsequent Monitoring and Evaluation work if they participate in this call? Implementing Partners of the Access to Health Fund may face a conflict-of-interest situation if they later apply to other contracts under the Fund (e.g. evaluation of the Fund).

Questions received by 19th July

13.4 Into which thematic area do the HIV activities among the general population (testing, referral, etc) fit in the states where they have been declared by NAP as generalised epidemic model? Should it be SRHR? There is not much described in the illustrative activities in the guidance note on HIV (P12). Does that mean this will not be seen as priority of this grant? The prioritized thematic area for HIV will be Drug Use and Health Consequences (Harm Reduction) under the Access to Health Fund. However, one of the activities under SRHR is provision of SRHR information and services. Hence, this scenario, HIV testing and referral service among the general population could be one of the SRHR activities. Partners are also welcomed to propose activities linked to prioritized thematic areas when these activities:

1. Would increase efficiency, increase the reach and impact of the program, address important causes of morbidity/mortality and disability in focus areas, and would contribute to providing more/better health-services to target populations
2. Represent a small portion of the overall program, with the bulk of the program under the Fund’s priority thematic areas.
13.5. Is there guidance available on which budget rates should be used when calculating per diem and transport costs for government partners?

Partners are suggested to use the latest version of UN government counterpart rate for calculating budget rates.

**Questions received by 23rd July**

13.6 The deadline 13th of August for the submission of the hard copy version of the proposal is on the 13th of August. Does this mean that we are expected to send it by mail before that day (with the date reported) or that the file has to arrive at UNOPS office within the 13th of August?

We will take soft copies submission time for deciding whether the submission is on time or not. Partners need to send the application set to submissions.accesstohealth@unops.org before 1 pm 13 August 2018. We encourage to submit hard copies on 13 August 2018 as well.

13.7 I understand from the guidelines that we need to submit the full proposal by 13th August. Please can you confirm that we do not need to submit a LOI prior to this?

Yes, no LOI is needed prior to this.

13.8 Are discounts provided by private businesses considered co-financing? If ‘yes’, how much discount in % from commercial list pricing is considered sufficient? If ‘no’, what exactly is considered co-financing? Will only cash contributions be considered?

Yes, this could be acceptable. No specific percentage is prescribed at this stage.

13.9 Is there any minimum % or amount for the matching grants required by the guideline, as it is said that activities must be complemented by other sources of funding?

There is no required minimum %. However, if partners are receiving funding from other sources, we encourage cost sharing among different funding sources as much as possible.

13.10 Do 3MDG fund guidelines, for example, operation guidelines, community feedback mechanism apply for Access to Health Fund?

The Access to Health Fund will provide updated guidelines to its implementing partners when they are finalized.

13.11 Can you provide the specific legends/abbreviations/definitions (e.g. implementors/ FMOs) for your HIV/AIDS township coverage mapping 2018-2020 and malaria township coverage mapping 2018-2020?

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<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>AHRN</td>
<td>Asia Harm Reduction Network</td>
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<td>IOM</td>
<td>International Organization for Migration</td>
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<td>MPG</td>
<td>Myanmar Positive Group</td>
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<td>MSF-CH</td>
<td>Médecins Sans Frontières Switzerland</td>
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<td>United Nations Office for Project Services (Principle Recipient for GFATM)</td>
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<td>UHF</td>
<td>USAID HIV/AIDS Flagship Project</td>
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13.12 Will the fund support an inception phase in areas where there has not been previous 3MDG funding?
There will not be a separate funding support as “inception phase”. However, we can be flexible for early phase of the project in new areas as partners need to recruit staff and set up new offices.

13.13 What is the Fund’s plan/guidelines for transition phase for current implementing partners to new partners?
We are hoping to announce the selected applicants latest by the end of September 2018. If current implementing partners are not selected, the discussion on smooth transition plan to the newly selected partners (to start operation on 1 January 2019) can be happened in the last quarter of this year.