

**THE GOVERNMENT OF THE UNION OF MYANMAR
MINISTRY OF HEALTH
DEPARTMENT OF HEALTH**

Letter No. 538 /NAP/UNGASS/2010

Dated. 26 March 2010

To

Mr. Michel Sidibé
Executive Director
UNAIDS

Subject: Union of Myanmar - UNGASS Report 2010

Dear Mr. Sidibé,

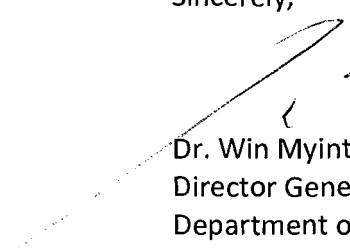
It is with great pleasure that I submit herewith the UNGASS report of the Union of Myanmar. The Government and its partners who implement HIV programmes take pride in sending you a complete report lying out the achievements in the national response to HIV.

There are a number of positive facts to be reported. The last two years have brought a substantial increase in the provision of care and treatment for those in need. Equally, the prevention for vulnerable populations has continued to be the focus of the national response to prevent new HIV infections and an increasing number of people are reached with targeted prevention interventions. The continuing improvement to our surveillance systems enables us to track the response and adapt national strategies to needs. There are remaining challenges and a lot remains to be done. To look back on the last years has given us the conviction that we can achieve even more in the years to come.

This report is the result of extensive consultations with stakeholders. Our partners from the civil society and UN Agencies have all contributed their valuable part to the completion of this report.

I look forward to seeing the publication of the global progress report.

Sincerely,


26/3/2010
Dr. Win Myint
Director General
Department of Health
Ministry of Health
Myanmar

UNGASS Country Progress Report

Myanmar

National AIDS Programme

Reporting period: January 2008 – December 2009

Submission date: 31 March 2010

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II. Acronyms and Abbreviations

ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BSS	Behavioural Surveillance Survey
CCM	Country Coordinating Mechanism
FSW	Female Sex Worker(s)
HSS	HIV Sentinel Surveillance
IDUs	Injecting Drug User(s)
M-CCM	Myanmar Country Coordinating Mechanism
MARP	Most-At-Risk Populations
MoH	Ministry of Health
MSM	Men who have Sex with Men
NAP	National AIDS Programme
NSP	National Strategic Plan
PMCT	Prevention of Mother-to-Child Transmission of HIV
STI	Sexually Transmitted Infection(s)
TSG	Technical and Strategy Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
VCCT	Voluntary Confidential Counselling and HIV Testing
WHO	World Health Organization
3DF	Three Diseases Fund

III. Status at a glance

III.1 Status of the epidemic

The HIV epidemic in Myanmar is concentrated, with HIV transmission primarily occurring in high risk sexual contacts between sex workers and their clients, men who have sex with men and the sexual partners of these sub-populations. In addition, there is a high level of HIV transmission among injecting drug users through use of contaminated injecting equipment, with transmission to sexual partners. Latest modelling estimated the HIV prevalence in the adult population (aged 15-49) at 0.61% in 2009. For key populations most-at-risk, surveillance data from 2008 showed HIV prevalence in the sentinel groups at 18.1% in female sex workers, 28.8% in men who have sex with men, and 36.3% in male injecting drug users.

It is estimated that around 238,000 people are living with HIV in Myanmar in 2009, of whom 74,000 are in need of antiretroviral therapy. In the same year, an estimated 17,000 people died of AIDS-related illness. Incidence is estimated at well above 10,000 new infections per year, confirming the continuing need for effective prevention efforts, with increased emphasis on reaching long term female sexual partners of male most at risk populations.

III.2 Policy and programmatic response

Oversight for national AIDS policy is provided by the National AIDS Committee, established in 1989 and chaired by the Minister of Health. State/division- and township-level AIDS Committees are also convened.

In addition, since 2006, a national coordinating body known as the Myanmar Country Coordinating Mechanism oversees the responses to AIDS, tuberculosis and malaria. The Myanmar Country Coordinating Mechanism is multi-sectoral in nature with broad participation, including representatives of international organizations, donors, NGOs, civil society, private sector and people living with HIV – all of them selected by the constituencies.

The AIDS Technical and Strategy Group is delegated with specific oversight of the national response to AIDS, and similarly involves various experts from ministries, United Nations organizations, NGOs, civil society, donors and people living with HIV. The Technical and Strategy Group supports seven Technical Working Groups to address specific programmatic areas, and these are open to participation by all interested stakeholders.

The Ministry of Health's National AIDS Programme provides coordination at national and sub-national levels, with a direct presence in the form of 46 AIDS/STD Teams. The National AIDS Programme's M&E Unit is tasked with coordinating national monitoring and evaluation requirements.

Since 2006, the national response has been aligned to the *National Strategic Plan on HIV and AIDS, 2006-2010*. This was developed in 2006 under the leadership of the Ministry of Health, for the first time through a participative process that involved a wide base of partners and stakeholders. The resulting document, along with its associated budgeted Operation Plan, has provided a prioritized strategic framework and reference for all partners in the national response and a basis for resource mobilization and allocation.

The National Strategic Plan's stated aim is to reduce HIV transmission and HIV-related morbidity, mortality, disability and social and economic impact. Its 13 Strategic Directions are prioritized on the basis of epidemiological data and HIV disease burden, with the Operational Plan suggesting equivalent resource allocations to prevention and to care and treatment. The strategies are classified into three prevention priority levels. The highest priority populations at greatest risk and vulnerability are sex workers and their clients, men who have sex with men, and injecting drug users, as well as the sexual partners of these groups.

The fundamental overarching strategies of the National Strategic Plan include meeting the needs of people living with HIV for comprehensive care, support and treatment, including prevention of mother-to-child transmission. With an estimated 74,000 people in need of antiretroviral treatment and over 17,000 yearly AIDS-related deaths, there is urgent need for scaling up care, treatment and support. This scale-up has so far been constrained by the lack of sufficient and longer-term funding.

In line with the priorities of the National Strategic Plan, a major programmatic focus in recent years has been HIV prevention in key populations at higher risk, especially sex workers, men who have sex with men, and injecting drug users, with NGOs delivering a large proportion of the services to these groups. Services include peer education and outreach for behaviour change, male and female condom and lubricant promotion, client orientated STI services and VCCT. Services provided to injecting drug users also include access to sterile needles and syringes, and methadone maintenance therapy. Despite increases in service availability and uptake in recent years, overall coverage is still low in terms of the proportion of the key populations reached by services. This is especially true for men who have sex with men, and injecting drug users as well as their long term sexual partners.

Likewise, there have been significant increases in the number of people receiving HIV counselling and testing services in recent years – in general population and most-at-risk groups – despite low geographical coverage of service delivery points offering testing. Again, as a proportion of estimated population sizes, coverage remains low.

Other priority groups for HIV prevention activities including mobile populations, institutionalized populations, uniformed services personnel and young people.

The prevention of mother-to-child transmission of HIV (PMCT) service has continued to scale up gradually, with both hospital and community based sites offering counselling and HIV testing and ARV prophylaxis for mother and baby. The number of women choosing to access the service has risen accordingly. In addition, enrolment of clinically eligible pregnant women in ART programmes has increased over the same period.

Scale-up of ART coverage continues as a national priority, within the constraints of limited resources. By the end of 2009, 21,138 adults and children were receiving ART, an increase of 90% since the end of 2007 but 70% of the planned target for 2009. This equates to one in four of people in need receiving ART, and provision is constrained by insufficient resources.

Involvement of people living with HIV in self-help groups has continued to increase significantly as this strategy has expanded to new areas with support of the Myanmar Positive Group and the National AIDS Programme. A range of NGO partners provide care in the home and community, and the number of people receiving support almost doubled between 2007 and 2008. Impact alleviation in the form of support for children

affected by AIDS, although increasing, has limited geographical coverage and remains seriously under-resourced.

III.3 UNGASS indicator overview

	Indicator	Status	
AIDS spending			
1	Domestic and international AIDS spending by categories and financing sources	Completed	
NCPI			
2	National Composite Policy Index (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	Completed	
Program Indicators			
3	Blood Safety-Donated	Completed	75.5%
4	HIV Treatment: Antiretroviral Therapy (2009)–	Completed	28.54%
4	HIV Treatment: Antiretroviral Therapy (2008)–	Completed	23.08%
5	Prevention of Mother-to-Child Transmission (2009)	Completed	55.41%
5	Prevention of Mother-to-Child Transmission (2008)	Completed	31.06%
6	Co-Management of Tuberculosis and HIV Treatment	Completed	10.52%
7	HIV-Testing in the General population	Partially filled	11.29%
8	HIV-Testing in Sex Workers	Completed	71.12%
8	HIV-Testing in Men who have Sex with Men	Completed	47.64%
8	HIV-Testing in Injecting Drug Users	Completed	27.31%
9	Prevention programmes: Sex Workers	Completed	76.17%
9	Prevention programmes: Men who have Sex with Men	Completed	69.09%
9	Prevention programmes: Injecting Drug Users	Completed	52.53%
10	Support for Children Affected by HIV and AIDS	Completed	No data available
11	Life skills-based HIV education in schools	Completed	No data available
12	Orphans: School Attendance	Not relevant	
13	Young People: Knowledge about HIV Prevention	Completed	47.51%
14	Knowledge about HIV Prevention: Sex Workers	Completed	71.48%
14	Knowledge about HIV Prevention: Men who have Sex with Men	Completed	68.31%
14	Knowledge about HIV Prevention: Injecting Drug Users	Completed	76.32%
15	Sex before the Age of 15	Completed	0.66%
16	Higher-risk Sex	Completed	6.63%
17	Condom Use during Higher-risk Sex (only male)	Completed	43.77%
18	Sex workers: Condom Use	Completed	95.85%
19	Men who have Sex with Men: Condom Use	Completed	81.55%
20	Injecting Drug Users: Condom Use	Completed	77.56%
21	Injecting Drug Users: Safe Injecting Practices	Completed	80.62%
22	Reduction in HIV prevalence	Completed	1.14%
23	Reduction in HIV prevalence: Sex Workers	Completed	18.09%
23	Reduction in HIV prevalence: Men who have Sex with Men	Completed	28.75%
23	Reduction in HIV prevalence: Injecting Drug Users	Completed	36.30%
24	HIV Treatment: Survival After 12 Months on Antiretroviral Therapy	Completed	87.51%
25	Reduction in Mother-to-Child Transmission	Completed	22.97%

IV. Overview of the AIDS epidemic

Myanmar has an estimated population of 56.5 million in 2007¹, of whom 60% live in rural areas. Administratively, the country is divided into 17 states/divisions, 65 districts and 325 townships.

The HIV epidemic in Myanmar is concentrated in nature. HIV transmission occurs primarily in high-risk sexual contacts between sex workers and their clients, men who have sex with men and the sexual partners of these sub-populations. In addition, the use of non-sterile, shared injecting equipment leads to a high level of HIV transmission among injecting drug users, with sexual transmission to partners.

Modelling in 2009 estimated the HIV prevalence in the adult population (aged 15-49) to be 0.61% for that year. Approximately 238,000 people (range 160,000-320,000) are infected with HIV (including adults and children), of whom 74,000 are in need of antiretroviral therapy (*Source: Presentation at the National Estimation Consensus Workshop, Nay Pyi Taw, 7 October 2009*). During that same year about 17,000 people were estimated to have died of AIDS-related disease. Since surveillance is conducted only in selected sites, a detailed analysis of geographical patterns is not possible. The available data, including HIV prevalence in pregnant women, suggest that prevalence is higher in urban than rural areas. According to the National AIDS Programme, when reported cases are mapped out geographically, a higher number of infections are in the eastern part of the country, and lowest numbers are in the western part. Injecting drug use is more prevalent in the northern parts of Myanmar.

Surveillance data show slow declines in HIV prevalence in most key populations in Myanmar over the last few years but with some stabilization in 2005 and 2006. Modelling based on these data implied that prevalence peaked in 2000 and has been slowly declining since then. However, such projections for the future are based on a surveillance system with limited geographic scope and size estimates that may not be accurate, thus further analysis and validation are needed, as well as more careful analysis by geographic sub-regions. Examination of Spectrum outputs shows that the slow decline since 2000 is partly explained by the large number of deaths of people with HIV who were infected earlier in the epidemic. New HIV infections are estimated to have peaked in the late 1990's and present estimates show a slow decline in new infections. Notably the prevention programmes for sex workers and their clients seem to show some impact. However, depending on the methodology used, incidence remains at more than 10,000 new infections per year, implying substantial room for implementing more effective prevention efforts.

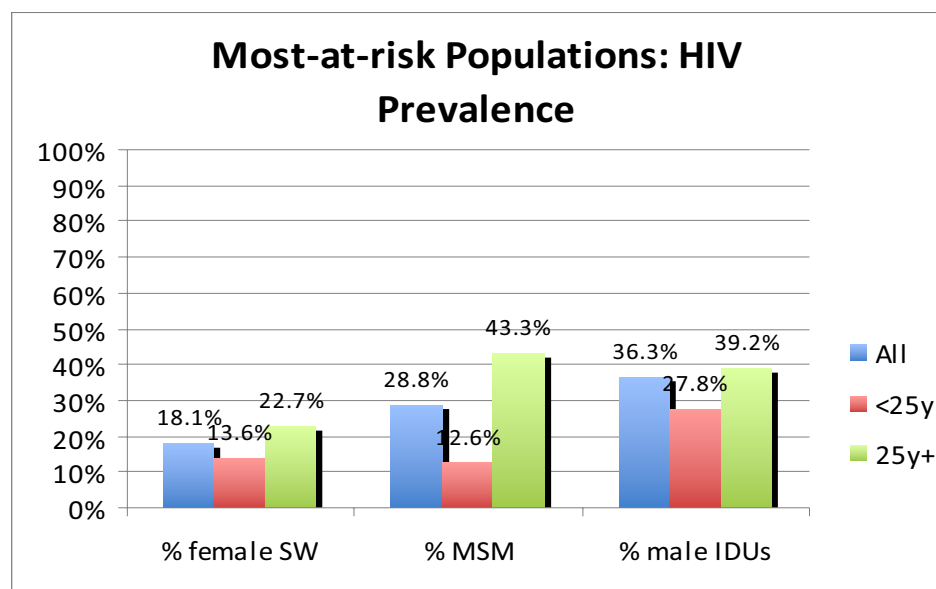
The National AIDS Programme has carried out HIV Sentinel Surveillance (HSS) of selected population groups in Myanmar on a yearly basis since 1992. The most recent published data are from 2008. The sentinel groups for low risk population are pregnant women attending antenatal clinics (ANC), new military recruits, and blood donors. Sentinel groups for high-risk populations are injecting drug users (IDUs), men who have sex with men (MSM), female sex workers (FSW) and male clients of STI services.

The HIV prevalence among pregnant women attending antenatal clinics is used as proxy indicator for UNGASS Indicator 22, *the percentage of young women and men aged 15–24 who are HIV infected*. Most recent HSS data from 2008 show prevalence of 1.1% in this group (0.8% in 15-19 years group, and 1.2% in 20-24 years group).

¹ 2007 Statistical Yearbook, Department of Population

Most recent HSS data available on *the percentage of most-at-risk populations who are HIV infected* (Indicator 23) are summarized in Figure 1, for female sex workers, men who have sex with men, and male injecting drug users.

Figure 1 Percentage of most-at-risk populations who are HIV-infected. Indicator 23. Source: HSS 2008.



The 2008 HSS surveyed 31,899 participants across 34 sentinel sites. HIV prevalence estimates from 2008 by sentinel group are presented in the table below. (Source: MoH, *Report of the HIV Sentinel Sero-surveillance Survey 2008, March 2009*)

Table 1 HIV prevalence among sentinel populations. Source: HSS 2008, p.29

Sentinel group	No. of Sites	No. HIV tested	No. positive	Sero-positive (%)	95% CI (%)	Median HIV Prevalence across sites (%)	Range (min-max) (%)
Male STI patients	33	4,469	242	5.42	4.8-6.1	4	0-22.3
FSW	5	818	148	18.1	15.8-21.2	18.0	15.5-23.6
IDUs	6	741	269	36.3	34.3-40.8	37.2	12.5-54
MSM	2	400	115	28.8	24.4-33.5	29	25-33
Pregnant women ²	32	12,284	156	1.27	1.1-1.5	1	0-6
Blood (units) donors	2	10,629	51	0.48	0.4-0.6	0.4	0-1
New military recruits	2	780	20	2.56	15.3-38.4	2.5	2.5-2.5
New TB patients	10	1,496	166	11.1	9.6-12.8	8.7	4.7-28.8

Trends in HSS prevalence data have been tracked over time and are presented in Figure 2 for low risk groups and Figure 3 for most at risk populations, from 1992 to 2008. Since 2005, new tuberculosis patients have been included in low risk sentinel groups, and since 2007, men who have sex with men have been included in most at risk populations.

² HIV prevalence was similar in primipara (1.1%) and multipara women (1.2%).

Figure 2 Trends in HIV prevalence among low risk sentinel groups. Source: HSS 2008.

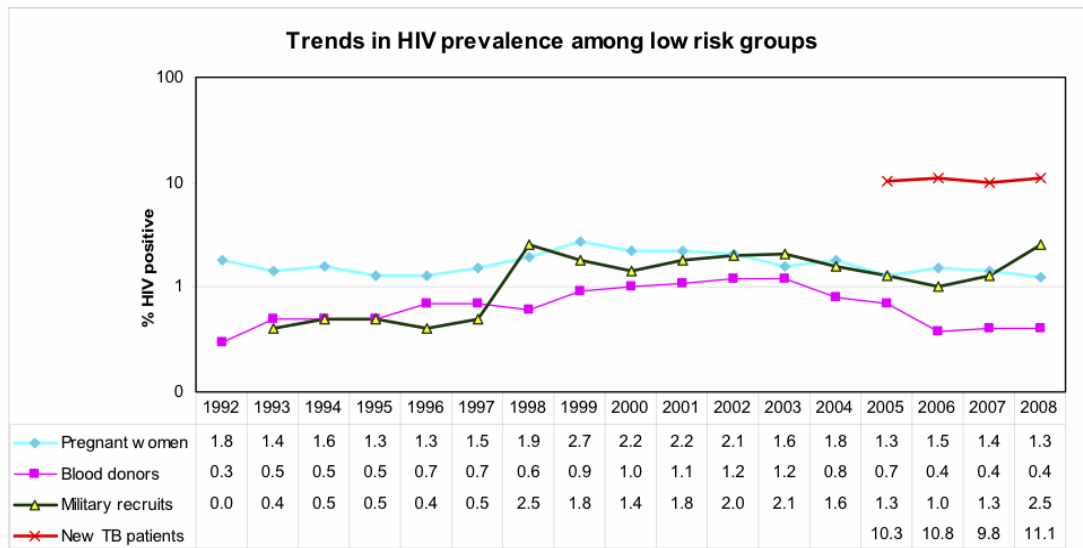
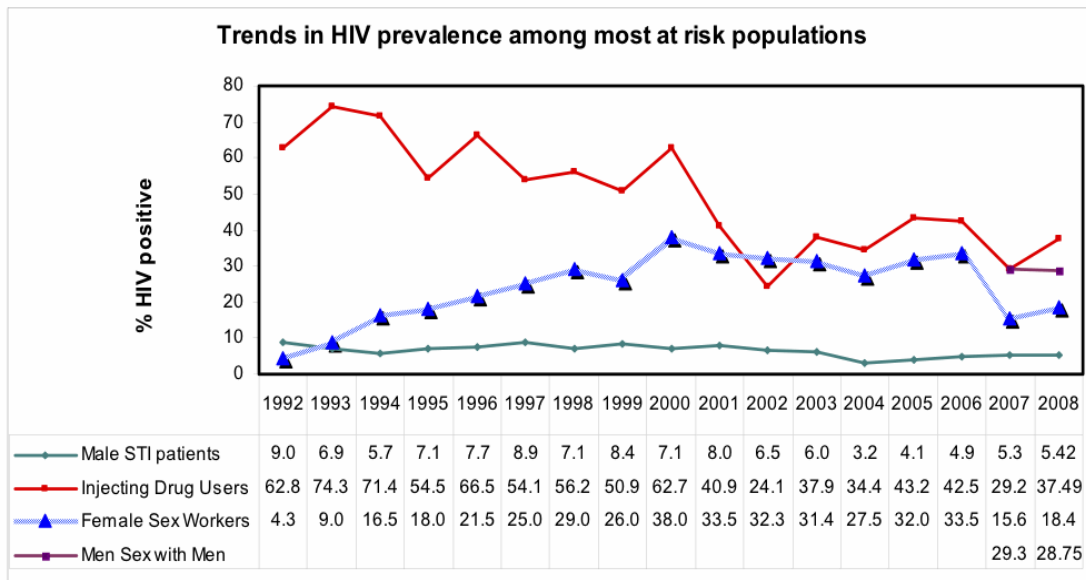


Figure 3 Trends in HIV prevalence among most at risk populations. Source: HSS 2008.



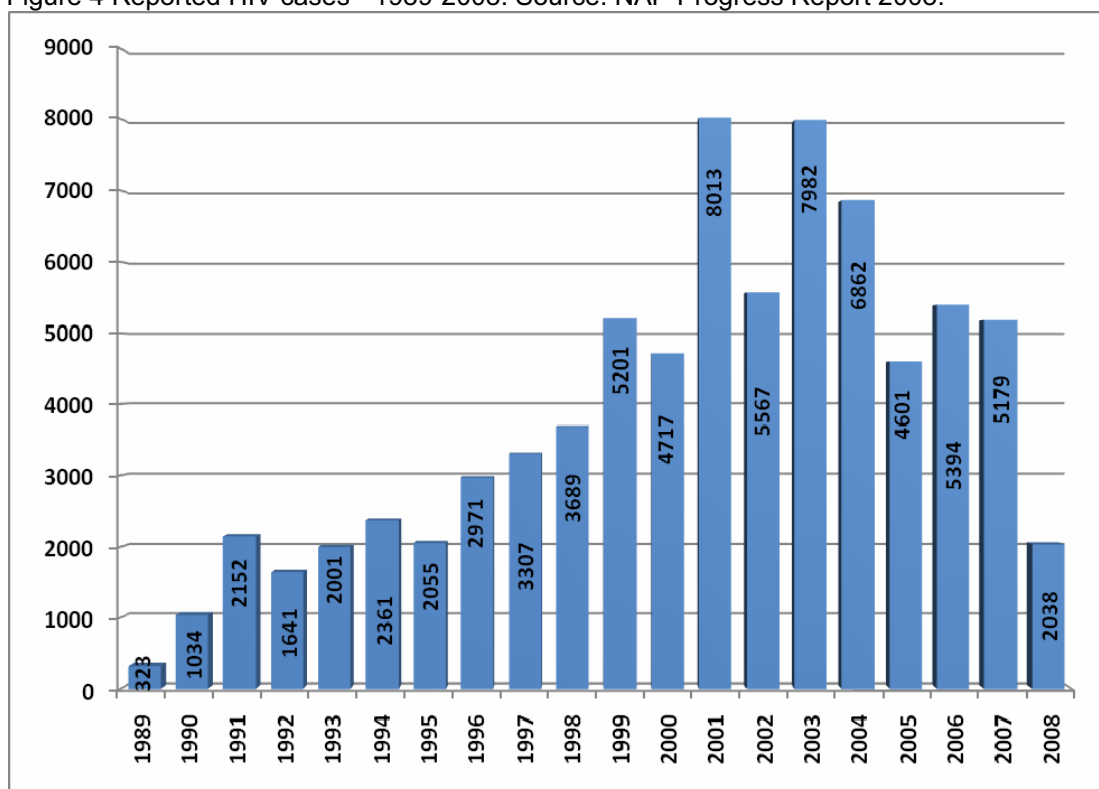
HIV case reporting and AIDS case reporting

The first case of HIV infection was reported in Myanmar in 1988 and the first AIDS case in 1991. HIV infections and AIDS cases are reported by the health services and public health laboratories. The basic variables collected are age, sex and place of residence. AIDS case reporting is currently based on the 1985 WHO clinical definition.

HIV case reporting

By December 2008, 77,088 cumulative cases of HIV infection (among blood donors and hospital patients) had been reported to the Ministry of Health. During 2008, 2,038 HIV infections were reported. Most HIV infections were reported in the 30-34 years age group (22%) followed by the 25-29 age group (20.3%). The male to female ratio has decreased from almost 8 to 1 in 1994 to 2.4 to 1 in 2008, showing a steady increase in the proportion of women being infected.

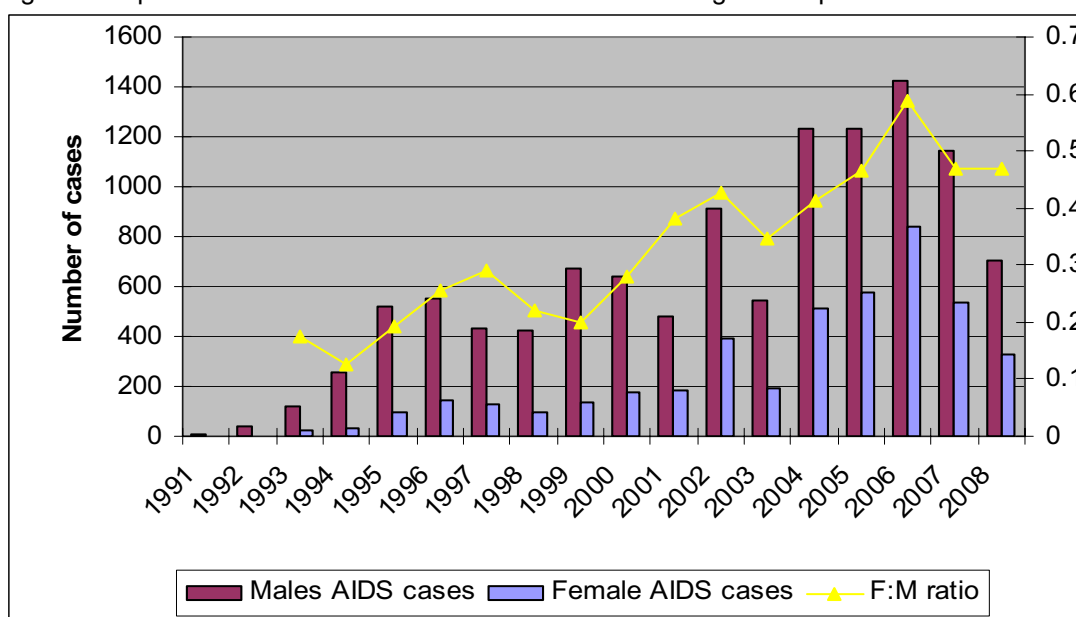
Figure 4 Reported HIV cases - 1989-2008. Source: NAP Progress Report 2008.



AIDS case reporting

In 2008, 1,067 AIDS cases, including 39 paediatric AIDS cases, were reported from hospitals. 32.3% were female and 67.7% were male. Of these reported cases, 72.8 % were attributed to sexual transmission, 3% to injecting drug use, 1.7% to blood transfusion, 2.8% to mother-to-child transmission and the remaining 19.7% to other causes. It should be noted however that the AIDS case reporting is relatively low compared to estimated number of AIDS cases.

Figure 5 Reported AIDS cases 1991-2008. Source: NAP Progress Report 2008.



V. National response to the AIDS epidemic

V.1 Policy environment

V.1.1 Timeline

An inter-sectoral National AIDS Committee chaired by the Minister of Health was established in 1989 and a short-term plan for HIV prevention was launched in the same year. The first national medium-term plan for the prevention and control of HIV/AIDS was formulated in 1991, followed by a plan formulated jointly by the National AIDS Programme and UNDP in 1994. In the late 1990s, several collaborative projects were undertaken with the support of United Nations entities and bilateral agencies. In line with priorities set forth by the *National Health Plan, a National Strategic Plan for Expansion and Upgrading of HIV/AIDS Activities in Myanmar, 2001-2005*, aimed at enhancing HIV prevention and care efforts as a national concern through a countrywide collaboration across sectors, both private and public, and with the active involvement of the community.

In addition to the National AIDS Committee, a Country Coordinating Mechanism (CCM) was established in 2003 for the development of Global Fund proposals and subsequently to oversee implementation. Several departments from the Ministry of Health, United Nations organizations, and national and international NGOs were represented on the CCM. The Ministry of Health also participated in the United Nations Expanded Theme Group on AIDS, which oversaw the development and implementation of the *UN Joint Programme for HIV/AIDS in Myanmar 2003-2005* and the associated Fund for HIV/AIDS in Myanmar (FHAM).

In August 2005, the Global Fund Secretariat terminated its approved grants to Myanmar early in implementation. As a consequence, the Ministry of Health entered into negotiations with several donors and in early 2006, it created a new Coordinating Body, chaired by the Minister of Health, including representatives of international NGOs and civil society who are selected by their constituencies, to coordinate international and national cooperation on AIDS, tuberculosis and malaria. The Coordinating Body is advised by three Technical and Strategy Groups, one for each disease, which similarly involve expert actors from several ministries, United Nations agencies and international and national NGOs.

The National AIDS Programme provides coordination at the national, state/division and township levels. The NAP has a direct presence in 45 priority townships in the form of AIDS/STD teams. In these townships, the NAP is able to actively coordinate the work of partners and support the functioning of AIDS Committees at the state/division, district and township levels.

V.1.2 Myanmar National Strategic Plan on HIV and AIDS

Between 2006-2009 several positive developments occurred in the strategic environment of the response to HIV in Myanmar. Starting in December 2005, the Ministry of Health led, for the first time, a process involving national and international actors to develop collaboratively the *National Strategic Plan on HIV and AIDS, 2006-2010* that is inclusive of the work of all partners and multiple ministries. The National Strategic Plan and its Operational Plans (2006-2009, subsequently updated to 2008-2010) are the key reference documents for partners working on HIV, providing the strategic framework of action including priority setting for resource allocation. The Operational Plan specifies the agreed yearly targets and costs for each of the 13 Strategic Directions constituting the National Strategic Plan. Both the National Strategic Plan and the Operational Plan will be reviewed in order to inform the development of a 2011-2015 National Strategic Plan.

The aim of the National Strategic Plan is to reduce HIV transmission and HIV-related morbidity, mortality, disability and social and economic impact. The strategic directions of the National Strategic Plan are prioritized on the basis of epidemiological data and HIV disease burden, with the Operational Plan suggesting equivalent resource allocations to prevention and to care and treatment. The strategies are classified into three prevention priority levels. The highest priority populations at greatest risk and vulnerability include sex workers and their clients, men who have sex with men, and injecting drug users.

The fundamental overarching strategies of the National Strategic Plan include meeting the needs of people living with HIV, including prevention of mother-to-child transmission. With an estimated 74,000 people in need of anti-retroviral treatment and over 17,000 yearly AIDS-related deaths (2009 estimates), there is urgent need for scaling up care, treatment and support. This scale-up has so far been constrained by the lack of sufficient and longer-term funding. Prevention of mother-to-child transmission is critical for an effective, community-driven response, and is being scaled up in the public health care system with National AIDS Programme support and in community settings, through NGOs.

Table 2 Priority setting of the National Strategic Plan on HIV and AIDS, Myanmar 2006-2010

Priority	Strategic Directions
Highest priority	1. Reducing HIV-related risk, vulnerability and impact among sex workers and their clients
	2. Reducing HIV-related risk, vulnerability and impact among men who have sex with men
	3. Reducing HIV-related risk, vulnerability and impact among drug users
	4. Reducing HIV-related risk, vulnerability and impact among partners and families of people living with HIV
High priority	5. Reducing HIV-related risk, vulnerability and impact among institutionalized populations
	6. Reducing HIV-related risk, vulnerability and impact among mobile populations
	7. Reducing HIV-related risk, vulnerability and impact among uniformed services personnel
	8. Reducing HIV-related risk, vulnerability and impact among young people
Priority	9. Enhancing prevention, care, treatment and support in the workplace
	10. Enhancing HIV prevention among men and women of reproductive age
Fundamental overarching issues	11. Meeting the needs of people living with HIV for comprehensive care, support and treatment
	12. Enhancing the capacity of health systems, coordination and capacity of local NGOs & community based organizations
	13. Monitoring and Evaluating

The National Strategic Plan is guided by the 'Three Ones', the participation of people living with HIV and emphasises programme outcomes. It strives to achieve universal access to prevention and care, and scaling up effective initiatives through capacity building. The development of national guidelines, partnership between government, national and international NGOs and private sector, and enhanced coordination form the strong foundations of the plan.

V.1.3 Travel

Myanmar has no HIV related travel restrictions. There are no requirements for HIV testing for entry, work or residence within the country.

V.2 Programme implementation

V.2.1 Most-at-risk populations

In alignment with the priorities of National Strategic Plan, the past years have seen an increased emphasis on the prevention of HIV transmission in most-at-risk populations. Programmes for sex workers, men who have sex with men and injecting drug users have been the focus of funding. Non-governmental organizations and community based organizations deliver a considerable proportion of the services made available to these groups. Services provided to sex workers and men who have sex with men include peer education and outreach for behaviour change, male and female condom and lubricant promotion, client orientated STI services and VCCT. Services provided to injecting drug users include access to sterile needles and syringes, peer education and outreach to support behaviour change, methadone maintenance therapy, and condom promotion.

The National Strategic Plan targets other priority groups for prevention activities, including mobile populations, institutionalized populations, uniformed services personnel and young people. A number of organizations are focusing on interventions and service provision for these groups.

Figure 6 Percentage of most-at-risk populations reached with HIV prevention programmes – female sex workers; Indicator 9. Source: BSS 2008.

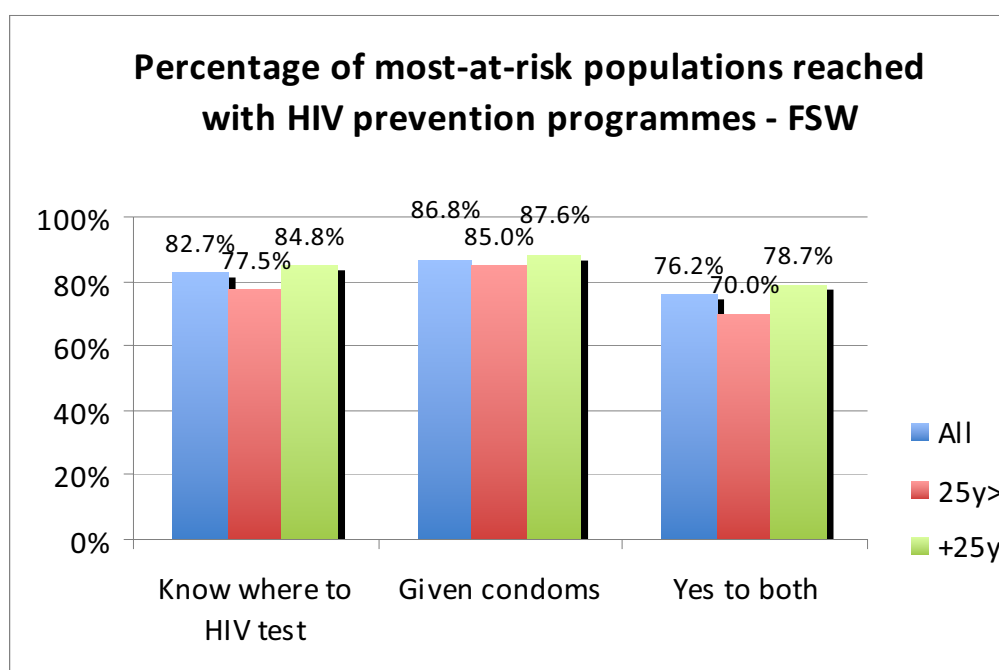


Figure 7 Percentage of most-at-risk populations reached with HIV prevention programmes – men who have sex with men; Indicator 9. Source: IBSS 2009.

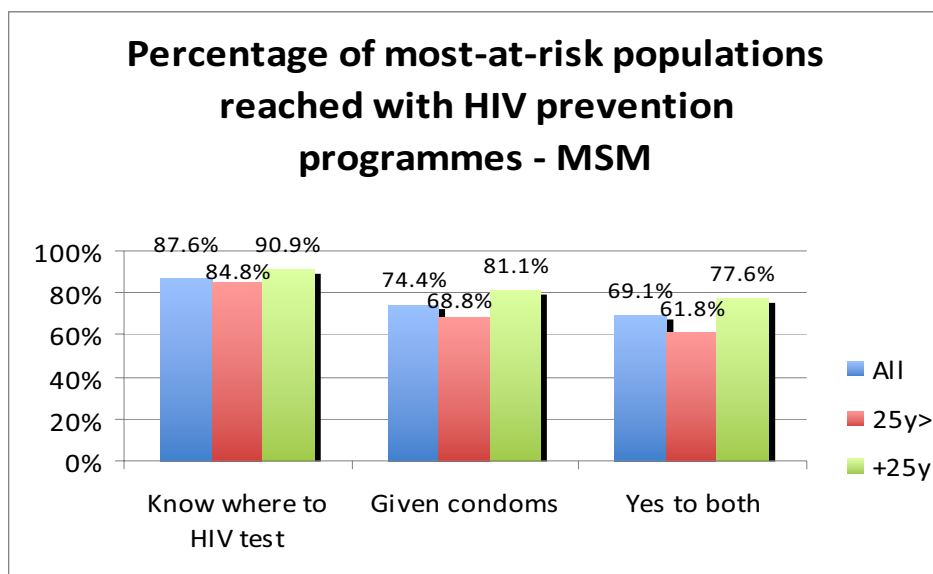
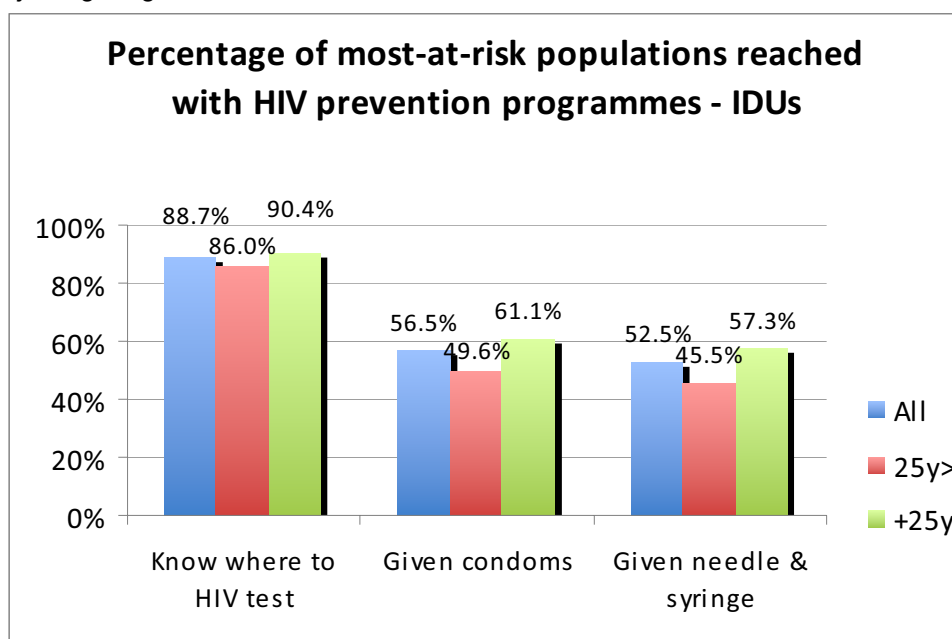
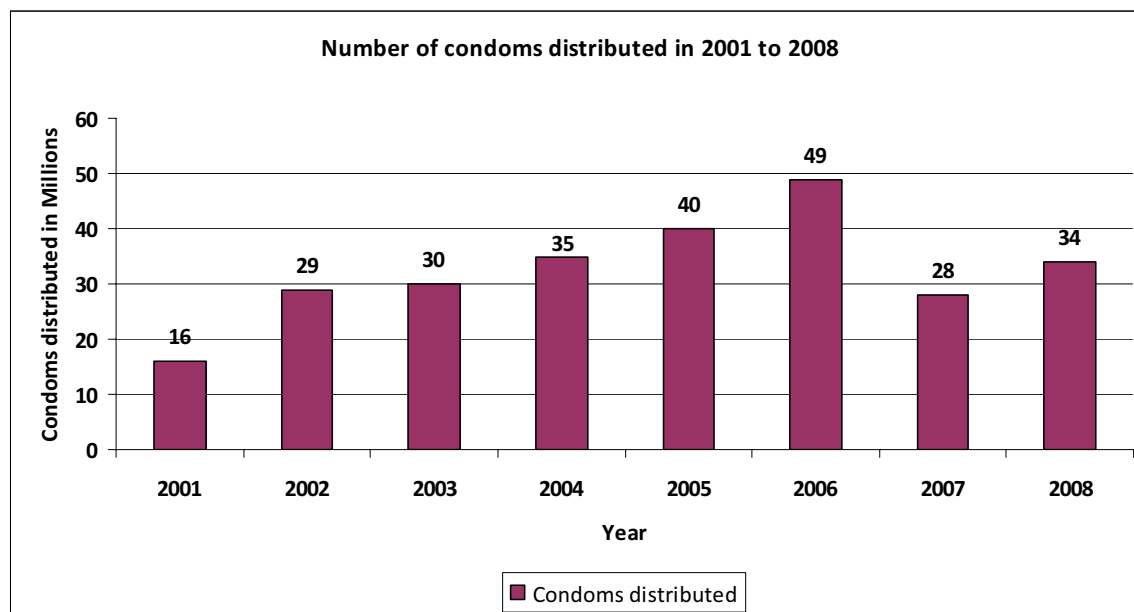


Figure 8 Percentage of most-at-risk populations reached with HIV prevention programmes – male injecting drug users; Indicator 9. Source: BSS 2008.



In 2008, around 34 million condoms were distributed, an increase of around 6 million from 2007. The coverage of free condom distribution has reduced since 2006 (in terms of locations and number of condoms provided) and is linked to the lack of availability of funding for the National AIDS Programme’s 100% Targeted Condom Promotion programme, which has condom provision to sex workers and their clients as its focus. The social marketing of condoms reached wider coverage than free condom distribution.

Figure 9 Condom provision – free distribution and social marketing. Source: NAP Progress Report 2008.



V.2.1.1 Sex workers and their clients

Around 48,800 sex workers were provided with prevention services, through both public and private for-profit and not-for-profit sectors – including clinics, drop-in centres and outreach projects – around 8% more than in 2007. However, this may include some double counting (low estimate 36,390 sex workers). Service provision was more concentrated in urban and semi-urban areas, with relatively low coverage in rural and some border areas. The complete package of services for sex workers was not available in all areas, and in some townships, service provision was limited to only condom social marketing. In certain urban areas, several partners were providing services, with possible overlapping and duplication of services, as well as for double counting of beneficiaries.

In general, there is a lack of knowledge of the clients of sex workers, as well as their intimate partners, and how best to reach them with HIV prevention services.

Table 3 Sex workers and clients. Source: NAP Progress Report 2008.

Impact/Outcome Targets	Size estimate	Baseline or latest figure (Year)	Target 2008	Results 2008
% of sex workers that are HIV infected	60,000	18% (2008)	23%	18.38% ⁽¹⁾
% of sex workers that have an STI (syphilis)	60,000	25% (2005)	20%	5.5%
% of sex workers that report the use of condom with most recent client	60,000	62% (2003)	90%	95% ⁽²⁾
% of clients of sex workers that are HIV infected ⁽²⁾	980,000	5.3% (2007)	3%	5.3%
Output/Coverage Targets				
Sex workers reached by package of BCC prevention and STI prevention /treatment	60,000	High 44,648 Low 33,512 (2007)	40,000	High 48,860 Low 36,390
Number of sex workers accessing VCCT	60,000	5,017 ⁽³⁾	20,000	7,921 ⁽³⁾
Condoms distributed (in million)		27.9 million (2007)	40	34 million

Source: Operational Plan 2008-2010, M&E table;

(1) HSS, 2008

(2) BSS, 2008

(3) Only some partners provide a breakdown by type of risk-behaviour, gender and age for VCCT

V.2.1.2 Men who have sex with men

Services for men who have sex with men were not scaled up significantly during 2008, but sustained at levels of the previous year. Coverage is still low, with around only 16% of the total estimated men who have sex with men population reached in 2008. The comprehensive package of services described in the National Strategic Plan is currently available in the few townships where a drop-in centre is operating. Most men were reached in Yangon, Mandalay, Ayeyarwaddy and Bago divisions, where the drop-in centres are located. Outreach activities were also carried out for behaviour change communication, including consistent condom use. In total, 38,286 men who have sex with men were reached with HIV prevention services in 2008, similar to 2007. This may include some double counting in townships where more than one service provider operates (low estimate 32,890 men who have sex with men). It was reported that 4,097 men who have sex with men accessed VCCT services in 2008, a sharp decrease on the number reported in 2007 (13,180 men), and well short of the target of 15,000. However, there is not consistent effort to reach the female intimate partners of men who have sex with men with prevention interventions.

Table 4 Men who have sex with men. Source: NAP Progress Report 2008.

Impact/Outcome Targets	Size estimate	Baseline (Year)	Target 2008	Result 2008
% of MSM that are HIV infected	240,000	29.3% ⁽¹⁾	31%	28.8% ⁽²⁾
% of MSM that have a STI (syphilis)	240,000	7% ⁽¹⁾	30%	14.1% ⁽²⁾
% of condom use by MSM at last anal sex	240,000	67% ⁽³⁾	75%	IBBS forthcoming
Output/Coverage Targets				
MSM reached by package of BCC prevention and STI prevention/treatment	240,000	High 39,180 ⁽⁴⁾ Low 31,546 (2007)	45,000	High 38,286 Low 32,890
Number of MSM accessing VCCT	240,000	2,931(2006)	15,000	4,097

Source: Operational Plan, M&E table; HIV prevalence data from HIV Sentinel Surveillance

(1) HSS, 2007

(2) HSS, 2008

(3) NAP, Mandalay 2005

(4) NAP, Progress Report 2007

V.2.1.3 Injecting drug users

In 2008, 8,274 people who inject drugs were reached with a package of services provided through drop-in centres, which represents less than 30% of the planned target. This was a decrease from 2007, which may be a result of improved registration and recording of individuals by service providers. Nonetheless, overall coverage remains low in relation to the total estimated number of injecting drug users. Table 5 shows the number of drug users reached through outreach activities and drop-in centres, presented disaggregated by sex. Around 6% of the people who inject drugs contacted through outreach were female, while only 2% of individuals accessing drop-in centres were female. There is clearly a need to ensure that female drug users are provided and access services. Equally, the female intimate partners of male drug users need to be included in prevention efforts.

Table 5 Number of drug users and injecting drug users reached. Source: NAP Progress Report 2008.

	Drug users		Injecting drug users	
	Male	Female	Male	Female
Outreach (contacts)	14,985	3,000	22,493	1,334
Drop-in-Centres (individuals)	8,031	396	8,084	190

Three additional drop-in centres were established in 2008 (two in Hpakant, one in Lashio), while two existing centres were closed (one in Muse, one in Pan Kham), bringing the number of drop-in centres to 36 across 16 townships. Certain townships have multiple drop-in centres each providing services for drug users, for example Lashio township has ten centres, Hpakant has six, while Muse and Myitkyina each have three. There is a need to continue to expand service delivery to new locations within the priority townships identified for HIV prevention in injecting drug use.

Table 6 Injecting drug users. Source: NAP Progress Report 2008.

Impact/Outcome Targets	Size estimate	Baseline (Year)	Target 2008	Results 2008
% of IDUs that are HIV infected	75,000	29.2% ⁽¹⁾	30%	37.5% ⁽²⁾
% of IDUs that avoid sharing injecting equipment in last month	75,000	BSS	71%	81%
% of condom use by IDUs at last sex (paid partner)	75,000	34% (2005)	40%	78%
Output/Coverage Targets				
Drug Users reached by Harm Reduction programme	2 drug users for 1 IDU ⁽³⁾	-	45,000	8,427
IDUs reached by Harm Reduction programme	75,000	21,050 ⁽⁴⁾	30,000	8,274
IDUs accessing VCCT	75,000		6,000	2,256
Needles distributed to IDUs (in million)		2.1 m ⁽⁵⁾	4.0m	3,511,232
Number of IDUs on MMT	75,000	390 (2007)	1,000	580 ⁽⁷⁾

Source: Operational Plan M&E table; HIV prevalence data from HIV Sentinel Surveillance

(1) HSS, 2007

(2) HSS, 2008

(3) UNODC, 2002

(4) NAP Progress Report 2007

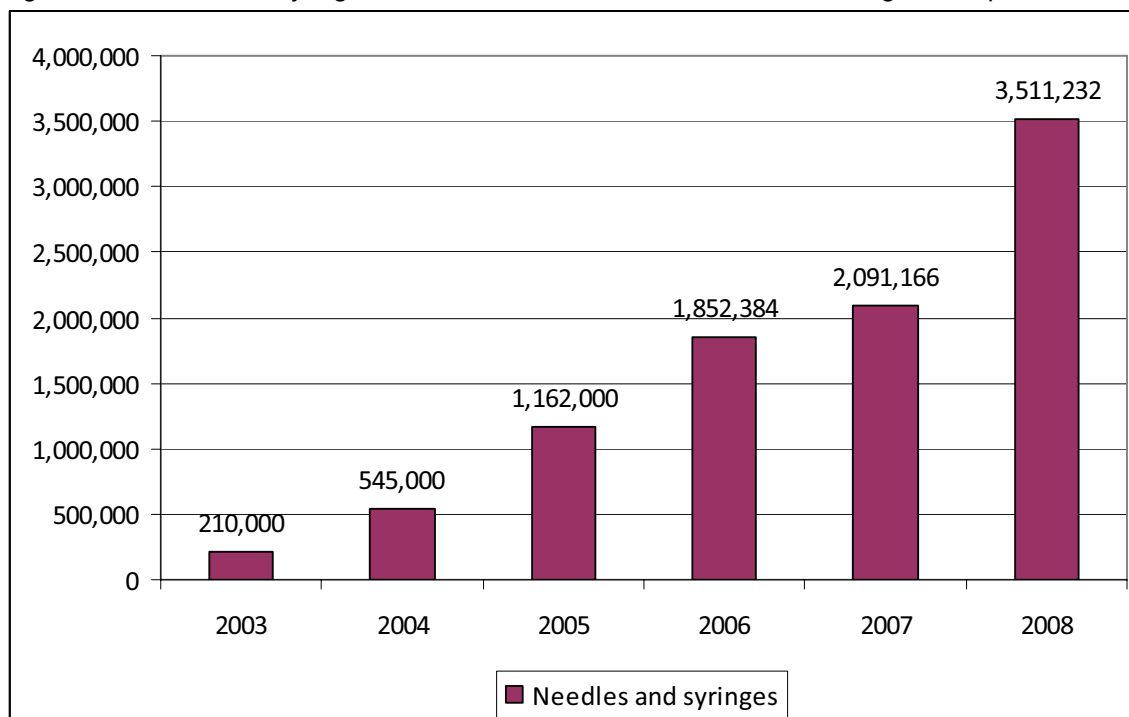
(5) Assumption used in the calculation of the unit costs in the Operational Plan

(6) Drop-in centres only

(7) DTC - till May 2009

The number of units of sterile injecting equipment distributed increased by two thirds on the previous year to over 3.5 million in 2008. Most of the needles and syringes were provided in the townships of Myitkyina, Hpakant, Lashio and Muse.

Figure 10 Needles and syringes distributed – 2003-2008. Source: NAP Progress Report 2008.



By September 2009, 756 former drug users were receiving methadone maintenance therapy, an increase of around 30% on the end of 2008, although short of the 2009 planned target of 2,000 patients. The programme started in 2005.

V.2.2 HIV testing and counselling

In 2008, 21 organizations reported on beneficiaries receiving Voluntary Confidential Counselling and HIV Testing (VCCT) services, including men and women of reproductive age and key populations at higher risk of infection. Most partner organizations provide pre- and post-test counselling, but outsource the actual testing to other providers. There was an increase in the number of people receiving HIV test results and post-test counselling in 2008 compared with the two previous years. This increase was reported for both general population (a 30% increase), and for key populations at higher risk, which doubled in number from 2007. The increase of around 100% was reported for sex workers and men who have sex with men, while the number of injecting drug users completing HIV testing increased by 80%. However, despite these increases, the number of people completing VCCT is still low when considered as a percentage of the estimated population sizes. It is worth noting that the numbers of sex workers and men who have sex with men completing the testing process may be under-reported, as not all service providers are able to categorize beneficiaries by population groups or risk behaviour. In the 2007 behavioural surveillance undertaken in 3 townships, a total of 11% of the adult population stated to have had an HIV test in the last 12 months. This appears high when compared to the known testing in the public and not-for profit clinics. It does however also indicate that a substantial part of the HIV testing may be undertaken by the private sector.

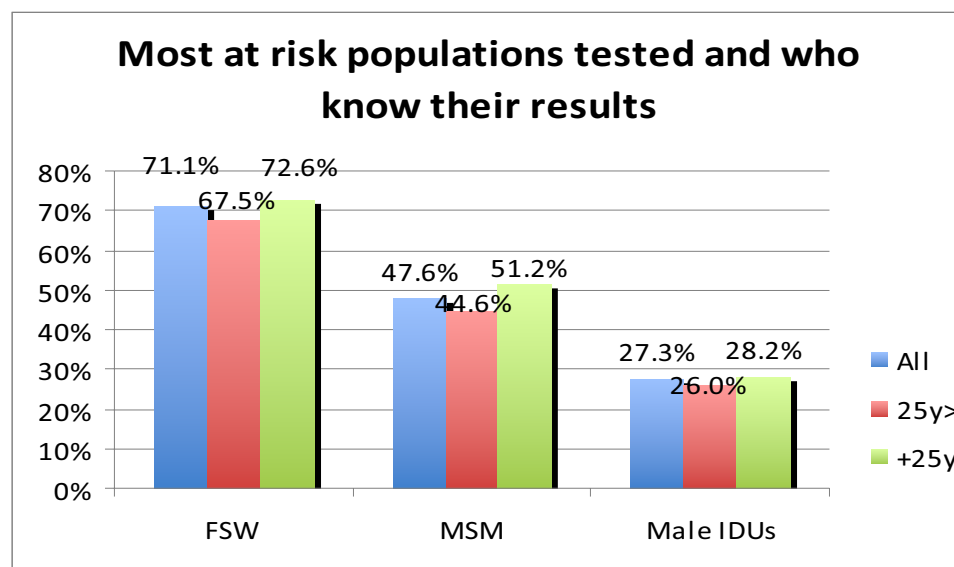
The results of the behavioural surveys conducted for sex workers and injecting drug users showed a relatively high numbers of respondents reporting to have taken an HIV test and who knew their status. In view of the limited coverage of government and NGO services, this implies that a substantial amount of testing takes place in the private for-

profit sector. It also likely reflects the fact that the surveys were conducted in Yangon and Mandalay, the two biggest cities with the highest density of service providers for sex workers,

Table 7 Number of people tested for HIV and received post-test counselling. Source: NAP Progress Report 2008.

	2006	2007	2008
Adults receiving HIV test and post-test counselling (excluding MARP)	70,948	64,169	83,996
MARP receiving HIV test and post-test counselling	6,320	6,827	13,612
Sex workers	3,132	3,727	7,791
Men who have sex with men	2,122	1,980	4,031
Injecting drug users	1,038	960	1,731
TB	13	160	59

Figure 11 Most-at-risk populations tested and who know their results – last 12 months. Female sex workers, men who have sex with men and male injecting drug users. Indicator 8. Source: BSS 2008, IBBS 2009.



V.2.3 Prevention of mother-to-child transmission of HIV

The National AIDS Programme's PMCT service has been gradually scaled up since its start in 2001, to cover 183 sites by 2008. Of these, 38 are hospital based and 145 community based. In 2008, the number of women accessing antenatal care services who received pre-test HIV counselling increased by 7% to 315,920. The number of women who accepted HIV testing and received test results with post-test counselling increased by 27% compared with 2007. 51% of women who accessed the PMCT service completed the process by receiving HIV test results and post-test counselling. The acceptance rate was 58% in 2008, varying between townships.

In 2009, 1,697 mother-baby pairs received a complete course of antiretroviral prophylaxis, which is around 21% more than in 2007, and approximately 65% of the Operational Plan target for 2009. Only 280 pregnant women were already on ART when they delivered their babies.

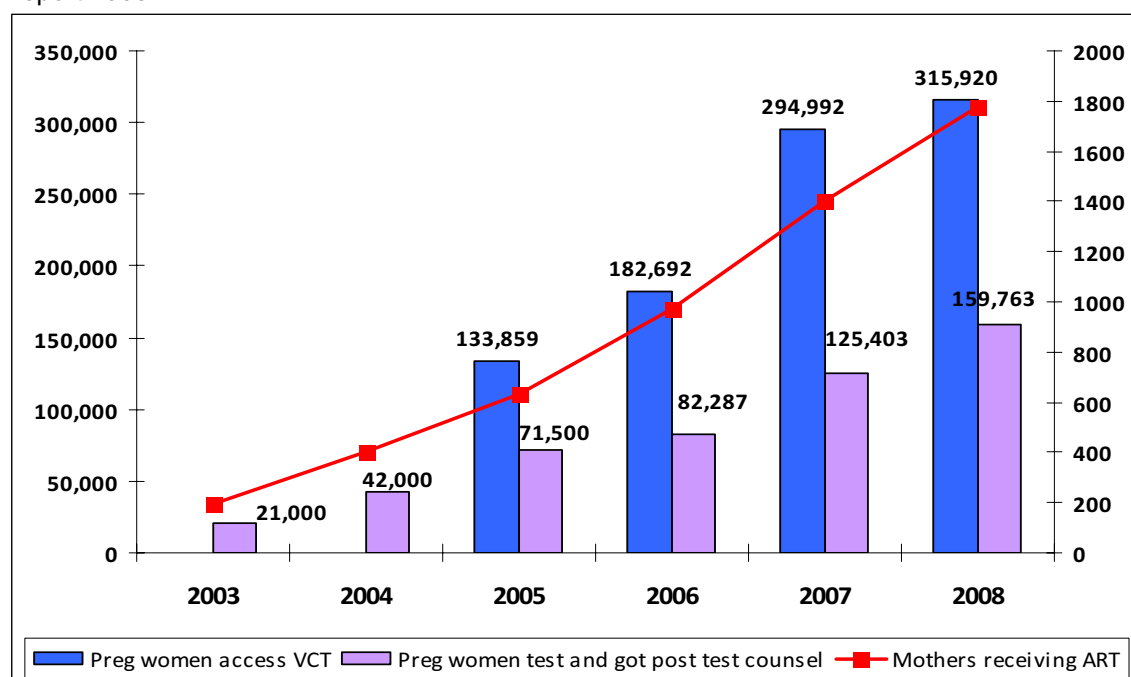
Between 2008 and 2009, there has been a shift in the national PMCT prophylaxis regimen towards provision of two ARV drugs, away from single-dose Nevirapine. This is reflected in the table below. In addition, enrolment of clinically eligible pregnant women in ART programmes has increased over the same period.

Table 8 Number of HIV-infected pregnant women who received ARV prophylaxis, by regimen. Source: Data collection for UNGASS, 2009.

Year	ARV prophylaxis for PMCT		ART for clinically eligible HIV infected pregnant women
	Single dose Nevirapine	Combination of 2 ARV drugs	
2008	1,223	528	172
2009	164	1,954	280

During 2009, an estimated 55.4% of HIV-infected pregnant women received antiretrovirals to reduce the risk of mother-to-child transmission (UNGASS Indicator 5). The value calculated by Spectrum for UNGASS Impact Indicator 25, *percentage of infants born to HIV-infected mothers who are infected* was 22.97%.

Figure 12 Pre-test and post-test counselling, ARV prophylaxis, 2003-2008. Source: NAP Progress Report 2008.



V.2.4 Care, treatment and support

By the end of 2009, 21,138 persons were receiving ART, an increase of 90% since the end of 2007 but 70% of the planned target of 30,000 for 2009. 43.3% of all ART patients were female. In spite of the significant increase in the number of people receiving ART, the needs continue to be much greater, at an estimated 74,000 persons. This equates to only one fourth of the estimated people in need currently receiving lifesaving ART. Substantial additional investment in ART provision is urgently needed.

Table 9 Number of people receiving ART at the end of 2009. Source: Data collection for UNGASS, 2009.

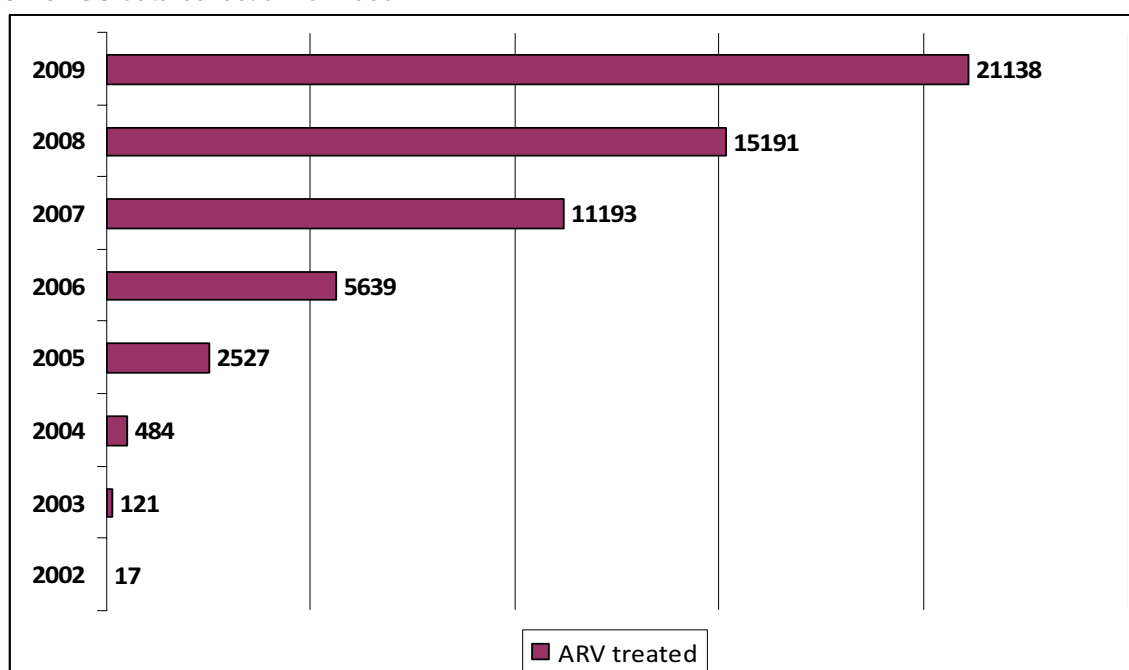
At 31 December 2009	Adults (15+ yrs)		Children (<15 yrs)	
	Male	Female	Male	Female
Total	11,201	8,402	786	749

Table 10 Percentage of adults and children with advanced HIV infection receiving ART. Indicator 4. Source: Data collection for UNGASS, 2009.

At 31 December 2009	Male	Female	Children	Adults
% of total receiving ART	56.7%	43.3%	7.3%	92.7%

In terms of geographical coverage, by the end of 2008, 57 sites were providing ART in 12 of Myanmar's states and divisions, compared with 30 sites in 2006. 85% of the total number of people on ART were in Yangon, Kachin, Shan, Mandalay and Tanintharyi states/divisions, while coverage was on a lower scale elsewhere.

Figure 13 Number of people receiving ART, 2002-2009. Source: NAP Progress Report 2008; UNGASS data collection for 2009.



Data for UNGASS Impact Indicator 24, *percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiviral therapy* were provided by MSF-Holland, which currently provides approximately 70% of the ART in Myanmar. The available survival data for 2009 are presented in the table below.

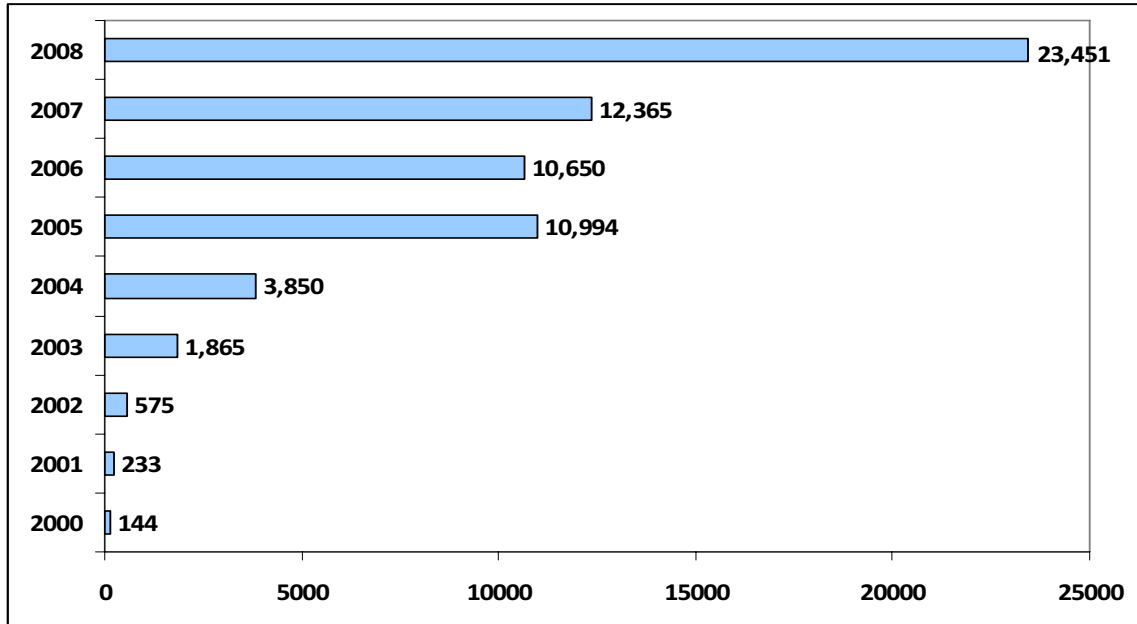
Table 11 Survival after 12 months on ART. Source: MSF-Holland, 2009.

2009	All (n=2,274)	Male	Female	<15 yrs	15+ yrs
% on ART after 12 months	87.5%	89.5%	85.3%	94.4%	86.9%

Regarding the co-management of tuberculosis and HIV treatment, it was estimated that approximately 10.5% of estimated HIV-positive incident TB cases received treatment for TB and HIV (UNGASS Indicator 6). These data are from 2007, and little variation by sex or age was noted.

Community home-based care services provided by partners during 2008 reached 23,451 beneficiaries with a variety of services. This is almost double the number of persons receiving services in 2007. Beneficiaries were male and female in equal proportion.

Figure 14 People receiving community home-based care services, 2001-2008. Source: NAP Progress Report 2008.



During 2008 the number of people living with HIV that were involved in self-help groups increased by 60% to around 13,247 persons, of whom 49% of participants were female. Around 40% of participants were involved in groups supported by the National AIDS Programme, three quarters of whom were in Mandalay division. The Myanmar Positive Group increasingly plays a role of coordinating and networking individual groups throughout the country, and regional branches have been established. People living with HIV participating in self-help groups are increasingly involved in implementation and the daily management of the groups.

V.2.5 Knowledge and behaviour change

Behavioural Surveillance Surveys (BSS) were conducted in 2007-2008 and included general population (2007), out-of-school youth (2008), female sex workers and injecting drug users (2008). The results for each population are summarized below.

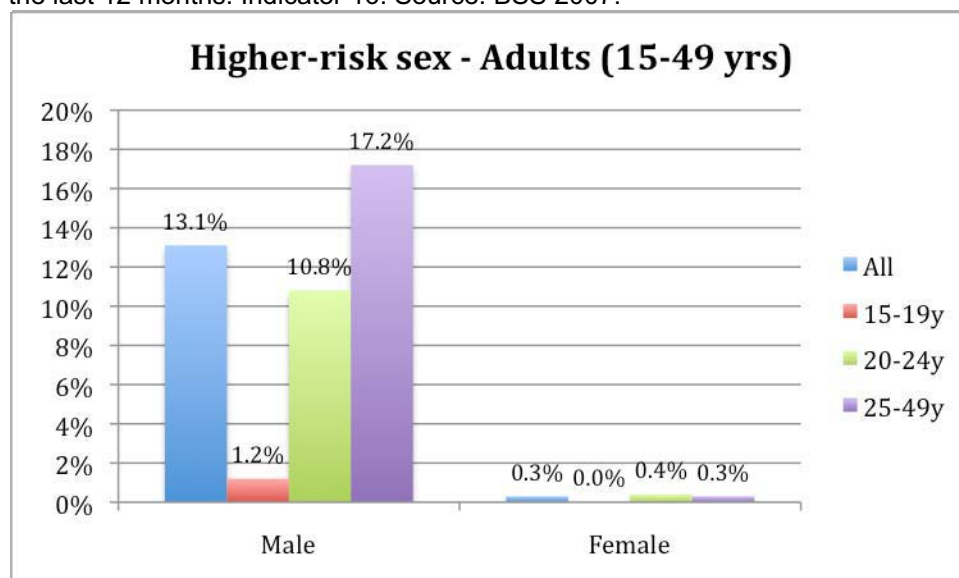
V.2.5.1 General population

During 2007, three survey sites were chosen (Shwebo, Kawthoung and Hpa-an) to assess the knowledge, attitudes and behaviours of the general population and youth with regards to HIV transmission and prevention. A total of 5,445 individuals (2,690 males and 2,755 females) were interviewed. Of these, 35% were youth aged 15-24 years. Although 97.5% of the population had heard about HIV, only 36.6% correctly identified all three methods of prevention of sexual transmission of HIV (abstinence, be faithful and consistent use of condom) and 42% were able to correctly reject the common misconceptions about HIV transmission. Among youth, females and the respondents with lowest level of education had the lowest knowledge of HIV prevention. Only around a quarter of the respondents were willing to buy food from an HIV-infected vendor, but 80% expressed willingness to care for an HIV-infected relative.

Among those who had genital discharge or genital ulcer, only one-third sought treatment for sexually transmitted infection (STI) symptoms. A large proportion of these consulted a

private practitioner or self-treated and only 15% visited a government hospital for STI treatment. 11.3% of male respondents had sex with a non-regular partner; 42.3% of them had protected sex (UNGASS Indicator 17, partial data). 80.7% of men used condoms consistently with a sex worker and 17.2% with a casual acquaintance. While 83% of respondents expressed the intent to access voluntary confidential counselling and HIV testing (VCCT), only 19% had actually been tested and received the result.

Figure 15 Percentage of women and men aged 15-49 who had sex with more than one partner in the last 12 months. Indicator 16. Source: BSS 2007.



V.2.5.2 Out-of-school youth

A total of 3,495 male and 3,459 female out-of-school youth participated in a behavioural survey carried out in 2008. The median age of male and female respondents was 19 years and 20 years respectively. 35% of male and 34% of female had a high school education. 63% were employed, with manual labour being the most common occupation. 99% had heard about AIDS. However, only 48% could correctly identify ways of preventing the sexual transmission of HIV and could reject major misconceptions about HIV transmission. 78% of the respondents were aware of STI. Self-reported prevalence of genital ulcer among males and females in the past 12 months was 4.8% and 2.5% respectively. Among those, 38% reported visiting a government outpatient clinic, 31% reported self-medication.

Only 41% were willing to buy food from an HIV-infected vendor and 69% were willing to eat with an HIV-infected person. 7.4% of young men reported having sex with a sex worker in the past 12 months. Of them, 90% used a condom at last sex with a sex worker and 70% of young men reported always using condoms. 4.7% of the male out-of-school youth reported having sex with a casual partner in the last 12 months. Only 52% reported using condom at last casual sex. 2.3% reported ever having sex with another man. Regarding utilization of health services, in all, 89% of male and 54% of female respondents had ever seen a condom. However, only 64% of male and 30% of female knew where to obtain a condom. Pharmacies, stores and betel shops were the most common places mentioned. Of the sexually active youth, 28% had ever taken an HIV test. 11.7% male and 12.6% female respondents reported having had an HIV test in the last 12 months and receiving their results, whereas 70% intended to get an HIV test. Of those tested, 52% were tested in a government health facility and 17% in an NGO facility. Only 37% of respondents were aware of ART programmes.

Figure 16 Percentage of out-of-school youth aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. Indicator 13. Source: BSS 2008, Out of School Youth.

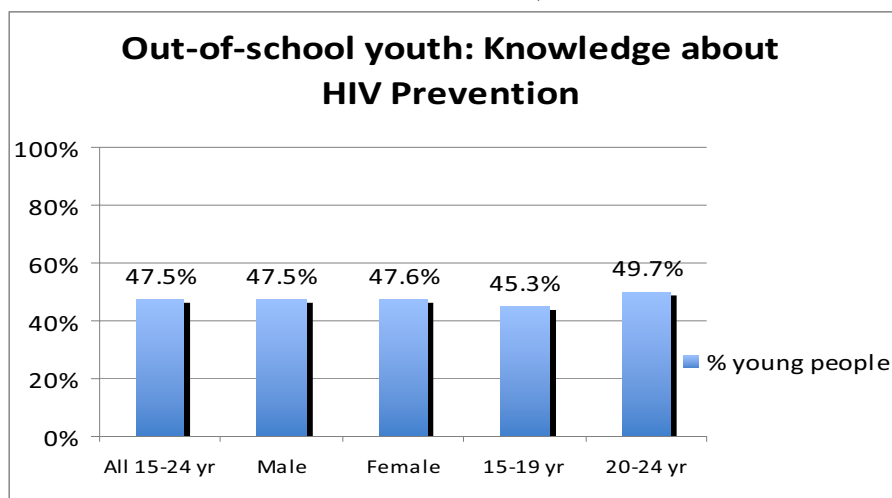


Figure 17 Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. Indicator 14. Source: BSS 2008, IBBS 2009.

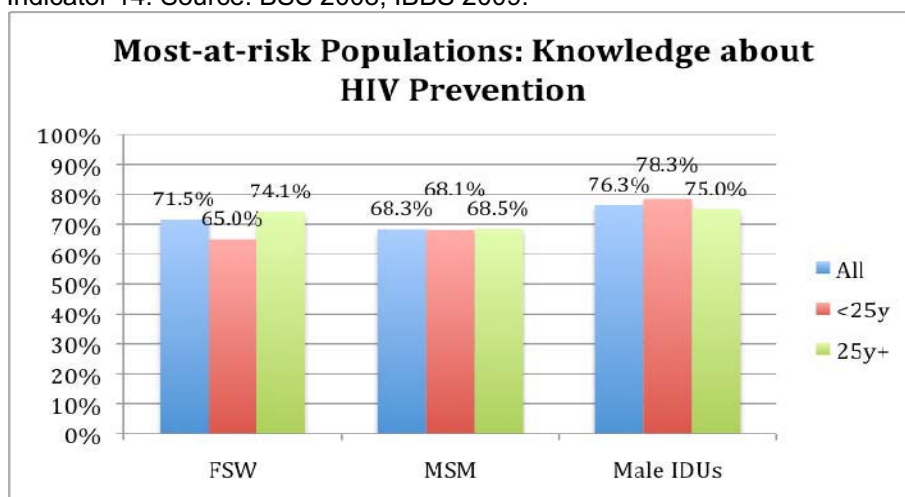
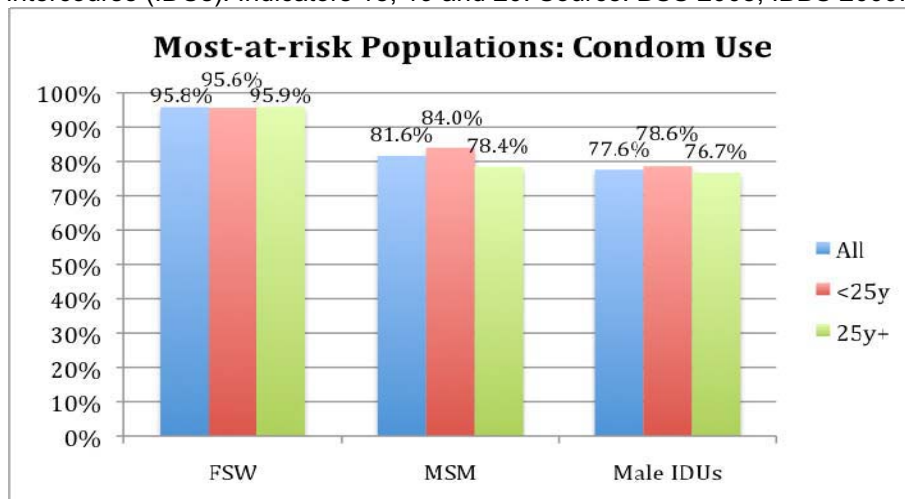


Figure 18 Percentage of most-at-risk populations reporting the use of a condom with most recent client (FSW); at last anal sex with a paid male partner (MSM); or the last time they had sexual intercourse (IDUs). Indicators 18, 19 and 20. Source: BSS 2008, IBBS 2009.



V.2.5.3 Male injecting drug users

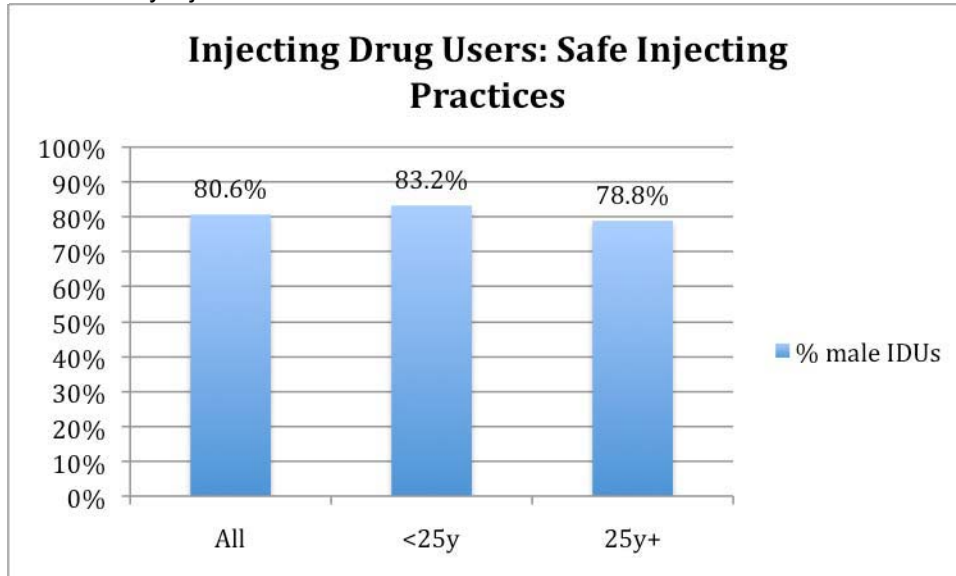
Four sites were selected for the 2008 BSS on injecting drug users: Lashio, Myitkyina, Mandalay and Yangon. The average age of injecting drug users participating in the survey varied across sites. Participants were younger in Mandalay and Myitkyina. 37% were under 20 years of age in Myitkyina. In Yangon and Lashio, the participants were older, almost 30% were over 35 years. New injectors were more prominent in Myitkyina (58% of the sample had injected for less than one year). The majority of injecting drug users in all sites were in employment. Injection more than once a day over the last six months was quite common in Myitkyina (65%) and Lashio (77%); compared to only 22% in Mandalay and 1% in Yangon. The respondents included in the Yangon sample, had particularly low injection frequency. Half of the sample reported injecting only 2-3 times in the last six months.

Heroin was the most commonly used drug in all survey sites. However, the use of amphetamines was also relatively high across all sites. In Yangon, a large percentage of injecting drug users also used tranquilizers by injection. In Myitkyina, 59% reported using codeine or cough syrup. The survey also found that injecting drug users primarily injected in their home or at a friend's home, but one fifth (23%) injected in public areas such as street sites, parks or public latrines. Mandalay differed in that 87% reported injecting at the dealer's site. The pattern of sharing needles and syringes varied. In Yangon, 31% of injecting drug users shared at last injection compared to 22% in Myitkyina, 19% in Lashio and only 5% in Mandalay. The percentages of respondents that always or almost always used injection equipment from others or giving used needles to someone else in the past six months were low in other areas except in Yangon (12% and 11% respectively). There was evidence that the use of prefilled syringes was still practised in all areas. In Myitkyina it was about 15%. The most common person to share injecting equipment with was a friend. The most common material used for cleaning for injecting equipment was plain water. Knowledge of where to obtain sterile injecting equipment was common, with most respondents mentioning pharmacies. The second most common places were NGO services, and then from health workers and drug dealers' places.

Knowledge of where to get condoms was also high. Concerning service utilization of targeted interventions, drop-in centres were visited most often by injecting drug users in Lashio (70%) compared to other sites. Almost 30% of injecting drug users in Yangon and Myitkyina mentioned having gone to an NGO service in the last month. Outreach coverage was highest in the Lashio sample (73%), compared to 43% in Mandalay, 28% in Myitkyina and 21% in Yangon. The experience with detoxification or maintenance therapy with methadone was very low (only 4-7%) among the respondents. However, of all types of treatment, detoxification with a non-methadone drug was the most common form. Use of HIV counselling and testing services was reported by only half of the respondents in Yangon, Mandalay and Myitkyina whereas in Lashio 70% had used the service. Approximately two thirds had been tested more than once. The majority went to an NGO centre for their last test, and 89%-97% received the result while 61%-88% shared their results with family or friends.

Regarding sexual risk behaviour, more than 90% of injecting drug users had sex in the past six months. Buying sex was reported by 48% of respondents in Mandalay, 41% in Yangon, 31% in Myitkyina and 9% in Lashio. Of those who bought sex recently, condom use at last sex with a paid partner was 61% in Yangon, 46% in Mandalay, 73% in Myitkyina and 87% in Lashio. The proportion of injecting drug users that had sex with casual partners in the past six months was 26% in Myitkyina, 21% in Yangon, 17% in Mandalay and 11% in Lashio.

Figure 19 Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected. Indicator 21. Source: BSS 2008.



V.2.5.4 Female sex workers

Female sex workers were surveyed in two sites, in the cities of Mandalay and Yangon. The sites attempted to sample different types of sex workers according to the location where they worked: brothel, street, and entertainment venue based. Assessment of network recruitment patterns suggested that in Mandalay, sex workers recruited primarily from their own type, resulting in separate chains of recruitment. The distribution of types of sex workers in the Mandalay sample was influenced by patterns of recruitment, and may not represent the actual proportion of different types of female sex workers in the population. In Yangon, sex workers participating in the survey were not as strongly associated with type. In part this reflects that a large percentage of sex workers in Yangon work in multiple types of venues. In the Mandalay survey, sex workers were slightly younger (median age 25 years) than in the Yangon sample (median age >30 years) and were equally distributed across brothel, street and entertainment venue based sex work. In Yangon, more than half of the sex workers in the sample were street based. The median age of starting sex work was 23 years in Mandalay and 24 in Yangon.

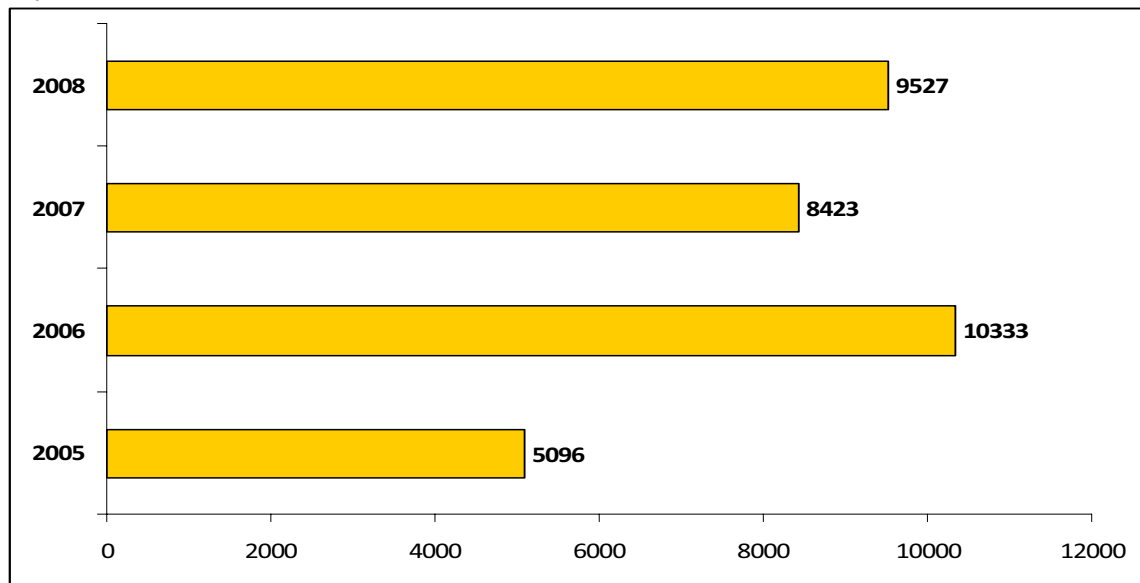
Higher risk intensity was found among Mandalay sex workers, more than one third of respondents had more than 10 clients in the last week, compared to less than 10% in Yangon. Reported condom use was high among sex workers in Mandalay (97% reported always or almost always using condoms) and moderately high in Yangon (83%). Despite high reported levels of condom use, more than half of sex workers in Mandalay and Yangon reported either a genital ulcer or discharge in the last year. Treatment seeking among those with a genital ulcer or discharge was moderately high (>70% in Yangon, and >60% in Mandalay). The vast majority sought treatment at a clinic, rather than self-medicating or using other types of medical care.

Patterns of access to services varied between sex workers in the Mandalay and Yangon surveys. In Mandalay, 48% of respondents had gone to an NGO clinic, 20% had been to another type of private clinic, and 68% had been contacted through outreach. In Yangon, a much higher proportion (72%) visited an NGO clinic and only 44% had been contacted through outreach. Respondents in Yangon did not commonly visit private clinics. A majority of sex worker respondents reported having an HIV test in the past six months (Yangon 74%, Mandalay 62%). The most common place for testing was an NGO clinic.

V.2.6 Impact alleviation

Provision of care and support for orphans and vulnerable children continued to be one of the more severely under-resourced programme areas in 2008, at only 25% of projected needs in the Operational Plan. However, the amount of resources available in 2008 increased by 61% compared with the preceding year. In 2008, care and support was provided to 9,527 orphans and vulnerable children, a 13% increase on the preceding year, although only 38% of the planned target (and equivalent to only around 0.6% of all orphans). Around 35% of all the children receiving support were in Mon State. Fourteen partners reported activities with orphans and vulnerable children in 2008.

Figure 20 Orphans and vulnerable children receiving support, 2005-2008. Source: NAP Progress Report 2008.



Although progress made at different degree over the past year in terms of achieving Universal Access, it will be quite challenging to meet the service coverage targets in time.

VI. Best practices

VI.1 Myanmar National Strategic Plan 2006-2010 and Operational Plans

In late 2005, the Government of Myanmar decided to embark on a comprehensive prevention, care and treatment strategy which would build on the experience and enrol the participation of all actors committed to responding to the HIV epidemic. Accordingly, the resulting *Myanmar National Strategic Plan on HIV and AIDS, 2006-2010*, was the first in Myanmar developed using fully participatory processes, with direct involvement of all sectors involved in the national response to the HIV epidemic. Contributions were made by the Ministry of Health, several other government ministries, United Nations entities, local and international NGOs, people living with HIV and people from key populations at higher risk.

The National Strategic Plan was prepared following a series of reviews which looked at the progress and experiences of activities during the first half of the decade. These included a mid-term review of the Joint Programme on HIV/AIDS in 2005 and a review of the National AIDS Programme in 2006, as well as diverse studies and reviews of particular programmes and projects. The National Strategic Plan identified what was further required to improve national and local responses, bring partners together to reinforce the effectiveness of all responses, and build more effective management, coordination, and monitoring and evaluation mechanisms. It aimed to build on current responses, identified initiatives that were working and needed to be scaled up to have maximum impact, built on key principles that would underline the national response, outlined broadly the approaches to be used for prevention, treatment, care and support, and delineated Strategic Directions and activity areas to be further developed in order to mitigate the impact of the epidemic. Ambitious service delivery targets were set, aiming towards 'Universal Access' to prevention and care services.

The subsequent formulation of a costed and budgeted Operational Plan translated key principles and broad directions set out in the National Strategic Plan into a directly actionable plan relevant to all aspects of the national response to HIV and to all partners in this effort.

The National Strategic Plan identified the key principles underpinning both the plan itself and its future implementation.

- Adherence to the "Three Ones" principle;
- Participation of people living with HIV in every aspect and at every stage of the programme;
- Emphasis on programme outcomes, emphasizing targeted behaviour change and use of services;
- Scaling up programme coverage and use of services at the maximum achievable pace;
- Selected "Accelerated Townships" are supported for accelerated programme implementation;
- A focus on supporting key populations at higher risk and vulnerability and with the greatest needs;
- Participation of vulnerable people and local communities in programme design, development and implementation;
- Fostering enabling environments conducive to an effective response to HIV;
- Use of evidence and strategic information to guide decision and action;
- Value for money, with incremental mobilization and efficient use of financial and other resources;

A multisectoral response to HIV with gradual expansion across sectors of government as capacity is built;
Partnerships: the strategy relies on collaboration between government and other public, private and non-government entities;
Effective Coordination, with enhanced mechanisms for coordination on the central and peripheral levels.

In a staged process, a series of initial workshops was followed by specific workshops to formulate various components of the strategic plan, with an emphasis on projected outcomes and the corresponding outputs required to attain these outcomes. A Steering Committee oversaw the entire process. A National Consensus Workshop in May 2006, with participation of more than 100 key partners in the national response, considered priorities and targets. The final National Strategic Plan was reviewed and then endorsed by the Ministry of Health.

The National Strategic Plan outlines the roles and responsibilities and possible contributions of different actors. These include government ministries and departments; United Nations entities (UNAIDS Co-sponsors) in Myanmar, using a division of labour for technical support provision, according to globally defined areas of work; and partners in implementation for each Strategic Direction.

The National Strategic Plan describes institutional arrangements. Overall oversight is provided by the Myanmar Country Coordination Body (M-CCM) for AIDS, Tuberculosis and Malaria. This was established by the Ministry of Health and its partners to oversee implementation of the national strategies for the three diseases, provide policy guidance, identify external support and coordinate efforts with national and international partners. This body amended its name and governing rules in 2008 in order to be able, in addition to its pre-existing function, to act as a Country Coordinating Mechanism for applications to and grants from the Global Fund. It is now known as the Myanmar Country Coordinating Mechanism (M-CCM).

Under the overall leadership of the M-CCM, the Technical and Strategy Group on HIV (TSG) assumes responsibilities in guiding the HIV response. The tasks delegated to the TSG include:

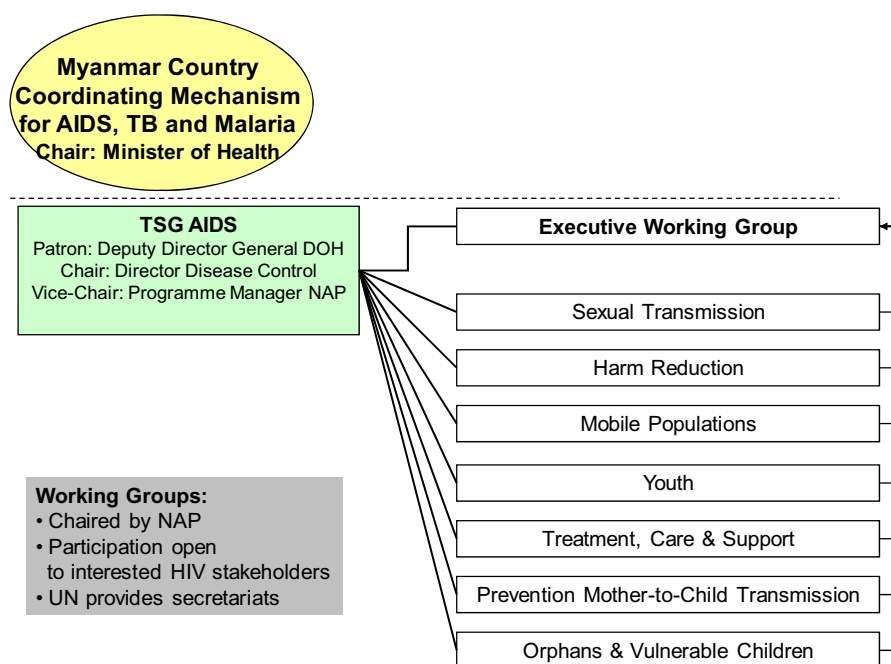
- coordinating implementing partners;
- advising on technical matters and acting as a forum for lesson learning and best practices;
- ensuring that national strategies for AIDS are up to date and relevant to the epidemic;
- assessing and amending the Operational Plan;
- programme monitoring and evaluation;
- supporting the organization of working groups;
- and advising the M-CCM on policy issues.

The Technical and Strategy Group on HIV meets on a regular basis and draws upon the technical expertise of its members. Several members play a representational role (for community organizations, professional associations, donors, NGOs) and provide information exchange to and from their constituencies. People living with HIV are represented. Secretariat support is provided by the UNAIDS Secretariat.

The AIDS Technical and Strategy Group also convenes open forum meetings, (known as Extended TSG) which are open to all interested stakeholders, and are often thematic in nature.

The AIDS Technical and Strategy Group also currently encompasses seven Thematic Working Groups, which are open to participation by all interested stakeholders. These are listed in the figure, below.

Figure 21 Institutional arrangements for the Myanmar National Strategic Plan



The National Strategic Plan encompasses 13 prioritized Strategic Directions, as described earlier in this report. Each Strategic Direction outlines definitions of target groups and services needed, activity areas, outputs, outcomes and indicators to measure progress.

The National Strategic Plan and its Operational Plans (2006-2009, subsequently updated to 2008-2010) are the key reference documents for partners working on HIV, providing the strategic framework of action including priority setting for resource allocation. The Operational Plan specifies the agreed yearly targets and costs for each of the 13 Strategic Directions. Both the National Strategic Plan and the Operational Plan will be reviewed in order to inform the development of a 2011-2015 National Strategic Plan.

The National Strategic Plan and Operational Plans have successfully been used as a framework for mobilizing resources for the response. The Three Diseases Fund priorities were established on the basis of the plan, and its resources were allocated in line with the plan's priorities. In 2009, the successful AIDS proposal to Round 9 of the Global Fund aims at filling gaps in the highest priority areas of the plan, on which basis it was developed.

The National Strategic Plan has resulted in a significant improvement in monitoring and evaluation of the national response. Partners are able to report progress against a uniform agreed set of standard indicators on an annual basis. The National AIDS Programme has synthesised the data provided by partners in the response and produced an Annual Progress Report on implementation of the National Strategic Plan since 2006. Availability of strategic information has improved significantly in recent years, including for reporting on progress against the UNGASS core indicators.

VI.2 Strategic Information

Myanmar has worked on improving the availability and use of strategic information in a number of areas. Firstly, the national Progress Report is compiled and disseminated yearly. The report is based on data from the points of service delivery of implementing partners and it contains summaries for the national level coverage as well as for decentralised levels. Beginning in 2008, selected township profiles were included in the annual report in addition to the national and state/divisional level. The assessment of resources spent against the 13 Strategic Directions of the National Strategic Plan enables an analysis of the actual expenditures against projected costs including. The report is being widely disseminated.

Secondly, the standard surveillance has been improved and expanded since 2007. The HSS has increased the sample size and included additional surveillance groups, i.e. men who have sex with men and TB patients. The National AIDS Programme also collaborates with non-governmental service providers in the recruitment of people for the sample. As a result the targeted sample size is reached quicker and it is assumed that the sample is more representative of the sub-population.

Thirdly, the country aimed at improving the models used for estimating the scope and direction of the epidemic. Estimations for numbers of people living with HIV, treatment needs for children and adults were established in 2007 and 2009. These estimations were based in the Epidemiological Projection Package (EPP) and Spectrum software packages. More recently, attempts were made to move to epidemiological models that estimate incidence rather than prevalence. Improved understanding of incidence will eventually enable to enhance the national response, including target setting for prevention of HIV transmission, resource allocation and geographical targeting. Preliminary work was done to estimate incidence using the Modes of Transmission and the Asian Epidemiological Model.

VI.3 M-CCM

In 2008, the country decided to respond to the call for proposals of Round 9 for the GFATM. In order to comply with GFATM requirements the existing national coordination body needed to be reformed. The country took the opportunity to form the Myanmar Country Coordinating Mechanism with a broad mandate in health. The responsibilities of the M-CCM are wider than Global Fund related issues thus ensuring that the Three Ones are supported at the highest level. Subsequently, the M-CCM submitted a proposal to the Global Fund that is based on the national strategy and addresses priorities therein based on a consensus of all constituencies. The fact that the HIV proposal being rated as category 1 by TRP symbolized the acknowledgement of the commitment of all concerned partners in the process of proposal development and revision, well coordinated by CCM.

VII. Major challenges and remedial actions

A combination of factors can impact access to, the reach and effectiveness of services for HIV and STI prevention, treatment and care. The population is spread over a large geographic area with diverse ethnicity including languages. The communications and transport facilities are poorly developed. The health system is poorly resourced with regard to infrastructure and equipment and there is a scarcity of appropriately skilled human resources, notably in rural and remote areas. Some parts of the population are hard to reach due to geographical isolation or ongoing security concerns due to conflict, mainly in border areas.

Domestic and international financial support remains largely insufficient to respond comprehensively to the HIV epidemic even in the most accessible parts of the country. Economic sanctions have added to the difficulties in sustaining health sector infrastructure and hospital and medical supplies. While the Government of Myanmar provides support for the response to AIDS by way of manpower, staff salaries, and training, some reporting forms, buildings and operational costs, overall government health expenditure in Myanmar remains low.

Currently, a large part of the funding for the implementation of HIV strategies comes from the Three Diseases Fund³ together with some additional assistance to HIV programmes through European Commission, Australia and funds raised directly by NGO headquarters. The United Nations agencies provide substantial financial support through core funds and additional resources raised. Aid from a number of donors is provided on humanitarian grounds. These funds are channelled almost exclusively through United Nations agencies and NGOs.

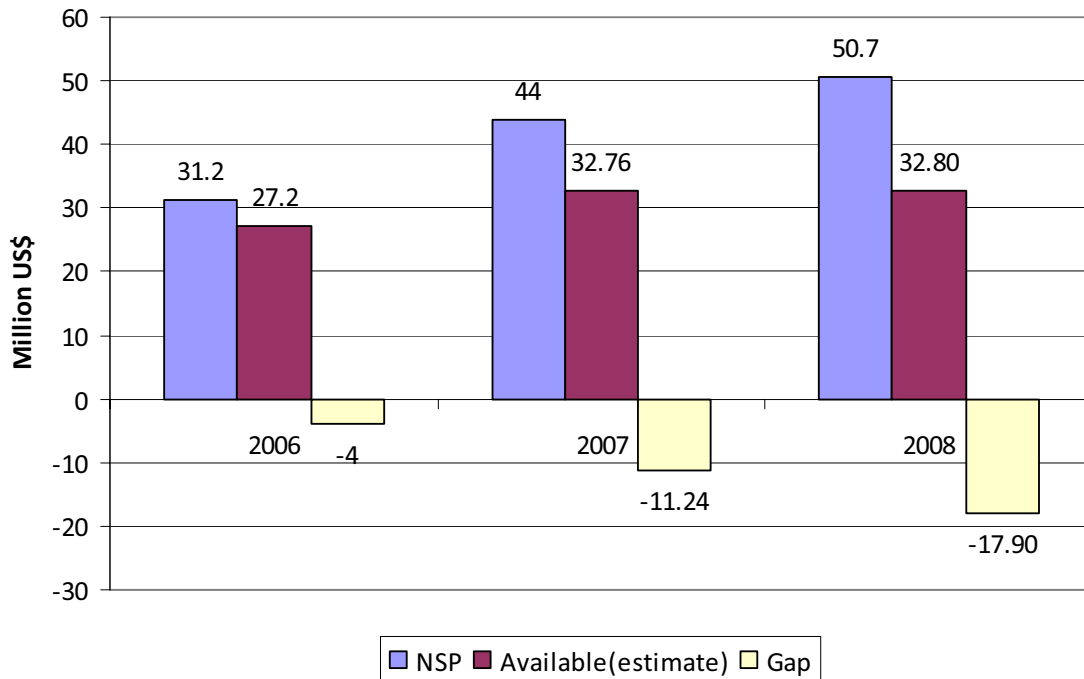
The government reported 1.5 billion Kyat expenditures on AIDS in 2007 (UNGASS Report 2008). This corresponds to about US\$ 1.2 million using an averaged annual UN exchange rate of 1,250 Kyats per US\$. As regards international financial contributions, data collected from all stakeholders for the National AIDS Programme's 2008 Progress Report showed that total resources for 2008 for HIV increased only slightly as compared to 2007 (from US\$ 30.9 to approximately US\$ 31.3 million). This corresponds to about US\$ 0.55 per capita which is less than half the level recommended by the Commission on AIDS in Asia for priority interventions and programme related costs in expanding and declining epidemics.⁴ With current levels of funding, service coverage cannot increase sufficiently to address the pressing needs for care and prevention. More resources are therefore urgently required, both from international and domestic sources.

The absence of any significant increase in funding resulted in a widening resource gap from 2006 to 2008 compared with the amount needed, as costed in the Operational Plan. In 2008 this represented a shortfall of approximately 38% compared with the Operational Plan. In 2008, when taken as a whole, the programmatic area of prevention received around 54% of the amount required, a greater shortfall than the previous year. Care treatment and support was resourced at around 65% of planned, a comparable level to 2007.

³ The Three Diseases Fund (3DF) is a US\$ 129 million fund established in 2006 to respond to the funding gap for HIV, TB and Malaria as a result of the withdrawal of the Global Fund in 2005. The 3DF is currently resourced by a consortium of seven donors (Australia, Denmark, European Commission, Netherlands, Norway, Sweden and United Kingdom).

⁴ Commission on AIDS in Asia, Redefining AIDS in Asia, 2008, p.100

Figure 22 Resource needs as per Operational Plan and actual resources, 2006, 2007 and 2008. Source: NAP Progress Report, 2008.



Capacity and resources are insufficient to effectively respond to the behaviours that are high risk for HIV and STI infection; vulnerabilities of sexual partners of those with high-risk behaviours; prevention and treatment needs of people living with HIV. Low levels of access to comprehensive treatment and care for marginalized groups with high-risk behaviours remains a persistent problem. Procurement, especially of ART and medicines for managing opportunistic infections, requires strengthening. Service points providing HIV counselling and testing are insufficient in number. Laboratory services are currently inadequate. Overall, coverage of HIV prevention services in Myanmar remains limited. In most programme delivery areas, only about 10% of people in need are receiving appropriate services. Sex workers are perhaps the most important exception, where coverage is estimated to be over 50 percent. Financial constraints significantly affect the national HIV outcomes, reflected in low ART coverage. Myanmar is one of 55 countries in the world with less than 25% ART coverage (*Source: UNAIDS, Report on the Global AIDS Epidemic 2008*).

The Ministry of Health is in full support of prevention programmes for these groups with high risk of HIV transmission. However, the law enforcement agencies in the areas where the services are provided are not always fully aware of prevention programmes. The 100% Targeted Condom Programme of the National AIDS Programme will continue to address this through advocacy with local authorities including law enforcement. Men who have sex with men are a largely hidden population. Little research has been undertaken to date to understand the scope and dynamic of HIV within this sub-population.

Stigma and discrimination remains a major issue for people living with HIV as was demonstrated in the most recent round of BSS. While many respondents state that they would care for a HIV infected relative, there are less than half who would buy food from a HIV infected vendor (BSS 2007 General Population, BSS 2008 Out of School Youth, Ministry of Health).

In 2009, the Myanmar Country Coordinating Mechanism's Round 9 proposal to the Global Fund was successful. The HIV component of the Round 9 proposal aims to address major gaps in service delivery within the National Strategic Plan and was prioritized according to epidemiological data and the HIV disease burden. It addresses the epidemic in line with the recommendations of the Commission on AIDS in Asia. Specifically, the proposal aims to increase coverage of targeted comprehensive prevention services for female sex workers, men who have sex with men, injecting drug users and pregnant women (for prevention of mother-to-child transmission). Comprehensive programming will include STI and VCCT services, male and female condom and lubricant promotion and distribution, needle and syringe exchange, methadone maintenance therapy, peer-led behaviour change, short-course ARV prophylaxis for pregnant women living with HIV, and positive prevention for people living with HIV. The strategy also responds to the multilingual needs of diverse national populations, the reproductive and sexual health needs of women and adolescents, addresses issues of stigma and discrimination, and aims to reduce the HIV/TB co-infection burden (addressed in both the HIV and TB components of the Round 9 proposal).

The proposal aims to increase the number of people living with HIV receiving support, including a package of care and treatment with ART. The target coverage is 19,000 after year one increasing to 43,500 after year five.

The proposal also aims to strengthen and expand the technical and implementation capacity of national staff as well as the organizational capacity of civil society and community-based organizations, with a priority focus on supporting the participation of people living with HIV, men who have sex with men, injecting drug users and female sex workers in self-help and support groups. A mix of government and NGO provision of services will be used in implementation.

VIII. Support from the country's development partners

The estimated amount of external resources available for the national response to HIV in 2008 was approximately US\$ 31.3 million, only a very slight increase of around US\$ 0.4 million on 2007. Most external funds are channelled through NGOs and United Nations organizations. In 2008, international NGOs channelled about two thirds of overall funds, while United Nations organizations managed about one third. United Nations agencies manage the flow of most donor funds made available to public health services.

The national response is resourced by a number of donors. The most numerous are 13 bilateral donors, most contributing amounts of less than US\$ 1 million (however, a group of bilateral donors also contribute to the Three Diseases Fund), to reach a total of US\$ 4.2 in 2008. Japan International Cooperation Agency supports the National AIDS Programme, the National Health Laboratory and National Blood Centre. The support extends to quality assessment for HIV testing, provision of HIV test kits and staff training. The largest contributors, at 45% (US\$ 15.8 million) of the total available in 2008 were the multilateral donors the Three Diseases Fund and European Commission. NGO and United Nations organizations' core funds combined amounted to approximately US\$ 13.6 million in 2008. United Nations organizations' funds (core funds and additional resources raised locally and internationally) account for proportionately higher amounts in the Myanmar national response than in those of other countries in the region. Myanmar does not currently access resources from the Global Fund, the World Bank or the Asian Development Bank.

In general, funding allocations tend to be of relatively short duration, and the lack of longer-term availability of funding remains a significant obstacle to programme planning.

The Three Diseases Fund (3DF) is a multi-donor pooled funding mechanism established in 2006 to respond to the funding gap for HIV, tuberculosis and malaria as a result of the withdrawal of the Global Fund in 2005. The 3DF is currently resourced by a consortium of seven donors (Australia, Denmark, European Commission, Netherlands, Norway, Sweden and United Kingdom). Initial pledges totalled US\$ 100 million for a period of five years, with 60% allocated to HIV. At the end of 2009, total contributions amounted to US\$ 129 million. The 3DF is currently supporting programmes until the end of 2011. The fund manager is the United Nations Office for Project Services (UNOPS).

While there is no United Nations Development Assistance Framework currently in place, there is a Joint United Nations Programme of Support for HIV in Myanmar (May 2007). This support is matched to Strategic Directions within the National Strategic Plan, contributing in technical assistance to the public sector, mobilization and support of community, private and civil society partners, the development and use of strategic information, and the mobilization of United Nations' and additional resources to fund service delivery for people in Myanmar. Some agencies play a wider role in programme management, including fund flow to national entities for activities, along with monitoring and support for implementation. National entities include the national disease control programmes, health authorities at township level and some national NGOs. This mechanism is applied to funds provided by the 3DF (with programme management provided through WHO, UNAIDS, UNFPA and UNODC).

Donors are providing support to the national response within the context of the National Strategic Plan, the costed Operational Plan and its implementation.

NGOs are key partners for delivering services to key populations at higher risk and that can be more difficult to reach through conventional public health services. This includes providing services through outreach and drop-in centres to sex workers, men who have sex with men, and people who use drugs. Sex work and drug use are illegal in Myanmar.

IX. Monitoring and evaluation environment

IX.1 Overview

IX.1.1 National level

IX.1.1.1 Oversight

The Myanmar Country Coordinating Mechanism entrusted the oversight and coordination for implementation of the Operational Plan to the AIDS Technical and Strategy Group (TSG). This includes ensuring monitoring and evaluation of the national response. The TSG further delegated technical issues to seven Technical Working Groups, which are open to all interested stakeholders, ensure that consultation is inclusive and that local expertise is used. The working groups communicate findings and recommendations to the TSG to inform decision-making, planning and implementation. The oversight structure including the TSG and its working groups are outlined in Figure 21, above.

IX.1.1.2 M&E Working Group

The national HIV and AIDS M&E Technical Working Group (TWG) comprises the National AIDS Programme M&E Officer, the UNAIDS Myanmar Country Office M&E Advisor, representatives from United Nations agencies, international and local NGOs and academic and research experts. As with the other TWGs, participation is open to all interested stakeholders. The group is charged with the providing technical assistance for implementation of the M&E activities, and of coordination of the country's monitoring data, evaluation activities, and supervision and coordination of special research projects.

IX.1.1.3 National AIDS Programme

The National AIDS Programme has the mandate of coordinating, monitoring and evaluating the national response to AIDS. The National AIDS Programme has a central-level M&E Unit, which is responsible for data management, including dissemination of results to stakeholders. It is staffed by an M&E focal person and a data analyst. The M&E Unit is responsible for data collection from all partners in the national response – including other ministries, public institutions and organizations – as well as for capturing the routine data generated by the National AIDS Programme's AIDS/STD teams. The M&E Unit also coordinates evaluations to measure programme outcomes.

IX.1.2 State or Division, District and Township levels

State and Division AIDS Committees are chaired by the secretary of State Peace and Development Council while State/Division AIDS/STD Officers serve as a joint secretary. State/Division AIDS Committees coordinate the state/division-level HIV activities of public and NGO sectors. The State/Division AIDS/STD Officers and AIDS/STD Team Leaders at the district/township level are responsible for monitoring and evaluation of district and township level programme activities implemented by the various actors including public sector, NGOs, CBOs and the private sector. They also report regularly on programme activity to the state/divisional level and to the central M&E Unit. In townships where there is no AIDS/STD team, data are collected from health service providers and reported through the township health structures (Township Medical Office) to the central National AIDS Programme's M&E Unit.

IX.1.2.1 NGOs, CBOs and the private sector

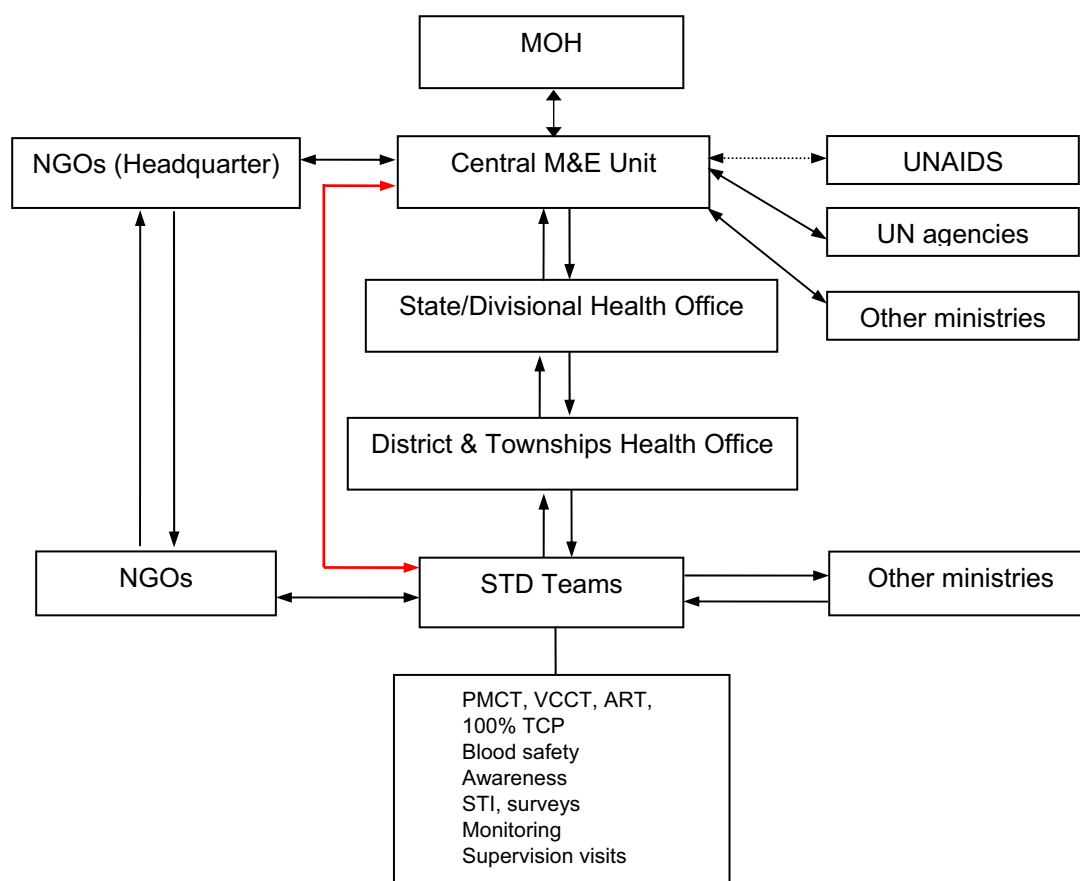
The NGOs, CBOs and private sector entities are responsible for monitoring their own programme activities and outputs, collecting and analyzing data, and sharing the information to the district/township AIDS/STD teams using the format provided for routine annual reporting.

IX.1.3 M&E system data flow

Stakeholders implementing HIV activities are expected to report programme/project-based data against relevant indicators annually using the standard national reporting form provided. At the end of the calendar year, the National AIDS Programme Manager writes to partners in the national response to request data on programmatic achievements for the year. Partners return the completed form to the National AIDS Programme Manager, with copy to UNAIDS. UNAIDS M&E staff provides technical support as required for the data verification, compilation, aggregation and reporting. Data flow between different stakeholders and the NAP, MOH is represented in the diagram below.

Figure 23 National M&E system data flow diagram.

Data Flow Diagram of M & E System



IX.1.4 Information products

The key HIV monitoring and evaluation information products for decision making and planning are:

National Annual Progress Report on the implementation of the National Strategic Plan. An annual progress report on the national response is produced based on a standard reporting format submitted by all partners implementing HIV activities. The reporting format includes the output and process indicators of the national monitoring framework that are included in the Operational Plan.

HIV Sentinel Surveillance report. HIV sentinel surveillance is conducted annually. In recent years the methodology has been improved by increasing sample sizes and by including additional population groups, notably men who have sex with men.

Behavioural surveillance reports - Behavioural sentinel surveillance is conducted regularly for key populations, every two years for some groups, and a report of the findings of each survey is published.

Resource mapping of expenditures on the national response to HIV, by National Strategic Plan Strategic Direction. Since 2007, comprehensive financial data have been collected by organization to allow analysis of resources available and spent by strategic direction and by donor type. This is currently also provided in summary form within the national Annual Progress Report.

Reports for global initiatives which currently include UNGASS, Universal Access and Millennium Development Goals.

IX.1.5 Data storage

A central-level depository of the final set of data aggregated from partners' annual reports is kept as a computer database at the National AIDS Programme and at UNAIDS. Certain other data sets are maintained centrally with the support of other partners. For example, the National AIDS Programme is supported by WHO for HIV Sentinel Surveillance and Behavioural Surveillance. At township level, a combination of computer-based and paper-based data tools are used.

IX.2 Challenges faced

The main challenges faced in the implementation of a national M&E system are the under-developed communications infrastructure, and a lack of capacity at the peripheral levels.

Telecommunication systems are poorly developed, with few fixed-line telephones, faxes and mobile phones. Internet connectivity is not available in many of the peripheral locations, and much of the M&E data still has to be carried by hand.

There is a shortage of skilled human resources at peripheral levels and those available are very busy with the demands of multiple programmes.

There is a need to strengthen monitoring and evaluation capacity at local level, especially among AIDS/STD teams.

The Ministry of Health and the National AIDS Programme function with insufficient budget and human resources. Increased levels of human and financial resources and improved communication, including internet connectivity, would improve the capacity for monitoring and evaluation.

X. Data sources

1. *Report from the Technical Working Group on Estimation and Projection of HIV and AIDS in Myanmar, 2007; National AIDS Programme, MoH*
2. *Report of the HIV Sentinel Sero-surveillance Survey 2008; National AIDS Programme, MoH, March 2009*
3. *Behavioural Surveillance Survey 2008, Out of School Youth; National AIDS Programme, MoH, March 2009*
4. *Behavioural Surveillance Survey 2008, Injecting Drug Users and Female Sex Workers; National AIDS Programme, MoH, July 2009*
5. *Behavioural Surveillance Survey 2007, General Population; National AIDS Programme, MoH, March 2009*
6. *National Strategic Plan for HIV and AIDS in Myanmar, Progress Report 2008; National AIDS Programme, MoH*
7. *Statistical Yearbook 2007; Department of Population*