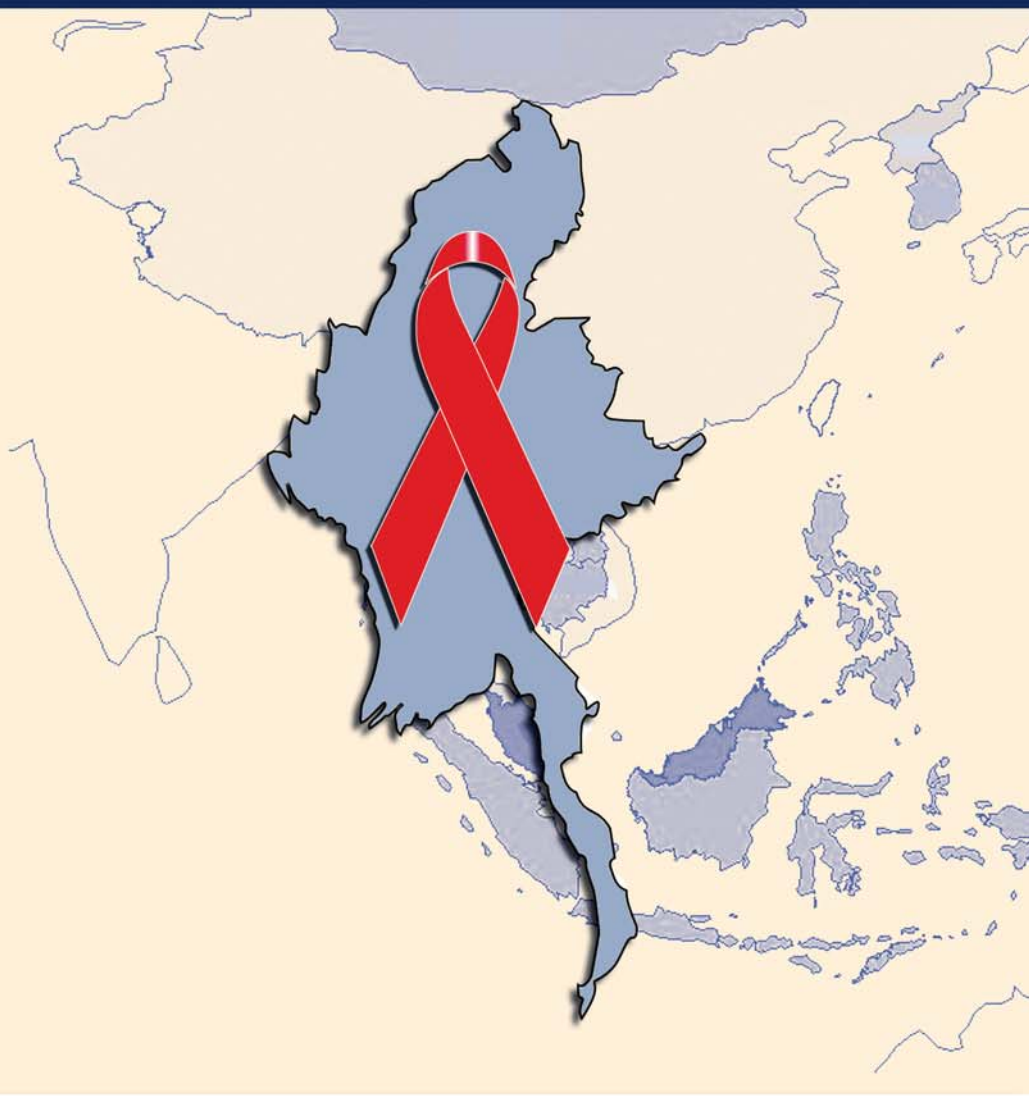
UNITED NATIONS EXPANDED THEME GROUP ON HIV / AIDS



Joint Programme for HIV / AIDS in Myanmar Progress Report 2003 - 2004

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Fund for HIV / AIDS in Myanmar (FHAM) Annual Progress Report April 2004 - March 2005

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Acronyms used in this report

Joint Programme/FHAM Implementing Partners

AFXB	Association François Xavier Bagnoud
AHRN	Asia Harm Reduction Network
AMDA	Association of Medical Doctors in Asia
AMI	Aide Medical International
ARHP	Asian Regional HIV/AIDS Project
BI-CHR	Burnet Institute's Centre for Harm Reduction
BI-CIH	Burnet Institute's Centre for International Health
CCDAC	Central Committee for Drug Abuse Control; Ministry of Home Affairs
Consortium	Myanmar NGO Consortium (5 member NGOs below)
CARE	CARE International
MNA	Myanmar Nurses Association
MSI	Marie Stopes International
SC-UK	Save the Children-UK
WVI	World Vision International
DEPT	Department of Education, Planning and Training; Ministry of Health
DDTRU	Drug Detoxification / Treatment Rehabilitation, Dept. of Health;
FHAM	Fund for HIV/AIDS in Myanmar
IHAA	International HIV/AIDS Alliance
LOP	Lashio Outreach Project (UNODC)
Malteser	Malteser International
MANA	Myanmar Anti-Narcotics Association
MBCA	Myanmar Business Coalition on AIDS
MCC	Myanmar Council of Churches
MDM	Médecins du Monde
MHAA	Myanmar Health Assistants Association
MMA	Myanmar Medical Association
MMCWA	Myanmar Maternal and Child Welfare Association
MRCS	Myanmar Red Cross Society
MRT	Ministry of Rail Transportation
MSF-CH	MSF-Switzerland
MSF-H	MSF-Holland (AZG)
NAP	National AIDS Programme, Dept. of Health; Ministry of Health
PACT	Pact International
PARTNERS	Partners NGO
PSI	Population Services International
SC-US	Save the Children-USA
TCU	Technical Coordination Unit (UNODC)

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNODC	United Nations Office on Drugs and Crime
WC	World Concern
WFP	United Nations World Food Programme
WHO	World Health Organization

Other acronyms

ANC	Ante-Natal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral(s)
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CSW	Commercial Sex Worker(s)
ETG	United Nations Expanded Theme Group on AIDS
FY	Financial Year
IDU	Injecting Drug User(s)
IEC	Information, Education, Communication
IP	Implementing Partner
JP	Joint Programme for HIV/AIDS in Myanmar
M&E	Monitoring and Evaluation
NCE	No-Cost Extension
PLHA	Person(s) Living with HIV/AIDS
PMCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infection(s)
TCP	Targeted Condom Promotion
TWG	Technical Working Group
VCCT	Voluntary, Confidential Counselling and Testing

Acknowledgements

This report was drafted by UNAIDS Secretariat staff, on the basis of data collected and reports submitted by Joint Programme partners. The National AIDS Programme, led by Dr Min Thwe, provided key information about national activities, inputs and data about the epidemic. In addition, Dr Min Thwe led the development of the Global Fund Round 5 proposal, whose text and analysis have been liberally borrowed here. All partners to the Joint Programme and the Fund for HIV/AIDS in Myanmar have submitted quarterly and annual reports, which are gratefully acknowledged, and have provided useful information. As noted in the foreword, a number of partners additionally volunteered their time to prepare pre-Review papers for the Mid Term Review. Their efforts are greatly appreciated. Finally, members of the FHAM Team and the M&E Team from the UNAIDS Secretariat office in Myanmar deserve thanks.

Thanks go to all of these people for the inputs, however any inadvertent errors or mistakes remain the responsibility of the UNAIDS Secretariat.

Foreword

Dear reader,

The Joint Programme for HIV/AIDS in Myanmar, 2003-05, and the Fund for HIV/AIDS in Myanmar (FHAM) have now been operating successfully for more than two years. Together, they represent the successful commitment of a variety of partners – international development agencies, the Government of Myanmar, national and international non-Governmental organizations, and the United Nations family – to find effective ways of helping the people of Myanmar fight AIDS. Many challenges were overcome to negotiate the initial agreement; others are faced in the course of daily implementation. While such challenges occasionally reduce the pace of activities temporarily while they are overcome, the core momentum has only grown throughout the Programme's first years. The Joint Programme and the FHAM demonstrate that it is possible to deliver assistance to the people of Myanmar successfully.

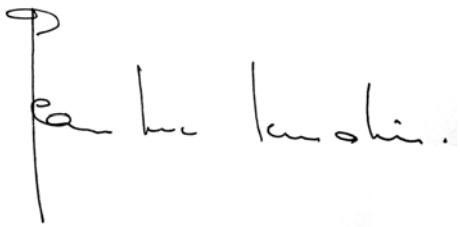
This report covers progress under both the Joint Programme and the Fund for HIV/AIDS in Myanmar because the two are so closely linked. It covers the calendar years 2003 and 2004 for the Joint Programme, and the second financial year for the FHAM, 2004 (1st April 2004 –31st March 2005). As all of the activities are ongoing, in some cases key events or achievements which have occurred later in 2005 – strictly speaking outside the reporting period – have been mentioned.

In April and May 2005, the Country Coordinating Mechanism in Myanmar prepared a proposal for the 5th Round of the Global Fund. This proposal mobilised more actors and resulted in probably the best Global Fund proposal to date. Much of the information that went into the proposal has been used and borrowed and is presented here, to ensure that the work that went into the analysis for the Global Fund receives a broader hearing.

Also in May, 2005, the Joint Programme underwent a three week, independent, external review. In preparation for this process, each of the five thematic Component Groups prepared pre-Review briefing papers which highlighted progress and identified key issues. These pre-Review papers have also informed this report, and the time and efforts of individuals who worked on them are hereby acknowledged. The Mid Term Review itself is contributing to a process of reflection and reorganisation, which will result in a Joint Programme document for 2006 and beyond, along with a resource mobilisation drive for the FHAM.

And finally some words on the mobilisation of new resources for AIDS in Myanmar. The concerning news of course is that the Global Fund grants for tuberculosis, malaria and AIDS have been terminated, leaving a gap in resources which the FHAM and other sources will be required to fill. The good news is that the Government of the Netherlands in July 2005 indicated it will contribute •4m to the FHAM, •1m for each of the years 2005-08. This brings to four the number of donors contributing to the FHAM - in addition to the United Kingdom's Department for International Development (DFID), Sweden's Agency for International Development Cooperation (SIDA), and the Norwegian Government - and provides the first concrete funding commitment for the next cycle of programming.

This report demonstrates that it is possible to deliver humanitarian assistance in Myanmar, and will, I hope, encourage donors to consider making such necessary investments in the fight against AIDS for the people of Myanmar.



Jean-Luc Lemahieu,
Chair, UN Expanded Theme Group on AIDS

Introduction

The Joint Programme for HIV/AIDS in Myanmar, 2003-2005, was designed and established by the UN Expanded Theme Group on HIV/AIDS to mobilise additional support for the national response to AIDS. It provided the logical framework to manage new contributions from a variety of donors – notably through the Fund for HIV/AIDS in Myanmar – to scale up programmes in support of the National Strategic Plan 2001-2005 and of the operational plans of implementing partners for this period. The Joint Programme stimulated and fostered an increasing number of national and international actors to fight AIDS, and has contributed to concrete achievements as detailed especially in Chapter III of this report.

In addition to enabling the expansion of activities, the creation of the Joint Programme has prompted the creation of a harmonised monitoring and evaluation system anchored on a set of indicators discussed and agreed by all partners. A thematic coordination scheme was established.

The goal of the Joint Programme is to reduce HIV transmission and enhance the quality of life of people living with HIV, especially by changing behaviour. It has five objectives, based on priorities agreed in 2002:

1) to reduce the risk of HIV infection through sexual transmission,
2) to reduce the risk of HIV infection among injecting drug users and their partners,
3) to improve knowledge and attitudes among the high-risk groups, the general population, and youth,
4) to increase access to and quality of care, treatment and support, and
5) to strengthen essential elements for an enabling environment.

Five thematic Component Groups were established – one for each objective – each co-chaired by one UN agency and one international non-governmental organisation. These Component Groups served as an initial coordination forum and as a means to ensure that all partners had opportunities to raise and address issues around implementation. A Technical Working Group (including representatives from UN organisations, the National AIDS Programme, and international and national NGOs) was established to provide supervision to the Joint Programme, which is overseen by the UN Expanded Theme Group on HIV/AIDS.[1]

The Joint Programme provided the basis for successful fundraising from the international community. Through a pooled-funding

[1] For a full description of the Joint Programme, including the logical framework, indicator set, partners, and governance structure, please see UNAIDS, UN Expanded Theme Group on AIDS in Myanmar, *Joint Programme for HIV/AIDS: Myanmar 2003-2005*. [http://www.unaids.org/html/pub/una-docs/jpmyanmar_15jul04_en_pdf.htm].

mechanism, the Fund for HIV/AIDS in Myanmar (FHAM) raised, as of the end of 2004, USD 25.2 million[2] for activities pursuing the five priority areas of the Joint Programme, from three donors: the United Kingdom's DFID (USD 17.3m), Sweden's SIDA (USD 5.5m) and Norway's Ministry of Foreign Affairs (USD 2.4m).[3] The governance structures that were established for the Joint Programme – notably the Component Groups, the Technical Working Group and the Expanded Theme Group, all served by the UNAIDS Secretariat – were similarly adopted for the FHAM. By 31st March 2005, the end of the financial year, USD 20.4 million had been allocated to projects, over the entire three-year period, and a process was underway to allocate the remainder.[4] The FHAM supports activities of 26 implementing partners, who provide services across the full spectrum of AIDS work, from outreach to at-risk groups, condom promotion, prevention efforts amongst youth and pregnant women, through to comprehensive care including anti-retroviral treatment. In the first two years of the functioning of the Joint Programme, it has been possible to launch, at least on a pilot scale, a wide range of evidence-based interventions with support from the FHAM.

This report covers progress both of the Joint Programme and the FHAM. It details the achievements of the first two years of the Joint Programme's existence, 2003 and 2004, while at the same time incorporates the 2nd annual report of the FHAM. It covers essentially the calendar year 2004 (although specifically follows the Myanmar financial year, from 1st April 2004 through 31st March 2005).[5]

Chapter II summarises the epidemiological and programmatic contexts, while Chapter III presents programme achievements. The remaining chapters cover coordination, governance and M&E (Chapter IV), FHAM resources and operational issues (Chapter V) and finally conclusions. Constraints and opportunities are discussed throughout the report, though especially in Chapter III linked to the thematic intervention areas, as well as in the conclusion.

[2] The exact amount varies depending upon currency exchange rates.

[3] In July 2005, the Netherlands Government indicated that it will contribute •4m to the FHAM, •1m each year, 2005-08.

[4] To date, USD 24.7 million have been allocated, including Rounds II and II (b) of the FHAM.

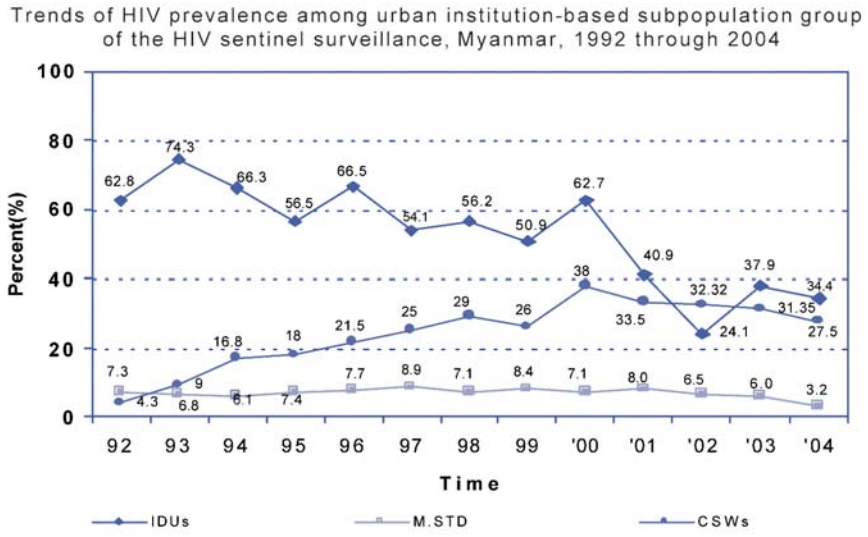
[5] Earlier reports on the FHAM include the 1st annual report: *Fund for HIV/AIDS in Myanmar: Annual Report (1 April 2003-31 March 2004);* and the first six-monthly progress report for the FHAM: *Fund for HIV/AIDS in Myanmar: Six-monthly progress report (1 April 2004-30 September 2004)*
[http://www.unaids.org/html/pub/publications/irc-pub06/fhamprogress%20report_myanmar_30mar05_en_pdf.pdf]

Overview of the epidemic in Myanmar [6]

HIV is a national concern in Myanmar, as one of three priority communicable diseases identified by the Ministry of Health (malaria, tuberculosis and AIDS). Myanmar, Thailand and Cambodia, have been identified by the United Nations as the three highest priority countries in South-East Asia. New estimates from the Ministry of Health for 2004 show 338,911 people infected with HIV (1.3% of the adult population), roughly two times the number for 2001. UNAIDS estimates a comparable range of 170,000 to 620,000.

Nevertheless, official surveillance data from 2004 show a slight decrease in rates of HIV infection among high-risk groups, as illustrated in the graph below: male clients of STI clinics (3.2%), sex workers (27.5%) and injecting drug users (34.4%) (chart 2.1). A decrease was reported between 2003 and 2004 in donated blood (0.8%) and new military recruits (1.6%) testing positive, while there was a slight increase within pregnant women attending ante-natal care (1.75%) (chart 2.2). Recent trends need to be

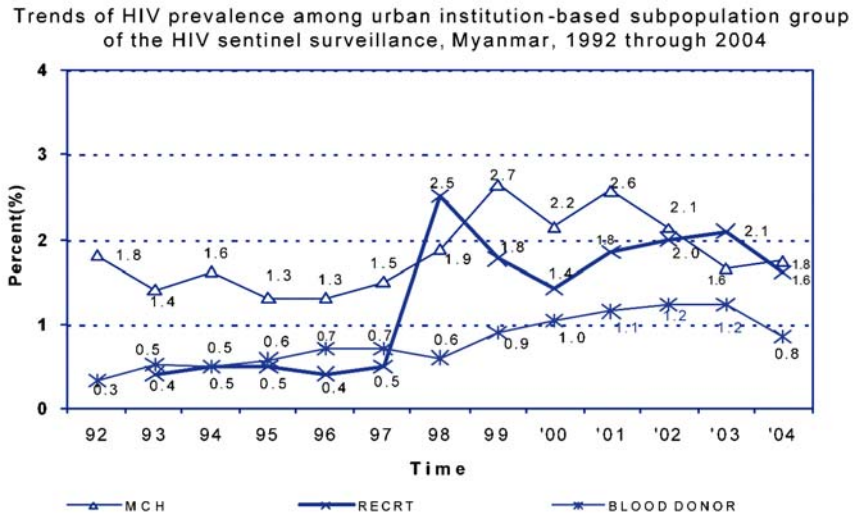
Chart 2.1 HIV prevalence in high-risk groups (IDU, CSW, Male clients of STI clinics)



Source NAP

[6] The HIV/AIDS epidemic update section is largely based on the collective work that was done for Myanmar's Global Fund Round V proposal.

Chart 2.2 HIV prevalence in low-risk groups (ante-natal care, military recruits, blood donors)



Source NAP

confirmed over time and other factors, like considerable geographical variation, especially between rural and urban areas, need further exploration.

The rise among low-risk groups such as blood donors and military recruits recorded since 1992 suggests that the virus has crossed from high-risk groups and is already circulating in the general population. The ratio of men to women infected has lowered from 12:1 at the initial stage of the epidemic in the early nineties, to approximately 4:1 at present. This trend is consistent with a movement towards a more generalised epidemic. Again, this ratio will be monitored in order to follow the evolution of the epidemic.

Because of the long time lag between HIV infection and death, the true impact of the epidemic is just beginning to be felt.

One finding of concern in the pattern of infection is that younger people are affected. Data from 2002 suggest that in some areas up to 1.8% of young people aged 15-24 are living with HIV.[7] Myanmar is one of the few countries in Asia able to report on HIV-prevalence in high-risk groups by age, and data reveal an important proportion of youth at risk: in 2003 the highest prevalence among commercial sex workers and injecting drug users was in young people under the age of 25.

Based on AIDS case reporting in 2002, it has been estimated that 68% of cases were attributable to sexual transmission, and 30% to injecting drug use. 2% of cases may be attributed to vertical transmission and transmission through the blood supply or through unsafe injection practices. While transmission patterns need to be verified and updated, these data nevertheless indicate an epidemic driven by commercial sex and injecting drug use. After initial outbreaks among injecting drug users in the 1990s, HIV rates have risen rapidly among heterosexual men and women, while concerns exist on the prevalence among men who have sex with men (MSM).[8]

[7] UNGASS report, 2002.

[8] Last available HIV-prevalence data on MSM from 1996, when it was determined to be 33.3%.

Geographical mapping of officially reported AIDS cases shows that eastern states/ divisions have been hardest hit. The central and delta region had moderate rates of infection, with the lowest found on the western border. Transmission through injecting drug use is mainly found close to drug-producing areas (Shan and Kachin states) where approximately 85% of the drug-dependent population reside, and in urban centres. Although anecdotal evidence suggests that sex workers are highly mobile within the country, sex work is also concentrated in identifiable areas, especially sites fostering migration such as mining areas, festival settings, or border areas.

Mobile populations, including truck drivers, migrant labourers and seafarers, also congregate or pass through identifiable geographic locations. In order to better locate the routes of infection, an informal mapping exercise was organised in November 2004 with the participation of many partners of the Joint Programme.[9] The workshop aimed to identify townships with high rates of HIV transmission for four high-risk populations: sex workers, IDU, MSM, mobile populations. A list of potential 'hotspot' townships (table 2.1 below) was suggested by the participants based on anecdotal field experience.

Table 2.1 Townships in Myanmar suggested as potential 'hotspots' for HIV transmission

SW	IDU	MSM	Mobile
1. Yangon	1. Phakant	1. Yangon	1. Muse
2. Mandalay	2. Mongshu	2. Mandalay	2. Phakant
3. Phakant	3. Tamu	3. Muse	3. Yangon
4. Mongshu	4. Myitkyina	4. Kawthoung	4. Mandalay
5. Thabeikkyin	5. Moegaung	5. Monywa	5. Singu
6. Muse	6. Lashio	6. Madaya	6. Thabeikkyin
7. Tachileik	7. Kutkai	7. Toungoo	7. Dawei
8. Kawthoung	8. Muse	8. Magway	8. Myawaddy
9. Pyay	9. Tachileik	9. Monglar	9. Mongshu
10. Magway	10. Mandalay	10. Taunggyi	10. Tamu
11. Monglar			11.Thazi
12. Myawaddy			12. Pyay
13. Myeik			13. Monywa

[9] The National AIDS Programme plans to carry out a formal mapping exercise in 2005-2006.

Summary of key prevalence data

Population[10]

	Male	Female	Total (,000)
< 5 yr	3,130	3,078	6,208
5-15	5,478	5,321	10,799
15-24	4,904	4,591	9,495
25-49	8,712	8,973	17,685
> 49	3,756	4,225	7,981
Total	25,980	26,188	52,168

Urban population:
13.04 million (25%)
Rural population:
39.13 million (75%)
Adult population (15-49 yrs.):
27.18 million

HIV Prevalence

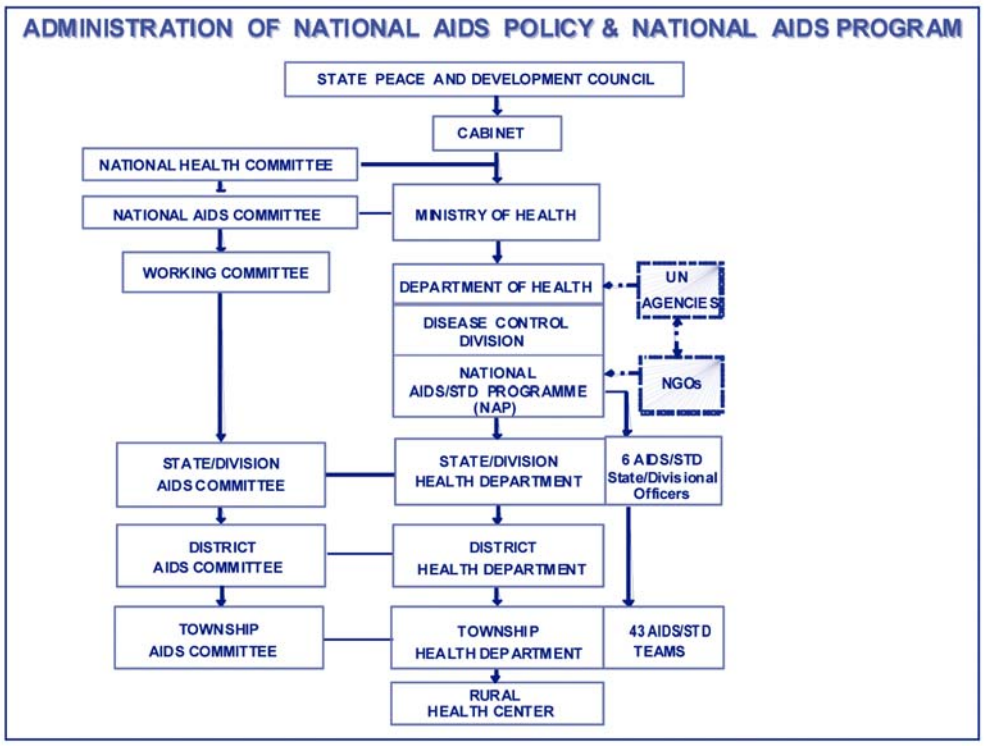
Indicator	Year	Estimate	Source
Estimated PLHA (Adults 15 -49)	2003	338,911 170,000 – 610,000	MoH Estimation Workshop UNAIDS
Prevalence in adult population	2003	1.2 [0.6-2.2]	UNAIDS 2004 Global Report
Prevalence among young (15-24)	2002	1.65 (Yangon), 1.8 (others)	UNGASS report
Prevalence among ANC attendees	2004	1.75	MoH Myanmar
Prevalence among female direct sex workers	2004	27.50	MoH Myanmar
Prevalence among IDU	2004	34.40	MoH Myanmar
Prevalence among men who have sex with men [11]	1996	33.30	EPI Fact Sheet
Prevalence among new military recruits	2004	1.60	MoH Myanmar
Prevalence among blood donations	2004	0.84	MoH Myanmar
Prevalence among male STI clients	2004	3.23	MoH Myanmar
Prevalence among female STI clients	2003	9.09	MoH Myanmar
Prevalence among TB patients	2002	10.90	WHO
Cumulative reported AIDS cases [12]	2004	8921.00	MoH Myanmar

Source: WHO/UNAIDS epidemiology fact sheet, 2004

[10] UNFPA/Dept of Labour, 2004.
[11] Myanmar Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 Update.
[12] SEARO member states do not report cumulative HIV cases but only AIDS cases.

National Health System and National AIDS Programme

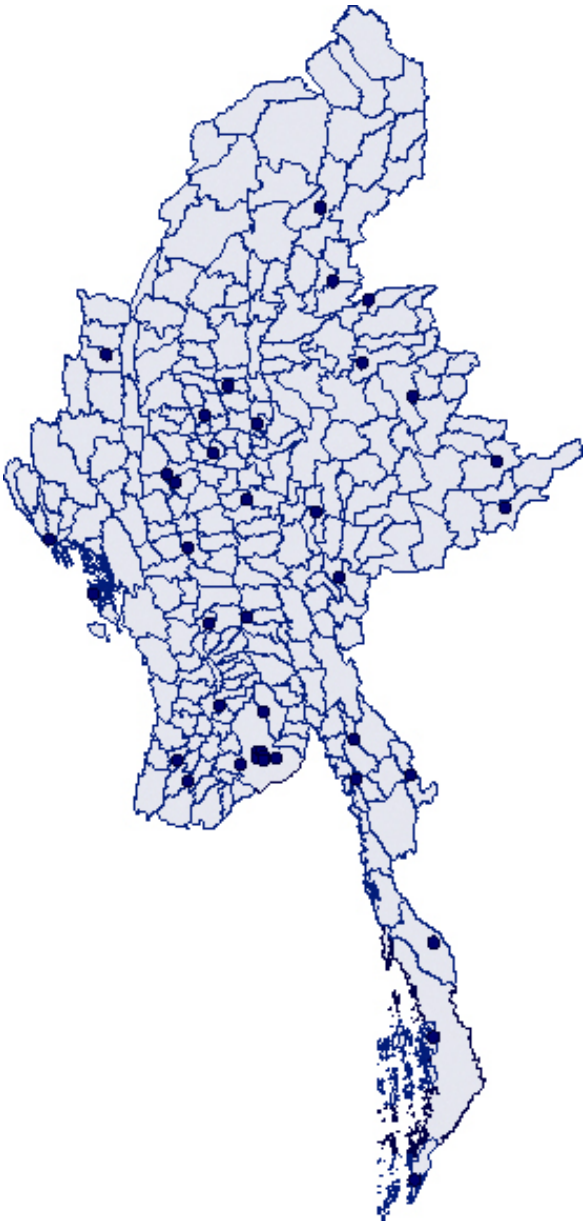
AIDS is one of the priority diseases of the National Health Plan of Myanmar. The National AIDS Committee, a multi-sectoral Government body created in 1989, is chaired by the Minister of Health and oversees the development and implementation of the National Strategic Plan (see figure). Health services are delivered through 824 government hospitals (of which 324 township hospitals), 442 dispensaries, 86 primary and secondary health centres, 348 maternal and child health centres, 1,452 rural health centres and 80 school health teams. There are 17,564 doctors working in Myanmar (6,473 in public sector, and 11,091 in co-operative and private sector), 17,864 nurses, and 1,767 health assistants.[13]



Leadership to fight AIDS is provided by the National AIDS Programme (NAP), which consists of the Programme Manager's Office, a Central AIDS/STD Clinic and AIDS Counselling team in Yangon, six state/divisional AIDS/STD offices, and 43 AIDS/STD control teams at township level, located at identified high-prevalence or high-risk areas throughout the country, covering 35 out of 63 districts[14] (map). It was planned to increase the number of township-level AIDS/STD teams by 10 per year over the next five years with Global Fund Round 3 funding.

[13] *Health in Myanmar*, 2005, Ministry of Health

[14] Myanmar is divided administratively into 8 States and 9 Divisions, each of which are in turn divided into districts (63 country-wide) then townships (324 country-wide).



Map: Townships with National AIDS Programme AIDS/STD teams

The general objective of the National AIDS Programme (NAP) is: *to increase the awareness and perception of HIV/AIDS in the community by promoting access to information and education leading to behaviour change and the adoption of a healthy lifestyle*. Strategic areas for action are:

- Advocacy to authorities and decision-makers, implementing partners, and private sector and community leaders
- HIV and STI prevention education
- Targeted interventions:
  - Prevention of sexual transmission
  - Prevention of HIV infection among injecting drug users
  - Prevention of mother to child transmission
  - Provision of safe blood and blood products
  - HIV prevention in health-care settings
- Care and Treatment of STI patients and PLHA
- Programme management and support including monitoring and supervision
- Capacity building

The AIDS activities in Myanmar are designed to help the country achieve in particular Millennium Goal No. 6, *Combat HIV/AIDS, malaria and other diseases,* specifically *To have halted by 2015 and begun to reverse the spread of HIV/AIDS*.[15]

Other sections of the health system are also mobilised to fight AIDS. The Department of Health's (DoH), Drug Dependency Treatment and Rehabilitation Unit (DDTRU) is responsible for harm reduction activities and treatment, including methadone maintenance, of addiction in drug users. Staff in selected Rural Health Centres are trained in the prevention of mother-to-child transmission. Rural Health Centres are used as a basis for other AIDS prevention activities, such as health education and youth involvement.

The Government structure is supplemented and complemented by the NGO sector which plays an important role in providing access to services, and particularly to vulnerable and hard to reach groups. The private-for-profit sector is also quite involved in AIDS. Some data suggest, for example, that patients seeking treatment for sexually-transmitted infections predominantly either self-treat, go to drug vendors directly, or visit private doctors.

[15] Myanmar's MDG report, 2005.

Current Expenditures and Estimated Needs

In general, Myanmar is a donor-constrained country. Development assistance per capita is an order of magnitude smaller in Myanmar than in neighbouring countries. In 2002, whereas Laos received approximately $53 per capita in overseas development assistance per year, Cambodia $30, and Vietnam $22, Myanmar was receiving an estimated $3 per capita per year.[16] Neither the World Bank nor the Asian Development Bank are present in Myanmar

Table 2.2 below shows details of a provisional estimation of needs and resource inflow, incorporating all funds to fight AIDS, that was made based on the following key assumptions: i) the Fund for HIV/AIDS in Myanmar will be replenished later this year at the existing level of $8m per year, ii) non-FHAM donors, UN agencies and international NGOs will be able to contribute core funds at the same, current rate, and iii) the Global Fund programme would be successfully launched. The Global Fund programme was recently terminated, although the full implications of this are not yet known.

Table 2.2 also provides a rough resource-gap analysis. A formal costing estimate will be undertaken later in 2005, but estimates, included in the table, were calculated for the Global Fund Round 5 proposal. In terms of scale, the analysis confirms that a lack of resources is already a contributing factor to low coverage of activities, and that without additional resources the gap will continue to grow.

Table 2.2 - Financial Contributions to the National Response to HIV and AIDS

Financial contributions in USD	2004	2005	2006	2007	2008	2009
Domestic (A) (including blood safety)	720,600	735,000	*753,500*	*776,000*	*792,500*	*810,000*
External (B)	**20,310,000**	**29,979,300**	***30,175,000***	***32,500,000***	***31,900,000***	***31,900,000***
- GFATM Round III	0	7,125,000	*9,500,000*	*11,500,000*	*11,500,000*	*11,500,000*
- FHAM	7,500,000	8,000,000	*7,000,000*	*7,000,000*	*7,000,000*	*7,000,000*
- USAID	2,000,000	2,000,000	*2,000,000*	*2,000,000*	*2,000,000*	*2,000,000*
- AUSAID	690,000	1,132,000	*675,000*	*600,000*	*not costed*	*not costed*
- E.C.	-	1,357,300	*900,000*	*1,300,000*	*1,300,000*	*1,300,000*
- JICA	250,000	285,000	*250,000*	*250,000*	*250,000*	*250,000*
- UN agencies	5,350,000	5,350,000	*5,350,000*	*5,350,000*	*5,350,000*	*5,350,000*
- INGO's	4,520,000	4,730,000	*4,500,000*	*4,500,000*	*4,500,000*	*4,500,000*
Total Resources available without GFATM Round 5	**21,030,600**	**30,714,300**	***30,928,500***	***33,276,000***	***32,692,500***	***32,710,000***
GFATM Round 5 (C)	0	0	*6,262,000*	*13,613,600*	*16,336,800*	*18,514,500*
Total available with GFATM Rd 5 approved (A+B+C)	21,030,600	30,714,300	*37,190,500*	*46,889,600*	*49,029,300*	*51,224,500*
Total need (D)	30,500,000	39,200,000	*52,441,000*	*64,263,000*	*not costed*	*not costed*
Unmet need if GFATM Rd 5 approved	9,469,400	8,485,700	*15,250,500*	*17,373,400*		
Unmet need if GFATM Rd 5 not approved	9,469,400	8,485,700	*21,512,500*	*30,987,000*		

Italicised figures are indicative only

[16] UN/ESCAP *Statistical Yearbook for Asia and the Pacific*, 2002

Programme Achievements

This chapter attempts to capture achievements made by all partners in the Joint Programme in Myanmar. A significant proportion have been made possible through contributions made via the Fund for HIV/AIDS in Myanmar, and these have been specified throughout the document. In addition, for each of the five priority areas, a special 'Focus on the Fund for HIV/AIDS in Myanmar' box draws out the particular achievements associated with funding from the FHAM.

Highlights in achievements

The Joint Programme's goal is to contribute to decreasing the spread of HIV and mitigating its impact on individuals, families and communities. Five key priority outputs were identified for the three-year programme:

1. Access to services to prevent the sexual transmission of HIV improved;
2. Access to services to prevent the IDU transmission of HIV improved;
3. Knowledge and attitudes improved,
4. Access to services for HIV care and support improved
5. Enabling environment and capacity building

Reducing sexual transmission of HIV by strengthening programmes promoting consistent use of condoms, safe and responsible sexual behaviour and treatment of sexually transmitted infections.

Condom distribution has increased by 24% since 2002, while the number of patients diagnosed and treated by partners for STI has greatly increased by almost 50% during the same period, attributed to a rapid scale up in the provision of services by the public health services and NGOs. According to a recent study,[17] the percentage of men that used condoms in all five last commercial acts rose from 49% in 2003 to 76% in 2005. The priority for condoms is shifting from simply increasing supply to meet demand, to increasing demand to meet the needs to protect Myanmar from the epidemic.

Reducing IDU transmission of HIV by establishing new harm reduction initiatives and strengthening existing ones.

During the two years of operation of the Joint Programme, partners have opened 14 drop-in centres in strategic townships offering a range of services with the aim of reducing the transmission of HIV. Half a million needles and syringes were distributed in 2004, double the previous year. However, the number of injecting drug users reached, at around 6,000, is still short of the actual need. Some partners suggest that coverage, although significantly increased, is still less than 5% of the estimated IDU population.[18]

[17] Expanded Theme Group presentation, 2004
[18] Mid-Term Review July 2005, unpublished draft

Improving knowledge and attitudes of the general population on HIV and AIDS, particularly youth and other specific vulnerable groups (sex workers, men who have sex with men, and injecting drug users), by implementing specific behavioural development change communication interventions targeting vulnerable populations.

Although there is a need to strengthen coverage indicators to measure this achievement, the last two years have seen an increase in HIV messages in the mass media, and in workplace HIV-prevention projects. Peer educators have been deployed for high-risk groups, youth and in the workplace. The FHAM has recorded 43,600 health-education or counselling sessions and the distribution of 5.45 million IEC materials on HIV and AIDS in the last year. However, one recent informal survey has suggested that only 41.6% of youth surveyed could identify the most common ways of preventing HIV. [3]

Increasing access to and quality of care, treatment and support of PLHA by improving the availability of standardised protocols, training and supplies to service providers and increasing access to PMCT services and VCCT to the general population in clinical and non-clinical settings.

Since 2002, when only a handful of patients were receiving ART, an increase of 100% every 6 months has been recorded, reaching around 1,000 patients by mid-2005[4]. VCCT is gearing up even more sharply, from 800 individuals in 2002 to 64,000 in 2004. PMCT is following the same trend, with 118 mother-baby pairs receiving *Nevirapine* in 2002 and 405 in 2004. While only 575 PLHA were receiving home-based care in 2002, the estimated number for 2004 is now 3,800. The last year has seen the establishment of a number of self-help groups for PLHA.

Enabling environment for an effective expanded national response strengthened through advocacy, improving monitoring and evaluation, capacity building, and improved coordination.

The operating and policy environment has improved considerably over the first two years of the Joint Programme, largely due to increased attention by Government, assistance and advocacy by partners, and increased resources. The most obvious progress is in the number of partners involved in the Joint Programme, today more than 40, including Ministries, UN agencies, local and international NGOs, against a dozen in 2002. Of the 26 organisations currently funded through the FHAM, 14 are new to Myanmar or were not significantly involved in HIV prevention or AIDS treatment and care activities 2 years ago. Partners are working in all states and divisions in Myanmar. Increased coordination has lead to the development of a unified M&E system and an improved consultation process among partners.

Since April 2003, the FHAM has enabled a significant increase in resources for HIV prevention and AIDS treatment and care in Myanmar. Following a first round of implementation, a new round of funding for two years was allocated by the Technical Working Group in April 2004, subsequent to a technical review of 47 proposals submitted for funding. A total of 22 projects were approved for a period of two years in Round II funding amounting to USD 12,800,000 (Chapter VI and annexes). This progress report covers implementation of projects by partners funded by Round II of the FHAM from 1 April 2004 to 31 March 2005.

[19] Expanded Theme Group presentation, 2004

[20] In 2004, WHO '3 by 5' mission estimated that 46,500 persons were in need of ARV. A rapid scale-up is required to meet the need.

1. Access to Services to Prevent The Sexual Transmission of HIV Improved

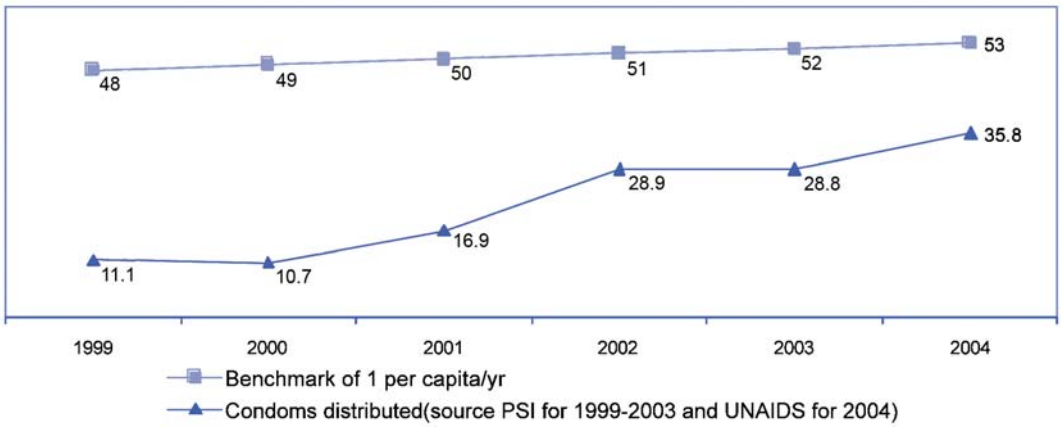
(Joint Programme Component 1)

Significant progress has been made in Myanmar over the last two years in increasing access to services to prevent the sexual transmission of HIV, especially in access to condoms and to treatment for STIs.

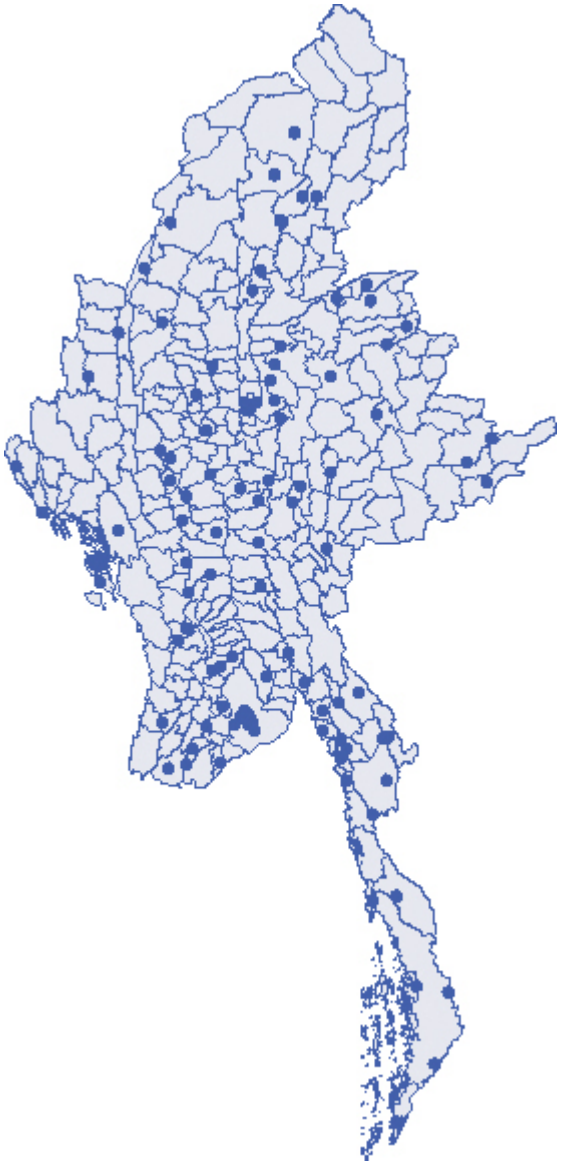
Condoms

Since 1999, estimates reveal that condom use has roughly tripled (chart 3.1.1). The National AIDS Programme and Population Services International-Myanmar (PSI) estimate that total consumption of condoms has increased from less than 3 million per year in 1996 to more than 35 million in 2004. Access to condoms has improved considerably, with condoms both widely available and affordable. Now, the challenge remains to increase their use among high-risk and vulnerable groups by overcoming resistance and ensuring safer behaviours. Per capita condom consumption in Myanmar has increased three-fold over the last five years, which is encouraging. Nevertheless, at less than 0.7 condoms per capita, consumption remains considerably less than that of Cambodia, Nepal or Thailand (around 2 per capita) or Laos (around 1.1 per capita).

Chart 3.1.1 **Condoms distributed in Myanmar, 1999-2004 (millions)**



In March 2001, the National AIDS Programme began implementation of the 100% Targeted Condom Promotion programme in 4 pilot townships. The programme is modelled on similar activities in other countries of the region, but its implementation has been adapted to the local culture and economic situation. The programme was expanded to 14 townships in November 2002, 57 townships in 2003 and 110 townships by early 2005 (map; chart 3.1.2). This expansion was supported by the FHAM, UNFPA, WHO, and the UNAIDS Secretariat. The programme includes targeted condom distribution and promotion to sex workers and their clients, training and IEC, peer education among sex workers, formation of the Condom Core Group and advocacy with police, local authorities and the owners of entertainment establishments for 100% condom use. In selected townships, the programme has partnered with NGOs like PSI to help ensure access to the groups at highest risk. NAP and WHO recently conducted a review of this programme in July 2005.

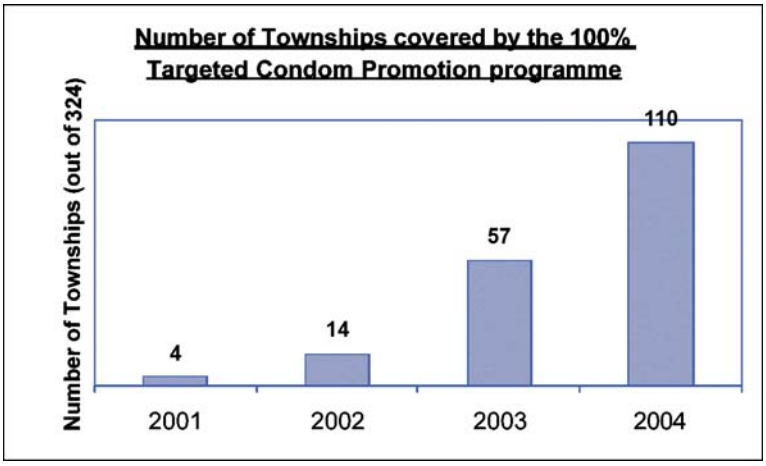


Map: Townships with 100% Targeted Condom Promotion

The social marketing network established by PSI has distributed 70% of the 35 million condoms recorded by the Joint Programme. The number of retail outlets purchasing condoms from PSI increased from 1,400 in 2000 to 10,000 in 2004, covering almost all of the 324 townships in Myanmar. Condoms subsidised by PSI are found on the market at a price equivalent to approximately 0.04 USD, while the commercial brands vary in price from 0.16 to 0.22 USD.

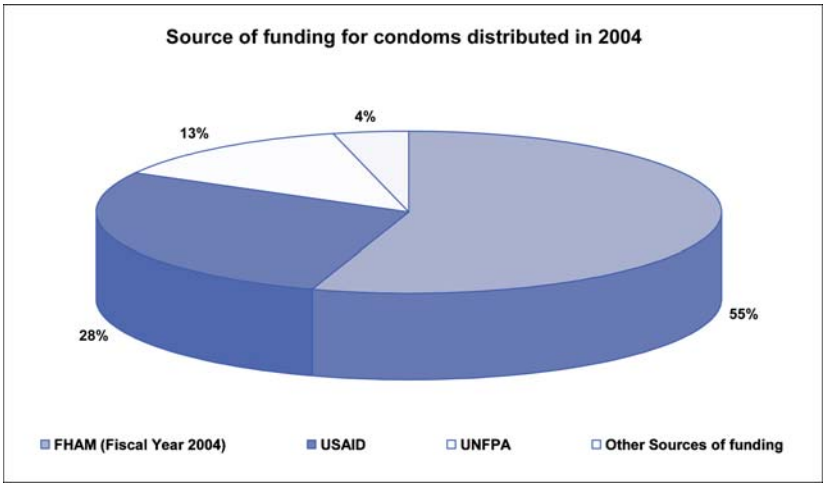
Condoms are also distributed free of charge by AIDS/STD teams and field staff of NGOs. In 2004, about 10 million condoms, or 30% of the total, were distributed in this way. Aside from PSI, the main organisations distributing condoms in 2004 were as follows: NAP 3.7 million; MSF-H 3.1 million; CARE 1.2 million; UNDP 680,000; World Vision 391,000 UNHCR 378,000; and SC-UK 277,000. MDM, MSI, AMDA and AMI each distributed between 100,000 and 200,000[21]. Most of the international NGOs distribute condoms sourced from PSI. The vast majority of the condoms distributed in Myanmar in 2004 were funded from three sources, the FHAM, USAID, and UNFPA (chart 3.1.3). Data for 2004 indicate that only around 10% (3.5 million) of the condoms consumed in Myanmar were bought from commercial sources (non social marketing).

Chart 3.1.2



[21] Other partners distributing condoms include: ADRA, AFXB, MSF-CH, PACT, PARTNERS, Progetto Continenti, SC-US, UNODC, World Concern; MANA, MBCA, MMA, MMCWA, MRCS, MRT.

Chart 3.1.3



Source UNAIDS

Targeted surveys among working class males and female sex workers in Yangon and Mandalay between 2002 and 2005 suggest that condom use has increased, as reported in the tables below. While these figures may reflect a reporting bias, they do suggest an upward trend.

Table 3.1.1 Findings from condom use surveys in Yangon and Mandalay

Indicator	Jan 2003	Jan 2004	Jan 2005
Reported condom use amongst working class males in Yangon and Mandalay			
Used condom in all of last 5 commercial sex acts	49%	53%	76%
Proportion of last 5 commercial sex acts in which condoms used	67%	69%	83%
Condom use in last commercial sex act	n/a	n/a	82%
Reported condom use amongst female sex workers in Yangon and Mandalay			
Used condom with all clients during the past week	64%	69%	85%
Proportion of clients in last week with whom condoms used	81%	88%	96%
Condom use with last client	n/a	n/a	95%

A large survey of young people aged 15-24 in 12 towns and cities in 2004 found that 24% of males reported that they had ever paid for sex; 85% of them reported having used a condom the last time they paid for sex.[22] As expected, surveys show that condom use by men in commercial sex is far higher than with girlfriends, which in turn is higher than with spouses. Working class males in four urban areas reported using condoms in 8% of last acts with their spouse, 26% of last acts with a girlfriend and 79% of last acts with a sex worker. There remains an urgent need to educate men to choose to use a condom. In a recent study of the reasons given by sex workers for non-use of condoms in paid sex, of those sex workers who reported not having used a condom, 94% said that their partner had objected. Behaviour change must be achieved among clients of sex workers.

All partners need to continue efforts to further increase the availability of condoms, especially where risky sex takes place, and to reinforce demand. Behaviour change communication should go beyond general awareness of HIV to focus on more profound

[22] Unpublished study, 2004

barriers to condom use. These include: the belief that healthy-looking people are less likely to have HIV; condom negotiation skills; skills and techniques for successful condom use; and understanding that oil-based lubricants break condoms.

NAP, NGOs and others have been encouraging condom use in high-risk sex, through small-group sessions and health talks, since the early 1990s. One partner carried out a survey of high-risk groups in urban areas, and found that 88% of respondents agreed with the statement that people can protect themselves from HIV by using a condom every time that they have sex. However, women still remain reluctant to carry condoms. Until 2001, possession of condoms could be used as *prima facie* evidence of prostitution. Since then, the police have repeatedly issued internal directives that this is no longer the case, but anecdotal evidence suggests that condom carrying is still viewed by police to be an act warranting arrest. The recent trend towards greater visibility of condoms in mass media should continue, in order to contribute towards de-stigmatisation of condoms and reinforce messages for consistent use.

Some activities could not be completely implemented due, at least in part, to constraints related to the acceptance of messages by the community, as well as cultural and environmental factors. For example, cultural constraints were experienced in some townships for conducting condom demonstration for young women. Occasionally it was not possible to use an anatomical model for condom demonstration since it embarrassed some women. Resistance to condom promotion and demonstration was reported when working with some faith-based organisations (Catholic and Buddhist). One implementing partner reported that it was not able to distribute condoms as planned as the target had been overestimated.

Female condoms

In July 2003, PSI introduced the *Feel* brand of female condom. Sales have been limited to direct channels and accompanied by training (by outreach workers and peer educators of PSI and other international NGOs). Sales through April 2005 have totalled 117,000 units and currently average about 5,000 per month. PSI plans to sell the product through selected retail outlets in the near future; NAP also plans to introduce the female condom. In a small-scale survey in January 2005, 78% of sex workers surveyed in Yangon and Mandalay reported that they had heard of the female condom, 42% said they had been shown it, 35% believed that they could use it correctly, and 19% said that they had used it. Access to female condoms and water-based lubricant needs to be increased.

Treatment of Sexually Transmitted Infections

Access to services for the diagnosis and treatment of STIs has also been expanded in recent years. According to NAP annual reports on STIs, the syphilis prevalence rate in first-time pregnant women has fallen steadily from a peak of 5% in 1993 to 2.2% in 2004. This trend is echoed by findings in one Yangon suburb of Hlaingthayar, falling from 8.5% in 2000 to 6.3% in 2004.[23] The same data showed falling rates of syphilis in female (from 26% to 11%) and male (from 21% to 14%) STI patients, and in sex workers (from 41% to 34%). Although concrete comparative evidence of the impact of behavioural change programmes on increased awareness of STIs is hard to come by, there is widespread anecdotal evidence of increased knowledge, particularly among high risk groups (sex workers and their clients, and men who have sex with men).

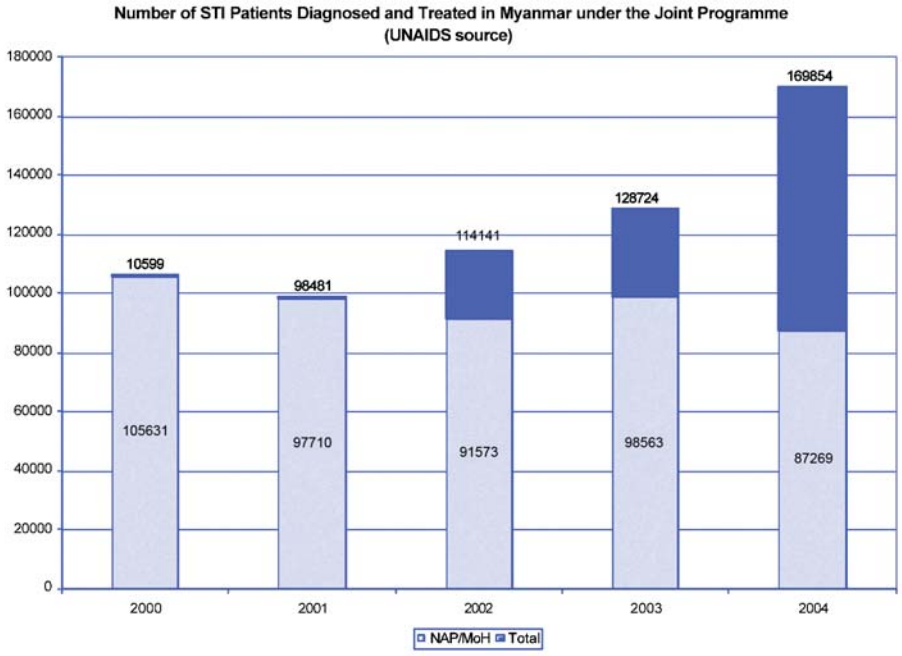
The Department of Health's National AIDS Programme has 43 STI/HIV teams located

[23] MSF-Holland, 2005

in 34 townships across the country. STI syndromic management training has been completed in 310 townships and services are being provided by different kinds of health care providers including basic health staff. UNFPA provided funds for central level training and township level training of NAP staff from 25 UNFPA supported townships.

The DoH Mother and Child Health section has also been implementing a reproductive health project in 93 townships in collaboration with UNFPA to provide STI services to women of reproductive age. More than 50% of the STI patients recorded by the Joint Programme have been treated through the public system (chart 3.1.4).

(chart 3.1.4)



The existing national treatment guidelines tor STIs were revised and tailored to the Myanmar setting through a consultative process involving NAP, WHO and other partners who provide STI services in the country, and with support from the FHAM. The Department of Health and NAP are now working to implement these new guidelines throughout the country. There is a considerable reluctance among medical staff to perform a thorough medical exam including a vaginal exam. There is insufficient of use/access to laboratory services. The majority of reproductive tract infection treatment is done syndromically. The effectiveness of this approach depends on how well signs, symptoms and risk definitions correlate with confirmed STIs. But most signs and symptoms weakly correlate with the major reproductive tract infection diagnoses and the relationships vary according to the socio-economic status and sexual behaviour. Many STIs are asymptomatic and missed by the syndromic approach. This leads to both under- and over-treatment of key diseases. In addition, a large database including over 12,000 women with STI complaints recently showed that in Myanmar risk assessment adds significant sensitivity and specificity to diagnosis and treatment compared to the WHO standard syndromic flow chart.

UNFPA and UNICEF provided drugs for STI treatment in selected townships. Seven international NGOs (AMI, Malteser, Marie Stopes International [a member of the Consortium[24]], MDM, MSF-Holland, MSF-

[24] The Myanmar NGO Consortium on HIV/AIDS was formed in 2003 as a means of increasing the impact and sharing the expertise and combining the comparative advantage of 5 long-standing NGOs working in Myanmar. The Consortium's mission is to mobilise experience, resources and partnerships for the people of Myanmar to reduce the devastating human consequences of HIV/AIDS. The Consortium 's 5 members are (in alphabetical order) CARE Myanmar, Marie Stopes International Myanmar; Myanmar Nurses Association; Save the Children UK and World Vision International.

Switzerland, PSI) have direct STI diagnosis and treatment service provision in 92 of the 324 total townships of Myanmar, according to UNAIDS data collection. Several national organisations (including MBCA, MMA and MRT) refer beneficiaries to other service providers for STI treatment. In 2005, four international NGO STI providers (MSF-CH, MSF-H, PSI and AMI), all supported by the FHAM, came together under the banner of the Thazin (Royal Orchid) Clinics to create a network of quality STI treatment providers (See 'Focus on the FHAM' box). The network encourages vulnerable and high-risk individuals to seek regular check-ups and provides an easily recognisable brand name for quality care.

Some partners reported that, although sex workers were interested in participating in projects, they were afraid of being identified by the police. In some townships, sex workers are mobile and difficult to follow up for STI treatment. One partner working in an area bordering China reported that many sex workers are foreigners and fear deportation if discovered seeking health care or HIV testing. This has a negative effect on the number of sex-workers who come forward for sexual health services.

Private sector clinics and shops provide a large amount of STI treatment, although real concerns remain with diagnostic and drug quality. A small number of Joint Programme partners have targeted the private sector in recent years working on improving skills, medications and attitude. PSI, for example, has created the Sun Quality Health Clinics - a network of 470+ private practitioners - who receive training and ongoing medical education, subsidised pharmaceuticals, and agree to charge a fixed low fee for consultation and treatment. PSI also developed pre-packaged treatment kits, one for urethritis and one for genital ulcers, and trained 108 Sun Quality health providers to use the kits with a syndromic management approach. Educating sufficient private practitioners to investigate, diagnose and prescribe effectively is a major challenge, as is reducing the damage done to individuals and public health by 'quacks'.

Since most treatment activities are more concentrated in urban areas and high risk sites such as areas of men-only industry, the access for high risk populations has probably improved more than for the general population, particularly as many Joint Programme partners have made specific efforts in this direction.

During the process of pre-review by partners in country, prior to the Joint Programme mid-term review, a number of issues were noted:

- The number of quality service providers of STI diagnosis and treatment, including the private sector, needs to be increased. While the ideal is to promote treatment by expert clinics, the reality is that many people will continue to self medicate. Activities to improve the practice of drug shops should be considered in the context of national guidelines. This could range from improving the quality of drugs and knowledge of the drug seller, through to health education issues such as the promotion of condoms when asked for STI drugs. Efforts by the state to regulate drug shops should be supported.
- A major effort to improve the quality of drugs is needed. All partners could be encouraged to import drugs instead of local purchase. Social marketing approaches can stimulate private practitioners and drug shops to use/sell quality-assured drugs.
- Continue to address the gaps in knowledge of STIs, through IEC, in perceptions and knowledge of how to treat STI, and in what is appropriate/effective self-medication.
- Promote the clinical practice of genital examination for every STI complaint prior to treatment.
- Provide VCCT services close to provision of STI services of quality.
- Reassess the impact that the fear of imprisonment is having on regular sex-worker attendance at STI clinics.

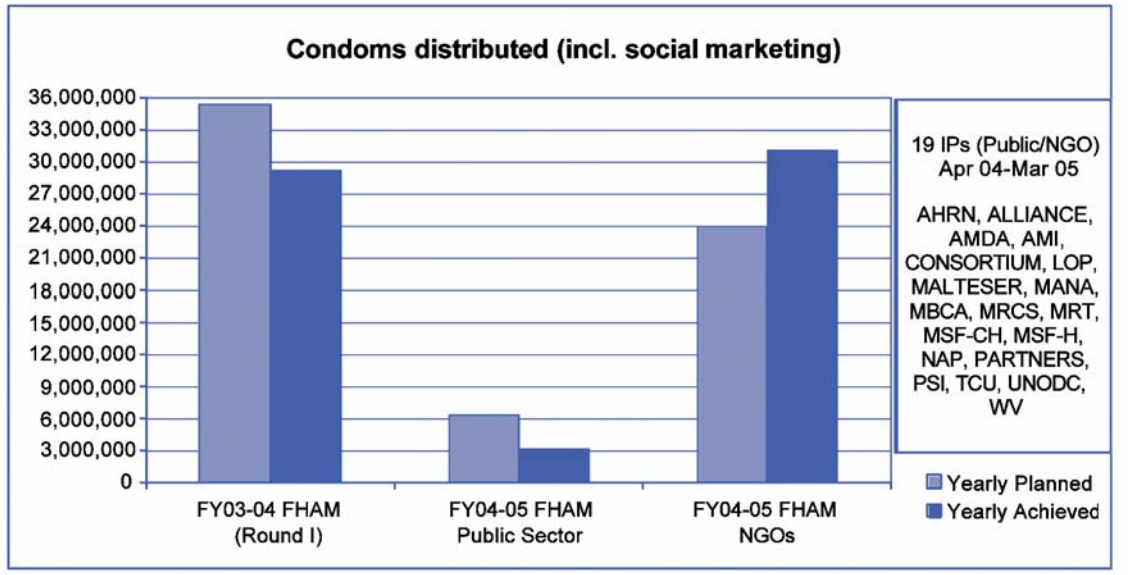
Focus on the Fund for HIV/AIDS in Myanmar (1 Apr 2004-31 Mar 2005)

Sixteen projects funded by the FHAM directly address the prevention of sexual transmission through the provision of services to high-risk groups and the general population. Funding contributes to two key outputs of the Joint Programme: increasing access to condoms, and improving the capacity for the prompt and effective management of sexually transmitted infections.

Access to affordable condoms for sexually active men, women and young people increased

34,332,000 condoms were supplied with support from the FHAM[25] and distributed by the end of the year, exceeding a combined target of 30,367,000 (chart 3.1.5). Condoms have been distributed to groups including sex workers, STI treatment seekers, men at higher risk in the general population, men who have sex with men (MSM), injecting drug users, vulnerable youth, seafarers, factory workers, and in both urban and rural areas. Distribution methods included social marketing at selected retail outlets near 'hotspots' (PSI), through health education activities (MBCA, MRT) and peer educators - especially for sex workers and high-risk men (PARTNERS, AMI, PSI and Consortium). Partners reported that the marked increase in the numbers of condoms distributed on the previous year was a result of higher demand, and development of a condom culture and of non-traditional outlets (MSF-H, Consortium).

Chart 3.1.5



The FHAM has supported the continuation of the 100% Targeted Condom Promotion programme (TCP) implemented by the National AIDS Programme (NAP) in 58 townships, and expansion in 20 additional townships, reaching a total of 110 townships[26]. Advocacy was supported at all levels, and training of peer educators and condom distribution have been supported at township level. A central level training for the health staff participating in the 100% TCP in 78 townships was conducted by the NAP with support from WHO.

[25] FHAM co-funded 40% of PSI condoms

[26] In addition, 6 out of 110 townships implementing 100% TCP were financially supported by WHO.

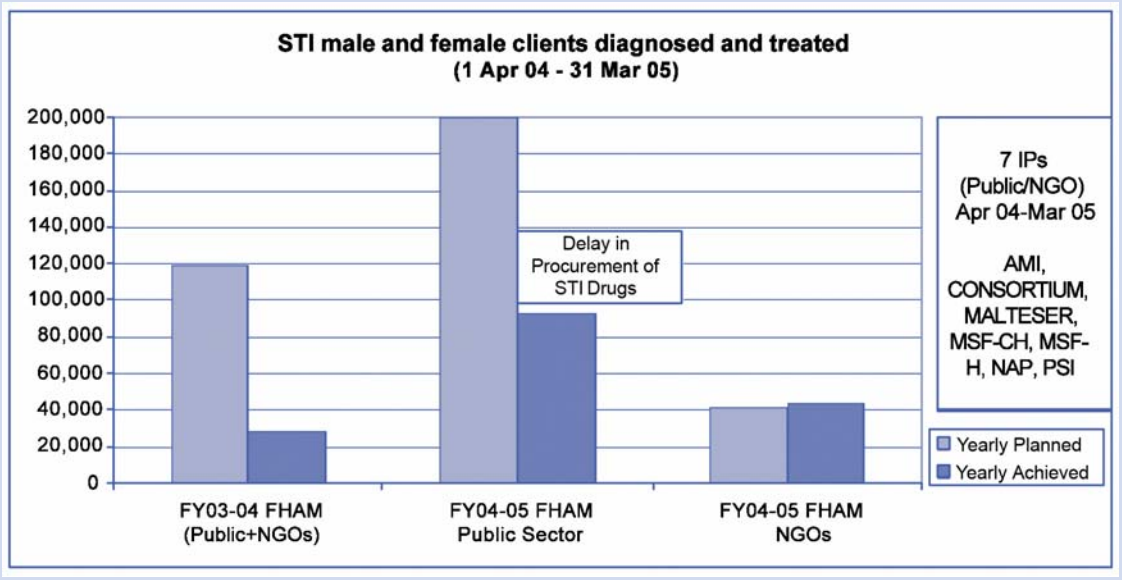
Implementing partners reported a number of constraints to planned implementation. Gaining permission to demonstrate the use of condoms in school settings is still difficult, and so one partner was unable to carry out condom demonstration as planned among high school students. Other partners reported that condom demonstration was found to embarrass some young women. Another partner was unable to carry out condom distribution as planned in STI clinics and entertainment establishments in the Wa Special Region, as it was not permitted by Wa Region health authorities.

Management of sexually transmitted infections increased

Seven implementing partners funded by the FHAM are working in this service delivery area. A total of 128 service delivery points providing quality STI treatment based on national guidelines in 71 townships are supported by the FHAM. During the last financial year, 139,778 patients were diagnosed and treated (chart 3.1.6), and 178,391 clients accessed STI services[27] during the period[28]. Monitoring data show that quality treatment services are in high demand. Many not-for-profit private facilities screened and treated higher number of patients than planned in their original targets and have observed an increasing demand for quality STI treatment services.

In the public sector, existing service delivery was strengthened through the provision of training and medical supplies to the 43 AIDS/STD teams of the NAP, and to 284 township hospitals countrywide. The FHAM supported the process of revision and standardisation of guidelines for the treatment and management of STIs with local experts from Government, WHO and NGOs. Myanmar Railways provides screening for STIs in collaboration with the NAP, and reported the need to scale up STI services to cover mobile workers in remote areas (MRT). In addition, the screening of pregnant women for STIs is routinely carried out by the NAP and three NGOs within the context of antenatal care.

Chart 3.1.6



[27] Not all partners are able to report on the number of clients accessing services.

[28] Co-funding in the case of PSI and MSF-Holland.

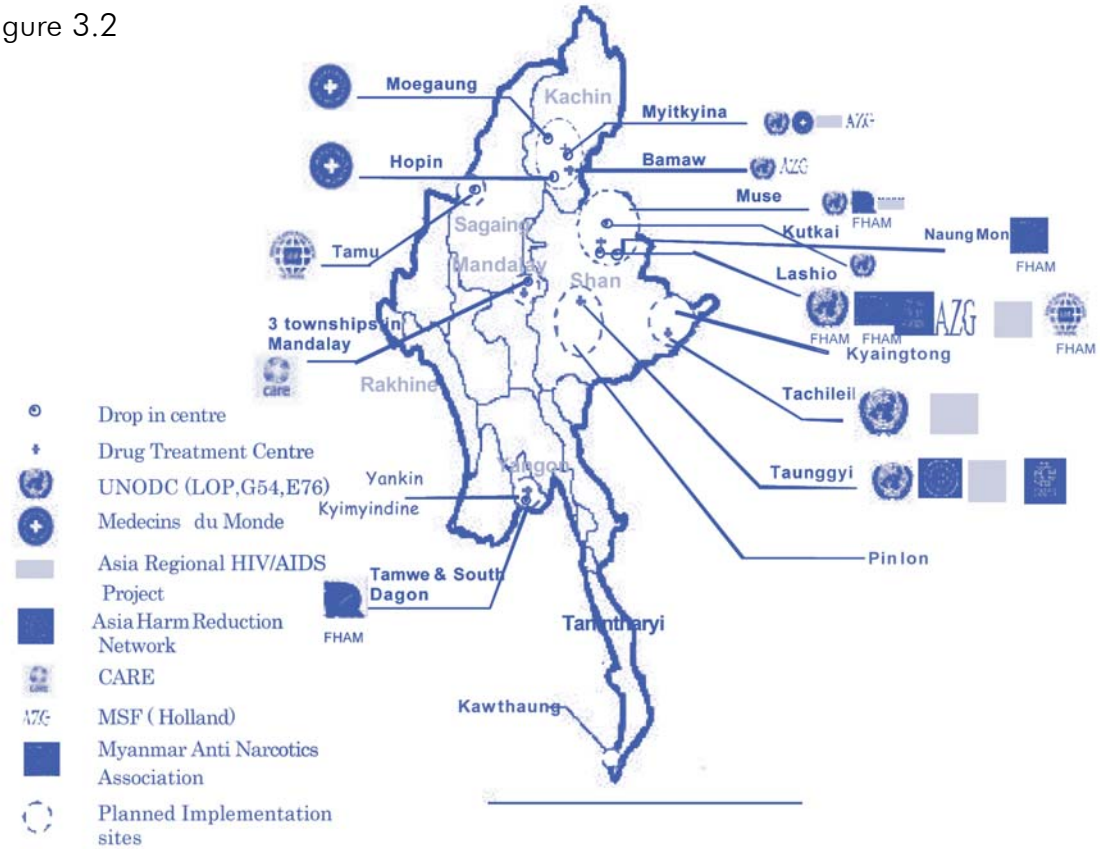
Four NGOs supported by the FHAM have come together and join efforts under a common brand name – Thazin clinics - to provide quality care especially for high-risk groups. These partners are working to ensure that STI services are provided to high-risk groups in a friendly, accessible and supportive environment. For instance, special arrangements are made with brothel owners for sex workers to attend the clinics and receive treatment as and when required. Transportation to and from the clinics is covered by some organisations. Opening times are convenient for sex workers, with clinics during the day and early evenings. Clients receive health education and condoms, and the number of STI patients treated almost doubled compared with the first year of the FHAM. In addition, clinic doctors have been successful in facilitating continuation of treatment in jail on humanitarian grounds. In Pathein, 25 sex workers were invited for an innovative two-day lifeskills workshop organised by MSI. Interest was higher than expected, with 40 sex workers attending, 35 of whom chose to enrol in a new STI treatment procedure of "presumptive treatment", and reported satisfaction with the service upon follow up (Consortium).

2. Access To Services To Prevent IDU Transmission Of HIV Improved

(Joint Programme Component 2)

Interventions to target the transmission of HIV through injecting drug use in Myanmar are relatively new and so are still in the early stages of implementation. Currently, the three main sources of external funding for harm reduction interventions are AUSAID in its support for the Asia Regional HIV/AIDS Project (ARHP); the European Commission through its financing of the UNODC-coordinated 'G54' Project; and the FHAM. ARHP provides a range of services, education and referrals for drug users and their families through centres in Northern, Southern and Eastern Shan states. To assess the situation and to demonstrate to local authorities the need for interventions for drug users, the ARHP carried out Rapid Assessment and Response surveys in six townships. The UNODC 'G54' Project aims to reduce the harmful consequences of injecting drug use among drug users and their families through capacity building and information strategies, and is implemented through a partnership between UNODC, CARE and Médecins du Monde. Its geographical focus is on communities and institutions in Kachin and Shan states, and in selected areas of Bago and Mandalay divisions. Significant additional scale-up and geographical expansion of services to reduce IDU transmission of HIV had been planned using Global Fund Round 3 resources, now terminated.

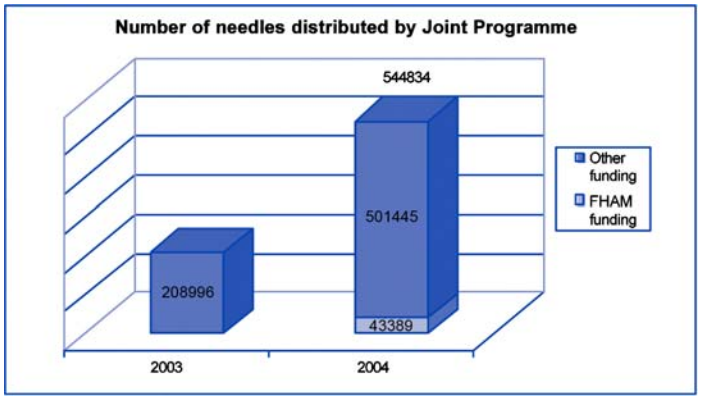
Figure 3.2



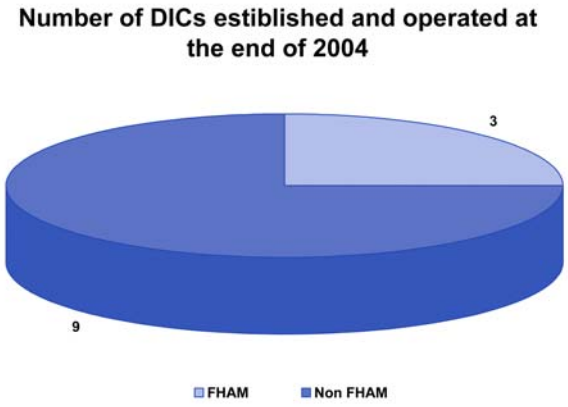
The prevailing abstinence approach to drug use control has required continuous advocacy for the introduction of harm reduction as a complementary but imperative approach to the mainstream of public health opinion. National leadership in the field of harm reduction is provided by the Central Committee for Drug Abuse Control (CCDAC) of the Ministry of Home Affairs, along with the Department of Health's Drug Detoxification/Treatment & Rehabilitation Unit (DDTRU). The impact of harm reduction programmes can only be demonstrated after several years of implementation in any country. As Myanmar is only in its second year of implementation, evidence of progress is based on achievements in the process of implementation. Services that have been established for drug users include drop-in centres and outreach into the community, with provision of primary health care services, and needle and syringe exchange programmes. Condom distribution with education on safer sex is also provided to address the sexual transmission of HIV to partners of drug users. IEC materials on harm reduction have been produced and distributed, as well for the primary prevention of drug use. Drug treatment and rehabilitation services are available.

An operational plan for effective control of the transmission of HIV in injecting drug users (IDU) was endorsed by all stakeholders and has been used to shape the overall harm reduction response. According to the operational plan, 20 townships were confirmed as top priority townships for intervention. To date, 16 of the 20 townships have at least one harm reduction project in place, implemented by a range of NGO partners[29] (figure 3.2).

Chart 3.2.1



Three of these townships in Northern Shan State (Lashio, Muse and Kutkai) were designated as top priority townships or 'Comprehensive Harm Reduction Initiative Townships (CHRI)'. In Lashio, a coordinated effort by Component 2 implementing partners aims to provide high coverage of harm reduction services, including drug-use prevention, treatment and rehabi-litation. In Muse, a smaller scale harm reduction programme is also being put in place. However, for Kutkai, authorisation to start a harm reduction programme has so far been postponed.



[29] Asian Harm Reduction Network (AHRN), Asia Regional HIV/AIDS Project (AHRP), CARE, Médecins du Monde (MDM), Myanmar Anti-Narcotics Association (MANA), MSF-Holland, United Nations Office on Drugs and Crime (UNODC)

Progress has been made in the 16 townships, as indicated by the numbers achieved in needle and syringe distribution, of previously out-of-reach IDU that have been contacted by outreach workers, and of vulnerable youths who have access to IEC materials and counselling services. Nearly 545,000 needles and syringes were distributed in 2004, compared with 209,000 in 2003 (chart 3.2.1). The needle return rate reportedly varies from 49% to 74%.

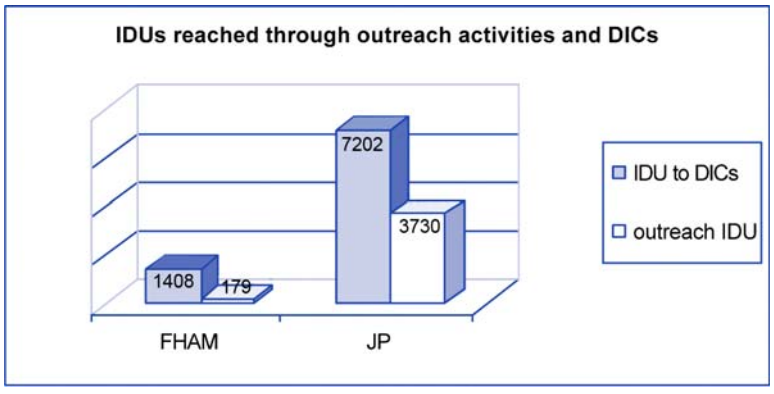
There are currently 14 drop-in centres and/or outreach projects in operation (12 at the end of 2004) in 10 townships. Coverage in Myanmar is low if seen from a national perspective, reaching only 16 townships out of 324 in the country. Poor access to some priority townships due to security reasons is a challenge, although expansion of harm reduction interventions to 15 new townships was nevertheless planned through Global Fund Round 3 funding. IDU have been reached either through those drop-in centres or through outreach workers. Partners reported the involvement in their projects of 154 IDU peer educators (all of whom male) and 177 other outreach workers.

In addition to these services, harm reduction interventions will be strengthened with the launch later this year of methadone maintenance therapy programmes, to be initiated in the four townships where the DoH's DDTRU operates major Drug Treatment Centres. The anticipated roll-out of substitution therapy linked with VCCT and ART services will create the enabling environment needed for IDU to stabilise their lifestyles to a level where adherence to ART is possible.

To inform planning, and for impact to be measured, regular surveys of HIV risk behaviours of IDU have to be undertaken. A national Behavioural Surveillance Survey will be launched by the end of 2005 by the National AIDS Programme with the technical assistance of a private company and UN agencies. IDU will be one of the four vulnerable groups surveyed, with a sample of more than 1,000 IDU in 4 sites: Yangon, Mandalay, Myitkyina and Lashio.

All partners in harm reduction have been carrying out advocacy at various levels, from central/national down to the local and community level, and aimed at many different individuals and sections of society. Study tours have been organised for decision makers (including police and regional commanders) to visit harm reduction projects in other countries (Pakistan, India, Hong Kong, Australia, Indonesia). National seminars have been held on subjects ranging from substitution treatment to prevention of HIV transmission in prison settings. Harm reduction partners have participated at national AIDS exhibitions. Advocacy meetings have been held for local authorities in harm reduction townships, and the concept of local Steering Committees and Working Groups has been introduced. These consist of representatives from local authorities, implementing partners and other stake-
holders, and play an important role in coordination of activities at the community level, and in knowledge transfer. Ongoing advocacy is needed, as knowledge of harm reduction remains low overall, and because of frequent staff turnover at official level. At present, acceptability of harm reduction is good at local level, although further advocacy is needed for high-level decision makers.

Chart 3.2.2



Capacity building has been an integral approach in harm reduction, and is essential in order to be able to provide the package of technical interventions to address HIV prevention in IDU. Topics covered in trainings by several partners have included: harm reduction concepts and practice, Rapid Assessment and Response (RAR), outreach, drop-in centres, substitution treatment, law enforcement and prisons.

Coordination of Injecting Drug Use and HIV prevention activities

The Joint Programme structure created the framework (Component 2) to foster coordination of stakeholders in interventions for injecting drug use. To facilitate coordination and ensure the effective implementation of projects and support of Component 2, a Technical Coordination Unit (TCU) was established in July 2003 by UNODC (Office on Drugs and Crime), and supported by the FHAM. The TCU acts as a resource centre for any organisation that carries out HIV prevention activities in injecting drug users in Myanmar. It coordinates IDU-related projects, undertakes the procurement of specialised supplies, prevents overlapping of activities, promotes exchange of information between implementing partners and identifies culturally appropriate guidelines to implement HIV prevention programmes for IDU. It also provides support in establishing a mechanism for monitoring and evaluating IDU and HIV-related activities.

In late 2004, Burnet Institute consulted with seven Component 2 implementing partners in an assessment of technical needs (see Focus on the FHAM box). This exercise identified a number of gaps in the capacity of partner organisations to deliver harm reduction services in Myanmar and proposed the following responses:

- Standardised operating systems across different areas of service delivery - Operations and procedures manual for harm reduction services; Development of Monitoring and Evaluation tools.
- Training workshops to establish minimum standards - General harm reduction training workshop; partner-specific training workshops based on need.
- Further development and increased scope of IEC materials, on topics including safer injection, risk behaviour related to HIV, sterilisation methods for injecting equipment, overdose management, brief overview of drugs and their effects followed by an explanation about harm reduction, abscess management, referral services, and other social and legal information.
- Development and implementation of a training database to improve information and resource sharing.
- Increased technical assistance for Central Committee for Drug Abuse Control (CCDAC) including: management and capacity building, curriculum development, drug diversion sentencing and referral systems.

A number of challenges have been experienced, related to the sensitive nature of some of the interventions in reducing harm, where some may see interventions as condoning illegal drug use. For example, in the case of needle and syringe distribution, some officials feared that drug users might resort to selling needles and syringes provided by needle distribution projects to raise cash to purchase drugs. However, given the controls on the numbers of needles and syringes distributed to individuals, this would not be feasible as a cash-generating proposition. Moreover, partners encourage the return of used needles for safe waste disposal.

Focus on the Fund for HIV/AIDS in Myanmar (1 Apr 2004-31 Mar 2005)

Interventions targeting the reduction of harm among drug users have been significantly developed with support from the FHAM. More actors are now involved in the prevention of HIV transmission among injecting drug users and work within an Operational Framework developed in Round II of the FHAM to ensure a coordinated expansion of activities. Seven implementing partners work in this service delivery area and include the National AIDS Programme, two UN organisations, two international NGOs and one national NGO. In addition, the Central Committee for Drug Abuse Control (CCDAC), a government department within the Ministry of Home Affairs, was approved for funding in the second round but was only recently able to sign a contract to start implementation. The CCDAC is a key harm reduction partner, which has been supporting the work of several partners since the beginning of the Joint Programme. The nature of the organisation makes it an important partner and opens a key opportunity to pioneer new activities in law-enforcement related fields. These include HIV prevention in the police force, in rehabilitation centres for drug users and importantly in prisons which often act as amplifiers of other health issues including TB and HIV. Through the FHAM, UNAIDS has actively fostered links and promoted close collaboration between the CCDAC and Burnet Institute's Centre for Harm Reduction (BI-CHR). As a result of harmonisation of activities, timely and appropriate technical assistance from Burnet Institute to CCDAC for the implementation of new harm-reduction related activities is now ensured in Round II.

The six other partners address the aims of this component through advocacy work, outreach activities and drop-in centres (AHRN, MANA, UNODC) or through the provision of technical assistance and coordination (BI-CHR, NAP, UNODC, WHO).

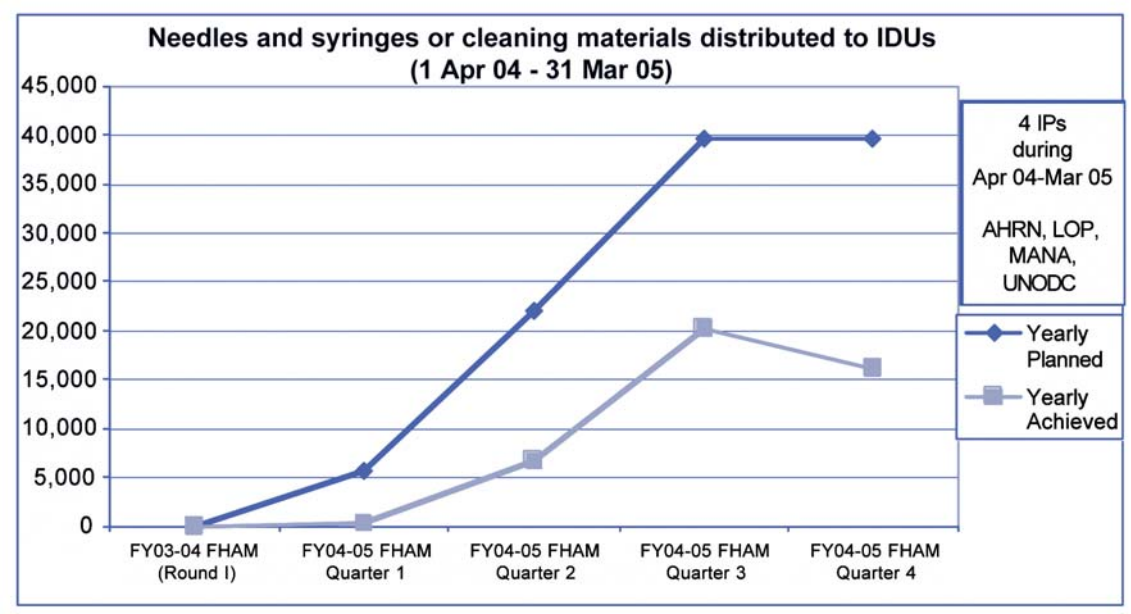
Access to harm reduction interventions increased

In total, four drop-in centres for drug users were established or continued to provide services (one in Tamwe township, Yangon (MANA) and three in Lashio, Northern Shan State (AHRN, UNODC, MANA)). They provide counselling, education on health and safer sex behaviour, condom distribution, needle and syringe distribution, and primary health care. One lesson learned was that provision of primary health care services to drug users constitutes an entry point for the provision of harm reduction and other interventions and is well accepted by the community. In each location, the drop-in centre services are complemented by a range of outreach activities contacting and reaching drug users in the community. Outreach workers were able to make more contacts and penetrate further within the IDU community in Lashio, while the wider community has made significant progress in understanding the importance of needle and syringe distribution. Clients are referred by outreach workers to the project drop-in centres for counselling and for primary health care services, to the AIDS/STD team for Voluntary Confidential Counselling and Testing (VCCT), and to the Drug Treatment Centre.

Between the projects in Lashio and Tamwe, 1,609 IDU accessed drop-in centres, and 43,389 needles, syringes and cleaning materials were distributed[30] (chart 3.2.3). 27 IDU were referred to AIDS/STD teams for VCCT services or to MSF-Holland for pre- and post-test counselling. 35 persons were referred to Drug Treatment Centres.

Harm reduction is still a very new concept and has required a lot of ground work, particularly on the part of organisations implementing outreach and drop-in activities for IDU. Much of the preparatory work included advocacy at all levels and the development of guidelines and systems. In the second year, 3 new drop in centres funded by the FHAM became operational. Although the overall target for needles and syringe distributed to IDU was not achieved, there was a steady increase from quarter to quarter, until quarter four when there was also a level-off of the planned figure (chart 3.2.3).

Chart 3.2.3



Implementing partners played a facilitation or coordination role in a number of harm reduction projects (UNODC, WHO). A two-day coordi-nation workshop was held for FHAM- and non-FHAM funded partners of the Joint Programme Component 2 group. An *Operational Framework to Effective Interventions for Reducing HIV Infection from Injecting Drug Use* was drafted in accordance with recommendations of the FHAM Technical Review Panel (Round II) and with the assistance of an international expert. It provides a common framework of operations under which organisations working with IDU cooperate. Progress included the translation of eight harm reduction guidelines or manuals, facilitating the planning of a Situation Assessment of Risk Behaviour in Taunggyi, the mid-term review for another harm reduction project, and a baseline study in Lashio township (UNODC). In terms of strategy development, the Technical Coordination Unit (TCU) (UNODC) served as focal point for the development of implementing partners' proposals for funding in Round II of the FHAM, holding coordination meetings in early April 2004. Technical assistance for national organisations (Government and NGO) was provided by a harm-reduction expert for 8 months in 2004 (WHO). This assistance included support to the Project Manager of the DoH's Drug Substances Abuse and Control Programme and the CCDAC. It also included a review of the legal environment surrounding interventions for injecting drug users, in particular regarding the Drug User Registration System. The review highlighted a range of obstacles that the current

[30] NB. For financial year April 04 to March 05. The AHRN drop-in centre established in November 2004 saw a rapid increase in the first quarter of 2005.

registration system presents for access of IDU to HIV prevention services and to drug treatment. Technical guidelines for methadone maintenance therapy were developed, and adopted officially by the MoH in December 2004.

Following a technical needs assessment, carried out by Burnet Institute Centre for Harm Reduction (BI-CHR) in 2004, capacity building in the form of formal training sessions, informal mentoring and on-the-job training was provided for organisations working in harm reduction. One training workshop was held for 55 outreach workers from 4 organisations working in harm reduction, and followed-up with 6 outreach coaching sessions in Lashio (AHRN). Two training sessions for outreach workers were held, in Myitkyina and in Lashio. The MANA team in Lashio also benefited from a 3-day coaching on outreach by AHRN trainers. A 3-day training on social mobilisation was conducted for 46 participants, including staff of the Social Welfare Department (AHRN). A 3-day training/coaching was also held for World Food Programme staff in Lashio on *Injecting Drug Use and Harm Reduction* (AHRN). One DoH/NAP staff member was supported to undertake a 1-year training programme in public health with specialisation in harm reduction, in Melbourne starting early 2005 (WHO).

Several technical tools and guidelines have been produced to support the implementation of harm reduction interventions. Four WHO toolkits on HIV and Injecting Drug Use were translated into Myanmar language: *Advocacy Guide; Outreach Training Guide; Technical Guide for Rapid Assessment and Response;* and *Policy and Programme Development Guide* (WHO). These guides are for distribution to and use by harm reduction stakeholders. In addition to the above, a *Glossary of Terms* to be used in translation of harm reduction texts into Myanmar language was defined through stakeholder participation (WHO). *Breaking the Link, a UN Position Paper on Reducing HIV among Drug Users*, was translated into Myanmar language. Four technical guidelines were produced by AHRN: *Operational Guidelines for DIC/Outreach Program Office; Guidelines and Operation Procedures for Outreach with Needle and Syringe Exchange; Handbook on Social Mobilisation* and *Harm Reduction for Social Volunteers* (AHRN). A Myanmar *Harm Reduction Operational Procedures Manual* is being produced through consultation with stakeholders (BI-CHR). It contains comprehensive best practice operating principles and guidelines for advocacy, primary health care, peer education, outreach, drop-in centres, needle and syringe programmes, and voluntary confidential counselling and testing. The document is being finalised, before being rolled out through a series of workshops (BI-CHR). In an effort to strengthen overall monitoring and evaluation of interventions, an M&E system and data collection tools for Component-2 projects are being developed (BI-CHR, UNODC).

3. Knowledge And Attitudes Improved

(Joint Programme Component 3)

The HIV epidemic is driven by behaviours that expose individuals to the risk of infection such as multiple sexual partners and injecting drug use. Information on knowledge and on risk behaviours related to HIV is essential in order to identify populations most at risk of HIV infection and to better understand the dynamics of the epidemic, and assess the impact of prevention programmes. Data against indicators on knowledge and misconceptions thus help prevention programmes to focus their efforts for behaviour change.

Activities implemented under Component 3 aim to increase awareness of the general population, three specific high-risk groups (sex workers, injecting drug users, men who have sex with men) and youth, of the mode of transmission and means of preventing HIV as well as perception of personal risk. Activities also aim to improve attitudes in the general population towards those living with or affected by HIV.

General population

In January 2005, a KAP (Knowledge, Attitudes, Practices) analysis was carried out covering population samples including trishaw drivers, taxi drivers, truckers, highway drivers, fishermen and miners as the sentinel male target group and female sex workers. The study revealed an improvement in knowledge and attitudes about HIV and condom use compared with previous years. Some significant findings were:

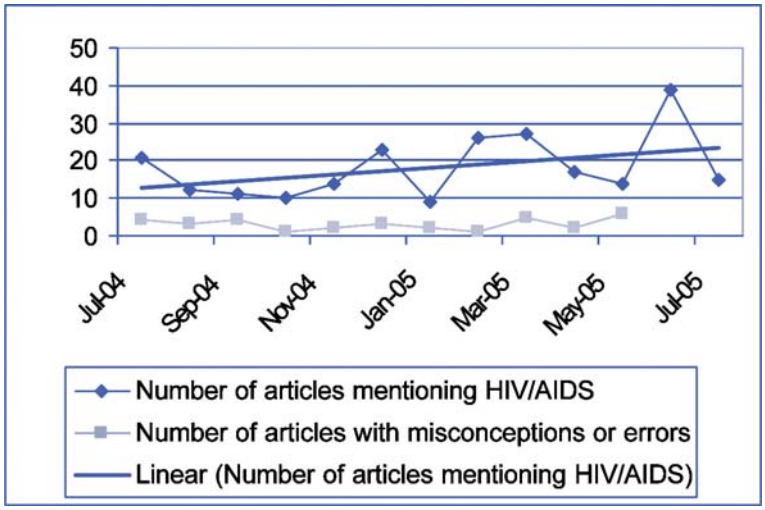
- the proportion of selected male occupational groups who know that a healthy looking person may have HIV increased from 45.7% in Jan 2003 and 51.7% in Jan 2004 to 53.4% in Jan 2005.

- the proportion of sentinel male occupational groups who "agree" or "strongly agree" with the statement "I am confident that I can use a condom correctly" increased from 74.2% in Jan 2003 and 78.4% in Jan 2004 to 84.5% in Jan 2005.

Mass media messages including advertisements in journals, billboards, IEC and TV series were used to reach a wider population. National TV stations have aired two TV series, produced by PSI, with more than 15 episodes with stories based on HIV themes. Two videos developed by UNICEF and the Central Health Education Department and the Myanmar Maternal and Child Welfare Association, respectively, were shown on national television on World AIDS Day 2004, addressing the theme: "Women, Girls, HIV and AIDS".

UNAIDS has monitored the frequency of articles related to HIV in a selection of 10 major periodic publications since July 2004, in order to inform the Joint Programme indicator "Number of mass media reports on HIV/AIDS". A trend of an increasing number of HIV messages has been noted over this period (chart 3.3.1).

Chart 3.3.1 Frequency of HIV messages appearing in 10 widely-read periodicals



Source UNAIDS Myanmar

The NAP and Health Education Department were supported by WHO to develop national communication strategies and key messages for the general population. A situational analysis on communication strategies of stakeholders was undertaken, and led to the development of a draft Communication-for-Behavioural Impact (COMBI) plan for HIV prevention in Myanmar. NAP, Ministry of Health, UN agencies and partners collaborated to organise AIDS exhibitions in Yangon and Mandalay, largely supported by UNICEF and the FHAM. They were very well attended by the public and highlight increased policy support of the Government for the fight against AIDS.

In order to reach population in remote areas through media, different types of outreach activities have been implemented. For instance, one partner (PSI) uses three *Love Boat* vessels for waterways and two *Love Bug* light trucks for inland travel, to disseminate HIV prevention messages to those who live in remote rural areas. Other partners use Myanmar traditional *Pwe* performances with HIV messages.

The National AIDS Programme has planned to intensify health education for the general population, with the support of the FHAM, through its network of 43 AIDS/STD teams located in the most populated and the most vulnerable areas around the country. Over the reporting period, NAP has developed and reproduced a large number of IEC materials for distribution to the general population, as well as to high-risk groups, youth, school-children and targeted groups including blood donors and mobile populations.

Since the start of the Joint Programme, the number of activities reaching people in their workplace has also multiplied, implemented by various partners. Notably, the Myanmar Business Coalition on AIDS (MBCA) was able to scale-up activities largely due to FHAM support, with contributions matched from the private sector, towards which its activities are targeted. The NAP carries out workplace HIV education in the public sector, as does the Occupational Health Division of the Department of Health. Myanmar Rail Transport's medical department has trained trainers and peer educators to work in its different geographical divisions. CARE has been active particularly with the uniformed forces, and in private sector garment, fish processing and recreation industries, and has trained peer educators (including initial training for those of MBCA, to whom CARE also provided capacity building and training materials). UNDP and the Myanmar Medical Association have collaborated in the hospitality industry in the Yangon area. Coordination mechanisms for HIV in the

workplace were also strengthened, with a central-level working group established between the Myanmar Medical Association, Ministry of Industry II and UNFPA to develop a guidelines manual, IEC material and a training plan for awareness raising campaigns among workers, and to reduce stigma and discrimination against PLHA.

High-risk groups (sex workers, injecting drug users, men who have sex with men)[31]

A key objective of the National AIDS Programme is to increase awareness of HIV among high-risk groups.[32] Its 43 AIDS/STD teams are working to reach sex workers and IDU with HIV prevention education and behaviour change communication, including through peer-education strategies. Sex workers and employers in the entertainment industry are reached through its 100% Targeted Condom Promotion programme (refer to discussion of Component 1).

The 2005 KAP (Knowledge, Attitudes, Practices) survey mentioned in the last section revealed that the number of female sex workers who consider themselves at moderate or high risk of HIV infection increased from 8.8% in Jan 2003 and 9.7% in Jan 2004 to 30.1% in Jan 2005.

In 2004, a study on STI-related knowledge in high risk groups, showed high awareness that condoms could protect against STIs. However women understood the need to protect themselves with a condom more than men. Condom negotiation remains difficult for female sex workers. There is still reluctance to acknowledge responsibility for spreading HIV - sex workers blame their clients and vice versa – and considerable ongoing misconceptions about what causes STIs, who is at risk, recurring and asymptomatic STIs, use of prophylactic antibiotics (giving false sense of security), the risks of incomplete or incorrect treatment, and what does not prevent STIs (vaginal washing and such like).

The study showed IEC efforts have had an impact on perception of the effectiveness of modern medications compared to traditional treatments among high-risk groups. The tendency to self-medicate is reportedly high and has replaced traditional medicine.

Peer education was a key strategy used by many partners in working with specific target populations, from which peer educators were selected, trained and involved in projects. Generally, peer education strategies are an effective means to involve and mobilise youth and other community members.

Some partners have established drop-in centres to provide health services and information for specific high-risk groups in context of user-friendly recreation facilities. One partner reported that 828 sex workers had registered at drop-in centres and made a total of 2,814 visits during the reporting period. Due to demand, the opening of drop-in centres was in some cases increased from twice weekly to daily. Outreach activities include interpersonal health education sessions, and directions on proper use of male and female condoms. Condoms and lubricants are made available at subsidised prices (refer to discussion in Component 1 section). According to figures reported for the FHAM supported activities alone in 2004-2005, 24,000 contacts were made with sex workers through more than 7,000 sessions (Health Education or counselling sessions), and 13,000 MSM were contacted through 3,800 sessions.

[31] An official estimation workshop held in September 2004 estimated the number of sex workers to be between 20,000 and 40,000; injecting drug users from 12,000 to 60,000 and MSM from 25,000 to 50,0000.

[32] *National AIDS Programme,* Dept. of Health (booklet), 2004.

There is a continued need to increase targeted interventions among high-risk groups. Although a growing amount of output data has become available, there is still a significant lack of data on the impact of these activities on knowledge, attitudes and behaviours. This underlines the importance of future surveys to assess evolution in risk and risk-reducing behaviours.

Youth

A significant number of partners have implemented projects focusing on Health Education for youth on HIV (see also Focus on the FHAM box below). The primary focus of youth HIV interventions is prevention messages that include life skills, behaviour change communication, adolescent reproductive health information, and HIV information education and communication (IEC).

Joint Programme partners working with youth

NAP, ADRA, AFXB, AMDA, CARE, Consortium, DEPT, Malteser, MCC, MDM, MHAA, MRCS, PARTNERS, SC-UK, SC-USA, UNFPA, UNICEF, UNODC, WC, WVI

Children

Life-skills classes that educate children about the danger of HIV and AIDS are taking place in Myanmar as part of a programme called the *School-Based Healthy Living and HIV/AIDS Prevention Education* (SHAPE). The SHAPE programme, which was introduced by UNICEF in 1998, is now part of the national curriculum in Myanmar. UNICEF reports that 2.14 million pupils have been reached by the SHAPE programme for the first semester of 2005 only. Through this programme, UNICEF has supported the training of more than 54,000 teachers on a range of health and social issues, including HIV, personal hygiene, nutrition and drugs – knowledge that they can pass on to their students. International NGOs, like AMI and PARTNERS, have been able to support the SHAPE programme with the participation of local authorities in middle and high schools in the suburbs of Yangon. UNICEF and its local NGO partner Pyinya Tazaung have recently launched "SHAPE Plus" – a similar programme that puts out-of-school youth in touch with positive young role models. Careful development of the government curriculum with technical assistance from UNICEF has ensured cultural acceptability and relevance, as well as technical rigour.

Adolescents

Additional partnerships for Adolescent Reproductive Health (ARH) between UNICEF, Myanmar Red Cross Society[33] and Department of Health Planning have assisted the government to provide necessary ARH services, through its structures, to government-prioritised areas. During the past years, fostered by UNFPA, youth trainings and youth HIV contests have been organised and youth-friendly corners established in 30 townships by the Department of Health in collaboration with the Department of Health Planning and Marie Stopes International (MSI). These activities aim to train adolescents and youth in reproductive health related issues, HIV prevention, promoting positive behaviour change among youth through peer education and outreach activities, counselling, and youth participation in development activities. Joint funding from the FHAM allowed UNFPA to provide training to youth peer educators and primary health care staff to address adolescents' reproductive and sexual health needs (including HIV prevention). Youth participation in the project activities is one of the main strategies to achieve effective behaviour change among youth. Through these project activities, youth produce their

[33] MRCS also received support from the IFRC-International Federation of Red Cross and Red Crescent Societies

own health messages, create their own songs with messages attractive to youth, short plays containing messages on ARH and HIV. These youth centres are thus run by youth peer educators and Basic Health Staff, trained by UNFPA on how to address adolescents' reproductive and sexual health needs. They are particularly important for the dissemination of adolescent reproductive health and youth HIV information, as they are able to reach out-of-school youth.

Key lessons learned to date

- One weakness that some partners are beginning to address is the gap between providing basic information but not information about how to access services (for example, STI, VCCT, PMCT, IDU services). Some organisations such as Marie Stopes International and UNFPA (through Government partners) have now focused efforts to provide both information on HIV and existing health services. The gap between providing information on HIV prevention and providing information about the availability and accessibility of services needs to be addressed not only by partners, but also on a wider policy level.

- HIV awareness coverage has been greater in urban areas and with in-school youth than youth in rural areas, for out-of-school youth, and migrant populations. This is problematic since it is these hard to access youth groups who may be more vulnerable to HIV infection.

- Partnerships between local NGOs and UN bodies have had a symbiotic result. Local NGOs are given financial and technical support, together with ongoing monitoring by the UN (although the amount of actual field monitoring may be limited by capacity), and the UN benefits from the local NGOs' links into the community (for example, UNFPA's relationship with MMCWA and UNICEF's relationship with MRCS and Pyinya Tazaung). These relationships are particularly important for the dissemination of Adolescent Reproductive Health and youth HIV information because they are able to reach out-of-school youth.

- The use of peer educators has been an instrumental way to access youth. If ongoing training and follow up is done with peer educators, not only are they a disseminator of HIV information, they can be a voice for youth and instrumental to the monitoring process. It is essential that the initial training of peer educators is not the last contact with this group. Using peer educators to deliver messages is one role, and if given support and follow up, these messengers can be the eyes and ears to what is going on in young people's world which can feed back into organisations' programmes.

- A survey on workplace policy should be undertaken to assess the coverage.

The following table provides Joint Programme indicators of the progress to date on reaching youth.

Joint Programme Indicators	Result
% of young people aged 15-24 yrs HIV infected (UNGASS)	● 1.6% Yangon, 1.8% other major cities (UNGASS report 2002)
% of young people 15-24 yrs reporting use of condom during sexual intercourse with a non-regular sex partner (UNGASS)	● 9.9% (UNGASS report 2002) ● 85.4% with paid partners, 44.5% with casual partners (unpublished study, 2004)
% of youth expressing accepting attitudes towards PLHA	● 26.5% (unpublished study, 2004)
% of youth who correctly identify the 3 most common ways of preventing HIV transmission (UNGASS)	● 21% (UNGASS report 2002) (NB. aggregated data with 3 major misconceptions) ● 41.6% (unpublished study, 2004)
% of youth who correctly reject the major misconceptions about HIV transmission (UNGASS)	● 25.1% (unpublished study, 2004)
% of youth who report accessing VCCT in the last 12 months	● 2.7% (unpublished study, 2004)
% of schools with teachers who have been trained in life skills-based education and who taught it during the last academic year (UNGASS)	● 32% primary, 46% secondary (UNGASS report 2002) ● 36% (UNICEF 2004)

Focus on the Fund for HIV/AIDS in Myanmar (1 Apr 2004-31 Mar 2005)

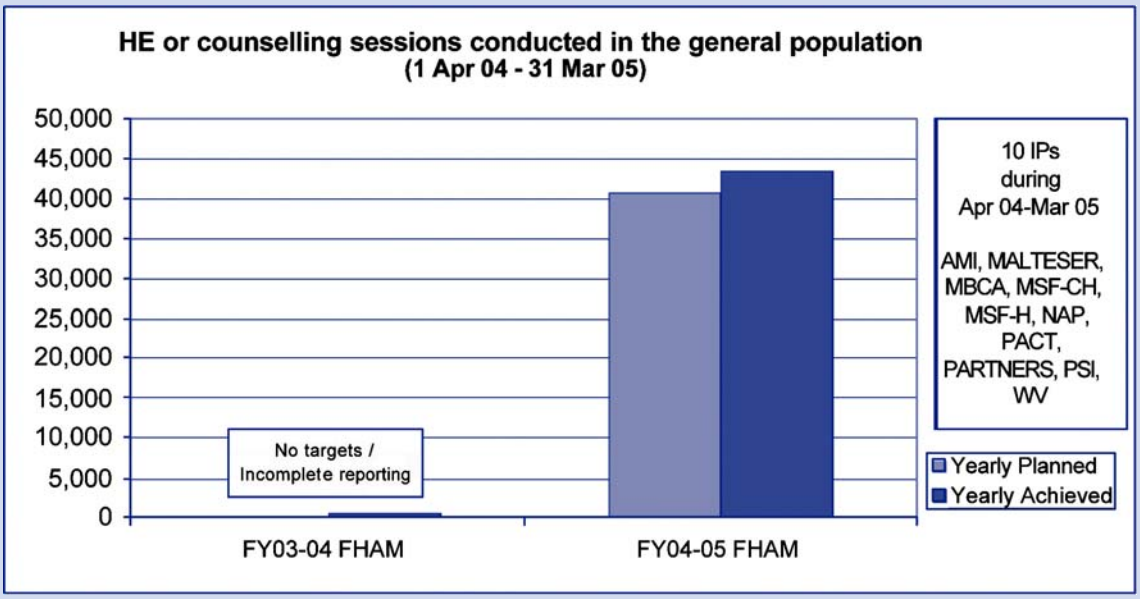
Sixteen implementing partners funded by the FHAM are working to improve the knowledge, perception and attitudes of personal risk and attitudes towards HIV infection. Two of the key outputs currently tracked for all 22 projects include health education sessions conducted, peer educators trained and involved and people reached through education sessions. There is as yet insufficient data on the impact of these activities on the HIV epidemic but the planned Behavioural Surveillance Survey is expected to provide valuable information in this area.

Knowledge of modes of transmission, perception of personal risk and attitudes regarding HIV and AIDS improved among general population

Ten implementing partners were working to increase the knowledge of HIV in the general population. Public places and crowded locations (video shows, tea shops, markets, etc.) in the community were chosen for mass awareness sessions to deliver health messages on HIV. During the reporting period, 43,602 sessions reached 401,286 persons from the general population (chart 3.3.1) (PSI 280,000; AMI 69,286; MRCS 20,000; MBCA 18,000; PARTNERS 14,000). Occasional assessments carried out during education sessions found that the level of knowledge of HIV increased in beneficiaries who had attended these sessions.

3,384,000 IEC materials have been distributed to the general population, and HIV IEC and promotional materials were produced in several of the languages spoken in Myanmar. Exchange of expertise and more coordinated efforts in producing and distributing IEC materials were reported (MSF-CH, MSF-H). Several partners chose to distribute existing printed IEC materials developed by the NAP in their projects. Fewer leaflets and posters were distributed than planned while more videos were requested. This can probably be attributed to increasing popularity of VCD, which also has the potential to reach a wider population.

Chart 3.3.1

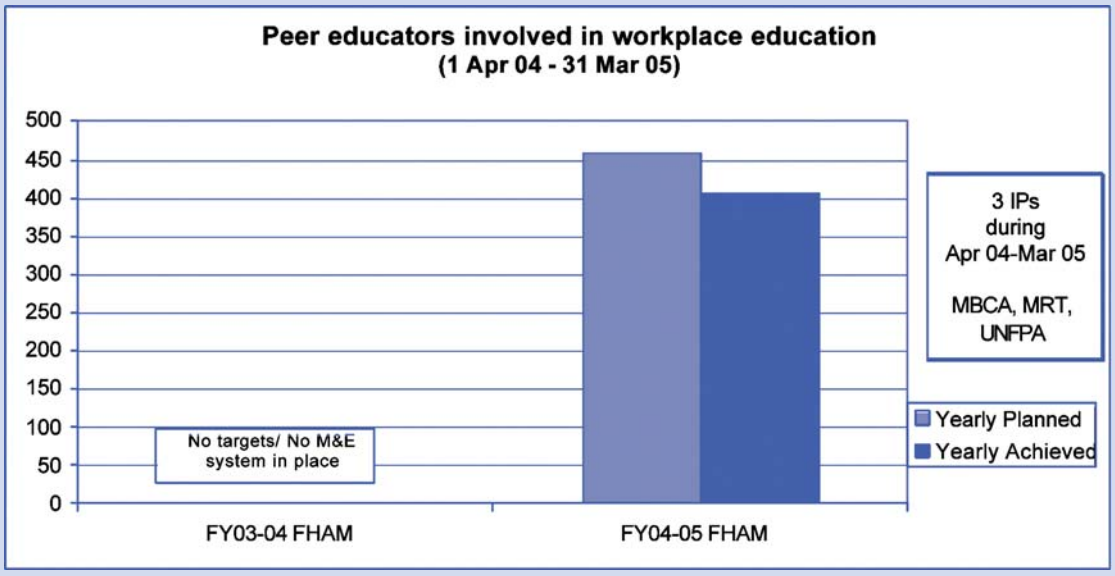


Support from the FHAM has provided a major boost to workplace interventions in Myanmar. Following the creation of the Myanmar Business Coalition on AIDS (MBCA) in 2003, by the end of the first year of Round II of the FHAM, 25 private-sector businesses had implemented workplace HIV programmes. Approximately 17,000 workers in the private sector have been reached through HIV education sessions (MBCA, PARTNERS). This represents a significant scale-up in HIV in the workplace interventions. Both organisations specifically focus on workplace education but a number of other NGOs carry out health education sessions in the workplace on an *ad hoc* basis.

Peer-education has been widely used as a strategy. In collaboration with the NAP counselling team, 94 male and female peer educators were trained on prevention and care activities including counselling (MBCA, UNFPA). Peer educators among workers and seafarers are raising HIV awareness in the workplace, with 406 peer educators involved at the end of the reporting period (MRT, MBCA and UNFPA) (chart 3.3.2). Partners conducted Behaviour Change Communication (BCC) sessions with the simultaneous distribution of condoms, and exceeded planned targets for condom distribution (MRT, MBCA, Consortium, PSI, MSF-H, MSF-CH, UNODC).

Factory workers were reported to be harder to reach than planned, as almost half of factories in the main project area had been closed, and only workers in small-scale industries could be reached by the project (MBCA). Most factories do not allow peer educators to carry out dissemination of information during working hours, and so they can only use their own private time (such as lunch time) for health education sessions. Consequently, it was a challenge to maintain their motivation and interest in the absence of a supportive working environment (MBCA, PARTNERS). For HIV in the workplace activities, it proved difficult to organise executive-level group meetings, and so one-to-one meetings were conducted instead. This proved to be more productive in some cases, and information on the individual business policies could be acquired during such meetings (MBCA).

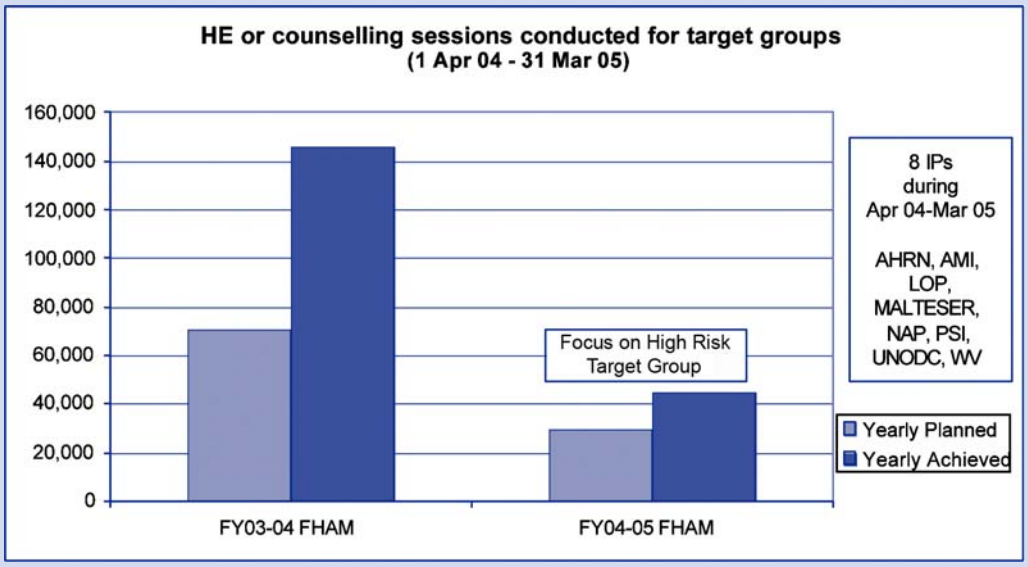
Chart 3.3.2



Positive attitudes, safe sexual behaviours and practices in specific target groups improved

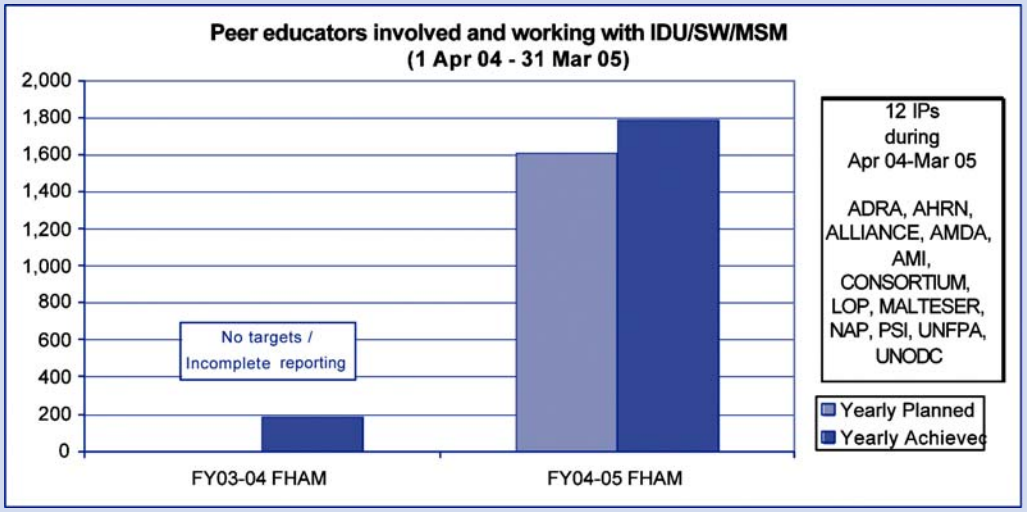
Eight partners were working to improve attitudes, behaviour and practices in high-risk groups including sex workers, injecting drug users and men who have sex with men. Activities include individual/group counselling, health education sessions, and treatment for STIs. More activities for target groups took place during the first year of FHAM II compared with FHAM I, and included 44,444 health education or counselling sessions. Chart 3.3.3 compares sessions held for targeted vulnerable groups in 2003/4 and 2004/5. Coverage was increased by establishing and providing services through new drop-in centres (for sex workers, IDU and MSM), and by geographical expansion to new locations.

Chart 3.3.3



All together, 1,793 peer educators from specific target groups were trained and involved in the projects of 12 implementing partners over this one-year period (NAP 395, AMI 20, Consortium 1,179, PSI 11). This represents a significant increase on the previous year (chart 3.3.4). A total of 1,315,000 IEC materials were distributed to high-risk groups.

Chart 3.3.4



For the injecting drug user target group, 539 education sessions were conducted in the field as well as in drop-in centres, and altogether 4,819 contacts with IDU were made for information and education to encourage safe sex and safe injecting practices. Vulnerable youth were also targeted by projects focusing on IDU, and 6,658 contacts received counselling and support services such as primary health care within youth activity centres. An additional 17 education sessions on safe sex and condom use, and 18 structured activities such as sport, music and English classes, reached 1,065 youth participants in Lashio. Moreover, 66 vulnerable youth took up skills and vocational training such as sewing and motorcycle repair (UNODC, AHRN, MANA). 54,657 IEC materials and poster about safe sex and safe injecting were distributed during the reporting period. 3 pamphlets on IDU issues for youth were developed, as were 2 BCC materials - on accidental needle stick injury, and on the need for harm reduction (UNODC). One mass awareness session, a poster contest, was organised.

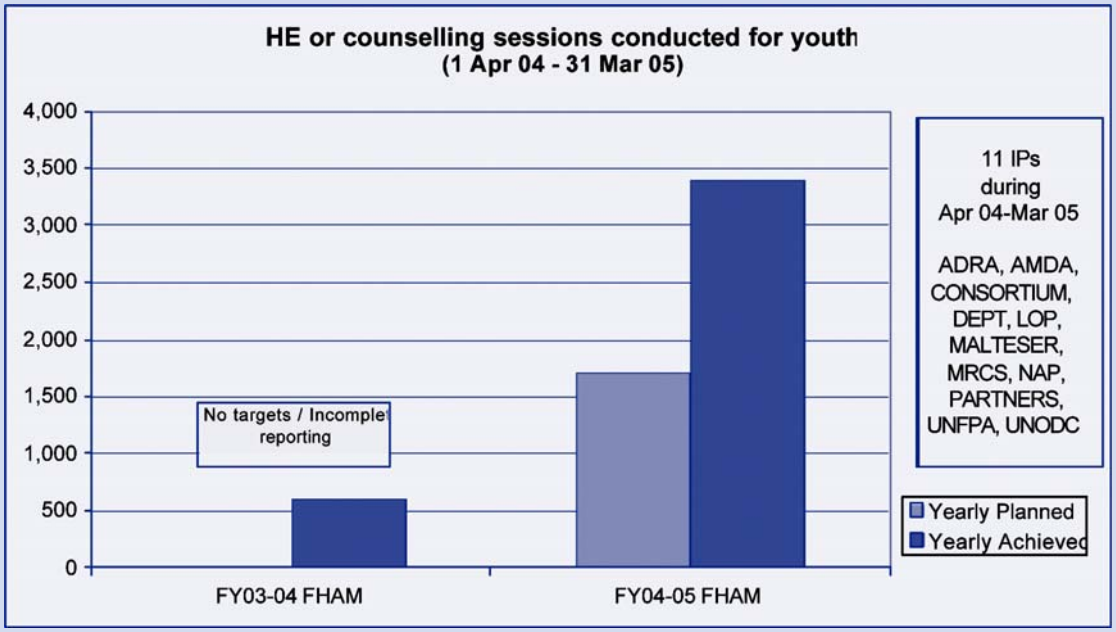
One implementing partner reported that networks have been developed in 21 townships for sex workers and in 12 townships for MSM, for behaviour change activities (Consortium). Fourteen social evenings were held at teashops targeting MSM in Lashio (UNODC).

The main constraint reported in supporting CBO work with vulnerable groups was the difficulty in identifying local NGO/CBOs that display interest, understanding and an appropriate attitude to work with sex workers and MSM. As a solution, one implementing partner is promoting development of CBOs within the population groups (IHAA).

Awareness of HIV and AIDS among youth improved

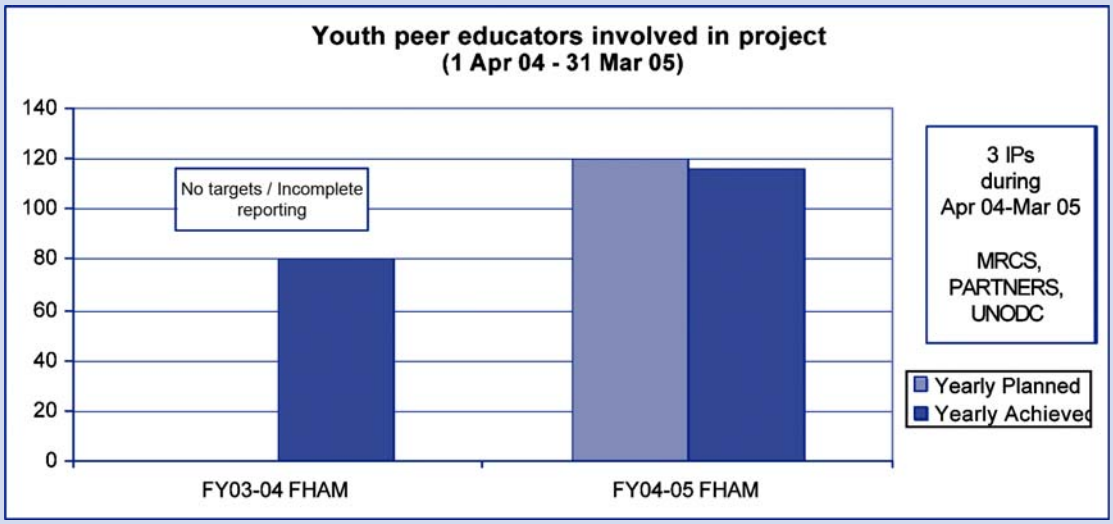
Fourteen partners implemented activities focusing on youth during the period. 3,384 health education sessions were conducted for in-school and out-of-school youth, reaching well over 15,000 participants (chart 3.3.5) (Consortium, MRCS, Partners, UNFPA, UNODC).

Chart 3.3.5



116 youth peer educators were involved in projects (chart 3.3.6) (MRCS, PARTNERS, UNODC). In collaboration with youth groups, songs about HIV were produced and distributed as cassette tapes and CDs (UNFPA). Training of youth leaders and volunteers took place in 4 townships, and volunteers were subsequently able to carry out communication/education activities in their communities to promote understanding of AIDS issues. 751,801 IEC materials targeting young people were distributed, although this fell short of the 2,615,000 originally planned[34] (NAP, PARTNERS, MRCS, UNFPA, UNODC). A review of the already available IEC materials showed that several aimed at young people were suitable for re-use, and it was decided to re-print some of the existing materials for distribution to youth groups, and during the national AIDS exhibition in Mandalay (UNFPA).

Chart 3.3.6



[34] The shortfall may be attributed in part to delays experienced by the NAP in production of a large amount of IEC materials, planned for distribution across different sectors, such as education, planning and public information libraries.

4. Access To Services For HIV Care And Support Improved

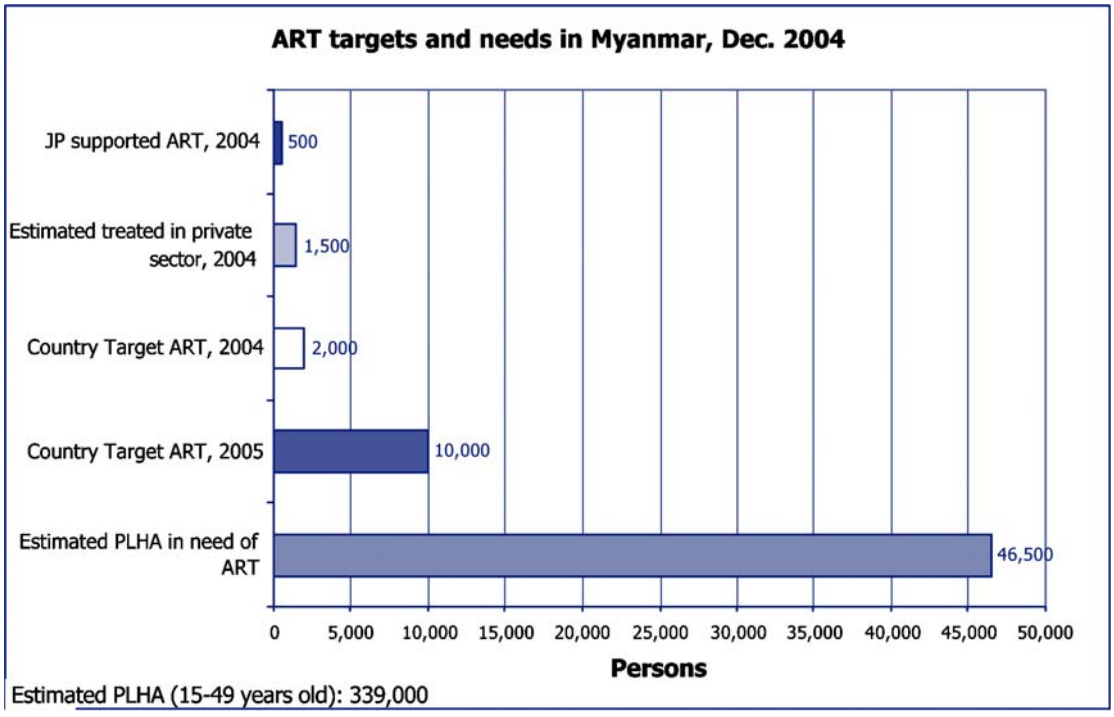
(Joint Programme Component 4)

Component 4 aims to expand coverage of quality care, treatment and support services for People Living with HIV or AIDS (PLHA). It includes scaling up access to appropriate antiretroviral therapy (ART), treatment for AIDS-related infections, and care in the home and community. Voluntary Confidential Counselling and Testing (VCCT) and Prevention of Mother to Child Transmission (PMCT) services are an integral part of the continuum of care within Component 4.

Anti Retroviral Therapy (ART)

In order to estimate needs for ART treatment in Myanmar, a '3 by 5' assessment mission was organised by WHO Myanmar and WHO South-East Asia Regional Office in February 2004. The number of people in need of ART nationwide was estimated to be 46,500. A national target was set to treat 2,000 patients by the end of 2004 and 10,000 by the end of 2005 (chart 3.4.1).

Chart 3.4.1



Source NAP

Triple combination antiretroviral therapy was initiated in Yangon in 2003 through a project implemented by MSF-Holland and the Waibargi Specialist Hospital for infectious diseases. By May 2005, there were 925 patients receiving treatment (MSF-H/NAP, MSF-CH, MDM, AFXB) while the NAP was preparing to start its national ART programme. In addition, the Department of Health estimated that there were approximately 1,000-2,000 patients receiving ART in the private-for-profit sector.[35] ARV are available in private pharmacies, but in the private-for-profit sector patients are often treated with sub-optimal drug combinations, which can lead to the early development of drug resistance. Some patients use a combination of 2 drugs (because it is cheaper) as long as they can afford it or until the treatment does not work anymore. They then stop ART altogether, as further treatment options are too expensive. These practices underline the need to invest in a scaled-up, publicly-provided system to deliver ART, giving people a better alternative to expensive and potentially dangerous private services. Some initiatives have been undertaken to inform or train the private sector in the appropriate management of ART, including a seminar organised by the Myanmar Medical Association (MMA) for the training of general practitioners in Mandalay in February 2005. Doctors of the Sun Quality Health network also received an orientation training on treatment of AIDS and opportunistic infections.

A number of essential preparations have been made for the scale-up of ART provision, in terms of guidelines and human resources. Clinical guidelines were developed by the NAP with technical assistance from WHO and support from the FHAM, and comprise national care and treatment guidelines for opportunistic infections and antiretroviral therapy in adults and adolescents, and clinical management guidelines of AIDS in children. NAP developed an ART training curriculum for medical doctors with the support of WHO, and participation of stakeholders including MSF. A number of doctors have been trained in multiple workshops in Yangon and Mandalay in the rational use of ART since the beginning of 2005, with technical assistance from WHO and support from the FHAM. These training course for doctors are planned to continue on a yearly basis, with the participation of an expert clinician from France. MSF-Holland has been engaged in continual training of medical staff for AIDS treatment and care.

With the aim of introducing and scaling up antiretroviral therapy in the public sector, technical support was provided by a joint mission, in 2004, by UNICEF and WHO to the Ministry of Health in order to assess the mechanism and systems required for the procurement and supply management of ART and related core commodities in Myanmar. All Component 4 stakeholders were consulted during the course of the mission, and it resulted in the creation of an ART taskforce and highlighted critical supply management issues that programme managers needed to take into account. (Much of this support was financed by the FHAM). An ART human resources capacity building assessment mission was then organised by WHO in September 2004, and the findings and recommendations of this mission were presented to the MoH and all stakeholders of Component 4 group. The increasing numbers of HIV and ART patients require a significant increase in staffing; in an effort to respond to the need, the number of national staff doctors and counsellors trained has increased by 50% in recent months and is expected to double by the end of this year. The Ministry of Health has assigned two hospitals for AIDS care.

[35] Other AIDS workers consider that it may be as high as 4,000.

Table 3.4.1 Actual and planned ART availability in Myanmar, 2005.[36]

Organisation	No. of patients receiving ART in May 2005	Target for end 2005
NAP FHAM Round I & II	30	1180
NAP Total/IUATLD	0	200
NAP Thai-Myanmar collaboration	0	200
MSF-Holland	800	2000
MSF-CH	80	200
MDM	30	100
AFXB	15	15
AMI	0	20
Total	**955**	**3915**

Alongside these preparatory activities, a number of Joint Programme partners are working on providing ART (table 3.4.1). Notably, the NAP will launch its free provision of ART programme with treatment for 285 patients, including 40 children, starting from July 2005 (FHAM support). A project for the integrated care of TB/HIV patients was launched in Mandalay in 2004, through partnership between the NAP, the International Union Against Tuberculosis and Lung Disease (IUATLD) and the petrochemical company TOTAL.[37] This partnership will provide ART to 1,000 patients within 5 years, starting from mid 2005. A meeting of the Ministries of Health of Thailand and Myanmar led to a commitment by Thailand to provide ART for 200 patients living in border areas. International NGOs continue to increase the numbers of patients receiving treatment, and additional international NGOs will start ART provision. Other organisations have no plans yet to directly provide ART but some have decided to refer patients in need of ART to existing service providers. ART for 1,500 patients by the end of 2006 was also planned with support of the Global Fund Round 3 AIDS grant. It is now unsure that this can be initiated without the certainty of sustainable funding for patients' treatment. As of May 2005, 955 patients were receiving ART, 95% of which was supported by the FHAM.

MSF-Holland has continued to build its ART provision programme in cooperation with the public services. It has established and maintained a cooperative relationship with doctors from the National Infectious Disease Hospital and other public hospitals in Lashio, Muse, Myitkyina and Bhamo for assessment and mutual consent of candidates for ART. The programme has now become a replicable model that allows integration of HIV treatment and care into ordinary medical services in order to increase the overall access to ART. In general, when antiretroviral therapy is first introduced the attrition rate can be high due to the relatively large numbers of patients who present very late for treatment. However, screening, pre-treatment counselling and consistent patient monitoring have ensured excellent adherence to ART so far (from 97% to 99% in 6 months[38]). In 2004 MSF-Holland reported that the total number of PLHA receiving care and the total number of new HIV patients increased by almost 50% and

[36] ART for 500 patients by the end of 2005 was planned using resources from Global Fund Round 3, now terminated.

[37] TOTAL also provides primary health care services to communities living in the area of its sites.

[38] MSF Holland

60% respectively as compared to 2003. The clinics report seeing growing numbers of patients who have previously been prescribed treatment at private clinics and hospitals, often with inadequate drug regimes. This impairs future treatment options, especially given the limited number of more expensive second-line drugs available in a resource-limited setting. As part of the programme, PLHA support activities are organised, such as PLHA meetings, peer counselling sessions and recreational activities.

Achievements made so far and the recently published progress report on the 3 by 5 initiative[39] highlight the urgent need for continued investment in treatment, care and support for PLHA. As soon as the start-up phase of ART in the public sector with appropriate follow-up care passes the initiation stage, additional resources will be essential to scale up in response to the needs.

Voluntary and Confidential Counselling and Testing (VCCT)

Provision and expansion of voluntary and confidential HIV counselling and testing (VCCT) services for the population is included as one of the strategies in the NAP strategic plan. It has been established through a network of laboratories situated at the AIDS/STD teams at township level. By establishing these VCCT services, the NAP aims to:

- increase access to services for urban and rural population
- provide the possibility of early diagnosis and prevent further HIV transmission
- educate to reduce risk behaviour
- provide a programmatic link for programmes such as PMCT and care and support including access to ART

Currently full VCCT services (which include counselling and testing) are only provided in public health settings through the network of 43 AIDS/STD Teams of the DoH/NAP, the National Health Laboratory, and within the facilities of township hospitals. Other organisations, mainly NGOs (including MSF, MDM, AMI, WVI, Malteser, PACT, CARE, MSI, MNA and MBCA) provide pre- and post-test counselling while referring to a public laboratory or the local AIDS/STD team for HIV testing. In this way NGOs facilitate access to VCCT services to general and vulnerable/high risk populations covered by their programmes such as sex workers, MSM and IDU. The NAP is currently revising the policy for further expanding VCCT services to include private and NGO - based laboratories. For this purpose and in order to ensure quality of services, the NAP in collaboration with the National Health Laboratory (NHL) is developing operational guidelines for accreditation. This accreditation system will include the regular participation of laboratories in a National External Quality Assessment Scheme (NEQAS) organised by the NHL.

Moreover, since 1992, the NAP/DoH has issued technical guidelines for HIV testing, and guidelines on HIV counselling along with relevant training sessions. In collaboration with the National Health Laboratory, these technical guidelines are currently under revision including the implementation of two rapid-test algorithms chosen from the WHO-evaluated panel of test kits. Utilisation of two rapid tests reduces the time for delivery of results and increases the chances of a high rate of return of clients to know the test results. NAP and NGOs organise regular training sessions to raise community awareness for VCCT and to train new counsellors.

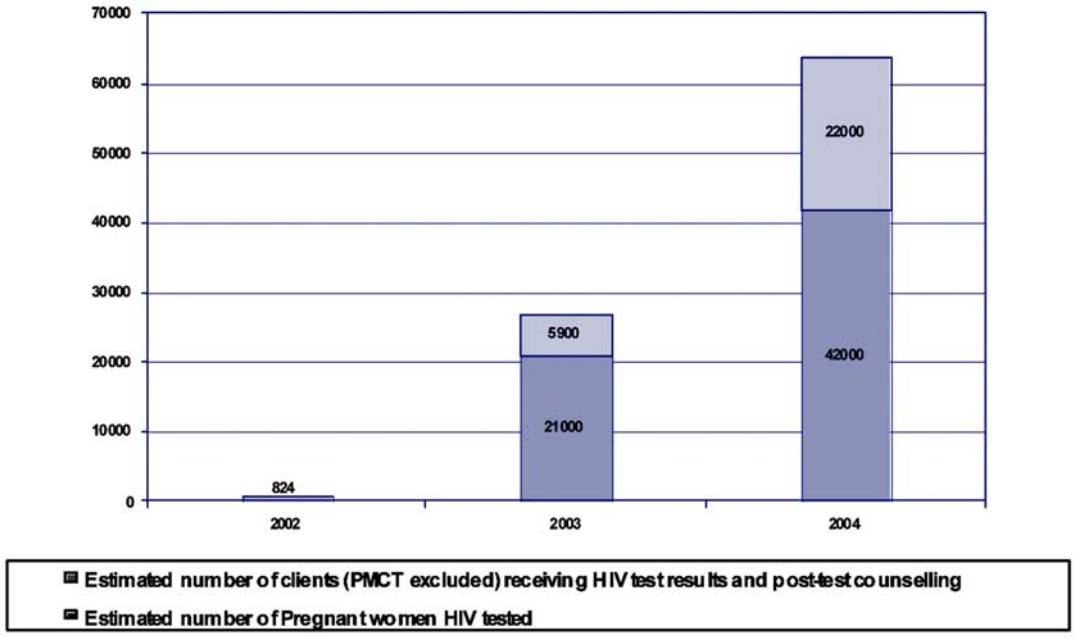
The bulk of HIV test kits for use in VCCT (as well as for blood safety) in the public sector have been provided by FHAM, JICA, UNDP, UNICEF and WHO.

[39] *3 by 5" Progress Report*, Dec 2004

By the end of 2004, 69 townships were providing VCCT services (including testing for PMCT) in 114 service delivery points, either through AIDS/STD teams directly or in collaboration with NGOs, ensuring services to more than 64,000 clients (chart 3.4.2). However, in spite of these efforts and the observed increase of service utilisation, access and uptake of VCCT is still considered to be very low in comparison with the needs and the demand for services.

Preliminary results from a recent BSS among men showed that although the majority (68%) expressed desire to have access to HIV testing, only 55% knew where to go for testing and only 5% reported ever having undergone HIV test.[40] Stigma and discrimination linked with AIDS have been reported as possible reasons for low uptake as well as the slim prospect of access to AIDS care in the event of a positive result.

Chart 3.4.2



Sources : NAP, PACT, Care, MSF-H, AMI, MSF-CH, Malteser, MSI, MDM, WV, MBCA, MNA

Significant expansion of VCCT services throughout the country had been planned using Global Fund Round 3 funds, including HIV testing through certain NGO programmes. The future of this planned expansion is now unclear. The new operational guidelines and policy in development by the NAP/NHL will facilitate the scale-up of VCCT, increasing access for VCCT not only for the general population, but will also bring VCCT closer to vulnerable groups. VCCT is a key entry point for supporting the planned expansion of ART services by the NAP and NGOs and should increase access to care and support services.

[40] National AIDS Programme data

Prevention of Mother to Child Transmission (PMCT)

There are an estimated 8,300 pregnancies in HIV-infected mothers in Myanmar annually, leading to about 3,000 potential infections of infants each year[41].

UNICEF promotes a four-pronged strategy for prevention of mother to child transmission:

- prevent young women from HIV infection before pregnancy through knowledge and life skills,
- prevent HIV-infected women from unintended pregnancies though appropriate family planning
- prevent infection of infants born from HIV-positive mothers by using drugs (mainly *Nevirapine* at present), safe delivery and safe infant feeding, and
- provide continuous care and support for HIV-positive mothers and babies.

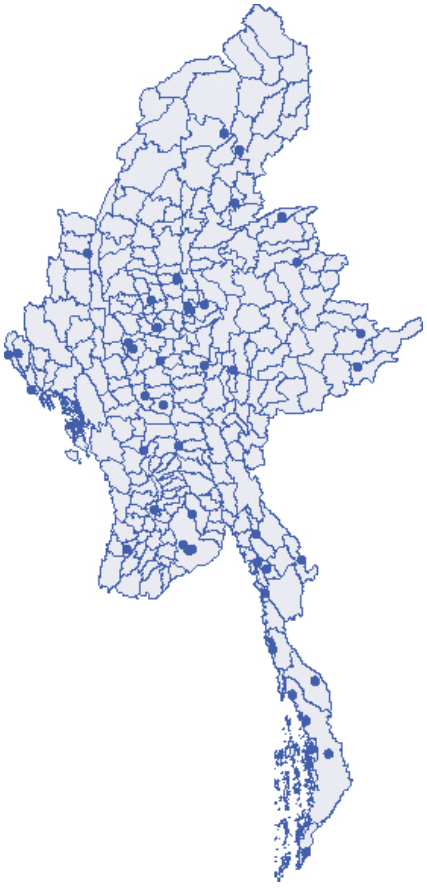


Figure 3.4: Townships with PMCT service – community- or hospital-based.

UNICEF supported the National AIDS Programme to initiate a PMCT programme in two townships in 2000. Since then, UNFPA and partner NGOs (MSF-H, MSF-CH and AMI) have joined UNICEF and the NAP to expand PMCT services to 50 townships (figure 3.4).

The programme was designed to deliver services initially at the community level in order to reach the majority of women in Myanmar who give birth at home.[42] Hospital-based PMCT was then developed so that pregnant mothers who presented with unknown HIV status could have better access to HIV medical care and treatment. Thus, in 2003, institutional based PMCT started in 5 hospitals. In 2004, 36 townships offered community-based PMCT and 17 townships offered hospital PMCT. In 2004, The NAP[43] and three international NGO partners provided *Nevirapine* to 405 mother and baby pairs (chart 3.4.3). Despite this rapid increase, it is estimated that around 2,800 babies are still being infected every year, with the PMCT programme in its current coverage reaching less than 5% of HIV-positive pregnant women in the country.

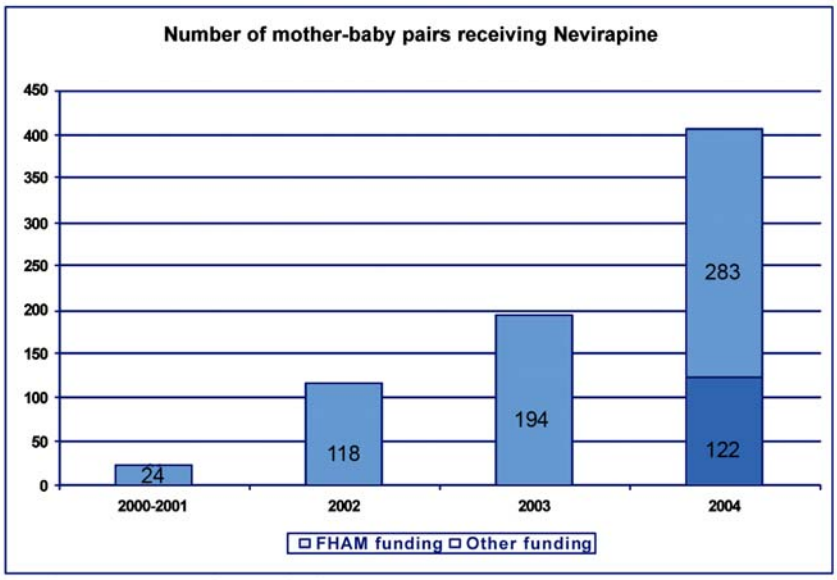
UNICEF implemented a comprehensive survey of infant feed practices in Myanmar, and on this basis, NAP developed, in consultation with partners, infant-feeding guidelines for HIV-positive mothers to inform choices for PMCT.

[41] Preliminary findings of the Workshop on Demographic Impact of HIV/AIDS in Myanmar – 30 Sept 2005
A different calculation with the seroprevalence of 1.75% of women attending Antenatal Care gives a number of 21,300 HIV+ pregnant women out of 1.2 million pregnancies per year. The number of children infected may therefore be higher than 5,300 with the standard default transmission rate of 25% (used in UNGASS guidelines). However, the seroprevalence of 1.75% in ANC may over-represent the pregnant women living in urban areas.

[42] 79% of births are in the home (Myanmar Reproductive Health Community Survey, MoH/UNFPA, 2002)

[43] With the support of UNICEF and UNFPA

Chart 3.4.3



Sources: NAP, MSF-H, MSF-CH

Key lessons learned to date are:

Acceptance of PMCT

Compared to other HIV interventions, PMCT is socially more acceptable, and can be readily promoted (which may not be the case with condom promotion/use, services for IDU). Acceptability of PMCT is exemplified by the fact that approximately two thirds of all VCCT were carried out in the context of ante-natal care. It may provide an entry point for wider VCCT acceptance and uptake.

Involvement of Male Partners

Involvement of men is a major constraint that has been identified by all partners. At UNFPA and UNICEF-supported PMCT sites, involvement of male partners is encouraged by offering free VCCT to partners of pregnant women.

Key Entry Points

All partners identified that the key successful entry points to identifying potential women for PMCT are through STI, maternal-and-child health, and principally ante-natal care services. Therefore, to increase PMCT uptake, three conditions should be met:

- VCCT coverage is extended to more of these services;
- more women are encouraged to utilise ante-natal care services;
- services (including VCCT) are free and confidential.

Ante-natal care is a particularly important entry point because it may be one of the first times a woman has the opportunity to talk to a health worker about HIV.

Involvement of Midwives, Auxiliary Midwives, and Traditional Birth Attendants

Midwives, auxiliary midwives and, to a degree, traditional birth attendants are key focal people for PMCT service delivery. International NGOs and the UN have incorporated these service providers into their activities to reach women. These key service providers can help encourage women to utilise ANC/MCH services, and provide information about PMCT. Some traditional birth attendants have received training and in some cases, safe delivery kits from international NGOs and UN. However programmes now focus on skilled birth attendants (midwives and auxiliary midwives). Trainings comprise PMCT and administration of *Nevirapine*, attitudes, acceptance and confidentiality rather than birthing procedures. It was determined that midwives working in the public sector have a heavy

workload and that activities could be better coordinated to integrate PMCT into their existing scope of community work rather than as a separate add-on activity. Better use of these key human resources, without overwhelming them with additional work, needs to be carefully considered.

o Building Better Relationships between Women and Service Providers

Three lessons learned illustrate the importance of quality service provision for improving the uptake of PMCT services and ensure women are returning for ongoing services – not just test results.

- Quality of services providers. Service providers' attitudes and judgments have been identified as a barrier for service uptake (in general as well as for PMCT). Some partners have made concerted efforts to improve the relationship between women and service providers. All health staff coming into contact with women are trained about how attitudes, judgments, and confidentiality are essential for ensuring that women return for services and feel supported. For counsellors, the priority is ensuring that counsellor training continues after initial training sessions including on-going follow up, weekly discussions of cases (anonymous), and having long-term staff work alongside counsellors to ensure quality.
- Provide women informed choice. Within a rights-based approach to PMCT, providing women informed choice on a variety of topics, together with support by health care staff for these choices has been instrumental to building a relationship with women to ensure high return rates (options around where to give birth, feeding practices, and follow-up of a health visitor). This requires that training strongly emphasises attitudes and judgments of healthcare staff towards women and the choices they make around PMCT.
- Packaged support response by service providers for HIV-positive mothers. This means that apart from the doctor and treatment administration, there is one central focal person (usually a midwife) who follows up women pre and post-partum. This focal person is responsible for providing counselling, birthing options, creating links with health workers for home visits (only if women accept), providing post-partum care, breastfeeding information, and following up the baby to 18 months.

Community and Home-based Care (CHBC)

One of the strategies of the Joint Programme in the component on care and services to PLHA, was to "design and provide a basic social benefit package for PLHA in need, and support families to provide home-based care". With the increase in resources available, this has been possible and a number of partners have been able to provide home-based care packages, which nevertheless still differ from partner to partner.

A technical forum on home-based care was organised in 2004 by WHO for 70 participants from government, international and national NGO sectors. To build capacity of national organisations (MNA, MMCWA, DoH/NAP) to plan for and provide community and home-based care, UNICEF arranged a study tour for six participants to Thailand. Participants were able to visit a range of organisations in Bangkok and Chiang Mai focusing on different aspects of community-based care for PLHA.

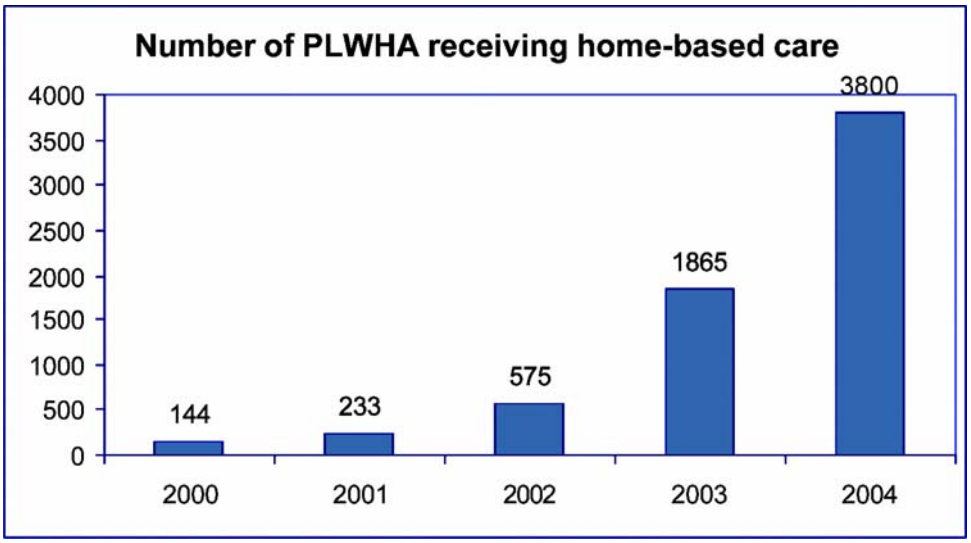
In 2004, in addition to Basic Health Staff of the public health services, eleven NGOs and three UN agencies[44] were working to provide home-based care to more than 3,800

[44] MNA, World Vision, Care, UNICEF, MSF-H, UNDP, AFXB, MSF-CH, WFP, ARHP, PACT, AMDA, MMCWA and MANA

PLHA[45], in some 40 townships over the country. The NAP provides material and some financial support to some local NGOs and CBOs for home-based care activities.

The figure below (chart 3.4.4) illustrates the steady increase since 2000, much of which can be attributed to the financial support of the FHAM (see Focus on the FHAM box below).

Chart 3.4.4



The provision of support to PLHA included counselling, nutritional support, prophylaxis and treatment of opportunistic infections (including tuberculosis), on an outpatient basis or through home-based care for those who are too sick to attend the clinic regularly. Psychological, social, legal and material supports have often been included in the service provided, but services vary considerably between service providers. Joint Programme partners will assist the National AIDS Programme to lead a process to develop a standard package of service for home-based care, along with eligibility criteria.

The World Food Programme has supported food security of PLHA and their families living in its project areas through provision of food rations.

UNICEF has worked to build capacity of caregivers to provide care and support to orphans and vulnerable children, with an additional emphasis on psychosocial support for children affected by HIV. UNICEF has also reviewed opportunities for alternatives to institution-based care for affected children, including community-based and alternative family environments.

Caring, protective and supportive environment

Providing a caring, protective and supportive environment for PLHA and their families has been a key aim of the Joint Programme. Strategies include developing the involvement of PLHA in project activities, enabling access to education, employment and social support, along with the engagement of community leaders to promote a positive behaviour around HIV issues.

Stigmatisation and acceptance of PLHA in the community continue to provide a challenge, which several projects are nevertheless addressing. MSF-Holland's programme provides an interesting example of successful implementation: 80% of the counsellors of the Yangon project are PLHA. The project has already employed a number of peer workers (sex workers, MSM, IDU,

[45] Figure not available for MSF-H

PLHA) as counsellors, health educators and outreach workers, and efforts are ongoing to hire more, and so to identify and better cater to the needs of target groups. As part of MSF-Holland's programme, peer and patient support group as well as other recreational activities have been organised. ART patients who are healthier as a result of their treatment and able to work are hired as caregivers for follow-up of PLHA. Some are hired to provide transportation to and from the clinics for patients; others in a painting programme in Yangon, to produce health education materials. Also, other NGOs, UN agencies[46] and commercial organisations are lobbied to develop an HIV policy for employees, to facilitate and offer them VCCT and ART, and to employ more PLHA.

Creation of self-help groups, almost inexistent in Myanmar in 2003, has been on the agenda of several organisations, including the National AIDS Programme, Association François Xavier Bagnoud (AFXB), CARE, the International HIV/AIDS Alliance (IHAA), MSF-Holland, Myanmar Council of Churches, Myanmar Nurses Association (MNA), PSI, and World Vision, as well as other local NGOs and Community Based Organisations. Groups operate with or without the provision of socio-economic assistance to PLHA, such as the provision of food, loans for income generation and educational support for children. AFXB, for example, has organised the Sunday Group with some 150 adults and 40 infected and affected children, along with vocational training, and income generating activities for PLHA. For the first time, a National Forum of PLHA was organised by the Myanmar Council of Churches, with the support of the IHAA, and brought together PLHA from different parts of the country to share experiences and influence the response of its members to HIV and AIDS. A number of small NGOs and CBOs have also been supported by the UNDP AIDS project to work with PLHA and orphans and vulnerable children.

The IHAA and Burnet Institute are supporting a number of local NGOs/CBOs including faith-based organisations to build their capacity to provide support to PLHA. This has led to the initiation of assessments and new projects by some organisations. The IHAA programme also works directly with PLHA support groups to build their organisational and technical capacity.

The majority of support groups are made up of PLHA and their family members who meet regularly and provide mutual support such as visiting each other when a member is sick and accompanying a member to the hospital if necessary. Many of the support groups are formed by NGOs and the groups remain informal and are not structured organisationally. Some NGOs are keen for the support groups to become more independent and to be managed by the PLHA themselves. Considerable capacity building, however, will be needed for this to happen.

On-going counselling for PLHA is being provided by many of the above organisations, through project staff, although this may sometimes happen through on-going contact rather than through established counselling structures. In addition, peer counselling between PLHA also takes place through the support groups.

PLHA are represented on the Global Fund Country Coordinating Mechanism (CCM), and also on the ART selection committees that have been established in the country.

[46] Myanmar Business Coalition on AIDS, CARE and UNFPA for example

Despite these initiatives, there has been insufficient involvement of people affected by HIV in programme design and implementation, and in livelihood activities. Studies have revealed significant stigma and discrimination in the community,[47] public services and among staff (specifically staff belonging to non-AIDS projects) that hinders PLHAs' access to services. Therefore, a number of approaches were introduced such as HIV mainstreaming and AIDS awareness raising for staff. More effective community awareness-raising activities will be funded by the FHAM in 2005-2006 to facilitate the involvement of PLHA in community resilience and impact mitigation (for example, in the Consortium's programme).

The National AIDS Programme, IHAA, MSF-Holland and UNDP are collaborating on an initiative to support a group of PLHA to develop a GIPA project to be funded by the UNDP Regional Project based in New Delhi. The project is being developed by a committee of PLHA members from different parts of the country. The committee members were nominated by various NGOs working with PLHA in the country. It is hoped that this could be the first step towards establishment of a PLHA network.

Stigma and discrimination are key factors limiting the involvement of PLHA. Many AIDS projects are aware of this and try to address this in their projects by providing information about how the disease is transmitted and not transmitted. CARE carried out a study to document the causes of HIV and AIDS-related stigma and discrimination experienced by PLHA and their families, the different types of stigma and discrimination, and the contexts in which it occurs. However, few specific interventions to address stigma and discrimination have yet been implemented.

Unfortunately, with an estimated 46,500 AIDS patients in need of ART nationwide[48], not enough impact can yet be claimed towards providing a caring, protective and supporting environment for PLHA, and many challenges remain to achieving this goal. Priorities include public leadership to change attitude, more organisation of PLHA networks and design and implementation of a national strategy to provide care and treatment.

[47] One unpublished study in 2004 revealed a very low level of accepting attitudes towards PLHA among young people.
[48] WHO *'3 by 5' Progress Report*, Dec 2004

Focus on the Fund for HIV/AIDS in Myanmar (1 Apr 2004-31 Mar 2005)

The projects of 12 FHAM-funded implementing partners contribute to this component.

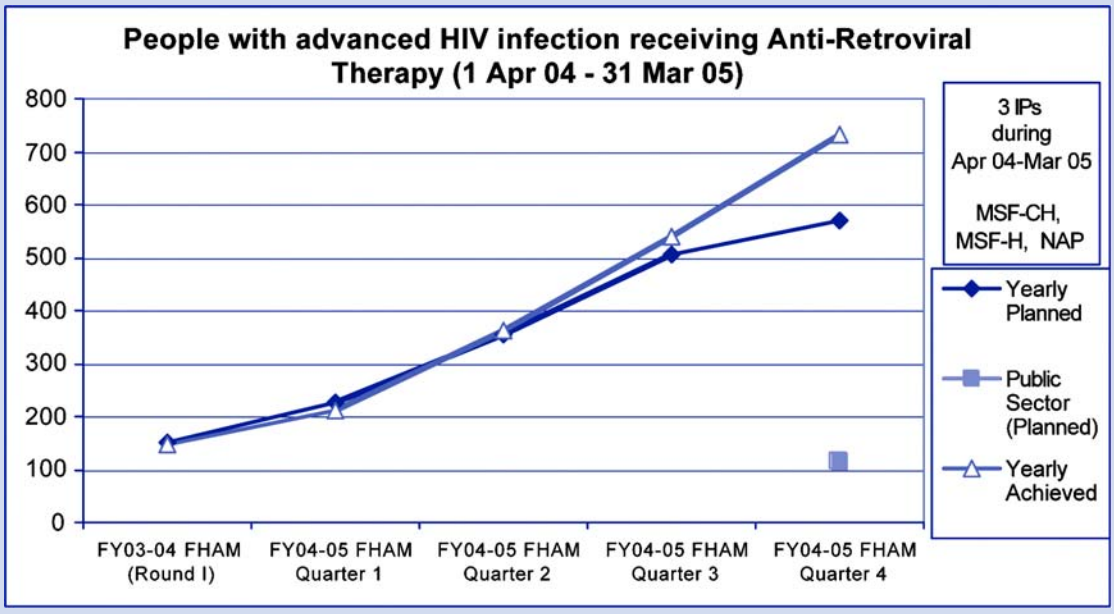
Quality and access to care and treatment services for PLHA improved

A number of essential steps were undertaken jointly with the Ministry of Health to prepare for the introduction and scale-up of ART in the public sector. These have included a WHO/UNICEF joint mission to review supply and management preparedness for diagnostic and medical supplies (ART) in August 2004; a mission to assess human resources requirements in the public sector in preparation for the scale up (WHO, NAP). At the same time, a consultative process was undertaken to develop standardised treatment guidelines for ART in adults, and in children (WHO, NAP).

Following the successful initiation of triple combination therapy in 2003, 146 late-stage patients were on antiretroviral therapy within the collaboration between the public health services and the NGO sector. Initiation of ART in Myanmar has led to a rapid increase in the number of patients treated by NGOs in collaboration with the Department of Health. By 31st March 2005, 734 patients were on triple combination ART while another 115 were about to start treatment in the public sector (chart 3.4.5). An additional 245 adult and 40 paediatric patients will be receiving treatment though the public health services by the end of 2005 (FHAM funding). Due to a lack of experience in procurement of ARVs, some initial delays were encountered in making them available, particularly in the public sector.[49]

ART was offered by two implementing partners in settings that include both smaller urban areas with access to fewer facilities, and rural and outlying areas. ART was also introduced in Muse, Bhamo and Myitkyina (MSF-H), and Dawei (MSF-CH) in 2004, bringing the total number of service delivery points providing ART to nine.

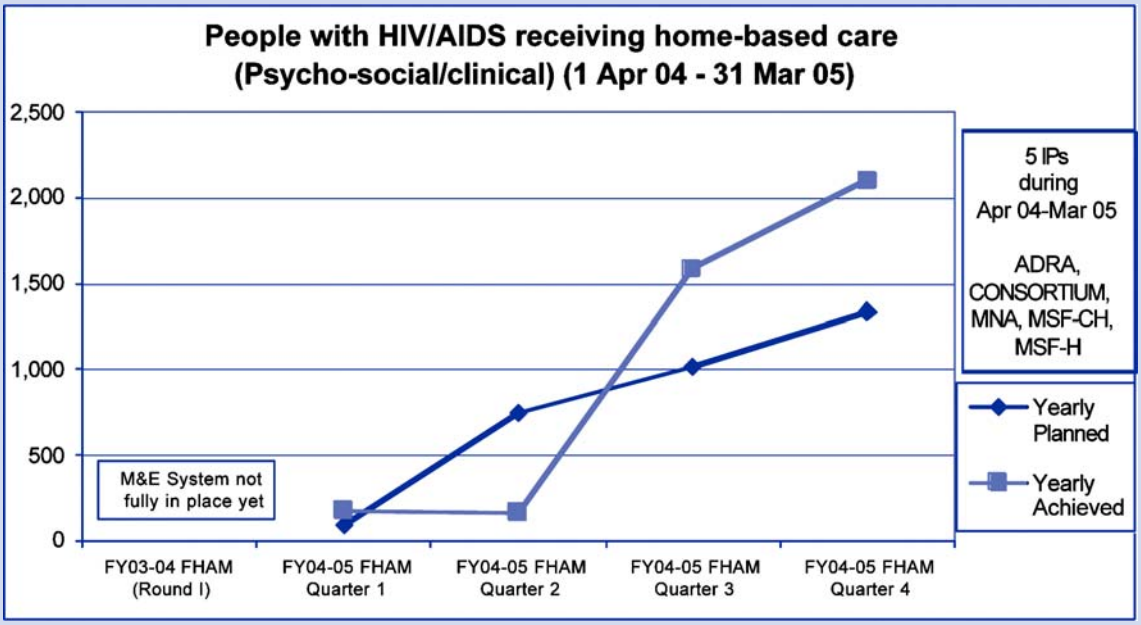
Chart 3.4.5



[49]Subsequent to the ARV scale-up mission in July 2004, the NAP and other Component-4 members are organising an ARV task force to coordinate technical issues regarding procurement and supply management of ARVs and other related core commodities.

Access to and provision of **home-based care** has been increased and exceeded the target with a total of 2,139 PLHA receiving home-based care during the period (chart 3.4.6), provided by three partners (Consortium, MSF-H, MSF-CH). A forum on Community and Home-based Care was conducted in May 2004 (WHO), and the NAP is working on the standardisation of home-based care packages, with support from WHO. Key partners are providing a range of services including clinical care and psycho-social support.

Chart 3.4.6

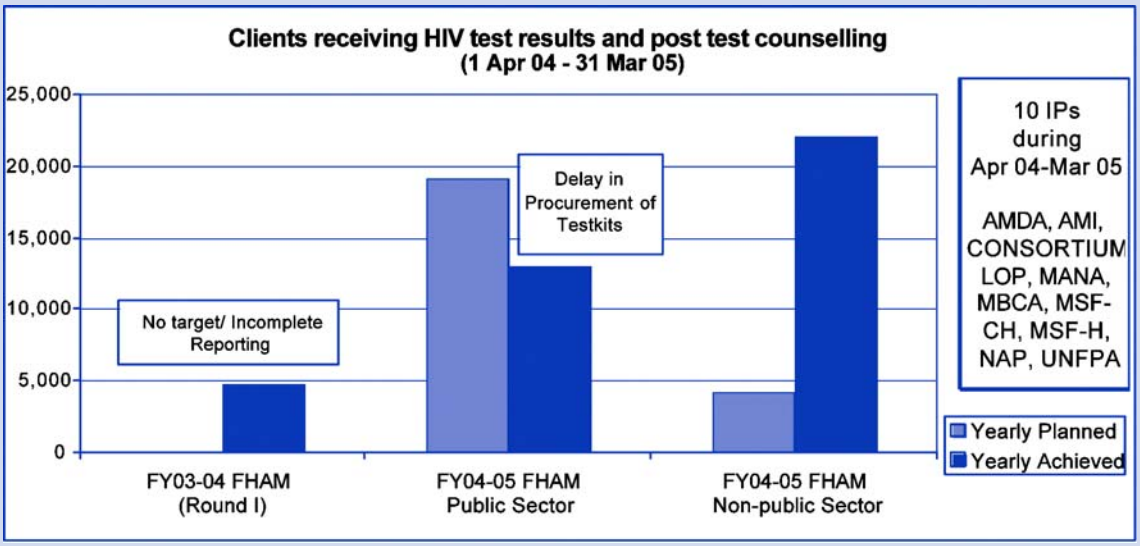


Quality of and access to voluntary confidential counselling and testing services improved

Resources from the FHAM have contributed to a marked increase in the availability of VCCT in the country. While NAP was provided technical support by WHO for the development of VCCT training manuals for trainers (with one manual designed specifically for harm reduction projects), six organisations have provided HIV test results and post-test counselling between 1st April 2004 and 31st March 2005, with direct provision of testing by the National AIDS Programme's AIDS/STD teams. During this period, 35,111 persons received HIV test results and post-test counselling services (chart 3.4.7), including pregnant mothers in the context of PMCT. Delays in the procurement process were responsible for the underachievement against target for testing in the public sector.

The majority of VCC(T) sessions were provided by one partner (MSF-H), which reported an average uptake of around 90% on VCCT offered through its network of 18 clinics. Interestingly, for planning purposes, a VCCT uptake rate of 50% had been assumed, underestimating the growing demand later reported from the field. Four partners also referred beneficiaries to AIDS/STD teams for VCCT, and 645 persons were referred in this period, 27 of whom were IDU (Consortium, MBCA, UNFPA, UNODC).

Chart 3.4.7

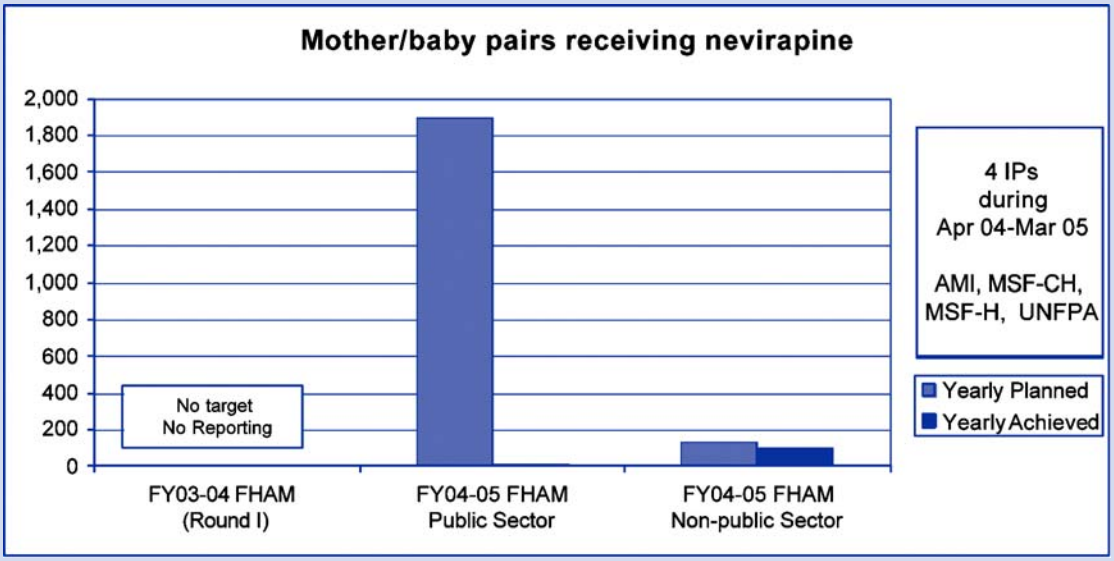


Overall results reflect a growing demand within the population for access to quality VCCT services. Service provision for quality VCCT needs to be expanded urgently.

Risk of mother-to-child transmission of HIV reduced

Five partners are working to reduce the risk of transmission of HIV from infected mothers to their newborn. 122 mother and baby pairs received *Nevirapine* at the time of delivery (chart 3.4.8) (NAP, AMI, MSF-H, MSF-CH, UNFPA). While four partners are providing direct services, UNFPA is working with the NAP to support community- and hospital-based PMCT in thirteen townships and providing technical support. The NAP experienced delays in the procurement of safe delivery kits for use in PMCT in 22 project townships, however they were able to use alternative supplies sourced from UNICEF and UNFPA. In some projects where individual pre-test counselling is provided, the acceptance rate among pregnant women is as high as 93% (AMI). Although the Joint Programme and the FHAM currently capture the provision of single dose *Nevirapine*, some projects will start reviewing protocols to reflect updated treatment guidelines.

Chart 3.4.8



5. Enabling environment and capacity building

(Joint Programme Component 5)

Component 5 works towards the creation of an enabling environment. It is wide-ranging in nature, and comprises the key sub-components of: advocacy towards opinion leaders; partnerships and for planning and implementation; making data available to inform planning and measure the impact of the epidemic; and capacity building at all levels. It also aims to reduce the risk of HIV transmission in health-care settings.
Some issues addressed by Component 5 are also discussed in the next chapter "Coordination, Harmonisation and Monitoring and Evaluation"

Advocacy

Advocacy has been an integral and essential component of all stages of implementation, and in all service delivery areas. Much advocacy is focused on enabling interventions with vulnerable groups, including PLHA, sex workers, and drug users. Some service delivery areas require more advocacy activity than others. For example, much advocacy for decision makers has been necessary for harm reduction, which is still a relatively new concept in Myanmar, starting in 2001 with an advocacy project co-organised by UNDESA, UNDP, UNODC, CCDAC and CARE.

The NAP organised two large, national AIDS exhibitions in Yangon and Mandalay, with the participation of a wide range of actors in the national response to HIV. These were very well attended by both the general public and by decision makers. In 2004, the second national exhibition was held in Mandalay, and featured displays from more than 20 organisations (UN, Government, NGOs/international NGOs and drug companies). Emphasis was on prevention among young people and VCCT, and this service was made available at the site. Advocacy issues related to specific interventions have been addressed in the pertinent component group sections.

In 2003-2004, CARE implemented a project in Mandalay for HIV prevention among workers in the entertainment industry. The project also targeted enforcement (Police) officers as a means to create an enabling environment for reducing HIV transmission among the entertainment workers. This was in direct response to condom possession being used as evidence of prostitution and grounds for arrest. For the enforcement personnel, it aimed to improve the knowledge, ability to assess self-risk and HIV-preventive behaviour of police personnel, and also to promote attitudes and practices that would support HIV prevention in the entertainment industries. The project was able to gain access to all of the police stations in the area, and the advocacy component was considered to be successful in generating an enabling environment for interventions in the two target groups. CARE's work with the uniformed services and their families is ongoing.

Advocacy for HIV prevention in the workplace has also been ongoing, both in the public and private sectors. MBCA works with private sector businesses, primarily in the garment, seafaring, hospitality and pharmaceutical industries, and advocates for the development of HIV in the workplace policies, including reduction of discrimination. To date, of the 55 businesses with which it has created links, four have

developed written policies, and seven unwritten policies. The NAP, MMA, Ministry of Industry-2, Myanmar Rail Transport, and CARE have also undertaken advocacy activities in this area.

Capacity building

Capacity building remains a key issue to be addressed particularly in view of increased resources made available for the implementation of AIDS-related activities. Although the need to build capacity and provide on-the-job training is recognised, the number of organisations specialised in, dedicated to, and able to provide training and technical assistance is still insufficient. Most of the capacity-building and training in the MoH and NAP, for example, is carried out by Medical Officers in the townships and AIDS/STD Teams, thereby placing additional workload and responsibilities that reduce their availability for other (eg. clinical) duties. The National AIDS Programme has a comprehensive training strategy, comprising training-of-trainers and multiplier trainings, with significant support from the FHAM. Topics covered include: syndromic management of STI; VCCT; HIV counselling for injecting drug users; HIV education and stigma reduction for Basic Health Staff; PMCT for Basic Health Staff; HIV counselling for various health-care staff; BSS; ARV therapy; HIV testing for laboratory technicians.

Among the gaps highlighted by organisations, the need for technical support and training are frequently stated. They include the need to ensure effective supervision, project management and monitoring at both national and field level, as well as training in finance required for implementation. Other areas identified include technical support or training on qualitative methods to inform monitoring and evaluation, including data collection and analysis for field project staff.

Capacity for implementation varies greatly from one organisation to the other, and main areas that need to be covered to strengthen implementation are:

- Increase availability of technical and/or managerial expertise
- Improve understanding of monitoring and evaluation
- Strengthen internal monitoring/systems within organisations
- Address staffing issues/high turnover and a limited pool of trained professionals
- Increase familiarity with programmatic reporting and standard donor requirements - "Little experience of working under contractual relations with clear monitoring requirements"[50]

HIV prevention in health-care settings

The National Blood Centre and the National Health Laboratory are responsible for ensuring a safe blood supply for the health services in Myanmar, and are supported in this by JICA, AUSAID and WHO. The majority of HIV test kits for use in screening donated blood have been supplied by JICA and UNDP. Strengthening of blood safety was identified within Myanmar's recent Global Fund Round 5 proposal as a priority area, and one that is currently under-funded, and for which alternative funding will now need to be sought.

Support was provided to the NAP for the development of technical guidelines on Post-exposure Prophylaxis (PEP), and the document is now in final draft (WHO and UNICEF). In 2004, with support from UNICEF, the drugs required for PEP were procured for 80 participating hospitals, to provide PEP for a potential 800 individuals.

NAP and UNICEF developed a set of guidelines for Universal Precautions to be observed in health-care settings, and procured the necessary equipment and supplies for use in public hospitals.

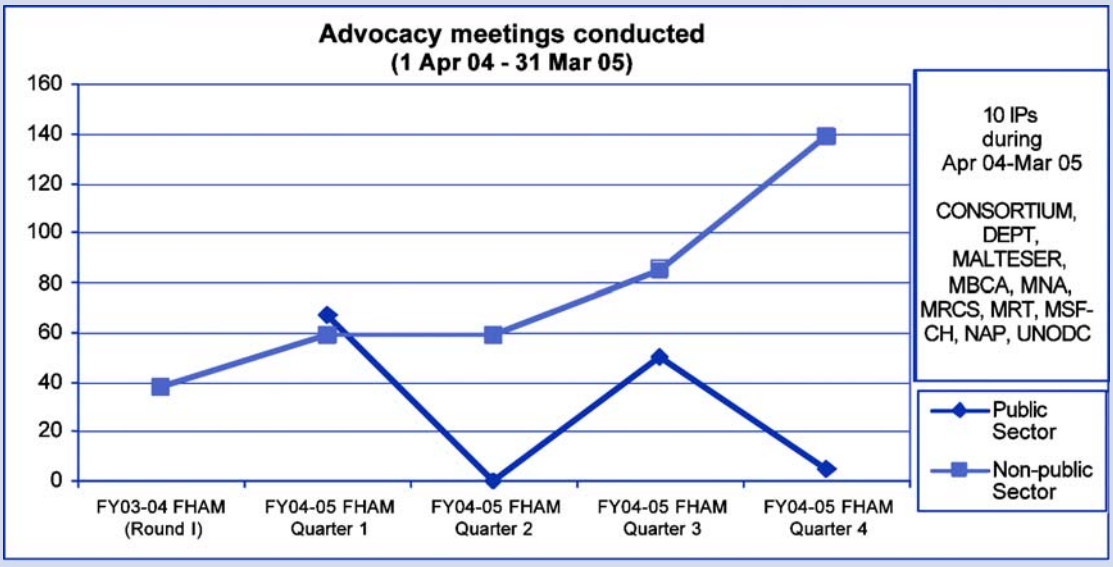
[50]Forsberg, May 2004

Focus on the Fund for HIV/AIDS in Myanmar (1 Apr 2004-31 Mar 2005)

Advocacy

The expansion of HIV prevention and AIDS care activities requires a range of preparatory steps, and advocacy is a major one. The context and relatively recent scale-up of the response and nature of some activities, such as interventions with injecting drug users, require significant advocacy at different levels and with various groups. While supporting a range of advocacy activities, the FHAM has specifically supported the need to advocate for harm reduction. A total of 401 advocacy meetings were conducted (against 268 planned) for opinion leaders and authorities at all levels. These advocacy meetings – essentially education and information sessions for local level stakeholders – have proven essential in Myanmar for fostering support of officials and communities for AIDS activities. While they are scattered across different service delivery areas, UNAIDS tracks the total number as way to demonstrate the scale-up of community level discussion of all kinds stimulated by the Joint Programme, especially funded by the FHAM. The graph below (chart 3.5.1) highlights the advocacy work done at different levels and throughout the period. Much advocacy was undertaken in the first quarter reflecting general advocacy at the start of most projects, followed with a reinforcement in the third quarter once activities had started in the interim. However the non-public sector shows a trend of ongoing and increasing advocacy activities.

Chart 3.5.1



Another area of work reflected in a majority of partners' projects includes coordination and multi-sectoral meetings. Again, these have proved essential to allow and promote support for effective implementation. Implementing partners organised 227 coordination and multi-sectoral meetings with funding from Round II of the FHAM.

Capacity building, training and technical assistance

With the increased availability of resources for health and AIDS programming in Myanmar, a strategic approach focusing on priorities to capacity-building will be essential. Priority training needs and appropriate recipients have to be assessed in a systematic manner to avoid excessive burden on professionals receiving multiple trainings. Links and synergies need to be promoted, fostered and maintained to ensure that needs are met with methods that suit recipients and its organisations. Examples of this include the needs assessment carried out by BI-CHR for Component-2 partners. The results have informed the development of a plan to support partners through workshops, mentoring, coaching and on-the-job training.

Resources have generally contributed to the increase in training and capacity-building activities, with a total of 1098 trainings/workshops provided during the period. 946 of these were carried out to build the capacity of health-care providers (chart 3.5.2). Most of the training of health-care providers was training of Basic Health Staff in HIV prevention and AIDS care undertaken by the NAP, which greatly exceeded its training targets during this period. This was due in part to the absence of this specific indicator in Round I of implementation, and the NAP implementing training in both Round II and no-cost extension during the reporting period. Peer educators were trained through 66 specific sessions (chart 3.5.3).

Chart 3.5.2

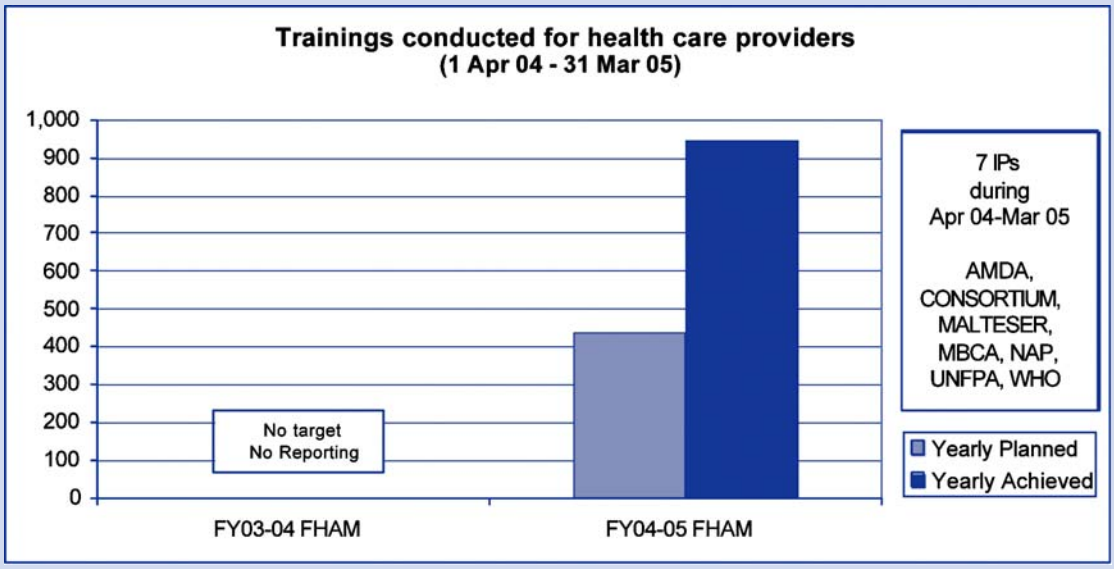
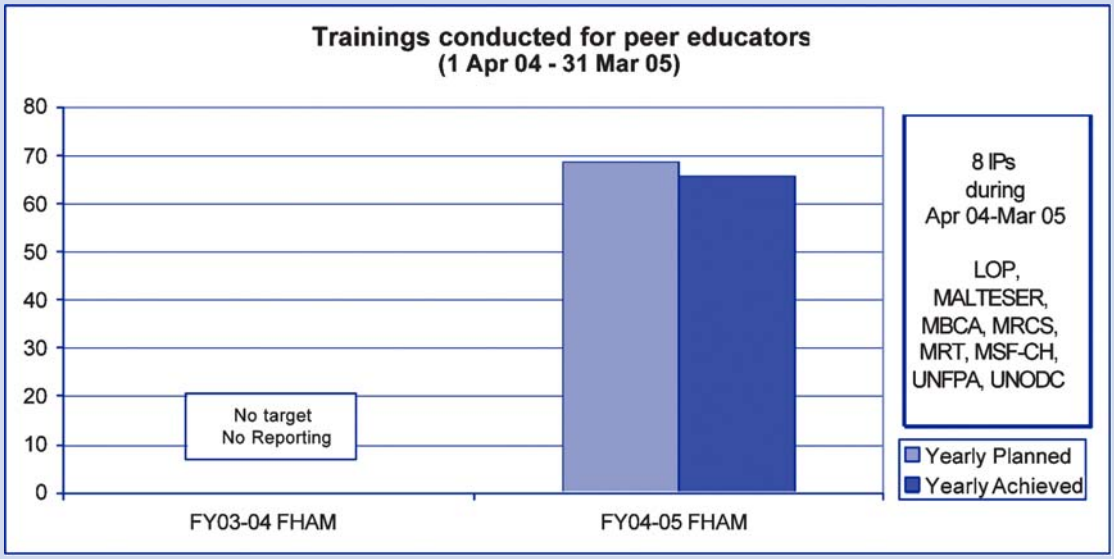


Chart 3.5.3



In addition, the FHAM offers unique opportunities to foster and promote appropriate and timely technical assistance between organisations that require and those who can offer technical assistance. Specific areas for improvement for a more effective and expanded national response were identified during Round I. As a result, key linkages for technical assistance and capacity building were created. Four partners to the response now receive funding through Round II of the FHAM with the specific objective of building technical and managerial capacity of national partners through workshops and on-the-job training and mentoring.

- International HIV/AIDS Alliance (IHAA): a number of national NGOs and Community-based Organisations have been identified to receive IHAA's support in terms of capacity building and seed grants for implementation, with a focus on targeting vulnerable groups including sex workers and MSM.

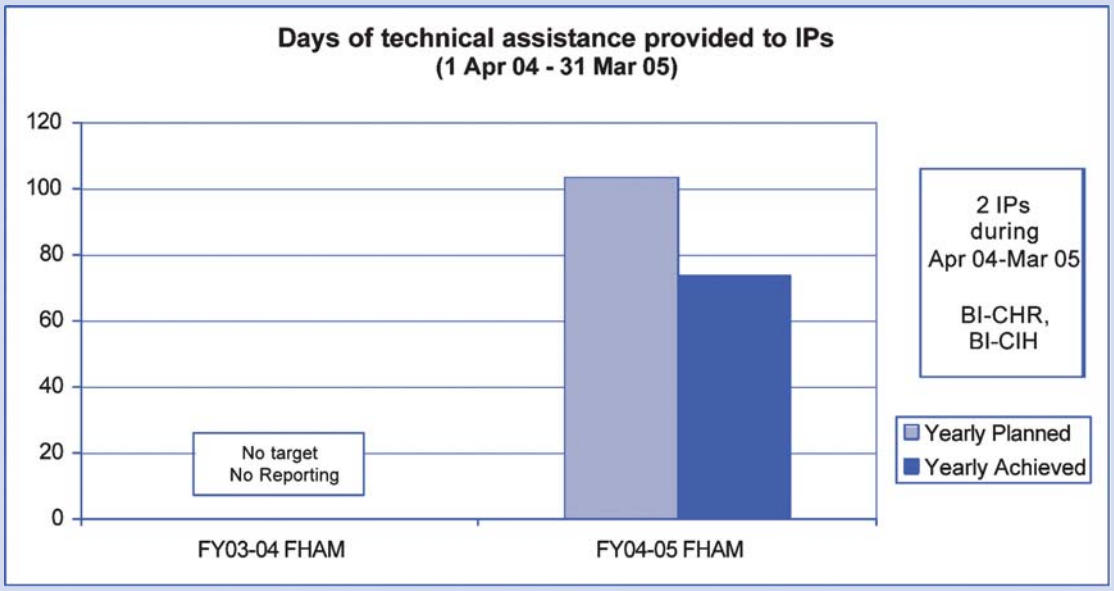
- Burnet Institute's Centre for Harm Reduction: technical assistance is being provided to national organisations in the implementation of interventions to prevent HIV transmission among IDU, to increase understanding and build expertise in Behaviour Change Communication (BCC) and to increase capacity among vulnerable groups and PLHA. The Burnet Institute's CHR provides on-going technical assistance to organisations working in this field, particularly the Central Committee for Drug Abuse Control (CCDAC) and Myanmar Anti-Narcotics Asso-ciation (MANA).

- Burnet Institute's Centre for International Health is providing BCC training to Myanmar Railways and on-going technical assistance to grassroots organisations, as well as seed-grant funding to 5 national NGOs for the implementation of HIV prevention activities, including condom distribution and provision of services for the prevention and treatment of STIs (Muslim Central Fund Trust, Karuna, Pyi Ghy Khin, Paung Daw Oo and Myanmar Red Cross Society).

- Asian Harm Reduction Network (AHRN) has been providing timely technical assistance and mentoring to the project workers of national NGOs providing services for injecting drug users.

In view of the importance of this area of work, and to better capture partner organisation contributions, additional indicators were created for technical assistance projects in Round II.

Chart 3.5.4



Coordination, Harmonisation and Monitoring & Evaluation

Governance and Coordination

Coordination and Management

The governing body of the Joint Programme is the UN Expanded Theme Group (UN ETG) on HIV/AIDS. The UN ETG comprises four representatives from the Ministry of Health, nine from UN organisations, three from international NGOs, three from national NGOs, and six from the donor community. The UN ETG meets quarterly and is presided by the Chair of the UN Theme Group on AIDS.

Members of the United Nations Expanded Theme Group (UN ETG)

UN System

Mr. Jean-Luc Lemahieu, Chair, UN Theme Group on HIV/AIDS
Mr. Charles Petrie, Resident Representative, UNDP (UN RC)
Ms. Akiko Suzaki, Deputy Resident Representative, UNDP
Ms. Carroll Long, Representative, UNICEF
Mr. Daniel Baker, UNFPA Representative
Prof. Adik Wibowo, WHO Representative
Mr. Bhim Udas, Country Director, WFP
Mr. Jean-Francois Durieux, UNHCR Representative
Mr. Brian Williams, UNAIDS Country Coordinator

Donors

HE. Mr. Bob Davis, Ambassador, Embassy of Australia
HE. Mr. Nobutake Odano, Ambassador, Embassy of Japan
HE. Ms. Victoria Bowman, Ambassador, Embassy of United Kingdom
HE. Mr. Jonas Hafström, Ambassador, Embassy of Sweden
HE. Mr. Friedrich Hamburger, Ambassador, Delegation of the European Commission
Yangon-based Ambassador representing rotating EU Presidency

Ministry of Health

Dr. Tin Win Maung, Director General, Department of Health
Dr. Kyaw Nyunt Sein, Director, Disease Control, Department of Health
Dr. Hla Hla Aye, Director, International Health Division, Ministry of Health
Dr. Min Thwe, National AIDS Programme Manager

International NGOs
Mr. Guy Stallworthy, Representative, PSI
Mr. Roger Walker, Representative, WVI
Mr. Willy De Maere, Country Coordinator, AHRN

National NGOs
Dr. Hla Myint, President, Myanmar Red Cross Society (MRCS)
Prof. Myo Myint, President, Myanmar Medical Association (MMA)
U San Thein, President, Myanmar Anti-Narcotic Association (MANA)

The programme is further supported by a Technical Working Group of 12 members: five UN representatives, the National AIDS Programme manager, one national NGO representative, and five international NGO representatives. The TWG is chaired by the UNAIDS Secretariat, meets monthly and oversees activities more closely. Finally, for thematic coordination and information sharing, five thematic component groups were established, which are open to any interested stakeholder.

Members of the Technical Working Group (TWG)
Mr. Jean-Luc Lemahieu, ETG Chair

UN System and Chair, Co-Chair of the subgroups
Mr. Brian Williams, TWG Chair
Mr. Daniel Baker, Chair, Component 1
Mr. Guy Stallworthy, Co-Chair, Component 1
Mr. Olivier Lermet, Chair, Component 2
Mr. Willy De Maere, Co-Chair, Component 2
Dr. Anne Vincent, Chair, Component 3
Ms. Joanna Hayter, Co-Chair, Component 3
Dr. Lianne Kuppens, Chair, Component 4
Dr. Frank Smithuis, Co-Chair, Component 4
U Tin Aung Cho, Chair, Component 5
Mr. Andrew Kirkwood, Co-Chair, Component 5

Ministry of Health
Dr. Min Thwe, Manager, National AIDS Program, DOH

NNGO Representative
Dr. Daw May Marlar, Joint Secretary, MMCWA

This governance structure has successfully led the Joint Programme and the FHAM through its first two years of existence, including two rounds of FHAM proposals with the allocation of over USD 20.4m to partners in Myanmar.[51] The significant participation of donors and members of the international diplomatic community in the Expanded Theme Group helped maintain momentum after initial agreement on the programme. The involvement of Government provided a bridge to the international community, helping to build relations enabling further policy discussions. And the Technical Working Group structure ensured that critical actors on the ground had a significant voice in guiding the programme.

[51] To date, USD 24.7 million have been allocated, including Round II (b) of the FHAM.

The structure does have some limitations, however, which have emerged as the programme has matured. After the first year, interest on the part of the diplomatic community began to wane as the discussions in the UN Expanded Theme Group inevitably shifted from big picture plans to more technical issues around implementation. At the same time, the large size and membership of the Expanded Theme Group has proven an unwieldy forum for such technical discussions. And at the Technical Working Group level, while it has successfully performed its core task of guiding the FHAM, it has come at the cost of undermining Government leadership on coordination and contributed to a sense of exclusion, since the TWG is small and has limited membership among interested stakeholders. The component groups functioned to varying degrees, largely depending upon the personalities who volunteered their time to lead them and/or the level of dedicated resources that different institutions provided. These limitations will be addressed in the preparation of the next phase for 2006 and beyond.

The UNAIDS Secretariat, as the Secretariat to the Joint Programme and as Chair of the Technical Working Group, has the principal responsibility of preparing progress reports for the Technical Working Group and the Expanded Theme Group. All draft technical reports shall be shared for a reasonable period with Joint Programme and FHAM partners for their review, prior to their release. Technical reports prepared by the UNAIDS Secretariat shall also present summarised FHAM financial information by implementing partner, while UNDP will prepare separately detailed financial reports for FHAM donors. All reports shall be made public via the internet, through the UNAIDS Secretariat website (www.unaids.org) and, possibly in the future, through Myanmar-based United Nations web portals/sites.

Harmonisation

The establishment of the Joint Programme has helped to advance the *'Three Ones'* [52] principles in Myanmar, although a few critical steps need now to be taken to advance to the next stage. Notably, the Joint Programme provided the basis to negotiate an M&E framework of indicators to which all actors working on AIDS in Myanmar contribute. It essentially meets the 'one M&E framework' principle, although increased ownership by Government of the framework would ensure sustainability and encourage the use of evidence in policy and activity design. As an important success of the Joint Programme, the M&E framework is discussed at length in the next section.

With respect to 'one agreed action plan', the Joint Programme does sketch out a vision of a comprehensive AIDS response, providing a vehicle for policy discussions and a framework for multi-sectoral contributions. It also overlaps with the Government's national strategic plan, however, causing some confusion and tension. This needs to be addressed in the next phase, ideally through the production of a participatory, multi-sectoral national strategic plan.

Finally, with respect to the principle of 'one broad-based coordinating authority', the current situation involves instead several bodies. The Government's National Health and National AIDS Committees play a policy leadership role, the Global Fund driven Country Coordinating Mechanism plays an important high-level coordination role with the Minister of Health as Chair, and the UN Expanded Theme Group provides a UN-led space for technical discussion and guidance of the use of FHAM resources. While – if the environment allows – some consolidation might be possible, the system functions reasonably well, especially given that the number of actors is not large. The current

[52] The *'Three Ones'* are principles aimed at supporting countries to strengthen nationally-led responses to the AIDS epidemic, namely: *One agreed HIV/AIDS Action Framework*, that provides the basis for coordinating the work of all partners; *One National AIDS Coordinating Authority* , with a broad-based multisectoral mandate; and *One agreed country-level monitoring and evaluation system*, to track progress, enable learning and inform improved action.

model has served an important purpose in being able to secure resources in what is to a significant degree a donor-constrained setting. Increased recognition of Government to lead technical coordination forums would be an important step in the right direction, while providing a working space for international donors to contribute to the response.

Monitoring and Evaluation

In 2003, at the start of the Joint Programme, a standardised M&E strategy to monitor the efforts of multiple implementing partners and measure their impact on the epidemic did not exist. While the National AIDS Programme has been tracking data for number of years, other partners were using different M&E systems and with varied levels of capacity to collect, interpret and integrate data into project management.

As part of the Joint Programme, the UNAIDS Secretariat was asked to establish a common M&E framework for Joint Programme's partners. A common basic data set has been designed, with agreed definitions against which implementing partners have been requested to report. A draft M&E framework was developed at the end of 2002 and was updated in January 2004 with support from UNAIDS and the London School of Hygiene and Tropical Medicine. As a result of these consultations, an M&E plan based on a set of 69 indicators was adopted. While the selected indicators ensure that the Joint Programme can report on essential elements of the national response to AIDS in Myanmar, they also reflect standardisation with international indicators, including UNGASS indicators.[53] As discussed below, a system has been designed to collect data regularly against this framework.

To improve the system further, however, national targets for each indicator in the logical framework need to be chosen. The M&E framework has been used so far as a guideline of what is to be measured rather than milestones to reach. Baseline measures and broader coordination among partners, consolidated during this phase, will help in the determination of acceptable common targets for each of the coming years. As the Joint Programme framework currently monitors the totality of activities in Myanmar, whether the framework is better housed in the National AIDS Programme also needs to be reviewed. This will be done in response to the Mid Term Review in 2005.

Monitoring the Joint Programme's contribution to the national response

In order to measure Joint Programme achievements, data on individual contributions of partners are being collected and aggregated at the national level.

Reporting on activities

A reporting form is sent by the UNAIDS Secretariat every 6 months to all 40 identified partners. Process and output indicators, irrespective of funding source, are collected and aggregated nationally (number of peer educators trained, number of condoms distributed etc.). 90% of the partners have reported on these indicators for the second semester of 2004, including all the major partners. A critical mass has been reached to consider having gained a representative picture of the response to the HIV epidemic by the Joint Programme. Data aggregated at Joint Programme level have been disseminated to the Technical Working Group and the implementing partners. Data resulting from this system are presented

[53] For a full description of the Joint Programme indicator set, refer to the publication UNAIDS, UN Expanded Theme Group on AIDS in Myanmar, *Joint Programme for HIV/AIDS: Myanmar 2003-2005*, pages 5-10

throughout chapter III "Programme Achievements".

Mapping of activities: Services Providers Matrix

The UNAIDS Secretariat has collected information from all partners on the type and location of their activities and compiles the information into a matrix that is updated regularly. This Service Providers Matrix has been distributed to all partners in country. The matrix is used to determine not only "who is doing what and where", but also to determine how many service providers are present at township, division or national level.[54]

Initial identification of potential HIV hotspots in Myanmar

In November 2004, CARE and UNAIDS organised an informal mapping exercise with all partners of the Joint Programme. About 40 participants from NGOs, UN agencies and Government (Central Committee for Drug Abuse Control) participated in this workshop. All participants had extensive experience of HIV in Myanmar and were requested to collectively select 10 townships in which HIV transmission could be considered at its highest with regards to four high-risk categories: sex-work, IDU, MSM, and population mobility. The methodology, currently being used thorough the Mekong sub-region, emphasises the collection and corroboration of local knowledge of those working to fight AIDS. The workshop resulted in identification of potential 'hotspot' townships that will help to identify the gaps in the response (see Chapter II). This initiative needs to be built upon and verified with in-depth work at local level and by involving more partners for potential transfer to the National AIDS Programme.

Evaluating the impact of the Joint Programme

Data against outcome and impact indicators have been collected by the National AIDS Programme.

Seroprevalence

To monitor the epidemic in the country, the NAP has been conducting HIV Sentinel Surveillance (HSS) since 1992 (twice a year initially, and then once yearly). Currently, HSS is being carried out in 30 sites (townships) (figure 4.1). The population groups for HSS include high-risk groups (female direct sex workers, injecting drug users and male clients of STD clinics) and low-risk groups (antenatal care attendees, blood donors and new military recruits). Samples are collected at the site level, then sent to the two reference laboratories (Yangon and Mandalay) that perform HIV testing for surveillance[55]. NAP publishes a yearly report of the HIV/AIDS/STD surveillance results reported by the health services. The epidemiological report is well disseminated among Myanmar's political and health authorities.[56]

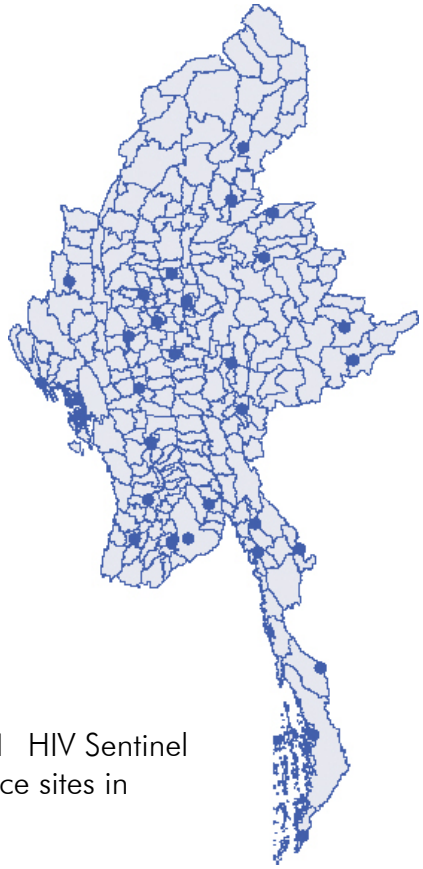


Figure 4.1 HIV Sentinel Surveillance sites in Myanmar

[54] UNAIDS plans to make the matrix – a living document – available on the UN Country Team's website.

[55] UNAIDS/UNICEF *Strengthening the HIV second generation surveillance system in Myanmar,* 2001

[56] The most recent published data is for 2003. 2004 data have been collected but not yet published.

In addition to HSS, the surveillance system consists of AIDS case notification, STI case notification and Behavioural Surveillance Survey (BSS).

Behaviour

A Behavioural Surveillance Survey (BSS) system in the general population of Myanmar was set up in 2000 by the NAP. A national behaviour survey was conducted in 2003 by NAP[57] with the support of WHO. This survey was undertaken during September-November 2003 to assess the knowledge, attitude and behaviours of the general population and youth with regards to HIV transmission and prevention at seven sites in Myanmar. The findings should be published in the second semester of 2005.

In the context of the Joint Programme, a national, 5-year BSS, funded by the FHAM, was due to start in 2004, to focus on targeted groups as well as the general population, but is behind schedule. The BSS will be conducted by the NAP with the technical assistance provided by an independent company, Compass Research, and with the support of UNAIDS and WHO. A selection of high and low risks groups will be included in the first year 640 sex-workers, 1,040 IDU, 16,700 young people (in school and out-of-school) and 3,500 factory workers. Methodology and questionnaires have been designed and will be finalised by the Ministry of Health. Results of the survey will be published by the NAP.

Overall, the M&E system has completed its first phase of development:

- indicators are well defined and harmonised with partners and donors
- a reporting mechanism is in place
- dissemination of strategic information has improved

The next phase should address the determination and costing of national targets against each indicator for maximising the cost-effectiveness of the national response. With such targets, coverage can be better tracked and financing of activities prioritised.

For the Joint Programme so far, the UNAIDS Secretariat has taken the lead in M&E implementation, as mandated by the Expanded Theme Group. However, to guarantee sustainability, to better enable the Government to meet its responsibilities to oversee and provide the space for an expanded response, and in line with the *'Three Ones'* strategy, the National AIDS Programme should play a leadership role in M&E, with support from UN and non-governmental partners, especially UNAIDS. Increased production, with technical support from the UN agencies, and dissemination of information by the NAP (including publication of 2003 BSS, of 2004 HSS, and undertaking the national BSS on targeted groups) will help the National AIDS Programme build a transparent and comprehensive M&E system.

[57] Nearly 10,000 persons (male and female) were interviewed, of these 35% were youth aged 15-24 years.

Focus on the Fund for HIV/AIDS in Myanmar (1 Apr 2004-31 Mar 2005)

M&E system and indicator framework

During Round I it became apparent that Monitoring & Evaluation for the Fund as a whole was insufficient. Due to its nature, the FHAM is in a position to support the Joint Programme to advocate and promote a common M&E framework. While the Joint Programme M&E framework was being finalised, Joint Programme core indicators were already being adapted for use by the FHAM in all projects starting after April 2004. In its M&E framework, the FHAM includes a list of core indicators that allow results-based progress to be tracked across Joint Programme priority objectives, outcomes and outputs. The core indicators set for the FHAM (developed from the Joint Programme indicator set) supports the dual purpose of programmatic monitoring and resource tracking. Positive feedback has been received from implementing partners on the simplified technical progress reporting form and system.The Fund's M&E system was considerably improved after the first year of operation, when it was less developed but permitted priority to be given to start-up. The FHAM M&E framework benefited from the finalisation of the Joint Programme M&E framework in July 2004. It therefore includes all relevant indicators reflecting priority areas of the Joint Programme as well as specific indicators common to different implementing partners. It allows for partner-by-partner target setting in the absence of national targets. Reporting on technical progress has been streamlined, in consultation with implementing partners, to reflect progress on selected indicators. As a result, and for the first time, it has been possible to present consolidated data for selected core indicators in this report.Data reflecting progress on outputs are now available as part of the regular monitoring for the FHAM and focuses on results achieved towards Joint Programme objectives. Information and data on the impact of activities however are still insufficient and require specific studies. To address this, FHAM funds have been invested in the BSS (see discussion on preceding pages). The BSS will provide critical information to inform the response and the future direction of efforts.

Quarterly financial and technical reports

Implementing partners submit technical progress reports and a financial report on a quarterly basis. The quarterly reports of the 26 partners are reviewed and analysed by UNAIDS Secretariat, and recommendations are forwarded to UNDP for financial consolidation and disbursement. Quarterly technical progress data are consolidated by UNAIDS. Issues are identified for follow-up with partners.

Field monitoring

Field visits were carried out to projects funded by the FHAM management team on a regular basis with site visits to projects in Lashio, Muse, Taunggyi, Kyaingtong and Tachileik (Shan State), Monywa (Sagaing Division), Yangon and Mandalay. These visits fulfilled the dual purpose of monitoring progress and feedback to partners on implementation.[58] In early 2005, UNAIDS aimed to improve the sharing and feedback of information gathered during field visits by instituting the practice of providing field reports to the Technical Working Group.

[58] Unfortunately, on two occasions in 2005, monitoring visits were postponed: one to Sagaing Division, and another to Eastern Shan State.

FHAM Resources and Operational Issues

Financial resources

The Fund for HIV/AIDS in Myanmar (FHAM) raised, as of the end of 2004, USD 25.2 million[59] for activities pursuing the five priority areas of the Joint Programme, from three donors: the UK's DFID (USD 17.3m), Sweden's SIDA (USD 5.5m) and Norway's Ministry of Foreign Affairs (USD 2.4m).

USD 7.1 million were allocated for the first year of FHAM implementation[60] and contracts for a value of USD 6.4 million were signed for the implementation of 19 projects. In the second round of funding,[61] USD 13.3 million were allocated, of which USD 12.0 million were for project implementation. Details of the budgets approved by partner and by sector for Rounds I and II are represented in Annexe 1: 'Budget overview'.

In both rounds, additional projects supporting the overall Monitoring & Evaluation (including UNDP's handling fee) of the Joint Programme were funded. These included the development of the Joint Programme Monitoring and Evaluation Plan, the Behavioural Surveillance Survey, the Technical Review Panel for Round II of the FHAM, external audit and the recruitment of a short-term Monitoring & Evaluation consultant. The underspend to date in this area in Round II of funding is largely due to delays in reaching consensus around technicalities for implementation of the planned Behavioural Surveillance Survey. In Round II, USD 432,000 remain to be allocated by the Technical Working Group for monitoring and evaluation of the Joint Programme.

Overall utilisation of funds in relation to budget varied between implementing partners from 29% to 100% during Round I of the FHAM. Therefore, a number of Round I projects required an extension into 2004/2005 financial year to complete planned activities. Of 19 projects in Round I, three completed activities within 12 months as planned, and another sixteen were prolonged from 1 to 9 months. These no-cost extensions were to ensure the completion of activities and to make up for initial delays in implementation due to procedural delays in issuing contracts and disbursements, procurement and administrative constraints, and varying degrees in absorption capacity for some organisations. Many partners therefore started Round II implementation in or after September 2004.

As of 31st March 2005, over the first two years of the FHAM's operation, a total of USD 11.1 million had been disbursed of the

[59] The exact amount varies depending upon currency exchange rates.

[60] Financial year 1st April 2003 – 31st March 2004

[61] Year 1 – financial year 1st April 2004 – 31st March 2005

USD 24.7 million available for implementation (table 5.1). Funds amounting to USD 6,653,313 were disbursed during the financial year 2004/ 2005, covering 22 Round II projects, and 16 projects in Round I no-cost extension (amounting to USD 1,497,081) (table 5.1).

Delays in starting Round II projects and activities, and delays in the signing of contracts, accounted for a seemingly lower utilisation in the first 6 months of Round II (from 1% to 22% between April 2004 and end September 2004).

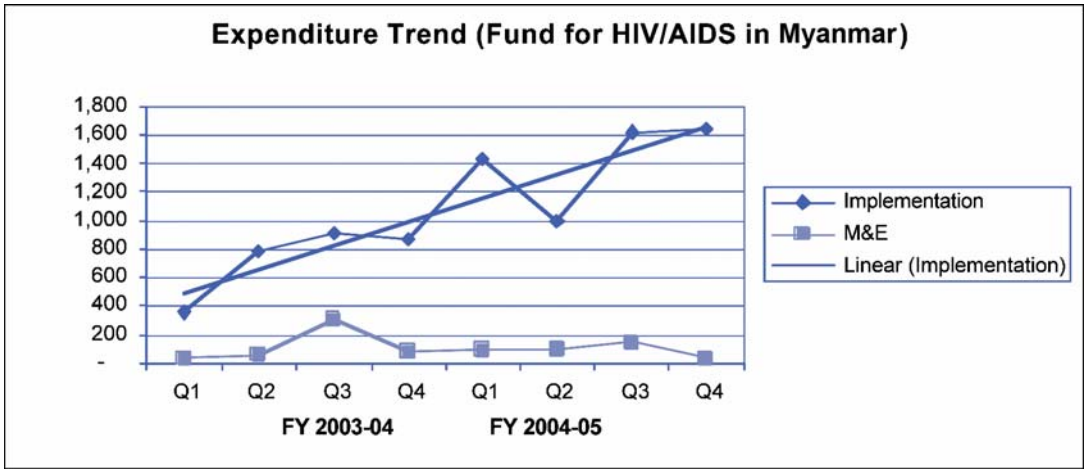
Table 5.1 Round I and Round II of the FHAM (FY 2003-04 and FY 2004-05)
Summary of Budget and Disbursement as of 31st March 2005 (USD)

Particulars	Budget	Disbursement				Total Disbursement	(%)
		FY I 2003-04	(%)	FY II 2004-05	(%)		
FHAM Round I Implementation	**6,423,933**	**3,950,495**	**61%**	**1,949,786**	**30%**	**5,900,281**	**92%**
Government	*1,828,881*	*531,416*	*29%*	*1,097,251*	*60%*	*1,628,667*	*89%*
INGOs	*2,989,279*	*2,611,679*	*87%*	*297,542*	*10%*	*2,909,221*	*97%*
NNGOs	*225,975*	*225,975*	*100%*	*-*	*0%*	*225,975*	*100%*
UN	*1,379,798*	*581,425*	*42%*	*554,993*	*40%*	*1,136,418*	*82%*
Monitoring & Evaluation	**712,951**	**530,268**	**74%**	**111,589**	**16%**	**641,857**	**90%**
TOTAL	**7,136,884**	**4,480,763**	**63%**	**2,061,375**	**29%**	**6,542,138**	**92%**
FHAM Round II + IIb Implementation	**15,611,578**	**-**		**4,314,076**	**28%**	**4,314,076**	***28%***
Government	*2,688,573*	*-*		*72,478*	*3%*	*72,478*	*3%*
INGOs	*9,616,276*	*-*		*3,169,056*	*33%*	*3,169,056*	*33%*
NNGOs	*585,083*	*-*		*205,474*	*35%*	*205,474*	*35%*
UN	*2,721,646*	*-*		*867,068*	*32%*	*867,068*	*32%*
Monitoring & Evaluation	**1,908,960**	**-**		**277,862**	**15%**	**277,862**	***15%***
TOTAL	**17,520,538**	**-**		**4,591,938**	**26%**	**4,591,938**	***26%***
GRAND TOTAL	**24,657,422**	**4,480,763**	**18%**	**(*) 6,653,313**	**27%**	**11,134,076**	

(*) Based on all disbursement authorised up to 31st March 2005
NB: percentage disbursed for Round II (last table column) is expressed as a percentage of the two years of funding, and so is expected to be at maximum 50%. In some cases these are lower than expected due to late start.

The expansion of HIV prevention and AIDS care activities made possible through additional funds from the Fund for HIV/AIDS in Myanmar is reflected in the graph below. After the initial start-up phase in April 2003, a gradual but still modest increase in implementation was seen in the first year (FY 2003-4). Many projects were started in new areas, or by partners new to the response and although many started on time, there were also some delays (reasons included Memorandum of Understanding pending,

Chart 5.1



late start up). In the second year however, the continued increase in expenditure (chart 5.1) may be attributed to a number of factors such as 1) key activities reaching their momentum (for example, in provision of ART) and 2) improvements in cash-flows (for reasons including improved internal systems, revised Operational Procedures).

Operational issues

A responsive and flexible approach has been necessary to support a range of projects and organisations with varying degrees of capacity for absorption and implementation. Building on the experience acquired during the first year of implementation, an improved approach to allocation decisions with more external participation was used for Round II to increase objectivity, focus resources and ensure that gaps were identified and addressed. Proposals submitted for Round II were reviewed by three independent experts using standard criteria such as technical merit, Joint Programme priority, value for money, and capacity for implementation. [62] Recommendations for the approval of funding allocation were submitted to the Technical Working Group. The competitive basis for the FHAM aims to ensure funding for the most effective interventions which reduce transmission of HIV and provide care to people living with HIV in Myanmar. The FHAM also supports smaller projects, thereby building capacity (and exposure) among partners who have fewer resources (or limited access to resources), yet have a role to play in the response.

In general, this call contributed to an increase in the number of actors and activities, particularly for the provision of technical assistance. As a result of Round II, for example, three non-health departments new to the response to HIV in Myanmar were involved: Myanmar Railways, the Department of Education Planning and Training, and Home Affairs (CCDAC). At the same time, a comprehensive review of current and future projects and activities by the review panel reduced duplication in programme activities.

The FHAM has served to promote and support a coordinated discussion on current priorities and gaps in the response where additional resources are needed. For example consolidated M&E data from Round II implementation were used in selecting priorities for the allocation of resources for Round II (b) of the FHAM. In Round II(b), the remaining funds[63] were allocated through a competitive bidding process for selected priority interventions, identified by the TWG as areas of critical need, based on M&E and implementation data and evidence. Round II(b) priorities aim to increase and/or strengthen voluntary confidential counselling and testing; treatment, care and support of people living with HIV; prevention targeting sex workers, their clients and men who have sex with men; IDU outreach programmes to increase prevention among injecting drug users; and treatment for sexually transmitted infections.

Discussions with organisations on their M&E and indicators highlighted that few of them had any internal Management Information System (MIS). The Joint Programme and in particular the FHAM provided an opportunity to advocate for and encourage projects to use common indicators and build capacity in this area.

The process of Round II has also led to ensure that critical areas where links between organisations need to be promoted, made and maintained are effectively addressed.

[52] TWG and other local existing actors decided directly on approval of FHAM I proposals

[63] Estimated at USD 3 million at current exchange rate

Important collaboration between the Burnet Institute's Centre For Harm Reduction, CCDAC and MANA was built into proposals and followed up. The Burnet Institute's Centre for International Health modified its plans for 2004-2005 to incorporate the immediate BCC training needs identified at Myanmar Railways.

As a result of experience gained during the first year of implementation, the operational procedures governing management and disbursements for the Fund were reviewed to improve cash-flows and provide added flexibility for implementing partners during implementation.

In late 2004, the FHAM operational procedures were revised a second time to improve cash flows. Resulting from issues raised in the Technical Working Group and during a working session organised by DFID in November 2004, several areas for improvement were identified. Since then, the UNAIDS Secretariat reviewed with UNDP their roles and responsibilities and have better communicated them to partners. Communications were improved, for example by instituting systematic communications about cash transfers to partners. The advance mechanism itself has been altered, by providing a second quarter's advance, to allow sufficient time (one quarter) to prepare, review thoroughly and approve technical and financial reports without disrupting implementation.

Monitoring data reported by organisations to the FHAM and the Joint Programme as a whole, now provide stronger evidence on gaps and priority areas of work for the Joint Programme for HIV/AIDS in Myanmar. The Review of the Joint Programme in May 2005 also benefited from a stronger evidence base to provide recommendations to enhance the response. Although covering a relatively limited period of time[64], the 6-month progress report allowed a number of conclusions to be drawn and strategic issues to be raised, on the strength of the data presented. Many of these were used to prioritise the allocation of funding in Round II(b).

A number of partners experienced some delay in starting projects. Reasons that partners cited for this included constraints from organisation headquarters, difficulty in planning due to lack of baseline data in certain geographical areas and target groups, high staff turn over, low availability of experienced staff to fill positions, insufficient planning for implementation of the project activities, and delayed disbursement of funding. Targets estimated on a 3-month basis were thus difficult to achieve.

[54] 1st April to 30th September 2004

Conclusion

This section discusses a number of lessons learned and challenges faced during the two years of existence of the Joint Programme and the Fund for HIV/AIDS in Myanmar. Many have emerged from partners funded by the FHAM as captured by programme reports and field visits. Many of these issues have also been raised and addressed in the context of the Joint Programme Mid-term Review.

Programme directions

Outreach programmes targeting women and men at highest risk and providing education for HIV prevention and AIDS treatment options can work in Myanmar. Many projects already reach sex workers and their clients in formal and informal settings. Data also suggest that while availability of condoms in the country has increased, the challenge remains to convince high-risk groups of the need to use them. In addition, more protection and commitment for these programmes is required by decision makers and better advocacy with law enforcement services is necessary to allow outreach activities to effectively reach groups at highest risk.

The treatment of sexually transmitted infections has seen expansion since 2003 with additional support from the Fund for HIV/AIDS in Myanmar. Currently 206 service delivery points provide STI services in 100 townships, out of 324.[65] Furthermore, STI services constitute a major entry point for access to routine HIV testing and treatment and care for AIDS. Every time a new service delivery point is opened, the demand for services is higher than expected.[66] Access to appropriate treatment for STIs remains a high priority and needs to be improved and increased. Strategies need to be developed to further increase the number and availability of services providing quality treatment.

Services targeting IDU such as voluntary confidential counselling and testing, needle and syringe exchange, prevention of sexual transmission to partners, methadone substitution therapy and ART provision need to be scaled up. Pilot projects have demonstrated the feasibility of community-based outreach including a degree of social support. However, the scale at present is far from sufficient, with less than 5% of the estimated IDU population within reach (currently 14 drop-in centres in 10 townships).[65] Based on progress made to date, services need to be scaled up and coverage increased.

Activities promoting knowledge and awareness of HIV have benefited from the overall increase in resources. There is currently insufficient data to inform the Joint

[67] UNAIDS data 2005

[66] UNAIDS, Fund for HIV/AIDS in Myanmar monitoring data 2005

Programme on how effective these activities are and on their actual impact on behaviour change, especially among targeted groups. Some recent evidence suggests that knowledge within the general population remains low, particularly among women, youth and those with lower levels of education. The Behavioural Surveillance Survey is expected to provide needed information on progress and achievements in relation to knowledge, attitudes and uptake of safer behaviours. Meanwhile, the effective use of different mass media needs to be expanded and supported.

The demand for voluntary, confidential counselling and testing has been consistently higher than anticipated and monitoring data[66] show significant achievements during implementation in Round II of the FHAM. Within the Joint Programme, VCCT is currently provided by 114 service providers in 71 townships.[65] Access to HIV testing needs to be significantly and rapidly scaled up, both to strengthen prevention and as an entry point for the treatment and care of persons living with HIV. The availability of testing needs to be increased by creating new service delivery points in the near future that offer testing through a range of entry points including routine health service delivery. Current regulations surrounding the implementation of VCCT limit potentially interested partners to provide complete VCCT services that include testing. High demand for VCCT suggests that there is still insufficient supply. To increase the coverage of VCCT requires enabling a range of partners to provide services, including advocacy to implement effectively with health authorities. A policy that facilitates testing, with availability of HIV rapid tests, should allow rapid one-day testing.

A small proportion of PLHA are currently being reached by programmes of any kind and less than 10% of AIDS patients requiring ART will be receiving the drugs by the end of 2005 from resources earmarked for treatment.[67] Treatment, care and support services (clinical, medical, psycho-social and community-based) available at present fall dramatically short of meeting the estimated need and should be scaled up as a matter of urgency. The treatment target should be significantly increased.

With still comparatively limited resources and in light of the above, capacity building remains a core area requiring continued support within the Joint Programme framework. Increasing knowledge and building the technical and managerial skills of national partners and networks will allow organisations that are critical to the national response to scale-up their activities and will ensure sustainability. Capacity building with a view to empowering vulnerable groups such as women and PLHA has started and needs to be further strengthened.

Enabling environment

The Government has shown strong commitment and worked to improve the environment over the last few years and the Joint Programme has benefited from an environment that is now more suitable for implementation of interventions in the main component areas. It has been demonstrated that it is possible to have pragmatic policies enabling key AIDS activities. Examples include the mechanism for allowing partners to offer pre- and post-test counselling in VCCT, while state laboratories perform the testing; the use of peer educators to reach key vulnerable groups; willingness to work in harm reduction; advocacy and HIV prevention with the uniformed services. There is a need for continued sensitivity to the context while advocating for wider adoption of these pragmatic policies to

[67] Projects funded by the FHAM and other sources aim to provide ART for approximately 3,900 patients by the end of 2005, of an estimated 46,500 patients in need.

provide solutions to scale up interventions and bring the epidemic under control.

The requirement for authorisation to travel reduces the flexibility of organisations, imposes rigid planning, and results in slower implementation than often expected. The need for explicit permission for detailed activity implementation can often cause delay. Implementing partners reported that it was not possible to obtain permission to operate in some geographical areas, with reasons of security being stated. Unfortunately, some of these areas are often where services are most needed, and vulnerable groups are located, and so more contact and communication is warranted, while advocacy at the highest level is needed.

Advocacy needs to be targeted at the appropriate level. Although at the local level all authorities may be contacted and briefed about the project and voice support, it was found that, there is often a turn over in staff positions at this level. To allow the actual implementation of any project, future advocacy activities will also have to focus more on the highest authorities at regional level, for instance, the regional commander. It is essential to establish very good working relationships with local hospitals, AIDS/STD team leaders and Township Medical Officers for the smooth implementation of projects. Some implementing partners stated that it was hard to organise advocacy activities due to difficulty in accessing the authorities identified for advocacy, and to the high demands on time of township/district level officials and authorities with competing commitments. As in many nations in the region and globally, some high-risk groups are by their nature engaging in activities that are illegal in Myanmar. This is particularly true for commercial sex workers and IDU. Reaching these key high-risk groups can be problematic, as target beneficiaries are afraid of law-enforcement officers and of arrest and punishment. The use of peer educators was reported to have met with some local level resistance. Some local officials expressed concern that IDU or former IDU might in fact promote drug use and that sex workers promote sex work. However, the use of peer educators has proved to be one of the most effective approaches to educate and promote behaviour change among marginalised, high-risk target groups, in Myanmar and elsewhere.

More than advocacy, experience shows the need for full community engagement. Some activities were not completely implemented due, at least in part, to constraints related to the acceptance of messages by the community, as well as cultural and environmental factors. For example, cultural constraints were experienced in some townships for conducting condom demonstration for young women. In common with many other countries, stigma and discrimination remain prevalent in Myanmar. This has particularly been experienced in rural settings, and hampers access to services for those most at risk. One implementing partner reported that more awareness-raising strategies were needed in its project communities to ensure access of PLHA into community resilience and impact mitigation activities.

Finally, the limited availability of data to inform programme planning and implementation is a constraint frequently cited by implementing partners. There is still a lack of baseline data in Myanmar on high-risk groups and HIV. It has particularly been pointed out that data on HIV in IDU are still lacking, and what is existing with different partners is not readily shared because of the actual or perceived sensitivity and politicising of information. All partners need to invest more in operational research and sharing of results.

Future

The Joint Programme is now at a key crossroads. Significant progress has been

made in the fight against AIDS in Myanmar. The operating environment is more open and supportive than in the past. Activities are being undertaken in all divisions and states across the country. It is easier to talk about AIDS in Myanmar than it was before, pilot programmes have begun on particularly sensitive issues, care — including access to ARVs — is improving, and programmes are slowly expanding in other areas of targeted prevention. With this foundation established, the Joint Programme can now turn to addressing other major challenges that lie waiting: to address quality by providing better technical assistance and undertaking improved performance monitoring, to address coverage by raising more resources and continuing advocacy with authorities and communities to permit and support expansion, and to address effectiveness by fine-tuning governance structures and mechanisms, including an improved strategy for capacity building. An additional challenge, responding to the termination of the Global Fund AIDS grant, has just been imposed as this report is prepared. Based on the Mid Term Review of the first years of experience, and taking into account the lessons of the Global Fund trial, all partners must now work towards defining a collective vision for 2006 and beyond, allowing the national response to AIDS to continue and expand.

Annexe 1: FHAM budget overview

FHAM Round I and II Budget Overview of IPs				
ImplementingPartners for year 1 (2003-2004)		Implementing Partners for Round II (FY 2004/5 & 2005/6)		
Organisations	**Budget (USD)**	**Organisations**	**Approved Budget (USD)**	**Percentage**
Government Agencies	**1,828,881**	**Government Agencies** (4)	**2,688,573**	**20%**
NAP	1,828,881	NAP	2,000,248	
		CCDAC	532,325	
		Department of Education Planning and Training	50,000	
		Ministry of Rail Transportation	106,000	
INGOs	**2,989,279**	**INGOs** (10)	**7,135,826**	**53%**
AHRN	297,942	AHRN	200,000	
AMI	112,000	AMI	330,000	
Consortium (SC-UK)	660,131	Consortium (SC-UK, CARE, MSI, WV, MNA)	2,085,000	
MSF(Holland)-AZG	300,000	MSF(Holland)-AZG	1,018,182	
PSI	879,631	PSI	1,646,018	
ADRA	120,078			
AMDA	155,785			
PACT	368,558			
WVI	95,154	*(WVI is part of the Consortium Round II)*		
		Malteser	249,984	
		MSF - Switzerland (MSF-CH)	300,000	
		Partners	99,818	
		Burnet Institute - CHR (to support MANA and CCDAC)	400,000	
		Burnet Institute - CIH (to support Ministry of Rail Transportation and other CBOs)	406,824	
		International HIV/ AIDS Alliance (to support CBOs and PLWA groups only)	400,000	
NNGOs	**225,975**	**NNGOs** (3) *	**409,805**	**5%**
MANA	81,807	MANA	100,000	
MBCA	50,000	MBCA	149,808	
MNA	94,168	*MNA is part of the Consortium Round II*		
		MRCS	159,997	
UN Agencies	**1,379,798**	**UN Agencies** (4)	**1,786,121**	**13%**
UNFPA	360,500	UNFPA	506,521	
UNODC	304,360	UNODC	700,000	
Outreach Activities (UNODC)	120,000	On going (Year 1)		
WHO	455,240	WHO	579,600	
WFP	139,698			
Sub Total	**6,423,933**	**Sub Total**	**12,020,325**	**91%**
Monitoring/Evaluation		**Monitoring/Evaluation**		
UNAIDS (Myanmar)	114,083	UNAIDS (Myanmar)	708,051	
UNAIDS (Geneva)	288,400	On going (Year 1)	-	
Monitoring/Evaluation	229,465	Monitoring/Evaluation	432,160	
M&E Sub Total	**631,948**	**Monitoring/Evaluation Sub Total**	**1,140,211**	**9%**
UNDP Handling Fee	81,003	UNDP Handling Fee	112,000	
UNDP Sub Total	**81,003**	**UNDP Handling Fee Sub Total**	**112,000**	**1%**
Grand Total	**7,136,884**	**Grand Total**	**13,272,536**	

* MNA USD 244,246 is included in the NNGO percentage calculation

Annexe 2: FHAM Summary of technical progress

FHAM Financial Year 2004-2005, Yearly planned and achieved

	CORE INDICATOR	YEARLY TOTAL PLANNED	YEARLY TOTAL ACHIEVED
Component 1: Sexual Transmission of HIV			
1.1 Access to affordable condoms for sexually active men, women and young people increased			
1	Number of condoms distributed	30366952	32868473
1.2 Capacity of both private and public sector health facilities for prompt and effective management of STIs improved			
2	Number of clients to STI services	136600	178391
3	Number of STI male and female clients at health care facilities appropriately diagnosed, treated and counseled	240650	136649
4*	Number of service delivery points (SDP) providing integrated STI services	160	128
5	Number of referrals to STI services	428	231
Component 2: Injecting Drug Use			
2.1Access to harm reduction interventions increased			
6	Number of needles and syringes or cleaning materials distributed to IDUs	48476	17349
7	Number of clients to IDU drop-in centres	856	1609
8*	Number of IDU drop-in centres established	3	2
2.2 Access to and quality of drug treatment in institutional and non-institutional settings improved			
9	Number of IDUs receiving detoxification treatment	0	0
10*	Number of IDUs receiving maintenance substitution therapy	74	0
11	Number of IDUs referred for drug treatment	137	33
Component 3: Knowledge and Attitudes			
3.1 Knowledge of modes of transmission, perception of personal risk, and attitudes regarding HIV/AIDS and those living with and affected by H improved among the general population			
12	Number of health education (HE) sessions on HIV/AIDS conducted	40716	41468
13	Number of mass awareness sessions held [video shows/TV spots aired]	1213	1323
14	Number of IEC materials distributed to general population	4767006	3384392
15*	Number of peer educators involved in workplace education	460	406
3.2 Positive attitudes, safe behavior and practices in specific target groups improved, (includes consistent condom use and safe injecting pract IDUs)			
16	Number of HE or counseling sessions conducted among target groups	29570	37228
17	Number of people among target groups reached through HE sessions	155825	191126
18	Number of IEC materials distributed to target groups	1699070	1315516
19*	Number of peer educators involved in project	1613	1605
3.3 Awareness of HIV/AIDS among youth, improved			
20	Number of targeted HE or counselling sessions conducted for youth	1716	1424
21	Number of youth reached through HE sessions	29750	14989
22	Number of IEC materials distributed to youth	2615300	751801
23*	Number of peer educators involved in project	120	116
Component 4: Care, Treatment and Support for People Living with HIV/AIDS			
4.1 Quality and access to care and treatment services for PLWHA improved			
24*	Number of people receiving ARV therapy [UNGASS]	687	734
25*	Number of people living with HIV/AIDS (PLWHA) receiving home-based care	1340	2108
26	Number of people receiving treatment for tuberculosis	1130	1900
4.2 Quality of and access to voluntary confidential counseling and testing services improved			
27	Number of clients receiving HIV test results and post test counselling	23398	32391
28	Number of people referred to VCCT services	320	645
4.3 Caring, protective and supportive environment for people living with or affected by HIV/AIDS improved			
4.4 Risk of mother-to-child transmission of HIV reduced			
29	Number of mother/baby pairs receiving nevirapine	2038	122
Component 5: Enabling Environment			
5.1 Active support of opinion leaders for promoting a supportive environment for implementation of effective prevention and care activities incr			
30	Number of advocacy meetings conducted	268	406
31*	Number of large enterprises/ companies that have HIV/AIDS workplace policies and programmes [UNGASS]	10	25
5.2 Multi-sectoral and coordinated partnership for planning and implementation strengthened			
32	Number of coordination and multi-sectoral meetings conducted	213	227
33	Number of best practices produced and distributed	1	0
34	Number of policies produced and distributed	0	0
5.3 Availability and utilization of data on programme impact, trends of HIV/AIDS over time and related behaviors driving the epidemic improved			
35	Needs assessment study conducted and report available	6	3
36	Number of base and end line studies conducted and report available	9	5
37	Number of evaluation or reviews conducted and report available	7	3
38	Number of operational research studies conducted	5	0
5.4 Capacity for implementation of HIV/AIDS prevention and care activities expanded at all levels			
39	Number of trainings or workshops conducted excluding health care providers and peer educators	128	86
40	Number of trainings conducted for health care providers	439	462
41	Number of trainings conducted for peer educators	69	64
42	Number of days of technical assistance provided to IPs	104	74
5.5 Risk of HIV transmission in health care delivery settings reduced			
43	Number of health staff receiving post exposure prophylaxis	2000	0

Annexe 3: Achievements by FHAM implementing partners

1. Access to services to prevent the sexual transmission of HIV improved (JP Component 1)

	NAP	MRT	AHRN	AMI	CONSORTIUM	MSF-H	MSF-CH	ALLIANCE	PSI	PARTNERS	MALTESER	MANA	MRCS	MBCA	UNODC	UNODC/LOP** (- Dec 04)	Total
Number of condoms distributed	3,160,000 (CSW, mobile population & GP)	204,000 (Workers & GP)	4,128 (IDU)	304,750 (CSW, men at risk &GP)	1,762,647	2,278,909 (CSW, MSM, GP)	116,468 (CSW & GP)	0	24,904,467 (CSW, MSM &GP)	36,599 (Youth & Workers)	32,194 (GP)	11,149 (IDU)	12,803 (Youth)	27,367 (Workers)	12,992 (IDU)	26,240 (IDU & Vulnerable youth)	32,894,713
Number of STI male & female clients at health care facilities appropriately diagnosed, treated and counselled	93,237	n/a	n/a	5,048	3,683	18,208	546	n/a	15,641	n/a	286	n/a	n/a	n/a	n/a	n/a	136,649
Number of service delivery points (SDP) providing integrated STI services	n/a	n/a	n/a	3	11	n/a	n/a	n/a	108	n/a	0	n/a	n/a	6	n/a	n/a	128
Number of referrals to STI services	n/a	132	n/a	n/a	97	n/a	n/a	0	n/a	n/a	n/a	n/a	2	n/a	n/a	n/a	231

*CCDAC – Project yet to be started
** Lashio Outreach Project operated as a separate project up to December 2004. From January 2005 onward, all LOP activities are incorporated in UNODC (TCU) report

2. Access to services to prevent IDU transmission of HIV improved (JP Component 2)

	AHRN	MANA	UNODC	UNODC/LOP**	Total
Number of needles and syringes or cleaning materials distributed to IDUs	0	2,630	14,719	26,040	43,389
Number of clients to IDU drop-in centres	159	756	694	1,265	2,874
Number of IDU drop-in centres supported and functioning	1	2	0	1	4
Number of IDUs referred to Drug Treatment Centres	0	26	7	2	35

*CCDAC – Project yet to be started

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3. Knowledge and attitudes improved (JP Component 3)

	NAP	DEPT	MRT	AHRN	AMI	CONSORTIUM	MSF-H	MSF-CH	ALLIANCE	PSI	PARTNERS	MALTESER	MRCS	MBCA	UNFPA	UNODC	UNODC/LOP**	Total
Number of health education (HE) sessions on HIV/AIDS conducted	453	n/a	n/a	n/a	1,259	n/a	38,747	193	n/a	n/a	443	149	n/a	224	n/a	n/a	n/a	41,468
Number of peer educators involved in workplace education	n/a	n/a	225	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	71	110	n/a	n/a	406
Number of HE or counselling sessions conducted among target groups	9,000	n/a	n/a	12	1,098	n/a	n/a	n/a	n/a	26,568	n/a	23	n/a	n/a	n/a	527	17	37,245
Number of peer educators involved in project among target groups	395	n/a	n/a	0	20	1,179	n/a	n/a	0	11	n/a	0	n/a	n/a	n/a	0	n/a	1,605
Number of targeted HE or counselling sessions conducted for youth	0	0	n/a	n/a	n/a	1,086	n/a	n/a	n/a	n/a	206	0	104	n/a	25	3	n/a	1,424
Number of peer educators involved in project among youth	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	59	n/a	38	n/a	n/a	19	n/a	116

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4. Access to services for HIV care and support improved (JP Component 4)

	NAP	AMI	CONSORTIUM	MSF-H	MSF-CH	ALLIANCE	MANA	MBCA	UNFPA	UNODC	Total
Number of people receiving ARV therapy [UNGASS]	0	n/a	n/a	654	80	n/a	n/a	n/a	n/a	n/a	734
Number of people living with HIV/AIDS (PLWHA) receiving home-based care	n/a	n/a	1,503	207	398	n/a	n/a	n/a	n/a	n/a	2,108
Number of clients receiving HIV test results and post test counselling	5,000	n/a	508	16,716	2,101	n/a	64	0	8,002	n/a	32,391
Number of people referred to VCCT services	n/a	n/a	453	n/a	n/a	0	n/a	5	160	27	645
Number of mother/baby pairs receiving nevirapine	n/a	13	n/a	88	3	n/a	n/a	n/a	18	n/a	122

5. Enabling environment: Policy development, advocacy, capacity building and research (JP Component 5)

	NAP	DEPT	MRT	AHRN	CONSORTIUM	MSF-CH	ALLIANCE	BI-CHR	BI-CIH	MALTESER	MANA	MRCS	MBCA	UNFPA	UNODC	WHO	UNAIDS	Total
Number of advocacy meetings conducted	122	1	7	n/a	171	18	n/a	n/a	n/a	12	n/a	28	41	n/a	6	n/a	n/a	406
Number of large enterprises/ companies that have HIV/AIDS workplace policies and programmes [UNGASS]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	25	n/a	n/a	n/a	n/a	25
Needs assessment study conducted and report available	n/a	n/a	n/a	n/a	n/a	n/a	n/a	1	0	0	n/a	2	n/a	n/a	n/a	n/a	n/a	3
Number of evaluation or reviews conducted and report available	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	n/a	n/a	2	0	n/a	1	0	n/a	0	3
Number of trainings or workshops conducted excluding health care providers and peer educators	20	0	7	8	9	n/a	3	6	2	2	2	n/a	13	12	2	n/a	0	86
Number of trainings conducted for health care providers	451	n/a	n/a	n/a	2	n/a	n/a	n/a	n/a	2	n/a	n/a	2	5	n/a	0	n/a	462

*CCDAC – Project yet to be started

Annexe 4: Round II of the FHAM (FY 2004-05): Budget, expenditure and utilisation by implementing partners

IP Code	Implementing Partners	Budget (USD)	Actual Expenditure (4-6/04)	(7-9/04)	(10-12/04)	(1-3/05)	(4-6/05)	(7-9/05)	Expenditure (USD)	Budget Utilisation (Expenditure/Budget) (4-6/04)	(7-9/04)	(10-12/04)	(1-3/05)	(4-6/05)	(7-9/05)	Utilisation (%)
	INGOs	**7,135,826**	**272,591**	**410,523**	**1,086,071**	**728,986**	**889,052**	**-**	**3,387,223**	**4%**	**6%**	**15%**	**10%**	**12%**	**0%**	**47%**
IP-3	AHRN	200,000	NCE RdI	NCE RdI	33,324	45,452	39,185	-	117,961	NCE RdI	NCE RdI	17%	23%	20%	0%	59%
IP-5	AMI	330,000	NCE RdI	32,722	28,888	34,483	30,536	-	126,629	NCE RdI	10%	9%	10%	9%	0%	38%
IP-6	Consortium	2,085,000	NCE RdI	73,125	230,817	245,327	300,735	-	850,005	NCE RdI	4%	11%	12%	14%	0%	41%
IP-7	MSF(Holland)-AZG	1,018,182	237,069	96,125	138,093	78,713	117,294	-	667,294	23%	9%	14%	8%	12%	0%	66%
IP-9	PSI	1,646,018	-	98,385	441,626	168,803	132,937	-	841,751	0%	6%	27%	10%	8%	0%	51%
IP-22	Alliance	400,000	-	32,509	72,459	12,371	98,746	-	216,086	0%	8%	18%	3%	25%	0%	54%
IP-23	BI (CHR)	400,000	-	-	57,803	57,979	46,964	-	162,746	0%	0%	14%	14%	12%	0%	41%
IP-24	BI (CIH)	406,824	-	8,989	24,284	40,204	41,905	-	115,382	0%	2%	6%	10%	10%	0%	28%
IP-25	Malteser	249,984	-	37,843	18,087	8,807	15,757	-	80,495	0%	15%	7%	4%	6%	0%	32%
IP-26	MSF(CH)	300,000	32,165	25,515	31,103	29,287	54,954	-	173,025	11%	9%	10%	10%	18%	0%	58%
IP-27	Partners	99,818	3,358	5,309	9,585	7,560	10,038	-	35,851	3%	5%	10%	8%	10%	0%	36%
	NNGOs	**409,805**	**27,720**	**32,533**	**49,375**	**54,771**	**54,697**	**-**	**219,096**	**7%**	**8%**	**12%**	**13%**	**13%**	**0%**	**53%**
IP-11	MANA	100,000	5,000	13,000	10,674	23,965	11,186	-	63,825	5%	13%	11%	24%	11%	0%	64%
IP-12	MBCA	149,808	16,022	13,895	20,115	16,174	17,847	-	84,053	11%	9%	13%	11%	12%	0%	56%
IP-28	MRCS	159,997	6,698	5,638	18,586	14,632	25,664	-	71,218	4%	4%	12%	9%	16%	0%	45%
	UN Agencies	**1,786,121**	**-**	**37,944**	**131,346**	**275,315**	**234,143**	**-**	**678,748**	**0%**	**2%**	**7%**	**15%**	**13%**	**0%**	**38%**
IP-14	UNFPA	506,521	NCE RdI	32,834	101,810	59,201	98,329	-	292,174	NCE RdI	6%	20%	12%	19%	0%	58%
IP-15	UNODC	700,000	NCE RdI	5,110	29,536	109,620	97,577	-	241,843	NCE RdI	1%	4%	16%	14%	0%	35%
IP-17	WHO	579,600	NCE RdI	NCE RdI	NCE RdI	106,494	38,237	-	144,731	NCE RdI	NCE RdI	NCE RdI	18%	7%	0%	25%
	Government Agencies	**2,688,573**	**-**	**6,285**	**13,588**	**19,423**	**21,557**	**-**	**60,853**	**0%**	**0%**	**1%**	**1%**	**1%**	**0%**	**2%**
IP-1	NAP (RdII)	2,000,248	NCE RdI	NCE RdI	NCE RdI	NCE RdI	NCE RdI	-	-	NCE RdI	NCE RdI	NCE RdI	NCE RdI	NCE RdI	0%	0%
IP-19	CCDAC	532,325	N/S	N/S	N/S	N/S	-	-	-	N/S	N/S	N/S	N/S	0%	0%	0%
IP-20	DEPT	50,000	-	2,148	835	-	-	-	2,983	0%	4%	2%	0%	0%	0%	6%
IP-21	MRT	106,000	-	4,137	12,753	19,423	21,557	-	57,870	0%	4%	12%	18%	20%	0%	55%
	Sub Total	**12,020,325**	**300,312**	**487,285**	**1,280,379**	**1,078,495**	**1,199,449**	**-**	**4,345,919**	**2%**	**4%**	**11%**	**9%**	**10%**	**0%**	**36%**
	Monitoring/Evaluation															
IP-18	UNAIDS (Myanmar)	708,051	5,747	43,988	41,419	29,517	66,326	-	186,997	1%	6%	6%	4%	9%	0%	26%
	(Behavioural Surveillance Survey)	272,000	-	-	-	-	-	-	-	0%	0%	0%	0%	0%	0%	0%
	(M&E Field Trip Visit)	6,160	-	-	380	371	187	-	938	0%	0%	6%	6%	3%	0%	15%
	(Mid Term Review for JP)	100,000	-	-	-	-	10,985	79,773	90,758	0%	0%	0%	0%	11%	80%	91%
	(Workplace)/(Health Facility Survey)	34,000	-	-	-	-	-	-	-	0%	0%	0%	0%	0%	0%	0%
	(External Audit RdII)	20,000	-	-	-	-	-	-	-	0%	0%	0%	0%	0%	0%	0%
	UNDP Handling Fees	112,000	-	-	86,498	-	-	-	86,498	0%	0%	77%	0%	0%	0%	77%
	Sub Total	**1,252,211**	**5,747**	**43,988**	**128,297**	**29,888**	**77,498**	**79,773**	**365,191**	**0%**	**4%**	**10%**	**2%**	**6%**	**6%**	**29%**
All IPs	**Grand Total**	**13,272,536**	**306,058**	**531,273**	**1,408,676**	**1,108,383**	**1,276,947**	**79,773**	**4,711,110**	**2%**	**4%**	**11%**	**8%**	**10%**	**1%**	**35%**

N/S – delayed start to project

IP Code	Implementing Partners	Budget (USD)	Actual Expenditure (4-6/03)	(7-9/03)	(10-12/03)	(1-3/04)	(4-6/04)	(7-9/04)	(10-12/04)	(1-6/05)	Expenditure (USD)	Budget Utilisation (Expenditure/Budget) (4-6/03)	(7-9/03)	(10-12/03)	(1-3/04)	(4-6/04)	(7-9/04)	(10-12/04)	(1-6/05)	Utilisation (%)
	Government Agencies	**1,828,881**	**50,206**	**166,406**	**77,518**	**52,646**	**315,714**	**45,273**	**176,500**	**626,409**	**1,510,672**	**3%**	**9%**	**4%**	**3%**	**17%**	**2%**	**10%**	**34%**	**83%**
IP-1	NAP (RdI)	1,828,881	50,206	166,406	77,518	52,646	315,714	45,273	176,500	626,409	1,510,672	3%	9%	4%	3%	17%	2%	10%	34%	83%

Joint United Nations Programme on HIV/AIDS

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