Myanmar National Strategic Plan on HIV and AIDS

2011-2015

FULL VERSION

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Executive Summary

The HIV epidemics in Myanmar are largely concentrated among key populations with higher risk, in particular female sex workers and their clients, men who have high risk sex with men, people who inject drugs, and increasingly among the mostly female sexual partners of all these groups. The National Strategic Plan I made significant progress in scaling up targeted prevention services for female sex workers and men who have high risk sex with men, as well as providing treatment for increased numbers of people living with HIV, although only 28% of people in need are receiving ART as of end 2009. Limited access to ART means that the burden of care among people living with HIV is increasing. During the implementation period of the National Strategic Plan I, there has been considerable expansion in the number, role and capacity of community based organizations and self help groups composed of people living with HIV, female sex workers, men who have sex with men and drug users.

Progress was much more modest in scaling up comprehensive harm reduction services, including opioid substitution treatment, to injecting and non-injecting drug users. Poverty, a poorly resourced health system, less effective coordination and insufficient financial, technical and service delivery capacity have all combined to limit progress.

Although the HIV epidemics in Myanmar are in the declining phase, it still has one of the highest HIV prevalence and caseloads in Asia. Furthermore, most responses have not been implemented on a scale sufficient to reduce prevalence below 5% in any high risk behaviour group, while the HIV prevalence among women attending ANC is just below 1% in 2009. People who inject drugs remain a population of concern given high prevalence and low coverage, and there is uncertainty about the direction of prevalence among men who have sex with men and transgender given limited data. In the current national health plan the top three priority diseases in ranked order are AIDS, malaria and tuberculosis. Consequently, the Government of Myanmar has decided to adopt a strategy which maintains a dual focus on scaling up access to prevention as well as treatment and care.

The NSP II has a vision of achieving the HIV-related MDG targets by 2015, if extraordinary efforts and commitment are made by all stakeholders. It aims to cut the new infections by half of the estimated level of 2010; bring ART to 80% of those who are eligible for treatment based on the current national treatment guideline and criteria, with no discrimination with regards to gender, ways of transmission, origin and location; ensure 80% of women living with HIV receive antiretroviral prophylaxis treatment to reduce the risk of mother-to-child transmission; increase intervention coverage for groups with risk behaviour as well as support to those in need, and to mitigate the impact of AIDS. The focus of prevention will continue to be female sex workers and their clients, men who have high risk sex with men, people who inject drugs and drug users. The sexual partners of these high risk behaviour groups will also be a priority within prevention, including the overlapping population of sexual partners of people living with HIV. Other populations are a prevention priority according to their

vulnerability and engagement in high risk behaviours, including mobile and migrant populations, young people (i.e. out-of-school youth), prison and rehabilitation facility populations, people in the workplace and uniformed services personnel.

Continued public sector scaling up of ART will be pursued as well as more effective ways to respond to chronic care in decentralised settings, and a higher priority approach to the needs of orphans and vulnerable children living with and affected by HIV. Given resource constraints, there will be more efficient use of existing resources; integration of harm reduction into community-based settings; increased private sector health service provision of ART; more effective implementation guided by a comprehensive packages of services; and greater reliance on strengthened community-based organizations and self help groups, within more effective, revitalised coordination mechanisms, particularly at district and township levels. The GAVI HSS grant for Myanmar offers a partnership and coordination approach at township level that should be the model for the HIV response.

The context of Myanmar being an additional safeguards country for the purposes of fund flow has required establishment of a range of fund flow mechanisms, which include direct disbursement, reimbursement and some advances. Key findings of a recent review of the Fund Flow Mechanism of the Three Diseases Fund point towards development of a one fund flow modality suitable for adoption in the Myanmar context, which could explicitly accommodate various policies and additional safeguards without compromise.

NSP II is composed of two parts: Part One, presenting situation analysis, vision, aim, objectives, guiding principles and strategic priorities; and Part Two, presenting, for each strategic priority, a number of interventions with target populations, activity area, outcomes, outputs, indicators and targets. Detailed guiding principles, information on the roles and responsibilities of participating entities, institutional arrangements and coordinating mechanisms can be found in annexes. The accompanying Operational Plan translates guiding principles and broad directions set out in NSP II into a directly actionable and costed plan relevant to all aspects of the national response to HIV and to all partners.

Building on previous experiences and lessons learned by all partners about what works best in the specific context of Myanmar, NSP II identifies the guiding principles underpinning both the plan itself and its future implementation. Among these are: the adherence to the “Three Ones” principles; working towards the key commitments of universal access and Millennium Development Goal 6 on HIV/AIDS – to halt and reverse the spread of the epidemic by 2015; a focus on evidence-informed and results-oriented programming and the Myanmar context of scarce resources requiring cost effectiveness, cost efficiency and prioritisation.

Guiding principles bring into focus populations with higher risk behaviour and vulnerability and with the greatest needs, ensuring that their needs are met to the maximum extent possible and that their participation in activities concerning them is secured. The development and implementa-

tion of a favourable policy and legal framework, a context characterised by compassion and understanding, is central to this approach. The call for effective and inclusive functioning of coordination committees, particularly at national and district and township levels was highlighted. The link is made between the protection of human rights in producing positive public health results against HIV; and gender and GIPA principle across all interventions.

NSP II aims to reduce HIV transmission and HIV-related morbidity, mortality, disability and social and economic impact. Its objectives are to: reduce HIV transmission and vulnerability, particularly among people at highest risk; improve the quality and length of life of people living with HIV through treatment, care and support; and mitigate the social, cultural and economic impacts of the epidemic.

There are three strategic priorities: (1) Prevention of the transmission of HIV through sexual contacts and injecting drug use; (2) Comprehensive continuum of care for people living with HIV; and (3) Mitigation of the impact of HIV on people living with HIV and their families. NSP II recognises the link between prevention, treatment and care, particularly for PMCT, VCCT, and for the sexual partners of people living with HIV. Finally there are three cross-cutting interventions; (1) health including the private health sector, non-health and community systems strengthening; (2) a favourable environment for reducing stigma and discrimination; and (3) strategic information, M&E and research.

The NSP II and the Operational Plan present an indicative budget envelope of US$ 343.6 million over 5 years, with a first two year budget of US$ 111.7 million.

The NSP II development process was the second such participatory and interactive exercise and involved many stakeholders at all levels in different parts of the country. Taking place over a period of approximately eight months, it involved all sectors of the national response to the HIV epidemic. Contributions were made by the Ministry of Health and non-health ministries, international and national NGO, local organizations – CBOs and self help groups of people living with HIV, most-at-risk groups, concerned community, and faith-based organizations – and the private sector. This consensus building process ensured ownership of NSP II by key stakeholders who will be involved in implementing the national response to HIV and AIDS from 2011-2015.

NSP II is a living document: it lends itself to adjustments and revisions as further experience is gained, resources are mobilized and evidence of success and shortcomings is generated through monitoring, special studies and mid-term and end-of-term evaluations and regular national partnership forums. The targets for the first two years and key partners can be found in part two of this plan, more detailed indicative targets and budgets for the five years covered are available in the operational plan.

Acronym

3DF	Three Diseases Fund
FXB	Francois-Xavier Bagnoud
AHRN	Asian Harm Reduction Network
AIDS	Acquired Immunodeficiency Syndrome
Alliance	International HIV/AIDS Alliance
AMI	Aide Médicale Internationale
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drugs
ASEAN	Association of South-East Asian Nations
AZG	Artsen Zonder Grenzen (MSF Holland, MSF-H)
BSS	Behavioural Sentinel Survey
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CoC	Continuum of Care
DU	Drug user
EC	European Commission
FBO	Faith Based Organization
FERD	Foreign Economic Relations Department
FSW	Female sex worker
GAVI	Global Action for Vaccine Initiative
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GP	General Practitioners
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
HSS	Health Sector Strengthening
INGO	International Non Governmental Organization
IOM	International Organization for Migration
MANA	Myanmar Anti Narcotics Association
MBCA	Myanmar Business Coalition on AIDS
M-CCM	Myanmar Country Coordinating Committee
MCWA	Maternal and Child Welfare Association
MdM	Médecins du Monde
MMA	Myanmar Medical Association
MNMA	Myanmar Nurse and Midwife Association
MoH	Ministry of Health
MPG	Myanmar Positive Group
MRCS	Myanmar Red Cross Society

MSF	Médecins Sans Frontières
MSF-CH	Médecins Sans Frontières - Switzerland
MSI	Marie Stopes International
MSM	Men who have sex with men
MWAF	Myanmar Women's Affairs Federation
NAP	National AIDS Programme
NGO	Non Governmental Organization
NSP	National Strategic Plan
NSP I	National Strategic Plan I (2006-2010)
NSP II	National Strategic Plan II (2011-2015)
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PGK	Pyi Gyi Khin
PMCT	Prevention of Mother-to-Child Transmission
PPPH	Private Partnerships for Public Health
PSI	Population Services International
PWID	Person who injects drugs/ People who inject drugs
SHG	Self Help Group
STI	Sexually Transmitted Infections
TB	Tuberculosis
The Union	International Union against Tuberculosis and Lung Disease
TSG	Technical and Strategy Group
TWG	Technical Working Group
UMFCCI	Union Of Myanmar Federation of Chamber for Commerce and Industry
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
VCCT	Voluntary Confidential Counselling and Testing
VDRL	Venereal Disease Research Laboratory test , a blood test for syphilis
WFP	World Food Programme
WHO	World Health Organization

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PART I :

Situation Analysis, the National Strategic Plan, Guiding Principles, Strategic Framework

1. SITUATION ANALYSIS

1.1 Epidemiology

In the current national health plan the top three priority diseases in ranked order are AIDS, malaria and tuberculosis. Overall AIDS is ranked[1] as the first priority disease on the basis of public health and political importance and potential socio-economic impact.

In Myanmar AIDS, TB and STI contribute 4.3%, 1.6 and 0.8% respectively for a total of 6.7% of overall disease burden expressed by Disability Adjusted Life Years.

Expressed by deaths, the overall disease burden for AIDS, TB and STD is 4.0%, 1.8% and 0.4% respectively of all deaths in the country combining to a total of 6.3%.[2]

The two-decade old HIV epidemic in Myanmar is largely concentrated among population subgroups with high risk behaviours. The majority of the HIV/AIDS cases are reported from large urban areas and from the northern and north-eastern parts of the country. While the overall HIV prevalence in Myanmar is estimated to be below 1%, there is a sizeable key populations at higher risk (female sex workers and their clients, men who have sex with men and people who inject drugs). These key populations are disproportionately affected by HIV. In 2009, the prevalence of HIV was estimated at 11.2% (range 9.2-13.6%; CI 95%) for female sex workers (FSW), at 34.6% (range 31.6-37.7%; CI 95%) for people who inject drugs (PWID) and at 22.3% (range 18.2-26.4%; CI 95%) for men who have sex with men (MSM)[3] . In selected sites, sexually transmitted infection (STI) rates are also high among key populations. Condom use in paid sex with female sex workers is reported to be high but unprotected sex among men who have sex with men and among people who inject drugs is common[4]. The large size of high risk behaviour populations, the high prevalence of syphilis, and risk behaviours, population mobility, poverty, HIV associated stigma, and limited coverage of effective prevention programmes for high risk behaviour populations are some of the important determinants that make Myanmar highly vulnerable to HIV.

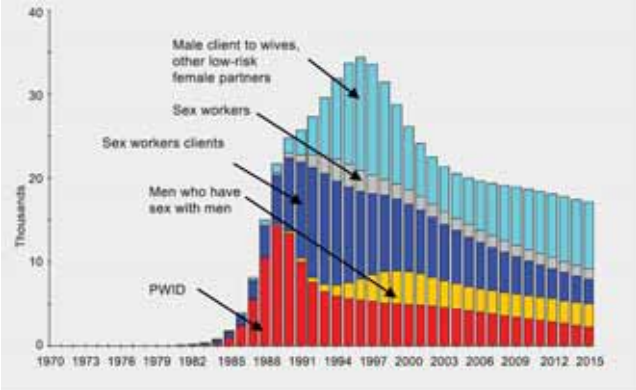
Systematic surveillance is carried out among key population groups in selected geographical areas since 1991. Over the years, the surveillance system has expanded to include new sentinel sites, new population groups and improved survey methodologies. Components of second generation surveillance system implemented in Myanmar include: HIV sentinel sero-surveillance; behavioural sentinel surveillance and; HIV/AIDS case reporting.

1.2 HIV incidence

Figure 1 shows trends in distribution of new HIV infections by subpopulation group. Like in other Asian countries, people who inject drugs (PWID) was the first group to be affected. HIV incidence in PWID peaked in the early 1990s. The PWID epidemic was followed by increase in cases among female sex workers (FSW) and their clients. Finally, following the infection of a large number of male clients of FSW, HIV incidence reached a peak in the so-called “low-risk” female population due to transmission from male clients of FSW.

[1] P. 14 Health in Myanmar, Ministry of Health 2009
[2] Reference Death and DALY estimates for 2004 by cause for WHO Member States (Myanmar). http://www.who.int/healthinfo/global_burden_disease/gbddeathdalycountryestimates2004.xls
[3] National AIDS Programme, Report of the HIV Sentinel Sero-Surveillance Survey 2009, Myanmar
[4] National AIDS Programme, BSS 2008 – Injecting Drug Users and Female Sex Workers, Myanmar, 2009

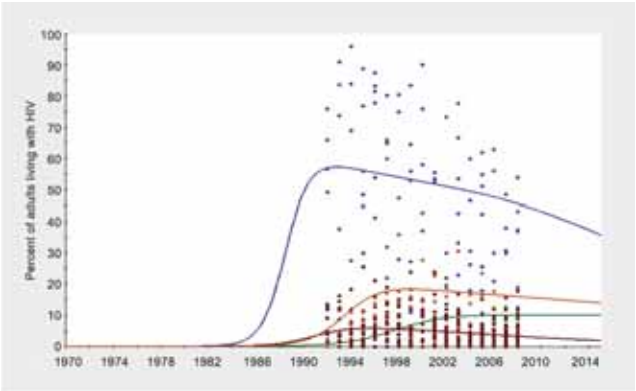
Figure 1 Trends in the distribution of new HIV infections by population subgroup [5]



1.3 Trends in HIV prevalence

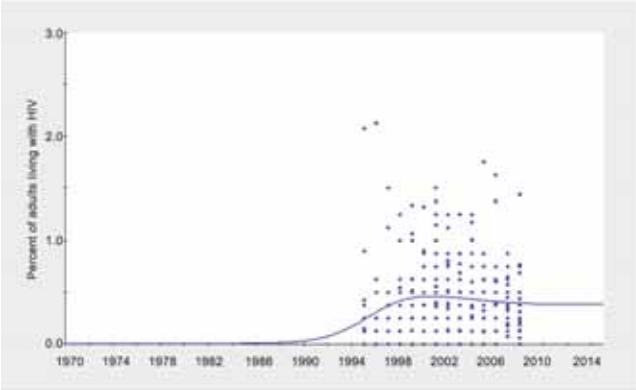
Figures 2 shows HIV prevalence trends among PWID, FSW, their clients and MSM. Notably, HIV prevalence is decreasing among all high risk behaviour groups except MSM where a large degree of uncertainty persists due to the limited number of data points.

Figure 2 Trends in HIV prevalence among high risk population groups [6]



Among the lower-risk female population, HIV prevalence peaked around 2000 and since then, there is a very slow decline (Figure 3).

Figure 3 Trends in HIV prevalence among female general population (15-49 years) [7]



Impact Results

The following section presents the main results/outputs from Spectrum software. In 2009, approximately 238,000 people were living with HIV, including children. Adult HIV prevalence peaked around 2000-2001 and since then there has been a steady decline (Figure 4).

Figure 4 Trends in adult HIV prevalence (15-49 years)[8]

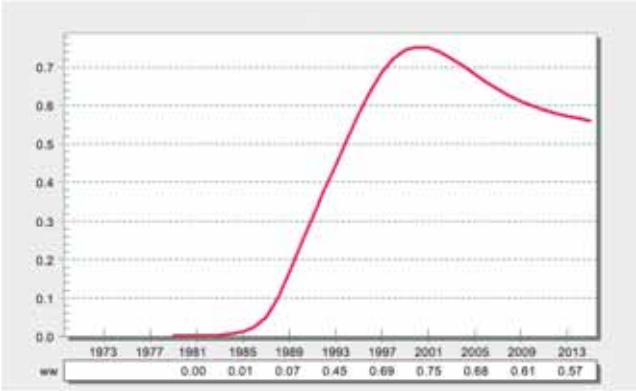


Figure 5 shows that the burden of HIV-related deaths peaked at 19,000 in 2005 and has been decreasing since. The decrease corresponds with increased access to ART since 2005 in the public and NGO sectors.

[5,6,7,8] National AIDS Programme, HIV Estimates and Projections, Myanmar 2008-2015, Myanmar 2010 (To be updated)

Figure 5 Annual AIDS deaths among adult population (aged >15 years) [9]

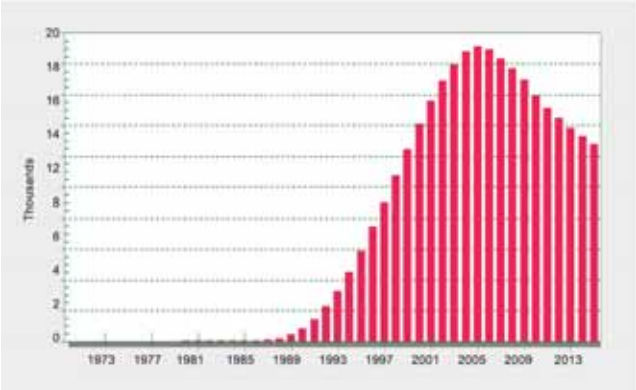
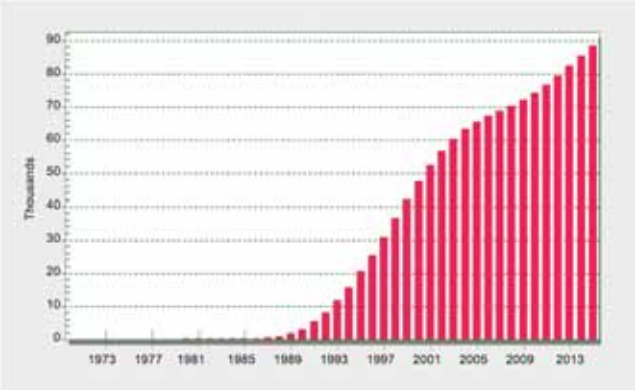


Figure 6 Number of adults with advanced HIV infection in need of antiretroviral treatment [10]



The majority of HIV infections in Myanmar have been in men, with the male to female ratio declining from 8 to 1 in 1993 to 1.9 to 1 in 2009. By 2015, it is projected that the male to female ratio will be 1.6:1. These women are largely the sexual partners of current and former FSW clients, PWID, and MSM. It is estimated that the number of pregnant women living with HIV was about 4,300 in 2009.

In Myanmar, ART is provided by the National AIDS Programme (NAP), international and local NGOs. As of the end of 2009, approximately 21,000 adults and children are on treatment. Estimates of the number of people needing ART in a given year are based on the NAP ART guideline recommendations from 2006. According to the national ART guidelines, patients with CD4 counts of less than 200 should receive ART and those with CD4 200-350 can be considered for treatment. Using a threshold of CD4 <200, approximately 74,000 adults needed ART in 2009. However, as more people needing treatment start to receive it, the need for ART will increase as more people will survive longer (Figure 6). When the national guidelines are revised to reflect the recommended change to start treatment at CD4 <350, then adult ART needs will increase accordingly.

1.4 Population groups

The following population groups are at higher risk of HIV infection. Assumptions regarding size and duration of risk behaviour for each population subgroup are found below [11]:

Injecting drug user: Based on a broad-based agreement, there are an estimated 75,000 (range: 60,000-90,000) PWID in the country, with a definition of a person who has injected a non medically prescribed substance at least once in the past 12 months. Most PWID are male. The Estimation and Projection Package software (EPP) default value of 10 years was used to reflect the average number of years the PWID remain active injectors. This value is consistent with the findings of the 2008 BSS among PWID, which also revealed that 14% of male PWID in Yangon reported having symptoms of ulcerative STI in past 12 months. While heroin is still the most widely used drugs, ATS has become more and more popular in Myanmar. The increased risk of overlapping unsafe sexual behaviour and injection behaviours by some using stimulant drugs are emerging concerns.

Men who have sex with men, including transgender persons[12]: According to the 2007 BSS among general population, 1.8% of men reported "ever having sex with another man". In the BSS among out-of-school youth (2008), 2.3% of male youth reported ever having sex with another man and 1.6% reported having sex with another man in the last 12 months. Applying the same ratio to general population males, the figure 1.25% was calculated as the proportion of men who had sex with another man in the last 12 months.

[9,10] National AIDS Programme, HIV Estimates and Projections, Myanmar 2008-2015, Myanmar 2010

[11] These assumptions and data sources are documented in the above mentioned document.

[12] In this document the usage of the term 'men who have sex with men' will include transgender persons. At this stage all prevention programmes for men who have sex with men include transgender persons as well. All self help groups are open to both men who have sex with men and transgender persons. Myanmar language distinguishes at least six sub-groups of men who have sex with men and transgender persons. The boundaries between groups sometimes appear blurred and more research is needed to improve the understanding of the local context.

Taking 1.25% as a minimum and 1.8% as a maximum, the average of 1.53% was calculated. Applying 1.53% to the adult male population for 2008, resulted in an estimate of 224,000 MSM (range 183,600 to 264,000). Through consensus it was assumed that MSM remain sexually active for 20 years. Syphilis prevalence among MSM was found to be as high as 14.1% in urban sentinel sites (HSS 2008).

Clients of female sex workers: In the 2007 BSS among general population, 5.6% of adult men reported having had sex with a sex worker in the last year. The clients of female sex workers population size of 880,000 was estimated by applying this rate to the adult male population (aged 15-49 years). The software default value of five years was applied for the duration of this group.

Female sex workers: Based on past estimates, there are 60,000 (range: 40,000-80,000) sex workers in the country. Data from 2008 BSS indicate that female sex workers engage in sex work for about eight years.

Male and female adult population: The total adult male and female population size for 2008 was obtained from national population projections of Myanmar. (Source: the Planning Department, Ministry of National Planning and Economic Development).

Institutionalized population: There are 43 prison facilities and 143 labour camps in Myanmar and an estimated 60,000 inmates are currently in these settings. About 25% of inmates are incarcerated due to drugs-related cases. Drug users could also be found in settings. There have been cumulated 100,846 male and 20,929 female inmates in prison facilities for drugs-related cases since 1984 (UNODC). There are only 35 medical officers recruited from Ministry of Health for prison facilities. Yangon (Insein township) and Mandalay prison facilities are affiliated with on-call specialist facilities. While there is a shortage of data on HIV prevalence and needs for ART among inmates, AZG is providing ART to about 90 male and 60 female inmates in Yangon. There are also more than 100 inmates getting ART in monthly doses brought by their families.

Military and uniformed services: HIV-related data are largely not available for military and uniformed services, and limited HSS among new military recruits in 2008 round shows an HIV prevalence of 2.5%. HSS in 2008 found that 10.2% of the new military recruits aged 25-29 years old are VDRL positive. In many other countries, uniformed services have been identified as a group that are at a higher risk of HIV infection[13].

Migrant and mobile population: Mobile population are persons who make frequent or periodic trips from one place to another regardless of the nature/purpose of the trip whereas migrants refer to individuals and/or their family members who have left their home places, seasonally or temporarily, for remunerated activities in other parts of the country or in other countries. While the data related to HIV risks and vulnerabilities among mobile and migrant population (MMP) in Myanmar are extremely limited, some studies showed low level of HIV knowledge, low level of condom acceptance and use (especially with casual sex partners), and relatively high STI and HIV prevalence in some Myanmar migrant groups in Thailand e.g. seafarers and sex workers[14,15]. Although mobility and migration in itself may not be the absolute risk factors for HIV infection and some mobile/migrant persons may not be engaged in high risk behaviours, the low level of knowledge and awareness could make them vulnerable to STI and HIV infection. It is important for the National Programme in Myanmar to address the needs to fill the knowledge gaps on HIV and safe mobility among its population, especially potential migrants and the communities prone to migration, and in preparing for care, support and treatment as well as for return and reintegration of people living with HIV who need to return home. In so doing, the under-resourced situation for programmes related to HIV and mobility has to be considered and improved.

Young people: Every year, new cohort of young people become sexually active or start engaging in high risk behaviour. While immediate HIV prevention may require targeting the highest risk group, NSP II also recognizes the need to address the systematic, institutionalized and multi-sectoral approach for reaching the new cohort of young people, increasing their knowledge about HIV and promoting safer behaviours as sexual behaviour patterns evolve among the young generation. Although there is little evidence about the HIV prevalence among university students and casual sex among them has not been considered high risk behaviour, the NSP II recognizes the need to study and monitor this group as a potentially at-risk population.

Compared to the young people in-school, out-of-

[13] Uniformed services HIV/AIDS Peer Leadership Guide, FHI, Futures, UNAIDS, USAID, 2001
[14] IOM Thailand, 2008. Migration and HIV/AIDS in Thailand: A desk review of migrant labour sectors
[15] IOM Thailand, 2010. Migration and HIV/AIDS in Thailand: Triangulation of biological, behavioural and programmatic response data in selected provinces.

school youth are exposed to more risk, especially due to migration and resulting disposable cash income. According to UNICEF, about 5-6% of out-of-school adolescents (10-17 years old) are engaged in migration in one way or another. According to the Behaviour Surveillance Survey in 2008 targeting Out-of-school Youth, only 48% could correctly identify ways of preventing the sexual transmission of HIV and could reject major misconceptions about HIV transmission. Only 52% reported using condom at last casual sex. Stigma and discrimination still existed among out of school youth towards people living with HIV, as only 41% were willing to buy food from an HIV-infected vendor and 69% were willing to eat with an HIV-infected person. 11.7% male and 12.6% female respondents reported having taken an HIV test in the last 12 months and receiving their results, whereas, 70% intended to get an HIV test.

HIV and tuberculosis (TB) combine their effects as a dual epidemic of increased concern in Myanmar. It is estimated that approximately seven percent of adult TB patients are also co-infected with HIV. TB is reported to be the leading opportunistic infection in people living with HIV, with nearly 70 percent developing active tuberculosis at some point in time. Formal structures for cooperation between TB and HIV programmes have been established and are currently active. Pilot projects are also contributing to programmatic learning. Access to voluntary and confidential counselling and testing for people with TB is a key intervention but is not offered in most areas. Strong informal mechanisms for co-management of people living with both diseases have emerged in some townships.

Overall, the HIV epidemics in Myanmar remain largely concentrated among people identified with high risk behaviours. This focus of the epidemics calls for the urgent and sustained efforts to strengthen prevention, care and treatment programmes addressing the needs of those populations.

1.5 National response to the HIV epidemic

The national response to the HIV epidemic commenced in the mid-1980s. A multisectoral National AIDS Committee chaired by the Minister of Health was established in 1989 and a short-term plan for the prevention of HIV transmission was launched in that same year.

The first National Strategic Plan covered 2006-2010. Following the review of its achievements and experiences, the National Strategic Plan 2011-2015 (NSP II) was prepared. During the process, the review of the National AIDS Programme in 2006[16] was considered, as well as many diverse studies and reviews of particular programmes and projects.

The magnitude of the epidemic has been recognized, and efforts to respond to it indicate the strong commitment of many partners to focus prevention, care and support efforts on the most-at-risk and vulnerable populations. Government, international and national non government and private entities have been contributing to the national response. The National AIDS Programme (NAP) successfully coordinated the inputs of national and international partners, and tools and technical guidelines have been produced for a broad range of programme components. Surveillance, monitoring and management systems are in place.

The reach and effectiveness of services for HIV and STI prevention, treatment and care are constrained by the following factors:

- The population is spread over a large geographic area with diverse ethnicity including many different languages[17].
- Communication and transport facilities are poorly developed.
- The health system is poorly resourced with regard to infrastructure and equipment.
- There is a scarcity of appropriately skilled human resources, notably in rural and remote areas.
- Some parts of the population are hard to reach due to geographical isolation such as in the remote mountainous area and/or ongoing security concerns due to conflict, mainly in border areas.
- Widespread poverty, which forces people to engage in unsafe behaviour and be in situations of high risk.

Domestic and international financial support (see also Section 1.7) remains largely insufficient to respond comprehensively to the HIV epidemic even in the most accessible parts of the country. While the Govern-

[16] DRAFT Review of the Myanmar National AIDS Programme, WHO, 2006

[17] Myanmar is one of most ethnically diverse countries in Southeast Asia with some 135 different ethnic groups identified within the eight major national races, which are: Bamar, Shan, Kayah, Kayin, Kachin, Chin, Mon and Rakhine. Chinese and Indian immigrants are two additional important groups of population.

ment of Myanmar provides support for the national response by way of manpower, staff salaries, training, buildings and operational costs, Government spending on health is amongst the lowest in the world. The government spends less than 1% of GDP on health. In 2007, this corresponded to under $1 per capita[18].

The contribution of the Government of Myanmar to the national response to AIDS is estimated at approximately US$ 1.52 million per year (UNGASS 2010).

Currently the funding to implement the national response to HIV comes in a large part from the Three Diseases Fund (3DF) together with some additional assistance from the European Commission (EC), Australia and funds raised directly by INGO. UN agencies provide technical and financial support. Aid from a number of donors is provided on humanitarian grounds, channelled almost exclusively through the UN and INGO.

Responses to the HIV epidemic in the phase of NSP I have continued to be diverse and provided a good number of lessons learned. Responses were based on stronger implementing capacity by government, INGO and, more recently, many local organizations and networks, largely of people living with HIV, those with high risk behaviours, and concerned local and faith communities. All organizations provided more condoms, VCCT/STI services, needle and syringe exchange and opioid substitution therapy, ART and TB treatments, and PMCT services. As a result, more people have higher awareness, openly discuss the sensitive issues of sex and drugs, and use more condoms, VCCT/STI, clean injecting equipment, and PMCT services. HIV prevalence has decreased among high risk behaviour populations and slightly decreased in ANC women. ART has prolonged quality life for about 28% of people living with HIV in need of ART. Responses to mitigate the impact in adults and orphans and vulnerable children (OVC), though diverse, have been limited.

Most responses, however, have not been implemented on a scale sufficient to reduce prevalence below 5% in any high risk behaviour group, and just below 1% in 2009 in ANC women. Scaling up interventions is both a challenge and opportunity for NSP II. Many constraints make it difficult to scale up interventions. External funding will remain below what is needed and the number of technical support and implementing organizations is limited. NSP II urges organizations able to do so, to scale up and expand to include priorities currently not sufficiently covered. Those who can be more efficient in what they are currently doing should make the necessary changes to allow this to happen. Government health systems must be strengthened, first by increasing in-country financial resources, and in the numbers and competence of staff. Limited coordination – particularly at national and township implementing levels – risks reducing the reach, effectiveness, efficiency and quality of services. Local/Community-based organizations have scarce organizational and technical abilities and struggle to be accepted among the mainstream of implementing partners. Finally, a combination of factors continues to create barriers to partnership to achieve the necessary results, namely – unfavourable policies, laws that do not embody a public health approach targeting sex workers, drug users and men who have sex with men; continued stigma and discrimination among some health service providers towards key populations at higher risk; and insufficient compassion and support for people living with, affected by and vulnerable to HIV.

There are also opportunities. A vibrant private health sector provides most of the medical care and can play an increased role in ARV, STI, TB and drug dependency treatments. A few successful models of cooperation between INGO and the private health sector exist and could be scaled up. Local organizations are capable of playing an important role if their technical and organizational capacity is developed, their governance structures put in place and if they have broader support from all government partners.

1.6 Funds flow mechanism

The context of Myanmar being an additional safeguards country for the purposes of funds flow has required establishment of a range of fund flow mechanisms, which include direct disbursement, reimbursement and some advances. The only substantial country-wide fund flow mechanism is that operated by 3DF, which was strategically reviewed in early 2010.[19] Key findings point towards development of a one fund flow modality suitable for adoption in the Myanmar context with a focus on servicing the health sector, but with the possibility of extending

[18] Ministry of Health, Myanmar Health Statistics 2010
[19] Strategic Review of Decentralised Funds Flow Modalities in the Health Sector in Myanmar, 3DF Yangon 20 April 2010

the concept to other sectors. The proposed one fund flow modality would rely on coordinated health funds management to handle a number of distinct funds through one manager and could explicitly accommodate the various policies and additional safeguards without compromise.

1.7 Environment of external financial support

Myanmar is part of the group of least-developed countries (LDC). Poverty adds to the vulnerability of people to HIV, and the lack of access to health care further compounds existing poverty.

However, Myanmar receives very low levels of development assistance. There has been no World Bank lending since 1987, no IMF programme since 1981-82 and there is no Asia Development Bank assistance available. Overall overseas development assistance to Myanmar is the second lowest per capita amongst low-income countries and among the lowest per capita in the world[20]. The response to the humanitarian impact of HIV reflects to a large extent this low level of external support.

Cyclone Nargis in May 2008 was followed by a significant international response. The Government worked cooperatively with the international community to provide assistance to the affected families and communities. The space created by the 3DF and the post-Nargis collaboration led by Tripartite Core Group (TCG to coordinate relief efforts consisting of the Myanmar Government, ASEAN and the United Nations) has increased the confidence of the international community, resulting in increased humanitarian support and attempts to move into more substantive development programming.

Termination of the Round 3 grant of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) in 2005 caused a significant reduction in funding for HIV in Myanmar. The US$ 100 million Three Diseases Fund (3DF)[21] (2006-2011) was set up by six donors to address this shortfall. Working with the Ministry of Health and implementing partners, 3DF was established as a competitive fund and committed an initial US$ 100m to cover the first five years, and an additional US$ 15.6 million in Round 3, of which 38 per cent was for HIV. Myanmar's HIV, TB and malaria proposals to the GFATM in 2009 were approved and grant negotiations were in progress in June 2010 as NSP II was being drafted. The HIV proposal has a budget ceiling of US$ 153 million, as approved by the GFATM Technical Review Panel, for the NSP II period.

At the time of drafting of NSP II, the funding direction for 3DF after 2011 remains unclear. Should the current level of financial support from 3DF to HIV related activities no longer be maintained, the level of external financial support to Myanmar for HIV will in fact not increase significantly, even with Global Fund Round 9 resources, and those brought in by the limited number of donors and INGOs.

1.8 Health System and expanded AIDS response

There are various factors that can have an impact on the programme outcomes of the National HIV programme and these include one or more of the pillars of the health care system:

- Human Resources – availability and training
- Supply Chain Management
- Diagnostic services
- Management and coordination of services
- Information and monitoring systems

The National Strategic Plan for HIV, through its intervention in the health sector response, addresses many of these issues to build up the capacity of the health system to effectively equip itself.

MOH in collaboration with WHO undertook a study on existing constraints in the health system in 2009, which identified three main clusters of health system barriers: 1) Service delivery barriers present in a range of ways depending on the location. Barriers may relate to geographical terrain, cultural diversity, remoteness or insecurity; 2) Management and organizational barriers usually present in the form of inability to manage at township level and below a complex system of vertical programmes and projects that are in many cases planned, managed and reported on independently from each other; 3) Human Resource barriers are most obvious in relation to the numbers, distribution, and mix of health staff at the most peripheral level

[20] Net Aid Transfers data set (1960-2007) - Updated 2/19/2009 Center for Global Development www.cgdev.org
[21] The Three Diseases Fund is a US$ 100 million fund established in 2006 by six donors (Australia, EC, UK, Netherlands, Norway and Sweden) to respond to the funding gap for HIV, TB and Malaria as a result of the withdrawal of the GFATM in 2005

of the health system (i.e. midwife and Public Health Supervisor 2 (PHS 2) at the sub rural health centre).

Overall health sector constraints are being addressed through a new US$ 33 million Health Systems Strengthening programme which has been approved by GAVI and is currently under negotiation. Although primarily targeted at improved child and maternal health outcomes, the investment in broad strengthening of health systems will have a positive impact on HIV, programming at township level. The approach is centred on the development of integrated annual township health plans and budgets which show the contribution to service delivery by both government and non government service providers. The development of the plan and reports against it will support coordination between service delivery partners at township level. Plans will identify specific health systems strengthening inputs to service delivery, such as support for training and supervision, facility renovation and equipment and supplies. Importantly, the programme will also examine and pilot incentives for health workers (particularly midwives) in remote and hard-to-reach areas. Innovative health financing schemes will also be piloted based on the recommendations of an analysis of health financing. The GAVI-funded HSS programme initially targets 180 of the 325 townships in the country.

The NSP II will strengthen township level planning, coordination and integration of services, which will both benefit from strengthened health system and contribution to a better functioned health system through staff training, improved information flow and reporting and improved procurement and supply management. Mobilizing and utilizing the private and general practitioners, as complement to public health system, is one feature of the NSP II and this will contribute to the improvement of access to high quality services in this resource-poor country.

2. THE NATIONAL STRATEGIC PLAN

2.1 Purpose of the National Strategic Plan

The purpose of the NSP II is to guide Myanmar's national response to HIV and AIDS. Implementation will involve many kinds of stakeholders and NSP II will guide decisions on priority interventions in their respective areas of competency and interest. NSP II priorities have been identified to ensure maximum impact in reducing new HIV infections, improve the lives of people living with HIV, and reduce the impact on those living with and affected by HIV, in a context of limited financial and human resources. NSP II and its accompanying Operational Plan will also serve as key tools for coordination and oversight to achieve optimal utilisation of community, international and health infrastructures. The later indicates the resource needs for the key strategies and areas of work, which could be used as a reference for resource mobilization. The NSP is a dynamic and living document that will be subject to regular critical review, update and change.

2.2 Vision

The National Strategic Plan on HIV and AIDS will contribute to the overall efforts of Myanmar to achieve its Millennium Development Goals, hence improve the wellbeing of Myanmar people. Specifically, the NSP II has the vision to achieve a society that is free of new HIV infections and where all people regardless of gender, age or origin have access to treatment and support that enables them to live a fulfilling life.

2.3 Development of the National Strategic Plan

The NSP II development process was the second such participatory and interactive exercise, involving all sectors of the national response to HIV at all levels in different parts of the country. Contributions were made by MoH and non-health ministries, UN agencies, international and national NGO, local organizations – CBOs and self help groups of people living with and affected by HIV, sex workers, men who have sex with men, drug users and other vulnerable and affected groups, concerned community and faith based organizations – and the private sector.

The Technical and Strategy Group for HIV and AIDS (TSG-HIV), chaired by the Director of Disease Control, oversaw the entire process, which had four inter-related phases: a) reviewing NSP I; b) documenting evidence for NSP II; (c) drafting NSP II; and d) operationalising and costing NSP II.

In late 2009, seven TSG-HIV Working Groups prepared issue papers summarising progress and gaps and recommendations for NSP II. In May 2010, introductory Expanded TSG-HIV meeting were followed by specific workshops organized by different working groups attended by a range of stakeholders including representatives from CBOs, key populations and self help groups. The workshops formulated various components of NSP II, with an initial emphasis on projected outcomes (i.e. changes in behaviours and practices), corresponding outputs (i.e. deliverables required to attain the identified outcomes), and opportunities and obstacles to expanding implementing capacity. The expanded TSG in June 2010 reviewed progress and provided guidance to the NSP I review and drafting of NSP II. Key parts of the draft NSP II were also translated into Myanmar language in August and circulated among key population networks, PLHIV self help groups and CBOs to provide opportunities for key populations to contribute remarks and comments. The draft NSP II was also sent for peer review to get comments from AIDS Strategy & Action Plan Service. All the comments and remarks from different key stakeholders were addressed accordingly to get the final draft of NSP II. It was presented at the Expanded TSG meeting in September and got consensus from different stakeholders.

The process was supported by a consultant team, initially comprised of three consultants, who first reviewed the current strategic plan and then drafted the new strategic plan. Data and background for documenting the evidence were gathered using a mix of methodologies including desk reviews, key informant interviews, focus group discussions at national, State/Regional and district and township levels, during the field visits by two groups in late May.

A synthesis report – 'Review of the Myanmar National Strategic Plan on HIV and AIDS 2006-2010' – was then developed by the consultants, reviewed by key informants and its main findings were used as the primary document to prepare the draft NSP II used in consultations with stakeholders at the second TSG meeting in Nay Pyi Taw in June 2010. A fourth consultant joined the process in June to support preparation of the costed operational plan 2011-2015.

At the outset of the planning process, guiding principles were formulated on the basis of national and international experience and best practices in responding to HIV. Importantly, these principles respond to findings arising from several recent programme reviews in Myanmar and address new challenges, in particular the need for rapid scaling up of what already works. These are summarized in Section 5 and further elaborated in Annex 1.

Inspired by the guiding principles, interventions were grouped under the three strategic priorities relevant to populations at higher risk and vulnerability.

(1) Prevention of the transmission of HIV through sexual contacts and injecting drug use
(2) Comprehensive continuum of care for people living with HIV, and
(3) Cross-cutting interventions

Comprehensive packages of the services and other support required for each intervention, expected outputs and outcomes, and partners were included in each of the specific and cross-cutting interventions, to serve as the starting point for preparing the operational plan. For each expected outcome, necessary outputs (i.e. key activities delivered in order to achieve these outcomes) were then formulated, with signs of prioritization. Specific targets and indicators suitable to provide a direction and monitor progress towards prevention, care and mitigation were identified for selected outputs and outcomes recognised as the most critical products of the strategy. These elements of NSP II will be expanded in the Operational Plan to include the following information: strategy and activity, outputs, unit costs, targets and annual budgets.

The structure of the new strategic plan is the same as that of NSP I;

- Part One: Presenting background information, vision, aim, objectives, guiding principles, strategic framework, information on roles of participating entities and coordinating mechanisms;
- Part Two: Presenting specific interventions for each strategic priority; with target populations, outcomes, outputs, partners, indicators and targets.

2.4 Implementation of the National Strategic Plan

The new National Strategic Plan describes a vision for how a multisectoral and multi-partner response to

the HIV epidemic can be expanded significantly within a five-year period. Managing this expansion will require a range of mechanisms and tools, including the cross-cutting interventions and the development of year operational plans with more detailed activities, potential partners, targets, indicators and indicative costing.

Funding will be sought from a variety of sources, including increased domestic contributions, pooled donor mechanisms such as the 3DF and its successor, donors, and future proposals to the GFATM.

The Operational Plan will begin in 2011. The operational planning cycles aim to encourage longer term financing and accommodate updates and changes. Implementation of the operational plan will be documented by annual review of progress that will take into account changing conditions and provide advice for annual planning adjustments.

A range of products will be associated with the planning, implementation and monitoring that require the input and involvement of many different stakeholders. These include:

- The strategic plan
- Up to date operational plans
- Annual progress reports on the national response based on agreed indicators as well as financial expenditure tracking.
- Specific strategies that will be developed for HIV and AIDS interventions in areas requiring improved coordination, elaboration or review, including strategies for prevention for the sexual partners[22] of high risk groups.
- State/Regional, district and township alignment to strategic plan
- Second Generation Surveillance
- UNGASS and other international reporting mechanisms
- Operational research in specific areas of programming where additional data and information are needed.

For those products requiring multiple partner input, flow-charts will be developed to clearly identify the steps, timing, and actors responsible for leading, providing technical support or being involved in different processes.

3. AIM

The National Strategic Plan for Myanmar aims at reducing HIV transmission and HIV-related morbidity, mortality, disability and social and economic impact.

4. OBJECTIVES

4.1 Reduction of HIV transmission and vulnerability, particularly among people at highest risk;

4.2 Improvement of the quality and length of life of people living with HIV through treatment, care and support; and

4.3 Mitigation of the social, cultural and economic impacts of the epidemic.

5. TARGETS

By 2015, the National Strategic Plan will have met the goals set in the MDGs and turned around the epidemic, if extraordinary commitment and efforts are made by all concerned stakeholders. Specifically, the following will have been achieved:

1. New infections are cut by half of the estimated level of 2010, the reduction of new infections of females will be at least equal to overall reduction
    - o Less than 5,000 new infections will occur in 2015
2. 80% of people living with HIV, who are eligible, will receive life saving ARV treatment based on the current national treatment guideline and criteria (i.e. CD4 count <200/mm3) that are non-discriminatory with regard to gender, type of transmission, age, ethnicity and location.
    - o 70,000 adults and children will be receiving ARV treatment in 2015
3. More than 80% of women living with HIV are receiving antiretroviral prophylaxis therapy to reduce the risk of mother-to-children transmission
    - o 2,680 women will receive ARV pro phylaxis in 2015
4. Much greater number of people living with HIV or affected by HIV receive support in line with the assessed needs
    - o 48,500 people will receive commu nity home based care in 2015

[22] Note: Sexual partner refers to spouse or any other sexual partner.

- 15,000 orphans and vulnerable chil dren will receive some form of support in 2015

5. Intervention service coverage for key populations at higher risk greatly improved
   - Consistent condom use of female sex workers will be over 80% in 2015
   - Consistent condom use of men who have sex with men will be higher than 70% in 2015
   - More than 80% of people who inject drugs will consistently avoid sharing needles

6. GUIDING PRINCIPLES

NSP II identifies the following guiding principles as essential to ensuring a more effective national response to the HIV epidemic. These principles build on previous experiences and lessons learned by all partners about what works best in the specific context of Myanmar. The guiding principles will underpin more effective national and local responses to the challenges of meeting the objectives of this strategic plan. They are described in more detail in Annex II of Part I of the NSP.

1. The "Three Ones" principles will be adhered to: One HIV and AIDS Action Framework; one National Coordinating Authority; and one Monitoring and Evaluation System.

2. Achieving Universal Access and the Millennium Development Goals on HIV/AIDS as national commitment.

3. Evidence-informed and results-oriented programming: building on evidence, strategic information will guide decision and action with key populations at higher risk and vulnerability and with the greatest needs, with an emphasis on programme outcomes.

4. The protection of human rights, both of those vulnerable to infection and those already infected, which also produces positive public health results against HIV.

5. Cost effectiveness/cost efficiency/prioritisation – the specifics of the Myanmar context, where AIDS work, like other health and development areas, is significantly under funded.

6. Scaling up: programme access, reach and implementing capacity will be expanded at the maximum achievable pace.

7. Partnership: the strategy will rely on collaboration between government and other public, private, non government, community and international entities.

8. Coordination: mechanisms for effective and inclusive coordination will be strengthened, especially at national and township levels.

9. Participation: people living with HIV and affected populations; vulnerable people and local communities should participate in every aspect and at every stage of the programme.

10. Favourable policy and legal context: compassion and understanding: the strategy will foster enabling environments conducive to an effective response to HIV.

11. Gender cuts across all interventions and implies an understanding of how social norms affect vulnerabilities of men and women and people of different sexual orientations differently and thus may require differential interventions.

12. The GIPA Principle – greater involvement of people living with HIV and AIDS in all aspects of the HIV response.

7. STRATEGIC FRAMEWORK

NSP II identifies three strategic priorities to address the most pressing needs of populations at higher risk of HIV infection:

- Strategic priority I: Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use
- Strategic priority II: Comprehensive Continuum of Care for people living with HIV
- Strategic priority III: Mitigation of the impact of HIV on people living with HIV and their families

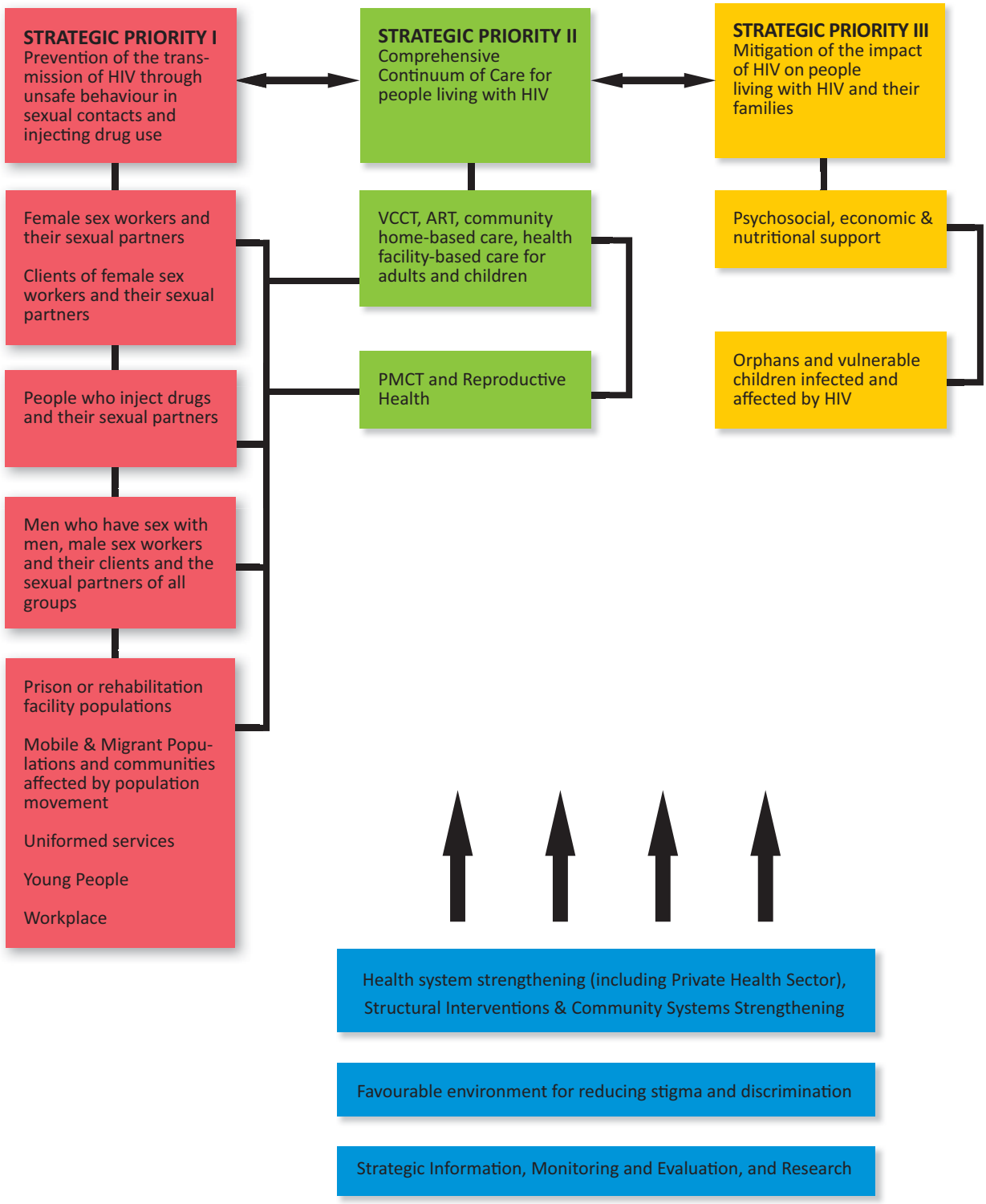
Specific interventions will be grouped under each of the three strategic priorities, and cross cutting interventions for all three strategic priorities will include:

- Health system strengthening (including Private Health Sector), Structural Interventions & Community Systems Strengthening
- Favourable environment for reducing stigma and discrimination
- Monitoring and evaluation, research, advocacy and leadership

At the level of interventions, target populations, implementing partners and activities are identified for each of these strategic priorities.

In Part Two of NSP II, target populations, interventions for each of the three strategic priorities – including implementing partners, activity areas, and planned outputs and outcomes – are presented in a tabular form for each intervention area. Within each intervention area, specific activities will be planned, prioritized and costed in the Operational Plan covering five-year periods, however, targets for the first two years are captured in Part Two of the NSP II.

Figure 7 The National Strategic Framework



Strategic Priority I:
Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use

Interventions
I.1 Female sex workers and their sexual partners; clients of female sex workers and their sexual partners
I.2 Men who have sex with men, male sex workers, clients of male sex workers and the sexual partners of all groups
I.3 People who inject drugs, drug users and their sexual partners
I.4 Prison or rehabilitation facility populations
I.5 Mobile and migrant populations and communities affected by population movement
I.6 Uniformed services personnel (military and police).
I.7 Young people
I.8 Workplace

Strategic Priority II:
Provision of a comprehensive Continuum of Care for people living with HIV

Interventions
II.1 VCCT, ART, community-based care, hospitals for adults and children
II.2 PMCT and Reproductive Health

Strategic Priority III:
Mitigation of the impact of HIV on people living with HIV and their families

Interventions
III.1 Psychological, economic and nutritional support for People Living with HIV and Their Families
III.2 Orphans and Vulnerable Children Infected and Affected by HIV

Cross cutting interventions IV:

IV.1 Health Systems Strengthening (Including Private Health Sector), Structural Interventions and Community Systems Strengthening
IV.2 Favourable Environment for Reducing Stigma and Discrimination
IV.3 Strategic Information, Monitoring And Evaluation, and Research

Strategic priorities, interventions & cross-cutting interventions

7.1 The comprehensive package of interventions

No single intervention will prevent or reverse HIV epidemics. The greatest impact on HIV prevention and treatment will be achieved if the interventions are implemented together as a package. The NSP II includes comprehensive packages of services within each intervention area. The detailed lists of services can be found in Part Two of this document. The Operational Plan includes costing that is based on these packages of services. The detailed services that are costed are listed in the Operational Plan. An effective and evidence-informed response is required to curtail the rapid spread of HIV among key populations at higher risk, and also to prevent transmission to the general population. In order to achieve these goals, the implementation of a 'comprehensive package' for the prevention, treatment and care of key populations at higher risk and people living with HIV is essential. The interventions should be delivered using a range of modalities, including community outreach and peer-to-peer work, and should be implemented both in the community, in prison facilities and other closed settings. Services should also be delivered within a human rights and public health approach, and alongside supportive (or advocacy to develop supportive) legal and policy frameworks. One critical element of the comprehensive package is the inclusion of sexual partners of those who are most at risk in intervention programmes.

7.2 Strategic Priority I: Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use

Population and geographic priority

Prevention of further HIV transmission will be based on the recognition that "what is driving the epidemic" is "what determines priorities". In the Myanmar context of scarce resources, NSP II gives priority to key populations most at risk of acquiring HIV infection – those identified with behaviours or situations that bring about higher than average prevalence of HIV (>5%) and who do not yet practise preventive behaviours consistently. These populations include the following:

- Female sex workers and their clients and the sexual partners of both
- Men who have high risk sex with men and their sexual partners
- People who inject drugs and their sexual partners
- Male sex workers and their clients and the sexual partners of both
- Sexual partners of people living with HIV
- Institutionalized (prison facilities, detention and rehabilitation centres) populations
- Children born to HIV-infected parents.

NSP II recognises that mobility often places people in situations of higher vulnerability with a greater likelihood of high risk behaviour. Mobility is also a characteristic of some sex workers, drug users and men who have sex with men. It is also a characteristic of many people in uniformed services. Street children and out of school young people also have a degree of mobility, may live in communities with higher HIV prevalence and incidence and higher concentration of high risk behaviours. Such street children and young people may also be sex workers, drug users and men who have sex with men. The workplace also provides access to people who are vulnerable to, or with high risk behaviour, or who are the sexual partners of key populations at higher risk. Such populations share high vulnerability and/or high risk behaviour and they are therefore a priority focus of NSP II, and include:

- Mobile populations vulnerable to/with risk behaviour
- Young people vulnerable to/with risk behaviour
- Uniformed services personnel vulnerable to/with risk behaviour
- People in the workplace vulnerable to/with risk behaviour

These populations are of primary concern as the extent and quality of support extended to facilitate their behaviour change are likely to be key determinants of the course of the HIV epidemic in Myanmar. Prevention focusing on these populations will be priority and will rely on high-intensity, sustained and focused interventions. Townships with the highest HIV prevalence and incidence and with the largest numbers of most-at-risk and vulnerable populations will be the priority locations for implementing the comprehensive packages of services. In addition interventions targeting the workplace enable harnessing the potential of private (business and health) sector contributions. Strategically expanding public private partnerships in this area will gain importance as privatization and investment increases.

The following populations are at a lower risk of HIV infection (<1% HIV prevalence): people displaying lower incidence of HIV and other STI, who do not engage in HIV-related risk behaviours and who are not exposed to risk-taking situations – including women and men in stable, mutual-monogamous relationships, in-school children and youth who have not yet experienced sexual activity, and women, men, boys and girls who consistently practise effective HIV prevention behaviours. While these people need to recognize the nature of HIV transmission and contribute to the collective response to the epidemic, as an essential component of developing an enabling environment, prevention focusing on these populations will emphasize risk awareness and the introduction and reinforcement of protective behaviours through broad based information, education and access to prevention services. These populations can be reached through existing education, primary and reproductive health programmes.

The importance of reaching people in prison and rehabilitation facilities

The NSP II also focuses on populations in prison and rehabilitation facilities. Prisoners most often come from disadvantaged and marginalized social groups, such as the urban poor, ethnic minorities, recent immigrants (from the countryside or from abroad) and PWID. HIV-infected populations shift frequently in and out of rehabilitation facilities. Prison facilities are key points of contact with large numbers of individuals living with or at high risk for HIV infection, who are largely out of reach of the medical system in the community. However, prisoners should be considered a part of the society. Prison facilities, in fact, are not cut off from the world outside. Most prisoners leave the prison facility at some point to return to their communities, some after only a short time inside, and some enter and leave prison facilities many times. In countries where injection of drugs is a significant route of HIV transmission, its prevalence rates in prison facilities are closely related to the rate of HIV infection among PWID in the community and the proportion of people who injected drugs prior to imprisonment. In general, several reasons for higher rates of HIV infection among prisoners include higher prevalence of risk factors associated with acquiring HIV infection, including injecting drug use, co-morbid mental illness, lower socioeconomic status, sex work, and lower level of education as compared with persons in the general community. [23]

[23] Module 2, Comprehensive Services for Injecting Drug Users, Treatment and Care for HIV-Positive Injecting Drug Users, ASEAN, USAID, WHO, FHI, 2007

The importance of peer leadership in uniformed services

According to experiences from other countries, uniformed services, including defence and civil defence forces, are a group highly vulnerable to STI, mainly due to their work environment, mobility, age and other facilitating factors, including gender norms, that expose them to higher risk of HIV infection. Uniformed services also offer a unique opportunity for HIV awareness and training with a large 'captive audience' in a disciplined and highly organized setting. In a uniformed services setting there are unique opportunities for strong and effective use of peer educators and peer leaders which have been successful with uniformed services in many parts of the world including China and Thailand. Peer leaders help others from their peer group go through the process of examining and ultimately changing behaviours that put them at risk for HIV infection. Peer leadership is a form of non-formal education that can be established with little cost. [24]

Counselling and Testing – supporting prevention and treatment

HIV counselling and testing play a fundamental role both in treatment and in prevention and are the necessary entry point for the continuum of care. A minority of those practicing high risk behaviours and likely to have been exposed to HIV have access to counselling and testing. Even in PMCT, where voluntary counselling and testing is routinely offered, many women and their sexual partners do not take the test for fear of stigma and discrimination. Scaling up HIV testing, therefore, should include improved protection from discrimination as well as access to prevention (e.g. BCC, condoms, co-trimoxazole, PMCT) and treatment (e.g. ART).

HIV testing should be conducted confidentially, with pre-test and post-test counselling and with informed consent (voluntary testing). Post-test counselling of people with HIV negative results is often neglected, however it is very important because it reinforces adherence to safe behaviours. Post-test counselling of people with HIV positive results must include psychological support as well as prevention of transmission to their partners and peer drug users (positive prevention).

There are four types of HIV testing: 1. Client-initiated voluntary counselling and testing, 2. Provider-initiated voluntary counselling and testing (a health care provider offers HIV testing to persons with history of risk behaviour, in STI clinics, in PMCT programmes) 3. Diagnostic HIV testing offered to people that show signs or symptoms consistent with AIDS, including tuberculosis, to aid clinical management. This kind of test is performed unless the patient declines. Provider initiated and diagnostic testing are justified in a context where provision of, or referral to, effective prevention and treatment services is assured. 4. Mandatory HIV screening (screening of blood and organ donors). National testing and counselling guidelines need to be developed in Myanmar. Testing is based on one rapid test and a second test is used for confirmation of a positive result. HIV testing and counselling need to be promoted at decentralized level, with client-friendly service hours and promote the same-day-result to improve the uptake.

Sexually Transmitted Infections – reducing HIV transmission

The presence of untreated STIs is an important factor for increased risk of HIV transmission. It is recognised that a choice of service providers will serve best the diverse needs of people with STIs. However, it is crucial that services are readily accessible, affordable, client-friendly and adapted to the needs of specific sub-population groups.

STI services are delivered by a number of different service providers, including government, private sector and not-for-profit organizations.

There are two main approaches to diagnosing and treating STIs: 1) diagnostic treatment which relies on laboratory services and 2) a symptomatic approach to initiate treatment, which is used in settings where the use of a laboratory is either not realistic or advantageous. The local context will indicate the most appropriate approach to be chosen.

[24] Uniformed services HIV/AIDS Peer Leadership Guide, FHI, Futures, UNAIDS, USAID, 2001

7.3 Strategic Priority II: Comprehensive Continuum of Care for People Living with HIV

Continuum of Care

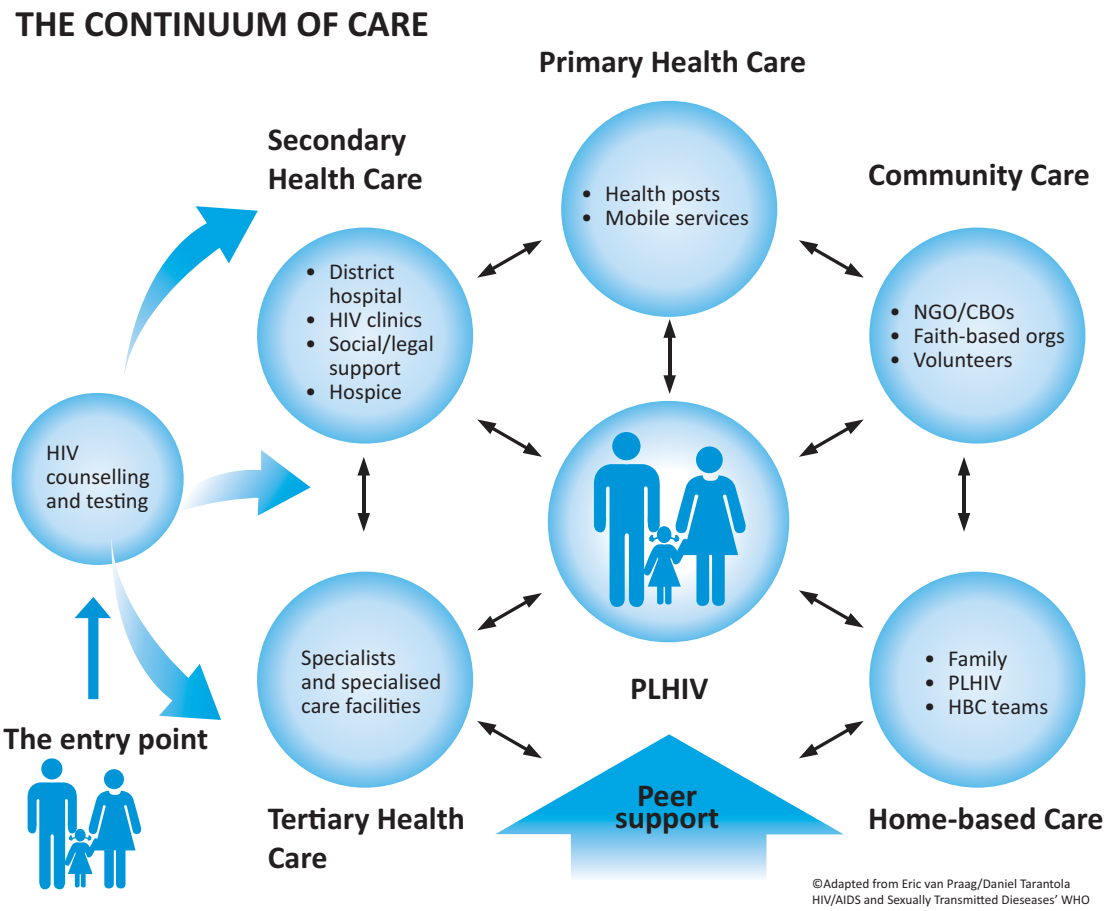
The continuum of care (CoC) is an effective strategy for scaling up HIV services. Care, treatment and impact mitigation services for HIV are increasingly available in Myanmar, but rarely linked and coordinated. The CoC has two characteristics:

1. The CoC is the group of services that together provide comprehensive support to people living with HIV and their families in a defined geographical area

2. The CoC is also a referral network that links and coordinates care, treatment and impact mitigation services. These services are provided in homes, in communities and health facilities. In Figure 8 the circles represent the sites of services and arrows represent the referral network that links the services.

Figure 8 Continuum of Care Framework

Figure 8 Continuum of Care Framework



The CoC is complete set of linked care, tratment and support services provided at all levels from health facility (hospital/health centre) to community and home by government, NGOs, CBOs, FBOs, PLHIV and family members.

Source: Adapted from: Narain JP, Chela C and van Parrag E. *Planning and implementing HIV/AIDS care programme: a step by step approch.* New Delhi, WHO Regional Office for South-East Asia, 2007

CoC is provided both at health facilities and within community.

CoC sites: Health facility based care

The CoC is centred in a 'CoC Hub' that acts as the focal point for activities. This could be the out-patient clinic of the township hospital, or an NGO clinic. The CoC Hub needs adequate physical space to function smoothly. The CoC Hub provides services, referrals and is the site of coordination meetings. Clinical services include: VCCT, ART, TB, OI, STI, palliative care and PMCT.

CoC sites: Community and home-based care and support (CHBC)

Complementary to the health facility sites are the community and home-based care and support (CHBC) sites, which work closely with people living with HIV. HIV prevention and nutritional support are integral elements of the comprehensive package for treatment and care.

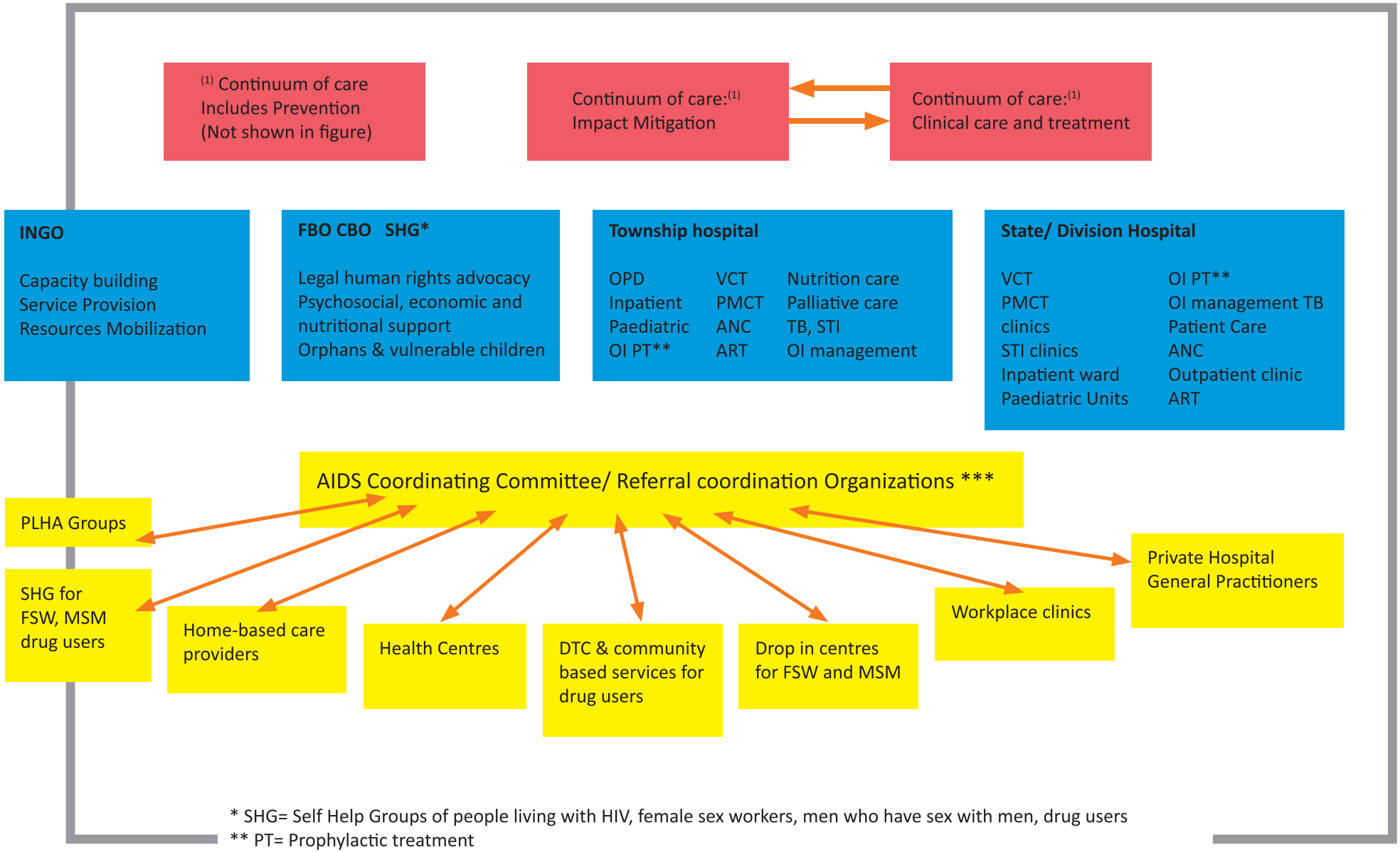
Packages of services will change as the CoC evolves over time, for example, as the availability of ART increases, CHBC service provision will decrease. Nutritional support is important, as HIV patients who begin ART malnourished have two to six times higher mortality than those who are not. HIV patients require energy above and beyond the usual needs, beginning with 10 percent at the asymptomatic stage and increasing to 30 percent for adults at later stages of the disease. Symptomatic HIV-positive children have a 50 to 100 percent increase in energy needs compared to HIV-negative children. All services will be as much as possible designed to provide 'One-stop service'.

Within the package, of particular importance is the provision of ART availability and adherence essential for reduction of OI, morbidity and mortality, creating demand for VCCT and decreasing stigma. Scarcity of financial and human resources make it a great challenge to increase ART provision from the present 28% coverage. Human resources could be increased with the involvement of private hospitals and general practitioners (GPs) who are widely present in all urban areas. Tapping this resource will require an investment in GP training and supervision by MoH to promote correct use of ART and OI treatment for the achievement of effective treatment and prevention of early drug resistance. Another challenge will be the friendly and continuous provision of ART services to at-risk stigmatised groups that do not access services due to mobility or fear of discrimination by health staff. Improving the capacity of clinical staff in HIV case management will contribute to the improving of overall health service quality, hence strengthening the health system.

Prevention of mother-to-child transmission (PMCT) – PMCT services cover more than one third of townships in Myanmar and are offered in ANC settings. In the future, PMCT will be offered to all women in areas with higher HIV prevalence and to women with high risk profiles. The CoC ensures that PMCT services, including couple counselling, is integrated into routine MCH and antenatal care services and linked to ART clinics for adults and children. The national guidelines on PMCT include counselling on voluntary contraception, natural vaginal child delivery and exclusive breast feeding. The roles and responsibilities of different categories of staff will be clarified including the responsibility of pro-actively tracing clients lost to follow up.

CoC implies a spectrum of services which includes even impact mitigation services as well (elaborated more in Strategic Priority III), all these services need a good coordination through CoC Coordination Committee (CoC CC). For places where a local AIDS Coordination Committee already exists, there is no need to establish a CoC CC but instead develop the existing local AIDS Coordination Committee for overall coordination, referral and resource allocation at local level as illustrated in Figure 9.

Figure 9 Continuum of Care Referral Network



* SHG= Self Help Groups of people living with HIV, female sex workers, men who have sex with men, drug users
** PT= Prophylactic treatment
*** Under the AIDS Coordination Committee, the Referral Coordinating organizations can be a health facility or an INGO

7.4 Strategic Priority III: Mitigation of the Impact of HIV on People Living with HIV and their families

Mitigation of the impact of HIV on people living with HIV and their families is part of the continuum of care and has two characteristics:

1. The *group of services*.
2. The *referral network*. As described in Strategic Priority II, providers must be aware of all services and know how to refer clients to them. This is important for people living with HIV who are poor or vulnerable. Managers of key services related to impact mitigation and business managers should sit on the local AIDS Coordinating Committee to promote better referral.

The *group of services* for impact mitigation covers a broad range of areas.

Support in nutrition and for daily living

Good nutrition is a critical element for effective ART and improved quality of life for people living with HIV. Community workers and caregivers will provide nutrition counselling, food supplementation and nutritional monitoring (up to six months for patients starting ART). People living with HIV and their families often require material support for basic needs including housing, food, transportation, clinical care and funerals. Small grants for income generating activities to help them start a small business and earn a living are often requested. In particular business managers will need to be involved in promoting economic activities among the poorest people living with HIV. Poverty significantly influences the impact of HIV causing rapid progression of the infection and limits access to social and health care services. The high costs involved in impact mitigation are beyond government capacity, and NSP II calls for development partners and the private sector to complement government efforts. Modalities must be found to mobilise funds for the support of community based interventions as demonstrated by the communities that have been able to provide funds with support from the private sector, NGO, FBO and individuals.

Psychosocial support

Psychosocial support aims to assist people living with HIV and their families to cope with psychological and social challenges and maintain their hope to lead fruitful lives as productive, valued members of the community. Psychosocial support includes the provision of individual, family and group counselling, peer support, spiritual support, specialized mental health services and social services (including support for domestic violence victims). Psychosocial support is needed to cope with HIV related stigma that remains widespread and plays a major role in fuelling HIV infection (by hindering openness and seeking testing) and in putting people with HIV into unnecessary hostile situations.

Legal support

Impact mitigation can only work within a supportive legal environment hence the importance of sensitizing local leaders to the needs of people living with HIV and at-risk populations and the harmful effects on public health and impact mitigation of harassment, exclusion and arrest. At the same time, in order to protect the rights of people living with HIV and at-risk populations facing discrimination on grounds of serostatus, gender, sexual orientation etc., individual legal aid provided by legal professionals is an important component of creating such a supportive legal environment.

People living with HIV self help groups

Viable self help groups of people living with HIV are an essential component of effective impact mitigation because they are best placed to understand and respond to the needs of their peers. These self-led groups meet regularly to provide services and support to group members and other people living with HIV. They participate in the AIDS Coordination Committee and in other activities such as determining who is eligible to start ART or advocating for those who do not receive the services they need. In 2010 there are more than 200 groups with about 10,000 members, but more groups need to be established. Their capacity is limited by poverty, illness, lack of training and discrimination, hence, they need strengthening through the support of NGO, CBO, NAP and other implementing partners. Groups should be strengthened to actively participate in and monitor service delivery. Finally experience from neighbouring countries has demonstrated that people living with HIV can be effective players in HIV positive prevention activities in providing preventive counselling and condom distribution to their peers.

Orphans and Vulnerable Children

Children suffer multiple problems when their parents or caregivers have HIV. They experience the illness and possible loss of a parent; rejection from the community and peers; reduced access to health care, education and food; and increased vulnerability to violence and abuse. These children should enjoy the same rights of all children, as expressed in the Convention on the Rights of the Child, including non-discrimination, health, education, housing, special protection, inheritance and the right to have their views sought and considered in matters that affect their lives. Children are more exposed to risks while their rights are often ignored. Government, NGO, CBO and FBO will have greater involvement in OVC issues and these organizations will participate in the AIDS Coordination Committee to make sure that OVC needs are adequately addressed. Meeting the needs of OVC requires a response from Ministries of Health, Social Welfare, Women's Affairs, and Education, and from all social sector organizations. Community and home-based care should include activities to support OVC to increase their access to appropriate HIV prevention, care, treatment and support services.

Given the scarcity of data on OVC it is fundamental to start with a situation analysis study to understand their situation, and to map resources and gaps in action, and disseminate the study findings for advocacy and effective planning. In addition data and indicators will be routinely integrated within existing information systems of the Department of Social Welfare and NAP for monitoring the Convention on the Rights of the Child and Myanmar Child Law.

Essential services for OVC include HIV counselling and testing, referral and follow-up to paediatric OI/ART services for all HIV positive children; access to education and support groups for young people and to specific support groups for children living with HIV. Services will provide social support that strengthens family-centred protection systems and community-based approaches. Institutional care (orphanages) will be used as the last resort. There is documented evidence that orphanages are detrimental to children's health and well being. Service provider skills in caring for OVC will be developed. More resources will be mobilised including the use of social health insurance schemes where these are viable.

7.5 Cross-cutting interventions

Intervention IV.1: Health system strengthening (including Private Health Sector), Structural Interventions and Community Systems Strengthening

A combination of international donor restrictions and limited government funding pose significant obstacles to public sector health and non-health system strengthening. NSP II calls on the UN, international organizations and donors to build on the training and technical assistance they provided to the public sector in NSP I, and to be encouraged by the approved GAVI Health System Strengthening proposal to support the health and non-health sector activity areas in Cross-cutting Intervention 1. International experience indicates the critical contribution of private sector health services, and this sector is actively engaged in the national response in Myanmar and has considerable opportunity for strengthening and expansion as referred to in 7.8a Private Sector Health Services.

An important function of the health sector is to continue to assure achieving universal access to safe blood transfusion. This will have a direct impact on the achievement of the health-related MDG 6 to reduce HIV as well as the MDGs 4 and 5 on child mortality and maternal health. Universal access to safe blood transfusion requires strengthening the implementation of key strategies to ensure access to a safe and sufficient blood supply, to achieve 100% voluntary blood donation and to ensure 100% quality-assured testing of donated blood. There is also need to optimize blood usage for patient health, develop quality systems in the transfusion chain, strengthen personnel in laboratories and management supply chain, keep pace with appropriate new technologies and build effective partnerships with blood donors groups and private service providers.

Learning from the GAVI HSS focus on township planning and coordination

The GAVI HSS grant for Myanmar offers a partnership and coordination approach at township level that is relevant to HIV. The NSP II focus on improved township coordination and planning is in particular informed by activity 1.5 of the GAVI HSS proposal[25] which organizes a township-level planning and review team composed of NGOs, local authorities, community health workers (CHW) and selected community representatives to

[25] P.41, GAVI HSS proposal, March 2008

develop and implement coordinated township health plans in 100% of HSS-targeted townships by 2011. The indicator is that all HSS targeted townships have coordinated health plans that include the activities of local NGOs, INGOs, CHW and local authorities. This activity supports the National Health Plan Objective. 2.6 which aims for stronger linkages between health related sectors and national and international NGOs.[26]

As outlined in the Technical Working Paper for HSS, INGOs are active in 41% of townships, with services expected to cover 10-20% of the population. National NGO are active across the country. According to a DOH study, of the original 40,000 community health workers trained, 50% are still active, and provide a vital link in the referral and health promotion chain, particularly in remote areas. However, coordination mechanisms with Township Health Teams, local authorities, NGOs and CHW are often not strong. CHW can assist midwives and Public Health Supervisor 2 to cover the population in the hardest to reach areas. This activity will assist to obtain the objective of increased access for MCH services for the population through strengthening township-level NGO coordination mechanisms, CHW support and training, and involvement of NGOs and local authorities in micro-planning. This includes advocacy to local authorities and stakeholders on HSS at township level. Investment will also be made in reactivating health committees at township and village level. Township Health Teams, State & Division Directors, DOH in collaboration with the Department of Health Planning are responsible for this activity.

Community systems strengthening

Community systems strengthening refers to the provision of financial, technical and other kinds of support to organizations and agencies that work directly with and in communities. Most entities in need of such support are local NGOs that comprise and/or provide services to people living with HIV, members of vulnerable populations and individuals who otherwise have sub-standard access to vital health services. The Global Fund Board now recommends "the routine inclusion, in proposals for Global Fund financing, of requests for funding of relevant measures to strengthen community systems necessary for the effective implementation of Global Fund grants." Applicants are therefore specifically encouraged to include community systems strengthening activities in their proposals where these interventions support increased demand for and access to service delivery at the local level for "key affected populations" – including women and girls, sexual minorities and people who are not reached with services due to stigma, discrimination and other social factors. The Global Fund has identified three interconnected areas of need that can be addressed as part of efforts to strengthen community organization responses to HIV: predictable financing, training and capacity building and coordination, alignment and advocacy. [27]

One of the key findings of the Review of NSP I was the considerable increase in the number and role of groups being formed to support prevention, care, treatment and support, comprised of the following:

- People living with HIV
- Men who have sex with men
- Female sex workers
- Drug users
- Local communities – including faith-based groups

Cross-cutting Intervention I under Community Systems includes the intensive and long-term support required for capacity building and development of organizational and governance structures of community based organizations. International experience shows that a significant contribution to effective national responses to HIV comes from community-based organizations made up of the most-at-risk, affected and concerned populations. NSP II gives priority attention to building on the NSP I achievements of such community-based organizations.

Intervention IV.2: Favourable Environment for Reduction of Stigma and Discrimination

The existence of a favourable legal and policy environment as well as compassionate, understanding and supportive communities and institutions is critical to an effective and sustainable national response to HIV. These issues are referred to throughout NSP II, under guiding principles, and within specific interventions. Creative use of diverse types of mass media for stigma reduction can cater effectively to different audiences by taking into account linguistic differences and varying levels of literacy.

Intervention IV.3: Strategic Information, Monitoring And Evaluation, and Research

NSP II recognises that an effective M&E system is urgently required to monitor national programmatic

[26] P.23, National Health Plan (2006-2011), Ministry of Health

[27] Page 6, Civil Society Success on the Ground, Community Systems Strengthening and Dual-track Financing: Nine Illustrative Case Studies, The Global Fund to Fight AIDS, Tuberculosis and Malaria and the International HIV/AIDS Alliance.

inputs, outputs (coverage), outcomes (behavioural trends), impact, and to evaluate the effectiveness of NSP II. Effective prevention, treatment and care also need to be regularly informed by relevant research. While it is acknowledged that a combination of international donor restrictions and limited government funding pose significant obstacles to public sector system strengthening – which impacts significantly on the area of strategic information, M&E and research – NSP II endeavours to strengthen capacity and the ability of systems to produce the strategic information that is urgently required to guide and review the national response to HIV, and to ensure that the rights and needs of marginalized and most at-risk populations are responded to. Planned activities will be used to identify programmatic gaps; to develop focused, uncomplicated advocacy messages for HIV prevention, treatment and care. Strategic information, M&E and research priorities in NSP II include improved data collection and reporting; systematic national size estimations of key populations at higher risk; expanded and strengthened surveillance and behavioural studies of key populations at higher risk; and research to expand the knowledge base on HIV and risk behaviours, and on the impact of the range of interventions in prevention, treatment and care.

Government coordination mechanisms in related fields

The core coordination structures for HIV will interact with a variety of other mechanisms which have unique but related tasks, including the Government's National Health and National AIDS Committees, State, Division, District and Township AIDS Committees, and the National AIDS Programme itself.

Beyond those focused directly on HIV or health matters, government structures which have important roles in the response to the HIV epidemic include the Central Committee for Drug Abuse Control and the National Education Committee. The roles of these committees are outlined in the table below.

Entity	Function for the Response to HIV	Chair & Membership
Government of Republic of the Union of Myanmar	Highest level oversight of political commitment to the response to HIV and AIDS	Head of Government of Republic of the Union of Myanmar
National Health Committee	Oversight of national health policy and implementation Approval of National Strategic Plan	Chair: Secretary 1 Members:
National AIDS Committee	Oversight of HIV policy and omplementation	Chair: Minister for Health Members: line ministries
National Education Committee	Provide policy guidelines for implementation of education activities (basic and higher education) approval of education projects and coordination among ministries.	Chair: Secretary 1 Members: 13 education-related ministers
Central Committee for Drug Abuse Control (CCDAC)	Policy and strategic guidance for harm reduction Technical delivery of harm reduction services Coordination with Anti-narcotic Taskforce	Chair: Minister for Home Affairs Members: Secretariat support: Ministry of Home Affairs, CCDAC
Myanmar Country Coordinating Mechanism (M-CCM) for AIDS, TB and Malaria	Oversight of the national response related to the three diseases of TB, malaria and HIV and coordination of the efforts of all partners. In relation to the Global Fund the M-CCM is mandated to develop and submit grant proposals to the Global Fund, and to provide effective grant oversight and support the implementation of grants that are funded by the Global Fund. Coordination of the all major programme related to the three diseases in country and supported by Technical and Strategy Groups and its Working Groups.	Chair: Minister of Health Members: • Government (10 members) • UN agencies (4 members) • Bilateral donors (1 member) • National NGO and Professional groups (3 members) • Community-based organizations (CBO) and faith-based organizations (3 members) • International NGOs (INGO) operating in-country (4 members) • Private sector (1 member) • People affected by HIV/AIDS, tuberculosis or malaria (2 members) • Academic sector (1 member)

PART II

Strategic Priorities, Interventions and Cross-Cutting Activities, Outputs, Outcomes and Indicators

PART II :

Strategic Priorities, Interventions and Cross-Cutting Activities, Outputs, Outcomes and Indicators

Introduction

This document presents a risk behaviour and service-focused set of strategic priorities, each grouped into interventions. For each intervention there are defined outcomes, outputs, suggested targets, monitoring indicators, implementing partners and comprehensive intervention package. Outcomes and outputs have been chosen according to their relevance to achieving the objectives of the National Strategic Plan, and then appraised according to their measurability.

The feasibility of outputs will depend on resource availability, partners' willingness or capacity to engage, and the evolving policy environment at national and township levels. The outputs marked with "*" are indicated as priorities. The Operational Plan will consider the feasibility of different outputs at that time and determine which interventions will be implemented as part of the national response.

NSP II is a living document: it lends itself to adjustments and revisions as further experience is gained, resources are mobilized and evidence of successes and shortcomings is generated through monitoring, special studies and mid-term and end-of-term evaluations, in 2013 and 2015, respectively.

STRATEGIC PRIORITY I:
PREVENTION OF THE TRANSMISSION OF HIV THROUGH UNSAFE BEHAVIOUR IN SEXUAL CONTACTS AND INJECTING DRUG USE

Intervention I 1. Reducing HIV-Related Risk, Vulnerability and Impact among Female Sex Workers and their Clients

Target Groups: Female sex workers and their sexual partners, the clients of female sex workers and their sexual partners.
Note: Sexual partner refers to spouse and any other sexual partner.

Activity Area 1: Ensure availability and equitable access to a combination of prevention programmes and comprehensive services that are highly effective because they are flexible, tailored and targeted by location, age, and gender, literacy, language and transmission behaviour.

Outputs	Outcomes
* Targeted Condom Promotion Programme strengthened. Access to resources - male and female condom provision, lubricants social marketing.	Increased proportion of sex workers practising safer behaviours to prevent HIV transmission. Increased proportion of clients of sex workers practising safer sexual behaviours.
* Ensuring tailored interventions for direct and indirect sex workers groups (freelance sex workers, entertainment workers, beer girls, hotel workers, brothel based sex workers, young sex workers), including outreach services.	
* Integration of information and support for sex workers with prevention programmes of specific ministries and workplaces (e.g. Railways and tourism industry).	
Linkages including referrals to counselling, testing, treatment (antiretroviral therapy and STI) and care as well as to other existing services such as drop-in-centres providing primary health care and social services.	Increased proportion of sex workers who were in need sought and got access to appropriate services. Increased proportion of clients of sex workers practising safer sexual behaviours.
* Voluntary counselling and testing, STI (including syndromic approach), sex worker friendly reproductive health services in public sector.	
* Voluntary counselling and testing, STI (including syndromic approach), reproductive health services sex worker friendly in, private sector (including non government organization programmes).	
Prevention of Mother-to-Child Transmission, care, support and treatment services available for sex workers.	
* Peer and outreach education programmes and partner disclosure targeting male groups identified as potential clients of sex work and their sexual partners.	

Activity Area 2: Ensure availability and equitable access to a continuum of effective and high quality STI treatment, care, and support services that are flexible, tailored and targeted by location, age, gender, and socio-economic status

Outputs	Outcomes
* National guide for risk reduction amongst the sexual partners of clients of female sex workers is developed, including: • IEC/BCC materials production and distribution • IEC/BCC events • Mobilization of community participation • Advocacy at township level • Collaboration of public and private sector • Pre-marital counselling. • Partner disclosure • Couple counselling More research on effectiveness of IEC in supporting healthy behaviours and relevant behaviour change	High risk situation sexual partners of clients of female sex workers have improved understanding of HIV and STI prevention, including safe sex. High risk situation sexual partners of clients of female sex workers have access to IEC and BCC materials and VCCT and PMCT.
* Reproductive health services for the sexual partners of clients of female sex workers are strengthened: • Integration of HIV prevention and care services with reproductive health clinics, maternal and child health clinics, youth centres, workplace clinics and other centres where women and men of reproductive age have access • Male-friendly services are established • Male involvement • Commodities re available, including HIV test kits, STI drugs, condoms, PMCT packages).	High risk situation sexual partners of clients of female sex workers use reproductive health services, including: • STI prevention • Condom use • VCCT • PMCT • Pre-marital counselling. More men are seeking reproductive health services.

Activity Area 3: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in programme design, development, implementation and evaluation.

Outputs	Outcomes
* Sex worker support groups established and functioning.	Programmes improved and focused on improving responses to HIV and AIDS.
* Participation of sex workers, including people living with HIV and/or clients if possible, in programme design and implementation.	
Build understanding of communities about issues affecting sex workers; including focus to address partners; address gender-based violence.	Understanding and empathy for sex workers is increased (Stigma and Discrimination reduced).

Activity Area 4: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

Outputs	Outcomes
Reform of Suppression of Prostitution Act, 1949.*	Prevention programmes and services able to expand and to operate more effectively. Better links between prevention, care and support. Less stigma, discrimination and violence against sex workers. Programmes and services more effective as trust is developed between implementers and sex workers.
* Enabling environment – national policies in place to indicate need for programmes for sex workers which respect consent and confidentiality.	
* Enabling environment – township environment, including from law enforcement and other authorities, is supportive of programmes and services for sex workers. Enforcement of policy in which condom possession is not used as liability of sex work.	
Coordination and multisectoral cooperation amongst stakeholders (including non government organizations) and gatekeepers (e.g. local authority, police, managers and owners of entertainment establishments).	
Research and special studies to better understand the context of sex industry including brokers and types of clients in order to improve prevention and care programmes.	Vulnerability to HIV is reduced as sex workers increase their capacity to care for themselves and each other.
Working environment for sex workers improved in establishments and entertainment facilities.	Reduce violence against women and supportive environment for conducting intervention activities
Recovery, re-integration and social services for women who want to leave sex work, including services tailored to the needs of under-age sex workers.	Increased proportion of sex workers able to reintegrate into other work and social environments.

Partners

Government: National AIDS Programme, Ministry of Social Welfare, Relief and Resettlement, Ministry of Home Affairs
INGO: AHRN, Alliance, AMI, AZG, CARE, FXB, IOM, Malteser, MDM, MSI, PSI, WVI
Local NGO/professional association: MANA, MNA, MMA, MRCS, PGK
Network/CBO/Self Help Group: Ma Hay Thi, Myitta Shin Pwint Phyo Toe Tet Yay, Twe Let Myar Shin Than Yar
UN: UNFPA, WHO

Partners to be mobilised

Ministry of Rail Transportation, Ministry of Transport, Ministry of Border Affairs, UNICEF
Private sector: Entertainment Facilities, Hotels and Motels, Transportation Workers' Association.

Suggested indicators and targets

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Impact/Outcome Targets							
% female sex workers who are HIV infected	40-80,000	11.2%	10%	9.5%	9%	8%	7%
% clients of female sex workers who are HIV infected	881,220	3.88%	3.3%	3.0%	2.7%	2.4%	2.0%
% female sex workers who used condom at last sex	40-80,000	95%		95%			
Output/Coverage Targets							
% female sex workers reached with HIV prevention programmes	40-80,000	76%		BSS			
% female sex workers who received an HIV test in the last 12 months and who know the result	40-80,000	71%		BSS			
Number of female sex workers reached with HIV prevention programmes	40-80,000	45,489	55,000	60,000	65,000	70,000	75,000
Number of clients of female sex workers reached with HIV prevention programmes	881,220	NA	88,122	110,153	132,183	154,214	176,244
Number of regular sexual partners of sex workers and clients reached with HIV prevention programmes	440,610	NA	10,000	15,000	20,000	25,000	30,000

Intervention I 2. Reducing HIV-Related Risk, Vulnerability and Impact among Men who have Sex with Men [33]

Target Groups: Men who have sex with men and their regular female partners, male sex workers and their sexual partners, clients of male sex workers and their sexual partners. Note: Sexual partner refers to spouse and any other sexual partner.

Activity Area 1: Ensure availability and equitable access to a combination of programmes and comprehensive services that are highly effective because they are flexible, tailored and targeted by location, age, and gender, literacy, language and transmission behaviour.

Outputs	Outcomes
Mass information provided – transmission, prevention, condom use, lubricants, and alternative sexual practices. Information about risks for specific groups of men who have sex with men.	Increased proportion of men who have sex with men practising safer behaviours to prevent HIV transmission. Increased proportion of men who have sex with men and women practising safer behaviours with male and female partners.
* Behaviour change support tailored for specific groups of men who have sex with men – peer education, negotiation skills, sexual skills (e.g. how to use lubricants).	
* Access to resources is improved - condom and lubricant provision in education programmes, social marketing, new sales outlets.	
* VCCT, STI services (including syndromic approach), treatment (incl. ART) care and support in men who have sex with men-friendly public sector health services.	Increased proportion of men who have sex with men sought and got access to appropriate services. Reduced STI and HIV incidence amongst men who have sex with men. More men who have sex with men know their HIV status.
* VCCT, STI services (including syndromic approach), treatment (incl. ART) care and support in men who have sex with men-friendly private sector health services (including non government organization programmes).	
Young men who have sex with men-friendly services established and improved – health as well as other social and support services.	

[33] In this document the usage of the term 'men who have sex with men' will include transgender persons. At this stage all prevention programmes for men who have sex with men include transgender persons as well. All self help groups are open to both men who have sex with men and transgender persons. Myanmar language distinguishes at least six sub-groups of men who have sex with men and transgender persons. The boundaries between groups sometimes appear blurred and more research is needed to improve the understanding of the local context.

Activity Area 2: Ensure availability and equitable access to a continuum of effective and high quality treatment, care, and support services that are flexible, tailored and targeted by location, age, gender, and socioeconomic status

Outputs	Outcomes
* National guide for risk reduction amongst the female sexual partners of: men who have sex with men, and male sex workers and their clients is developed, including: • Pre-marital and couple counselling. • Support for partner disclosure • Mobilization of community participation • Advocacy at township level • Collaboration of public and private sector • IEC/BCC events and materials production/ distribution * More research on effectiveness of IEC in supporting healthy behaviours and relevant behaviour change	Female sexual partners of: men who have sex with men, male sex workers and their clients have improved understanding of HIV and STI prevention, including safe sex. Female sexual partners of: men who have sex with men, male sex workers and their clients have access to IEC and BCC materials and VCCT and PMCT.
* Reproductive health services for the female sexual partners of: men who have sex with men, male sex workers and their clients are strengthened: • Integration of HIV prevention and care services with reproductive health clinics, maternal and child health clinics, youth centres, workplace clinics and other centres where women and men of reproductive age have access • Male-friendly services are established • Male involvement • Commodities re available, including HIV test kits, STI drugs, condoms, PMCT packages).	Female sexual partners of: men who have sex with men, male sex workers and their clients use reproductive health services, including: • STI prevention • Condom use • VCCT • PMCT • Pre-marital counselling. More men and women are seeking reproductive health services.

[1] In this document the usage of the term 'men who have sex with men' will include transgender persons. At this stage all prevention programmes for men who have sex with men include transgender persons as well. All self help groups are open to both men who have sex with men and transgender persons. Myanmar language distinguishes at least six sub-groups of men who have sex with men and transgender persons. The boundaries between groups sometimes appear blurred and more research is needed to improve the understanding of the local context.

Activity Area 3: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in programme design, development, implementation and evaluation.

Outputs	Outcomes
* Men who have sex with men are better able to initiate their own prevention and care and support programmes (i.e. activities could be capacity building activities, etc.).	Reduction of risk behaviour among men having sex with men
* Participation of men who have sex with men, including those infected with HIV, in advocacy, programme design and implementation (i.e. activities could be support to local support groups and networks).	Programmes improved as they become more tailored to the expressed needs of beneficiaries. Behaviour change increases as education becomes more effective – e.g. men become more confident to negotiate and practise safer sex with other men, and more willing to care for each other. Stigma and Discrimination reduced.

Activity Area 4: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

Outputs	Outcomes
* Enabling environment – national policies in place to indicate need for programmes for men who have sex with men.	Prevention programmes and services able to expand and to operate more effectively. Better links between prevention, care and support. Less stigma, discrimination and violence against visible groups of men who have sex with men. Programmes and services more effective as trust is developed between implementers and men who have sex with men.
Reform of less supportive law which criminalizes sex between consenting adult males.	
Enabling environment – township environment is supportive of HIV prevention programmes and services for men who have sex with men.	
Coordination and multisectoral cooperation amongst stakeholders (e.g. local authority, police, managers and owners of entertainment establishments).	Prevention able to reach more men who have sex with men, in ways that are more helpful.
Research and special studies to better understand the local context of men who have sex with men, their sub-groups and transgender persons and to improve prevention and care programmes.	Care and support more effectively able to respond to the specific needs of different sub-groups of men who have sex with men as well as transgender persons.

Partners
Government: National AIDS Programme, Ministry of Social Welfare, Relief and Resettlement
INGO: Alliance, AMI, AZG, CARE, FXB, IOM, MDM, MSI, PSI, Save the Children, WVI
Local NGO/professional association: MANA, MNA, MRCS, PGK
Network/CBO/Self Help Group: Light, The Help, HLHS, Mr. Lady, Mee Aim Shin Lay Myar, Khine Hnin See
UN: UNFPA, UNDP, UNAIDS

Partners to be mobilised
Ministry of Home Affairs (Police Force, Prison Department)

Suggested indicators and targets

Estimated number of men who have sex with men in Myanmar: 224,000 [34]

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Impact/Outcome Targets							
% men who have sex with men who are HIV infected	224,000	22.3%	20.5%	19.5%	18.5%	17.0%	16.0%
% men who have sex with men who used condom at last sex	224,000	81%			85%		
Output/Coverage Targets							
% men who have sex with men reached with HIV prevention programmes	224,000	69% [35]			BSS		
% men who have sex with men who received an HIV test in the last 12 months and who know the result	224,000	48% [36]			BSS		
Number of men who have sex with men reached with HIV prevention programmes	224,000	59,985	65,000	70,000	75,000	80,000	85,000
Number of female sexual partners of men who have sex with men reached with HIV prevention programmes	45,000	NA	2,250	2,813	3,375	3,938	4,500

[34] Estimation Report 2009

[35] BSS, 2008: This surveillance used Respondent Driven Sampling (RDS) and covered Mandalay and Yangon. These two locations are relatively well covered with services which would indicate that the national average would be lower, The service statistics indicate indeed that the actual coverage is lower (see next note).

[36] Based on the total numbers of men who have sex with men reached with at least one prevention intervention and reported by service providers.

Intervention I 3. Reducing HIV-Related Risk, Vulnerability and Impact among Drug Users

Primary target group: Primarily drug users, with a special focus on people who inject drugs
Secondary target group: Sexual partners and families of drug users and youth-at-risk.
Note: Sexual partner refers to spouse and any other sexual partner.

Activity Area 1: Ensure availability and equitable access to a combination of programmes and comprehensive services that are highly effective because they are flexible, tailored and targeted by location, age, gender and transmission behaviour.

Outputs	Outcomes
Specific interventions for drug use primary prevention particularly for youth.	The proportion of youth engaging in drug use is reduced.
* Strengthen drug education and HIV education for drug users and other young people – mass communication to include information about how to prevent HIV transmission associated with drug use and abuse, as well as drug demand reduction.	Increased proportion of drug users practising safer behaviours to prevent HIV transmission through drug use. Increased proportion of drug users practising safer behaviours to prevent HIV transmission through sex. Increased proportion of drug user's access education and behavioural support through institutional and non-institutional interventions.
* Behaviour change education and outreach for specific groups of drug users – peer education, skills in safer drug use and safer sexual behaviour, peer support, life skills.	
* Access to needle and syringe programmes and condoms and lubricant promotion and distribution are increased from drop in centres and through outreach programmes.	
* Primary health care provided for drug users (i.e. activity is these services provided by DTC, drop-in centre, etc.).	

Outputs	Outcomes
Referrals to counselling, testing, rehabilitation and treatment services for drug users.	Increased proportion of drug users sought and got access to appropriate services. Reduced STI and HIV incidence among drug users and their sexual partners, friends, fellow-users, clients More drug users know if they are infected with HIV, and get proper counselling More drug users able to stop using drugs and reintegrate into society using appropriate detoxification and treatment methods Drug users who are living with HIV have access to the social support they need to help them benefit from treatments for opportunistic infections and from anti-retroviral treatment. Social and psychological support for drug users is improved, especially for people living with HIV.
Develop of programmes to include family/care-giver in all aspects of recovery and support.	
* Drug dependency treatment, drug substitution treatment (methadone, opium tincture, buprenorphine), therapeutic communities and outpatient drug treatment programmes expanded.	
* Scale up successful community based detoxification programmes under the supervision of DDTRU/Drug Dependency Treatment and Research Units.	
* Voluntary confidential counselling and testing, STI services (including syndromic approach), treatment for opportunistic infections, tuberculosis, screening for hepatitis B and C and ART are provided in settings that are friendly for drug users and youth vulnerable to drug use. (Settings include public and private sector, non government organizations and for-profit services).	
Tailored services for young drug users and youth vulnerable to drug use established and improved – health as well as other social and support services.	
Alternative vocational training for drug users, especially people living with HIV (reinsertion and socio economical reintegration), promoted through community programmes.	

Activity Area 2: Ensure availability and equitable access to a continuum of effective and high quality treatment, care, and support services that are flexible, tailored and targeted by location, age, gender, and socioeconomic status

Outputs	Outcomes
* National guide for risk reduction amongst the sexual partners of drug users, including: • IEC/BCC materials production and distribution • IEC/BCC events • Mobilization of community participation • Advocacy at township level • Collaboration of public and private sector • Pre-marital counselling. • Partner disclosure • Couple counselling More research on effectiveness of IEC in supporting healthy behaviours and relevant behaviour change	High risk situation sexual partners of drug users have improved understanding of HIV and STI prevention, including safe sex. High risk situation sexual partners of drug users have access to IEC and BCC materials and VCCT and PMCT.
Reproductive health services for the sexual partners of drug users are strengthened: • Integration of HIV prevention and care services with reproductive health clinics, maternal and child health clinics, youth centres, workplace clinics and other centres where women and men of reproductive age have access • Male-friendly services are established • Male involvement • Commodities re available, including HIV test kits, STI drugs, condoms, PMCT packages).	High risk situation sexual partners of drug users use reproductive health services, including: • STI prevention • Condom use • VCCT • PMCT • Pre-marital counselling. More men are seeking reproductive health services.

Activity Area 3: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in programme design, development, implementation and evaluation.

Outputs	Outcomes
* Participation of drug users, ex-drug users and their families, including people living with HIV, in programme design and implementation for their own groups.	Programmes improved as they become more tailored to the expressed needs of beneficiaries.
* Local support groups and networks of drug users and ex drug users are established to support sustained behaviour change and empower participation with a focus on economic and income generating activities. Ex-drug users contribute to local coordination-groups. Link local networks to assist one another and share best practices.	Programmes improved as they become more tai lored to the expressed needs of beneficiaries. Behaviour change increases as education becomes more effective – e.g. drug users become more confident to negotiate and practise safer drug use and safer sex, and more willing to care for each other. Compassion, understanding and empathy for drug users are increased (Stigma and Discrimination reduced). This makes it easier for the community to support HIV prevention, care and support for drug users.

Activity Area 4: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

<table>
<tr><th>Outputs</th><th>Outcomes</th></tr>
<tr><td>* Key community leaders learn about public health benefits of harm reduction programmes (i.e. activities are advocacy and education of community leaders).</td><td rowspan="3">Prevention programmes and services able to expand and to operate more effectively.

Standard and multisectoral approaches used nationally, based on evidence of what works.

Better links between prevention, education, treatment and rehabilitation initiatives.

Less stigma, discrimination and violence against drug users.

Programmes and services more effective as trust is developed between implementers and drug users.

Institutional policy and practices changed or reviewed (e.g. alternate sentencing, deferment policy).

Enabling environment supportive of programmes and services for drug users</td></tr>
<tr><td>* National policies in place to indicate need for multisectoral programmes for drug users, including prevention, education, treatment and rehabilitation, in line with the broad definition of Drug Demand Reduction (activities are advocacy, media use).</td></tr>
<tr><td>* Effective coordination and multisectoral involvement at local level exists for use of evidenced-based interventions and accountability (i.e. activities are local level advocacy and support for coordination).</td></tr>
<tr><td>* Strategic information gathered and available, including needs analysis and documentation of impact and good practices of programmes and policies.
Compile best practices and lessons learned at district and state level to replicate and provide evidence-basis for policy change recommendations.</td><td>Better understanding of the extent of drug use and the health and social needs of drug users.</td></tr>
<tr><td>Exposure of decision makers to international good practices (study tours, trainings, coaching).</td><td>Policy makers and programme designers are aware of what works best in other countries and other locations within Myanmar.</td></tr>
</table>

Partners
Government: MOH, NAP, DOH and Drug Treatment Centres, Ministry of Home Affairs,
Central Committee for Drug Abuse Control (CCDAC), Ministry of Social Welfare, Relief and Resettlement
INGO: AHRN, AZG, Burnet Institute, CARE, MDM, MSI, PSI
Local NGO/professional association: MANA
Network/CBO/Self Help Group: Swifts, Youth Empowerment, Oasis, Omega,
Black Sheep Peer Support Group, MNDN
UN: UNODC, WHO

Partners to be mobilised
Ministry of Home Affairs (Police Force, Prison Department)

Suggested indicators and targets
Estimated number of people who inject drugs in Myanmar: 75,000[37]
Estimated number of non-injecting drug users: 150,000 (assumption that 2 DU for 1 PWID)

National AIDS Programme will lead a national exercise working with local multisectoral implementing partners to estimate local populations, current coverage to help set future targets

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Impact/Outcome Targets							
% of people who inject drugs who are HIV infected	75,000	34.6%	31.20%	28.70%	26.10%	23.40%	21.00%
% of people who inject drugs who used sterile needles and syringes at last injection	75,000	81%		84%			
% people who inject drugs who used condom at last sex	75,000	77%		80%			
Output/Coverage Targets							
% people who inject drugs reached with HIV prevention programmes	75,000	52%		BSS			
% people who inject drugs who received an HIV test in the last 12 months and who know the result	75,000	27%		BSS			
Number of people who inject drugs/ drug users reached with HIV prevention programmes (Out reach)		NA	10,000	12,500	15,000	17,500	20,000
Number of people who inject drugs/ drug users reached with HIV prevention programmes (DIC)		21,214	25,000	28,000	31,000	35,000	38,000
Number of sterile injecting equipment distributed to people who inject drugs in the last 12 months	75,000	5.3 m	8 m	12 m	15 m	20 m	20 m
Number of drug users receiving methadone maintenance therapy	75,000	771	2,000	3,000	4,000	5,000	8,000
Number of regular sexual partners of PWIDs reached with HIV prevention programmes	20,550	NA	5,138	8,438	10,625	12,813	12,330

[37] Estimation Report 2009

Intervention I 4. Reducing HIV-Related Risk, Vulnerability and Impact among Prison and Rehabilitation Facility Populations

Target Groups

Men, women and children institutionalised within:

1. Prison facilities (those convicted and those under-trial; including children who have come into contact with the law or who are residing with their mothers)
2. Police lock-ups and other areas of temporary custody (including those in police stations, remand centres, and those for other temporary purposes)
3. Juvenile detention centres (including Department of Social Welfare training schools);
4. Rehabilitation centres for sex workers

Activity Area 1: Ensure availability and equitable access to a combination of programmes and services that are highly effective because they are flexible, tailored and targeted by location, age, gender and transmission behaviour.

Outputs	Outcomes
* Information provided – transmission, prevention, alternative practices.	Increased proportion of prison and rehabilitation facility populations practising safer behaviours to prevent HIV transmission, including use of prevention commodities and harm reduction behaviours
* Behaviour change support – peer education, negotiation skills.	
Access to resources – prevention commodities, social marketing.	
Interventions tailored for specific problems of different prison or rehabilitation facility groups by gender, age, and context.	
Integration of information and support programmes for prison and rehabilitation facility populations with prevention programmes of specific ministries and workplaces (e.g. residential treatment staff, non government organization workers).	

Outputs	Outcomes
Referrals to counselling, testing and treatment services. * Voluntary confidential counselling and testing, STI services, support for behaviour change and harm reduction, appropriate resources including condoms, are available within prison and rehabilitation facilities. Services and programmes friendly for young drug users and youth vulnerable to drug use developed within prison and rehabilitation facilities where relevant and appropriate.	Increased proportion of prison and rehabilitation facility populations has: - Access to STI, HIV behaviour change, harm reduction services, and prevention commodities. - Made use of voluntary and confidential counselling and testing services. - Knowledge of heir HIV status. - Access to harm reduction services and resources.
Improved knowledge of institutionalized individuals, their families and spouses. Increased proportion of prison and rehabilitation facilities provide counselling and treatment for Prevention of Mother-to-Child Transmission amongst people who are, or have been in such facilities.	Reduced incidence of HIV arising from Mother-to-Child Transmission which occurs when women are in institutions or soon after they leave prison and rehabilitation facilities.
* Ensure treatment, care (for Opportunistic Infections including TB, STI, Anti-Retroviral Therapy, Post-Exposure Prophylaxis {for staff and inmates}, and Prevention of Mother-to-child Transmission — PMCT and PMCT plus) and support for people living with HIV in prison and rehabilitation facilities and for the staff of these institutions. Provide methadone maintenance and drug treatment in prison and rehabilitation facilities. Procurement system in place to ensure regular and sufficient supply of drugs and other materials. Arrange referrals on discharge so individuals can continue treatment (including Antiretroviral Therapy and treatment for Opportunistic Infections).* Support and extend the range of available health services in the settings, including the infrastructure needed for TB control. Capacity of prison and rehabilitation facility staff is developed through training and on-going continuing education.	Prison and rehabilitation facility populations living with HIV have longer, higher quality lives. Prison and rehabilitation facility populations who use drugs are less likely to be involved in transmission of HIV, and less likely to acquire long term illness as a result of drug use while they are in institutions. TB is reduced in prison and rehabilitation facilities. Decision makers and care givers in prison and rehabilitation facilities are supportive of the objectives of NSP II and are themselves involved in the national response to the HIV epidemic.
Capacity strengthening of Social Welfare Department, psychosocial services and support systems.	More families have access to social welfare services including psychosocial services and support.

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in programme design, development, implementation and evaluation.

Outputs	Outcomes
* Increased participation of vulnerable groups in tailored interventions for prison or rehabilitation facility groups, as well as increased participation of relevant stakeholders (Ministries and bodies as well as NGOs)	Programmes improved as they become more tailored to the expressed needs of beneficiaries. Behaviour change increases as education becomes more effective. Stigma and Discrimination reduced within institutions.
Programmes and services in prison or rehabilitation facilities ensure confidentiality of prisoners having access to HIV related services.*	More prisoners seek access to relevant services, improve their health and reduce further transmission of HIV within prison facilities and within their own communities upon release. Community acceptance, understanding and empathy for children and adults living in for prison or rehabilitation facilities is increased (Stigma and Discrimination reduced)
Participation of people living with HIV in programmes for prison or rehabilitation facility populations.*	Programmes improved and focused on improving responses to HIV and AIDS.

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

Outputs	Outcomes
National guidelines in place to ensure HIV interventions take place in for prison and rehabilitation facilities.	Prevention programmes and services able to expand and to operate more effectively. Better links between prevention, care and support. Less stigma, discrimination and violence within prison and rehabilitation facilities and within communities. Programmes and services more effective as trust is developed between implementers and institutionalized groups Vulnerability to HIV is reduced as prison and rehabilitation facility population increase their capacity to care for themselves and each other. Township environment outside prison and rehabilitation facilities is supportive of programmes and services (decision makers and communities are supportive).
Advocacy has occurred at township and local levels to encourage prison and rehabilitation facilities to participate in the national response to the HIV epidemic.	
Development of follow-up systems and structures at community level to assist with re-integration of prison and rehabilitation facilities residents when they are released. Ensure confidentiality, psychosocial support and socioeconomic reintegration. Link prison and rehabilitation facilities and community services. Offer HIV prevention, including Voluntary and Confidential Counselling and Testing, and "Map" services as part of compiling information about local networks.	
Advocacy outside institutions to develop township support for HIV related programmes within institutions – advocacy amongst decision makers and communities.	
Coordination and multisectoral cooperation amongst stakeholders and gatekeepers (e.g. local authority, police, religious groups, managers and owners of entertainment establishments) at local levels.	
* Advocacy and linkages with law enforcement agencies to gain their support for HIV prevention, treatment, care and support programmes.	
Recovery, re-integration and social services for those who are de-institutionalized. Creation of a community-based visitor programme to support reintegration and continuity of access to services for people when they leave prison and rehabilitation facilities.	Increased proportion of prison and rehabilitation facility population is able to reintegrate into other social environments.

Partners
Government: NAP, Ministry of Social Welfare, Relief and Resettlement
INGO: AHRN, CARE, FXB, MDM
Local NGO/CBO/professional association: MANA
UN: UNODC

Partners to be mobilised
Ministry of Home Affairs (Police Force, Prison Department), CCDAC

Suggested indicators and targets
Estimated number of prisoners: 62,300 (14% female)

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Output/Coverage Targets							
Number of prisoners reached with HIV prevention programmes	62,300	13,472	21,805	28,658	36,134	42,987	49,840

Intervention I 5. Reducing HIV-Related risk, Vulnerability and Impact among Mobile and Migrant Populations

Definitions and Target Groups:

1. Migrant (internal and external)
A person, or the family member of a person who has left his/her home place, seasonally or temporarily, to be engaged in a remunerated activity in another part of the country or in another country. Migrants who have left their home and resettled permanently in another part of the country or in another country are excluded from this definition.

2. Mobile person
A person who, regardless of the nature of his/her activity (professional, studies, business), makes frequent/ periodic trips from one place to another requiring at least one overnight stay away from home, or moves from place to place.

3. Migration-impacted communities
A community that is impacted (positively or negatively) by mobility and/or migration either because it is the home place which migrants/mobile leave and eventually come back to (source community), or because migrants/mobile pass though it when they travel (transit community), or because it is the final destination for migrants, the place where they settle temporarily (destination community).

4. Communities affected by population movement
Communities affected by natural disaster such as cyclone, or humanitarian crisis, armed conflicts, requiring temporary relocation as a result of damage/destruction to housing and community facilities. Such populations should be provided with prevention information and male/female condoms.

5. Sexual partners of sexual partners of mobile and migrant populations
In places possible, sexual partners of mobile and migrants populations shall be covered by prevention Programmes.

Activity Area 1: Ensure availability and equitable access to a combination of programmes and services that are highly effective because they are flexible, tailored and targeted by location, age, gender, literacy, language and transmission behaviour.

Outputs	Outcomes
* Increased prevention programmes at border points and transit zones for migration (BCC programmes, etc) carried out collaboratively across borders.	Reduction of risky behaviour (sexual and other practices), and thus reduced HIV transmission, amongst mobile/migrant populations. More mobile/migrant populations know their HIV status and gain access to health services including treatment.
International/cross-border construction, infrastructure and natural-resource projects integrate prevention programmes.	
Prevention programmes (including for sexual partners) are integrated into infrastructure (large construction) projects wherever feasible.	
* Increased migrant-friendly services which are multi-lingual, well-known/advertised, and portable ("health history books", referral systems).	
Large companies and industries employing mobile/migrant populations implement more prevention and care/treatment/support programmes. * Safe mobility package including pre-departure, post-arrival, and return and reintegration education modules developed and implemented in key source, transit, destination and return communities.	

Outputs	Outcomes
Continuum from prevention to care, support and treatment programmes established at major hot spots/ mobility hubs with effective referral systems and networks. * More community-based prevention and care/ treatment/support programmes are implemented in identified mobility-affected communities in a coordinated and participatory fashion using migrant-friendly methods (see above), linked to and supporting existing services wherever possible. Safe places (drop-in centres) for mobile/migrant populations at destination communities and border points. Interventions focusing on mobile/migrant young people as they are likely out of school and more vulnerable because of lower education in general, lack of access to school-based programmes, out of traditional community context with other sources of prevention information, living in mobile communities with other increased vulnerabilities. Focus on industries employing youth, such as fishing industry and informal/cottage industry. Integration of HIV awareness raising safe sex messaging and condom provision in humanitarian work in emergency settings.	

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in programme design, development, implementation and evaluation.

<table>
<tr><th>Outputs</th><th>Outcomes</th></tr>
<tr><td>Increased interaction between existing and new/neighbouring/potential source communities to share information/knowledge/experience.*</td><td rowspan="4">Programmes improve as they become more tailored to the expressed needs of mobile/migrant populations.

Behaviour change increases as education becomes more effective.

Reduced stigma against mobile/migrant populations living with HIV.

Communities vulnerable to HIV because of their association with mobile/migrant populations become more resilient and able to make the most of mobility-related opportunities for development.</td></tr>
<tr><td>Community development processes to build HIV resilient communities by bringing together mobile/migrant and other people, including employers.</td></tr>
<tr><td>* Advocacy campaigns developed with the involvement of mobile/migrant people, including young people.</td></tr>
<tr><td>Research on attitudes towards mobile/migrant population in general, including young people) to improve/inform advocacy and programming.</td></tr>
<tr><td>* Participation of people living with HIV, including mobile/migrant people, in design and implementation of programmes and policies affecting mobile people.

Provision of safe places gives mobile/migrant populations a sense of empowerment.</td><td>Programmes improved and focused on improving responses to HIV and AIDS.</td></tr>
</table>

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

Outputs	Outcomes
Mobility thematic groups are established at national, state and township levels. They receive capacity-building assistance and lead planning, coordination and implementation of HIV programmes for mobile/migrant populations and mobility-affected communities. Conduct studies on typology of mobile/migrant populations and their associated risks and vulnerabilities to HIV as well as access to health and HIV related services along the migration routes (at source, transit, destination and return communities).	Prevention and care programmes in mobility and HIV become more effective as strategic information and expertise are developed specifically for these complex issues.
* Increased cross-border multicultural cooperation relative to HIV vulnerability and mobility. Expanded authority and mechanisms for actors on both sides of a border to meet and programme collaboratively.	Decision makers in economic development within Myanmar and across national borders recognise the importance of addressing the associations between HIV and mobility/migration, and encourage development of prevention programmes.
Advocacy to authorities and decision-makers to address increased vulnerabilities of mobile/migrant populations (at national and township levels).	
Stronger partnerships established between HIV and anti-trafficking policy makers and programmes (including law enforcement, general administration, projects), and HIV prevention modules included in anti-trafficking programmes.	HIV prevention is reinforced through integration with programmes addressing other factors which make some mobile/migrant people vulnerable to exploitation.
Improved analysis of migration patterns using common tools to facilitate regional sharing (common database, mapping at state level, collection instruments, early warning systems etc.) leads to improved programmes.	Programmes focus on most-at-risk mobile/migrant people, and policy makers keep up with changes in patterns of mobility so that this focus remains. Programmes in different locations are linked, so that mobile people can access continued prevention and care support as they move around.
Bilateral collaboration among neighbouring countries increased to facilitate referrals, transport, safe return, continuity of care for mobile/migrant persons.	

Partners
Government: NAP
INGO: AMI, AZG, CARE, FXB, Malteser, MSF-CH, PACT
Local NGO/CBO/professional association: MANA, MBCA, MRCS, PGK
UN: IOM, UNODC, UNHCR

Partners to be mobilised
Ministry of Home Affairs, Ministry of Foreign Affairs, Ministry of Social Welfare, Relief and Resettlement, Ministry of Rail Transportation, Ministry of Construction, Ministry of Transport, Ministry of Labour, Ministry of Border Affairs and Ministry of Immigration and Population.

Suggested indicators and targets

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Output/Coverage Targets							
Number of mobile and migrant population reached with HIV prevention programmes	NA	105,941	150,000	200,000	250,000	300,000	500,000

Intervention I 6. Reducing HIV-Related Risk, Vulnerability and Impact among Uniformed Services Personnel

Target Groups: Uniformed services personnel (USP) and their sexual partners, family members, USP including the military, police, prison facility staff, Bureau of Special Investigation, immigration, fire brigade, customs, other special forces in border areas and some civilians (e.g. working for the military in accounting and factories).

Activity Area 1: Ensure availability and equitable access to a combination of programmes and services that are highly effective because they are flexible, tailored and targeted by location, age, gender and transmission behaviour.

Outputs	Outcomes
Capacity building for Behaviour Change Initiatives within uniformed services.	Increased safe sexual behaviour including condom use among uniformed services personnel and family members.
* Behaviour Change Initiatives occur within all uniformed services at all levels, especially of new recruits.	
* Condoms and lubricant promotion and distribution within all uniformed services.	
STI treatment capacity building for uniformed services health personnel.	Increased utilization of STI, HIV, counselling and PMCT health services by unformed personnel and family members. Increased proportion of uniformed services and family members sought and received access to appropriate STI, HIV and voluntary counselling and testing services. Reduced STI and HIV incidence amongst uniformed services. More uniformed services and family members know that they are infected with HIV. Universal precautions in uniformed health services – sterile injecting equipment, safe blood supply, and access to post exposure prophylaxis for health workers. Safe work practices (e.g. police aware of potential for needle stick injuries when working with drug users).
* Behaviour Change Initiatives to promote health seeking behaviour and utilization of STI and VCCT health services (including mobile services) by uniformed personnel and their families.	
Clean injecting equipment and PEP supplies available, health staff trained in safe injection procedures and PEP procedures.	
Safe blood supply system ensured within all uniformed services health sections.	
Capacity building in voluntary and confidential counselling, HIV testing and referral networks for uniformed services health personnel.*	
Prevention of Mother-to-Child Transmission policies developed, supplies available, and health services staff trained.	
Referral systems established between uniformed and civilian health services, after initial advocacy and collaboration meetings at national level, starting with highest prevalence and incidence Townships.	

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in programme design, development, implementation and evaluation.

Outputs	Outcomes
Participation of uniformed services personnel and their families in programme design and implementation for their own groups.	Programmes improved as they become more tailored to the expressed needs of uniformed services personnel. Behaviour change increases as education becomes more effective – e.g. uniformed services personnel become more confident to negotiate and practise safer sex. Programmes within uniformed services and civilian sectors are harmonious and mutually supportive.
Involvement of uniformed services in collective responses against HIV as well as in partnerships in prevention, care and treatment.	
* Participation of people living with HIV in programmes for uniformed services. Gender and sex-work issues addressed in prevention programmes for uniformed services	Programmes improved and focused on improving responses to HIV and AIDS. Stigma and discrimination reduced for people living with HIV among uniformed services personnel.

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

Outputs	Outcomes
* Advocacy communication with senior officials and policy/decision makers.	Prevention programmes and services able to expand and to operate more effectively. Better links between prevention, care and support.
Exposure and exchange opportunities for officials and policy/decision makers at National, State and Division and Township levels.	
Review of policies related to HIV-positive uniformed service members, once Antiretroviral Therapies are introduced and generalized.	
Research and special studies to better understand contexts in which unformed services and their family members are vulnerable to HIV transmission, extent of risk behaviours and attitudes within uniformed services. Coverage of proven prevention interventions for police should be scaled-up quickly.	Prevention able to reach more unformed services personnel who are vulnerable to HIV transmission, in ways that are more supportive of behaviour change. Care and support more effectively able to respond to the specific needs of uniformed personnel and their families.

Partners

Government: NAP, Ministry of Defence, Ministry of Home Affairs (Police Force, Prison Department), Immigration
INGO: AMI, AZG, CARE, FXB, Malteser
Local NGO/CBO/professional association: MANA
UN: UNODC

Suggested indicators and targets

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Output/Coverage Targets							
Number of uniformed services personnel reached with HIV prevention programmes	NA	15,601	30,000	35,000	40,000	45,000	50,000

Intervention I 7. Reducing HIV-Related Risk, and Vulnerability among Young People

Target Groups: Young people (10 to 24 years old): early adolescents (10-14 years), late adolescents (15-19 years) and late youths (20-24 years). A distinction by age subgroups is necessary due to the different needs of these subgroups. Street children include those aged below 10.

1. Young people engaging in high risk behaviours (sex work, male to male sex, injecting drug use). Young people make up a large percentage of these marginalized groups and are reached through specialised activities within interventions 1.1, 1.2 and 1.3

2. Young people more vulnerable to engaging in high risk behaviours (out-of-school, street children and migrants/mobile). Mobile young people including students who live in dormitories (including some university and colleague students) are said to engage in risk behaviours. Migrants and mobile young people are reached through specialised activities within interventions 1.5 and 1.8.

3. Young people at low risk and low levels of vulnerability to HIV infection (large majority who live in low HIV prevalence areas, live in relatively stable families, work and/or attend school). These young people are reached by mass media and by prevention information and skills already integrated into national programmes such as the compulsory life skills education in primary and secondary schools, the adolescent reproductive health programmes, youth union activities, scouts, youth clubs preventing young people to engage in high risk behaviour, reducing stigma and discrimination. These interventions could be largely covered by other source of funding for education and youth programmes.

4. Young people not reached by other interventions and included in intervention 1.7 are out-of-school young people and children living on the street.

Activity Area 1: Ensure availability and equitable access to a combination of programmes and services that are highly effective because they are flexible, tailored and targeted by location, age, gender and transmission behaviour.

Outputs	Outcomes
Young people friendly centres are more available and accessible to all young people and, in particular, for those out-of-school In collaboration with public health and social services more non government organizations, International non government organizations and the private sector, are officially involved in provision of services for out-of-school young people. Community capacity for developing their own young people-friendly services is enhanced, More social workers and staff from faith-based organizations, community based organizations and non governmental organizations are trained, and employed for working with young people * Young People Centres for all young people and, in particular, for those out-of-school are established and provide one or more of the following services: life skills education, behaviour change communication, counselling, condoms distribution, group activities, use of internet, entertainment, livelihood training, non-formal education, referral to VCT and health services, * Young People Centres services integrated with out- reach activities by peer educators and outreach staff Local monitoring systems are developed and local partners are trained in the use of monitoring systems for Young People Centres. Research is conducted to determine whether out-of school young people needs are met. Quantitative research conducted to determine the extent and characteristics of anecdotal reports of unsafe sex and substance use behaviour among students, including university students, living in dormitories far from their families	The capacity of persons working with young people is developed. The quantity, diversity and quality of services provided in young people centres are increased. The quality of services provided. Young people, in particular those of out school, make greater use of services provided by young people friendly centres. More out-of-school young people abstain from or practise safer sexual and drug use behaviours

Outputs	Outcomes
Services are more available to street children In collaboration with public health and social services more NGO, INGO, CBO, and the private sector are involved in provision of services Professionals working with street children employed and retained. These professionals include street educators, supervisors of street educators, project managers of street children programmes and social workers. Information, behaviour change communication and counselling on sexual and reproductive health, substance use, on health seeking and other issues available. Skills learned: Life skills (e.g. self-esteem, communication); Practical skills (e.g. correct condom use, how to play sports); vocational and livelihood skills (e.g. literacy, learning a craft to earn a living). * Selected commodities available; e.g. condoms, oral and injectable contraceptives, through adolescent and youth friendly reproductive health services * Centres for street children support, advice, education and counselling established: Community based young people centres, drop-in centres and shelters for overnight and longer stay. * Centres with out- reach activities by peer educators and out-reach staff available. Referral networks created to link street children with families of origin or new families, young people support groups, local schools for re-entry to school, health services for screening/treatment for substance use, sexual reproductive health and others.	The capacity of persons working with street children is developed. The quantity, diversity and quality of services provided to street children are increased. Street children make greater use of provided services. More street children abstain from or practice safer sexual and drug use behaviours

Outputs	Outcomes
High quality mass-media campaign and behavioural change communication for HIV prevention among young people. Local monitoring systems developed and local partners trained in the use of monitoring systems for assessing interventions with street children. Research conducted to determine whether needs of street children are effectively met.	
Review and Standardisation of BCC strategies related to HIV and AIDS for street children and young people out-of-school: Updates for parents and families on HIV issues and vulnerability to HIV infections. * BCC materials (e.g. posters, brochures, pictures stories, role plays/ street theatre plots, puppet shows, video cassettes) produced (age and gender appropriate). BCC supported by outreach activities led by peer educators, project staff Mass and/or targeted media used to reach out-of-school young people and street children with BCC. Skill-based non formal education programmes endorsed * Social marketing techniques applied to promote increased condom use among sexually active young people and street children Forums for out-of school young people and street children to exchange knowledge and experiences on effective ways to change and support safe behaviours Local monitoring systems developed and local partners trained in the use of monitoring systems for assessing behaviour change communication interventions Research is conducted to determine the coverage and effectiveness of BCC among young people.	More street children and young people out of school have reduced risk behaviour More young people and are supported in healthy decision-making.

Activity Area 2: Promote meaningful involvement and empowerment of out-of school young people and street children, so that they are able to participate in programme design, development, implementation, and evaluation. The term 'young people' used in this section refers to all young people but in particular, to out-of-school young people and street children

Outputs	Outcomes
Current level of young people participation in organizations and projects assessed, including organizational capacity and shifts in attitudes on the way that young people and adults view each other. Meaningful and integral ways of young people involvement determined. Involvement in all stages and levels of an organization and project ensured (design, implementation, and evaluation of policy, programmes, service provision, education and outreach). Clear goals, expectations, and responsibilities for youth and adults established. Young people role in decision-making ensured Power between young people and adults shared (young people-adult partnership). Selection, recruitment, and retention of young people done by including differences in age, sex, education, ethnicity and HIV-positive status. Mentoring and skills-building supported. * Peer support groups that include positive and negative children of people living with HIV established. Collaboration with other persons, including older peers with more experience established. Participatory learning and action (PLA) activities, using peer- and adult-led approaches facilitated. Conferences and forums run by and for young people established and inclusive of young people with high risk behaviours, vulnerable and less vulnerable peers Formal, rather than informal, evaluation of youth participation reported with quantitative and qualitative indicators. More research is conducted to determine whether real involvement of young people takes place.	Improved programme outcomes and relevance. More young people have increased individual capacity (self-awareness, self-reliance and confidence, decision making, problem solving, communication skills) to maintain safe behaviours. More young people are actively promoting healthy behaviour to one another. More young people make use of health and social services

Activity Area 3: Strengthen the enabling environment through advocacy at all levels and by increasing awareness of the general population. The term 'young people' used in this section refers to all young people but in particular, to out-of-school young people and street children

Outputs	Outcomes
Advocacy done with authorities at different levels to support the development of preventive care and support services for young people, including development of young people and street children centres (including advocacy to police and other local justice staff to ensure that their work supports national strategies). * Comprehensive street children policy developed Local organizations and community capacity enhanced to understand and protect rights and needs of street children for shelter, education, recreation, health and full development. Lawyers and new organizations interested in protecting street children rights are involved. Legal action taken against individuals who commit violence against street children. Better collaboration between anti-trafficking, especially of girls and street children, and HIV prevention, care and impact mitigation programmes continued * Advocacy for treatment for young people (availability of Antiretroviral Therapies, treatments for Opportunistic Infections and STI treatments to increase demand for prevention and care activities).	More policies are in place that promote and support young people's behaviour change and avoidance of HIV-related risk taking behaviour. The involvement of community leaders, media, faith leaders, corporations and businesses, educational institutions and others can address issues of livelihoods and employment, food security and nutrition, workplace policies to address discrimination, providing information and skills to parents and families of PLHIV, higher education opportunities, behaviour change communication, etc.
Focal persons and task forces from relevant line ministries are identified to advocate, educate, and provide direction as champions of HIV prevention and care within their ministries. Existing central policies are disseminated to State, Division and Township levels, and Township initiatives are encouraged with central support.	Multisectoral support for and participation in, HIV programmes for young people. More young people know where to get all of the services they need to support them to reduce their risk behaviours.

Outputs	Outcomes
National communication guidelines developed to continually update leaders at Township level about HIV and community development issues. Guidelines developed for how Township AIDS Committees can use the communications strategy to develop their own initiatives.	Communities more aware of HIV issues concerning young people.
More research conducted to determine what opportunities should be enhanced and what barriers should be removed for effective intervention with young people.	Use of relevant and effective services by young people is increased.

Partners
Government: NAP, Ministry of Social Welfare Relief and Resettlement, Ministry of Education (for formal and non-formal education), State/Regional Ministry Departments; Township Level,
INGO: Alliance, Consortium, AZG, CARE, FXB, MDM, MSI, PSI, Save the Children, WVI
Local NGO/CBO/professional association: MANA, MRCS
UN: UNFPA, UNICEF, WHO,

Partners to be mobilised
Government Ministry of Information, Ministry of Home Affairs (Police Department)
Local NGO/CBO/professional association: Community leaders

Suggested indicators and targets
Estimated number of young people (15-24) in Myanmar: 10,293,000 (Planning Department, 2009)

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Impact/Outcome Targets							
% young people aged 15-24 who are HIV infected (pregnant women 15-24)	NA	0.91%	0.85%	0.79%	0.72%	0.66%	0.60%
% young people who used condom at last sex	NA						
Output/Coverage Targets							
Number of Out-of-school youth reached with HIV prevention programmes	2,653,750	184,191	200,000	212,500	225,000	237,500	250,000

Intervention I 8. Enhancing Prevention, Care, Treatment and Support in the Workplace

Target Groups: Employees of formal and informal workplaces and their families

Priority to businesses with large workforce, businesses linked to mobile populations, and businesses related to sex work. Priority business sectors include mining, construction, seafarers, truck drivers, accommodation (including guest houses) and entertainment (including karaoke bars, discotheques).

Activity Area 1. Ensure availability and equitable access to a combination of prevention, treatment, care and support services that are highly effective because they are flexible, tailored and targeted by age, gender, location, and transmission behaviour.

<table>
<tr><th>Outputs</th><th>Outcomes</th></tr>
<tr><td>Prevention strategies appropriate for worksite employees are further developed and evaluated, and what works best is scaled up.</td><td rowspan="2">HIV and STI among formal worksite employees reduced.

More workers seeking and gaining access to prevention, treatment, care and support services.</td></tr>
<tr><td>* All workplaces, commencing with the largest work sites, to develop programmes to ensure that workers have:

• BCC including participatory learning, peer education and negotiation skills
• Prevention education provided to families
• Worksite outreach programmes
• Private places in workplaces so that people can talk about HIV and reproductive health
• Access to resources – harm reduction materials, condom provision, social marketing, support groups—in worksite settings
• Access to condoms and lubricant promotion services
• Referral to VCCT so that workers can safely find out HIV status
• Referral to services which offer couples counselling and education for partners of people living with HIV.</td></tr>
<tr><td>Business AIDS Networks further developed and then work to strengthen HIV prevention work in informal workplaces such as tea shops and guest houses.

Informal work place managers to be invited to join Business AIDS Networks or to form other groups and networks.</td><td>HIV and STI among informal worksite employees reduced.

More workers and customers at informal workplaces seek prevention, treatment, care and support services.</td></tr>
</table>

Outputs	Outcomes
* Non-Health Government Sectors further develop HIV prevention, care and support services, commencing with strengthening of existing services in ministries with their own health sectors (e.g. Railways, Social Welfare, other workers' hospitals). These will include: • Prevention, care and support are provided in workplaces (STI diagnosis and treatment, treatments for Opportunistic Infections, counselling, social support, leave, time off, zero tolerance to stigma and discrimination, insurance) • Blood safety programmes promoted in railway and worker hospitals • Ensure treatment, care (TB, STI, OI and ART, PEP, PMCT for staff and clients) and support for people living with HIV in worksite settings and their families. • Referral system for care and treatment are in place for workers, families and clients of non-Health ministries • Support and extend the range of available health services in government workplace settings.	More government workers, their families and clients have access to HIV programmes.

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in programme design, development, implementation and evaluation.

Outputs	Outcomes
Participation of employees and their families in workplace-related HIV prevention programmes. Involvement of supervisors/managers in HIV programmes. * Local support groups and networks established in large workplaces where there are many vulnerable people or many people living with HIV.	Programmes improve as they become more tailored to the expressed needs of different workplaces. Behaviour change increases as education becomes more effective. Understanding and empathy for vulnerable people in workplaces is increased (Stigma and Discrimination reduced).
More people living with HIV are involved in worksite prevention, treatment, care and support programmes. * Business sector expertise (i.e. marketing skills) utilized to help SHG and communities in income generation activities.	Understanding and empathy for people living with HIV is increased (Stigma and Discrimination reduced). Services for people living with HIV are improved.

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

Outputs	Outcomes
* National Task Force on workplace policy formed and its development supported with: • Capacity building programmes for workplace leaders • Strategic skills development • Technical skills development * This will lead to improved workplace HIV programmes as well as: • Strengthened linkages between the Division for Occupational Health in Department of Health and the National AIDS Programme • National policies on HIV and AIDS in the workplace are developed and implemented • Business networks on HIV are formed at all levels and work on advocacy, fund raising, events, and programme implementation • Public media is used for advocacy to promote HIV programmes in workplaces • Business networks are linked with government and non government organization programmes on HIV • Business leaders become more active in advocacy to support HIV programmes • Township environments are more supportive for HIV programmes and services as local businesses indicate support for these • Coordination and multisectoral cooperation is improved.	Prevention programmes and services able to expand and to operate more effectively. Better links between prevention, care and support. Less stigma, discrimination and violence in and around workplaces. Vulnerability to HIV is reduced as people living with HIV increase their capacity to care for themselves and each other.

Partners
Government: NAP and other relevant departments of Ministry of Health
INGO: AMI, AZG, CARE, FXB
Local NGO/professional association: MANA, MBCA, MNMA
Network/CBO/Self Help Group:
UN:

Partners to be mobilised
Ministry of Labour, Ministry of Industry, Ministry of Social Welfare, Relief & Resettlement, Ministry of Transport, Ministry of Rail Transportation, Ministry of Mine, Ministry of Construction, Ministry of Agriculture and Irrigation, Ministry of Energy, UMFCCI, Ministry of Livestock Breeding & Fisheries.

Suggested indicators and targets
Estimated number of working population: 25 million (number of people in formal workplace not known)

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Output/Coverage Targets							
Number of people in workplace reached with HIV prevention programmes	NA	49,192	100,000	125,000	150,000	175,000	200,000

STRATEGIC PRIORITY II: COMPREHENSIVE CONTINUUM OF CARE FOR PEOPLE LIVING WITH HIV

Intervention II 1.VCCT, TB, ART, Community Home-Based Care, Health Facility-Based Care and Referral

Target Groups: People living with HIV and their families

Comprehensive continuum of care and treatment will be provided to all those who are infected and affected according to the guiding principle that no one shall be denied care and treatment on the basis of their cause of infection, gender, age, living arrangements, means of earning a living, ability to pay or other social or economic factors.

Activity Area 1: Ensure availability and equitable access to a combination of programmes and services that are highly effective because they are flexible, tailored and targeted by location, age, gender, and transmission behaviour.

Outputs	Outcomes
Voluntary confidential counselling and testing and provider initiated counselling and testing services, as entry point of the continuum of care, are more widely available and attractive to different types of people. Benefits of VCCT services are promoted through: • Awareness of benefits • Stigma and discrimination reduction • Networking of people living with HIV • Attentive listening and facilitation of client's decision • Strict confidentiality • Counselling, testing and result given in one visit • Post test counselling of HV positive as well as HIV negative results to maintain primary HIV prevention and prevention among discordant couples Increased number and quality of voluntary confidential counselling and testing services offered at several sites (STI clinics, TB clinics, reproductive health services including ANC, stand-alone services) in public and private sectors.	More people know the benefits of VCCT and use it. More people, including children, know their HIV status

Outputs	Outcomes
Home-based care, prevention and treatment are more widely available and are linked to community based care for impact mitigation and health facility based care: • Family members, people living with HIV and home-based care teams capacity enhanced to deliver effective minimum and comprehensive packages of home based care services including ART adherence, DOTS, nutrition support and linked to community based impact mitigation and health facility-based care. • In collaboration with public health and social services more non government organizations, CBO, faith based organizations, self help groups and private sector officially involved in providing effective minimum and comprehensive packages of home based care linked to community based impact mitigation. • Home-based care services and links with community based impact mitigation services and health facility-based services increased.	More persons living with HIV and AIDS, their children and partners seek diagnosis, treatment, care, and impact mitigation services. More people living with HIV their children and partners have access and use packages of multiple services. More communities take responsibility for the care and impact mitigation of their HIV-positive members.

Outputs	Outcomes
* Health facility based care (preventive, diagnostic, and treatment) is more widely available. Health facility-based care includes health centres, public, private for-profit / non-profit clinics, general practices, and hospitals (township and State/Regional hospitals). • ART services (including CD4 count and other lab tests) increased in number and quality in townships, State/Regional hospitals and, under the regulatory role of MOH/NAP, among general practitioners, private for-profit/ non-profit clinics and hospitals. • Fee structure for ART introduced with fully, partly and no subsidised treatments according to the patients' ability to pay. • Prevention (including prophylactic co-trimoxazole) and treatment of OI infections widely available. • Services for TB/HIV co-infected people increased in number and quality. • Services for STI diagnosis, treatment and partner notification increased in number and quality. • Services for paediatric diagnosis of HIV infection and paediatric care (including ART and OI management) increased in number and quality	In more sites, more people living with HIV, including children, have access, receive and adhere to appropriate ART. In more sites, more people living with HIV, including children, have access and receive appropriate OI and STI diagnosis, prevention and treatment. In more sites, more people co-infected with HIV and TB have access and receive appropriate diagnosis, care and treatment for the two infections. In more sites, more people living with HIV, including children, have access and receive appropriate nutritional and palliative care. In more sites, more people living with HIV their children and partners receive active referral to appropriate VCCT, PMCT and Reproductive Health services. Improved provision of quality commodities without stock out.
Enhance the continuum of care for people living with HIV by strengthening the referral mechanisms among all levels of the health system including community, home based care services and health facilities (public and private sectors) and between Prevention and Impact Mitigation. Effective minimum and comprehensive packages of care are provided through multisectoral collaboration at each level. Packages adapted to increase attractiveness to key population subgroups (e.g., women, men, children, adolescents, sex workers, drug users and TB patients).	In more sites, more people living with HIV their children, partners and other family members receive active referral between Care/Treatment, Prevention and Impact Mitigation services. Increased equity and efficiency of delivery Increased use of services by specific population subgroups
Action research conducted to assess and improve quality of services. Studies of drug resistance undertaken.	Research results disseminated and used for policy formulation and planning implementation of effective interventions Quality of services improved Drug resistance is prevented and controlled

Activity Area 2: Promote meaningful involvement and empowerment of people living with HIV and their families, so that they are able to participate in programme design, development, implementation, and evaluation

Outputs	Outcomes
* Self help groups for people living with HIV in different areas strengthened and their social capital developed. Capacity-development for networks of people living with HIV provided.	More people living with HIV, including children, are involved in care and support groups. More people living with HIV are involved in service delivery from home to hospital levels. Communities and health providers value and use the skills and experience of people living with HIV.
People living with HIV included in all committees. Planning committees include people living with HIV. People living with HIV have responsible positions in key organizations. Increased capacity / knowledge of people living with HIV including adherence and options to treatment.	People living with HIV provide meaningful contribution in service planning and provision. People living with HIV are less “marginalised”. People living with HIV are more accepted.

Activity Area 3: Strengthen the enabling environment through advocacy at all levels and by increasing awareness of the general population

Outputs	Outcomes
More advocacy for people living with HIV done at all levels. Advocacy for treatment for young people (availability of ART, OI and STI treatments will increase demand for involvement in prevention and care activities.) Policies against mandatory HIV testing in pre-employment and any other circumstances. * Three Cs principle (informed consent, confidentiality and counselling) strictly followed and national guidelines for comprehensive testing and counselling (embracing VCCT and PITC) developed. Guidelines against stigma and discrimination followed.	Health care and social welfare providers at all levels and organizations have more compassion and understanding towards people living with HIV. More people living with HIV recruited into and retain productive employment. Reduced stigma and discrimination.
Interventions for access to services to all those in need including populations in remote areas put in place. Interventions by faith-based organizations planned, implemented and evaluated. Local resources are mobilized to support activities for infected and affected people. Local leaders support service provision for infected and affected families and children. Correct education to the general public is provided through the media.	More people living with HIV in remote areas are able to access services. More people living with HIV have access to services provided by faith-based organizations. More people living with HIV disclosed their status because they feel accepted and have access to services.

Partners
Government: NAP, Hospitals with ART services
State/Regional Ministry Departments; Township Level
INGO: AHRN, Alliance, AMI, AZG, Consortium, FXB, Malteser, MDM, MSF-CH, PPPH, PSI, the Union, MSI
Local NGO/CBO/professional association: MANA, MNMA, MPG, MRCS, MMA,PGK, Ratana Metta and other FBO
Network/CBO/Self Help Group: Myanmar Positive Group (See Annex III), 3N, Phoenix
UN: WHO, IOM, UNFPA,, UNICEF

Partners to be mobilised
Government
Local NGO/CBO/professional association: MMA, more FBO
Community leaders
Private sector: general practitioners, private for profit clinic and hospitals, pharmacists

Suggested indicators and targets

Estimated number of people living with HIV at an advanced stage of infection: 76,095 (estimates for 2010 based on CD4 count less than 200 – adults and children)[38]

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Impact/Outcome Targets							
% adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	NA	80%	81%	82%	83%	84%	85%
% adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy	NA	NA	81%	82%	83%	84%	85%
Output/Coverage Targets							
Number of adults with advanced HIV infection receiving ART	76,631	19,603	30,200	40,050	50,100	60,050	70,000
Number of children in need provided with ART		1,535	1,800	2,100	2,400	2,700	3,200
Number of people living with HIV receiving Cotrimoxazole prophylaxis who are not on ART	50,428		10,000	12,500	15,000	17,500	20,000
Number of TB patients who are tested positive for HIV and have started ART during the reporting period	7,596	NA	2,127	2,725	3,323	3,921	4,519

[38] Estimation Report 2009: In the case that the national guidelines will be amended to be in line with the global recommendation of starting ART at a CD4 count of less than 350, the people in need of treatment would raise to approximately 120,000 in 2010.

Intervention II 2.PMCT and Reproductive Health

Target Groups: Men and women 15 to 49 years of age

Activity Area 1: Ensure availability and equitable access to a continuum of effective and high quality treatment, care, and support services that are flexible, tailored and targeted by location, age, gender, and socioeconomic status

Outputs	Outcomes
* Integration of HIV prevention and care into reproductive health services gradually expanded to all townships, starting from those with higher HIV prevalence, to include: • VCT into reproductive health clinics, maternal and child health clinics, youth centres, workplace clinics and other centres where women and men of reproductive age have access • Adoption of male-friendly attitudes and procedures • Male involvement • Steady availability of commodities including HIV test kits, STI drugs, condoms, PMCT related supplies. • Production and distribution of Behaviour Change Communication materials on HIV prevention and, when relevant, ARV literacy.	More individuals use reproductive health services, including: • STI prevention • Condom use • VCCT • Pre-marital counselling. More men are seeking reproductive health services.

Outputs	Outcomes
Four PMCT components (primary prevention, prevention of unintended pregnancies, ART prophylaxis to mother and baby and referral for enrolment into ART) available in all reproductive heath services of township hospitals. In areas with high prevalence available in stations hospitals and big rural health centres as well if these facilities are distant from township hospitals. PMCT available in INGO clinics and private for profit facilities and general practitioners. * All PMCT providers adequately trained on friendly attitudes and communication, counselling skills to discuss client risk behaviour, condom use, benefits/risks of HIV testing, safe sex behaviours after receiving HIV positive and negative results, disclosure of positive result, ART prophylaxis, natural vaginal delivery and exclusive breast feeding. Capacity for supplies planning and management developed so that PMCT providers have constant supplies of HIV tests, prophylactic ARV, condoms and contraceptives according to national guidelines. * All PMCT providers instructed and committed to referral to clinical services, including ART, and impact mitigation services when appropriate. In relevant townships PMCT integrated in GAVI project on 'Health System Strengthening'	More women and their partners access and use family planning, ante-natal, delivery and post partum services as entry point for HIV testing. All HIV positive pregnant women and their babies take dual ART prophylaxis in pregnancy delivery and postpartum Most babies delivered by natural vaginal delivery while CS is limited to emergency situations. More women adopt exclusive breast feedings. All HIV positive, women their partners and babies are enrolled and followed up for ART

Outputs	Outcomes
In groups with high risk behaviours primary prevention in HIV negative women achieved through targeted interventions 1.1, 1.2, 1.3 and the Strategic Plans for Adolescent Health 2009-2013 (112 Townships). Primary prevention in female sexual partners at risk of HIV exposure achieved through Family Planning and MCH services with male involvement and couple counselling. Prevention of unintended pregnancies in HIV positive mothers achieved through family planning counselling (including couple counselling), provision of contraceptives of couple's choice and condoms for dual STI and pregnancy protection. Difficult cases referred to hospitals with one-stop service, involving people living with HIV counsellors and peer support as in North Okkalapa Hospital model. Clarification of roles and responsibilities of different categories of staff established including responsibility for actively tracing clients lost to follow up. * Facilitated referral system among services at the same level and between higher and lower levels established within the continuum of care. People living with HIV involved in referral and clients tracing. With WHO, UNICEF assistance new standardised ANC register and reporting mechanism developed by the MOH and inclusive of data used for the calculation of PMCT indicators. Operational research for assessment of reproductive decision making related to status, sero-discordance and treatment within couples.	

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so they are able to participate in programme design, development, implementation, and evaluation

Outputs	Outcomes
* Guidelines to involve more men in HIV prevention and reproductive health services adopted including: • Antenatal clinics which are couple friendly so that men as well as women attend antenatal clinics • Contact tracing in STI services • Gender specific BCC materials and distribution channels • HIV prevention in places often frequented by men (drinking places, teashops, workplaces)	More men of reproductive age are participating in HIV prevention and reproductive health services (family planning, antenatal, and STI services)

Activity Area 3: Strengthen the enabling environment through advocacy at all levels and by increasing awareness of the general population

Outputs	Outcomes
Reproductive health policy and guidelines, integrating HIV prevention and care, adapted and implemented, with special attention to safeguard reproductive health rights of women	More people of reproductive age are aware of HIV know at least two ways to prevent it and practise safe sex with all their sexual partners. Research results disseminated and used for policy formulation and planning implementation of effective interventions. Stigma and discriminations reduced.
* National BCC strategy and guidelines developed for increased access to integrated reproductive health and HIV prevention and care services offered to men with high risk behaviour to protect their sexual partners including wives and stable partners. Formative research conducted to identify ways to reduce the risk of HIV infection among women in stable relations with partners with multiple sexual partners.	
National policy and guidelines on stigma and discrimination developed, disseminated and evaluated.	
Partners collaborate to improve referrals and coordination.	

Partners
Government: NAP, Specialist Infectious Disease Hospitals
State/Regional Ministry Departments; Township Level
INGO: AHRN, Alliance, AMI, AZG, FXB, Malteser, MDM, MSF-CH, MSI, PPPH, PSI, Save the Children, Union
Local NGO/CBO/professional association: MANA, MNMA, MPG, MRCS, PGK, Ratana Metta and other FBO,
UN: UNICEF, IOM, UNFPA, WHO, UNAIDS

Partners to be mobilised
Local NGO/CBO/professional association: MMA, more FBO
Traditional birth attendants and community leaders
Private sector: general practitioners, private for profit clinic and hospitals, pharmacists

Suggested indicators and targets
Estimated number of women and men of reproductive age (15-49): 33.3 million
(2010, estimate from Spectrum 3.49)
Estimated number of HIV-infected mothers in Myanmar: 4,000 to 5,000
For VCCT suggested indicators and targets see intervention II.1

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Impact/Outcome Targets							
% Infants born to HIV infected mothers who are infected	4,600	22%	15%	13%	13%	12%	11%
% Pregnant women are HIV infected		0.96%	0.90%	0.85%	0.80%	0.75%	0.67%
Output/Coverage Targets							
Number of pregnant women attending ante-natal care services at PMCT sites who received HIV pre-test counselling	1,391,813	356,641	400,000	425,000	450,000	475,000	500,000
Number of pregnant women attending ante-natal care services who received HIV testing and test result with post test counselling	1,391,813	170,862	240,000	276,250	315,000	356,250	400,000
Number of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission	3,536	2,136	2,520	2,601	2,700	2,779	2,680

STRATEGIC PRIORITY III: MITIGATION OF THE IMPACT OF HIV ON PEOPLE LIVING WITH HIV AND THEIR FAMILIES

Intervention III 1. Psychosocial, Nutritional and Economic Support

Target Groups: People living with HIV, their families and communities

The impact of HIV has affected all aspects of social life. Discrimination based on serostatus calls for legal protection. Impact mitigation also acknowledges the interrelatedness of economic stability and the emotional and physical well-being of individuals. The key areas of social support include: counselling and psychosocial support; economic support, food security, social protection initiatives including continuation of education for infected and affected children (see OVC in Intervention III.2) addressing the legal environment. The critical emphasis of this intervention is also to integrate the continuum of HIV prevention, care and treatment services with impact mitigation.

Activity Area 1: Ensure availability and equitable access to a combination of programmes and services that are highly effective because they are flexible, tailored and targeted by location, age, gender, literacy, language and transmission behaviour.

Outputs	Outcomes
* Psychosocial support, including spiritual support, to people living with HIV and their family members, in particular women and girls, provided; - Package of psychosocial support activities, including counselling, developed and addresses isolation, depression, anxiety, other psychiatric impairment and serious interpersonal problems as a result of HIV and AIDS. - Existing psychosocial support activities and gaps documented. - Appropriate policy recommendations and guidelines provided. - Capacity for psychosocial support of services providers from government, INGO, local NGO, CBO and self help groups enhanced including communication skills. - Drop in centres for people living with HIV established with support from government, INGO, FBO, self help groups and private sector.	Quality of life and motivation to live are effectively optimised among people living with HIV and their family members.

Outputs	Outcomes
* Livelihoods and economic empowerment of affected communities and households enhanced - Business approach, good practice in design and implementation of income generation activities for various beneficiaries promoted. - Income generation programmes for affected families and communities including elderly caregivers funded, with special attention to women. - Traditional coping mechanisms to enhance sustainable livelihoods of affected households strengthened. - Provision of financial and essential material support to people living with HIV and households affected by HIV facilitated, with special attention to women. - Formal and informal education, vocational education, livelihoods and life skills development for people living with HIV and their family members promoted and supported.	People living with HIV, their household members and communities have access to, make use of livelihoods and economic support and improve their income.
* Food and nutrition security interventions among people living with HIV, their households and communities promoted and supported - National food and nutrition policies/guidelines for people living with HIV and their households developed and mechanisms for their implementation at national and local level established. - Mechanisms that promote sustainable food and nutrition security to people living with HIV and their households strengthened. - Gender equity and support interventions that reduce food insecurity and nutrition vulnerability of women and children affected by HIV enhanced. - Collaboration among government social welfare, UN agencies, I/NGO, CBO, FBO, self help groups involved in the promotion of food and nutrition security strengthened.	People living with HIV, their household members and communities have increased access to food and nutrition security.
* I/NGOs, CBO, FBO, self help groups of people living with HIV and volunteers capacity enhanced to deliver impact mitigation services Mechanisms for increasing referral and coordination within the continuum of care (impact mitigation, care, treatment and prevention) increased. Interventions to ensure access to services in hard-to-reach populations in remote areas in place.	People living with HIV have access to and make use of impact mitigation services and are linked to care, treatment and prevention services. More NGO, CBO, FBO, take responsibility for the care of their HIV-positive members More hard-to-reach people living with HIV in remote areas access services.

Outputs	Outcomes
Operational research on the quality and packages of impact mitigation services is conducted and result disseminated.	Quality and packages of impact mitigation services improved through application of research results.

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so they are able to participate in programme design, development, implementation, and evaluation

Outputs	Outcomes
* Self help groups for people living with HIV strengthened and more confident in different areas of service provision within the continuum of care. * Technical, organizational and managerial capacity building for networks of people living with HIV provided. Self help groups of people living with HV increased in number and quality. Self help groups of family members of people living with HIV created (either as separate groups, or as part of people living with HIV groups). Community members made aware of and empowered with means to support people living with HIV and their families. Capacity of the social service system to reach people living with HIV and their families increased	More people living with HIV are involved in support groups and provision of the continuum of care More people living with HIV are valued and receive an income for their roles in service delivery Programmes improve as they become more tailored to the expressed needs of people living with HIV and their families.
People living with HIV are included in all AIDS committees and working groups. People living with HIV and/or their family members always included in planning, implementation, monitoring and evaluation of continuum of care interventions. People living with HIV have positions of responsibility in key organizations working for the HIV and AIDS response	More vulnerable groups are involved in service planning and implementation and evaluation

Activity Area 3: Strengthen the enabling environment through advocacy at all levels and by increasing awareness of the general population

Outputs	Outcomes
* Sensitisation and awareness creation on human rights and protection mechanisms of people living with HIV, their households, and self help groups. Correct education through the media to the general public provided	People living with HIV are more accepted.
Ratification and implementation of HIV/AIDS workplace policies in place and against pre-employment and mandatory HIV testing.	More people living with HIV start and retain productive employment.
Appropriate policies, laws and legal support developed as detailed in cross cutting intervention IV.2.	See cross cutting intervention IV.2
Advocacy and interventions against stigma and discrimination, in place as detailed in cross cutting intervention IV.2.	See cross cutting intervention IV.2
Local resources to support activities for people living with HIV and their families mobilized.	More people with HIV disclose their status and with their families live a normal life in their communities.
Service provision for people living with HIV and their families supported by local leaders.	

Partners
Government: NAP, Ministry of Social Welfare, Relief and Resettlement,
State/Regional Ministry Departments; Township Level,
INGO: AHRN, Alliance, AMI, AZG, Consortium, FXB, Malteser, MBCA, MDM, MSF-CH, PPPH, PSI, Union
Local NGO/CBO/professional association: MRCS, MPG, MRCS, MMCWA, PGK, Ratana Metta, MWAF, PACT
UN: IOM, UNDP, UNFPA, UNICEF, UNOPS, WFP,

Partners to be mobilised
Local NGO/CBO/professional association: more FBO
Community leaders, religious leaders
Private sector: Business and corporate sector

Suggested Indicators and Targets
Estimated number of people living with HIV: 225,000

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Output/Coverage Targets							
Number of people receiving community home based care	50,428	31,361	48,430	51,335	52,332	50,927	48,500
Number of people living with HIV associated with self help groups	237,684	15,577					

Intervention III 2. Orphans and Vulnerable Children Infected and Affected by HIV

Target Groups: Orphans and vulnerable children (OVC) their families and communities

For this strategic plan, orphans are children who are infected with HIV or who have lost one or both parents due to AIDS. Orphans due to AIDS causes can be HIV positive or negative. Those HIV positive will have additional services as described in intervention II.1. All orphans will be assisted to avoid community resentment that is common when only orphans due to AIDS are assisted.

Vulnerable children are children infected or affected and whose parents are still alive (one or both parents infected). Other vulnerable children include children of sex workers and drug users because they have particular difficulties.

As the life-prolonging effects of ART spread, there will be a rise in the number of HIV positive OVC who were infected perinatally and who survive to adulthood. They will require ongoing treatment, care, support and prevention during the challenging adolescence phase.

Many boy and girl OVC are compelled to participate in paid work, exposed to early and forced sex or, for girls, to early marriage with older men who may be already living with HIV. As a result, OVC are likely to be at greater risk of exposure to HIV. They are also more likely to become street children. There are, however, not much data or research on OVC in Myanmar to understand their situation well.

Activity Area 1: Ensure availability and equitable access to a combination of programmes and services that are highly effective because they are flexible, tailored and targeted by location, age, gender, and transmission behaviour.

Outputs	Outcomes
* Psychosocial and spiritual support provided to OVC (particularly girls) and their family members, provided: - Package of psychosocial support activities, including counselling, specific for the needs and characteristics of OVC developed and addresses isolation, depression, anxiety, other psychiatric impairment and serious interpersonal problems as a result of HIV/AIDS. - Prevention education provided to children of people living with HIV who are at risk. - Package of psychosocial support activities, including counselling, specific for the caregivers of OVC developed. - Existing psychosocial support activities and gaps among OVC and their family members documented. - Appropriate policy recommendations and guidelines for OVC provided. - Capacity for psychosocial support of services providers from government, INGO, local NGO, CBO and self help groups enhanced specifically for OVC.	Quality of life and motivation to live are effectively optimised among OVC and their family members.

Outputs	Outcomes
* Livelihood and economic empowerment of affected communities and households enhanced. - Income generation programmes for affected families, including elderly caregivers, and communities with OVC funded. - Traditional coping mechanisms to enhance sustainable livelihoods of households with OVC strengthened. - Provision of financial and essential material support to OVC and households affected by HIV facilitated	OVC, their household members and communities have access to, make use of livelihoods and economic support and improve their income.
* Food and nutrition security interventions among OVC, their households and communities promoted and supported. - Gender equity and support interventions that reduce food insecurity and nutrition vulnerability of OVC enhanced. - Collaboration among government social welfare, UN agencies, INGO, local NGO, CBO, FBO, self help groups involved in the promotion of food and nutrition security strengthened.	OVC, their household members and communities have increased access to food and nutrition security.
Capacity of families, communities, NGO, CBO, FBO, self help groups of people living with HIV and volunteers enhanced to protect and care for orphans and vulnerable children. Community based responses that protect, care for and support OVC and their caregivers supported. These responses include day care centres, psychosocial support, including foster care, formalized kinship care and social houses. Community centres for OVC established with support from government, INGO, FBO, self help groups and private sector. Mechanisms for increasing referral and coordination of OVC interventions within the continuum of care (impact mitigation, care, treatment and prevention) increased and strengthened at community and at the township level. Specific action for sexual and reproductive health among OVC adolescents promoted because they are especially vulnerable.	OVC and their families have access to and make use of impact mitigation services and are linked to care, treatment and prevention services More NGO, CBO, FBO, take responsibility for the care of their OVC.

Outputs	Outcomes
Develop routine OVC data collection systems, including mapping of existing resources, and indicators for M&E that are integrated with existing national and sub-national information systems of the Department of Social Welfare and NAP with attention to data already collected for monitoring the Convention of the Rights of the Child and the Myanmar Child Law.	The situation of OVC in Myanmar is understood and more relevant interventions planned and implemented.
Conduct a situation analysis study to better understand the situation of OVC. Organize a seminar for disseminating the study findings and advocating OVC issue among stakeholders.	Quality and packages of impact mitigation services improved.

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so they are able to participate in programme design, development, implementation, and evaluation

Outputs	Outcomes
* Self help groups for OVC and informal gatherings HIV positive OVC strengthened. These groups may for example offer recreation as well as art therapy. Capacity-building for supportive supervision of OVC groups provided. Self help groups of OVC increased in number and quality. Community members made aware of and empowered with means to support OVC their families. Local NGO, CBO, FBO and government social service system capacity to reach OVC and their families increased. OVC communication and relationship skills increased so that they can attend forums for young people and have their voices heard.	More OVC are involved in self help groups. Programmes improve as they become more tailored to the expressed needs of OVC.

Activity Area 3: Strengthen the enabling environment through advocacy at all levels and by increasing awareness of the general population

Outputs	Outcomes
More awareness of civil society groups in OVC issues and protection in the broader context of the Convention of the Rights of the Child and Child Law, sexual and reproductive health rights of adolescents enhanced by advocacy. More awareness to include an information-sharing centre in Yangon then progressively expanded to most affected townships. Increased knowledge on OVC issues provided through the media to the general public provided.	OVC are more accepted and supported without discrimination. More OVC retained in school until completion of education.
OVC are better protected by policy and legislation by revising the child protection policy and National Plan of Action on Children to address specific issues of OVC.	Enforcement of relevant policies and legislations addressing the children affected by AIDS.
Risk of HIV infection among OVC including street children, institutionalized children, children in vulnerable family etc., are identified and specifically responded to.	HIV prevention programmes include and respond to the prevention among OVC and most-at-risk adolescents.

Partners
Government: NAP, Ministry of Social Welfare, Relief and Resettlement,
State/Regional Ministry Departments; Township Level,
INGO: AHRN, Alliance, AMI, AZG, FXB, Malteser, MBCA, MDM, MSF-CH, PPPH, PSI, Save the Children, Union
Local NGO/CBO/professional association: MRCS, MPG, MRCS, PGK, Ratana Metta, MWAF, PACT
UN: IOM, UNDP, UNFPA, UNICEF, UNOPS, WFP,

Partners to be mobilised
Government
Local NGO/CBO/professional association: more FBO
Community and religious leaders
Private sector: Business and corporate companies

Suggested indicators and targets
Estimated number of people living with HIV: 225,000

Standard Indicators	Denominator	Baseline 2009	Targets				
			2011	2012	2013	2014	2015
Output/Coverage Targets							
Number of orphans and vulnerable children affected by HIV receiving package of support		5,332	8,000	9,750	11,500	13,250	15,000

CROSS-CUTTING INTERVENTIONS IV:

Intervention IV 1. Health Systems Strengthening (including private health sector), Structural Interventions and Community Systems Strengthening

Health

Inadequate health systems are one of the main obstacles to scaling-up interventions to secure bette health outcomes for HIV and AIDS (and all other health problems). WHO[39] Health Systems Strengthening is based on six 'essential building blocks':

1. Effective leadership and governance (for strategic policy frameworks, effective oversight, coordination and coalition-building thorough regulations, incentives, and accountability)
2. Good health financing system
3. Well-performing human resources
4. Well-functioning procurement and supply system for access to quality essential pharmaceutical, products and technologies
5. Good health service delivery
6. Well-functioning information system (Cross-Cutting Intervention IV.3 M&E)

Activity Area 1. Effective Leadership, Governance and Good Health Financing. Strengthen policy-setting, coordinating, planning, financing and costing, monitoring and evaluation and reporting roles of the Ministry of Health, the National AIDS Programme and Local Government

Outputs	Outcomes
Roles Increased capacity of NAP and MoH staff to plan, coordinate and manage multi-sectoral response, including public-private partnership, and execution of the ministry regulatory role increased. * State/Regional and District and township AIDS Committees to adapt national HIV prevention and AIDS care policies to local context. Planning skills improved within all stakeholder organizations in all sectors and at all levels. * Data collection systems are joined and reporting is coordinated and jointly submitted to the Ministry of Health.	Myanmar's multisectoral public-private partnership functions productively and harmoniously The policy-level National AIDS Committee is better informed and prepared for high-level decision making "Scaling up" activities are informed, effective and equitable. Resources are rationally allocated and made available to State/Regional and District and township AIDS Committee for their function. Preparation of quality operational plans based on the NSP, especially at local level. Stronger information base at both peripheral and central levels
Financing * Different financing modalities for key HIV and AIDS services delivery within the health sector investigated. HIV disbursements assessed quarterly, by sector, and linked directly to prepared work plans. NAP budget projection presented annually to national coordinating bodies. Stronger advocacy skills developed and concerted joint efforts for fund-raising increased.	Ability in place to identify the most viable and effective financing modalities and to design and implement effective fund-raising strategies Adequate operating funds available and allocated according to the priorities indicated in NSP II.

[39] Everybody's business :health systems strengthening to improve health outcomes .WHO's framework for action .Geneva, World Health Organization – 2007 http//:www.who.int/healthsystems/strategy/everybodys_business.pdf

Outputs	Outcomes
NAP is capable of costing all programme activities using standard tools, and of revising the national budget requirements annually. NAP produces a convincing annual report of national expenditures using standard tools (National AIDS Spending Assessment, with standard categories agreed by ASEAN membership).	Allocation of funds adjusted annually according to cost-effectiveness of the programme and priorities determined in the NSP II.
Financial Officers are in place and operational for the NAP and for State and Division AIDS/STD teams. Performance and cost are analysed by the NAP annually. Unit costs by thematic areas of intervention are revised annually.	Programme accountability of resources allocated and used is in place. Duplicated efforts reduced or eliminated.

Activity Area 2. Well-Performing Human Resources. Develop a coherent plan for the overall strengthening of human resources for the HIV and AIDS response in the Ministry of Health, NGO and private sectors, including general practitioners, pharmacists, drug sellers and traditional practitioners.

Outputs	Outcomes
Ministry of Health Required competencies defined for all levels of staff responsible for AIDS programme delivery. Detailed human resources plan and post descriptions developed and updated for all staff positions involved in AIDS response in the Ministry of Health Line ministries supported by the Ministry of Health in defining the roles of their staff responsible with HIV and AIDS response. A standardized, competency based instrument, developed for evaluation of job candidates, periodic testing of in-place staff, and re-planning of training activities. Management skills of staff at all levels upgraded by in-country and international training activities.	Human resources are in place, well distributed and meet the needs of the national strategic plan. Programme management improved, especially at the peripheral levels.

Outputs	Outcomes
AIDS and STD teams Change of "AIDS/STD team" name into a non-stigmatising name (e.g. "Sexual Health Centre") promoted. * Detailed Centre staff (AIDS/STD teams) terms of reference revised to include competences, collaboration with private sector and NGO/CBO. Increased budget and staff attached to the Centres to reflect steadily increasing responsibilities: advocacy, training, sentinel surveillance, distribution of test kits, condoms, ART, STI treatment, supervision and monitoring. Transport and communications capacity of the teams increased through provision of adequate transport means and funds for the purchase of fuel.	More availability and utilisation of 'user-friendly' confidential STI and HIV preventive and care services at District and Township levels. Effective local programme management system in place for strategic planning and programme implementation. Improved systematic local collaboration with the private sector and with NGO/CBO/SHG.
Private Specialists and General Practitioners The expertise and experience of specialists and general practitioners mobilized in support of implementation of the national response and in educational, training activities. * Continuing training of general practitioners to apply standards and guidelines for testing, care, and treatment (PMCT, ART, TB, OI, STD) in place with collaboration of NAP. * Private medical practitioners and private laboratories full partners in the VCCT, PMCT, TB and ART reporting network coordinated by NAP and the National Health Laboratory. Effective formal, structured referral, including feedback, systems between private specialists, general practitioners and other providers of HIV and AIDS services in place.	Specialists and general practitioners expertise and practical experience fully part of the national response. International best practice and national standards and guidelines on VCT, PMCT, ART, TB, OI and STI treatments followed by all private and public sectors health providers. Data concerning activities carried out in the private sector available to NAP.
Pharmacists and drug sellers Roles of pharmacists and drug sellers in HIV prevention, and AIDS care and treatment identified and their service provision increased. * Capacity building of pharmacists and drug sellers conducted regularly at District and township and community levels. Approaches for engaging pharmacists and drug sellers effectively in a HIV and AIDS service provision identified.	Coverage and effectiveness of preventive activities and continuum of care increased Use of harmful and ineffective treatments decreased.

Outputs	Outcomes
Traditional practitioners Roles of traditional practitioners, traditional births attendants in HIV prevention, and AIDS care and treatment identified and their service provision increased. Collaboration with traditional medicine practitioners and exchange of knowledge between traditional and science-based medicine established and maintained.	Coverage and effectiveness of preventive activities and continuum of care increased. Use of harmful and ineffective treatments decreased.

Activity Area 3. Well-Functioning Procurement And Supply System. Improve efficiency, timeliness and transparency of the system for procurement, storage, transport and distribution of supplies and commodities

Outputs	Outcomes
Incoming commodities, medications, supplies and equipment from all sources recorded and reported by the central level periodically. * Procurement and supply officers stationed at township level ensure uninterrupted delivery of goods to peripheral facilities. Training, refresher training, and periodic performance evaluation of supply officers established. Emphasis is placed on determination of requirements, stock management, quality control for health commodities and reporting, and intermediate distribution strategies. HIV staff involved by CMSD. Requirements for commodities, drugs and equipment estimated at the peripheral level and an upward system for advance requests elaborated and used. Storage practices rationalized; clear guidelines developed and implemented; strict use of stock cards maintained.	Procurement and supply management systems in place meeting the goals of the national response to HIV. Comprehensive and integrated HIV procurement supply and management systems strengthened and stock-outs avoided.

Activity Area 4. Good Health Service Delivery. Develop a realistic and sustainable plan for effective, nationwide, government and private sectors, HIV laboratory capacity, confidential counselling and testing (VCCT), blood supply, universal precautions, standards and guidelines.

Outputs	Outcomes
Laboratories * Rational and feasible plan for the establishment and maintenance of effective public health laboratory formulated to support VCCT, ART, OI treatment and maintenance of a safe blood supply. Countrywide, coordinated CD4 testing programme, progressively incorporating private sector testing, in place. National Laboratory Guidelines available to all providers of laboratory services. * Internal and external quality assurance systems (National External Quality Assessment Scheme /NEQAS) in place for all laboratories in private for-profit, private non-profit and public sectors.	Enhanced trust in and demand for laboratory services increased. Patient care based on reliable laboratory evidence. Patient care conducted in accordance with international best practice.
Laboratory capacity for commodities improved through training and consultation. Laboratory managers and technical staff are provided with initial and follow-up training at regular intervals. Importance of confidentiality, pre-test and post-test counselling in HIV testing understood by all laboratory staff.	Supplies distributed in a timely equitable way and stock-out does not occur. Laboratories function in accordance with international best practice.
Counselling and Testing * Strengthen and expand voluntary confidential counselling and testing (VCCT) and provider-initiated counselling and testing (PICT) Oriented by a finalized national test and counselling guidelines. * Counsellors trained in and practice request of consent, confidentiality, post-test counselling for HIV negative and HIV positive results, active listening, partner disclosure, risk reduction planning and facilitating client decision making. Private practitioners and private laboratories are trained in counselling techniques and adhere to testing standards.	Role of VCCT and PICT as critical entry point for continuum of care enhanced. VCCT service delivery points are diversified and multiplied. Counsellor capacity strengthened through technical support networks. Number of people using VCCT increased.

Outputs	Outcomes
Counsellor technical support network established. NEQAS for all laboratories providing HIV testing in place. Systems in place for formal, structured referral, including feedback, of patients to VCCT from several services (CHBC, STI, Reproductive health PWID, TB and outpatients/inpatient).	
Blood Supply Blood transfusion services re-organized according to the national policy. Voluntary, non-remunerated, regular blood donors recruited and retained. Self-deferral of potential blood donors with risk history promoted. * All donated blood screened for HIV and other blood-borne diseases. Training of clinicians for the rational use of donated blood. Internal and NEQAS for all blood laboratories in place.	Safe blood and blood products available nationwide through a network of blood laboratories. Voluntary, non-remunerated and regular blood donors available nationwide.
Universal Precautions Training of health care staff in key principles of Universal Precautions, including injection safety, conducted periodically. Personal protective equipment for Universal Precautions procured for all hospitals. Sufficient PEP kits with detailed user instructions available wherever risk of infection is present. The disposal of hazardous waste is performed in accordance with international guidelines.	Risk of HIV transmission in health care settings decreased. All health-care workers aware and use post-exposure prophylaxis. Reporting of transmission incidents and use of PEP in health care settings standardised and implemented.

Outputs	Outcomes
Standards and Guidelines Relevant multi-agency working groups meet regularly, as sub-committees of the TSG, to establish and update a priority list of standards and guidelines for clinical management. Guidelines inclusive of ethical and social aspects of care and treatment of people living with HIV, including non-discrimination and equity. Inventory of available standards and guidelines prepared, gaps identified and filled in through regional and global consultation, final guidelines reviewed and endorsed by the TSG.	Myanmar prevention, care and treatment standards and guidelines for HIV and AIDS are available and consistent with international best practice.

Non-health

Activity Area 1. Strengthen policy-setting, coordinating, monitoring and evaluation and reporting roles of the key non-health ministries.

Outputs	Outcomes
Increase the capacity of the Ministries of Home Affairs (CCDAC, Police, Prison and General Administration Department), Education, Social Welfare and other non-health ministries to plan, coordinate and manage multi-sectoral action programmes (mostly refer to Intervention I).	Increased capacity of key ministries to develop and implement prevention, treatment and care services. Establishment of an enabling environment and public health approach:

Activity Area 2. Strengthen national capacity to plan, finance and cost services, in order to identify the most viable and effective financing modalities and to design and implement effective and productive fund-raising strategies

Outputs	Outcomes
Planning skills are improved within all stakeholder organizations in all sectors and at all levels.	Better operational plans based on the NSP, especially at local level
Exploring different financing modalities for key HIV and AIDS services delivery within the non-health sector. * Data collection systems are joined and reporting is coordinated and jointly submitted to the Ministry of Health. Stronger advocacy skills are developed and concerted joint efforts for fund-raising are increased.	Adequate operating funds are available and the budget is allocated according to the priorities indicated in the National Plan Adequate funding mechanisms for key HIV and AIDS services within the non-health sector are in place

Outputs	Outcomes
Ministries of Home Affairs, Education, Social Welfare and other non-health ministries are capable of costing all programme activities using standard tools, and of revising national budget requirements annually.	Allocation of funds is adjusted annually according to cost-effectiveness of the programme and priorities determined in the National Plan

Activity Area 3: Develop a coherent plan for the overall strengthening of human resources recruitment, training, support and evaluation in key ministries engaged in HIV and AIDS activities

Outputs	Outcomes
In Ministries of Home Affairs, Education and Social Welfare, required competencies are defined for all levels of staff responsible for supporting NSP II interventions.	Human resources are in place and meet the needs of the national strategic plan. Optimal distribution, deployment of human resources.
Management skills of staff at all levels upgraded by in-country and international training activities.	Programme management and coordination improved, especially at national and district and township levels.

Community

Activity Area 1: Increase the involvement of community-based organizations working with key populations at higher risk and people living with HIV in the national response to HIV through fostering greater participation in prevention, treatment and care services in their communities.

Outputs	Outcomes
Establish and strengthen appropriate systems and mechanisms for community-based organizations (including self help groups) participation in activity exchange and review of progress representing people living with HIV and key populations at higher risk, especially at national and district and township levels. * Local action plans are developed with the systematic participation of community-based organizations.	Increased involvement of civil society – especially community-based organizations representing key populations at higher risk and people living with HIV – in the national response to HIV. Increased number of coordination bodies/meetings, reviews and other events in which organizations of people living with HIV and key populations at higher risk are actively represented and participating.

Outputs	Outcomes
Share and disseminate good practices regarding local community participation in HIV and AIDS responses particularly in the area of awareness raising and prevention of HIV transmission. * Develop approaches for collaboration between public sector with non government and community based organizations working with key populations at higher risk and people living with and affected by HIV, particularly in the area of awareness raising, prevention and linkages with care and support services.	A national partnership forum is established. Local community capacity for improved local competence, local dialogue, action planning and monitoring are increased. Programme effectiveness improved through higher demand for preventive and care services, more consistent condom use, better supervision of Anti-retroviral administration. Greater community capacity to deal with other development challenges. Increased coverage of preventive and care services for those in need.

Activity Area 2: Promote meaningful involvement and empowerment of people living with HIV and key populations at higher risk so that they are able to participate in programme design, development, implementation and evaluation.

Outputs	Outcomes
People living with HIV and their families are involved in self help groups (either separate groups, or they are invited to join groups of people living with HIV). Participation of groups of people living with HIV in design and implementation of programmes.	Programmes improve as they become more tailored to the expressed needs of beneficiaries. Behaviour change increases as prevention activities become more effective. Treatment, care and support improved as services respond to expressed needs of the people living with HIV and their families. Understanding and empathy for people living with HIV is increased and partners and families are more able to understand and respond to their own needs.
Female sex workers	
Sex worker support groups established and functioning.	Programmes improved and focused on improving responses to HIV.
* Participation of sex workers, including people living with HIV and/or clients if possible, in programme design and implementation.	
Build understanding of communities about issues affecting sex workers.	Understanding and empathy for sex workers is increased.

Outputs	Outcomes
Men who have sex with men	
Men who have sex with men are better able to initiate their own prevention and care and support programmes.	Reduction of risk behaviour among men having sex with men.
* Participation of men who have sex with men, including those infected with HIV, in advocacy, programme design and implementation (i.e. participation in local support groups and networks).	Programmes improved as they become more tailored to the expressed needs of beneficiaries. Behaviour change increases as education becomes more effective – e.g. men become more confident to negotiate and practise safer sex with other men, and more willing to care for each other.
Drug users	
* Participation of drug users, ex-drug users and their families, including people living with HIV, in programme design and implementation for their own groups.	Programmes improved as they become more tailored to the expressed needs of beneficiaries. Behaviour change increases as education becomes more effective – e.g. drug users become more confident to negotiate and practise safer drug use and safer sex, and more willing to care for each other. Compassion, understanding and empathy for drug users are increased. This makes it easier for the community to support HIV prevention, care and support for drug users.
Local support groups and networks of drug users and ex drug users are established to support sustained behaviour change and empower participation with a focus on economic and income generating activities. Ex-drug users contribute to local coordination groups. Link local networks to assist one another and share best practices.	

Activity Area 3: Strengthen the technical and management capacity and governance and organizational structures of community-based organizations.

Outputs	Outcomes
Capacity building of the core processes of CBO s through physical infrastructure development – including obtaining and retaining office space, holding bank accounts, strengthening communications technology; or organizational systems development – including improvement in the financial management of CBO s (and identification and planning for recurrent costs); development of strategic planning, M &E, and information management capacities. Systematic partnership building at the local level to improve coordination, enhance impact, avoid duplication, build upon one another's skills and abilities and maximize service delivery coverage for the three diseases; and/or Sustainable financing: creating an environment for more predictable resources over a longer period of time with which to work.	Long-term sustainability of community-based organizations providing essential prevention, treatment and care services

Partners:
Government, International Organizations, national and local organizations, donors.

Intervention IV 2. Favourable Environment for Reducing Stigma and Discrimination

Activity Area 1: Strengthen the enabling environment for people living with HIV and their families through advocacy and education to ensure that interventions are as effective as possible.

Outputs	Outcomes
International instruments to which Myanmar is signatory[40] used to help set common standards, sensitise stakeholders on their role as actors, and respond to the obligation to promote human development and wellbeing.	More quality, development based and participatory interventions for people living with HIV and their families.
* National policies, including the National Strategic Plan, workplace policies, in local language promoting compassion, understanding and access to services and jobs for people living with HIV and their families.	Prevention programmes and services able to expand and to operate more effectively. Treatment, care and support services and community activities are more easily able to reach and support people living with HIV who might not yet know their HIV status and key populations at higher risk.
Existing policy guidelines disseminated and enforced (e.g. clinical management of HIV infection in adults and children).[41]	
Advocacy has occurred at National, State/Regional and township level, for institutions as well as communities to ensure recognition of rights and needs of people living with HIV and their families.	Better links between prevention, care and support. Better connections between people living with HIV and key populations at higher risk and the rest of their local communities. Greater compassion, understanding and support.
Township environment is supportive of programmes and services for people living with HIV.	
* Coordination and multisectoral cooperation amongst stakeholders and gatekeepers (e.g. local authorities, health services, social welfare services), increasing recognition of and commitment on the needs of people living with HIV and their families. Advice and legal support available to people living with HIV to ensure security of job, property, housing, succession, physical safety and participation to social event.	
Routine monitoring and evaluation, research and special studies conducted to better understand the situation of People living with HIV and their families and use research results for policy and programme development.	Better policies and programmes.

[40] e.g. Convention on the Rights of the Child, Elimination of all Forms of Discrimination against Women, General Assembly Session on HIV/AIDS Declaration of Commitment, 2001

[41] Guidelines for the Clinical Management of HIV Infection in Children In Myanmar, Second Edition National AIDS/STD Prevention and Control Programme Department of Health, October 2007, and July 2007

Activity Area 2: Strengthen the enabling environment for key populations at higher risk through advocacy and education to ensure that interventions are as effective as possible.

<table>
<tr><th>Outputs</th><th>Outcomes</th></tr>
<tr><td colspan="2">Female sex workers</td></tr>
<tr><td>Enabling environment – national policies in place to indicate need for programmes for sex workers which respect consent and confidentiality.</td><td rowspan="6">Prevention programmes and services able to expand and to operate more effectively.
Better links between prevention, care and support.
Less stigma, discrimination and violence against sex workers.
Programmes and services more effective as trust is developed between implementers and sex workers.</td></tr>
<tr><td>Enforcement of policy in which condom possession is not used as liability of sex work.</td></tr>
<tr><td>Legal reform workshops</td></tr>
<tr><td>Enabling environment – township environment, including from law enforcement and other authorities, is supportive of programmes and services for sex workers.</td></tr>
<tr><td>Coordination and multisectoral cooperation amongst stakeholders (including non government organizations) and gatekeepers (e.g. local authority, police, managers and owners of entertainment establishments).</td></tr>
<tr><td>Research and special studies to better understand the context of sex industry including brokers and types of clients in order to improve prevention and care programmes.</td></tr>
<tr><td>Working environment for sex workers improved in establishments and entertainment facilities.</td><td>Vulnerability to HIV is reduced as sex workers increase their capacity to care for themselves and each other.</td></tr>
<tr><td>Recovery, re-integration and social services for women who want to leave sex work, including services tailored to the needs of under-age sex workers.</td><td>Increased proportion of sex workers able to reintegrate into other work and social environments.</td></tr>
<tr><td>Enabling environment – national policies in place to indicate need for programmes for sex workers.*</td><td>Prevention programmes and services able to expand and to operate more effectively.
Better links between prevention, care and support.
Less stigma, discrimination and violence against visible groups of sex workers.
Programmes and services more effective as trust is developed between implementers and sex workers.</td></tr>
</table>

Outputs	Outcomes
Men who have sex with men	
Enabling environment – national policies in place to indicate need for programmes for men who have sex with men.	Prevention programmes and services able to expand and to operate more effectively. Better links between prevention, care and support.
	Less stigma, discrimination and violence against visible groups of men who have sex with men. Programmes and services more effective as trust is developed between implementers and men who have sex with men.
Enabling environment – township environment is supportive of HIV prevention programmes and services for men who have sex with men.	
Coordination and multisectoral cooperation amongst stakeholders (e.g. local authority, police, managers and owners of entertainment establishments).	Prevention able to reach more men who have sex with men, in ways that are more helpful.
*Research and special studies to better understand the local context of men who have sex with men, their sub-groups and transgender persons and to improve prevention and care programmes.	Care and support more effectively able to respond to the specific needs of different sub-groups of men who have sex with men as well as transgender persons.
Drug users	
Key community leaders learn about public health benefits of harm reduction programmes (i.e. activities are advocacy and education of community leaders).	Prevention programmes and services able to expand and to operate more effectively. Standard and multisectoral approaches used nationally, based on evidence of what works. Better links between prevention, education, treatment and rehabilitation initiatives. Less stigma, discrimination and violence against drug users. Programmes and services more effective as trust is developed between implementers and drug users. Institutional policy and practices changed or reviewed (e.g. alternate sentencing, deferment policy). Enabling environment supportive of programmes and services for drug users
National policies in place to indicate need for multisectoral programmes for drug users, including prevention, education, treatment and rehabilitation, in line with the broad definition of Drug Demand Reduction.	

Outputs	Outcomes
Enforcement of Directive 2001 from Myanmar Police Force Headquarters regarding not making arrests for possession of hypodermic needles (Ref. to add p.31 Law and Policy Review by HAARP, July 2009). Revision of Narcotic Law of 1974 regarding one month hospitalization of drug users identified	Better supported needle syringe exchange and MMT programme
Effective coordination and multisectoral involvement at local level exists for use of evidenced-based interventions and accountability (i.e. activities are local level advocacy and support for coordination).	Better understanding of the extent of drug use and the health and social needs of drug users.
Strategic information gathered and available, including needs analysis and documentation of impact and good practices of programmes and policies. Compile best practices and lessons learned at district and state level to replicate and provide evidence-basis for policy change recommendations.	Policy makers and programme designers are aware of what works best in other countries and other locations within Myanmar.
Exposure of decision makers to international good practices (study tours, trainings, coaching).	Process for amending or re-interpreting laws started.
Current relevant laws and policies that undermine HIV treatment and prevention programmes identified.	More coverage, effectiveness and use of interventions for groups with high risk behaviours.
Laws criminalizing, sex work homosexuality and narcotic drugs amended to remove obstacles to public health approaches that are effective in reducing new cases of HIV infection among those affected by these laws. While waiting for legal reforms, specific governmental directives are issued that make public health interventions for groups at high risk easier. Talks between representatives of health implementing agencies and local law enforcement authorities are held to promote understanding of public health benefits of HIV interventions for groups at high risk and to encourage use of the local authorities' discretionary powers to allow for the implementation of these interventions.	

Outputs	Outcomes
Mobile and migrant populations	
Policies on internal and cross-border migration and HIV/AIDS vulnerability in place.	Vulnerability of mobile populations reduces.

Activity Area 3: Support community mobilization, empowerment, and social transformation to change social norms and provide structural protection towards people living with HIV and key populations at higher risk.

Outputs	Outcomes
Intensive mass and targeted media campaigns promoting tolerance, compassion and understanding for people living with HIV and key populations at higher risk and their families.	Social and community mobilization and empowerment of marginalized groups to encourage tolerance, compassion and understanding (and resist stigma and discrimination) —and structural interventions, especially laws and policies that protect the rights of people living with HIV, key populations at higher risk and others affected. [42] Social norms of tolerance, compassion and understanding towards people living with HIV and their families and key populations at higher risk and their families.
Support for strengthening of community-base organizations made up of people living with HIV and key populations at higher risk (see Intervention IV.1) enhanced to ensure their participation in advocacy, decision- making and in the implementation of HIV-related legislation and policies.	
Support for the GIPA Principle – the greater involvement of people living with HIV. [43]	
Social and economic realities that make certain groups of society most vulnerable addressed.	
Training in tolerance, compassion and understanding of people living with HIV and key populations at higher risk for all district and township leaders, community and religious leaders, health service providers/health professionals, police, prison and rehabilitation facility staff, teachers and others in positions to support the national response to HIV.	

[42] Page 15, HIV/AIDS related Stigma and Discrimination: a Conceptual Framework and an Agenda for Action, Richard Parker and Peter Aggleton, Population Council 2002.

[43] Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA) principle, which promotes the active involvement of people living with HIV and AIDS in government ministries and civil society organizations to both empower and to encourage positive perceptions of/support for people living with HIV and AIDS organizations and networks, which have enabled people living with HIV/AIDS to demand recognition of their existence, needs, and rights.

Partners:
Government, international organizations, national and local organizations, donors, community, religious and private sector leaders, mass media

Indicators
HIV included in the national Five-Year National Development Plan and Poverty Reduction Strategy Paper
Evidence that people living with HIV, OVC and disadvantaged caretakers and their households having access to legal services

Number and contents of policies and programmes informed by research findings

Intervention IV 3. Strategic Information, Monitoring and Evaluation, and Research

Objective: To establish a national monitoring and evaluation system, in line with the Three Ones principles, that provides strategic information to guide the national response to HIV and AIDS in Myanmar.

Activity Area 1: Monitoring system

Level	Outputs	Outcomes
National	* M&E unit operational with trained staff and sufficient resources. M&E plan in line with the NSP operationalised: - Routine monitoring system functional - Research agenda developed - Information is collected, analysed and disseminated to stakeholders, including beneficiaries, on a regular basis. - Programme Costing and Expenditures are assessed annually. Reports provided to international frameworks (UNGASS, Millennium Goals, ASEAN) are submitted in time. Mid-term review (2013) End-of-term evaluation (2015)	Policy makers use Strategic Information on a timely basis to develop and/or modify policies. Strategic Information is used for resource mobilization and allocation. Efficiency of programmes is assessed Partners use data to improve/adjust their programmes. Myanmar is able to report to international agreed frameworks (UNGASS, Millennium Goals, ASEAN, etc). National Programme Strategy is revised as needed to respond to evolving needs, resources and capacity
Division / State	* Regional M&E focal unit operational with trained staff and sufficient resources. Regional office collects and aggregates the information from township level and forward to central level. Regional office analyses data and provides feedbacks to the township level.	Partners use data to improve/adjust their programmes.
Townships	* M&E focal person identified and trained. All partners report regularly on routine indicators using standardized tools. Results of programme are reported to stakeholders, including beneficiaries.	Services Providers use data to improve/adjust their projects. Community is aware of programme results and activities

Activity Area 2: Strengthening the national HIV/AIDS surveillance and research system

Level	Outputs	Outcomes
National	Quality control mechanisms are fully integrated into the surveillance system. Selected integrated behavioural and biological sentinel surveys (IBBS) carried out Existing STI surveillance improved by integrating STI testing other than syphilis. ART drug resistance surveillance system is implemented. Behavioural Surveillance Survey. * Mapping, size estimation and description of high risk groups are regularly conducted. Evaluation studies on specific HIV interventions conducted to assess impact, effectiveness. * HIV and AIDS projection and demographic impact analysis is conducted periodically. * Development of national research agenda, special studies as specified in the research agenda carried out and disseminated	Integrated Second Generation Surveillance provides a reliable epidemiological profile. Surveillance information is used to inform programmes in order to address gaps and emerging issues. Information on programme effectiveness is used to improve programming approaches
Division / State	* Mapping, size estimation and description of high risk groups are regularly conducted. Surveillance activities are coordinated at div. level. Decentralized laboratories capacity strengthened.	Better data transfer and improved quality of surveillance information.
Townships	Available information is analysed in view of local context	Interventions are appropriate in local context

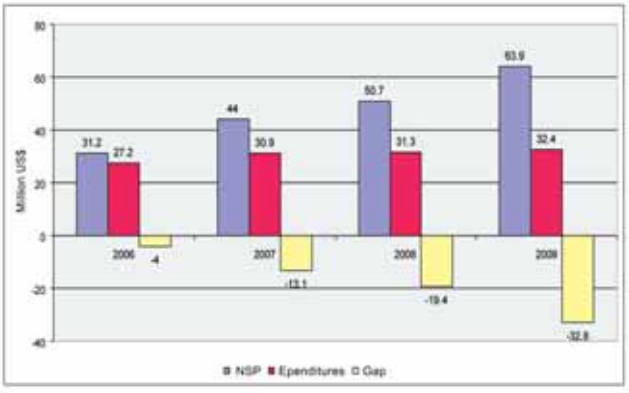
Activity Area 3: Coordinating and cooperating with partners

Level	Outputs	Outcomes
National	* Strategic Information and M&E Working Group established and functional to oversee development of M&E system, advise on research agenda and national estimation processes. Results of research and surveys synthesized and disseminated. Capacity of jointly conducting operational research strengthened for M&E staff and partners.	Commonly agreed information on the epidemic widely available

Annex I
SUMMARY OF PROGRESS DURING NSP I

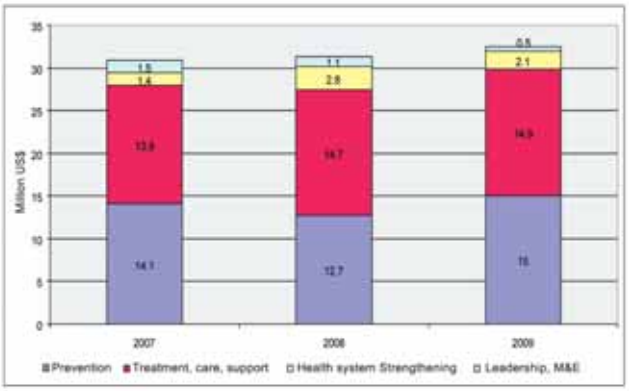
NSP I was accompanied by a costed Operational Plan (2006-2009) that spelled out clear priorities for the implementation of key interventions. The main directions were aimed at increasing the coverage of targeted prevention services for the key populations at higher risks and a substantial scale-up of treatment for people living with HIV. Targets set were modest, as they were calculated taking into account national implementing capacity and constraints to resource mobilisation. As shown in figure A-1 below, resources available for the HIV response remained roughly stable from 2007 to 2009. As a result, the resource gap grew year by year. By 2009, the gap between actual and planned resources grew to US$ 32.8 million. However, by 2009 it became clear that a number of the targets set in the Operational Plan would not be met by the end of 2010. This implies that the targets for 2011 will need to be adjusted to levels that correspond to the actual expected achievements by the end of 2010. At the same time a thorough review of the unit costs will provide the basis for an up to date costed operational plan.

Figure A-1. Gap between planned and available resources 2006 to 2009



Investment in the national response to HIV followed the proportional allocation reflected in the Operational Plan. Prevention, and treatment, care and support each received on average almost 45% of available resources each year. As shown in figure A-2 below, health system strengthening, capacity building and M&E received only modest amounts, corresponding to about 10% of total resources.

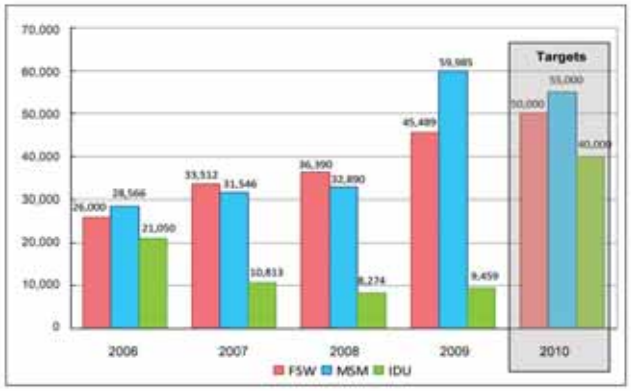
Figure A-2. Allocation of resources



Programmes for FSW and MSM considerably increased their coverage, both in geographical terms and in reaching more people in existing locations. Figure A-3 below shows the progress from 2006-2009. For 2010, the targets in the Operational Plan are used. Coverage for FSW is on track to reach the targets, while in 2009 programmes for MSM had already exceeded 2010 targets.

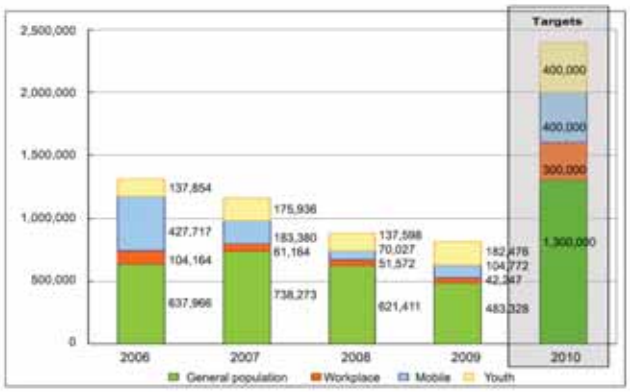
Scale-up of services for people who inject drugs and drug users was lagging behind. Changes in the definition of the indicator for "People who inject drugs reached" as a result of reporting issues, hinder comparison over time. While the reported number of people who inject drugs reached with harm reduction services has been largely stable since 2007, the change of indicator definition implies that there has been an actual increase in coverage. There was a considerable increase in the number of sterile syringes distributed, increasing from 1.9 million in 2006 to 5.3 million in 2009. The 2010 target was 6 million.

Figure A-3. Reach to FSW, MSM and PWID



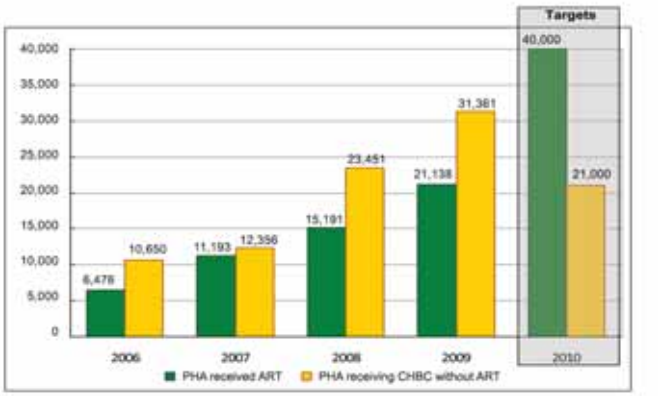
The Operational Plan (2006-2009) also set ambitious goals for prevention activities for mobile populations, youth, the workplace and men and women of reproductive age. Fluctuations in the reported number of people reached are assumed to be due to organizations classifying people under different categories in different years. However, as shown in figure A-4 below, cumulative figures for these four population groups declined consistently from 2007 to 2009, and it is unlikely that 2010 targets will be achieved.

Figure A-4. Prevention activities aimed at mobile populations, youth, the workplace and adults of reproductive age



There have been annual increases in the provision of care, treatment and support services. Scale-up of antiretroviral treatment (ART) was slower than anticipated because of the following reasons; (1) the major non-governmental provider of ART stopped recruitment of new patients for a period of time; (2) limited funding available for ART constrained the number of new patients; and (3) many organizations starting ART found that the initial phase of patient enrolment was slower than planned. As a result, 2010 targets will not be met and ART provision is currently 28% of people in need. Provision of community home-based care grew rapidly after 2007, already reaching the 2010 target in 2008.

Figure A-5. People living with HIV receiving ART and people living with HIV receiving community home-based care



Annex II
GUIDING PRINCIPLES

1 The "Three Ones"

This Strategic Plan is consistent with global commitments to align the AIDS response at country level with the "Three Ones"[28], encompassing the following elements:

- One HIV/AIDS Action Framework that will be a framework for the national response, not just the Government response, encompassing all actors and all activities within and outside the health sector
- The existence of One National Coordinating Authority which will build on the Government's central leadership role, and also recognize the importance of participation of non government sectors, including people living with HIV, in coordination efforts
- Further development of One Monitoring and Evaluation System that will ensure accountability both to local communities, particularly to people living with HIV, and to funding partners, as well as the systematic analysis and use of the evidence needed to adapt the strategy to evolving realities, capacities and needs.

2 Universal Access[29] and Millennium Development Goal 6 on HIV/AIDS

Reaching the Millennium Development Goal 6 on HIV/AIDS – to halt and reverse the spread of the epidemic by 2015 – requires far greater access to HIV prevention services and AIDS treatment, care and support than is currently available.

Myanmar is committed to achieving MDGs and following the global commitment of the Declaration of Commitment on HIV/AIDS of 2001 and the Political Declaration on HIV/AIDS in 2006, which calls for, inter alia, halting and beginning to reverse, by 2015, the spread of HIV/AIDS, and scaling up significantly national efforts to achieve the goal of universal access to comprehensive prevention programmes, treatment, care and support by 2010.

Participation and country focus are defining features of this effort. Other critical elements of the process are:

- It occurs within and builds upon existing processes at all levels.
- Countries own and drive the process supported by international and bilateral institutions and donors, in line with the "Three Ones" principles.
- It covers the scale-up of a comprehensive and integrated AIDS response, including prevention, treatment, care and support.
- It focuses on finding practical solutions to the main obstacles to scaling up, building on decisions already made.
- The participation of a wide range of stakeholders—especially civil society, affected population and people living with HIV—is critical to its elaboration and success.
- It encourages countries to set their own roadmaps – including midpoint targets and milestones – in order to advance toward universal access and to achieve the Millennium Development Goal on HIV/AIDS.

The successful implementation of NSP II will not only reach HIV-related MDG-6 targets in Myanmar, but also directly contribute to the achievement of other health and social development MDG targets, for example: the targets related to MDG 2 (primary education), 4 (child mortality), 5 (maternal health), targets related to malaria and TB, due to strengthened health system, and indirectly contribute to the achievement of MDG 1 (poverty reduction).

3 Rights and public health

The protection of human rights, both of those vulnerable to infection and those already infected, is not only right, but also produces positive public health results against HIV. In particular, it has also become increasingly clear that:

- National and local responses will not produce intended results without the full engagement and participation of those affected by HIV,

[28] Final Report of the Global Task Team on improving AIDS coordination among multilateral institutions and international donors (UNAIDS, 14 June 2005).

[29] Measuring progress towards universal access "Access" is a broad concept that measures three dimensions of key health sector interventions: availability, coverage and outcome and impact.

particularly people living with HIV.
- The human rights of women, young people and children must be protected if they are to avoid infection and withstand the impact of HIV.
- The human rights of marginalized groups (sex workers, people who use drugs, men who have sex with men, prisoners) must also be respected and fulfilled for the response to HIV to be effective.
- Supportive frameworks of policy and law are essential to an effective HIV response.

In pursuit of universal access and Millennium Development Goals for HIV, governments have committed themselves to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV and members of vulnerable groups. This includes promoting access to HIV education and information; full protection of confidentiality and informed consent; intensifying efforts to ensure a wide range of prevention programmes, including information, education and communication, aimed at reducing risk-taking behaviours and encouraging responsible sexual behaviour, delaying sexual debut, encouraging fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; a safe blood supply; early and effective treatment of STI; developing strategies to combat stigma and social exclusion connected with the epidemic.

4 Evidence-informed and results oriented programming.

NSP II utilises the two fundamental principles of 'evidence-informed programming' and 'result-oriented' programming.

Evidence-informed programming means making decisions on the basis of the best available scientific evidence, using data and information systematically, and disseminating what is learned. NSP II wants to increase the understanding and endorse the importance of translating evidence-based HIV prevention programmes into practice.

First of all, evidence has shown that where the epidemic is mainly fuelled by groups with high risk sexual and injecting drug use behaviours, these groups must receive highest priority behaviour interventions for highest impact on HIV control. In Myanmar these groups include female sex workers and their clients, drug users, men who have sex with men, prison or rehabilitation facility populations, street children, some mobile/migrant populations and the regular sexual partners of all these groups. These partners might be married women or men who have no idea that their husbands or wives are engaging in high risk behaviours. Modelling work using the Asian Epidemic Model has shown that a large number of infections will occur among couples who are sero-discordant. Targeted prevention approaches reaching this population should have substantial benefits towards reducing the number of new infections. Evidence also shows that the involvement of people living with HIV in care and impact mitigation interventions is critical for preventing new infections.

Secondly, the evidence-informed approach plays an important role in increasing access to programmes proven to lower HIV infection rates and improve access to AIDS treatment. NSP II pushes for broader implementation of compelling evidence-informed harm reduction initiatives among people who inject drugs, such as needle exchange programmes and opioid substitution therapy that have a proven public health impact with dramatic reductions in new HIV and other blood borne virus infections, including Hepatitis C, a reduction in the proportion of users who inject drugs and the frequency of injection. Evidence also shows that opioid substitution therapy is associated with improved social functioning, integration into the workforce and education system, as well as substantial reduction in criminal activity. The programmes are cost-effective, have no convincing evidence of unintended negative consequences (such as stigma, discrimination or violations of privacy), and show increased recruitment into drug treatment. Vaccinations for the other hepatitis variants can be provided cheaply and cost effectively. Research/surveillance to provide information about the scope and magnitude of hepatitis C in Myanmar is needed, as well as feasibility and planning for diagnosis and treatment of hepatitis C and HIV co-infection. The global and regional approach to supporting treatment for hepatitis C has changed considerably in 2009-2010. More effective treatment regimens are now being offered globally and the diagnosis and treatment of hepatitis C-HIV co-infection are included in the regional strategy to halt and reverse the HIV epidemic among people who inject drugs in Asia and the Pacific 2010-2015, as agreed by WHO, Member States in Asia, UN agencies and major development agencies, international and national NGOs and civil society networks.[30]

[30] A strategy to halt and reverse the HIV epidemic among people who inject drugs in Asia and the Pacific: 2010-2015, WHO 2010 (and UNAIDS, UNODC, The Global Fund and ANPUD)

Similarly NSP II targets condom use behaviours that have been empirically demonstrated to be most amenable to change and reduce new HIV infections among FSW, their clients and MSM. Finally, there is clear evidence that new HIV infections continue to outpace the rate of new patients accessing antiretroviral therapy. NSP II has therefore put renewed emphasis on sound, evidence-based prevention interventions while providing increased access to effective ART that has transformed AIDS into a manageable chronic illness.

NSP II will strengthen evidence based programming through further development and more effective use of routine monitoring, sero-surveillance/behavioural surveillance and evaluation. Coordination mechanisms and new institutional arrangements will be used to increase and improve information flow, from data collection and consolidation, to analysis, use and feed-back to the providers of data. NSP II is calling for all implementing agencies to make evidence-informed decisions when planning 2011-2015 interventions.
Result oriented means that NSP II is focused on achieving results at outcome level (behaviour changes and use of services) and, at impact level (reduced new HIV infections).

Behaviour changes will include regular condom use in risk prone situations, use of sterile injection equipment in drug use, use of opioid substitution therapy, VCCT, PMTC and ART, replacement of discriminatory behaviours with supportive behaviour, and maintenance of confidentiality. The outcome level will be achieved through dissemination of knowledge, change of attitudes, development of skills, provision of services and availability of commodities.

Myanmar is committed towards Universal Access to prevention, care and support. Specific targets have been set within each strategic direction area by considering global Universal Access targets and then adjusting them according to national capacity of all implementing and funding partners, based on programme assessments preceding the plan. The targets may be modified over time as experience is gained and resources secured.

5 Cost effectiveness/cost efficiency/prioritisation – the specifics of the Myanmar context.

Cost-effectiveness analysis is an effective tool to determine how to achieve the maximum effects within in a given budget. Given the low level of in-country resources devoted to the HIV response, despite the new external sources coming from the Global Fund Round 9 grant, and assuming the same level of traditional external funding, there are insufficient funds in Myanmar to implement all of the desired interventions for HIV prevention, care and impact mitigation. NSP II, therefore, places great importance on how to allocate limited resources. The best method to do so is by cost-effectiveness analysis that compares the relative costs and effects of two or more interventions. Examples of cost analysed and compared interventions are STI management for sex workers, needle and syringe exchange programmes, safe blood supply, condom use in groups with high risk and low risk behaviour, VCCT and PMCT. The effect is often measured as number of life years gained.

The limited availability of country data and of cost-effective analysis studies in Myanmar is a constraint in setting priorities based on cost-effectiveness and indicates a major research gap to be filled in the near future. There are, however, many cost-effectiveness studies conducted in low and high income countries with concentrated epidemics. The results of these studies have informed the choice of strategic plan priorities. These studies clearly show that HIV prevention interventions are much more cost-effective than ART. Among the most cost effective prevention interventions are those targeting groups with high risk behaviours compared to those targeting the general population. Recent work using the Asian Epidemic Model strongly indicates that the major routes of HIV transmission remain among the population with high risk behaviour and their sexual partners. Analysis of potential intervention scenarios demonstrates that increasing targeted prevention efforts with populations with high risk behaviours will have the highest benefit in terms of infections averted and DALYs gained.

The studies also show the cost-effectiveness of working with members from community-based organizations compared to government or other organizational staff on a regular pay roll. Hence the priority of NSP II to facilitate and develop the capacity for greater involvement of self help groups in prevention, care and impact mitigation activities.

Improved accountability and financial management is a proven means to reduce costs and achieve more efficiency. NSP II, therefore, emphasises the continuous need for capacity building in these areas for all stakeholders and in particular for community-based organizations. Optimal financing mechanisms will be developed to allow resources to flow directly and rapidly to entities engaged in township level activities.

6 Scaling up

Scaling up does not only mean expansion, but in the context of NSP II comprises (a) expansion in the level of existing service to provide greater coverage both geographically and numerically; (b) expansion in the range of services based on needs of each target group; and (c) greater focus on quality of services and ensuring minimum standard of services. In order to reach expanded targets, a major focus of this strategic plan will be on scaling up of initiatives that have been demonstrated to be effective. There will also be ongoing analysis of barriers to reaching targets. Scaling up occurs in different ways, in the thinking, in the time frames, in maximising the reach and impact of service delivery, and strengthening and expanding the role of community-based support. It is important to think broadly and not be limited by current obstacles – to be inspired by people living with HIV, drug users, men who have sex with men and female sex workers – all showing considerable imagination, commitment, resilience and willingness to achieve, based on limited personal and community resources, and in the face of significant obstacles. In terms of time frames it is important to look at what has been achieved over the current five-year period and look ahead even more ambitiously at the coming five years. In terms of maximising the reach and impact of service delivery, there are two areas in particular where the country should immediately redouble efforts to achieve targets. Firstly in scaling up access to, and ensure reach of ART for the 53,000 to 89,000 estimated to be in need of treatment;[31] and secondly in exponentially scaling up access to comprehensive harm reduction services including opioid substitution therapy for the more than 74,000 people who inject drugs currently without access. Finally, in terms of community-based support there has been enormous expansion in the numbers and capacity of self help groups and CBOs of people living with HIV, drug users, men who have sex with men, female sex workers and local and faith-based communities. This provides the basis for phased scale-up of investment in their capacities, organizational development and governance structures in order to scale up and strengthen their role in prevention, care, treatment and support.

7 Partnership

The Myanmar context of scarce financial resources and implementing capacity, and the nature of the epidemic and the multifaceted responses required to curb its course and mitigate its impacts require partnership involving government sectors in addition to the health sector becoming more active in developing responses to the HIV epidemic. During NSP I, different ministries have been involved in the national response to the HIV epidemic. For example, the Ministry of Education has developed programmes for in-school and out-of-school youth, the Ministry of Home Affairs has enabled development of innovative harm reduction programmes to assist drug users to avoid HIV transmission, and the Ministry of Social Welfare has developed minimum standards for institutional care for orphans and vulnerable children.

However, there has not always been consistency in approaches, continued involvement, effective collaboration between ministries, or direct involvement of all ministries whose participation in the national response to HIV would be important.

NSP II describes key decisions and actions each sector may consider as its contribution to the national response to HIV and outlines specific roles for government ministries and departments which are immediately concerned with highly vulnerable populations (Annex III). It also outlines processes to advocate for the involvement of other ministries and to carefully build their capacities to participate in the national response. The engagement of other sectors of government will occur through staged processes, will be monitored and evaluated throughout the period of the plan, and will recognise that not all ministries may have the required capacity to participate at the desired level.

NSP I was characterised by partnership between government ministries and departments and international and national non government organizations. An achievement of NSP I was the considerable expansion, strengthening, and greater role of community-based organizations and self help groups consisting mostly of people living with HIV as well as sex workers, men who have sex with men, drug users and concerned communities. Private sector health providers are also increasingly contributing to the national response.

NSP II recognises the importance of partnership involving all of these actors: Government, international and national NGO, CBO and self help groups, professional associations, national and international entities, researchers, policy developers and the private sector will work together to engage the cooperation and collaboration of communities and the participation of the people most affected by the epidemic.

[31] Based on the current estimation of 74,000 people in need of ART of whom approximately 21,000 are on treatment; and estimating 110,000 who may be in need of treatment if CD4 eligibility is raised to 350 as recommended in revised WHO treatment guidelines.

Involvement of different actors will be developed through processes consistent with other components of NSP II – analysis of current responses, capacity building, improving enabling environments, and improving mechanisms for coordination and collaboration. This collaborative response to HIV which has underpinned the open process applied to the development of the present strategy will occur at national, state and divisional levels and particularly at township level where most services are delivered.

The most effective processes to facilitate this will be identified through monitoring, evaluation and the sharing of information and experience.

8 Coordination.

Coordination is required to effectively reach agreed objectives. It requires the following:

- Guidelines to support systematic consistent functioning.
- Timely, sufficient and regular communication.
- Good planning.
- Inclusion of all relevant players.
- Documentation to support feedback and follow up.

Coordination using these components is an effective and necessary mechanism supporting partnership, participation and scaling up. Coordination combines experience exchange, planning and review. The experience of the previous strategic plan was that coordination needs to be more systematic and inclusive at all levels, and its benefits understood on two levels, between the different levels, as well as laterally at each level.

Effective coordination at the national level, builds on inclusion of key ministries and departments responsible for achieving the three strategic priorities of NSP II through implementation of all interventions and cross cutting activities. Effective coordination at the national level, well communicated to state and division, district and township levels, will support and give needed legitimacy for effective coordination at lower levels.

Coordination is required not only for planning and implementation of activities, but also for technical assistance efforts by the United Nations and other international partners.

District and Townships AIDS Committees will play central roles in coordinating the design of local programmes, overseeing the development of the institutional and human resources needed for effective responses, and maintaining the highest possible level of programme and financial accountability. Township coordination is particularly important for NSP II as this is the level where most service delivery takes place, providing opportunities for the participation and collaboration of government, (international and local) non government and community based organizations and affected populations.

9 Participation

NSP II lists 'Participation' as an essential element of several guiding principles. Participation is required of stakeholders such as people living with HIV and their families, people with high risk behaviours, and of community members affected by HIV. Participation empowers stakeholders be better able to avoid HIV infection or to cope with HIV and its effects, and communities to be compassionate and caring towards those who live with or are affected by HIV. Participation will take place at three levels: individual, group (e.g. self help groups) and group networks.

Participation will start from using services, then expand to contributing money, material goods, time, labour and information, and further expand to having people involved in managing interventions. This highest level of participation will have the greater impact on the epidemic.

Participation is based on the recognition of people as people, rather than as objects of interventions; people as creative and capable actors. People will come together to do their own data collection appraisal and analysis, to enhance their own awareness, to plan and implement their own action and to evaluate their results. People will participate under the guidance of good facilitators using many participatory approaches and methods such as Mapping Stigma, Before and Now Diagrams, Health Journey, Gender Roles Chart, Story with a Gap, Picture Codes and Role Plays. These methods have proved to be powerful, especially in such sensitive areas of social life as sexual activity and drug dependency. The potential of using participatory methods for improving prevention, care and impact mitigation is far from being realised due to four major obstacles. First, these methods can only work if they are well facilitated, but the behaviour and attitudes of facilitators have rarely been given priority. Second, just a few methods are adopted, neglecting many others. Third, the transformations these methods can support in people are not easy to measure and to cost. Fourth, being time consuming and dependent upon skilled facilitation, they lack the simple appeal of top-down interventions. INGO, government and

donor agencies will cooperate in removing these obstacles and promote full participation of the affected people and groups. Facilitators will be trained on attitudes and skills in using participatory methods and processes. Many clear, comprehensive, varied and accessible participatory materials specifically designed and tailored to HIV are already available and will be adapted for use with different groups in the Myanmar context.

10 Favourable environment for reducing stigma and discrimination

NSP II recognises that the response to HIV must include a favourable legal and policy context to support changes in individual behaviour for HIV prevention, care and mitigation of impact. NSP II recommends policies that are both internationally recommended and proven effective at country level, and stresses the need for strengthening implementation of specific policies including the following:

- Combating all forms of stigma and discrimination by all sectors at all levels.
- Public sector commitment and leadership outside the health sector and at township level.
- Active participation of members of affected groups at central, State/Regional and township level.
- Attention to professional ethics, with emphasis on confidentiality and consent in HIV testing and counselling.
- Adoption of behaviour change communication and not just information dissemination.
- Universal access to diagnosis and treatment including free, subsidised and full cost recovery for ART.
- Expanded research, abiding by institutional regulations.

Policies may be subject to review during NSP II in order to address emerging issues.

The legal context, in some instances, creates conflicts between implementing public health policies and laws and pursuing a public health approach to prevention, treatment and care. These conflicts obstruct implementation of activities for HIV prevention, care and mitigation of impact. Examples of conflicts come from the 'Prostitution Act', 'Provision 377 of the penal code against homosexuality' and 'Narcotic drugs and psychotropic substances law'. These laws make it difficult to implement policies of active participation, behaviour change communication, quick and maximized enrolment into Methadone Maintenance Treatment (MMT) for people who inject drugs and combating all forms of discrimination among groups affected by these laws.

NSP II recognises that the pace of legal reform may be time consuming and complicated by institutional, social and cultural issues, and calls for their modification in order to remove obstacles to public health approaches being used. Secondly, while acknowledging the need for legal reform, NSP II encourages the use of governmental directives that make public health interventions easier, e.g. the directive specifying that possession of condom is not evidence of prostitution (although is not always applied). Thirdly NSP II encourages discussion between representatives of implementing agencies and local law enforcement authorities for a common understanding of the benefits that HIV prevention, care and mitigation activities bring to the affected groups and the public at large. Local authorities could then use their discretionary powers and allow for the implementation of these activities.
Compassion and support towards people living with and affected by HIV and AIDS, and towards those who are vulnerable to HIV, including sex workers, men who have sex with men and drug users are an essential component of an environment conducive to access to prevention, treatment and care. Focusing on compassion and understanding will also lead to a reduction in stigma and discrimination and are critical elements of strategic communication used in mass media as well as with affected local communities. People living with HIV and those vulnerable to HIV need more than medical support; they need emotional and spiritual support, they need to live in caring communities and a stigma and discrimination free workplace. These are among the lessons learnt during the previous strategic plan which need to be strengthened and expanded in the current strategic plan. As the NAP continues to consult systematically with self help groups and CBO especially at national and township levels, and as they take up an increasing role in prevention, treatment and care, their increased participation and visibility will lead to greater compassion and understanding. The cultural environment in which activities take place will also be improved as outputs of NSP II will foster better community attitudes towards people who are vulnerable and towards people living with HIV. The combination of policy and cultural environments will facilitate more effective locally based responses to the HIV epidemic.

11 Gender

NSP II recognises that vulnerabilities of women and men, girls and boys differ in terms of both sex and gender, and that interventions for men and women

need to differ accordingly. Sex refers to those differences between females and males that are biologically determined. Gender refers to the social differences that are learned, and though deeply rooted in every culture, are changeable over time and have wide variations both within and between cultures. "Gender" determines the roles, power and resources for females and males in any culture. Historically, attention to gender relations has been driven by addressing women's needs and circumstances as women are typically more disadvantaged than men. NSP II also recognizes the need to know more about what men and boys face and can do. There are two main reasons for male involvement; women cannot achieve gender equality by themselves, and gender norms also affect men's health (e.g. assumptions of masculinity may promote risk-taking behaviour among men). Without male involvement HIV programmes will not succeed and gender equality will not be achieved. Gender equality refers to the equal enjoyment by females and males (of all ages and sexual orientations) of rights, socially valued goods, opportunities, resources and rewards.

Gender equality is important in relation to HIV. Women and men experience different health risks, engage in different health seeking behaviour, and usually receive different responses from health services. As power is distributed unequally, women have less access to health information, care and services, and resources to protect their health.

Participation of men and women in prevention, care and impact mitigation will take place following the previously described process of appraisal and analysis (who does or uses what, how and why, in relation to men and women), enhancing awareness, planning and implementing activities that address health inequalities and evaluate their outcomes for the disease.

A gender sensitive approach is of particular importance for groups practising high risk behaviours and vulnerable groups, as they are even more affected by sexual violence and inequitable gender relations. NSP II provides support for a gender sensitive approach as follows:

- Collection of epidemiological data by sex and age and provision of disaggregated data indicators for outcomes.
- Promotion of research on gender analysis (e.g. to describe and analyze different inequalities in access to services and experience with health providers, in prevention and treatment options, needs, challenges, gaps, and opportunities to reach men and women as well as differential impact).
- Gender sensitive interventions (following the gender analysis, to design specific interventions to reach groups of men and women according to their specific needs).

NSP II recognises that attention to gender must be integrated in all programmes activities to ensure an effective response to HIV. Health staff, CCM members, AIDS Coordination Committee members, implementing agencies and self help groups all require knowledge and awareness of the ways in which gender relates to the epidemic.

12 The GIPA Principle – greater involvement of people living with HIV and AIDS

Overlapping with many of the other guiding principles and referred to throughout NSP II, the GIPA principle – the greater involvement of people living with HIV and AIDS – is the backbone of many interventions worldwide. People living with HIV understand each other's situation better than anyone and are often best placed to counsel one another and to represent their needs in decision- and policy-making forums. The idea that the personal experiences of people living with HIV could and should be translated into helping to shape a response to the AIDS epidemic was first voiced in 1983 at a national AIDS conference in the USA. It was formally adopted as a principle at the Paris AIDS Summit in 1994, where 42 countries declared the Greater Involvement of People Living with HIV and AIDS (GIPA) to be critical to ethical and effective national responses to the epidemic.

People living with, or affected by HIV are involved in a wide variety of activities at all levels of the response to AIDS; from appearing on posters, bearing personal testimony, and supporting and counselling others with HIV, to participating in major decision- and policy-making activities. The engagement of people living with HIV is all the more urgent as countries scale up their national AIDS responses to achieve the goal of universal access to prevention, treatment, care and support services.

Annex III
ROLES, RESPONSIBILITIES AND INSTITUTIONAL ARRANGEMENTS

This annex outlines general roles and responsibilities of key constituency groups. In each strategic direction area roles of different constituencies are outlined, to be further detailed by specific actors in the operational plan.

Government

The Government of the Union of Myanmar leads the national response, drawing on the Three Ones principles: One HIV/AIDS Action framework for the national response encompassing all actors and all activities within and outside health sector; One National Coordinating Authority under the government leadership acknowledging the involvement of non-government and community organizations; One monitoring and Evaluation System ensuring accountability to communities – especially the range of self help groups and CBO formed by people living with HIV, key populations at higher risk and concerned communities – and funding partners. Evolving realities, capacities and needs will be addressed through systematic analysis and evidence-based strategy.

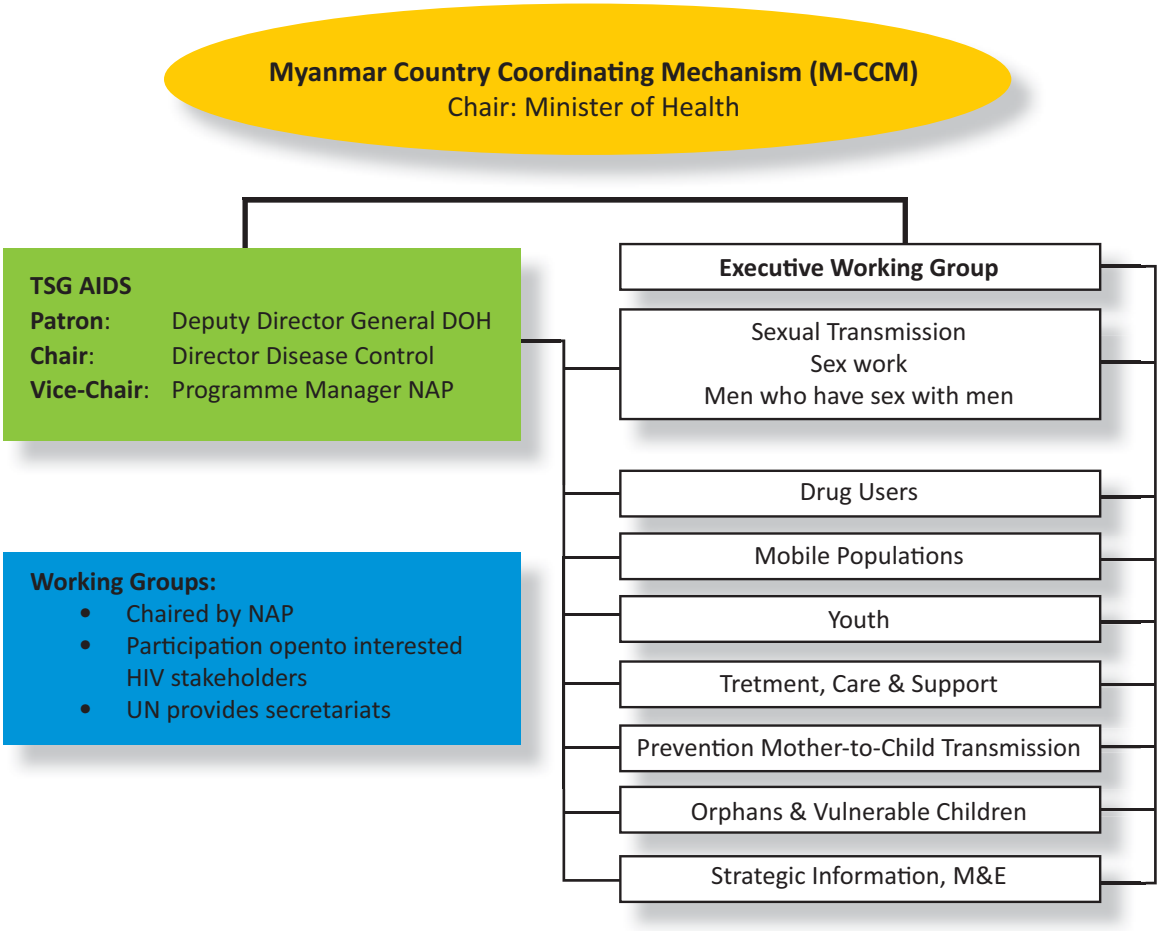
Myanmar Country Coordinating Mechanism

The Country Coordinating Mechanism for AIDS, Tuberculosis and Malaria is chaired by the Minister of Health, with the participation of other ministries, and includes UN organizations, non government and community organizations. This Body oversees implementation of the National Strategic Plan, provides policy guidance and identifies appropriate external support. The Secretariat consists of the Deputy Director-General of Disease Control, Director of Disease Control, the Programme Managers of the National Programmes for AIDS, Tuberculosis and Malaria, and one representative from the Attorney General's Office.

The formal health system serves as the backbone of the national response to HIV. NSP II calls for major efforts to mainstream HIV work with the focus on townships, using existing health and other services as means of delivering activities, goods and financial resources. If suitable alternate delivery mechanisms are identified, linkages and mutual accountability among implementing partners will be essential to the optimal use of resources and the avoidance of wastage and duplication.

The Technical Strategy Group (TSG) is chaired by the Director Disease Control and the Vice-Chair is the National AIDS Programme Manager. This group meets regularly to exercise planning, monitoring, troubleshooting and coordination through regular meetings. Technical expertise is drawn from the UNAIDS Secretariat and UNAIDS cosponsors including UNFPA, UNICEF, UNODC and WHO. Members including community organizations, professional associations, international and national NGOs and UNAIDS Secretariat participate and provide feedback and draw opinions and information from their constituencies. Membership of the TSG will be revised from time to time responding to evolving needs. Other members nominated or appointed by their ministries and other Departments of MOH will provide technical and policy expertise based on their organization's involvement in the national response to HIV. People living with HIV and representatives of high risk behaviour populations and concerned communities are important participants.

The TSG in turn reports to the Myanmar Country Coordinating Mechanism, chaired by the Minister of Health.



The principal tasks of the TSG are:

- Coordination of implementing partners and their activities
- Advising implementing partners on technical matters
- Develop the operational plan
- Oversee annual assessment of and amendments to the operational plan
- Ensure monitoring and evaluation of the national response
- Monitor and support working groups on key issues
- Oversee implementation of the National Strategic Plan
- Advise the Coordination Mechanism on HIV related policy issues

The TSG delegates technical issues to the nine working groups (including two sub groups for Sexual Transmission). The working groups, which are open to all stakeholders, ensure that consultation is inclusive and that local expertise is used. The working groups communicate findings and recommendations to the TSG for consideration in the decision making process.

The NSP I review identified several areas where Working Group organization and functioning could be strengthened to enable a more strategic focus and discussion, more systematic inclusion of the activities and issues from the networks and forums, and fuller participation by representatives of networks and forums. The key recommendations have been adopted in NSP II for action by the TSG and Working Groups, including:

- Establishment of a separate Working Group for men who have sex with men and male sex workers.
- All Working Groups to develop terms of reference including purpose of individual membership, realistic annual plans including such things as mapping to be done, papers to be produced and strategic issues for action, and a strategy for inclusion of and engagement with relevant networks and forums.

- Standard operating procedures to include timely preparation of an agenda prior to meetings and minutes or record of key action points following each meeting, with sufficient time for input and feedback by all members.
- Participants who are active, willing to work and with direct experience in implementation – including representatives from I/NGOs to be appointed on an annual basis to co-Chair Working Group with the NAP, with specific responsibility to take the lead on developing a strategic agenda, annual workplan, and strategy for engagement with relevant networks and forums.

M-CCM and the TSG-HIV are the forums to ensure donor support are aligned with the national strategy to avoid overlapping and major gaps.

Participation of other government sectors

NSP II calls for significantly scaled-up action on the part of ministries beyond the Ministry of Health. All ministries have a role to play to prevent the transmission of HIV, to contribute to care and support for people living with HIV, and to facilitate enabling environments for the implementation of the response at all levels. With the exception of the Ministries of Health, Home Affairs, Social Welfare, Relief and Resettlement, and Education, few ministries have HIV strategies and are actively involved in the national response.

NSP II includes priority attention to strengthening the functioning and role of ministries working with most-at-risk and vulnerable populations, including the Ministry of Home Affairs (CCDAC – the Central Committee for Drug Abuse Control, Myanmar Police Force, and the Prison Department) in their work with drug users, people in closed settings (prison and rehabilitation facilities) and their understanding and support for a public health approach to key populations at higher risk. The Ministry of Home Affairs also has a critical role to play in strengthening coordination at national and district and township levels. NSP II draws attention to strengthening the role of the Ministry of Social Welfare, Relief and Resettlement in their responsibility for contributing to the development of an overall impact mitigation strategy, including setting of standards for care of orphans and vulnerable children; improving gender-sensitive AIDS programming and services towards vulnerable women. The NSP II focus with the Ministry of Education will be to develop the implementing mechanisms to extend their prevention work to out-of-school young people who are most vulnerable and engaged in high risk behaviour.

Existing and envisaged contributions of different ministries to the national response to HIV are identified in Annex IV of NSP II. During the NSP II period, ministries other than Health will be supported to develop their own responses as opportunities arise, with direct assistance provided for capacity building, policy development and programme implementation. The two tables in Annex IV outline key functions and initial outcomes that should be achieved by each ministry. Table 1 in Annex IV addresses those ministries principally concerned with coordination, the enabling environment and facilitation of implementation, though some will also deliver services (especially the Ministry of Health). Table 2 in Annex IV considers line ministries which have responsibilities for delivering HIV prevention and care services in the following areas:

a) Contribute to an enabling environment: A review of sectoral policies will be carried out to ensure that each ministry contributes to the creation of a favourable environment for the reduction of HIV transmission and do not inadvertently increase people's vulnerability to HIV, or create obstacles to their access to care, treatment and support. All sectors will ensure that HIV testing is carried out in voluntary and confidential ways, and that HIV test results do not lead to exclusion from the workforce or from the benefits made available through their sector.
b) Address the needs of sectoral workforces: Each sector should review and modify human resources policies and practices to ensure that the sectoral workforce receives appropriate information about HIV relevant to themselves, their families and the communities they serve. Each sector should work with other partners to create enabling environments and opportunities to scale up prevention, treatment, care and support initiatives to minimise the social and economic impact of the epidemic affecting their workforce and communities.
c) Build sectoral capacity: Each sector will collaborate with the National AIDS Programme to acquire and further develop the knowledge and skills to engage in the creation of an enabling environment and the response to the needs of their workforce in relation to HIV. This will require specific plans of action and financial resources.

The above are starting points to promote the involvement of all sectors in NSP II and in the development of sectoral plans and budgets.

State/Regional, District and Township AIDS Committees

Existing State/regional, district and township AIDS Committees will be revitalized with a priority focus on enabling national leadership and coordination roles and the key service delivery and implementation at township level, including Continuum of Care. They will be supported and held accountable to undertake tasks related to situation assessments in their own areas, prioritization of communities needing assistance, involvement in analysis of surveillance data, coordination, monitoring and reporting. To support effective coordination at township and city levels, terms of reference and guidelines will be developed to inform coordination and the assignment of roles and responsibilities to different stakeholders. Coordination should be seen as an opportunity for inclusive convening of all partners at township level allowing for the participation of local organizations, networks and self help groups, as well as international organizations. Township coordination meetings should be regular and open opportunities for experience exchange, review and planning, and discussion of how to overcome challenges to effective implementation.

Multilateral organizations, donors and international development partners

The United Nations plays a variety of supporting roles providing technical support to government and non-government partners in policy development, research, normative and technical guidance, planning, coordination, monitoring, procurement and implementation. The UN also assists in advocacy for funding; support to programmes implemented by government and non-government partners; assurance of cooperation with international agreements and programmes on HIV and AIDS, and promotes sharing of the results of research and advocacy for the application and adaptation to the national context of international best practice. This includes cooperation in provision of opportunities, and mechanisms for the regional and global dissemination of information and lessons learned from the national response. Concerning the provision of technical support to government and non-government partners, UNAIDS and its cosponsors have agreed to a Division of Labour, which identifies comparative advantages of each UN entity to maximize the value of the technical support to be provided by the UN. This also helps mobilize the national counterparts of different agencies to join the national response to HIV. UN agencies collaborate through a Joint UN Team mechanism, coordinated by a UN Theme Group on AIDS, with overall guidance from the UN Country Team.

International development partners and donors will provide technical assistance, funding and advocacy support to the implementation of Myanmar's National Strategic Plan for HIV/AIDS. They also participate in the AIDS coordinating forums such as the M-CCM.

They will act in the recognition that the HIV epidemic impact is heavy on many levels – individual, family, community, national and economic – requiring international cooperation and humanitarian assistance.

Non-government organizations

Non government organizations covers a wide spectrum of organizations from local non government organizations, community-based organizations including self help groups and faith based organizations to national professional associations and international non government organizations. Their contribution covers an equally wide spectrum, ranging from the provision of technical expertise, design and delivery of care and prevention services, and capacity building of national partners.

A critical role is to ensure that the views of communities and individuals for whom services are intended are articulated and put at the centre of design, implementation and monitoring of activities. They will continue to play crucial roles in the response to HIV by providing community leadership and guidance, faith-based spiritual guidance and leadership within communities, and advocacy in the interests of affected communities. These organizations will work directly with people and groups with specific needs who are not easily reached by the public sector. They will provide implementation expertise at the community level, advocate for more volunteerism within communities, provide counselling, care and support for orphans and other vulnerable children and for people living with HIV. They will mobilise human, financial and material resources, motivate and support for establishment of self help groups, and strengthen community resilience to prevent increased transmission and to encourage compassion and understanding of people living with and affected by HIV as well as to the situation and needs of people vulnerable to HIV. They will integrate HIV prevention and control activities into sporting, religious and other local cultural events.

A broad range of professional associations and local non government organizations are already engaged in the national response to the HIV epidemic and are listed within each intervention. Over time, the contribution of these groups should be maximised through

inter-sectoral cooperation at all levels. Their responses will continue to be supported, evaluated and improved throughout the period of implementation of the National Strategic Plan.

International non government organizations will continue to provide technical and implementing expertise at all levels including research, planning, coordination, monitoring, procurement, and programme delivery. They will:

- Facilitate scaling up of interventions to conceptualise and then implement new and innovative approaches appropriate and suitable to Myanmar and specific local contexts and populations.
- Play a major role in evaluation of programmes and policies at all levels, research and advocacy for adapting international best practice to the national context.
- Identify potential new partnerships to address emerging priorities; provide support to strengthen enabling legal and ethical environments; and provide support for the mitigation of social and economic impact.
- Motivate and support people living with HIV and people more vulnerable to HIV – including sex workers, men who have sex with men and drug users – to establish self help groups and CBO, and work to build their capacity, organizational functioning and governance structures so they can more actively contribute to policy and programme development and implementation.
- Assist with mobilizing international funding.

Community-Based Organizations

An effective and scaled-up national response to HIV will only be successful with the full participation of CBO/self help groups including the following:

- People living with HIV
- Female sex workers
- Men who have sex with men
- Drug users
- Local communities – including faith based groups.

During NSP II there will be a priority focus on strengthening CBOs, in particular in: (1) Building the capacity and organizational functioning of CBOs to provide an increased range and quality of services through physical structure and organizational systems development, including improving financial and project management; (2) Building partnerships at the local level to improve coordination, enhance impact and avoid duplication of service delivery, and; (3) Sustainable financing focussing on supporting initiatives to plan for and achieve predictability of resources over a longer period of time for improved impact and outcomes.

People living with HIV

The key roles of people living with HIV will include:

- Facilitating networking and support for people living with HIV.
- Identifying strategies to increase the well being of all people infected or affected by HIV by promoting positive living, self reliance and reduction of infection through education, (positive prevention, treatment literacy, HIV prevention, VCT promotion, condom distribution), prevention and care programmes.
- Participating in strategy development, programme and activity design and review.
- Coordinating, information sharing and advocacy to identify gaps in services and support.

Private Health Services Providers

The private health sector plays an important role in HIV diagnosis, treatment and care. With deregulated production and sale of pharmaceutical drugs, pharmacies are the most frequently used health care facilities and self-treatment is common. Some pharmacies sell ARV and TB drugs even though this is not allowed. There is concern that this sale may accelerate TB and ARV drug resistance.

Myanmar also has an active private medical sector and the importance of private general practitioners (GPs) has grown to the point that they provide well above 50% of health care in urban areas and to a lesser extent in rural areas. For this reason NSP II seeks to increase the involvement of the private sector and to improve their practices in the management of people living with HIV, with and without TB.

The feasibility of involving private-sector providers (GPs and pharmacists) in STI, TB and ARV services has been demonstrated during NSP I implementation, through the initiatives of INGO. These initiatives now need to be expanded to maximize the impact of the private health sector in TB and HIV case management (detection, treatment, and prevention). Expansion will require strengthening the capacity of pharmacists and GPs to deliver quality TB- and HIV-related information, services, treatment and referrals (e.g. to VCCT or hospital for complicated cases) to their clients. This will involve improving the knowledge and interpersonal skills of pharmacists and GPs. Support-

ive supervision will be necessary to ensure that the new knowledge is put into good practice. Procedures for 'fully', 'partially' and 'non' subsidised ARV treatments will be developed according to the ability of the clients to pay.

NSP II calls for efforts to improve communication and coordination between private and government health service providers and to develop effective relationships between the private pharmacy sector and other providers of TB- and HIV-related services. The collaboration between for-profit and non-profit private (INGO) and public health sectors should be formalised at State/Regional and Township/District levels by inclusion of representatives of the private health sector in AIDS Committees or other appropriate HIV and AIDS management groups (e.g. STD teams).

GPs provide TB and ARV treatments but the Ministry of Health is not involved in the quality control of the drugs provided and of protocols GPs use for patient management. The Ministry of Health will exercise its regulatory role and pass a decree aimed at improving collaboration between the public and privates sector health services on TB-HIV diagnosis, treatment and patient management.

Private sector

The private sector will focus on advocacy and training to strengthen the participation of owners and managers, entrepreneurs and business associations in HIV prevention, treatment and care. Strategies will be clarified for workplace interventions and types of workplaces targeted. In NSP II, the private sector will be encouraged to develop HIV-related corporate policies and practices consistent with the guiding principles of NSP II in collaboration with private sector and other partners.

The private sector will work to eliminate discrimination against workers, promote gender equality, promote healthy working environments, ensure that HIV testing is voluntary and confidential and that HIV status remains confidential, encourage employers to continue to employ people living with HIV ensuring that employees with HIV and their families have access to affordable health services and the benefits of occupational health schemes. Development of further Business Coalitions on HIV will be strategically encouraged in townships, states and divisions prioritising geographic locations and populations where prevalence, incidence and impact are highest.

Annex IV

ENVISAGED CONTRIBUTION OF DIFFERENT MINISTRIES TO THE NATIONAL RESPONSE TO HIV IN MYANMAR

Table 1. Ministries Principally Dealing with Coordination, Facilitation and Establishment of an Enabling Environment for the National Response

Ministry	Function	Initial Outputs
Ministry of Health	Leadership on policy, strategy development, coordination and monitoring for HIV Technical management of health service systems for care and treatment and linkages to other disease management Technical delivery of national HIV prevention programmes Technical responsibility for HIV/STI research, surveillance and monitoring	National Strategic Plan and Operational Plan developed and implemented National AIDS Committee meeting regularly M-CCM meeting regularly and coordinates AIDS programmes TSG operational National AIDS Programme capacity strengthened
Ministry of Home Affairs	Policy on links between law enforcement and public health for targeted condom promotion and other HIV programmes Delivery of prevention and impact mitigation programmes for HIV across police and prison departments and in prisons Policy development, coordination and support of PWID harm reduction programme Facilitation of expanding number of national non government organization partners Support Township AIDS Committee decisions and programmes at township level through General Administration	Operational plan for contributing to HIV response
Ministry of Defence	Articulation of senior-most political support for the national response to HIV	Statement of support for implementation of National Strategic Plan in all regions Develop HIV prevention and care strategy for the military
Ministry of National Planning and Economic Development	International cooperation and coordination through the Foreign Economic Relations Department (FERD) Development planning to ensure resources allocated for HIV programmes	Development of policy to support implementation of National Strategic Plan

Ministry	Function	Initial Outputs
Ministry of Border Affairs	Ensure regions of the country where they work are sufficiently covered by HIV prevention and care and support programmes Coordination of HIV actions in their areas	Assessment of HIV actions in NaTaLa areas Development of HIV strategy to support actions in their area
Ministry of Foreign Affairs	International cooperation and coordination, linking with regional inter-governmental organizations (i.e. ASEAN).	Facilitation of entry of new international partners working on or financing HIV activities
Ministry of Finance	Administration of disbursement systems for HIV and AIDS funding Coordination of resource allocation and reporting across government sectors	Initial assessment of HIV allocation and expenditures

Table 2. Ministries Principally Implementing Activities for HIV Prevention and Care

Ministry	Function	Initial Outputs
Ministry of Education	Policy on HIV workplace education for staff and students HIV policy for out-of-school children Administration and delivery of in school & out-of-school HIV education programmes	Development of multi-year HIV prevention strategy for education
Ministry of Social Welfare, Relief and Resettlement	Policy development for support and care of orphan and vulnerable children in and out of training schools Workplace policies to minimise negative impacts of HIV and develop prevention programmes for staff and residents across adult training schools and rehabilitation centres Coordination of prevention, care and support programmes with community participation	Assessment of impact of HIV on Ministry of Social Welfare work planning Development of multi-year HIV prevention and care and support strategy Reflection of HIV prevention and care needs in National Action Plan for the Advancement of Women
Ministry of Immigration and Population	Design and implementation of policies to prevent negative impacts of HIV and AIDS	Assessment of interaction between Ministry of Immigration and HIV issues Development of HIV prevention strategy

Ministry	Function	Initial Outputs
Ministry of Religious Affairs	Facilitation and coordination of expanded role of faith-based responses to HIV Delivery of HIV prevention programme with support of religious communities	Development of HIV prevention strategy
Ministry of Information	Strategic development of mass media campaign Authorisation for national publications dissemination	Development of HIV prevention strategy
Ministry of Labour	Design and implementation of workplace policies to prevent negative impacts of HIV and AIDS, and address prevention in all workplaces Technical coordination of workforce HIV prevention programmes	Review of labour regulations impact on HIV prevention and care Development of HIV prevention programme
Ministry of Construction	Design and implementation of workplace policies to prevent negative impacts of HIV and AIDS, and address prevention Technical coordination of construction sector-based HIV prevention programmes	Assessment of impact of HIV on construction activities Development of HIV prevention strategy
Attorney Generals Office	Support legal reform to protect people living with HIV (in the workplace) Support legal reform to enable access and outreach for HIV practitioners working at community level	Review of legal environment on HIV transmission and prevention actions
Ministry of Rail Transportation and Ministry of Transport	Workplace policy to prevent negative impacts of HIV and address prevention Technical coordination of transport sector-based HIV prevention programmes	Review of current HIV prevention and care activities Design of HIV prevention and care programme
Ministry of Agriculture and Irrigation	Design and implementation of policies to prevent negative impacts of HIV and AIDS Coordination of agricultural sector based prevention programmes Coordination of food security and distribution mechanisms	Development of HIV prevention programme

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