

**Myanmar National Strategic Plan
on HIV and AIDS**

Operational Plan
April 2006- March 2009

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1. Introduction

The Operational Plan 2006 -2009 was developed following the development of the National Strategic Plan 2006 – 2010.

The Operational Plan, using the National Strategic Plan as a guide for decisions on priorities and scaling up, provides a range of products associated with the planning, monitoring and implementation that require the input and involvement of many different stakeholders. A NSP flow-chart has been developed to clearly identify the steps, timing, and actors responsible for leading and/or being involved in processes (cf annex).

A training workshop was conducted in April 2006 on estimation of resources need and provisional rapid costing for resource mobilization. As a result, yearly targets and estimated cost of each component and sub-component of the strategic plan 2006 - 2010 were formulated. A core team of experts for the same to undertake future costing work was also formed.

The Operational Plan incorporates all existing resources. The three year Operational Planning Cycle aims to encourage longer term financing. Each year, the immediately forthcoming year will be developed in greater detail to ensure coordination, identify specific actors and geographical areas, assess key enabling environment issues which need to be addressed, and better plan financial flows. The annual review of a three-year rolling plan thus balances the desire for longer-term financing with the need for annual review of progress, changing conditions and more detailed planning.

Funding for Year 1 (April 2006 to March 2007) includes existing resources from the Global Fund and the FHAM which are mostly available up to December 2006. Funding to fill the gaps will be sought from a variety of sources, including increased domestic contributions, pooled donor mechanisms such as the 3-Diseases Humanitarian Fund for Myanmar, bilateral development agencies and other sources.

The Operational Plan is composed of a set of documents, including:

- description of the strategic directions and indicators with targets, including scaling-up and geographical priorities
- business plan and budget
- Monitoring and Evaluation Framework

2. National Strategic Plan on HIV/AIDS

The National Strategic Plan on HIV and AIDS, 2006 – 2010, was the first in Myanmar developed using participatory processes, with direct involvement of all sectors involved in the national response to the HIV epidemic. It was prepared following a series of reviews which looked at the progress and experiences of activities during the first half of the decade. These included a review of the National AIDS Programme in 2006 and a mid-term review of the Joint Programme for HIV/AIDS in 2005, as well as many diverse studies and reviews of particular programmes and projects.

The National Strategic Plan identifies what is required to improve national and local responses, bring partners together to reinforce the effectiveness of all responses, and build more effective management, coordination, monitoring and evaluation mechanisms. The Plan, building on key principles underlying the national response over the next five years, spelt out specific strategic

directions relevant to populations at higher risk, corresponding activity areas and expected outcomes to serve as the starting point of the planning process. Approaches applicable to prevention, care, support and treatment and impact mitigation and to the creation of the required implementing capacity were then elaborated as a means to define the boundaries of the Strategy and inform priority setting. For each expected outcome, necessary outputs (i.e. key activities delivered in order to achieve these outcomes) were formulated. Specific activities, targets and indicators suitable to provide a direction and monitor progress towards 'Universal Access' to prevention and care services were expressed for selected outputs and outcomes recognized as the most critical products of the Strategy.

Aims:

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

Objectives:

1. Reduction of HIV transmission and vulnerability, particularly among people at highest risk.
2. Improvement of the quality and length of life of people living with HIV through treatment, care and support.
3. Mitigation of the social, cultural and economic impacts of the epidemic.

Strategic directions:

The National Plan addresses 13 strategic directions that are most pressing needs of populations at greater risk and essential enhancement of the capacity of health systems to help respond to these needs. Strategic Directions 1 – 11 are population focussed, while Strategic Directions 12 – 13 are intended to create and/or further expand national capacity to formulate, implement, monitor and evaluate the Strategic Plan, update it as required and account for its achievements.

3. The Operational Plan April 2006 – March 2009

This Operational Plan translates key principles and broad directions set out in the National Strategic Plan 2006 – 2010 into a directly actionable and costed plan for the first 3 years relevant to all aspects of the national response to HIV and to all partners.

3.1 Key issues

Primary attention and resources will be directed to building capacity and enhancing resilience among **populations at highest risk and vulnerability**, and to those most severely impacted by the HIV epidemic. Community-based activities will be directed to **reduce stigma and discrimination** towards people infected and affected by HIV and those whose behaviours is perceived as being associated with infection. In particular, initiatives will aim to reduce stigma and discrimination against sex workers, injecting drug users, and men who have sex with men, thereby ensuring that all these populations can play a central role in curbing the course of HIV and mitigating its impacts. **Building on evidence generated through implementation** of the National Strategic Plan, sound public health policies and practices, and monitoring and evaluation system in line with the Three-Ones principles, will provide a framework for the design of focused approaches suited to specific populations.

3.2 Prioritization of Strategic Directions

The National Strategic Plan recognizes 3 levels of risks and vulnerability:

- Key populations at highest risk and vulnerability in Myanmar include sex workers, clients of sex workers, drug users, men who have sex with men, and partners of people living with HIV. These populations are of primary concern as the extent and quality of support extended to facilitate their positive and sustained behaviour change are likely to be key determinants of the course of the HIV epidemics in Myanmar. Prevention focusing on these populations will be the utmost priority and will rely on, high-intensity, sustained and focused effective interventions.
- Populations vulnerable to risk of HIV infection – those who, for economic, social, cultural reasons are most likely to engage in risk-taking behaviours or be exposed to risk-generating situations risk in the near future. These populations include children and youth out of school, institutionalized populations, mobile populations and uniformed personnel, orphans and other vulnerable children.
- Populations at lower risk of HIV infection– people displaying lower incidence of HIV and other sexually transmitted infections, who do not engage in HIV-related risk behaviours and who are not exposed to risk-taking situations. These populations include women and men in stable, monogamous relationships, in-school children and youth who have not yet experienced sexual activity, and women, men, boys and girls who consistently practice effective HIV prevention behaviours.

Based on this consideration, the 13 Strategic Directions laid out in the National Strategic Plan are prioritized as follows:

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

3.2.1 Strategic Direction 1: Reduction HIV-related Risk, Vulnerability and Impact among Sex Workers and their Clients

Impact/Outcome Targets	Denominator	Baseline	Apr 2006-Mar 2007	Apr 2007-Mar 2008	Apr 2008-Mar 2009
% of sex workers that are HIV infected	40,000	31.98%	30.5	28.5	26.5
% of sex workers that have a STI (syphilis)	40,000	25.0% (2005)	23%	21%	19%
% of sex workers that report the use of condom with most recent client	40,000	62% ¹	70%	80%	90%
% of clients of sex workers that are HIV infected (by proxy: male with STD)	1,361,000	4.07% ²	4%	3.5%	3%
Output/Coverage Targets					
Sex workers reached by package of BCC prevention and STI prev/treatment	40,000	30,000 ³ (2005)	30,000	35,000	40,000
Number of sex workers accessing VCCT	40,000		10,000	15,000	20,000
Condoms distributed (in million)		41 ⁴	46	51	56

Priority rating: Highest priority prevention programme

Scaling-up Priorities

This is one area of prevention programming where significant progress has already been made, demonstrating the feasibility of undertaking peer education-based and outreach programmes for behavior change: in 2005 an estimated 30,000 sex workers were reached with varieties of this basic package including STI treatment. Social marketing of condoms targeted to clients has also proven effective. The National AIDS Programme's 100% Targeted Condom Promotion Program (TCP) underlines the Government's priority to expand condom programming, especially in high-risk settings. Challenges remain over having better data (including on mobility pattern of sex-workers), access (especially to indirect sex-workers) and the regulatory environment.

Resources will be aggressively invested in scaling-up peer education-based behavior change programmes in as many townships as possible. The Government's 100% Targeted Condom Promotion Programme, incorporating recommendations from the 2005 review, will focus on the enabling environment, especially through advocacy to township authorities and the creation of condom core groups, monitoring and coordination of programmes. Sustained advocacy is considered particularly crucial at township and central levels in order to ensure supportive involvement of other key non-health sector bodies such as the Ministry of Home Affairs and law enforcement authorities.

Geographical Priorities

Investments should firstly focus on all urban areas, expansion of partnerships in 100% TCP townships to ensure coverage and strengthening of peer education-based programmes, and ensure minimal overlap between individual partners. The National AIDS Programme with support from UN agencies and other partners is encouraged to improve the national mapping of these activities.

¹ BSS NAP 2003

² HSS 2005

³ Estimates according to partners annual report 2005 – NAP

⁴ Partners annual report 2005 – NAP

3.2.2 Strategic Direction 2: Reduction HIV-related risk, vulnerability and impact among MSM

Impact/Outcome Targets	Denominator	Baseline	Apr 2006- Mar 2007	Apr 2007- Mar 2008	Apr 2008- Mar 2009
% of MSM that are HIV infected	267,208 ⁵	33% (1996) ⁶	33%	32%	31%
% of MSM that have a STI (syphilis)		35.12% ⁷	35%	34%	33%
% of condom use by MSM at last anal sex	267,208	67.0%	70%	72%	75%
Output/Coverage Targets					
MSM reached by package of BCC prevention and STI prev/treatment	267,208	21,000 ⁸	22,000	40,000	53,000
Number of MSM accessing VCCT	267,208		5500	16,000	25,000

Priority rating: Highest priority prevention programme

Scaling-up priorities

Programmes for men who have sex with men are relatively new in Myanmar. Informal data suggests that prevalence might be quite high amongst several population groups of men who have sex with men with different identities and behaviors. The current environment all lows for some community-based programming, while policy advocacy remains essential at higher levels. A situation analysis of the dynamics involved in MSM interactions need to be carried out and an appropriate strategy to be developed. Priorities are particularly to increase the number of urban areas in Myanmar with at least one community-based programme for men who have sex with men, alongside a series of awareness raising workshops for a variety of health and HIV service providers.

Geographical priorities

Currently, the most significant programmes for MSM are in Yangon and Mandalay. Situation analysis will provide useful information about priority areas for interventions.. This provision list will be used to guide initial investments.

⁵ Scenario 2% of Adult male population – Tim Brown 2005

⁶ MoH 1996

⁷ NAP study Mandalay 2005

⁸ Partners annual report 2005 – NAP

3.2.3 Strategic Direction 3: Reduction HIV-related risk, vulnerability and impact among Injecting Drug Users

Impact/Outcome Targets	Denominator	Baseline	Apr 2006- Mar 2007	Apr 2007- Mar 2008	Apr 2008- Mar 2009
% of IDU that are HIV infected	60,000	43.24% ⁹	41.00	39.00	36.50
% of IDU that avoid sharing injecting equipment in the last month		65% ¹⁰	67	69	71
% of condom use by IDU at last sex		34% (2005)	40%	50%	60%
Output/Coverage Targets					
Drug Users reached by Harm Reduction programme			75,000	120,000	180,000
IDU reached by Harm Reduction programme	60,000	11,500 ¹¹	12,500	20,000	30,000
% of IDU accessing VCCT	60,000		4,375	7,000	10,500
Needles distributed to IDU's		1,2 M ¹²	2	3	4
Number of IDU on MMT			300	1,000	2,000

Priority rating: Highest priority prevention programme

Scaling-up Priorities

Programmes for drug users in the 2003-2006 period demonstrated the feasibility carrying out harm reduction for Myanmar. Currently 15 DICs are running in 12 townships, but the coverage is probably sufficient (>50%) in only one township (Lashio). In all the other townships the coverage is estimated fewer than 50% and still requiring more coverage in the currently operated township and unaddressed ones. Methadone maintenance therapy started in 2006. Baseline figures are known of number of injecting drug users reached. As the exact number of the total number of either drug users or injecting drug users is currently only roughly estimated, targets in the short run will remain focused on absolute numbers of drug users reached (rather than percentages) and townships coverage. More comprehensive behavioral data with representation from most priority areas will be collected by upcoming surveys. Investments will focus on expanding coverage of community-based peer education and outreach prevention and support programmes, as well as scaling-up of MMT. Continued advocacy will be required to ensure an enabling environment, especially with non-health ministries. Interventions will need to cover as well spouses/partners and families of IDU's.

Geographical Priorities

The following table indicates the 29 priority townships currently indicated for drug use, and whether or not programmes exist. Investments should focus on i) continuing all current programmes, ii) expanding activities to townships in the table that are currently not covered.

Hpakant	Myawaddy	Kutkai	Pinlaung
Moegaung	Mogoke	Kyaingtone	Tachileik
Moemauk	Aung Myay Thazan	Lashio	Taunggyi
Putao	Chan Aye Thazan	Laukkai	Kawthaung
Myitkyina	Waingmaw	Maingshu	Tamwe
Tanai	Monywa	Monglar	Yankin
Bhamaw	Tamu	Muse	
Hpa-an	Hopan		

⁹ HSS 2005

¹⁰ UNODC report 2002

¹¹ Implementing Partners annual report 2005 – NAP

¹² UNAIDS estimates for 2005

3.2.4 Strategic Direction 4: Reduction HIV-related Risk, Vulnerability and Impact among Partners and People Living with HIV

Impact/Outcome Targets	Denominator	Baseline	Apr 2006- Mar 2007	Apr 2007- Mar 2008	Apr 2008- Mar 2009
Output/Coverage Targets					
Number of PLHIV involved in self-help groups	338,911 (2004)	3,000 ¹³ (2005)	5,000	8,000	10,000

Priority rating: Highest priority prevention programme

Scaling-up Priorities

Most work in this area is done currently in the context of care, treatment and support (see Strategic Direction #11). There are a few additional programmes focusing on psycho-social support to people living with HIV (such as the Sunday Empowerment Group in Yangon), but these are limited. Outside of the care, treatment and support work, there is a need to ensure that people living with HIV have networks that they can turn to for support, ranging from psycho-social to socio-economic, including for income, to prevention behavior change. There is also a need to involve these networks in improved treatment support among people living with HIV.

Geographical Priorities

Current data is insufficient to adequately map current existence of self-help groups and informal networks of people living with HIV, although some partners are currently undertaking such exercises. What data exists suggests that efforts are largely limited to only a few numbers of people living with HIV involve in self help group and difficult to say what are the activities that they are participating. Stigma and discrimination against these groups hinder their involvement in self help groups. Pending improved information, investments are being prioritized to urban areas. The National AIDS Programme in collaboration with partners active in this area will be working to improve its strategic planning in this area within the first year of the 2006-2010 National Strategic Plan.

¹³ HIV/AIDS International Alliance survey 2006

3.2.5 Strategic Direction 5: Reduction HIV-related risk, vulnerability and impact among Institutionalized population

Impact/Outcome Targets	Denominator	Baseline	Apr 2006- Mar 2007	Apr 2007- Mar 2008	Apr 2008- Mar 2009
Output/Coverage Targets					
Prisoners reached by health education	62,300 ¹⁴	5,000 ¹⁵	6,000	20,000	30,000
Number of prisoners having access VCCT			<i>Targets to defined after feasibility study</i>		

Priority rating: High priority prevention programme

Scaling-up priorities

Limited work has been undertaken to date on HIV in prison and other institutionalized settings. Accordingly, targets in the first year are low while programming opportunities are sought in the support of the National Strategic Plan. With support from the National AIDS Programme and technical partners, the Ministry of Home Affairs has activities outlined in the National Strategic Plan to advance planning in this area. Assessment of the feasibility of specific interventions, such as Voluntary and Confidential Counseling and Testing, strengthening care and support, should be carried out for institutionalized population within the context of Myanmar without delaying scaling up of interventions in this sector. Advocacy will be supported and undertaken with the aim of expanding programming opportunities.

Geographical coverage

Current level of activity is near zero in this area. Mapping is required as part of initial stages of strategic planning.

¹⁴ Statistical Year Book 2001

¹⁵ CARE and UNODC reports, 2006

3.2.6 Strategic Direction 6: Reduction HIV-related Risk, Vulnerability and Impact among Mobile Population

Impact/Outcome Targets	Denominator	Baseline	Apr 2006- Mar 2007	Apr 2007- Mar 2008	Apr 2008- Mar 2009
Output/Coverage Targets					
Mobile and migrant population reached by package of prevention programme			100,000	110,000	121,000

Priority rating: High priority prevention programme

Scaling-up Priorities

Considerable activities are currently undertaken in this area. Due to the wide variety of projects falling in this category, data is impossible at this stage to aggregate into a cohesive picture. Main groups targeted currently include mining sites, transport workers (trishaw drivers, taxi and bus drivers, train employees, seafarers). Some activities falling into this category are seen firstly as workplace programmes, causing further challenges to efficient planning. Investment priorities are to i) finance all existing activities based on current reach and ii) fund improved data collection and mapping in order to better plan future expansion. As a high priority activity with a large potential population base, future expansion will have to take into account the need to focus activities in the areas of highest risk, as all mobile/migrant populations and their affected communities (see definition in National Strategic Plan) provide too broad a base to be addressed in current funding scenarios.

Geographical Priorities

Current data is insufficient to map adequately under-served but prioritized townships, activity sites and/or population groups. A planning workshop on mobile populations will address this issue. Transit points for cross-border population will be especially targeted; Myanmar will be looking for a coordination mechanism with ASEAN partners. Internal migrants should also be covered by programmes.

3.2.7 Strategic Direction 7: Reduction HIV-related Risk, Vulnerability and Impact among Uniformed Services Personnel

Impact/Outcome Targets	Denominator	Baseline	Apr 2006- Mar 2007	Apr 2007- Mar 2008	Apr 2008- Mar 2009
Output/Coverage Targets					
Uniformed personnel reached by package of prevention programme		100,000 ¹⁶	50,000	200,000	250,000

Priority rating: High Priority Prevention Programme

Scaling-up Priorities

Current programmes in this area involving international assistance are limited to two or three activities working with the police. The current training of trainers programme for the police¹⁷ should be financed so that its coverage can be made national. Careful monitoring needs to ensure programme effectiveness. Advocacy with the Ministry of Home Affairs will seek to strengthen links between uniformed services and advances in security and public health in Myanmar. Although not currently involved in collaborative multi-partner work on HIV, the Ministry of Defense has been engaged in the National Strategic Planning process and providing them with technical support for the development of an HIV strategy is an immediate priority. This participation provides a window opportunity for NAP, NGO's and other international organizations to engage with concerned ministries for prevention and care activities.

Geographical Priorities

The current police training work is being carried out in 80 townships under Global Fund. Committed funding will enable the expansion of this activity to a larger number of townships. Resources will be allocated to fund its expansion to national coverage.

The following areas will be of priority starting 2006:

- border areas
- mining areas
- transit areas
- military units and police units

¹⁶ Only partial package of services provided so far

¹⁷ Supported by UNODC and CARE International.

3.2.8 Strategic Direction 8: Reduction HIV-related risk, vulnerability and impact among Young people

Impact/Outcome Targets	Denominator	Baseline	Apr 2006-Mar 2007	Apr 2007-Mar 2008	Apr 2008-Mar 2009
% of young people that are HIV infected	9,572,450	2.2% ¹⁸	2.09	1.98	1.87
% of condom use by young people at last paid sex		78.34% ¹⁹	80	85	90
% of youth who correctly identify the three common ways of preventing HIV transmission	9,572,450	21%	30%	40%	50%
% of youth who reject misconceptions	9,572,450	27%	30%	40%	50%
% of youth expressing accepting attitudes	9,572,450		20%	30%	40%
Output/Coverage Targets					
Out of school youth (15-24) reached by prevention programme		200,000 ²⁰	250,000	400,000	500,000
Young people (15-24) having access VCCT	9,572,450	20,000	30,000	50,000	80,000
In-school youth (10-16) reached by life-skills programme	2,450,000	900,000	900,000	1,300,000	1,800,000
% of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	39,405	36.3% ²¹	50%	60%	70%

Priority rating: High Priority Prevention Programme

Scaling-up Priorities

Numerous programmes are currently working on youth programming, both in out-of-school and in-school contexts. This is a large population group, with widely varying at-risk behavior and vulnerabilities. Data is currently insufficient to map activities and coverage more precisely. There is not a specific national youth strategy currently defined, beyond that in the National Strategic Plan. With these limitations, scaling-up priorities will steer investments towards: i) ad-hoc scaling-up and expansion of existing out-of-school youth programmes, ii) national coverage of the in-school youth SHAPE life-skills programme, iii) improved national planning specifically targeted on youth.

Geographical Priorities

Aside from the formal in-school curriculum programme which has known coverage and expansion needs, data is currently insufficient to guide investments. Further data and strategic planning will be undertaken in the first year of this operational plan in the context of the National Strategic Plan 2006-2010.

¹⁸ HSS 2005 for new military recruits

¹⁹ NAP BSS 2003

²⁰ Partners annual report 2005 – NAP

²¹ UNGASS report 2004

3.2.9 Strategic Direction 9: Reduction HIV-related Risk, Vulnerability and Impact in the Workplace

Impact/Outcome Targets	Denominator	Baseline	Apr 2006- Mar 2007	Apr 2007- Mar 2008	Apr 2008- Mar 2009
Output/Coverage Targets					
Number of people in workplace reached by package of prevention programme	25,000,000	200,000 ²² ; ²³	100,000	200,000	400,000
Number of large enterprises practicing workplace policies			5	10	20
% of large enterprises who have HIV/AIDS workplace policies and programme			Survey to be conducted		

Priority rating: Priority Prevention Programme

Scaling-up Priorities

Workplace programmes in Myanmar have been developed on a largely ad-hoc basis. Although a national estimate of workers reached is currently available, greater detail is unavailable to assist planning. Many in this category are also mobile populations, for example seafarers. UNGASS data around large enterprises is not known. The National AIDS Programme with support from technical partners will have to develop specific strategies for prioritizing within this broad category for allocation of resources. Support to non-health Government ministries to develop workplace programmes is a priority. Investments will be allocated to i) continuation of current activities and ii) more detailed planning for this sub-sector, likely in collaboration with work on mobile populations.

Support should be also provided to the private sector to involve the workers in industrial zones.

Geographical Priorities

Current data is insufficient to geographically guide allocation of resources, particularly in the absence of a national sub-strategy around this area of work.

²² Only partial package of service provided so far

²³ Partners annual report 2005 – NAP

3.2.10 Strategic Direction 10: Reduction HIV-related risk, vulnerability and impact among men and women of reproductive age

Impact/Outcome Targets	Denominator	Baseline	Apr 2006- Mar 2007	Apr 2007- Mar 2008	Apr 2008- Mar 2009
Output/Coverage Targets					
Men and women of reproductive age reached by prevention programme	27,180,000	450,000 ²⁴	600,000	800,000	1,000,000
Adults accessing VCCT each year (excluding targeted pop)	27,180,000	81,674	150,000	170,000	200,000
% of people with STI appropriately diagnosed, counselled and treated		Survey to conduct	40%	50%	60%
Number of patients treated for STI		130,000	150,000	170,000	190,000

Priority rating: Priority Prevention Programme

Scaling-up Priorities

This is a very large population group. Programmes currently are restrained to a number of efforts around sexual and reproductive health, linked to varying degrees explicitly to HIV. Funding in this area is reserved to additional marginal costs for mainstreaming HIV work into existing sexual and reproductive health work, by either Government or non-Government partners. Existing PMCT programme should enhance prevention services to this population.

Geographical Priorities

The National AIDS Programme's list of 183 priority townships for work on HIV (linked to HIV prevalence) provides a guide for the scaling-up of these mainstreaming activities. Expansion of activities will involve building capacities of peripheral community-based workers to support HIV prevention and care activities in conjunction with TB and malaria program.

²⁴ Partners annual report 2005 – NAP

3.2.11 Strategic Direction11: Meeting the needs of people living with HIV for Comprehensive Care, Support and Treatment

Package of care and support with or without ARV	Denominator	Baseline	Apr 2006-Mar 2007	Apr 2007-Mar 2008	Apr 2008-Mar 2009
Impact/outcome Targets					
% of TB patients that are HIV infected		10.3% (2005)	9.8	9.3	8.8
% People still alive at 1 year after initiation of ARV		94.6% ²⁵	95	95	95
Output/Coverage Targets					
Number of People Living with HIV in need receiving ARV (including package of support)	67,000	3.7% ²⁶	6,000	9,000	11,000
Number of people receiving Cotrimoxazole as prophylaxis	250,000	7000	10,000	30,000	35,000
Number of people receiving CHBC package of support (without ARV)	250,000	10,000	15,000	20,000	25,000
Number of TB/HIV co-infected patients referred to HIV services ²⁷			800	1040	1520
Prevention of Mother to Child Transmission					
Impact/outcome Targets					
% of infant born to HIV infected mother that are HIV infected	8,000	24.78%	24%	23%	21%
Output/Coverage Targets					
Pregnant women having access to VCCT	1,283,382	138,885	208,327	347,212	607,621
% of mother-baby pair receiving a complete course of ART prophylaxis for PMCT	7,700	629 (8%)	12%	20%	35%
Number of orphans receiving support		27,800 ²⁸	34,000	59,500	85,000
Number of children in need provided with ARV	1960 ²⁹	136	150	350	500

Priority rating: Fundamental overarching issue

Scaling-up Priorities

Further expansion of PMTCT and ART programs should be linked within a continuum of care approach. Systems to systematically refer all HIV positive pregnant women as well as TB/HIV co-infected patients for comprehensive HIV care at the time of HIV diagnosis should be established. Coverage of each essential service need to be expanded, including provision of VCCT services to TB patients. Referrals and utilization can be improved only after the services become available. Particularly, OI management, ART, community and home based care for infected and affected population, VCCT and PMCT should be made available more widely, utilizing available public health facilities, NGOs and GPs.

²⁵ UNGASS report 2004

²⁶ Partners annual report 2005 – NAP

²⁷ Targets only for public health sector by NTP/NAP

²⁸ UNICEF Myanmar estimates 25,000 orphans in facilities ; Annual partners report for 2005 : 2,800 orphans supported– NAP/UNAIDS

²⁹ Workshop Demographic Impact of HIV – Nov 2005 Yangon

Health systems to support provision of HIV care including ART are being developed and strengthened. Priority should be given to supply management systems, the development of a comprehensive national HIV care training programme and support for ART sites from central level.

For the majority of people living with HIV/AIDS the entry point for community and home based care is self-referral or referral by a family or community member to a local home based care team. Barriers to referral due to the stigma associated with home visiting need to be addressed.

Given the maturity of the epidemic in Myanmar, it is expected that the number of AIDS orphans will increase. Accordingly, an assessment on the situation should be conducted to provide information for scaling up interventions.

Geographical Priorities

PMCT will aim for expansion towards a national coverage.

The expansion of Community and Home- Based Care and provision of ART services will be prioritized for HIV high prevalence areas and urban areas in the context of the Continuum of Care.

Expansion of activities will involve building capacities of peripheral community-based workers to support HIV prevention and care activities in conjunction with TB and malaria program.

3.2.12 Strategic Direction12: Enhancing the capacity of health systems, coordination and capacity of LNGOs and CBOs

Impact/outcome Targets	Denominator	Baseline	Apr 2006-Mar 2007	Apr 2007-Mar 2008	Apr 2008-Mar 2009
% of townships implementing HIV test with no stock out of HIV test kits	325	95%	100%	100%	100%
Proportion of HIV testing laboratories participating in NEQAS for HIV serology		25% ³⁰	50%	75% ³¹	
Output/Coverage Targets					
Proportion of transfused blood units screened for HIV	200,000	95.2% ³²	100%	100%	100%
Number of Service Delivery Points offering VCCT		122 ³³	211	295	414
% of need for PEP that is met			100%	100%	100%
Amount of national funds disbursed by government		78.05 MK	206 MK ³⁴	To be calculated	
% of AIDS/STD teams with a local strategic plan including all partners		0	10	77	154
Number of AIDS committee meeting at national level			1	1	1
Number of AIDS committee meeting at state/divisional level			17	34	34
Number of AIDS committee meeting at district level			47	94	94
Number of AIDS committee meeting at township level			136	325	325

Priority rating: Fundamental overarching issue

Scaling-up Priorities

The blood safety programme which includes donor selection, donor deferral, and HIV screening of blood donations has made good progress. HIV testing is conducted in hospitals with the supply of test kits from the NAP. Main constraints include the lack of blood banking facilities especially and related infrastructure such as constant electricity supply, and the significant proportion of replacement blood donors.

VCCT is provided in a number of settings. Within the public sector the majority of VCCT is performed as part of the PMCT programme in health centres/sub-centres and hospitals. Access to VCCT should be expanded through opening of health centre/sub-centre VCCT to the general public, establishment of hospital VCCT teams including 'drop-in' access for the general public, routine offer of VCCT for TB patients, STI patients, IDU and MSM clients of Drop in Centers as well as the increase in the number of AIDS/STD clinics. There is also a need for expanding the number of approved private not-for-profit VCCT services (particularly those run by NGO's) and establishment of outreach VCCT for most at risk population. HIV test kit procurement needs to be significantly increased to support current and future demand and HIV test kit supply management needs to be improved.

³⁰ National Health Laboratory/NAP data 2006

³¹ Target to increase whenever regulation on blood transfusion is extended to private sector

³² UNGASS report 2004

³³ Partners annual report 2005 – NAP

³⁴ DoH data for NAP only

Priority should be given to strengthen laboratory support for VCCT, STI services, blood transfusion services, Opportunistic Infections and HIV and AIDS treatment and care.

As part of strengthening capacity of health system, it is also essential to reinforce community participation, i.e. by developing networks of voluntary community workers and for some areas with efforts of mobile teams, particularly in the case of hard-to-reach populations and populations from difficult-to-reach areas. Community participation includes as well the building capacity of CBOs to participate in the national response to HIV and AIDS.

Geographical Priorities

Priority should follow the expansion of the AIDS/STD teams clinics, as well as expansion of 100% TCP and where services are provided to high vulnerable groups, including hard-to-reach population and populations from difficult-to-reach areas.

3.2.13 Strategic Direction13: Monitoring and Evaluation

Priority rating: Fundamental overarching issue

Scaling-up Priorities

HIV second generation surveillance system should be updated to incorporate new elements, including new surveillance groups, increasing number of sites and sample size to allow comparison over time and among sites as well as strengthening behavioral surveys and STI surveillance.

There has been no surveillance or monitoring of HIV drug resistance so far. It is one of the priorities to undertake since HIV resistance testing was done in private sector for clinical purpose.

All partners report at the national level to NAP/UNAIDS on standard agreed indicators. Local partners should be requested to report to the local AIDS/STD Team on their activities through a standard format, using output and coverage indicators agreed in the national framework. Standard format currently utilized at national level by all partners could be adapted to the local level. Capacity building at local level/township/district level will give better data flow to a monitoring system.

Geographical Priorities

In line with the principle of the “Three Ones” monitoring systems will aim to cover the national response in a coherent and coordinated manner. The aim is to establish and / or improve a system that will inform the national and local response.

AIDS/STD Teams have the responsibility to implement NAP programmes and activities in their geographic area. Initially, particular attention may be given to townships with STD teams in order to establish data collection and management systems that can be rolled out to other townships. It should be strengthen reporting go through the state / divisional level where data will be compiled and sent to the central level.

3.3 Scaling up

Scaling up will include identification of **“accelerated townships”** - where the needs are greatest and where existing programs, services, leadership, enabling environments and community involvement are promising of rapid capacity enhancement. These townships will be allocated further resources to enable rapid scaling up of what already works along with new initiatives, ahead of other townships where conditions for effective responses to the HIV epidemic do not yet prevail.

3.4 Roles and responsibilities

Roles and responsibilities of key constituency groups: Ministry of Health and National AIDS Programme, other Government sectors, State, Division, Township and District AIDS Committees, UN , NGOs, people living with HIV, private sector and business coalitions and donors are outlined in the Strategic Plan document.

3.5 Institutional arrangements

Toward the efforts, institutional arrangements for implementation of the National Strategic Plan have been developed. The National Coordinating Body for AIDS, Tuberculosis and Malaria will oversee the policy guidance and identification of external support. This will be chaired by the Minister of Health. It will include participation of several ministries, UN organizations and non-government organizations. The Technical and Strategy Group (TSG) for HIV and AIDS, draws upon the technical expertise of UNAIDS cosponsors, will meet regularly to undertake planning, monitoring, trouble-shooting and other coordination exercises. Members from community organizations, professional associations, International NGOs and other members appointed by different ministries and health departments will contribute technical and policy expertise based on their organizations' involvement in the national response to the HIV epidemic.

Annex: Flow Chart for Development process of National Strategic Plan

