

# **Global AIDS Response Progress Report**

## **Myanmar**

### **National AIDS Programme**

*Reporting period: January 2010 – December 2011*

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Table of Contents

I.	Status at a glance.....	4
I.1	Reporting process.....	4
I.2	Status of the epidemic.....	4
I.3	Policy and programmatic response.....	4
I.4	Indicator overview.....	7
II.	Overview of the AIDS epidemic.....	8
III.	National response to the AIDS epidemic.....	15
III.1	Policy environment.....	15
III.1.1	Myanmar National Strategic Plan on HIV and AIDS 2011-2015.....	15
III.1.2	Travel.....	16
III.2	Programme implementation.....	16
III.2.1	Strategic Priority I: Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use.....	16
III.2.1.1	Sex workers, their clients and their sexual partners.....	18
III.2.1.2	Men who have sex with men.....	19
III.2.1.3	People who inject drugs, drug users and their sexual partners.....	20
III.3	Strategic Priority II: Comprehensive continuum of care for people living with HIV.....	22
III.3.1	Prevention of mother-to-child transmission of HIV.....	22
III.3.2	Care, treatment and support.....	23
III.4	Strategic Priority III: Mitigating the impact of HIV on people living with HIV and their families.....	25
IV.	Best practices.....	26
IV.1	Myanmar National Strategic Plan 2011-2015.....	26
IV.2	Myanmar-Country Coordination Mechanism.....	26
IV.3	Strategic Information and M&E Working Group.....	26
V.	Major challenges and remedial actions.....	27
V.1	Financial resources.....	27
V.2	Health system.....	27
V.3	Policy and legal frameworks.....	27
V.4	Coordination at national and sub-national levels.....	27
V.5	Community systems.....	28
VI.	Support from the country's development partners.....	29
VII.	Monitoring and evaluation environment.....	30
VII.1	Oversight.....	30
VII.2	National AIDS Programme.....	30
VII.3	State or Division, District and Township levels.....	31
VII.4	NGOs, CBOs and the private sector.....	31
VII.5	M&E system data flow.....	31
VII.6	Strategic Information and M&E Working Group.....	31
VII.7	Information products.....	32
VII.8	Challenges faced.....	32
VIII.	Data sources.....	33

## Figures

Figure 1 HIV prevalence of adult population aged 15+ = Myanmar 2010-2020. ....	8
Figure 2 Number of people living with HIV – Myanmar 1991-2015.....	9
Figure 3 Trends of HIV prevalence among different sentinel populations 2006-2011. ....	10
Figure 4 Trends of HIV prevalence among pregnant women and new military recruits 2006-2011. .....	10
Figure 5 Percentage of most-at-risk populations who are HIV-infected.....	11
Figure 6 HIV Prevalence among young FSW and PWID (15-24 years) – 2000-2011. ....	11
Figure 7 Incidence by key affected population – Myanmar 1995-2020.....	12
Figure 8 Distribution of new infections among key affected populations – Myanmar 1995-2020. .....	13
Figure 9 New infections by transmission route – Myanmar 2010-2020. ....	13
Figure 10 Number of estimated annual deaths due to AIDS – Myanmar 2010-2020.....	14
Figure 11 Condom provision – free distribution and social marketing. ....	17
Figure 12 People receiving HIV test and post-test counselling. ....	17
Figure 13 Females sex workers reached by state and regions 2006 and 2010. ....	18
Figure 14 Men who have sex with men reached by state and region 2006 and 2010. ....	19
Figure 15 Needles and syringes distributed – 2003-2008. ....	21
Figure 16 People on MMT 2006-2011.....	21
Figure 17 Pre-test and post-test counselling, ARV prophylaxis, 2003-2010. ....	23
Figure 18 Number of people receiving ART, 2002-2009. ....	24
Figure 19 Orphans and vulnerable children receiving support, 2005-2008.....	25
Figure 20 Governing Structures of HIV in Myanmar .....	30

## Tables

Table 1 HIV prevalence among sentinel populations. ....	9
Table 2 Priority setting of the National Strategic Plan on HIV and AIDS, Myanmar 2006-2010 ....	16
Table 3 Number of drug users and injecting drug users reached 2010. Source: National Progress Report 2010. ....	20
Table 4 Number of HIV-infected pregnant women who received ARV prophylaxis, by regimen..	23
Table 5 Number of people receiving ART at the end of 2010 and 2011. ....	23
Table 6 Percentage of adults and children with advanced HIV infection receiving ART.....	24
Table 7 ART treatment - 12 months retention. ....	24

### **Acronyms and Abbreviations**

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

## **I. Status at a glance**

### **I.1 Reporting process**

The reporting process has been led by the National AIDS Programme of the Ministry of Health. Data on coverage data and financial resources were collected directly from implementing partners. These data are part of the annual data collection for the Progress Report of the implementation of the NSP. UNAIDS, UNICEF and WHO assisted in populating the indicators with the latest available information.

UNAIDS assisted in the writing of the narrative report. Two national consultants contracted by UNAIDS compiled the NCPI Part B. A NCPI Part B consensus workshop was held with representatives of people living with HIV network, positive women network, men who have sex with men networks, interfaith network as well as national and international NGOs.

The draft narrative report was sent to stakeholders implementing HIV activities for comments.

The draft results were presented to a stakeholder meeting under the auspices of the Technical and Strategy Group on AIDS. The meeting was chaired by the NAP. 70 representatives of Government, national and international NGOs, CBOs, and networks of people infected and affected by HIV attended this event.

### **I.2 Status of the epidemic**

The HIV epidemic in Myanmar is concentrated, with HIV transmission primarily occurring in high risk sexual contacts between sex workers and their clients, men who have sex with men and the sexual partners of these sub-populations. In addition, there is a high level of HIV transmission among injecting drug users through use of contaminated injecting equipment, with transmission to sexual partners. Latest modelling estimated the HIV prevalence in the adult population (aged 15 and more) at 0.53% in 2011. For key populations most-at-risk, surveillance data from 2011 showed HIV prevalence in the sentinel groups at 9.6% in female sex workers, 7.8% in men who have sex with men, and 21.9% in male injecting drug users. All sentinel groups have shown a considerable decrease in prevalence over the last years.

It is estimated that around 216,000 people were living with HIV in Myanmar in 2011, of which 36% were female. In the same year, an estimated 18,000 people died of AIDS-related illness. Incidence was estimated at well above 8,000 new infections in 2011, confirming the continuing need for effective prevention efforts.

### **I.3 Policy and programmatic response**

In 2008, the country re-engaged with the Global Fund and applied for the Round 9. In order to comply with GF demands, the Myanmar Country Coordinating Mechanism (M-CCM) was re-established. The M-CCM has a mandate to oversee the responses to AIDS, tuberculosis and malaria and since 2012 also for maternal and child health. The M-CCM is multi-sectoral with broad participation, including representatives of international organizations, donors, International and local NGOs, private sector and people living with HIV – all of them selected by the constituencies.

The AIDS Technical and Strategy Group is delegated with specific oversight of the national response to AIDS, and similarly involves various experts from ministries, United Nations organizations, and from other constituencies of the M-CCM. The Technical and Strategy Group supports 8 Technical Working Groups to address specific programmatic areas, and these are open to participation by all interested stakeholders.

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

Since 2006, the national response has been aligned to the *National Strategic Plan on HIV and AIDS, 2006-2010*. In 2010 the second NSP, covering 2011–2015 was developed under the leadership of the Ministry of Health with the participation of a broad range of partners. The NSP II provides the strategies for reaching Universal Access. It is costed and includes yearly targets for a set of agreed indicators. The NSP II serves as a reference for all partners in the national response and forms the basis for resource mobilization and allocation.

The NSP II for Myanmar aims at reducing HIV transmission and HIV-related morbidity, mortality, disability and social and economic impact. The 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 use of contaminated needles
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

Cross cutting interventions for all three strategic priorities include:

- Health system strengthening (including private sector health services), structural interventions and 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.

The major programmatic focus in recent years remains the prevention of HIV transmission in key populations at higher risk, especially sex workers, men who have sex with men, and injecting drug users. Civil society organisations deliver a large proportion of the services to these groups. These services include drop-in centre and outreach based services for behaviour change, the provision male and female condom and lubricant promotion, client orientated STI services and VCCT. Services provided to injecting drug users also include access to sterile needles and syringes, and methadone maintenance therapy.

While there have been significant increases in the number of people receiving HIV counselling and testing services in recent years, in consideration of the proportion to estimated population sizes, coverage remains low.

The prevention of mother-to-child transmission of HIV (PMCT) services have reached a relatively large part of the country. The number of women choosing to access the service has risen continually. The services are constrained by a relatively low attendance to ante-natal care services in rural areas and a considerable loss to follow before and after birth. However, enrolment of clinically eligible pregnant women in ART programmes has increased substantially.

By the end of 2011, nearly 40,000 adults and children were receiving ART. The coverage remains low however with an estimated 120,000 people in need of treatment when the new accessibility criteria of less than 350 CD count are applied.

Myanmar Positive Group has an increasing number of group members from all parts of the country. In 2011, a total of XXX groups were registered with the MPG.

#### I.4 Indicator overview

	Status	Value
<b>Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015</b>		
1.1 Young people: Knowledge about HIV Prevention	Data available	47.51%
1.2 Sex before the age of 15	Data available	0.66%
1.3 Higher-Risk-Sex	Data available	6.63%
1.4 Condom use during high risk sex	Data available	43.77%
1.5 HIV Testing in the General Population	Data available	11.29%
1.6 Reduction in HIV Prevalence	Data available	0.65%
1.7 Sex workers: Prevention programmes	Data available	76.17%
1.8 Sex workers: Condom Use	Data available	95.85%
1.9 Sex workers: HIV Testing	Data available	71.12%
1.10 Sex workers: HIV Prevalence	Data available	9.39%
1.11 Men who have sex with men: Prevention programmes	Data available	69.09%
1.12 Men who have sex with men: condom use	Data available	81.55%
1.13 Men who have sex with men: HIV testing	Data available	47.64%
1.14 Men who have sex with men: HIV Prevalence	Data available	7.75%
<b>Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015</b>		
2.1. People who inject drugs: Prevention Programmes (Needles per person and year)	Data available	118
2.2 People who inject drugs: Condom use	Data available	77.56%
2.3 People who inject drugs: Safe Injecting Practices	Data available	80.62%
2.4 People who inject drugs: HIV testing	Data available	27.31%
2.5 People who inject drugs: HIV Prevalence	Data available	21.91%
<b>Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths</b>		
3.1 Prevention of mother-to-child transmission	Data available	54.3%
3.2 Early Infant Diagnosis	Data available	4.8%
3.3. Mother-to-Child transmission rate (modeled)	Data available	13.0%
<b>Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015</b>		
4.1 HIV Treatment: Antiretroviral Therapy	Data available	43.81%
4.2 HIV Treatment: 12 month retention	Data available	87.27%
<b>Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015</b>		
5.1 Co-management of TB and HIV Treatment	No data	--
<b>Target 6. Reach a significant level of annual global expenditure (US\$22-24 billion) in low and middle-income countries</b>		
6.1 AIDS spending (2011, in Myanmar Kyats million)	Data available	34,072
<b>Target 7. Critical enablers and synergies with development sectors</b>		
7.1 National Commitments and Policy Instruments (NCPI)	Data available	--
7.2. Prevalence of Recent Intimate Partner Violence (IPV)	No data	--
7.3 Orphans and non-orphans school attendance	Not relevant	--
7.4. Economic support for eligible households	No data	--



## II. Overview of the AIDS epidemic

Myanmar is divided into 17 states/regions, 65 districts and 325 townships.

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

Modelling in 2011 estimated the HIV prevalence in the adult population (aged 15+) to be 0.53% for that year. Approximately 216,000 people were infected with HIV (including adults and children). During that same year about 18,000 people were estimated to have died of AIDS-related disease. The available data, including HIV prevalence in pregnant women, suggest that prevalence is higher in urban than rural areas.

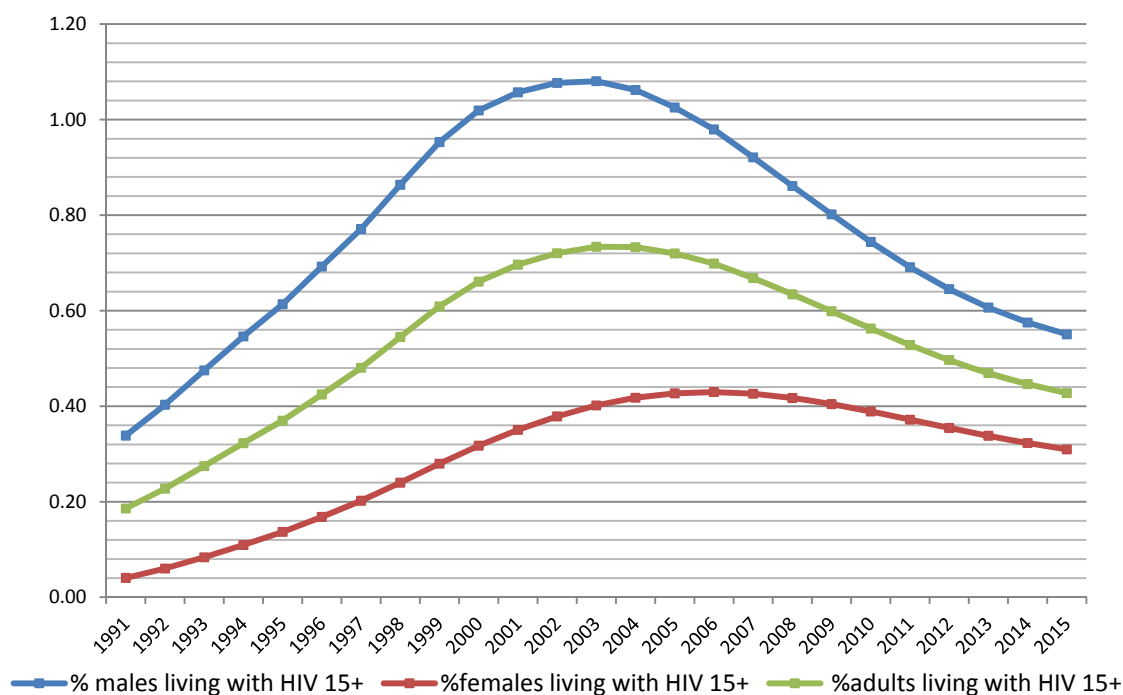


Figure 1 HIV prevalence of adult population aged 15+ = Myanmar 2010-2020.  
Source: HIV Estimates and Projections Myanmar 2010-2015

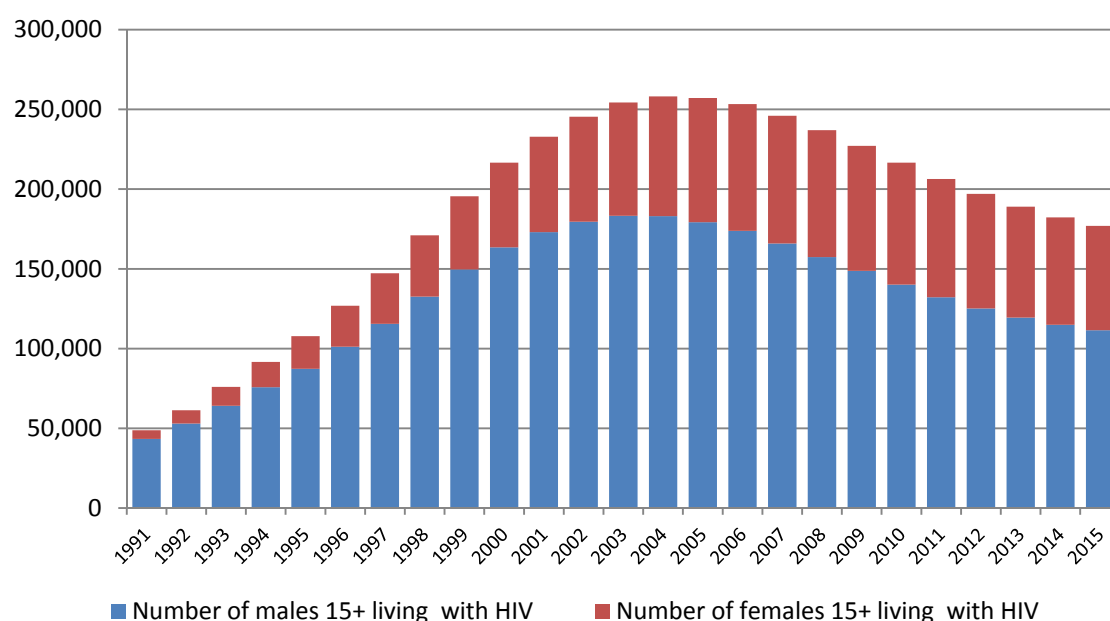


Figure 2 Number of people living with HIV – Myanmar 1991-2015.

Source: HIV Estimates and Projections Myanmar 2010-2015

The National AIDS Programme has carried out HIV Sentinel Surveillance (HSS) of selected population groups in Myanmar on a yearly basis since 1992. The most recent published data are from 2011. The sentinel groups are pregnant women attending antenatal clinics (ANC), new military recruits, blood donors, people who inject drugs (PWID), men who have sex with men (MSM), female sex workers (FSW), male clients of STI services and new TB patients. Table 1 summarizes the results from the 2011 round of surveillance.

Sentinel Group	# tested for HIV	# HIV positive	sero positive (%)	Range			95% CI
				Minimum (%)	Median (%)	Maximum (%)	
Male STI patients	4874	225	4.6%	0%	4%	16.7%	4.0% - 5.2%
FSW	990	93	9.4%	4.7%	8.3%	18.0%	7.6% - 11.2%
IDU	1100	241	21.9%	11.0%	20.3%	32.5%	19.5% - 24.4%
MSM	400	31	7.8%	6.5%	7.8%	9%	5.1% - 10.4%
Pregnant Women	13802	118	0.9%	0%	0.8%	4.5%	0.7% - 1.0%
New Military Recruits	800	12	1.5%	1.3%	1.5%	1.8%	0.7% - 2.3%
New TB patients	2870	284	9.9%	2.0%	10%	19.1%	8.8% - 11.0%
Blood Donors	14818	33	0.22%	0.00%	0.18%	1.70%	0.1% - 0.3%

Table 1 HIV prevalence among sentinel populations.

Source: NAP, HSS 2011

Figure 3 shows the trends of HIV prevalence among key populations at risk. While all groups show declining or stable trends, the absolute values remain nevertheless high. People who inject drugs had the highest prevalence, followed by female sex workers and new TB patients.

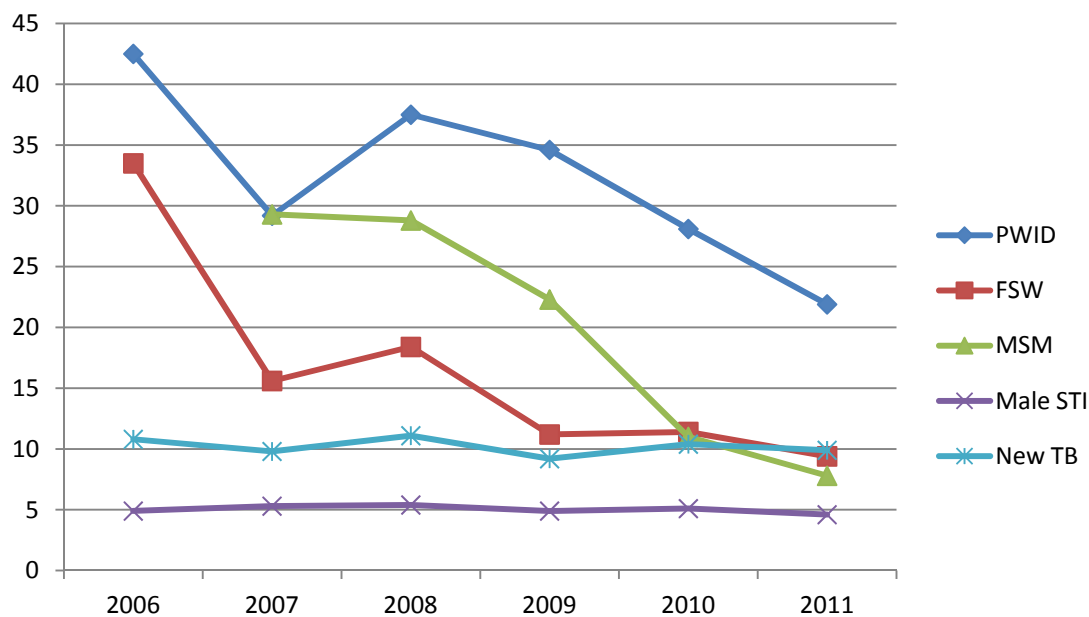


Figure 3 Trends of HIV prevalence among different sentinel populations 2006-2011.  
Source: NAP, HSS 2011

The prevalence for pregnant women has remained stable over the last three years just under 1%. The prevalence of new military recruits is assessed in two sites. The measured prevalence has shown considerable fluctuations over the last years. While this group does not represent the young male population, it confirms that younger people continue to be infected by HIV.

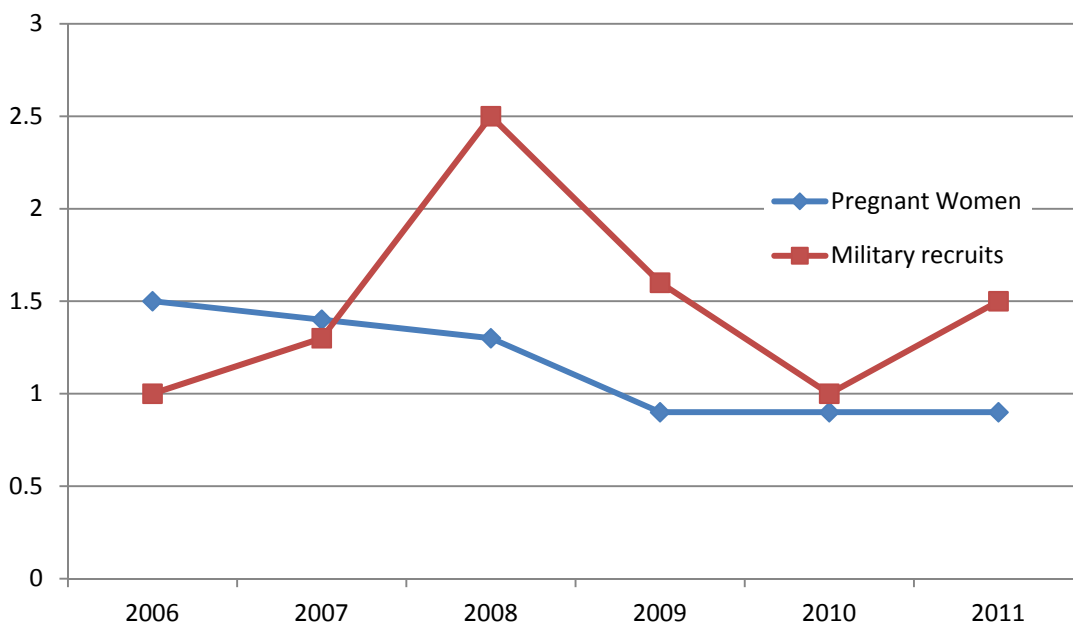


Figure 4 Trends of HIV prevalence among pregnant women and new military recruits 2006-2011.  
Source: NAP, HSS 2011

The HSS allows for an analysis of the younger subjects that are tested for HIV in the HSS. In 2011, the people who inject drugs and men who have sex with men aged 15-24 showed a substantially lower prevalence than average. The younger female sex workers had nearly the same prevalence as the average.

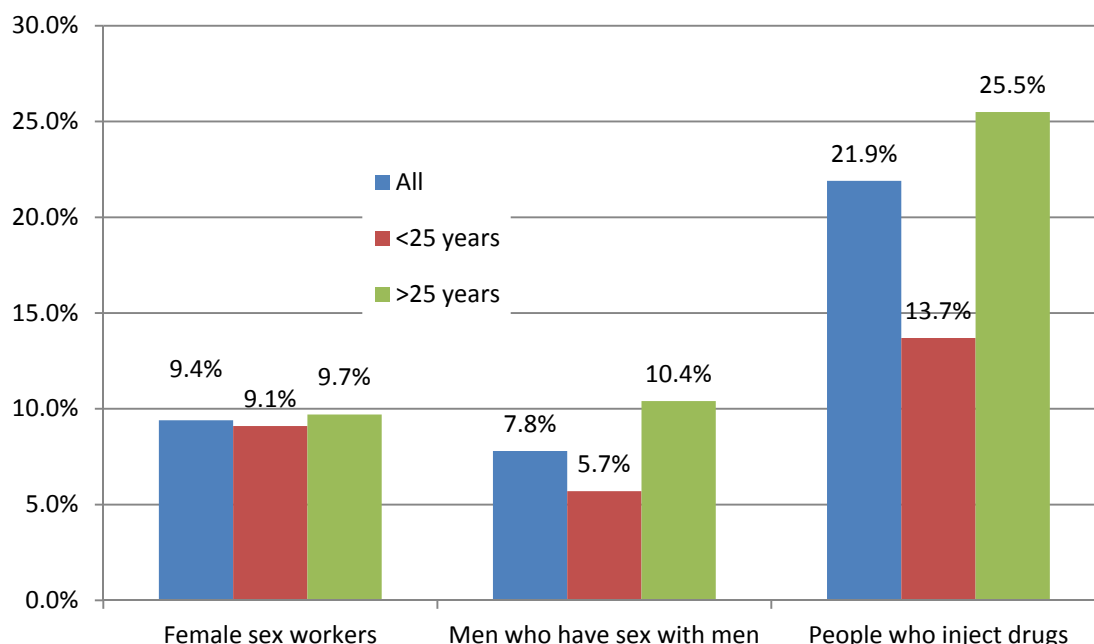


Figure 5 Percentage of most-at-risk populations who are HIV-infected.  
Source: NAP, HSS 2011

The trends of HIV prevalence among younger female sex workers and people who inject drugs have generally been falling on line with the overall prevalence for these groups. However, the decline of the prevalence among younger female sex workers has slowed in recent years and seems even to have stabilised. This raises concern, since these women would have been engaged for a shorter period of time in sex work. This will need to be followed closely.

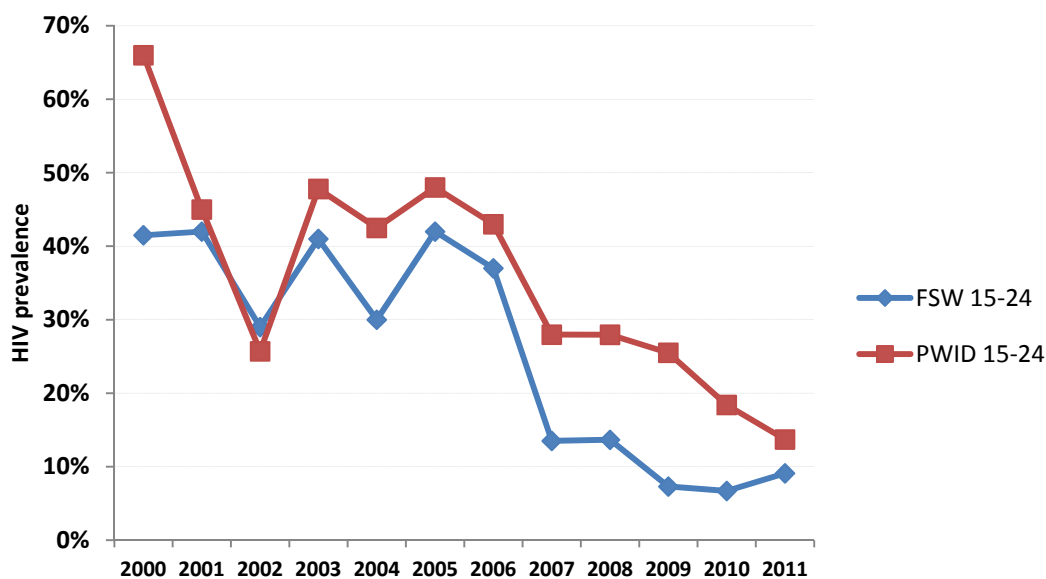


Figure 6 HIV Prevalence among young FSW and PWID (15-24 years) – 2000-2011.  
Source: NAP, HSS 2011

In 2011, the country engaged in modeling the epidemic using the Asian Epidemiological Model (AEM). This provided estimates of incidence in key populations at risk. The results of the AEM suggest that total incidence has peaked in 1999 (Figure 7). Since then there has been a steady decline of new infections every year. This will continue in future years, provided the services coverage of prevention interventions for key populations at risk remains at least at the level of 2010.

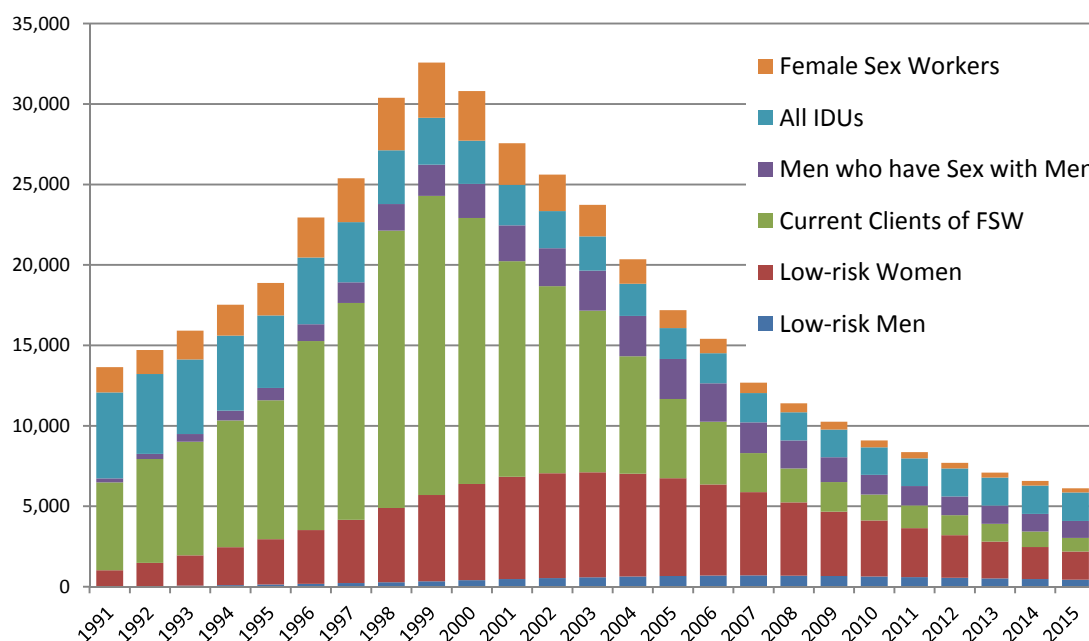


Figure 7 Incidence by key affected population – Myanmar 1995-2020.  
Source: HIV Estimates and Projections Myanmar 2010-2015

The AEM also suggests that the distribution of injections among the sub-populations included in the model has changed and will continue to change. As of 2011, over 60% of the new infections occurred among female sex workers, their clients, people who use drugs and men who sex with men. By 2015, these groups will constitute over 70% of new infections. In the 2011, the largest proportion of new infections occurred among low-risk women, i.e. partners of men with high risk behaviour. By 2015, people who inject drugs will contribute the largest part of new infections.

The female proportion among the new infections will decline after peaking in 2008.

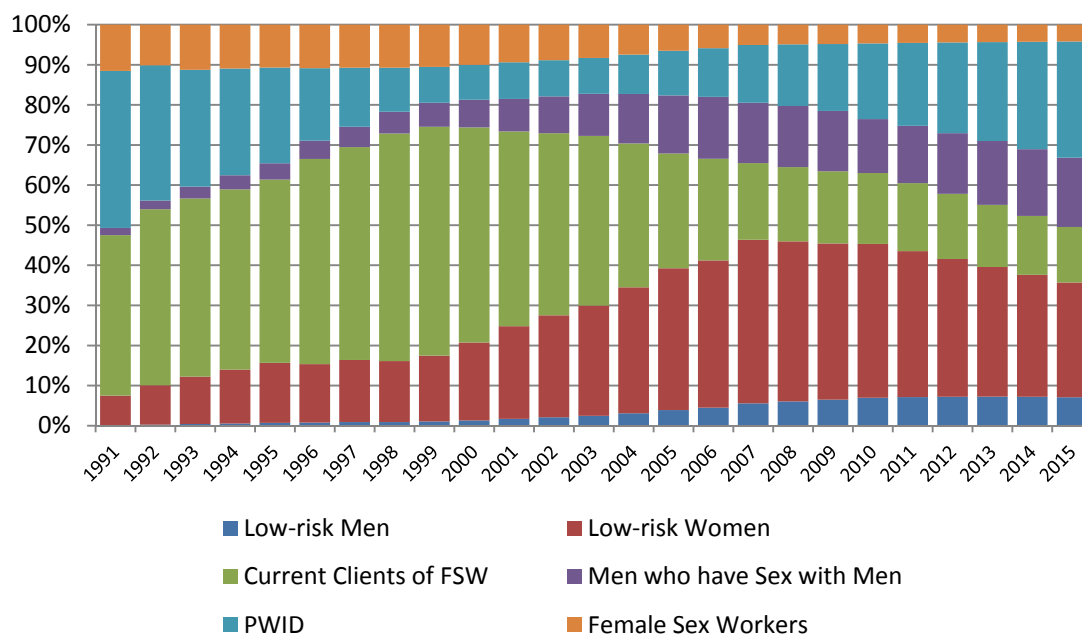


Figure 8 Distribution of new infections among key affected populations – Myanmar 1995-2020.  
Source: HIV Estimates and Projections Myanmar 2010-2015

The new infections by routes of transmission are shown in Figure 9. The decline of HIV transmission in sex work and among regular partners is steepest, albeit they start from high levels. The decline in male-to-male sex is much less pronounced. And new infections through the sharing of contaminated injecting equipment remain flat.

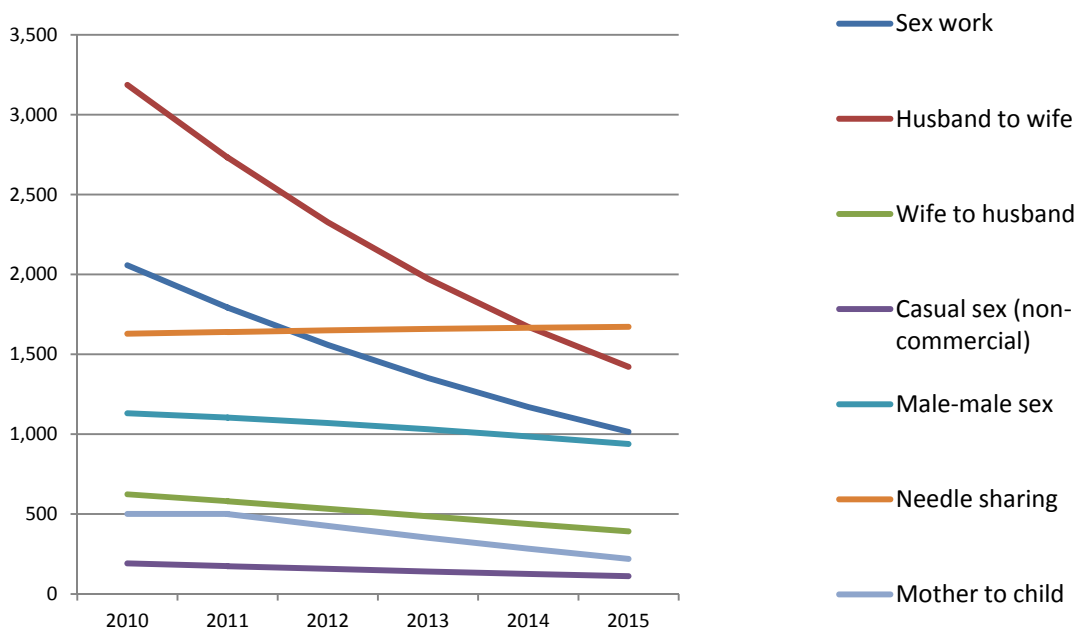


Figure 9 New infections by transmission route – Myanmar 2010-2020.  
Source: HIV Estimates and Projections Myanmar 2010-2015

A large number of people continue to die of AIDS related illnesses. The numbers are declining though as a result of the declining incidence and the recent gains in ARV provision.

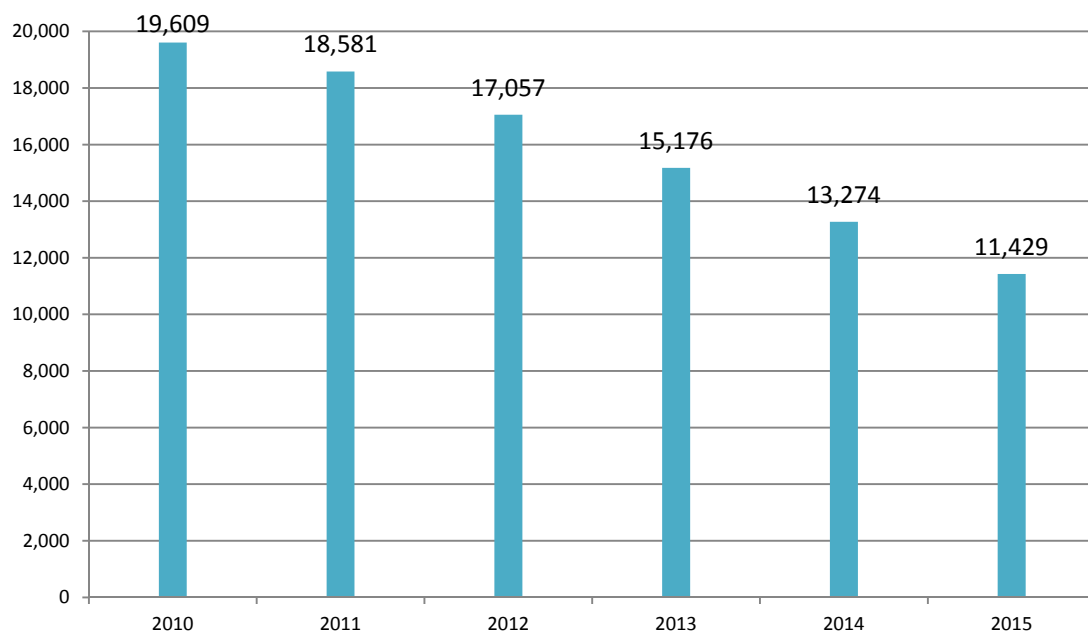


Figure 10 Number of estimated annual deaths due to AIDS – Myanmar 2010-2020.

Source: HIV Estimates and Projections Myanmar 2010-2015

### III. National response to the AIDS epidemic

#### III.1 Policy environment

##### III.1.1 Myanmar National Strategic Plan on HIV and AIDS 2011-2015

The National Strategic Plan 2011-2015 is guided by the 'Three Ones', the participation of people living with HIV and emphasises programme outcomes. It strives to achieve universal access to prevention and care, and scaling up effective initiatives through capacity building. The development of national guidelines, partnership between the government, national and international NGOs and private sector, and enhanced coordination form the strong foundations of the plan.

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 HIV 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.
  - 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/mm<sup>3</sup>) that are non-discriminatory with regard to gender, type of transmission, age, ethnicity and location.
  - 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-child transmission
  - 2,680 women will receive ARV prophylaxis in 2015
4. Much greater number of people living with HIV or affected by HIV receive support in line with the assessed needs
  - 48,500 people will receive community home-based care in 2015
  - 15,000 orphans and vulnerable children will receive some form of support in 2015
5. Intervention service coverage for key population at higher risks greatly improved
  - Consistent condom use by female sex workers will be over 80% in 2015
  - Consistent condom use by men who have sex with men will be higher than 70% in 2015
  - More than 80% of people who inject drugs will consistently avoid use of contaminated injection equipment



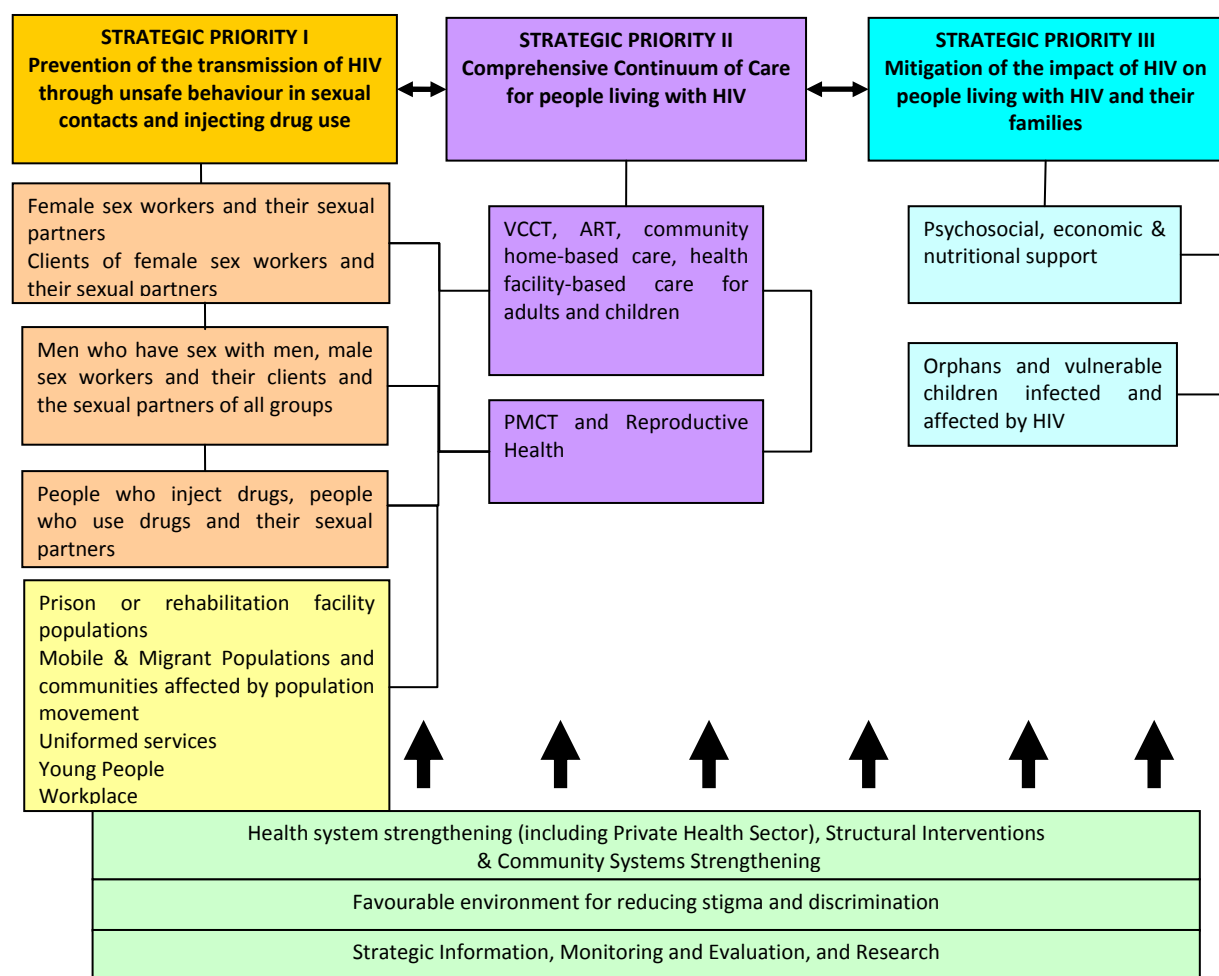


Table 2 Priority setting of the National Strategic Plan on HIV and AIDS, Myanmar 2006-2010

### III.1.2 Travel

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

## III.2 Programme implementation

### III.2.1 Strategic Priority I: Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use

The provision of free and socially marketed condoms has gained momentum after a big drop in 2007. The total number of condoms is about equally divided between free and sold. In addition, the condoms captured in the service statistics of government and NGOs, there are number of private for-profit providers. Findings of a qualitative study from one of large service providers using in-depth interviews suggest that accessibility to and availability of condoms is not considered a major constraint by sex workers. The major barriers for consistent condom use are rather related to emotional bounds between sex worker and client, monetary incentives and the perception of the client by sex worker.

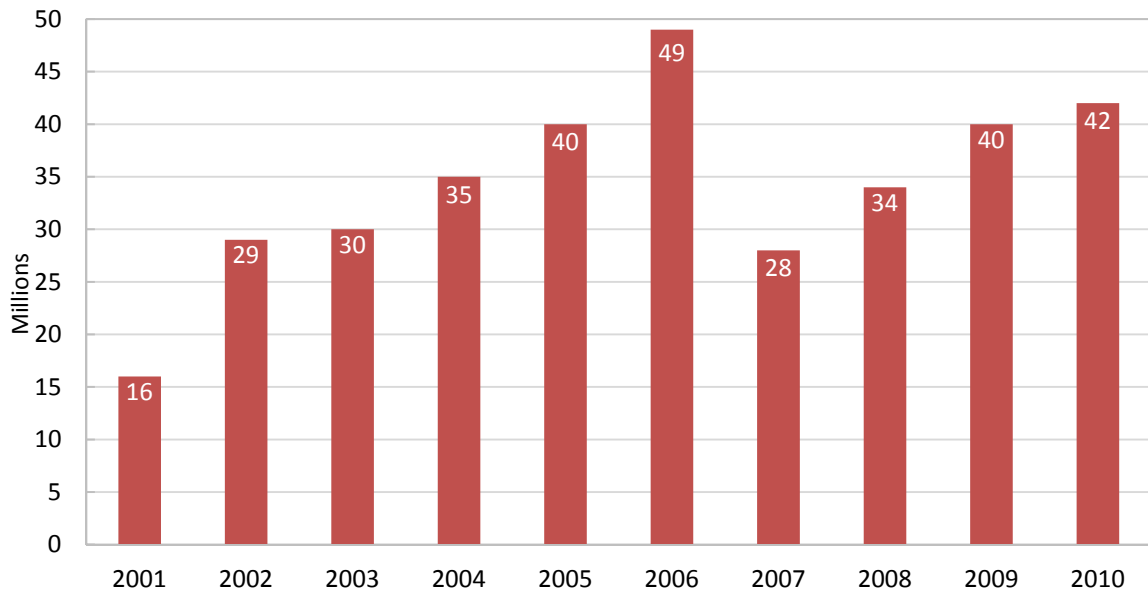


Figure 11 Condom provision – free distribution and social marketing.  
Source: National Progress Report 2010.

Voluntary and confidential testing for HIV continues to be low. There has been hardly any reported growth since 2008. There are still only a handful of non-governmental organisations that can provide the full range of testing services. This is considered an important impediment to accessing testing services, since many providers cannot give same day or same session results. It is thought that private sector testing, usually without counselling, continues to be an important venue for many people who want to know their HIV status.

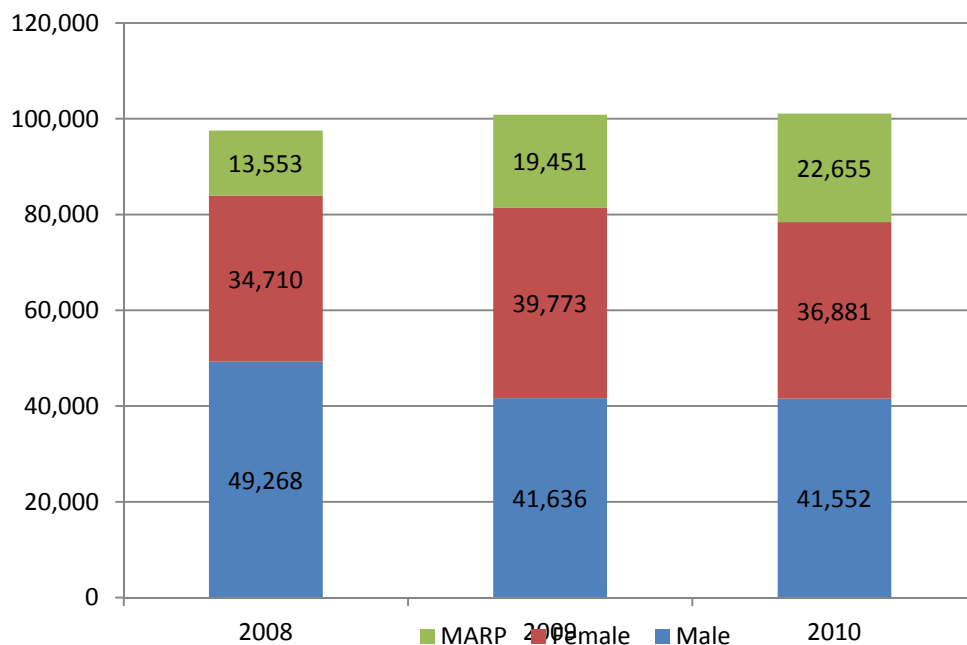


Figure 12 People receiving HIV test and post-test counselling.  
Source: National Progress Report 2010.

**III.2.1.1 Sex workers, their clients and their sexual partners**

Programmes for female sex workers have greatly expanded over the last years. The programmes have notably moved out of Yangon, the largest city and former capital. The targeted prevention programmes operate through drop-in centres as well as outreach programmes. The programmes provide condoms, STI screening, HIV counselling and testing. With the increasing coverage of these prevention programmes there is a need to identify overlaps between different service providers. This will require improved coordination, information sharing and joint evaluation as well as research.

The prevalence rate of female sex workers measured through the annual HSS has dropped from 18.4% in 2008 to 9.4%. There is some concern that the prevalence rate of young sex workers is only slightly lower than the average (9.1% in 2011; source: HSS 2011).

There are still few programmes targeting clients of sex workers other than condom provision through social marketing and some work in hotspots where behaviour change messages are provided.

The reach of sexual partners of clients as well as regular partners is not known, but it is likely to be low.

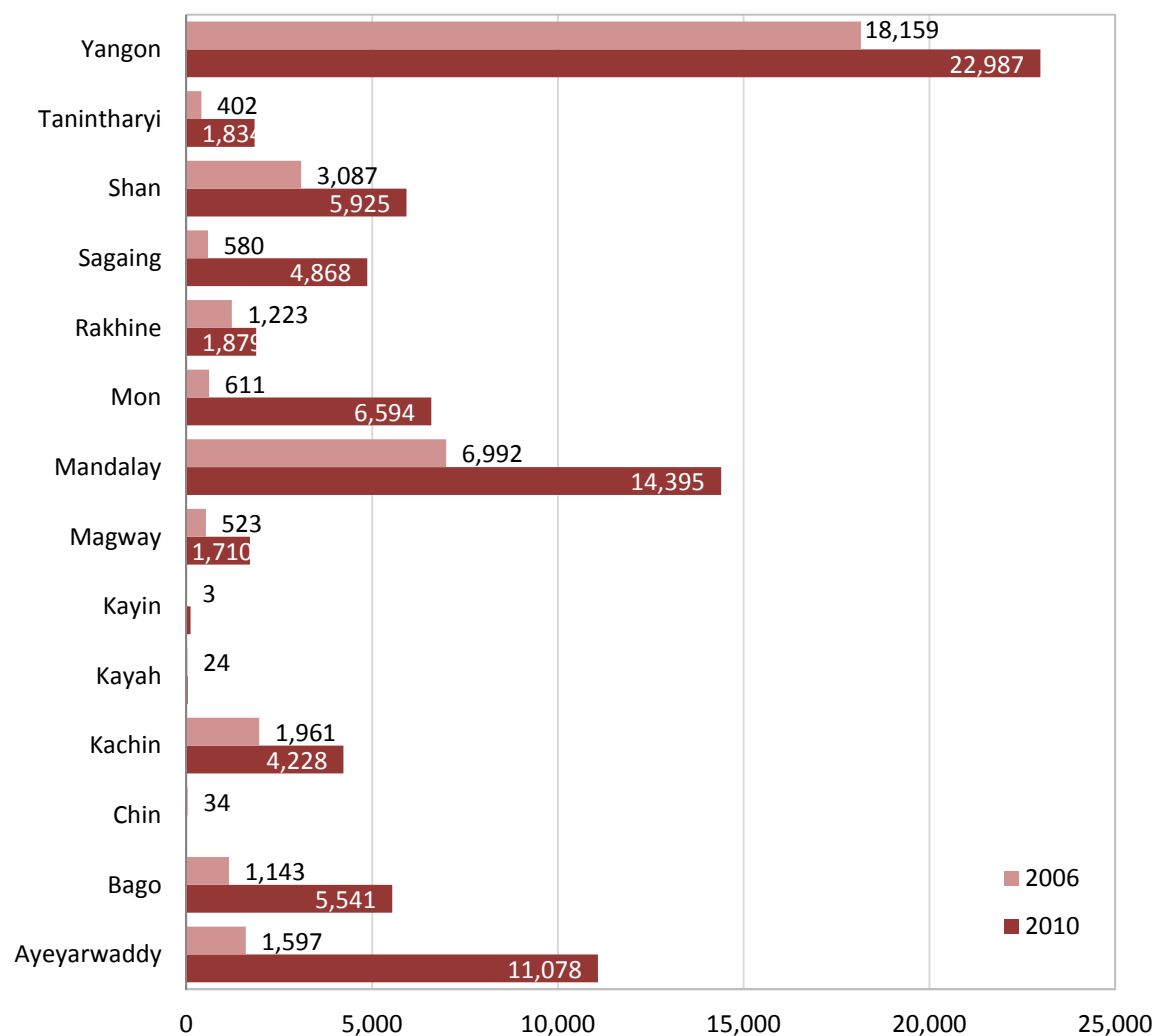


Figure 13 Females sex workers reached by state and regions 2006 and 2010.  
Source: National Progress Report 2010.

**III.2.1.2 Men who have sex with men**

Targeted interventions for men who have sex with men have grown considerably during the last 5 years. This included the establishment of new sites as well as an expansion in existing sites. The prevalence rate measured by the HSS remains high with 7.8% in 2011. The younger men who have sex with men (15-24 years) had a lower prevalence rate of 5.7% in the same year. Programmes for men who have sex with men reach mainly the openly gay part of this sub-population. There is a need to know more about the hidden part of the men who have sex with men who may be married.

Men who sex with men have started organising in networks, based on the informal groups that existed already. This provides an opportunity to involve men who sex with men in designing and implementing their own programmes.

Stigma and discrimination of men who have sex with men is reportedly still high and notably appears to affect their desire to access public health facilities. Reducing discrimination of public health services and increasing the choice of client friendly services will both need to be pursued.

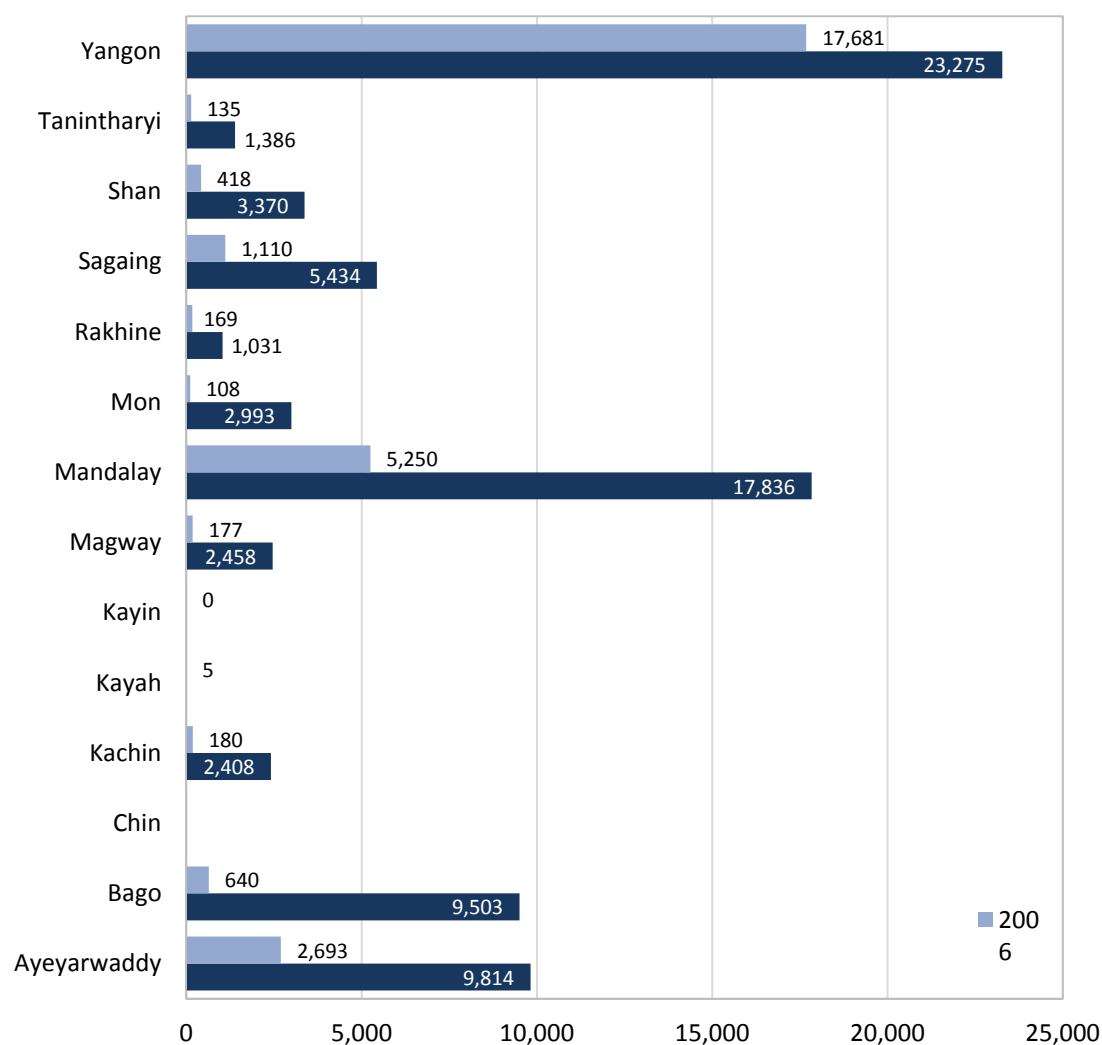


Figure 14 Men who have sex with men reached by state and region 2006 and 2010.

Source: National Progress Report 2010.

**III.2.1.3 People who inject drugs, drug users and their sexual partners**

Harm reduction programmes have continued to extend their reach in 2010. The number of people who inject drugs reached in drop-in centres was reported as 13,368, an increase of 40% from 2009. However, in view of the estimated 75,000 people who inject drugs, the coverage remained insufficient. The prevalence was measured at 21.9% in 2011.

The expansion of harm reduction programmes is constrained by a number of factors. A number of sites with known populations of people who inject drugs are not accessible. The Methadone programme has still only a few distribution points, but it demands daily presence by the clients. This is impractical and costly for methadone patients.

	People who use drugs (not injecting)		PWIDs	
	Total	Female %	Total	Female %
Outreach (contacts)	20,303	28%	36,814	9%
Drop-in-Centres (individuals)	8,520	9%	13,368	4%

Table 3 Number of drug users and injecting drug users reached 2010. Source: National Progress Report 2010.

In 2010 nearly 7 million needles and syringes were distributed. This corresponds to a 30% increase from 2009. In 2011, the needle and syringe distribution had grown to 8.9 million. This corresponds to another 75% of the needles and syringes were distributed in Kachin state suggesting that the local conditions are particularly suited for larger scale needles and syringes programmes.

The needle and syringe distribution has grown twelve fold since 2004, when only 545,000 needles and syringes were distributed. In 2010 the HIV prevalence of PWIDs was measured at less than 30%. If confirmed by the 2011 HIV surveillance, this would suggest that the prevention efforts started showing some results. However, the prevalence remains unacceptably high and coverage of harm reduction services are less than needed.

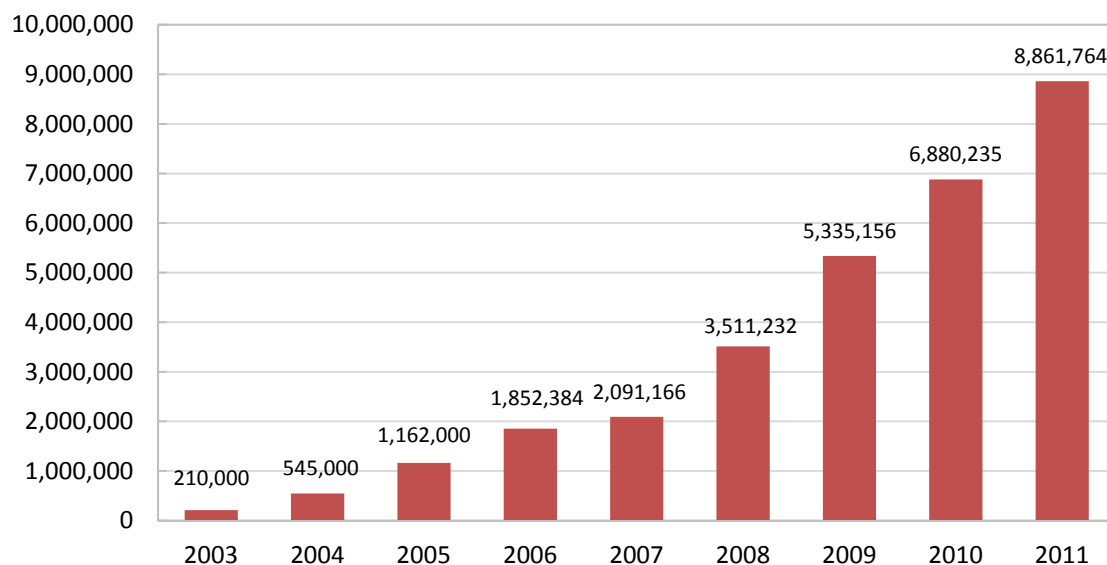


Figure 15 Needles and syringes distributed – 2003-2008.  
Source: National Progress Report 2011 (Draft).

By December 2011, 1,637 former drug users were receiving methadone maintenance therapy, an increase of over 100% from the end of 2009. The programme started in 2005.

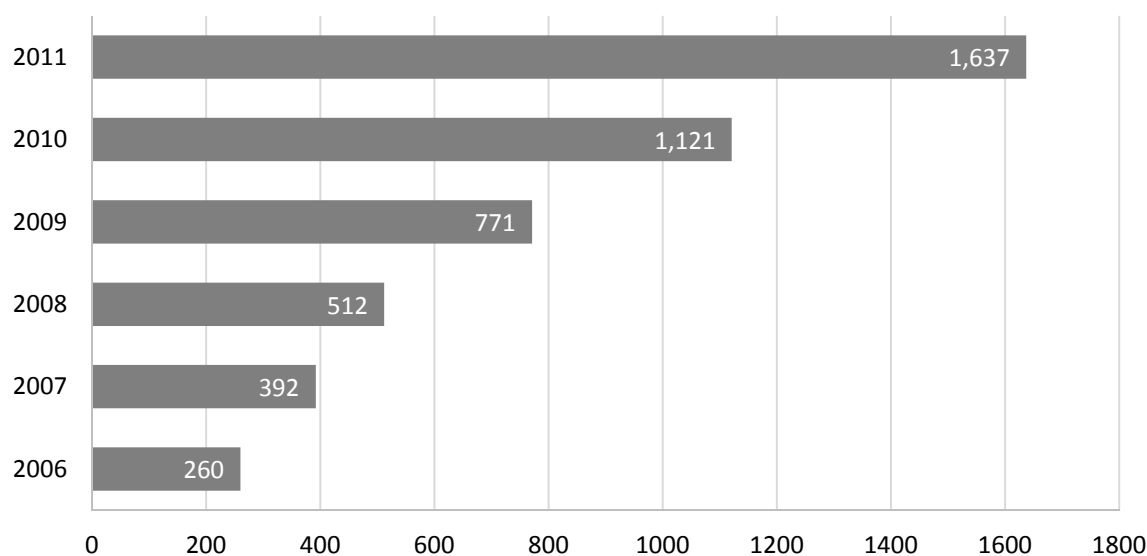
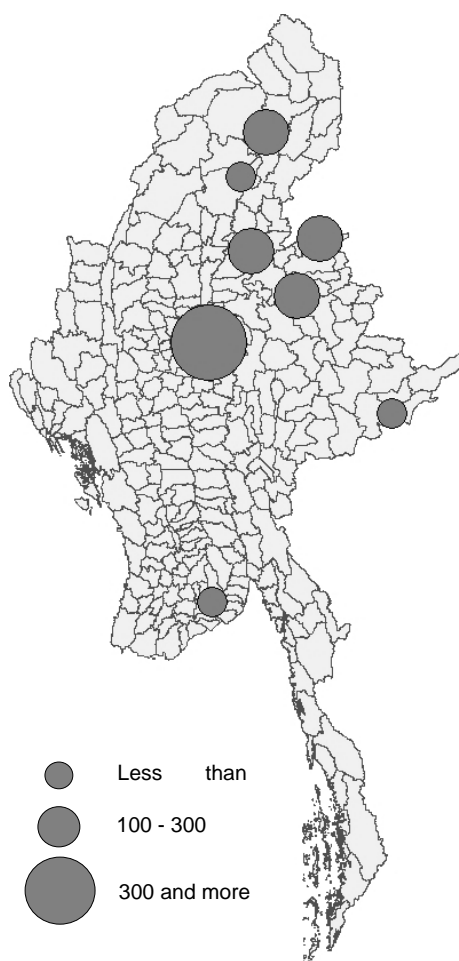


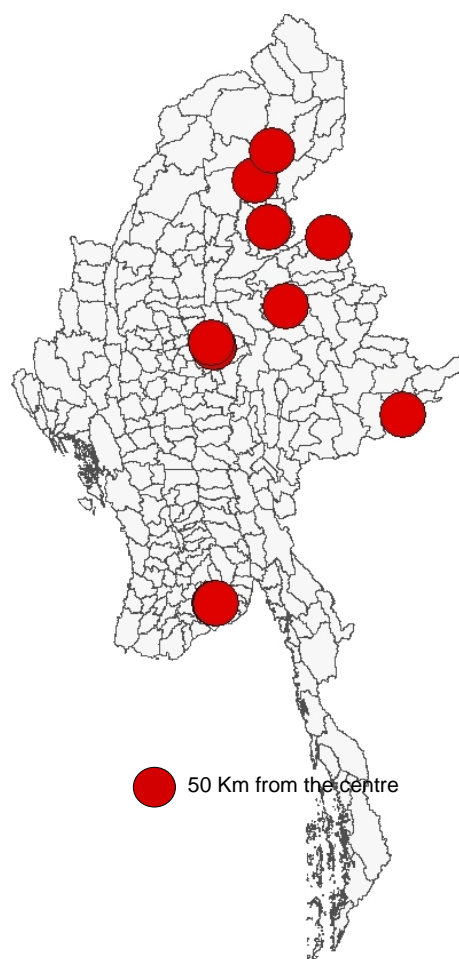
Figure 16 People on MMT 2006-2011  
Source: National Progress Report 2011 (Draft).

The expansion of harm reduction programmes is constrained by a number of factors. A number of sites with known populations of people who inject drugs are not accessible. The Methadone programme has still only a few distribution points, but it demands daily presence by the clients. The daily transportation costs and the time spent travelling add to the difficulties in scaling up Methadone maintenance therapy. Map 1 shows the Methadone sites in 2010 on the left side. On the right side a 50 kilometer diameter is drawn around each site. Given the weak road infrastructure in these parts of the country, this would entail 2 hour journeys or more for people living further away from the sites. As a result, the potential reach of methadone remains limited.

People on MMT (2010)



Distance between MMT sites



### III.3 Strategic Priority II: Comprehensive continuum of care for people living with HIV

#### III.3.1 Prevention of mother-to-child transmission of HIV

The National AIDS Programme's PMCT service has been gradually scaled up since its start in 2001, to cover 248 sites by 2010. Of these, 38 were hospital based and 210 were community based. In 2010, the number of women accessing antenatal care services who received pre-test HIV counselling attained 539,728. The number of women who accepted HIV testing and received the test results with post-test counselling increased reached 250,938.

In 2011, a total of 3,003 pregnant women were reported as having received PMCT services from Government and NGO service providers. Of those, 2,097 received a 2 drug combination to prevent HIV transmission. A total of 906 women were reported as being on ARV treatment during delivery. The treatment had either started before or during the pregnancy. In 2011, there were no more reports of single dose Nevirapine treatment.

Year	ARV prophylaxis for PMCT		ART for clinically eligible HIV infected pregnant women
	Single dose Nevirapine	Combination of 2 ARV drugs	
2011	0	2,097	906

Table 4 Number of HIV-infected pregnant women who received ARV prophylaxis, by regimen.

Source: National Progress Report 2011 (draft).

There has been continuous progress in the number of women accessing VCCT as well as women receiving their HIV test.

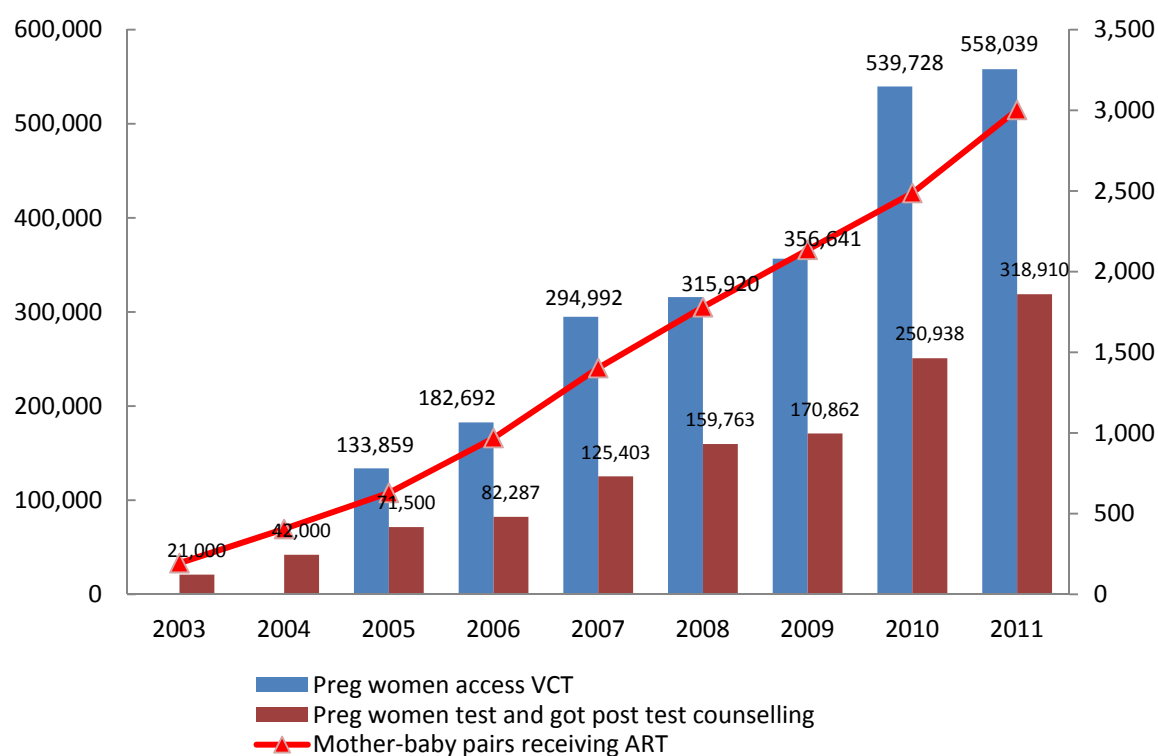


Figure 17 Pre-test and post-test counselling, ARV prophylaxis, 2003-2010.

Source: National Progress Report 2011 (draft).

### III.3.2 Care, treatment and support

By the end of 2011, 40,128 persons were receiving ART, an increase of nearly 100% since the end of 2009. In 2010 and 2011, the proportion of males and females remained unchanged at 44% females against 56% males under treatment. The proportion of children was 7% for both years.

	Adults (15+ yrs)		Children (<15 yrs)		Grand total
	Male	Female	Male	Female	
Dec 2010	15,680	12,035	1,088	1,022	29,825
Dec 2011	20,938	16,195	1,559	1,436	40,128

Table 5 Number of people receiving ART at the end of 2010 and 2011.

Source: National Progress Report, 2010 and 2011 (draft).



% of total receiving ART	Male	Female	Children	Adults
Dec 2010	56%	44%	7%	93%
Dec 2011	56%	44%	7%	93%

Table 6 Percentage of adults and children with advanced HIV infection receiving ART.  
Source: National Progress Report 2010 and 2011 (draft).

In terms of geographical coverage, by the end of 2011, nearly 100 sites were providing ART in all of Myanmar's states and regions except one, compared with 57 sites in 2008. Over 70% of the total number of people receiving ARV were in Yangon, Kachin state and Mandalay. The coverage in other states and regions remained relatively low.

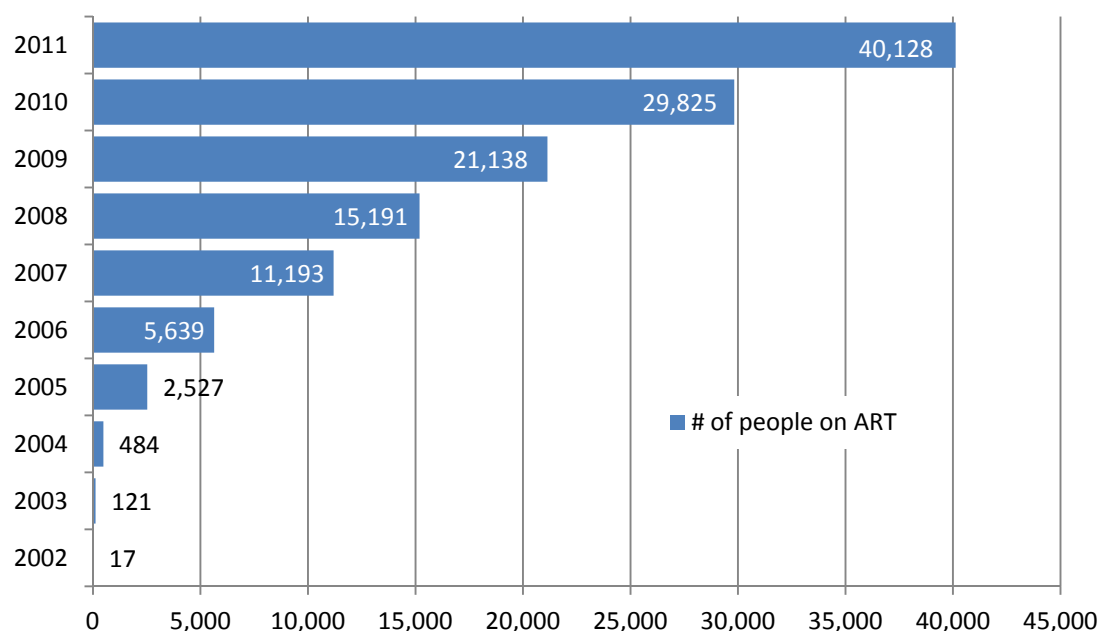


Figure 18 Number of people receiving ART, 2002-2009.  
Source: National Progress Report 2011 (draft).

Table 7 shows the percentage of people who have started ART in 2010 and are still known to be on treatment 12 months later. The data has been collected from the biggest providers of ART representing about 90% of the total ARV patients that initiated treatment in 2010.

2010	All (n=6,361)	Male	Female	<15 yrs	15+ yrs
% known to be still on ART 12 months after start of treatment	87%	85%	90%	94%	87%

Table 7 ART treatment - 12 months retention.  
Source: NAP, MSF-Holland, MSF-CH.

### III.4 Strategic Priority III: Mitigating the impact of HIV on people living with HIV and their families

Provision of care and support for people living with HIV and their families as well as orphans and vulnerable children continued to be an area of challenge to reach sufficient scale. Nevertheless, partners could expand the reach of programmes. In 2008, care and support was provided to 9,527 orphans and vulnerable children. In 2010, a total of 16,550 orphans and vulnerable children were reportedly reached by partners.

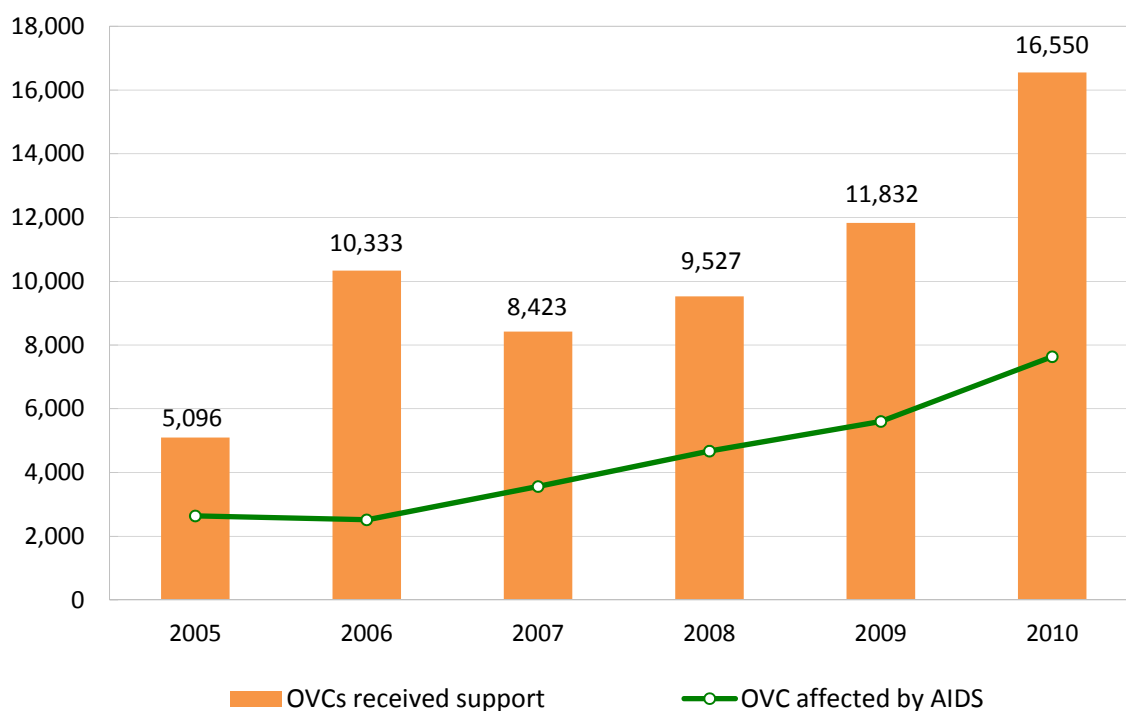


Figure 19 Orphans and vulnerable children receiving support, 2005-2008.  
Source: National Progress Report 2010.

## **IV. Best practices**

### **IV.1 Myanmar National Strategic Plan 2011-2015**

The second National Strategic Plan for HIV and AIDS covering the years 2011 to 2015 was developed in close consultation with all stakeholders. The process developing the NSP included:

- An inclusive review of the first NSP 2006-2010 that included regular sessions with the Technical Working Groups and organisations representing people living with HIV as well as those affected by HIV;
- A revision of the available epidemiological information leading to the development of data using the Asian Epidemiological Model. The incidence trends from the AEM were used for prioritization and target setting in the new NSP;
- Feedback and consultation sessions with the Technical and Strategy Group (TSG) on AIDS;
- A series of dissemination workshops that were conducted at the central level as well as at decentralised levels. The aims of these dissemination events were to raise the awareness of the national HIV strategy among government officials outside of the NAP; to bring together civil society and government to discuss priorities for different states and regions.

### **IV.2 Myanmar-Country Coordination Mechanism**

The country received its first full Global Fund grants funding only with Round 9. The M-CCM, transformed from the Country Coordination Board of the Three Disease Fund, had a chance to reform its functioning and governance with the latest guidelines from the Global Fund.

Recognising that the M-CCM was the only multi-stakeholder forum in the country at that level, the M-CCM was designed to serve as a forum for all issues regarding AIDS, Malaria, TB and Maternal Newborn and Child Health rather than giving it a narrow Global Fund focus.

The M-CCM has been praised as a good example by the recent Global Fund OIG mission.

### **IV.3 Strategic Information and M&E Working Group**

In 2010, the country set out to make better use of the available information on HIV. In first step, a Strategic Information and M&E working group was formed. The Working Group consists of members from 3 different MOH departments, NGOs and UN Agencies.

The Working Group worked on three principal outputs in its first two years: the application of the Asian Epidemiological Model (AEM) in Myanmar, the development of the National M&E Plan and the National Research Agenda for HIV. In addition, it served as a panel for the review of HIV related research and studies.

The development of the AEM provided the opportunity to undertake a thorough review of the existing information used for models. In addition, the previously used information was triangulated with other sources of information. An open and transparent analysis of the information led to a number of improvements to the input data for the AEM.

The National M&E Plan provides the third pillar of the national planning framework after the NSP and the operational plan. The Working Group engaged a number of stakeholders including Principal Recipients and other fund managers in the discussions to ensure that all major stakeholders agree on the indicators, reporting cycles and data collection systems.

Finally, the research agenda provides principal directions of research needed to improve the understanding of HIV and enhance service delivery.

## **V. Major challenges and remedial actions**

### **V.1 Financial resources**

Myanmar receives the second least ODA per head of all LDCs. This has impeded scale up of the national response. Government contribution to the national response remains limited and comes mostly in the form of staff and buildings.

The Parliament is discussing the government budget for the first time. The Government plans to substantially increase the resource allocation to the social sectors, including health. The detailed allocation of the increased resources is still being discussed.

### **V.2 Health system**

The shortage of staff at all levels poses some serious challenges to the scale up of service delivery in the public health sector. There is not yet a policy and tradition of shifting non-specialized medical tasks to other health cadres or to specifically trained lay persons (such as to people living with HIV). There is a lack of national systematic planning and monitoring of workshops and other training activities in the context of continuing education or on the job training for doctors, pharmacists, midwives and laboratory technicians. The flow of information, M&E, procurement and supply management, including the Logistic Management Information System are in urgent needs for improvements.

The Phase II request for the Global Fund Round 9 that will need to be submitted before the end of 2012 will offer the opportunity to systematically review the trainings provided. The “hospital initiative” which aims to transfer technical expertise and knowledge from the most experienced INGOs involved in ART provision to public hospitals has a good potential of assisting the strengthening of capacity of AIDS patient management of public hospitals.

### **V.3 Policy and legal frameworks**

Laws which criminalize behavior of groups who are most at risk (sex workers, men who have sex with men and people who use drugs) remain in place. This may lead to incidents of harassment of key affected populations which discourages effective and open interventions with these populations.

The Parliament reviews at this moment many laws. Advocacy with the appropriate sub-committees should be undertaken to ensure that relevant laws take into consideration the potential impact on key populations at risk.

### **V.4 Coordination at national and sub-national levels**

Ministries which are leading and supporting the national response to HIV and AIDS appreciate the opportunity to meet and exchange experiences and identify where closer collaboration and coordination might take place. Unfortunately, coordination meetings among ministries, organizations and concerned groups at all levels are usually not regular, systematic or inclusive of all partner, namely government, international and local NGO and community-based organizations.

The new NSP has called for a stronger central and local level coordination. The national planning and monitoring framework provides the opportunity to coordinate the national response at all levels.

## **V.5 Community systems**

The full participation of civil society organisations in funding opportunities, planning and coordination is not always guaranteed. Some international organizations have difficulties in expanding their services due to the lengthy and complex procedures of negotiating Memorandum of Understanding (MOU) with the counterpart government authorities. Some organizations have been hesitant to expand programming due to funding or the perceived sensitivities around certain areas of work. Coordination among all partners and stakeholders, including community members varies widely, depending on openness of local authorities to engage with other stakeholders, the capacity of organizations present and willingness to regularly address issues at the local level.

The Ministry of Health recognises the important contribution that non-governmental organisations make to the national HIV response. Pending MOU are being worked on as a matter of priority.

## VI. Support from the country's development partners

The estimated amount of external resources available for the national response to HIV in 2011 was approximately US\$ 43 million, which corresponds to an increase of around US\$ 5 million from 2010. Most external funds are still channelled through NGOs and United Nations organizations, since sanctions pose restrictions on donors to channel funds directly to the government. For the same reasons, Myanmar does not currently access resources from the World Bank or the Asian Development Bank.

Donors are providing support to the national response within the context of the National Strategic Plan and the costed Operational Plan. Indicators and targets are aligned to the national framework.

The Three Diseases Fund (3DF) is a multi-donor pooled funding mechanism established in 2006 to respond to the funding gap for HIV, tuberculosis and malaria as a result of the withdrawal of the Global Fund in 2005. The 3DF has been the most important source of funding for HIV since its inception. However, the 3DF ended the majority of its support by the end 2011. The Global Fund has returned with its support to the Round 9 application of Myanmar and programme implementation started in 2011. The first year of operation was undertaken in close collaboration with the 3DF. Many targets were actually untied enabling a smooth transition from the 3DF to the Global Fund implementation.

The 3DF was resourced by a consortium of seven donors (Australia, Denmark, European Commission, Netherlands, Norway, Sweden and United Kingdom). It is estimated that the 3DF provided for about 60% of the funds for HIV during its lifetime. In addition, there are bilateral donors contributing directly to the national response. However, these programmes are relatively small in size and typically amount to less than US\$ 1 million per year.

NGOs are key partners for delivering services to key populations at higher risk who can be more difficult to reach through conventional public health services. This includes providing services through outreach and drop-in centres to sex workers, men who have sex with men, and people who use drugs. Sex work and drug use are illegal in Myanmar. However, NGOs also manage an important part of the treatment programme. ARV treatment has been funded by the donors as well as direct contributions by NGOs. This has provided considerable flexibility to their operations.

There is currently no United Nations Development Assistance Framework in place. However, the United Nations Agencies have developed a Strategic Framework that entails their support to the national development strategies. The Strategic Framework includes the work of the UN on HIV. There has been a United Nations Joint Team on HIV in Myanmar since May 2007. The UN Agencies have been essential partners in planning, implementing and reporting on the response to HIV. This technical and financial assistance to the public sector, mobilization and support of community, private and civil society partners, the development and use of strategic information, and the mobilization of United Nations' and additional resources to fund service delivery for people in Myanmar. Some agencies play a wider role in programme management, including fund flow to national entities for activities, along with monitoring and support for implementation.

## VII. Monitoring and evaluation environment

The country has developed a National M&E Plan that guides the monitoring and reporting of the national response. The National M&E Plan includes a description of the M&E system, the reporting tool, data quality insurance, the research agenda and the indicators.

### VII.1 Oversight

The Myanmar Country Coordinating Mechanism entrusted the oversight and coordination for implementation of the AIDS Operational Plan to the Technical and Strategy Group – AIDS (TSG). This includes ensuring monitoring and evaluation of the national response. The TSG further delegated technical issues to eight Technical Working Groups, which ensure that consultation is inclusive and that local expertise is used. The working groups communicate findings and recommendations to the TSG to inform decision-making, planning and implementation. The oversight structure including the TSG and its working groups are outlined in Figure 20.

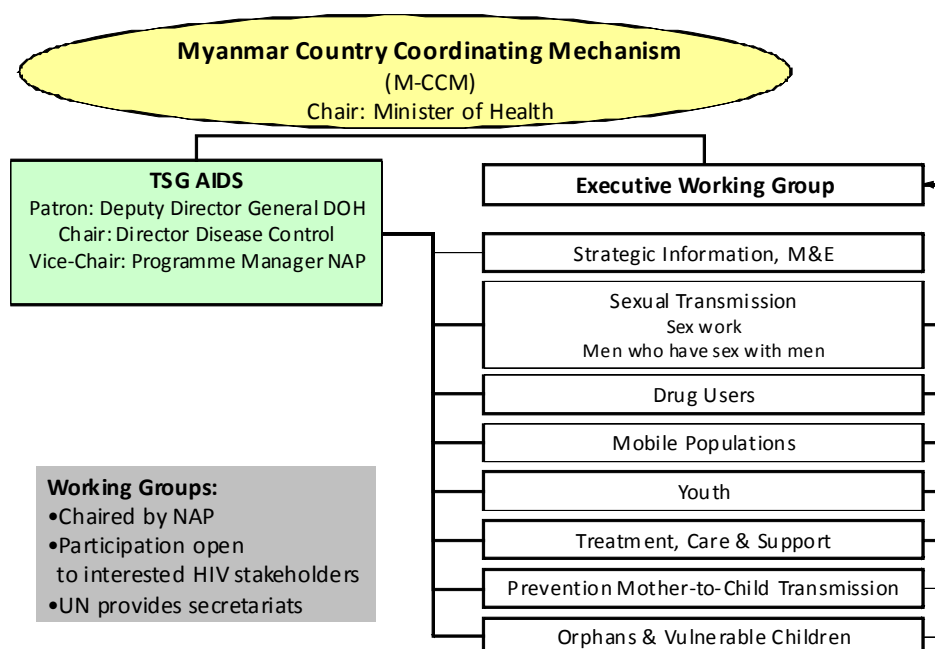


Figure 20 Governing Structures of HIV in Myanmar

### VII.2 National AIDS Programme

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

measure programme outcomes. In additions, it leads the surveillance and other research undertakings.

### **VII.3 State or Division, District and Township levels**

The State/Regional, District and Township AIDS committees are established with State/Regional AIDS/STD officers serving as a joint secretary. Their purpose is to coordinate the State and Regional response of HIV and AIDS of public and NGOs sectors. The State/Regional AIDS/STD officers and Township AIDS/STD team leaders at the district/township level are responsible to lead on M&E at the corresponding levels. A total of 7 State/Regional AIDS/STD officers and 46 AIDS/STD teams are in place at strategic geographic locations. State/Regional AIDS/STD offices also manage the HIV commodity sub-depots. They have the responsibility of monitoring programme activities implemented by different actors including public sector, NGOs, CBOs and the private sector operating at the district and township level. They also have to report the programme activities on a regular basis to the State/Regional level and to the central M&E unit. If there is no AIDS/STD teams at the township level, data must be collected from the health care providers (basic health staffs) and reported through the township health structures (Township Medical Officer) to the M&E unit of the NAP.

### **VII.4 NGOs, CBOs and the private sector**

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

### **VII.5 M&E system data flow**

Stakeholders including AIDS/STD teams implementing HIV and AIDS programmes are expected to regularly report on program indicators that are relevant to the type of activity they are undertaking. The annual reporting forms are already established to collect the data at the field level. An overview of potential M&E data responses among HIV stakeholders is depicted in following two illustrations based on the availability of a State/Regional office.

### **VII.6 Strategic Information and M&E Working Group**

The SI/M&E Working Group (chaired by NAP) coordinates with all HIV service providers in order to harmonize in country M&E procedures and to minimize the duplication. Under the guidance of TSG, the SI/M&E Working Group identifies strategies, oversees planning and implementation of M&E measures for the national HIV response. Joint M&E activities with representatives from different organizations have already been conducted and important findings and feedback will be disseminated on regular basis. These practices will be continued with greater involvement from State/Regional AIDS/STD offices.

The National AIDS Programme actively advocates for M&E among donors, line ministries and within the Ministry to acquire political commitment and financial investment in M&E. Timely dissemination of progress reports, surveillance reports and other research studies will ensure that a comprehensive picture of HIV epidemic trends and updates in the national responses



including achievements, challenges and recommendations for action are available to policy maker, donors and implementers.

## VII.7 Information products

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

- **National Annual Progress Report** on the implementation of the National Strategic Plan. An annual progress report on the national response is produced based on a standard reporting format submitted by all partners implementing HIV activities. The reporting format includes the output and process indicators of the national monitoring framework that are included in the Operational Plan.
- **HIV Sentinel Surveillance report.** HIV sentinel surveillance is conducted annually. In recent years the methodology has been improved by increasing sample sizes and by including additional population groups, notably men who have sex with men.
- **Behavioural surveillance reports** - Behavioural sentinel surveillance is conducted regularly for key populations, every two years for some groups, and a report of the findings of each survey is published.
- **Resource mapping** of expenditures on the national response to HIV, by National Strategic Plan Strategic Direction. Since 2007, comprehensive financial data have been collected by organization to allow analysis of resources available and spent by strategic direction and by donor type. This is currently also provided in summary form within the national Annual Progress Report.
- **Estimation and Projections of HIV.** The country has moved to using AEM to model the epidemic.
- **Reports for global initiatives**

## VII.8 Challenges faced

The major challenges faced in the implementation of the national M&E system are the under-developed communications infrastructure, and a lack of staff dedicated to M&E at all levels as well as staff capacity at the peripheral levels.

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

The Government plans to implement a decentralised system of governance. However, the details of the extent of this decentralisation are not yet known. At present, there is a shortage of M&E staff at the decentralised levels. The restructuring of the state and region health services, including the AIDS/STD teams will influence the type of expertise required at these levels. Regardless on the type of decentralised system, a substantial increase of skilled human resources at peripheral levels will be required in order to fulfil reporting requirements and enhance state/region level planning and implementation.

## VIII. Data sources

1. *HIV Estimates and Projections Myanmar 2010-2015; Strategic Information and M&E Working Group, March 2012*
2. *Report of the HIV Sentinel Sero-surveillance Survey 2011; National AIDS Programme, MoH, March 2012*
3. *Behavioural Surveillance Survey 2008, Out of School Youth; National AIDS Programme, MoH, March 2009*
4. *Behavioural Surveillance Survey 2008, Injecting Drug Users and Female Sex Workers; National AIDS Programme, MoH, July 2009*
5. *Behavioural Surveillance Survey 2007, General Population; National AIDS Programme, MoH, March 2009*
6. *National Strategic Plan for HIV and AIDS in Myanmar, Progress Report 2010; National AIDS Programme, MoH*