STRATEGIC TECHNICAL ALIGNMENT FOR RESULTS (STAR) PROCESS

Burma

Country/Regional Operational Plan

(COP/ROP) 2017

Strategic Direction Summary

March 2, 2017

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1.0 Goal Statement

The vision for the President's Emergency Plan for AIDS Relief (PEPFAR) in Burma for COP 17 is to support the country's efforts to achieve epidemic control using the "90-90-90" global targets as a framework for HIV program planning and prioritization. PEPFAR in Burma support will continue to focus on technical assistance (TA) and targeted support to improve the cascade of HIV prevention, testing and treatment, especially for key populations (KP) affected by high HIV prevalence and limited access to and low coverage of HIV services. PEPFAR in Burma will also assist with strengthening laboratory, health information and supply systems to sustain the program in the long-term. PEPFAR in Burma's overarching goals for FY 18/19 aim to achieve high yield of HIV testing among KP, as well as early enrollment and high rates of retention in treatment services for those who are HIV infected. These goals place particular emphasis on scaling up harm reduction services and medication-assisted therapy (MAT), as well as improving case detection and linkage to treatment for people who inject drugs (PWID). The PEPFAR program in Burma is strategically structured to capitalize on site-level "incubator" innovations and service delivery models in order to inform higher level TA linked to policy and guideline shifts that support scale-up and impact of HIV programming and resources. To this end, close collaboration with all key in-country actors, including the government, civil society, the community and other stakeholders, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and its partners, will be enhanced to identify cutting-edge solutions to national epidemic control challenges, invest in these ideas, test them and work to scale the solutions that promise the greatest impact.

2.0 Epidemic, Response and Program Context

2.1 Summary statistics, disease burden and country or regional profile

Burma, a sovereign nation bordered by Bangladesh, China, India, Laos and Thailand, is made up of one Union Territory, 14 states and regions, 74 districts, 330 townships and 13,602 village tracts. It has a population of 51,486,253 people and comprises at least 138 ethnic groups. About 89 percent of the population is Buddhist.

Burma is one of 35 countries that account for 90% of new HIV infections globally (UNAIDS Fast Track Update on Investments, 2015). Burma has an estimated 224,794 people living with HIV (PLHIV) (AEM, Spectrum 2016). The HIV epidemic in Burma was at its height in 2005, when HIV prevalence reached 0.73% of the general population. In 2015, HIV prevalence declined to 0.59%. The HIV epidemic in Burma remains concentrated among KP, with HIV transmission primarily occurring among people who inject drugs (PWID), men who have sex with men (MSM), transgender people (TG), and female sex workers (FSW) and their clients.

According to the Third Myanmar National Strategic Plan for HIV: 2016-2020 (NSP III), at the end of 2015, 106,490 persons were receiving antiretroviral treatment (ART). This represented 47 percent of all those in need of treatment as specified by national treatment guidelines. With TA provided by PEPFAR and other partners, accelerated ART scale up has started to show results, and, while the official release is still pending, according to the National AIDS Program (NAP), 127,402 individuals were receiving ART by the end of 2016. The national program has ambitious treatment targets, including having 196,743 individuals on ART by 2020 (NSP III, 2016 NAP). However, supply chain and laboratory systems supporting scale-up need further strengthening, and regular monitoring of results at all levels does not occur.

Important policy and strategy changes in Burma include the transition to Test and Start for all PLHIV, which is a 'Core' activity for COP 16. The existing treatment guidelines currently stipulate a

policy of immediate ART for HIV-positive pregnant women, children under 5 years of age, tuberculosis (TB) patients and KP, and the guidelines are being revised with anticipated roll-out of Test and Start for all PLHIV in 2017.

Currently available KP size estimates are 66,000 FSW and 252,000 MSM. Based on the results of the Integrated Bio-Behavioral Survey (IBBS) of PWID, which was completed in 2014, there are an estimated 83,000 PWID in Burma. Data collection for IBBS of FSW and MSM was completed in 2015, and data analysis is ongoing with full release of findings expected shortly; results of the ongoing national drug user survey will inform PWID activities. Additional data received from other surveys and implementing partners (IPs) will help to improve modeling estimates of the epidemic trends within Burma and facilitate further tailoring of the PEPFAR response.

HIV prevalence rates among KP are much higher than those of the general population. As such, the HIV epidemic disproportionately affects KP and their intimate partners. National HIV prevalence is 28.5% among PWID (NSP III, AEM, 2014 PWID IBBS); 14.6% among FSW (NSP III, 2015 FSW IBBS draft report); and 11.6% among MSM (NSP III, 2015 MSM IBBS draft report). Prevalence varies geographically: for example, in the north and north-eastern parts of Burma (Muse (Northern Shan State) and Waingmaw and Bamaw (Kachin State)), nearly one in two PWID who participated in the IBBS in 2014 tested HIV-positive, which is the 5th highest HIV prevalence level among PWID in the Asia/Pacific region. Similarly, HIV prevalence among MSM was 27% in Yangon and 22% in Mandalay; HIV prevalence among MSM in Yangon is the highest in a specific geographical site in the Asia/Pacific region. However, there is limited information at sub-national levels, and the surveillance results do not include the large parts of the country where there is ongoing civil unrest. Numbers disaggregated by KP are shown in tables 2.1.1 and 2.1.2, although concerns about data quality limit their use and interpretation.

Despite limitations in data quality, tables 2.1.1 and 2.1.2 show differences in HIV prevalence between the total population (0.60%) and KP, with highest prevalence among PWID at 28.5%. This will inform a prioritization of programming in COP 17/18 designed to respond to key PWID prevention and treatment needs. In addition, it points to the need for HIV testing and treatment among patients with TB and sexually transmitted infections (STIs), as there is likely an overlap in risk behaviors: HIV prevalence among TB patients with known HIV status is estimated at 9% (2015, Global TB Report).

The HIV Sentinel Surveillance is conducted every two years, with data reported from around 35 of 330 townships.

Incidence rates for KP are not available, though estimates and projections of incidence, i.e., new infections, are generated by the AIDS Epidemic Model (AEM) (formerly the Asian Epidemic Model). A large proportion of new infections (29%) is attributable to PWID. The PEPFAR in Burma team is concerned about potential future increases of HIV transmission through injection drug use and sharing of needles and syringes, should service provision for PWID remain inadequate or decrease further; a significant drop in donor funding to support prevention programs for KP has already been observed.

While available data suggests that relatively high coverage for FSW, MSM, TG and PWID has been achieved in terms of the individuals 'reached' with prevention interventions, those accessing HIV testing and counseling (HTC) have remained low. According to national estimate data and program data from the *National AIDS Program 2015 Annual Program Review*, of an estimated total of 401,000 KP individuals, 137,336 were reached with HIV prevention programmes by the National AIDS Program other partners. However, of those 401,000 KP individuals reached, only 90,195 were

tested for HIV. Therefore, with only 27,865 FSW, 34,528 MSM and 27,802 PWID reported as tested for HIV and receiving the result in 2015, there is a need to prioritize HTC service provision for KP. Disaggregates for KP by HIV sero-status were not available in the National AIDS Program report, so the PEPFAR program plans to provide TA to establish cascade monitoring for both PEPFAR-funded and non-PEPFAR-funded HIV programs are moving forward.

Despite the very high HIV prevalence estimates for PWID, the number of PWID who accessed HTC services was low: a reported 27,802 PWID were tested and received their results in 2015, with 33.5 percent of that group having HTC uptake. The number was also low for the number of PWID receiving Medication Assisted Therapy (MAT) with methadone (12,488 in 2016). A reported total of 18.5 million needles and syringes were distributed in 2015. This lack of services for PWID is likely based on the geographical politics of Burma, as HIV services have been focused on the Burmese heartland, while ethnic peripheral areas such as Kachin and Shan states, where the majority of PWID reside, have historically received less attention. Needle and syringe exchange programs (NSEP), MAT and ART are known to result in HIV incidence reduction among PWID, yet accelerated rollout of these services in geographical areas where injection drug use is most prevalent have significant challenges.

Regions that have the highest HIV prevalence rates among PWID include Kachin state (47 percent) and Northern Shan state (43 percent). These states have been caught in ethnic-driven movements for political autonomy for more than half a century in addition to complex struggles for control of lucrative natural resources. Despite being rich in resources (e.g. jade, copper, gold, iron ore, coal, timber, etc.), control over parts of these states is fought for by Burmese and Chinese businesses, central government, allied Kachin and Shan paramilitary forces, local military commanders and the Kachin Independence Organization. Additionally, civilian-led anti-drug campaigns that include drug crop eradication efforts and forced detoxification programs for drug users are on the rise. A number of areas within these states cannot yet be accessed freely, hindering provision of health and HIV services to people living and working there. As such, addressing the drug epidemic in Burma is a high priority for the U.S. Embassy in Burma.

The program gaps identified above point to the urgent need for HIV programs among KP. Such gaps provide an opportunity for PEPFAR to provide strategic TA to significantly improve the cascade of HIV prevention, care and treatment services for FSW and MSM, and to help identify strategies to scale and strengthen services for PWID. The PEPFAR in Burma program will continue to support surveillance and surveys, and the program will support strengthening of data collection systems needed to monitor the cascade, assess program impact and better target services moving forward. The inclusion of civil society groups in the COP planning process over the past year will also continue, with new ways of collaboration utilized.

Table 2.1.1 Host Country Government Results											
	Total		<15				15+				
			Female		Male		Female		Male		*Source, Year*
	N	%	N	%	N	%	N	%	N	%	
Total Population, 2016	51,486,253	100	7,102,665	14	7,296,904	14	18,948,521	37	16,931,810	33	2014 Burma Census
HIV Prevalence (%)		0.60		0.01		0.01		0.41		0.81	AEM estimates for 2015
AIDS Deaths (per year)	9,675		205		217		2,289		6,964		AEM estimates for 2015
# PLHIV (2016)	224,794		4,708		4,774		77,238		138,074		AEM estimates for 2015
Incidence Rate (Year)		NA		NA		NA		NA		NA	
New Infections Adults	11,583		374		383		3,507		7,319		AEM estimates for 2015
Annual births (2015)	944,000	100									*UNICEF: State of the World's Children 2016 Statistical Tables*
% of Pregnant Women with at least one ANC visit (new attendees)	845,623	60.8	NA	NA			NA	NA			Report on the evaluation of the 2011-2016 NSP on HIV
Pregnant women needing ARVs	4,365	0.01									AEM estimates for 2015
Orphans (maternal, paternal, double)	NA		NA		NA		NA		NA		
Notified TB cases (2015)	140, 700		NA		NA		NA		NA		2016 WHO Global TB Report
% of TB cases that are HIV infected (2015)*	7,918	9*	NA	NA	NA	NA	NA	NA	NA	NA	2016 WHO Global TB Report
Estimated Population Size of MSM	252,000	1.4									2015 IBBS, preliminary data
MSM HIV Prevalence		6.6 (11.6)									HSS mean, 2014 (IBBS, 2015)
Estimated Population Size of FSW	66,000	0.3									2015 IBBS, preliminary data
FSW HIV Prevalence		6.3 (14.6)					NA	6.3 (16.2)			HSS mean, 2014 (IBBS, 2015)
Estimated Population Size of Transgender											
Transgender HIV Prevalence											
Estimated Population Size of PWID	83,000	0.5									2014 IBBS Final Report
PWID HIV Prevalence		23.1 (28.5)									HSS mean, 2014 (IBBS, 2014)
Estimated Size of Priority Populations (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Estimated Size of Priority Populations Prevalence (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	

*% of TB patients with known HIV status who are HIV positive

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (national data)										
Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
	Total Population Size Estimate (#)106,490	**HIV Prevalence (%)**	**Estimated Total PLHIV (#)**	**PLHIV Diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	51,486,253 (2014 Census)	0.60 (2015 AEM)	224,794 (2015 AEM)	NA	106,490 (2015)	47% (2015 UNAIDS)	NA	257,178 (2015)	10,826 (2015)	22,582 (2015)
Population less than 15 years	14,399,569 (2014 Census)	NA	9,482 (2015 AEM)	NA	7,086 (2015 UNAIDS)	75% (2015 UNAIDS	NA	NA	NA	NA
15+ year olds	35,880,331 (2014 Census)	0.60	215,312 (2015 AEM)	NA	99,404 (2015 UNAIDS)	46% (2015 UNAIDS)	NA	NA	NA	NA
15-24 year olds	8,271,091 (2014 Census)	NA	NA	NA	NA	NA	NA	NA	NA	NA
25+ year olds	28,597,717 (2014 Census)	NA	NA	NA	NA	NA	NA	NA	NA	NA
MSM	252,000 (2015)	11.6 (2015)	22,498 (2015)	NA	NA	NA	NA	34,528 (2015)	NA	NA
FSW	66,000 (2015)	14.6 (2015)	9,348 (2016)	NA	NA	NA	NA	27,865 (2015)	NA	NA
PWID	83,000 (2014)	28.5 (2014)	21,585 (2016)	NA	NA	NA	NA	27,802 (2015)	NA	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Data sources:

1. UNAIDS country factsheets, MYANMAR 2015
2. 2015 AEM/ Spectrum
3. PWID IBBS 2014
4. MSM and FSW IBBS 2015
5. Program data from National AIDS Program Annual Review 2015

2.2 Investment Profile

Burma is a lower-middle income country with a gross national income per capita of USD 1,160 (2015), ranked 184th in the world (Atlas Method). The World Health Organization (WHO) reports that total expenditure on health, as a percentage of gross domestic product (2015), is 3.4 percent. Burma's HIV response is heavily reliant on the Global Fund, which provided almost half of the total funding for HIV in 2015 (USD 42 million). PEPFAR began scaling TA activities 2014 and contributed 11.9 percent of total funding for HIV in 2015. According to the National AIDS Spending Assessment for Burma (NASA), in 2015, the Government of Burma's contribution was approximately 12 percent of the total spending for HIV. This represented a substantial increase from 2014, when the contribution was USD 3.6 million. Then in 2016, the Government of Burma committed USD 9 million (USD 8 million for antiretroviral drugs (ARVs) and USD 1 million for MAT). USD 15 million (14 million for ARV and 1 million for MAT) have been committed for 2017. With the re-establishment of Global Fund support in 2011 after a 6-year gap, donors who had been contributing funds to the HIV response through the Three Diseases Fund (the main source of HIV funding from 2008 to 2012) shifted their investments to a new funding mechanism, the Three Millennium Development Goal Fund (3MDG) fund. However, the 3MDG fund focuses primarily on health systems strengthening (HSS) and maternal and child health (MCH), with only a small proportion of funding for HIV.

Thus, despite the significant Global Fund investments, current funding levels are insufficient to support Burma's ambitious HIV program scale-up plans to achieve 90-90-90, and existing donor commitments are insufficient to ensure adequate HIV services can be provided to and accessed by all KP and PLHIV in the country.

Funding for ARVs in 2017 – 2018 will be provided by the Global Fund with additional contributions (USD 14 million) from the Burma government; therefore, PEPFAR in Burma does not currently request funding for the procurement of ARVs. According to the 2015 NASA, over 50 percent of HIV resources were targeted for HIV care and treatment programs; spending for treatment has increased as the number of PLHIV receiving treatment has grown. The Burma government only began funding for HIV programs such as STI treatment and harm reduction in 2013, including the aforementioned USD 1 million for MAT.

Table 2.2.1 Investment Profile by Program Area[1]

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	43,236,905	7	49	24	
Community-based care, treatment and support	340,576				
PMTCT	971,156				
Laboratory	1,046,842				
HTS (excluding KP and PMTCT)	294,243	16	34	22	
Priority population prevention	1,317,467				
Key population prevention	15,110,283				
SI, surveys and surveillance	2,159,258	42	40		
HSS	7,633,558				
Programme Management	11,945,858	7	63		
Total	**$84,056,146**	**12%**	**50%**	**12%**	**26%**

Table 2.2.2 Procurement Profile for Key Commodities (2016)*

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs				USD 8,000,000	
Rapid test kits					
Other drugs					
Lab reagents					
Condoms		USD 626,688			
Viral load commodities					
MAT				USD 1,000,000	
Other commodities					
Total		**USD 626,688**		**USD 9,000,000**	

*Information about percent contribution is not available.

Table 2.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	5,500,000				
USAID TB	6,500,000				
USAID Malaria	10,130,062				
USAID Emerging and Pandemic Threat	1,700,000				
NIH					
CDC (Global Health Security)	250,000				
Peace Corps					
DOD Ebola					
MCC					
Total	**$24,080,062**				

[1] National AIDS Spending Assessment, 2015; all amounts in USD

2.3 National sustainability update
Leadership in the Ministry of Health and Sports (MOHS) have signaled that current legal reforms in parliament present an opportunity for advocacy with the appropriate sub-committees to change laws and ensure that relevant laws take into consideration the potential negative impact on KP. The National AIDS Program has also expressed a desire to create a favorable environment for reduction of stigma and discrimination affecting KP as described in the NSP III. PEPFAR will work with stakeholders in country—particularly with civil society networks and organizations—to advance legislation that reduce stigma and discrimination.

Laws that criminalize MSM, FSW and PWID remain in place, directly fueling stigma and discrimination against these populations and impeding their access to HIV prevention, treatment and care services. A national drug policy review effort began in April 2016, and it is anticipated that a new narcotics control policy could be released as soon as April 2017. Little progress has been made to address the other issues.

2.4 Alignment of PEPFAR investments geographically to disease burden
Limited data are available to conduct in-depth analyses of investments by state or to inform geographical prioritization in Burma; HIV burden and number of PLHIV by state are not yet available. However, during the development of the NSP III in 2015, townships were categorized as high, medium and low burden (Figure 1) using data triangulation. The results of the national triangulation align well with PEPFAR prioritization efforts carried out in 2015, which identified Yangon, Mandalay, Northern Shan and Kachin as priority catchment areas.

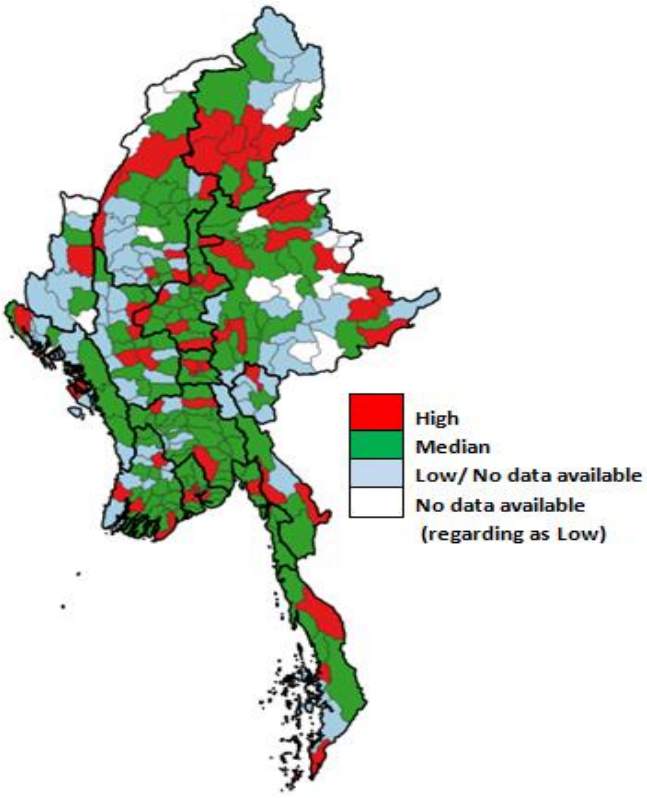

Figure 1: Burma Township Classification

In 2016, in preparation of the NSP III and Global Fund Concept Note, Burma townships were prioritized at a national level through a process of triangulating population size estimates of: priority populations, known HIV prevalence, HIV positive and TB/HIV positive reported data, number of PLHIV on ART, and PMTCT/HIV positive reported data. This analysis resulted in the classification of 85 high-priority townships, 151 medium-priority townships and 94 low-priority townships. In terms of need, between 63% and 77% of KP are found in high-priority townships. Between 19% and 31% of KP and adults on ART are found in medium-priority townships, and only up to 6% of priority populations are found within low-priority townships. This analysis undertaken by the national government validates the catchment areas selected by PEPFAR in the "pivot" of COP 15.

2.5 Stakeholder Engagement

The PEPFAR team consulted with the NAP, other national and subnational health authorities, the Global Fund and its PRs, the Joint United Nations Programme on HIV/AIDS (UNAIDS), and key civil society organizations (CSOs) during this year's COP planning process. With these consultations informing comparative data sets, coordinated activities and collaborative strategies will serve as the basis for COP 17 implementation. The first PEPFAR stakeholder meeting was held on January 24, 2017, in Burma's capital city, Nay Pyi Taw. During the meeting, PEPFAR representatives described the overall COP process and stakeholders discussed key COP 17 priorities and approaches to implementing the "incubator" approach to scaling up services for KP. Discussions held with Global Fund recipients looked at how Global Fund and PEPFAR can support and engage with CSOs without duplicating efforts. The U.S. government team is represented on the Multi-Health Sector Country Coordinating (M-HSCC) mechanism that coordinates funding from the Global Fund and other donors, as well as the technical working groups (TWGs), for different areas of the HIV response. U.S. government staff collaborate closely with United Nations Office for Project Services (UNOPS) and Save the Children, the current Global Fund principal recipients (PRs), and take part in broader stakeholder meetings. As mentioned above, Global Fund PRs have requested and are tapping into TA from PEPFAR, one example being a recent request for laboratory TA.

PEPFAR regularly engages with UNAIDS and WHO to review how both parties can support the National AIDS Program and coordinate provision of technical support and information on global best practices. PEPFAR supports projects conceived by the affected communities for their communities and also funds nine national HIV/AIDS civil society networks in a project that builds capacity.

3.0 Program Activities for Epidemic Control

3.1 Description of strategic outcomes

The strategic outcomes are based upon the priorities identified in the NSP III.

Strategic Outcome #1:
Contribute toward improving coverage and quality of testing and ART services as described in the NSP III by at least 25% in 2 years.

- Develop innovative models to increase case finding and to inform scale up and treatment for KP
- Achieve 12 month retention of 89%
- Make viral load testing available for 30% of people on ART
- Improve national capacity to track progress and measure impact of national HIV response, including KP monitoring

Strategic Outcome #2:
2a: In close collaboration with the Global Fund, support expansion of PWID programming to support 25% increase in MAT in 2 years;

2b: Develop innovative models to increase case finding and inform scale up and treatment for PWID by at least 25% in 2 years.

Due to the concentrated nature of the epidemic in Burma, there is a necessity for enhanced outreach for KP, primarily PWID, FSW and their clients, MSM and TG.

Because of relative size of budgets, the national response has been directed primarily through the Global Fund for program implementation. However, available resources from Global Fund, MOHS and other donors will not be sufficient to support full implementation of the NSP III. Therefore, additional focus of TA in COP 17/18 will be to identify and develop plans to scale-up cost efficient systems, such as differentiated HIV service delivery models, task shifting and continuing to transition patients receiving ART from INGO-managed facilities to the public sector. Systems to monitor and address quality of care, especially in the transition sites, will be finalized and rolled out in the priority areas in FY 17/18.

PEPFAR activities aim to provide TA and build capacity so that Burma can achieve its vision of 90-90-90 by 2030. COP 17/18 will build on successful partnerships and activities, including close collaborations with the NAP, National Health Laboratory, the Global Fund PRs and sub-recipients, civil society groups and multilateral organizations to improve and expand access to HIV testing services (HTS), ART and other supportive services for KP. In addition, beginning in 2017, PEPFAR will work closely with the MOHS National Drug Abuse Control Program and partners providing TA to plan and scale up HIV treatment services for PWID. PEPFAR will complement existing in country partners currently supporting harm reduction for PWID, addressing identified programmatic gaps and use this opportunity to pilot catalytic testing models and innovations designed for national impact. The emphasis on PWID in strategic outcome #2 warrants the need to implement the following innovative strategies to scale up integrated HIV services for PWID to:

- Expand coverage and ensure an increased number of drug users access HIV treatment, harm reduction and needle/syringes services and overdose management;
- Expand MAT and one-stop comprehensive HIV services; and
- Build capacity, coordinate support and improve the legal framework and legal support.

PEPFAR Burma

Program Strategy

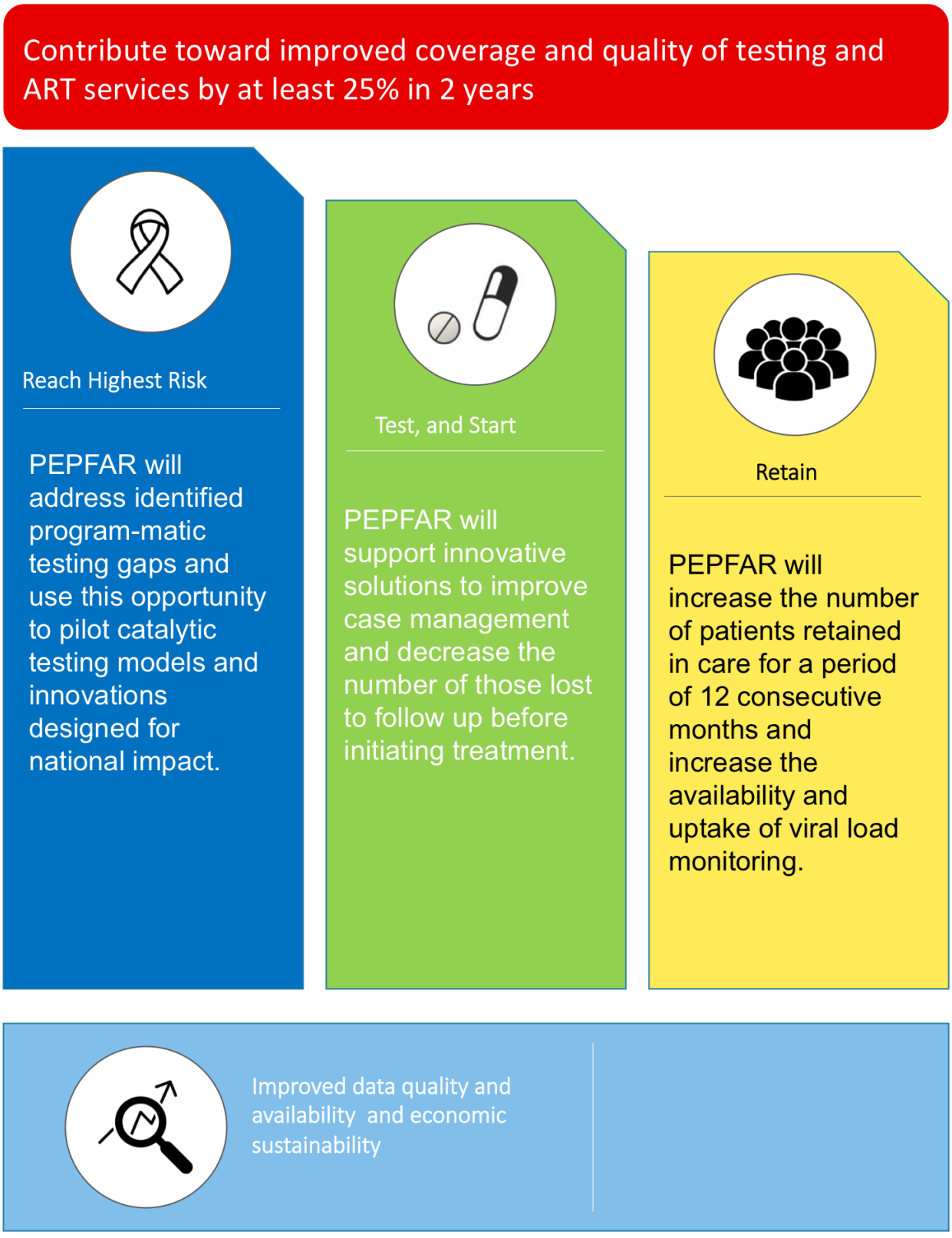

Figure 2: PEPFAR Strategy

3.2 Site-level (rationale, geographic and population prioritization)

Given the concentrated nature of the HIV epidemic in Burma, with the highest prevalence of infection in KP, and the relatively small size of the COP 17 budget envelope, the PEPFAR in Burma strategy is to support the development of innovative service delivery models that can then be adopted, taken to scale and owned by the national government and other stakeholders (i.e., the Global Fund). This approach is exemplified from the successful models developed by PSI in COP 15 efforts related to case detection using KP focused outreach HIV testing, index testing and other innovative testing approaches served to facilitate a near doubling of testing yield (6% to 12%), as well as a 340% increase in 'new patients on treatment' within the PSI-supported TOP centers in FY 16. These models were then adopted by a Global Fund Principal Recipient (Save the Children) for scale-up and application within their KP programs; this model will continue to serve as the basis for the intensified KP programming in COP 17, with particular emphasis on case detection and linkage to treatment for PWID.

The PEPFAR in Burma site-level and above-site strategy cycle is visualized in Figure 3.

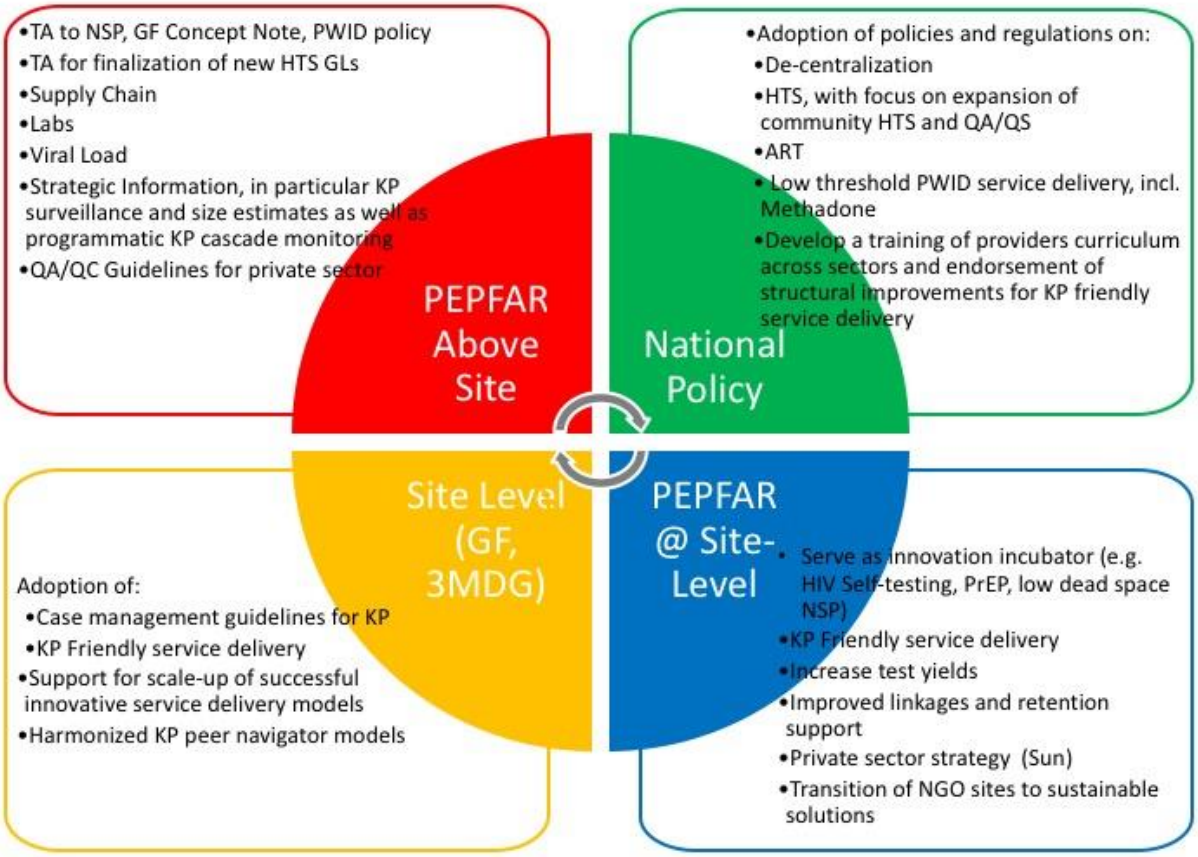

Figure 3: Above-Site to Site Cycle

The cycle works not only in proving concepts at site-level and sending them up for national adoption, but also in using policy and guidance created above-site for testing and implementation at the site level.

PEPFAR works at the above-site level to advocate and promote policy and guidance on HTS, especially for KP focused outreach testing. This policy advocacy and promotion is grounded in the clinical realities of PEPFAR-supported sites as well as others. Through the efforts of the CDC with the MOHS and appropriate departments and programs, guidance for HTS is being drafted. Once approved and adopted as national policy, USAID can operationalize these new guidelines and put them into action and explore further innovations. Program output and outcomes are measured,

and successes will again be transferred to the MOHS. They will then be implemented through Global Fund PRs and the MOHS through the public health system. PEPFAR in Burma targets are set at levels that achieve impact, yet allow for flexibility and space to test innovations and devote attention to demonstration projects. With this unique flexibility, PEPFAR makes an important investment in national epidemic control. Whether the innovation begins above-site (as in the HTS example) or at the site-level (as in the case management success of PSI), PEPFAR in Burma's Strategic Technical Alignment for Results (STAR) role is to innovate and incubate through the above-site/site-level cycle described here.

PEPFAR in Burma will concentrate on improving service delivery for KP in the four high burden catchment areas decided in the COP 15 "pivot," through NGOs and private and public sector settings to enhance services and accelerate HIV diagnosis yield, treatment uptake and retention of KP. The four priority catchment areas are:

- Yangon: All KP.
- Mandalay: All KP.
- Kachin: New PWID support, other existing KP support maintained.
- Shan: New PWID support, other existing KP support maintained.

At the national level, PEPFAR will continue to provide TA to strengthen ART decentralization and strategic information, laboratory and supply chain systems.

IPs are managing comprehensive programs that demonstrate a solid understanding of the various KP groups in Burma, and USAID recognizes the benefits of continuing with these partners as the best option for an effective and coordinated scale-up of existing programs. USAID also recognizes room for additional improvement of consolidating these partners into a single implementing mechanism, as well as leveraging and focusing their individual areas of expertise across the PEPFAR portfolio.

3.3 Critical above-site systems investments for achieving sustained epidemic control

As described above in Section 3.1, PEPFAR is working to assist Burma in achieving national epidemic control and the 90-90-90 goals by 2030. Above-site support since 2015 has focused on supporting the development of national plans and strategies and mobilizing resources, primarily through the Global Fund for program implementation. Following the endorsement of the NSP III in September 2016 and submission of Global Fund Concept Note for TB/HIV, focus of above-site activities shifted towards operationalizing the plan, including developing guidelines for HIV testing to increase reach and yield (especially among KP), strengthening TB/HIV programming, and updating the viral load scale up plan.

Introduction of KP focused outreach HIV screening and HIV confirmation prior to ART initiation in 2017 will result in the rapid increase in the number of testing sites in Burma. As a result, there is an urgent need to build capacity of staff in providing HTS and quality control monitoring, and to increase participation in external quality assurance systems. In 2016, PEPFAR initiated activities in partnership with the Japan International Cooperation Agency (JICA) and the MOHS to address these issues. PEPFAR will continue to engage with PEPFAR site-level partners and Global Fund PRs to monitor implementation of KP focused outreach HIV testing, and PEPFAR will continue to consult with stakeholders regularly to identify gaps and challenges in HTS during this time of transition.

Weak infrastructure and limited capacity have slowed the rollout of viral load (VL) for routine monitoring. To address this, PEPFAR is supporting the development of a VL scale-up plan for Burma and assisting NAP, the National Health Laboratory (NHL) and the Global Fund to identify

and procure equipment. PEPFAR is also providing TA to build technical capacity to implement the laboratory tests and improve laboratory quality.

As noted in COP 16, low uptake of ART among TB/HIV co-infected patients (38%) is a major challenge. As a strategy to address this, MOHS recently proposed initiating ART in all facilities where TB/HIV services are co-located (as opposed to requiring ART initiation in tertiary initiation sites). During COP 17/18, PEPFAR will continue to assist in developing training materials and building capacity of staff in those facilities to initiate and monitor ART. PEPFAR will also continue to identify other gaps through analysis of TB and HIV program data, site assessments and discussions with health providers and patients.

During group discussions with Civil Society Organizations, KP and PLHIV have reported facing stigma and discrimination in care and treatment facilities. To address this, in collaboration with National AIDS Program and KP networks, PEPFAR has been supporting development of KP-friendly services in public facilities. In FY 18/19, PEPFAR will support the introduction of tools and methodologies to monitor and address stigma and discrimination and will provide TA for the introduction and roll-out of KP cascade monitoring.

PEPFAR is in its third year of supporting national HIV/AIDS CSO networks. The first two years focused outreach on skills building in organizational development; the highlight of the second year was a joint advocacy session in Nay Pyi Taw, where CSO representatives met with members of the national parliament and key ministry officials in Health, Social Welfare and Home Affairs. In COP 17/18, those ambitions will expand to engage communities in projects of their own design. This includes:

- Support the newly established legal fund for KPs who suffer from discrimination in the health care sector;
- Engage the PWID CSOs to pilot new interventions for prevention or treatment in regions where access is difficult; and
- Facilitate the design and implementation of a CSO-driven community-based case management system.

As noted earlier, a major new focus of COP 17/18 will be to support the national response to the HIV epidemic among PWID. Initially, above-site activities will focus on providing technical support to the Ministry of Health and Sports; National Drug Abuse Program and National AIDS Program for coordination and oversight of national MAT service expansion. Although MAT has scaled up substantially since it was first introduced in Burma in 2006, only 12,488 of the estimated 83,000 PWID were receiving MAT at the end of 2016. In addition, low dosing and poor retention in some locations point to a need to improve the quality of provided services and to develop strategies that address both rural- and urban-specific issues. Of particular concern is the reduced funding envelope expected in 2018-2020, when Global Fund resources will be reduced substantially. Although the MOHS has committed USD 1 million/year for methadone, it is not sufficient to sustain or cover the costs for scale-up. PEPFAR will work closely with MOHS, Global Fund and other partners to identify cost efficiencies and advocate for adequate resources to sustain and scale up MAT and HIV services for PWID.

3.4 Description of how PEPFAR will support greater sustainability

PEPFAR contributes to global health diplomacy in Burma: led by Ambassador Scot Marciel, PEPFAR is increasingly engaged as a key partner in promoting human rights for KP, providing access to treatment and care for all PLHIV and addressing the growing drug epidemic with strong effort from the U.S. Government. Current government actors include PEPFAR, the Centers for Disease Control and Prevention (CDC), USAID, the U.S. Drug Enforcement Administration, and

the State Department Bureau of International Narcotics and Law Enforcement Affairs. Through PEPFAR, the U.S. Government provides almost one third of the Global Fund budget to Burma. PEPFAR in Burma serves to provide oversight to this U.S. Government contribution and ensure that the funds are well managed to support progress in addressing the national epidemic. The U.S. Government and PEPFAR actively participate alongside the 3MDG multilateral health fund in Burma as donor partners and program collaborators. The Government of Burma is embarking on its new National Health Plan, which includes the nascent planning of a universal health coverage scheme. PEPFAR is working to facilitate the inclusion of HIV and AIDS treatment as part of the essential health package.

4.0 Management and Staffing Considerations

PEPFAR Burma consists of a small but committed team. In April 2014, USAID hired a full-time HIV/AIDS advisor, and the CDC country director began in January 2015. All positions are filled (with the exception of one health program assistant who left in 2016; logistics and other restrictions have prevented the team from filling the vacancy since the departure.) However, the team is still very limited in its ability to provide the level of support and oversight that is needed for PEPFAR programs and to regularly engage with NAP, Global Fund and others in HIV programming in Burma. Given limitations in funding and office space, the likelihood of robust growth in the PEPFAR team is slim.

Staffing priorities will be for experts with backgrounds in clinical/laboratory work and health systems strengthening, and for help with reporting requirements. A new position is requested for COP 17 with expertise in clinical and laboratory work. This position will support PEPFAR CDC's above-site work with the National Health Laboratory including viral load scale-up and HIV rapid test kit evaluation and validation. New positions are also requested in order to provide TA for managing the workload created by MER/SIMS/POART reporting requirements. Additional information on these positions, including salaries and benefits, can be found in the cost of doing business section.

PEPFAR currently utilizes the expertise of USAID staff in the mission for key program support, such as program planning and communications, and works closely with technical experts from headquarters and across agencies to develop and monitor strategies. PEPFAR also provides support for technical advisors within partner agencies, including WHO (for care and treatment) and UNAIDS (for strategic information and civil society strengthening).

There is an estimated increase in the cost of doing business due to the additional salaries of the requested new positions as well as salary increases for current staff. This increase also includes relocation costs and housing allowances for U.S. direct hire staff.

APPENDIX A

A.1 Planned Spending in 2017

Table A.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spending
$1,506,743	**$8,493,257**	**$10,000,000**

*Data included in Table A.1.1 should match FACTS Info records and can be checked by running the "Summary of Planned Funding by Agency" report.

Table A.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$0
HVAB	Abstinence/Be Faithful Prevention	$0
HVOP	Other Sexual Prevention	$869,675
IDUP	Injecting and Non-Injecting Drug Use	$951,247
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$1,238,555
HBHC	Adult Care and Support	$258,178
PDCS	Pediatric Care and Support	$0
HKID	Orphans and Vulnerable Children	$0
HTXS	Adult Treatment	$1,800,924
HTXD	ARV Drugs	$0
PDTX	Pediatric Treatment	$0
HVTB	TB/HIV Care	$169,868
HLAB	Lab	$778,725
HVSI	Strategic Information	$710,008
OHSS	Health Systems Strengthening	$746,682
HVMS	Management and Operations	$969,395
TOTAL		**$8,493,257**

*Data included in Table A.1.2 should match FACTS Info records and can be checked by running the "Summary of Planned Funding by Budget Code" report.

A.2 Resource projections

Resource projections for COP FY17/18 were based on review of expenditure analysis (EA) available data from national surveillance surveys; estimates and projections; national and partner program results; projected activities and outcomes; and projected external donor and government resource projections.

EA was used to determine budget projections for both continuing and new implementing mechanisms. For the continuing implementing mechanisms, PEPFAR in Burma used EA data to assess spending and burn rates and projected changes in program activities or focuses to determine funding levels for each mechanism. Similarly, EA and burn rates were used for new mechanisms where program activities were expected to be similar to old or expiring mechanisms. In particular, EA data were used to provide target-based budgeting for the HVOP, IDUP and HVCT budget codes. The EA data navigation tool was used to provide unit expenditures for KP-FSW, KP-MSMTG and HTC based on FY 2016 work.

Implementing mechanisms were also analyzed by budget code to ensure mandatory earmarks and budgetary requirements are met (e.g., care and treatment) and to maximize impact of the funds.

Increased resources are projected for activities related to PWID to address the available data on the current routes of HIV transmission in Burma. Increased resources are also projected for laboratory support to address the expanding laboratory activities and responsibilities including KP focused outreach HIV testing quality control systems, HIV rapid test kit evaluation and validation and viral load scale up.

APPENDIX B

Focused Outcome and Impact Table (FOIT), saved as a separate excel worksheet

Focused Outcome and Impact Table (FOIT)
Burma

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Outcome 1: Contribute toward improving coverage and quality of testing and ART services as described in the National Strategic Plan III by at least 25% in 2 years							
Service delivery and quality improvement: key populations	TA to National AIDS Program on international and global evidence on HIV prevention, care and treatment strategies , including evidence on cost efficiencies and differentiated care models	1) Implementation of 2017 national HTS guidelines, clinical guidelines and operational guidance assessed for revision to maximize effectiveness and efficiency; 2) Global guidelines and policies on self-testing and patient monitoring adapted; 3) Guidance on sub-national planning and response developed based on initial experiences with a few regions and states	1) Operational guidance revised and updated to maximize effectiveness and efficiency; 2) Implementation of the guidance on sub-national planning and response assessed for revision				$360,000
Systems: Governance (including policy)	Support to UNAIDS to 1) Ensure fast track implementation of HIV responses, and, 2) Improve the response to drug use in Myanmar as it relates to the HIV AIDS epidemic, through a sub-grant to UNODC	1) Program staff recruited and GF grant implementation receives high performance rating 2) Strengthened community relations and empowerment around drug use 3) Draft report and recommendation available on how to improve the cost effectiveness of the harm reduction program	1) National Drug Law revised and approved; 2) Harm reduction policies adopted by Ministries of Health, Home Affairs and Social Welfare; 3) Cost effeciencies realized in Global Fund to maximize resources.				$167,000
Service delivery and quality improvement: key populations	As part of the 1st 90, to reach the highest risk, USAID will work with PSI, utilizing the TOP Key Populations Service Centers and Sun Quality Network of private medical providers, to test innovative and cost-efficient approaches to increase HIV testing volume and yields for FSW, MSM and TG key populations in the four PEPFAR catchment areas of Yangon, Mandalay, Kachin and Shan.	1) Reach to key populations has increased into new epidemological hotspots; 2) Testing yield has maintained an average of 15% yield across FSW, MSM and TG key populations; 3) Transgender-specific support groups organized. 4) All TOP Centers are actively implementing KP case finding for HTS; 5) An increasing trend from Q2 FY17 to Q2 FY18 of KP individuals accessing HIV-related services; 6) An increase in KP-friendly SUN sites from FY17 to FY18; 7) Unique Identier Code system implemented in all TOP Centers; 8) Results of "Rapid appraisal of facilities to determine which factors influence KP-friendliness and KP demand" is available for dissemination; 9) Completed demonstration project with case finding rates similar to surveillance and over 80% linking rate to treatment.	1) 25% increase from baseline HTS for FSW, MSM and TG; 2) HTC_TST_POS results are comparable with regional and KP category HIV prevalence rates; 3) KP-focused Outreach Rapid Testing approach piloted by TOP Peer Navigators.	KP_PREV; HTC_TST; HTC_TST_POS			$1,000,000

Focused Outcome and Impact Table (FOIT)
Burma

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Service delivery and quality improvement: key populations	TA for roll out of National HTS guidelines and development of operational guide for KP focused outreach HTS	1) 2017 Myanmar National guidelines on HIV Testing Services disseminated 2) Stakeholder consultation conducted and companion guide for KP focused HTS developed based on the new National Guidelines 3) Operational guide for KP focused outreach HTS drafted;	1) Operational guide for HTS finalized and disseminated 2) Quality assurance monitoring system for KP focused outreach HTS initiated 3) Operational guidance for partner testing and self-testing drafted		National Indicator	Number of FSW who received an HIV test and who know the result in the last 12 months; Number of MSM who received an HIV test and who know the result in the last 12 months; Number of PWID who received an HIV test and who know the result in the last 12 months	$100,000
Systems: Laboratory	TA and capacity building for evaluations and validation of HIV test kits, and scale up of HIV testing quality control systems	1) Revised and recommended rapid test algorithm disseminated to public, NGO and private providers 2) National Health Laboratory staff trained to conduct HIV rapid test kit evaluation and validation 3) Quality control plan for community level screening/testing, facility based HIV confirmation and verification testing approved by National Health Laboratory and National AIDS Program 4) HIV testing training curricula and tools developed and trainings initiated by National Health Laboratory/National AIDS Program and designated NGOs 5) All PEPFAR supported NGOs implementing confirmatory testing enrolled in national EQAS program	1) Implementation of remediation plans for testing sites with low performance during Yr 1 2) Presentation of QC/QA findings and lessons learned from remediation to stakeholders at HIV technical steering committee meeting				$290,000
Service delivery and quality improvement: key populations	TA to build capacity to improve TB screening and provision of TB preventive therapy for PLHIV as well as TB/HIV co-infection management	1) Protocols for referral mechanism for TB diagnosis and treatment from HIV prevention and care programs for KP developed 2) Protocols and training materials for ART initiation at decentralized sites for TB/HIV co-infected patients developed 3) Stakeholder discussions to address barriers and evidence for TPT preventive therapy carried out 4) Protocols and training materials for TPT preventive therapy at decentralized sites for eligible PLHIV developed	1) Integrate lessons from site level experiences into national guidelines and differentiated care models 2) Quarterly monitoring uptake of TPT and ART among eligible PLHIV at sub national level in focus areas		National Indicator	Number of HIV positive new and relapse TB patients on ART during TB treatment; % of people newly enrolled in HIV care who are started on TB preventive therapy	$100,000

Focused Outcome and Impact Table (FOIT)
Burma

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Service delivery and quality improvement: key populations	Funding to UNAIDS to support the Civil Society Strengthening (CSS) project, which includes national level CSO networks, including, but not limited to, organizations working with FSW, MSM, TG, PWID and PLHIV.	1) A Transgender Network is established by 2018, separate from the MSM network, with adequate resources to carry out core network advocacy functions; 2) Township HIV teams and CSOs have implemented programmatic mapping in most affected areas; 3) CSO networks have successfully applied for and won micro-grants to implement projects of their own design.	1) At least two CSO groups are qualified to apply as sub-recipients for Global Fund support; 2) At least one case of stigma and discrimination brought to court by a CSO member of the CSS project.				$166,000
Systems: Supply chain and essential medicines	Working at the national level, strengthen the HIV supply chain system to ensure commodity availability and improve testing and treatment scale up.	1) Support start-up of the Supply Chain Management unit within the MOHS; 2) By Q2 FY18, strengthen national AIDS program (NAP) lab supply chain system by HIV Lab Commodities Supply Chain System Design; 3) Completed NAP lab commodities forecasts for viral load and EID for 2018; 4) Quarterly Stock monitoring and EWS for lab commodities for Viral load and EIDare in place.	1) Creation of a national supply chain task force, particularly around procurement and LMIS; 2) By Q2 FY19, an integrated and functional LMIS and eLMIS will be providing reports on stock data availability; 3) By Q2 FY19 an integrated national lab logistics system is in place.				$500,000
Systems: Strategic information	Provide technical and staff support to UNAIDS to strengthen strategic information data collection and products for use by government and stakeholders.	1) A strategy and a work plan for the data hub by November 2017; 2) Advisory committee meets quarterly including membership from National Aids Program, the Department of Medical Research and National Statistics Institute; 3) HR capacity building plan completed by Q2 FY18; 4) M&E training curriculum developed, including one in-service training; 5) Establishment of an in-country M&E Core Team	1) Establishment of a database of trainees and trainers on startegic information data collection and use; 2) M&E focal points from high burden townships are trained on how to improve data collection, reporting and use; 3) Research agenda defined and national committee for research operational;				$167,000
Systems: Strategic information	Provide technical and staff support to improve HIV surveillance systems, including enhanced HIV sentinel surveillance	Protocol, data collection instruments, and database for PWID IBBS and population size estimation exercise revised and approved	1) PWID IBBS data analyzed and report drafted 2) Protocol and data collection tools for enhanced HSS developed and approved				$50,000

Focused Outcome and Impact Table (FOIT)
Burma

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Service delivery and quality improvement: key populations	As part of the 2nd 90, USAID will work with PSI, utilizing the TOP Key Populations Service Centers and Sun Quality Network of private medical providers to support innovative solutions to improve case management and decrease the number of those lost to follow up before initiating treatment.	1) Increased number of National AIDS Program-approved TOP sites and SUN providers to initiate and dispense ART, from baseline at Q2 FY17; 2) Increased number of sites meeting criteria to implement multi-month scripting/dispensing of ART; 3) Increased number of patients eligible for multi-month scripting and dispensing of ART; 4) Preliminary results of self-testing demonstration project and 'cohort follow-up to final outcome' appraisal available for dissemination to local stakeholders.	1) Data management system for HTC, ART and surveillance disseminated and implemented across all implementing partners; 2) TX_NEW 25% increase from baseline of individuals from KPs who are newly enrolled on ART; 3) 85% increase from baseline in the number of KP individuals retained in treatment using multi-month scripting/dispensing initiatives; 4) 85% increase from baseline in the number of KP individuals retained in treatment using community-based ART distribution initiatives; 5) 85% increase from baseline in the number of KP individuals retained in treatment using standardized adherence counseling and support protocols.	TX_NEW; TX_CURR			$1,200,000
Service delivery and quality improvement: key populations	TA to National AIDS Program for implementation of Test and Start and differentiated ART service delivery models including development of operational guidance to improve referral linkages, referral systems and retention	1) Revised clinical guidelines, including Test and Start for all and differentiated ART service delivery models finalized and disseminated 2) ART quality monitoring system in place and implemented at two high output public ART facilities 3) PLHIV and KP peer navigators active in 40 percent of ART initiation and maintenance facilities in PEPFAR priority areas 4) Training curricula and structural intervention package for KP friendly services revised and training rolled out to 5 facilities	1) Operational guidelines modified to reflect lessons learned from field and clinical settings 2) ART quality monitoring system implemented in 4 PEPFAR priority areas 3) PLHIV and KP peer navigators active in 80 percent of ART initiation and maintenance facilities in PEPFAR priority areas 4) Training for KP friendly services rolled out in high burden townships		National Indicator	% people living with HIV and on ART who are retained on ART 12 months after initiation; Number and % of newly diagnosed HIV positive people newly enrolled in and receiving care; % of people living with HIV who are receiving ART	$600,000
Service delivery and quality improvement: key populations	Mentoring and training to increase capacity of State and Regional AIDS Officers in use of programmatic and other information to strengthen response and program monitoring at sub national level	At least 2 states and regions using local information to monitor program and developed a data driven sub-national HIV program plans	Sub national data used by State and Regional AIDS Officers in quarterly and annual review meetings with Ministry, NGO and civil society participating				$100,000
Service delivery and quality improvement: key populations	As part of the 3rd 90, USAID will work with PSI, utilizing the TOP Key Populations Service Centers and Sun Quality Network of private medical providers to increase the number of patients retained in care for a period of 12 consecutive months and increase the availability and uptake of viral load monitoring.	1) Increase in the number of ART adherence counseling trainings per quarter; 2) Increase in the number of new Community ART Groups (CAG); 3) Increase in the number of CAG members; 4) TX_RET 85% increase in the number of KP patients retained in treatment through ART delivery models.	1) Increase in the number of ART adherence counseling trainings per quarter; 2) Increase in the number of new CAGs; 3) Increase in the number of CAG members; 4) TX_RET 85% increase in the number of KP patients retained in treatment through community-based ART delivery models	TX_RET			$400,000

Focused Outcome and Impact Table (FOIT)
Burma

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Laboratory	Improve capacity of National Health Laboratory and National AIDS Program to scale up viral load testing for routine ART monitoring	1) Viral Load Scale-up Plan endorsed by the HIV technical working group and approved by MOHS 2) Specimen transport systems and requisition/reporting forms developed and approved by National Health Laboratory/National AIDS Program 3) 50 percent of laboratories carrying out VL tests enrolled in external quality control program and plan for routine quality monitoring and calibration of equipment developed 4) Viral load testing available for at least 20% of people on ART 5) Meeting to review VL scale up carried out by National AIDS Program and National Health Laboratory	1) 85% of laboratories (public, NGO and private) carrying out viral load testing enrolled under National AIDS Program and NRL external quality control programs 2) Viral load testing available for at least 30% of people on ART 3) Semi-annual review and monitoring of VL scale-up in place and conducted.		National Indicator	% of PLHIV on ART who have achieved viral suppression; % of PLHIV on ART who have achieved viral suppression among those tested for viral load in the last 12 months; % of PLHIV on ART with viral load suppression at 12 months after treatment initiation; Number of PLHIV on ART received viral load measurement during the reporting period	$300,000
Systems: Strategic information	Provide technical assistance including training and mentoring to strengthen capacity for cascade monitoring, especially for KP	1) Protocol for monitoring cascade at national level developed 2) KP specific cascade systems developed after identifying data gaps and strengthening data collection and monitoring systems	1) KP cascade data available at the national level 2) Protocols for sub national cascade monitoring finalized and report developed 3) Training initiated at national level 4) Systems to monitor stigma and discrimination (Myanmar's 5th 90) proposed, including use of Stigma Index				$150,000

Focused Outcome and Impact Table (FOIT)
Burma

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Outcome 2: 2 a: In close collaboration with the Global Fund, support expansion of PWID programming to support 25% increase in MAT in 2 years; 2 b: Develop innovative models to increase case finding and to inform scale up and treatment for PWID by at least 25% in 2 years.							
Service delivery and quality improvement: key populations	Working with Government, Harm Reduction NGOs, and experts on PWID programming, USAID will identify and address programmatic gaps in the outreach to testing gap for PWID, and pilot catalytic models and innovations designed to increase testing intake and yield.	1) Enhanced PWID outreach for targeted case finding; 2) An increase in the number of PWID accessing MAT, HTS and ART services; 3) Improvement in the legal framework and legal support surrounding injecting drug use and HIV prevention; 4) Demonstrated the feasibility of methadone take-home doses and innovative delivery models.	25% increase from baseline of PWID individuals accessing MAT and ART using existing programs	KP_PREV; HCT_TST;HCT_TST_POS			$1,420,000
Service delivery and quality improvement: key populations	Working with Government, Harm Reduction NGOs, and experts on PWID programming, USAID will support innovative and cost-efficient solutions to improve PWID case management and decrease the number of PWID lost to follow up before initiating treatment.	1) Increase ART coverage among PWID who are newly tested positive; 2) An increase in the number of existing FSW- and MSM-focused programs offering ART for PWID individuals; 3) Decrease lag time from case identification to ART initiation among PWID.	25% increase from baseline of PWID individuals accessing ART using existing programs.	TX_NEW; TX_CURR; TX_RET			$700,000
Service delivery and quality improvement: key populations	Provide technical assistance to improve reach and quality of public sector MAT and ART 'One-Stop-Shop' sites for PWID	1) An addendum to the current clinical and operational HIV program guidelines to add MAT management developed 2) Supervision check lists and quality monitoring tools for One-Stop-Shop PWID sites and MAT sites drafted, tested, and finalized	Lessons learned and Quality improvement visits conducted in at least 30% of One-Stop-Shop MAT sites		National Indicator	Number of people who inject drugs received an HIV test and who know the result; Number of people who inject drugs receiving methadone maintenance therapy; % of individuals receiving methadone maintenance therapy for at least 6 months; Number and % of newly diagnosed HIV positive people newly enrolled in and receiving care; % of people living with HIV who are receiving ART; % people living with HIV and on ART who are retained on ART 12 months after initiation	$50,000

Focused Outcome and Impact Table (FOIT)
Burma

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Systems: Strategic information	Provide technical assistance to strengthen MAT dosing capacity and integration of MAT monitoring into electronic HIV & Health monitoring system	1) Consultations with organizations supporting electronic HIV and health systems carried out to inform integration of MAT M&E and data 2) National AIDS Program and Drug Control Program select equipment and software for individual MAT patient monitoring and dosing and feasibility of introduction assessed at one site	1) Equipment and software procured and installed at 4 high output MAT sites in PEPFAR priority catchment areas 2) MAT dosing and monitoring system established in at least 4 MAT sites		National Indicator	Number of people who inject drugs receiving methadone maintenance therapy; % of individuals receiving methadone maintenance therapy for at least 6 months; Number and % of newly diagnosed HIV positive people newly enrolled in and receiving care; % of people living with HIV who are receiving ART; % people living with HIV and on ART who are retained on ART 12 months after initiation	$100,000
Service delivery and quality improvement: key populations	Collaborate and support National Drug Abuse Control Program and National AIDS Program to develop and operational plan for PWID services based on National Strategic Plan for PWID	1) Stakeholder consultation conducted to seek inputs, collect data from best practices from public and NGO sector 2) National Operational Plan and M&E framework drafted	Operational plan for PWID services approved, disseminated and initiated.				$50,000