



Response to HIV & AIDS *in Myanmar*

Progress Report 2005



National AIDS Program



Acknowledgement

This report “Response to HIV & AIDS in Myanmar - Progress Report 2005” is the product of the first attempt to document the concerted efforts of all stakeholders participating in the response to HIV and AIDS in Myanmar during 2005. It is somehow an attempt to address one of the principles of the “Three Ones”: trying to integrate the Monitoring and Evaluation efforts of stakeholders so as to consolidate under one Monitoring and Evaluation system.

First of all, the National AIDS Programme would like to express its gratitude to H.E. Professor Kyaw Myint, Minister for Health and Chairman of the National AIDS Committee, for his overall guidance in the response to HIV and AIDS in Myanmar. Our heartfelt thanks also goes to H.E. Professor Mya Oo, Deputy Minister for Health, H.E. Professor Paing Soe, Deputy Minister for Health and Dr. Tin Win Maung, Director General of the Department of Health for their encouragement and support in preparation of the report. Dr. Kyaw Nyunt Sein, Deputy Director General of Department of Health and Dr. Saw Lwin, Director Disease Control of the Department of Health have also contributed in editing the report.

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The National AIDS Programme would also like to thank all the stakeholders who had contributed in the preparation of this report. Last but not the least, we would like to express our sincere thanks to members of the civil society who had contributed significantly in responding to HIV and AIDS in Myanmar.

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Introduction

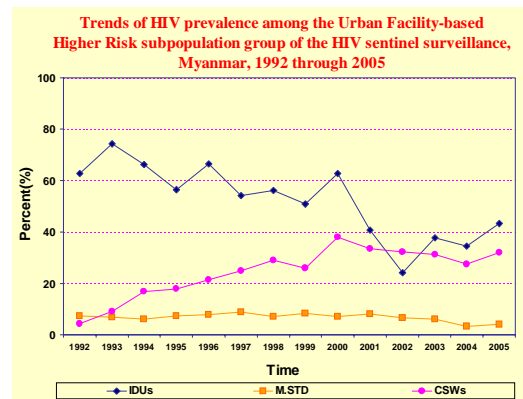
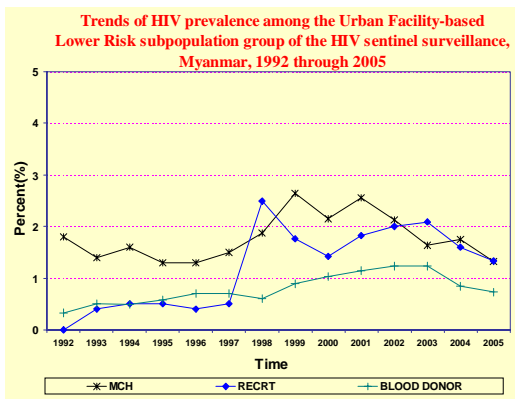
The purpose of the 2005 Progress Report on the National Response to HIV is to provide a quick overview of the response to HIV and AIDS in Myanmar during the year. In its role as the coordinator of the national response to HIV and AIDS, the National AIDS Programme has collected data and information from all partners working on HIV in Myanmar, including those from Government Departments, United Nations organizations and national and international non-governmental organizations. This report therefore presents a snapshot for 2005 of the collective activities of programmes on HIV in Myanmar.

Data has been collected and aggregated after having agreed upon a common framework of basic indicators in 2004. This system has now been running for two years and provides an ability to track programme expansion of all partners working in Myanmar, and will continue to do so in the future. Complementary efforts, notably the external Review of the Myanmar National AIDS Programme undertaken in March and April, 2006, provide additional analysis which is not duplicated here. The expression and use of language is based on the standard language used in international practices.

Summary of HIV Epidemiology in Myanmar

Myanmar is one of the hardest hit countries by the HIV epidemic in Asia. In 2004, an estimation workshop organized by the National AIDS Programme (NAP) with WHO and UNAIDS support, estimated that 338,911 adults (15 to 49 years) were living with HIV. Basic surveillance data collected by the National AIDS Programme for both high-risk and lower risk populations is provided in Tables 1 and 2. Prevalence remains elevated in high risk groups, notably sex workers and injecting drug users. However, a decline has been noted in national HIV prevalence in tested pregnant women from 2.2% in 2000 to 1.8% in 2004.

A demographic impact review by the National AIDS Programme in September 2005 in Yangon, undertaken with support from WHO and UNAIDS, looked at all available data from both public and private sources and tried to estimate trends through time. Provisional estimates from this workshop suggest that HIV prevalence may have peaked in Myanmar at the beginning of the century and may now be levelling off. UNAIDS estimates that an estimated 360,000 people were living with HIV and national adult HIV prevalence stood at 1.3% at the end of 2005, compared to an estimated 1.4% at the end of 2003.¹ More detailed behavioral and prevalence data is needed to better under-



¹ 2006 Report on the Global AIDS Epidemic, UNAIDS.

stand the precise evolution of the epidemic, which also varies regionally across Myanmar, and determined the role that various programmes may have had in this evolution. The preliminary estimate also depends on size of various groups, such as sex workers, injecting drug users and men who have sex with men, requiring

more detailed data. The trend analysis suggested that there were roughly 27,000 people newly infected with HIV per year, 40,000 new AIDS cases per year, and 38,000 annual AIDS-related deaths. (For further information on planned surveillance and related activities, see section 14 Monitoring and Evaluation).

Organization and Coordination of the National Response

The national response to HIV began in the mid-1980s; an inter-sectoral National AIDS Committee chaired by the Minister of Health was established in 1989 and a short term plan for the prevention of HIV transmission was launched in that same year. The first national medium-term plan for the prevention and control of HIV/AIDS was formulated in 1991, followed by a plan formulated jointly by the National AIDS Programme and UNDP in 1994. In the late 1990s, several collaborative projects were undertaken with the support of UN entities and bilateral agencies, in particular the Japanese International Cooperation Agency (JICA). In line with priorities set forth by the National Health Plan of Myanmar, a National Strategic Plan for Expansion and Upgrading of HIV/AIDS Activities in Myanmar, 2001-2005, aimed at enhancing the nation-wide AIDS control and care efforts as a national concern through a countrywide collaboration with all sectors, both pri-

vate and public, and with the active involvement of the community.^{1,2}

In addition to the National AIDS Committee, in 2003 a Country Coordinating Mechanism (CCM) was established to oversee the development and submission of Global Fund proposals and, subsequently, to oversee their implementation. Several Departments from the Ministry of Health, United Nations organizations, and national and international non-governmental organizations sat on the Committee. The Ministry of Health also participated in the United Nations Expanded Theme Group on AIDS, which oversaw the development of the UN Joint Programme for HIV/AIDS in Myanmar 2003-2005 and the associated Fund for HIV/AIDS in Myanmar (FHAM).

During 2005, these structures and guiding documents evolved considerably. First, in December

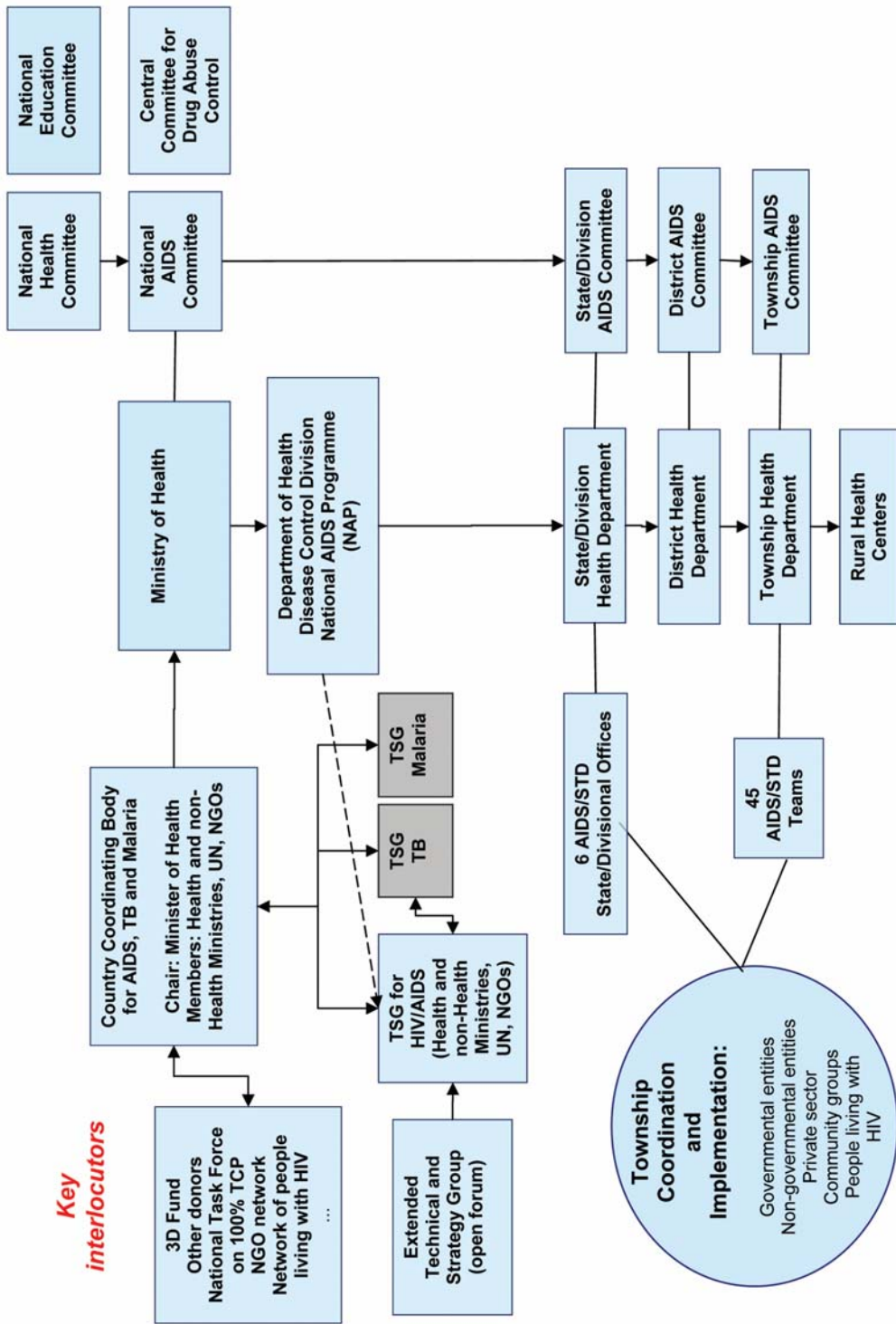
¹ *National Health Plan, 2001-2002 to 2005-2006, Department of Health Planning, The Government of the Union of Myanmar*

² *National Strategic Plan for Expansion and Upgrading of HIV/AIDS Activities in Myanmar, 2001-2005, Department of Health, Ministry of Health, Union of Myanmar.*

2005 the Ministry of Health launched a participatory process to develop a new, multi-sectoral and multi-partner National Strategic Plan 2006-2010. The process aims to involve other Government Ministries and Departments, national and international non-governmental as well as United Nations organizations. Second, approved Global Fund grants were terminated by the Global Fund Secretariat in August, 2005. As a consequence, the Ministry of Health of Myanmar began negotiations with several donors. In early 2006, it created a new Coordinating Body, chaired by the Minister of Health, including self-selected representatives of international NGOs and civil society, to coordinate international and national cooperation on AIDS, tuberculosis and malaria. The Coordinating Body is advised by three Technical and Strategy Groups covering the three diseases and similarly involving actors from several

Government Ministries, United Nations' agencies and international and national non-governmental organizations. The Technical and Strategy Groups are Chaired by the Director (Disease Control) of the Department of Health and are advised by the Programme Managers of the National AIDS, Tuberculosis and Malaria Programmes respectively. The new coordination structure for AIDS is presented in figure below.

The National AIDS Programme not only oversees coordination at the national level, but also at the State/Division and Township levels. The NAP has a direct presence in 45 priority townships where there are Sexually Transmitted Diseases & AIDS Teams (STD/AIDS) . In these townships, the NAP can actively coordinate the work of partners and support the functioning of AIDS Committees at the state/ division, district and township levels.



Coordination structure for HIV and AIDS

1) Sex workers and their clients

Based on cumulated AIDS cases reported up to 2005, it has been estimated that 68% of cases are attributable to sexual transmission. It is believed that most of the new transmissions still occur between sex workers and clients or from clients to their wife.

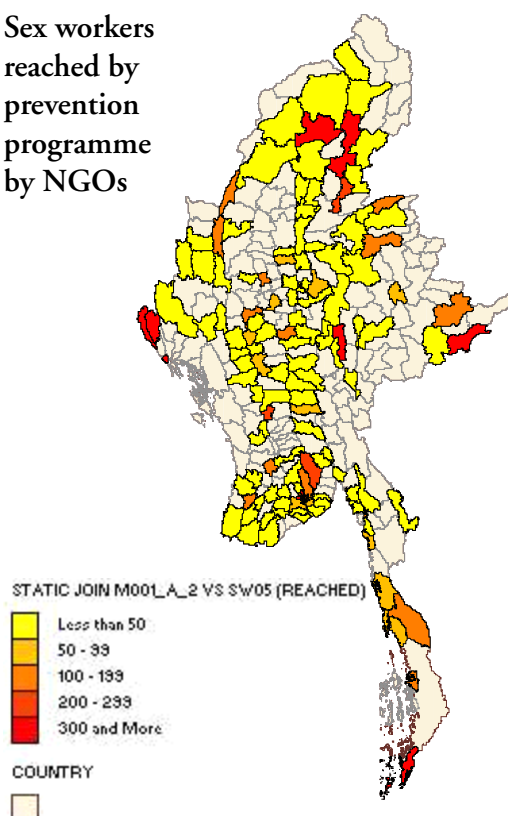
For prevention activities, sex workers are typically reached by peer-educators, out-reach and community workers through health education sessions,.

Coverage for sex-workers

In 2005, the NAP, with its network of 45 STD/Teams, reports having reached 22,000 sex-workers with prevention programme including condoms distribution, health education and, also through provision of STI treatment. For the same period 15 NGO's reported having reached more than 29,000 sex workers¹ It is estimated that at least 50% of sex-workers are receiving services from several partners and therefore double-counted. The number of sex-workers reached is thus believed to be around 25,500.

411 sex workers were reported as being involved in projects as peer-educators in 2005.

Sex workers reached by prevention programme by NGOs



Partners working with sex-workers:
NAP, AMI, AZG, ARHP, CARE, IFRC, MSF CH, Malteser, MANA, MDM, MSI MRCS, PACT, PSI, SC UK, WVI, UNFPA

¹ Number of sex-worker reached, not number of contacts

Targeted Condom Programme

100% Targeted Condom Programme (TCP) launched by the National AIDS Programme in 4 pilot sites in 2001, has expanded systematically year after year to cover 154 sites in 2005. This expansion was supported by the FHAM, the Global Fund, UNFPA, WHO, and UNAIDS. The main activities are:

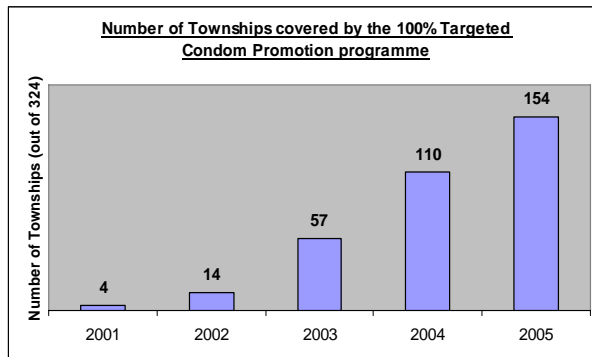
- Training of focal persons
- Advocacy meetings for local authorities and implementing partners
- Multiplier training of basic health staff and NGO's
- Situation assessment for geographical mapping
- Advocacy meetings with entertainment establishments managers and FSW's
- Advocacy meeting with GP's

- Conducting outreach sessions by trained peer-educators and outreach workers
- Regular supply of quality condoms and STI services
- Production and distribution of IEC materials
- Monitoring and supervision including regular Condom Core Group (CCG) meetings and site visits
- Conducting mid-year review and report

Annual review meeting and report findings

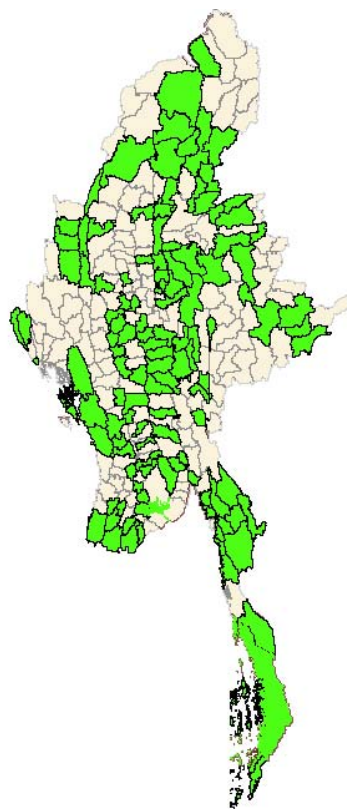
Review of the 100% Targeted Condom Promotion Programme

A review of the 100% Targeted Condom Promotion programme in Myanmar was conducted in July 2005, under the initiative of the National AIDS Programme, with support from WHO. The objective of the review was to provide recommendations for improving programme implementation and to propose adjustments in the coverage, quality and approaches of the programme.



- Baseline and follow-up surveys of condom distribution, usage and STI (and HIV)
- Training of FSW's on peer education and community volunteers for outreach activities

“The review team had the impression that there was variability in the performance of the 100% TCP programme in the different townships visited. Performance seems to vary with the maturity of the programme at township level (with good results observed in townships which were included in the pilot phase), but even more so, with the intensity of relevant programme inputs at the township level and with the degree of ownership and cooperation of local stakeholders and most particularly with senior law and order officials.”



In many cases, it was noted a high level of commitment and interest to the 100% TCP among the

health sector officials. At the township level, the AIDS/STD teams or the Township Medical Officer’s teams provide the impetus for implementation and the other township officials represented in the Condom Core Group express their strong support. They all understand the threats posed by HIV and express commitment to take action at the local level. The 100% TCP is widely judged to be “good for health”. All parties interviewed during the review reported increasing openness about sex and condoms in the last 2-3 years. The same, NGO’s (both international and local) have in many areas made an important contribution to the planning and implementation of the 100% TCP.

The programme was however found to face a number of challenges in its efforts to increase coverage both in terms of increasing the number of townships involved, but also in terms of saturating sex worker population in a particular township while maintaining quality. There is a need at all townships to move beyond the implementation of condom promotion activities to realize the full range of activities required to create an enabling environment for the “no condom, no sex” principle of the 100% TCP programme.

The organization of sex work in Myanmar is complex and since buying and selling sexual services is illegal, the operations of sex work is increasingly shifting from brothel based to indirect sex work. Sex workers are also a highly mobile population which adds to the difficulties to conduct effective prevention programme.

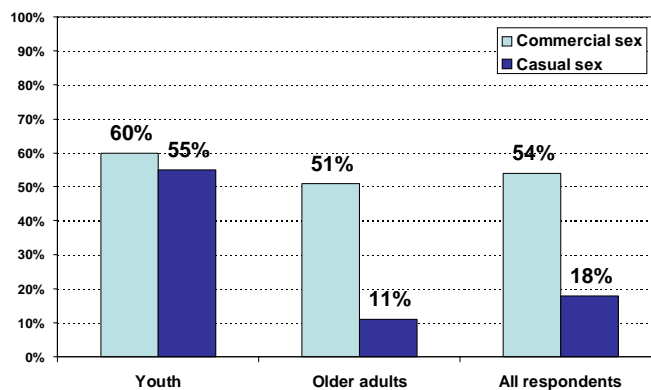
To face these challenges, the review team recommended an intensification of efforts to reach out and support sex workers through peer outreach and stronger advocacy efforts at all levels that emphasize the critical importance of reducing HIV transmission through sexual means.

Condom use in paid sex

While the expansion of condom distribution has led to improved access to condoms (see chapter on “men and women of reproductive age”), the challenge remains to increase their use, especially among vulnerable groups.

Data on high risk behaviour from the NAP Behaviour Surveillance Survey carried out in 2003 shows that the proportion of men who reported using condom consistently with sex workers was 54% (60% among youth and 51% among adult men).

These official figures are supported by the results of “condom market surveys”¹. These market survey covers client’s samples including trishaw drivers, taxi drivers, truckers, highway drivers, fishermen and miners and female sex workers. The studies, conducted in Mandalay and Yangon only, revealed an improvement in condom use compared with previous years.



Consistent condom use with non-regular partners in the last year among youth and older men

¹ PSI conduct condoms market survey every year

2) Men who have sex with men (MSM)

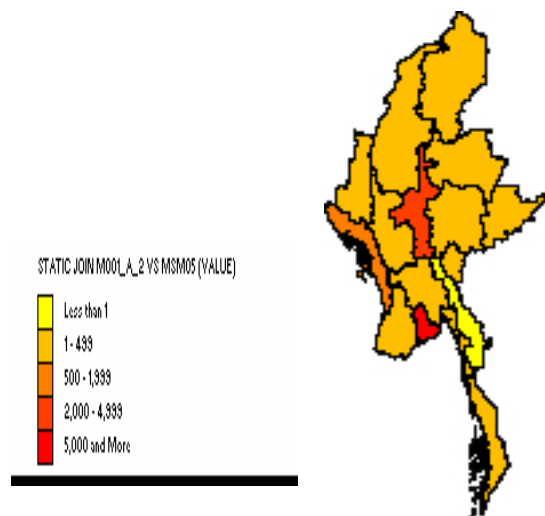
Prevention efforts with men having sex with men are still limited in Myanmar, although a number of organizations are working with this category of population.

In 2005, 13 organizations reported having reached 22,000 MSM through health education sessions, equivalent to 8% of the estimated MSM population. Social study needs to be conducted to determine what could be the sub-categories of MSM and the level of risk behaviour attached.

Five organizations PSI, CARE, PACT, World Vision and AMI have trained 77 MSM peer educators who are now involved in their projects.

In Yangon, while MDM has a focus on male sex workers, PSI opened its first drop-in center for sex workers, MSM and transgender in 2004. In 2005, one more drop in center was established in Mandalay and one more is planned to open in Patheingyi in 2006. The aim of the centers is to provide more focused and regular outreach and services to high risk groups such as Female Sex workers and MSM.

Reports from partners show that most of the activities with MSM is done in Yangon and Mandalay, while few happens in other major cities.



Partners working with MSM:
ARHN, AMI, AZG, CARE,
IFRC, MDM, PACT, PSI,
SC(UK), WVI, MANA,
PGK, UNFPA, UNODC

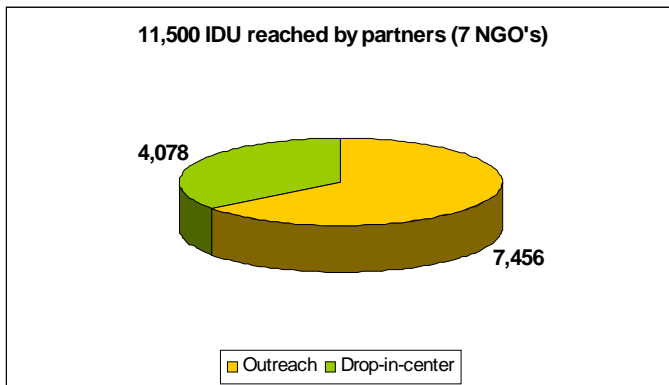
3) Drug Users

Injecting drug users form one of the major risk groups for HIV transmission in Myanmar. In 2005 HSS data indicated that 43.2% of the IDU population was infected with HIV¹, with higher prevalence rates in some regions. People who are addicted to illegal drugs are required by law to register. As of June 2003, 66,838 drug users were registered, of which 20% are injecting and thus particular vulnerable to HIV. The trend in injection is however declining from 37.8% of drug users injecting in 2000².

Committee for Drug Abuse Control (CCDAC), Chaired by the Minister of Home Affairs, took the lead in implementation of activities, along with the Department of Health's Drug Detoxification/Treatment and Rehabilitation Unit (DDTRU). The Deputy Minister of Health chairs the Sub-Committee on Drug Treatment.

UNODC's Technical Coordination Unit (TCU) is the primary United Nations counterpart supporting activities in this area, acting as an interface between Government and other partners. While supporting Government coordination of the Drug Use and HIV Group (Component 2 group), the TCU also provides support with technical, advocacy and coordination issues to partners working in this area.

Advocacy and education with authorities at all levels and communities has paid off with increased possibilities to reach drug users. Compared to virtually no services three years ago, seven NGO partners reported having reached 11,500 injecting drug users up to 2006. Geographically the services



Comprehensive HIV prevention and care interventions for drug users in Myanmar have been growing since 2003. Central

¹ HIV Sentinel Surveillance 2005 - NAP

² Communication CCDAC "Law Enforcement Workshop" Sept 2006

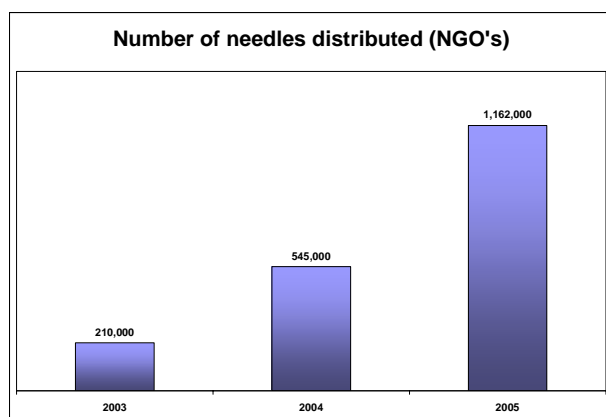
are concentrated in three areas: 58% of services are located in Shan State, 31% in Kachin State and 10% in Mandalay Division (ETG). Northern Shan State has been designated by the Central Committee for Drug Abuse Control as a priority area for pilot interventions.

In total there are 16 drop-in centers in Myanmar, supported and run by UN, national and international non-governmental organizations. They provide counseling, education on health and safer sex behaviour, condom distribution, needle and syringe exchange and primary health care. In each location, the drop-in center services are complemented by a range of outreach activities contacting reaching drug users in the community. In 2005 more

11,500 people. Significant progress has been made in distributing needles and syringes with UNODC-TCU supporting their procurement. In 2005 a total number of 1,161,929 needles were distributed free of charge compared to 545,000 needles in 2004. The NGOs working with needle exchange programmes reported a return rate of 80% of needles distributed.

In 2005, preparations were also undertaken for launching methadone treatment. Trainings were done for operational and clinical management of methadone, initially to roll out in four sites in 2006. High level advocacy was also undertaken, with high-level workshop organized in July.

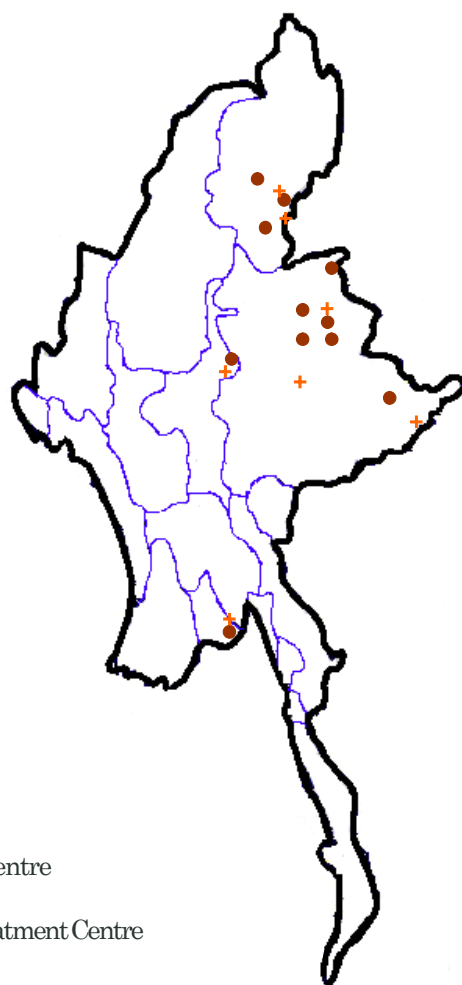
Working with drug users requires careful collaboration between the authorities and partners. In Lashio in Northern Shan State, UNODC-TCU has pioneered and supported the development of the Township Steering Committee, which increases transparency and sustainability while facilitating an enabling environment for the implementation of activities. The Township Steering Committee undertakes a mixture of advocacy with the community, troubleshooting over sensitive issues, and basic coordination among partners and the hope is that this model will be replicated in other townships.



than 100 outreach workers and 60 IDU peer-educators were working with the IDU population. The total number of IDUs reached through drop-in centers and outreach programs amounted to

Together the partners in Lashio provide comprehensive services for drug users, including: detoxification, substitution therapy, VCCT, STI treatment, condom distribution, mobile outreach, needle and syringe exchange, long term rehabilitation services for drug users, preventive drug abuse education, health education, technical assistance and monitoring and evaluation. During 2005, more than 11,500 drug users were reached through

formal and informal channels. The use of drop-in centres and outreach workers enables programmes to expand their reach significantly beyond the Drug Treatment Centres. Some of the findings of ad hoc studies suggest that programmes have already achieved some impacts in behavioural results: sharing of injecting equipment has reduced significantly between 2003 and 2005, from 44% to 23%.¹ Similarly, according to surveillance data provided by the National AIDS program, HIV prevalence amongst injecting drug users in Lashio has also been found to have decreased, from 75 to 55 per cent between 2003 and 2005.



- Drop in centre
- ⊕ Drug Treatment Centre

DIC and Outreach Map for IDU

While expansion is occurring, it is hoped that the emphasis the National Strategic Plan on HIV and AIDS, 2006-2008 places on this area and the success of pilot programs will facilitate increased support from all sectors and result in rapid scale-up to ensure the problems are addressed on a national scale.

Geographical focus on IDU interventions (20 out of 325 townships) in 2005

Partners working with Drug Users
 MoH / Drug Treatment Centers
 UNODC, WHO
 AHRN, AHRP, Burnet Institute, CARE, MANA, MDM, MSF Holland

¹ UNODC Periodic Follow-Up Survey October 2005

4) People living with HIV, their partners and families

Creation of self-help groups, almost inexistent in Myanmar after beginning of the decade, has been on the agenda of several organisations, including the National AIDS Programme, UNDP, Association François Xavier Bagnoud (AFXB), CARE, MDM, PSI, the International HIV/AIDS Alliance (IHAA), MSF-Holland, MSF CH, Myanmar Council of Churches, Myanmar Nurses Association (MNA), PSI, and World Vision, as well as other local NGOs and Community Based Organisations. Self Help Groups usually operate with the provision of socio-economic assistance to People Living with HIV, such as the provision of food, loans for income generation and educational support for children.

Although partners and families of People Living with HIV is considered by the new National Strategic Plan for 2006-2010 as one of the most vulnerable population for programming interventions, data collection is still incomplete for this specific group. The NAP review conducted in March-April 2006 identified 24 Support Groups accounting more than 2,200

members. A survey conducted in 2006 by the International HIV/AIDS Alliance (IHAA) focused on the geographic areas of Yangon, Mandalay, Mawlaymyaing, Myitkyina and Lashio. 1,788 were accounted as members of existing Self-Help Groups in those 5 areas only. The total number of People Living with HIV to be involved in self help groups is believed to be somewhere between 2,500 to 3,000 members.

The majority of support groups are made up of People Living with HIV and their family members who meet regularly and provide mutual support such as visiting each other when a member is sick and accompanying a member to the hospital if necessary. Many of the support groups are supported by NGOs and the groups remain informal. If these Self Help Groups are to grow, become sustainable and expand their geographic coverage, they will need significant capacity building support.

The National AIDS Programme supports the GIPA principle, which is also being put into

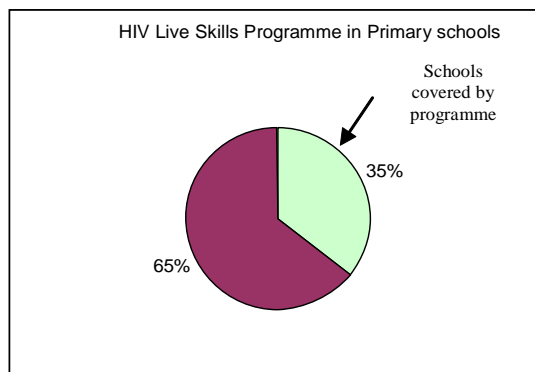
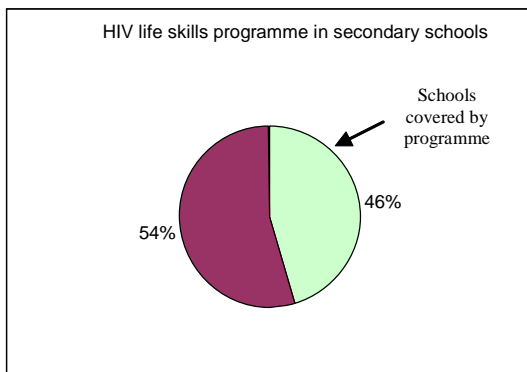
5) Young People

Young people are particularly vulnerable and are the key to the future course of HIV epidemic. They are the essential focus for prevention messages in every sexual health programme. Since most new infections are in young people, even modest changes in behaviour will have significant impact on the epidemic.

A significant number of partners have implemented projects focusing on Health Education for youth on HIV, both in out-of-school and in-school contexts. The primary focus of youth HIV interventions is prevention messages that include life skills, behaviour change communication, adolescent reproductive health information, and HIV information education and communication (IEC).

In-school youth

Life-skills classes that educate children about the danger of HIV are taking place in Myanmar as part of a programme called the *School-Based Healthy Living and HIV/AIDS Prevention Education* (SHAPE). The SHAPE programme, which was developed by the Government of Myanmar and UNICEF in 1998, is now part of the national curriculum. UNICEF reports that 2.14 million students have been reached by the SHAPE programme for the first semester of 2005 only. Through this programme, UNICEF has supported the training of more than 54,000 teachers since 1998, on a range of health and social issues, including HIV, personal hygiene, nutrition and drugs – knowledge that they can pass on to their students. UNICEF and



action by several partners including UNDP and the International HIV/AIDS Alliance. Currently a numbers of networks of People Living with HIV have occurred in some places where priority programmes are located.

While these positive steps are important, much remains to be done. As in many other countries, participation of people affected by HIV in programme design and implementation needs to escalate and livelihood support activities is not enough yet..

Significant stigma and discrimination exist in the community, private and public services that hinders People Living with HIV' access to services. Self-stigma continues to be evident as people are still reluctant to disclose their status even to their own families. More efforts are needed to fight stigma and discrimination, including greater use of mass-media. All organisations working on HIV need to expend this involvement of People Living with HIV in all aspects of programme design, monitoring and implementation.

a local NGO partner Pyinya Tazaung have launched in 2004 “SHAPE Plus” – a similar programme that puts out-of-school youth in touch with positive young role models.

In the 2004 country report “follow-up of declaration of commitments” (UNGASS), Myanmar reported that 14,307 schools out of 39,405 have at least one teacher trained in the last 5 years and teaching the subject on a regular basis to all classes in the last academic year, i.e. 36.3%. The achievement is notably higher when considering secondary schools alone: 1,433 schools out of 3,138 (45.7%) reached the same result.

The consistency of application across grades (primary, secondary and educational colleges), quality, coverage and impact of the programme will however require continued attention.

Out-of-school youth Coverage of prevention activities

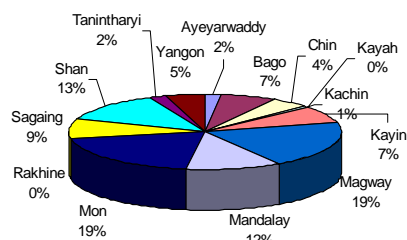
Numerous partners have developed projects targeting out-of-school youth. Reports received from NGO’s for 2005 show a cumulative number of more than 216,000 out-of-school youth reached by prevention programme.

Additional partnerships for Adolescent Reproductive Health (ARH) between UNICEF, Myanmar Red Cross Society¹ and Department of Health Planning have assisted the government to provide necessary ARH services, through its structures, to prioritised areas determined by MoH. During the past years, fostered by UNFPA, youth trainings and youth HIV contests have been organised and youth-friendly corners established in 30 townships by the Department of Health in collaboration with the Department of Health Planning and Marie Stopes International (MSI). These activities aim to train adolescents and youth in reproductive health related issues,

Coverage of prevention activities for out-of-school youth

AHRN	947
AMI	3,041
BURNET	540
CARE	28,142
Malteser	250
MSI	1,689
PACT	11,435
PSI	43,905
SCUK	72,167
WVI	16,653
MANA	717
MBCA	900
MMA	600
MFCT	480
Karuna	114
MMCWA	17,248
UNDP	1,310
MRCs	16,335

Repartition of total number of young people reached per division/state (NGO's 2005)

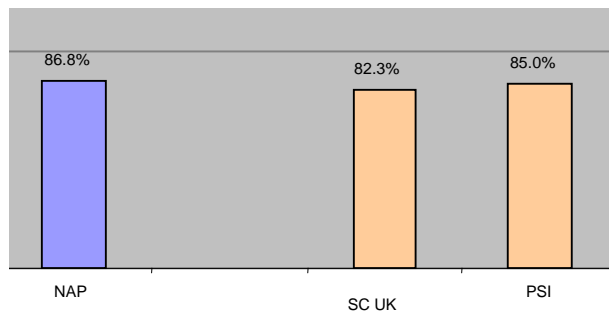


¹ MRCs also received support from the IFRC-International Federation of Red Cross and Red Crescent Societies

HIV prevention, promoting positive behaviour change among youth through peer education and outreach activities, counselling, and youth participation in development activities.

Utilisation of peer-educators has been particularly privileged by partners who reported having trained and involved 20,264 young peer-educators in their programme in 2005, including 13,600 trained by the Department of Health Planning with UNICEF support.

paid for sex and 85% of them reported having used a condom the last time they paid for sex.² Similarly, a third survey conducted in 2004 found a result of 82.3% of young people reporting use of condom at last paid sex³.



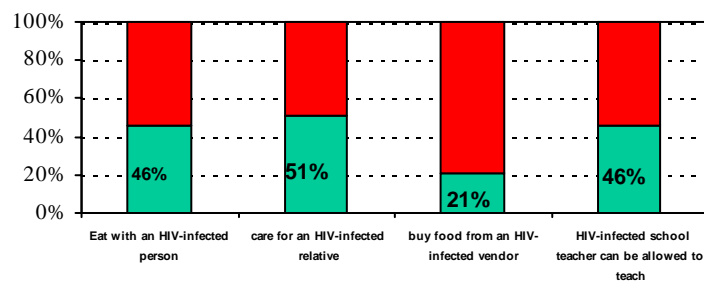
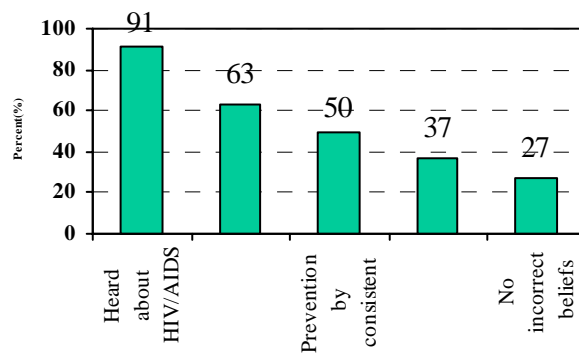
Results from 3 different surveys on condom use by young people at last paid sex (2003-2004)

Behaviour, knowledge and attitudes in Young People

A Behaviour Surveillance Survey conducted by NAP in 2003 found out that 86.8% of young people that exposed to paid-sex, reported using condom at last paid sex¹. This figure was confirmed by two independent studies. A condom market survey conducted end of 2004 found that 24% of males reported that they had ever

Knowledge on prevention method seems however far from been satisfactory and not consistent with relatively good result on behaviour relevant to sexual transmission of HIV. The BSS conducted by NAP in 2003 found out that only 23.9% of young male and 21.2% of young female could correctly identified the 3 common ways of preventing HIV transmission and reject the major misconceptions about HIV transmission.

¹ NAP BSS 2003 – survey on 3,380 young people in 7 major cities
² PSI condom market survey 2004 – survey on 4,800 young people in 12 major cities
³ Save the Children BSS 2004 – survey on 6002 young people in 10 townships (Kayin and Mon States)



Similarly, accepting attitudes toward people living with HIV is reported to be considerably low, according to the same survey (NAP BSS 2003)

6) Mobile Populations

As in many countries around the world, individuals and communities affected by mobility have heightened vulnerability to HIV infection in Myanmar. The definition of mobile populations is very comprehensive, ranging from people involved in mobile livelihoods (truck and taxi drivers, trishaw men, day and longer-term fishermen, traders etc.) through to people on the move for longer periods of time, such as seasonal migrants seeking work. Examples of affected communities in Myanmar receiving specific attention for HIV during 2005 include rural communities in the south-east which are source communities for labor, mining

communities in Shan and Kachin States and Sagaing Division, fishing communities along the coast, rubber plantations, and mobile professions such as train and truck employees, truck and trishaw drivers throughout the country.

While significant progress was achieved in 2005 in this area, improved monitoring and planning is required in order to obtain a comprehensive picture of programmatic outputs, coverage, remaining needs and impact. In late 2006 or 2007, a national review of mobile populations and HIV is planned, with technical assistance from the International Organisation for Migration.

Partners targeting mobile livelihoods

NAP	STD/AIDS teams reaching out to truck, bus, taxi drivers
MRT	Awareness and STI treatment for train employees
Burnet	Providing technical assistance to MRT and national NGO partners
PSI	Stimulating demand for condoms among mobile populations
Pyi Gyi Khin	Trishaw drivers, fishermen
MSF-H	Mining communities in Kachin and Shan States
PACT	In dry zone

7) Uniformed Services

Globally, people in uniformed services are also vulnerable to HIV. Therefore, uniformed services – especially the police and the military – are important for the national response to HIV in two ways: firstly they are at heightened vulnerability to HIV infection, and second they have a key role to play in the response above and beyond protecting themselves. As an example of the latter, in 2001 the police issued an internal directive indicating that carrying a condom was not to be used as evidence of prostitution, which is illegal. In this way, the police have significant impact on the enabling environment for a number of key HIV interventions. While the police remain responsible for law enforcement, a more sophisticated understanding of their impact on the public health can lead to better health and less HIV in Myanmar.

During 2005, work with the police was undertaken particularly through those working on drug use issues, through the Central Committee for Drug Abuse Control (CCDAC). CCDAC and police officials in more than 15 townships with drug user programmes were involved in assuring an enabling environment for on-going programmes. In addition, the Asian HIV Regional Project (AHRP) was working with the police to develop a curriculum for basic training that involved HIV awareness. UNODC and CARE have been involved in activities with police since 2004. By the end of 2005, 140 police trainers at Central Police Training Institute and three Training Depots had received Training of Trainer course on HIV prevention. As of end 2005, nearly 2,500 new recruits had benefited from the HIV prevention curriculum which the police trainers

had learned. Police posts in the border areas of Tachilek and Muse also received training. A post project survey indicated that police involved in the activity had improved their knowledge and attitudes towards people living with HIV, sex workers and drug users had improved. Significant work

remains, however, as many still see HIV as ‘punishment for guilt and sin’.¹

The National Strategic Planning process launched in late 2005 envisions exploring further the area of uniformed services, so that a more comprehensive strategy can be developed.

¹ *End-of-project Survey on HIV/AIDS Among Myanmar Police Force*, CCDAC and CARE, June 2005.

8) Workplace

Efforts to undertake awareness raising and behavior change communication through the workplace have been undertaken by a number of partners in Myanmar in 2005. Some Government departments, such as the Myanmar Railways and Transport Ministry, have started awareness and STI treatment programmes. A national NGO, the Myanmar Business Coalition on AIDS, expanded in 2005 from Yangon to Mandalay and Pyay, using their model of encouraging business engagement in HIV. A number of international NGOs, as well as the MBCA, also reach out to at-risk individuals through the workplace, especially in the mobile populations category including trishaw, bus and taxi drivers, fisherman, mining communities and factories. In 2005, more than 225,000 workers were reached by partners.

More research is required to enable a comprehensive picture of the extent of geographical and sectoral coverage of activities. More study is also required on the behavior change which is resulting from these efforts.

Numbers of workers reached in 2005 by selected partners

<u>Partner</u>	<u>Workers Reached</u>
PSI	130,480
World Vision	25,505
MBCA	13,747
AMI	12,686
MSF-H	12,111
PARTNERS	10,489
ARHP	5,373
MNA	5,063
MRT	4,400
NAP	3,895

9) Prevention for women and men of reproductive age

Coverage for health education on HIV

This category reflects the prevention programme in direction of the general population not including the most vulnerable groups (see above for those populations).

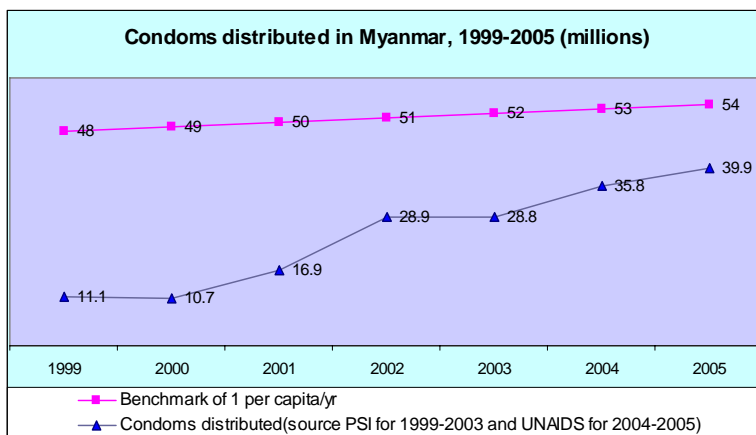
Report from partners show that more than 540,000 men and women of reproductive age were reached by health education sessions, in small or large groups. The real number is believed to be higher as report from some partners was not available.

Condoms distribution and sales

Overall, access to condoms has improved significantly with condoms being both widely available and affordable. Since 1999, estimates reveal that condom distribution and sales have roughly been multiplied four fold. It is estimated that 40 million condoms were distributed in the country in 2005. This represents ~0.8 condoms per capita per year compared to 1.1 in Laos and 2.0 in Thailand and Cambodia. More than half of these condoms, 23 million, were

distributed through social marketing by PSI. The NAP distributed 6.6 million condoms free of charge through their AIDS/STD Teams. Other large distributors were Care and AZG with a distribution of 2.2 and 2.1 million condoms respectively.

Besides these large distributions of condoms, 8 other partners distributed over 100,000 condoms each (see table below).



Prevention and treatment of Sexually Transmitted Diseases

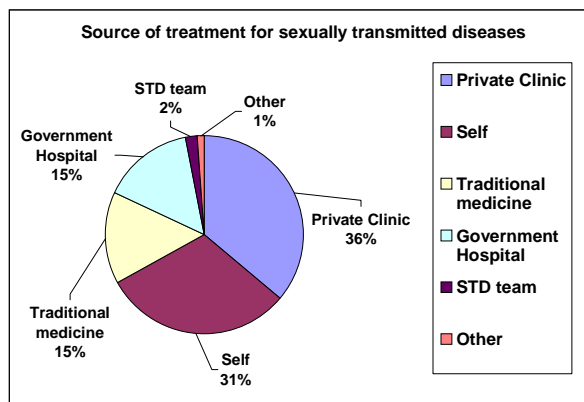
According to NAP annual reports on STIs, the syphilis prevalence rate in primapara has fallen steadily from a peak of 5% in 1993 to 2.2% in 2004. This trend is echoed by findings in one Yangon suburb of Hlaingthayar,

falling from 8.5% in 2000 to 6.3% in 2004.¹ The same data showed falling rates of syphilis in female (from 26% to 11%) and male (from 21% to 14%) STI patients, and in sex workers (from 41% to 34%).

Based on 2003 behavioral survey, only a quarter of people with genital discharge or genital ulcers sought treatment. There were various sources of treatment for STDs. The most common source is private or NGO's clinics (36%), followed by self treatment (31%); only 15% of the patients with an STD consulted a governmental hospital/clinic.

Condom distribution and sales by partners in 2005

AHRN	25,747
AMI	377,430
AZG	2,139,400
ARHP	91,565
BURNET	1,500
CARE	2,234,273
PARTNER	108,745
MSF-CH	108,205
Malteser	52,190
MSI	898,244
MDM	280,309
PACT	42,405
PSI	23,293,525
Progetto Continenti	4,048
SCUK	487,323
SCUS	28,632
WVI	260,632
MANA	21,296
MRCS	970,951
MMA	23,640
MHAA	380
MCFT	9,100
MMCWA	18,576
NAP	6,670,000
MRT	597,000
UNODC	44,034
UNDP	1,065,434
IFRC	18,465

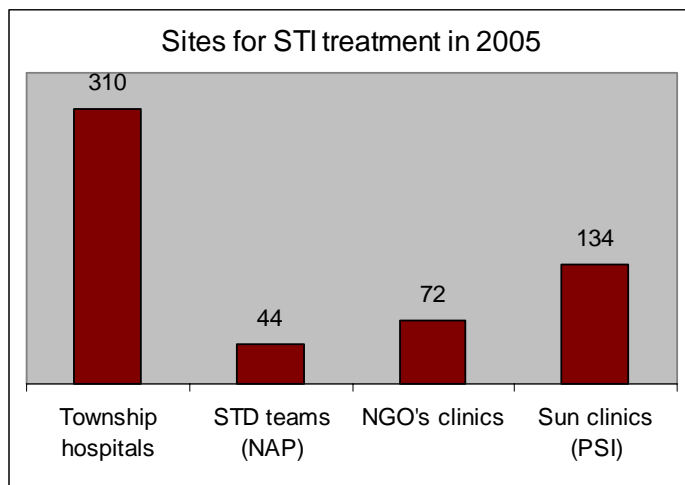


Source of treatment for sexually transmitted diseases

¹ *Communication MSF-Holland, 2005*

Access to services for the diagnosis and treatment of STIs has been expanded in recent years. In the non-for-profit sector, STD care is available at AIDS/STD Control Teams at the district level and in a number of clinics run or supported by NGO's. According to report from partners, there were 560 sites in Myanmar where patients can be treated for STIs for free or a subsidized price. Activities usually include outpatient case management, health education and in some cases laboratory services.

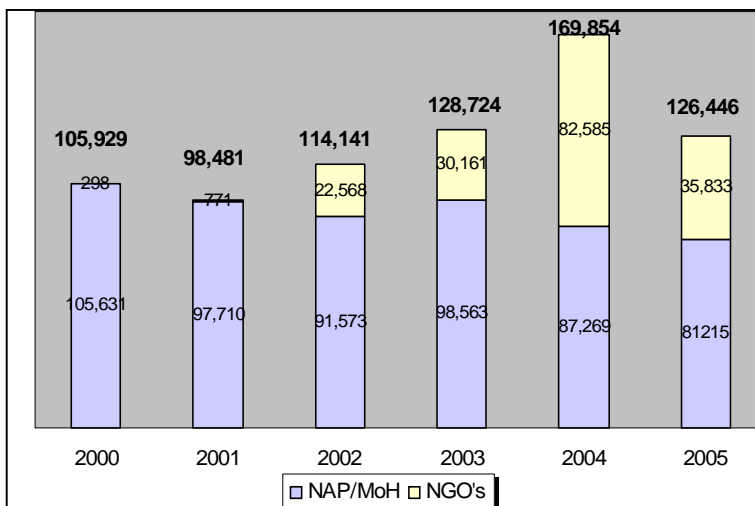
network of private practitioners - who receive training and ongoing medical education, subsidised pharmaceuticals, and agree to charge a fixed low fee for consultation and treatment. PSI also developed pre-packaged treatment kits, one for urethritis and one for genital ulcers, and trained Sun Quality health providers to use the kits with a syndromic management approach. Educating sufficient private practitioners to investigate, diagnose and prescribe effectively is a major challenge, as is reducing the damage done to individuals and public health by 'quacks' and encouraging people to seek professional help more often.



Number of patients diagnosed, treated and counselled in the non-for-profit sector has regularly increased

Private sector provides a large amount of STI treatment, although the number is not known and real concerns remain with diagnostic and drug quality. Some partners have targeted the private sector in recent years working on improving skills, medications and attitude. PSI, for example, has created the Sun Quality Health Clinics - a

from 2001 to 2004, reflecting a growing activity of NGO's. However, 2005 show a sharp decline in number of patients consulting NGO's clinics while the public sector remained at a relatively constant level.



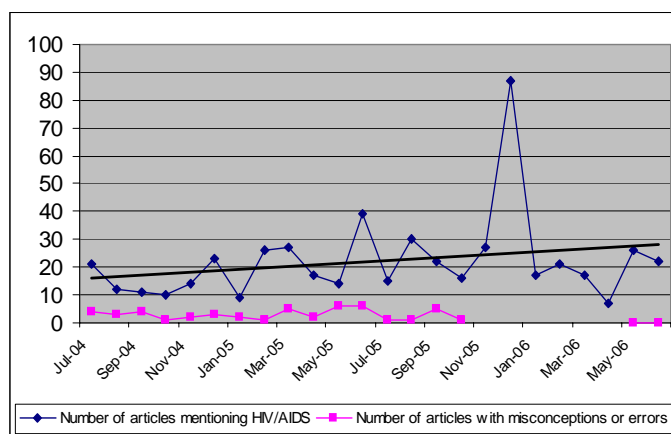
Mass campaigns and role of media

Festivals, competitions, public talks, video shows, World AIDS day, traditional theatre shows, exhibitions and displays have been an important way of awareness raising among general population, especially lower-risk groups. These events are particularly important to reduce the stigma associated with HIV, to inform on the modes of transmission and how services can be accessed.

In 2005, PSI, NAP and MRT were able to produce 8 TV spots and 2 TV series which were aired mostly during popular sport broadcasts.

Regular monitoring of press articles in a selection of newspapers shows that number of messages on HIV or AIDS are consistently increasing.

Evolution of number of articles on HIV/AIDS in a selection of 10 newspapers (UNAIDS ongoing survey)



10) Voluntary and Confidential Counselling and Testing (VCCT)

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

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

Currently full VCCT services (which include counselling and testing) are mainly provided in public health settings through the network of 45 AIDS/STD Teams of the DoH/NAP, the National Health Laboratory (as part of PMCT services), and within the

facilities of some township hospitals. Other organisations, mainly NGOs (see table below) provide pre- and post-test counselling while referring to a public laboratory or the local AIDS/STD team for HIV testing. In this way NGOs facilitate access to VCCT services to general and vulnerable/high risk populations covered by their programmes such as sex workers, MSM and IDU. The NAP is currently revising the policy for further expanding VCCT services to include private and NGO based laboratories. For this purpose and in order to ensure quality of services, the NAP in collaboration with the National Health Laboratory (NHL) is developing operational guidelines for accreditation. This accreditation system will include the regular participation of laboratories in a National External Quality Assessment Scheme (NEQAS) organised by the NHL. Two NGO's (MSI and PSI) have been granted the license to perform HIV testing in their facilities.

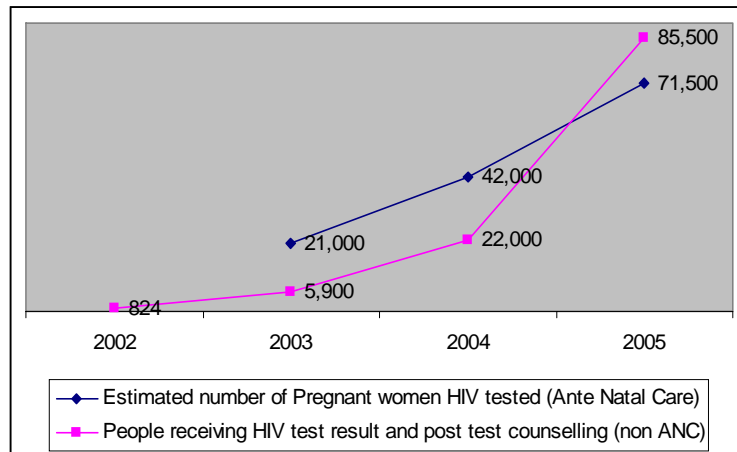
The NAP/DoH, with the help of WHO, has recently updated

technical guidelines for HIV testing, and guidelines on HIV counselling along with relevant training sessions. In collaboration with the National Health Laboratory, the technical guidelines have been disseminated and include the implementation of two rapid-test algorithms chosen from the WHO-evaluated panel of test kits. Utilisation of two rapid tests reduces the time for delivery of results and increases the chances of a high rate of return of clients to know the test results. NAP and NGOs organise regular training sessions to raise community awareness for VCCT and to train new counsellors. The bulk of HIV test kits for use in VCCT (as well as for blood safety) in the public sector have been provided by FHAM, JICA, UNICEF and WHO.

By the end of 2005, 73 townships were providing VCCT services (including testing for PMCT) in 122 service delivery points, either through AIDS/STD teams directly or in collaboration with NGOs, ensuring services to more than 200,000 persons for pre-test counselling alone and 157,000 for testing and post-test counselling.

In 2005 by partners	
NAP	129,144
AHRN	16
AMI	1,196
AZG	17,865
CARE	1,137
Malteser	1,068
MANA	207
MDM	1,291
MSFCH	2,084
MSI	406
PACT	83
PSI	1,625
TCU	205
WVI	923

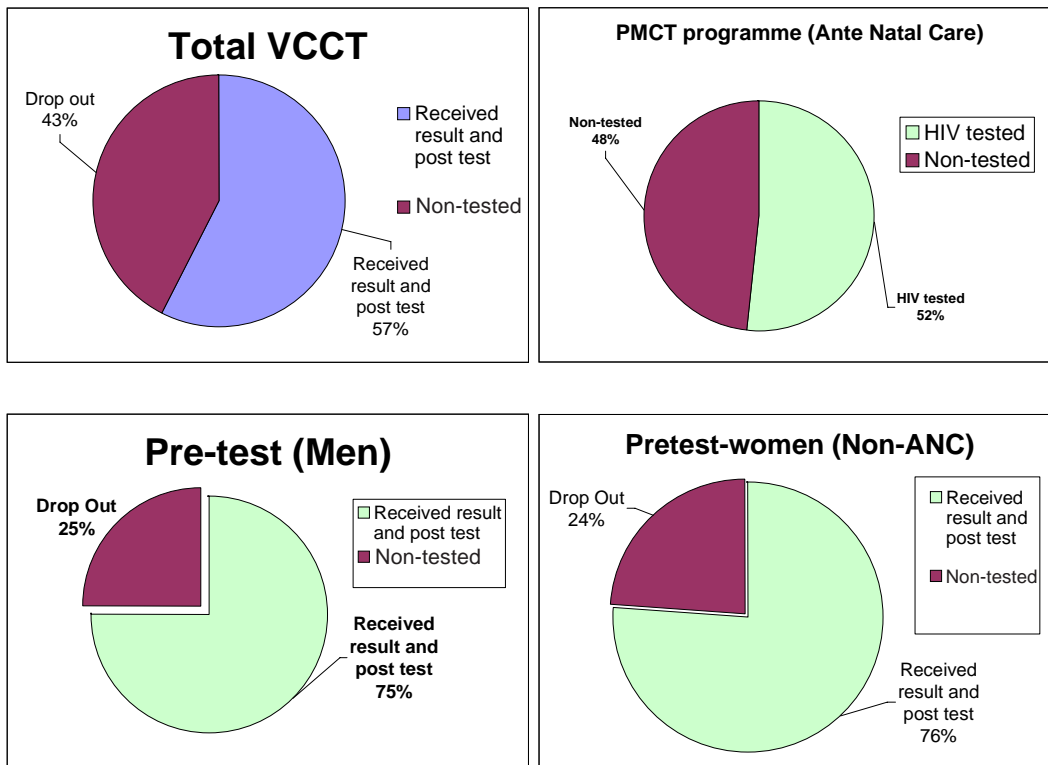
Number of persons tested and counselled¹



However, in spite of these efforts and the observed increase of service utilisation, access and uptake of VCCT is still considered to be very low in comparison with the needs and the demand for services. Results from a 2003 BSS among men showed that although the majority (68%) expressed desire to have access to HIV testing, only 55% knew where to go for testing and only 5% reported ever having undergone HIV test.¹ Stigma and discrimination linked

with AIDS have been reported as possible reasons for low uptake as well as the slim prospect of access to AIDS care in the event of a positive result.

The following charts provide an insight on acceptance of testing among people who receive a pre-test counseling, whether it's an individual or a group session². Although 76% of men and 75% of women that have received a pre-test counseling accept to be tested and come back to receive

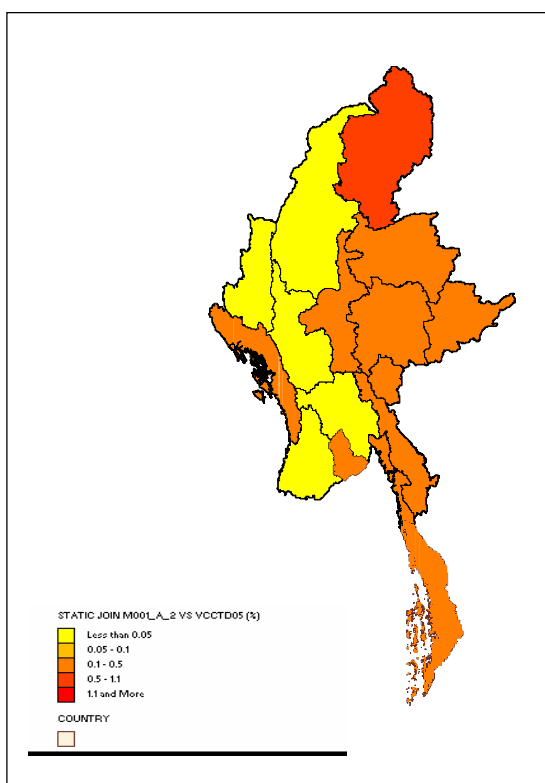


¹ NAP BSS 2003

² Testing done for driving license renewal not included in the charts

the test result, the acceptance rate is much lower when including women that received a pre-test counseling during their ante natal care visit. The proportion of women who took serotest option is about 52%. Whether this low acceptance rate is due to stigma associated with HIV testing and

AIDS in general or attributed to other factors requires more information. A better knowledge of factors influencing the acceptance of testing will help to better design the programme and improve the acceptance rate.



Percentage of adult population having accessed VCCT in 2005
(PMCT and taxi drivers surveillance non-included)

11) Prevention of Mother-to-Child Transmission (PMCT)

In 2005, an estimated 7,680 pregnant women were HIV+, leading to 2,000 potential infections of infants.

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

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

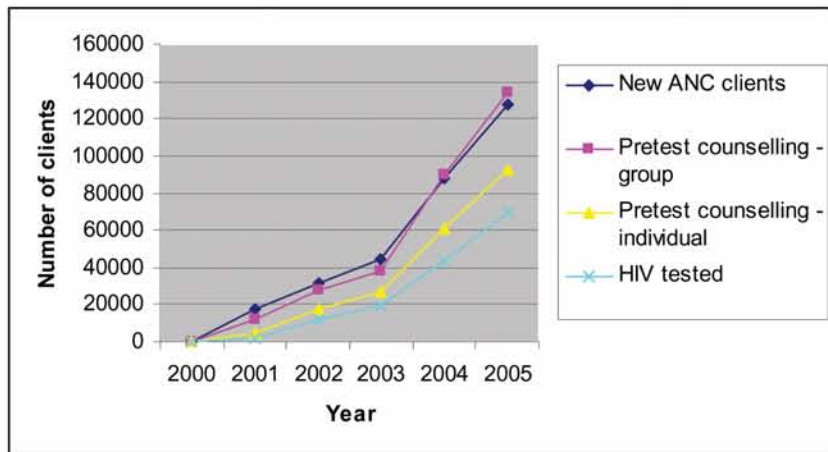
The PMCT programme was launched by NAP in 2000 with the support of UNICEF and was extended regularly to increase coverage. UNFPA and partner NGOs (MSF-H, MSF-CH and

AMI) have joined UNICEF and the NAP to expand PMCT services to 50 townships. A low level of PMCT activities is reported in the private sector.

The programme was initially designed to deliver services at the community level in order to reach the majority of women in Myanmar who give birth at home.¹ Hospital-based PMCT was then developed so that pregnant mothers who presented with unknown HIV status could have better access to HIV medical care and treatment. Hospital based services have been included since 2004. An evaluation of the hospital based program is planned for late 2006. Prior to the cessation of the Global Fund program expansion was planned to accelerate to 40 townships per year.

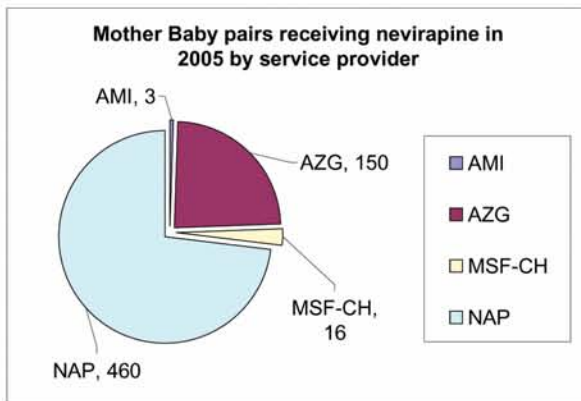
The cumulative total of women accessing counselling prior to testing was 140,000 by the end of 2005, out of which 52% accepted to be tested and returned to receive the result.

¹ 79% of births are in the home (Myanmar Reproductive Health Community Survey, MoH/ UNFPA, 2002)



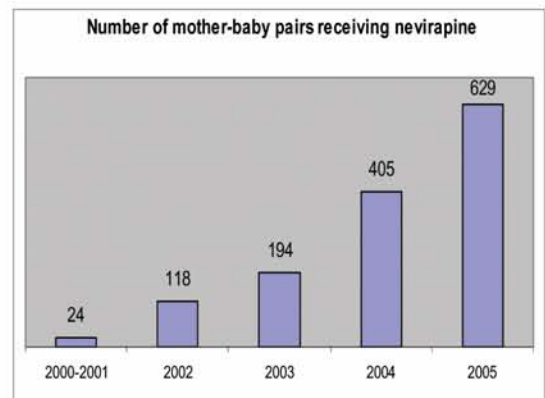
The NAP¹ and three NGO's provided *Nevirapine* to 629 mother-baby pairs. Despite a significant increase, the PMCT programme in its current coverage is barely reaching 8% of

HIV positive pregnant women in the country. The overall percentage of infection from HIV+ mothers to new-borns was still 24,40% in 2004²



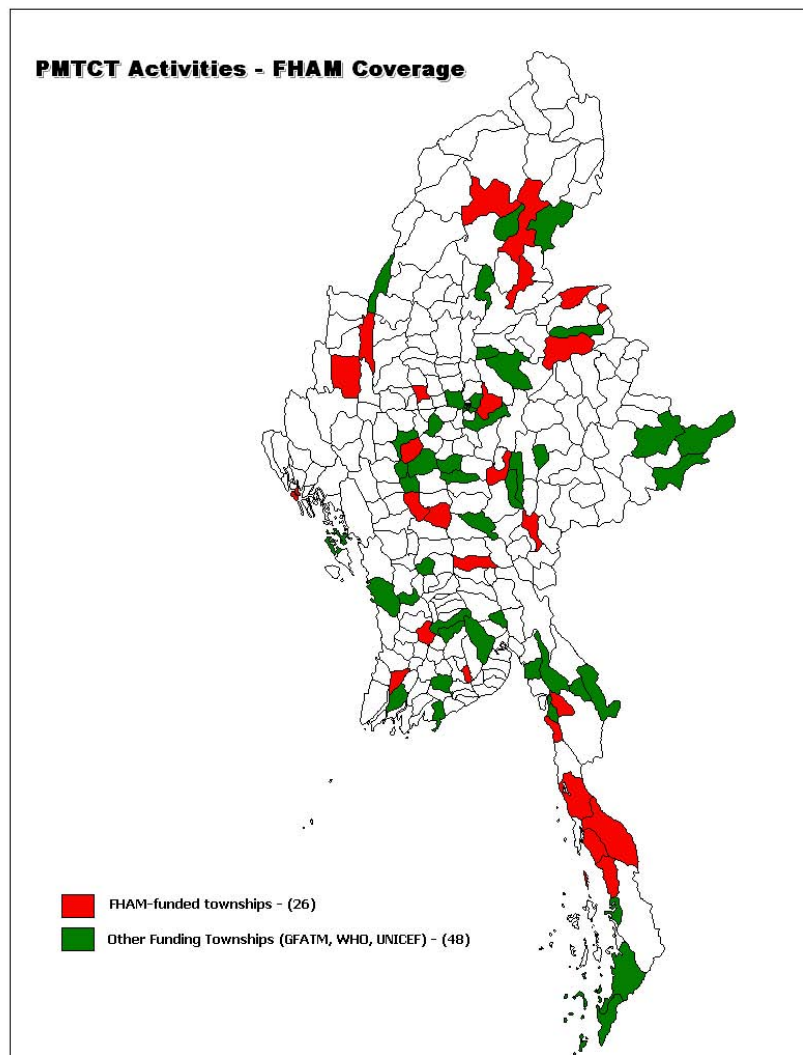
Graph Sources:
NAP, MSF-H, MSF-CH,

Number of mother-baby pairs receiving nevirapine



¹ With the support of UNICEF and UNFPA

² Myanmar UNGASS report 2004. Default rate is considered 25% in the absence of intervention.



Townships with PMCT service – community- or hospital-based.

12) HIV prevention in health care settings

Blood Safety

The NAP in collaboration with the National Health Laboratory (NHL) has continued to strengthen blood safety all over the country. Approximately 200 000 blood and blood product transfusions are performed every year throughout the health care system. The NHL ensures the distribution of HIV test kits to a network of more than 400 laboratories in order to ensure that no-transfusion is done without HIV testing.

The NAP and the NHL with WHO input have collaborated in the development of national HIV antibody testing guidelines currently on finalisation. The process of development of these guidelines have facilitated standardisation of HIV test kits procured for utilisation in the country as to ensure minimum quality standards in HIV testing.

With the support of WHO and JICA the NHL has started the implementation of a National External Quality Assurance Scheme (NEQAS) for HIV testing. The NEQAS helps to monitor quality and performance of HIV testing by laboratories and provides the opportunity of

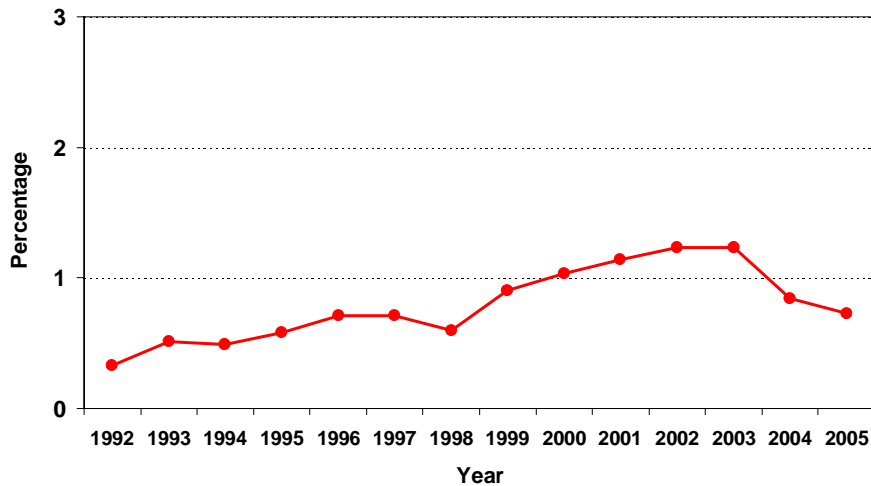
continued training of laboratory technicians. In 2005 two NEQAS rounds covered a network of 65 laboratories in the public health sector. The NHL is gradually expanding coverage with 97 laboratories planned for 2006. Results from the NEQAS rounds reports highlights a good level of quality of HIV testing within public health system in Myanmar.

Another important aspect of blood safety is the recruitment of voluntary non-remunerated blood donors. For this purpose, AIDS/STD teams are active organising blood donor recruitment advocacy meetings and trainings at township level. With the support of JICA the National Blood Centre has introduced a computer based registration system for blood donors. This system is operational in the main blood centers of Yangon and Mandalay as is being expanded to other main blood centers such as Patheingyi (Irrawaddy Division) and Myittha (Kachin State). A new deferral form for screening blood donors has been developed and is now in utilisation in most blood centers in the country. These efforts in recruitment of voluntary non-remunerated blood

donors and deferral of potentially risk blood donors helps to explain the observed reduction of HIV prevalence among blood donations observed by the HIV surveillance during the last few years (graph).

During 2005 with the support of UNICEF and FHAM, PEP kits were distributed and made available to health care workers in over 200 hospitals in the country. Basic guidelines were developed and distributed at the same time

HIV prevalence among blood donors—Myanmar, 1992–2005

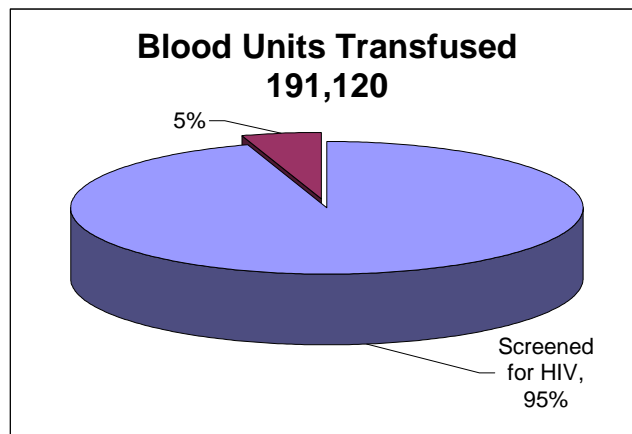


Source: National AIDS Programme, Department of Health

The NHL also organises twice yearly training sessions for staff working in peripheral hospitals in technical issues for blood safety including blood donor recruitment and rational use of blood for medical doctors.

and health care workers were trained for utilisation. With WHO input, the NAP is currently revising existing guidelines on universal precautions and updating existing PEP guidelines.

Universal Precautions and Post-Exposure Prophylaxis (PEP) in health care settings:

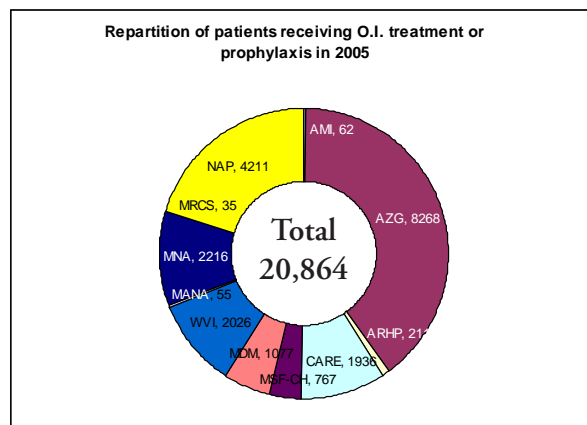


13) Treatment and care for People Living with HIV

Being infected with HIV, People Living with HIV face various and changing care needs. After diagnosis of HIV infection, they should be referred to necessary services either clinical or social. They need extensive psychological support including counselling and continuous medical follow up including OI prophylaxis. As the clinical stage progresses, they need to be seen by clinicians for treatment of OI including TB and, if available, antiretroviral treatment.

Treatment of Opportunistic Infections

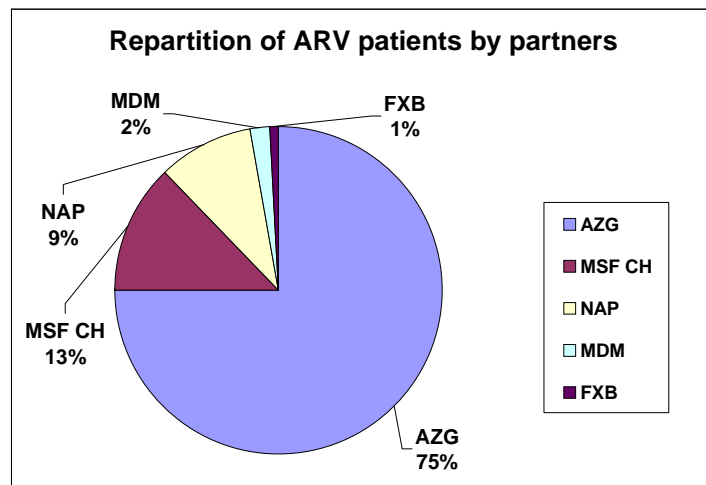
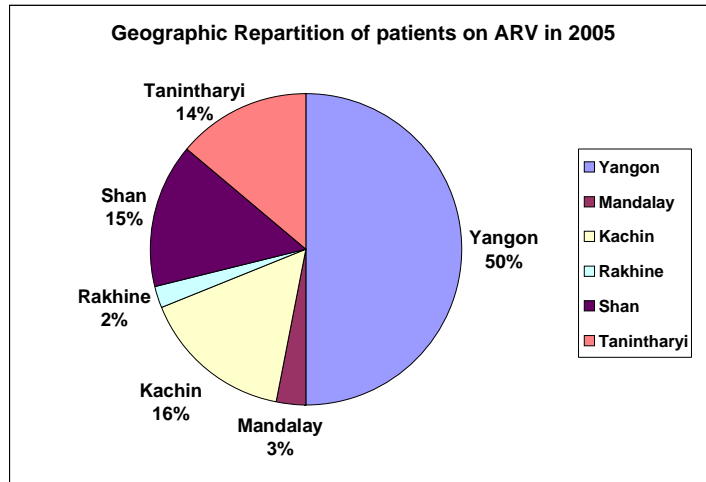
Number of patients receiving OI prophylaxis or treatment was reported to be more than 20,000 in 2005 for the public and the non-for-profit sector. No data was collected in previous years. No data is either available for the private sector, although OI drugs are widely available on the market. The number of patients treated is thus believed to be considerably higher.



Anti-Retroviral Therapy (ART)

Triple combination antiretroviral therapy was initiated in Yangon in 2003 through a project implemented jointly by MSF-Holland and Department of Health. By end of 2005, there were 2,527 patients receiving treatment (MSF-H, MSF-CH, NAP, MDM, AFXB) In addition, it is estimated that more than 4,000 patients are receiving ART in the private-for-profit sector.¹ ARV is available in private pharmacies, but in the private-for-profit sector patients are sometimes treated with sub-optimal drug combinations, which can lead to the early development of drug resistance. Some patients use a combination of 2 drugs (because it is cheaper) as long as they can afford it or

until the treatment does not work anymore. They then stop ART altogether, as further treatment options are too expensive. These practices underline the need to invest in a scaled-up, publicly-provided system to deliver ART, giving people a better alternative to expensive and potentially dangerous private services. Some initiatives have been undertaken to inform or train the private sector in the appropriate management of ART, including several seminar organised by NAP, the Myanmar Medical Association (MMA) and WHO for the training of general practitioners.



A project for the integrated care of TB/HIV patients was launched in Mandalay in 2004, through partnership between the NAP, the International Union Against Tuberculosis and Lung Disease (IUATLD) and the petrochemical company TOTAL. This partnership will provide ART to 1,000 patients within 5 years and started mid 2005. As well Thailand has started to provide ART for 200 patients living in border areas. NGOs continue to increase the numbers of patients receiving treatment, and additional NGOs will start ART provision.

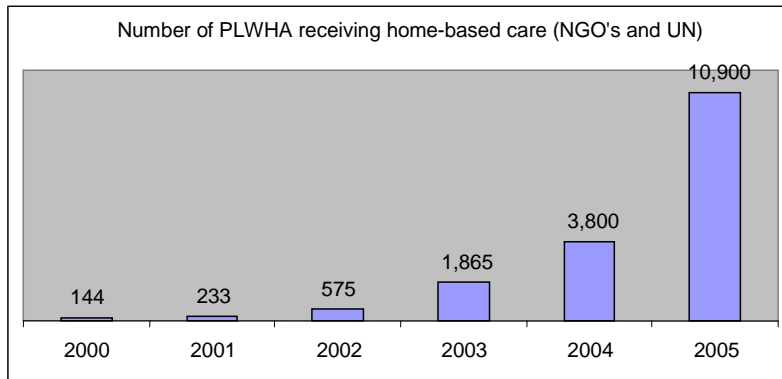
Community and Home Based Care

One of the strategies of the National Strategic Plan is to “design and provide a basic social benefit package for People Living with HIV in need, and support families to provide home-based care”. With the increase in resources available, this has been possible and a number of partners have been able to provide home-based care packages, which nevertheless still differ from partner to partner.

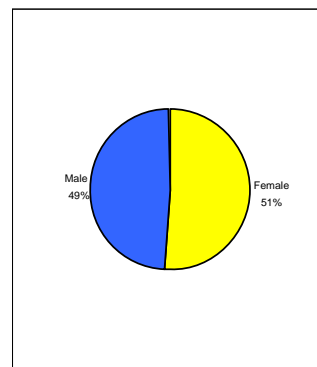
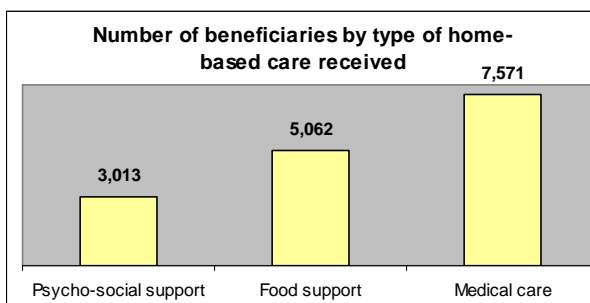
In 2005, in addition to Basic Health Staff of the public health services, 15 NGOs and 2 UN agencies¹ were working to provide home-based care to more than 10,900 people in some 40 townships over the country². The

The provision of support to PLHA included counselling, nutritional support, prophylaxis and treatment of opportunistic infections (including tuberculosis), on an outpatient basis or through home-based care for

those who are too sick to attend the clinic regularly. Psychological, social, legal and material supports have often been included in the service provided, but services vary considerably between service providers.

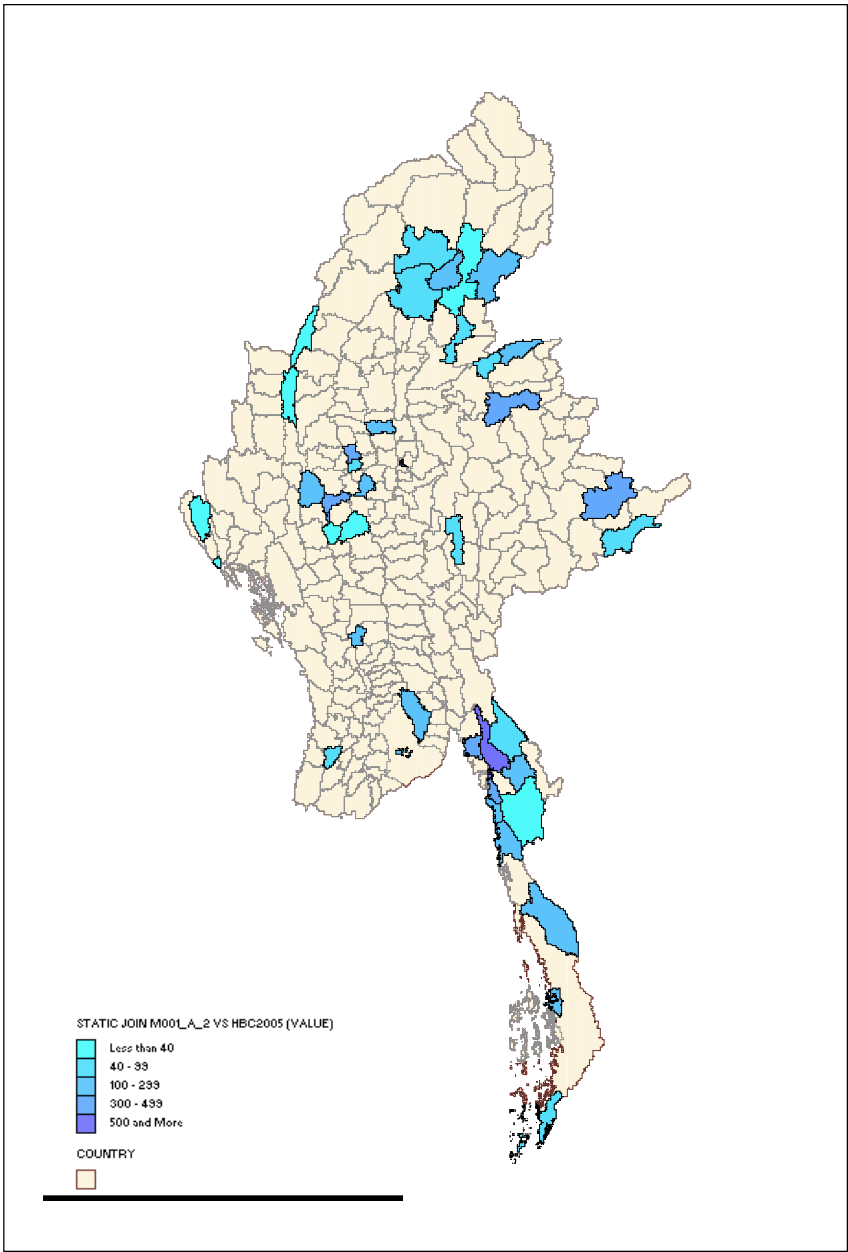


NAP provides material and some financial support to some local NGOs and CBOs for home-based care activities. The figure below illustrates the steady increase since 2000.



¹ MNA, World Vision, Care, UNDP, WFP, AZG, MSF-CH, AFXB, MDM, MRCS, Pyi Gyi Khin, AMI, MBCA, ARHP, PACT, MMCWA and MANA

² Notably a local NGO, Myanmar Nurses Association (MNA) who is providing Home Based Care to more than 4,200 persons



Number of people receiving home based care in 2005 by township

14) Monitoring and Evaluation

One agreed country-level monitoring and evaluation system.

The Three Ones principles are now recognized as guiding principles for an effective, harmonized and scaled-up response to HIV and AIDS and were endorsed by a wide range of international and national partners. Many countries have established *coordination mechanisms, strategic frameworks*, and are in the process of establishing *harmonized monitoring and evaluation systems*.

A national M&E framework was established for all partners in Myanmar since 2004. A common basic data set has been designed, with agreed definitions against which implementing partners have been requested to report. While the selected indicators ensure that the system can report on essential elements of the national response to AIDS in Myanmar, they also reflect

standardisation with international indicators, including UNGASS indicators.¹ As discussed below, a system has been designed to collect data regularly against this framework.

Data collected against each indicator in 2005 have been used to establish baselines and determine acceptable common targets for each of the coming years of the new National Strategic Plan.

Monitoring the contribution to the national response

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

- Reporting on activities

A reporting form is sent by the National AIDS Programme every year to all identified partners².

¹ For a full description of the Joint Programme indicator set, refer to the publication UNAIDS, UN Expanded Theme Group on AIDS in Myanmar, Joint Programme for HIV/AIDS: Myanmar 2003-2005, pages 5-10

² Currently around 40 partners are identified, whether they are INGO, local NGO, ministries or UN agencies

Process and output indicators, irrespective of funding source, are collected and aggregated nationally (number of peer educators trained, number of condoms distributed etc.) with the technical assistance of the UNAIDS Secretariat. Most of the partners have reported on these indicators for the year 2005, including all the major partners. A critical mass has been reached to consider having gained a representative picture of the response to the HIV epidemic.

- Mapping of activities: Services Providers Matrix

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

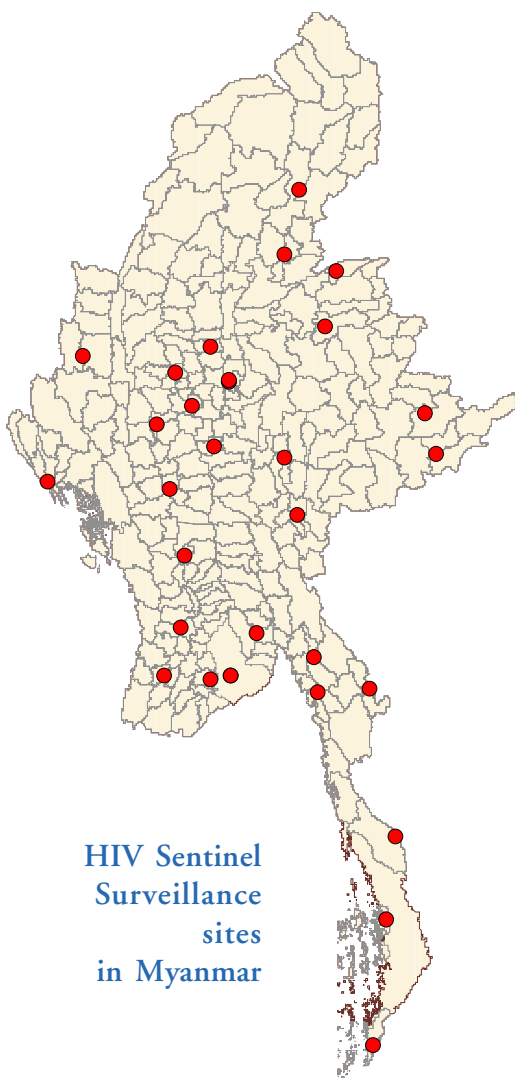
Evaluating the impact of the national response

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

- Seroprevalence

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

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



HIV Sentinel Surveillance sites in Myanmar

- Behaviour

A Behavioural Surveillance Survey (BSS) system in the general population of Myanmar was set up in 2000 by the NAP. A national behaviour survey was conducted in 2003 by NAP with the support of WHO. This survey was undertaken during September-November 2003 to assess the knowledge, attitude and behaviours of the general population and youth with regards to HIV transmission and

prevention at seven sites in Myanmar. The findings have been published in the second semester of 2005 (cf references in diverse chapters).

In addition, the National AIDS Programme is working with WHO, UNAIDS and a local research company to broader behavioural surveillance by looking at more high-risk and low-risk groups, including sex-workers, Injecting Drug Users, young people (out and in-school) and factory workers. Methodology and questionnaires have been designed and will be finalised by the Ministry of Health. Results of the survey will be published by the NAP.

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

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

Main objectives of the next phase will consist in:

- the determination of national targets against each indicator of the National Strategic Plan
- the costing of each activity and measure of cost-effectiveness
- the dissemination of information at national and decentralised level to better influence programme design and implementation.

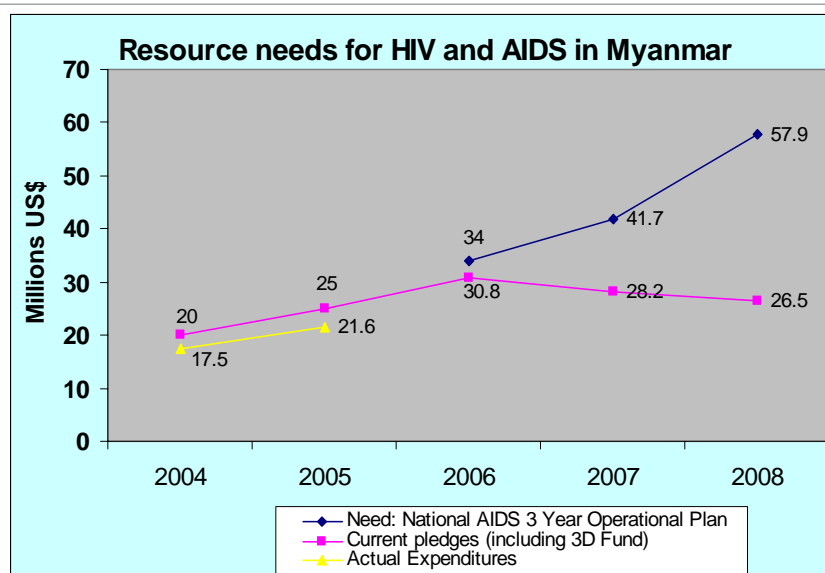
15) Financial resources and expenditures

In general, Myanmar is a donor-constrained country. Development assistance per capita is an order of magnitude smaller in Myanmar than in neighbouring countries. In 2002, whereas Laos received approximately \$53 per capita in overseas development assistance per year, Cambodia \$30, and Vietnam \$22, Myanmar was receiving an estimated \$3 per capita per year.¹ Neither the World Bank, the Asian Development Bank nor the President's Emergency Plan (PEPFAR) are present in Myanmar. On top of that, the Global Fund for TB, AIDS and

Malaria withdrew its support by cancelling a 100 MUS\$ grant initially planned to cover the period 2005-2008.

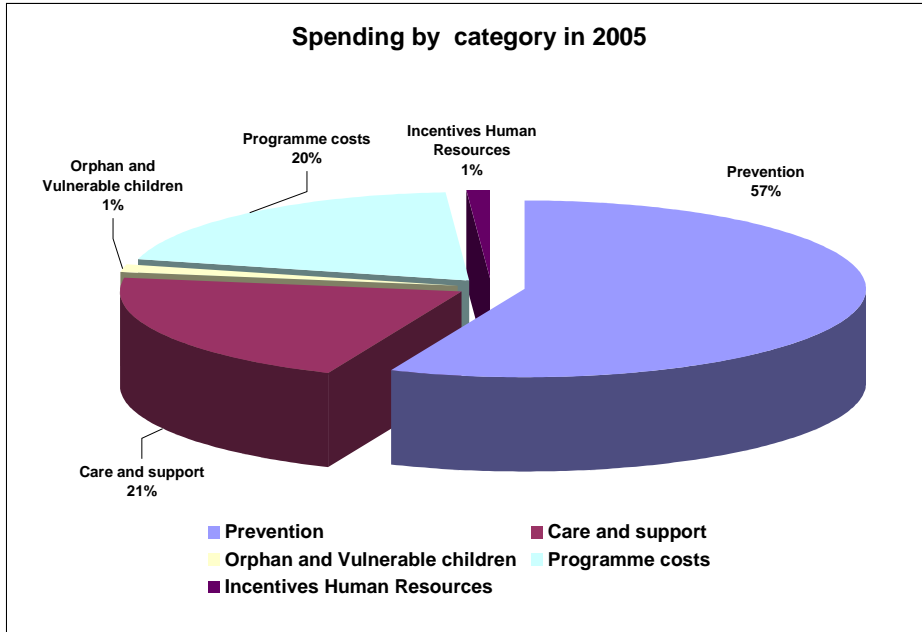
External support has however increased since 2003, mainly due to the establishment of the Fund for HIV and AIDS in Myanmar (FHAM), channelling financial resources from several governments (UK, Sweden, Norway, Netherlands and recently Australia).

The chart below shows progression of expenditures for 2004 and 2005 and resource estimates for 2006.



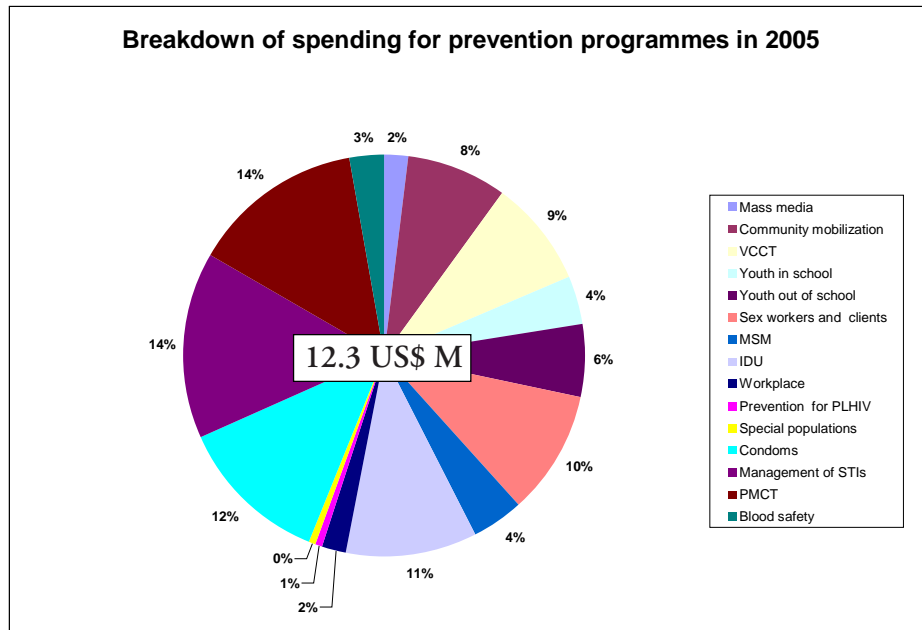
The expenditures on HIV and AIDS by all partners were assessed for 2005. 57% of the 21.6 million US\$ spent on HIV and AIDS were in prevention programme, while 21% were in Care and Support.

¹ UN/ESCAP *Statistical Yearbook for Asia and the Pacific*, 2002.



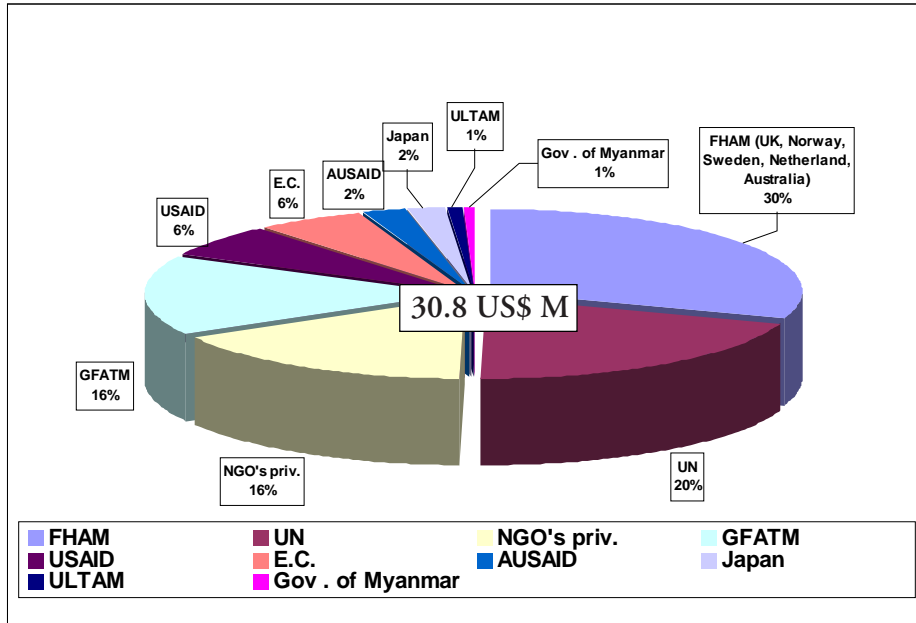
Total Spending by category in 2005 (21.6 US\$ M)

Out of 12.3 million US\$ spent on prevention activities, the categories reporting most expenditures were in management of STI, PMCT, Condoms, IDU, Sex workers, VCCT and young people out of school.



Breakdown of spending for prevention activities only in 2005

An assessment of the financial resources expected for 2006 was conducted. An estimated 30.8 million US\$ is available for 2006 programme. Figure below gives the breakdown by source of funding.



Breakdown of estimated resources other than government's contribution for HIV and AIDS in Myanmar 2006