Global AIDS Response Progress Report

Myanmar

National AIDS Programme

Reporting period: January 2012 – December 2013

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Acronyms and abbreviations

AEM	AIDS Epidemiological Model
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BSS	Behavioural Surveillance Survey
CBO	Community Based Organization
CSO	Civil Society Organization
CCM	Country Coordinating Mechanism
DHS	Demographic and Health Survey
FSW	Female Sex Worker(s)
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	HIV Counselling and Testing
HSCC	Health Sector Coordination Committee
HSS	HIV Sentinel Sero-Surveillance
IBBS	Integrated Biological and Behavioural Surveillance
INGO	International Non-Governmental Organization
KAP	Key Affected Population(s)
M-CCM	Myanmar Country Coordinating Mechanism
MoH	Ministry of Health
MCH	Maternal and Child Health
MMT	Methadone Maintenance Therapy
MOU	Memorandum of Understanding
MSM	Men who have Sex with Men
MTR	Mid-Term Review
NAP	National AIDS Programme
NFM	New Funding Mechanism
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PSE	Population Size Estimation
PSM	Procurement and Supply Management
PWID	People Who Inject Drugs
SI	Strategic Information
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection(s)
TSG	Technical and Strategy Group
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
VCCT	Voluntary Confidential Counselling and HIV Testing
WHO	World Health Organization
3DF	Three Diseases Fund
3MDG	Three Millennium Development Goals Fund

I. Status at a glance

I.1 Reporting process

The National AIDS Programme (NAP) under the Ministry of Health (MoH) in collaboration with stakeholders and with support from UNAIDS, WHO and UNICEF, led the reporting process in Myanmar. The NAP has worked and consulted together with many partners to complete the data to measure progress and to produce a narrative report.

The reporting process also gained impetus from and builds upon the recently concluded mid-term review (MTR) of the National Strategic Plan on HIV and AIDS (2011–2015)[1] as well as of the MTR of progress against the Ten Targets conducted in April 2013.[2] Coverage and financial data presented in this report are part of the annual data collection cycle and was collected directly from implementing partners.

Representatives from Government completed the National Commitment and Policy Instrument (NCPI) Part A with coordination by the NAP. NCPI Part B was finalised through a separate consultative processes in which representatives of civil society, multilateral and bilateral organizations participated. A two-day consultation workshop was organized by 3N, the national NGO network on HIV and AIDS. More than 45 representatives from organizations and networks of people living with HIV (PLHIV) and of key affected populations (KAPs) from a number of different townships across the country participated. In addition, a meeting was organized to gather inputs into the NCPI Part B from NGOs, bilateral and multilateral organizations.

A national joint validation workshop consolidated and confirmed NCPI A and B as well as the coverage and financial data included in this report. The workshop, which was opened by Dr Min Than Nyunt, Director General, Department of Health, MoH, had broad representation from NAP, Government, PLHIV, men who have sex with men (MSM), female sex workers (FSW), people who inject drugs (PWID), interfaith network, United Nations and bilateral agencies as well as national and international NGOs.

I.2 Status of the epidemic

HIV prevalence in Myanmar has declined from 0.94% in 2000 to an estimated 0.47% in 2013 among general population aged 15 years and above. However, it remains relatively high in key populations such as PWID, MSM and FSW and their clients. The epidemic in these sub-populations is driven primarily through high risk sexual contact and the use of contaminated needles and syringes.

The last published estimates modelled in 2011 showed HIV prevalence in the adult population aged 15 years and older at 0.53% in 2011.[3] Latest surveillance data from 2013 indicated prevalence in the sentinel groups of: FSW 8.1%, MSM 10.4% and PWID 18.7%.[4] Prevalence has fallen from 9.6% in FSW and 21.9% in PWID, but has increased in MSM from 7.8% in 2011.[5]

[1] Mid-Term Review of the Myanmar National Strategic Plan on HIV and AIDS 2011–2015: Consolidation Report, Draft 5 March 2014.
[2] Midterm Review of Progress on the Ten Targets in Myanmar, NAP, June 2013.
[3] HIV Estimates and Projections, Asian Epidemiological Model, Myanmar 2010–2015, SI and M&E TWG, 2011.
[4] Result of HIV Sentinel Sero-surveillance 2012, Myanmar, NAP, February 2013.
[5] Result of HIV Sentinel Sero-surveillance 2012, Myanmar, NAP, March 2012.

The number of people living with HIV in Myanmar was estimated at around 189,000 in 2013, of which 37% were female.[6] An estimated 15,000 people died of AIDS-related illness in the same year. New infections declined in this reporting period, but over 7,000 new infections are estimated to have occurred in 2013, confirming the continuing need for effective prevention efforts.

I.3 Policy and programmatic response

High level political commitment drives the national response to the HIV epidemic in Myanmar. The NAP is a significant institution in the MoH. Government representatives at national and sub-national levels regularly participated in AIDS related public events including World AIDS Day. Government is represented in all essential AIDS committees and working groups with regular meetings with civil society organizations, private sector and other stakeholders.

The Myanmar Country Coordinating Mechanism (M-CCM), overseeing the national responses to AIDS, tuberculosis, malaria, and maternal, newborn and child health, has recently been transformed into the National Health Sector Coordination Committee (HSCC). The HSCC is multi-sectoral with broad participation, including representatives from international organizations, donors, international and local NGOs, private sector and people living with HIV – all selected by their respective constituencies.

The HIV Technical and Strategy Group (TSG) has specific oversight of the national response to HIV, and has various experts and specialists from ministries, United Nations organizations, and from other constituencies of the HSCC. The TSG supports eight Technical Working Groups (TWG) to address specific programmatic areas. TWGs are open to representation from all stakeholders who wish to participate. One TWG operates specifically to coordinate and oversee M&E system strengthening efforts and activities aimed at making improved strategic information (SI) available to track the epidemic and national response.

The NAP coordinates policies and activities at national and sub-national levels directly through 46 AIDS/STD teams throughout the country. The M&E Unit of the NAP coordinates the national monitoring and evaluation demands.

The National Strategic Plan on HIV and AIDS (2006–2010) guided the national response until 2010 when the second NSP (2011–2015), or NSP II, was developed. The MoH led the process in which a wide range of partners participated. The NSP II has three objectives:

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

The NSP provides the strategies for achieving the objectives. It sets annual targets for a set of agreed indicators, and is costed. The NSP is the platform for resource mobilization and allocation and is the reference for all partners in the national response.

The NSP II identifies three strategic imperatives for the most urgent needs of key affected populations and persons infected and affected by HIV:

[6] HIV Estimates and Projections, Asian Epidemiological Model, Myanmar 2010–2015, SI and M&E TWG, 2011.

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

The following cross-cutting interventions support all three strategic priorities:

- Health system strengthening (including private sector health services), structural interventions and community systems strengthening
- Favourable environment for reducing stigma and discrimination
- Monitoring and evaluation, research, advocacy and leadership

Targeted populations, implementing partners and activities for each of these strategic priorities are identified at the level of intervention.

The recent MTR recommended that programmatic focus should be on the prevention of sexual transmission of HIV, reducing HIV transmission through unsafe injecting practices among PWID, prevention of mother to child transmission of HIV (PMTCT), antiretroviral treatment and reduction of tuberculosis (TB) and HIV co-infection.

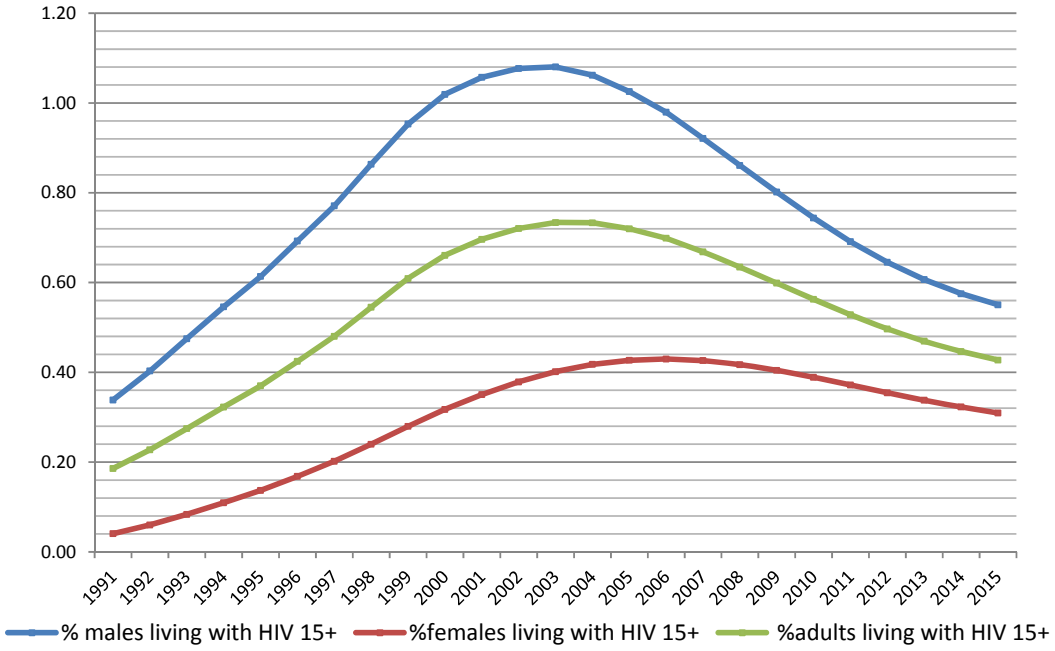
I.4 Indicator overview

	Status	Value
Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015		
1.1 Young people: Knowledge about HIV prevention	Data available	47.5%
1.2 Sex before the age of 15	Data available	0.7%
1.3 Higher-risk sex	Data available	6.6%
1.4 Condom use during high risk sex	Data available	43.8%
1.5 HIV Testing in the general population	Data available	11.3%
1.6 Reduction in HIV Prevalence	Data available	0.4%
1.7 Sex workers: Prevention programmes	Data available	76.2%
1.8 Sex workers: Condom use	Data available	95.9%
1.9 Sex workers: HIV testing	Data available	71.1%
1.10 Sex workers: HIV prevalence	Data available	8.1%
1.11 Men who have sex with men: Prevention programmes	Data available	69.1%
1.12 Men who have sex with men: Condom use	Data available	81.6%
1.13 Men who have sex with men: HIV testing	Data available	47.6%
1.14 Men who have sex with men: HIV prevalence	Data available	10.4%
Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015		
2.1. People who inject drugs: Prevention Programmes (Needles per person and year)	Data available	147
2.2 People who inject drugs: Condom use	Data available	77.56%
2.3 People who inject drugs: Safe injecting practices	Data available	80.62%
2.4 People who inject drugs: HIV testing	Data available	27.31%
2.5 People who inject drugs: HIV Prevalence	Data available	18.7%
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths		
3.1 Prevention of mother-to-child transmission	Data available	90.2%
3.2 Early infant diagnosis	No data	--
3.3. Mother-to-child transmission rate (modelled)	No data	--
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015		
4.1 HIV treatment: Antiretroviral therapy	Data available	54.1%
4.2 HIV treatment: 12 month retention	Data available	84%
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015		
5.1 Co-management of TB and HIV treatment	No data	--
Target 6. Reach a significant level of annual global expenditure (US$22–24 billion) in low and middle-income countries		
6.1 AIDS spending (2012, in USD)	Data available	38,983,739
Target 7. Critical enablers and synergies with development sectors		
7.1 National Commitments and Policy Instruments (NCPI)	Data available	--
7.2. Prevalence of Recent Intimate Partner Violence (IPV)	No data	--
7.3 Orphans and non-orphans school attendance	Not relevant	--
7.4. Economic support for eligible households	No data	--

II. Overview of the HIV epidemic

In 2011, HIV prevalence was expected to have decreased to 0.43% by 2015. It has been on a steady decline in the general adult population for many years and is calculated at 0.5% in 2013, down from 0.6% in 2010.[7] However, HSS data collected on an annual basis shows that HIV prevalence continues to be relatively high among PWID, MSM, FSW and their clients.

Figure 1: Prevalence in general population, 15 years old and above (1991–2015)

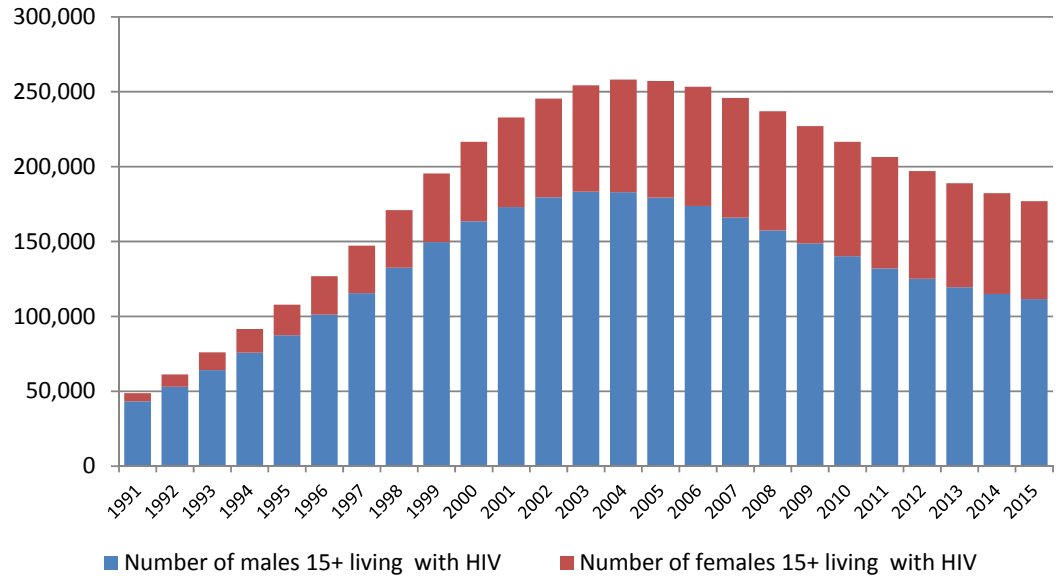


Source: HIV Estimates and Projections Myanmar, AEM, Myanmar 2010–2015

The reduced HIV prevalence since the peak in 2004 (Figure 2) is largely attributed to fewer new infections and a large number of AIDS-related deaths before antiretroviral treatment became available on a larger scale at the end of the 2000s.

[7] HIV Estimates and Projections, Asian Epidemiological Model, Myanmar 2010–2015, SI and M&E TWG, 2011.

Figure 2: Number of people living with HIV in Myanmar by sex (1991–2015)



Source: HIV Estimates and Projections Myanmar, AEM, Myanmar 2010–2015

Since 1992, the NAP has carried out annual HIV Sentinel Surveillance (HSS) of selected population groups in Myanmar, and the most recent data are from 2013. The sentinel groups are pregnant women attending antenatal clinics (ANC), new military recruits, blood donors, PWID, MSM, FSW, male clients of STI services and new TB patients. Table 1 summarizes the results from the 2013 round of surveillance.

Table 1: HIV prevalence among sentinel populations, HSS 2013

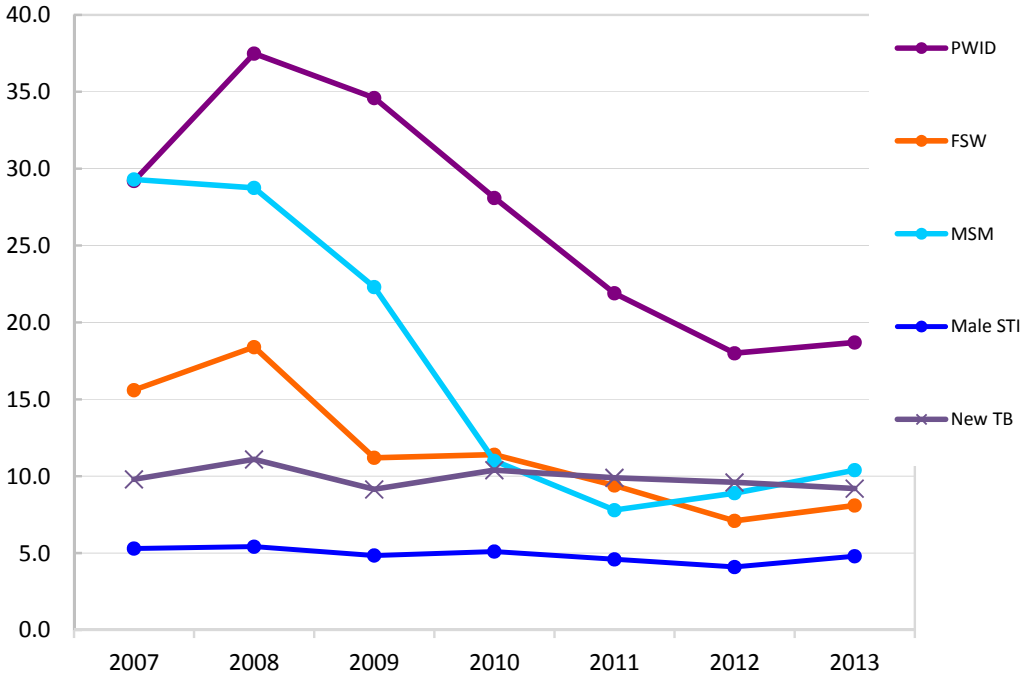
Table 1. HIV Prevalence among sentinel groups, HSS 2013

Sentinel Group	# tested for HIV	# HIV positive	sero positive (%)	Range			95% CI (%)
				Min (%)	Median (%)	Max (%)	
Male STI patients	4,703	228	4.8	0.0	3.3	2.5	4.2 - 5.5
FSW	1,946	158	8.1	2.1	5.5	24.5	6.9 - 9.3
IDU	975	182	18.7	5.4	15.7	35.5	16.2 - 21.1
MSM	756	79	10.4	6.0	7.8	19.5	8.3 - 12.6
Pregnant Women	13,999	78	0.6	0.0	0.5	1.5	0.4 - 0.7
New Military Recruits	500	9	1.8	0.0	1.1	2.2	0.6 - 2.9
New TB patients	3,351	307	9.2	0.0	9.3	28.8	8.2 - 10.1
Blood Donors	11,147	25	0.2	0.0	0.1	0.5	0.1 - 0.3

Source: HSS 2013, NAP, March 2014

The steady decline in HIV prevalence among PWID since it peaked in 2008. Although the general trend in HIV prevalence among PWID and FSW is downwards, prevalence among MSM has increased over the last two years. Prevalence among newly diagnosed TB patients persisted at around 10% since 2010, indicating the strong inter-relationship between HIV and TB.

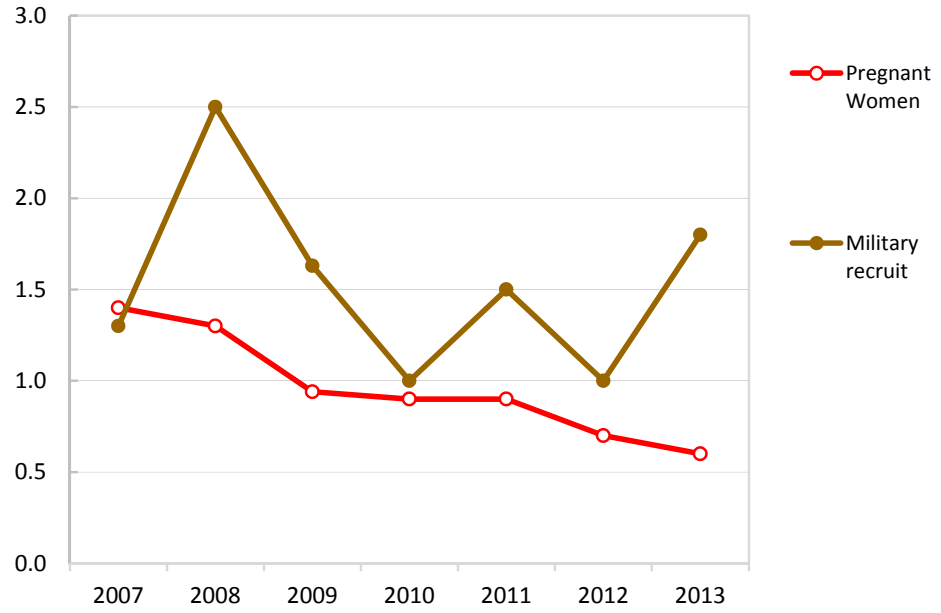
Figure 3: HIV prevalence among sentinel populations (2007–2013)



Source: HSS 2007–2013, NAP

HIV prevalence among pregnant women attending ANC stabilised over the last three years at just under 1%. Assessed in two sites, the prevalence of new military recruits has shown considerable fluctuation over recent years (Figure 4).

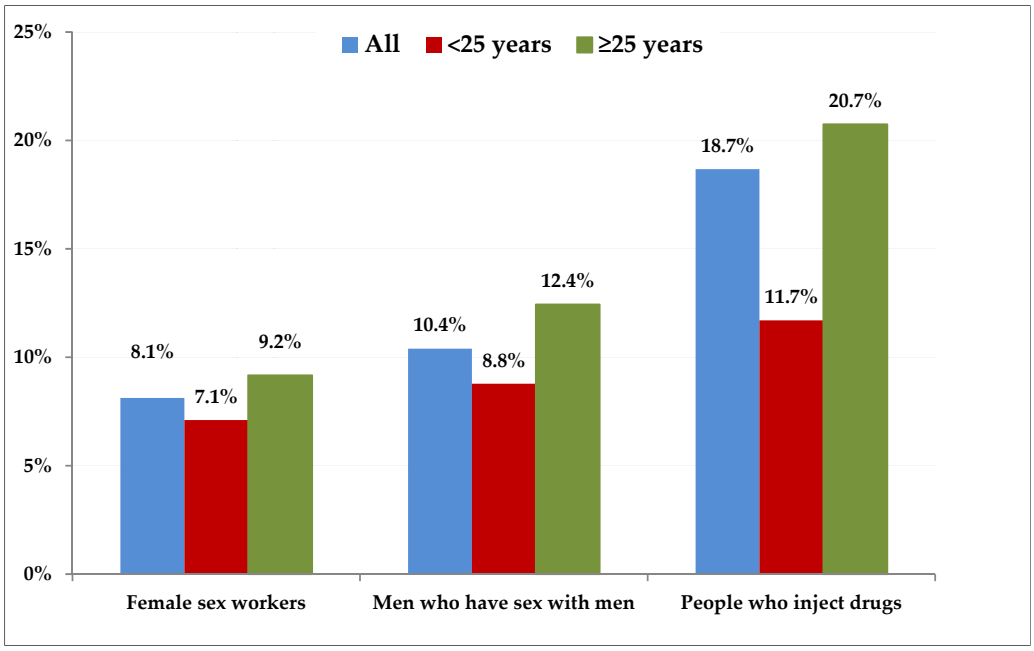
Figure 4: HIV prevalence among pregnant women and new military recruits (2007–2013)



Source: HSS 2007–2013, NAP

In 2013, the HIV prevalence in PWID and MSM aged 15–24 was lower than the average (all ages) for these sub-populations (Figure 5). The younger female sex workers had almost the same prevalence as the average.

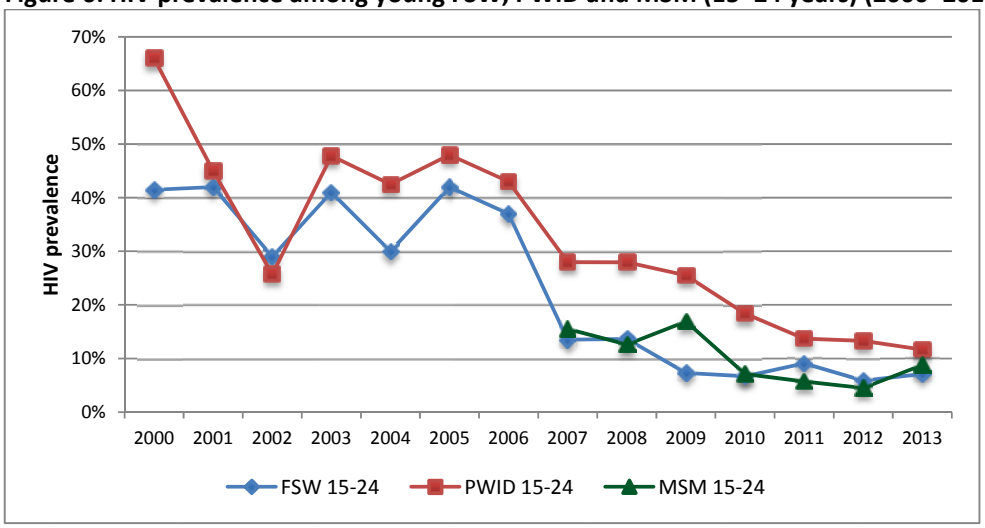
Figure 5: HIV prevalence in key affected populations by age group (2013)



Source: HSS 2013, NAP, March 2014

The HIV prevalence among younger FSW, MSM and PWID continued the downward trend, consistent with the decline in overall prevalence for these groups (Figure 6).

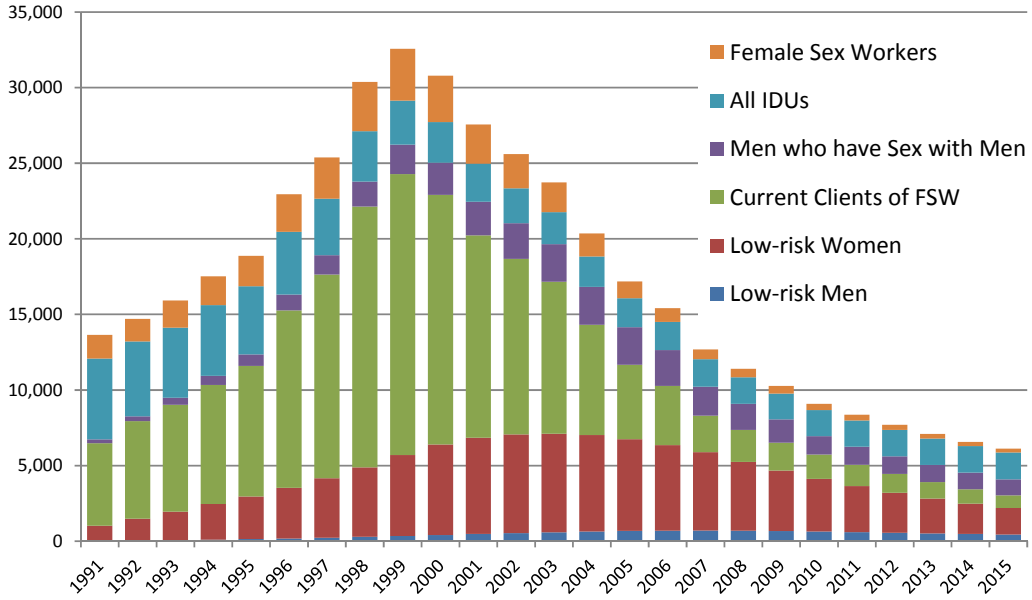
Figure 6: HIV prevalence among young FSW, PWID and MSM (15–24 years) (2000–2013)



Source: HSS 2000–2013, NAP

Myanmar's HIV estimates show that incidence peaked in 1999 (Figure 7). There has been a steady decline of new infections every year since. This trend is projected to continue in future years, provided the service coverage of prevention interventions for key populations at risk remains at minimum at the level of 2010.

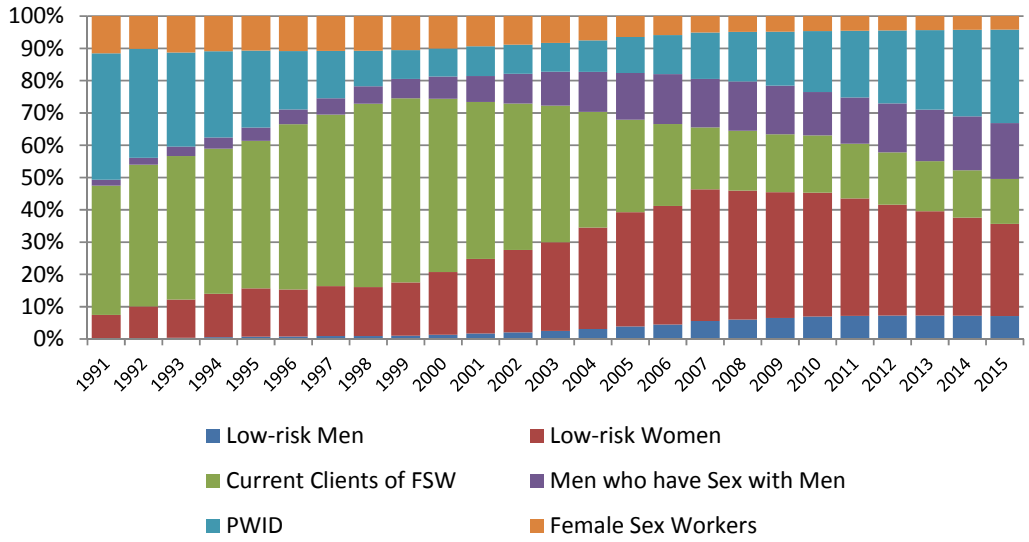
Figure 7: Incidence by key population (1991–2015)



Source: HIV Estimates and Projections Myanmar 2010–2015

Figure 8 shows the considerable shifts in the relative weight of new infections across the years. In the late 1990s, a large proportion of sex workers and their clients were becoming infected. This eventually resulted in a large increase in women being infected by their male partners. After 2010, this pattern shifts again and people who inject drugs and men who have sex with men contributed increasingly to the total of new infections. Low risk women continue to represent a substantial proportion of new infections, but the numbers of new infections per year are also declining.

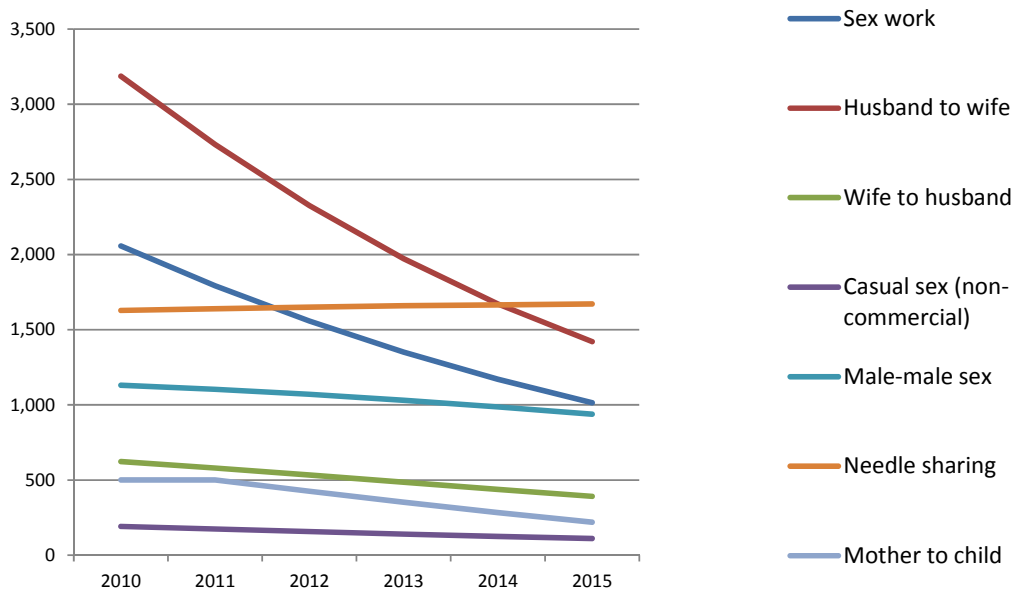
Figure 8 Distribution of new infections among key populations (1991–2015)



Source: HIV Estimates and Projections Myanmar 2010–2015

As demonstrated in Figure 9, sexual transmission was the main route of transmission in 2010, contributing 77% of all new infections. AEM suggests that in 2015, this proportion will have fallen to 67%. Transmission through casual (non-commercial) sex and mother-to-child transmission are relatively small and will fall with general decline in incidence.

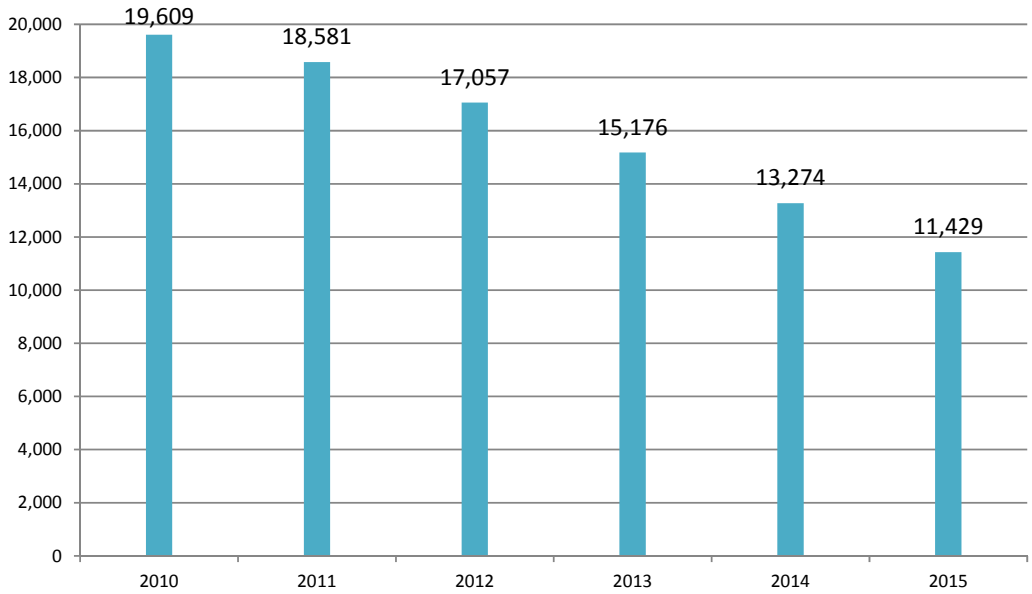
Figure 9: New infections by mode of transmission (2010–2015)



Source: HIV Estimates and Projections Myanmar 2010–2015

Many people continue to die of AIDS-related illnesses, but the number is declining due to recent gains in ART provision (Figure 10).

Figure 10: Number of estimated annual deaths due to AIDS (2010–2015)



Source: HIV Estimates and Projections Myanmar 2010–2015

III. National response to the HIV epidemic

III.1 Policy environment

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

The National Strategic Plan 2011–2016 guides Myanmar's response to the HIV epidemic. The NSP was originally planned until 2015 but was extended to the end of December 2016 to align with the end-date of the Global Fund grant. It emphasises wide participation of stakeholders and identifies and prioritises key affected populations in order to achieve maximum impact. The NAP has solid foundations built on the development of national guidelines, partnership among government, national and international NGOs and private sector, and effective coordination.

Following the Mid-term Review in 2013, the NSP was updated to reflect recommendations made in the Review. These recommendations are aimed at bolstering efforts to achieve the 10 Targets to which the country has committed. The NAP has begun to implement some recommendations. The scale-up and decentralization of HIV counselling and testing and antiretroviral treatment began in 2013, with the country adopting provider-initiated HIV counselling and testing at health facilities and expanding the service to facilities based in and near local communities. This development is expected to eliminate the loss through referral to testing centres outside of these communities, as well as reduce the overall loss through referrals.

Early results are promising. At the end of 2012, 53,709 persons were receiving ART; 13,834 were added in 2013, bringing the total of adults and children receiving ART to 67,643. Myanmar plans to provide ART to 106,058 people in need by 2016.

Myanmar is on track to achieve the goals set in the MDGs and turn around the epidemic. Specifically, the following will have been achieved:

1. New HIV infections are cut by half of the estimated level of 2010, the reduction of new infections of females will be at least equal to overall reduction
    - Less than 5,000 new infections will occur in 2016

2. 86% of people living with HIV, who are eligible, will receive life-saving ARV treatment based on the current national treatment guideline from 2011 (i.e. CD4 count <350/mm^3) with criteria that are non-discriminatory in regard to gender, type of transmission, age, ethnicity and location
    - 119,039 adults and children will be receiving ARV treatment in 2016

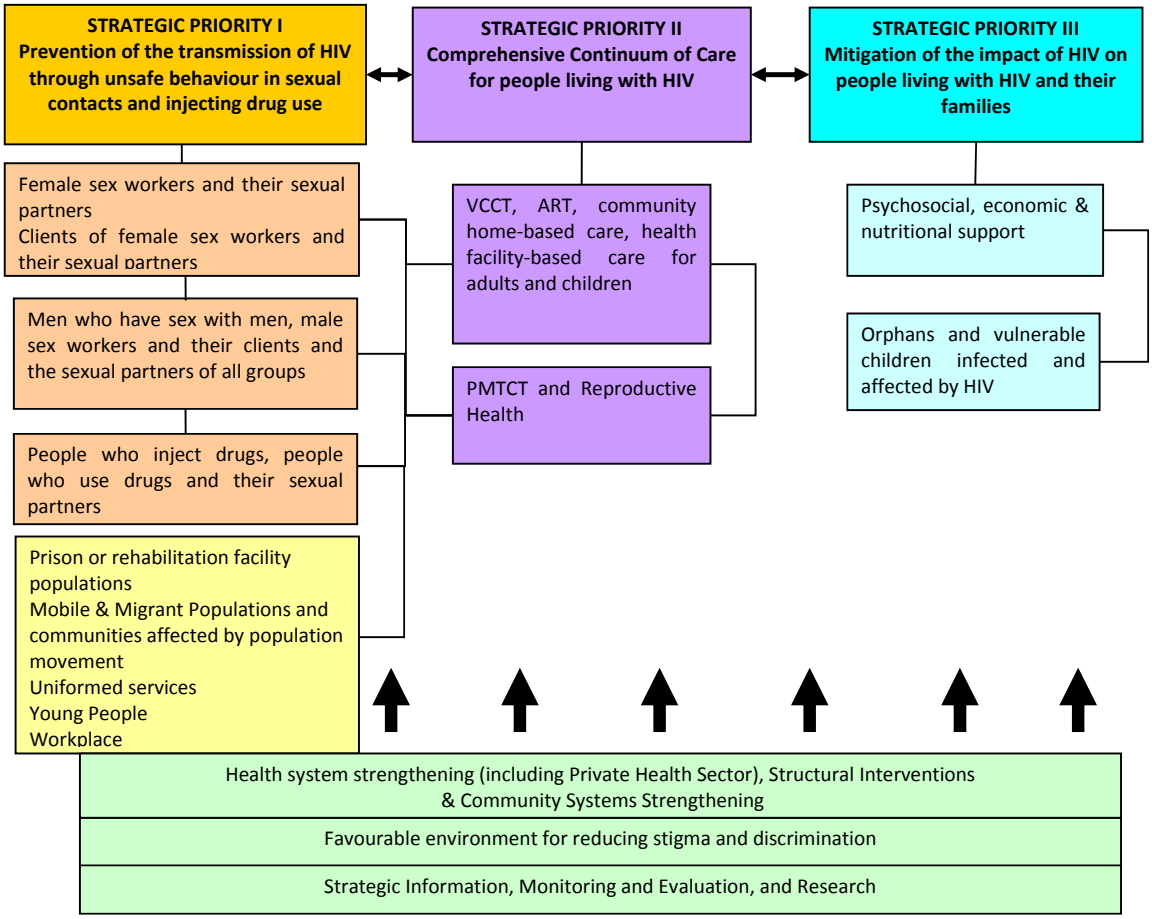
3. More than 80% of pregnant women living with HIV receive antiretroviral prophylaxis to reduce the risk of mother-to-child transmission
    - 3,229 women will receive ARV prophylaxis in 2016

4. Much greater number of people living with HIV or affected by HIV receive support in line with the assessed needs
    - 30,000 people will receive community home-based care in 2016
    - 13,000 orphans and vulnerable children will receive some form of support in 2016

5. Intervention service coverage for key populations at higher risk greatly improved
    - Consistent condom use by female sex workers will be over 97% in 2016

- Consistent condom use by men who have sex with men will be higher than 86.5% in 2016
- More than 80% of people who inject drugs will consistently avoid use of contaminated injection equipment

Figure 11: Priority setting of the National Strategic Plan on HIV and AIDS, Myanmar 2010–2015



III.1.2 Travel

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

III.2 Programme implementation

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

The national response in Myanmar aims to prevent sexual transmission of HIV by targeting FSW and MSM as well as their partners and clients to promote safe sexual behaviours. In 2010, it was estimated that there were around 70,000 FSW and 880,000 clients of FSW in the country and roughly 230,000 MSM.[8]

No new behavioural surveillance data has become available since the last round of reporting. To address this problem of lack of up-to-date data, an assessment of surveillance and population size estimation (PSE) systems was conducted in 2013. The assessment has helped to document the strengths and weaknesses of these systems and to identify areas for improvement. It has acknowledged the notable expansion of the surveillance system and commended efforts undertaken thus far to improve HIV sentinel surveillance (HSS) over the years.

The surveillance assessment recommended that behavioural surveys be regularly repeated and thorough PSE be conducted for all three KAPs. It also suggested conducting PSE in combination with integrated biological and behavioural surveillance (IBBS) surveys. These recommendations were taken into account by NAP and partners, who quickly developed a five-year surveillance and PSE plan. The plan was costed and financial resources were mobilised through the GFATM's NFM grant application mechanism. Implementation of the IBBS and PSE among PWID started in 2013 and results will become available in 2014.

While up-to-date behavioural surveillance data is being produced, routine monitoring data are used to track progress in the expansion of programme coverage. These data show that the coverage of HIV prevention interventions to reduce sexual transmission has dropped in the past two years.[9] The number of FSW reached with such interventions in 2012 was less than that recorded in 2010. The interventions include HIV education and awareness raising activities through outreach, along with the distribution of condoms and referral to HIV counselling and testing (HCT) and STI services. The interventions are conducted especially in several hotspots.

The number of MSM reached by prevention also decreased in the reporting period. The reasons why the coverage of prevention interventions diminished include a drop in funding and also changes in the way this indicator is defined and measured. The MTR suggested that the decrease in coverage of MSM prevention interventions is primarily due to changes made in monitoring and reporting to apply more strictly a head count and avoid double or multiple counting of people reached with a given service.

Harm reduction activities, such as the provision of methadone maintenance treatment (MMT), have instead been significantly scaled up over the past two years. The number of sterile needles and syringes distributed to PWID has also considerably increased since 2010, but the number dropped from 2011 to 2012 because of weakened funding flows for HIV-related interventions.

Behavioural surveillance survey (BSS) data collected among out-of-school youth in 2007 showed that less than half of young women and men aged 15–24 (47.5%) correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV

[8] HIV Estimates and Projections, Asian Epidemiological Model, Myanmar 2010–2015, SI and M&E TWG, 2011.
[9] Mid-Term Review of the Myanmar National Strategic Plan on HIV and AIDS 2011–2015: Consolidation Report, Draft 5 March 2014.

transmission (GARP indicator 1.1).[10] Today, seven years later, it is not possible to know if progress has been made in expanding knowledge related to HIV, as this kind of survey has not been repeated. For the same reason, it is not possible to ascertain changes in the proportion of young people (aged 15–24 years) who have had sexual intercourse before the age of 15 (GARP indicator 1.2). This indicator was 0.66% in 2007.[11]

Surveillance data to measure a change in higher risk sex (GARP indicator 1.3) and on reported condom use in higher risk sex (GARP indicator 1.4) are even older as their source is the 2006 BSS.[12] This survey found 6.63% of respondents reporting that they had had higher risk sex, defined as having had more than one sexual partner in the past 12 months. Among these respondents 43.8% declared they had used a condom during the last time they had sexual intercourse. A Demographic and Health Survey (DHS) is planned for the first time in Myanmar in 2014–2015 and this will generate new data to measure these GARP indicators.

Based on the projected modes of transmission from 2010, the 2013 MTR concluded that progress to reduce prevalence in FSW by 50% by 2015 is on track, but that it is not on track for MSM (Figure 8).[13] The modelling shows that new infections among MSM are falling much more slowly, at a pace that needs to be accelerated if the MSM-related target is to be met by 2015.

A considerable scale-up of efforts to prevent sexual transmission of HIV has begun in the second half of 2013, after Myanmar was awarded new funding from the GFATM. These efforts should accelerate in the coming years with a larger pool of financial resources available. Interventions are being scaled up for MSM and increasing efforts are being made reach hidden MSM.

Special attention is now focused on promoting early HIV testing and enrolment in treatment to improve treatment and prevention outcomes. Plans are being made to fine tune efforts to target the clients and partners of FSW and MSM. Interventions to reduce stigma and discrimination and create a more enabling environment for the implementation of prevention among key affected populations are ongoing but need significant political support. Improved collaboration and coordination by stakeholders at national and sub-national levels remains an important aim. Capacity strengthening and involvement of community networks in the planning, implementation and monitoring of interventions for KAPs is gaining momentum but needs to be highly prioritised.

More robust strategic information to more effectively target prevention efforts at KAPs and at their sexual partners is expected to become available early 2015 from the IBBS and PSE that currently are being conducted among PWID. The planning and preparation of IBBS and PSE among FSW and MSM will begin in the second half of 2014 and the results are expected in early 2016.

There is also no new behavioural surveillance data available to measure progress made in recent years on the promotion of HIV counselling and testing (HCT). Data from the 2006 BSS in general population found a testing rate of 11.3% among respondents.

[10] 2007 BSS Out of School Youth, NAP, 2008.
[11] Ibid
[12] 2006 BSS General Population, NAP, 2007.
[13] Mid-Term Review of the Myanmar National Strategic Plan on HIV and AIDS 2011–2015: Consolidation Report, Draft, 5 March 2014.

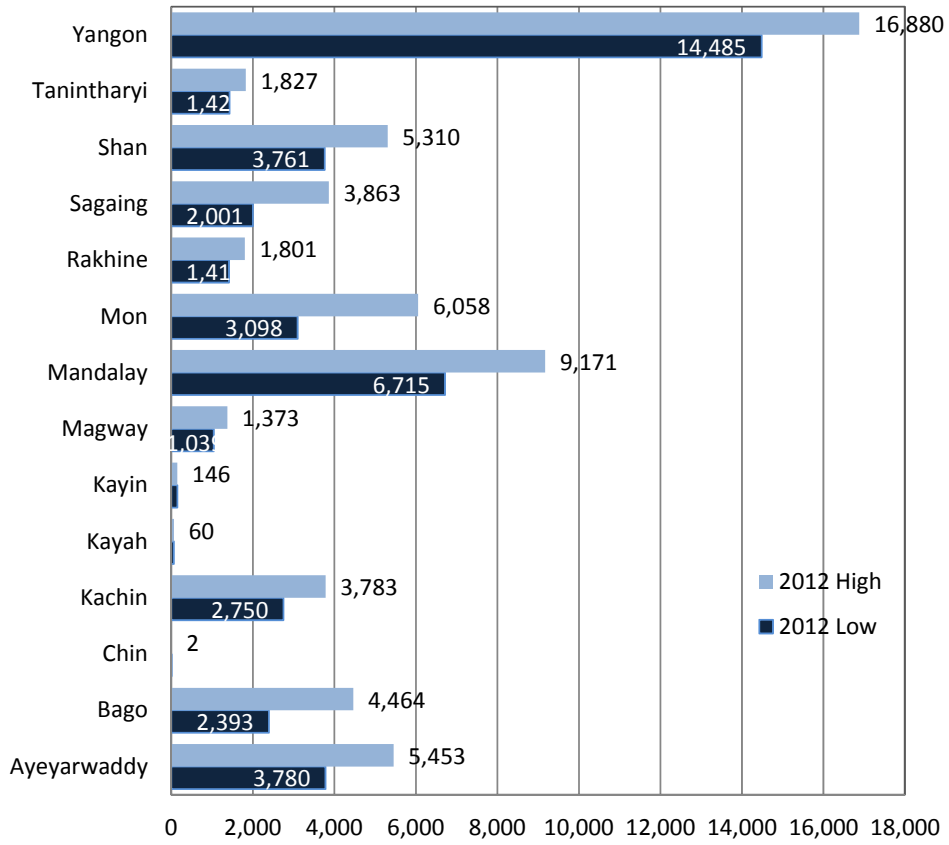
While routine monitoring data on HCT are not comprehensive, they can provide an indication of trends. Data from NGOs working with KAPs suggest that HCT uptake dropped between 2012 and 2013 – a trend which has developed since 2008.[14]

HCT uptake remains especially low among KAPs and results in late enrolment of people in need in HIV treatment programmes. One of the problems has been that an insufficient number of NGOs are allowed to provide testing services. This bottleneck will hopefully be overcome in 2014, as in the context of decentralization of testing and treatment and the introduction of rapid HIV tests, NGOs will be trained to provide HCT on a much larger scale and also in hard-to-reach areas of the country.

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

Most recent surveillance data available to measure GARP indicator 1.7 is from 2008 and shows that 76.2% of FSW were reached by HIV prevention programmes. In the absence of more up-to-date information, routine monitoring data were used. These show that coverage of prevention programmes for FSW has reduced in the past two years.

Figure 12: Female sex workers reached by state and region (2012)[15]



Source: Progress Report 2011, NAP 2012

[14] Ibid

[15] Since in some geographical areas more than one organisation may be providing services and because of mobility or migration there usually is some double-counting of individuals reached by interventions. This issue has been dealt with in this report like in the past to allow for comparisons over time. The figure recorded under "Low" constitutes the number of individuals in each township reached by only the organisation that reported to have reached the largest number of individuals. The number reflected under "High" represents the sum of all of the individuals reached by all of the organisations in a given township.

Prevention targeted at FSW continues to involve HIV education and awareness raising activities in drop-in centres (DIC) and through outreach programmes. Free condoms are also provided to this group. In 2012, a total of 38 million condoms were distributed, compared to 35 million in 2011, either free of charge or through social marketing, which is 7 million fewer than distributed in 2010.

It is unknown if condom use rates (GARP indicator 1.8) have improved in recent times as a consequence of condom distribution programmes, as these data can only be obtained from a survey targeting people who are meant to use condoms. BSS 2008 found a condom use rate of 95.9% among FSW, which seems too high to be realistic. It could be explained by desirability bias, which means that respondents in a survey tend to answer questions in a way that they think will be viewed favourably by the interviewer.

In addition, HCT and STI screening services are offered to FSW either by service providers themselves or through referral. In 2013, the contents of the prevention package for FSW were defined in quite some detail. Discussions were led by a large group of different stakeholders to determine a minimum set of services that all FSW should be able to access. The guidelines and definitions will be useful for costing as well as monitoring and reporting purposes.

HIV prevalence among FSW was 8.1% in 2013, down from 9.4% in 2011 and 18.4% in 2008.[16] The HIV prevalence among young FSW (aged 15–24 years) was 7.1%, only marginally lower than the average, which confirms the need for interventions that target young people.

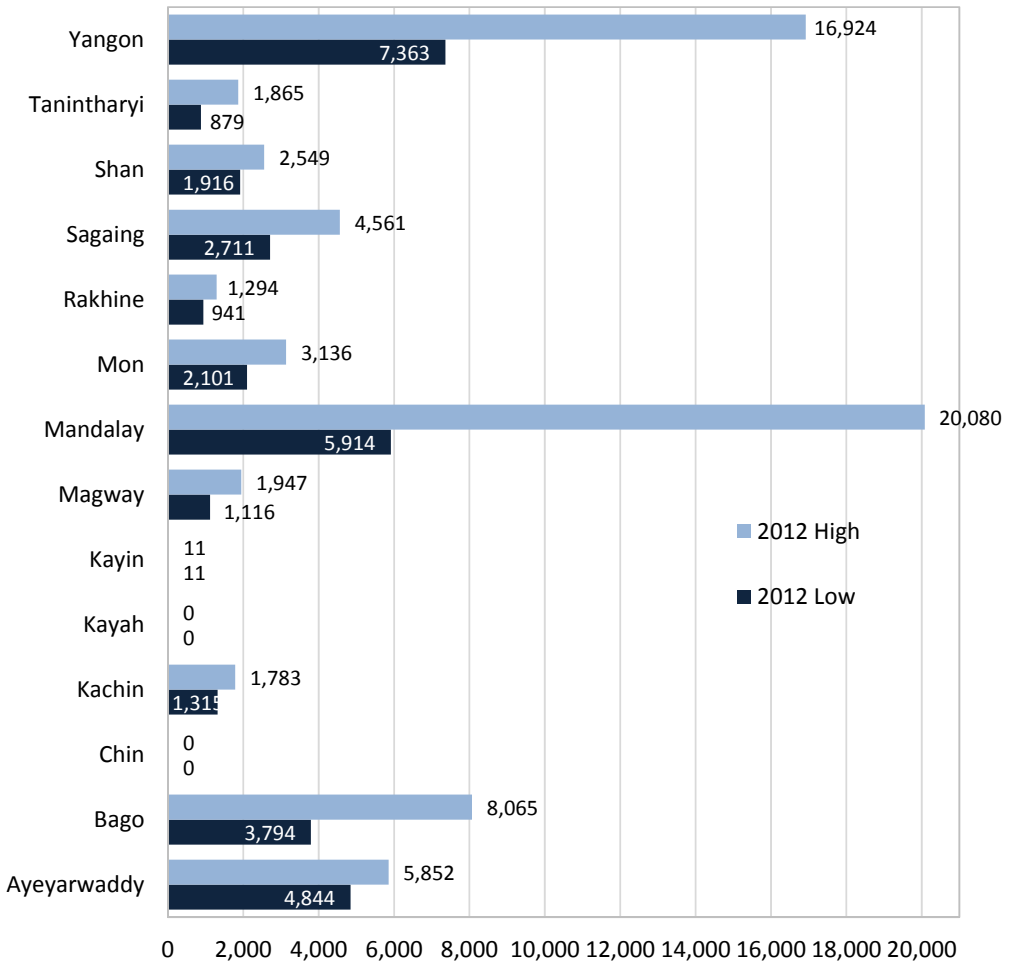
III.2.1.2 Men who have sex with men

There also is no new behavioural surveillance data yet to measure progress made through the scale-up of the coverage of interventions targeted at MSM. The 2009 IBBS found that 69.1% of respondents had been reached with HIV prevention programmes, according to the definition of GARP indicator 1.11.

Data from routine monitoring has shown a decrease in the last two years, although the coverage grew overall compared to seven years ago. The greatest numbers of MSM reached by prevention interventions were in Yangon and Mandalay.

[16] HSS 2008, 2011, 2012 NAP.

Figure 13: Men who have sex with men reached by state and region (2012)



Source: Progress Report 2012, NAP

In the 2009 IBBS among MSM, the use of a condom at the last time they had anal sex with a male partner, was reported by 81.6% of respondents (GARP indicator 1.12).[17] As in the case of FSW, this condom use rate seems unrealistically high, which may be due to the desirability bias that often occurs in interviews. HIV testing was 27.3% in the 2009 IBBS (GARP indicator 1.13). The current situation is not known as new data to measure this indicator has yet to become available.

Routine monitoring data shows that HIV testing among MSM increased in the reporting period.[18] It increased by 83% compared to 2010, but the rate is still far from the target set in the NSP II. This is why the MTR recommended a much stronger focus on promoting HIV testing among MSM as well as in other KAPs. The decentralization of counselling and testing in the coming years should facilitate achievement of the target, but more will also need to be done to address

[17] IBBS 2009 MSM, NAP.
[18] Mid-Term Review of the Myanmar National Strategic Plan on HIV and AIDS 2011–2015: Consolidation Report, Draft 5 March 2014.

stigma and discrimination in facilities and the communities at large in order to reach hidden MSM.

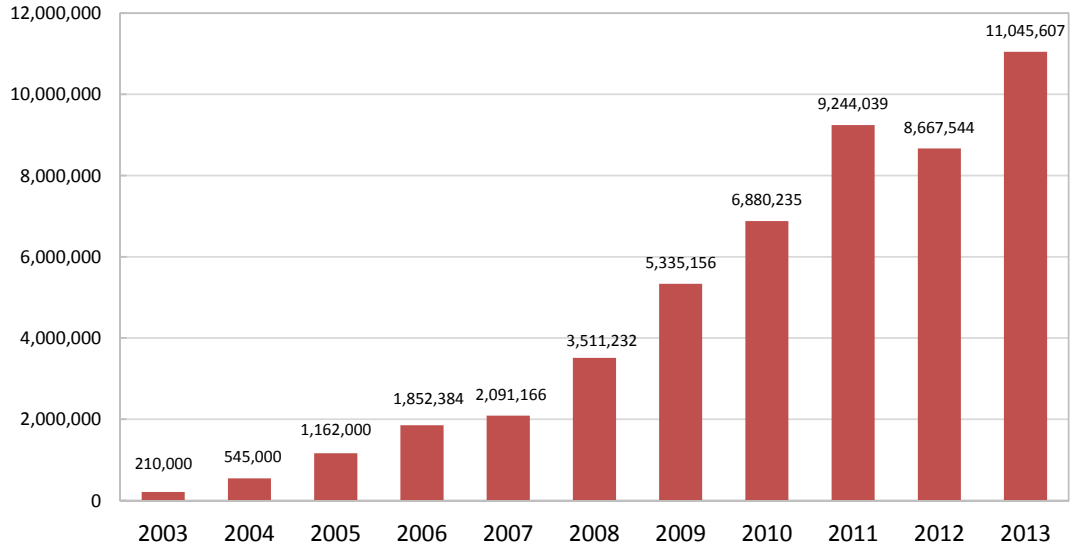
The HIV prevalence in MSM as recorded by the 2013 HSS remains high at 10.4% (GARP indicator 1.14). This is higher than the HIV prevalence recorded in 2011 (7.8%), but slightly lower than that from 2010 (11%). The HIV prevalence among younger men who have sex with men (aged 15–24 years) was only slightly lower than the average at 8.8% in 2013. More robust data is needed to analyse the situation of the epidemic among younger age groups, and the 2014–2015 IBBS among MSM and FSW will provide an opportunity to gather data needed for this purpose.

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

Increasing efforts have been made to reduce new infections among PWID, who are concentrated in the north-east of the country where opium production is widespread. However, injecting drug use is both an urban and a rural phenomenon in Myanmar, requiring a wide geographical coverage of prevention interventions, which has been difficult to achieve in rural, mining and border areas where large numbers of PWID are present. In HSS 2013, HIV prevalence in PWID was 18.7%, ranging from 5.4% to 35.5% across survey sites (GARP indicator 2.5).[19]

Progress in improving the coverage of prevention programmes for PWID in GARP reporting is measured through the number of needles and syringes distributed per person who injects drugs per year. This number in 2013 was 147, up from 118 in the last reporting round. The number of sterile needles and syringes distributed to PWID increased from 8.7 million in 2010 to over 11 million in 2013. Needle and syringe distribution has grown twentyfold since 2004 when only 545,000 needles and syringes were distributed.

Figure 14: Number of sterile needles and syringes distributed in Myanmar (2003–2013)



Source: National Progress Reports, NAP

New behavioural surveillance data that is needed to assess trends in condom use by PWID will become available later this year. In the 2007 BSS among PWID, 77.6% of respondents claimed to

[19]

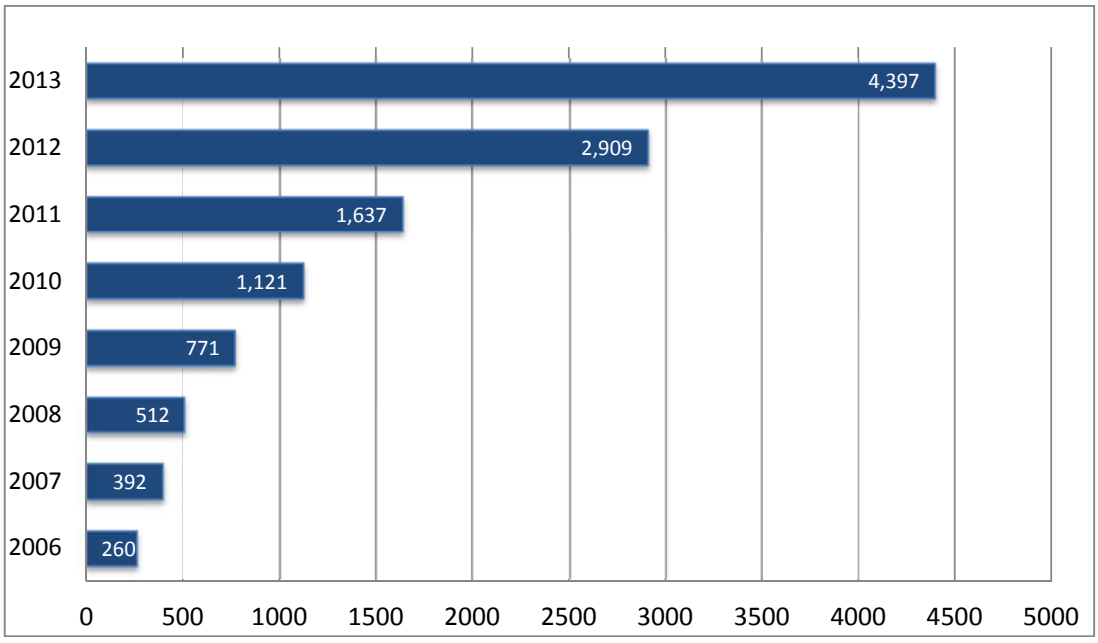
use condoms consistently (GARP indicator 2.2).[20] This level of condom use seems rather high and could be explained by the desirability bias occurring in surveys. It will be interesting to see if these earlier results are reconfirmed by the current IBBS among PWID.

The percentage of PWID who reported use of sterile injecting equipment the last time they injected was 80.6% in 2007 (GARP indicator 2.3). HIV testing among PWID that year was very low at only 27.3%. Much higher uptake of HIV counselling and testing by PWID will be required to prevent new infections and avert AIDS-related deaths in this group.

Information gathered through regular monitoring of programme outputs shows that the provision of sterile needles and syringes, MMT, HIV education and distribution of condoms, and other services for PWID have expanded significantly in the last two years. This demonstrates the growing coverage of HIV prevention and harm reduction programmes for PWID.

The number of patients on MMT has increased by roughly 70% from 2012 to 2013 with an average dose of 60–80 milligrams of methadone offered daily in 18 sites in 16 townships across the country. This number has increased substantially since the programme started in 2006, growing from 1,637 in 2011 to 4,397 in 2013 (Figure 15). Despite the successful scale-up of this opioid substitution programme, the 2013 MTR concluded that in order to achieve a meaningful reduction of new HIV infections among PWID, a greater expansion of the MMT and sterile needles and syringes programmes is needed.

Figure 15: People on methadone treatment (2006–2013)



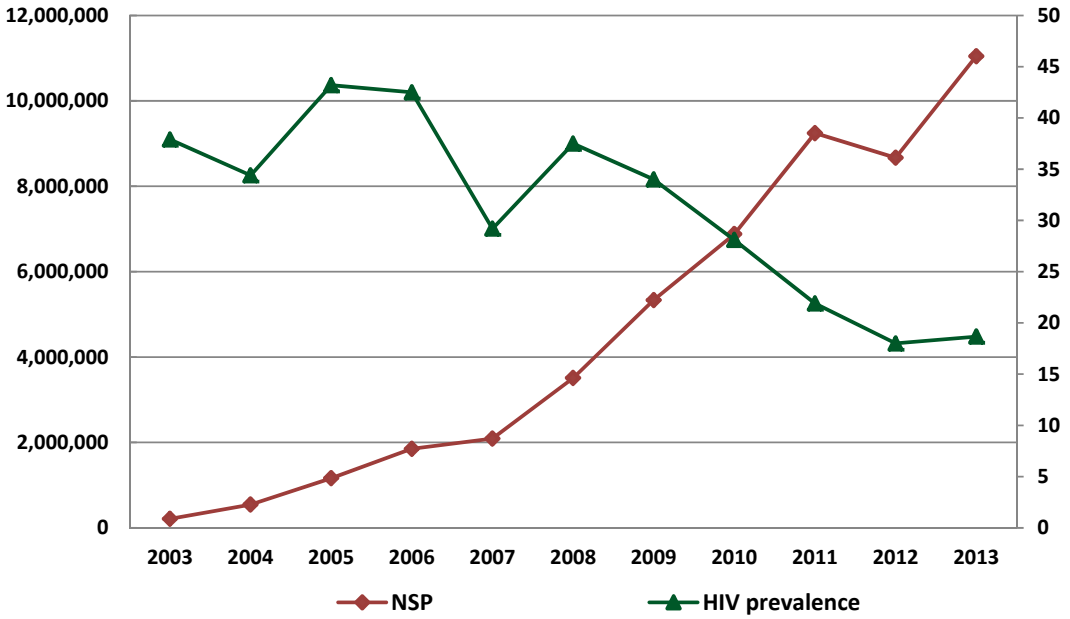
Source: National Progress Reports (NAP)

There is in inverse relationship between the distribution (and use) of sterile needles and syringes and HIV transmission. Figure 16 shows the increasing number of injecting equipment distributed and falling HIV infection rates among PWID. In 2010, the HIV prevalence in PWID was measured

[20] BSS 2007 PWID and FSW, NAP.

at less than 30%. Prevalence has fallen to 18.7% in 2013 from the peak in 2008, suggesting that the prevention efforts are showing some results. However, HIV prevalence remains high in PWID and is the highest among the key affected populations, with pockets of very high prevalence in geographical areas where it remains difficult to provide adequate HIV prevention and treatment services.

Figure 16: Needle and syringe distribution and HIV prevalence among PWID (2003–2013)



Source: HSS and National Progress Reports, NAP

Strong political commitment and significant investments will be required to reverse this situation. Availability of GFATM and 3MDG funding to address this challenge presents new opportunities in this regard. However, the main challenge is to expand services in hard-to-reach areas where there is conflict and lack of security. Many PWID are concentrated in these areas and their access to vital services is very limited. New providers are needed to help deliver services to PWID and a more enabling environment for the delivery of services for PWID is also necessary.

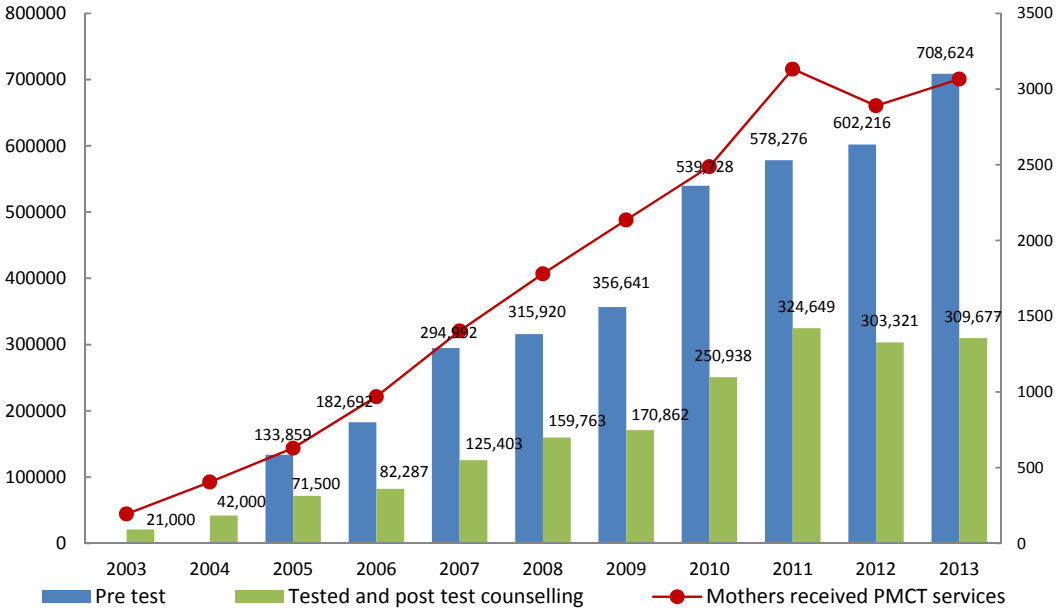
III.2.2 Strategic Priority II: Comprehensive continuum of care for people living with HIV

III.2.2.1 Prevention of mother-to-child transmission of HIV

Myanmar is committed to eliminating new infections among children, and progress is on track to achieve this target. The percentage of HIV-positive pregnant women who received ARV prophylaxis to reduce the risk of mother-to-child transmission reached 90.2% by the end of 2013, according to indicator calculations based on estimates of the number of pregnant women who are in need of ARV medication (GARP indicator 3.1).

This PMTCT indicator value seems too high, which is probably due to an underestimation of the number of pregnant women in need of ARV prophylaxis.[21] This indicator measurement represents an increase of 68% in the reporting period, which is unlikely considering the low HIV testing rates and the large numbers of pregnant women who decide not to get tested for HIV or do not come back to get the results of their test.

Figure 17: HIV counselling for pregnant women and ARV prophylaxis (2003–2013)



Source: National Progress Reports, NAP

While there has been progress in the number of women accessing HIV testing and getting test results, much remains to be done to promote this practice. In 2013, the number of pregnant women accessing antenatal care (ANC) services who received pre-test HIV counselling was 708,620. Of these women, 364,445 accepted to get tested for HIV and 309,677 of those who took the test received the test results along with post-test counselling. This shows that much more needs to be done to improve the quality of pre-test HIV counselling and to ensure that pregnant women who take a test get their results.

Data to calculate the percentage of infants born to HIV-positive women that received a virological test for HIV infection within two months of birth (GARP indicator 3.2) are not available as tests are not always conducted within two months. In 2013, 598 infants were tested for HIV, which also includes infants tested at over two months of age.

The decentralization and expansion of HIV testing, which is to be integrated in all ANC settings nationwide, is expected to facilitate further progress. Capacity building and health systems strengthening are also important areas that need to be addressed. Greater investments will also be required to improve the links and referral between HIV, sexual and reproductive health and

[21] This estimation comes from the 2010 HIV Estimates and Projections, AEM Myanmar 2010-2015.

maternal and child health services, which will also contribute to strengthening health systems in general.

III.2.2.2 Care, treatment and support

At the end of 2013, 67,643 persons were receiving ART (GARP indicator 4.1). This represented 54% of all those in need of treatment as specified in national treatment guidelines.[22] 45% of the people on treatment were females and 7% were children aged 0 to 14 years.

Figure 18: Number of people receiving ART (2005–2013)

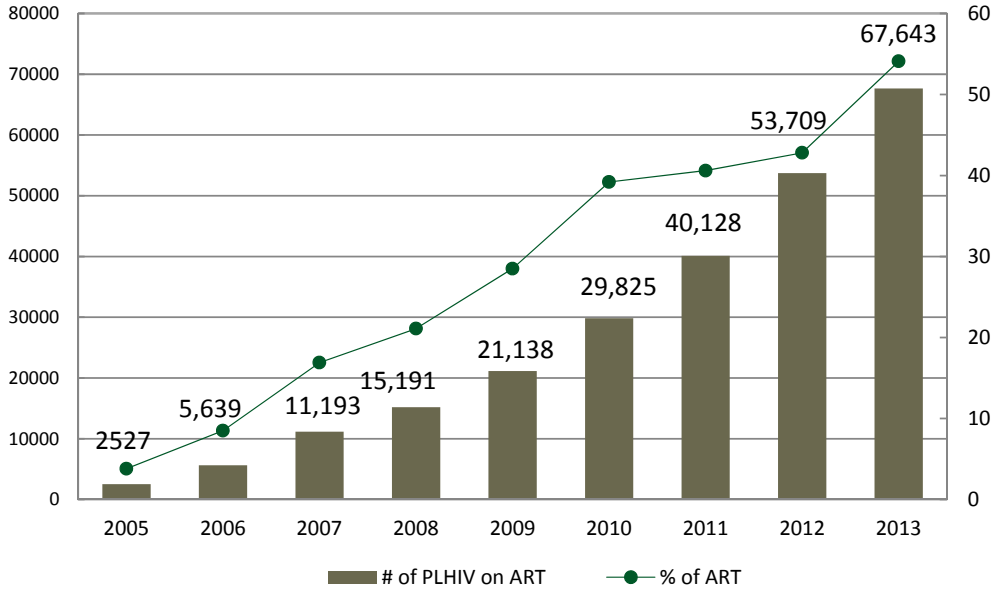


Table 2: Number of people receiving ART (2012 and 2013)

	Adults (15+ yrs)		Children (<15 yrs)		Total
	Male	Female	Male	Female	
Dec 2013	34,216	28,502	2,562	2,363	67,693
Dec 2012	27,361	22,315	2,111	1,922	53,709

Source: ART routine monitoring, NAP, 2012 and 2013

In terms of geographical coverage, by the end of 2013, 147 sites were providing ART across almost all of the states and regions of the country, compared to 57 sites in 2008. Out of the 147 ART sites, 100 were providing paediatric ART.

[22] In 2013, the nationally approved treatment protocol (following WHO/UNAIDS standards) stipulated that all PLHIV with CD4 cell count of less than or equal to 350 were eligible to receive ART free of charge.

Cohort data assembled by the NAP from various ART providers were used to calculate the percentage of people who were still known to be on ART 12, 24 and 60 months after they started (GARP indicators 4.2a, 4.2b and 4.2c).

Table 3: Percentage of people who were still known to be on ART 12, 24 and 60 months after they started treatment

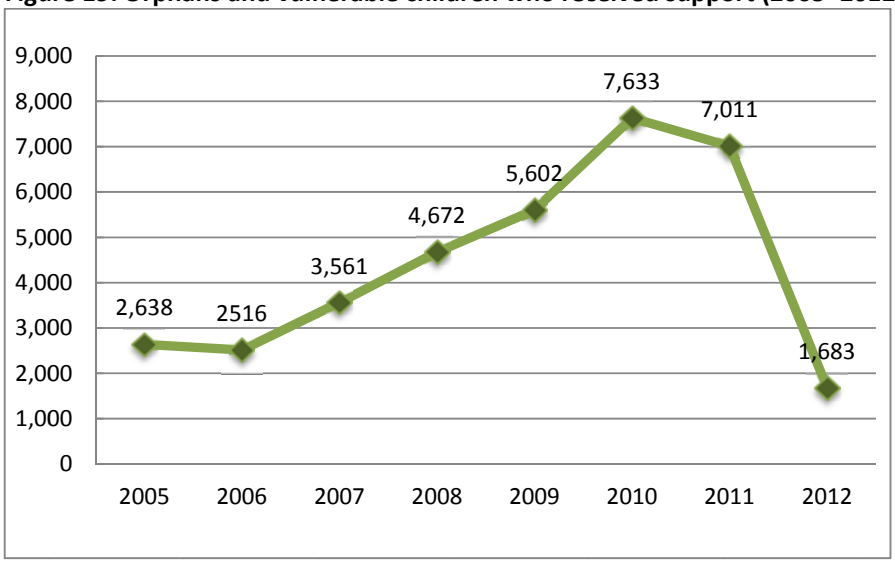
2013	12 months	24 months	60 months
% of people who are still known to be on treatment	84%	80%	76%

The percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV (GARP indicator 5.1) could not be calculated, because there is no estimation of the total number of TB-HIV co-infected people in Myanmar. However, in 2013, 3,911 adults and children with HIV infection who received ART were started on TB treatment (in accordance with national TB programme guidelines).

III.2.3 Strategic Priority III: Mitigating the impact of HIV on people living with HIV and their families

Care and support for PLHIV and their families as well as orphans and vulnerable children (OVC) dropped significantly in the present reporting period. Whereas in 2010, 7,633 OVC received support, in 2012 the number was only 1,683. This represents a reduction of almost three quarters. Again, the reason why these programmes shrank so significantly may be due to a reduction in funding in the 2012–2013 biennium. If this is the case, however, there is relatively little chance of seeing an expansion in the reach of programmes in the near future as the NFM grant does not include support for this kind of intervention. In the longer term it is hoped that social protection programmes will be HIV sensitive to cater for the special needs of PLHIV, HIV-affected OVC and their families, a need that the Government acknowledged during the recent MTR.

Figure 19: Orphans and vulnerable children who received support (2005–2012)



Source: National Progress Reports, NAP

IV. Best practices

IV.1 Myanmar National Strategic Plan 2011–2016 (NSP II)

Progress made against the targets set in the NSP II was assessed in the 2013 Mid-Term Review (MTR) by the National AIDS Programme in collaboration with all relevant stakeholders and with support of the UN Joint Team on AIDS. The MTR built on findings of a series of reviews and assessments, which were conducted on different areas of the national response. A consolidation report was prepared with key recommendations for the future.

The results of the MTR have been used to update and improve the NSP. For example, recognizing that the HIV response will not be successful without a supportive, enabling environment, more emphasis was placed on the important cross-cutting issues such as gender, human rights and legal issues following assessments of the situation and needs in each of these areas. Strategies and activities in the areas of prevention, treatment and care have been revised to enable Myanmar to achieve its ambitious targets, while identifying strategic opportunities to integrate HIV into wider health and development efforts. Due attention is given in the revised NSP II to the issues of HIV in humanitarian contexts. The strategic role of nutrition has also been recognised for both ART and TB patients. Interventions for strengthening strategic information were made on the basis of on an assessment of surveillance and population size estimation systems that was carried out in April 2013.

The MTR results and proposed changes to the NSP II were discussed and agreed upon in a national validation meeting. Subsequently, NSP II targets were revisited and adjusted in consultation with members of different technical working groups (TWGs). New costs of the NSP II will be determined in 2014, to inform resource mobilization efforts to fund gaps for critical interventions from 2014 to 2016.

IV.2 Myanmar's Successful Application under GFATM's NFM

Myanmar has not received abundant resources from external partners for its HIV response, compared with countries with similar magnitude HIV epidemic. The Global Fund only resumed its financial contribution to Myanmar in 2010 with Round 9, after it withdrew support in 2005. However, through persistent resource mobilization efforts supported by strategic information on funding gaps, resource needs and standard unit costs, Myanmar succeeded in being the first country in the Asia Pacific region to access the GF New Funding Model. The proposal development process is a good practice model – participatory, consultative approach working with key partners from all constituencies: government, UN, NGO, INGO, civil society, PLHIV and KAPs.

A total of US$ 161 million have been secured from GFATM through the New Funding Model application especially for the scale-up of treatment and care, decentralisation of HIV counselling and testing and expansion of prevention programmes among PWID. However, there remain significant gaps for prevention, especially for female sex workers, men who have sex with men, transgender persons and clients of sex workers.

IV.3 Myanmar's Health Sector Coordinating Committee

Since the transition period started in 2011 in Myanmar, there has been increased interest and pledges of support from donors around various issues including health. Responding to the need to strengthen coordination in the health sector, the Minister for Health recommended that the Myanmar Country Coordinating Mechanism (M-CCM) that was set up as the Global Fund country coordinating and oversight body for AIDS, TB and malaria be transformed into the Myanmar Health Sector Coordination Committee (M-HSCC) to look at the whole health sector. In September 2013, the M-HSCC met for the first time.

The Committee maintains its multi-sector, multi-constituency format, with members from government, bilateral agencies, development partners, NGOs and people living with the diseases. The Minister for Health chairs the Committee. With its expansion, a new governance manual has been endorsed and outlines the governing and operational procedures for the M-HSCC and its Technical and Strategy Groups.[23] As with the M-CCM, UNAIDS also provides technical support to the M-HSCC (through financial support from GFATM and the United States government).

The M-HSCC is a good model of health sector coordination leading to enhanced integration of HIV with other health issues, taking AIDS out of isolation.

IV.4 Strategic Information and M&E Working Group

The SI and M&E TWG was established in 2010 to provide technical advice and to support the collection and use of data from multiple sources. In the last 18 months, it has considerably expanded and its work has gained momentum, as interest of partners in SI-related issues has grown and new opportunities for surveillance and M&E system strengthening have presented.

The TWG has served as an effective planning, coordination and monitoring platform to guide key tasks: assessment of SI and data needs including for MTRs; development of surveillance and M&E system strengthening plans and related resource mobilization; revisions of HIV estimates and projections by using the AIDS Epidemiological Model (AEM) and Spectrum; harmonisation of HIV and AIDS indicators and reporting procedures; sharing and use of strategic information; and production of reports and publications. The TWG also reviewed HIV research and studies.

[23] There are now seven TSGs: (1) HIV; (2) Malaria; (3) TB; (4) RHMNCH; (5) Health Systems Strengthening; (6) Public Health and Emergency Preparedness; (7) Strategic Information and M&E

V. Major challenges and remedial actions

V.1 Health system strengthening

One of the greatest challenges that needs to be overcome if Myanmar is to reach the targets set for 2016 remains the shortage of health personnel in the public sector. This problem impedes the Government's capacity to deliver the services that are required to avert new HIV infections and AIDS-related deaths. It has grown even more acute in the current context of decentralization of HIV counselling and testing and of treatment and the growing shift of ART patients from NGOs to public services. It is hoped that the new initiative launched by the President of Myanmar in January 2014 to reform the health sector will prioritize human resources for health at all levels. The World Bank's commitment to support Myanmar in reaching its vision of Universal Health Coverage by 2030 is also an opportunity to address to this need.

Concretely, in the area of HIV it is anticipated that capacity of health personnel will need to be strengthened over the coming years and viable task-shifting strategies have to be developed. The transfer of non-specialized medical tasks from health staff to specifically trained lay persons has been recommended in the previous GARP report, as well as by the 2013 ART review that was conducted with the help of high level national and international experts. These recommendations have already started to be implemented.

Another priority is the development of capacity of the NAP and its AIDS/STD Teams operating at the township level. A multi-pronged capacity development strategy and plan will be needed following an assessment of needs and priorities to ensure impact of training efforts. These will focus on several skills and competencies including management, strategic planning, M&E and procurement and supply management (PSM). While the new funding from GFATM provides enough financial resources to procure ARV drugs and medical supplies, PSM systems and capacity need strengthening to ensure life-saving medicines are regularly available where needed. More rigorous assessment of needs and strategic planning will be required at all levels by promoting a better use of evidence.

The 2013 MTR process has brought many stakeholders together to review progress, discuss achievements and challenges. Many valid recommendations have been formulated and some have already been adopted. In the coming two years, the focus should be on the implementation of these recommendations to ensure targets and commitments are met.

V.2 Policy and legal frameworks

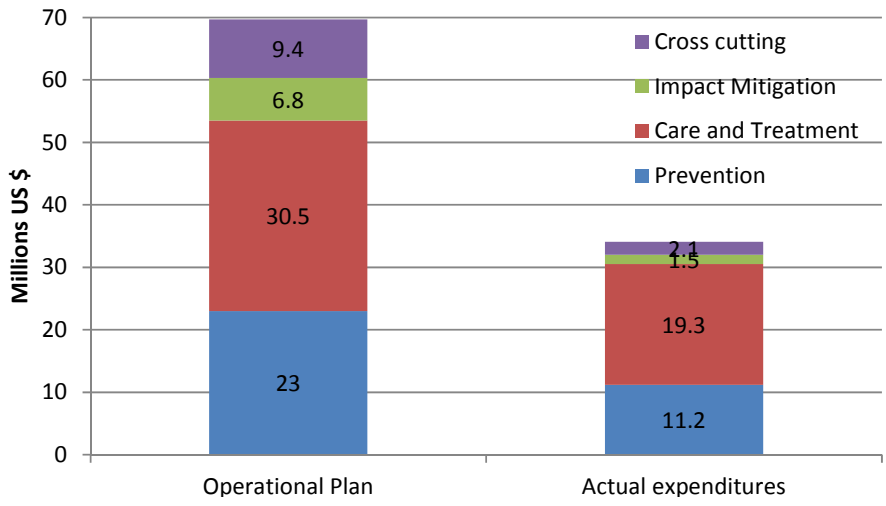
In the last biennium, the Parliament started reviewing a number of laws, but revision of many has yet to be completed. A comprehensive legal review was carried out in 2013 as part of the MTR of the NSP and concluded that there are still are many laws that hamper the national response to HIV. The NCPI Part B included in this report confirms this assessment. Although diminishing, stigma and discrimination against PLHIV and KAPs persist. Behaviours of key affected populations are illegal and therefore, sex workers, MSM and people who inject drugs are often harassed and arrested. More needs to be done to advocate for acceptance and tolerance and adopt a public health approach to protect the community, which includes

members of the key affected populations. As part of the MTR of the NSP, a new technical working group focusing on Human Rights and Gender has been established to develop a workplan to follow-up on reviewing policy environment and drafting laws to protect people living with HIV and key affected population groups from discrimination and harassment.

V.3 Closing the financial resource gap

When the NSP II was developed in 2010 it was also costed. The resource need was updated in 2012 following revisions to the NSP Operational Plan. The total resource needs for HIV-related interventions in 2012 were estimated at US$ 69.7 million, compared to the total expenditure of US$ 38 million. This means there was a resource gap of 45% of total resources needed for the national response.

Figure 20: HIV resource needs and actual expenditure by spending category (2012)



Source: Progress Report 2012, NAP

In 2012, US$ 9.7 million were spent on HIV prevention for KAPs including FSW and clients, MSM and PWID. This constituted 87% of total HIV prevention expenditure. Spending on prevention interventions has declined both in absolute and proportional terms.

Table 4: Prevention expenditure and needs for key affected populations, 2011–2012

KAP	Actual expenditure 2011 (US$ m)	Estimated resource need 2012 (US$ m)	Actual expenditure 2012 (US$ m)	% difference between 2011 and 2012 actual	% difference between 2012 actual & resource need
PWID	4.4	6.7	3.5	- 20	- 48
MSM	3	4.1	2.6	- 13	- 37
FSW and clients	5.6	7.3	3.6	- 36	- 51

Source: Mid-Term Review of the Myanmar NSP on HIV and AIDS 2011–2015: Consolidation Report, Draft

Both in 2011 and in 2012, there were considerable gaps in funding for prevention. There has not been enough continuity and predictability in resource flows, which resulted in a significant drop in coverage of prevention programmes. While the treatment programme needs to be fully funded, it is equally important to continue to have programmes to prevent new HIV infections in order to avoid long-term costs for putting more people on life-long treatment.

ART is currently almost entirely funded by the GFATM. The reliance of one single donor source for the care of several thousands of people requiring life-long treatment is risky. Gradually, the Government must take on greater responsibility in providing ARV and treatment for opportunistic infections to people living with HIV. This is possible as was already demonstrated in 2013, when the government increased its financial contribution to the HIV response. While currently only two per cent of GDP is allocated to health, public health expenditure has increased four-fold and the Government has pledged commitment to increase it further to reach five per cent of GDP.

V.4 Community systems strengthening

With an increasing role in the national response to the HIV epidemic, civil society organizations (CSO) have higher expectations for representation, but their full participation in decisions concerning funding opportunities, planning and coordination is not always guaranteed. Civil society organizations currently have four representatives on the Myanmar Health Sector Coordinating Committee. The HIV Technical and Strategy Group is also open to all interested parties to attend and welcomes participation from CSO and key affected populations.

For the first time in 2013, under the HIV GF New Funding Model grant, community systems strengthening and human rights components were included and approved for funding. As part of the rapidly changing environment in Myanmar, CSOs and people living with HIV have also managed to advocate successfully for the establishment of a Parliamentary Committee on HIV. This Committee is chaired by a Member of Parliament that heads the Parliament Health Upgrading Committee with members from civil society, people living with HIV and UNAIDS.

At the implementation level, some NGOs and CBOs reported difficulties in expanding their services due to the lengthy and complex procedures of negotiating a Memorandum of Understanding (MOU) with the counterpart government authorities. There are also issues related to the perceived sensitivities around certain areas of work. Coordination among all partners and stakeholders including community members, varies widely, depending on the

openness of local authorities to engage with other stakeholders, the capacity of organizations present and willingness regularly to address issues at the local level.

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

VI. Support from the country's development partners

In 2012, a total of US$ 34.1 million were spent on HIV-related interventions from external donors. This was US$ 8.8 million less than the amount spent in the preceding year. The vast majority of these financial resources for the HIV response were managed by UN agencies, bilateral partners, or international NGOs and not by the Government. In 2013, for the first time with the GF New Funding Model grant, the National AIDS Programme became a Sub-Recipient, with funds managed by UNOPS, the Principal Recipient for public sector programmes.

In 2012, the Three Diseases Fund (3DF) for AIDS, TB and malaria – which was established in 2005 to fill the gap following the Global Fund's withdrawal – transitioned into the 3MDG fund, to which donors pledged US$ 300 million over five years, with a new focus on maternal and child health and only around 15% of resources earmarked for AIDS, TB and malaria.

With the closure of the 3DF in 2012, the AIDS response saw a significant drop in financial resources, particularly for HIV prevention and impact mitigation.

Continued resource mobilization efforts in the last two years have resulted in increasing financial contributions for the health sector and HIV in particular from key partners such as the United States Government, 3MDG, the Asian Development Bank and the World Bank.

Donors provide support to the HIV response according to priorities identified in the National Strategic Plan in order to reach the set targets. Indicators to track progress are standardised and described in the National M&E Plan for HIV and AIDS. In 2013, further progress has been made to harmonise indicator definitions and monitoring and reporting mechanisms used by the recipients of GFATM and 3MDG funding, as well as other stakeholders.

Since 2013, NGOs and CBOs have started to receive more funding. This has helped increase their active involvement in the response to HIV, as discussed in the NCPI Part B. The number of organizations working in the HIV sector has increased in recent times.

Myanmar still has no UN Development Assistance Framework, but a Strategic Framework has been developed. The UN is in the process of developing a joint UN Transition Strategy for Myanmar, which will address priority development and security needs of the country. The UNAIDS Cosponsors at country level work through various joint programmes to address priority areas of the National Strategic Plan on HIV and AIDS: scaling up ARV treatment for people living with HIV; ensuring adequate attention is placed on prevention of new HIV infections; scaling up HIV counselling and testing at all levels; as well as improving the enabling environment, particularly ensuring favourable and supportive policy and legislation to protect people living with HIV.

VII. Monitoring and evaluation environment

Myanmar has a National M&E Plan that guides the monitoring and reporting of the national response. It describes the M&E system and includes the reporting tools, data quality insurance, the research agenda and the indicators. The M&E Unit at the NAP is operational and has trained staff. However, M&E and strategic information staffing at national and sub-national level remains insufficient. Routine monitoring systems are becoming stronger, especially through alignment of reporting standards and mechanisms in line with National M&E Guidelines.

Annual and global reports have regularly been produced and submitted in a timely manner (Annual Progress Reports; GAPR and UA reports, etc.) Mid-term reviews have been conducted as planned (MTR of 10 Targets, MTR of NSP II). Data are regularly collected and disseminated, but deficiencies in data analysis and use exist.

Programme expenditures have been assessed annually through annual reporting. A National AIDS Spending Assessment is planned in 2014 as well as a cost study and cost-effectiveness analysis, an effort that will build on work done to produce an investment case. Also a new research agenda will be developed in 2014. An inventory of research done by various GFATM grant sub-recipients has been done in 2013.

At the sub-national level, decentralization of M&E is being rolled out following pilots in two states in 2012. M&E focal points have been identified and trained in a number of townships. These developments should improve the use of data at regional/township level to better understand the epidemic in the local context and tailor interventions accordingly. However, partners continue to report mainly through their central offices in Yangon on an annual basis and feedback of data and information to sub-national level remains insufficient.

VII.1 Oversight

The Technical and Strategy Group – AIDS (TSG) in the M-CCM has oversight responsibilities for coordination and implementation of the AIDS Operational Plan, including ensuring monitoring and evaluating the national response. The TSG delegates technical issues to eight specialist Technical Working Groups, ensuring inclusive consultation and utilization of local expertise. The working groups report findings and recommendations to the TSG to inform decision-making.

VII.2 National AIDS Programme

The mandate to coordinate, monitor and evaluate the national response to AIDS resides with NAP. This is carried out by a central-level M&E Unit in the NAP with responsibility to manage data, including dissemination of results to partners and stakeholders. An Assistant Director and support staff carry out the functions. These functions include data collection from all partners in the national response – including other ministries, public institutions and organizations – as well as gathering the routine data generated by the National AIDS Programme's AIDS/STD teams. The M&E Unit also oversees reviews and evaluations to measure programme outcomes and leads the surveillance, population size estimations and other research activities.

VII.3 State or Region, District and Township levels

State, regional and township AIDS/STD Teams were established by the NAP and also have the responsibility to lead on M&E at the corresponding levels. These teams coordinate the response to HIV in the public and NGOs sectors. They are also responsible for monitoring programme

activities implemented by different organizations including from the public sector, NGOs, CBOs and the private sector operating at the district and township levels, then report to the central M&E Unit at NAP. Certain data, such as those on ART, PMTCT and HCT, must be collected on a quarterly basis from the health care providers and reported through the AIDS/STD Teams and through the Township Medical Officer to the M&E Unit of the NAP where there is no AIDS/STD Team. Once a year the NAP also collects with help of UNAIDS Myanmar a wider range of data from all stakeholders involved in the national response to compile the Annual Progress Reports.

VII.4 NGOs, CBOs and the private sector

Partner NGOs, CBOs and private sector entities have the responsibility for monitoring their own programme activities and outputs. They collect and analyse data, and share the information to the district/township AIDS/STD Teams using the format provided for routine annual reporting.

VII.5 M&E system data flow

Generally, all AIDS/STD Teams and stakeholders implementing HIV programmes are expected to report regularly on programme indicators that are relevant to the activities they undertake. Collecting data for the annual reporting is done regularly with standard forms used to collect field level data. Data from HSS and other national-level surveys are collected under the coordination of the NAP M&E Unit and entered and managed directly at that the central level.

VII.6 Strategic Information and M&E Working Group

Under the chair of the NAP, the SI/M&E TWG coordinates with all HIV service providers to harmonize in-country M&E procedures and to minimize duplication. With guidance from the TSG, the SI/M&E TWG determines strategies, oversees planning and implementation of M&E measures for the national HIV response. The SI/M&E TWG with representatives from different organizations jointly conducted M&E activities, and important findings and feedback are disseminated regularly. These practices will be continued with greater involvement from State/Regional AIDS/STD offices.

To gain political commitment and financial investment in M&E, the NAP actively advocates for M&E among line ministries and within the Government and with donors. Routine and timely dissemination of information outputs including progress reports, surveillance reports and other research studies will ensure that a comprehensive picture of HIV epidemic trends and updates in the national response including achievements, challenges and recommendations for action are available to policy makers, donors and implementers.

VII.7 Information products

Strategic information is necessary to inform the national response. The monitoring and evaluation and reporting of results to meet this requirement is carried out in line with agreed national and global indicator frameworks. The monitoring system aims to make reliable data on the epidemic and the response available to enhance NSP II programme planning. The plan also calls for more rigorous assessments to evaluate the efficacy, efficiency and cost-effectiveness of different programmes.

The following are the main monitoring and evaluation outputs:

1. **National Annual Progress reports** on the implementation of the NSP are prepared with data consolidated from standard reporting formats that are submitted each year by all partners implementing HIV activities. The reporting format includes output as well as process indicators of the national monitoring framework that are included in the NSP M&E framework.

2. **HIV Sentinel Surveillance reports** present the results of annual HIV sentinel surveillance. Though improvements to HSS have been made in recent years through adding new sites and improving sample sizes, a review carried out in 2013 suggested further efforts to strengthen surveillance especially for better representation of KAPs. The IBBS currently being conducted will add data from a wider representation of the targeted communities.

3. **Behavioural Surveillance and Integrated Bio-Behavioural Surveillance survey reports** present behavioural data concerning KAPs. Behavioural surveillance surveys should ideally be conducted every 3–4 years, which has not been the case in Myanmar. This is why two rounds of IBBS together with population size estimations are now planned for each of the KAPs (PWID, MSM and FSW) in the next years. The PWID IBBS/PSE have already started and data are expected at the end of 2014.

4. **Expenditure reports** provide analysis of spending of HIV-related interventions compared to resources that were available in a given year by spending categories and donor sources.

5. **HIV Estimations and Projections.** Myanmar has in 2013 revised the PSE and projections for the key populations to improve on that which was done in 2011 using AEM to model.

6. **Other reports.** Myanmar aims to meet the reporting requirements for the global response to AIDS and produces reports such as this one.

VII.8 Challenges faced

In the MTR, a thematic paper was prepared by members of the SI and M&E TWG that discussed the main achievements and challenges ahead in the strengthening of Strategic Information and M&E systems in Myanmar. The analysis concluded that good progress is being made with improving surveillance and producing updated population size estimations, developing up-to-date HIV estimates and projections, coordinating research and evaluation, and alignment and harmonization of M&E reporting systems.[24]

The review highlighted the following actions that need to be undertaken as a priority in the coming years to accelerate progress:

1. Increase the number of NAP M&E/SI staff at national and sub-national levels.
2. Develop capacity of NAP staff and epidemiologists at national and sub-national levels in implementation and supervision of data collection, analysis and interpretation, and in triangulation and use of data from different sources.
3. Continue decentralization of M&E and sub-national capacity development.
4. Further standardize reporting formats and alignment of reporting practices (e.g. for ART).

5. Expand ART cohort studies and consolidate the use of early warning indicators.

[24] Issue Paper Strategic Information M&E and Research 2013, UNAIDS

6. Strengthen the HIV case reporting system to reduce reliance on prevalence surveys over time.
7. Implement the Three Interlinked Patient Monitoring Systems (3ILPMS) to integrate and strengthen health systems and track patients across several services— HIV/ART, TB, MCH/PMTCT.
8. Expand and strengthen HSS and consider conducting it only every other year.
9. Conduct IBBS together with PSE for each of the KAPs for at least two rounds including in new sites away from services and hard-to-reach hot spots.
10. Measure trends in STI prevalence among key populations and consider integrating with IBBS.
11. Update HIV estimates and projections as new data becomes available, including census data.
12. Develop and implement an HIV research agenda and carry out research on key issues such as uptake of HIV testing, condom use, stigma and discrimination (Stigma Index), HIV spending, unit costs, etc.
13. Conduct evaluation of new intervention models to assess their efficacy and cost-effectiveness, and the final evaluation of the NSP in 2016.
14. Enhance the use of strategic information at all levels including through data triangulation.
15. Strengthen data feedback mechanisms and use of strategic information at sub-national level for planning and the targeting and tailoring of interventions.

Other challenges that remained at the end of 2013 since the last GARP report include weak telecommunication systems, which are still developing. There are relatively few fixed-line telephones, faxes and mobile phones. Internet connectivity is not available in many of the peripheral locations, most of the communication is done by phone and much of the M&E data still has to be carried by hand. It is hoped that the situation will improve in the near future.

Governmental and legal reforms currently under discussion are expected to facilitate the growth of a favourable environment for HIV prevention interventions for KAP and more support for PLHIV. There is a need to improve M&E capacity at the sub-national levels in order to facilitate a better understanding of the epidemic and the response in the different local contexts. Capacity development efforts should focus on states and regions with the greatest pockets of risk behaviour and HIV transmission. A considerable increase of skilled human resources at sub-national levels is needed to carry out all of the M&E, surveillance, size estimation and strategic planning activities that are planned in the coming years.

VIII. Data sources

1. Mid-Term Review of the Myanmar National Strategic Plan on HIV and AIDS 2011–2015: Consolidation Report, Draft 5 March 2014
2. Myanmar National Monitoring & Evaluation Plan on HIV and AIDS 2011–2015
3. Midterm Review of Progress on the Ten Targets in Myanmar, NAP, June 2013
4. HIV Estimates and Projections, Asian Epidemiological Model, Myanmar 2010–2015
5. HIV Sentinel Sero-surveillance 2013, Myanmar, NAP, March 2014
6. HIV Sentinel Sero-surveillance 2012, Myanmar, NAP, February 2013
7. BSS 2007, Out of School Youth, NAP, 2008
8. BSS 2006, General Population, NAP, 2007
9. IBBS 2009, MSM
10. National Treatment Guidelines, NAP
11. National Legal Review Report: Review of Myanmar's legal framework and its affect on access to health and HIV services for people living with HIV and key affected populations, December 2013
12. Issue Paper Strategic Information M&E and Research 2013, UNAIDS